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# Increasing Opioid Abuse Screening in Primary Care Clinic: An Evidence-Based Quality Improvement Project

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# Increasing Opioid Abuse Screening in Primary Care Clinic: An Evidence-Based Quality Improvement Project

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A DNP project submitted in partial fulfillment of the requirements

for the degree of Doctor of Nursing Practice

Davis & Henley College of Nursing

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This is to certify that the DNP Project Final Report by

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has been approved by the DNP Project Team on

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for the Doctor of Nursing Practice degree

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## Abstract

### Introduction

To address substance abuse multiple organizations recommend increase drug abuse screening as part of routine health care. CAGE AID is five-question tool used to screen for drug and alcohol use, answering yes to two or more questions indicates further assessment is advised. Unfortunately, most primary care centers do not use screen for substance abuse using validated instrument tools such as the CAGE-AID tool.

### Purpose

The purpose of this evidence-based practice (EBP) project is to implement the CAGE-AID Substance abuse screening tool by nurse practitioners students in a family clinic located in Bridgeport in order to increase to number of referrals to primary provider or further evaluation.

### Intervention/Setting

The institute of healthcare improvement (IHI) model for improvement and the EBP model was utilized to guide the implementation of this project in family clinic located in Bridgeport, where screening was not the current practice. The project manager educated two advance licensed practitioners students (ALPS) who were doing their clinical hours at the family clinic (one nurse practitioner student and one physician assistant student). The goals, of the education was to show them how to use the CAGE-AID substance abuse screening tool. The two ALPS were assigned to screen 200 adult patients presenting to clinic for any complaints using the CAGE aid tool before primary care provider (MD/NP/PA) had a face-face encounter. The screeners recorded the number of patients screened per week and the number of patients referred to the primary provider for further assessment. Data was scheduled to be collected over 8 weeks.

The Outcomes were measured after the implementation of screening with the number of positive screens referred to the primary care provider for further testing.

**Results**

The project manager did not achieve full project implementation due to loss of buy-in from key stakeholders due to the covid 19 pandemic. From the total 200 planned patients to be screened, only 18 were screened over a period of two weeks. Out of the 18 patients, only two patients screened positive for substance abuse. One of the patients had a previous history of substance abuse but another referral was made. The other patient was referred to the primary doctor for further assessment. Other limitations included resistance to change, and inability to return to the clinic to continue implementing the project.

**Evaluation**

Full implementation was not achieved, from 18 patients screened, two were referred (11%) for possible substance abuse and brought to the attention of the primary care provider for further assessment. There was no data before implementing the QI project regarding the number of screened patients for substance abuse, so this was a new change in practice.

**Discussion**

There was a 11% increased referral for further assessment compared to no recorded data prior implementation. But considering the small sample limitation and incomplete implementation of this project, this writer recommends further studies/testing to corroborate that increasing substance abuse screening can increase patient referrals to primary provider for further evaluation. This project did not lead to a change of practice protocol in regard of substance abuse screening at the family clinic.

*Keywords:* CAGE aid tool, substance abuse screening, primary care

# Increasing Opioid Abuse Screening in Primary Care Clinic: An Evidence-Based Quality Improvement Project

## Phase 1

## Problem Identification & Evidence Review

### Background and Significance of Problem

More than 70,000 Americans died from a drug-involved overdose in 2019, including illicit drugs and prescription opioids, according to the National Institute on drug abuse (NIDA, 2020). Across the United States, individuals, families, communities, and health care providers are struggling to cope with the impacts of the opioid crisis. more than 20 million adults and adolescents in the United States have had a substance use disorder in 2016 (Lipari, & Van, 2017). Opioid misuse and opioid use disorders have devastating effects, including the loss of life by overdose and increased transmission of STDs. In addition, opioid abuse affects productivity, increase healthcare cost, child neglect, increase violence and crime (SAMHSA, 2019).

In response to this crisis, multiple organizations have issued statements recommending increase drug abuse screening as part of routine health care. Substance abuse and mental health services (SAMHSA) recommend universal screening for substance abuse through brief intervention and referral SBIRT (Padnode, &etal., 2020). The American academy of pediatrics (APP) recommends adolescents through their 20s at every annual physical evaluation (AAP, 2020). The Bright futures initiative also recommends that all adolescents aged 18-21 be screened for substance abuse as part of their psychosocial history (Hagan, Shaw, & Duncan, 2017). Lastly, the American association of family practitioners (AAFP) recommends that clinicians selectively

screen and refer adults aged 18 years and older to OUD treatment after weighing the benefits and harms of screening and treatment (AAFP, n.d.).

