TIME TO ASK
Education that transforms conversations about alcohol use

Addressing Unhealthy Alcohol Use in Maine

A Programmatic Evaluation of the Time to Ask Pilot Project: A Blended Learning Education Program Addressing Unhealthy Alcohol Use for Interprofessional Teams in Primary Care

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March 2019

KEY FINDINGS

- The content and design of the interprofessional curriculum was well received by participating health care professionals.
- Although individuals entered the training with varied levels of expertise and exposure to individuals with AUDs, the majority of participants across a variety of disciplines reported gaining new knowledge and skills that they will apply to their role.
- Results indicate the education had a positive impact on provider attitudes and behaviors. Participants reported that they would change behavior by:
  - screening all patients for unhealthy alcohol use;
  - promoting collaboration within the care team; and
  - changing their interaction with patients to be more patient-centered.
- Onsite consultative practice support by Lunder-Dineen played a key role in promoting enhanced alcohol screening polices.
- Heath care professionals overwhelmingly indicated that the peer support they received as part of the expert consultation was one of the most valuable components of the program.

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In collaboration with Massachusetts General Hospital

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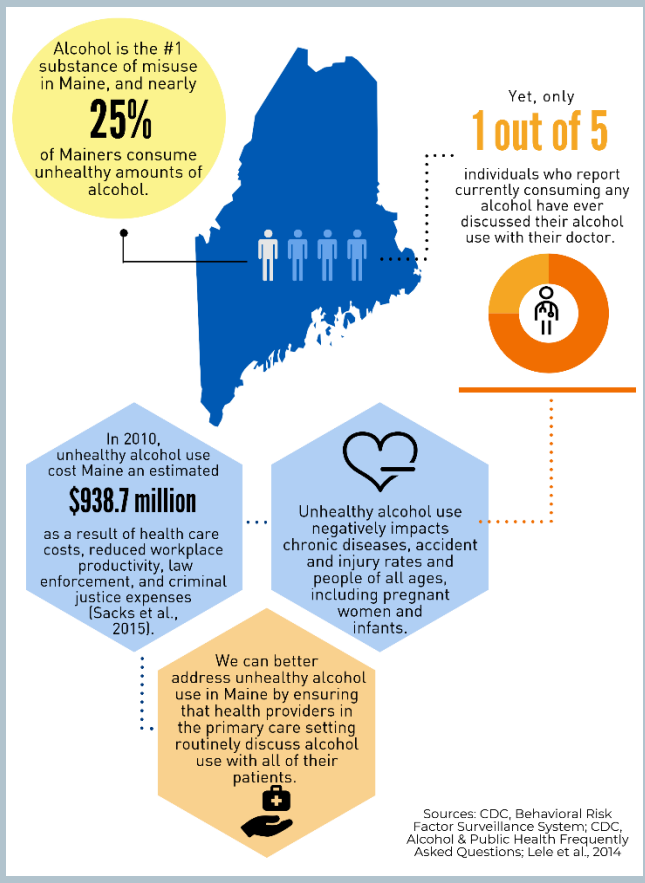
BACKGROUND

Unhealthy alcohol use, which is associated with high rates of morbidity and mortality, is a serious and costly individual and public health issue. Alcohol misuse contributes to a range of acute and chronic medical conditions and is the third leading cause of preventable death in the United States.[i]



Alcohol use exists on a continuum, and alcohol misuse describes a wide spectrum of unhealthy alcohol intake behaviors. Alcohol Use Disorder (AUD), a severe form of alcohol misuse, is a medical diagnosis that describes a chronic brain disease characterized by compulsive and uncontrollable alcohol use.[ii] AUDs continue to remain under diagnosed and treated. Studies show that discussions on alcohol use between health care providers and patients occur less frequently than is recommended by public health experts. Nationally, only 1 in 5 individuals who consume alcohol report having ever discussed their alcohol use with a clinician.[iii] This rate remains low among special populations, including pregnant women (17%) and binge drinkers[1] (25%).[iv] Meanwhile, only 10% of individuals with an AUD receive treatment services.[v]

National efforts have focused on expanded screening in primary care settings to promote early detection and intervention among individuals who present with unhealthy alcohol use. Early identification of unhealthy alcohol use is critical because lower severity and early onset cases of unhealthy alcohol use are pervasive and commonly affect over 20% of individuals seen in primary care settings.[vi] Moreover, many of the medical consequences of unhealthy alcohol use such as accidental injury, depression, cardiovascular disease, and cancer do not just manifest in individuals with severe AUDs but are commonly experienced by a large proportion of people with mild

[1] Binge drinking is defined as men drinking 5 or more alcoholic drinks or women drinking 4 or more, in about 2-3 hours.

moderate alcohol misuse.[vii] **Therefore, widespread, regular screening and monitoring of alcohol consumption in primary care is seen as a cost-effective, population-wide, preventative intervention.[viii]**

Because primary care providers have frequent contact with patients, primary care settings are seen as an ideal site for early detection and secondary prevention for individuals who may be at high risk for unhealthy alcohol use or are currently using alcohol in an unsafe manner.

