



OCTOBER 2015

Vol. 27, No. 10; p. 109-120

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## Hourly rounding is key contributor to patient-centered care at high-performing hospitals

*ED experts are big proponents of rounding, but note the practice must be done effectively and consistently to get results*

**H**ealthcare experts talk a lot about the importance of delivering “patient-centered” care, but how do hospital and ED administrators move the needle on such an elusive target? Researchers from Johns Hopkins University decided to seek answers to this question by investigating the practices used by 52 of the hospitals with the highest scores on the Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS), the survey that is commonly used to gauge patient impressions of their hospital experience.

“There have been many studies trying to explore this topic mainly in outpatient settings, but very little has been done within the hospital environment,” explains **Hanan Aboumatar**, MD, MPH, the lead author of the research, an assistant professor of medicine at Johns Hopkins University School of Medicine, and a member of the Johns Hopkins Armstrong Institute for Patient Safety

and Quality in Baltimore. “Patients and families are very overwhelmed in the hospital. So many things are happening, they might have a lot of questions, there might be some concerns and major decisions to be made. Thoughtful attention to how care can be delivered in a better way is really needed.”

Through interviews with organization leaders and medical personnel at high-performing hospitals, investigators came up with a series of core best practices they say are most associated with patients reporting their needs were a priority during their hospital or ED stay, and that they had a positive experience.

When it comes to improving responsiveness, the practice most commonly cited was proactive nurse rounding, reported by 83% of the queried hospitals.

“This involves every nurse on the unit passing by every one to two hours, checking on the patients, making sure they are not in any pain, repositioning them, helping them to get to the

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ISSN 1044-9167, is published monthly by AHC Media, LLC  
One Atlanta Plaza  
950 East Paces Ferry Road NE, Suite 2850  
Atlanta, GA 30326.  
Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.

**POSTMASTER:** Send address changes to:  
ED Management®  
P.O. Box 550669  
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restroom, and asking them if they need anything else," Aboumatar observes. "When you employ something like that, obviously it is very hard initially to implement; it is in some ways a change of practice, because typically we are more reactive than proactive in these types of services."<sup>1</sup>

While Aboumatar's study refers to rounding in all areas of the hospital, the concept is certainly not new to ED administrators, although many experts concur that it can be particularly challenging to make the practice stick in the fast-paced ED environment. Nevertheless, there is also wide agreement that when done effectively, regular rounding in the ED can provide a powerful booster shot to anemic patient satisfaction scores.

## Reset patient expectations

"Creating some sort of model where we are purposefully going into the rooms on a regular basis and touching base with the patients resets their expectations, and then really demonstrates to the patients that we care about them and that we are there for whatever needs they might have on a proactive basis," explains **Eric Heckerson**, EdD, RD, FACHE, a health coach for the Nashville, TN-based Health Stream Engagement Institute.

When teaching the practice to healthcare professionals, Heckerson says he commonly uses an aviation analogy.

"If I am on the tarmac waiting to take off, I would much rather hear from the pilot every once in a while [to say], 'here is where we are, here is what is going on,' [and that] we haven't been forgotten," he says.

"This just gives us an expectation about where things are going as opposed to wondering, because no information makes people wonder what is going on. Is something wrong? Did they lose me?"

A common criticism of rounding is that it takes too much time away from frontline clinicians who are already overburdened with important clinical tasks. However, Heckerson maintains this is not really the case.

"It actually saves time by making sure patient needs are handled more proactively rather than reactively," he notes. "If you go into a room and purposefully check on what they need, and just really quickly mention what is on the white board, and ask whether there is anything else that you can get for them before you leave, there is an opportunity for patients to [get their questions answered] right then and there as opposed to being on the call bell in a few minutes."

Heckerson says he has worked with many busy EDs all over the country and has yet to see one where clinicians are too busy to round regularly on patients. However, he recommends involving ED technicians and other personnel in rounding to spread around the responsibility.

"Nurses round at the top of the hour and the techs round on the half hour," he says. "That way, we know everyone is touching base with patients on a regular basis."

Some of the high-performing organizations in Aboumatar's study reported they would play music on the hour as a reminder to staff that it is time to round on patients. Heckerson is less of a stickler about the precise time interval between rounds in the ED as long as staff are rounding on a regular basis.