**Description of Local Problem/Organizational Priority**

The family clinic which serves the residents of Fairfield County Ct treats approximately 23,000 patients annually. This is a private clinic that provides primary care. The staff includes one primary care physician, three family nurse practitioners, medical/PA/NP students from nearby universities, four medical assistants, three receptionists, and one office manager. This clinic is located Bridgeport CT. The clinic does not consistently screen for substance abuse unless there is a request to do so, or the patient has an obvious need. This project was performed at the Bridgeport CT location.

This family medicine clinic is in good position to improve care for individuals with both behavioral health, including substance use and primary care needs. Moreso due to its locations, according to Connecticut open data from 2012-June 2020, Bridgeport is the 4th city with high accidental deaths (508) associated with drug overdose, following Newhaven (586), Waterbury (617), and Hartford 896 deaths, respectively (CTdata.gov, 2020).

**Focused Search Question**

The literature was searched for evidence to answer the clinical question In adult patients from primary care (P), how does the use of a CAGE-AID substance abuse screening tool (I) compared with current practice ( C ) influence identification of patients with substance abuse (O)?

**Evidence Search**

**External Evidence.**

Databases that were searched included Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, CINAHL, Medline, and PubMed. Searches were limited to those published between 2016 and 2021. The search was limited to English only articles. Keywords included primary care, opioid abuse, alcohol abuse, substance abuse, CAGE-aid, opioid abuse screening tool, alcohol abuse screening tool.

Articles were selected for review that had a main focus on opioid abuse screening tool in primary care. Six articles met these criteria. The John Hopkins Nursing Evidence-Based Practice Quality Guide (JHNEBP) was used to rate the overall quality of the articles (The Johns Hopkins Hospital, n.d.) and the Melnyk LOE Hierarchy was used to determine the level of evidence of the articles (Melnyk & Fineout-Overholt, 2019).

**Internal Evidence**

Currently prior to patient encounter with primary care provider in the clinic, the Nurse practitioners students (NPS) or physician Assistant student (PAS) see the patient and evaluate the patient according to chief complain, then NPS or PAS presents the case to primary provider, after presentation primary provider then does a face to face assessment of the patient.

There is no baseline data collection regarding number of patients screened and referred to the primary provider, and no baseline data if NPS/PAS screen patient for substance abuse. From anecdotal interviews with several PAS they stated that they only screen if the chief complaint was related to substance abuse then they would proceed to assess further. The interview with all of the physician assistants revealed they only have some knowledge of substance abuse screening tools but they have not used any during their assessments.

The lack of screening of substance abuse by PAS and NP suggests the need for education on available validated screening tools for opioid abuse screening in the clinic.

**Evidence Appraisal, Summary, and Recommendations**

A total of one level 1 systematic reviews met the criteria for inclusion in this evidence review, one article level II, three articles were level IV, and one level V.

Appendix A is the synthesis of evidence on the outcome for external referral, reduction of risk behaviors, reduced mortality, harms of intervention, accuracy of screening tool, applicability on pregnant and adolescent. Most of the screening tools for substance abuse was associated with increase referrals. All the arrows are in the direction that suggest improvement (e.g., External health referral, mental health discussion). harms of intervention were not addressed in 5 studies. Accuracy of drug screening tools were addressed on 3 studies. Lastly, no studies presented clear data between screening tool and reduced mortality

Based on this evidence review and synthesis, Evidence supports that the substance abuse screening tool increase external referrals and mental health discussions.

