

Screening, Brief Intervention, and Treatment in a Latina Immigrant Prenatal Clinic

by

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Abstract

Problem & Purpose: Babies born in Maryland found with drugs in their systems has increased 57.6 percent in the last 9 years. The American College of Obstetricians and Gynecologists recommends universal screening for substance use disorders at first prenatal visit. Substance use disorders are usually interrelated with other behavioral health issues requiring more comprehensive screening at primary care sites for better screening and treatment success. The use of a Screening, Brief Intervention, and Referral to Treatment (SBIRT) protocol combined with motivational interviewing (MI) has shown success in earlier identification and more successful referrals of behavioral health issues. The aim of this MAP-IT guided (Mobilize, Assess, Plan, Implement, Track) quality improvement project is to educate, better detect, and successfully refer out a Latinx immigrant prenatal patient population with suspected behavioral health issues to specialty behavioral health treatment centers to decrease negative long term behavioral health issues occurring in the community.

Methods: Implement an SBIRT protocol for behavioral health. Train and use MI techniques when interacting with patients; support patients throughout the specialty referral process by being present and using same-day appointments; increase education about of behavioral health issues and their treatment; and track behavioral health issues from the clinic to the specialty referral site.

Results: During the 12-week implementation period, four patients were identified with behavioral health issues with one patient being successfully referred to county behavioral health.

Conclusions: The Latinx immigrant culture stigmatizes behavioral health. Increasing education and trust for behavioral health treatment must be a focus. Prenatal clinic employees should be trained in MI techniques and cultural engagement to successfully engage in patient collaboration for behavioral health issues. Repeated behavioral interventions are needed to increase the motivation needed to accept treatment. Behavioral health experts embedded in prenatal clinics would help make referrals and treatment more successful.

Introduction

The U.S. is experiencing a public health crisis that continues to escalate. Between 2005 and 2014, the national rate of opioid-related hospitalizations increased 64% and death rates increased with over 42,000 Americans dying of opioid overdoses in 2016 (Lyden and Binswanger, 2019).

The U.S. health care system is fragmented when it comes to SUD (Substance Use Disorder) prevention and treatment. There is no universal substance screening and treatment process (Wright, et al., 2016). This fragmentation leads to inconsistent screening, treatment and referral processes. SUD screening is even less consistent with pregnant women. Moyer, Johnson, Klug, & Burd (2017) found that pregnant women admitted to EDs (Emergency Departments) were 75% less likely to be screened for opioid use disorder than non-pregnant women when capturing ED admissions over a six-year period of time (2010-2016), covering 61,222 ED visits by women of child-bearing age.

ACOG (American College of Obstetricians & Gynecologists), ASAM (American Society of Addiction Medicine), and SMFM (Society for Maternal-Fetal Medicine) have all called for the universal use of SBIRT at the earliest encounter (ACOG, 2017). Substance use disorders are a subset of behavioral health and other behavioral health problems are often comorbid and/or contributory to SUDs leading to adverse health outcomes. An integrated approach is needed. SBIRT has been shown to not only be effective in SUD detection and referral, but also in depression (Dwinnels, 2015) and other behavioral health disorders. Implementation of a well-formulated SBIRT plan which incorporates not just substance use disorders, but also mental health issues can help prevent patients from falling through the cracks and being inadequately served by treatment programs (DiClemente, et al., 2012).

The purpose of this DNP project was to implement a QI project that implements SBIRT in a Latina immigrant prenatal clinic to better identify and successfully refer mothers with behavioral health issues to appropriate behavioral health treatment, resulting in better health outcomes for both mother and developing baby.

