Creation of a Policy for a Behavioral Health Center

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Abstract

Background: Patients diagnosed with Alcohol Use Disorder (AUD), who could benefit from outpatient pharmacological treatment;however, they are not commonly offered it. It is estimated that 99,000 deaths each year can be attributed to AUD. The overall cost to society in 2010 was $249 billion per the CDC's report. Studies showed that less than 11% of patients are being treated for their AUD in outpatient settings. The aim of this project is to increase outpatient care for patients with AUD by creating a standardized policy for a behavioral health clinic. Proper alcohol screening, assessment, and referral will increase care for those with chemical health problems. The expectation is that patients should have access to effective outpatient AUD management.

Objectives: Initial objective was a review of available literature on AUD. A policy to provide standardized care was created and reviewed by 4 professionals in the chemical health field. The final revised policy will be presented to the clinic project manager who can decide if it will be implemented or not.

Methods: Creation of an alcohol use disorder policy to assist in standardizing outpatient access at the behavioral health clinic so that patients with AUD have the option of receiving outpatient care by a primary provider. Four experts in the field of Substance Use Disorders were asked to provide feedback to help revise the created policy based upon analysis of the current literature. The policy addresses professional conduct, training, coordination of services, non-delay of treatment, referral, documentation of care plan and provider roles.

Results: Results as to whether this policy makes a significant improvement in the care of patients with AUD will have to be analyzed after the clinic is in operation.

Conclusion: Conclusions as to the effectiveness and influence of this policy in increasing screening, treatment, and management of AUD will not be known until after it has been implemented. The creation of this policy and implementation hopes to bring more awareness that outpatient treatment of AUD is needed.

Keywords: alcohol use disorder, AUD treatment, AUD policy, outpatient care, chemical health

Creation of a Policy for a Behavioral Health Clinic

The World Health Organization estimated there are 3 million deaths worldwide annually that are associated with harmful use of alcohol (World Health Organization, n.d.). Alcohol is used by 85% of adults over the age 18, but when alcohol use becomes excessive, it can have a negative impact on a person's health, finances, and relationships (SAMHSA, Center for Behavioral Health Statistics and Quality, 2019). Alcohol Use Disorder (AUD) is the third leading cause of preventable death in the United States (Center for Disease Control & Prevention [CDC], 2019). The estimated cost is based on loss of productivity, medical expenses, and criminal justice expenses. This cost does not consider pain and suffering and quality of life for the person and their families or those they may have injured during a motor vehicle accident (CDC, 2019).

The Healthy People initiative started in 1980 to help guide the United States government in understanding what areas of health are needed and keeps statistics on how close the nation has met the set goals and objectives (National Center for Health, 2020). The decrease of drugs and alcohol use (or addictions) and decrease is in alignment with Healthy People 2030 goals to increase the health of the nation. There are four alcohol reducing objectives in Healthy People 2030, and they are to reduce alcohol consumption, to decrease binge drinking in adults over 21, to decrease motor vehicle deaths involving drunk driving, and to reduce deaths due to chronic cirrhosis of the liver (U. S. Department of Health & Human Services, 2020).

Most of the statistics began in the year 2017 so updates on some of those percentages are not available yet. According to Healthy People 2030 (US Department of Health & Human Services, 2020), current baseline statistics on alcohol consumption of those over age 12 is 5.4% with the goal of reducing to 3.0%. For binge drinking, the baseline of self-report is 26.6% of the population and the goal is to reduce that number to 25.4%. Deaths from drunk driving are 29.3% and the goal is to reduce it to 28.3%. The most recent update on deaths from cirrhosis has risen

to 11.3 out of 100,000 from 11.1 out of 100,0000, and the goal is reduction to 10.9 out of 100,000 people.

AUD replaced both alcohol use and dependence disorders in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) (National Institute on Alcohol Abuse and Alcoholism, 2021). A diagnosis of AUD consists of having at least 2 of the 11 criteria listed which may include the following symptoms or behaviors of increasing tolerance, withdrawals, craving, recurring use even though it would cause physiological or psychological issues. A severity rating of mild, moderate, or severe is dependent on the number of symptoms or behaviors present in a given time. The presence of 2-3 symptoms of AUD level of severity is mild; 4 to 5 symptoms are moderate; and 6 or more symptoms are severe in the past year. In the US, 13.9% of adults meet the criteria for AUD diagnosis for a 12-month period, while 29.1% of adults meet the diagnosis of AUD at one point (Ray et. al., 2019).

Out of the 13.9% of adults that meet the criteria for AUD diagnosis, only a small percentage of these people were treated with FDA-approved medication. In several studies, medication-assisted treatment of AUD ranged from 6.8% to 11.1% (Glass et al, 2016; Kelly et al., 2017; Kranzler, 2018; Rubinsky et al., 2015). Thus, a large percentage of the outpatient population who meet the diagnosis of AUD are not treated. Many try to quit on their own or must use peer support or to reduce their alcohol use.

The DNP project goal is to create a policy to ensure proper alcohol screening, assessment, and referral at the behavioral health center in St. Louis County to help those with chemical and mental health problems. The expectation is that patients should have access to effective AUD pharmacological and non-pharmacological methods in the treatment of their AUD The PICO question is, in adults 18 years and older, diagnosed with alcohol disorder, what are the effects of having an alcohol use disorder policy focusing on the reduction of excessive alcohol compared to no policy?

Problem Statement

The problem for this DNP project is focused on standardized access to treatment of AUD at a behavioral health clinic. There is no current policy, but it will be needed since the population this clinic will serve is those with substance use and mental health issues. Standardized care for patients will ensure all patient's needs are met in the same manner (Coulton, et. al., 2017). Some may require more intensive services than others, but everyone will be assessed for their needs.

There is evidence that pharmacological treatment of AUD is effective and approved by the FDA, but it is underutilized (Qeadan et. al, 2021; Rubinsky, et. al., 2015; Williams, et al. 2018). Pharmacological treatment includes FDA approved medications (naltrexone, disulfiram, and acamprosate) to off labeled medications such as gabapentin, baclofen, varenicline and so forth. Naltrexone and acamprosate are the first-line treatment for AUD ((Ray et al., 2019). Several studies have noted that the low percentage of use of FDA approved medications to treat AUD. According to Qeadan et al (2021), from 2000 to 2018, the reported prescription of naltrexone in substance abuse centers in the US only grew from 0.49% to 1.64%.

Primary care providers, who can treat patients with AUD, are not treating this population. Many primary care providers cite their lack of knowledge about treating AUD with prescribing and stigma associated with this population (Possemato, et. al., 2016; Williams, et. al., 2018). According to Glass, et. al (2016) even when the chemical health assessment shows the patient has an issue with alcohol use, most doctors are not addressing it. Increasing access to outpatient pharmacological treatment for AUD patients via primary care providers would help meet the needs of those who do not qualify for intensive inpatient treatment or those who do not want specialty care due to stigma associated with it (Barry, et al., 2016; Wallhed, et. al., 2018).

Background to the Problem

Problem Scope

Many patients diagnosed with AUD, who could benefit from pharmacological treatment with or without psychotherapy, but it is not commonly offered (Rittenberg et. al., 2018). It is estimated that 99,000 deaths each year can be attributed to AUD, (CDC, 2019). Not only does AUD affect the patient but it affects society, families, friends, co-workers, employers, and other drivers on the road. Studies showed that less than 11% of patients are being treated for their AUD. Without any intervention, the problem will go unaddressed and consequently there will be loss of productivity and an increased cost of medical care for patients due to unintended injuries and diseases associated with AUD. This disorder will also cause family dysfunction due to the patient's inability to fulfill their role.