## Get leaders involved

Heckerson acknowledges achieving buy-in for regular rounding is a challenge. He recommends administrators spend as much time as possible on the “why” when presenting the concept to staff.

“It has a very nice effect on the patient experience,” he says. “But [it’s important] to help staff understand that is not the only reason [to round].”

For example, Heckerson recommends spending time talking about the impact regular rounding can have on patient safety and quality, because these issues resonate with ED personnel. However, even a good presentation about rounding, along with early staff buy-in, will not be enough to cement the practice into the daily routine for long, he acknowledges. To do that, Heckerson advises all leaders participate in rounding.

“I like to see the senior leaders — the C-suite — round in the ED on a regular basis. Not every day or all the time, but if the staff sees senior leaders rounding ... they say, ‘OK, I think I have to play my part in that, too,’” Heckerson notes. “That is the way I teach it. You teach the leader rounding first, and then you go to the staff rounding.”

Indeed, in Aboumatar’s study, 62% of the high-performing organizations who were queried about their practices employed leadership rounding. Aboumatar stresses they weren’t referring to traditional executive rounds, where an executive might appear in the unit once a month as part of an executive improvement team.

“This was much more intimate engagement where the leaders view [rounding] as part of their job, and they are held accountable for doing

## EXECUTIVE SUMMARY

According to new findings, hospitals with the highest HCAHPS scores suggest that hourly rounding on patients is one of the best ways to elevate the patient experience.

- In a survey of top-performing hospitals, 83% reported they employed the practice of regular nurse rounding on patients, and 62% employed leadership rounding.
- When rounding on patients, experts suggest nurses should always consider pain, the plan of care, and duration, or “PPD.”

that part of their job, and they build ways to make sure they can do that part of the job,” Aboumatar explains. “We were seeing organizations where leaders [were booking on their calendars] one or two hours every day to round.”

Aboumatar notes this kind of engagement changes priorities.

“It says to the people in the hospital that our leaders are much more engaged with us,” she says. “It allows for channels of communication that were not there, so they can hear people close up, whether that involves the patients or the frontline clinicians with whom they are interacting.”

### Address pain, plan of care, duration

**Stephanie Baker, RN, MBA,** CEN, the emergency services division leader for the Studer Group, a healthcare consulting firm based in Pensacola, FL, says rounding in the ED is about PPD: pain, plan of care, and duration.

“If you look at the key drivers across the country for the ED patient perception of care and what is going to help people feel engaged and satisfied with their experience — those are really the top three drivers,” she says.

“Patients care about pain

management in the ED, they want to know what is going to happen, and they want to know when, so every hour an ED nurse should certainly check on patients and make sure that if any patient has pain that they are managing that pain,” she explains.

For instance, nurses should gauge whether patients are experiencing more or less pain since they last provided them with medication, and they should consider any other comfort measures that should be taken to address pain, Baker explains.

“If the patient has an ankle sprain, obviously they need to ice and elevate,” she says. “Acuity will drive how frequently we should see our patients. Obviously, sicker patients are going to need more frequent attendance than once per hour, but if we are talking regular ED patients who are fairly stable, then the research shows that [once per] hour works well and that patients respond well to that.”

Patients also need to be updated at least once per hour on what their plan of care is in terms of where they are in the process and what they can expect in the next 60 minutes, Baker notes.

“If we reset that clock for the patient about every hour, that shows compassion, it shows we care about them as a person, it keeps them informed, it reduces their anxiety,

and it helps them feel involved,” she explains.

Baker encourages staff to be specific when discussing lab timeframes.

“Don’t say the labs will be back in a little bit because [patients] don’t understand that. They think that means 20 minutes and we think it means an hour and a half, so we really encourage [ED personnel], as they are talking about a plan of care, to talk about a reasonable duration and also to use real time to do that.”

In addition to addressing PPD, Baker stresses that before leaving a patient’s room nurses should always ask patients if they have any questions or if there is anything else they need.

“A lot of the high-performing EDs we are coaching and working with — even though they may still have patients who are in the ED for three or four hours — they can still maintain at about the 90th percentile on patient perception of care if they are using the rounding [process] very specifically and keeping patients informed,” Baker explains.

## Commit to full training

With such results, why do many EDs struggle to implement rounding? Baker suggests many hospital and ED administrators underestimate the amount of training and follow-up that are required to cement rounding into routine practice.