Recent guidelines recommend that primary care providers screen all adult primary care patients to promote the identification of individuals with unhealthy alcohol use as well as abuse and dependance.[ix] Unfortunately, most primary care providers do not have regular conversations with their patients about alcohol use due to limited education and training related to AUDs, time constraints, competing priorities, and organizational barriers such as the absence of systematic integration into practice work flows.[x] Clinicans' lack of confidence in assessing alcohol use and providing brief advice is a significant barrier to expanding screening and brief interventions. **Therefore, education and training programs that improve clinicans' knowledge and skills related to AUDs are critical to promoting population-wide preventative screening for unhealthy alcohol use and AUDs.**

TTA PROGRAM OVERVIEW

In an effort to expand regular screening and monitoring of unhealthy alcohol use in Maine, a state ranked 11th in the nation for excessive drinking, Lunder-Dineen Health Education Alliance of Maine is currently leading a two-phase pilot project: *Time to Ask* (TTA). **The *Time to Ask* program was designed and developed to address the education gaps and interprofessional learning preferences that were identified in the pre-program clinical needs assessment as well as a thorough review of the literature and best practices for implementing interprofessional education and practice transformation in primary care.** Findings from the clinical needs assessment indicated that providers felt they had a working knowledge of alcohol use and its effects on the body, but lacked the clinical skills to feel comfortable integrating SBI techniques into their practice. Lack of knowledge influences providers' perspectives on working with patients who consume alcohol; 44% of providers at baseline were ambivalent about working with patients who consume alcohol and 18% had no interest working with this population. Increasing provider knowledge through educational initiatives has been shown to positively affect provider perspectives towards working with patients who consume alcohol.

TTA Concept

The program design utilizes a multi-dimensional approach to advance skills of the interprofessional care team in discussing alcohol use with their patients. The blended learning program, in combination with onsite support and expert consultation, will facilitate practice changes to reduce organizational barriers to screening patients for alcohol use.

Working in partnership with interprofessional teams in primary care practices, *Time to Ask* is providing education and training to health care professionals working to promote proper identification, assessment, and brief intervention and/or referral to treatment for patients who may be affected by unhealthy alcohol use.

Throughout the course of the Phase 1 pilot initiative, Lunder-Dineen engaged in quality improvement activities and partnered with practice staff to implement strategies designed to build program awareness and refine program elements. Feedback from the first Phase 1 pilot site helped shape the program in numerous areas, including input on educational content and scenario development of Module 2, and guidance on final patient education materials and tools including handouts, posters, and flyers. See the box below for additional ways that feedback from the first Phase 1 pilot site was used to inform the program's design and improve delivery for the second Phase 1 pilot site.

Actions Taken by Lunder-Dineen to Improve TTA

For the second pilot site, Lunder-Dineen:

- Developed an implementation manual for *Time to Ask* participants, both detailed and abbreviated versions
- Recommended that a prescriber participate on the site's *Time to Ask* committee
- Created pocket guides for clinicians
- Developed FAQ sheet for learning management system (LMS)
- Abbreviated data points, in consultation with evaluator
- Encouraged practice manager/prescriber to be Site Champion

Between April 2016 and February 2019, the *Time to Ask* initiative piloted the program at two primary care sites: a mid-sized practice in Hancock County and a small practice in Somerset County. The *Time to Ask* program utilizes a multi-pronged approach, informed by a pre-program clinical needs assessment of three primary care practices in Maine to uncover unmet education needs, includes: education and training for health care professionals and staff; onsite practice support and consultation provided by Lunder-Dineen; and expert consultation to guide the care of patients. Lunder-Dineen developed three learning modules to meet training and education needs for health care professionals and staff. Initially, the learning modules were designed to be administered individually, online; however, due

