



Management

Best Practices – Patient Flow – Federal Regulations – Accreditation

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Giving patients control over their pain medicines boosts patient and provider satisfaction.

Great strides have been made in the treatment of sickle cell disease, the inherited blood disorder that occurs most commonly in African-Americans. Patients with the disease used to die before reaching adulthood, but today many patients live well into their 40s and beyond. However, experts point out that sickle cell patients often have a difficult time getting the treatment they need when they present to the ED for care.

“Sickle cell disease is a chronic, life-long illness with acute episodes of pain that are really severe,” explains **James Eckman, MD**, director of

EXECUTIVE SUMMARY

Patients with sickle cell disease commonly experience episodes of extreme pain that prompt them to seek care in the ED. However, emergency providers sometimes mistake these patients as drug-seekers, delaying effective pain relief and often resulting in under-treatment that can prolong suffering and result in repeat visits.

- Experts recommend development of specialized sickle cell protocols that fast-track patients toward the care they need, and give patients some control over how much pain medication they need.
- Experts say ED-based sickle cell protocols can improve patient and provider satisfaction while also reducing repeat ED visits as well as length-of-stay when patients need to be admitted.
- New research suggests that ED use spikes as sickle patients reach adulthood.
- Experts say ED providers can play a role in helping these patients transition into effective primary care settings.

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the Georgia Comprehensive Sickle Cell Center at Grady Memorial Hospital in Atlanta. “When patients go into pain, they usually treat it at home, but when that doesn’t work, they tend to go to the ED, and EDs are really busy. The waits to get in and actually to be seen are often quite long.”

Another issue may then compound the suffer-

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ing that sickle cell patients face while awaiting care. “These patients are primarily presenting with extreme pain but no other physical findings or lab changes to indicate whether or not they are in a crisis, so they are commonly not believed,” adds Eckman. “This is really one of the main issues that causes difficulty with the disease — not only for the patients because they are suffering from pain, but also for health care systems because they really have a great deal of difficulty dealing with these patients in the ED.”

Grady has eliminated this problem by creating an emergency clinic specifically for the management of sickle cell disease pain. It is open 24/7 so sickle cell patients who are experiencing a pain crisis can simply bypass the ED and go straight to the emergency clinic. “We offer eight hours of intensive treatment with pain relief and IV hydration,” says Eckman. “About 80% of the time that is adequate so that the patients can then go home on oral therapy. If it is not, and their pain is too great, then we admit them to the hospital.”

While most EDs do not see enough sickle cell patients to warrant a separate emergency clinic just for these patients, some hospitals have taken steps to optimize care for these patients so that they don’t suffer the indignity of not being believed, and they don’t have to wait two or three hours for the analgesic therapy and IV hydration they need to relieve their acute pain.

Implement a protocol

For example, **Matthew Lyon, MD, RDMS**, the director of the observation unit in the ED at Georgia Health Sciences Medical Center in Augusta, GA, has developed a protocol so that all sickle cell patients who present to the ED with pain will be sent directly to the observation unit for treatment as soon as any potential complications related to sickle cell disease are ruled out. The approach is designed to eliminate treatment delays and improve management of the relatively large population of sickle cell patients in the Augusta area.

Lyon, who has been fine-tuning the protocol for years, developed the approach because he observed evidence that many sickle patients were being treated as if they were drug-seekers when they presented with true pain crises. “Sickle cell patients kind of get lumped into that group of patients because they don’t exhibit pain the way you or I would,” he explains, noting that many of these patients have lived with pain their entire lives.

A sickle cell pain crisis typically lasts for 10 to 14 days, but what used to happen is that patients presenting to the ED in severe pain would be under-treated. “If you under-treat their pain in the ED, and then the pain goes on more than a few days, then they end up coming back,” says Lyon. “Then they look like they are seeking drugs when really they are just trying to find relief for their pain.”

To fix the problem, Lyon decided to use the observation unit as a tool to eliminate the opportunity for such judgments to impact care, and to standardize the way sickle cell patients are treated. As a result, the wait time for sickle cell patients who present to the ED with a pain complaint is now less than 15 minutes. “They are bypassing the normal processes because we know what is wrong with them, we already have a diagnosis, and we have already screened out most of the bad things, and so they are ready to be put on the treatment plan,” notes Lyon. “The quicker we can start them recovering from their pain, the quicker they can go home, which is really the goal — to decrease admissions and to improve their care.”

