

A Clarion Call for Nurse-Led SBIRT Across the Continuum of Care

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This commentary discusses the impact of the study by Broyles and colleagues (2012) that reported on hospitalized patients' acceptability of nurse-delivered screening, brief intervention, and referral to treatment (SBIRT). This cross-sectional survey study assessed patient acceptability for and comfort with nurse-delivered SBIRT. The majority (95%) of inpatients found it acceptable for the nurse to ask about and/or discuss alcohol use during their hospitalization. This is a significant finding, as hospitals in the United States consider whether and how to implement The Joint Commission's performance measures related to SBIRT for hospitalized patients. The findings related to subgroups of patients who are more accepting of SBIRT and those who expressed some degree of discomfort highlight the importance for individualized patient-centered approaches. This study raises several important implications for nurse-delivered SBIRT. First, intensive efforts must be directed to enhancing the knowledge and competence of healthcare providers in general, and the current and future nursing workforce in particular, related to alcohol use and evidence-based care for patients who are drinking alcohol above recommended limits. Second, registered nurses, working to the full extent of their education and licensure are in key roles as members of the interdisciplinary team to provide cost-effective care at the bedside and across the continuum of care. Nurse-led SBIRT implementation models could help bridge the curricular gap and promote widespread and sustained integration of SBIRT as standard nursing care across all specialties and practice settings.

Key Words: Nursing; Education, Nursing; Early Medical Intervention; Inpatients; Alcohol Consumption.

NEARLY 3 IN 10 adults in the United States drink alcohol in a hazardous way, placing themselves and others at risk (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2005). Hazardous alcohol use is defined as the consumption of alcohol in amounts that exceed NIAAA recommended limits, that is, >14 standard drinks per week or >4 per occasion for men, and >7 standard drinks per week or >3 per occasion for women and healthy individuals over age 65 (NIAAA, 2005). Collectively, screening, brief intervention, and referral to treatment (SBIRT) are a set of clinical strategies used to address unhealthy alcohol use. SBIRT is based on public health principles and harm reduction approaches with the intent of reducing the burden of injury, disease, and disability associated with hazardous alcohol use (Babor et al., 2007). The study by Broyles and colleagues (2012) is exciting because it establishes patient acceptability among hospitalized patients for nurse-delivered SBIRT tasks, particularly providing brief counseling about alcohol,

providing educational materials about changing alcohol use, and providing information about alcohol self-help groups. These activities are within the skill set of registered nurses (RNs). Yet, RNs may not view these activities as part of their role or responsibility.

There is compelling evidence for alcohol screening and brief intervention (Babor et al., 2006) with a proliferation of mandates and guidelines from various entities regarding SBIRT provision (e.g., Department of Veterans Affairs, 2009; NIAAA, 2005; U.S. Preventative Services Task Force, 2004). Providing these interventions saves money; for every dollar invested in SBIRT, \$3.80 could be saved in future healthcare costs for emergency care (Gentilello et al., 2005) and \$4.30 for primary care (Fleming et al., 2002). While coding and coverage policies vary, Medicaid, Medicare, and commercial health plans reimburse clinicians for screening and brief intervention. Yet, despite evidence for efficacy and healthcare savings and other financial incentives, widespread and sustained implementation of these strategies into clinical practice has not occurred (Nilsen et al., 2006; Williams et al., 2011). Many different initiatives will be required to influence the provision of SBIRT as part of routine care.

A major influence for U.S. hospitals to provide SBIRT will likely be the recent performance metrics from The Joint Commission, a U.S.-based nonprofit healthcare accreditation organization. These performance metrics detailed in the Specifications Manual for National Hospital

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Inpatient Quality Measures relate to evidence-based substance use screening for all hospitalized patients (http://www.jointcommission.org/specifications_manual_for_national_hospital_inpatient_quality_measures.aspx). While these Joint Commission metrics are optional at the current time, prospective payment for SBIRT provision will augment the clinical incentive for hospitals to adopt these standards.