“People say, ‘let’s start rounding on people,’ and the next day they try to roll it out, and it rolls out poorly,” she explains. “A lot of times there is not adequate training.”

The training should cover what the purpose of rounding is, as well as what the practice brings to the table in terms of patient safety, efficiency, and the patient experience. However,

Baker notes that personnel also need to see and experience how effective rounding should be done.

“We don’t just say, ‘go out there and round.’ We actually take [ED personnel] through simulations, and we show them what ‘right’ looks like, and we perform validations with them, so they walk away with competency,” she explains. “You are not going to get success in the outcomes you want if you simply ask

**ONCE FULL TRAINING HAS TAKEN PLACE, LEADERS NEED TO TAKE RESPONSIBILITY FOR MAKING SURE STAFF MEMBERS ARE ROUTINELY ROUNDING ON PATIENTS, AND THAT THEY ARE DOING IT EFFECTIVELY.**

patients how it is going. That is not an hourly round; you don’t get any benefit from that and results can, in fact, decline.”

Once full training has taken place, leaders need to take responsibility for making sure staff members are routinely rounding on patients, and that they are doing it effectively; they can do this by regularly rounding on patients themselves, Baker offers.

In fact, Baker says when she rolled out hourly rounding in her own ED, she rounded on patients every day, asked them when they last saw their nurse, and what the nurse shared with

them while in the room.

“This gave me validation that not only had I trained the staff [effectively], but that the patients were feeling it and that they were able to articulate that it was happening,” she explains. “Then I would share that [patient feedback] with the staff during huddles every day. You have to have a ‘trust but verify’ system.”

Baker suggests that when people fail at implementing hourly rounding, it is usually because they have not committed to full training or they have not provided accountability feedback.

“If you are not sharing results about whether [the team] is getting better or not, people tend to fall back to what they know and do,” Baker says. “When you are rolling out behavioral tactics [like rounding], you have to treat them just like clinically technical tactics. You are not going to let someone put in an IV line if they don’t know how to do it ... you are not going to leave it to chance.”

While Baker is a big proponent of hourly rounding, she notes that it should not necessarily be the first step that struggling EDs take to improve the patient experience.

“If your staff are not explaining things [well to patients] or using a white board, you’ve got to go back to basics before you can even think about having success with more specific and targeted rounds,” she says. “I always tell leaders this is not the first tactic to roll out.”

How can you tell that rounding is making a difference? It is difficult to pinpoint the impact of any one particular tactic, Heckerson notes.

“People always ask me what the secret is to [improving the] patient experience, and I am not sure there is any one thing,” he says. “I think tools and tactics act in synergy.”

For example, calling to check

on patients after they have been discharged is almost an extension of the rounding concept, Heckerson offers. In Aboumatar's study, more than half (54%) of the high-performing organizations surveyed reported that they performed post-discharge phone calls to patients.

A process of calling patients after discharge requires a team effort. At time of discharge, it is a best practice to have the discharge nurse or technician advise the patient (or family) that a follow-up call may be received, and to confirm a correct phone number. Otherwise, many phone numbers obtained during the registration process turn out to be inaccurate, and the process fails in a high percentage of attempts.

"You have people checking pretty regularly on you when you are in the ED, and then you go home and get another phone call," Heckerson says. "Organizations that are really knocking it out of the park are the ones that have figured out ways of doing both of those things ... but it is really hard to quantify [the impact] of any single tactic."

Aboumatar's findings lend credence to this view.

"These [high-performing] organizations moved beyond thinking about [a high-level] patient experience as a nicety," she observes. "They thought about it in a different

way, in a way that is much more tied to the mission and what they are all about."

In this context, the patient experience relates to tasks such as making sure that every patient understands what you are telling them, that they know how to take care of themselves when they return home, and that they have the help they need after discharge, Aboumatar notes.

AT TIME OF DISCHARGE, IT IS A BEST PRACTICE TO HAVE THE DISCHARGE NURSE OR TECHNICIAN ADVISE THE PATIENT OR FAMILY TO EXPECT A FOLLOW-UP PHONE CALL AND TO CONFIRM A CORRECT PHONE NUMBER.

