Standardizing Substance Use Screening and Increasing Access to Harm-Reducing Treatment Through a Pilot Implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT)

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Abstract

The objectives of this project are to introduce standardized universal screening for substance use through the implementation of the screening, brief intervention, and referral to treatment (SBIRT) tool at Country Doctor Community Health Centers (CDCHC). The patient population for this pilot were patients ages 18 and older seen in person by one of the four participating providers at CDCHC. The specific aims of the pilot were to: 1) increase drug and alcohol use screening rates for patients ages 18 and older from 0% to 25% by April 1st, 2022, and 2) to offer a brief intervention and/or referral to treatment to at least 50% of the patients who screened positive. The workflows created for this project went into effect on January 1st, 2022. Quantitative data related to the aims above and patient demographics were collected via an electronic medical record (EMR) data report and manual chart review on April 2nd,2022. In addition, a post-implementation survey was developed and distributed to staff involved in the pilot to evaluate barriers to implementation and to inform changes necessary prior to expansion. Overall, the core aims for this project were met. Substance use screening for the eligible group of patients increased from 0% to 38% and brief interventions or treatment referrals for indicated patients increased from 0% to 66%. The results from the post implementation survey were thematically analyzed to inform our recommendations for future project expansion. A summary of this pilot's findings and recommendations was distributed to core CDCHC stakeholders.

Background and Literature Review

The United States' substance use epidemic continues to grow at an alarming rate with overdose deaths reaching record numbers of over 100,000 in 2021 (Centers for Disease Control and Prevention, 2021). According to 2020 data, overdose rates in Washington state rose 35% - the second highest increase in the country (Katz et al., 2020). The growing availability of fentanyl and other synthetic opiates as well as fentanyl containing stimulants are suspected to be responsible for over half of overdose fatalities (Volkow, 2021). Continued rising mortality related to substance use reinforces the need for universal substance use screening and harm reduction efforts in the primary care setting.

Of people ages 12 and older in 2020, 11.7% reported illicit drug use in the past month (Centers for Disease Control and Prevention, 2019), with 6.6% meeting criteria for an illicit drug use disorder (Substance Abuse and Mental Health Services Administration (SAMHSA), 2021). Health risks associated with illicit drug use are severe and variable depending on the specific drug and route of administration, with injection drug use being the riskiest. In 2018, it was estimated that 750,000 people in the United States injected drugs (Visconti et al., 2019). People who inject drugs (PWID) are at higher risk of many health outcomes including endocarditis, bone and joint infections, sepsis, thromboses, human immunodeficiency virus (HIV), hepatitis C, and wounds or skin and soft tissue injuries (SSTIs) (Larney et al., 2017).

While illicit drug use is risky and especially stigmatized, alcohol is the most commonly used and abused substance. In 2020, 22.2% of people ages 12 and older reported binge alcohol consumption and 10.2% (over 15% for adults 18-25) met criteria for an alcohol use disorder (AUD) (SAMHSA, 2021). Heavy alcohol use increases risk for many health issues including anxiety, depression, hypertension, stroke, cardiomyopathy, alcoholic hepatitis, cirrhosis, pancreatitis, and many forms of cancer (Centers for Disease Control and Prevention, 2022).

Overall, in 2020 14.9% of people age 12 and older were categorized as needing substance use disorder (SUD) treatment, but only 1.4% received any treatment (including non-medical treatment) (SAMHSA, 2021). One study found that SUDs increased the cost of emergency department (ED) and inpatient encounters; the adjusted mean medical cost attributable to SUD diagnosis at the ED and inpatient setting were increased by $1,985 and $9,693 respectively (Peterson et al., 2021). This increase is related to medical complications related to substance use, increased acuity, and longer hospital stays. This represents an opportunity for primary care providers to more effectively screen and treat patients with SUDs. Despite the availability of validated screening tools and treatment recommendations, people using substances are not always identified in the primary care setting before negative health consequences arise (Aldridge et al., 2017). One such tool is Screening, Brief intervention, and Referral to Treatment (SBIRT). The use of SBIRT is recommended by the United States Preventive Services Task Force, applicable across several clinical settings, and effective in reducing substance use. One study showed that alcohol use decreased by 35.6% and illicit drug use by 75.8% in all patients screening positive through the SBIRT process (Aldridge et al., 2017). Screening and intervention through SBIRT have also been found to cut healthcare costs; one study showed that for every dollar spent on SBIRT services, nearly four dollars were saved in emergency room and hospital costs (Aldridge et al., 2017).

Verified Substance Use Screening Tools

Four verified screening tools were used for the implementation of this project. The single alcohol screening questionnaire (SASQ) and single drug screening questionnaire (SDSQ) are simple yes or no questions that will prompt the participant to complete further screening if they answer “yes” (Saitz et al., 2014). A “yes” answer on the SASQ is considered positive and prompts completion of the Alcohol Use Disorder Identification Test (AUDIT). A “yes” answer on the SDSQ is considered positive and will prompt completion of the Drug Abuse Screening Test (DAST) (see Appendix A).

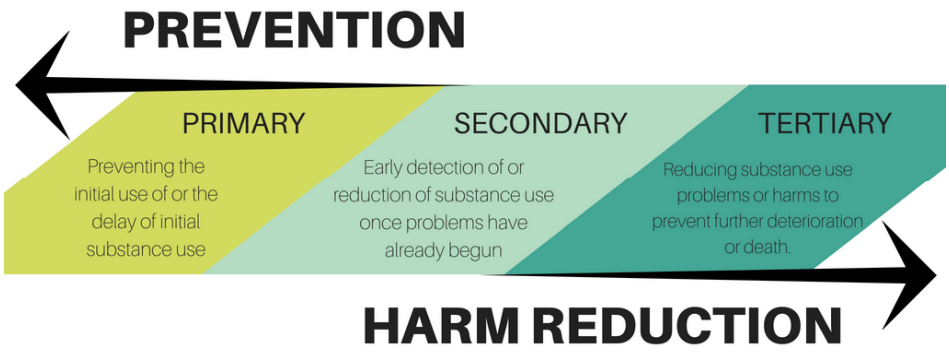
The AUDIT consists of 10 questions regarding the frequency and quantity of alcohol use. According to the World Health Organization, scores between 1-7 suggest low risk alcohol consumption while a score greater than 7 suggests risky or harmful consumption (Saunders, n.d.). The DAST consists of 10 questions about specific drug use practices and each question is worth one point. A score of 0-2 is considered low risk, a score of 3-5 is considered moderate risk, and a score 6 or higher is considered severe (University of Missouri, Kansas City, n.d.). The score of the AUDIT and/or DAST will determine the type of intervention appropriate to the patient. The interventions will be described in greater detail in the "Project Design" section of this paper. Participants will be trained on interpretation of these screening tools through the SBIRT online training program (University of Missouri, Kansas City, n.d.). The AUDIT and DAST have been verified in several languages and settings, and both English and Spanish versions were utilized for this project (Perez Galvez et al., 2010) (see Appendix B).