to time constraints, one practice chose to view two modules in person as a group during a regularly scheduled meeting. Currently, the program includes three training modules for health care professionals to be delivered online or in-person; ongoing onsite consultation with practices to engage interprofessional teams in the process of aligning work flows and processes to promote alcohol screening, treatment and referral; assistance with the use of clinical data to monitor alcohol use among patients; and peer-to-peer presentations for health care professionals on topics related to the treatment of patients with AUDs. The *Time to Ask* program is intended to be an interprofessional education program. All members of the primary care team as well as practice support staff were able to participate in the program, including nurse practitioners (NPs), registered nurses (RNs), medical assistants (MAs), social workers (MSWs), doctors (MDs/DOs/PhDs), Physician's Assistants (PAs), dentists, and administrative staff.

TTA Training Modules
MODULE ONE: Alcohol Use in Everyday Life
This webinar provides the learner with background information on unhealthy alcohol use, the impact of alcohol misuse on individuals and families across all ages, the criteria for determining At Risk Drinking and Alcohol Use Disorder, and the importance of reducing stigmatizing language. The module also focuses on how interprofessional education and team-based practice will advance alcohol screening and care for patients in primary care settings.
MODULE TWO: The Art and Science of Conversation
This interactive webinar is designed to familiarize the learner with alcohol screening techniques during a patient office visit. The scenarios address best practices around the patient interview process, responsibilities for seamless care and interprofessional team-based practice.
MODULE THREE: Addressing Unhealthy Alcohol Use and AUD in Primary Care
This webinar provides the learner with background information on interpreting alcohol screening results, addressing risks associated with unhealthy alcohol use, conducting interventions for unhealthy alcohol use and alcohol use disorder care, identifying the care pathways for patients who screen positive and incorporating recovery capital and recovery support in to care planning.

The *Time to Ask* program targets barriers to AUD screening at three levels. Barriers to providers' knowledge and skills will be addressed by the education and training provided to improve clinicians' AUD-related knowledge and skills and by providing clinicians with access to evidence-based resources and best practice guidelines for implementing alcohol screening, brief intervention and treatment. Time constraints will be addressed by advancing an interprofessional collaborative practice model of patient care that utilizes the skill set of each team member to assist in the screening and brief intervention and patient teaching components of patient care. The organizational barriers are explored within individual practice settings in order to identify specific action steps to address practice specific barriers, such as updating workflows and identifying appropriate Current Procedural Terminology (CPT) codes for data tracking and monitoring within the electronic medical record.

METHODOLOGY

As part of the Phase 1 pilot, with funding from the Lunder-Dineen Health Education Alliance of Maine in collaboration with Massachusetts General Hospital, researchers from the Muskie School of Public Service at the University of Southern Maine are conducting an evaluation to assess the impact of the intervention. Information from the program evaluation will be used to help refine the content and delivery of the program before expanding the initiative to health care professionals throughout the state.

The principal goals of the mixed-methods evaluation are to:

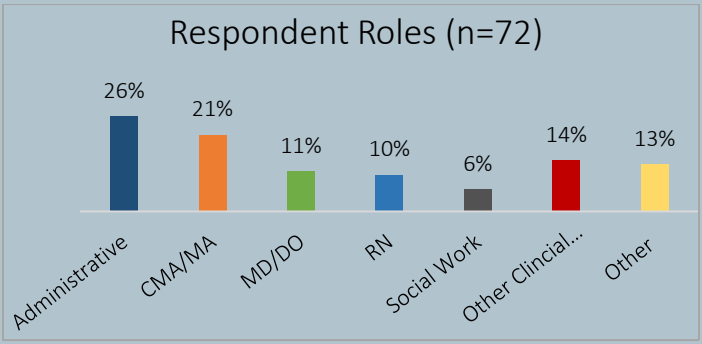
1. evaluate the content and delivery of the three *Time To Ask* educational modules;
2. examine if the impact of the onsite support and expert consultation strategies on organizational culture, systems and behaviors (practice transformation) related to addressing unhealthy alcohol use; and
3. assess the impact of the intervention strategies on provider knowledge and behavior related to addressing AUDs in their clinical practice.

The primary sources of data for the program evaluation included administrative data as well as surveys and focus groups with key stakeholders such as practice leadership, support staff, and a broad range of health care professionals (i.e. MD/DOs, CMA/MAs, RNs, PAs, MSW, Psychology, and dental). Administrative data collected was collected to analyze practice transformation efforts to improve provider's capacity to address alcohol use disorder, including screening and referral rates as well as new practice level policies and procedures related to alcohol use. Data collected from surveys and interviews focused gathering feedback on the presentation and delivery, content, and impact of the educational modules, as well as gathering in-depth information from health care professionals on knowledge gain and behavior change related to addressing AUDs.