"It changes your perspective about the importance of ... improving

the experience of people in your hospital entirely," she says. "All the [high-performing] organizations we have talked with have really worked on multiple levels and employed multiple strategies to get from a place where there is less attention to patient centeredness of care delivery to a place where they are really performing highly in terms of the patient experience." ■

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## SOURCES

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## Challenges remain for ED-based screening program adept at identifying hepatitis C

*Experts suggest EDs with effective HIV screening programs in place are likely best positioned to offer hepatitis C screening, although frontline staff may resist additional tasks*

While use of emergency settings for screening purposes remains controversial, it is hard to ignore the potential opportunities they present for public health intervention.

With effective, new treatments now available for hepatitis C — the most common chronic blood-borne infection in the United States — some inner-city EDs are moving on

the opportunity to identify the vast numbers of patients who are infected, estimated to be around 3 million, and connect them to care.

Building on earlier work in this

area, investigators at Highland Hospital in Oakland, CA, are among the latest to test a hepatitis C screening protocol in the ED, and early reports on this effort reveal a striking public health opportunity.<sup>1</sup> Targeting screening toward the 10% of the ED population considered most at risk for hepatitis C, researchers found slightly more than 10% of these patients tested positive for hepatitis C antibodies in the six-month study, and 70% of these patients were confirmed to be chronically infected with the disease. The researchers found that only 24% of the patients who tested positive for hepatitis C were aware that they were infected.<sup>2</sup>

However, while researchers uncovered a significant need for intervention, they also report coming up against a number of challenges — both in introducing the screening protocol in the ED and in linking the infected patients to appropriate care. Nevertheless, while investigators now

have industry funds to support the screening program, they're hoping to fine-tune the process to the point where it can be self-sustaining. Further, they note some of the roadblocks that have long prevented hepatitis C screening programs from being viable in the emergency setting are now a thing of the past.

## Anticipate some staff resistance

The protocol investigators devised involves targeting patients considered at high risk for hepatitis C, such as baby boomers, IV drug users, and patients with an unspecified liver disease. Questions about such risks were embedded in the triage process. However, the approach encountered early trouble.

“The nurses were very concerned about privacy and talking about sensitive issues, such as IV drug use, in a non-private setting,”

explains **Sara Pfeil**, BS, the program coordinator of the hepatitis C screening initiative in the Department of Emergency Medicine at Highland Hospital and a co-author of the hepatitis C screening study. “The nurses were afraid of making patients uncomfortable.”

Investigators looked at the issue in some sub-studies and found the nurses' perceptions of how patients were feeling were more negative than what the patients were actually feeling, Pfeil adds.

However, she notes there was also some pushback from nurses who were concerned about time.

“There is pressure to complete the triage-per-patient [process] at our site in six minutes, and the nurses were concerned that adding additional questions to the screening they already ask in their intake and triage process would slow that down and negatively impact ED flow,” Pfeil explains. “On average, the [hepatitis C screening questions] add 30 seconds to one minute to each triage, which can add up, but not appreciably.”

On the physician side, there was no pushback at all to the screening program, but that doesn't necessarily mean the introduction of hepatitis C screening programs at other ED facilities would be as readily accepted by physicians.

“We have more than a decade of experience of integrating public health interventions like this,” explains **Douglas White**, MD, the lead author of the study and director of both HIV and hepatitis C screening in the ED at Highland Hospital. “HIV is what we have the most experience with. We have some of the first physicians in the country to perform large-scale HIV testing, disclosing HIV results and linking HIV patients into care, so being able

## EXECUTIVE SUMMARY

In a six-month study, investigators evaluating an ED-based screening program for hepatitis C have found that when they target screening toward groups deemed most at risk for the infectious disease, more than 10% of those who accept testing do, in fact, test positive for hepatitis C. However, nurses offering the screening have concerns about protecting patient privacy as well as slowing down the triage process. Further, there are multiple barriers involved with ushering patients through the required testing algorithm and linking those who test positive for the disease to care.

- Groups targeted for screening during triage include baby boomers, IV drug users, and patients with an unspecified liver disease.
- Investigators say adding the hepatitis C screening questions at triage adds 30 seconds to one minute to the process.
- While improvements in testing have enabled EDs to integrate hepatitis C testing into the normal lab workflow process, many patients are discharged before test results return, creating barriers for disclosure and linkage to confirmatory testing.
- With limited appointments available for specialty hepatitis C care, patients must typically wait several months before seeing a specialist.

to layer on hepatitis C testing was not a challenge for the physicians,” he says. “Obviously, it is additional work, and it was new, so additional education needed to happen, but the physicians weren’t a barrier in this roll out.”

