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Screening, Brief Intervention and Referral to Treatment Implementation in the Emergency Department

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Abstract

We sought to qualitatively evaluate impediments in implementing a novel Screening, Brief Intervention and Referral to Treatment (SBIRT) protocol into normal emergency department (ED) workflow for patients with at-risk drug/alcohol behavior. From 2010, administrative and nursing champions trained nurses at a single ED (census: 50,000 visits/yr) in SBIRT and incorporated SBIRT into normal ED nursing workflow in 2012. To qualitatively analyze impediments in SBIRT implementation, we created a semi-structured questionnaire for protocol champions with subsequent follow-up. Investigators analyzed responses using qualitative methodology based on a modified grounded theory framework. In 2012, 47693 visits by 31525 patients met SBIRT protocol initiation criteria with a protocol execution rate of 83.4%. Interview data identified the following impediments: (1) Need for multi-layer leadership support; (2) Application of an overarching vision to constantly address personnel attitudes towards SBIRT appropriateness in the ED; (3) Continuous performance monitoring to address implementation barriers close to real time; (4) Strategic and adaptive SBIRT training; and (5) External systemic changes through internal leadership. Qualitative analysis suggests that impediments to SBIRT implementation in the ED include views of SBIRT appropriateness in the ED, need for continuous reinforcement/refinement of personnel training / protocol execution, and fostering of additional administrative/financial champions.

Keywords

Emergency Department, Emergency Nurse, Qualitative Methodology, Screening-Brief Intervention-Referral to Treatment, Substance Use Disorders

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We sought to qualitatively evaluate impediments in implementing a novel Screening, Brief Intervention and Referral to Treatment (SBIRT) protocol into normal emergency department (ED) workflow for patients with at-risk drug/alcohol behavior. From 2010, administrative and nursing champions trained nurses at a single ED (census: 50,000 visits/yr) in SBIRT and incorporated SBIRT into normal ED nursing workflow in 2012. To qualitatively analyze impediments in SBIRT implementation, we created a semi-structured questionnaire for protocol champions with subsequent follow-up. Investigators analyzed responses using qualitative methodology based on a modified grounded theory framework. In 2012, 47693 visits by 31525 patients met SBIRT protocol initiation criteria with a protocol execution rate of 83.4%. Interview data identified the following impediments: (1) Need for multi-layer leadership support; (2) Application of an overarching vision to constantly address personnel attitudes towards SBIRT appropriateness in the ED; (3) Continuous performance monitoring to address implementation barriers close to real time; (4) Strategic and adaptive SBIRT training; and (5) External systemic changes through internal leadership. Qualitative analysis suggests that impediments to SBIRT implementation in the ED include views of SBIRT appropriateness in the ED, need for continuous reinforcement/refinement of personnel training / protocol execution, and fostering of additional administrative/financial champions. Keywords: Emergency Department, Emergency Nurse, Qualitative Methodology, Screening-Brief Intervention-Referral to Treatment, Substance Use Disorders

At-risk behavior due to drug and alcohol use represents a significant burden to patients, the health care system and society as a whole. The Centers for Disease Control and Prevention report that 80,000 individuals die each year in the United States due to excess alcohol use (Centers for Disease Control and Prevention, 2013). Globally, the World Health Organization estimates that there are 185 million users of illicit drugs and 2 billion users of alcohol, a significant portion of the latter with evidence of abuse and dependency (World Health Organization, 2015). From 2004 to 2010, there was a near-doubling of the number of emergency department (ED) visits due to substance abuse (Substance Abuse and Mental Health Services Administration, 2012).

The ED, as the gateway to the acute health care system, inevitably sees the consequences of the burden of at-risk substance use behavior. To address this challenging patient population, protocols in Screening, Brief Intervention and Referral to Treatment (SBIRT) have been developed to allow assessment and the application of motivational interviewing techniques to individuals who present to the ED related to alcohol or drug abuse or dependency. (Academic ED SBIRT Collaborative, 2007; Bernstein et al., 2009; Estee et al., 2010; D'Onofrio et al., 2012) The evidence supporting such SBIRT programs suggests they can make a positive impact upon patients and lead in some cases to long-term rehabilitation. However, the sustainability of such programs is often dependent upon outside grant funding or additional personnel. To translate into widespread practice, EDs need to find a way to incorporate SBIRT into existing operational patterns without additional personnel (Cunningham et al., 2009). How to pragmatically accomplish this is therefore of considerable relevance to EDs, hospitals and the health care system as a whole.