Theoretical Framework

While SBIRT in itself provides a conceptual framework to screen, provide brief interventions, and referrals to treatment (University of Missouri, Kansas, City, n.d.), the goals of this project are harm-reduction focused. The use of SBIRT as a screening and intervention tool relies on both preventative and harm-reduction theoretical frameworks; see Figure 1 for the intersection of these two public health efforts (Recovery Research Institute, 2019). The screening portion of the SBIRT process aims to standardize and normalize the screening of substance use which has been historically underperformed, possibly due to the stigma associated with substance use. This method of screening and intervention is not an abstinence-based model, instead SBIRT aims to reduce the risk and negative outcomes associated with substance use (Stockings et al., 2016). There are several approaches to substance use and associated treatment, and the purpose of utilizing SBIRT is to tailor the intervention to the needs, goals, and individual circumstances of each patient in order to reduce harm.

Figure 1

The Intersection of Prevention and Harm Reduction Efforts in SBIRT



Note. SBIRT is both a preventive screening tool and a harm reduction framework. Adapted from Recovery Research Institute. (2019, June 17). Special Topics and Resources. https://www.recoveryanswers.org/resource/drug-and-alcohol-harm-reduction/). In the public domain.

Setting and Problem Statement

Country Doctor Community Health Center (CDCHC) is a Federally Qualified Health Center (FQHC) with multiple clinics located in Seattle, Washington. Country Doctor Community Clinic (CDCC) is located in the Capitol Hill neighborhood of Seattle, and the Carolyn Downs Family Medical Center (CDFMC) is located in the city's Central District. CDCHC has been offering primary care services to uninsured, underinsured, and low-income individuals since the clinic's first iterations in the early 1960s (Country Doctor Community Health Centers, 2021). Currently, CDCHC also offers outpatient addiction medicine treatment and has a growing addiction medicine program. There are a total of 15 providers at the CDCC and 19 providers at CDFMC.

Prior to the implementation of this project, CDCHC did not have a standardized substance use screening or addiction-treatment referral process. Not all patients at risk of poor health outcomes related to substance use were being identified and none were receiving brief interventions or referrals to treatment from SBIRT-trained clinicians. Better identification of at-risk individuals could lead to earlier

intervention, reduced use of substances, decreased risk for poor health outcomes, and reduced healthcare costs associated with such outcomes (Babor et al., 2017). These clinics were chosen as our clinical sites due to their commitment to improving community healthcare through harm reduction and their growing addiction medicine programs.

Purpose and Aims

The purpose of this project is to standardize a substance use screening, intervention, and treatment referral process at CDCHC through a pilot implementation of SBIRT. This project aims to reduce negative consequences associated with substance use by creating opportunities for partnership and empowerment while reducing risk and mortality. Given that the goals of this project are harm-reduction focused, the use and interpretation of the screening tools within SBIRT (SASQ, SDSQ, AUDIT, and DAST) as well as the training of all participating staff will be implemented through a harm reduction approach.

The specific aims of this pilot were to: 1) increase drug and alcohol use screening rates for patients ages 18 and older from 0% to 25% between January 1st, 2022, and April 1st, 2022, and 2) to offer a brief intervention and/or referral to treatment to at least 50% of the patients who screened positive. Improved rates of screening, brief intervention, and treatment referrals will hopefully lead to improved access to supportive, harm reduction-based counseling as well as specialized treatment. Ultimately, we hope these efforts help improve the health outcomes of people who use substances and reduce associated healthcare costs.

Methods

Project Approvals

This quality improvement project was implemented at CDCC and CDFMC and was approved by the CDCHC Director of Quality Improvement and Risk Management (see Appendix C). Furthermore,

Seattle University Institutional Review Board reviewed the details of this project and deemed it non-human subjects research requiring no further approval on November 8th, 2021 (see Appendix D).

Participants and Training

Critical to the implementation of this project was the training of all involved staff. Participating staff include both SBIRT trained and non-SBIRT trained personnel. The training, SBIRT for Health and Behavioral Health Professionals, is a free, 8-hour online set of modules and activities available through the University of Missouri - Kansas City School of Nursing and Health Studies website (University of Missouri, Kansas City, n.d.). SBIRT trained participants included providers, nurses, and behavioral health specialists. Only SBIRT trained clinicians, required to submit a certificate of completion of the training, provided brief interventions and/or treatment referrals. Non-SBIRT trained staff integral to the implementation of this project includes front desk staff and medical assistants. Non-SBIRT staff received training on the distribution of the screening questionnaires, assistance in completing the questionnaires and instruction on how to enter the patient's answers into the electronic medical record (EMR).

Stakeholders

Primary internal stakeholders of this pilot include the four SBIRT trained medical providers across the two CDCHC sites (two at CDCC and two at CDFMC), SBIRT trained nurses and behavioral health specialists, certified medical assistants, and front desk staff. Additional primary internal stakeholders not directly involved with the project implementation include members of the Quality Improvement Team and clinic managers. The CDCHC Leadership Team and Quality Improvement Team were involved in the planning process and were key recipients of the project outcomes, results, and recommendations. Secondary external stakeholders include patients of the participating providers, local hospitals and emergency departments, urgent care facilities, and specialized substance use treatment facilities.

Tools and Surveys

As previously discussed, the SASQ, SDSQ, AUDIT, and DAST were utilized to determine risk levels associated with substance use and the appropriate intervention. The SASQ was adjusted from binary gendered language to a single question for all patients regardless of gender. This leads to a slightly lower threshold for patients assigned male at birth with four drinks on any given occasion considered positive instead of five. Eliminating the use of binary gendered language better meets the needs of the diverse population of patients seeking care at CDCHC. All other screening tools have been left intact, and a validated Spanish version was utilized to better serve our Spanish-speaking patient population. The Spanish questionnaires explicitly matched their English counterparts (see Appendix B).

A brief survey via Qualtrics, an online survey software platform, was also provided to all participating staff (regardless of SBIRT training) at both CDCHC sites to identify and qualify barriers to successful implementation of the pilot. Such barriers are discussed in greater detail. The reported barriers are described in greater detail in the “Results” section of this paper. Survey results and their thematic analysis were provided to the CDCHC Quality Improvement Team to aid in the continuation of this project beyond its pilot form.