## Phase 2.

## Project plan

**Project Goals**

1. Identify validated tools for screening substance abuse in primary care
2. Increase assessment for substance abuse through use of validated tool
3. Disseminate information on CAGE-AID screening tool to providers

**Framework**

The IHI Model for Improvement will guide this project. The steps in the model of improvement are:

- What are we trying to accomplish?
    - Increase substance abuse screening in primary care
- How will we know that a change is an improvement?
    - If the number of referred patients to primary provider for substance abuse assessment by PAS/NPS increases, compared to current practice (0)
- What change can we make that will result in an improvement?
    - The adoption of CAGE AID screening tool by NPS/PAS and referral to primary care physician for further assessment.
- Testing changes on a small-scale using Plan-Do-Study-Act (PDSA) cycles (IHI, 2021).
    - During the “plan” of this project, the project manager will provide education on screen tool to PAS/NPS, including benefits of screening for substance abuse, and risks of substance abuse if untreated. Overview of project will be discussed separately with each stakeholder according to availability, permitting feedback to increase buy in.
    - During the “do” NPS/PAS will use screen tool twenty patients each week for 5 weeks
    - During the study project manager will review data on monthly bases.
    - During the act project manager will modify project using information obtained in the “do” phase

**Context**

The family medicine clinic is a primary health center that provides medical, urgent care, pediatric care, immigration physicals, department of transportation physicals to individuals and families in the Greater Bridgeport area. The clinic serves approximately 23040 patients a year and is in an underserved community.

**Key Stakeholders, staff, and Buy-in**

The key stakeholders were the clinics chief medical officer, the nurse practitioner, students, the physician assistant student, and the office manager. The author of this paper was the project manager.

Open dialogue with key stakeholders for buy-in, providing clear communication of project goal, mission, timeline and plans for using validated tools to increase screening for substance abuse was done over several meetings. Both NPS and PAS voiced interest in learning about the screening tool for substance abuse. It was emphasized that the time needed to implement this project was not significant and would not impact their workload or workflow. All parties agreed to move forward with this project and at the time appeared to have buy-in to complete this. Also appealing was that the research suggest screening alone significantly influence participant to reduce their substance abuse (Bavor, Delvoca, & Gray, 2017).

**Possible barriers to implementation**

The barriers to implementing this project were: resistance to change, loss of buy-in, time restraints, language barriers, patient refusal to answer question, and covid19 pandemic impact on the clinic workflow and its ability to see patients.

**Timeline**

**Jul-Aug 2021**

- Complete project proposal draft

**Aug 2021**

- Complete official DNP project proposal and present to project stakeholders
- Revise project proposal as needed

**Sept 2021**

- Identify & obtain the required review and approval needed for implementation

**Oct 2021**

- Implement project
- Track any deviations from project plan and make changes if needed (PDSA)

**Oct-Nov 2021**

- Track number of screened patients and number of referrals to primary provider

**Jan-May 2022**

- Present final DNP project
- Submit final DNP project
- Submit executive summary

**Resources**

Anticipated resources for this project include:

1. People: Patients, nurse practitioner student, physician assistant student, chief medical officer, and project manager.

2. Capital:

   Capital for materials required.

3. Material:

   Educational materials related to the project (poster, pamphlets),

**Ethical Merit**

This project met the criteria for Quality Improvement project and did not require a IRB review to be implemented . Permission was obtained from chief medical officer (see appendix C).

Table 2 displays a completed quality improvement and research screening tool. The answers to questions 1-10 are marked yes, and for questions 11-14, the answers are marked no then according to the tool, the project meets the criteria for a quality improvement project, and does not qualify as human subjects research, and does not have to go through the Institutional

Review Board at Sacred heart University.

Table 2.

Differentiating Quality Improvement and Research Activities Tool

| Question | **Yes** | **No** |
|---|---|---|
| 1. Is the project designed to bring about immediate improvement in patient care? | X | |
| 2. Is the purpose of the project to bring new knowledge to daily practice? | X | |
| 3. Is the project designed to sustain the improvement? | X | |
| 4. Is the purpose to measure the effect of a process change on delivery of care? | X | |
| 5. Are findings specific to this hospital/setting? | X | |
| 6. Are all patients who participate in the project expected to benefit? | X | |
| 7. Is the intervention at least as safe as routine care? | X | |
| 8. Will all participants receive at least usual care? | X | |
| 9. Do you intend to gather just enough data to learn and complete the cycle? | X | |
| 10. Do you intend to limit the time for data collection in order to accelerate the rate of improvement? | X | |
| 11. Is the project intended to test a novel hypothesis or replicate one? | | X |
| 12. Does the project involve withholding any usual care? | | X |

| | | |
|---|---|---|
| 13. | Does the project involve testing interventions/practices that are not usual or standard of care? | X |
| 14. | Will any of the 18 identifiers according to the HIPAA Privacy Rule be included? | X |

Adapted from Foster, J. (2013). Differentiating quality improvement and research activities. Clinical Nurse Specialist, 27(1), 10–3. https://doi.org/10.1097/NUR.0b013e3182776db5

**Data collection plan**

Baseline data was collected, including the number of substance abuse screening referrals from NPS or PAS to the primary care provider. This was achieved by requesting records from the office manager. Data was stored in an excel spreadsheet.