Previous publications have highlighted emergency nurses' role in implementing SBIRT protocols (Slain et al., 2014). However, that article did not evaluate how administrative stakeholders, primarily emergency nurse leaders, viewed the process of developing and implementing the SBIRT protocol in ED practice. We sought to use qualitative research strategies to elucidate how administrative stakeholders viewed the incorporation of SBIRT in normal ED nursing workflow at this center. We hypothesized that we would be able to identify attitudinal and structural barriers to implementing SBIRT in the ED by emergency nurses without additional personnel or external resources. The description of these barriers will have relevance to emergency nurses who want to execute innovations in the challenging ED environment.

Role of the Researchers

The two principle researchers in this study were a practicing emergency physician and an experienced qualitative researcher. Neither individual served as a supervisor of the administrative and nursing champions interviewed in this study nor were either involved in the original genesis of the SBIRT project in the ED. As noted below, each participant in the study provided written informed consent under an institutional review board approved protocol prior to interviews. The researchers analyzed data within the context of focus on structural and attitudinal barriers to implementation of SBIRT in normal ED nursing workflow. Given these factors, we do not perceive significant bias or ethical concerns in the methodology described below.

Methods

Protocol Background and Implementation

As previously published, beginning in 2010, administrative and emergency nursing champions at this center trained emergency nurses on SBIRT and integrated its use into the normal workflow of a single, tertiary care center with an annual ED census of approximately 50,000 visits per year (Slain et al., 2014). In the first year of implementation (2012), 47,693 visits by 31,525 patients met protocol inclusion criteria. 83.4% of visits received the initial assessment step of the SBIRT plan at triage. However, while 21.4% of included visits showed evidence of at-risk alcohol or drug use, only 2% of all visits received brief interventions. An additional 20.5% of visits that were eligible for brief interventions did not receive this action from the treatment emergency nurses. We concluded that emergency nurses are capable of identifying patients with evidence of at-risk alcohol and drug use, but are significantly

challenged by clinical responsibilities to incorporating motivation interviewing and referral to treatment into their practice responsibilities. In addition, the protocol fell short of expectations in generating revenue, which represents a significant barrier to sustainability (Cunningham et al., 2009).

Identification of Protocol Stakeholders

Given the operational challenges from developing and implementing the SBIRT protocol at this center, the researchers sought to evaluate the views of those stakeholders who had championed this plan and assisted in its implementation to elucidate the operational challenges they had encountered in developing and implementing the SBIRT protocol. We also wished to determine how these stakeholders viewed the benefits and drawbacks of putting this protocol into effect for patients, the institution and themselves professionally.

To identify the relevant stakeholders, we approached the administrative leadership of the ED to identify all those staff members most intimately involved with internal development and implementation of the SBIRT protocol two years after it began at this center. The internal stakeholders identified as most involved in program development and implementation and contacted were four emergency nurses and one outside rehabilitation treatment provider (TP interview subject in quotes below) who was embedded within our center during protocol implementation to receive referrals of relevant patients. The four emergency nurses included:

1. The ED nursing director at the time of protocol design – ND1 in quotes below
2. The ED nursing director at the time of protocol implementation – ND2 in quotes below
3. The emergency nurse educator most intimately involved with protocol training and information technology integration of the protocol documentation into the electronic medical record – NE1 in quotes below
4. The emergency nurse educator involved with providing continuing oversight of quality assurance of emergency nurse clinical activities at this center – NE2 in quotes below

Each of the above individuals provided written informed consent under Institutional Review Board approval to participate in focused interviews on their experience with developing and implementing the SBIRT protocol.

Development of Semi-Structured Interview Instrument and Conduct of Focus Group

We created a semi-structured survey instrument to identify how respondents viewed the process of SBIRT program development, implementation, benefits/accomplishments and barriers to effectiveness. Employing a qualitative design, we administered either by phone or email the following initial seven question semi-structured survey and recorded the respondents' complete answers for analysis.