KEY FINDINGS

<u>Participant Overview:</u> Eighty percent of practice staff at each Phase 1 pilot site participated in the *Time to Ask* learning modules. Eighty individuals completed one or

more of the *Time to Ask* learning modules and 90% of those individuals completed at least one module evaluation. Based on the size of the Phase 1 pilot practices, the health care professionals is Phase 1 have the potential to positively affect the lives of nearly 10,000 patients. The majority of participants were female (86%), 45 years or older (75%) and classified as clinical staff (61%). Given the broad spectrum of health care workers who participated in the training, it is not surprising that women comprise the majority of the sample. Recent statistics indicate that that women comprise 75% of healthcare practitioners and technical occupations as well as 87% of healthcare support occupations.[xi]



Most of the participants completed two (26%) or three modules (49%). Administration of the modules varied with 83% of individuals completing Module 1 online; a greater proportion of participants completed Modules 2 and 3 in-person, 39% and 46% respectively.

Presentation and Delivery: The *Time to Ask* curriculum was designed using evidence-based principles of blended learning. Participants were able to complete the modules individually online or in a group setting at the practice site. Overall, participants felt that the presentation and delivery of the education modules was appropriate, easy to navigate and clearly presented. However, individuals who completed the modules online reported higher levels of satisfaction with the presentation and delivery of the materials.

The majority of respondents strongly agreed/agreed that the content in all three modules was well organized and easy to follow (M1=81%; M2=85%; M3=84%). Individuals completing modules online were significantly more likely than those completing the training in person to strongly agree/agree that the information was clearly stated. In addition, respondents felt the length of time it took to complete the modules was appropriate. However, it is important to note that individuals who completed Module Two in-person were significantly more likely than those who reviewed the content online to agree that the length of time of the module was appropriate. This is most likely due to the fact that individuals who completed the training in-person were not able to complete the module at their own pace and the in-person presentation of the module involved much more group interaction and discussion which increased the time it took to complete the curriculum.

Content: In general, participants reported that the *Time to Ask* curriculum was timely, important and, among clinical staff, relevant to their role within the practice team. The majority of respondents strongly agreed/agreed that the modules presented information and knowledge that was new to them, particularly among administrative and other support staff who were significantly more likely to indicate that they learned something new. Moreover, social workers, dental staff and other clinical workers were more likely than CMA/MAs, RNs and MD/DOs to report new knowledge gain. Most of the MD/DOs, RNs, and behavioral health staff who have had more exposure to working with patients with AUDs felt that some of the content was too basic but they acknowledged that it was helpful to have a refresher on AUD and the importance of integrating regular screening into their practice. For MAs at one of the Phase 1 pilot sites, they reported a better understanding of why they screened for AUDs at wellness visits, and were better able to communicate the importance of screening to patients after taking the modules.

Many participants indicated that the patient scenarios were helpful for skill development. This was particularly true for non-clinical staff as well as other clinical staff and social workers, who were significantly more likely than clinical staff (MD/DO, RN, CMA/MA) to strongly agree/agree that the scenarios were realistic and helped their learning. This finding highlights the importance of the use of interprofessional education for primary care team members who have less frequent interaction with patients.

Respondents were varied on their opinions on the utility of the curriculum. Nearly a quarter of participants felt that the curriculum was not relevant to their position, most likely due to the fact that 26% of participants identified as administrative support staff and reported no direct interactions with patients.

Sixty percent of respondents felt that Module One was relevant to their current role and 65% of trainees felt Modules Two and Three were relevant to their work. Clinical staff who completed Module One were significantly more likely than non-clinical staff to strongly agree / agree that the topics covered were relevant to their role at the practice. In addition, non-clinical staff were more likely to report feeling neutral or disagree that the topics covered in Modules Two and Three were relevant to their current work. This finding can most likely be attributed to the fact that the final two modules had a large focus on building clinical skills and modeling provider-patient interactions,

which non-clinical staff reported as being uncommon in their current role at the practice. It is important to note that practices wanted to engage all staff in the training because administrative staff members are often the first members of the practice to interact with patients. Although non-clinical staff were less likely to indicate that curriculum directly related to their job, they reported learning new information and feeling more confident interacting with patients with AUDs, and they valued the opportunity for interprofessional learning.