Literature Review

Many, large population, pre/post SBIRT studies have concluded that SBIRT is effective at improving behavioral health outcomes and referral rates in primary care settings. One of the largest was conducted in 2017 (Aldridge, Linford & Bray) by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). It included over 17,575 patients culled from various primary care sites (cohort 1) that was evaluated before and after implementing SBIRT for 6 months. It was found that SUD severity was significantly reduced, quoting a large effect size, and that greater BI intensity and frequency was correlated with greater decreases in SUD severity outcomes. BIs, an integral part of SBIRT, have been shown to help increase the success of specialty treatment referrals in many other studies over the years. More recently, Schwarz, et al. (2019) examined 609 clients. They wanted to study whether embedding alcohol MI experts in within a primary clinic would increase the success rate of referrals and enrollment into long-term (defined as greater than 18 months) SUD programs. Although only 6% of patients from the study were found to be enrolled in outpatient treatment at the 18-month follow-up, most of those had been in the cohort that received repeated BIs. This is not surprising to those that support the Recovery Management (RM) model of behavioral health which posits that it can take two or more years of continuous interventional support and checkups, along with integrated community recovery services to being to see consistent, sustained improved health outcomes that will off-set the initial costs (Dennis, et al., 2014).

Although there are encouraging studies of SBIRT helping to improve SUD outcomes, there are unique challenges with the prenatal population. A qualitative study by Petersen, et al. (2015), showed that negative health staff attitudes toward pregnant women identified with SUDs affected this patient population's willingness to disclose issues and hampered truthful assessments. Language, gender, and cultural differences between providers and patients can decrease the effectiveness of SBIRT. Understanding and addressing these barriers is crucial for successful SBIRT implementation (Williams, et al., 2015).

There are a few, high profile studies have questioned the effectiveness of SBIRT. In 2014 study by the American Medical Association, Byrne, et al. (2014) concluded that a brief behavioral intervention with telephone booster had no effect on reducing drug use in a primary care setting. They concluded that widespread adoption of SBIRT for drug use in primary care was questionable. Since then, many experts, including physicians specializing in behavioral health, have pointed out flaws with that study. University of Maryland, Baltimore assistant professor, Dr Fornili (2016) posits that focusing on outcomes after a one-time, brief behavioral intervention of clients is not realistic "treatment" for an SUD, especially if it is severe. Many other experts, including an official position paper by SAMHSA (SAMHSA, 2014), state that the study had missed the purpose for incorporating SBIRT. SAMHSA points out that introducing SBIRT in primary care is not meant to treat SUDs in the primary care setting, but rather to enable earlier detection, create greater insight in patients about recognizing behavioral health issues, and create an environment at primary care sites conducive for more successful referrals to treatment earlier, thereby addressing these kinds of problems before it becomes more difficult to treat later. Another flaw with these kinds of studies stem from the misunderstanding that brief behavioral interventions are treatment. In fact, BIs are not intended to successfully treat patients

who have a moderate to high severity behavioral issues, rather repeated BIs are meant to help move a patient from a stage of pre-contemplation to accepting referral to treatment. A more detailed summary of the major studies used in the implementation of this project can be found in Appendix A, table 1. Universal adoption of SBIRT in all primary care sites is a proven and well-researched way to ensure an integrated, evidence-based approach for earlier detection and more successful referrals to treatment of behavioral health disorders.

Theoretical Framework

The Recovery Management (RM) model (White & Kelly, 2011) is the theory that informed this DNP project implementation. RM is a middle-ground theory founded on recovery-oriented addiction treatment. According to Fornili (2016), the RM model uses “recovery” as the phenomenon of interest focusing resources and processes on a recovery “continuum” rather than a single episodic “fix”. The RM model’s focus on recovery is derived from a rich knowledge base garnered from specifically and practically addressing the difficulties of treating chronic, severe SUDs. Another tenant of the RM model is the recognition of the primary care provider fulfilling the role of being the continuous locus of interaction (White & Kelly, 2011). There is a responsibility by the primary care provider to be a source of encouragement, engagement, cultural sensitivity, and facilitator in appropriate treatment referrals. Patients with behavioral issues may enter and re-enter into specialty services, and the primary care provider must understand the obstacles to treatment and recovery engagement for that patient. The SBIRT + RM model supports an acceptance of behavioral health as a critical factor in successful health outcomes. A hallmark of the RM model is supporting and empowering the client to engage with long-term community Recovery-Oriented Systems of Care (ROSC), not just traditional hospital and/or clinic services. According to SAMHSA (2010), a ROSC is a “coordinated network of

