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Local Implementation of Alcohol Screening and Brief Intervention at Five Veterans Health Administration Primary Care Clinics: Perspectives of Clinical and Administrative Staff ☆

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ABSTRACT

Background and Objective: Population-based alcohol screening, followed by brief intervention for patients who screen positive for unhealthy alcohol use, is widely recommended for primary care settings and considered a top prevention priority, but is challenging to implement. However, new policy initiatives in the U.S., including the Affordable Care Act, may help launch widespread implementation. While the nationwide Veterans Health Administration (VA) has achieved high rates of documented alcohol screening and brief intervention, research has identified quality problems with both. We conducted a qualitative key informant study to describe local implementation of alcohol screening and brief intervention from the perspectives of frontline adopters in VA primary care in order to understand the process of implementation and factors underlying quality problems.
Methods: A purposive snowball sampling method was used to identify and recruit key informants from 5 VA primary care clinics in the northwestern U.S. Key informants completed 20–30 minute semi-structured interviews, which were recorded, transcribed, and qualitatively analyzed using template analysis.
Results: Key informants (N = 32) included: clinical staff (n = 14), providers (n = 14), and administrative informants (n = 4) with varying participation in implementation of and responsibility for alcohol screening and brief intervention at the medical center. Ten inter-related themes (5 *a priori* and 5 emergent) were identified and grouped into 3 applicable domains of Greenhalgh's conceptual framework for dissemination of innovations, including values of adopters (theme 1), processes of implementation (themes 2 and 3), and post-implementation consequences in care processes (themes 4–10). While key informants believed alcohol use was relevant to health and important to address, the process of implementation (in which no training was provided and electronic clinical reminders "just showed up") did not address critical training and infrastructure needs. Key informants lacked understanding of the goals of screening and brief intervention, believed referral to specialty addictions treatment (as opposed to offering brief intervention) was the only option for following up on a positive screen, reported concern regarding limited availability of treatment resources, and lacked optimism regarding patients' interest in seeking help.

☆ Views expressed in this article are those of the authors and do not necessarily represent the views of the Department of Veterans Affairs, the University of Washington, or Group Health Research Institute.

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Conclusions: Findings suggest that the local process of implementing alcohol screening and brief intervention may have inadequately addressed important adopter needs and thus may have ultimately undermined, instead of capitalized on, staff and providers' belief in the importance of addressing alcohol use as part of primary care. Additional implementation strategies, such as training or academic detailing, may address some unmet needs and help improve the quality of both screening and brief intervention. However, these strategies may be resource-intensive and insufficient for comprehensively addressing implementation barriers.

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1. Introduction

Population-based alcohol screening, followed by brief intervention for primary care patients who screen positive for unhealthy alcohol use (Saitz, 2005), is widely recommended in primary care settings (Jonas et al., 2012; National Health Service, 2010; National Institute on Alcohol Abuse and Alcoholism, 2007), and is considered a top prevention priority (Maciosek, Solberg, Coffield, Edwards, & Goodman, 2006), but has been very challenging to implement (Le et al., 2015; Nilsen, 2010; Nilsen, Aalto, Bendtsen, & Seppa, 2006; Solberg, Maciosek, & Edwards, 2008; Williams et al., 2011). Implementation studies across multiple settings have had limited success (Johnson, Jackson, Guillaume, Meier, & Goyder, 2011; Nilsen, 2010; Nilsen et al., 2006; Williams et al., 2011). However, new policy initiatives in the United States, including the Affordable Care Act (ACA), which established alcohol screening and brief intervention as standard preventive benefits, may help launch widespread implementation (HealthCare.gov, 2013a, 2013b).

The U.S. Veterans Health Administration (VA) is the largest integrated healthcare system in the United States; it is centrally administered and has a nationwide electronic medical record and system of performance measures to incentivize recommended care (Kerr & Fleming, 2007; Kizer, Demakis, & Feussner, 2000; Kizer & Dudley, 2009). Using a combined strategy of performance measures and electronic clinical reminders to prompt and facilitate documentation of care, the VA has accomplished high sustained rates of both documented alcohol screening (Bradley et al., 2006) and brief intervention (Bradley, Johnson, & Williams, 2011; Bradley & Williams, 2009; Lapham et al., 2012). More than 90% of active primary care patients have had documented alcohol screening since 2004 (Bradley et al., 2006), and rates of brief intervention have gone up over time (Lapham et al., 2012), with the most recent evaluations suggesting that more than 75% of screen-positive patients have documented brief intervention (Bradley, Johnson, & Williams, 2011). These successes have distinguished the VA as a leader in implementation of these recommended practices (Moyer & Finney, 2010; Williams et al., 2011). Therefore, other healthcare systems implementing screening and brief intervention (Mertens, Sterling, Weisner, & Brumder-Ross, 2013) in response to new policies are likely to rely on similar system-level implementation strategies.