Problem Consequence

The consequences of not treating someone with AUD are many and it affects not only the patient but their support system, their physical and psychological health and society at large. From a societal point of view, AUD is an expensive illness that cannot be ignored. The estimated cost of Alcohol Use Disorder (AUD) was $249 billion in 2010 (CDC, 2019). Most common cost is due to decrease in productivity because the patient cannot fulfill their role in providing financial support for themselves and their family.

AUD is a complex illness since it affects many aspects of a patient's life. There are over 200 conditions that are associated with too much alcohol use such as cirrhosis, cancer, tuberculosis, depression, and injuries due to vehicular accidents (World Health Organization. (n. d.). Long-term and excessive use of alcohol also lead to different medical illnesses. Alcohol seemed to be a carcinogen in animal studies, but it is not definitive. The amount of alcohol consumed will affect whether it will cause cancer. Common cancers due to excessive alcohol intake includes cancers of the esophagus, larynx, colon, liver; however, it also appeared to be a protective factor in if alcohol intake was mild or moderate in the prevention of Hodgkin's lymphoma, non-Hodgkin's lymphoma, and renal carcinoma ((Shields, et. al., 2013).

Not only is a patient's physical health affected, but their mental health may also be affected. Alcohol can increase memory issues, impair ability to make sound decisions such as drinking and driving. Alcohol has been found to increase the risk of bipolar disorder (Sheilds, et. al., 2016). Patients have been known to treat their mental health symptoms with alcohol.

Not only are patients affected by their drinking but other people around them are also affected. AUD can be one of the causes of family dysfunction, homelessness, unemployment and injuries or deaths associated with car accidents. The patient may not be able to fulfill their role as a spouse or parent which can cause others around them anger, sadness, or depression. They may be too impaired and may lose custody of their children or their spouse may divorce them. Patients may have trouble holding a job because they are drinking daily and cannot function or are impaired at work and cause co-workers to worry and must take on more responsibilities to make up for the decrease in their productivity. Due to their inability to keep employment, they may lose their job and maybe become homeless.

Knowledge Gap

Problems that cause underutilization of medications for AUD include lack of knowledge by providers and patients, philosophy of treating AUD and stigma. The low statistical significance in studies due to the heterogeneity of patients with AUD leads many providers to not prescribe medications (Possemato, et. al., 2016; Williams, et. al. 2018).

As noted by LaPaglia (2011), treatment for addiction came into existence a little differently than for other disorders. The philosophy of treating this population tended to be more focused on self-recovery and support within their community. This may reflect the low number of patients being offered pharmacological treatment and treatment of addiction is generally done in specialized settings. Some facilities do not use medications to treat and will not provide services if patients are using medications. Information about the use of FDA-approved AUD medication is available but isn't being pushed to prescribers who do not specialize in addiction medicine

therefore lack experience prescribing them makes prescribers less likely to prescribe them (Glass, et. al., 2016; Williams, et. al., 2018).

According to Litten et al (2020) many providers may be unfamiliar with using pharmacological treatment of AUD and this population needs specialty treatment. Some may feel that they don't have that specialized training and don't want to do harm so would prefer to refer a patient to a specialist. Several studies have indicated that treatment at the primary care level would reach more people; however, most primary care providers are not trained in this area. The American Psychiatric Association has guidelines for providers to follow when prescribing medications for AUD, but some providers need more training and mentorship. Beyond education, mentorship with another provider who is familiar in this area is limited (Williams et al, 2018).

There is also a knowledge gap with patients because pharmacological treatment is uncommon. The exception is if they are accepted into a specialty outpatient or inpatient treatment program and space is limited for inpatient care. Patients may seek treatment but if the timing is not right for them, they may go back to drinking and will have lost their chance for treatment.

Many patients do not feel they can ask for help because of the stigma that surrounds excessive drinking (Williams et al, 2018). Patients are embarrassed that they must ask for help. Some patients see this as a personal flow or failure. Also, some providers have expressed a desire not to work with this population because they think AUD patients are deceitful and manipulative (Williams et al., 2018).

Limitations in research studies increases the knowledge gap healthcare providers have about this population. Some of the limitations include a small number of subjects or clinics who participated, convenience sampling which increases bias, missing data, self-reported data are not always accurate, and some research studies cannot be generalized. There has not been a lot of replicated studies so it's difficult to compare studies. Most of the studies are unique so you

cannot generalize to the public. For example, a study of treatment in the VA system cannot be generalized to regular clinics because they operate differently. In addition, most VA patients may have specific issues or experiences so the results may differ depending on the subjects.

Proposed Solution

Treatments for AUD consist of both pharmacology and psychosocial treatment and with psychosocial treatments as the most used. Most patients are referred to psychosocial treatments such as Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Brief Interventions, Mindfulness Based Therapy, 12-Step, or Alcoholics Anonymous (Ray et. al., 2019). The literature review by Ray et. al. shows for psychosocial treatments, CBT and Motivational Interviewing as having higher clinical evidence.

Pharmacological treatment of AUD could be used in primary care settings or an outpatient specialty clinic that has primary care integrated. Moving the management of AUD to the primary care setting may increase comfort, continuity of care, and decrease stigma (Steinberg et. al., 2019). The behavioral health clinic's focused is on mental health and substance use and is available to residents in St Louis County and surrounding counties, but also contains other services that meets the patient's needs such as a pharmacy, dental, psychiatry, psychotherapy, care coordination/case management, crisis response team, and so forth. All the patient's needs are conveniently located under one roof so the patient will not have to travel to a different location.

A policy that provides direction for clinical staff on serving the AUD population is needed to ensure that assessment, diagnosing, and referrals are appropriately completed. Standardized evidence-based care will ensure every patient is provided with the same type of care. With a policy in place, healthcare professionals will know their roles and responsibilities to their patients and policies will be enforced.

Literature Search Process

The literature search process consisted of inputting keywords of “alcohol use disorder,” “treatment,” “addiction,” “alcoholism,” “addictions,” and “therapy” into EBSCO to search all journal articles. The studies that were pulled up were then sorted so that only the most recent studies that were peer-reviewed, with full text, listed as written in English, and geography was USA. There were still many articles that came up and they were further sorted by reviewing the titles and abstract to identify their relevance to AUD, alcohol treatment or barriers to treatments. It was narrowed down to 102 articles that were further reduced to 11 and was included in this paper.

After reviewing numerous articles, there were ten research studies and one systematic review. There were different types of studies including surveys, regression analysis of public data, randomized control studies, and qualitative studies. The articles were reviewed and inputted into a literature matrix table.

Literature Matrix Table

The literature matrix table is an easy way to visualize the available literature gathered. The main points such as the aim of the study, its subjects, methods, results, and limitations were entered. There was limited research on this subject. Each study’s purpose was different from the next study, so it was difficult to say with certainty that their conclusions were the right ones. Some were commentaries or review articles on the topic that shed light on the subject but did not fit within the parameters of the Matrix Table. See Appendix A for the Literature Matrix Table.

Literature Synthesis

The literature reviews were reviewed for consensus on the subject. Articles with results and conclusions were reviewed for their strengths and weaknesses. The main conclusions from the articles reviewed are primary care setting is the ideal place to treat most patients with AUD, training and mentorship is needed for providers, patients also need education on the subject, and stigma is still a factor in assessment and treatment (Williams, et. al., 2018).

Most studies agreed that primary care was an appropriate setting to provide pharmaceutical treatment but very few patients are being treated even after an assessment showed the need for intervention. According to Wallhed et. al (2018), results for decrease in drinking were not significantly different between primary care providers and specialty providers were similar. Also, the patient's primary care provider is the one that patients will have the most contact. Most patients would feel more comfortable talking to their primary doctor since they may have seen that person for most of their life compared to a specialist who may see patients for a limited time.

Some primary care providers are unwilling to treat patients with AUD. They are uncomfortable with treating something they have no training or education and didn't feel it was within their scope of practice (Williams, et. al., 2018). In the same article, other primary care providers were willing to treat if they had the resources and knowledge to do so. In Hunter et al (2018), two clinics that were treating patients with AUD felt funding and buy-in from staff were the most important factors in sustaining this type of service.