> "I do not interact with patients at all in my job here. The information is good, though, and will help me understand more about the issue."
>
> -Administrative Support Staff

Participants overwhelmingly indicated that the most beneficial component of the curriculum was the patient scenarios that provided information as well as simulations on how to effectively communicate with individuals about alcohol use. Participants also felt that the curriculum provided valuable strategies on how to seamlessly integrate regular conversations about alcohol use into patient visits. Reaction to the supplemental materials and resources, such as brochures for patients, pocket guides for prescribers, and wall-mounted posters for appointment rooms, was mixed between the two Phase 1 pilot sites. Participants at one pilot site reported that the supplemental materials and resources were helpful tools in communicating with patients, that they sparked conversations between providers and patients, and that they would continue to use the materials. On the other hand, staff at the second pilot site found the materials unhelpful, confusing, and too general, noting that AUD is an individualized disease that does not always fit neatly into guidelines.

WHAT PARTICIPANTS FOUND MOST USEFUL

- How to integrate conversations into visits
- Facts and statistics about unhealthy alcohol use and AUDs
- Resources , information and supplemental materials that can be given to patients
- Patient scenarios / modeling of Motivational Interviewing techniques
- Information on how to reduce stigma

Programmatic Impact: In addition to being satisfied with the content and delivery of the *Time to Ask* program, results indicate that the training and education had an impact on provider attitudes and behaviors. The majority of program participants (70%) indicated that they would apply the information they learned as part of the training in their role at the practice; clinical staff were significantly more likely to indicate they would utilize the information in their job. Of the individuals who said they would apply the skills and knowledge they learned from the training, most indicated they planned to use the information immediately (M1=61%, M2=73%, M3= 68%). Although there were no statistically significant differences in participants' confidence in applying what they have learned by role or mode of delivery, clinical staff were more likely to strongly agree/agree that they have confidence in their ability to apply what they learned in their role. Participants were less confident in applying the skills and knowledge from Modules Two and Three, which focused on clinical interactions with patients, in their current role (M1=67%, M2=65%, M3=61%).

Those participants who indicated that they would not apply the materials (33%) covered in the *Time to Ask* training program were significantly more likely to be non-clinical support staff who felt that they would have limited opportunities to apply the knowledge and skills they learned in their job. However, it is important to note that non-clinical staff did indicate that they appreciated the opportunity to participate in a practice-wide training and felt that they could apply the information presented to other relationships, including co-workers, family and friends.

Many participants reported that they would change their behavior including: screening all patients for unhealthy alcohol use; working to promote more collaboration and integration across disciplines within the primary care team; changing their interaction with patient to use non-judgmental language; and making efforts to provide more patient-centered care. Staff at one pilot site felt that stigma towards alcohol use had decreased, particularly among MAs, as a result of the practice-wide participation in the modules.

Knowledge and Behavior Change: Providers who participated in the training completed a post-intervention survey (n=33) to examine the effectiveness of the intervention strategies by assessing knowledge and behavior change. Post-intervention survey results were compared to baseline survey data collected through the *Time to Ask* Clinical Needs Assessment (n=35). Pre- and post-implementation survey responses were analyzed by comparing overall scores across survey domains in order to examine changes in knowledge and behavior among provider at the *Time to Ask* Phase 1 pilot sites.

Overall, post-implementation survey results indicate that providers' knowledge of and behaviors towards treating individuals with AUDs improved across all four domains of

the survey after participating in the *Time to Ask* Phase 1 program, including role adequacy, role legitimacy, role support, and motivation to work with patients who drink. After the implementation of the *Time to Ask* Phase 1 program, providers were significantly more likely to report having a working knowledge of alcohol and alcohol related problems as well as the psychological effects of alcohol ($P \leq 0.05$). An increase in the overall role adequacy score indicates that the knowledge gained from the training increased provider's confidence in working with patients who drink. In addition, providers were significantly more likely to indicate that they had a clear idea of their responsibilities related to address alcohol use in their clinical practice and felt that they had the skills to help drinkers ($P \leq 0.05$). These findings indicate that the practice transformation strategies helped to facilitate a working environment that offers providers the resources necessary to screen and address unhealthy alcohol use and AUDs as part of their clinical practice.