However, because the VA is very expansive—made up of 21 regional networks, divided into 150 facilities, with nearly 1,000 clinics across the U.S. (Veterans Health Administration, 2014)—strategies used to implement alcohol screening and brief intervention at individual VA clinics in response to national implementation efforts are unknown. Moreover, research has suggested problems with the quality of both alcohol screening and brief intervention in the VA (Bradley, Lapham, et al., 2011; Hawkins et al., 2007). Specifically, the sensitivity of clinical screening appears to be low, with clinical screening missing a substantial proportion (61%) of patients who screened positive for unhealthy alcohol use on self-administered surveys (Bradley, Lapham, et al., 2011). In addition, an early evaluation suggested that brief intervention documented in the VA may not be having its intended effect—changing drinking among patients who initially screen positive for unhealthy alcohol use (Williams et al., 2014). Together findings from those studies across many VA sites suggested that, in routine practice, both screening and brief intervention may not have been implemented in the high-quality manner intended. Understanding implementation processes, experiences, and results from the perspectives of frontline adopters could help elucidate issues underlying quality problems with alcohol screening and brief intervention in the VA. Such information could also be used to identify issues that may be addressed by supplemental or different implementation strategies in order to refine VA's implementation and inform other healthcare systems as they move forward with implementation.

A previous observational qualitative study in 9 VA primary care clinics identified several specific screening practices that were likely to undermine the sensitivity of screening (e.g., non-verbatim screening and/or omission of one of the screening questions) and suggested several implementation barriers that may have resulted in these practices (e.g., lack of training and perceptions of patient discomfort) (Williams et al., 2015). However, that study was observational and did not directly solicit the experiences and perspectives of frontline adopters. Moreover, that study did not identify issues that may impact the quality of brief intervention. Therefore, the purpose of the present qualitative study was to describe local implementation of alcohol screening and brief intervention from the perspectives of frontline adopters at 5 VA primary care clinics in a different city in the western U.S. The ultimate objective was to further identify factors that may underlie quality problems in order to improve implementation of alcohol screening and brief intervention in VA and inform other healthcare systems as they implement these important, recommended, and incentivized clinical practices.

2. Materials and methods

2.1. Study setting and recruitment of key informants

This qualitative study relied on semi-structured interviews with "key informants" from 5 geographically distinct, free-standing primary care clinics affiliated with a large VA medical facility in the northwestern U.S. This included a large urban primary care clinic at the medical facility, two large suburban free-standing clinics, and two VA-managed community-based outpatient clinics (CBOCs), one suburban, one urban.

Recruitment and sampling of potential key informants were conducted purposively, such that we attempted to identify people with differing roles and responsibilities related to patient care and quality improvement, as well as varying roles regarding implementation of alcohol screening and brief intervention. Therefore, potential key informants included clinical staff responsible for alcohol screening, such as registered nurses (RNs), licensed practical nurses (LPNs), health technologists (health techs), and medical assistants (MAs); providers responsible for delivering brief interventions, including attending and resident medical doctors (MDs), nurse practitioners (NPs), and social workers (MSWs); and administrative leaders in quality improvement and clinical care who had roles in the implementation of screening and brief intervention.

To identify and recruit potential key informants, we first established contact with two administrative leaders at the main medical center and obtained contact information for clinical leaders at each of the other clinics. We then initiated communication with a key point-of-contact (such as the clinic manager) at each individual clinic to introduce the study and determine the desired method of recruiting participants and conducting interviews at each clinic, with the aim of having as little disruption of clinic flow and patient care as was possible. Depending on the clinic, this entailed either coordinating recruitment via email with individual potential participants to arrange a specific time for