Give patients some control

Under the sickle cell protocol, the nurses in the observation unit will immediately start the patients on fluids, oral medications, and a patient-controlled pump for their narcotics. “That was an adjustment we made right at the beginning, and the reason for [the patient-controlled pump] is so that the patients can control how much pain medication they are receiving,” says Lyon. “They are not over-dosed or under-dosed, and they are not having to listen to someone tell them that they don’t really think they are in pain. There is no one making that determination except the patient.”

With the pump, the patients get a continuous infusion per hour, although the machine limits how much they can receive. “Generally what you will see is that when someone comes in with acute pain, they will be pushing the button fairly rapidly, perhaps five to seven times per hour,” says Lyon. “As their pain comes down, they may only push it two times per hour, and then as their pain starts being well-controlled, they might not be pushing the pump at all.”

When the patients stop pushing the pump, they are generally ready to go home, but it is up to them to make the decision that they can handle their pain on their own with oral medications. “What we have found is that our typical

length-of-stay (LOS) for sickle cell patients is 16 hours,” says Lyon. “Most of the patients stay a little bit longer than they would in the regular ED. However, our admission rate with these patients is very low.”

Lyon aims for an admission rate that is below 15%, and he is generally able to keep it at about 12%. This compares very favorably to the 40% or 50% admission rate that results when sickle cell patients receive typical care in the ED, he says. “And there is a downstream impact, too. When our sickle cell patients are admitted from the observation unit, their admission LOS is about three days,” says Lyon, noting that the approach slices about two inpatient days off of what typically happens when sickle patients are admitted directly from a traditional ED.

While it can be difficult to provide these patients with the optimal dose of narcotics when they present to the ED with a sickle cell pain crisis for the first time, Lyon uses a database to track the care that each patient receives so that it can be used as a reference for future visits. “That allows us to give each of our patients an individualized dose so that every time they come in they will get the exact same dosage of meds,” says Lyon. “I adjust the dosages over time, but this takes a lot of the anxiety away from the patients because they know exactly what they are going to get every time they come in. They know what their situation is going to be and what is going to happen.”

Consider patient and provider satisfaction

Eliminating anxiety from the equation can only help these patients recover from their pain crisis more quickly, and they are also more satisfied with their care, says Lyon. “The providers are happier, too. Emergency physicians don’t have to feel like they are negotiating with patients,” he says. “This is taking a subset of patients and moving them into a controlled setting where the physicians don’t have to have any anxiety about under-treating or over-treating them. It is just part of the standardized pathway.”

What’s more, with the protocol in place, the nurses in the observation unit have become experts in sickle cell care just as they are experts in treating low-risk chest pain, another major pathway in the observation unit, says Lyon.

Roughly 50 sickle cell patients a month are treated in the observation unit at Georgia Health Sciences Medical Center. This is, in part, because Georgia Health Sciences University operates a

comprehensive sickle cell center and clinic nearby, and this draws patients from surrounding communities. However, Lyon believes his specialized protocol could work well in other EDs that may not see large numbers of sickle cell patients or even have observation units. In fact, he is currently using grant funding to help EDs in other communities put his protocol in place.

“I am going to places that don’t have sickle cell centers to set this up because I believe this is the best way to treat people,” says Lyon. “It is best for the patients, but it is also best for the health care systems. It can save them a lot of money from [the avoidance of] repeat admissions.” ■

SOURCES

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Study: Emergency providers can play a role in helping sickle cell patients transition into effective primary care as they reach adulthood

There is new evidence that people with sickle cell disease tend to rely more on the ED as they transition from pediatric to adult care. While sickle cell experts have observed this phenomenon for years, researchers at Washington University School of Medicine in St. Louis, MO, have unveiled data that strongly support this trend in ED utilization. The researchers analyzed the Medicaid data of more than 3,200 patients with sickle cell disease, and found that between the ages of 15 and 24, ED visits tripled in this group.¹

Less clear is precisely why ED visits begin to spike in the later teen years, but experts suggest

there are probably several contributing factors.