After implementing the project, data was ongoing and evaluated biweekly to determine the effectiveness of practice change. The project manager collected the screening tools used at the end of each week during the implementation. The number of screens using cage aid tool and the number of positive screening referrals were recorded. Data was saved to an excel spreadsheet by the project manager. A bar graph that included the number of screens and referrals was generated.

**Data analysis plan**

Data will be collected and stored in a spreadsheet excel file. Total data will be aggregated, and baseline data will be compared with project data for comparison. Data collected will include the number of patients screened and the number of patients referred to primary care

providers due to positive screening.

A bar graph will consist of the number of patients screened and the number of positive screenings referred to the primary care provider. The total number of patients will be summarized in a table to determine if project goals were met.

## Phase 3

## Implementation

### Description of actual project implementation

The proposed practice change was to add the screening tool CAGE-AID for substance abuse identification during the initial assessment of the patient before doctor evaluation and to refer positive screens to the primary provider (CMO, NP).

NPS and PAS were educated on using the screening tool CAGE-AID (see appendix B); once educated, both students were expected to screen ten patients using a verbal interview; screening was only to be done on the day the project manager was on-site. The CMO was only notified for further assessment if a positive screen is noted. One main education point is that a screening tool only indicates possible substance use disorder and requires further examination; it is not a diagnostic tool.

The Implementation of the project started on Oct 19th and finished on Nov 1st. Melnyk & Fineout-Overholt (2019) noted that it is not enough to know the best evidence; knowledge must be translated into clinical practice and requires support and commitment throughout the organization. Therefore, the project started with stakeholder education and continued throughout, stressing that Implementation of EBP is known to improve healthcare quality to promote full implementation and sustainability.

### Sample/setting

The target population for this EBP project was adult patients that presented tot family medicine primary care clinic. The inclusion criteria for implementation and data collection included any adult patient meaning 17yr or older, with any presenting chief complaint. Exclusion criteria included any patients under 17yr old. No other exclusion parameters were included in this project.

**Design**

Implementation strategies for EBP from the IOWA model were utilized to implement this project. According to Cullen et al. (2018), The Implementation Strategies for Evidence-Based Practice provides a planning model and uses effective strategies to promote the adoption and integration of evidence-based health care. The model includes 4 phases: 1) Create awareness and interest, 2) build knowledge and commitment, 3) promote action and adoption 4) pursue integration and sustained use.

*Create awareness*

One of the strategies to create awareness and interest was to highlight current problems screening patients for substance abuse and highlight the advantages of increased substance abuse screening. Current issues and benefits were discussed with stakeholders. This was conducted during an informal meeting at the beginning of each week with each stakeholder at their convenience. Current practice is that practitioners do not use a standardized approach for the risk assessment for substance misuse or addiction either at the initial evaluation or at follow-up visits. Many practitioners still rely on subjective impressions and personal judgments to judge risk levels despite oversight agencies' recommendations, guidelines, and widespread epidemic rates of overdose and death (Ducharme & Moore, 2019).

The other strategy to market the process change is to create sound bites and announce them in a

staff meeting to make the implementation eye-catching and memorable. According to Cullen et al. (2018), sound bites are short and memorable phrases of three crucial points relevant to the target audience. Examples of sound bites applied to handoff standardization are as follow:

- More than 70,000 Americans died from a drug-involved overdose in 2019 (NIDA, 2020).
- More than 20 million adults and adolescents in the United States have had a substance use disorder in 2016 (Lipari, & Van, 2017).
- My validated aid tool is better than your….. Judgment