## Leverage improved testing processes

However, White acknowledges it is generally outside the scope of the mission of most EDs to take on screening when the primary focus is to take on more immediate life-threatening medical illnesses.

“There is that whole concept of changing the culture and thinking about the scope and mission of an inner-city ED,” he says.

Further, White adds that ED administrators interested in developing hepatitis C screening programs should consider the numerous technical challenges involved.

“Integrating screening is impractical in the sense that it takes time and it requires resources in terms of staff,” he says. “You need to dedicate time in order to complete the offering process and the actual testing process, and then you have all the challenges involved with disclosing results while integrating that entire process into standard ED operations when your primary aim is taking care of people with acute medical complaints.”

Along with these challenges, though, White observes that advances in testing have made a big difference in facilitating the screening process in a sustainable manner.

“The hepatitis screening test as well as the HIV screening test that we perform are now fully integrated into the laboratory system and automated

so we are no longer performing them at the point of care,” he explains. “They are actually managed completely in house by the laboratory, and the results are automatically populated into our electronic medical record (EMR) system, so that takes a lot of the burden out of the testing process for us.”

Such improvements have enabled the ED to integrate testing into the normal blood draw, which is part of routine practice in the ED, and the results are delivered just like the results of any other lab test, White observes.

**THE ED INTEGRATED TESTING INTO THE NORMAL BLOOD DRAW, WHICH IS PART OF ROUTINE PRACTICE IN THE ED, AND THE RESULTS ARE DELIVERED JUST LIKE THE RESULTS OF ANY OTHER LAB TEST.**

“In the past ... some places had dedicated testing staff and it was treated very differently than other ED processes, and now that you can [fully] integrate it into the lab workflow I think has normalized [the testing process],” he says.

## Understand the limitations

In the study, while the hepatitis

C testing process was greatly streamlined, the time it took to complete laboratory testing proved to be a major obstacle. Investigators report that it typically took between 60 and 90 minutes to receive results back from the lab. While that is not such a long turnaround time for an ED, as many as half the patients who underwent hepatitis screening were already discharged by the time their results came back, and that was a huge issue, according to White.

“If a patient is discharged, you can’t disclose the result. It is that simple,” he explains.

“About a third of our ED patients who get triaged are funneled into the fast-track area, and those patients have an incredibly quick turnaround time,” White notes. “Say these patients accept screening and the test gets ordered and performed ... no one in fast track, for the most part, has a 1 or 2 hour visit. They are very short visits, so testing in specific areas of the ED where we know [the visits] are going to be faster, like in the fast track, will always be a barrier to results disclosure.”

This is a challenge that EDs interested in setting up hepatitis screening programs need to be aware of, White stresses.

“You have to know this is a limitation if you choose to screen in settings where patient turnover is fast,” he says. “There needs to be a mechanism in place for contacting these patients.”

The protocol at Highland Hospital did not require investigators to track down patients who received negative results. Instead, investigators focused their efforts on finding patients with positive results so they could arrange for confirmatory testing.

“These antibody tests need to be confirmed in a second blood test to determine what proportion of the

patients actually have chronic active hepatitis C, and this is a step that is a barrier and a challenge,” White says.

Pfeil concurs, noting that completing the testing algorithm on patients who were discharged before receiving their initial lab results presented early obstacles.

“We had a huge drop-off where we had a lot of antibody-positive patients who we tried to call back to redirect ... using a secondary clinic or going directly to phlebotomy [and then] to the lab with a slip that Dr. White would write to get their confirmatory tests performed,” she says. “That was the first breakdown — bringing people back in who didn’t get their confirmatory tests done at their initial ED visit.”

## Use the EMR to your advantage

White observes that staff had to be creative in figuring out ways to get patients back into the system, and one way they did that was by leveraging the department’s EMR.