“In some areas, the lack of adult providers is a big issue for sickle cell specifically, and in other places, insurance sometimes changes once a child becomes an adult, and that is an issue,” explains **Morey Blinder, MD**, a hematologist and associate professor of medicine at Washington University School of Medicine. “It is also possible that for some of these people their disease is getting worse as they age ... so all of these problems crop up at the time of transition.”

James Eckman, MD, director of the Georgia Comprehensive Sickle Cell Center at Grady Memorial Hospital in Atlanta, says there is no question that sickle cell disease tends to act up in patients as they enter their late teens and 20s, and that this is playing a role in driving up utilization of the ED, but he notes that a large number of patients also lose their insurance just as they begin to have new problems with their disease.

“Many of these patients are covered by Medicaid until they are 18, and then when they become young adults, they lose coverage and, therefore, become dependent on the ED for health care,” explains Eckman. “Also, there are really many fewer adult physicians who specialize in hematology related to sickle cell than there are pediatric physicians ... so all of these factors tend to increase utilization of EDs and increase the fragmentation of care, which is not only a burden on the health system, but also often leads to poor health outcomes.”

Develop ties with PCPs who have sickle cell expertise

Blinder adds that many teenagers with sickle cell disease form such strong bonds with their pediatric caregivers that they really don’t want to transition to adult providers. “What my pediatric colleagues call this is a failure to lift off. These patients just are not able to break those bonds very easily because they are getting good care,” he says. The result may be that these patients end up using the ED rather than connecting with a provider who can oversee their care over the long term, says Blinder.

Transitioning to a new provider is never easy for someone with a chronic disease, and both Blinder and Eckman suggest that EDs have a strong role to play in helping to connect sickle cell patients with a provider who has the skills and experience to manage their disease and overall care on an ongoing basis. “We have started to incorporate [ED

providers] into our transition process, particularly for these patients who fail to lift off,” says Blinder. “Here in St. Louis, our ED has all the information that it needs to be able to help the transition along and put these patients in our adult [sickle cell] clinic. ED staff also have information on primary care physicians who are willing and able to take care of sickle cell patients.”

Similar efforts are under way at Grady Hospital in Atlanta. “Both the ED providers and the hospitalists who are discharging patients after they have been admitted really do have to develop some sort of mechanism to try and get these patients into primary care health maintenance activities and hopefully reduce their dependency on the ED,” explains Eckman. “We are trying to use primary care providers as a way of being able to partner these patients with ongoing health care, and then some of us who specialize in sickle cell disease are trying to figure out ways that we can support the primary care providers.” ■

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Collaborative effort in Washington state slashes non-essential use of the ED by Medicaid patients, delivering millions in projected savings

Emergency providers say the approach can work in other states, too, but a collaborative framework is key.

An unprecedented, state-wide effort aimed at curbing non-essential use of the ED by Medicaid recipients appears to be making an impact in Washington state. Preliminary results, including data from the first six months of the initiative, suggest the “ER is for Emergencies Program” is saving the state more than 10% in Medicaid fee-for-service emergency costs, and that accumulated savings could reach \$31 million in the program’s

first year, slightly exceeding initial goals. These findings are included in *Emergency Department Utilization: Assumed Savings from Best Practices Implementation*, a report to the Washington state legislature by the Washington State Health Care Authority (WSHCA), one of the groups that spearheaded the approach, along with the Washington Chapter of the American College of Emergency Physicians (WA-ACEP), the Washington State Hospital Association (WSHA), and the Washington State Medical Association (WSMA).

Other findings in the report include a 23% reduction in ED visits among Medicaid recipients with five or more visits, a 250% increase in the number of providers who have registered in the state’s Prescription Monitoring Program, a database designed to facilitate the identification of patients with narcotic-seeking behavior. In addition, the number of shared care plans, intended to improve care coordination for patients, has doubled, and the number of hospitals exchanging ED information electronically has grown from 17 to

EXECUTIVE SUMMARY

Early data suggest a coordinated, state-wide effort has reduced non-essential use of the ED by 10% among Medicaid recipients in Washington state, and is projected to save the state an estimated \$31 million in the first year of the approach. The effort includes the adoption of seven best practices by hospitals across the state. These include the creation of an Emergency Department Information Exchange, so that EDs can immediately access a patient’s utilization history, strict narcotic prescribing guidelines, and regular feedback reports to hospitals regarding ED utilization patterns.

