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Time to Ask: An Alcohol Education Pilot for Healthcare Professionals. Clinical Needs Assessment

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Time to Ask: An Alcohol Education Pilot for Healthcare Professionals

Clinical Needs Assessment
March 2016

UNIVERSITY OF SOUTHERN MAINE

TIME TO ASK
Education that transforms conversations about alcohol use

LUNDER • DINEEN
Health Education Alliance of Maine
In collaboration with Massachusetts General Hospital

Time to Ask: An Alcohol Education Pilot for Healthcare Professionals

March 2016
University of Southern Maine
Muskie School of Public Service

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I. Executive Summary

Introduction and Background

Unhealthy alcohol use is a serious and costly public health issue. Alcohol is the most commonly consumed substance in Maine with highest need for treatment.[1] Primary care practices are uniquely situated to identify patients who may be at risk for excessive alcohol use, but many health care providers do not have regular conversations with their patients about alcohol use.

The Muskie School of Public Service at the University of Southern Maine was contracted by Lunder-Dineen Health Education Alliance of Maine to conduct a clinical needs assessment for three practices participating in an alcohol education program. Lunder-Dineen is a non-profit organization whose mission is to improve the overall health of Maine residents by expanding their knowledge and advancing the expertise and skills of health professionals in Maine. The foundation is currently leading a pilot project called "*Time to Ask*," which is designed to provide education and training to help health care professionals working in primary care practices properly identify, assess, and recommend treatment for patients who may be affected by unhealthy alcohol use.

Methodology

The clinical needs assessment conducted by the Muskie School was designed to help inform the alcohol use education and training program for health care professionals as part of the pilot project. Our assessment utilized a mixed methods design which included a literature review, surveys at both the practice and provider-levels, as well as key informant group interviews with clinicians. Data collection took place between June of 2015 and December of 2015. The overall goal of the clinical needs assessment was to address the following evaluation questions:

1. What are the practice-level factors (across and within sites) that may influence the design, content, roll-out, and success of the pilot project?
2. What are the provider-level factors (across and within sites) that may influence the design, content, roll-out, and success of the pilot project?
3. What are the practice and provider-level facilitators and barriers to implementation?

Quantitative and qualitative data analysis techniques were used to analyze and triangulate data collected from practices and providers through the surveys and interviews. Data in this report has been de-identified and presented in the aggregate at either the practice or provider-level. Results collected in this clinical needs assessment will serve as baseline data for the forthcoming post-implementation program evaluation.

Responding Practice Characteristics

Practices participating in the "*Time To Ask: Education that Transforms Conversations about Alcohol Use"* pilot project span Northern and Central Maine. All three practices are recognized as Patient Centered Medical Homes (PCMH) and two of the sites are Federally Qualified Health Centers (FQHC). The participating pilot sites all specialize in family medicine and utilize an electronic medical records system. Pilot site staff include Doctors of Medicine (MD)/Doctors of Osteopathy (DO), Physician Assistants (PA), Licensed Practical Nurses (LPN), Registered Nurses (RN), Certified Medical Assistants (CMA), Medical Assistants (MA), and behavioral health staff including

psychologists and Licensed Clinical Social Workers (LCSW). All practices reported using a chronic disease management focused, team-based approach where multidisciplinary clinical staff are involved in providing and managing patient care. Practices also reported systems in place to monitor health behaviors and provide counseling or refer patients to community partners, but fewer services were available for alcohol use when compared to other health behaviors.

Responding Provider Characteristics

Fifty-seven clinical staff members completed the provider-level survey, the majority of whom were female and between the ages of 45 and 64. Medical assistants were the largest group of respondents, followed by registered nurses, and other allied health staff, which reflects the staffing profiles given in the practice-level survey.

Summary of Results: Organizational Context

Organizational readiness for change in healthcare settings is necessary for successful implementation of new policies, programs, and practices. Even with a high level of organizational readiness, actual transformation at the practice-level is often difficult to achieve. The majority of participating organizations and clinical staff reported that their practice had a history of change including changing how the practice does business, their approach to improving patient care, and modifying the way practice staff relate to one another and to patients. Despite reporting histories of change, all sites agreed that it was hard to make changes within their practice and had a common feeling of being overwhelmed by change.

Organizational leadership also plays a pivotal role in facilitating the implementation and maintenance of change. Pilot sites had mixed views about practice leadership. The majority of organizations feel that the leadership at their practice is available to discuss problems within the organization yet do not always promote a work environment where things can be accomplished or support practice efforts. These mixed results about practice leadership may indicate a disjuncture between the goals and strategic priorities of the larger health care system and those of the individual practices within the system.

Organizational culture is increasingly recognized as a key determinant of readiness for change and successful implementation of quality improvement efforts. Health care organizations that emphasize teamwork, coordination, and group affiliation have been associated with higher rates of successful implementation of quality improvement activities. The majority of pilot sites reported an emphasis on teamwork and frequent communication in taking care of patients and all of the sites reported good working relationships between staff and providers. Additionally, two out of three practices agreed that members of the organization treat each other with respect and are willing to help one another out when needed. Pilot sites also exhibit high capacity for learning and development within the practice but, approximately a third of practices and providers felt that they were sometimes asked to do tasks they are not trained for. This may indicate that, although organizations are generally doing a good job training staff, some organizations may struggle to keep pace with the increasing need for provider training in a constantly evolving health care environment.

Learning preferences are an important consideration when developing training programs. It is

essential to understand the learning preferences of the target audience and recognize that preferences may vary among target audience members. Learning preferences at the pilot sites certainly varied, with classroom training with an instructor reported as the most effective training method, followed by blended learning and lectures or demonstrations. The majority of respondents also reported that interactive learning was an important component of training, however, there was a recognition among respondents that person learning may be difficult to integrate due to the busy schedules of providers.

During interviews, providers reported being interested in developing the skills necessary to confidently engage in conversations with patients about alcohol use. In addition, several interviewees mentioned an interest in developing skills needed to elicit honest and accurate information from patients, and having an opportunity to test scripts so their approach would feel comfortable and be well-received by the patients. Several participants mentioned an interest in learning how to influence patients' readiness for change using new clinical techniques such as "motivational interviewing."

Summary of Results: Provider Perspectives and Behaviors

Primary care providers recognize the importance of addressing alcohol misuse and see it as part of their clinical responsibilities, but rates of screening remain low. All three pilot sites reported screening for alcohol use at annual and new patient visits, however, office processes around screening were typically not fully standardized. Practices reported that they screen using questions from standardized alcohol risk screening tools, but may ask only a question or two from the tool. Clinicians also indicated that alcohol use data may be collected at other appointments or in other ways, such as through informal conversations with other staff.

When asked about the extent to which alcohol data is used at the practices, staff at each practice reported that primary care providers were the main users of alcohol use data, and that it was used to identify risk, decide what care is needed, and determine the most appropriate course of action for an individual patient. No practice reported using alcohol data in a systematic manner, such as managing population health. Practice staff also noted many barriers to collecting patient alcohol use data. Collecting data from patients regarding alcohol use is not a regular practice at most organizations for a variety of reasons.

During interviews, providers acknowledged the benefits to discussing alcohol use with their patients and collecting data about patient alcohol use. Providers noted that discussing alcohol use can give them an opportunity to see what is going on behind the scenes, alerting them to other areas in a patient's health that might need to be addressed. Providers see these conversations as an opportunity to help patients develop more skills to manage stress in a healthy way, rather than through unhealthy drinking habits. Although providers are not fully convinced in their ability to integrate regular conversations about alcohol use into their clinical practices, they did indicate some degree of comfort engaging patients around alcohol use. Given that many of the providers expressed a level of comfort discussing alcohol use with patients, it is not surprising that many of the providers reported initiating conversations about alcohol use with their patients.

The overwhelming majority of providers (80%) feel that they had a good working knowledge of alcohol and are comfortable carrying out their roles when working with patients who consume alcohol (66%). Nearly 60% of respondents also feel that they are capable of advising patients about drinking and its effects. However, over 25% percent of clinicians do not feel equipped to advise patients about alcohol use and an additional 15% were unsure. Moreover, nearly half of all providers (48%), did not feel

that they have the skills necessary to counsel patients who use alcohol over the long term. These findings indicate a need for continued education and training with a specific focus on building the skills necessary to assess and manage patients' alcohol use.

Providers report feeling supported in their efforts to work with patients who consume alcohol. The majority of respondents feel they can find someone to clarify their professional role (67%) and help them formulate the best way to approach patient alcohol use (72%). So, in spite of the fact that providers feel they have adequate support for working with individuals who use alcohol, over 50% feel that the best thing they could do for these patients is to refer them to someone else and 16% reported feeling that there is little they can do to help patients who consume alcohol. Most providers are ambivalent about wanting to work with patients who use alcohol (44%) and nearly 18% had no interest in working with this population. These conflicting provider views point to the continued need to educate providers about the key role they can play in the prevention of unhealthy drinking and emphasize a need for strategies that help motivate primary care providers to want to work with patients who consume alcohol.

Summary and Implications

Research has shown interventions that target providers, as well as the practice or larger health care system, are critical to improving the quality of care. Therefore, it is suggested the *Time To Ask* intervention should help facilitate change at both the practice/health system and provider-levels. Current best-practices in health care transformation suggest that an effective quality improvement initiative designed to promote regular conversations about alcohol use in primary care should include both education and training for providers, as well as practice facilitation and expert consultation to primary care practices to assist them with necessary transformation efforts. Transformation efforts may include updating workflows, defining staff roles and responsibilities, and assisting with the standardization of data collection and use to improve care and population health management.

II. Introduction and Background

Introduction

The prevalence of unhealthy alcohol use is a serious, but often underrated, public health issue. Excessive alcohol use is estimated to be responsible for 88,000 deaths in the United States each year and in 2010 excessive drinking cost the United States $249 billion, due to lost workplace productivity, healthcare expenses, criminal justice costs, and motor vehicle crash costs.[2] Excessive alcohol use, which includes binge drinking, heavy drinking, alcohol use by people under the legal drinking age, and alcohol use by pregnant women, has been associated with chronic diseases, unintentional injuries, violence, fetal alcohol spectrum disorders, sudden infant death syndrome, and alcohol abuse or dependence.[3] According to the Centers for Disease Control and Prevention,[4] in 2014, Maine had a higher prevalence of adults who had at least one drink of alcohol in the past 30 days (59%), as well as a higher prevalence of binge drinking (17%) and heavy drinking (7%) compared to the U.S. median. Alcohol is the most commonly consumed substance in Maine and is also the substance associated with the highest need for treatment in the state. The majority of inpatient hospital admissions related to substance abuse in Maine are due to alcohol and, in 2014, nearly one in four motor vehicle crashes in the state involved alcohol.[1]

Most public health strategies for reducing excessive alcohol use depend on state and local laws (e.g. limits on the days/hours of alcohol sales, alcohol taxes). However, the primary care setting offers a unique opportunity for healthcare professionals to identify patients who may be at high risk for unhealthy alcohol use or are currently using alcohol in an unsafe manner. Unfortunately, health care professionals often have limited education and training around substance use disorders and therefore, know very little about its effect on our body or what constitutes unhealthy alcohol use. Moreover, many health care providers do not have regular conversations with their patients about alcohol use due to time constraints, competing priorities, and organizational barriers. In an analysis of 44 states and the District of Columbia, only one in six adults, one in five individuals who report current alcohol consumption, and one in four binge drinkers ever discussed alcohol use with a physician or other health professional.[5] This is unfortunate; brief intervention sessions have been shown to be effective in reducing weekly alcohol consumption, reducing binge drinking, and increasing adherence to recommended drinking limits.[5] Through the use of standardized screening tools and the integration of standardized protocols into practice workflows, primary care providers and professionals can identify patients who may benefit from a brief intervention with personalized feedback about the risks and consequences of unhealthy alcohol consumption.

Background

The Lunder-Dineen Health Education Alliance of Maine is a non-profit organization whose mission is to improve the overall health of Maine residents by expanding their knowledge and advancing the expertise and skills of health professionals in Maine.[6] The foundation is currently leading a pilot project, *Time to Ask*, which is designed to provide education and training to health care professionals working in primary care settings to promote proper identification, assessment, and brief intervention or referral to treatment. The goal of the project is to develop an educational program that increases providers' comfort and confidence to work with primary care patients who may be affected by unhealthy alcohol use. Three practices in Northern and Central Maine volunteered to participate in the initial pilot phase of the *Time to Ask* initiative.

While most health care providers receive little education about alcohol use,[7] the Lunder-Dineen *Time to Ask* initiative aims to develop an educational program that will raise awareness about alcohol-related issues, provide interprofessional education and skills, and address the gap between alcohol assessment and treatment.[8] The long-term goal of the initiative is to increase the comfort and confidence of Maine's primary care providers to provide care for patients who may be affected by unhealthy alcohol use. The expectation is that through the early identification of at-risk patients, primary care professionals can briefly intervene or refer patients to treatment if needed which may help in reducing the prevalence of unhealthy alcohol use in Maine and ultimately aid in the decrease the public health burden of alcohol-related health problems. A detailed logic model outlining the major components of the *Time to Ask* intervention, as well as desired short, intermediate, and long-term outcomes is available in Appendix A.

As part of this initiative, in January of 2015, the Muskie School of Public Service at the University of Southern Maine was contracted by Lunder-Dineen to conduct a clinical needs assessment aimed at understanding the practice and provider-level factors that may influence the design, content, and roll-out of the *Time to Ask* educational program for

health care professionals. The clinical needs assessment was designed to: help the development, implementation and refinement of the *Time to Ask* educational intervention; provide ongoing feedback to the *Time to Ask* Pilot Advisory Team to inform program design and content; and provide a summative assessment of anticipated facilitators and barriers to implementation.

III. Methodology

Overview

Internal practice and provider-level factors play a critical role in determining how, and to what extent, an initiative is integrated into the practice and sustained over time. The clinical needs assessment conducted by the Muskie School was designed to help inform the delivery, design, and dosage of the alcohol use education and training program for health care professionals being designed and implemented as part of the *Time to Ask* pilot project. Our assessment utilized a mixed methods design which included surveys at both the practice and provider-levels, as well as key informant interviews with clinicians. The overall goal of the clinical needs assessment was to address the following questions:

1. What are the practice-level factors (across and within sites) that may influence the design, content, roll-out, and success of the pilot project?
2. What are the provider-level factors (across and within sites) that may influence the design, content, roll-out, and success of the pilot project?
3. What are the practice and provider-level facilitators and barriers to implementation?

Table 1 provides a more detailed description of the key areas of interest, data collection strategies, and analytic plans employed during the clinical needs assessment.

TABLE 1. PROPOSED METHODS BY CLINICAL NEEDS ASSESSMENT QUESTIONS

What are the practice-level factors (across and within sites) that may influence the design, content, roll-out, and success of the pilot project?		
Areas of Interest	**Rationale**	**Methods**
• Practice characteristics (e.g., staff, size, patient population, policies) • Capacity for change (e.g., QI infrastructure, experience, and perceived value • Adaptive reserve (e.g., learning culture, work environment) • Continuing education and training (e.g., current practices/policies)	1. Identify practice-level facilitators and barriers to implementation. 2. Inform the development of the pilot project.	**Data Collection Strategies:** • Office Systems Survey submitted via email to Practice Managers **Data Analysis:** • Thematic analysis of facilitators and barriers within and across all sites
What are the provider-level factors (across and within sites) that may influence the design, content, roll-out, and success of the pilot project?		
Areas of Interest	**Rationale**	**Methods**
• Staff attitudes and beliefs (e.g., role, expectations, etc.) • Staff practices (e.g., screening rates and alcohol use discussions) • Education and training preferences (e.g., learning styles) • Practice considerations (e.g., types of support needed)	1. Identify provider-level facilitators and barriers to implementation. 2. Inform the development of the pilot project	**Data Collection Strategies:** • Written survey administered to all providers on-site during a site visit • Semi-structured group interviews conducted during a site visit **Data Analysis:** • Frequency assessment for all survey items • Thematic analysis of interview data

Data Collection Methods

OVERVIEW: Data collection for this project took place between June of 2015 and December of 2015 and was in compliance with federal and university policies regarding the protection of human subjects. All data collection protocols were reviewed and approved by the University of Southern Maine's Institutional Review Board for protection of human subjects in research. All research participants who took part in the qualitative interviews and/or completed the provider or practice surveys were asked to consent to the collection of data and participation in the research was completely voluntary, which was clearly stated on all consent forms. All data has been de-identified and is presented in aggregate form. An overview of data collection efforts and a timeline can be found in Appendix B.

A. Office Systems Survey

SURVEY DESIGN: The Office System Survey was designed to gather practice-level data including: practice characteristics, organizational leadership, and alcohol screening protocols, as well as organizational capacity and readiness for change (See Appendix C for a complete copy of the

instrument). The Muskie staff used the broad clinical needs assessment questions and domains presented above in Table 1 to develop and select specific survey domains and items. Our review of the literature indicated that there were a number of key characteristics associated with effective practice transformation and implementation including: adaptive reserve, readiness and capacity for change, and organizational culture. To the extent possible, questions from existing surveys [9-12] were used. Throughout the survey design process, we consulted with key stakeholders including the Lunder-Dineen Health Education Alliance of Maine and the *Time to Ask* Pilot Advisory Team.

The final Office System Survey included two primary sections: 1) Practice Overview and 2) Organizational Characteristics. In section one of the survey, participating sites were asked to provide basic information about their practice including: a general overview of their practice's patient panel, staff capacity, current prevention strategies, use of technology and experience participating in quality improvement activities. The second section of the survey focused on each organizations' culture; information was collected about each practice's ability to make and sustain change (adaptive reserve), practice readiness and capacity for change, and organizational characteristics such as leadership, conflict resolution and organizational decision making. Finally, the survey included questions about office processes and standardization, how and if staff are trained, and how practices retain and transfer knowledge (organizational learning) within their agency.

SURVEY ADMINISTRATION: The Office System Survey was e-mailed to all three participating pilot sites in June of 2015; cover letters were addressed to the practice manager or designee appointed by the agency. It was anticipated that it would take approximately 30 minutes to complete the survey. All survey packets included instruction for completion as well as a cover letter explaining the voluntary nature of the study, risks/benefits of participation, and key contact information for project and relevant USM staff. Participants were asked to complete and return the survey within the designated time frame (two weeks) using the self-addressed envelope provided. Email follow-up reminders were sent to participating sites prior to the due date and in two week intervals after the designated time frame for completion.

RESPONSE AND COMPLETION RATES: All three pilot sites responded to the Office System Survey and completion rates were high with participating organizations completing at least 90% of survey items.

B. Clinician Survey

SURVEY DESIGN: The Clinician Survey was designed to gather data on provider-level factors that may influence the design and implementation of an interdisciplinary alcohol education program for health care professionals including: learning preferences and training needs; knowledge and attitudes regarding working with patients who consume alcohol and; facilitators or barriers to implementing regular conversations about alcohol use into primary care practice (See Appendix D for a complete copy of the instrument).

The Muskie staff used the broad clinical needs assessment questions and domains presented above in Table 1 as well as the desired clinician level outcomes outlined in the project logic model (Appendix A) to develop and select specific survey domains and items. To the extent possible, the Muskie team used questions from existing surveys. In addition, we consulted with key stakeholders throughout the survey design process including the Lunder-Dineen Health Education Alliance of

Maine and the *Time to Ask* Pilot Advisory Team.

The final clinician survey was comprised of four principle sections: 1) Demographics, 2) Education and Training, 3) Practice Dynamics, and 4) Clinician Views and Attitudes. The first section of the survey collected basic demographic information on survey participants including age, gender, and professional degree. The Education and Training questions in section two were modeled after the Michigan Institute of Technology Training Delivery Methods Survey[13] which was designed to gather information about preferred mechanisms for education and training. Respondents were given a glossary of learning styles and asked to rate the most and least effective education and training methods on a 5-point Likert scale. This section also included open-ended, follow-up questions which provided respondents with the opportunity to explain their choices regarding education and training mechanisms. The Practice Dynamics section gathered information from clinicians and staff regarding their practice's learning processes, staff training, organizational capacity for change, and the respondent's attitudes towards improvement work. In the final section, Clinician Views and Attitudes, respondents were asked to complete the Alcohol and Alcohol Problems Perception Questionnaire (AAPPQ), a validated multi-dimensional measure of clinicians' attitudes toward working with patients who use alcohol. The AAPPQ was based on a theoretical framework involving two connected concepts: role security and therapeutic commitment. The first concept, role security, assesses how secure one feels working with patients who consume alcohol and has two domains: (a) role adequacy (having adequate knowledge about working with individuals who use alcohol) and (b) role legitimacy (feeling that it is appropriate to deal with alcohol issues with patients).[14] The second concept, therapeutic commitment, has three domains: (a) willingness or motivation, (b) work satisfaction, and (c) self-esteem.[15,16] Some of the language in the AAPPQ was slightly altered in the Clinician Survey to better assess how clinicians feel about working with patients who consume alcohol across the full spectrum of consumption from at-risk to heavy use. Appendix D contains the survey instrument.

SURVEY ADMINISTRATION: All surveys were distributed and administered during on-site visits conducted by the Muskie staff at each of the pilot sites in November and December of 2015. All clinical staff were eligible to participate in the survey. For the purposes of this study, a "clinician" was defined as a person involved in the observation and treatment of patients, including but not limited to physicians, nurses, medical assistants, behavioral health professionals, and social workers. Using staffing information obtained from the Office System Survey, recruitment emails were sent to all eligible participants prior to site visits. Recruitment emails explained the purpose of the survey and described the voluntary nature of participation. In order to increase participation rates, individuals were offered a $25 gift certificate to a selected local vender such as Walmart, Hannaford, or Irving, for taking the 10-15 minutes to complete the survey. At each site, Muskie staff were given a designated area in the practice where they were able to distribute and collect completed survey packets, which included a waiver of consent as well as instructions for completion. Additional survey packets with self-addressed return envelops were left at each site for staff who may not have been onsite during day of the site visit. Gift certificates were distributed on site when staff returned the completed survey, or were mailed to respondents who returned completed surveys after the site visit.

RESPONSE AND COMPLETION RATES: We had a strong response rate for the Clinician Survey (92%). Of the 62 eligible clinical staff at the three pilot sites, 57 staff members completed the survey. In addition, completed surveys contained very little missing data; survey item completion rates exceeded 95% for all completed surveys.

C. Group Interviews

INTERVIEW PROTOCOL DESIGN: Our review of the literature indicated that clinicians' knowledge and attitudes towards working with patients who consume alcohol plays a key role in successfully implementing quality improvement efforts aimed at increasing screening, assessment, and treatment for individuals affected by at-risk or heavy drinking. In order to gather more in-depth information from clinical staff, we conducted semi-structured group interviews with clinical staff at each of the participating pilot sites. The interview guide focused on two primary domains: 1) organizational context, and 2) provider perceptions and behaviors. The first phase of the interview focused on discussing current clinical practice around the collection and use of data related to patient alcohol use. The second portion of the interview gathered information on providers' comfort, attitudes and training needs related to working with individuals who use alcohol (See Appendix F for the complete interview guide). Similar topics were covered in both the clinician surveys and group interviews in order to facilitate validation of the clinical needs assessment data through triangulation of the survey and interview data.

INTERVIEW ADMINISTRATION: All interviews were conducted by trained facilitators during on-site visits at each of the pilot sites in November and December of 2015. All clinical staff were eligible to participate in the interviews. Participants were initially recruited via e-mail and offered the opportunity to opt out of participation. We then worked with administrators at each pilot site to compile a convenience sample of clinical staff who were eligible to participate, did not opt out of the interview process, and were available to participate in an interview during the designated dates and times. In order to increase participation rates, interviews were conducted in multiple groups at each site and facilitated by at least two members of the Muskie team. Interviews were conducted at the pilot sites in office space designated by the practice. Participants were asked to provide verbal consent prior to the start of the interview and were given a $50 gift certificate to a local vender after participating in the 45- minute group discussions. All interviews were recorded and later transcribed by staff at the Muskie School.

RESPONSE AND COMPLETION RATES: The Muskie staff were able to conduct a total of eight interviews during visits to the pilot sites. Using a group interview strategy allowed us to reach a greater number of clinical staff and ultimately lead to the participation of 43 of the 62 clinical staff eligible to participate (69%). Our convenience sample of participants was fairly representative of the staffing profiles of the participating sites and included representation from the following disciplines: Certified Medical Assistant (CMA), Medical Assistant (MA), Registered Nurse (RN), Licensed Practical Nurse (LPN), Nurse Practitioner (NP), Physician Assistant (PA), Medical Doctor (MD)/Doctor of Osteopathic Medicine (DO), social work, and behavioral health staff.

Data Analysis and Limitations

OVERVIEW: The information contained in this report was collected in the summer and fall of 2015 and has been used to help inform the design of the *Time to Ask* educational intervention. Additionally, information collected as part of the clinical needs assessment will serve as baseline data (pre-intervention) for the period of June 2015 through December 2015 for the forthcoming program evaluation (post-implementation). We utilized both quantitative and qualitative data analysis

techniques to analyze and triangulate data collected from practices and providers through the surveys and interviews. In order to maintain the confidentiality of respondents, all survey and interview data presented in this report has been de-identified and presented in the aggregate at either the practice or provider level.

QUANTITATIVE DATA ANALYSIS: Organizational and Clinician survey responses were scanned and uploaded into IBM SPSS® Version 20 (IBM Corp), a widely used software program in health and social science research which is used for statistical analysis, data management, and data documentation. Quantitative administrative and clinician survey data was analyzed using appropriate descriptive statistics including frequencies, means, and chi-square for comparisons of key categorical variables. The charts present overall frequencies or means for individual survey items.

QUALITATIVE DATA ANALYSIS: Qualitative interview data was systematically coded using the qualitative software program NVivo 11.0® (QSR International), a computer assisted qualitative analysis software program, for analysis. All interviews were audio recorded (with permission from participants), transcribed and then uploaded into NVivo for analysis. Qualitative data analysis was done iteratively to build a coding scheme for all textual data based on constructivist grounded theory techniques, in which codes are drawn from the text and coding involves frequent comparative analysis of the data.

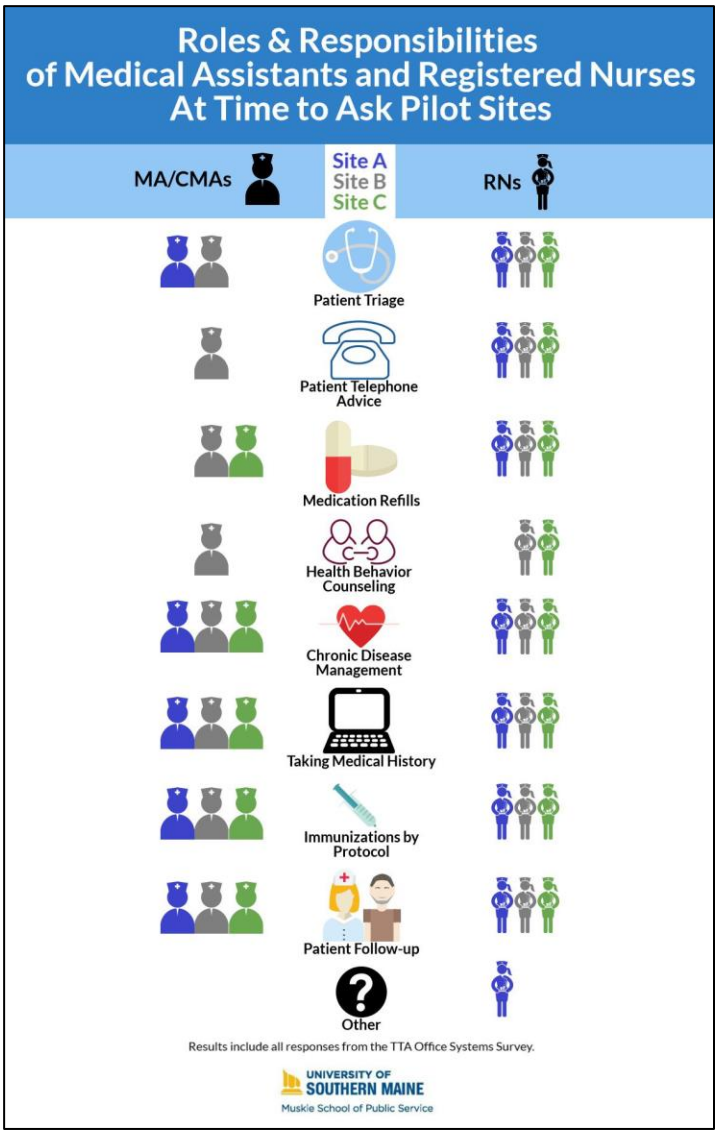
An initial set of codes was created to capture topics included in the interview questions and prompts. A team of four researchers independently coded two transcripts each, for a total of four double-coded transcripts. During the analysis phase regular team meetings were held to discuss the coding process, compare coding, refine code 'definitions,' and review (and discuss whether to adopt) new codes. This iterative process was used by the Muskie staff to continually update the coding scheme with emerging themes and constructs with attention to those elements suggested to be important facilitators or barriers to implementation of regular conversations about alcohol in primary care practices (See Appendix F for final coding scheme). Using the modified codes, each team member then coded four additional transcripts in NVivo, so that each transcript was again, double coded.

Once the coding was complete, Kappa scores and agreement percentages were generated to examine inter-rater agreement. These scores were reviewed to examine where there was disagreement and where there were actual coding errors versus differences in interpretation. Two researchers were assigned to independently summarize emergent themes for a set of half of the major codes. Narratives were reviewed and combined into a single summary of the qualitative interview data.

LIMITATIONS: There are several limitations to the data presented in this report. The first limitation of the data collected as part of this clinical needs assessment is that it is a small, non-probability convenience sample. Second, participating sites self-selected to participate in the *Time to Ask* pilot and thus may be more motivated to participate in efforts to integrate regular discussions, screening, and assessment for alcohol use into their clinical practice. Moreover, all three participating sites are Patient Centered Medical Homes (PCMH) and/or Federally Qualified Health Centers (FQHC) so these sites are more likely to have experience with practice transformation and quality improvement work. Therefore, the results of this analysis may not be reflective of the organizational climates and provider perspectives that exist in primary care practices throughout Maine. An additional limitation of our data is our reliance on self-reported survey data which is limited by the fact that it cannot be independently verified and is subject to self-report biases including selective memory, over or under reporting, and telescoping. The reliance on self-reported data, the sample size and sampling methodology, as well as the homogeneity of the sample limit the generalizability of the data collected.

However, this assessment was intended to be exploratory in nature, thus our primary intent was to use the results to help inform program development and implementation, not to generalize findings to the larger provider community. IV. Responding Practice Characteristics

IV. Overview of Practice Sites



Three practices in Northern and Central Maine are participating in the *Time to Ask* pilot project. Each of the three pilot sites are recognized as Patient Centered Medical Homes (PCMH) and two are Federally Qualified Health Centers (FQHC). A PCMH is a model of team-based primary care delivery with five functions and attributes: comprehensive care; patient-centered; coordinated care; accessible services; quality and safety.[19] A FQHC is an organization that provides primary care services for medically-underserved areas/populations and qualifies for enhanced reimbursement from Medicare and Medicaid.[20]

All three pilot sites have been in operation for over ten years; in the range of 12 to 40 or more years in practice. All three pilot site practices specialize in family medicine. In addition, two sites also offer behavioral health services and see pediatric patients, and one site has a specialty in internal medicine. The pilot sites also employ a diverse group of health care professionals to provide services and care to their patients. On average, practices had three full-time physicians; two practices also employed Osteopaths (mean=0.7, Full Time Employees). Medical Assistants (CMA/MA) represent the largest proportion of staff with each practice employing an average of 4.5 full time MAs. Each practice had at least two full time RNs and all practices employed either full or part-time behavioral health staff. Other practice staff included PAs, social workers, allied health staff, and patient educators.

All practices reported utilizing a chronic disease management, team based approach to care where a variety of clinical staff are involved in providing care at the practice. At the pilot sites, this was evidenced by the wide range of CMAs and RNs responsible for patient triage, chronic disease management, and patient follow-up (See Roles at Time to Ask Pilot Sites Infographic above).

Practices also reported having systems in place to monitor health behaviors and provide counseling or refer patients to community partners (See Figure 1). However, fewer services were available for alcohol use when compared to other health behaviors such as tobacco use or physical education. Only one practice reported using nurses or health educators to provide individual counseling for those affected by unhealthy alcohol use and only two out of three practices reported using health risk assessment protocols or questionnaires to identify individuals who may benefit from counseling for alcohol use.