1) What do you think has been accomplished at this center with the SBIRT Program?
2) What has the SBIRT Program accomplished for you professionally?
3) What are some of the successes of the project?
4) What were some of its challenges?
5) Why do you think this center was able to succeed with this project?
6) Has this center been able to overcome the project's challenges?
7) What do you see for the future of this project?

These seven items were generated by the investigators separately considering a series of open-ended questions on SBIRT program development and implementation from both a logistical and personal professional development perspective. We then collaboratively collapsed our initial series of queries into the seven items noted by eliminating redundant queries and considering whether respondents could use these questions to be reflective of their experience and to provide content validity to the issues addressed in the survey. Once consensus had been reached across the investigators, the questionnaire was then disseminated. However, while the data from the survey were important in their own right to provide initial insights from the study subjects on structural and attitudinal impediments to SBIRT implementation, the main purpose for the instrument was to generate questions for the focus group described below.

We then conducted a follow-up focus group to allow participants to reflect collectively on the issues that arose from their initial survey responses. This focus group was conducted in a conference room of the emergency department two years after initial program implementation by an investigator with qualitative methodology expertise along with the study principal investigator for a total of two hours. The investigator with qualitative methodology was not acquainted with the study participants. Initially, study subjects were asked, in an open-ended manner, their attitudes and opinions on the process in which the SBIRT program at this center was developed and implemented. The investigators then drew upon the provided email and phone responses to guide discussion towards a thematic exploration of the barriers to effective development, implementation and operationalizing of the SBIRT program at this center. This then led to a discussion of the attitudes of the interviewed study subjects towards the value of the SBIRT program to ED patients, their own professional development and the institution as a whole. Finally, the investigators steered the focus group participants towards reflection on the future of the SBIRT program at this center and the potential lessons learned of relevance to other centers developing SBIRT programs. We recorded the entire focus group session to allow analysis of responses using qualitative methodology.

Qualitative Analytic Strategy

We analyzed the responses from both the initial semi-structured survey and the focus group utilizing a modified grounded theory framework. We chose a modified grounded theory approach over a more general interpretative approach for two reasons. First, grounded theory allows the use of open-ended questions to derive relevant themes based on repetitive comments, concepts, elements and ideas. This was important to us because we wanted to make sure any conclusions that we were able to draw were situated in the actual statements and language of our participants. In this fashion, we sought to avoid an additional interpretative "layer" between what they said and what we were able to begin to build as the beginnings of a "theory" of SBIRT use in ED settings.

The second reason we used a modified grounded theory approach was based on the fact that, since its inception, grounded theory has allowed for a variety of adjustments and modifications. Interestingly enough, this discourse on whether grounded theory should be a "pure" method or instead flexible to the circumstances of its use, was present at its very outset (Glaser & Strauss, 1967). To this end, we modified our initial open-ended approach in the surveys to guide respondents in the focus group toward a reflection to a "lessons learned" framework that would be of relevance to a wider audience of emergency nurses and emergency department staff (Charmaz & Belgrave, 2012). In other words, there were a number of potential and fruitful theoretical directions that could have been pursued. Given that we used their survey answers to guide our focus group, this assured us that our participants were not "prepared" by

us to go in any specific direction, but in their own directions. In this way, we felt comfortable in using their words as prompts to the more directed task of articulating lessons learned.

In summary, semi-structured short answer questions are an effective way to get a consistent body of answers for a set of critical questions (Sittig, Ash, Guappone, Campbell, & Dykstra, 2008), but the focus group was also necessary in order to allow for participants to reflect collectively on their responses and other important and inter-related matters (Shank, 2005). In this fashion, we utilized the responses from the semi-structured survey to identify underlying themes that were relevant in guiding the reflection process in the focus group towards a conclusion of lessons learned.