community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.” Traditional medical care tends to have episodic or limited-time structures where a patient is treated until detoxed or a patient “graduates” a treatment program. The “treatment” then ends and the patient is left on their own even though it is highly unlikely that they are “cured” of the disease with a single treatment. This method of treating mental and behavioral health issues do not mirror the actual needs of most patients with these kinds of issues. Primary care providers must be educated about RM+SBIRT in order to create the urgency and support needed to fully integrate behavioral health services within primary care sites along with long-term, community-based support to improve overall health outcomes.

Methods

This QI project took place at a prenatal clinic open from 9am to 4pm, Monday through Friday. Patient population statistics were provided by clinic RN manager who gathered the data along with three MA’s over the 12-week project implementation. Approximately 90% of the patient population consisted of undocumented immigrants from various south and central American countries with median age of 25. There were approximately 15 patients seen per day with 422 new patients seen during the project implementation. The inclusion criteria included all seen prenatal clinic patients. The clinic staff was composed of an obstetrics and gynecology physician (OBGYN) clinic director, a masters-level registered nurse (MSN RN), and three to five, 6-month contracted (OBGYNs). The RN clinic manager and the three MAs all spoke Spanish and originated from central and south American countries which helped with interacting with the clinic population. The clinic RN manager did all psycho-social assessments, BIs and

referrals during the project. Most of the OBGYNs were not bi-lingual and did not share a similar culture as the clinic population which was an identified barrier to fully implement SBIRT with input and participation from the physicians.

The main changes implemented by this QI project was as follows: Addition of ACEs questionnaire (Appendix A, figure 1), use of MI techniques, further education of patients on culturally predominant mental health, performing three-to-five-minute MI-based behavioral interventions for those positively identified, and tracking of mental health referrals. The SBIRT process map is summarized in Appendix A, figure 2.

A series of four educational videos was used to illustrate SBIRT and demonstrate the use of MI-informed BIs (Maryland SBIRT resources, n.d.). This was followed by an interactive role-playing session to apply the techniques (see Appendix A, table 2). A class was held presenting RM model theories and goals. Total time for training was approximately two hours over two sessions for four hours total. The RN clinic manager was trained who in turn, trained the three medical assistants. Physicians were informed but did not take official training. If future employees needed to be educated on these topics, the public video websites used (Maryland SBIRT, n.d.) was available as well as project materials. Motivational interviewing scripts were also available for reference and future trainings. The two-hour sessions were done over 2 weeks. The positive screening instrument (appendix A, table 3) was included in the written standard operating procedures (SOP) for the clinic for future reference and use.

Implementation of the DNP QI project was over a 12-week period of time, from September 13th to November 22nd, 2019. There was a pre-post qualitative assessment of the implementation from the viewpoint of the clinic employees with suggestions for improvement.

Data collection and analysis tools included the behavioral issue audit (Appendix A, table 3) and data was analyzed using a run-chart plot (Appendix A, figure 3). Baseline data was unknown since MI-informed BIs had not been done and behavioral health issue occurrences and referrals had not been previously tracked.

No human experiments or medication treatments were performed for this project. Patient information was contained within the prenatal clinic. Safeguards included password protected, encrypted storage of patient encounters and records, including physical safeguarding of written materials behind closed doors attended by clinic personnel educated about HIPPA requirements. At night, materials were locked away in the RN clinic manager's office and also additionally locked in metal file cabinets with key access held by clinic staff only. Approval for this DNP QI project was obtained by the hospital's institutional review board (IRB) and the University of Maryland, Baltimore's IRB for a Non-Human Subjects Research (NHSR) before implementation.