Project Design

The SBIRT process at CDCHC went live on January 1st, 2022. Project implementation began with the dissemination of the screening form (containing the SASQ, SDSQ, AUDIT, and DAST) provided by front desk staff to all patients 18 years and older checking in to see a participating provider at CDCHC. Both the AUDIT and DAST categorize patients based on their numeric score into categories of risk associated with their substance use. The medical assistant notified the participating provider of the patient score. Workflows for administering and recording the results of the screenings were developed and provided to medical assistants and front desk staff. A score greater than 7 on the AUDIT or higher

than 2 on the DAST is considered a positive screen and warrants either a brief intervention by SBIRT-trained personnel and/or a referral to addiction treatment.

A brief intervention and/or referral to treatment should be offered by the participating provider to every patient scoring positive on the AUDIT or DAST. Depending on the provider's availability, they chose to do the brief intervention and/or referral to treatment or enlist another SBIRT-trained participating staff to do so. A secure chat group was created within CDCHC's EMR for providers to quickly reach SBIRT trained staff to assist with brief interventions and referrals to specialized treatment when needed. The brief intervention encompasses a short (5-15 minute) conversation regarding the patient's substance use, their motivation for change, and an introduction to harm reduction practices. Referrals to treatment should be offered to any patient who is interested in exploring treatment options to help reduce their substance use. Referrals could be internal (to CDCHC's addiction medicine program) or external for inpatient or residential treatment.

For patients open to specialized substance use treatment who needed or desired an external referral, a resource document was created with supervised medical detoxification, inpatient treatment, and outpatient treatment options in the King County area (see Appendix E). Harm reduction resources including needle exchange programs were also included. These resource documents were converted to an EMR smart phrase for easy access to SBIRT trained staff and for dissemination to interested patients.

Data collection

Project metrics included whether the screening for patients 18 and older seen by a participating provider was done and entered in the EMR (metric 1) and whether or not a brief intervention/referral to treatment was offered to patients who screened positive on either the AUDIT or DAST (metric 2). Project metrics are directly related to the project aims of increasing drug and alcohol use screening rates for 18 and older patients from 0% to 25% by March 2022 (aim 1), and to offer a brief intervention and/or referral to treatment to at least 50% of the patients who screen positive on the AUDIT or DAST (aim 2).

The project metrics and aims further relate to our greater goal of standardizing substance screening and increasing access to harm-reducing treatment at CDCHC.

Both metrics were measured by collection and evaluation of quantitative data using descriptive statistics. Data were collected using CDCHC's EMR (Epic) in collaboration with the clinic's data analysis team. Data for the evaluation of the two measures were collected on April 2nd, 2022. Data collection was completed using an electronic Epic report of all patients 18 and older seen at an office visit by a participating provider between January 1st and March 31st, 2022. This report provided the total pool of patients eligible for SBIRT screening and those who had results of any screening (SASQ/SDSQ/AUDIT/DAST) recorded in Epic. Data from this Epic report addressed the first aim of the project.

Another portion of this report identified the number of patients whose screenings were marked positive of the pool of patients who received any screening. All patients who scored greater than 7 on the AUDIT and/or greater than 2 on the DAST were identified as positive. Of these patients with positive screens, a manual chart review was completed to determine if a brief intervention and/or referral to treatment was offered and documented. Data collected from this chart review addresses the second aim of the project.

In addition to our core metrics, the data included pertinent patient demographic information (gender, age group, race, ethnicity, and language). These demographic variables were utilized to draw conclusions about the population of patients who received screenings, those who screened positive, and those who received a brief intervention or treatment referral.

The post implementation survey evaluating barriers to implementation of the SBIRT process was made available via email to participating staff at both CDCC and CDFMC on April 1st, 2022. The survey was sent to 26 medical assistants, 4 medical providers, 10 front desk staff, 10 behavioral health specialists, and the 3 nurses (excluding the researchers) who received SBIRT training for a total of 53 staff

members. The survey was open until April 30th with two reminder emails sent on April 11th and April 20th, respectively. Responses from the post-implementation survey disseminated to all participating staff were extracted from Qualtrics software and organized using thematic analysis.

Data Analysis

Project evaluation and data analysis took place during April 2022 and was completed utilizing descriptive statistics. All reports generated from Epic and data collected through manual chart review were stripped of protected health information and transcribed using Excel spreadsheets. A comprehensive report was designed and run with the assistance of the Epic data analytics team.

This report provided the percentage of patients eligible for screening who had screening results recorded in Epic. This proportion was compared to our goal of 25% (Aim 1). To address Aim 2, a manual chart review was performed on all patients who were screened and scored greater than 2 on the DAST or greater than 7 on the AUDIT. These charts were reviewed to determine whether a brief intervention/referral to treatment was offered and documented. This proportion was calculated to determine whether our goal of 50% (Aim 2) was reached.

In addition to the quantitative data analysis, results of the post-implementation Qualtrics survey were organized using thematic analysis. Responses from participating staff were evaluated to identify the barriers to successful implementation of the SBIRT process. This analysis was used to generate recommendations to improve screening rates and improve the workflow for future expansion of the SBIRT pilot across both CDCHC clinics.

Results

Metric 1

A total of 952 patients 18 and older were seen in person by participating providers between January 1st and March 31st, 2022. Of these patients eligible for screening, a total of 365 received any screening tool (SASQ/SDSQ/AUDIT/DAST) for a rate of 38%. This is greater than our goal percentage of

25%. Therefore, the first aim of the project was successfully met. Table 1 contains a summary of this metric in addition to screening rates for positive AUDIT and DAST scores.

Table 1

SBIRT Screening Rates

Screening status	n	%
Patients 18+ w/any screening	365	38
Patients 18+ w/AUDIT >7	30	3
Patients 18+ w/DAST >2	17	2

Note. N = 952. Any screening can include SASQ, SDSQ, AUDIT, or DAST.

Metric 2

A total of 30 patients scored greater than 7 on the AUDIT and a total of 17 patients scored greater than 2 on the DAST. The total number of patients screening positive was 47, or 13% of the total number of patients screened. Of the patients screening positive on the AUDIT, 70% had a brief intervention or treatment referral documented in their visit notes. Of the patients screening positive on the DAST, 59% had a brief intervention or treatment referral documented in their visit notes. All patients who had a new documented referral to treatment also received a brief intervention, but not all patients with a documented brief intervention received a referral to treatment. The percentage of patients scoring over 7 on the AUDIT who received a new referral to treatment was 20%; of this population a total of 37% were referred to treatment or already enrolled in treatment. For patients scoring over 2 on the DAST, 24% received a new referral to treatment; of this population a total of 53% were referred to treatment or were already enrolled in treatment. Of all patients who should have received a brief intervention or treatment referral (those with positive AUDIT or DAST scores), 66% had one documented in their visit notes. This is greater than our goal percentage of 50%; therefore, the second project aim was also successfully met.