*Build knowledge and commitment*

One strategy to build knowledge and commitment is to provide education to clinicians, leaders, and key stakeholders. In the clinic lounge, education sessions focused on using validated tools compared to using judgment to screen patients for substance abuse; sessions were scheduled for the first day of the week's work and the first hour, designed to include all stakeholders. Education sessions should be face-to-face to increase urgency and commitment. Also, education reinforces evidence that many organizations have issued statements recommending increasing drug abuse screening as part of routine health care. Examples include substance abuse and mental health services (SAMHSA), recommending universal screening for substance abuse through brief intervention, and referral SBIRT (Padnode &etal., 2020). the American academy of pediatrics (APP) recommends adolescents through their 20s at every annual physical evaluation (AAP, 2020). The Bright futures initiative also recommends that all adolescents aged 18-21 be screened for substance abuse as part of their psychosocial history (Hagan, Shaw, & Duncan, 2017). And the American association of family practitioners (AAFP)

recommends that clinicians selectively screen and refer adults aged 18 years and older to OUD treatment after weighing the benefits and harms of screening and treatment (AAFP, n.d.).

*Promote action and adoption*

Two strategies were implemented to promote action and adoption, "elevator speech" and providing recognition at the point of care. The project manager used the elevator speech strategy (brief and straightforward) whenever he encountered any new provider. The speech included the three soundbites to create urgency and promote action. Also, the project manager provided verbal recognition at every point of implementation, when the screeners used the CAGE aid tool, when stakeholders requested extra information, during informal face-to-face meetings, at the end of the week, and even when buy-in declined. Another strategy to promote action and adoption is to practice change in a short-term trial and small-scale pilot. It facilitates the identification of components of EBP that need change and can provide an initial analysis of outcome data (Cullen et al., 2018).

*Pursue integration and sustained use.*

One strategy to pursue integration and sustained use is celebrating progress, even if it is small. Celebrating nurses who practice correctly the new process should be recognized through emails or during huddles. During this public celebration, crucial messages should be restated. Another strategy that can increase integration and sustained use is audits and feedback on routine bases by clinical leadership and unit nurses or through boards. This feedback should also contain data, or the steps need it to improve. If practice change is successful, it should be incorporated into the daily clinical practice.

***Deviations from project plan.***

Deviation from the plan included lost buy-in to continue the project due to the surge in

covid 19, inability to obtain baseline information, and resistance to change. One screener missed a day collecting data due to a personal emergency. Covid 19 surge also made circumstances difficult to arrange meetings in small spaces like the lunchroom to continue to educate and encourage the staff participation.

## Phase 4

## Evaluation

### Process measure

In this project, the process measure was introducing the cage aid tool for substance abuse screening on an adult patient presenting to the clinic for initial evaluation or follow-up. This was done by NP or PA students who interviewed the patients using the cage aid questionnaire. If a positive screen, then PAS or NPS will alert the primary care provider for further assessment.

### Outcome Measures

The purpose of measuring aspects of healthcare delivery is to improve patient outcomes; in this project, the outcome measure is the number of referrals of positive substance abuse screening that were referred to the primary care provider for further assessment.

### Project results

Baseline data was collected and reviewed. Data included the number of referrals made by PAS and NPS to the primary provider due to positive screening for substance abuse and baseline data of the knowledge cage aid screening tool. There was no documented baseline data for the number of referrals the primary care provider received from NPS or PAS. According to the chief medical officer, substance abuse screening by NPS and PAS before primary care provider was standard practice.

Unfortunately, the project manager did not achieve full project implementation due to lack of

support, loss of buy-in from key stakeholders, and the covid 19 pandemic. Of the 200 planned patients to be screened, only 18 were screened over two weeks. Of 18 patients, two patients were screened positive for substance abuse, one with a previous history of substance abuse. The other patient was referred to the primary MD for further assessment.

Other limitations included resistance to change, and inability to return to the clinic to continue implementing the project.

**Evaluation**

Full implementation was not achieved from the planned 200 patient screen over two months; only 18 patients were screened over two weeks, and two were referred (11%) for possible substance abuse and brought to the attention of the primary care provider for further assessment. There was no data before implementing the quality improvement project regarding the number of screened patients for substance abuse, so this was, in a way, a new change in practice.