FIGURE 1. PRACTICES' USE OF HEALTH RISK ASSESSMENTS AT PILOT SITES

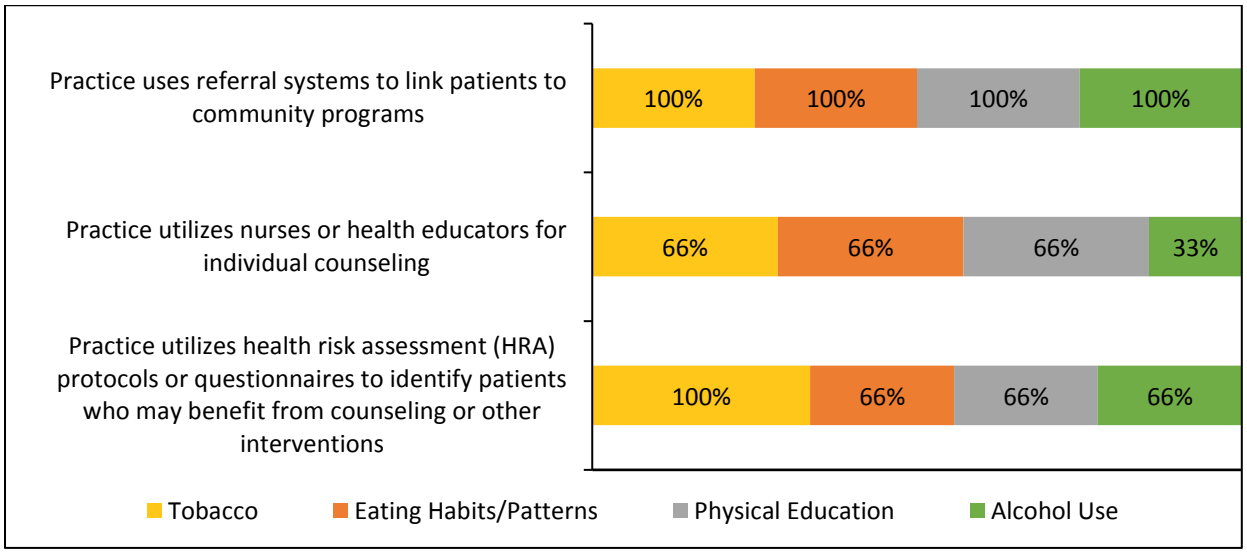
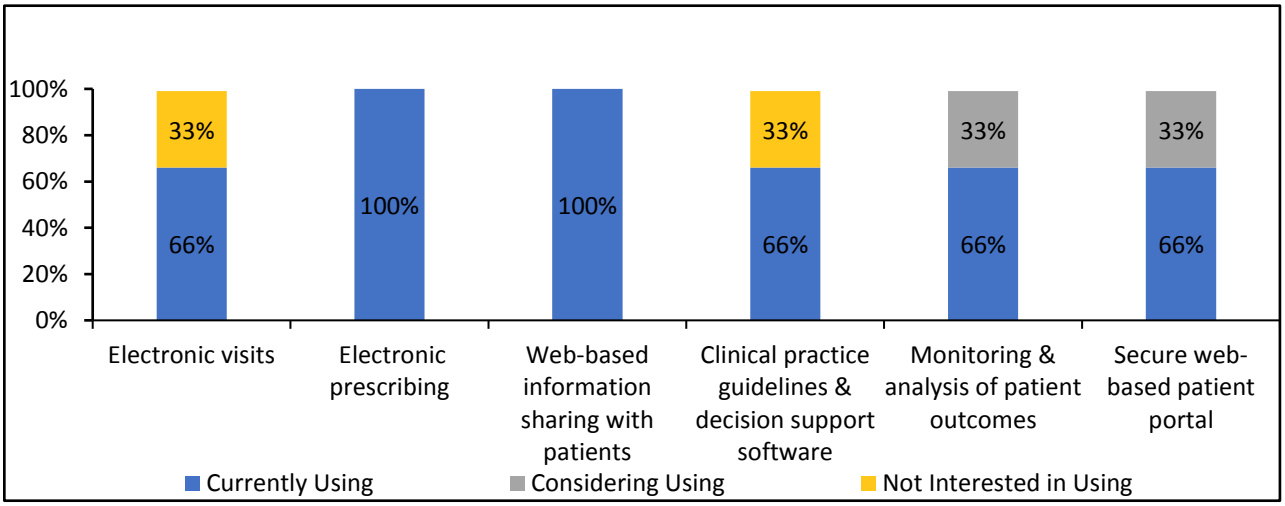


FIGURE 2. TECHNOLOGY UTILIZATION AT PILOT SITES



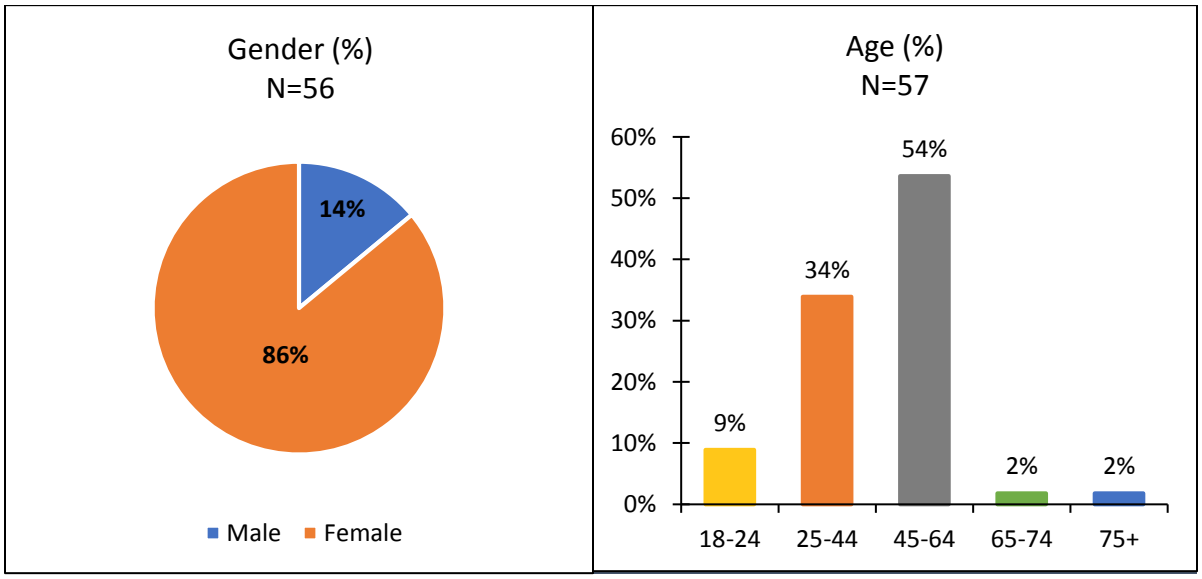
All of the *Time to Ask* pilot sites use electronic medical records (EMR), although each of the three sites has a unique EMR vendor. Practices also reported using technology for a number of other practice related activities including billing, electronic prescribing, and information sharing with patients

(Figure 2). Interestingly, practices were less likely to report using technology for clinical practice guidelines and decision support, as well as monitoring and analyzing patient outcomes or electronic visits, indicating that some practice sites have varying degrees of technology integration. Although the overall prevalence of EMR adoption and the use of technology in health care settings has increased in recent years, the adoption of technology continues to vary among specialties, particularly given differences in the confidentiality, workflow, and information needs of different providers.[21]

V. Responding Provider Characteristics

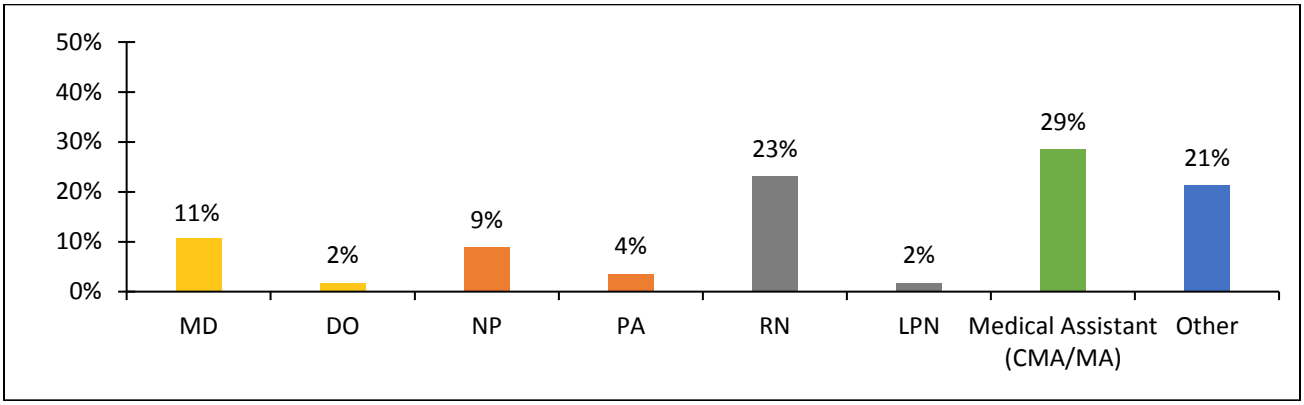
Of the nearly 60 clinical staff members (n=57) who completed the Clinician Survey, 86% were female and the majority were between the ages of 45-64 (See Figure 3).

FIGURE 3. CLINICIAN SURVEY: PARTICIPANT DEMOGRAPHICS



The largest proportion (29%) of respondents were Medical Assistants (CMA/MA), followed by RNs (23%) and other allied health staff (21%) including social workers and behavioral health staff (See Figure 4). The distribution of Clinician Survey respondents is reflective of the staffing profiles provided by participating practices in the Office Systems Survey. On average, respondents reported being at the participating pilot site for 6.6 years and 46% of the clinicians report six or more years with their current employer indicating less staff turnover than is typically reported by primary care practices.

FIGURE 4. CLINICIAN SURVEY: PARTICIPANT DEGREES



VI. Summary of Results

OVERVIEW: The goal of this document is to present the information that was gathered as part of the *Time to Ask* needs assessment in a user-friendly format for relevant stakeholders including the Lunder-Dineen Health Education Alliance of Maine and the *Time to Ask* Pilot Advisory Team. Information is grouped by topic area and infographics, frequencies and mean scores as well as information from qualitative interviews, including exemplar quotes, to describe key points and highlight relevant themes. The information presented is designed to help inform the development and implementation of an alcohol education and training program for primary care practices and providers. For a complete representation of all the data collected as part of the clinical needs assessment, refer to the Appendices.

For the purposes of this assessment, a "clinician" is a person in a practice that is involved in the observation and treatment of patients, including but not limited to physicians, nurses, medical assistants, behavioral health professionals, social workers, etc. Throughout this report we use the terms "clinician", "clinical staff", and "providers" interchangeably. When necessary, specific staff member roles are referred to by their professional title.

Section I. Organizational Context

A. Practice Transformation: Organizational Readiness for Change

KEY POINTS FROM THE LITERATURE: ORGANIZATIONAL READINESS FOR CHANGE
➢ Research indicates that under the right circumstances, primary care practices that are ready to implement evidence-based care can do so if they are provided with effective facilitation and training.[22] In addition, there is a growing body of literature that suggests that better health outcomes are associated with particular organizational attributes.[22,23] A key element of a practice's ability to maintain and improve quality of care for patients is their ability to adapt to:

- an evolving understanding of medicine in the rapidly changing healthcare environment;
- ever-increasing demands for enhanced clinical performance and;
- changes in the larger health care systems.

LITERATURE SUMMARY: Organizational readiness for change in healthcare settings is integral to the successful implementation of new policies, programs and practices.[24] Primary care practices are increasingly facing the pressures of operating in a constantly evolving healthcare environment in which new public health policies, emerging market necessities, and technological advances are changing the way practices provide care and interact with the larger healthcare environment. In busy primary care settings, such change efforts are often difficult to implement effectively and evidence indicates that without sufficient organizational readiness for change, it is challenging to implement and sustain practice transformation efforts.[25,26]

Organizational Readiness for Change is a multi-level (individual and organization levels) construct and is often defined as organizational members' collective motivation and capacity to implement change;[24,25,27] it refers to both the psychological and behavioral readiness of an organization's members. Although research on readiness for change is still evolving, there is a growing body of evidence suggesting several key organizational resources for change that play a pivotal role in creating and sustaining change in primary care practices: change commitment, resource readiness, and change efficacy. Organizational readiness for change involves commitment from organizational leadership and staff. According to Kotter [28], half of all failures to implement organization change occur because leadership failed to establish a level of readiness within the organization and among staff prior to implementation. Another key factor of organizational readiness is resource readiness: the financial investment and time commitment needed to support quality improvement are key to successful implementation. Finally, successful organizational change is rooted in an organization's shared goals and vision. Change efficacy is high when organizational members know why they are doing something, have an understanding of their roles and responsibilities, and are given the resources necessary to implement the change.[24]

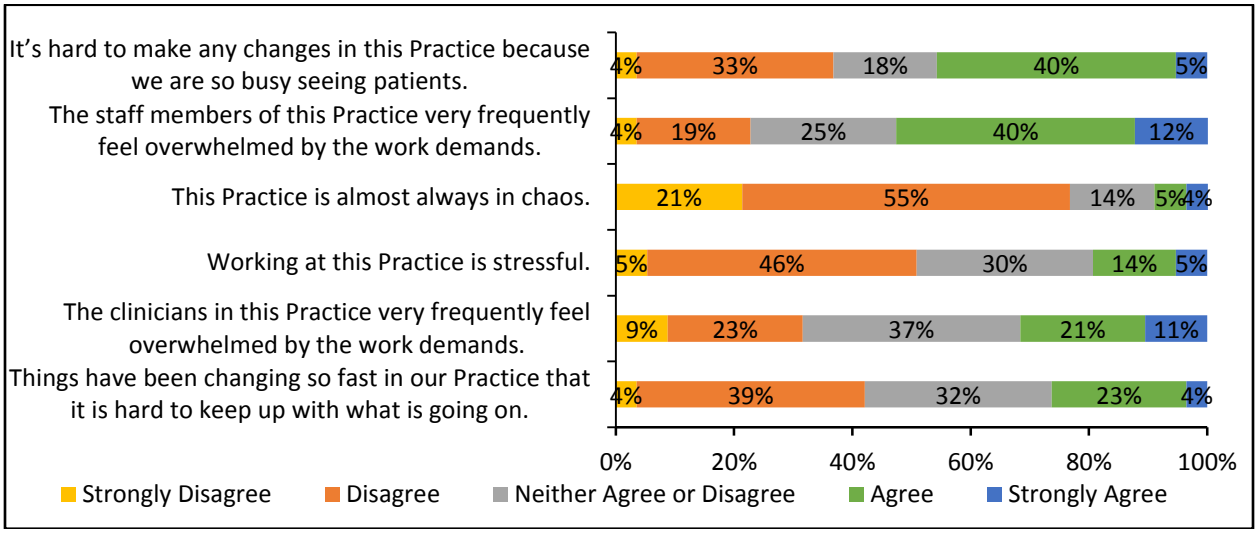
Contextual factors, including the organizational environment, may also help to predict readiness to improve care and explain variations in uptake between practices. When organizational readiness for change is high, members are more likely to initiate change, expend more effort on implementation, exhibit greater persistence, and demonstrate more cooperative behaviors which lead to more effective implementation.[24] Even with a high level of readiness, actual transformation at the practice level is often difficult to achieve. Research indicates that putting discrete components of a model in place appears to be far easier than modifying existing roles and work patterns.[29] Given the importance of practice transformation to the successful implementation of quality improvement work, we felt it was important to assess organizational readiness for change among the participating *Time to Ask* pilot sites.

SUMMARY OF RESULTS: The majority (66%) of participating organizations and similar rates of clinical staff reported that their organization had a history of change including changing how the practice does business, changing their approach to improving patient care, and modifying the way practice staff relate to one another and to patients. Although reporting histories of change, a key component in predicting the successful implementation of future quality improvement efforts, all

participating sites agreed that it was hard to make changes within the practice. Additionally, 45% of practice clinical staff reported that it was difficult to make changes because they are busy seeing patients (See Figure 5). Most practice sites agreed that changes are happening so rapidly in their practice that it is often hard for administrators to keep up with what is going on, however, only 27% of clinical staff felt it was difficult to keep up with new protocols and practices (See Figure 5).

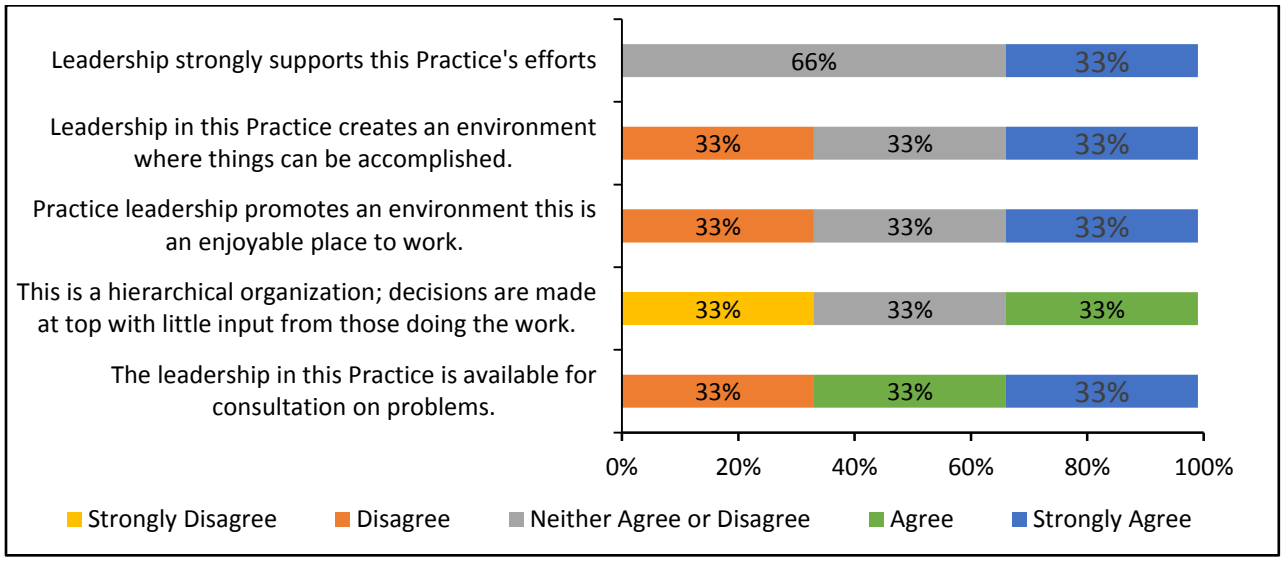
Despite their rapidly changing environment, organizations and health care providers do not feel that their practice is in a state of chaos. But, practices did agree that physicians (66%) and other clinical staff (33%) can feel overwhelmed. Interestingly, when respondents to the clinician survey were asked the same question, a much larger proportion of clinical staff (52%) reported frequently feeling overwhelmed with their work demands compared to only 33% of physicians (Figure 5). This may be reflective of shifting roles within the organization, as practices move to a team-based approach to care, clinical staff such as CMAs and PAs are playing a greater role in the management and treatment of patients.

FIGURE 5. CLINICAL STAFF VIEWS OF THEIR WORKPLACE ENVIRONMENT



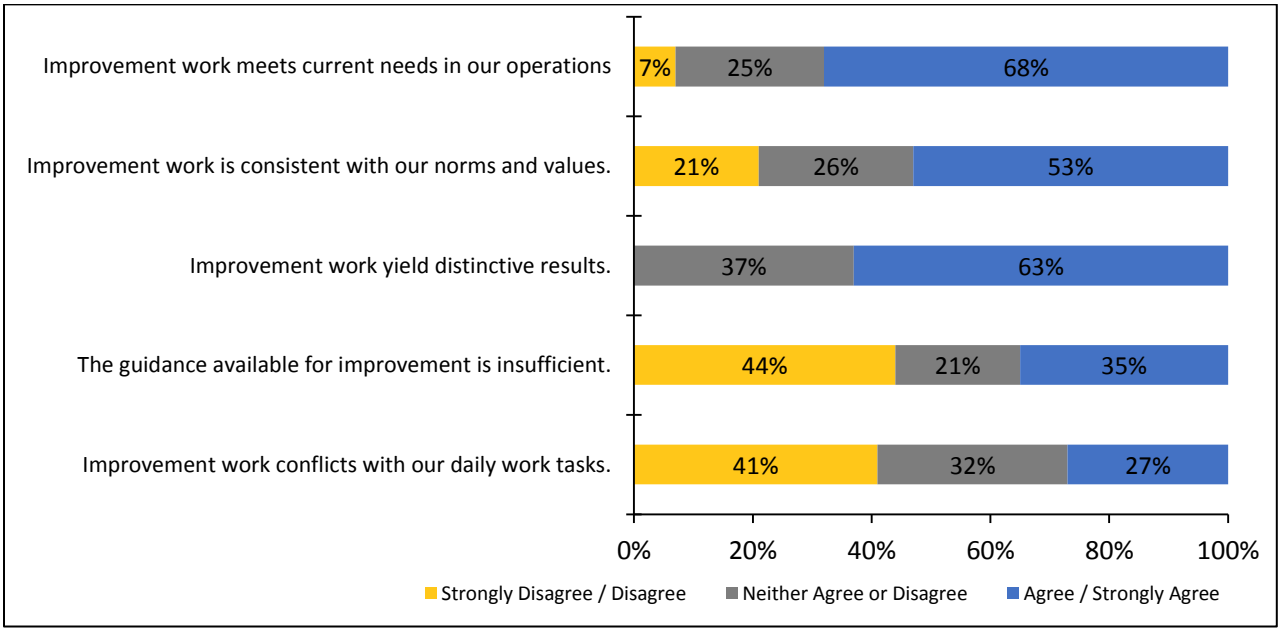
Organizational leadership plays a pivotal role in facilitating a practices ability to implement and sustain change. Participating pilot sites had mixed views about their practices' leadership. The majority of organizations feel that the leadership at their practice is available to discuss problems within the organization (See Figure 6). Yet, only one in three practices felt that the leadership at their organization promotes an enjoyable work environment where things can be accomplished. Moreover, two out of three practices do not feel that leadership supports practice efforts. These mixed results about practice leadership may indicate a disjuncture between the health care system and those within the practice, i.e., staff feel supported by the leadership of their individual practice but do not feel supported by the larger health care system organization.

FIGURE 6. PRACTICE LEADERSHIP



As discussed above, in order to successfully execute change within health care settings, organizations need to have a clear vision, well-defined plans and expectations of clinicians as well as staff support for implementation. In general, respondents seemed to see the value of participating in quality improvement work. The majority of clinicians (53%) agreed that improvement work is consistent with the norms and values of their organization and does not conflict wither their daily work tasks (41%). In addition, 68% of providers felt that improvement work meets current needs within their practice and yields distinctive results (63%). Yet, over a third of survey respondents (35%) feel that the guidance available for improvement work is insufficient (Figure 7).

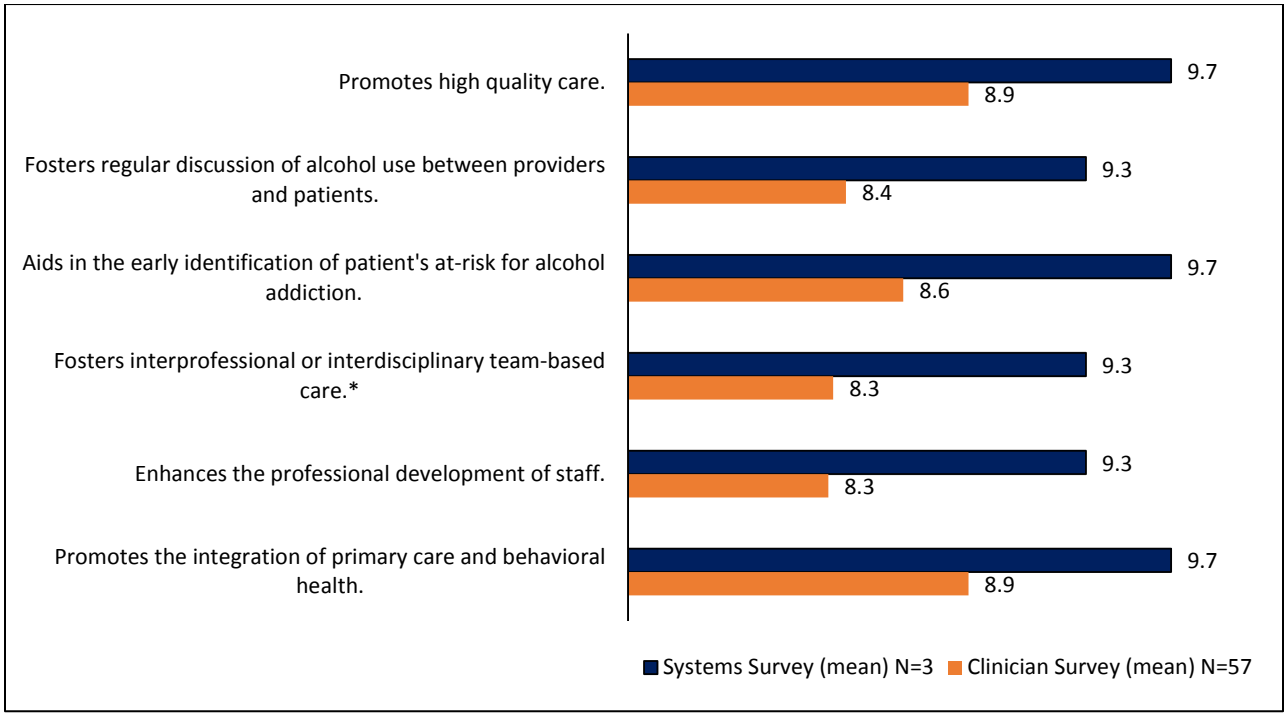
FIGURE 7. CLINICIAN ATTITUDES TOWARD IMPROVEMENT WORK



In addition to having staff buy-in for quality improvement work, it appears that the *Time to Ask* pilot

sites and the associated clinical providers have similar goals related to the integration and/or expansion of standard practices, as well as shared values of the importance of addressing alcohol use in primary care. When asked to evaluate the strategic goals of their practice, both practices and providers ranked promoting high quality care and the integration of primary care and behavioral health as principal motivations for participating in an alcohol education and training program (See Figure 8). Practices and providers also recognize an increasing need for prevention efforts; both groups felt that education and training for primary care practices could contribute to early identification for patients at risk for unhealthy alcohol use (See Figure 8).

FIGURE 8. COMPONENTS OF AN ALCOHOL EDUCATION PROGRAM -- RANKED BY IMPORTANCE



BEST PRACTICES TO INFORM PROGRAM DESIGN

- Key principles of organizational readiness for change that promote practice transformation include:
  - Providing continuous learning
  - Providing strategic leadership
  - Promoting inquiry and dialogue amongst leadership and staff
  - Encouraging collaboration and team learning
  - Creating embedded structures for capturing and sharing learning
  - Empowering people toward a shared vision
  - Making systems connections

IMPLICATIONS FOR ORGANIZATIONAL READINESS FOR CHANGE: Research indicates that while efforts to improve the delivery of evidenced-based care focused only on provider knowledge and decision support have been largely unsuccessful, interventions that target providers as well as the organization or larger health care system are critical to improving the quality of care.[29] Therefore, it is suggested the *Time to Ask* intervention should facilitate change at both the organization and provider levels. Current best-practices in health care transformation indicate that an effective quality improvement initiative designed to promote regular conversations about alcohol use in primary care should include: both education and training for providers, as well as practice facilitation and expert consultation to primary care practices, to assist them with necessary transformation efforts such as updating workflow; defining staff roles and responsibilities; and standardizing data collection and dissemination. This type of multi-layered quality improvement initiative requires a comprehensive design and approach and a thorough commitment to practices before and throughout the transformation process.

B. Practice Transformation: Organizational Culture

KEY POINTS FROM THE LITERATURE: ORGANIZATIONAL CULTURE

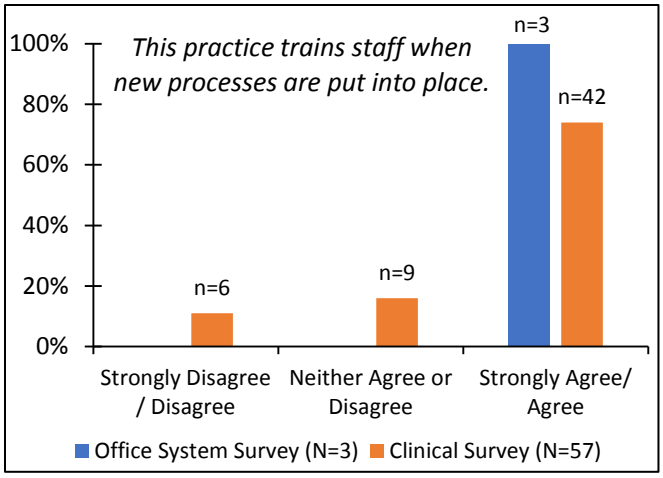
- Research suggests essential characteristics of high performing organizations include:[1,4,14,15,22,30,31]
  - A teamwork based climate
  - Coordination among multidisciplinary teams to maximize collaboration
  - Coordination among multidisciplinary strategies to maximize results
  - Infrastructure that promotes quality improvement
  - Learning opportunities for staff that are designed to meet several different learning styles
  - Universally supported goals within organization
  - Integrated communication throughout organization
  - Utilizing clear processes designed to reach end result

LITERATURE SUMMARY: Organizational culture, a term used to describe the common behavioral norms, beliefs, attitudes and values held by the members of an organization that shape its behavior, is increasingly being recognized as a key determinant of readiness for change and performance in health care organizations.[32] Although there is a need for additional research to fully understand the relationship between organizational culture and performance, current evidence suggests that organizational culture is key to the successful implementation of major improvement strategies and plays an integral role in an organizations ability to adapt the constantly evolving health care environment.[31,33,34]

For example, health care organizations that emphasize teamwork, coordination, and group affiliation have been associated with higher rates of successful implementation of quality improvement activities whereas practice cultures that emphasize formal structures and regulations appear to be negatively associated with successful implementation efforts.[35] Additionally, recent PCMH demonstration projects have further illustrated the importance of organizational culture to successful implementation; practices with an internal capacity for learning and development,[29] or "adaptive reserve", have been shown to be the most effective at transforming their practices into PCMH.

SUMMARY OF RESULTS: Results of both the Office Systems and the Clinician Surveys indicate that the *Time to Ask* pilot sites possess characteristics of successful organizational cultures. The majority of organizations reported an emphasis on teamwork and frequent communication in taking care of patients and all of the sites reported good working relationships between staff and providers. Additionally, two out of three practices agreed that members of the organization treat each other with respect and are willing to help one another out when needed. The practices reported regular communication among the practice teams, holding weekly meetings to discuss clinical issues (2 out of 3) and monthly meetings to deal with administrative issues (2 out of 3). Finally, most of the pilot

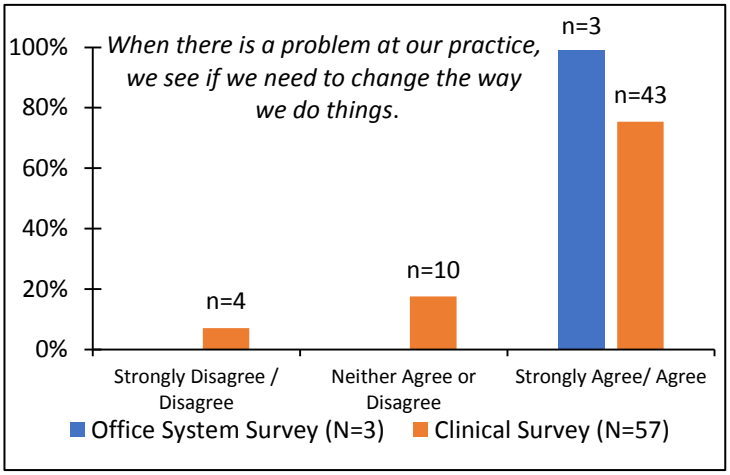
FIGURE 9. MECHANISMS FOR STAFF TRAINING



sites reported including staff and clinicians in decisions about quality improvement activities and clinical operations; clinical staff are also encouraged to take the initiative to implement and sustain change within the organization.

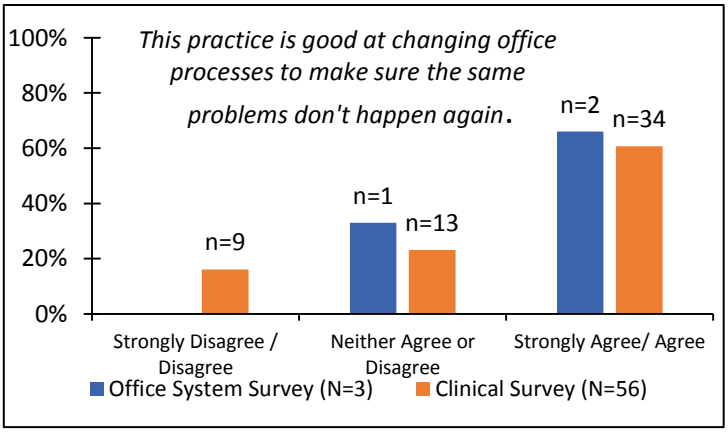
In addition to promoting a culture of cooperation and open communication, the pilot sites also exhibit high capacity for learning and development within the practice or, adaptive reserve. The majority of staff (74%) and practices (100%) agree that their organization has established mechanisms for training clinical staff when new process are put into place (Figure 9). Additionally, two out of three practices and 68% of providers feel that they are able to get the on-the-job training they need. Yet, just under a third of practices and providers who participated in the survey felt that they were asked to do tasks they are untrained for. This may indicate that, although organizations are generally doing a good job training staff, some organizations may be struggling to keep pace with the increasing need for provider training in a constantly evolving health care environment and underscores the importance of proper training prior to implementation of a new initiative.