Table 2

Rate of Brief Intervention and Referral to Treatment in Patients with Positive Screenings

Positive Screening Status	Total Screened Patients		Patients w/ Brief Interventions		Patients w/new Referrals to Treatment		Patients w/both DAST >2 and AUDIT >7	
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Patients 18+ w/AUDIT >7	30	8	21	70	6	20	8	27
Patients 18+ w/DAST >2	17	5	10	59	4	24	7	41

Note. N = 365 (n= 30 for Patients 18+ w/AUDIT >7, n= 17 for Patients 18+ w/DAST >2).

Patient Population and Screening Rates

Demographic data was collected for all patients eligible for screening (see Table 3). The population of patients eligible for screening was 60% (n=572) female identifying, 40% (n=377) male identifying, and 0.3% (n=3) identifying as non-binary or without a specified gender in their chart. Of patients who received a screening, 63% (n=228) identified as female, 37% (n=135) identified as male, and 0.6% (n=2) identified as non-binary or without a specified gender in their chart.

Of the 952 patients eligible for screening, the majority were between the ages of 36-59 (49%). Of the remaining age groups, 29% were between ages of 18-35 and 22% were age 60 or older. Of the 365 patients who received a screening, again the majority (51%) were between the ages of 36 to 59, 29% were of age 18-35, and 20% were age 60 or older.

Patients identifying as Hispanic made up 20% of those eligible for screening, and 20% of patients who received a screening also identified as Hispanic. The racial makeup of the 952 patients eligible for screening was 55% white, 25% black or African American, 5% multiracial, 5% Asian, 0.8% American Indian or Alaska Native, 0.4% Hawaiian or Pacific Islander, and 9% had an unreported race. Of the 365 who were screened, 58% were white, 24% were black or African American, 9% were multiracial, 6% were

Asian, 0.6% were Hawaiian or Pacific Islander, none were American Indian or Alaska Native, and 5% had unreported race.

Of the 952 patients eligible for screening, 85% had English identified as their primary language and 12% had Spanish identified as their primary language. Other languages were represented but not included in data analysis because SBIRT forms were only available in English and Spanish for the purposes of this pilot. Of the 365 patients who received a screening, 85% had English as their primary language and 13% had Spanish as their primary language.

Table 3

Sociodemographic Characteristics of Participants

Baseline **characteristic**	Total Patients 18+		Patients 18+ w/any screening		Patients 18+ w/AUDIT >7		Patients 18+ w/DAST >2	
	n	*%*	*n*	*%*	*n*	*%*	*n*	*%*
Gender								
Female	572	60	228	62	5	17	8	47
Male	377	40	135	37	24	80	9	53
Other	3	<1	2	<1	1	3	0	0
Age								
18-35	272	29	106	29	11	37	8	47
36-59	466	49	187	51	16	53	6	35
60+	214	22	72	20	3	10	3	18
Ethnicity								
Hispanic	190	20	74	20	5	17	2	12
Non-Hispanic	762	80	291	80	25	83	15	88
Race								
American Indian/Alaska Native	8	1	0	0	0	0	0	0
Asian	47	5	21	6	1	3	0	0
Black/African American	233	25	86	24	5	17	5	29
Hawaiian Native/	4	<1	2	1	0	0	0	0

Other Pacific Islander								
Multiracial	49	5	19	5	2	7	1	6
Unreported/Refused to Report	83	9	26	7	2	7	0	0
White	528	55	211	58	20	67	11	65
Language								
English	807	85	310	85	26	87	16	94
Spanish	113	12	46	13	4	13	1	6

Note. N= 952 (n= 365 for Patients 18+ w/any screening, n= 30 for Patients 18+ w/AUDIT >7, n= 17 for Patients 18+ w/DAST >2).

Patient Population and Positive Screening Rates

Table 3 also details demographic information for patients who screened positive on the AUDIT or DAST. Of the 30 patients who scored above 7 on the AUDIT, 80% identified as male, 17% identified as female, and 3% identified as another gender or had no gender specified in their chart. Of this patient pool, 37% were ages 18-35, 53% were ages 36-59, and 10% were age 60 or older. A total of 5 patients (17%) screened positive on the AUDIT identified as Hispanic. Of this group of 30 patients, 67% identified as white, 17% identified as black, 7% as multiracial, 3% as Asian, and 7% had unreported race. 87% of patients scoring over 7 on the AUDIT had English as their primary language while 13% had their primary language as Spanish. As previously displayed in Table 2, 27% of patients who screened above 7 on the AUDIT also had a score greater than 2 on the DAST.

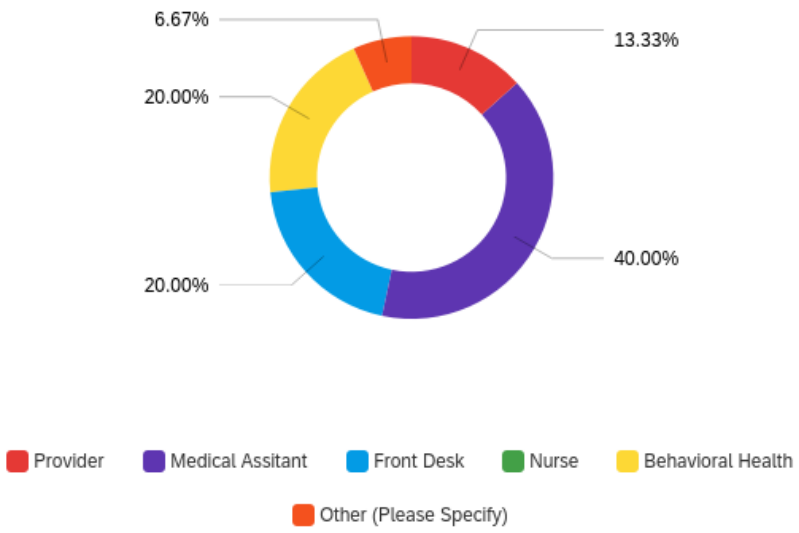
Of the 17 patients who screened greater than 2 on the DAST, 53% identified as male and 47% identified as female. Of this population, 47% were ages 18-35, 35% were ages 36-59, and 18% were 60 or older. 12% of patients scoring greater than 2 on the DAST identified as Hispanic. Of this same population, 65% were white, 29% were black, and 6% were multiracial; 94% had English as their primary language and 6% had Spanish as their primary language. As seen in Table 2, 41% of patients who screened above 2 on the DAST also screened positive on the AUDIT.