Results

Four patients were positively identified as having behavioral health issues over a 12-week period with one successful referral in the last week of the project (Appendix A, figure 3). A successful referral was confirmed by the patient showing up for treatment at the Montgomery county behavioral health clinic. It was believed that the increased focus and education about mental health issues combined with practicing repeated behavioral interventions using MI techniques in a culturally focused and sensitive way led to the willingness of the patient to seek treatment.

Several barriers and initial errors in project conception became apparent after implementation. The original concept of the "warm handoff" was counterproductive for this

population. The “warm handoff” concept was to convince the patient to see treatment if an issue was detected and set up the appointment in the same session that a possible problem was discovered. Unfortunately, the first patients reacted to this by becoming alarmed and withdrawing from further interactions in this area and many did not show up to the clinic again. The “warm handoff” was quickly abandoned in favor of using MI techniques to develop greater rapport with the patient, educate about behavioral health symptoms and consequences down the road, and to motivate the patient to commit to further clinic visits in order to have the chance for repeated behavioral health interventions. These repeated interventions would lead to greater divulgement and insight to avoid premature referral to treatment.

The key facilitator for this project was the RN clinic manager who suspected underlying behavioral health problems were present that were not being fully explored and addressed. She was responsible for all the psycho-social assessments for the clinic and was aware of the cultural stigmas and attitudes of the clinic patient population to mental health treatment and wanted tools to better educate and address observed behavioral health misconceptions and symptoms.

Discussion

The percentage of patients (1.1%) that were positively identified as exhibiting behavioral health symptoms fell far below expectations. Mental health disorders during the perinatal period appear to be relatively common with a 12-month prevalence of 25.3% for pregnant women (Vesga-Lopez, et al., 2008). Additionally, antenatal and postnatal depression can affect up to 42% of migrant women compared to 10–15% of native-born women (Collins, et al., 2011; Miskurka et al., 2012). Central American immigrants were 76% more likely to have experienced a traumatic event than non-Latino Whites (Holman, et al., 2000) and links between PTSD and depression has long been acknowledged (Creamer, et al., 2001).

The difference in expected versus actual detection rates may be due to not being able to address the many barriers that exist for this population. There is ample evidence that Latinx in need of mental health care underutilize mental health services compared to non-Latinx Whites (Cabassa, et al., 2006; Perez-Stale, et al., 1990; Simon, 2002). Many immigrant and ethnic minority families demonstrate reluctance to utilize mental health services, unfortunately leading to poorer quality of care (Pham, et al., 2016). A lack of insurance, finances and ignorance of how the healthcare system works and what is offered, the paperwork process, transportation issues and language barriers also are significant. Cultural isolation, stigmatization and lack of education about behavioral health, and perceived risk of deportation, especially in these politically charged times can help to discourage further attention to themselves by utilizing specialty care services. Lara-Cinisomo, et al. (2019) found that more than 40% of perinatal immigrants had fears of being deported. Finally, fear of child protective services if any behavioral health issues were admitted to was also found to be a fear. A unique barrier present in the project setting was the timing of behavioral health screenings at the prenatal clinic. Most immigrant patients were celebrating the beginning of a new and brighter future for themselves and their expectant child after successful immigration to the U.S. This jubilant time may temporarily mask mood symptoms. In fact, De Maio and Kemp (2010) have observed that there is an initial healthy migrant effect for mental and physical health that then deteriorates over time.

The population and implementation was unique to this clinic and the qualitative nature of the “treatment”, short project length, the low number of detected cases, low number of patients with repeated BIs, and the many barriers present doesn’t allow for this project to be generalizable.

Conclusion

Sustainability of this project is high. The RN clinic manager who performs the clinic's psychosocial assessments has incorporated the new processes into her job. Cost was free. The state has also set aside grant money specifically for introducing and supporting SBIRT in primary care settings. However, once the clinic RN manager leaves, the project will probably not be sustained without the participation and support of the physicians and upper management.