Therefore, the study by Broyles and colleagues (2012) is especially timely as U.S. hospitals consider adopting these metrics that are intended to contribute to positive outcomes (e.g., increasing the rate of hospitalized patients screened for alcohol use, the rate of eligible patients receiving brief interventions, the proportion of patients accepting referral for treatment of those referred, and the proportion of discharged patients contacted within 30 days and follow-up information regarding alcohol use is collected). As integral members of interdisciplinary teams in hospital settings as well as the patient-centered medical home teams in primary care, nurses are in key positions to take an active role in providing SBIRT. RNs and members of various professions exchange knowledge and ideas about how to deliver high-quality health care; this interprofessional team collaboration involves recognition of the expertise of others within and outside one's profession and referral to those providers when appropriate (American Nurses Association [ANA], 2010). Nurses, in hospital settings and primary care are positioned to play key roles in a reformed healthcare system focused on primary care, prevention, and chronic disease management (ANA, 2010).

The study by Broyles and colleagues (2012) highlights the importance for RNs to have the knowledge and competence for engaging in SBIRT-related discussions that are patient-centric, specifically related to the patient's perception of his/her risk. Furthermore, with 20% of patients reporting some degree of personal discomfort with alcohol-related discussions, approaching them with sensitivity and skill is important (Broyles et al., 2012). The need for substance abuse education across the health professional workforce has been identified (Haak and Adger, 2002) with recent studies specifically pointing to the lack of alcohol-related content in undergraduate (Mollica et al., 2011) and graduate (Campbell-Heider et al., 2009) nursing curricula.

This study by Broyles and colleagues (2012) focusing on nurse-delivered SBIRT places a spotlight on (i) the central role of nurses in detecting hazardous alcohol use among hospitalized patients and providing brief interventions, and (ii) the urgent need for continuing education and curricular development for the current and future nursing workforce because nurses are often the first healthcare provider to interact with the patient in the hospital setting. This foundational study by Broyles and colleagues (2012) commands attention to the development of innovative models to promote widespread implementation and sustained integration of nurse-delivered SBIRT within the interdisciplinary team to promote positive patient outcomes.

SBIRT AND THE ROLE OF THE REGISTERED NURSE

A recent report from the Institute of Medicine (IOM) calls for nurses to practice to the full extent of their education (IOM, 2011). Because nurses are often the first healthcare providers that patients encounter and because nurses spend the most time with hospitalized patients (Hendrich et al., 2008), provision of SBIRT is a logical part of their role. Screening for health risk behaviors, including alcohol use, with appropriate assessment and referral activities are within the scope and standards of practice for RNs set forth by the ANA (2010). The optimal time for engaging patients in brief intervention is immediately after the alcohol screening—information that nurses commonly collect as part of the initial admission assessment. Thus, RNs can seamlessly move from alcohol screening to the provision of brief interventions and referral to specialty treatment. These activities are consistent with nursing standards of practice for RNs: assessment, diagnosis (of the patient's responses to actual or potential health conditions or needs), identification of outcomes, planning, implementation, and evaluation.

When nurses provide SBIRT and engage in risk-reduction communications around hazardous alcohol use, patients receive the same message across providers and settings (Vimont, 2011). A characteristic tenet of nursing practice is the coordination of care through established partnerships (ANA, 2010). In partnership with persons, families, support systems and other providers, RNs seek to reach a shared goal of delivering patient-centered care. Rubenstein and colleagues (2010) underscored the value of the RN in providing coordinated care for patients with depression. Specific characteristics of RNs in that role included good communication skills, organizational skills, ability to educate and activate patients while keeping interactions short and targeted, comfort with medication monitoring and patients with chronic medical illness, active independent problem-solving skills, ability to foster collaboration, ability to connect patients to internal and external resources, and serving as a bridge between team members (Rubenstein et al., 2010). These nursing skills are also aligned with the ANA (2010) standards of professional nursing practice and performance, such as coordination of care, health teaching and health promotion, communication, leadership, and collaboration.