FIGURE 10. ASSESSING PROBLEMS WITHIN THE PRACTICE



Organizational processes and procedures are critical to the implementation, ongoing evaluation, and sustainability of change in primary care practices. As described above, the majority of practices have standardized processes for clinical care as well as mechanisms for evaluating the quality of care within their organization (See Figure 10). Respondents also indicated that their organizations have implemented learning processes to evaluate clinical care within their practices. Just over 75% of clinicians reported that when there are problems within their practice, staff members assess whether changes need to be made in the organizations' policies or practices (See Figure 10). Moreover, two out of three practices and 61% of providers felt that their organization did a good job of changing to ensure problems do not arise in the future (See Figure 11); all practices indicated that they revisit any changes they have

FIGURE 11. IMPLEMENTING CHANGE TO ADDRESS



implemented in their organizations to verify that they have been successful in addressing the intended issue.

BEST PRACTICES TO INFORM PROGRAM DESIGN

- To facilitate a shift in organizational culture that enhances practices ability to implement standardized alcohol screening and brief intervention in primary care, interventions should focus on incorporating the strategies briefly outlined below.
  - Conduct an environmental scan of individual primary care practices to identify potential barriers to practice transformation.
  - Provide practices with a facilitator who can work with them to overcome barriers to change, foster a culture of change within the practice and help implement strategies that enhance organizations ability to implement Screening and Brief Intervention (SBI).
  - Work with primary care practices to foster an organizational culture of learning by establishing mechanisms for the acquisition, distribution and interpretation of knowledge within the organization through ongoing activities such as continued professional development.
  - Ensure that the entire leadership team supports and serves as champions for incorporating SBI into practice workflows.
  - Understand and articulate the impact of the quality improvement work on the various staff within the organization.
  - Mobilize clinical staff to help design and implement SBI so that they feel ownership over the process.
- Provide expert facilitation to help practices identify and embed SBI within the fabric of the organization.

IMPLICATIONS FOR ORGANIZATIONAL CULTURE: Given the important role organizational culture and climate play in ensuring the successful implementation of clinical interventions,[36] it will be important for the *Time to Ask* pilot project to upfront invest in technical assistance resources for practices in order to help facilitate practice environments that will be well situated to successfully implement and sustain changes within their clinical practices. As part of this process, it will be important to work with primary care practices to assess and address organizational issues that impede the implementation of new policies and practices for working with patients who consume alcohol. Moreover, working with practices to identify organizational barriers and devise strategies to effectively respond to any potential obstacles to implementation prior to the introduction of the pilot could improve the intervention's adoption and ultimately lead to greater rates of sustainability rates

over time, eventually resulting in better outcomes for patients.

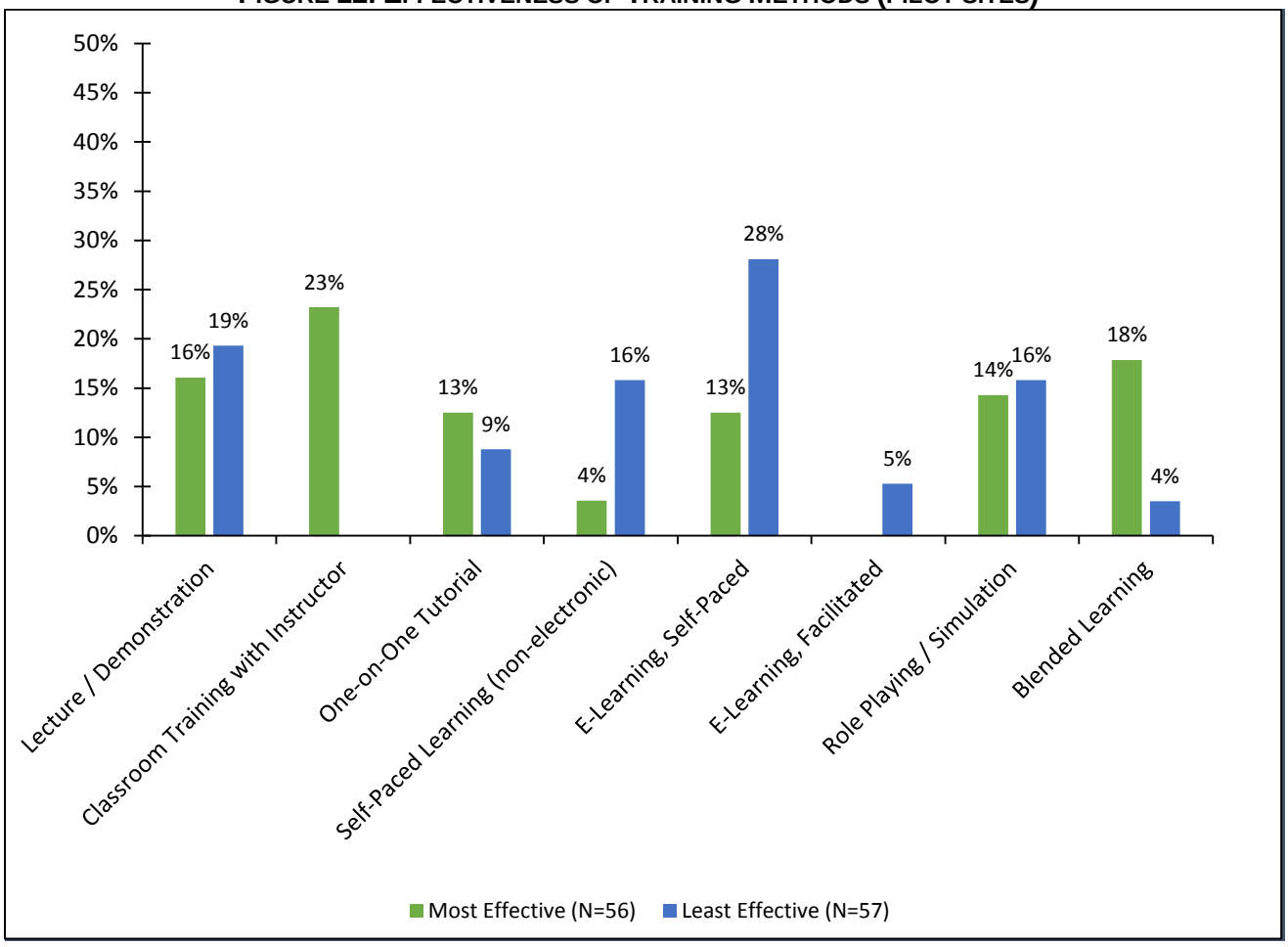
C. 21st Century Learning Styles

KEY POINTS FROM THE LITERATURE: 21st CENTURY LEARNING STYLES
➢ Research on internet-based learning is young and still developing, but early indications are that e-learning is equally effective for professional development for health care providers, though a comparative advantage over traditional methods has not emerged.[37]
➢ Learners perceive benefits of blended learning, which combines internet-based components with traditional in-person classes/workshops.[38]

LITERATURE SUMMARY: When designing and creating an effective training program, it is essential to understand the learning preferences of the target audience. Individual learning styles — how individuals perceive, process, and retain information — may vary among those in the target audience. The most common learning styles are visual, auditory, reading/writing, and kinesthetic (hands-on).[39] As primary care practices are comprised of diverse staff members (e.g. different roles and levels of education), it is highly likely that preferred learning styles within office settings will vary. In order to understand what training methods will enable staff members at primary care practices to benefit from an alcohol education training program, the Muskie School incorporated questions about preferred learning and training styles into the Clinician Survey and the semi-structured interviews that took place during pilot site visits.

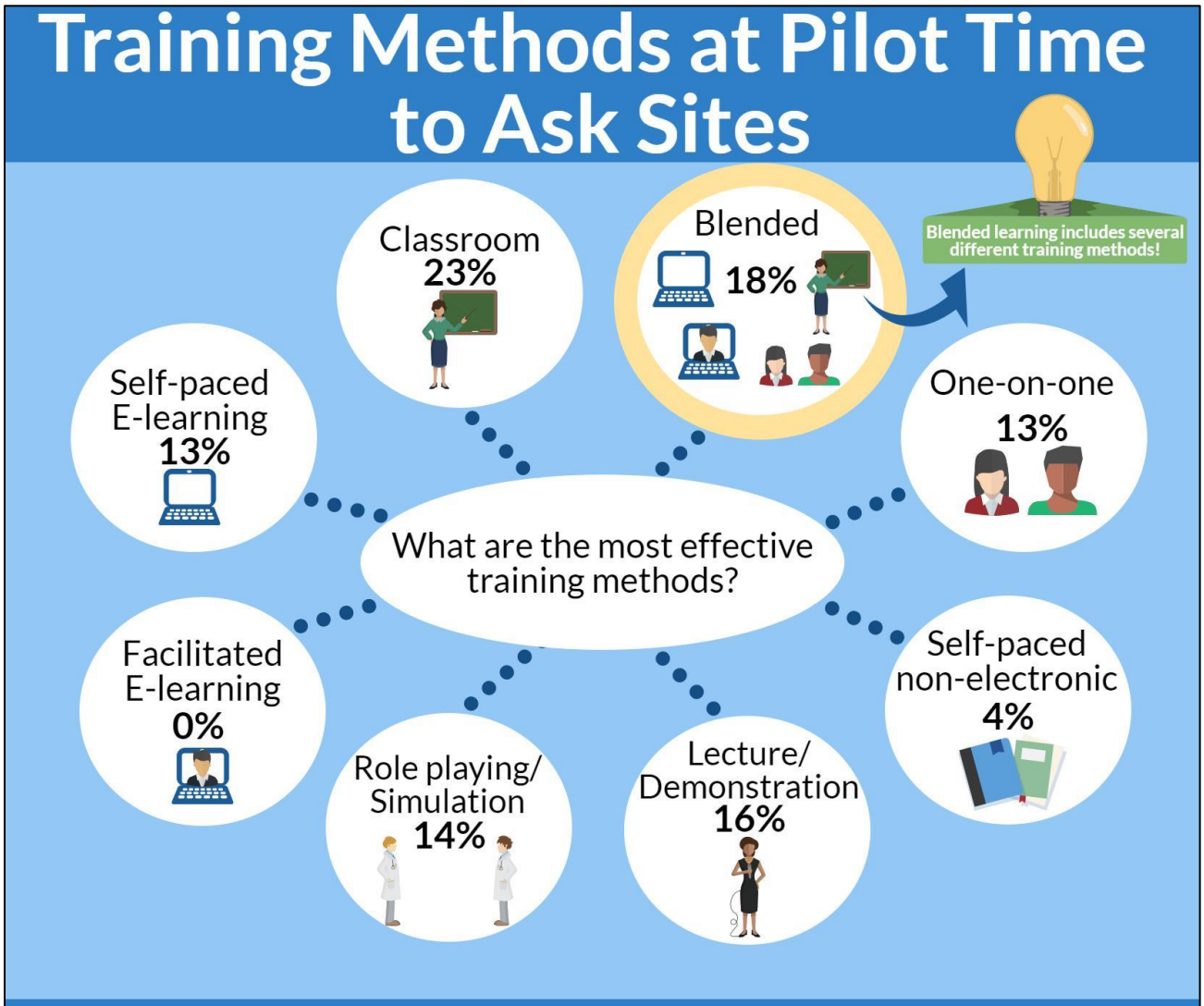
SUMMARY OF RESULTS: An important part of the *Time to Ask* clinical needs assessment was to gather information on the education and training preferences and needs of providers in order to help inform the design and implementation of the pilot project. Given what we know about differences in learning styles, it is not surprising that clinical staff reported diverse learning preferences (See Training Methods at Time to Ask Pilot Sites Infographic). Classroom training with an instructor (23%) was seen as the most effective training method followed by blended learning (18%) and lectures and demonstrations (16%). When Clinician Survey participants were asked to describe why they had chosen a particular training mechanism as the "most effective", the majority of respondents (65%) mentioned that interactive learning was an important component of training. Trainings that catered to individual learning styles (32%), blended learning techniques (23%), and opportunities for flexible scheduling (12%) were also commonly mentioned components of preferred training methodologies.

FIGURE 12. EFFECTIVENESS OF TRAINING METHODS (PILOT SITES)



Given the large number of respondents with preferences for in person or blended learning, it is not surprising that the most frequently reported least effective training mechanism were self-paced e-learning (28%) and lecture or demonstration (19%). When survey respondents were asked, "why is this the *least* effective training method for you," many respondents mentioned they did not like a certain training method because of a lack of interaction or the inability to apply what they were learning (35%) or because the training style was not engaging (32%). A number of respondents also mentioned time constraints (16%), general dislikes of specific training styles (9%), and technology barriers (4%) (See Figure 12).

Training Methods at Pilot Time to Ask Sites



Specific Themes by Profession

33% of MD and DOs reported Role playing or Simulation was the LEAST effective training method	56% of LNP and RNs reported Self-Paced E-learning was the LEAST effective training method	44% of CMA and MAs reported Lecture or Demonstration was the LEAST effective training method
Half of the social workers reported that Blended Learning was the MOST effective training method	Among clinicians, there was a low level of agreement as to which training method is most effective	Approximately 1 out of 3 NP and PAs reported Self-Paced E-Learning was the MOST effective training method

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Results include all responses from the TTA Clinician Survey.

Additional information on provider education and training was collected during interviews with practice staff. Participants were asked to describe how an education and training program could best help equip clinical staff to have routine conversations with patients about alcohol use. In response, many interviewees mentioned the importance of learning opportunities that:

- address clinical skill development;
- provide team-based learning opportunities, e.g. reviewing cases to learn from evidence and peers, and;
- offer opportunities to work through practice transformation, with colleagues, at their practices.

Interview participants were interested in developing the skills necessary to confidently engage in conversations with patients about alcohol use. In addition, several interviewees mentioned an interest in developing skills needed to elicit honest and accurate information from patients, and having an opportunity to test scripts so their approach would feel comfortable and be well-received by the patients. Several participants mentioned an interest in learning how to motivate change and how to conduct "motivational interviewing."

Some participants mentioned that they would benefit from team-based learning opportunities with their colleagues. Some suggested using case studies to allow for realistic application of the training material. Others mentioned their interest in engaging in group discussions and learning how their colleagues would handle certain situations.

During these discussions several interview participants indicated that they would need some training to support the practice transformation that would be necessary if staff and providers were to routinely engage in conversations with patients about alcohol use. They suggested that training include a "hands-on" approach for their practice setting and an opportunity to work with colleagues to determine how they might, for example, make needed workflow changes.

Participants also described their preferences for how and when they prefer to train and what might entice them to participate in training. Webinars were mentioned favorably, for some, because they may offer the flexibility to be viewed at a time that is most convenient for individual staff and providers. However, some participants mentioned that they liked participating in a group at webinars and would welcome web-based learning opportunities that offered an element of group learning or practical application at their practices. Several participants mentioned that they would benefit from opportunities to ask real questions in real time, noting this as a shortcoming of prerecorded webinars/training. Participants mentioned role-playing as beneficial training practice, but recognized that this training method may make some staff uncomfortable.

Learning logistics also came up during the group interviews. Participants mentioned "lunch and learns" favorably and mentioned that they did not want to learn outside of existing work hours, but also that they wanted learning opportunities before patients arrive or when they are not being seen because that tends to undermine participation in the training. A couple of participants mentioned that they enjoyed conferences, but recognized that this option is not practical. A couple of participants mentioned appreciating the opportunity to earn continuing education units (CEU) when training, but acknowledged that not all positions need CEUs and so this might not be a participation incentive for all providers.

BEST PRACTICES TO INFORM PROGRAM DESIGN

- A blended learning curriculum design is recommended, as a combination of methods is likely to be most effective, convenient, easily-disseminated, efficient, and well-received by providers.

- It is important to maintain realistic expectations about how much change can be accomplished, and at what pace, with educational strategies in isolation.

  - Knowledge increases are easier to achieve than the incorporation of new provider behaviors.[40]

  - To achieve and sustain implementation of new provider behaviors requires embedding the educational strategy within an organizational change strategy that comprehensively supports the adoption and spread of the desired provider behaviors.

IMPLICATIONS FOR 21st CENTURY LEARNING STYLES: Pilot practices' and staff have diverse education and training needs, and providers vary in their preferred training mechanisms. Although there were no statistically significant differences in training preferences by staffing type or age, physicians expressed a greater need for e-learning opportunities. Given their increasing time constraints and competing clinical demands, physicians emphasized a need for education and training opportunities that can fit into their busy schedules. In contrast, as other clinical staff such as MAs, nurses and social workers, expressed a need for training that focuses on building clinical skills. As practices increasingly focus on utilizing team-based models of care, traditional roles and responsibilities for clinical staff are evolving and allied health care professionals are often taking on greater responsibilities for the management and follow-up of patient care. Thus, there is a great need for education as well as hands-on training activities focused on skill building for a variety of health care staff. Primary care practices will need technical assistance to clearly define clinical roles and responsibilities; practices would also benefit from assistance in operationalizing clinical staff work flows and standardized practices.

Section II. Provider Perspectives and Behaviors

A. Alcohol Use Disorders: Provider Screening Behaviors

KEY POINTS FROM THE LITERATURE: PROVIDER SCREENING BEHAVIORS

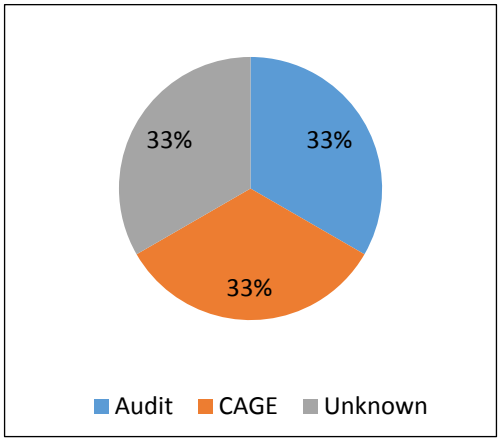
- Professional and social norms, the perceived control over one's practice site, and reimbursement are all related to practitioners screening and referral for care.[41]
- Practitioners' management of behavioral risk factors are influenced by:[42]
  - attitudes
  - normative influences from both patients and the profession and;
  - external control factors (time, cost, availability, and practice capacity).

LITERATURE SUMMARY: In general, primary care providers recognize the importance of addressing alcohol misuse and see it as part of their clinical responsibilities. However, despite ambitious efforts to implement and expand screening and counseling for alcohol use in a variety of health care settings, rates of screening remain low among primary care providers.[43] Providers cite a number of barriers to integrating regular discussions and standardized screenings into their clinical practice including: time constraints, competing demands, lack of organizational resources and the absence of systematic integration into workflows.

SUMMARY OF RESULTS: In the organizational survey all three sites reported using an alcohol screening tool at their practice, although one practice was unsure of the particular screening tool used by clinical staff. This is an indication of a common problem: a lack of standardization around the collection and use of patient alcohol use data (Figure 13). The lack of standardized processes within and between practices was confirmed during interviews with clinical staff at each of the pilot sites when clinical staff were asked to describe how practices collect, store, share and document alcohol use data. While all practices routinely collected alcohol use data on an (at least) annual basis using at least one question about alcohol use, practice personnel did not describe standard processes implemented throughout their

"Every check in, we ask tobacco and alcohol use – [that] was how I was taught. It's a standard, you know, have you had a drink of alcohol in the last year and if they answer yes, you ask frequency and amounts. Yes, we are asking them."

FIGURE 13. ALCOHOL SCREENING TOOL USED BY PILOT SITES



practices. Instead, practice staff descriptions of how these data are stored, shared, and documented varied substantially, suggesting a lack of standardized processes around alcohol use data.

Alcohol use data collection varies among primary care practices. Each of the sites engage patients in some form of alcohol screening during annual or new patient visits. Practices screen patients using questions from various standardized alcohol risk screening tools, but may ask only a question or two from the tool (e.g. CAGE, CRAFT, SBIRT, AUDIT-C). The questions may be embedded in paper patient forms containing many questions about patient health or may appear on a separate alcohol use screening form. Forms may be provided to the patient in advance or at the appointment. Medical Assistants may ask the questions if the patient has not completed them by the time of the visit. If the MA has not been able to ask the screening questions, the provider may conduct the screen. The forms are often scanned and added to the medical record. However, practice staff acknowledged that a screening form that is scanned into an EMR may not be easily seen or found in a patient's medical record. At least one practice has the nurse or MA input the result into the EMR so that the primary care physician (PCP) has to view and sign off on the result. Other practices reported having screening questions embedded in the practices EMR; the EMR automatically scores the form and flags when follow-up is indicated. Unfortunately, some practice expressed some concern about whether alcohol use data or screen results can be found in an EMR, since "*there are so many places in an EMR the data can be input[ed].*"

Screening and Brief Alcohol Use Intervention in Primary Care

- According to the federal CDC, across 44 states:[5]
  - Approximately 88,000 deaths in the U.S. are attributed to excessive alcohol use and cost the U.S. $224 billion each year.
  - Only about 1 in 6 adults reported ever having a health professional discuss alcohol use with them.
  - Only about 1 in 4 individuals who engage in binge drinking reported ever having a health professional discuss alcohol use with them.
  - Alcohol use discussion is most prevalent with patients between 18-24 years of age and those who reported binge drinking ≥ 10 times in the past month.
  - Increased alcohol screening and brief intervention procedures could help reduce excessive alcohol consumption and related health implications.
  - Research indicates that brief 6-15 minute interventions were effective in significantly reducing weekly alcohol consumption and binge drinking episodes and increasing adherence to recommended drinking limits.

"It may be different with different providers, but I know that when I am seeing a new patient for the first time, I address the alcohol issue, how much they actually drink a day, if they're worried about alcohol use or concerned about it, or somebody else in their family is concerned about their use and then I document it in our history section so it can be brought up every time if you import that past medical history in the notes so that way it gives you a chance to reevaluate that or not."

Clinicians also indicated that alcohol use data may also be collected at other appointments or in other ways such as through informal conversations with other staff. One of the pilot practices has begun to screen patients at every appointment, including acute care visits, as part of their PCMH practice transformation work. In addition, practices told us that they may collect data on alcohol use from patients if they have learned about alcohol-related issues from a non-traditional method (e.g. through public reporting of driving under the influence, from a concerned family member, or if a patient shows up for an appointment with obvious signs of intoxication).

Practice personnel expressed some concern about collecting and documenting data on alcohol use. One staff member noted that, *"Once we put it on a problem list, it is always there. So if she went through a divorce five years ago and was drinking and the Doctor made a note of that, it shows up on her life insurance, even though that is long ago and far away."* Another staff member was concerned about how the practice documents alcohol use data may be received by patients who may have access to their data through a patient portal.

When asked about the extent to which alcohol data is used at the practices, staff at each practice reported that primary care providers were the main users of alcohol use data, and that it was used to identify risk, decide what care is needed, and determine the most appropriate course of action for an individual patient. For example, a patient might be identified as at-risk of alcohol abuse and their record will be flagged to alert the PCP of the issue. Practices with in-house behavioral health services use the data to refer patients for further assessment with a behavior health provider; others used individual patient information to make referrals for external services or programs.

No practice reported using alcohol data in a systematic manner, for example, to manage population health. Routine clinical data collected in the primary care setting can be aggregated to provide population-level information on patient behaviors. This may provide insight as to what interventions may be beneficial to help improve care and health outcomes, as well as contain health care costs. For example, understanding the prevalence of unhealthy drinking behaviors among a population may provide incentive for organizations to focus on an educational campaign that may change individuals' drinking behaviors and therefore put them at lower risk for chronic diseases such as cancer or cardiovascular diseases.

"Some patients just don't want to answer, they don't feel comfortable or they will bring in their paperwork and that page is blank."

Unfortunately, practice staff noted many barriers to collecting patient alcohol use data. Collecting data from patients regarding alcohol use does not happen regularly at practice sites for a variety of reasons. Interview data collected on these barriers can be divided into the following categories:

- Patient reluctance and/or truthfulness
- Provider prioritization/ triage
- Staff/MA reluctance or role adherence
- Organizational practice or lack of systemized data collection
- Time and resource limitations
- Technology/EMR limitations
- Regulatory (e.g. insurer consequences, program requirements, Quality Improvement fatigue)
- Stigma

All eight interview groups discussed patient reluctance and time as barriers to opportunities to meaningful conversations with patients that can garner data. A majority of the interview groups (6 of

"Rarely in my practice [do] I see people who walk in and say 'I have a problem with alcohol.'"

8) also discussed staff priorities and training and organizational restrictions as barriers, and half of the interviews mentioned regulatory pressures and technology as a barrier in collecting and using alcohol use data, thus stymieing conversations. Lack of treatment resources were also mentioned in 7 interviews, though it was not seen as a barrier to gathering data on alcohol use — rather, a barrier to treatment.

Time limitations were mentioned as a barrier to conversations about alcohol nearly as frequently as patient reluctance. Practice staff and providers described feeling that there is simply not enough time for these conversations. Providers discussed their limited time with patients and the fact they already have a significant amount of data to collect, prioritize, and respond to without talking about alcohol use. Providers admit to reluctance in talking about alcohol when their triage expertise is telling them to *"prioritize... do the colonoscopy or mammogram... deal with blood work and their hospitalization last week for a heart attack."*

"I think also that patients don't see it as a problem. So why would you talk about it with the provider. It's not what they came here for.'"

Providers feel that patients are averse to talk about their alcohol use, and even if it is discussed, patients may not be completely truthful, thus making it difficult to collect any useful data from patients. Providers offered a variety of reasons why a patient might be reluctant: not trusting of the patient/provider relationship, not seeing their alcohol use a problem worthy of discussing with a provider, not wanting to admit if there is a problem or admit how much alcohol they consume, or feeling blindsided by an alcohol discussion when they are visiting the office for other health reasons not immediately related to alcohol. However, it is important to note that previous studies suggest that patients are comfortable talking to their providers about alcohol use. Many patients expect providers to ask them questions about aspects of their lifestyles that influence their health (i.e. weight, smoking, drinking, and fitness) and although conversations about alcohol are rare, most patients find these discussions useful.[44]

"Time is always a barrier. It is always a judgement call, should we talk about alcohol use today or not. Sometimes it may be the provider's lack of time why are not going to dive into this today and maybe next time but I think it is absolutely the providers who say we are not going to dig into this today."

Finally, staff at two of the three pilot sites discussed technology and/or the EMR as a barrier to collecting alcohol use data; if there is no way to document and use the data, it is hard to prioritize collecting it, and it is also difficult to remember to have conversations without data (e.g. being prompted by the EMR). Additionally, staff do not always see documentation describing prior conversations about alcohol use or abuse in the EMR and thus don't ask about it, even when doing so could be important.

BEST PRACTICES TO INFORM PROGRAM DESIGN

- Studies indicate that the likelihood of screening rates among practitioners significantly increase when practitioners:[41]
  - Feel good about their training and continuing education (attitude);
  - Believe the desired intervention is within their scope of practice (social norm) and;
  - Believe they have control over the establishment of office protocols (control).

IMPLICATIONS FOR PROVIDER SCREENING BEHAVIOR: Regularly asking patients about alcohol use can substantially reduce the under-recognition of unhealthy drinking behavior. In spite of ongoing state and federal efforts to standardize the collection of alcohol use data in primary care practices, the participating pilot sites are still struggling to operationalize effective collection mechanisms. Although practices reported incorporating preventive screening of and counseling for behavioral health risks as part of standard clinical care, providers reported less frequent conversations or assessments about alcohol use than for other health behaviors. The barriers to screening data collected from participating *Time To Ask* clinical staff mirror those found in the screening and intervention literature and include: lack of time, training, and self-efficacy; discomfort discussing alcohol use; perceived difficulty of working with patients who use alcohol; skepticism of treatment efficacy; and patient reluctance.[5] These are the same topics providers named when discussing barriers to regularly integrating discussions with patients about alcohol use in their clinical practice. In order to increase rates of screening in primary care practices *Time To Ask* intervention strategies will need to involve a multi-pronged approach that addresses both organizational and provider level barriers to screening including implementing strategies that: facilitate consistent screening practices among providers; build organizational capacity and resources for working with patients who consume alcohol; and engage community partners to promote linkages between primary care and specialty services. Given the complexity of the internal and external factor that impact screening behaviors, it is likely that intervention strategies may need to be tailored to meet the unique needs of individual practices, clinicians, patient groups and communities.

"We have certain things we look at like diabetes, we look at coronary heart disease, we look at tobacco use, we look at obesity, alcohol is nowhere on the list of data we collect for patients or that we share across the practice, well we might share about an individual patient but it's not systematized at all. There is not portal where anybody enters alcohol information. We wouldn't even have the capacity to do that right now. If we begged them to run a report they might do that but there would be so many diagnosis....we don't even do that. There is no unifying place to enter that and we would have to be trained."

B. Alcohol Use Disorders: Provider-Patient Interactions

KEY POINTS FROM THE LITERATURE: PROVIDER-PATIENT INTERACTIONS

- Physicians speak to patients about alcohol use much less frequently than about other health-related behaviors.[45]
- Alcohol-related discussions with physicians tend to be short and rare but when they occur, patients find these discussions useful.[46]
- Practitioners agree their role in alcohol harm reduction is important and are aware of national drinking guidelines and alcohol screening tools but not do not regularly utilize them.[46]
- Research has been able to identify key primary barriers that include provider-level, practice-level, and patient-level factors.[46-48]

OVERVIEW: Alcohol misuse is a common but preventable source of morbidity and mortality in the United States. Research has shown that screening and brief intervention in primary care settings can reduce unhealthy alcohol use.[49] Typically, effective brief alcohol counseling is patient-centered and includes expressions of concern, feedback linking the patient's drinking and health, explicit advice to reduce drinking and agreement on a patient oriented plan.[50] Primary care is seen as an ideal context for prevention and early detection of alcohol related problems.[49,50] Although providers generally believe that addressing unhealthy alcohol use is an important clinical responsibility, rates of screening and brief intervention in primary care remain low;[5,51] in a recent study only one in six adults in the United States reported ever discussing alcohol consumption with a health professional. Moreover, we have very limited knowledge of how, when, and why providers actually talk to patients about alcohol use.[43] New research indicates that when conversations about alcohol use occur between patients and providers, patients often disclose information about their use but providers often do not explore the topic further. In addition, when brief intervention does occur it is typically vague and tentative and providers are often uncomfortable.[43]

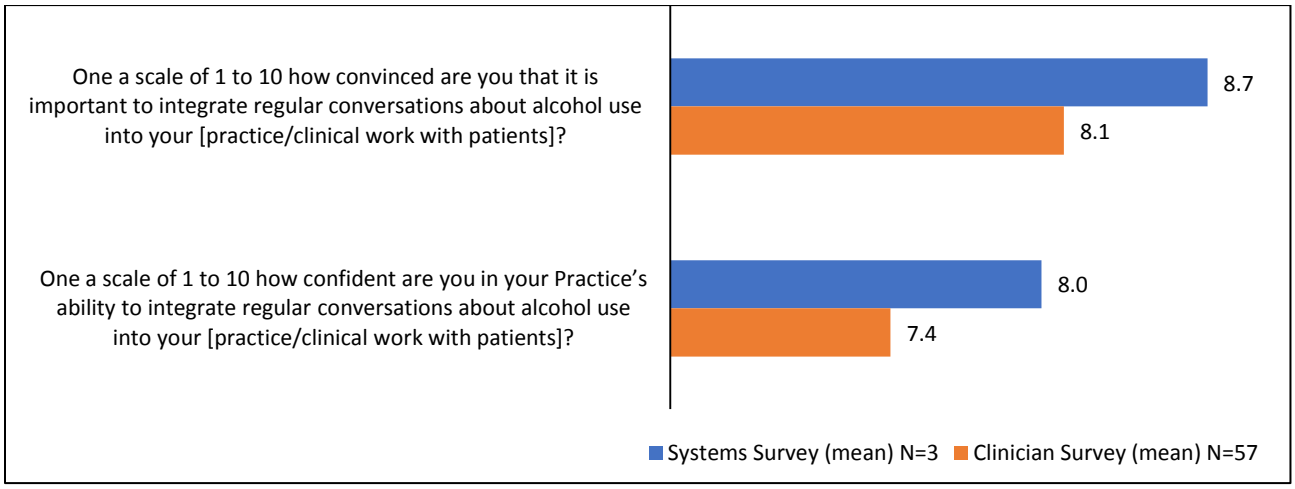
"Alcoholism has a profound impact on so many other health problems…"

SUMMARY OF RESULTS: During our interviews, providers acknowledged the benefits of discussing alcohol use with their patients and collecting data about patient alcohol use. Providers noted that discussing alcohol use can give them an opportunity to see what is going on behind the scenes, e.g., is the patient self-treating for another underlying issue, and can alert them to additional areas of inquiry that might lead them to provide better care to their patients. Providers see these conversations as opportunities to help patients develop more skills to manage stress in a healthy way, rather than

"I think one of the best benefits is you can catch people before they get worse, you can intervene and they can get some support or if they are in crisis they can get right in where they can see someone."

through unhealthy drinking habits. Asking about and tracking alcohol use precipitates earlier intervention when needed; it can help to "*catch people before they get in a worse place*" and if the patient is in crisis it can get them help more immediately. Providers recognize the importance of discussing alcohol use as a part of "whole-person health" and see it as a modifiable risk factor for chronic conditions such as cancer, coronary heart disease, and hypertension. They indicated that they view discussions of alcohol use as an opportunity to share information and educate patients about what is considered "healthy" drinking behavior. Although practices and providers see the value of integrating regular conversations about alcohol use into their practice and clinical work with patients they may not be as confident in their ability to implement this type of program.