Another main problem noted throughout most studies is the lack of education for both patients and providers which leads to the stigmatization of AUD or not identifying this as a problem (Barry, et. al., 2016; Williams, et. al. 2018). Patients may not want others to know they have this issue because they blame themselves for not being able to stop their drinking (Possemato, et. al, 2016). Providers feel patients with AUD cause the issue, they could stop anytime, and don't want to be associated with this population (Willams, et. al, 2018).

A policy on management of AUD will help address some of the major issues found during the literature review**.** The policy should address what is expected of the healthcare professionals in their relationship with patients, collaboration with other healthcare professionals, need for initial and continual training, and treating AUD as a chronic illness.

As with any patient population, clinic staff's behavior and demeanor will set the tone on how much they can help the patient. Behaviors, body language and words can have a big

influence on a patient's willingness to discuss their issues, to learn and take new steps to help themselves. For example, a nurse practitioner calling a patient an “addict” or “drunk,” while correct in their description of the person will come off as judgmental and biased already. Using diagnostic terms or neutral descriptive terms will ensure patients recognize their professionalism and desire to see to help.

Depending on the complexity of the patient, healthcare professionals cannot manage this illness on their own. A collaborative effort among several healthcare professionals may be needed to provide the best outcome. A good care plan and clear role expectations will help each staff contribute to the patient’s care without duplication of services or wasted effort. A collaboration may help a patient who may be homeless, has alcohol use disorder, PTSD and has no health insurance. This patient will most likely need a prescriber for alcohol treatment (if the patient is interested in treatment), financial worker, case manager, and a therapist. Each staff has a different role with the patient and a good care plan will indicate their role in the patient’s care.

As with any disorder, training is required to stay on top of new information that is discovered. It should be an expectation that a novice provider will require a larger amount of training at the beginning than someone who has experienced already. The expectation would be that yearly training in AUD appropriate for their role. A doctor would be expected to have more in-depth training in prescribing, drug interactions or pathophysiology as compared to case manager who may only need basic training on AUD symptoms, available AUD resources and so forth.

Finally, AUD should be managed as a chronic illness. Most patients do not go into remission after one inpatient treatment or just several months of medication treatment. It takes many tries and years before a patient can maintain sobriety or not drink to excess. Many will relapse and then will start the journey towards sobriety again.

Theoretical Framework

Theory Application

The middle-range theory selected for this project is the theoretical framework used for this project is Proschaska and DiClemente's Transtheoretical Model of Change (TTMC) was developed in 1977 (Siddarthan et. al., 2021). TTMC is a known theoretical model for behavior modification in chemical dependency treatment, smoking cessation, and weight loss. The theory is based on their analysis and combination of different theories on understanding human behavior and factors that influence people's motivation to change. The strength of this model is that it can be used to gauge a patient's readiness for change for a multitude of behaviors, in different countries, age groups, or clinical settings (Siddarthan, 2021; Wilson, 2021). TTMC can help practitioners understand when to actively treat a patient for Alcohol Use Disorder. It can also be applied to analysis of provider's willingness to make changes in their practice.

There are five stages and people can go up incrementally in order or can skip stages. The different stages are pre-contemplation, contemplation, preparation, action, and maintenance (Siddarthan, 2021). In the first stage, pre-contemplation, a provider may be in denial that treating patients with AUD is beyond their scope of practice. In the second stage of contemplation, providers may realize their patient has a problem with drinking and are unsure what interventions are required to help change their behavior. In the third stage of preparation, the provider is aware of their patient's issue and has developed a care plan to make changes. In the fourth stage, action, the provider is actively engaging their patient to start making changes behaviorally. In the last stage, maintenance, the provider will have completed care plans for their patients for a minimum of six months, so the goal is to make sure they continue to sustain the momentum and continue to follow up with their patient's progress.

Some providers are uncertain how to treat AUD and this theory would be a helpful guide for those who are uncertain about what to do. For outpatient providers, this framework helps the clinical manager understand what is needed to help the provider along in their change. For

example, if a provider is unwilling to assess and treat their patient due to stigma or lack of education, then it can be assumed they are still in the first stage of change and will need education and training. They may be more open when other providers are successfully treating patients. Some providers may not feel comfortable treating but may feel they can assess and refer.

Additional training or mentorship may be needed for some providers to move them to the next stage. The next stages of TTMC are when the providers are making the most progress. The maintenance stage is when the provider has provided care to several patients with AUD and is more comfortable providing education and options for patients.

TTMC is easy to remember; its stages of change are flexible, and the framework is a quick analysis of where providers are at with their comfort with providing treatment which is an important part of the mission of the behavioral health clinic.

Organization

The project's aim is to create a policy that helps standardize care for patients with AUD in an outpatient clinic setting. The new behavioral health center opening up in the St Louis County area would be an ideal setting for this type of policy since they will have a multitude of different services that will serve patients with AUD. According to their mission, providers will provide holistic care to this population. Services included are primary care, behavioral health home, crisis team, peer support and recovery specialists, financial worker, pharmacy, and NAMI advocacy. Each service provided there will play a role in providing support, education, or treatment for patients (Barry et. al., 2016; Hunter, et. al., 2018; Possemato, et. al., 2016; Williams, et. al., 2018).

The AUD population is complex and a team approach is needed to meet all their needs. More than one profession will be required to be involved for successful management of this problem. A standardized policy will ensure that all patients are assessed, treated, or referred to specialty clinics. The site will have multiple services that will enhance the treatment of AUD. For

example, there will be on-site care coordination through Behavioral Health Home, medical, psychotherapists, psychiatry, a crisis team, and pharmacy.

Goals & SMART Objectives

There are three main goals for this project: planning, implementation, and evaluation. The initial goal is to review the literature, then create feedback form and a rough draft of a policy on management of AUD and obtain approval to start the DNP project of obtaining feedback on the created AUD policy. The second goal was obtaining feedback from experts in the field on the rough draft of the policy and revising the policy. Feedback form and revised policy were sent out three times which provided sufficient information to have a final policy. The final goal is the presentation of the policy to the behavioral health clinic project manager to find out if implementation of the policy is a possibility.

Goal I: Planning

The first goal of planning includes a couple of SMART objectives. The initial objective was to research the subject of AUD and review possible issues with screening and treatment. The planning phase occurred over one month. Recent peer-reviewed research articles published within the past 10 years were reviewed. Issues researched were specific to lack of outpatient treatment, reasons for lack of care and its impact on patients. The number of research articles required were a minimum of ten research articles and at least 5 or 6 supporting articles. The research articles were reviewed and synthesized.

The next objective was to recruit several experts from the field of AUD in one months time to review the rough draft of a policy on management of AUD. The plan was to recruit four or five professionals who were experts in the field of AUD or Substance Use Disorders by March to review the rough draft of the policy from different organizations. Four professionals agreed to participate.

Next was the creation of questionnaire forms by April to be used in the implementation step. The first form included questionnaires on the expert's education and experience. This was

completed in February. The second set of questionnaires provided a way for the experts to provide constructive feedback several times to help revise the AUD management policy.

And finally, prior to contacting the experts for feedback, the IRB form was completed, submitted and approved. The IRB forms were started in March and revised several times. It was submitted to the IRB at the end of April and approved May 9th.

Goal II: Implementation

The second goal, implementation, was started in June after IRB approval. The main objective during this stage is the emailing of the questionnaires and rough draft of the AUD policy to the professionals experts to review and provide feedback then the policy would be revised and sent back for further feedback.. This will occur several times before final revision of the policy to be completed and given to the clinic project manager to review. The plan is for the revision to be completed by mid-July.