“A lot of our patients use the ED [repeatedly], so we actually created an alert in our EMR. If a patient came back to the ED who hadn’t had their initial results disclosed or who needed a confirmatory hepatitis C test, the system would alert the provider,” he explains. “We were able to achieve [confirmatory] testing and linkage to care — but not always on that index visit. Sometimes it happened on a patient’s next encounter or even the third encounter in the ED.”

In this case, patient recidivism turned out to be very helpful for a number of antibody-positive patients, Pfeil offers.

“There was quite a large burden of work to try to get those confirmatory test results and to try to get people

back into the ED,” she says. “We would call patients and a lot of the phone numbers were non-working numbers, and it was really difficult to track patients down that way. We also had a letter system in place for patients with non-working phone numbers that we integrated into our protocol.”

When tests confirmed a patient had a chronic hepatitis C infection, intervention staff eventually worked out a system where they could schedule the patient to be seen in the hospital’s hepatitis C clinic.

**“HAVE EVERYONE AT THE TABLE IN THE PLANNING... EVERYONE IN THE SYSTEM NEEDS TO BE ON BOARD. IF YOU HAVE MULTIPLE LAYERS OF CARE PROVIDERS INVESTED, FEWER PATIENTS WHO TEST POSITIVE WILL FALL THROUGH THE CRACKS.”**

“We have five slots per week [for direct booking] into the clinic, which we did not have originally,” Pfeil notes. “Our hepatitis C clinic is new and up and coming, so we have kind of reached a critical capacity.”

White agrees, noting that the prevalence of hepatitis C is so high that the ED screening program quickly exceeded the capacity of the clinic’s ability to care for these patients.

“There is no doubt about it. Once they opened up slots, we filled them. They are now filled through the beginning of next year with patients waiting to go to the hepatitis C clinic,” he observes.

Fortunately, with hepatitis C most patients do not need to receive immediate treatment.

“It is not an absolute necessity that these patients be treated today or even tomorrow,” White notes. “The majority can be treated at some point in the future, so we do have a little time in terms of getting these patients into care and treatment. That is generally how we look at it.”

## Plan ahead, collaborate

While the six-month study at Highland Hospital has concluded, the screening program for hepatitis C is ongoing with funding through Gilead Sciences, the Foster City, CA, biotechnology company responsible for developing Sovaldi and Harvoni, two of the new treatments for hepatitis C.

“We are really trying to refine the model so that it is sustainable, but what is really clear after doing this [for a year and a half] is that the challenges with linkage to care are so great that we don’t recommend taking on a program [like this] without a supplemental workforce to handle [that aspect],” White advises. “Right now, it is too big a challenge to be integrated into most ED processes.”

White adds there may be some systems already in place in some settings that can handle at least part of the workload.

“Look at the healthcare environment you work in and take advantage of the existing systems,” he says.

White also stresses that a successful program needs to be collaborative.

“Have everyone at the table in the planning, from all ED personnel who are going to be involved to referral systems to the hepatologists who are going to be taking care of the patients and the primary care practitioners (PCPs) who may be the intermediaries,” he says. “Everyone in the system needs to be on board. If you have multiple layers of care providers invested, fewer patients who test positive will fall through the cracks.”

White envisions a push toward the education and training of PCPs to be the referral physicians for hepatitis C patients.

“It may be that a patient doesn’t require ongoing care by a liver specialist in order to receive treatment,” he says. “Expanding the capacity of PCPs to provide treatment will offset some of the work challenges of linkage.”

Pfeil stresses that an effective mechanism for connecting patients with specialty care needs to be in place before screening begins.

“You will be inundated with hepatitis C-positive patients almost immediately, so it is crucial to have a linkage-to-care protocol that you know will work before implementing screening,” she says. “Have personnel on board who can help in that

process ... and make sure the testing algorithm happens as seamlessly as it can so linkage will be easier on the back end.”

## Consider population needs

The EDs most prepared to initiate hepatitis screening programs are those that already have successful HIV screening programs in place, much like the ED at Highland Hospital, White observes.

“It is almost like a parallel process. You are layering on a second screening intervention,” he says. “Programs that have the tools and the experience in place for HIV screening can very easily add on hepatitis C screening.”

However, even in these cases, White adds that there is often a challenge in convincing ED administrators and the people on the front lines responsible for doing the work.

“They are always leery about one more intervention, one more thing to screen,” he says. “There is always a concern of when it will end in terms of adding more work and responsibility to the ED.”