Post-Implementation Survey

Seventeen responses were collected through the post-implementation Qualtrics survey. Of 53 staff members who were involved in the pilot implementation project, this constitutes a 32% response rate. However, not all medical assistants participated in the SBIRT pilot because only medical assistants assigned to work with the four participating providers were involved. Of the responses from the survey, six were from medical assistants, three from front desk staff, two from providers, and one identified as "other" without the role specified. The survey responses were exported from Qualtrics, reviewed, and categorized by theme.

Figure 2

Role Breakdown for Post-Implementation Survey Responses



Note. Data collected and figures created through Qualtrics software.

The first question of the post-implementation survey inquired about portions of the pilot that went well. Six of the nine responses identified the questionnaire forms being distributed at the front desk as a positive part of the workflow, while three of the nine respondents did not address the question.

Table 4

Parts of the Pilot Identified by Staff as Working Well (N=9)

Parts of the pilot that worked well	Example Quote	Frequency, n (%)
Front desk providing form	"It was helpful when front desk remembered to give the patients the form to fill out." "When given to patient at front desk and patient fills out the form"	6 (67)
Question not addressed	"I've heard more people getting screened"	3 (33)

The survey question requesting examples of areas of the pilot that require improvement received ten responses. A large proportion of respondents, 50%, identified issues with entering the results in the EMR (Epic) as a major barrier. In addition, three respondents noted that sometimes patients either would not have the forms or the forms would not be complete prior to the provider entering the room, making it impossible to offer the appropriate intervention. Lastly, one respondent mentioned that they never received a request through the Epic secure chat SBIRT workgroup, suggesting this work group was not utilized.

Table 5

Parts of the Pilot Identified by Staff as Needing Improvement (N=10)

Parts of the pilot that need improvement	Example Quote	Frequency, n (%)
Patients hadn't completed forms prior to provider entering room	"Many times patients hadn't filled out the surveys prior to me walking into the room and so without the screening, really couldn't provide any brief intervention" "Where are the forms when front desk do not give it to the patient."	3 (30)
Lack of clarity on how results should be entered	"how to enter results" "Documentation in the chart."	5 (50)

	"The format of the form doesn't match epic, makes it harder to enter results."	
SBIRT secure chat workgroup wasn't utilized	"I was never called for a warm handoff for an SBIRT screen and I've never seen anyone do a call-out using the SBIRT epic groups."	1 (10)
Question not addressed	"I did not find any areas that needed adjustments."	1 (10)

The survey question requesting suggestions to improve the process received ten responses. Responses to this question were more variable, with two respondents pointing out that the paper screening forms provided to patients did not exactly match the forms for entering the results in Epic. Another two respondents suggested further training to make it clear where and how results should be entered. Lastly, two respondents noted that patients were sometimes offended by the screenings regarding substance use and were resistant to completing them. All suggestions received were thematically analyzed and organized in Table 6.

Table 6

Suggestions from Staff for Improvements in SBIRT Workflow (N=10)

Suggestion theme	Example Quote	Frequency, n (%)
Make entering the results in Epic more user friendly	"OCHIN EPIC making it more obvious how to enter in JUST SBIRT questions in the screening section"	2 (20)
Provide more instruction on how to enter results	"clear direction on how to enter and who should get one"	2 (20)
Patients offended by questions/declined to complete screening forms	"Patients have been indignant at times regarding the SBIRT. There are a few who refuse to complete as they feel attacked by the content. Explaining it thoroughly seems to help"	2 (20)
Combine SBIRT with other questionnaires	"Sometimes the patients are due for both the SBIRT & PHQ (sometimes health history form as well if they're new) and get overwhelmed from filling out so many forms. Maybe it would	1 (10)

	be more seamless to combine them if possible so it's all on one sheet."	
Utilize secure chat workgroup	"I certainly think it is a valuable experience but wasn't asked by any providers to help. The only SBIRT I performed was what I do in my everyday work."	1 (10)
MAs should reinforce importance of completing form	"I think it would be great for MAs to make sure that patients have the screening tools and really reinforce the importance of filling them out before our visit. I realize that many times even when we convey the importance of the screening, patients may not be interested in completing."	1 (10)
No suggestions	"I don't have any suggestions"	1 (10)

The final question of the post-implementation survey was aimed at understanding participant's opinions on how valuable the SBIRT process is. Overall, participants rated this experience at an average of 4.14 on a 5-point scale, with 5 being the most valuable. 93% of respondents gave a value rating of 3 or greater, indicating that staff members who participated in the survey recognized the value of the SBIRT implementation. The findings from this thematic analysis were consolidated for future recommendations in the discussion portion of this paper.

Dissemination of Results

A summary of our results and recommendations was provided to crucial CDCHC stakeholders, including Quality Improvement Workgroup, Addiction Medicine Program Director, and Behavioral Health Integration and Program Manager. Referral resources created for this pilot project were made available to all staff through a system-wide Epic smart phrase. Given this pilot's findings and success, there are plans to expand the use of SBIRT to all CDCHC Providers.

Limitations

There were several factors that limited the implementation of this project. Overall, data were collected over a short three-month period, limiting the pool of patients eligible for screening and the number of patients who received a screening. Additionally, this pilot only applied to patients being seen

in person by participating providers, while many patients at both CDCC and CDFMC continued to be seen through telehealth modalities in the setting of COVID-19. This possibly skewed not only the number of people eligible for screening but also the population of patients screened as we must consider the subgroup of patients likely to seek in-person appointments. There are multiple barriers that prevent many patients from making and keeping in person appointments who may benefit from substance use screening and intervention.

In addition, there were multiple snow related closures and disruptions related to a computer system security breach that limited clinic computer and phone access for nearly two weeks at the beginning of January 2022. The training aimed toward medical assistants regarding the SBIRT workflow was completed over Zoom and not all participants attended, leading to gaps in understanding of the process. Furthermore, both facilitators of this project were located at the CDCC site, possibly limiting support at the CDFMC site. Regardless of site, it is also important to recognize the limitations inherent to a FQHC including high acuity healthcare needs and socioeconomic disparities. Most providers at CDCHC see patients every 20 minutes, leading to a significant time constraint in providing screening and associated interventions related to substance use.

Additionally, there were technical limitations in data collection, mostly stemming from the electronic medical record. There were 31 patients who had a DAST and/or AUDIT completed without a brief screening tool recorded in Epic. It is unclear whether this results from patients not completing the full paper screening, or limitations in transcribing the screenings into Epic. Finally, there was no standard documentation strategy for brief interventions or treatment referrals, possibly impacting the data related to the second metric. Many of these limitations will be further addressed in the recommendations section of this paper.