One tool that was utilized in this project that has implications for improved identification of patients with behavioral health issues was the use of the Adverse Childhood Events (ACEs) questionnaire (Appendix A, figure 1). This tool was used in addition to the standard psychosocial history taking in order to focus identification of mothers who may have a higher probability of suffering from a mental health problem (Atzl, et al., 2019). A patient who scored ≥ 4 was automatically given a brief behavioral intervention including further education and more careful assessment. The discussion of the dose-dependent correlation between ACEs score and cardiac health was also useful in illustrating to patients how unaddressed stressors can affect a patient's physical health and the future health of their children. Then talk of possible coping strategies and referral to behavioral health experts for more education could be more easily introduced.

To improve success and sustainability of future projects, the entire staff that interacts with patients should be educated on MI techniques and continuously practice them. Acceptance of the value of an SBIRT process by the physicians and upper management is essential to success. The RM model is a useful in guiding the development of future SBIRT QI projects. Closer integration of behavioral health and primary care is needed. Embedding behavioral health clinicians (social workers, psychiatric nurse practitioner, and/or psychiatrists) within the prenatal clinic site would be an ideal way to more quickly improve the assessment, education, and smooth

transition of patients into evidence-based treatment compared to the separated silos of care common today.

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Appendix A

Table 1
Evidence Review Summary

Author, year	Study objective/intervention or exposures compared	Design	Sample (N)	Outcomes studied (how measured)	Results	*Level and Quality Rating
Aldridge, Linford & Bray, 2017	Pre-post SBIRT implementation analysis of SUD outcomes	Data were obtained from the Services and Accountability Improvement System (SAIS). Baseline data for substance use gathered 6 months pre-SBIRT introduction and compared to same data 6 months post SBIRT implementation. All behavioral interventions used motivational interviewing techniques by MI experts utilizing transtheoretical model of change	754,525 patients where 171,921 screened positive for SUD and received behavioral interventions and/or referred for specialty treatment. All patients were medically stable adults entering a SAMHSA cohort 1 medical site from 2004-2010.	SBIRT screening results (DAST, AUDIT, & ASI-Lite data as well as EHR assessment), discharge status, and SBIRT services performed and planned. Substance screening done on 1 st encounter and last 30 days of use six months post-1 st encounter.	Statistically significant results with large effect size. Prevalence of alcohol use was lowered by 35.6%, heavy drinking by 43.4%, and illicit drug use by 75.8%. Greater intervention intensity and frequency was associated with greater decreases in substance use.	Level II Quality B

		and FRAMES model approach.				
Everett-Murphy, et al., 2010	A quasi-qualitative study evaluating effect of five A's (SBIRT-like process) on smoking cessation in antenatal clinics in Cape Town, South Africa	Baseline cohort (TAU=prescriptive recommendation to quit smoking by provider and nurse) was compared to intervention cohort (intervention was 15-20min counseling at the antenatal clinic by midwives utilizing ACOG 5A's and MI principles and techniques gained from two 2-hr MI training sessions with role playing evaluations.	N=979 pregnant, self-revealed smoking women volunteered for the study. 443 were assigned to the control group and 536 were assigned to the behavioral intervention group	Primary outcome measured was quitting which was verified by cotinine level below 100ng/ml. Secondary outcomes measured were self-reported cessation, reductions, or attempts at quitting smoking.	Difference in quitting between the two cohorts 7.7% (p<0.0001). There were almost no quitters in the control group. Women in the intervention cohort that did not quit had reduced their cotinine levels by half compared to 16% in the control cohort. Women in the cohort group also reported significantly more attempts at quitting compared to the control cohort indicating that an attitude change had happened towards attempting a behavior change and accepting assistance.	Level: II Quality : B
Madras, et al., 2008	SAMHSA initiated pre-post SBIRT implementation study across 6 sites in 6 states and in a variety of	All sites screened for alcohol and illicit substance use through questionnaire. BIs were done for those that screened moderate severity substance misuse,	N=459,599. Selected consecutively by each site using universal screening instruments. 72,954 (15.9%) were positive for low severity and had brief behavioral interventions, 14,498	Positive scores on AUDIT, DAST, CAGE-AID, ASSIST, 4Ps, or CRAFFT were followed-up by assessing severity of	Among those with reporting baseline illicit drug use, rates of drug use at 6-mo follow-up were 67.7% lower and heavy alcohol use was 38.6% lower. Significant self-reports of improvement in general health, mental health, employment, housing status,	Level I Quality B