FIGURE 14. INTEGRATING REGULAR CONVERSATIONS ABOUT ALCOHOL INTO PRACTICES



Although providers are not fully convinced in their ability to integrate regular conversations about alcohol use into their clinical practice, they did indicate a level of comfort engaging patients around alcohol use. However, many also indicated that they could be more skilled at eliciting honest information and motivating change. Practice staff generally viewed patient alcohol use as within the scope of practice for primary care, with MAs and nurses often setting the stage for discussions when they are needed, e.g. by administering screening questions, scoring screening questions, or flagging on paper or in an EMR the need for provider follow-up.

"I think asking about someone's tobacco usage is much less threatening then asking about their alcohol intake."

Comfort level, for some staff, depended on several factors. Staff indicated they are more comfortable initiating conversations with patients they perceive to be open to the discussion (e.g. the patient had initiated the conversation, the topic came up in the context of a medical issue) or if they have an established relationship with the patient. MAs and nurses were generally not comfortable having conversations with patients who presented at an appointment apparently intoxicated or smelling of alcohol. In these cases, MAs or nurses tended to communicate

"I feel that if we had clearer questions to ask that would be very beneficial."

information about alcohol to the provider and leave follow-up to the primary care provider.

Given that many of the providers expressed some degree of comfort discussing alcohol use with patients, it is not surprising that many of the providers reported initiating conversations about alcohol use with their patients. In all three pilot practices, PCPs were more likely than MAs and nurses to initiate conversations about alcohol use with patients. However, MAs and nurses discussed being "on the look-out" for warning signs and are often involved in administering screening questions for alcohol use. When risk is identified, nurses and MAs generally do not engage patients in conversation, but instead communicate their concerns to providers. However, in some instances, other clinical staff may have discussions about alcohol use, particularly when the patient brings up the topic or when alcohol use is germane to the discussion at hand for example discussions around patient medical conditions that may be exacerbated by alcohol use.

"Ultimately, it is a patient provider conversation, and other folks can help set the stage and this something that we can talk about here but there is only so much opportunity for our providers to take that any further."

"If you have a good rapport with someone, they bring it up and share it and they will identify it as a problem. And sometimes it is you identifying it to them."

Practice staff identified numerous reasons why conversations about alcohol use may be initiated with a patient. For example, all of the pilot practices said that they routinely ask questions about alcohol use at annual physicals and at all new patient visits. Conversation may be initiated when the responses to those questions indicate some level of risk or if risk is identified in another way. Providers and staff mentioned a number of reasons why they may initiate a conversation about alcohol use. For example, information in a patient's medical record, in a patient's history, problem list or elsewhere in a medical record may prompt a provider to initiate a conversation with a patient about alcohol. Discussions with patients about alcohol use also may be initiated by the patient, because a family member has expressed concern, because a provider is aware of a recent alcohol-related incident or because a patient presents at an appointment intoxicated or smelling of alcohol. Finally, conversations may be initiated because of a medical condition, prescriptions, or laboratory results. A provider may discuss alcohol consumption or probe further for abuse risk when a patient has a medical condition, such as diabetes or insomnia that can be aggravated by alcohol use or abuse. Also if a patient is taking or prescribed a new medication, the provider may initiate a discussion about alcohol use. Practice staff also reported that conversations about alcohol, or referral to a behavioral health specialist, may follow the receipt of laboratory tests that indicate overuse of alcohol, e.g. high liver enzymes.

Interviewed staff mentioned a number of factors that may influence and in many cases hinder, the likelihood of patient/provider conversations about alcohol use. Some of the factors were related to the individual patient, to the provider, the provider/patient relationship, to the organization, or were external to the practice.

"You get to know your patients and [alcohol use] is listed in their history I will ask, 'Are we drinking the same amount today, how are things going there? Are you getting any help or are you interested in getting any help?'"

Patient readiness to talk honestly about alcohol was one of the patient-related factors influencing whether a conversation would occur. Provider or staff perception that a patient was not ready to talk honestly negatively affected the likelihood of a conversation. One interviewee noted, ***"I think we can ask the questions all we want but it's a matter***

of the people wanting to be on board with treatment…" At the same time, several staff members mentioned that they would like to become more skilled in having the kind of conversations that are more likely to elicit honest conversations with patients. Patient readiness to change was also mentioned as a factor in whether conversations are initiated. When a provider perceives that a patient may be motivated, for example, to reduce his or her blood glucose levels, the provider may be more likely to engage the patient in a conversation about alcohol use. Another patient factor mentioned was when a patient's lab results indicate a medical condition that might indicate excessive alcohol use or a condition that could be worsened by alcohol use or excessive alcohol use.

"[If a patient has] coronary artery disease or they have hypertension or diabetes, then I always include questions about alcohol use, because it is a pretty big factor with people with high blood pressure – or if their liver enzymes are elevated, any potential sign of liver disease or alcohol is a risk factor. But if they are coming in for a cough or a sore throat, I do not routinely address their alcohol use.'"

Staff and providers also mentioned the patient-provider relationship as a factor in whether conversations about alcohol use take place. Group interview participants mentioned that a trusting provider-patient relationship is necessary for open conversations about alcohol. Others mentioned that it can be difficult to elicit information about alcohol use when a patient is new to the practice because they have not yet built a trusting relationship. Nurses and MAs mentioned that sometimes they do not engage patients in conversations about alcohol because patients tend to have more of a relationship with their PCP than with other practice staff. One staff member stated, *"You have to be realistic about this, it's always the first time patient coming in and you get bombarded by all these questions, what is the likelihood that you are going to get accurate answers when people are kind of guarded."*

"Unless they volunteer it, I don't like to bring it up."

Several provider factors were mentioned as influencing the likelihood of conversations about alcohol. Two frequently mentioned topics were the providers' perceptions of whether such discussions were within the scope of practice and each provider's sense of obligation to discuss alcohol once a problem or potential problem has been identified. ***"****You have a responsibility to someone if you identify this problem."* For the most part, providers and other staff alike, viewed screening and conversations about alcohol as well within the scope of practice for PCPs. MAs and nurses generally saw the responsibility as the PCP's purview and several MAs and nurses indicated that they were not comfortable having those discussions, for fear of escalation or because they viewed those discussions as outside of the scope of practice for their position.

Time constraint was the most commonly mentioned organizational barrier to initiating provider-patient conversation about alcohol. *"Part of it is how many minutes you have with the patient and how many more serious problems do they have. Sometimes alcohol is not the most serious one*." Time constraints were primarily seen as an organizational limitation, however one provider raised patient time constraints as an additional issue. *"Time…That is a factor whether or not we really are going to get into a conversation, for both of us…If a patient is in a hurry they are not going to open that what could be a can of worms either."* Additionally, pressing medical needs often take precedent to conversations about alcohol. In interviews at all practice sites, practice staff mentioned that some patients have more pressing medical needs than their alcohol use and with these patients, discussions about alcohol use may not take precedent. *"Part of it is how many minutes you have with the patient and how many more serious problems do they have. Sometimes alcohol is not the*

most serious one." And finally, practice workflows also impact on the probability of initiating a conversation with a patient about alcohol use; the expectation to discuss alcohol is currently not included in the workflow of many clinical staff such as MAs and nurses.

Lastly, providers mentioned their reluctance to initiate patients in regular conversations about alcohol use because of limited intervention and treatment options in the state. The lack of access to treatment negatively influenced the likelihood of a conversation about alcohol. Barriers to treatment, including long waitlists and high costs, were also mentioned as factors detracting from the likelihood of conversations about alcohol use. Providers may not engage patients in conversations about alcohol use because if they identify a problem there are often no referral and treatment options.

BEST PRACTICES TO INFORM PROGRAM DESIGN

- A training curriculum for providers will be most effective if it acknowledges/addresses the following barriers to discussing patients' alcohol use:[47]
  - Sensitive nature of the topic
  - Acuteness of the patient's presenting issue/reason for visit
  - Prioritization of competing demands
  - Time constraints
  - Availability of intervention tools
  - Expectations about the effectiveness of interventions
  - Perceptions of patient dishonesty

IMPLICATIONS FOR PROVIDER-PATIENT INTERACATIONS: Many of the concepts and themes that emerged in our discussions with providers about initiating conversations with patients about alcohol use have been identified in previous qualitative studies.[43,46-48] In general, the clinical providers who participated in the qualitative interviews indicated that they were comfortable initiating conversations with patients about alcohol use, but often did not for a variety of reasons such as time constraints, perceptions about patient honesty, the taboo nature of the subject, addressing more pressing medical needs, and limited external treatment resources. The most common triggers for discussing alcohol use with patients were positive screens to medical tests, a history of alcohol use documented in the medical record, family concerns or if the patient was visibly intoxicated or smelled of alcohol. It is worth noting that the majority of interviewees felt comfortable initiating conversations about alcohol use but felt that they need more training to successfully implement regular discussions about alcohol use into their clinical practice. Given these facts, the *Time To Ask* pilot should place an emphasis on providing training that incorporates practical clinical skills such as motivational interviewing. Typically, patients do not seek help for alcohol problems, but may present in primary care with a variety of other complaints which can be alcohol-related; this can serve as an opportunity for well-trained providers to use motivational interviewing techniques to seamlessly initiate

conversations about alcohol use within the context of the patient's presenting condition and overall health. Talking about alcohol use as part of patients' overall health can increase both patient and provider comfort and help reduce the stigma often associated with such discussions. Other important strategies for training providers may include expert consultations from leaders in the field and clinic-based educational activities. It will be important to help organizations establish mechanisms for accessing performance and patient outcomes so that clinicians can have ongoing feedback from peers and patients.

C. Alcohol Use Disorders: Provider Perspectives

KEY POINTS FROM THE LITERATURE: PROVIDER PERSPECTIVES

- Providers' lack of knowledge and training can contribute to negative or neutral attitudes towards persons with unhealthy drinking habits.[52] Furthermore, research indicates the delivery and quality of services provided to patients with unhealthy drinking habits are indirectly influenced by their providers:
  - Attitude towards patients who consume alcohol;
  - Norms and values within their practice;
  - Beliefs and knowledge of screening and intervention practices and;
  - Beliefs about insurance reimbursement policies.[52-55]

OVERVIEW OF THE LITERATURE: As the focus of the health care delivery system in the United States shifts from traditional hospital settings to ambulatory and community based care, much attention is being payed to the changing roles and responsibilities of providers working in primary care settings. Primary care providers and other clinical staff are uniquely situated to identify and help patients with unhealthy alcohol use; advice and early intervention when appropriate can save a lot of resource on subsequent care for this group of patients.[51] Research indicates that perspectives of clinical providers including their attitudes towards working with patients who use alcohol, their beliefs and knowledge of screening and intervention practices, norms and values within their practice, as well providers beliefs about insurance reimbursement policies, can all indirectly influence the delivery and quality of services provided to individuals with unhealthy drinking.[52-55] The knowledge and attitudes toward alcohol misuse, screening, and intervention services among primary care providers has the potential to negatively influence provider motivation and implementation of programs targeted at assessing and addressing alcohol use in primary care. Negative or neutral attitudes regarding individuals with unhealthy alcohol use may be partially driven by providers' lack of knowledge and training, therefore, there is reason to believe that additional training and support can lead to increased role adequacy, legitimacy, and therapeutic commitment among providers leading to improved overall

"Providers today are doing a lot of screenings already because (they are) forced by all the insurance ... I think it is sometimes unrealistic how much information they are required to gather..."

attitudes towards working with patients who consume alcohol.[52]

SUMMARY OF RESULTS: Questions from the standard Alcohol and Alcohol Problems Perceptions Questionnaire (AAPPQ) were included in the Clinician Survey to assess staff members' attitudes of working with patients who may have alcohol problems. The standard AAPPQ can be broken down into six sub-scales, four of which were included in the Clinician Survey. As shown in Table 2, the four sub-scales are: role adequacy, role legitimacy, role support, and motivation. A total of eighteen questions were included in the survey and the full results are included in Appendix E.

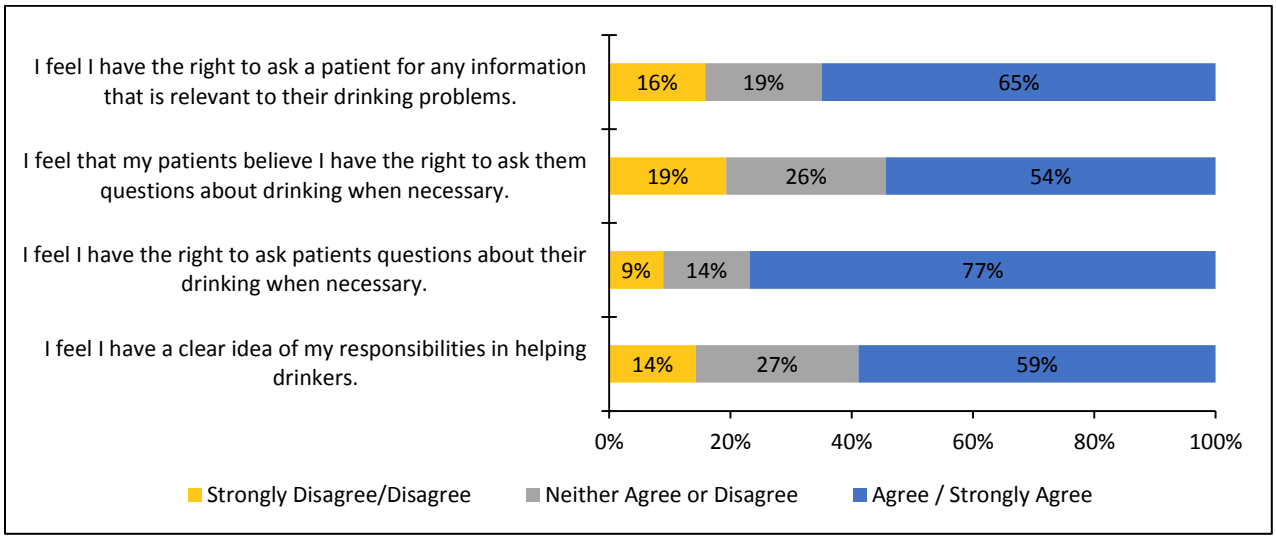
TABLE 2. RESPONDENTS' SCORES ON THE ALCOHOL AND ALCOHOL PROBLEMS PERCEPTIONS QUESTIONNAIRE (AAPPQ)

Clinician Survey: AAPPQ Results								
	N	**Possible Score Range (median)**	**Minimum Score**	**Maximum Score**	**Mean Score**	**Standard Deviation**	**Percent Below Median**	**Percent Above Median**
AAPPQ Overall	54	18-90 (54)	42	86	64.2	10.1	13.0%	87.0%
Role Security								
Role Adequacy	55	7-35 (21)	8	35	24.2	32.5	21.8%	78.2%
Role Legitimacy	56	4-20 (12)	4	20	14.5	11.3	16.1%	83.9%
Role Support	57	3-15 (9)	3	15	10.9	7.2	17.5%	82.5%
Therapeutic Commitment								
Motivation	57	4-20 (12)	8	18	14.0	3.5	7.0%	93.0%

Overall, total respondents' scores on the AAPPQ were high (mean 64.2). There was little variation in the mean between the three pilot sites (range 62.1-64.1). While the mean scores of the Role Security sub-scales indicate that respondents perceived themselves adequate in skills and knowledge related to working with patients who consume alcohol, the mean score of the motivation sub-scale under Therapeutic Commitment (relative to its maximum score) was the highest, indicating that most respondents are motivated and interested in working with and assisting patients with alcohol problems.

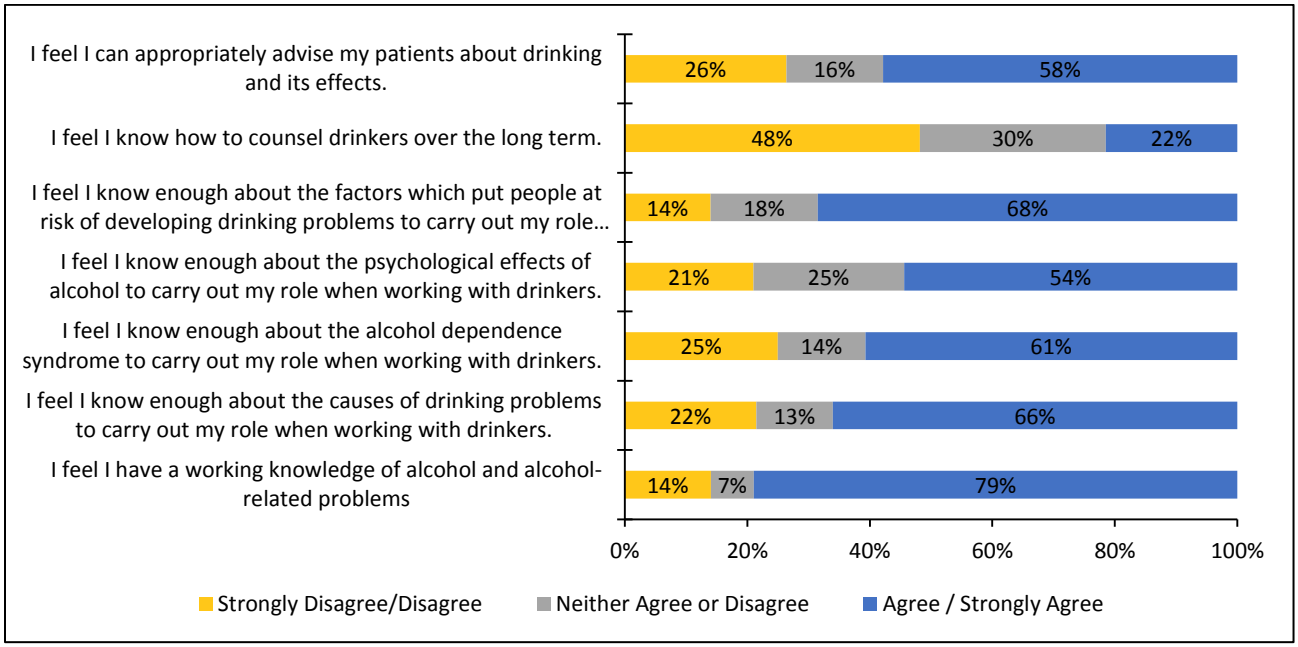
Responses to the individual questions comprising the subscales of the AAPPQ offer insights into areas where providers may need additional education or training. The providers exhibited high levels of role legitimacy; the majority of providers felt they had the right to ask patients questions and obtain relevant information regarding alcohol use behavior. However, clinicians were less likely to report feeling that patients believed that they had the right to ask them questions about their drinking (59%) (Figure 15). Additionally, nearly 15% of providers did not feel that they had a clear idea of their responsibilities related to working with patients who use alcohol and an additional 27% reported a neutral response (Figure 15). Information from the qualitative interviews supports these findings; clinical staff, including medical assistants and nurses, did not know if addressing patient alcohol consumption was in their scope of practice, and in most cases assumed it was the physicians' responsibility to act on any of the information they collect about a patients' alcohol use.

FIGURE 15. WORKING WITH PATIENTS WHO CONSUME ALCOHOL: ROLE LEGITIMACY



The overwhelming majority of providers (80%) feel that they had a good working knowledge of alcohol and are comfortable carry out their roles when working with patients who use alcohol (66%). Nearly sixty percent of respondents also feel that they are capable of advising patients about drinking and its effects. However, over 25% of clinicians do not feel equipped to advise patients about alcohol use and an additional 15% were unsure (See Figure 16). Moreover, nearly half of all providers (48%), did not feel that they have the skills necessary to counsel patients about their alcohol use over the long term (See Figure 16). These findings indicate a need for continued education and training with a specific focus on building the skills necessary to assess and manage patients' alcohol use.

FIGURE 16. WORKING WITH PATIENTS WHO CONSUME ALCOHOL: ROLE ADEQUACY



Providers report feeling supported in their efforts to work with patients who consume alcohol. The majority of respondents feel they can find someone to clarify their professional role (67%) and help them formulate the best way to approach addressing patient alcohol use (72%) (See Figure 17). In spite of the fact that providers feel they have adequate support for working with this population, over 50% feel that the best thing they could do for patients who use alcohol is to refer them to someone else and 16% reported feeling that there is little they can do to help patients who consume alcohol (See Figure 18). Most providers are ambivalent about wanting to work with patients who consume alcohol (44%) and nearly 18% had no interest in working with population (See Figure 18). These conflicting provider views point to the continued need to educate providers about the key role they can play in the prevention of unhealthy drinking and emphasize a need for strategies that help motivate primary care providers to want to work with patients who use alcohol.

FIGURE 17. WORKING WITH PATIENTS WHO CONSUME ALCOHOL: ROLE SUPPORT

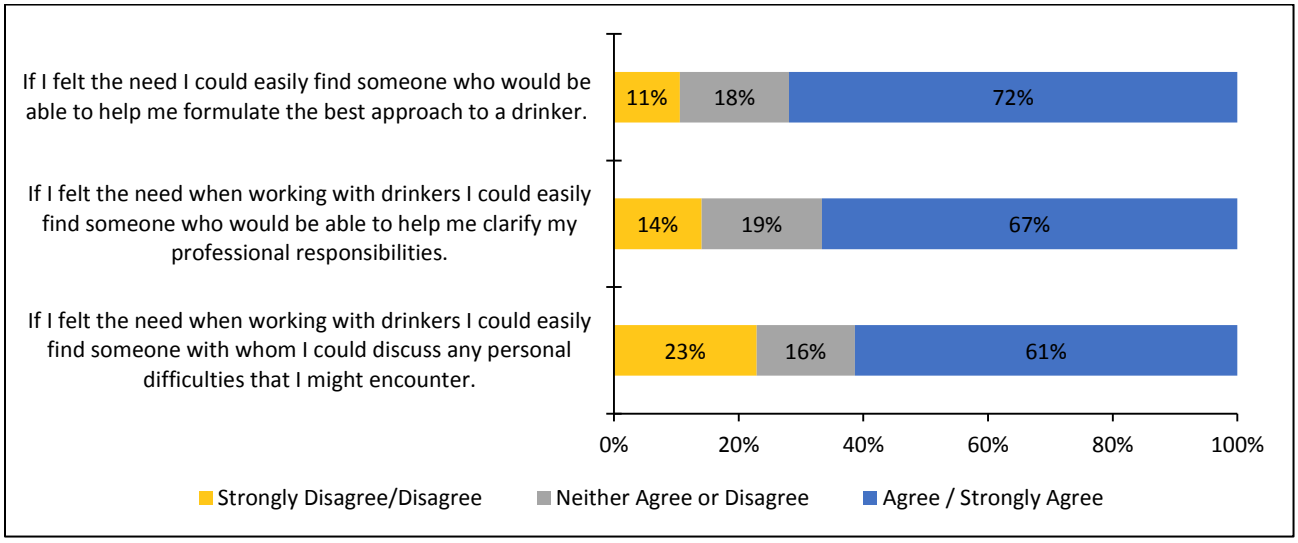
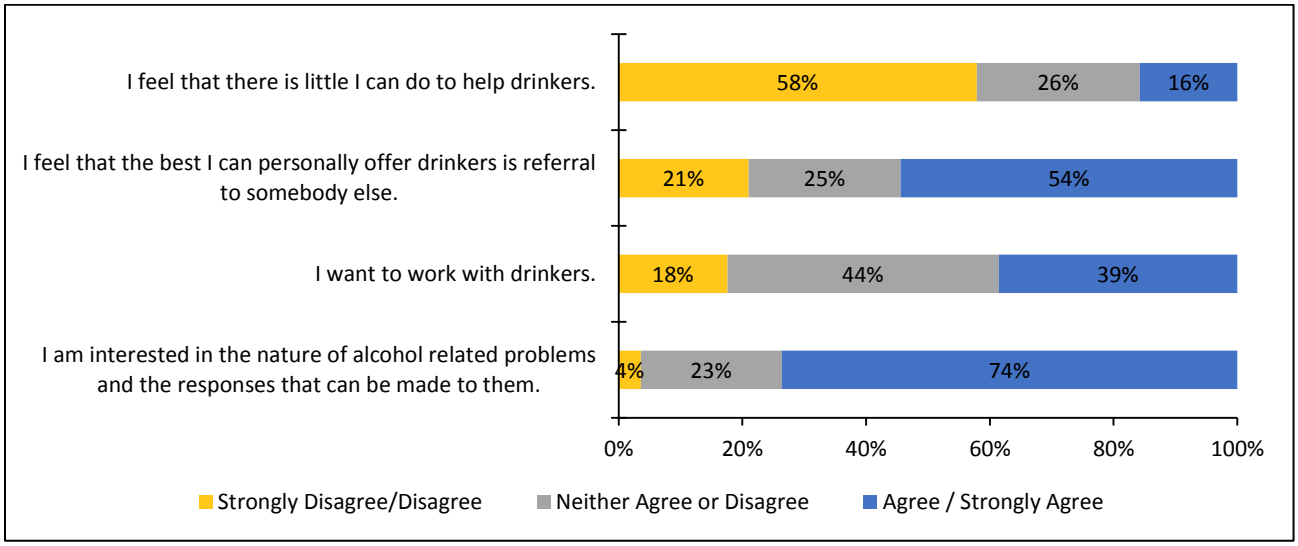


FIGURE 18. WORKING WITH PATIENTS WHO CONSUME ALCOHOL: THERAPEUTIC COMMITMENT



BEST PRACTICES TO INFORM PROGRAM DESIGN

- Despite agreement among providers about the importance of their role in minimizing the harm associated with alcohol use in their patients, in reality alcohol is often not discussed with patients. Key components of a training curriculum for providers include the following:
  - Changing the frame of reference when discussing alcohol use in medical training and in health education from an addictive disease to a behavioral risk factor is a critical to: shifting providers' attitudes; reducing the stigma associated with alcohol use; and promoting a disease model of care for alcohol use among primary care providers.
  - Providers felt they had a working knowledge of alcohol use and its effects on the body but lacked the tangible clinical skills to feel comfortable integrating SBI into their practice. Training opportunities should focus on building clinical skills of providers including stressing the efficacy of brief intervention and building provider confidence to undertake SBI.
  - Clinical staff often reported not having enough tools in their practice to manage unhealthy drinking; help practices develop standardized SBI protocols and delineate clear roles and responsibilities for clinical staff around alcohol screening and brief intervention.

Implications for Provider Perspectives: Research indicates that practitioner attitudes, normative influences from both patients and the provider community, and perceived external constraints (i.e. time, costs, resources and practice capacity) all influence providers' management of behavioral risk factors such as alcohol use.[42] Increasing provider knowledge through educational initiatives has been shown to positively impact provider perspectives towards working with patients who consume alcohol. Additionally, the *Time To Ask* initiative will need to place an emphasis on raising primary care providers' therapeutic commitment for working with individuals who use alcohol. A key element of program messaging is to educate providers about what is expected of them, as establishing clearly defined clinical roles and responsibilities are critical to shifting provider attitudes. Furthermore, providers need reassurance that committing to working with individuals with unhealthy alcohol use is not going to disrupt their clinical practice or require intensive chronic disease management. Although we recognize the limited treatment infrastructure in the state of Maine, providers overwhelmingly express a desire to have resource and links to community resources so that when they encounter a patient with high treatment needs they can refer them for appropriate care.

VII. Summary

Research indicates that efforts to improve the delivery of evidenced-based care that focus only on provider knowledge and decision support have been largely unsuccessful. Interventions that target providers, as well as the organization or larger health care system, are critical to improving the quality of care.[29] Therefore, it is suggested the *Time to Ask* intervention should help facilitate change at both the organization and provider-levels. Current best-practices in health care transformation suggest that an effective quality improvement initiative designed to promote regular conversations about alcohol use in primary care should include both education and training for providers as well as practice facilitation and expert consultation to primary care practice to assist them with necessary transformation efforts such as updating workflows, defining staff roles and responsibilities as well as assisting with standardization of data collection, use, and intervention implementation.

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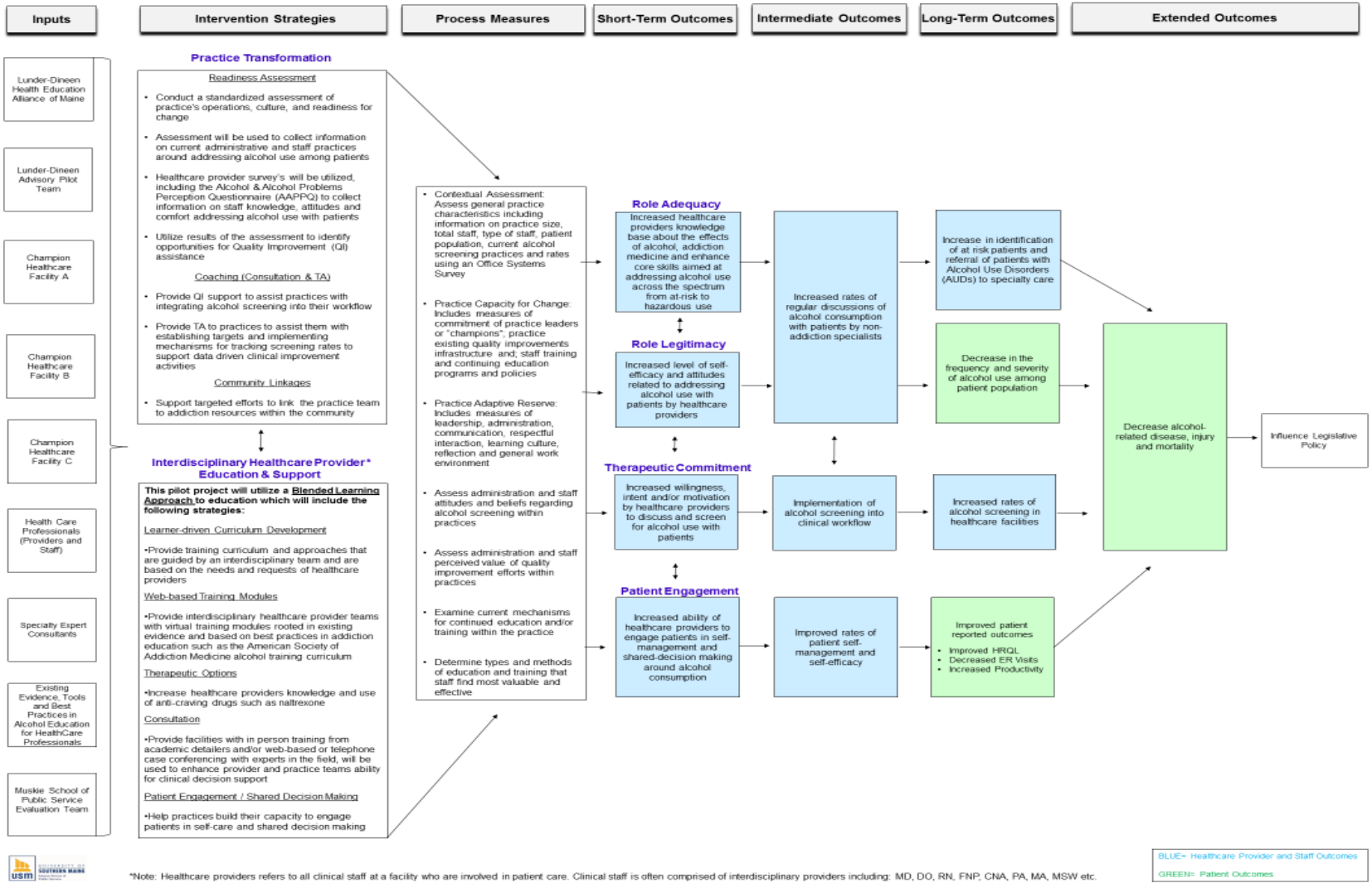
IX. Appendix

Appendix A:

Logic Model

Time to Ask Logic Model



Appendix B:

Overview of Clinical Needs Assessment and Data Collection Efforts

Time To Ask: An Alcohol Education Pilot for Healthcare Professionals
Overview of Context Assessment & Data Collection Efforts

Context Assessment

This phase is designed to address the following questions through surveys and semi-structured interviews:

1. What are the practice-level factors (across and within sites) that may influence the design, content, roll-out, and success of the pilot project?
2. What are the provider-level factors (across and within sites) that may influence the design, content, roll-out, and success of the pilot project?
3. What are the agreed upon intervention strategies and intended outcomes of the pilot project?