Conclusion and Discussion

Overall, the core aims for this project were met. Substance use screening for the eligible group of patients was increased from 0% to 38% and brief interventions or treatment referrals for indicated patients were increased from 0% to 66%. This indicates that implementation of SBIRT to improve screening and clinical intervention for risky and harmful substance use is feasible within the setting of CDCHC. The remainder of this section will discuss additional findings not directly related to the two-core metrics of this project.

Patient Population

The demographic data collected highlighted important considerations for future expansion of the pilot. Overall, patients identifying as female were screened at a slightly higher rate than those identifying as other genders. The most represented and screened age group were patients between 36-59 years, while the screening rates for patients older than 60 were lowest. This represents an opportunity to encourage more thorough substance use screening for older adults. Interestingly, screening rates for patients identifying English as their primary language were comparable to patients identifying Spanish as their primary language, indicating that Spanish language was not a barrier to screening as one might expect. No patients identifying as American Indian/Alaska native were screened, despite a larger number of patients with this identity being eligible for screening than other racial groups with higher screening rates. This presents an opportunity to further identify screening barriers for certain populations for more equitable screening and interventions in the future.

Patient Population with Positive Screenings

A more specific set of data containing patients who screened positive on the AUDIT (>7) or DAST (>2) were also collected. Despite women being screened at a higher rate, positive screens for both the AUDIT and DAST were more common in patients identifying as male. Furthermore, the patients screening positive on the AUDIT were overwhelmingly white (67%) and male (80%). This may be related

to the known trend that men consume more alcohol than women (Wilsnack, et al. 2018), or another variable specific to this study population. Gender representation in patients screening positive on the DAST was more comparable to the screened population in general. Despite the highest rates of screening in the 36-59 year-old population, the majority of patients screening positive for the DAST were in the 18-35 year-old age group. There were patients who screened positive on both the AUDIT and the DAST. A greater percentage (41%) of patients screened positive on the DAST also screened positive on the AUDIT. However, only 27% of patients who screened positive on the AUDIT also screened positive on the DAST. This represents an opportunity to consider the prevalence of alcohol consumption in all patients, including those using illicit substances that might be considered riskier (i.e. injection drug use) (Visconti et al., 2019).

Brief interventions or treatment referrals were documented more frequently for patients screening positive on the AUDIT than the DAST, representing an opportunity for improved discussion around illicit substance use. The lack of documentation also leaves unknowns regarding the reason for positive DAST screening including the specific substance and route. For patients screening positive on the DAST, 24% had a new treatment referral documented while 29% were already engaged in treatment based on chart review. For those screening positive on the AUDIT, 20% had a new treatment referral documented while 17% were already engaged in treatment. In our population, those screening positive on the DAST were more likely to already be enrolled in some sort of treatment than those screening positive on the AUDIT.

Implications for Practice and Recommendations for Project Expansion

This pilot has served as an introduction to standardizing substance use screening and offering harm-reduction based interventions at CDCHC. Based on the feedback received in the post-implementation survey, patient resistance to screening was a barrier to successful screening. Prior to this pilot, there was no universal screening method for substance use at CDCHC. Therefore, it is

understandable that some patients found the screening surprising, offensive, or even accusatory. Normalizing this screening like a PHQ-9 (patient health questionnaire -9, a depression screening tool) or diabetes screening could help patients to expect it, and thus not feel targeted when they are asked to complete it. In the immediate future, we recommend the development of scripting for the front desk and medical assistants to utilize when a patient expresses resistance or confusion about the screening. Further discussion is necessary to design a workflow and documentation process when a patient declines the screening so that the care gap can be closed.

Another barrier identified in the post-implementation survey was a lack of clarity on how and where screening results should be entered into Epic. This was discussed in detail at the medical assistant training held prior to the pilot implementation; however, the training was held remotely and not all medical assistants were available to attend. An additional written workflow was distributed via email to all medical assistants and front desk staff at both CDCC and CDFMC, but we recognize that communication of the new workflow via email is not the most effective. We recommend making this training mandatory for medical assistants and front desk staff, setting aside clinical time to devote to training, and holding it in person. This will allow for more beneficial demonstration and troubleshooting of any technical issues that might be encountered.

Though not mentioned in the post-implementation survey, we recommend standardizing the documentation of brief interventions and treatment referrals. When completing chart review for the second aim of this project, it became clear that documentation of brief interventions and treatment referrals varied between the providers and between visits, making it more difficult to understand what intervention was offered, if any. To streamline and standardize documentation in the future, an Epic smart phrase was created to auto-load a concise template into the assessment and plan of the visit note. We recommend the universal use of this smart phrase for documentation of SBIRT services.

Equal screening rates between English and Spanish speaking patients indicated that language was not a barrier to screening within the SBIRT framework, so we recommend expanding this project to include other languages. A growing body of research supports the use of the SBIRT model in culturally and ethnically diverse populations (Manuel et al., 2015), and screening tools have been validated in many languages including Spanish, Arabic, Korean, Japanese, German, Russian, Farsi, and multiple Chinese dialects (Saunders, n.d.). We recommend the expansion of SBIRT screening to other languages represented in the patient population at CDCHC. Lastly, we recommend that demographic data is re-collected throughout the expansion of this project to identify and address any barriers to successful screening of underserved and underrepresented populations.

In addition to improving outcomes and saving money related to emergency department visits and hospital stays, SBIRT services are billable and reimbursable in the primary care setting (SAMHSA, 2022). This represents another motivator to offer universal screening and interventions for risky and harmful levels of substance use. Overall, this pilot laid the groundwork for expansion of universal substance use screening and intervention at CDCHC. A system-wide implementation of SBIRT is scheduled for mid-summer 2022 across both CDCC and CDFMC. We hope the findings, resources, and recommendations developed through this pilot increase patient access to supportive and collaborative healthcare through a harm-reduction framework.

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COUNTRY DOCTOR COMMUNITY HEALTH CENTERS

CDCHC SBIRT Questionnaire (English)

Patient Name: Date of Birth:

PRE-SCREENING

We're asking these questions because drug and alcohol use can affect your health as well as medications you may take. Please help us provide you with the best medical care by answering the questions below.

Are you currently in recovery for alcohol or substance use? ◯ Yes ◯ No

Alcohol: One Drink =  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

	None	1 or more
How many times in the past year have you had 4 or more drinks in a day?	◯	◯

*If you answered 1 or more, please fill out the **Alcohol Screening Questionnaire below.**

Drugs: Recreational drugs include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (benzodiazepines like Xanax), cocaine, ecstasy, hallucinogens (LSD, mushrooms), or opioids (such as heroin or pills).