We conducted an iterative process to evaluate the themes elucidated by the respondents and described below in the results section. We classified these responses within the framework of describing the lessons learned from their experience to provide relevance both to this center and others. Given our focus on these lessons, our goal was on achieving recognition, acknowledgement and, to some degree, consensus on at least the major dimensions of those lessons as learned by our participants. We felt that this provided the sort of situated saturation needed for the purposes of deriving the lessons learned.

We present those themes by drawing upon complete quotations from the respondents both from the semi-structured survey and the focus group. It is only through these extensive and complete quotes that we can actually contextualize the nuances and complexities not only of our participants' responses, but also of the complex circumstances that govern the use of SBIRT in an ED setting.

Results

We received responses through the semi-structured survey process and the focus group from all five respondents. Based on these responses, we identified three thematic areas of relevance in the implementation of SBIRT programs in the ED. We provide full quotations from the study subjects to support the themes identified using a grounded framework. The only modifications to these quotations, shown in brackets, are to ensure the anonymity of both the individuals involved and the peer-review process.

Motivations for Development and Implementation of the SBIRT Program

The administrative and emergency nursing champions interviewed supported the goal of emergency nurses screening and providing counseling to patients presenting to the ED with at-risk alcohol or drug use behavior. The administrative champions expressed confidence that emergency nurses could and should have as part of their professional responsibilities an ability to motivate these patients to take actions in their lives that might prevent them from presenting again to the ED by controlling a chronic ailment, as opposed to just focusing on the acute presentation. This professional responsibility, in this context, should take the form of knowledge of specific skills in assessing rigorously the extent of the patient's at-risk alcohol or drug use, motivating the patient to pursue treatment in a validated way and assistance in referring patients who are willing to treatment.

- Safe Landing [The name of this project at this center] has opened a door for patients with addiction to be treated appropriately, empathetically and with compassion. It has also enhanced the ability of the nursing staff to skillfully deal with the concerns of the patient either by streamlining their care or by contacting the appropriate agencies. (NE1)

- We have been successful in implementing a training program within the ED that provided ongoing training to our staff to increase their knowledge and understanding of the substance use and abuse issues in our community. (ND2)
- Since we have started this project, we have accomplished a few things. All of our nurses are able to do a screening and understand the importance of it. We have had positive feedback from our patients and their families. (NE2)
- I believe that we have helped a few patients make the connections necessary for recovery. We have increased the awareness of our staff regarding substance abuse, intervention and the recovery process. (ND2)

The rationale for supporting the development and implementation of this program is the value of patient-centered care. This is an ideal, in the viewpoint of the interviewed champions, for emergency nurses.

- It is nice to see patients that genuinely want assistance. We have had at least one success story where we referred a man, and he wrote us a letter to thank us for turning his life around. That letter stayed on the bulletin board of our break room for months. (ND2)
- I truly believe we have succeeded in keeping this project alive by the many dedicated people involved that understand that there is an epidemic in the community with substance use and abuse. We are health care professionals who want to help patients not only with their acute diseases but also with their chronic diseases. When a patient comes into the department with a laceration on his or her arm, through the Safe Landing note and brief intervention we provide, we identify serious issues with the patient's alcohol or drug use. It is a great feeling of success for a health care worker to be able to provide a warm hand off to treatment facility to start the patient on his or her journey of recovery. (NE1)

Barriers to Implementation

The second theme identified is the need to address logistical challenges in real time. Without doing so, the continued buy-in by busy emergency nurses to execute this program was difficult. The administrative and emergency nursing stakeholders interviewed for this study expressed great frustrations with the lack of institutional support mechanisms to make this project a priority over the medium and long-term. They highlighted the importance of dedicated individual champions to ensure continued protocol compliance and that ideally this should have been coupled with partnership with emergency physicians. As noted specifically by the respondents, there is a significant question as to whether emergency nurses, with their other clinical responsibilities, can take on the logistical challenges posed by referral to treatment of patients in the emergency department.