- The effort was prompted by threats by the state legislature to limit Medicaid payments for ED visits deemed not medically necessary in the emergency setting. The legislature backed down when emergency physicians in the state countered with their own proposal to reduce non-essential use of the ED. They worked with other health care groups in the state to develop the plan.
- Data on the first six months of the effort are included in a report to the state legislature by the Washington State Health Care Authority. Among the findings are a 23% reduction in ED visits among Medicaid recipients with five or more visits, a 250% increase in providers who have registered with the state’s Prescription Monitoring Program, aimed at identifying patients with narcotic-seeking behavior, and a doubling in the number of shared care plans, intended to improve care coordination.
- Emergency providers say big challenges remain, including a need for more resources for patients with mental health and dental care needs.

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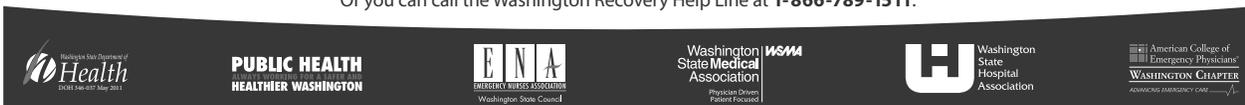


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85. (The full report from WSHCA can be accessed at www.hca.wa.gov/leg_reports.html.)

There is no question that this is an auspicious beginning for the program — particularly considering the contentious back and forth that prompted its creation in the first place. The state legislature had first threatened to limit Medicaid payments to EDs for visits or conditions deemed not medically necessary or appropriate for the emergency setting. The legislators backed down when the state's emergency physicians came up with the outlines of what became the "ER is for Emergencies Program."

Now that the approach is getting positive results, ED leaders and politicians in other states are eyeing the approach to see if a similar effort might work elsewhere. Indeed, in a news release coinciding with WSHCA's report on the program, Andrew Sama, MD, FACEP, the president of ACEP, called the effort a "model for the nation," and he noted the approach proves that medical providers can work together to improve patient care and save money.

Consider IT-driven communication tools

The "ER is for Emergencies Program" consists of seven best practices that were developed by

WA-ACEP, in collaboration with the other partnering groups. The seven best practices include:

- Adoption of an emergency department information exchange (EDIE) so that EDs can quickly share information about patient visits to other hospitals;
- Education for patients about appropriate use of the ED;
- A process for disseminating lists of frequent users so that they can be identified by the EDIE;
- A process to equip frequent users with care plans and assist them in getting in to see their PCPs within 72 to 96 hours of their ED visit;
- Adoption of strict guidelines for the prescribing of narcotics;
- Provider enrollment in a state Prescription Monitoring Program (PMP), so that providers can see in an online database what prescriptions have been previously filled by patients; and
- Regular review of feedback reports on ED utilization so that hospitals can take corrective action, where needed.

While there were certainly technical challenges on a global level across the state to get the EDIE up and running, implementation of the best practices at the hospital level was not too overwhelming, explains Nathan Schlicher, MD, the associate

medical director at St. Joseph Medical Center in Tacoma, WA, and a newly appointed state senator who is now on sabbatical from the ED so that he can attend the state's legislative session. "Getting the feedback reports is something that takes some getting used to, but I think they are useful," he says. "But [the seven best practices] were mostly things that physicians had wanted to see for a long time to make their jobs better, so getting people on board was not that difficult."

Julianna Yu, MD, FACEP, the section head for emergency medicine at Virginia Mason Medical Center (VMMC) in Seattle, WA, says physicians there were also mostly supportive of the seven best practices, although there were some initial concerns that implementation of the stricter guidelines for narcotic prescribing would increase the number of patient complaints. However, she explains that ample use of educational signage and patient handouts that explain the narcotic prescribing policy, as well as why it is important, have gone a long way toward easing these concerns. (*See patient handout, Fig. 1, p. 42.*)

"One of the things we were able to demonstrate through the education of patients and providers was that there has been a marked increase in overdose deaths from prescription narcotics," says Yu. "Having a lot of patient education visible in each of our treatment rooms, and having pamphlets and brochures to hand out to our patients at the time of the visit, have helped providers feel supported that they are really doing the right thing for our patients in the long run."