Goal III: Evaluation/Dissemination

Once the last revision was completed, step 3 is evaluation of the product by the behavioral health clinic for possible implementation at the clinic. The final revised policy will be sent to the clinic project manager by the end of July. The clinic will ultimately decide if the policy meets their mission statement and if it is appropriate for their clinic. The effectiveness of the policy will also be evaluated at this stage.

GANTT Chart

The GANTT chart is a stepwise organization of actions required to complete the DNP project. The deadlines for each step are listed in the graph along with the approximate completed date and number of days required to complete each step. In this GANTT chart, these are the different objectives: obtaining enough expert volunteers to give feedback, creating a feedback form, and policy for experts to review and obtaining IRB approval, obtaining feedback, and revising the policy and finally, the revised policy will be discussed with the behavioral health clinic for approval and implementation (See Appendix B).

The initial step is obtaining enough experts in the field to get a good variety of opinions on what should be in the policy. Several experts from the addictions field will be required. The minimum number of experts will be four, but more would increase the amount of feedback to revise a brand-new policy. Participants of this project will be several health care professionals familiar with the care of patients with alcohol use issues from Minnesota and other states. The participants are mental health practitioners from a Substance Abuse Disorder practitioner group.

The second task is to create two questionnaires. The initial questionnaire will ask each expert provider to answer questions about their experience in the field including type of education, years of experience, type of education, and so forth. The second questionnaire will be asking for feedback on the policy created. Their expertise in the field will be beneficial in the feedback form and it will be used to guide the revision of the policy.

The third task was to write up an all-inclusive policy since the clinic is an integrated clinic with primary and psychiatric healthcare providers, along with other behavioral health staff such as care coordinators, crisis team, and therapists. The policy will set the tone for providing care for this population. The plan was for the rough draft to be completed. A rough draft of this policy will be emailed to experts in April along with the feedback form mentioned in the second task.

The fourth task is to obtain approval for the project by completing the necessary Institutional Review Board paperwork and submitting for approval. Forms completed for approval include a description of the project, a review of the risks and benefits, and a consent form. The consent form will also be included in the initial email to each expert so they can review what is expected of them during the project. Each expert will sign the form indicating they consent to participate in the project.

Once the project is approved, the experts will be contacted via email. Three forms will be sent out in the initial email. They include the consent form, the questionnaire about their

background and feedback form #1 and the policy rough draft #1. Once all initial feedback is returned about 1 week, the policy will be revised and within 3 days. The second round of email will be sent out which will include only the feedback form #2 and the rough draft #2. The process would be repeated another time to ensure no further revision is needed. If there are revisions needed, then another round of feedback back form and revised policy will be sent. Final policy draft will be reviewed for completeness and the final step is to present the policy to the clinic manager and whether the policy meets their mission statement and is a policy they will want to implement.

Work Breakdown & Communications Matrix

The Work Breakdown Structure (WBS) is a method to view the different levels of tasks that are needed to be completed within the main project (Zaccagnini & Pechacek, 2021). In this project's WBS, there are four main projects to be completed: recruiting experts to review the created policy, creation of 2 questionnaires, completing IRB form for project approval and the action of sending out the feedback forms and policy and revising it several times (See Appendix C).

Each of the four main WBS tasks for the project is listed in the diagram and below that level is even more specific tasks to be completed. In creating a policy, it simply reviewing the idea of what is a policy and using current evidence-based studies that help shape it. In obtaining experts to review the policy, it was first calling organizations and healthcare professionals to request their cooperation in reviewing the policy. Other steps include obtaining their email and then sending out the policy. Creating a survey was necessary to obtain consistent feedback from the healthcare professionals giving their opinion on the created policy. The IRB form completion and approval is an important step in starting up the project.

The Communication Matrix for this project enables all those parties to view what steps are required, and update on the completion of each goal/objective, ownership of each task

(See Appendix D). The project chair was advised of tasks that were completed and what tasks still needed to be completed prior to the next zoom meeting. The communication matrix lists the main objectives and the WBS is a breakdown of each main objective into smaller tasks.

The Communication Matrix contains nine objectives that need completion. The objectives are: recruit experts to provide feedback, create questionnaire forms, create policy, complete IRB forms, and submit IRB forms, send out forms to experts, revise the policy three times, and finally present the completed product to the clinic for approval.

Logic Model

The Logic Model is an overview of the required input for the project, the activities required in the project, the output, and the outcomes (See Appendix E). The inputs needed for this project included current review of the literature and feedback from experts who can assist in making sure the policy is sound. The activity that is required is creating the policy for the behavioral health clinic.

The output for this project is a policy that will standardize the practice of an integrated behavioral health clinic. The expected short-term outcome is that all patients who use this clinic will receive the care that they need for their alcohol use. As noted in the literature, females are less likely to be offered treatment compared to males (Glass et al, 2016). The intermediate outcome from this project is an improvement in care for this population and healthcare providers will have increased comfort in assessing, treating, or referring patients. The long-term outcomes expected are remission of AUD, improvement in the patient's quality of life and a decreased cost to society.

Methodology and Analysis

Since this project is on creating a policy, there are no measurements to be completed. If it was to be implemented, the outcomes measurements would include the number of patients assessed, treated, or referred compared to the total number of patients served. For the process measurement, the project would be the number of providers who implemented AUD

assessments/treatment/referrals over the total number of providers at the clinic. A balancing measurement for implementing this policy would include the estimated number of minutes used during office visits to complete any tasks related to the policy to see if any task can be better streamlined.

In this policy project, there will not be any numerical analysis of data beyond reviewing the surveys completed by the healthcare professionals on the new AUD policy. The questionnaires will be reviewed to find out if there are specific issues or themes mentioned by the different health care professionals. More weight will be given to similar comments that come from more than one source and the policy will be revised in that fashion. The opinions of each healthcare professional will also be weighed against current review of the literature. If there are conflicting views, then those matching what is evidenced-based will be added to the policy.

Data will also be collected on the healthcare professional's demographics. This data will describe the healthcare professional's education and experience that completed questionnaires. This will help ensure the policy was reviewed by experts in that field and if there are specific differences due to their discipline. This data will strengthen the quality of the policy since it was researched for evidence-based knowledge and reviewed by current healthcare professionals.

IRB/Ethical Considerations

An application was submitted to the St Scholastica's Institutional Review Board (IRB) after being reviewed and approved by the project chair as one of the requirements prior to implementation of the project. The application process was very straightforward. Besides the form, a signed consent was created and other forms to be used during the project were submitted. The form asked for pertinent information so the IRB has an understanding of the goal of the project. The IRB response was very quick since this project is not a clinical research project where data would be collected from subjects and then analyzed.

In the IRB application, a description of the project was included along with methods to ensure that data shared by the subject was kept confidential and any risks to the subject's emotion or physical health was taken into consideration and mitigated. This project is in compliance with the American Nurses Association (ANA). There is no private health information collected from the subjects so the Health Insurance Portability and Accountability Act (HIPAA) does not apply.

The questions they would be answering are minimally invasive since it is for the subjects to review a policy and give their professional opinions. The surveys will not be associated with a particular subject. All returned responses will be reviewed together but no names attached to the questions. The information collected will be by email to the project lead's school email which is password protected. Any information downloaded will be to Google Drive and not on a specific computer. Even if Google Drive was breached, the information collected is not sensitive to the subject's personal life. There are no conflicts of interest between these subjects and the project's goal or researchers. They are giving their opinions without compensation and understanding they are part of furthering the study on AUD. No information has been withheld and no deception is needed in this project.

For the project, no vulnerable subjects were used and there would be no risk to the subject's health. The subjects of this project are professionals who work in the behavioral health field. In two different Facebook groups for Nurse Practitioners, they were asked if anyone would be willing to review documents for a DNP project on AUD. These facebook groups are licensed Nurse Practitioners seeking to support each other professionally were asked to see who would be willing to review some documents for a DNP project around the subject of AUD. Out of several hundreds, there were four people who volunteered their time. They were informed that information would be sent to their email addresses to be reviewed and sent back once the project was approved.