Figure 1. What to Expect: An Overview of Our Data Collection Efforts and Timeline

Office Systems Survey

Timeframe:
- June-July, 2015
  Complete

Format (Off-site):
- Written

Process:
- Mailed to practice manager or designee

Focus:
- Practice characteristics, culture, capacity for change, adaptive reserve, strategic priorities, policies, readiness for change

Rationale:
- To identify practice-level facilitators and barriers to implementation
- Gather baseline information on practices that may be helpful in interpreting results of the future evaluation
- To inform the development of the pilot project

Time Commitment for participants:
- 30 minutes

Due Date: June 17th

Clinician Survey

Timeframe:
- October-November, 2015

Format (On-Site):
- Written survey

Process:
- Administered on-site to all clinicians

Focus:
- Practices, attitudes, learning preferences, patient engagement, training needs

Rationale:
- To identify provider-level facilitators and barriers to implementation
- The Alcohol and Alcohol Problems Perception Questionnaire (AAPPQ) data collected as part of the clinician survey will serve as baseline data for the evaluation (Pre-Post information on role adequacy, legitimacy, therapeutic commitment, patient engagement)
- This survey will also be used to collect sensitive information that staff may not feel comfortable sharing in interviews
- To inform the development of the pilot project

Time Commitment for participants:
- 15-20 minutes

Incentive:
- $25 Gift Card (Vendor TBD)

Clinician Interviews

Timeframe:
- October-November, 2015

Format (On-Site):
- Face-to-face, semi-structured

Process:
- Interviews conducted in small groups or one-on-one

Focus:
- Roles, protocols, practices, barriers, value of and ideas for training, practice culture

Rationale:
- To gather more in-depth information from staff that cannot be obtained through survey data
- Facilitates validation of data through cross verification from two or more sources of data from the interviews, office systems and clinician surveys (i.e., Triangulation)
- To inform the development of the pilot project

Time Commitment for participants:
- 45 minutes

Incentive:
- Gift Card
  $50 Gift Card (Vender TBD)

Time To Ask: An Alcohol Education Pilot for Healthcare Professionals
Overview of Context Assessment & Data Collection Efforts

Table 1. Detailed Updated Timeline

DATE 2015	TASK	STATUS / NOTES
May 29	Office Systems Surveys mailed	Complete
Week of June 1st	Re-submit IRB materials with incentive information	Approved
June 17	Office Systems Surveys due back	All returned by 8/3/2015
September 2nd	Muskie presents preliminary findings for org assessment surveys to group	Complete
September 11th	Office contact at each side provide Muskie with email addresses for clinicians in practice for Clinician Survey	Contact information for 2 sites received as of 9/1
September 14th	Send recruitment letters for onsite interviews to clinicians, send email to site point person that interviews will be scheduled in October-November	Set due date for opt-out to 10 days after email is sent Sent out recruitment letters to 2 sites on 8/31/2015
Week of September 21th	Begin scheduling site visits/ interviews	
November-December	Site visits, interviews, clinician surveys	

Logistics for Site Coordinator, Time to Ask Practices: Muskie Interviews and Surveys

- Each practice will send USM team the name, email address and phone number of one site coordinator/site contact for practice
- Site coordinator will be responsible for working with the Muskie School on coordinating data collection site visit. The coordinator at each pilot site will:
    - Provide Muskie with the email addresses for each clinician in your practice. A clinician is anyone in your practice that is involved in the observation and treatment of patients, including but not limited to doctors, nurses, medical assistants, behavioral health professionals, social workers etc.
    - Be point of contact between Muskie and site practice for coordination and scheduling of data collection at your site including surveys and interviews, which will take place over the course of 1-2 days at practice site this fall.
    - Schedule times for all clinicians participating in interviews and provide private meeting room/space for these interviews.
    - For written surveys that are distributed by Muskie staff: if there is staff that is not available to take written survey while Muskie is there, distribute to absent staff and ensure they return to Muskie in self-addressed envelope.

Updated 9/1/2015

Appendix C:

Office Systems Survey Recruitment Materials and Instrument

Lunder-Dineen Health Education Alliance of Maine: Office Systems Survey

TIME TO ASK
Education that transforms conversations about alcohol use

Dear:

Your practice is voluntarily participating in a pilot project aimed at creating an alcohol use education and training curriculum for primary care practices. The research project is being conducted by the Muskie School, at the University of Southern Maine, for the Lunder-Dineen Health Education Alliance of Maine. The goal of the project is to develop an educational program that increases providers' comfort and confidence to properly identify, assess, and recommend treatment for patients who may be at risk or affected by unhealthy alcohol use.

We are asking for your input to help us create a team approach for staff education. This will consist of a survey that will assess your organization's capacity, policies and strengths in learning styles. The information you provide will help us to further consider the factors that are relevant to each setting as we develop the educational pilot program. Your input will help us develop a new approach to alcohol use training that can be used across the nation.

There are no foreseeable risks and no direct benefits to participation in this study. However, by participating you will be providing important feedback that could help influence the design of the educational program and curriculum. There are no costs associated with the future training. Any demographic data that you provide will not be associated with your name or your organization. The survey should take about 30 minutes to complete and this single survey can be completed by any and all staff members within the practice.

The results of this survey will be shared with the Lunder-Dineen Health Education Alliance of Maine, funders of this project and possibly in professional or academic publications. None of the results will include any personally identifiable information or link to any individuals participating in the study.

Your participation is voluntary. If you choose not to participate, it will not affect your current or future relations with the University of Southern Maine or the Lunder-Dineen Health Education Alliance of Maine. Additionally, your position and work performance will not be judged or impacted by your answers to the questions on this survey.

The researcher conducting this study is Mary Lindsey Smith, PhD, MSW, Principal Investigator, Population Health and Health Policy, at the University of Southern Maine. If you wish to opt out of this survey, please contact her using the information provided below.

For questions or more information concerning this research you may contact Lindsey Smith at (207-228-8370) or mlsmith@usm.maine.edu. If you have any questions or concerns about your rights as a research subject, you may call the USM Human Protections Administrator at (207) 228-8434 and/or email usmirb@usm.maine.edu.

TIME TO ASK
Education that transforms conversations about alcohol use

SECTION 1. PRACTICE OVERVIEW

In this section of the survey, you will be asked to provide general information regarding Practice's patient panel, staff capacity, current prevention strategies, use of technology and experience participating in quality improvement activities.

I. Practice Profile:

1. Contact Information:

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____

Email: _____

2. Years of operation: _____

3. Which clinical specialties are represented at this Practice? (Select all that apply.)
   - O Family Medicine
   - O Internal Medicine
   - O Pediatrics
   - O OB/GYN
   - O Surgery
   - O Behavioral Health
   - O Other: (Please specify) _____

4. Is this Practice a residency training practice?
   - O Yes
   - O No

5. Do you precept any students at this Practice?
   - O Yes
   - O No

6. Does this Practice have other office sites? If yes, please list name(s) and address(es) below.

Name	Address

II. Patient Demographics:

7. What is the approximate percentage of patient visits at this Practice, by specialties listed below? (Approximate number of patient visits, per type of visit, in the last 12 months. This may add up to over 100% because patients come in for multiple reasons.)

____ % Family Medicine

____ % Internal Medicine

____ % Pediatrics

____ % OB/GYN

____ % Surgery

____ % Behavioral Health

____ % Other: (Please specify) _____

8. What is the approximate percentage of your patients by gender? (Must total 100%.)

____ % Male

____ % Female

____ % Other

9. Approximately what percentage of patients that visit this Practice fall into the following age ranges?

____ % Under 3 years of age

____ % 3 – 17 years of age

____ % 18 – 24 years of age

____ % 25 – 44 years of age

____ % 45 – 64 years of age

____ % 65 – 74 years of age

____ % **WWW.** and over years of age

III. Professional and Clinical Staffing:

10. Please complete the following to describe the physicians in this Practice: (Use one line for each physician.)

Physician Name	Degree(s)	Specialty

11. Please indicate the number of full and part time clinical positions at this Practice: (Full Time + Part Time = Total FTE.)

	Type	Full Time	Part Time	Total FTE (Full Time Equivalent)
a.	MD			
b.	DO			
c.	NP			
d.	PA.			
e	Other Clinician(s):			
f.	RN			
g.	LPN			
h.	Medical Assistant (CMA/MA)			
i.	Behavioral Health			
j.	Social Worker			
k.	Allied Health Staff (lab, X-ray Tech., EKG Tech., Physician Therapist, etc.)			
l.	Practice Manager			
m.	Patient Educator			
n.	Dietician			
o.	Other:			

12. Please indicate this **Practice's Medical Assistants' (CMA/MA)** involvement in the following:
(Select all that apply.)
   - O Patient Triage
   - O Patient Telephone Advice
   - O Medication Refills
   - O Health Behavior Counseling
   - O Chronic Disease Management
   - O Medical History Taking
   - O Immunizations by Protocol
   - O Patient Follow-up
   - O Not Applicable
   - O Other: (Please specify) _____

13. Please indicate this **Practice's Nurses' RN** involvement in the following: (Select all that apply.)
   - O Patient Triage
   - O Patient Telephone Advice
   - O Medication Refills
   - O Health Behavior Counseling
   - O Chronic Disease Management
   - O Medical History Taking
   - O Immunizations by Protocol
   - O Patient Follow-up
   - O Not Applicable
   - O Other: (Please specify) _____

14. Please indicate this **Practice's Nurses' LPN** involvement in the following: (Select all that apply.)
   - O Patient Triage
   - O Patient Telephone Advice
   - O Medication Refills
   - O Health Behavior Counseling
   - O Chronic Disease Management
   - O Medical History Taking

- O Immunizations by Protocol
- O Patient Follow-up
- O Not Applicable
- O Other: (Please specify) _____

15. How are clinicians compensated in this Practice?

_____ Salary

_____ Salary Plus Incentives

_____ Other: (Please specify) _____

16. How many clinicians and staff have left this Practice in the last 12 months?

_____ Clinicians

_____ Staff

17. How many clinicians and staff have joined this Practice in the last 12 months?

_____ Clinicians

_____ Staff

IV. Patient Satisfaction:

18. How does this Practice measure clinician and staff satisfaction? (Select all that apply.)

- O Suggestion Box
- O Survey(s)
- O Doesn't Measure
- O Other: (Please specify) _____

19. Has this Practice made any changes based on your measurement of clinician and staff satisfaction?

- O Yes
- O No

V. Workplace Communication:

20. How often does this Practice hold meetings to discuss administrative issues?
    - O More than once a week
    - O Weekly
    - O Monthly
    - O Quarterly
    - O Annually
    - O Never
    - O Other: (Please specify) _____

21. How often does this Practice hold meetings to discuss clinical issues?
    - O More than once a week
    - O Weekly
    - O Monthly
    - O Quarterly
    - O Annually
    - O Never
    - O Other: (Please specify) _____

22. Please indicate who attends regular meetings for this Practice: (Select all that apply.)
    - O Clinicians
    - O Staff
    - O Clinicians and Staff Together
    - O Other Affiliated Practices: (Please specify) _____

VI. Education, Screenings, and Preventive Health Strategies:

23. Does this Practice use a registry to track patients with specific conditions?
    - O Yes
    - O No

24. Does this Practice utilize health risk assessment (HRA) protocols or questionnaires to identify patients who may benefit from counseling or other interventions in the following categories? (Select all that apply.)
    - O Tobacco Use
    - O Eating Habits/Patterns
    - O Physical Activity
    - O Alcohol Use

25. Does this Practice utilize nurses or health educators for individual counseling in the following categories? (Select all that apply.)
    - O Tobacco Use
    - O Eating Habits/Patterns
    - O Physical Activity
    - O Alcohol Use

26. Does this Practice utilize group counseling activities for your patients in the following categories? (Select all that apply.)
    - O Tobacco Use
    - O Eating Habits/Patterns
    - O Physical Activity
    - O Alcohol Use

27. For which of the following categories do your Practice use referral systems to link your patients to community programs, e.g., patient education classes, support groups, and/or individual counseling?(Select all that apply.)
    - O Tobacco Use
    - O Eating Habits/Patterns
    - O Physical Activity
    - O Alcohol Use
    - O Community Programs: (Please specify) _____

Please indicate this Practice's utilization of:		Currently Using	Considering Using	Not Interested in Using
28.	A team approach, where clinical staff are more involved in providing care	O	O	O
29.	Group visits (Group visit meaning a meeting of patients with similar needs that's conducted by the physician and another clinical professional, involving patient education concerning areas of common concern to the group, as well as the management of individual health problems of group members.)	O	O	O
30.	Chronic disease management (Chronic Disease Management meaning team-based consultations concerning diet, maintenance of medications, coordination of care, etc.)	O	O	O
31.	Service to the community and/or engagement with community resources	O	O	O

32. Does your Practice currently have a standardized protocol for routinely screening patients for alcohol use?

O Yes

O No

If yes please illustrate how alcohol screening is integrated into your clinical workflow and identify any standardized screening tools (i.e., AUDIT, CAGE) routinely used by your clinical staff.

_____

_____

_____

_____

33. Does this Practice do community health screenings or health fairs, or give lectures or workshops at schools or other community gatherings? If so, how many in the past 12 months?

O Yes

O No

Number of health screenings in the past 12 months: _____

VII. Technology:

34. Does this Practice currently use any of the following? (Select all that apply.)

- O Electronic Billing System
- O Electronic Medical Records
- O Computer-based Physician Order Entry PDA (Personal Digital Assistant)
- O Online Literature searches (Medline, Ovid, Medscape, Etc.)
- O Internet/ knowledge-based Websites (WebMD, Mayo Clinic, Etc.)
- O Other: (Please specify) _____

35.	Please indicate this Practice's utilization of:	Currently Using	Considering Using	Not Interested in Using
a.	Electronic visits (Electronic visit meaning use of email or Internet to communicate with patients.)	O	O	O
b.	Electronic prescribing	O	O	O
c.	Web-based information sharing with patients	O	O	O
d.	Clinical practice guidelines and decision support software	O	O	O
e.	Monitoring and analysis of patient outcomes	O	O	O
f.	Secure web-based patient portal	O	O	O

VIII. Participation in Quality Improvement Activities:

36.	While thinking about an educational program designed to increase staff knowledge, skills and attitudes about alcohol use, please rate on a scale of 1-10 how important each of the following are to the strategic goals of your Practice.										
		Not at all Important 1	2	3	4	5	6	7	8	9	**Extremely Important** 10
a.	Promotes high quality care	O	O	O	O	O	O	O	O	O	O
b.	Fosters regular discussion of alcohol use between providers and patients	O	O	O	O	O	O	O	O	O	O
c.	Aids in the early identification of patient's at-risk for alcohol addiction	O	O	O	O	O	O	O	O	O	O

36.	While thinking about an educational program designed to increase staff knowledge, skills and attitudes about alcohol use, please rate on a scale of 1-10 how important each of the following are to the strategic goals of your Practice.										
		Not at all Important 1	2	3	4	5	6	7	8	9	**Extremely Important** 10
d.	Fosters interprofessional or interdisciplinary team-based care	O	O	O	O	O	O	O	O	O	O
e.	Enhances the professional development of staff	O	O	O	O	O	O	O	O	O	O
f.	Promotes the integration of primary care and behavioral health	O	O	O	O	O	O	O	O	O	O

37. Are there any additional reasons this Practice wants to participate in the Lunder-Dineen Education Pilot?

38. Are there any concerns or potential barriers regarding your Practice's participation in the Lunder-Dineen Education Pilot?

SECTION 2. ORGANIZATIONAL CHARACTERISTICS

This Section of the survey gathers information about your practice's ability to make and sustain change (adaptive reserve), as well as how your Practice works as a team, its capacity for change, and organizational culture. There are also questions about your office processes and standardization, how and if staff is trained, and how your Practice retains and transfers knowledge (organizational learning). You will also be asked about your involvement with community resources. All of this information will inform the pilot alcohol education and training curriculum for your practice and practices like yours.

39.	For each statement, fill in the circle for how much you agree or disagree with the following statements about this Practice's **ability to make and sustain change (adaptive reserve).**					
		Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
a.	Mistakes have led to positive changes in this Practice.	O	O	O	O	O
b.	People in this Practice have many opportunities to grow in their work.	O	O	O	O	O
c.	People in this Practice actively seek new ways to improve how we do things.	O	O	O	O	O
d.	People at all levels of this Practice openly talk about what is and isn't working.	O	O	O	O	O
e.	Leadership strongly supports this Practice's efforts.	O	O	O	O	O
f.	After trying something new, we take time to think about how it worked.	O	O	O	O	O
g.	Most of the people who work in this Practice seem to enjoy their work.	O	O	O	O	O
h.	It is hard to get things to change in this Practice.	O	O	O	O	O
i.	This Practice learns from its mistakes.	O	O	O	O	O
j.	Practice leadership promotes an environment that is an enjoyable place to work.	O	O	O	O	O
k.	People in This Practice operate as a real team.	O	O	O	O	O
l.	When we experience a problem in this Practice, we make a serious effort to figure out what's really going on.	O	O	O	O	O
m.	Leadership in this Practice creates an environment where things can be accomplished.	O	O	O	O	O

40.	For each statement, fill in the circle for how much you agree or disagree with the following statements about **how people work together** at your Practice.					
		Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
a.	When someone in the office gets really busy, others help out.	O	O	O	O	O
b.	In this office, there is a good working relationship between staff and providers.	O	O	O	O	O
c.	In this office, we treat each other with respect.	O	O	O	O	O
d.	The office emphasizes teamwork in taking care of patients.	O	O	O	O	O

41.	For each statement, fill in the circle for how much you agree or disagree with the following statements about this Practice's **capacity for change**.					
		Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
a.	When there is a conflict in this Practice, the people involved usually talk it out and resolve the problem successfully.	O	O	O	O	O
b.	Our staff has constructive work relationships.	O	O	O	O	O
c.	There is often tension between people in this Practice.	O	O	O	O	O
d.	The staff and clinicians in this Practice operate as a real team.	O	O	O	O	O
e.	This Practice encourages staff input for making changes and improvements.	O	O	O	O	O
f.	This Practice encourages nursing and clinical staff input for making changes and improvements.	O	O	O	O	O
g.	All of the staff participates in important decisions about the clinical operation.	O	O	O	O	O
h.	Practice leadership discourages nursing staff from taking initiative.	O	O	O	O	O
i.	This is a very hierarchical organization; decisions are made at the top with little input from those doing the work.	O	O	O	O	O

42.	For each statement, fill in the circle for how much you agree or disagree with the following statements about this Practice's **capacity for change**.					
		Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
a.	It's hard to make any changes in this Practice because we are so busy seeing patients.	O	O	O	O	O
b.	The staff members of this Practice very frequently feel overwhelmed by the work demands.	O	O	O	O	O
c.	The clinicians in this Practice very frequently feel overwhelmed by the work demands.	O	O	O	O	O
d.	Working at this Practice is stressful.	O	O	O	O	O
e.	This Practice is almost always in chaos.	O	O	O	O	O
f.	Things have been changing so fast in our Practice that it is hard to keep up with what is going on.	O	O	O	O	O
g.	Our Practice has changed how it takes initiative to improve patient care.	O	O	O	O	O
h.	Our Practice has changed how it does business.	O	O	O	O	O
i.	Our Practice has changed how everyone relates.	O	O	O	O	O
j.	The leadership in this Practice is available for consultation on problems.	O	O	O	O	O
k.	The Practice defines success as teamwork and concern for people.	O	O	O	O	O
l.	Staff are involved in developing plans for improving quality.	O	O	O	O	O

43.	For each statement, fill in the circle for how much you agree or disagree with the following statements about this Practice's **office processes and standardization**.					
		Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
a.	This Practice is more disorganized than it should be.	O	O	O	O	O
b.	We have good procedures for checking that	O	O	O	O	O

43.	For each statement, fill in the circle for how much you agree or disagree with the following statements about this Practice's **office processes and standardization**.					
		Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
	work in this Practice was done correctly.					
c.	We have problems with workflow in this Practice.	O	O	O	O	O
d.	Staff in this Practice follow standardized processes to get tasks done.	O	O	O	O	O

44.	For each statement, fill in the circle for how much you agree or disagree with the following statements about this Practice's **organizational culture**.					
		Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
a.	Physicians who develop inappropriate patient care practices will be "talked to."	O	O	O	O	O
b.	We encourage internal reporting of patient care adverse events.	O	O	O	O	O
c.	The quality of each physician's work is closely monitored.	O	O	O	O	O
d.	There is an open discussion of clinical failures.	O	O	O	O	O
e.	We emphasize patient satisfaction.	O	O	O	O	O

45.	For each statement, fill in the circle for how much you agree or disagree with the following statements about how your Practice **interacts with the community**.					
		Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
a.	This Practice works effectively together as a team with community organizations.	O	O	O	O	O
b.	This Practice utilizes community resources to meet the healthcare needs of patients.	O	O	O	O	O
c.	This Practice is aware of community resources that are accessible to patients.	O	O	O	O	O
d.	People in this Practice are connected with community organizations that serve patients.	O	O	O	O	O

46. One a scale of 1 to 10 how **convinced** are you that it is important to integrate regular conversations about alcohol use into your Practice?

Not Convinced									**Extremely Convinced**
1	2	3	4	5	6	7	8	9	10
O	O	O	O	O	O	O	O	O	O

47. One a scale of 1 to 10 how **confident** are you in your Practice's ability to integrate regular conversations about alcohol use into your practice?

Not Confident									**Extremely Convinced**
1	2	3	4	5	6	7	8	9	10
O	O	O	O	O	O	O	O	O	O

48. For each statement, fill in the circle for how much you agree or disagree with the following statements about this Practice's current **mechanisms for staff training**.

		Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
a.	This Practice trains staff when new processes are put into place.	O	O	O	O	O
b.	This Practice makes sure staff get the on-the-job-training they need.	O	O	O	O	O
c.	Staff in this Practice are asked to do tasks they haven't been trained to do.	O	O	O	O	O

49. For each statement, fill in the circle for how much you agree or disagree with the following statements about this Practice's **organizational learning processes**.

		Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
a.	When there is a problem in our Practice, we see if we need to change the way we do things.	O	O	O	O	O
b.	This Practice is good at changing office processes to make sure the same problems don't happen again.	O	O	O	O	O
c.	After this Practice makes changes to improve the patient care process, we check	O	O	O	O	O

49.	For each statement, fill in the circle for how much you agree or disagree with the following statements about this Practice's **organizational learning processes**.					
		Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
	to see if the changes worked.					

50. Indicate everyone in this Practice who participated in completing this survey.

Name	Title/Position

Thank you for completing this survey.
Please return completed surveys to the Muskie School using the enclosed pre-paid self-addressed envelope.

Appendix D:

Clinician Survey Recruitment Materials and Instrument

Lunder-Dineen Health Education Alliance of Maine: Clinician Survey

TIME TO ASK
Education that transforms conversations about alcohol use

Dear:

Your practice is voluntarily participating in a pilot project aimed at creating an alcohol use education and training curriculum for primary care practices. The research project is being conducted by the Muskie School, at the University of Southern Maine, for the Lunder-Dineen Health Education Alliance of Maine. The goal of the project is to develop an educational program that increases providers' comfort and confidence to properly identify, assess, and recommend treatment for patients who may be at risk or affected by unhealthy alcohol use.

We are asking for your input to help us create a team approach for staff education. This will consist of a survey that will assess your organization's capacity, policies and strengths in learning styles. The information you provide will help us to further consider the factors that are relevant to each setting as we develop the educational pilot program. Your input will help us develop a new approach to alcohol use training that can be used across the nation.

There are no foreseeable risks and no direct benefits to participation in this study. However, by participating you will be providing important feedback that could help influence the design of the educational program and curriculum. There are no costs associated with the future training. Any demographic data that you provide will not be associated with your name or your organization. The survey should take about 30 minutes to complete and this single survey can be completed by any and all staff members within the practice.

The results of this survey will be shared with the Lunder-Dineen Health Education Alliance of Maine, funders of this project and possibly in professional or academic publications. None of the results will include any personally identifiable information or link to any individuals participating in the study.

Your participation is voluntary. If you choose not to participate, it will not affect your current or future relations with the University of Southern Maine or the Lunder-Dineen Health Education Alliance of Maine. Additionally, your position and work performance will not be judged or impacted by your answers to the questions on this survey.

The researcher conducting this study is Mary Lindsey Smith, PhD, MSW, Principal Investigator, Population Health and Health Policy, at the University of Southern Maine. If you wish to opt out of this survey, please contact her using the information provided below.

For questions or more information concerning this research you may contact Lindsey Smith at (207-228-8370) or mlsmith@usm.maine.edu. If you have any questions or concerns about your rights as a research subject, you may call the USM Human Protections Administrator at (207) 228-8434 and/or email usmirb@usm.maine.edu.

TIME TO ASK
Education that transforms conversations about alcohol use

Introduction:

The Lunder-Dineen Health Education Alliance of Maine has partnered with Muskie School of Public Service at the University of Southern Maine to identify alcohol use education needs in primary care settings in order to develop, implement, and evaluate an interdisciplinary alcohol education program for health care professionals. The goal of the project is to develop an educational program that increases providers' comfort and confidence to accurately identify, assess, and recommend treatment for patients who may be at risk or affected by unhealthy alcohol use. As part of this effort, the Muskie School is conducting organizational surveys at each of the participating pilot sites to gather background information that will inform the development and evaluation of the pilot project. We are asking for your input to help us create a team approach for staff education. Working in partnership with you, we believe our work together will lead to a new approach to alcohol use training that can be used across the nation. We appreciate your time and input.

Participation:

This survey should take approximately 15 minutes of your time. The survey is completely voluntary; your participation will have no impact on your relationship with the Lunder-Dineen Health Education Alliance of Maine. Additionally, your position and work performance will not be judged or impacted by your answers to the questions on this survey. You can choose to answer all, some or none of the questions. Individual responses will be kept confidential to the maximum extent permitted by law. Completed surveys will be de-identified and kept in locked file cabinets or on secure drives at the Muskie School; only the core research team will have access to the survey data. A summary of our findings from the survey will be included in a final evaluation report, which will be submitted to the Lunder-Dineen Health Alliance of Maine. No names or identifying information will be included in the summary report we plan to prepare.

Risks and Benefits of Participation:

There are no anticipated risks associated with participating in this survey. No individual practice level data will be presented, survey results will be reported as totals across all participating sites. Although there are no direct benefits to participating in this survey by completing the questionnaire you will be providing important feedback that could help influence the design of the pilot project. Participation is voluntary. You may discontinue your participation at any time without penalty.

Contacts and Questions:

The person conducting this study is Mary Lindsey Smith, PhD, MSW, at the University of Southern Maine. For questions or more information concerning this study you may contact Lindsey Smith at mlsmith@usm.maine.edu or (207) 228-8370.

If you have any questions about your rights as part of this study, you may contact: Assistant Provost, Office of Research Integrity and Outreach, USM at (207)780-4340, or usmirb@usm.maine.edu, or TTY (207)780-5646.

Thank you in advance for participating in this timely and important survey.

TIME TO ASK
Education that transforms conversations about alcohol use

Overview of Survey

This survey has four sections: 1) Demographics, 2) Education and Training, 3) Practice Dynamics and 4) Clinician Views and Attitudes. In the first section of the survey you will be asked to provide basic demographic information. The Education and Training questions in section two are designed to gather information about your preferred mechanisms for education and training. In the Practice Dynamics section, we would like to know your opinions on this practice's organizational learning processes, how staff are trained at this practice, the Practices capacity for change, and your attitudes towards improvement work. In the final section, Clinician Views and Attitudes, we will be asking you about your personal convictions, thoughts and attitudes about the importance of working with patients who consume alcohol. The information gathered from this survey will be used to help design and implement an interdisciplinary, interprofessional alcohol education program for clinicians working in primary care settings.

Thank you for taking the time to complete this survey, we appreciate your input.

Survey Instructions

Your Privacy is Protected. All information that would let someone identify you will be kept private. The Muskie School will not share your personal information with anyone. Your responses to this survey are also **completely confidential**.

Your Participation is Voluntary. You may choose to answer this survey or not. If you choose not to, this will not affect your relationship with your employer, the Muskie School or the Lunder Dineen Health Education Alliance of Maine.

Completing the Survey. Please fill in the circle or fill in the blank for each question below. You may notice a number on the cover of the survey. This number is used only to let us know if you returned your survey.

What To Do When You're Done. Once you complete the survey, place it in the envelope that was provided, seal the envelope, and return the envelope to Muskie Staff at your Practice site.

TIME TO ASK
Education that transforms conversations about alcohol use

Section I. Demographics

In this section we are gathering demographic information that will help us in our research.
Please remember this information is de-identified and will not be shared.

1. What is your age group?
   - O 18 – 24 years of age
   - O 25 – 44 years of age
   - O 45 – 64 years of age
   - O 65 – 74 years of age
   - O 75 and over years of age
2. What is your gender?
   - O Male
   - O Female
   - O Other
3. What is your degree?
   - O MD
   - O DO
   - O NP
   - O PA
   - O RN
   - O LPN
   - O Medical Assistant (CMA/MA)
   - O Other: _____
4. What is your role in the practice? _____
5. What is the total number of years working you have been at this practice? _____

Section II. Education and Training

In this section of the survey we will be asking you questions about education and training opportunities as well as training delivery methods. **Please refer to the glossary on the right when answering these questions.**

6. On a scale of 1 – 5 where 1 is "Not at all Effective" and 5 is "Highly Effective", how effective do you feel each training method is for you?

		Not at all effective 1	2	3	4	Highly Effective 5
a.	Lecture / Demonstration	O	O	O	O	O
b.	Classroom Training with Instructor	O	O	O	O	O
c.	One-on-One Tutorial	O	O	O	O	O
d.	Self-Paced Learning (non-electronic)	O	O	O	O	O
e.	E-Learning, Self-Paced	O	O	O	O	O
f.	E-Learning, Facilitated	O	O	O	O	O
g.	Role Playing/Simulation	O	O	O	O	O
h.	Blended Learning	O	O	O	O	O
i.	Other (Please Specify):					

GLOSSARY

Lecture/Demonstration: In-person lecture/demonstration on a particular topic with limited interaction and practice.

Classroom Training w/ Instructor: Participants attend training where an instructor presents material and there is an opportunity for interaction and hands-on learning or practice.

One-on-One Tutorial: Instructor provides individual instruction to one learner.

Self-paced Learning Non-electronic: Learner follows a course of study, setting own learning pace (e.g., with printed materials such as books or manuals, not via the Internet).

E-learning, Self-paced: Training delivered electronically (e.g., computer-based via the internet or with CD-ROMs) in which learner sets own learning pace.

E-learning, Facilitated: Instruction delivered

7. Overall, if you had to choose one training method, which would be the **most effective** for you? (Choose one)
   - O Lecture/Demonstration
   - O Classroom Training with Instructor
   - O One-on-One Tutorial
   - O Self-Paced Learning (non-electronic)
   - O E-Learning, Self-Paced
   - O E-Learning, Facilitated
   - O Role Playing / Simulation
   - O Blended Learning
   - O Other (Please Specify) _____
8. Why is this the **most effective** training method for you?

_____

_____

_____

_____

_____

9. Overall, if you had to choose one training method, which would be the **least effective** for you? (Choose one)
   - O Lecture/Demonstration
   - O Classroom Training with Instructor
   - O One-on-One Tutorial
   - O Self-Paced Learning (non-electronic)
   - O E-Learning, Self-Paced
   - O E-Learning, Facilitated
   - O Role Playing / Simulation
   - O Blended Learning
   - O Other (Please Specify) _____

10. Why is this the **least effective** training method for you?

11. Please share any additional thoughts you have about training methods that may assist with the development of a clinical alcohol education and training program for primary care staff.

Section III. Practice Dynamics

In this section, we would like to know your opinions on this practice's organizational learning processes, how staff is trained at this practice, its capacity for change, and attitudes towards improvement work. Please think about the culture of your Practice and recent change initiatives when answering this section.

12. For each statement, fill in the circle for how much you agree or disagree with the following statements about this Practice's current **mechanisms for staff training**.

		Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
a.	This Practice trains staff when new processes are put into place.	O	O	O	O	O
b.	This Practice makes sure staff get the on-the-job-training they need.	O	O	O	O	O
c.	Staff in this Practice are asked to do tasks they haven't been trained to do.	O	O	O	O	O

13.	For each statement, fill in the circle for how much you agree or disagree with the following statements about this Practice's **organizational learning processes**.					
		Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
a.	When there is a problem in our Practice, we see if we need to change the way we do things.	O	O	O	O	O
b.	This Practice is good at changing office processes to make sure the same problems don't happen again.	O	O	O	O	O
c.	After this Practice makes changes to improve the patient care process, we check to see if the changes worked.	O	O	O	O	O
d.	Leadership strongly supports Practice change efforts.	O	O	O	O	O
e.	This Practice has a clear vision.	O	O	O	O	O
f.	There is frequent and good communication throughout the Practice about how the different change initiatives are going.	O	O	O	O	O
g.	The Practice has experienced many past change successes.	O	O	O	O	O
h.	Once this practice implements a change, the change tends to stick.	O	O	O	O	O

14.	For each statement, fill in the circle for how much you agree or disagree with the following statements about this Practice's **attitudes toward improvement work.**					
		Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
a.	Improvement work is something positive here.	O	O	O	O	O
b.	Improvement work meets current needs in our operations.	O	O	O	O	O
c.	Improvement work is consistent with our norms and values.	O	O	O	O	O
d.	Improvement work yields distinctive results.	O	O	O	O	O
e.	The guidance available for improvement is insufficient.	O	O	O	O	O

14.	For each statement, fill in the circle for how much you agree or disagree with the following statements about this Practice's **attitudes toward improvement work.**					
		Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
f.	Improvement work conflicts with our daily work tasks.	O	O	O	O	O
g.	Improvement initiatives are difficult to test on a limited scale.	O	O	O	O	O
h.	Approaches to, and methods for, improvement are difficult to use.	O	O	O	O	O
i.	Improvement work is in conflict with the roles and positions of different professional groups.	O	O	O	O	O

15.	For each statement, fill in the circle for how much you agree or disagree with the following statements about this Practice's **capacity for change**.					
		Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
a.	It's hard to make any changes in this Practice because we are so busy seeing patients.	O	O	O	O	O
b.	The staff members of this Practice very frequently feel overwhelmed by the work demands.	O	O	O	O	O
c.	This Practice is almost always in chaos.	O	O	O	O	O
d.	Working at this Practice is stressful.	O	O	O	O	O
e.	The clinicians in this Practice very frequently feel overwhelmed by the work demands.	O	O	O	O	O
f.	Things have been changing so fast in our Practice that it is hard to keep up with what is going on.	O	O	O	O	O
g.	Our Practice has changed how it takes initiative to improve patient care.	O	O	O	O	O
h.	Our Practice has changed how it does business.	O	O	O	O	O
i.	Our Practice has changed how everyone relates.	O	O	O	O	O

15.	For each statement, fill in the circle for how much you agree or disagree with the following statements about this Practice's **capacity for change**.					
		Strongly Disagree	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
j.	The leadership in this Practice is available for consultation on problems.	O	O	O	O	O
k.	The Practice defines success as teamwork and concern for people.	O	O	O	O	O
l.	Staff are involved in developing plans for improving quality.	O	O	O	O	O

Section IV. Clinician Views and Attitudes

This section gathers information about your personal convictions, thoughts and attitudes about the importance of working with patients who consume alcohol.