Table 3. Total number of patients screened using cage aid tool (n=20)

| Timeframe oct 18th-nov 1st | # Number of adult patient screen for substance abuse using cage aid tool |
|---|---|
| Screener A (PAS) | 10 |
| Screener B (NPS) | 8 |
| Total | 18 |

Table 4. Total number of patients referred due +screening to primary care provider (n=20)

| Timeframe oct 18th-nov 1st | # number of adult patient screen for substance abuse using cage aid tool |
|---|---|
| Screener A (PAS) | 2 |
| Screener B (NPS) | 0 |
| Total | 2 |

## Phase 5

## Dissemination

### Dissemination Plan

Although full implementation was not completed, a plan and proposed internal dissemination include a PowerPoint presentation to stakeholders (MD, FNP, clinic manager) and medical/FNP/PA students. The PowerPoint will consist of purpose, process, synthesis of evidence, practice change, implementation strategies, evaluation, conclusions, and acknowledgment (Cullen et al., 2018). Again, this dissemination plan was not completed because the project was terminated before effective implementation and completion.

### Key lessons learned

The main lesson learned in this project is that maintaining “buy-in” is critical; losing support from main stakeholders can be devastating after dedicating a lot of time to evaluating evidence. Another lesson learned in the central area is that time management regarding meeting with other stakeholders at their convenience is very challenging; scheduling zoom meetings or in-person meetings was challenging and took time. Improvement in communication is an area that needs improvement.

Another lesson is that the project could have added more exclusion criteria; one example was a history of previous substance abuse or a history of mental disability. To better understand the effectiveness of the project.

**Sustainability**

Sustainability in health care occurs when a new safety innovation becomes embedded into the daily workflow. The improvements in patient outcomes are maintained or improved after the initial implementation project ends (Agency for Healthcare Research and Quality, 2015). An action plan for Sustainability includes reviewing team members to focus on integration, garnering senior leadership support, internal strategic reporting, and mobilizing QI methods (Cullen et al., 2018).

Sustainability for this project includes continuing education and adapting as needed; the project manager will continue educating clinicians, leaders, and key stakeholders to build knowledge and commitment actively. Education sessions should focus on the advantages of adopting the CAGE-AID screening tool (see appendix B), and education also should be face-to-face to increase urgency and commitment. Another strategy to pursue integration and sustained use is celebrating progress, even if it is small. Celebrating PAS or NPS for complying with screening should be recognized using individual name recognition during meetings and providing small tokens of appreciation, providing a voucher for free cafeteria lunch or coffee. During this public celebration, crucial messages should be restated, especially the transmission of screening for substance abuse disorders is the first step of treatment. It can lead to improving quality of life. Lastly, identifying team members that are not functioning should be removed.

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Appendix A

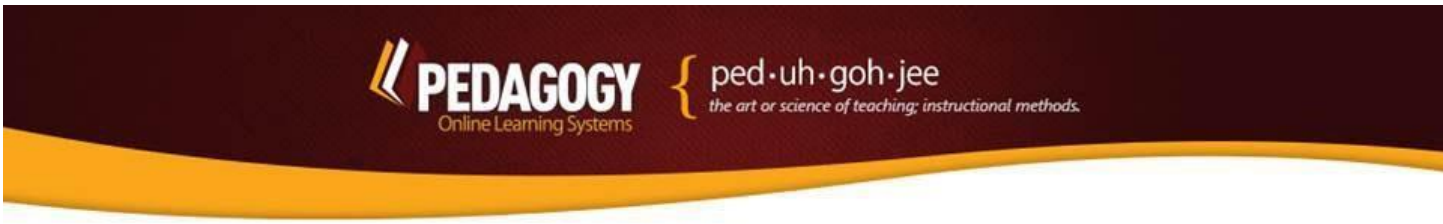
Table 1. Evidence Synthesis Table

| Articles | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| External referral provided | ↑ | - | ↑ | ↑ | ↑ | |
| Reduction of risk behaviors | ↑ | NE | - | NE | - | - |
| Mental health discussion | ↑ | ↑ | ↑ | NE | ↑ | - |
| Reduced drug use | ↓ | NE | NE | - | - | - |
| Reduced mortality | - | - | NE | - | - | - |
| Harms of intervention | NE | - | — | ↓ | ↑ | - |
| Accuracy of drug screening tool | ↑ | ↑ | - | NE | - | - |
| Pregnant and adolescent screening | ↑ | - | — | ↑ | - | - |

**SYMBOL KEY**

↑ = Increased, ↓ = Decreased, — = No Change, NE = Not Examined, NR = Not Reported (introduced at beginning but never reported at the end), ✓ = applicable or present, NC= No change

Appendix B




**CAGE-AID Substance Abuse Screening Tool**

The CAGE-AID screening tool was adapted from the CAGE alcohol assessment tool to include questions about drug use. The target population for the CAGE-AID is both adults and adolescents and can be administered by patient interview or self-report. These tools are not used to diagnose diseases, but only to indicate whether a problem might exist.