Implementation

To recruit experts in this field, many options were reviewed. Initially, cold calls to organizations who work with this population were completed. No calls were returned so the project lead asked previous co-workers for leads. Four professional experts in the field of Substance Use Disorders were recruited via Facebook groups for Nurse Practitioners providing support and consultation to other Nurse Practitioners. These experts were contacted via email to participate in giving feedback.

Each participant was contacted individually and consent to participate in the project was signed. Once the consent forms were returned, the demographics information form, rough draft of the policy and feedback form was sent via email for completion. Two experts did not complete the consent form and did not respond to emails sent to them. A psychologist agreed to participate in the project. Each participant signed the consent form, reviewed and added comments and returned the feedback form.

All three participants were asked about their educational and professional background. All had some similar experiences and education but there were still some differences. Two experts had PHDs and one had a Master's degree. Two were Nurse Practitioners and one was a psychologist. Both nurse practitioners prescribe medications to treat AUD; while the psychologist is unable to prescribe any type of medication due to her license. The psychologist and one of the nurse practitioners had 20 years and 11 years of experience, respectively. The other nurse practitioner had 15 months of experience in this field. The hospital nurse practitioner reported having an AUD policy in place and as well as one of the nurse practitioners who was in private practice and at a Mental Illness and Chemical Dependency (MICD) clinic. The nurse practitioner who only did private practice does not have a policy.

The feedback from one of the participants was in depth in the review of the policy, while the other two had brief but important feedback. Some of the feedback asked for clarification of different procedures for patients to obtain treatment and referrals, safety of patients attending their appointment while under the influence, types of screenings that would be used, types of

training for staff and resources. Most of the suggestions were added on to the policy; however, some suggestions were beyond the scope of what a policy should be and were procedural steps needed. Procedural steps will be better suited for the clinic managers to establish since currently the behavioral health clinic is still in the planning stage and not all services are known at this time.

A link was added to the professional conduct for staff to use in working with AUD patients. The link is to a government website that recommends using words in a certain way to decrease stigma (National Institute on Drug Abuse, 2021). Other links were added for the CAGE and AUDIT-C screening tools.

There are two brief screening tools, AUDIT-C and CAGE, that could be used at each visit. AUDIT-C is a three questions screening tool developed by the World Health Organization in 1988 and is used in other countries besides the United States (Moehring et al, 2019). AUDIT-C stands for Alcohol Use Disorders Identification Test-Concise. CAGE is an acronym for C – Cutting down, A – Annoyance by criticism, G – Guilty feeling, and E – Eye-openers (Ewing, 1988). Either screening tools have been validated and can be used in an outpatient setting. If a patient has a positive screening, then the provider can discuss with the patient about getting a diagnosis and may begin treatment if the patient desires.

Another addition worth noting is an emergency services policy. One expert noted that with this population, there could be instances of patients presenting to the clinic while under the influence and the clinic may have some liability if a patient gets injured or causes injuries to others. While this is not in any research, it is a real world safety issue that a clinic could occur.

The policy was reviewed once by the experts in this field (see Appendix G). Most of the major revisions were done after the first feedback form was returned. The plan was for several revisions but that did not happen. With additional feedback, the policy could have been revised further.

Conclusion

Almost a third of the US adult population have met the diagnosis of AUD in their lifetime; however, the access to current specialty care is not available or desirable byr all patients. The main barriers preventing care are stigmatization of this disorder, lack of training for providers, patient's lack of knowledge of their options. This project aim was to create an alcohol use disorder policy to assist in standardizing outpatient access at the behavioral health clinic so that patients with AUD have the option of receiving outpatient care by a primary provider. A policy was created and revised several times with the feedback provided by experts within the field of Substance Use Disorders.

Limitations of this project included lack of high quality research in this subject matter, a low number of professionals willing to provide feedback and inability to implement the policy to see results.

While there were eleven articles that did shed light into the issues with AUD; all the research studies looked at different issues with AUD.. For example, there was only one article on stigma and one article on sustaining treatment in primary care, another on comparing treatment of AUD to other psychiatric disorders, and another on comparison of primary care to speciality care in treating AUD. Without researching the same issues over and over again, it is uncertain if the conclusions from the one article can be generalized.

Many health organizations were not interested or did not return calls. Four Nurse Practitioners were recruited but only two participated. Two practitioners did not respond to the sent emails. One additional expert was contacted and she agreed to participate. While there were participants, a larger number of experts who could view the rough draft of the policy would have been better.

However well written a policy, one that has not been implemented and tested will not show its weaknesses. A policy may look good on paper but may be difficult to implement or may be confusing or too vague for those who have not seen it. In this case, this is not just a revision of an existing policy but a newly created one that may need to be re-tweaked once

implemented. Also, once implemented, careful collection of data would be needed to see how well it works to increase quality of care and increase AUD treatment.

The planning for this project should have started earlier so that if the participants took a little longer to return the forms, it would have still worked out. The plan was for the experts to review the policy a couple times but time ran out.. So, the policy has been revised just once. Further revisions would have been useful to make sure the policy had all the components needed.

Future quality improvement research implementation of policy at the clinic and gather information on how well it is followed, percentage of patients actually obtaining treatment, satisfaction of care by patient, level of burden on the healthcare professionals in following the policy, and whether the different providers understood their role as written in the policy. Also, policies require several revisions even after implementation because what is ideal may not reflect what the clinic needs in reality.

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Appendix A

Literature Matrix

Source	Purpose	Sample	Methods	Instruments	Findings	Implications	Limitations
Comparative utilization of pharmacotherapy for alcohol use disorder and other psychiatric disorders among U.S. Veterans Health Administration patients with dual diagnoses (Rubinsky, Chen, Batkim, Williams, & Harris)	describe rates of receipt of guideline-congruent medication for AUD compared to non-substance use psychiatric disorders and tobacco use disorder among VA patients with dual diagnoses.	This cross-sectional study included VA patients who had an AUD and a comorbid non-substance use psychiatric disorder or tobacco use disorder documented in their electronic health record (EHR) in fiscal year 2012 (FY12)	Descriptive analyses were used to characterize the overall study sample and subsets of patients with AUD and each of the five co-occurring conditions of interest in terms of socio-demographics. For each subset, we then estimated the proportion of patients who received medications for their AUD and the proportion who received medications for their comorbid disorder.	All analyses were conducted using Stata 13 software	Among subsets of patients with AUD and co-occurring schizophrenia, bipolar disorder, PTSD or major depressive disorder, receipt of medications for AUD ranged from 6.8% to 11.1%, receipt of medications for the comorbid psychiatric disorder ranged from 68.5% to 82.3%, among the subset of patients with AUD and co-occurring tobacco use disorder, 6.0% received medications for AUD and 33.9% received medications for tobacco use disorder; In sensitivity analyses limited to the subset of first-line medications for schizophrenia, bipolar disorder, and PTSD with the strongest support, receipt of pharmacotherapy for these conditions was 5-10 times higher than for AUD: 71.8% vs. 6.5%, 78.1% vs. 11.1%, and 43.9% vs. 8.1%	7-11 times more likely to prescribe for MI dx and 6 times more likely for tobacco; meds underutilized	AUD vs alcohol dependence disorder diagnosis may make a difference in whether provider would prescribe; VA may prescribe meds differently than other health care systems;