The skills and activities identified earlier are in keeping with the role of the RN relative to caring for patients who are at risk for physical and/or psychological problems because of alcohol use. While experienced RNs specialize in certain roles or domains, all RNs are prepared to care for patients with common adverse health consequences of alcohol use, such as traumatic injury, hypertension, liver disease, and coexisting psychiatric conditions to name a few. Thus, RNs with requisite knowledge and competencies are vital partners within the healthcare team who can and should address the prevention of unhealthy alcohol use, alcohol abuse, and dependence. RNs are represented across different specialties (e.g., medical, surgical, psychiatric/

mental health) and settings (e.g., inpatient units, primary care clinics, emergency departments). Therefore, as members of the healthcare team, RNs are instrumental in preventing unnecessary readmissions among patients with hazardous alcohol use.

HOSPITAL READMISSIONS RELATED TO ALCOHOL USE

Among nonobstetric Medicaid patients from 21 to 64 years of age, about 1 in 10 had at least one readmission within 30 days after discharge from their first stay; 8% of the readmissions involved alcohol/substance abuse (Jiang and Wier, 2010). Gilmer and Hamblin (2010) found that nearly half (49.7%) of Medicaid beneficiaries with disabilities who were readmitted had no claims for physician visits between discharge and readmission. The likelihood of readmission increased with the number of chronic conditions, among which substance use disorders were ranked in the top 3 categories (Gilmer and Hamblin, 2010). Other categories included skin infections, cancers, gastrointestinal (cirrhosis), heart failure, infections (e.g., AIDS, HIV), renal failure, and type 1 diabetes, conditions that are common consequences of hazardous alcohol use (Gilmer and Hamblin, 2010) and conditions that are addressed by RNs across all specialties and practice settings. Lower rates of readmission were associated with the provision of more primary care visits, including paying a higher average price per visit (Gilmer and Hamblin, 2010).

The findings from the analysis of the claims data are relevant for RNs working in hospitals and relevant to the findings that patients are accepting of RN-delivered SBIRT (Broyles et al., 2012). First, more systematic and focused nurse intervention around alcohol use among hospitalized patients could result in reduced rates of readmission. Second, RNs are instrumental in coordinating patient care during the inpatient stay and in formulating patient-centered discharge plans. Moreover, cognizant of the importance of continuity of care, RNs facilitate the patient's transition between settings and healthcare providers (ANA, 2010). The RN can thus be influential in educating patients on the importance of timely follow-up in primary care or specialty care, which may positively impact the proportion of patients seen within 30 days of discharge.

To promote this potentially increased quality and cost-effective care, RNs should have an in-depth understanding of alcohol use, abuse, and dependence to provide competent quality care to patients. However, nursing education has not kept pace with the evidence-base related to the continuum of alcohol use in general and SBIRT in particular.

ALCOHOL-RELATED CONTENT IN NURSING CURRICULA

Current nursing curricula provide little education and clinical practice time devoted to providing care for alcohol use,

abuse, and dependence (Campbell-Heider et al., 2009; Mollica et al., 2011; Naegle, 2002). This gap suggests that nurses in the current workforce lack the knowledge and competence to detect hazardous alcohol use among their patients and intervene accordingly. Because harmful use of alcohol is the third leading factor for poor health globally (World Health Organization, 2011), nurses need to understand the relationship between hazardous alcohol use and general health consequences.