There was a significant shift in providers' perceptions of role adequacy and motivation to work with patients who drink between the pre- and post-implementation groups. In addition, the number of providers indicating that they know how to counsel individuals about alcohol use over the long term increased from 23% at baseline to 58% after the implementation of the Phase I pilot program representing a 152% increase ($P \leq 0.05$). After completing the *Time to Ask* training, providers felt more motivation to work with patients who drink and were more likely to respond that working with patients who drink should be part of their role, signaling a shift in providers' views about addressing unhealthy alcohol use and AUDs in their clinical work. Conversely, there was no change in motivation between survey groups: "I want to work with drinkers" and "I feel that there is little I can do to help drinkers." These findings are consistent with data from follow-up interviews where providers indicated that they felt they had adequate knowledge on how to identify address unhealthy use but were less confident in their ability to apply clinical skills, such as motivational interviewing, to address unhealthy alcohol use in their clinical practice.

Practice Facilitation: In addition to offering education and training to providers, the *Time to Ask* program offered onsite practice support by Lunder-Dineen to the primary care Phase 1 pilot sites to assist with overcoming institutional barriers to implementing more widespread alcohol screening within each practice. Both sites formed *Time to Ask* committees and identified onsite Champions to work with Lunder-Dineen. In their role as facilitators, the on-the-ground staff of Lunder-Dineen engaged in four activities with practice staff, including: **understanding gaps in current alcohol screening policies; updating practice workflows to increase alcohol screening rates; developing tools for providers to use in clinical practice; and working with health informatics staff to promote the use of clinical data to promote ongoing monitoring of programmatic progress and patient outcomes.** The strategies employed by Lunder-Dineen to build site capacity for practice transformation emphasize the importance of building relationships with practice staff.

KEY ELEMENTS OF PRACTICE TRANSFORMATION INCLUDED IN THE *TIME TO ASK* PROGRAM

- Building relationships with practice leadership and champions by engaging in all aspects of program development, implementation and refinement
- Working with staff to identify key performance metrics and mechanisms for tracking before implementation
- Assisting with defining staff roles/responsibilities and developing AUD related workflows early in the initiative
- Developing user-friendly tools such as pocket guides and posters to assist providers
- Spending time, in-person with practice staff to discuss challenges and identify strategies to overcome barriers to implementation

There were several positive outcomes associated with the onsite practice support provided by Lunder-Dineen as part of the *Time to Ask* program. For example, after a review of current screening practices revealed that only 40% of the site's patient panel received an annual alcohol screening at one of the pilot sites, practice policies were updated to reflect the most recent guidance on screening in primary care settings. Second, practice leadership at both sites worked with the facilitator to foster an organizational culture of learning by mandating all staff to complete the *Time to Ask* training. Lunder-Dineen also worked with one site to update onboarding procedures to mandate that all new staff complete the *Time to Ask* training. Moreover, leadership at both pilot sites demonstrated a commitment to practice change by shifting organizational alcohol screening polices. **After engaging in the *Time to Ask* program, both pilot sites shifted from screening only at annual wellness visits to conducting a standardized alcohol screening at all patient visits**. Finally, the sites were able to engage providers and other key staff in updating workflows, defining staff roles and responsibilities, and identifying appropriate CPTO codes for data tracking within the EMR. *Time to Ask* pilot sites reported having positive experiences working with Lunder-Dineen. Staff at one pilot site felt that Lunder-Dineen listened to their feedback when creating resources and materials for patients. For example, Lunder-Dineen was able to be responsive to their patient panel's language needs. **Overall, program participants felt**

that the onsite consultative support helped the practices embed alcohol screening into the fabric of their organization.

Despite these successes, challenges remain to fully implementing widespread screening and monitoring of AUDs at both of the participating sites. Practice leadership and staff recognized that they will need to continue to devote time and resources, which is often difficult in busy primary care practices with competing demands, to overcome some of the remaining barriers to implementation including data tracking and extraction for ongoing monitoring, which remains a major obstacle.

CHALLENGES TO PRACTICE TRANSFORMATION

- Partnering with providers to facilitate team engagement
- Finding the time and resources to engage in quality improvement work
- Getting agreement on alcohol screening work flows
- Competing organizational and provider priorities
- Extracting data from the electronic medical record (EMR)
- Standardizing ICD-10 codes to document AUDs

Expert Consultation: In the final component of the *Time to Ask* program, practice staff were provided expert consultation, which included accessing the expertise in the local community to enhance the education and application of best practices for unhealthy alcohol use provided by the *Time to Ask* program. Expert-informed decision support to primary care teams is critical to facilitating the identification and management of AUDs in primary care. Expert decision supports include provider education, facilitated consultation, standardized assessment tools, and evidence-based treatment algorithms.[xii] As part of the *Time to Ask* program, participating practices received both ongoing education as well as consultation from experts in the field of addiction medicine, which is particularly important given the relative lack of medical education and training in the area of substance use disorders.