Sustaining alcohol and opioid use disorder treatment in primary care: a mixed methods study (Sarah B. Hunter, Allison J. Ober, Colleen M. McCullough, Erik D. Storholm, Praise O. Iyiewuare, Chau Pham, and Katherine E. Watkins)		implementation support. Methods: Data from two clinics operated by one multi-site federally qualified health center (FQHC) in the US, including administrative data, staff surveys, interviews, and focus groups, were used to gather information about changes in organizational capacity related to alcohol and opioid use disorder (AOUD) treatment delivery during and after a multi-year implementation intervention	an organizational readiness intervention and a collaborative care intervention; first 6 months during implementation and 1 year later; staff survey and therapy receipt	survey	: The two clinics sustained multiple components of AOUD care 1 year following the end of implementation support, including care coordination, psychotherapy, and medication-assisted treatment. Some of the practices were modified over time, for example, screening became less frequent by design, while use of care coordination and psychotherapy for AOUDs expanded. Participants identified staff training and funding for medications as key challenges to sustaining treatment.	treatment was sustained; concerned about training new people; there was buy-in by staff to continue with assessment/tx -- as part of primary care	staff turn-overs; funding
Treatment for Alcohol Dependence in Primary Care Compared to Outpatient Specialist Treatment—A Randomized Controlled Trial (S. Wallhed Finn, A Hammarberg ,	To investigate if treatment for alcohol dependence in primary care is as effective as specialist addiction care	Total: 288; (144 or half assigned to primary and half to specialist -- at start of study); results from 109 in primary care; 119	Randomized controlled trial: primary care vs specialist care group; results compared alcohol use at start to 6 months after start of intervention;	Intent to Treat, chi square, ANOVA, t-tests;	No significance in result between primary care and specialist groups; limit of 50g of alcohol at 6 months were not met by either group; subjects were more satisfied with specialty tx	no difference in where patient is treated but patient feel they got more out of their treatment by a specialist; subjects with depression - better treated with specialist; severity of	80% -- completed study; Primary care received one day of training and no supervision during study; self-reported ;

and S. Andreasson (2018)		from specialist care				alcohol use (high severity -- need specialist care);	low-moderate AUD can be treated in primary care
Naltrexone effects on subjective responses to alcohol in the human laboratory: A systematic review and meta-analysis (Lara A. Ray, ReJoyce Green, Daniel J.O. Roche, Molly Magill, Spencer Bujarski, 2018)	systematic review & meta-analysis; the aims of this meta-analytic review are to examine the effects of naltrexone on subjective response to alcohol across the four domains of (a) craving, (b) stimulation, (c) sedation, and (d) negative affect	20 studies; 822 subjects from all studies;	Meta-analysis	robust variance estimation meta-analysis; RVE intercepts model-- to measure effect size,	Sedation/motor intoxication outcomes were the most common with 77 outcomes, followed by stimulation/hedonic reward (44 outcomes), then craving (29 outcomes), and lastly negative affect (21 outcomes)	small effect with craving ; reduced alcohol stimulation; significance with heavy drinkers and not light drinkers; sign sedation more in light drinkers vs no sign with heavy drinkers; negative mood for all drinkers -- all small effect sizes	missing data; publication bias (unreported outcome studies); lack of predictors of treatment efficacy leads to small effect size

Alcohol Screening and Intervention Among United States Adults who Attend Ambulatory Healthcare (Joseph E. Glass, K M. Bohnert, , and R L. Brown, 2016)	e to identify the prevalence of self-reported alcohol assessment and to describe the types of alcohol services provided to subpopulations of drinkers for which care was appropriate	public data from 2013 National Survey on Drug Use and Health; subjects: 17,266	regression analysis; prevalence estimates of sociodemographic and clinical characteristics	regression analysis of public data	19.9% heavy episodic drinkers; 3.5% met dx of AUD; 2.7% alcohol dependence; 71.1% assessed; those with alcohol abuse and alcohol dependence who received an alcohol assessment, heavy episodic drinkers without alcohol use disorder who were assessed for alcohol use or problems, 4.4 %, received advice to cut back as recommended. Advice was more common among those with alcohol abuse (8.7 %) or alcohol dependence (22.0 %). 2.9 % and 7.0 %, respectively, were offered information about alcohol treatment; 17.2 % with alcohol abuse and 15.5 % of those with alcohol dependence obtained treatment or went to a mutual help program; women assessed in higher numbers but received less advice/referral;	assessment is not an issue; intervention and providing education is needed; intervention remains low	patient-reported; provider may not be aware of severity -- if episodic drinking;

Screening for At-Risk Alcohol Consumption in Primary Care: A Randomized Evaluation of Screening Approaches ------Simon Coulton , Veronica Dale , Paolo Deluca , Eilish Gilvarry , Christine Godfrey , Eileen Kaner , Ruth McGovern , Dorothy Newbury-Birch , Robert Patton , Steve Parrott , Katherine Perryman , Thomas Phillips, Jonathan Shepherd, and Colin Drummond, 2017	relative efficiency and effectiveness of targeted versus universal screening for at-risk alcohol use in a primary care population in the UK	survey; 29 general practice from may 2008 to july 2009l 83% reponses;	randomized clinic to perform target or general screening;	FAST and SASQ screening tools; valid tools; logistic regression to estimates odds ratio of each group;	targeted group: 36.2%; higher number of at risk; general: 25.6%; 81% of universal screening didn't have key conditions to meet targeted screening;	should be part of clinic practice;	small number of conditions for screening;
Reliability and Validity of a Treatment Barriers Scale for Individuals With Alcohol Use Disorder -- K Possemato, J Funderburka, S Spinola, D Hutchinson, S A. Maistoa, L J. Lantinga, and D W. Oslind	provide an initial psychometric investigation of a measure of barriers to seeking addictions treatment	196 Vets referred by PCP after positive screen for drinking using AUDIT	collection of demographics; multiple tests to assess for MH dx; Duke Social Support Index; tests to assess alcohol use and past tx;	does score from TBS matches variable from other tests; Principal Component Analysis on Treatment Barriers Scale;	4 factors: stigma; concerns about tx process; problem ID; logistics concerns; less barrier to care in those who were motivated for tx and had most cares at VA; depression & PTSD - reported more barriers, with high risk suicide with most barriers; those randomly assigned to tx in primary care that lack of problem identification was negatively related to number of treatment visits	lack of problem identification leads to disengagement; continuity of care/care at same system/place may help people feel there are less barriers; use CBT to reframe leading to less barriers or motivational interviewing to identify problem	convenience sampling; subjects are Vets; small sample size; mostly male subjects

Estimating demand for primary care-based treatment for substance and alcohol use disorders C L. Barry, A J. Epstein, D A. Fiellin, L Fraenkel & S H. Busch	web-based randomized experiment using the GfK survey research panel. Screened for those diagnosed with substance or alcohol use disorder but never had treatment;	T: 978; divided into 3 groups with unique treatment vignettes to view and respond;	Logistics regression for willingness to get tx; pairwise Wald test to compare across groups; Linear regressions to assess co-pays or incentives for tx;	regression analysis of response to vignette	large group did not feel they needed treatment (78%); 24% willing to get tx; 37% for primary care; 34% for collaborative care; low copays - 70% willing to pay; 19% willing to go with $10/visit; increase incentive minimal change in % willing to go;	problem identification; a lot of people have limited knowledge of treatment or contact with primary care;	subjects not motivated to seek treatment; no real experience - only vignette and questions about their preference; sampling bias;
Prevalence and pathways of recovery from drug and alcohol problems in the United States population: Implications for practice, research, and policy--- John F. Kelly , Brandon G. Bergmana , Bettina B. Hoeppnera , Corrie Vilsainta , William L. White	assisted vs unassisted recovery	from National Recovery Survey; T: 25,229; survey via email; those in recovery;	prevalence	yes; matches national averages	9.1% - reported AOD; most common was alcohol; male age 25-49; about 50%: severe AOD: factors: onset- 15 y.o.; use of 3 or more subs 10+ times, hx arrest; 54% - assisted; most common mutual help groups, 8.6% meds; natural recovery - occurs with those with less complex use and MH; cannabis users - unassisted; 45% used mutual help; 25% faith-based;	medications least used - could be used more; drug court helpful to get people into treatment; there are more than one way to recovery	"recovery" - not clearly defined; survey open to interpretation; not all who had an AOD issue would have dx per DSM; does have details on how many tx, what sort of tx, etc.
Correlates of alcohol use disorder pharmacotherapy receipt in medically insured patients. (rittenberg et al)	prevalence of prescribing MAUD in a large, commercial database of medically insured individuals to assess if findings of low prescription rates from the current literature	123,000+ patients with AUD dx from insurance claims over a time period	review of data set; prevalence; chi square test; odds ratio	reliable;	64% male; age 35-44 at 41%; 11% evaluated by PMD; 9.3% of dx alcohol dependence received Meds for AUD; psychiatrist more likely to prescribe meds; male - decrease change of meds prescribed; MH dx also increase chance of prescription	Primary care providers are not prescribing meds	right coding; don't know why males are not prescribed meds; did not assess for off label used meds; no reason as to why AUD pts are not prescribed