When thinking about drug use, include illegal drug use and the use of prescription drugs other than as prescribed

| | | | |
|---|---|---|---|
| **C** | Have you ever felt the need to **cut** down on your drinking or drug use? | Yes | No |
| **A** | Have people **annoyed** you by criticizing your drinking or drug use? | Yes | No |
| **G** | Have you ever felt **guilty** about drinking or drug use? | Yes | No |
| **E** | Have you ever felt you needed a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (**EyeOpener**)? | Yes | No |

**Scoring**

A "yes" answer to one item indicates a possible substance use disorder and a need for further testing.

References

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Appendix C

To whom concern,

After review the proposed QI project, Bridgeport Family Medicine does not require IRB approval, and this organization has agreed to support this project. Also agreed that no patient identifiers or data gathered will be identified.


Chief Medical Officer

Awais Malik MD

Appendix D

Table 2.

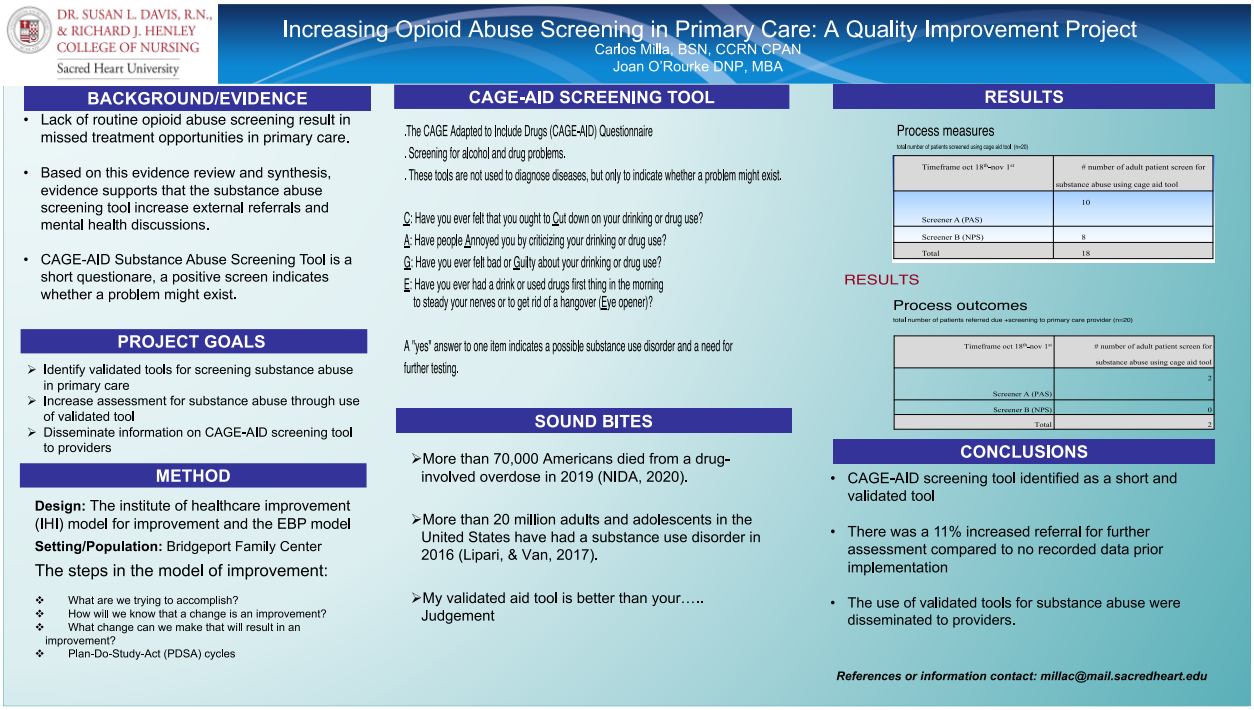
Differentiating Quality Improvement and Research Activities Tool