Health care professionals who participated in the program overwhelmingly indicated that the peer support they received as part of the expert consultation was one of the most valuable components of the program.

> "…She was able to say this works better than this, here are the advantages to this, and from my experience etc."
>
> -**Provider about expert consultation in-service training**

Peer-to-peer learning from experts in addiction medicine on diagnosis, prescribing and monitoring medications, and assistance with brief interventions or referrals to specialty care was frequently mentioned as a critical component of the program and essential for supporting primary care providers in addressing AUDs. Participants reported that they would like to receive more peer support through additional sessions that focus on skills building and strategies to overcome ongoing barriers to addressing AUDs in primary care, as well as opportunities for interactive, case-based sessions to discuss difficult cases that they have encountered.

RECOMMENDATIONS FOR PHASE TWO EXPANSION

Findings point to several components of the program that could be refined to enhance the delivery and content of the initiative.

- **Content and Delivery:** Results suggest that participants who are able to complete the modules online versus in-person have greater satisfaction with the training and a higher likelihood of applying the skills and knowledge to their current role. In addition, it appears that, while including all staff in the program promotes interprofessional collaboration, some modules may not be appropriate for all staff. Participant feedback also suggests that there may be a need to develop a screening method to direct participants with greater exposure to and expertise in working with individuals with AUDs to sub-modules with more advanced content. To address these concerns, at the next site, Lunder-Dineen plans to require all staff participate in the first module, but limit participation in all three modules to clinical staff only. Participants also reported that the amount of information in modules was overwhelming at times, and suggested streamlining the information and reducing the need for navigating between multiple windows and presentation formats (i.e. video, reading text, etc.). The time commitment to complete the modules presented challenges for both busy providers and hourly-wage employees, and could be addressed through shorter modules. Participant feedback also indicated a desire for receiving CME credit for participation in the modules; Lunder-Dineen staff is currently working on certifying module three of the program for CME credits.

  Provider feedback also suggests that the supplemental materials could be further refined to better communicate information about AUDs. Given the varied responses to the supplemental materials and resources that Lunder-Dineen provided to Phase 1 pilot practices, it would be valuable to explore why participants thought the patient education posters and pocket guides were

not useful. Additionally, Lunder-Dineen could follow up with the pilot sites at a designated post-program implementation point to see if they have utilized the tools within the *Time to Ask* program, and if so, which tools were most helpful.

Participants had several suggestions on topics of interest for further education. Finding mental health and community resources for patients was frequently mentioned. Facilitating linkages to mental health and community resources is critical to supporting the management of AUDs in primary care settings. Many participants indicated that there was a critical need for strategies or support on creating community care linkages. Recognizing the importance of wrap-around services and the varied access to resources between pilot sites, Lunder-Dineen has begun developing a Resource Listing template to guide sites in identifying local community linkages. The template as well as best practices for identifying resources will be included in the implementation manual developed by Lunder-Dineen.

SUGGESTED TOPICS FOR PHASE TWO EXPANSION

- Motivational Interviewing
- Brief Intervention (simulations)
- Community and mental health resources for patients
- Creating clinical-community linkages
- Referral pathways for patients with severe AUDs
- Prescribing methods for medications for AUDs
- Risk stratification for patients

- **Practice Facilitation**: Facilitation activities should recognize the challenges and competing demands faced by busy primary care practices. Facilitation activities should focus on understanding the unique needs of practices by providing ongoing support and feedback through regular meetings, data monitoring, and other strategies while at the same time acknowledging the time and resources constraints of busy primary care practices. It is important to build capacity incrementally, without trying to do too much too soon, to mitigate "change fatigue".

  As part of the *Time to Ask* onsite support by Lunder-Dineen, a number of key strategies were found to be successful in promoting change and overcoming obstacles. Expanding upon and tailoring these approaches to the unique needs of primary care practices will be essential to helping facilitate transformation at participating sites.

- **Expert Consultation:** In addition to facilitating organizational change to support efforts to address alcohol misuse and use disorders in primary care, education and training opportunities for staff are critical to building primary care practices' capacity to address substance use disorders. Organizational resources and supports can help to increase providers' confidence in identifying and addressing AUDs in primary care settings. Moreover, professional mentoring, particularly among providers with limited clinical experience with AUDs, is essential for enhancing providers' clinical skills and therapeutic commitment to working with individuals with AUDs.