16. One a scale of 1 to 10 how **convinced** are you that it is important to integrate regular conversations about alcohol use into your clinical work with patients?

Not Convinced									**Extremely Convinced**
1	2	3	4	5	6	7	8	9	10
O	O	O	O	O	O	O	O	O	O

17. One a scale of 1 to 10 how **confident** are you in your Practice's ability to integrate regular conversations about alcohol use into your clinical work with patients?

Not Confident									**Extremely Confident**
1	2	3	4	5	6	7	8	9	10
O	O	O	O	O	O	O	O	O	O

18. Have any of your personal or professional experiences impacted your willingness to work with drinkers? ***(for purposes of this survey, these are patients in your practice that consume any alcohol.)***

O Yes

O No

19.	Please indicate how much you agree or disagree with each of the following statements about working with ***drinkers (for purposes of this survey, these are patients in your practice that consume any alcohol.)***	**Strongly Disagree**	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
a.	I feel I have a working knowledge of alcohol and alcohol-related problems.	O	O	O	O	O
b.	I feel I know enough about the causes of drinking problems to carry out my role when working with drinkers.	O	O	O	O	O
c.	I feel I know enough about the alcohol dependence syndrome to carry out my role when working with drinkers.	O	O	O	O	O
d.	I feel I know enough about the psychological effects of alcohol to carry out my role when working with drinkers.	O	O	O	O	O
e.	I feel I know enough about the factors which put people at risk of developing drinking problems to carry out my role when working with drinkers.	O	O	O	O	O
f.	I feel I know how to counsel drinkers over the long term.	O	O	O	O	O
g.	I feel I can appropriately advise my patients about drinking and its effects.	O	O	O	O	O
h.	I feel I have a clear idea of my responsibilities in helping drinkers.	O	O	O	O	O
i.	I feel I have the right to ask patients questions about their drinking when necessary.	O	O	O	O	O
j.	I feel that my patients believe I have the right to ask them questions about drinking when necessary.	O	O	O	O	O
k.	I feel I have the right to ask a patient for any information that is relevant to their drinking problems.	O	O	O	O	O
l.	If I felt the need when working with drinkers I could easily find someone with whom I could discuss any personal difficulties that I might encounter.	O	O	O	O	O

19.	Please indicate how much you agree or disagree with each of the following statements about working with ***drinkers (for purposes of this survey, these are patients in your practice that consume any alcohol.)***	**Strongly Disagree**	**Disagree**	**Neither Agree or Disagree**	**Agree**	**Strongly Agree**
m.	If I felt the need when working with drinkers I could easily find someone who would be able to help me clarify my professional responsibilities.	O	O	O	O	O
n.	If I felt the need I could easily find someone who would be able to help me formulate the best approach to a drinker.	O	O	O	O	O
o.	I am interested in the nature of alcohol related problems and the responses that can be made to them.	O	O	O	O	O
p.	I want to work with drinkers.	O	O	O	O	O
q.	I feel that the best I can personally offer drinkers is referral to somebody else.	O	O	O	O	O
r.	I feel that there is little I can do to help drinkers.	O	O	O	O	O

20.	While thinking about a clinical education and training program regarding patient alcohol use, in your opinion, how important are the following to that program?	**Not at all Important** 1	2	3	4	5	6	7	8	9	**Extremely Important** 10
a.	Promotes high quality care.	O	O	O	O	O	O	O	O	O	O
b.	Fosters regular discussion of alcohol use between providers and patients.	O	O	O	O	O	O	O	O	O	O
c.	Aids in the early identification of patient's at-risk for alcohol addiction.	O	O	O	O	O	O	O	O	O	O
d.	Fosters interprofessional or interdisciplinary team-based care.	O	O	O	O	O	O	O	O	O	O
e.	Enhances the professional development of staff.	O	O	O	O	O	O	O	O	O	O
f.	Promotes the integration of primary care and behavioral health.	O	O	O	O	O	O	O	O	O	O

21. Please share any additional thoughts you have about participating in a clinical education and training program designed to increase staff knowledge, skills and attitudes about alcohol use.

Thank you for completing this survey.
We appreciate your participation in this important and timely survey.

Appendix E:

Full Survey Results

Full Survey Results

Mechanisms for Staff Training	Responses	Clinical Survey		Office System Survey	
		%	n	%	n
This Practice trains staff when new processes are put into place.	Strongly Disagree / Disagree	11%	6	0%	0
	Neither Agree or Disagree	16%	9	0%	0
	Strongly Agree/ Agree	74%	42	100%	3
	Total		57		3
This Practice makes sure staff get the on-the-job-training they need.	Strongly Disagree / Disagree	11%	6	0%	0
	Neither Agree or Disagree	21%	12	33%	1
	Strongly Agree/ Agree	68%	39	67%	2
	Total		57		3
Staff in this Practice are asked to do tasks they haven't been trained to do.	Strongly Disagree / Disagree	42%	24	67%	2
	Neither Agree or Disagree	28%	16	0%	0
	Strongly Agree/ Agree	30%	17	33%	1
	Total		57		3

Organizational Learning Processes	Responses	Clinical Survey		Office System Survey	
		%	n	%	n
When there is a problem in our Practice, we see if we need to change the way we do things.	Strongly Disagree / Disagree	7%	4	0%	0
	Neither Agree or Disagree	18%	10	0%	0
	Strongly Agree/ Agree	75%	43	100%	3
	Total		57		3
This Practice is good at changing office processes to make sure the same problems don't happen again.	Strongly Disagree / Disagree	16%	9	0%	0
	Neither Agree or Disagree	23%	13	33%	1
	Strongly Agree/ Agree	61%	34	67%	2
	Total		56		3
After this Practice makes changes to improve the patient care process, we check to see if the changes worked.	Strongly Disagree / Disagree	11%	6	0%	0
	Neither Agree or Disagree	25%	12	0%	0
	Strongly Agree/ Agree	65%	39	100%	3
	Total		57		3

Capacity for Change	Responses	Clinical Survey		Office System Survey	
		%	n	%	n
It's hard to make any changes in this Practice because we are so busy seeing patients.	Strongly Disagree / Disagree	37%	21	33%	1
	Neither Agree or Disagree	18%	10	33%	1
	Strongly Agree/ Agree	46%	26	33%	1
	Total		57		3
The staff members of this Practice very frequently feel overwhelmed by the work demands.	Strongly Disagree / Disagree	23%	13	33%	1
	Neither Agree or Disagree	25%	14	33%	1
	Strongly Agree/ Agree	53%	30	33%	1
	Total		57		3
This Practice is almost always in chaos.	Strongly Disagree / Disagree	77%	43	67%	2
	Neither Agree or Disagree	14%	8	33%	1
	Strongly Agree/ Agree	9%	5	0%	0
	Total		56		3
Working at this Practice is stressful.	Strongly Disagree / Disagree	51%	29	33%	1
	Neither Agree or Disagree	30%	17	33%	1
	Strongly Agree/ Agree	19%	11	33%	1
	Total		57		3
The clinicians in this Practice very frequently feel overwhelmed by the work demands.	Strongly Disagree / Disagree	32%	18	33%	1
	Neither Agree or Disagree	37%	21	0%	0
	Strongly Agree/ Agree	32%	18	67%	2
	Total		57		3
Things have been changing so fast in our Practice that it is hard to keep up with what is going on.	Strongly Disagree / Disagree	42%	24	33%	1
	Neither Agree or Disagree	32%	18	0%	0
	Strongly Agree/ Agree	26%	15	67%	2
	Total		57		3
Our Practice has changed how it takes initiative to improve patient care.	Strongly Disagree / Disagree	14%	8	33%	1
	Neither Agree or Disagree	25%	14	0%	0
	Strongly Agree/ Agree	61%	35	67%	2
	Total		57		3
Our Practice has changed how it does business.	Strongly Disagree / Disagree	18%	10	33%	1
	Neither Agree or Disagree	28%	16	0%	0
	Strongly Agree/ Agree	54%	31	67%	2
	Total		57		3
Our Practice has changed how everyone relates.	Strongly Disagree / Disagree	30%	17	33%	1
	Neither Agree or Disagree	39%	22	0%	0
	Strongly Agree/ Agree	32%	18	67%	2
	Total		57		3
The leadership in this Practice is available for consultation on problems.	Strongly Disagree / Disagree	11%	6	33%	1
	Neither Agree or Disagree	23%	13	0%	0
	Strongly Agree/ Agree	67%	38	67%	2
	Total		57		3

Capacity for Change	Responses	Clinical Survey		Office System Survey	
		%	n	%	n
The Practice defines success as teamwork and concern for people.	Strongly Disagree / Disagree	7%	4	0%	0
	Neither Agree or Disagree	16%	9	66%	2
	Strongly Agree/ Agree	77%	43	33%	1
	Total		56		3
Staff are involved in developing plans for improving quality.	Strongly Disagree / Disagree	18%	10	0%	0
	Neither Agree or Disagree	23%	13	33%	1
	Strongly Agree/ Agree	60%	34	67%	2
	Total		57		3

Organizational Learning Processes	Responses	Clinical Survey	
		%	n
Leadership strongly supports Practice change efforts.	Strongly Disagree / Disagree	11%	6
	Neither Agree or Disagree	21%	12
	Strongly Agree/ Agree	68%	39
	Total		57
This Practice has a clear vision.	Strongly Disagree / Disagree	4%	2
	Neither Agree or Disagree	30%	17
	Strongly Agree/ Agree	67%	38
	Total		57
There is frequent and good communication throughout the Practice about how the different change initiatives are going.	Strongly Disagree / Disagree	21%	12
	Neither Agree or Disagree	26%	15
	Strongly Agree/ Agree	53%	30
	Total		57
The Practice has experienced many past change successes.	Strongly Disagree / Disagree	2%	1
	Neither Agree or Disagree	39%	22
	Strongly Agree/ Agree	60%	34
	Total		57
Once this practice implements a change, the change tends to stick.	Strongly Disagree / Disagree	9%	5
	Neither Agree or Disagree	37%	21
	Strongly Agree/ Agree	54%	31
	Total		57

Attitudes Toward Improvement Work	Responses	Clinical Survey	
		%	n
Improvement work is something positive here.	Strongly Disagree / Disagree	5%	3
	Neither Agree or Disagree	19%	11
	Strongly Agree/ Agree	75%	43
	Total		57
Improvement work meets current needs in our operations	Strongly Disagree / Disagree	7%	4
	Neither Agree or Disagree	25%	14
	Strongly Agree/ Agree	68%	39
	Total		57
Improvement work is consistent with our norms and values.	Strongly Disagree / Disagree	21%	12
	Neither Agree or Disagree	26%	39
	Strongly Agree/ Agree	53%	6
	Total		57
Improvement work yields distinctive results.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	37%	21
	Strongly Agree/ Agree	63%	36
	Total		57
The guidance available for improvement is insufficient	Strongly Disagree / Disagree	44%	25
	Neither Agree or Disagree	21%	12
	Strongly Agree/ Agree	35%	20
	Total		57
Improvement work conflicts with our daily work tasks.	Strongly Disagree / Disagree	41%	23
	Neither Agree or Disagree	32%	18
	Strongly Agree/ Agree	27%	15
	Total		56
Improvement initiatives are difficult to test on a limited scale	Strongly Disagree / Disagree	27%	15
	Neither Agree or Disagree	47%	26
	Strongly Agree/ Agree	26%	14
	Total		55
Approaches to, and methods for, improvement are difficult to use.	Strongly Disagree / Disagree	50%	28
	Neither Agree or Disagree	30%	17
	Strongly Agree/ Agree	20%	11
	Total		56
Improvement work is in conflict with the roles and positions of different professional groups.	Strongly Disagree / Disagree	55%	31
	Neither Agree or Disagree	27%	15
	Strongly Agree/ Agree	18%	10
	Total		56

Working With Drinkers	Responses	Clinical Survey %	n
I feel I have a working knowledge of alcohol and alcohol-related problems	Strongly Disagree / Disagree	14%	8
	Neither Agree or Disagree	7%	4
	Strongly Agree/ Agree	79%	45
	Total		57
I feel I know enough about the causes of drinking problems to carry out my role when working with drinkers.	Strongly Disagree / Disagree	22%	12
	Neither Agree or Disagree	13%	7
	Strongly Agree/ Agree	66%	37
	Total		56
I feel I know enough about the alcohol dependence syndrome to carry out my role when working with drinkers.	Strongly Disagree / Disagree	25%	14
	Neither Agree or Disagree	14%	8
	Strongly Agree/ Agree	61%	34
	Total		56
I feel I know enough about the psychological effects of alcohol to carry out my role when working with drinkers.	Strongly Disagree / Disagree	21%	12
	Neither Agree or Disagree	25%	14
	Strongly Agree/ Agree	54%	31
	Total		57
I feel I know enough about the factors which put people at risk of developing drinking problems to carry out my role when working with drinkers.	Strongly Disagree / Disagree	14%	8
	Neither Agree or Disagree	18%	10
	Strongly Agree/ Agree	68%	39
	Total		57
I feel I know how to counsel drinkers over the long term.	Strongly Disagree / Disagree	48%	27
	Neither Agree or Disagree	30%	17
	Strongly Agree/ Agree	22%	12
	Total		56
I feel I can appropriately advise my patients about drinking and its effects.	Strongly Disagree / Disagree	26%	15
	Neither Agree or Disagree	16%	9
	Strongly Agree/ Agree	58%	33
	Total		57
I feel I have a clear idea of my responsibilities in helping drinkers.	Strongly Disagree / Disagree	14%	8
	Neither Agree or Disagree	27%	15
	Strongly Agree/ Agree	59%	33
	Total		56
I feel I have the right to ask patients questions about their drinking when necessary.	Strongly Disagree / Disagree	9%	5
	Neither Agree or Disagree	14%	8
	Strongly Agree/ Agree	77%	43
	Total		56
I feel that my patients believe I have the right to ask them questions about drinking when necessary.	Strongly Disagree / Disagree	19%	11
	Neither Agree or Disagree	26%	15
	Strongly Agree/ Agree	54%	31
	Total		57
I feel I have the right to ask a patient for any information that is relevant to their drinking problems.	Strongly Disagree / Disagree	16%	9
	Neither Agree or Disagree	19%	11
	Strongly Agree/ Agree	65%	37
	Total		57

Working With Drinkers	Responses	Clinical Survey	
If I felt the need when working with drinkers I could easily find someone with whom I could discuss any personal difficulties that I might encounter.	Strongly Disagree / Disagree	23%	13
	Neither Agree or Disagree	16%	9
	Strongly Agree/ Agree	61%	35
	Total		57
If I felt the need when working with drinkers I could easily find someone who would be able to help me clarify my professional responsibilities.	Strongly Disagree / Disagree	14%	8
	Neither Agree or Disagree	19%	11
	Strongly Agree/ Agree	67%	38
	Total		57
If I felt the need I could easily find someone who would be able to help me formulate the best approach to a drinker.	Strongly Disagree / Disagree	11%	6
	Neither Agree or Disagree	18%	10
	Strongly Agree/ Agree	72%	41
	Total		57
I am interested in the nature of alcohol related problems and the responses that can be made to them.	Strongly Disagree / Disagree	4%	2
	Neither Agree or Disagree	23%	13
	Strongly Agree/ Agree	74%	42
	Total		57
I want to work with drinkers.	Strongly Disagree / Disagree	18%	10
	Neither Agree or Disagree	44%	25
	Strongly Agree/ Agree	39%	22
	Total		57
I feel that the best I can personally offer drinkers is referral to somebody else.	Strongly Disagree / Disagree	21%	12
	Neither Agree or Disagree	25%	14
	Strongly Agree/ Agree	54%	31
	Total		57
I feel that there is little I can do to help drinkers.	Strongly Disagree / Disagree	58%	33
	Neither Agree or Disagree	26%	15
	Strongly Agree/ Agree	16%	9
	Total		57

Adaptive Reserve	Responses	Systems Survey %	n
Mistakes have led to positive changes in this Practice.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	0%	0
	Strongly Agree/ Agree	100%	3
	Total		3
People in this Practice have many opportunities to grow in their work.	Strongly Disagree / Disagree	33%	1
	Neither Agree or Disagree	0%	0
	Strongly Agree/ Agree	67%	2
	Total		3
People in this Practice actively seek new ways to improve how we do things.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	0%	0
	Strongly Agree/ Agree	100%	3
	Total		3
People at all levels of this Practice openly talk about what is and isn't working.	Strongly Disagree / Disagree	33%	1
	Neither Agree or Disagree	0%	0
	Strongly Agree/ Agree	66%	2
	Total		3
Leadership strongly supports this Practice's efforts.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	67%	2
	Strongly Agree/ Agree	33%	1
	Total		3
After trying something new, we take time to think about how it worked.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	33%	1
	Strongly Agree/ Agree	66%	2
	Total		3
Most of the people who work in this Practice seem to enjoy their work.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	33%	1
	Strongly Agree/ Agree	67%	2
	Total		3
It is hard to get things to change in this Practice.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	0%	0
	Strongly Agree/ Agree	100%	3
	Total		3
This Practice learns from its mistakes.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	33%	1
	Strongly Agree/ Agree	66%	2
	Total		3
Practice leadership promotes an environment that is an enjoyable place to work.	Strongly Disagree / Disagree	33%	1
	Neither Agree or Disagree	33%	1
	Strongly Agree/ Agree	33%	1
	Total		3

Adaptive Reserve	Responses	Systems Survey	
People in This Practice operate as a real team.	Strongly Disagree / Disagree	33%	1
	Neither Agree or Disagree	0%	0
	Strongly Agree/ Agree	66%	2
	Total		3
When we experience a problem in this Practice, we make a serious effort to figure out what's really going on.	Strongly Disagree / Disagree	33%	1
	Neither Agree or Disagree	0%	0
	Strongly Agree/ Agree	66%	2
	Total		3
Leadership in this Practice creates an environment where things can be accomplished.	Strongly Disagree / Disagree	33%	1
	Neither Agree or Disagree	33%	1
	Strongly Agree/ Agree	33%	1
	Total		3

How People Work Together	Responses	Systems Survey	
		%	n
When someone in the office gets really busy, others help out.	Strongly Disagree / Disagree	33%	1
	Neither Agree or Disagree	0%	0
	Strongly Agree/ Agree	66%	2
	Total		3
In this office, there is a good working relationship between staff and providers.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	0%	0
	Strongly Agree/ Agree	100%	3
	Total		3
In this office, we treat each other with respect.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	33%	1
	Strongly Agree/ Agree	66%	2
	Total	99%	3
The office emphasizes teamwork in taking care of patients.	Strongly Disagree / Disagree	33%	1
	Neither Agree or Disagree	0%	0
	Strongly Agree/ Agree	67%	2
	Total	100%	3

Capacity for Change	Responses	Systems Survey	
		%	n
When there is a conflict in this Practice, the people involved usually talk it out and resolve the problem successfully.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	33%	1
	Strongly Agree/ Agree	66%	2
	Total		
Our clinical staff have constructive work relationships.	Strongly Disagree / Disagree	33%	1
	Neither Agree or Disagree	0%	0
	Strongly Agree/ Agree	66%	2
	Total		
There is often tension between people in this Practice.	Strongly Disagree / Disagree	33%	1
	Neither Agree or Disagree	33%	1
	Strongly Agree/ Agree	33%	1
	Total		
The clinicians in this Practice operate as a real team.	Strongly Disagree / Disagree	33%	1
	Neither Agree or Disagree	0%	0
	Strongly Agree/ Agree	66%	2
	Total		
This Practice encourages clinical staff input for making changes and improvements.	Strongly Disagree / Disagree	33%	1
	Neither Agree or Disagree	0%	0
	Strongly Agree/ Agree	66%	2
	Total		
This Practice encourages nursing and clinical staff input for making changes and improvements.	Strongly Disagree / Disagree	33%	1
	Neither Agree or Disagree	0%	0
	Strongly Agree/ Agree	67%	2
	Total		
All of the clinical staff participates in important decisions about the clinical operation.	Strongly Disagree / Disagree	33%	1
	Neither Agree or Disagree	0%	0
	Strongly Agree/ Agree	66%	2
	Total		
Practice leadership discourages clinical staff from taking initiative.	Strongly Disagree / Disagree	67%	2
	Neither Agree or Disagree	33%	1
	Strongly Agree/ Agree	0%	0
	Total		
This is a very hierarchical organization; decisions are made at the top with little input from those doing the work.	Strongly Disagree / Disagree	33%	1
	Neither Agree or Disagree	33%	1
	Strongly Agree/ Agree	33%	1
	Total		

Office Processes and Standardization	Responses	Systems Survey	
		%	n
This Practice is more disorganized than it should be.	Strongly Disagree / Disagree	33%	1
	Neither Agree or Disagree	33%	1
	Strongly Agree/ Agree	33%	1
	Total		3
We have good procedures for checking that work in this Practice was done correctly.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	33%	1
	Strongly Agree/ Agree	67%	2
	Total		3
We have problems with workflow in this Practice.	Strongly Disagree / Disagree	33%	1
	Neither Agree or Disagree	33%	1
	Strongly Agree/ Agree	33%	1
	Total		3
Staff in this Practice follow standardized processes to get tasks done.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	33%	1
	Strongly Agree/ Agree	66%	2
	Total		3

Organizational Culture	Responses	Systems Survey	
		%	n
Physicians who develop inappropriate patient care practices will be "talked to."	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	33%	1
	Strongly Agree/ Agree	66%	2
	Total		3
We encourage internal reporting of patient care adverse events.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	33%	1
	Strongly Agree/ Agree	66%	2
	Total		3
The quality of each physician's work is closely monitored.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	67%	2
	Strongly Agree/ Agree	33%	1
	Total		3
There is an open discussion of clinical failures.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	67%	2
	Strongly Agree/ Agree	33%	1
	Total		3
We emphasize patient satisfaction.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	33%	1
	Strongly Agree/ Agree	66%	2
	Total		3

Interaction with the Community	Responses	Systems Survey	
		%	n
This Practice works effectively together as a team with community organizations.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	0%	0
	Strongly Agree/ Agree	100%	3
	Total		3
This Practice utilizes community resources to meet the healthcare needs of patients.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	0%	0
	Strongly Agree/ Agree	100%	3
	Total		3
This Practice is aware of community resources that are accessible to patients.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	0%	0
	Strongly Agree/ Agree	100%	3
	Total		3
People in this Practice are connected with community organizations that serve patients.	Strongly Disagree / Disagree	0%	0
	Neither Agree or Disagree	0%	0
	Strongly Agree/ Agree	100%	3
	Total		3

Appendix F:

Semi-Structured Interview Recruitment Materials and Guide

TIME TO ASK

Education that transforms conversations about alcohol use

Your practice is voluntarily participating in a pilot project aimed at creating an alcohol use education and training curriculum for primary care practices. The research project is being conducted by the Muskie School, at the University of Southern Maine, for the Lunder-Dineen Health Education Alliance of Maine. The goal of the project is to develop an educational program that increases providers' comfort and confidence to properly identify, assess, and recommend treatment for patients who may be at risk or affected by unhealthy alcohol use.

We are asking for your input to help us create a learner-driven interdisciplinary team approach for staff education designed to give healthcare professionals the skills they need to integrate regular conversations about alcohol use into primary care. **As part of this project, we are conducting in-person interviews with key staff in your practice.** These interviews will be used to help us assess your organization's capacity, policies and strengths in learning styles. The information you provide will help us to further consider the factors that are relevant to each setting as we develop the educational pilot program. Your input could lead to a new approach to alcohol use training that can be used across the nation.

There are no foreseeable risks and no direct benefits to participation in this study however, by participating you will be providing important feedback that could help influence the design of the educational program and curriculum. There are no costs associated with the future training. Any demographic data that you provide will not be associated with your name or your organization. **The interview should take about 45 minutes to complete and will be done at your convenience at your practice site. The interview(s) can be done in a small group setting or one-on-one, depending on your staff's preferences.** Your participation is voluntary. If you choose not to participate, it will not affect your current or future relations with the University of Southern Maine or Lunder-Dineen.

As a thank you for speaking with us, you will receive a $50 gift card upon completion of the interview.

The results of these interviews will be shared with the Lunder-Dineen Health Education Alliance of Maine, funders of this project and possibly in professional or academic publications. None of the results will include any personally identifiable information or link to any individuals participating in the study.

The researcher conducting this study is Mary Lindsey Smith, PhD, MSW, Principal Investigator, Population Health and Health Policy, at the University of Southern Maine. If you wish to opt out of the interview portion of this research, please contact her using the information provided below. Otherwise, a person from the Muskie research team will be contacting your office within 15 days to schedule interviews with applicable staff members.

For questions or more information concerning this research you may contact Mary Lindsey Smith, PhD, MSW, at the University of Southern Maine at (207-228-8370) or mlsmith@usm.maine.edu. If you have any questions or concerns about your rights as a research subject, you may call the USM Human Protections Administrator at (207) 228-8434 and/or email usmirb@usm.maine.edu.

TIME TO ASK
Education that transforms conversations about alcohol use

Thank you for agreeing to be interviewed. I appreciate your time. Before I begin, I have a consent statement that I need to read to you.

Introduction:

As you may know, a small group of us at the University of Southern Maine's Muskie School have been working with the Lunder-Dineen Foundation on an alcohol-related pilot project they plan to develop and evaluate. The goal of the project is to encourage providers to routinely ask patients about their alcohol use. As part of our contract, we are interviewing key staff at your center to gather information that could inform the development and evaluation of the pilot project.

Participation:

This interview will take approximately 45 minutes of your time. Your participation is voluntary. No names or identifying information will be included in the summary report we plan to prepare.

Risks and Benefits of Participation:

There are no anticipated risks with this interview. However, by participating, you will be providing important feedback that could help influence the design of the pilot project.

Questions:

Do you have any questions for me before we get started?
Is it okay with you if I record our conversation?

Okay, let's begin…

Section #1: Organizational Context

The first few questions focus on how alcohol use information is captured in your center and the ways in which is it used.

1. I'd like to understand the ways in which patient alcohol use data are typically collected. Would you describe the process for me?

   Probes:
   - Who usually collects the data?
   - What type of data is collected?
   - How is the data collected (e.g., paper, EMR)?
   - At what point in the visit is the data collected?
   - Which patients are asked to provide this data?
   - Are any components of the process standardized?

2. Given your experience, what are the barriers to *collecting* patient alcohol use data?

   Probes:
   - Organizational barriers?
   - Staff barriers?
   - Time and resources?

3. In your opinion, to what extent is the patient-level alcohol data used?

   Probes:
   - By whom?
   - How?

Section #2: Provider Behavior and Background

Now I'd like to spend a little time learning more about your practices, background, and opinions.

4. I'm interested in learning about how conversations on alcohol come up in your visits with patients? Typically, how are these discussions initiated and handled during a visit?

Probes:
- Who initiates conversation?
- Decision-making process (when/who do you decide to ask?)

5. How comfortable are you engaging your patients in conversations about their alcohol use and why?

6. In your opinion, what factors (positive or negative) influence the likelihood of patient/provider conversations about a patient's alcohol use in your center?

Probes:
- Internal (e.g., organizational?)
- External (e.g., reimbursement?)
- Individual (e.g., provider attitudes?)

7. What would it take for all the providers in your center (including you) to routinely ask patients about their alcohol use?

Probes:
- Skills/training?
- Organizational changes?

8. Let's suppose the providers in your center had access to the best resources about having conversations with patients about alcohol use? What would these resources look like and include?