	extend to this population						
Barriers to and Facilitators of Alcohol Use Disorder Pharmacotherapy in Primary Care: A Qualitative Study in Five VA Clinics (Williams, EC, Achtmeyer, CE, Young, JP, Berger, D, Litt, M, 2018	qualitative survey; barriers to treating AUD in primary care;	24 primary care providers from VA clinics	in-person interviews;	thematic analysis, Rapid Assessment Process, independent coders; discrepancies were discussed and consensus used to categorize;	Barriers: 1. limited knowledge of meds ("not in scope of practice"); 2. specialty addiction tx is the only option and needs counseling too; 3. stigma (should be able to quit if they want to, don't want to be associated with "them," and character flaws). Facilitators themes: wants training & education; external support from MH or RPH; on-site specialist for therapy; beliefs dictates if they are willing to treat or not	some providers are willing to treat w/ meds if certain things are in place (ie training/education/mentorship/support)	all 24 providers are from 5 VA clinics in NW of United States; may not be generalized to other states; some may be providing answers to make them look good in front of interviewers; limited questions to meds treatment only

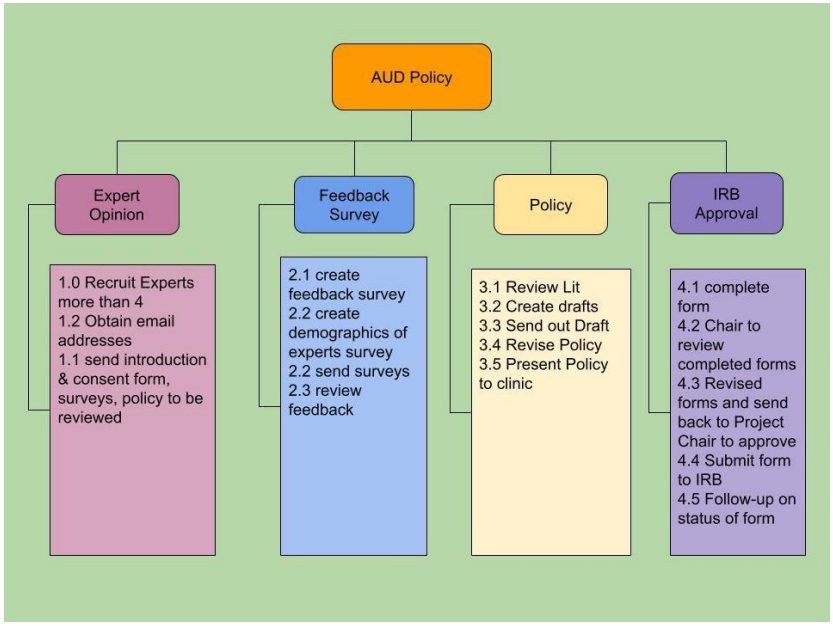
Appendix B

GANTT Chart

Task	Owner	Completed	Start	Days	Feb	Mar	Apr	May	JUN
AUD Professionals									
Compile list of volunteer emails	MX	100	2/19/2022	3					
Demographic	MX		2/24/2022	3					
Create Policy									
Draft 1	MX	100%	4/10/2022	7					
Sent Draft 1	MX		4/25/2022	3					
Revise Draft 2	MX		5/3/2022	5					
Send Draft 2	MX		5/3/2022	3					
Revise Draft 3	MX		5/10/2022	5					
Send Draft 3	MX		5/10/2022	3					
Final Policy	MX		5/17/2022	3					
Survey									
Make survey	MX	100%	2/24/2022	5					
Send Survey 1	MX		4/25/2022	3					
Send Survey 2	MX		5/3/2022	3					
Send Survey 3	MX		5/10/2022	3					
IRB Approval									
Complete Form	MX	100%	3/26/2022	5					
Review with Advisor	MX		4/18/2022	3					
Submit Form	MX		4/20/22	1					

Appendix C

Work breakdown Structure



Appendix D

Communication Matrix

DNP Project Charter/Action Plan

Update and review twice per term. Groups/Individuals complete this form collectively.

Project Communication Matrix

Stakeholder Communication Sheet Link - Communicate with project stakeholders twice per semester minimally. See these meeting guidelines for agenda formation.

Team Members: Maikao Xiong

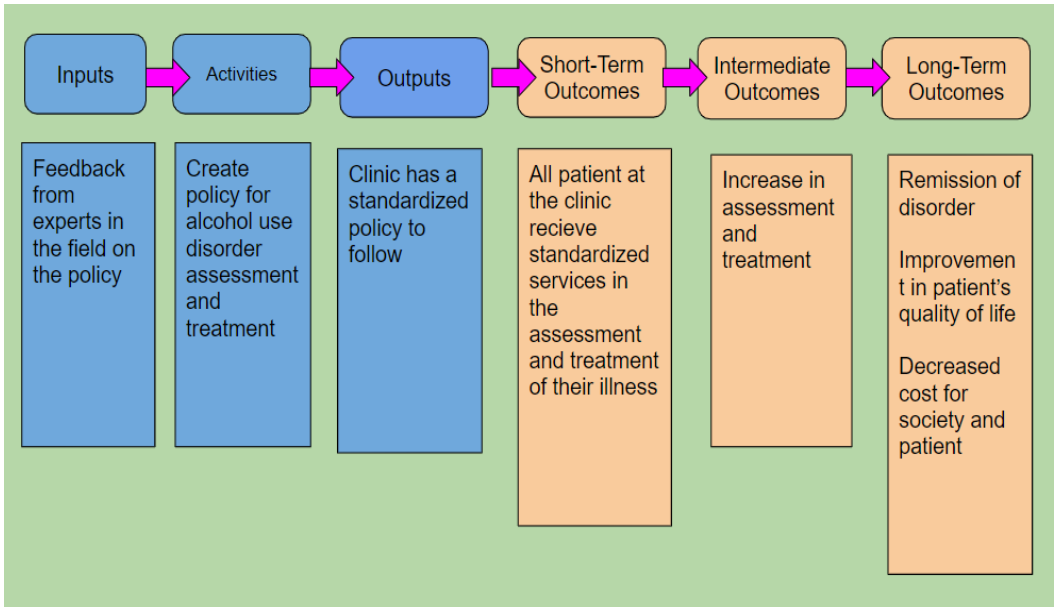
Project Chair: Rhea Ferry

Project Title: : Creation of Alcohol Use Disorder Policy for Behavioral Health Clinic

ID #	Purpose/Objectives	Method Of Communication	Frequency	Recipients	Person Responsible	Notes
01	Recruit experts in the field	zoom	Every 2-3 weekly		MX	done
02	Create feedback survey	zoom				completed
03	Create demographics survey					100% done
04	Create Policy					80% done
05	IRB completion					Waiting for IRB approval
06	IRB submission					Waiting for IRB approval
07	Send out survey & policy for review					completed
08	Revise policy x 3					Needs to be reviewed by Chair, the will submit
09	Present policy to clinic					