- Honestly if a few key people did not push the project and keep on it, it would have failed. (NE2)
- Challenges included the health care staff buy in. Nursing in the ED is a challenge of its own. When you add time and a compassion for dealing with addiction you tend to hit a brick wall. Being one of two programs like this [made it] very difficult to get physician support. If it was not best practice initially they did not want to do it. We ran the program with no physician support for the first year. (ND2)

- I believe [this center] has been successful because of our tenacity the first year. I mentored [the emergency nurse educator] to take on the project. Dr. [XXX] became the physician champion who I know is a top notch researcher with the ability to take the next step. [This center] invested in this program after we had worked hard to initiate it. I would say that my inexperience did not help the end result but I am passionate and wanted this program to succeed. I am just thankful that it has succeeded and that I was an integral part in that. (ND1)
- We faced challenges with getting our patients placed somewhere for rehab. (NE2)
- [The first rehabilitation referral agency] did not take all patients with drug and alcohol issues. The staff was never educated on what to do with the patients who needed detox. This issue was concerning for several reasons: Our staff was trained to first identify a substance abuse issue then second to contact [the first rehabilitation referral agency] to assist with transportation and placement. There were several issues with transportation. [The first rehabilitation referral agency] would have a several hours delay picking up patients. All the patients that we sent to [the first rehabilitation referral agency] were already discharged from the ED. These patients would have to wait either in their rooms (if the ED did not need the room for another patient) or in the waiting room. When [the first rehabilitation referral agency] would come to the department, they would often times deem the patient intoxicated and unsafe to transport. There was not an intox criteria taught to the staff. An alcoholic patient will never have an alcohol level of 0.0. They could fully function with an alcohol level of .08-.1. The other issue is after this long wait [the first rehabilitation referral agency] would inform us the patient needed detox. We were not educated on patients who needed detox. The staff was discouraged. The easy process they were promised was not working. (NE1)

In addition, the administrative champions expressed frustration with the lack of financial benefit from the program due to difficulties with reimbursement by payers as well as the absence of institutional recognition of this attempt to help a very difficult patient population.

- We are having a hard time getting any kind of reimbursements; we are still not receiving any funding. (ND2)
- I have received no professional recognition at all for this work. (NE2)

The combination of both logistical barriers to referral of patients to treatment and reimbursement for services provided as well as the lack of professional recognition and internal institutional support eventually filters down to front-line emergency nurses and their willingness to continue with this project. This is compounded by the documentation requirements that are necessary to appropriately determine the type of brief intervention that may be most beneficial to the patient.

- It is an ongoing challenge to get the staff to be fully vested in this project. We have provided education to the staff to increase their compliance in completing the Safe Landing note. (ND2)
- It was hard getting the staff to buy in, because it is such a long screening. (NE2)
- If a patient is using alcohol or one or more drugs, we could end up asking up to 50 or more questions. Many of the questions are repeated for each drug. Some

of the patients complain that they are being badgered – I already told you that I use drugs, why are you badgering me? (NE1)

- We have no idea if our screening efforts have been successful, other than the one letter we received. (NE2)

- This project, in order for it to succeed, needs to have a dedicated employer in the department to do the survey once the patient has been identified as having a substance abuse issue by the triage nurse. I have tried to get social workers more involved without success. To do the survey and give a brief intervention with a referral can take up to 30 minutes. This is a lot of time taken away from a[n emergency] nurse who is attending to 3 to 5 sick patients. I feel there would be more success with this project if there were dedicated people to do all the preventative care required in the ED. As of this date the RNs in the ED are required to ask a survey on the following; Flu vaccine, Pneumonia vaccine (if the patient wants the vaccine then the nurse is responsible to administer the vaccines) HIV screening on all patients between the ages of 13 and 65 years (the nurse provides this screening which takes 20 minutes), Safe Landing – screening, complete the questions and provide brief intervention and referral can take up to 30 minutes. This is a ton of time removed from [emergency] nurses that are dealing with true emergencies. (NE1)

- Even if we only help one person, and we know for sure that we have helped that person, then this will have been worth doing. But if we have 80 people doing this screening at any given time, then we might never know for sure. That is part of the challenge of this work. (ND2)

Finally, the administrative and emergency nursing champions expressed a significant need to identify a visible clinical leader to continue to motivate staff to execute the protocol and to represent the program with external parties whose cooperation is needed for success.