9. What's the best way to make these resources available to busy providers like you?

Appendix G:

Qualitative Coding Scheme

Section #1: Organizational Context	Nodes and Subnodes
1. I'd like to understand the ways in which patient alcohol use data are typically collected, document and communicated. Would you describe the process for me? Probes: • Is alcohol screening data currently collected by the practice? • Who usually collects the data? • What type of data is collected? • How is the data collected (e.g., paper, EMR)? • How and where are the data stored? • How is the data shared with the team? • At what point in the visit is the data collected? • Are all patients screened for alcohol use? • If no, which patients are asked to provide this data? • Are any components of the process standardized?	(Alcohol) Use Data Process ▪ Collected (e.g. type collected, when collected, how collected) ▪ Documented/Stored (how/where?, e.g. EMR)) ▪ Communicated/Shared (shared with team, ▪ Standardized Processes
2. As you consider discussing or screening patients for alcohol use, what do you perceive are the benefits of collecting this data?	(Perceived) Benefits of: ▪ Discussing ▪ Screening ▪ Collecting Data ▪ Patient Education/Prev. ▪ Patient-follow-Up/Referral
3. Given your experience, what are the barriers to *collecting* patient alcohol use data? Probes: • Organizational barriers? (e.g. Not an organizational priority, no standard protocol/policy around SUD screening) • Staff barriers? (e.g. Lack of training, time constraints) • Time and resources? (e.g. Competing priorities, reason for visit)	Barriers (to <u>collecting</u> alcohol use data) ▪ Patient barriers ▪ Provider barriers ▪ Staff/MA barriers ▪ Organizational barriers ▪ Time and resource bar. ▪ Technology/EMR ▪ Regulatory (e.g. insurer consequences, program requests, QI fatigue) stigma

4. In your opinion, to what extent is the patient-level alcohol data used? Probes: • By whom? • How? • If not used, Why?	Extent of (patient-level SUD) data use
Section#2: Provider Behavior and Background	
5. I'm interested in learning about how conversations on alcohol come up in your visits with patients? Typically, how are these discussions initiated and handled during a visit? Probes: • Who initiates conversation? • Decision-making process (when/who do you decide to ask?)	Conversation initiation ▪ Who initiates ▪ Why initiated ▪ Decision rules (e.g. if intoxicated, if Dx=x, if in recovery)
6. How comfortable are you engaging your patients in conversations about their alcohol use? Probes: • Who initiates conversation? • Decision-making process (when/who do you decide to ask?)	Comfort (level)
7. In your opinion, what factors influence the likelihood of patient/provider conversations about a patient's alcohol use in your practice? Probes: • Internal (e.g., organizational?) {practice policies/workflow, time constraints}External (e.g., reimbursement?) {competing QI and measurement priorities} • Individual (e.g., provider attitudes?) {therapeutic commitment, comfort skills} • Access to treatment or know how or where to refer?	Conversation likelihood factors ▪ Organizational (e.g. time, resources) ▪ External (e.g. reimbursement, competing priorities) ▪ Provider factors ▪ Patient factors ▪ Access to treatment referral ▪ Triage ▪ Conversation barriers

8. In your opinion, what would it take for all the providers in your center (including you) to have routine conversations with all patients about their alcohol use? Probes: • Skills/training? • Organizational changes? (e.g., changes in workflow or practice policy) • Change in staff motivation, comfort and attitudes?	TTA Facilitators ▪ Skill-building/training ▪ Organizational change (e.g. changes in workflow/ policy) ▪ Staff changes (e.g. motivation, comfort, attitudinal change) ▪ Evidence- why important. TTA Barriers
9. Let's suppose the providers in your center had access to the best resources about having conversations with patients about alcohol use? What would these resources look like and include? Probes: • Webinar? • Lunch and Learn? • Academic Detailers? • Expert Consultation?	Resources needed
10. What's the best way to make these resources available to busy providers like you? Probes: • For training? • Continuing education	Learning preferences ▪ Cases, joint clinicals ▪ Webinars ▪ Likes ▪ Dislikes
Additional Nodes	
	Quotes
	"Open" codes TBD during transcript review Community Context Practice Context

Appendix H:

Office System Survey Presentation

TIME TO ASK
Education that transforms conversations about alcohol use

Office System Survey Results

PRESENTED BY: MUSKIE SCHOOL OF PUBLIC SERVICE

Practice Profile

Practice Demographics

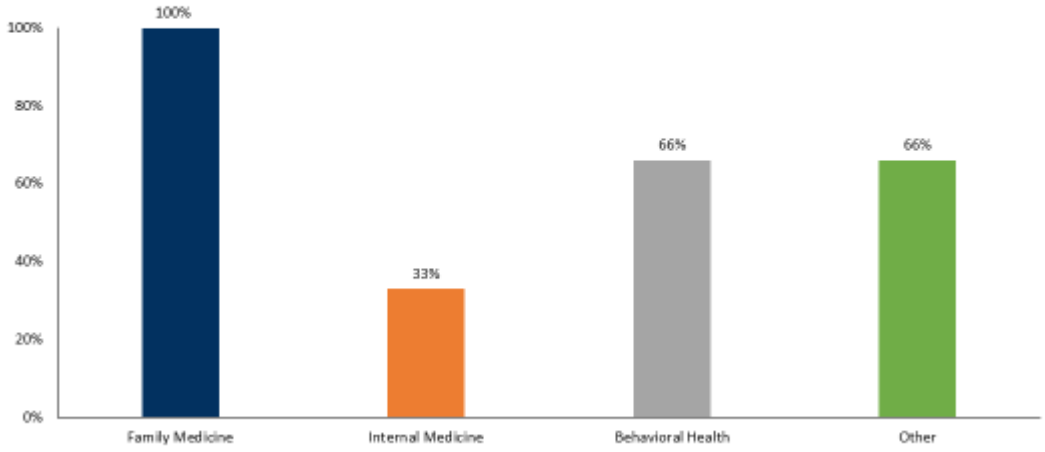
General practice overview:

- 66% Residency Training Practice
- 66% Precept Students
- 33% or 1 site has other office sites

Years in practice:

- 15 years
- 41 Years

Which clinical specialties are represented at this practice (n=3)



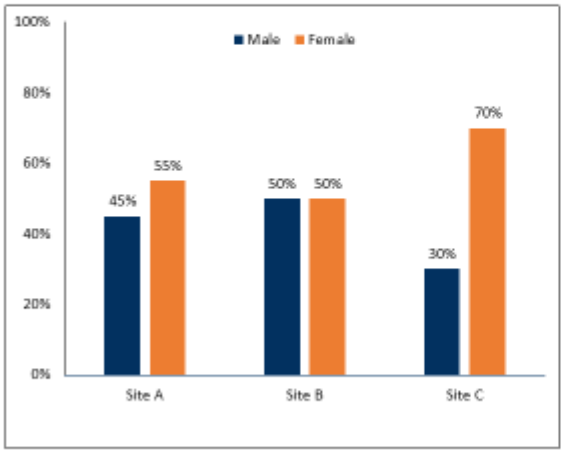
Patient Demographics

Percentage of patient visits at this practice (n=3)

	Site A	Site B	Site C
Family Medicine	Missing	20%	70%
Internal Medicine		45%	
Pediatrics		20%	12%
OB/GYN			10%
Surgery			
Behavioral Health			8%
Other			

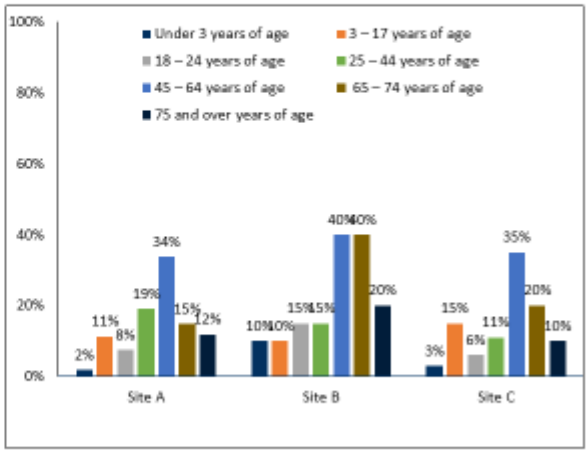
PATIENTS BY GENDER

(N=3)



PATIENTS BY AGE GROUP

(N=3)



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Professional and Clinical Staffing

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Total FTE -Full Time Equivalent by practice (n=3)

	Site A	Site B	Site C
MD	3.6	3.0	3.0
DO	0.6		0.8
NP	0.4	3.0	1.0
PA		1.0	0.7
Other Clinicians	2.0		
RN	2.4	2.0	2.0
LPN			
Medical Assistant (CMA/MA)	5.0	5.0	4.0
Behavioral Health	4.4	2.0	0.5
Social Worker			0.25
Allied Health Staff	4.0	1.0	
Practice Manager	1.0	1.0	0.4
Patient Educator	Contracted	1.0	0.2
Dietician	Contracted	1.0	
Other	4.0		1.0

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Practice's Medical Assistants' (CMA) Involvement

	Site A	Site B	Site C
Patient Triage	X	X	
Patient Telephone Advice		X	
Medication Refills		X	X
Health Behavior Counseling		X	
Chronic Disease Management	X	X	X
Medical History Taking	X	X	X
Immunizations by Protocol	X	X	X
Patient Follow-up	X	X	X

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Practice's Nurses' (RN) Involvement

	Site A	Site B	Site C
Patient Triage	X	X	X
Patient Telephone Advice	X	X	X
Medication Refills	X	X	X
Health Behavior Counseling		X	X
Chronic Disease Management	X	X	X
Medical History Taking	X	X	X
Immunizations by Protocol	X	X	X
Patient Follow-up	X	X	X
Other	X		

Compensation

	Site A	Site B	Site C
Salary	X		
Salary Plus Incentive		X	X

Staff Turnover

Over the past 12 months:	Site A	Site B	Site C
Clinicians who have left	X	Missing	
Staff who have left	X		X
Clinicians who have been hired	X		
Staff who have been hired	X		X

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Workplace Communication

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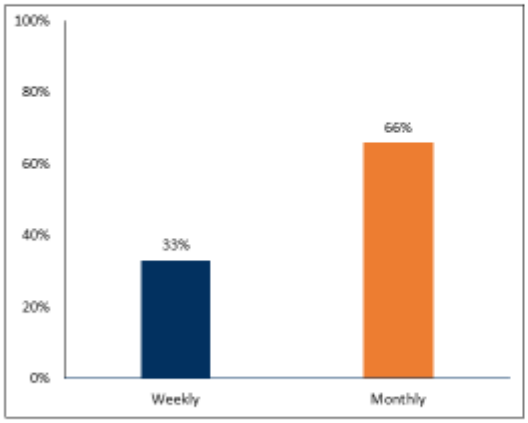
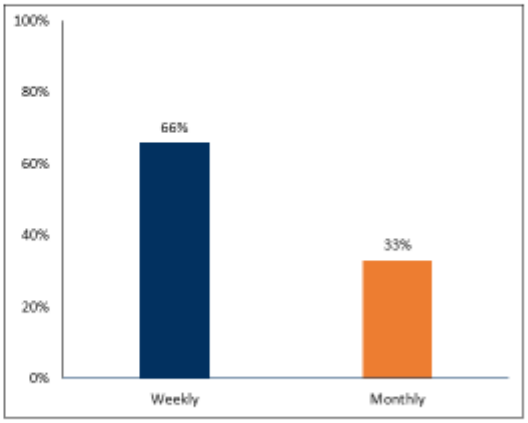
HOW OFTEN DOES THESE PRACTICES HOLD MEETINGS TO DISCUSS ADMINISTRATIVE ISSUES?

(N = 3)



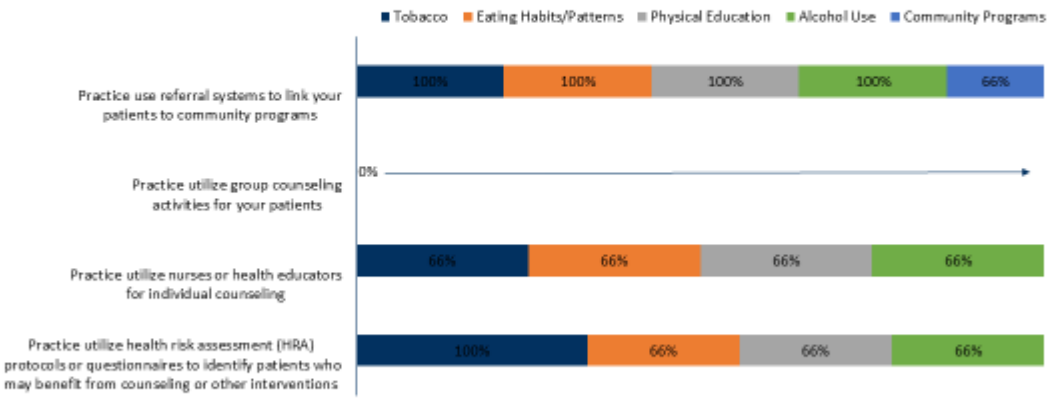
HOW OFTEN DOES THESE PRACTICES HOLD MEETINGS TO DISCUSS CLINICAL ISSUES?

(N = 3)

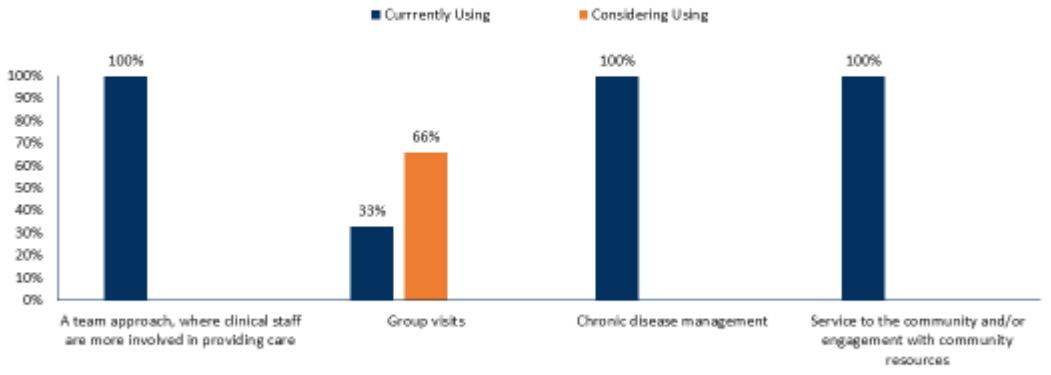


Education, Screenings, and Preventive Health Strategies

Health Risk Assessments (n = 3)

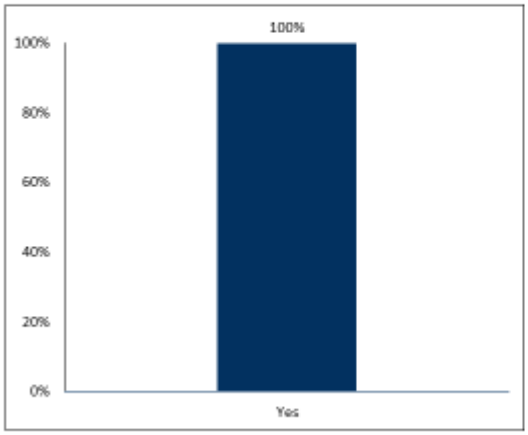


Practice Utilization



DOES YOUR PRACTICE USE A STANDARDIZED PROTOCOL FOR ROUTINELY SCREENING PATIENTS FOR ALCOHOL USE?

(N = 3)



STANDARDIZED SCREENING TOOL BEING USED

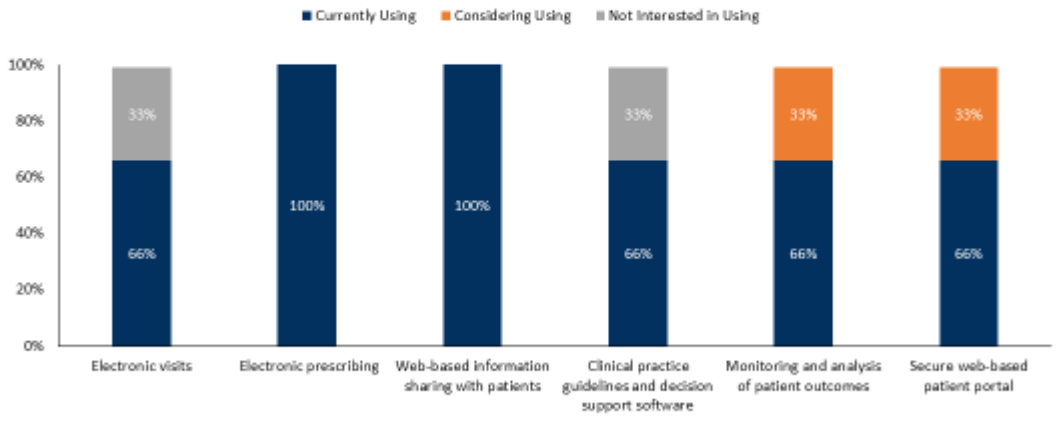
- 33% use the Audit
- 33% use the CAGE
- 33% unknown

Technology

Practices Currently Use:

	Site A	Site B	Site C
Electronic Billing System	X	X	X
Electronic Medical Records	X	X	X
Computer-based Physician Order Enter PDA	X	X	
Online Literature searches	X	X	X
Internet / Knowledge-based Websites	X	X	X

Technology Utilization (n = 3)



Participation in Quality Improvement Activities

Strategic goals of your Practice:

Promotes high quality care

Not important	2	3	4	5	6	7	8	9.67	Extremely important

Fosters regular discussion of alcohol use between providers and patients

Not important	2	3	4	5	6	7	8	9.33	Extremely important

Aids in the early identification of patient's at-risk for alcohol addiction

Not important	2	3	4	5	6	7	8	9.67	Extremely important

Fosters interprofessional or interdisciplinary team-based care

Not important	2	3	4	5	6	7	8	9.33	Extremely important

Enhances the professional development of staff

Not important	2	3	4	5	6	7	8	9.33	**Extremely important**

Promotes the integration of primary care and behavioral health

Not important	2	3	4	5	6	7	8	9.67	Extremely important

Alcohol Use

One a scale of 1 to 10 how convinced are you that it is important to integrate regular conversations about alcohol use into your Practice?

One a scale of 1 to 10 how confident are you in your Practice's ability to integrate regular conversations about alcohol use into your practice?

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Section 2

ORGANIZATIONAL CHARACTERISTICS

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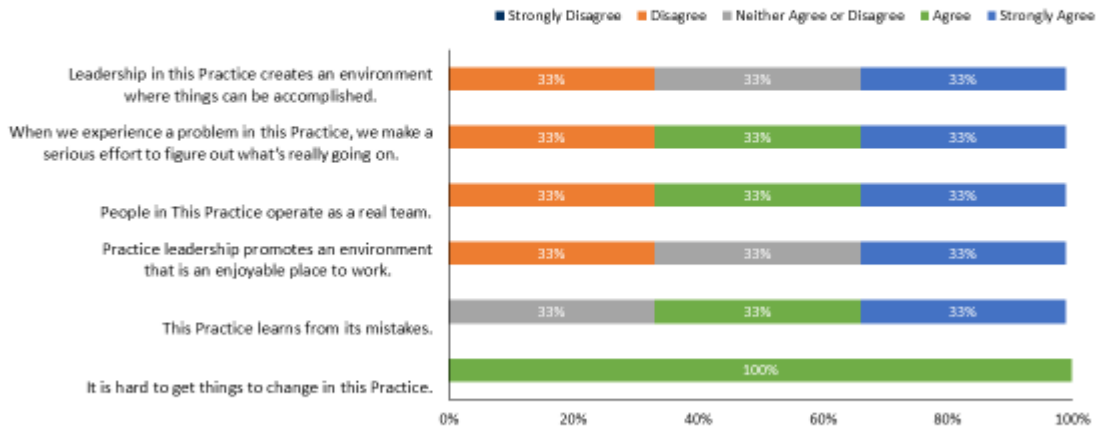
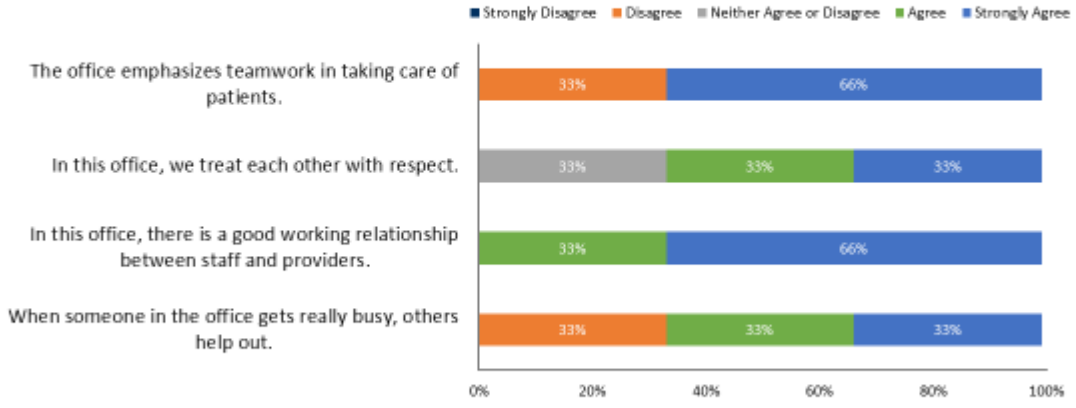
Adaptive Reserve

Adaptive Reserve



How People Work Together



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Capacity for Change

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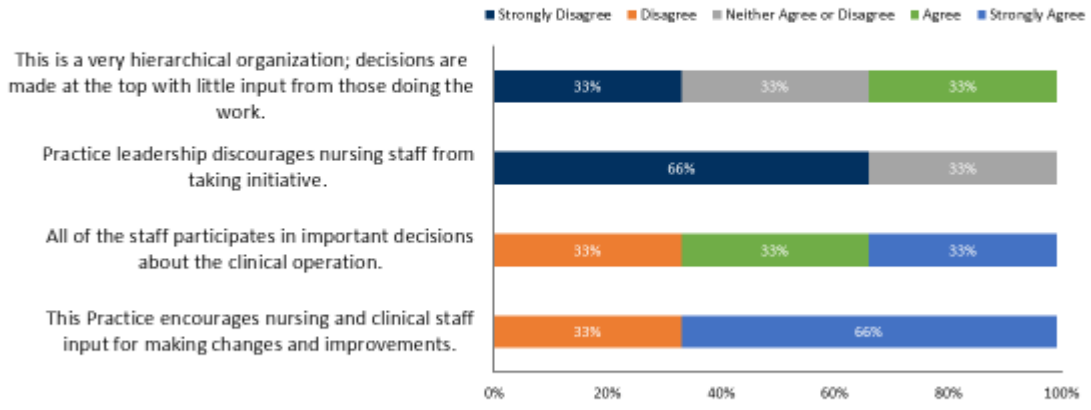
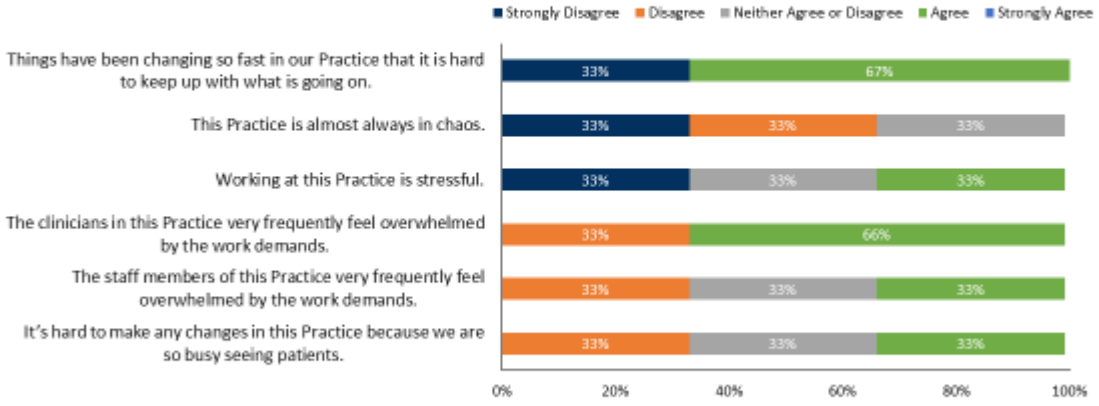
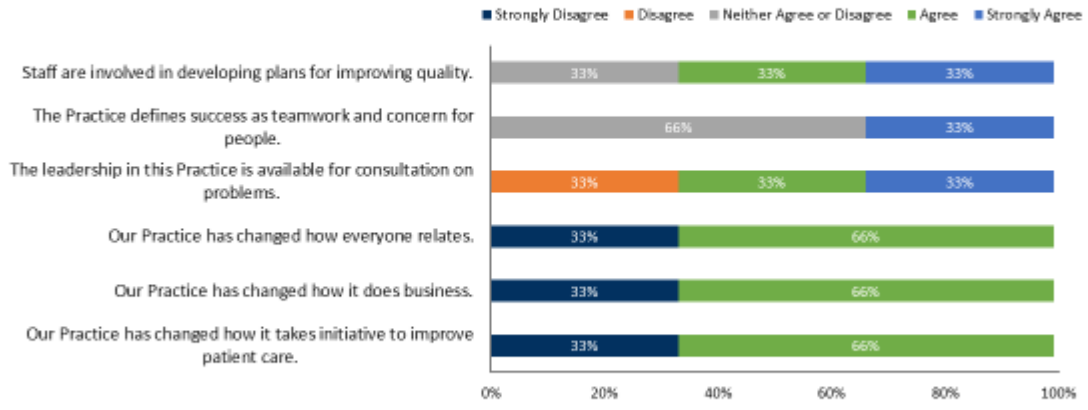
Capacity for Change



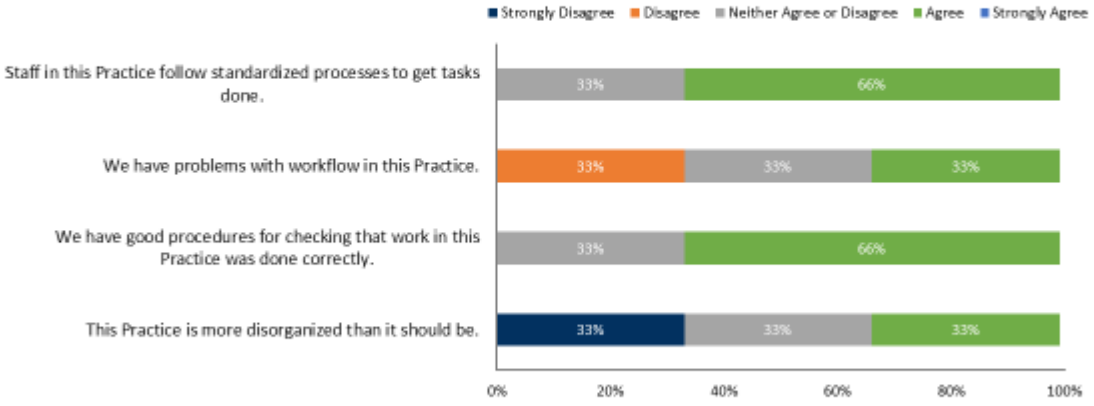
Capacity for Change



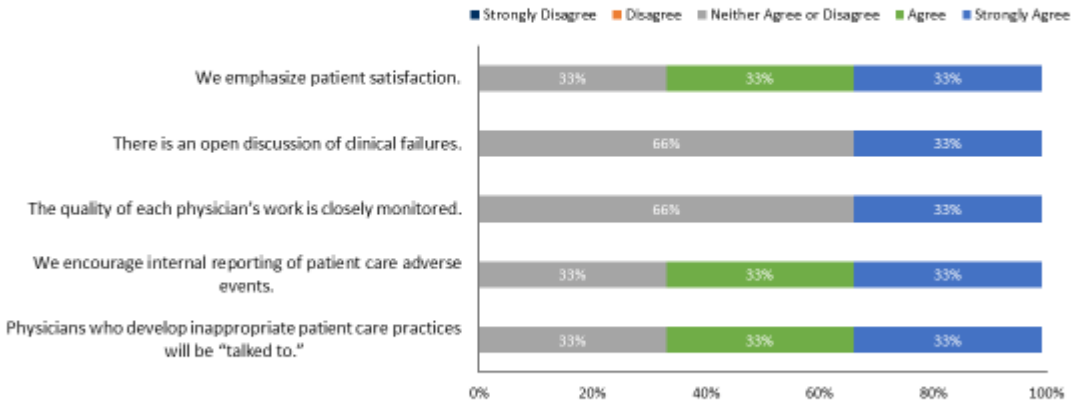
Capacity for Change



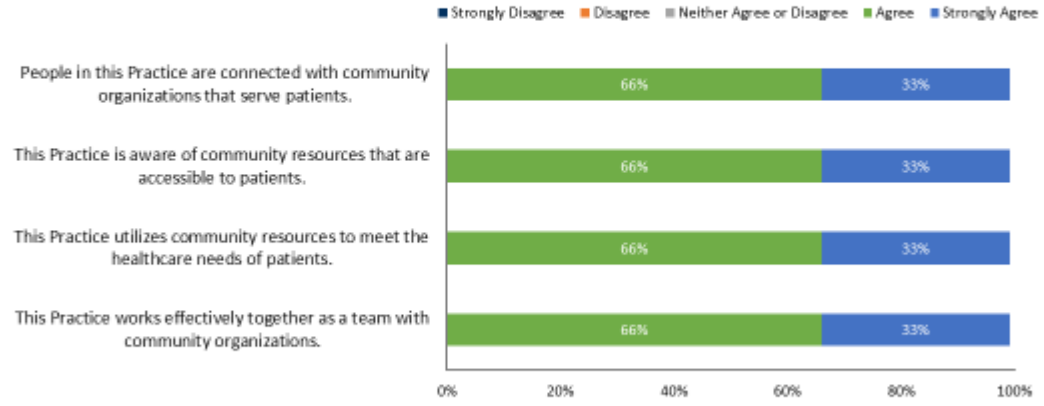
Office Processes and Standardization



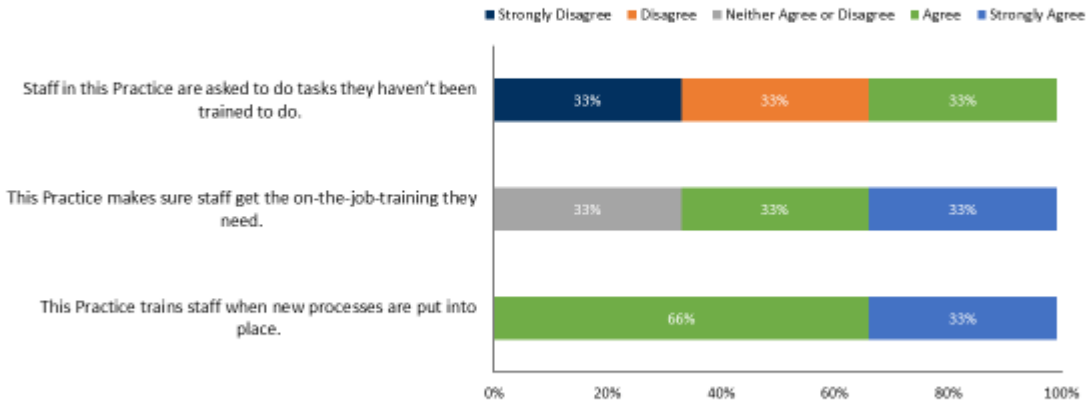
Organizational Culture



Interacts with the Community



Mechanisms for Staff Training



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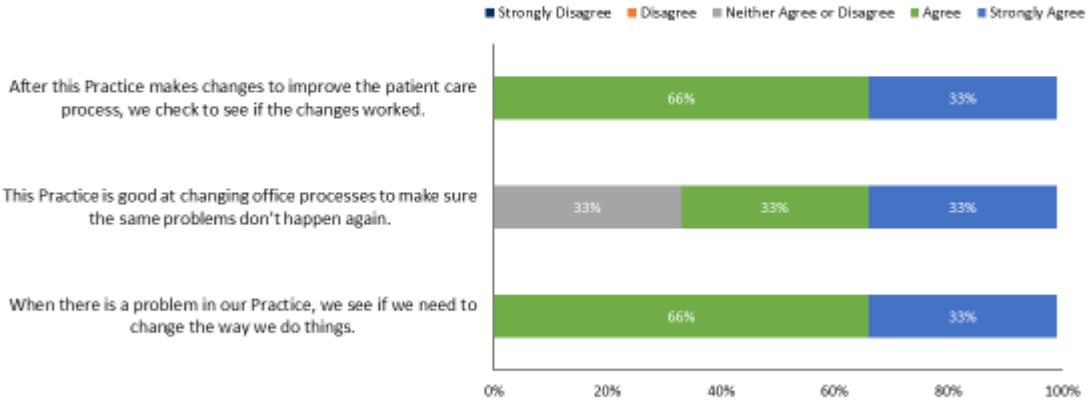
Organizational Learning Processes



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Next Steps – Data Collection

DATE	TASK	NOTES
September 11th	Office contact at each side provide Muskie with email addresses for clinicians in practice for Clinician Survey	
September 14th	Send recruitment letters for onsite interviews to clinicians, send email to site point person that interviews will be scheduled in October-November	Set due date for opt-out to 10 days after email is sent
Week of September 21th	Begin scheduling site visits/ interviews	
October-November	Site visits, interviews, clinician surveys	

Questions – Contact information

Muskie Project Team:

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Appendix I:

Clinician Survey Presentation

TIME TO ASK
Education that transforms conversations about alcohol use

Clinician Survey Results

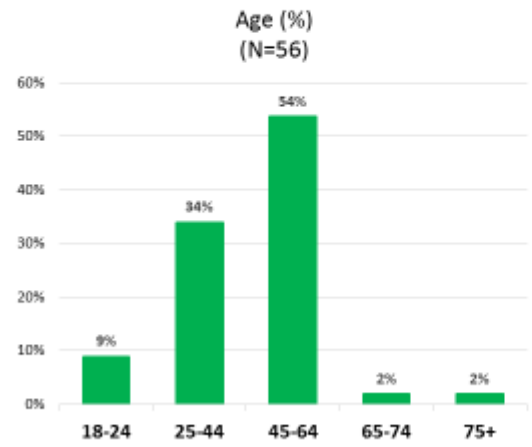
PRESENTED BY: MUSKIE SCHOOL OF PUBLIC SERVICE

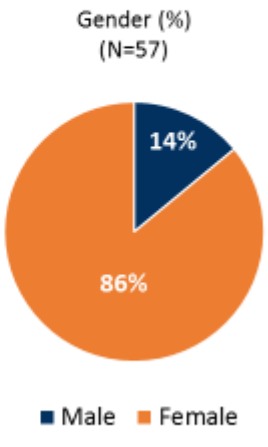
Overview

- Demographics
- Education and Training
- Practice Dynamics
- Clinician Views and Attitudes

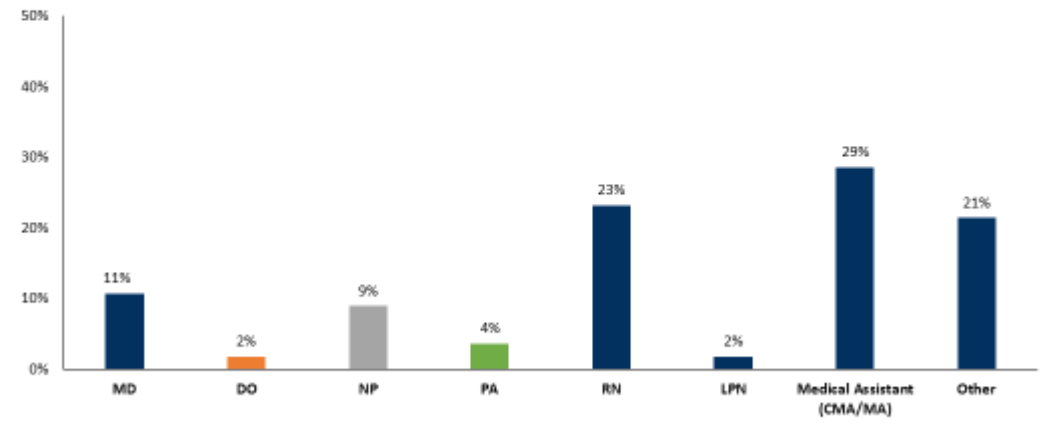
Demographics

Survey Participant Demographics





Participant Degrees
(N=56)



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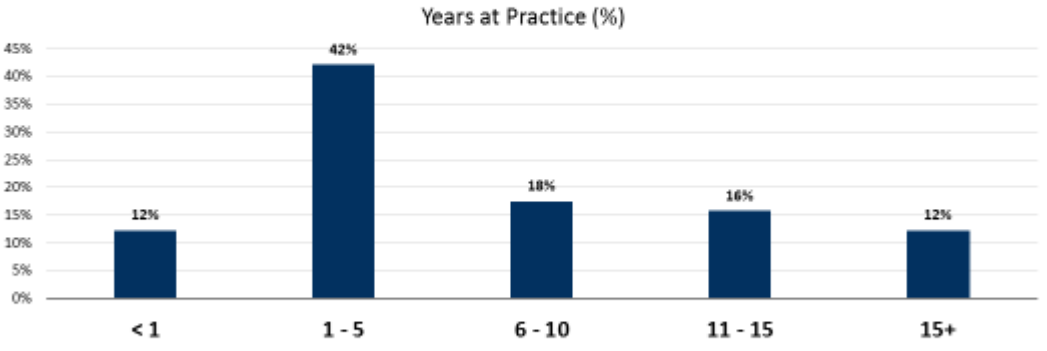
Survey Participant Demographics
(N=57)



Mean years at practice (individual survey participants): 6.6 years

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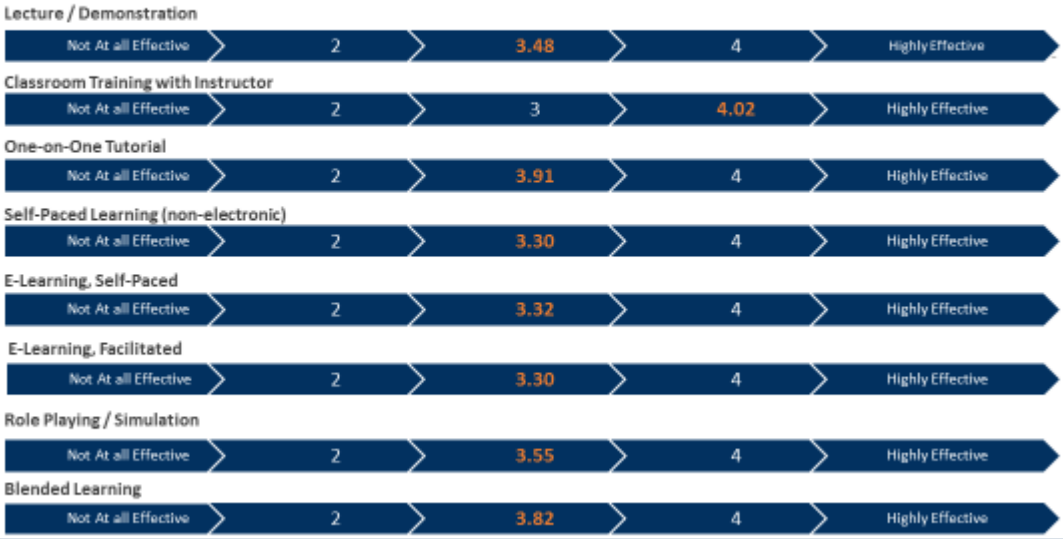
Education and Training

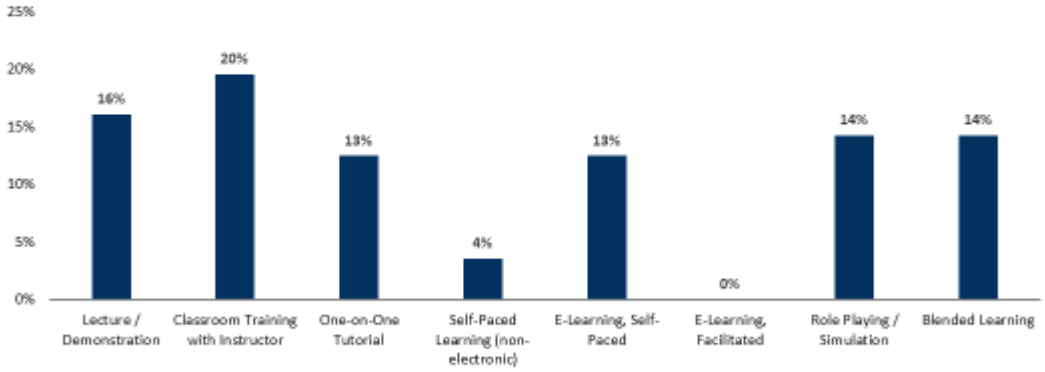
Training Methods

How effective do you feel each training method is for you?