	<p>patient settings comparing intake vs 6-month follow-up of changes in illicit drug use compared to pre-SBIRT baseline</p>	<p>while those that self-reported more than 5 drinks at a sitting within last 30 days and/or any heavy or frequent illicit substance use within 30 days were referred to treatment. Brief interventions were performed differently at all 6 sites with all doing FRAMES, some adding MI, some doing one session, while others did multiple sessions.</p>	<p>(3.2%) were moderate severity and given brief behavioral treatment, while 17,053 (3.7%) were referred to specialty treatment</p>	<p>substance misuse. Comparison of severity category at baseline and 6-mo follow-up, plus narrative of changes to health and behavior regarding substance use, and</p>	<p>and criminal behavior were reported among those that had brief behavioral interventions, behavioral treatment, and/or attendance to specialty treatment as compared to baseline (no SBIRT process, no behavioral interventions, no referral follow-ups).</p>	
<p>Schwartz, et al., 2019</p>	<p>Investigate if brief behavioral interventions result in greater attendance of alcohol tx compared to TAU</p>	<p>Single-blind RCT in Denmark of consecutive adult patients of a large public hospital scoring 8+ on AUDIT split into 2 groups: control group (TAU{ educated about substance use by</p>	<p>N=6102. Included all adults consecutively added to study that had an AUDIT score of 8+ (n=609). Included members were alternated between TAU group or Relay group consecutively.</p>	<p>18-month follow-up of alcohol treatment enrollment in the community after discharge from hospital</p>	<p>Significantly more patients in the relay group sought alcohol treatment versus the TAU group. However, long-term treatment enrollment success was still low overall with only around 6% of positively screened patients enrolled at 18-month follow-up</p>	<p>Level II. Quality : B</p>

		<p>non-behavioral expert (usu. nurse or provider) and the other (Relay group) that had a brief behavioral intervention done by expert alcohol therapist using motivational interviewing techniques with encouragement to follow-up with community assistance.</p>				
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Note. Melnyk, B.M. & Fineout-Overholt, E. (2014). *Evidence-based practice in nursing & healthcare: A guide to best practice* (3rd ed.). New York: Lippincott, Williams & Wilkins.
 TAU= Treatment as Usual