While it is clear the prevalence of hepatitis C in the population is already quite high and threatening to surge even higher, given the exploding

problem of IV drug abuse around the country, the patients most likely to benefit from hepatitis screening programs are probably those who frequent safety net hospitals, White says.

“We just don’t have enough cumulative experience doing hepatitis C testing at this point to make recommendations on who should and who shouldn’t adopt screening programs.” ■

## REFERENCES

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## SOURCES

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# Brief motivational interventions to reduce excessive drinking, intimate partner violence fail to positively impact outcomes

*Investigators say results clarify the need for more intensive, long-term solutions for patients with multiple risk factors*

**N**ew findings lend credence to concerns that ED-based brief

motivational interventions for heavy drinking may be less effective in

women and victims of violence. The latest evidence comes from a large,

randomized clinical trial that tested a program that aimed to reduce incidents of excessive drinking and intimate partner violence (IPV) in women presenting to the ED. Investigators found that women who received a brief motivational intervention in the emergency setting followed by a reinforcing phone call did not experience fewer days of heavy drinking or incidents of IPV than women in control groups.<sup>1</sup>

While the new data conflict with some earlier studies that found brief interventions to be effective in reducing both alcohol consumption and preventing injuries among women who engage in hazardous drinking, the results suggest researchers should develop and test more comprehensive solutions, according to **Karin Rhodes, MD, MS**, the lead author of the study and director of the Center of Emergency Care Policy & Research in the department of Emergency Medicine at Perelman School of Medicine at the University of Pennsylvania in Philadelphia.

“Our study results clarify that identification and brief interventions alone will not be adequate to change the course of relationship violence and heavy drinking,” she observes. “Patients with multiple risk factors will likely need much more intensive interventions for longer periods of time.”

## IPV, excessive drinking decline

The trial was conducted at two Philadelphia-based academic medical centers between January 2011 and November 2013. Out of a total of 600 eligible participants, 242 were randomized to receive

## EXECUTIVE SUMMARY

Findings from a large, randomized clinical trial suggest that the use of an ED-based motivational intervention is not sufficient to reduce incidents of heavy drinking or intimate partner violence (IPV) among women who present to the ED. Investigators have found that while heavy drinking and incidents of IPV declined in all groups being evaluated, the intervention, which involved a 20- to 30-minute motivational interview by a masters-prepared social worker and a follow-up reinforcement call, did not make a difference in outcomes. Investigators conclude that more comprehensive solutions are needed.

- Participants for the study were recruited from two urban-area EDs in Philadelphia between January 2011 and December 2014. Patients were randomized to an intervention group or one of two control groups.
- At one year post-enrollment, nearly half (45%) of all the study participants reported no incidents of IPV in the previous three months, and the researchers found that 22% of all participants were consuming alcohol at safe drinking levels. However, there was no evidence that the intervention influenced outcomes.
- Investigators recommend EDs set up routine screening to identify IPV and co-occurring psychosocial risk factors, and train social workers and IPV advocates to perform safety assessments and provide referrals for more intensive, evidence-based interventions that are tailored to the patient’s needs and goals.

a 20- to 30-minute motivational intervention delivered by masters-level therapists in the emergency setting. Investigators report the approach borrowed from ED interventions designed to target both drinking and risky driving, and that the goal of these sessions was to identify self-reported reasons for change and personal goals. Further, during the sessions therapists would attempt to get patients to draw the links between their alcohol use and incidents of IPV and help them move toward positive behavioral changes. The sessions were followed by a telephone “booster” call from the same therapist about 10 days after the original ED visit.

Both the intervention group and a second group of 237 participants who did not receive the sessions with therapists underwent interviews upon enrollment and weekly assessments for 12 weeks.

Also, follow-up measures were recorded by telephone at three, six, and 12 months. Additionally, 121 participants in a third “no contact” control group were assessed at three months.

At 12 weeks, the researchers report that excessive drinking — or the consumption of four or more drinks per day — and incidents of IPV declined in both the intervention group and the control group in which participants were only referred to social service resources.

Further, over time, investigators found that incidents of IPV and heavy drinking declined significantly in the intervention group as well as both control groups. For example, at one year post-enrollment, nearly half (45%) of all the study participants reported no incidents of IPV in the previous three months, and the researchers found that 22% of all

participants were consuming alcohol at safe drinking levels. However, there was no evidence that either the intervention or the frequent assessments that took place in one of the two control groups had any influence over these outcomes.