As nursing educators expand undergraduate and graduate-level curricula to include the requisite knowledge and skills for addressing the entire spectrum of alcohol use, enhanced continuing education for practicing nurses will simultaneously be needed to ensure an adequately prepared current and future nursing workforce. Nurses have identified strong interest in attaining continuing education related to caring for patients with alcohol problems (Happell and Taylor, 2000). However, providing education to nurses in the workplace is challenging given the need for 24-hour, 7-day a week scheduling. Advanced practice RNs or other specialist RNs with expertise in alcohol SBIRT could be instrumental in addressing the critical gaps in the alcohol-related knowledge and competencies of nurses at the bedside and in outpatient settings.

NURSE-DELIVERED SBIRT IMPLEMENTATION MODELS

Employing nurse-delivered SBIRT implementation models would include a specialist RN who models professional, patient-centered, and respectful care to nurses who are on the front line of caring for this population. Ideally, this expert nurse would be certified at the generalist (i.e., Certified Addictions Registered Nurse [CARN]) or advanced practice level (i.e., CARN-AP) recognizing the attainment of a level of expertise and commitment in this specialty (Finnell et al., 2004). A nurse-led alcohol liaison service for hospitalized patients has demonstrated considerable impact on the identification of medical inpatients at risk because of alcohol consumption, positive outcomes on patients' reduction of alcohol intake, reduced hospitalizations, and reduced bed days (Ryder et al., 2010).

SBIRT implementation and sustainability requires workforce development for skills related to identifying and addressing hazardous alcohol use with a preventative, early intervention approach. The specialist RN would function as a member of the interdisciplinary team, providing direct patient care and clinical recommendations, as well as ongoing clinical guidance, education, and role support for RNs. The expert nurse would have the knowledge and competencies to provide patient-centric care to specific subgroups identified in the study by Broyles and colleagues (2012) such as older patients, patients with a positive alcohol screen, and patients with low perceived ability to reduce alcohol-related risk. By providing ongoing modeling for and coaching of

staff nurses to facilitate new skill and role acquisition in SBIRT, the nurse-delivered SBIRT implementation model is potentially superior to episodic or one-time training and is a promising model for promoting SBIRT uptake and sustainability.

Importantly, this nurse-delivered SBIRT model is a first step in changing practice. Proposed here is the need for a sustainable SBIRT implementation model to help ensure widespread and sustained integration of these activities into clinical practice across the continuum of care. To date, SBIRT implementation models have evolved from the grantees of the Substance Abuse and Mental Health Services Center for Substance Abuse Treatment. Three major models have evolved: (i) “In-house generalist” where existing clinicians are responsible for SBIRT services, (ii) “In-house specialist” where existing behavioral health or other specialists are specifically assigned to conduct services, and (iii) “Contracted specialist” where outside behavioral health or other specialists are hired to conduct services; trials comparing these models have not been published (Bernstein et al., 2009). Thus, once routinely integrated into clinical practice, the next challenge will be to implement effective monitoring and follow-up to evaluate outcomes over time.

FUTURE DIRECTIONS

Although there is ample evidence for alcohol screening and brief intervention in primary care and trauma settings (Babor et al., 2006, 2007), Broyles and colleagues (2012) point to the need for studies on SBIRT among hospitalized patients. Establishing whether hospitalized patients are willing to accept nurse-delivered SBIRT lays the foundation for subsequent efficacy and effectiveness studies. Such a program of research would have clear implications for education of the current and future nursing workforce.

Known from the Broyles and colleagues’ (2012) study is that patients accept nurse-delivered SBIRT. Clearly, RNs are sufficiently prepared to undertake those activities, yet can benefit from enhanced education in the workplace. The nurse-delivered SBIRT implementation model is proposed as a viable solution to help hospitals prepare for the new SBIRT performance measures set forth by The Joint Commission and the provision of SBIRT to hospitalized patients. Future studies are needed to evaluate the implementation and clinical effectiveness of nurse-driven SBIRT delivery models across the continuum of care. A hybrid design as described by Curran and colleagues (2012) would be ideal for such a study that simultaneously examines implementation and clinical outcomes associated with an “in-house” nurse implementation model.

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