	None	1 or more
How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?	◯	◯

*If you answered 1 or more, please fill out the **Drug Screening Questionnaire on the back of this form.**

ALCOHOL SCREENING QUESTIONNAIRE (AUDIT)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0-2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year

Have you ever been in treatment for an alcohol problem? ◯ Never ◯ Currently ◯ In the past

I	II	III	IV
0-3	4-9	10-13	14+

DRUG SCREENING QUESTIONNAIRE (DAST)

Using drugs can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Which recreational drugs have you used in the past year? (Check all that apply)

- ◯ methamphetamines (speed, crystal)
- ◯ cocaine
- ◯ cannabis (marijuana, pot)
- ◯ narcotics (heroin, oxycodone, methadone, etc.)
- ◯ inhalants (paint thinner, aerosol, glue)
- ◯ hallucinogens (LSD, mushrooms)
- ◯ tranquilizers (valium)
- ◯ other _____

How often have you used these drugs? ◯ Monthly or less ◯ Weekly ◯ Daily or almost daily

1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse (use) more than one drug at a time?	No	Yes
3. Are you always able to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	No	Yes
	0	1

Do you inject drugs? ◯ No ◯ Yes

Have you ever been in treatment for a drug problem? ◯ No ◯ Yes

I	*II*	*III*	*IV*
0	1-2	3-5	6

COUNTRY DOCTOR COMMUNITY HEALTH CENTERS

CDCHC SBIRT Questionnaire (Spanish)

Nombre del paciente: Fecha de cumpleaños:

MONITOREO INICIAL

Alcohol: Una Bebida =  12 oz. de cerveza (aprox. 5% de alcohol)  5 oz. de vino (aprox. 12% de alcohol)  1.5 oz. de alcohol (aprox. 40% de alcohol)

	Ninguna vez	uno o más*
¿Cuántas veces durante el año pasado ha tomado usted más de 4 bebidas en un día?	○	○

*Si usted respondió 1 o más, por favor llene el **Cuestionario de Monitoreo de Consumo de Alcohol** a continuación:

Drogas: Drogas recreacionales incluyen metanfetaminas ("speed," cristal), cannabis (marijuana, "hierba"), inhalantes (diluyente de pintura, aerosol, pegamento), sedantes (diazepam o Valium), barbitúricos, cocaína, éxtasis, alucinógenos (LSD, hongos), o narcóticos (heroína).

	Ninguna vez	uno o más*
¿Cuántas veces durante el año pasado ha usado usted una droga recreacional o usado un medicamento recetado por razones no médicas?	○	○

*Si usted respondió uno o más, por favor llene el **Cuestionario de Monitoreo de Uso de Drogas** al otro lado de este formulario.

CUESTIONARIO DE MONITOREO DE ALCOHOL (AUDIT)

1. ¿Con qué frecuencia consume alguna bebida alcohólica?	Nunca	Una o menos veces al mes	De 2 a 4 veces al mes	De 2 a 3 veces a la semana	4 o más veces a la semana
2. ¿Cuantas bebidas alcoholicas suele consumir en un dia de consumo normal?	0-2	3-4	5-6	7-9	10 o mas
3. ¿Con qué frecuencia toma 5 o más bebidas alcohólicas en un solo día?	Nunca	Menos de una vez al mes	Mensual-mente	Semanal-mente	A diario o casi a diario
4. ¿Con qué frecuencia en el curso del último año ha sido incapaz de parar de beber una vez que había empezado?	Nunca	Menos de una vez al mes	Mensual-mente	Semanal-mente	A diario o casi a diario
5. ¿Con que frecuencia en el curso del ultimo año no pudo hacer lo que se espereba de usted porque había bebido ?	Nunca	Menos de una vez al mes	Mensual-mente	Semanal-mente	A diario o casi a diario
6. ¿Con qué frecuencia en el curso del último año ha necesitado beber en ayunas para recuperarse después de haber bebido mucho el día anterior?	Nunca	Menos de una vez al mes	Mensual-mente	Semanal-mente	A diario o casi a diario
7. ¿Con qué frecuencia en el curso del último año ha tenido remordimientos o sentimientos de culpa después de haber bebido?	Nunca	Menos de una vez al mes	Mensual-mente	Semanal-mente	A diario o casi a diario
8. ¿Con qué frecuencia en el curso del último año no ha podido recordar lo que sucedió la noche anterior porque había estado bebiendo?	Nunca	Menos de una vez al mes	Mensual-mente	Semanal-mente	A diario o casi a diario
9. ¿Usted o alguna otra persona ha resultado herido porque usted había bebido?	No		Sí, pero no en el curso del último año		Sí, el último año
10. ¿Algun familiar, amigo o profesional ha mostrado preocupacion por su consumo de alcohol o ha sugerido que deje de beber?	No		Sí, pero no en el curso del último año		Sí, el último año

Ha estado usted en tratamiento para dependencia de alcohol alguna vez? ○Nunca ○Actualmente ○En el pasado

I	II	III	IV
0-3	4-9	10-13	14+

CUESTIONARIO DE USO DE DROGAS (DAST-10)

El uso de drogas puede afectar su salud. Ayudenos a proveerle con el mejor cuidado medico respondiendo las siguientes preguntas.

¿Que drogas recreacionales ha usado en el ultimo año? (Marque todo lo que corresponda)

- ◯ Metamfetaminas
- ◯ Cannabis (Marijuana)
- ◯ Inhalantes (diluyentes de pintura, etc)
- ◯ Tranquilizantes
- ◯ Cocaina
- ◯ Narcoticos (heroina, oxicodona, etc)
- ◯ Alucinógenos (LSD, hongos)
- ◯ Otros: _____

¿Que tan seguido ha usado ha usado esta(s) droga(s)?