  Findings indicate that individuals valued the experiential education and training components of the *Time to Ask* educational curriculum and welcomed the opportunity for future opportunities for expert consultation. Participants clearly expressed that the expert consultation was extremely beneficial and that they would like more opportunities for peer-to-peer learning and skills building, indicating a possible need to expand this portion of the program to address the specific training needs identified by learners. Lunder-Dineen has indicated that at future sites additional consultation will be provided to assist practices in making important communication connections to support patients with complex needs.

- **Data Tracking and Monitoring:** Findings indicate that there remain significant barriers to accessing and using electronic medical records data (EMRs) to improve care and monitor population health. Data tracking and monitoring is a universal problem in primary care settings, and studies have shown that many barriers exist to EMR adoption in office practices.[xiii] Current challenges include time (collecting, compiling, and recording data), technology (pulling data from EMRs; AUD reporting not set up in EMR), lack of standardized processes to collect data (documenting unhealthy alcohol use in different places in EMR or with various ICD-10 codes), and resources for data tracking and monitoring (allocating staff time for monitoring data; competing demands on HIT staff). Ongoing facilitation and expert consultation specifically devoted to overcoming data tracking issues and tailored to practice needs is critical to the success and sustainability of practice transformation efforts.

SUMMARY

Findings from our evaluation of the *Time to Ask* Phase 1 pilot program indicate that the content and design of the

interprofessional curriculum focused on identifying and addressing unhealthy alcohol use and AUDs was well received by the health care professionals who participated in the program. Although it is evident from participant feedback that individuals entered the training with varied levels of knowledge, skills, and exposure to individuals with AUDs, participants across disciplines and professional roles were satisfied with the content and delivery of the *Time to Ask* Phase 1 pilot program.

Results of the *Time to Ask* Phase 1 pilot program indicate that training programs that combine skills-based education in conjunction with onsite support and expert consultation can be used in primary care practices to advance health care professionals' knowledge, skills, and self-efficacy related to AUDs. Our findings highlight the importance of using interprofessional teams to address the complex medical and social needs of individuals with AUDs. Interprofessional relationships are essential for providing high quality care for patients.

Quality improvement activities and rapid-cycle feedback allowed Lunder-Dineen to refine program design elements, address barriers, and successfully implement strategies to overcome some of the challenges associated with addressing AUDs in primary care settings. The results of the evaluation indicate that Lunder-Dineen was able to demonstrate proof of concept with the Phase 1 pilot program of *Time to Ask*. Both sites that participated in the *Time to Ask* Phase 1 pilot program were successful in implementing practice changes to reduce organizational barriers to screening patients for alcohol use, including:

- implementing mandatory training to increase knowledge about unhealthy alcohol use and AUDs;
- updating clinical workflows to integrate regular alcohol screening;
- clearly defining staff roles and responsibilities related to alcohol screening; and
- updating practice policies to include alcohol screening at every visit.

Systematically screening for alcohol use has not only facilitated a change in organizational culture, but it has also had a significant impact on clinical practices related to addressing alcohol use within the participating sites. Findings indicate a substantial shift in both provider knowledge and attitudes related to alcohol use pre- and post-implementation. After completing the *Time to Ask* training, providers were significantly more likely to indicate that they were motivated and equipped to address unhealthy drinking and AUDs as part of their clinical practice. Results from the evaluation also suggest that participants in the *Time to Ask* Phase 1 pilot were more comfortable engaging patients in conversations about their alcohol use after the training and that the program helped to reduced stigma towards AUDs within the participating practice sites.

In summary, evidence indicates that the *Time to Ask* Phase 1 pilot program was successful in promoting practice change to facilitate the integration of regular screening and monitoring of alcohol use within the Phase 1 pilot sites. Moreover, findings indicate that the program had a positive impact on providers' knowledge of and behaviors towards addressing alcohol use and AUDs. Providers overwhelmingly agreed that the program equipped them with the tools to engage in regular, meaningful conversations with patients about alcohol use. Overall, findings point to the importance of using multi-dimensional approaches to addressing unhealthy alcohol use in primary care settings that promote changes in both organizational and provider behaviors.

To learn more about Lunder-Dineen's initiative, *Time to Ask*, please visit: www.lunderdineen.org.

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