- This program was started five years ago by a toxicologist who had a passion for this work. His original goal was to help patients be aware of the harmful impact of drugs and alcohol in their lives.   After he left, the focus shifted to rehabilitation referrals. (ND1)

- I know who used to be in charge, but he left last year. I'm not clear who is actually in charge now. I suppose it might even be me. (ND2)

Solutions through Teamwork and Delegation of Responsibilities

Despite the above barriers to successful SBIRT program execution, the study subjects would continue to support the implementation of this project. However, they keenly feel that other health care professional staff in the ED should be responsible for the full SBIRT protocol after initial identification of at-risk patients. In this center, the most likely candidates for that splitting of responsibilities are ED social workers, who are in the ED at all times and have relevant expertise with referral of patients to outside treatment resources.

- I think it is a great project; everyone is trained and able to complete an assessment. I would like to see social workers become involved as well. The social workers are on call anyway, and they are trained to do these sorts of clinical assessments. Besides, if the patients need referrals, it is the social workers who do those anyway. (TP)

- If I were asked to work at Safe Landing the way it was when we started in 2009, I would say no. But now, in 2014, I feel it is finally starting to work. It is a shame that it has taken five years for us to get here, though. (NE2)
- We now have three rehabilitation referral agencies who work cooperatively with both the ED and each other. This cooperation has been a long time coming, but it has definitely made things much better. (NE1)

Discussion

We have presented a qualitative analysis of the implementation of a novel SBIRT program in the normal workflow in the ED without additional resources or personnel. This complements our previously published article on this program showing its outcomes from both an operational and financial perspective (Slain et al., 2014). Our analysis, based on a modified grounded theory framework, provides evidence for practical lessons that are applicable to other EDs interested in developing SBIRT programs for patients presenting with at-risk alcohol and drug use behavior. Our analysis is particularly relevant given that most SBIRT programs that have been discussed in the peer-reviewed literature have relied on external resources and additional personnel (Academic ED SBIRT Collaborative, 2007; Bernstein et al., 2009; Estee et al., 2010; D'Onofrio et al., 2012). To develop a sustainable model that can be disseminated across EDs, SBIRT programs will need to more regularly rely upon existing resources and personnel (Cunningham et al., 2009). This study along with our previously published investigation provide a portrait both qualitatively and quantitatively how a self-sustaining SBIRT program can be developed and executed along with expected outcomes in the ED, largely on the initiative and efforts of emergency nurses.

Based on the three qualitatively derived themes identified above, we would note five lessons learned that are relevant both to emergency nurses and EDs as a whole. First, to develop an effective SBIRT program, there needs to be a visible and multi-layered leadership that drives the program. In our center, initially, there was leadership on both the nursing and physician level (the ED nursing director and the staff toxicologist) to spearhead the development of this program. However, due to personnel changes, the program was quickly turned over to an emergency nurse educator. While this individual was able, with the support of the new emergency nursing director, to train the ED nursing staff and initiate the program, larger logistical issues related to billing and referral to treatment have been unsuccessful. This center has seen improvements in this regard by combining emergency nursing stakeholders with emergency physician and administrative leadership. The lesson, in essence, is that all operational parties have to make the SBIRT program a priority to be effective.

The second lesson is that continual staff investment in an SBIRT project requires an overarching vision that reinforces underlying professional values. In this study, the interviewed stakeholders stated clearly that a focus on patient-centered care should extend beyond the acute ED presentation. This is a value that emergency nurses shared based on their initial enthusiasm for the SBIRT project. Yet the logistical barriers that appeared – difficulties with referral and the length of the required documentation along with poor reimbursement – challenged the willingness of emergency nursing staff to continue to execute the SBIRT initiative. Despite these impediments, the program has continued, largely due to it fitting into a viewpoint that emergency nurses and emergency staff as a whole should care about their patients beyond the initial care. The applicable lesson is that the leaders of public health initiatives in the ED need to relate this to more fundamental professional values, in this case a global perspective on patient-centered care, to aid with buy-in from front-line staff and referral agencies.

The next lesson is that the leadership of initiatives like SBIRT needs to be able to monitor the real-time implementation of the program to address barriers as quickly as possible.