◯ Una vez al mes o menos ◯ Semanalmente ◯ Diario o casi Diario

1. ¿Ha usado drogas que no eran requeridas por razones médicas?	No	Sí
2. ¿Ud. abusa (usa) más de una droga a la vez?	No	Sí
3. ¿Ud. Puede dejar de usar drogas cuando quiere ?	No	Sí
4. ¿Ha tenido “perdidas de conocimiento” o una “memoria repentina” como resultado del uso de drogas?	No	Sí
5. ¿Alguna vez se siente mal o culpable en relacion a su uso de drogas?	No	Sí
6. ¿Alguna vez su pareja (o familiares) se han quejado de su uso de drogas?	No	Sí
7. ¿Alguna vez a descuidado a su familia por su uso de drogas?	No	Sí
8. ¿Alguna vez se ha involucrado en actividades illegales para obtener drogas?	No	Sí
9. ¿Alguna vez ha experimentado síntomas de abstinencia (sentirse enfermo) cuando dejó de usar drogas?	No	Sí
10. ¿Ha tenido problemas médicos como resultado de su uso de drogas (perdida de la memoria, hepatitis, convulsiones, hemorragia, etc.)?	No	Sí
	0	1

¿Usted se inyecta drogas? ◯ No ◯ Si

¿Ha estado usted en tratamiento por uso de drogas? ◯ No ◯ Si

I	*II*	*III*	*IV*
0	1-2	3-5	6

Seattle University IRB Letter

SEATTLEU
INSTITUTIONAL REVIEW BOARD

Admin 201 | 206-296-2585
irb@seattleu.edu

November 8, 2021

Sydney Berkman and Lianabell Soto-Silva
College of Nursing
Seattle University

Dear Sydney and Lianabell,

Your application for the DNP project **Standardizing Substance Use Screening and Increasing Access to SUD Treatment through a Pilot Intervention of the SBIRT Tool** indicates that activities will involve

- Surveys and chart review related to SBIRT screening for a quality improvement project at Country Doctor Community Clinic.

Given the nature of these activities, this project does not meet the federal regulatory definition of human subjects research, and you do not need to go through further IRB review and approval process.

Note that this determination does **not** indicate IRB "approval." *Do not include statements for publication or otherwise that the SU IRB has "reviewed and approved" this study*; rather, say the SU IRB has identified the study as "Not Human Subjects Research (NHSR)." Please retain this letter with your study files.

If your project alters in nature or scope, please contact the IRB right away. If you have any questions, I'm happy to assist.

Best wishes,

Andrea McDowell, PhD
IRB Administrator

cc: Dr. Jeanne Lowe, Faculty Adviser; Molly Engle, Co-Investigator, Country Doctor Community Clinic

COUNTRY DOCTOR COMMUNITY HEALTH CENTERS

Quality Improvement Project Charter

Project Title: Standardizing Substance Use Screening And Increasing Access To SUD Treatment Through a Pilot intervention of the SBIRT tool
Project Lead: Sydney Berkman RN, Lianabell Soto-Silva RN
Project Sponsor: Lorraine Hoover (QI), Molly Engle (BH)

Description	
Aim Statement	Standardize screening for drug and alcohol use. Increase access to harm reduction counseling and referral to treatment.
Brief Project Description	Develop a pilot to standardize drug and alcohol screening and access to harm reduction-based counseling and treatment through use of the SBIRT tool.
Current Situation	There is no standard screening or workflow in place for patients who endorse drug or alcohol use.

Goals and Measures		
How will we know a change is an improvement?	Our specific aims are to increase drug and alcohol use screening rates for 18 and older patients from 0% to 25% by March 2022 (goal 1), and to offer a brief intervention and/or referral to treatment to at least 50% of the patients who screen positive (goal 2)	Measures: Project metrics will include whether the screening form was completed by 18 and older patients present for office visits with a participating provider (metric 1) and whether a brief intervention/referral to treatment was offered to patients who screened positive on either the AUDIT or DAST (metric 2). Project metrics are directly related to the project aims of increasing drug and alcohol use screening rates for 18 and older patients from 0% to 25% by March 2022 (goal 1), and to offer a brief intervention and/or referral to treatment to at least 50% of the patients who screen positive on the AUDIT or DAST (goal 2)

Scope

COUNTRY DOCTOR COMMUNITY HEALTH CENTERS

Boundaries	Includes: Two providers at CDCC Two Provider at CDFMC 5 RNs trained for SBIRT intervention Entire BH team trained for SBIRT intervention All patients >18 who see a participating provider	Excludes: All non-trained clinical staff All patients under the age of 18 or patients seen by non-participating providers
Constraints	Data collection must be complete by March 15, 2022	

Project Team Members	
Name	**Role**
Lorraine Hoover	QI Manager
Molly Engle	BH Manager
Glenna Martin	Addiction Medicine Program Director
Sydney Berkman	Addiction Medicine RN
Lianabell Soto-Silva	Triage RN

Appendix E

Substance Use Recovery Resources in King County

Important Phone Numbers

Washington Recovery Helpline: 1-866-789-1511
SAMHSA hotline: 1-800-662-4357
Country Doctor Addiction Medicine Line: 206-299-1666
Carolyn Downs Addiction Medicine Line: 206-299-1999
King County Crisis Connections: 866-427-4747
King County 211: 800-621-4636

- Housing, financial, and food assistance

Outpatient Treatment Options

Outpatient Medication options for OUD and AUD
Country Doctor and Carolyn Downs: see numbers above

- Vivitrol and Depade (Naltrexone) for AUD and OUD
- Suboxone (Buprenorphine-naloxone) for OUD

Therapeutic Health Services: 1-833-278-HELP, several branches in greater Seattle area

- Methadone for OUD
- Suboxone for OUD
- Counseling

Valley Cities: 253-833-7444

- Suboxone for OUD
- Intensive outpatient treatment

UW at Harborview: 206-744-9657

- Suboxone for OUD
- Mental health medication management

Evergreen Treatment Services: 206-223-3644

- Multiple locations in King County
- Suboxone for OUD
- Methadone for OUD

DESC: 206-464-1570

- Suboxone for OUD

Inpatient Treatment and Detox

Swedish Addiction Recovery: 206-781-6048

- Primarily for expecting mothers, sometimes have beds for general admission

Valley Cities/Recovery Place Seattle: 206-731-7213 and 206-731-7193

- 3-5 day detox, option for inpatient 30 or 60 day treatment
- Typically have beds available in 1-3 days
- 24 Hr Crisis Line: 866-427-4747

- Takes all insurance

Cascade Behavioral Health: 206-248-4787

- Accept CHPW and Medicare

Schick Shadel: 206-244-8100

- Private insurance only
- Inpatient option is counter-conditioning (poor evidence)

Other Resources

STEP Clinic

- Suboxone for OUD
- HIV and Hep C testing
- Needle Exchange

King County Needle Exchange, several locations: 206-263-2000

- Needle exchange
- Abscess/wound care
- HIV and Hepatitis testing

The People's Harm Reduction Alliance: http://phra.org/hours

- Multiple locations as well as mail order option
- Syringes, needles, smoking kits

Recovery Cafe: https://recoverycafe.org/

- Programming, resources, and support
- In person and virtual/phone support offered

SMART recovery: smartrecovery.org

- To find a specific meeting or location: https://meetings.smartrecovery.org/meetings/location/

12-step model:https://seattlena.org/meetings/

For finding a counselor:

Psychologytoday.com

Openpathcollective.com