Most Effective Training Methods

If you had to choose one training method, which would be the most effective for you?



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*Why is this the **most** effective training method for you?*

Major themes:

- Flexible scheduling allows for working at own pace
- Demonstrations, interactive learning, and blended learning give more than one way to learn
- Being able to ask questions and practicing application of new skills allows for hands on experience in a safe setting

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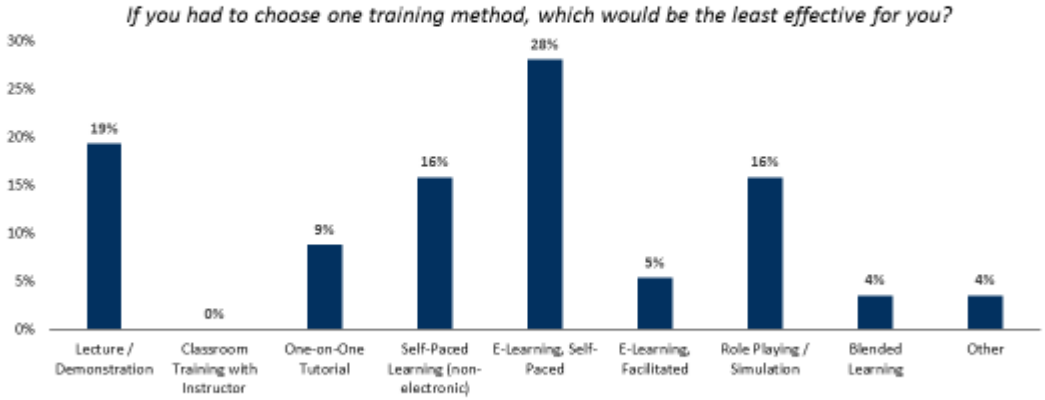
Least Effective Training Methods



*Why is this the **least** effective training method for you?*

Major themes:

- Lack of motivation to learn and allows for too many distractions
- Too time consuming
- Don't take a lot of information away
- Feedback and interaction is limited
- Technology issues can impact learning

Please share any additional thoughts you have about training methods that may assist with the development of a clinical alcohol education and training program for primary care staff.

Major themes:

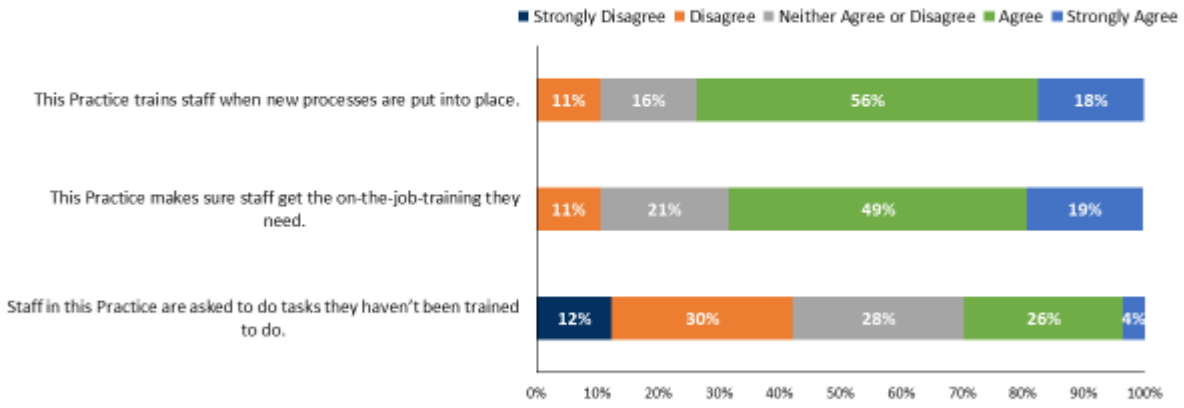
- Learning about local treatment and funding options to help patients
- Learning from personal experience or from a person with a specialized skill set in helping patients struggling with alcohol misuse
- On going, flexible, and interactive trainings are most impactful

Summary – Education and Training

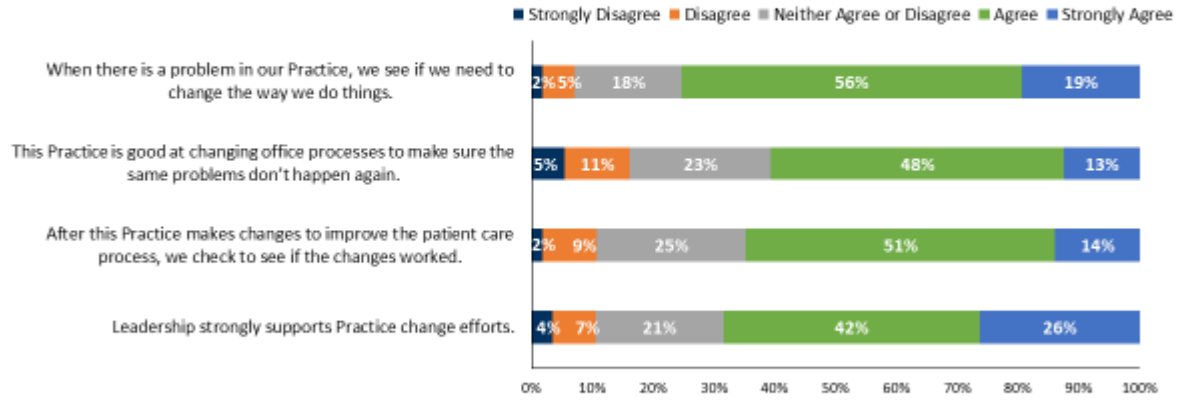
- Classroom training with an instructor was rated as the **most effective** training method.
- Non-electronic self-paced learning and e-learning (self-paced and facilitated) received lower ratings of effectiveness.
- Choosing one training method, most respondents felt self-paced e-learning would be the **least effective**.

Practice Dynamics

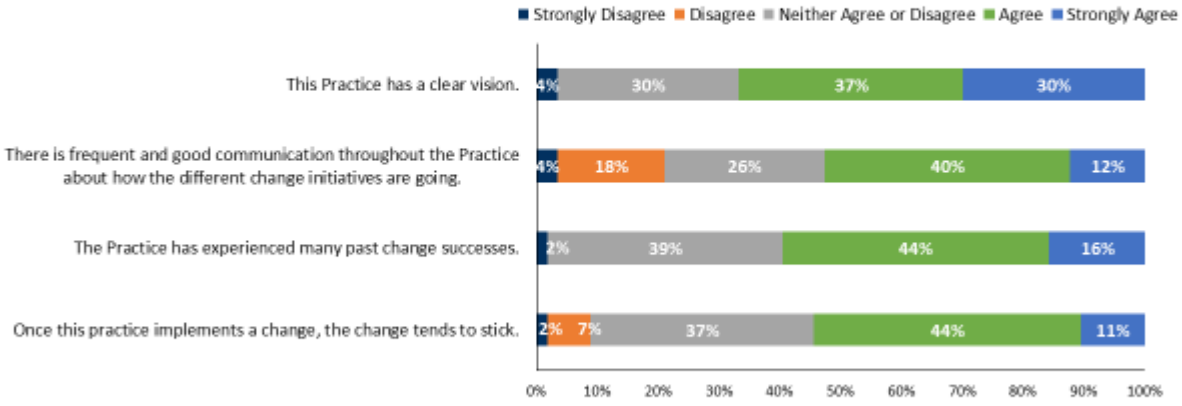
Mechanisms for Staff Training



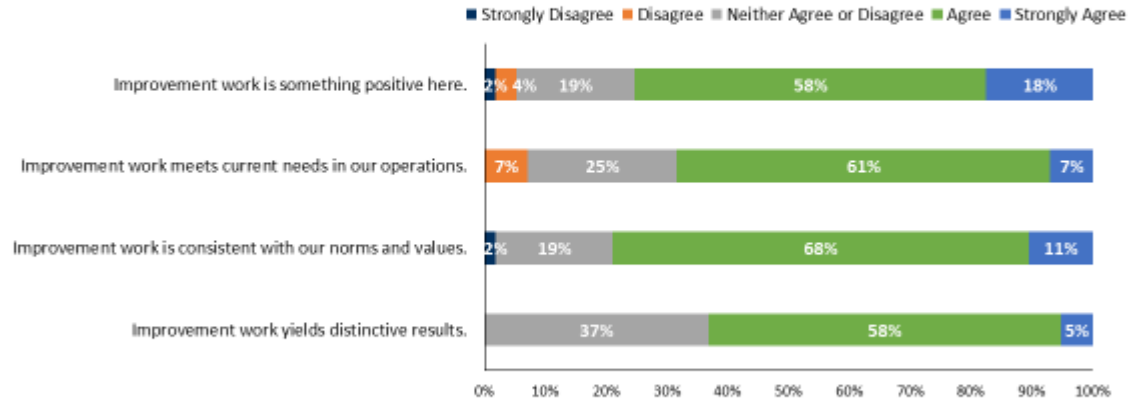
Organizational Learning Processes



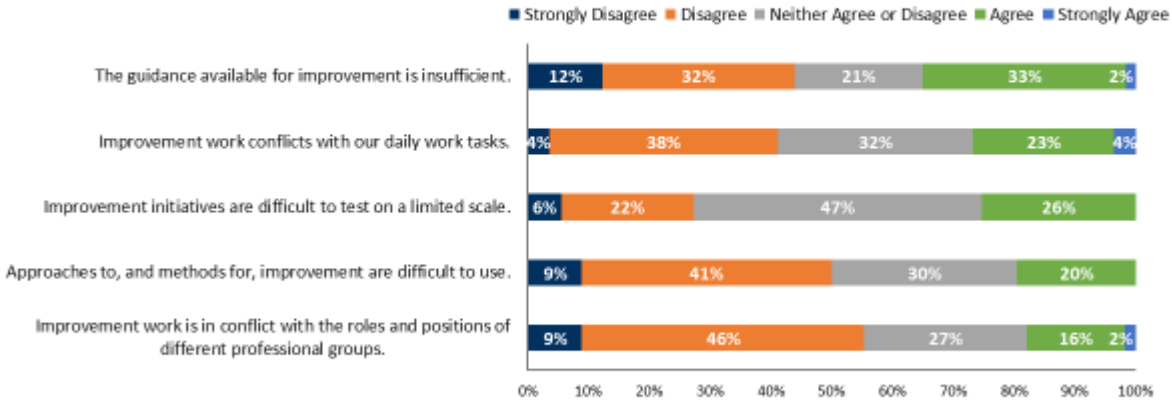
Organizational Learning Processes



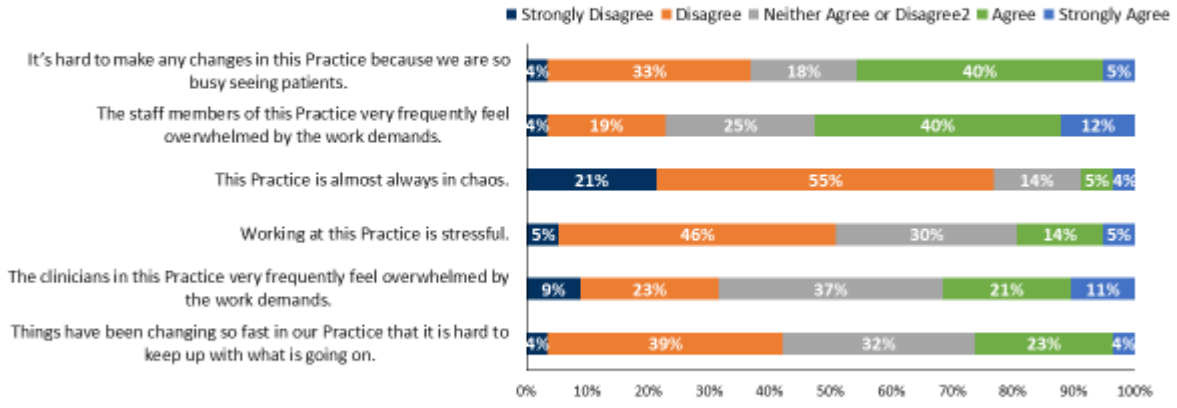
Attitudes Toward Improvement Work



Attitudes Toward Improvement Work



Capacity for Change



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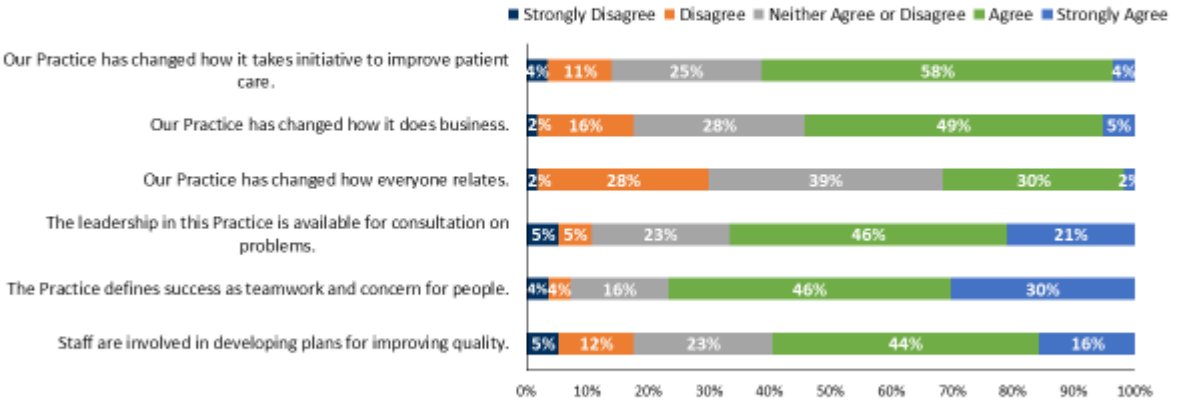


Summary – Practice Dynamics

- The majority of respondents felt staff received on-the-job training, including for new processes.
- Thirty percent of respondents felt staff are asked to do tasks without training.
- Frequent and good communication about how different change initiatives are going is an organizational learning process that has room for improvement (20% strongly disagree/disagree that there is frequent/good communication).

Summary – Practice Dynamics

- While most respondents felt improvement work is consistent with their practice's norms and values, a majority of respondents also felt improvement work is in conflict with the roles and positions of different professional groups.
- While respondents indicated there is high capacity for change, 52% of respondents agreed or strongly agreed that staff members very frequently felt overwhelmed by work demands.
- Success was commonly defined as teamwork and concern for people.

Clinician Views and Attitudes

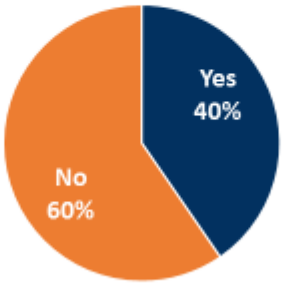
Working with Patients Who Consume Alcohol

How convinced are you that it is important to integrate regular conversations about alcohol use into your clinical work with patients?

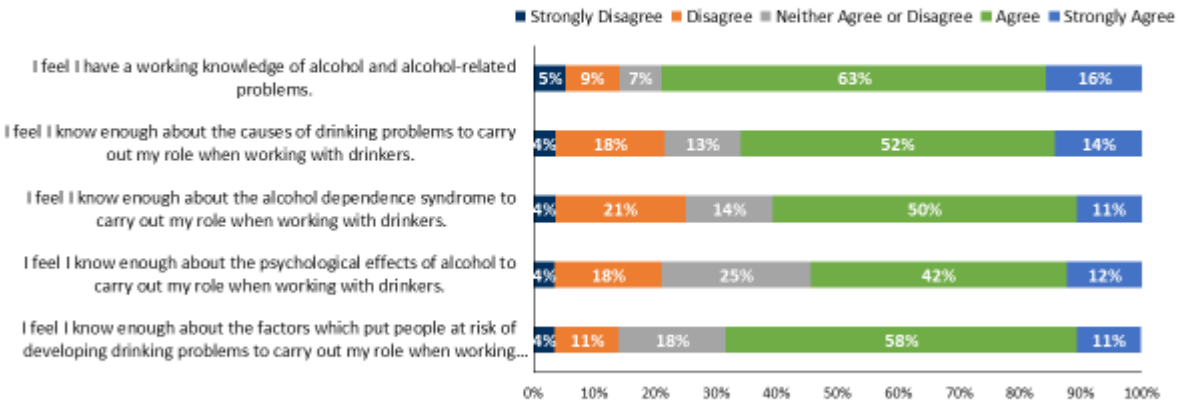
How confident are you in your Practice's ability to integrate regular conversations about alcohol use into your clinical work with patients?

Working with Patients Who Consume Alcohol

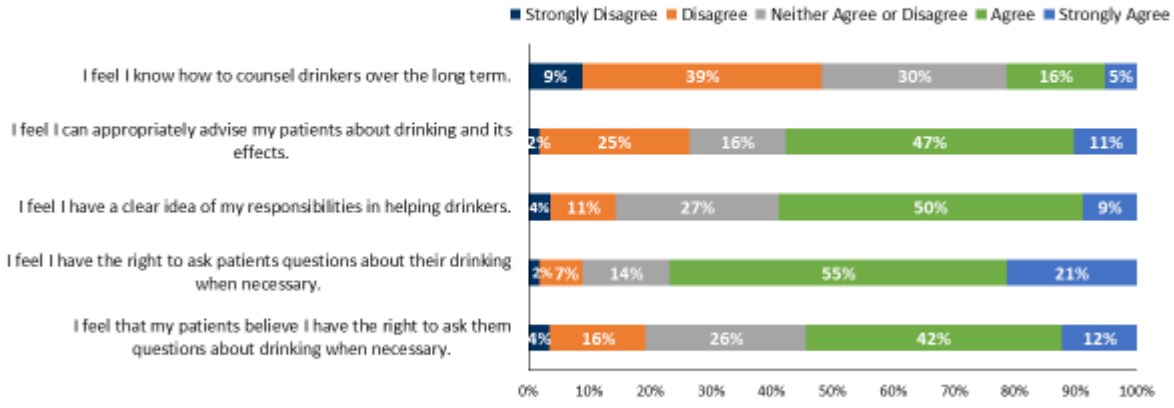
Have any of your personal or professional experiences impacted your willingness to work with drinkers?



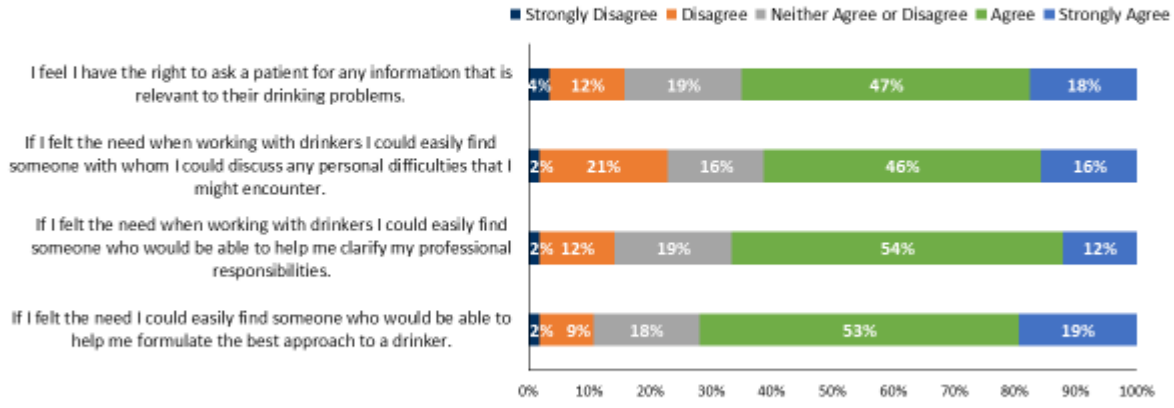
Working with Patients Who Consume Alcohol



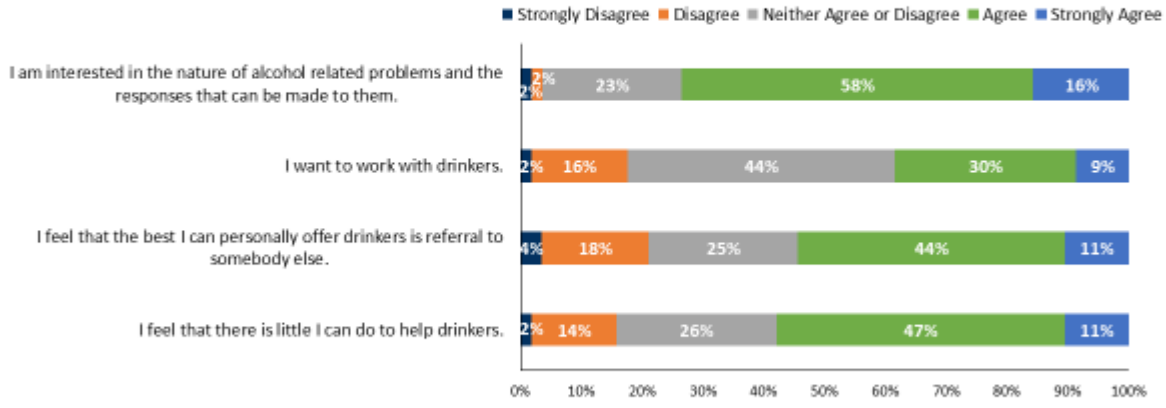
Working with Patients Who Consume Alcohol



Working with Patients Who Consume Alcohol



Working with Patients Who Consume Alcohol



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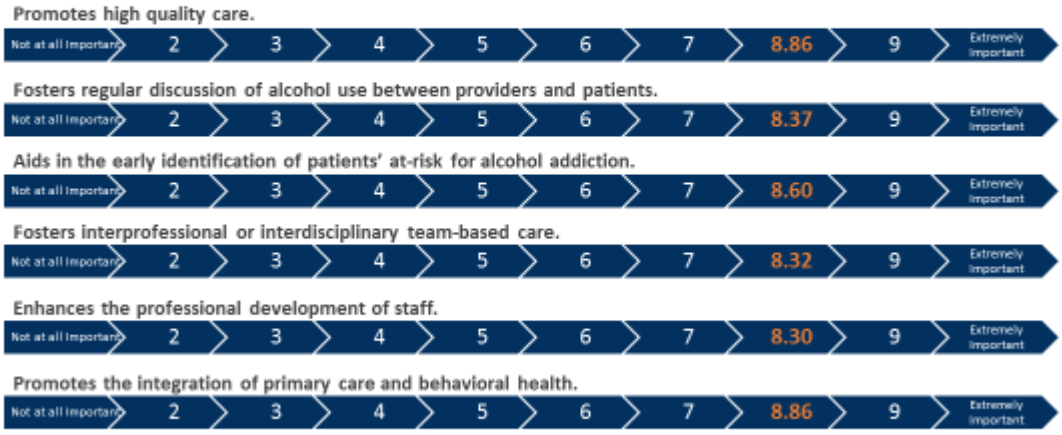
Clinical Education and Training Programs

While thinking about a clinical education and training program regarding patient alcohol use, in your opinion, how important are the following to that program?



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Summary – Clinician Views and Attitudes

- Most respondents were highly convinced (8.09/10) that it is important to integrate regular conversations about alcohol use into clinical work, although confidence about integrating these conversations into clinical work was slightly lower (7.39/10).
- While many respondents felt they know enough about alcohol-associated problems, 48% of respondents strongly disagreed or disagreed that they could counsel drinkers over the long term.
- Nearly 3 out of 4 respondents agreed or strongly agreed that they are interested in the nature of alcohol related problems and the responses that can be made to them.
- Promoting high quality care and the integration of primary care with behavioral health were the two highest rated factors in regards to clinical education and training programs.

Next Steps – Data Synthesis

DATE	TASK	NOTES
March 2016	Final Time to Ask Report including results from office system survey, clinician survey, and clinician interviews.	

Questions – Contact information

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Appendix J:

Alcohol Drinking Patterns Infographic


ALCOHOL CONSUMPTION PATTERNS
There are no known safe levels of alcohol consumption and all patterns of use carry some risk. The alcohol consumption patterns outlined below are intended to describe various levels of alcohol use, all of which are associated with short and long-term health risks.
what is a standard drink?
12 fl oz of regular beer
8-9 fl oz of malt liquor
5 fl oz of table wine
3-4 fl oz of fortified wine (e.g. sherry, port)
2-3 fl oz of cordial or aperitif
1.5 fl oz of brandy or cognac (one jigger or shot)
1.5 fl oz shot of 80 proof distilled spirits (e.g. whiskey, gin, rum, tequila)
5%
7%
12%
17%
24%
40%
40%
approximate alcohol content
what is low-risk drinking?
MEN
WOMEN
having up to...
2
DRINKS PER DAY
1
who should not drink any alcohol?
those who are currently...
taking medications that interact with alcohol
managing a medical condition that may be made worse by drinking
pregnant or trying to get pregnant
recovering from alcoholism or are unable to control amounts consumed
UNDER 21
underage
what is binge drinking?
MEN
WOMEN
typically having...
5+
4+
in a single occasion (generally 2-3 hours)
what is heavy drinking?
MEN
WOMEN
typically having...
15+
8+
PER WEEK
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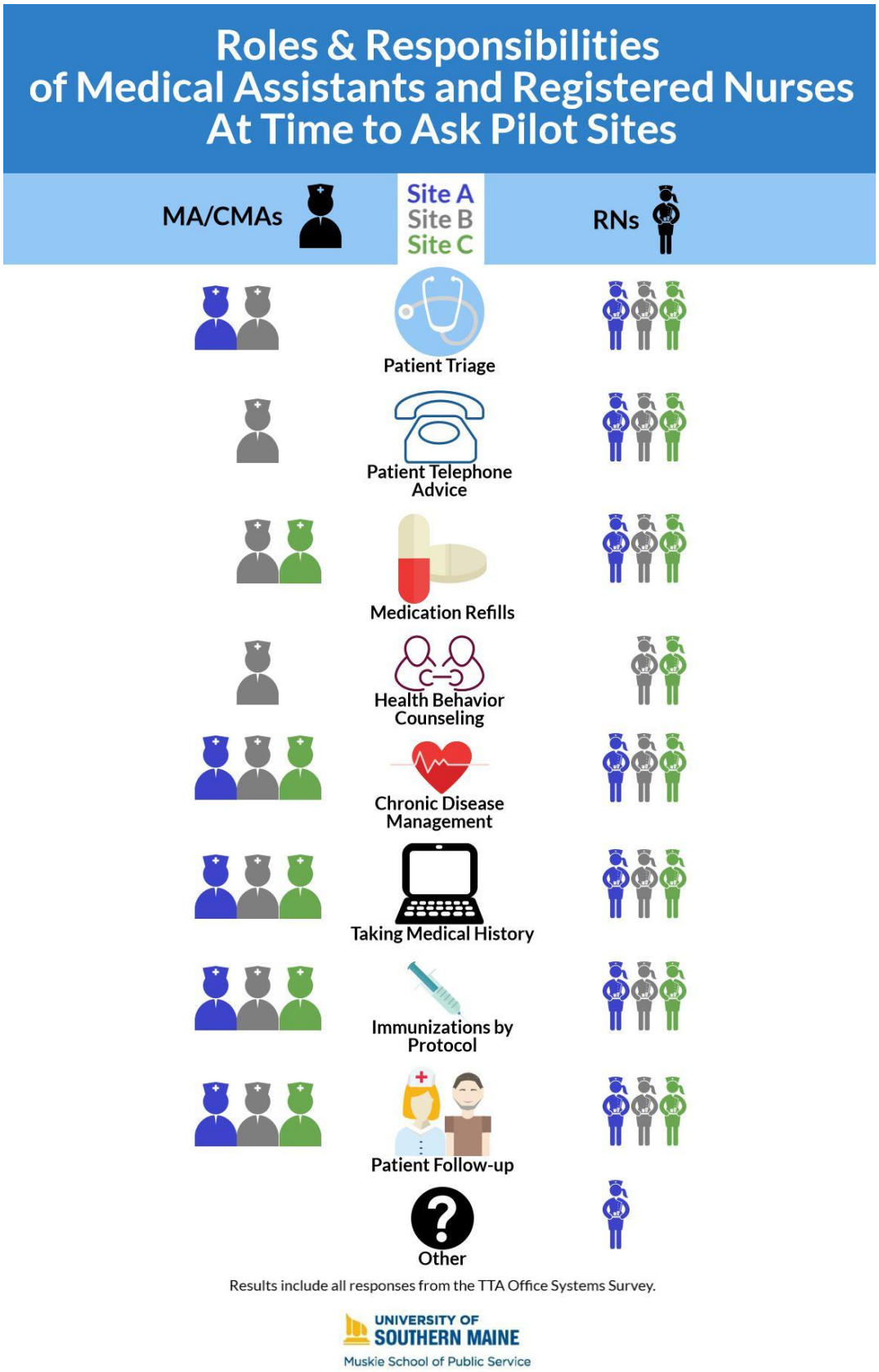
Source:
www.cdc.gov/alcohol/faqs.htm

Appendix K:

Roles and Responsibilities of Medical Assistants and Registered Nurses at Time to Ask Pilot Sites Infographic


Roles & Responsibilities
of Medical Assistants and Registered Nurses
At Time to Ask Pilot Sites
MA/CMAs
Site A
Site B
Site C
RNs
Patient Triage
Patient Telephone Advice
Medication Refills
Health Behavior Counseling
Chronic Disease Management
Taking Medical History
Immunizations by Protocol
Patient Follow-up
Other
Results include all responses from the TTA Office Systems Survey.
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Appendix L:

Training Methods Infographic

Training Methods at Pilot Time to Ask Sites

Specific Themes by Profession

33% of MD and DOs reported Role playing or Simulation was the LEAST effective training method

56% of LNP and RNs reported Self-Paced E-learning was the LEAST effective training method

44% of CMA and MAs reported Lecture or Demonstration was the LEAST effective training method

Half of the social workers reported that Blended Learning was the MOST effective training method

Among clinicians, there was a low level of agreement as to which training method is most effective

Approximately 1 out of 3 NP and PAs reported Self-Paced E-Learning was the MOST effective training method

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Results include all responses from the TTA Clinician Survey.