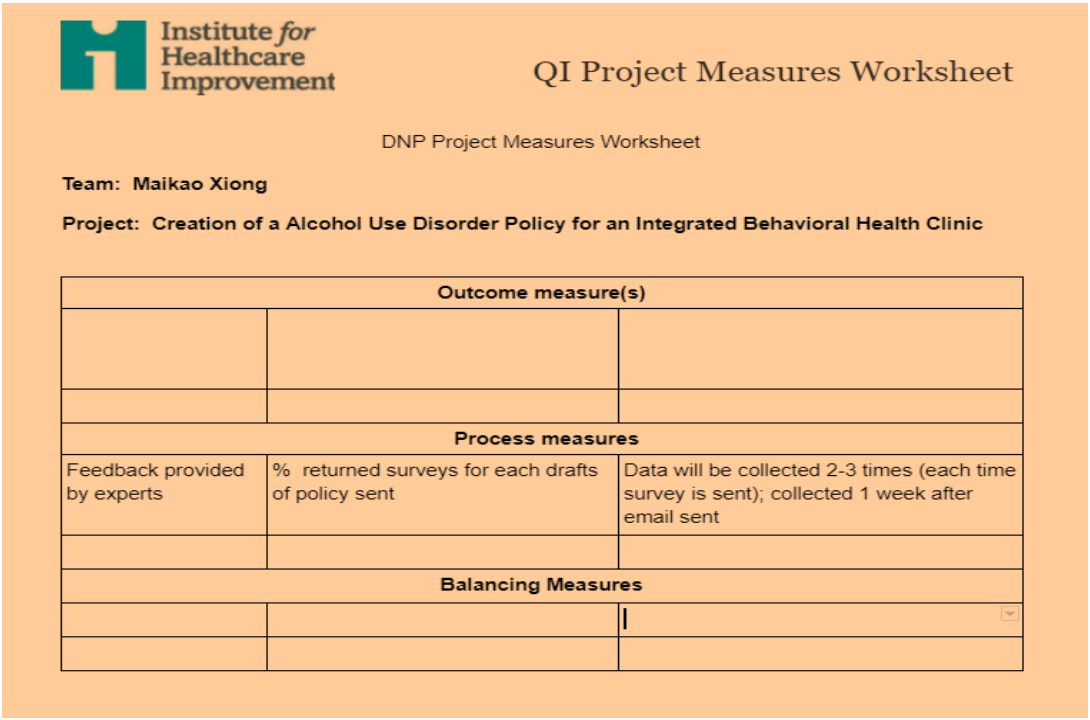
Appendix E

Logic Model



Appendix F

Project Measures Worksheet



Institute for Healthcare Improvement

QI Project Measures Worksheet

DNP Project Measures Worksheet

Team: Maikao Xiong

Project: Creation of a Alcohol Use Disorder Policy for an Integrated Behavioral Health Clinic

Outcome measure(s)		
Process measures		
Feedback provided by experts	% returned surveys for each drafts of policy sent	Data will be collected 2-3 times (each time survey is sent); collected 1 week after email sent
Balancing Measures		

Appendix G

Alcohol Use Disorder Management Policy

Purpose	The purpose of this policy is to ensure all patients of this organization receive appropriate assessment, treatment, or referral for an alcohol use disorder (AUD). Alcohol use is a common occurrence. About 85% of US adults have used alcohol (SAMHSA, 2019). Of the 29.1% of adults who meet the criteria for the diagnosis of an Alcohol-Use-Disorder, less than 11% receive treatment. Primary care settings offer equivalent AUD treatment as a specialty clinic and can help increase access.
Scope	All staff

Objectives	1**. Professional conduct**: Staff shall treat the patient with professionalism. Staff will refrain from using derogatory words such as “addict” or “drunk,” to describe patients. Use of diagnostic terms or neutral descriptive terms are acceptable. Professionalism is expected of all staff, even when patients are not present. See website for preferred language to use (https://nida.nih.gov/research-topics/addiction-science/words-matter-preferred-language-talking-about-addiction). 2. **Training**: It is an expectation that every staff will complete training correlating to their job description and role. Motivational Interviewing training or another counseling approach to work with this population shall be a part of everyone’s training. Training on diversity and AUD will occur annually. Core competencies for each clinical role will be assessed annually by the supervisor. Clinical supervisors in each department will set the number of training hours and types of training required annually. Training hours will be documented in each staff’s training record. 3. **Screening**: All clinic patients will receive a brief screening for AUD such as AUDIT-C or CAGE at each visit. Longer assessments may be warranted by a qualified provider if the brief assessment is positive. All screenings will be documented. After a positive screening, the provider shall discuss completing a diagnostic assessment and then treatment and referrals for AUD. A service plan of care if a patient wants treatment or referrals. The provider will document in the patient's chart if there is a refusal. 4. **Treatment**: Clinical providers will work up to their scope of practice. Treatment of AUD shall not be delayed in primary care. Primary care providers shall provide medication treatment if patients are stable, do not have psychiatric needs, or do not wish to be treated in specialty care. Referrals to psychiatric providers or other treatment facilities may be completed while the patient receives treatment. Documentation shall be done by any department who becomes aware that a patient has outpatient treatment through an outside agency. 5. **Referrals**: Prompt referrals to other departments or organizations will be completed and tracked in the patient's chart. Referrals can be made via the electronic health record by primary care providers, psychiatric providers, therapists, and case managers. Any release of information needed shall be signed by the patient during the clinic visit. Progress of the referrals will be reviewed by Medical Assistants or Care Coordinators or a designated staff. Referral response time will be within one week of referral date or time frame set by each department if needed. 5. **Collaboration**: Coordination between different departments is expected for quality patient care. Healthcare providers shall evaluate patients’ level of service needs. Care coordinator/case management should be considered for patients with multiple service needs or needs assistance to follow through with care.

	6. **Care Management Plan**: A service care plan will clearly state the role expectations of service providers involved (including outside providers/agencies) and will be updated as changes occur. Each department will be responsible for updating its role in the patient care. Departments will have access to the service care plan. Medical Assistants can update this during clinic visits. Care coordinators may also update changes to the care plan. 7. **Emergency Services**: Patients shall be referred to the crisis team or the ED if detox or immediate acute medical care is required. Patients who appear to be under the influence during clinics shall be assessed for safety and EMS shall be contacted to transport to ED if needed.
Definitions	AUDIT-C: Three question screening assessment for AUD developed by World Health Organization in 1988. Form is found on this website: https://cde.nlm.nih.gov/formView?tinyId=myWNfJaZwe CAGE: Four question screening for AUD. Acronym stands for Cutting down, Annoyance by criticism, Guilty feeling, and Eye-openers. Service Care Plan: a document that lists providers involved; their role in the patient's care; patient goals and objectives for each department, and progress and results of interventions.
Questions	See Department supervisor/clinic manager
References	American Psychiatric Association. (2017). Practice Guideline for the pharmacological treatment of patients with Alcohol Use Disorder. https://www.psychiatryonline.org/doi/pdf/10.1176/appi.books.9781615371969 Ewing J. A. (1984). Detecting alcoholism. The CAGE questionnaire. JAMA, 252(14), 1905–1907. https://doi.org/10.1001/jama.252.14.1905 SAMHSA, Center for Behavioral Health Statistics and Quality. (2019). National Survey on drug use and health. Table 5.4B – Alcohol Use Disorder in past year among persons aged 12 or older, by age group and demographic characteristics: Percentages, 2018 and 2019. https://www.samhsa.gov/data/sites/default/files/reports/rpt29394/NSDUHD…
Approved Date	
Effective Date	

Review	Annually or sooner if necessary