Figure 1

ACEs questionnaire

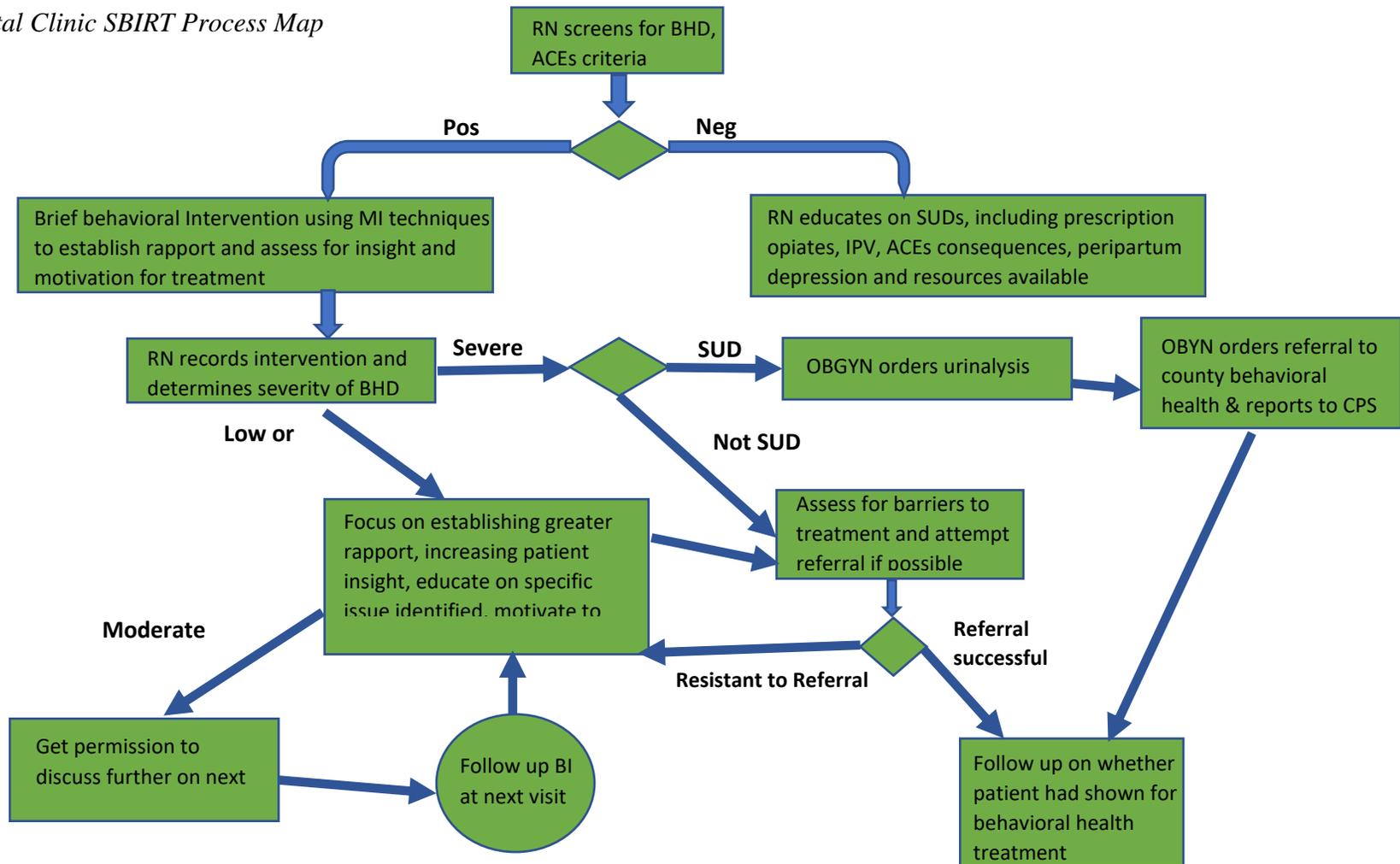
Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
No ___ If Yes, enter 1 ___
2. Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
No ___ If Yes, enter 1 ___
3. Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
No ___ If Yes, enter 1 ___
4. Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
No ___ If Yes, enter 1 ___
5. Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
No ___ If Yes, enter 1 ___
6. Were your parents ever separated or divorced?
No ___ If Yes, enter 1 ___
7. Was your mother or stepmother:
Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
No ___ If Yes, enter 1 ___
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
No ___ If Yes, enter 1 ___
9. Was a household member depressed or mentally ill, or did a household member attempt suicide? No ___ If Yes, enter 1 ___
10. Did a household member go to prison?
No ___ If Yes, enter 1 ___