| Question | **Yes** | **No** |
|---|---|---|
| 1. Is the project designed to bring about immediate improvement in patient care? | X | |
| 2. Is the purpose of the project to bring new knowledge to daily practice? | X | |
| 3. Is the project designed to sustain the improvement? | X | |
| 4. Is the purpose to measure the effect of a process change on delivery of care? | X | |
| 5. Are findings specific to this hospital/setting? | X | |
| 6. Are all patients who participate in the project expected to benefit? | X | |
| 7. Is the intervention at least as safe as routine care? | X | |
| 8. Will all participants receive at least usual care? | X | |
| 9. Do you intend to gather just enough data to learn and complete the cycle? | X | |
| 10. Do you intend to limit the time for data collection in order to accelerate the rate of improvement? | X | |
| 11. Is the project intended to test a novel hypothesis or replicate one? | | X |
| 12. Does the project involve withholding any usual care? | | X |
| 13. Does the project involve testing interventions/practices that are not usual or standard of care? | | X |
| 14. Will any of the 18 identifiers according to the HIPAA Privacy Rule be included? | | X |

Adapted from Foster, J. (2013). Differentiating quality improvement and research activities.

Clinical Nurse Specialist, 27(1), 10–3. https://doi.org/10.1097/NUR.0b013e3182776db5

Appendix E


DR. SUSAN L. DAVIS, R.N., & RICHARD J. HENLEY COLLEGE OF NURSING
Sacred Heart University
Increasing Opioid Abuse Screening in Primary Care: A Quality Improvement Project
Carlos Milla, BSN, CCRN CPAN
Joan O'Rourke DNP, MBA
BACKGROUND/EVIDENCE
• Lack of routine opioid abuse screening result in missed treatment opportunities in primary care.
• Based on this evidence review and synthesis, evidence supports that the substance abuse screening tool increase external referrals and mental health discussions.
• CAGE-AID Substance Abuse Screening Tool is a short questionare, a positive screen indicates whether a problem might exist.
PROJECT GOALS
➢ Identify validated tools for screening substance abuse in primary care
➢ Increase assessment for substance abuse through use of validated tool
➢ Disseminate information on CAGE-AID screening tool to providers
METHOD
Design: The institute of healthcare improvement (IHI) model for improvement and the EBP model
Setting/Population: Bridgeport Family Center
The steps in the model of improvement:
❖ What are we trying to accomplish?
❖ How will we know that a change is an improvement?
❖ What change can we make that will result in an improvement?
❖ Plan-Do-Study-Act (PDSA) cycles
CAGE-AID SCREENING TOOL
.The CAGE Adapted to Include Drugs (CAGE-AID) Questionnaire
. Screening for alcohol and drug problems.
. These tools are not used to diagnose diseases, but only to indicate whether a problem might exist.
C: Have you ever felt that you ought to Cut down on your drinking or drug use?
A: Have people Annoyed you by criticizing your drinking or drug use?
G: Have you ever felt bad or Guilty about your drinking or drug use?
E: Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?
A "yes" answer to one item indicates a possible substance use disorder and a need for further testing.
SOUND BITES
➢More than 70,000 Americans died from a drug-involved overdose in 2019 (NIDA, 2020).
➢More than 20 million adults and adolescents in the United States have had a substance use disorder in 2016 (Lipari, & Van, 2017).
➢My validated aid tool is better than your….. Judgement
RESULTS
Process measures
total number of patients screened using cage aid tool (n=20)
Timeframe oct 18th-nov 1st
# number of adult patient screen for substance abuse using cage aid tool
Screener A (PAS) 10
Screener B (NPS) 8
Total 18
RESULTS
Process outcomes
total number of patients referred due +screening to primary care provider (n=20)
Timeframe oct 18th-nov 1st
# number of adult patient screen for substance abuse using cage aid tool
Screener A (PAS) 2
Screener B (NPS) 0
Total 2
CONCLUSIONS
• CAGE-AID screening tool identified as a short and validated tool
• There was a 11% increased referral for further assessment compared to no recorded data prior implementation
• The use of validated tools for substance abuse were disseminated to providers.
References or information contact: millac@mail.sacredheart.edu