The stakeholders studied in this investigation recurrently brought up the difficulty with addressing barriers related to referral, requirements of documentation and reimbursement. Whether due to changing personnel or the lack of empowerment of those individuals, these barriers could not be addressed quickly, leading to decreased operational efficiency and staff perceptions of the SBIRT program at this center in the opinion of those interviewed. A potential solution lies in the first lesson of ensuring that there is multi-layered leadership of ambitious programs such as the SBIRT initiative here described to allow delegation of responsibilities based on authority within the organization. For example, an ideal leadership structure would have included emergency nursing, administrative and physician champions to ensure all clinical stakeholders were represented in program development, implementation and execution.

Fourth, the training program and preparation for an SBIRT initiative has to be strategic and adaptive to changing circumstances. As the interviewed study subjects noted, the challenges of documentation of the patient screening and referral to rehabilitation might have been better addressed by incorporating social work staff into the program. However, the initial training program of the emergency nurses made an assumption that referral would be relatively straight forward which turned out not to be the case. The lesson for other centers is that they should be prepared to shift the education of their staff and the implementation of their SBIRT program based on the clinical circumstances that arise in practice. At this ED, we have drawn upon the lessons from our interviews of these stakeholders to expand our SBIRT training to our social workers and incorporate them into a revised protocol. In this protocol revision, the emergency nurses will identify patients with at-risk drug and alcohol behavior while social workers perform the formal SBIRT and are responsible for clinical documentation in this regard.

Finally, the interviewed stakeholders reveal a theme that departmental leadership is not enough. Their statements that they received little recognition for their efforts raise the concern that external validation and recognition is critical to ensuring continued stakeholder investment in the SBIRT program. In addition, the statement by the original ED nursing champion that he was inexperienced and that this may have led to difficulties in initial implementation suggests that having outside expertise contribute to the initial training of staff, program development and execution is critical. This expertise would ideally relate directly to the nature of the ED clinical environment.

To our knowledge, this is the first qualitative analysis of an ED-based SBIRT program that was implemented without additional funding or outside personnel. In that context, it is notable that our findings are largely congruent with two previous relevant studies. In the first, a qualitative study of nursing students trained in SBIRT concluded that there was support for nurse performance of SBIRT, but that whether it should be more targeted is a critical issue (Braxter, 2014). In the second, a qualitative study of an initiative for ED nurses to identify and refer patients with hypertension, similar conclusions were reached, namely that logistical issues of establishing follow-up were critical (Pirotte, 2014). Our study supports and adds to these previous investigations by addressing both the attitudinal and logistical factors involved in implementing protocols like SBIRT which are additional to the typical clinical responsibilities of ED nurses.

The primary limitation of this qualitative analysis is that it is a single center's experience with implementing SBIRT in the normal workflow of the ED. While our program may be largely unique in not relying upon outside resources or additional personnel, there is a need to validate our findings in other EDs. There also is a need for a separate, additional analysis on how frontline staff views the value of SBIRT in their clinical responsibilities. Qualitative analysis of frontline staff views would further aid in the sustainability of SBIRT protocols in the ED without external resources or additional staffing.

This qualitative study has two major implications for ED and nursing practice. First, the results of this study suggest that emergency nurses are key stakeholders in the development of public health initiatives in the ED and that they can drive the motivation of other groups within the ED to support such programs. In the case of SBIRT, the value of patient-centered care that emergency nurses hold and was enunciated by the study subjects provides a fundamental basis for how programs that extend ED efforts beyond the acute issue may be made relevant to all staff. However, a second implication of this analysis is that emergency nurses cannot and likely should not expect that they alone can drive the successful development and execution of an SBIRT program in the ED. Rather, there needs to be a collaborative and delegated leadership structure that draws upon other disciplines and is adaptable to changing clinical circumstances.

Conclusion

In this investigation, qualitative analysis of SBIRT incorporation into normal ED workflow suggests that attitudinal and structural impediments to program success include views of SBIRT appropriateness in the ED, need for continuous reinforcement/refinement of personnel training/protocol execution, and fostering of additional administrative/financial champions. Emergency nurses are key stakeholders in overcoming these impediments to allow EDs to extend their role beyond the acute care setting to the larger, long-term health care issues of patients in need.

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