Now add up your "Yes" answers: _ This is your ACE Score

Figure 2

Prenatal Clinic SBIRT Process Map



BHD: Behavioral Health Disorder
 SUD: Substance Use Disorder

Figure 3

Behavioral Health Issues Identified & Successfully Referred

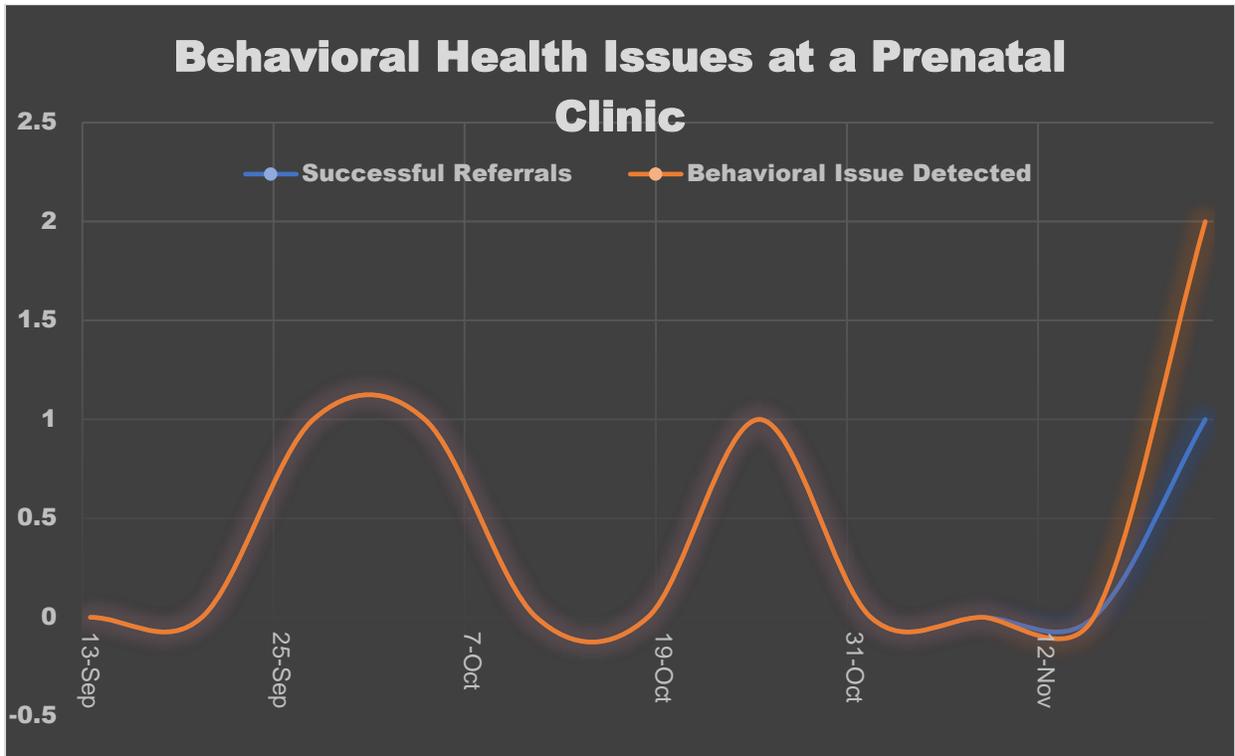


Table 2

Staff Education Plan

Learning Objectives	Content Outline	Method of Instruction	Time Spent	Method of Evaluation
SBIRT familiarity	Maryland SBIRT overview	Video	30 min	Post video Q&A
BI using MI techniques	Instruction by MD Behavioral Health and actual BIs observed	Video	40 min	Post Video Q&A
RM model theory & resources	Importance of ROSC & PRSS Familiarize with community PRSS & ROSC resources	Class powerpoint presentation	20 min	Post class Q&A
Mock BI	Run through BI utilizing typical patient encounter behaviors	Class using active participation	30 min	Observation & feedback

Table 3

Behavioral Health Audit

Pt ID #	Date of Encounter	Disorder & severity (Low/Med/Hi)	BI done?/ By who?	BI duration	Stage of Change	Referred?	Xfer POC info	# of BIs	Successful contact?
2356	23-Feb-18	Alcohol - Med	Y/Ms R.	10min	1	Y	240-777-1323/Ex Sxxxxxxxxx	2	Y

Notes:

MI Stages of Change: 1=Precontemplation, 2=Contemplation, 3=Preparation, 4=Action

Referred means that the patient accepted referral to outside treatment

of BIs: BIs are successful when they are repeated so the number of total BIs should be recorded for that encounter date

Successful contact? Whether the patient was able to be contacted for follow-up info after agreeing to outside treatment