## Patients have unmet needs

Why didn't the intervention have more of an impact? Rhodes suggests part of the problem likely relates to the prevalence of psychosocial problems in the study participants.

"As an emergency physician, I have spent years trying to improve routine patient psychosocial screening and ED provider-patient communication about behavioral risks that impact patient health outcomes," she explains. "I have identified that patients at urban academic medical centers have a high degree of unmet need."

For instance, Rhodes notes that many of the patients screened at the study sites reported experiencing too much stress, depression, and use of tobacco. Additionally, nearly half reported one or more adverse financial circumstances, such as not having enough food, not being able to see the doctor, cost-related medication non-compliance, or housing instability.

"We found a significant graded relationship between the number of adverse financial circumstances and patients' poor/fair self-rated health, depressed mood, high stress, smoking, and illicit drug use," Rhodes notes.

"The findings from psychosocial health risk screening underscore the imperative for hospital-based social workers to design models of routine social health risk screening and

system interventions that address patient financial and social well-being."

A number of studies have examined the impact of having the medical providers themselves engage in motivational interviewing to help nudge patients toward changing a behavioral risk factor. Could involving the medical providers in the intervention in this case have made a difference in the study results? Rhodes suggests most of these earlier studies focused on a single risk factor and much less advice from the medical provider.

"The model for those interventions is 'Ask-Advise-Refer,' and even that is difficult to integrate into routine ED practice," she says. "We tried to do a much more intensive, high-quality motivational interview (MI) targeted at both risk factors, and we recorded the interviews to make sure our therapists were doing an excellent job of motivational interviewing."

Rhodes adds that emergency providers would need to undergo a lot of extra training to accomplish what the therapists, who were trained IPV-MI social workers, were able to do during the study. Further, even if medical providers wanted to provide the type of intervention that was provided during the study, it would be impractical for them to do so in the emergency setting.

"Emergency providers do not have the time for 20- to 30-minute motivational interviews," Rhodes observes. "The flow and acuity of the ED makes this too difficult."

However, Rhodes notes ED physicians, nurses, and administrators can establish routine screening to identify IPV and co-occurring psychosocial risk factors.

"Also, train social workers and IPV advocates to perform safety assessments and provide referrals for more intensive, evidence-based interventions that are tailored to the patient's needs and goals," she advises, suggesting there is room for improvement on many different levels.

"I am still interested in designing and testing new models of routine psychosocial screening and social worker response as one part of a broader system of interventions that address psychosocial health and mental health issues in vulnerable populations," Rhodes adds. ■

## REFERENCE

1. Rhodes K, et al. Brief motivational intervention for intimate partner violence and heavy drinking in the emergency department. *JAMA* 2015;314:466-477.

## SOURCE

- **Karin Rhodes**, MD, MS, Director, Center of Emergency Care Policy & Research, Department of Emergency Medicine, Perelman School of Medicine, University of Pennsylvania, Philadelphia. E-mail: karin.rhodes@uphs.upenn.edu.

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## CME/CNE QUESTIONS

- 1. Three key drivers for the ED patient perception of care and what is going to help people feel engaged and satisfied with their experience are:**
  - A. pain, plan of care, duration of visit.
  - B. care quality, environment, efficiency.
  - C. provider personality, organization, efficiency.
  - D. none of the above.
- 2. The reason why so many EDs struggle to implement hourly rounding is:**
  - A. lack of resources.
  - B. not enough staff.
  - C. inadequate training.
  - D. nurse resistance.
- 3. How many minutes does it typically take to receive results back from the lab on hepatitis C screening tests?**
  - A. 30 minutes
  - B. 2 hours
  - C. between 60 and 90 minutes
  - D. 24 to 48 hours
- 4. According to a randomized clinical trial testing the impact of a brief motivational intervention on incidents of heavy drinking and intimate partner violence among women who present to the ED, one of the reasons why the intervention did not influence outcomes likely relates to:**
  - A. the prevalence of psychosocial problems in the study participants.
  - B. the lack of time to carry out interventions in the ED.
  - C. inexperienced therapists.
  - D. pushback from providers.