In fact, the overall impact of the seven best practices in the ED at VMMC has been a gradual *decrease* in patient complaints over the past year, and an improvement in patient satisfaction, says Yu. "I think once things were really in place and our providers felt more comfortable with the day-to-day implementation of the seven best practices, they were able to see the benefits," she adds.

In particular, Yu explains that the EDIE has been a valuable tool for conserving resources. "Since it is an information-sharing system between all of the Washington state EDs, it really helps EDs communicate with each other in a timely manner so that we can reduce over-testing and identify patients who are high-utilizers of emergency services," she says. "For example, if we have a patient who has been at a nearby ED, perhaps that same day, and has had blood work and X-rays done, we are able to access that information right away when the patient arrives, so we can discuss any concerns with the patient up front and reduce over-testing."

In addition, the state's Prescription Monitoring Program has strengthened opioid guidelines that VMMC had put in place in 2011. "We had some time even before the seven best practices to really start focusing in on that aspect of emergency care, but once the state policy took effect in mid-2012, it helped to insure we are prescribing narcotics appropriately from the ED," says Yu.

"We are able to pull up patient prescribing histories at the time of an ED visit."

Watch for unintended consequences

From the start of the approach, emergency providers have been monitoring the program's impact to make sure there are no unintended consequences from the effort, says Schlicher. "Right now, we haven't seen that. People are still able to get care," he says. "If anything, care is safer because patients who may have addiction issues or other reasons why they are shopping between hospitals are now receiving coordinated care, so they have stopped getting as many CT scans or other procedures than they were before we had any idea that they were shopping between institutions."

In fact, making sure that there are no unintended consequences going forward is one of the reasons why Schlicher is now serving a stint in the state senate. "I want to be there as a physician and patient advocate to make those [potential consequences] clear ahead of time so that we don't get into this kind of situation again," he says.

Further, while the seven best practices have had a positive impact to date, Schlicher emphasizes that there is still ample room for further improvement to emergency care. In particular, he stresses that the state has done "a very poor job" with respect to mental health. "We have a long way to go. There are some laws we need to clean up, we need to work on increasing funding for mental health, and we really need to see how we can better utilize the resources we have," he explains.

Yu agrees, noting that many patients with behavioral health needs have seen funding slashed for ongoing outpatient mental health care. "Many of these patients have a lot of social needs, so they are frequenting the ED, not necessarily for narcotics, but because they have struggles with coordinating their outpatient care, accessing follow-up appointments with their primary care providers, or getting regular refills for their chronic care medicines," she explains.

Emergency departments across the state are also still seeing patients with unmet dental care needs,

adds Yu. “Dental care is still a struggle for a lot of our patients,” she says. “So once we reduce their unnecessary use of the ED, we need to make sure that we have the appropriate outpatient resources available to these patients.”

While hefty challenges remain, Schlicher points out that there is now an infrastructure in place to assist stakeholders in working toward collaborative solutions. It is the kind of framework that he advises ED leaders and policy makers in other states to build. “I think it is really about building a coalition of the willing,” he says. “That is what we did. We got the hospitals and the medical associations together and we looked at this from the standpoint of: How can we improve our practice to deliver better patient care in a way that saves the state money? The elements that we came up with do all of those things.”

In the past, Schlicher notes that there were many instances in which health care organizations did not come to the table and propose a solution. “This time we did because we thought it was right and we wanted to try to rehabilitate a broken, strained relationship,” he says. “I think many ED providers struggle with that same challenge. I would just encourage them to look at the problem from a team work and collaborative basis rather than an adversarial one.” ■

SOURCES

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Experts: Despite time constraints, motivational interviewing techniques can have lasting impact on drinkers, drug abusers

The Brief Negotiation Interview (BNI) can lead patients toward healthy changes, but effective implementation requires training and practice.

Emergency providers are trained to deal with crises, but it can be frustrating to see the same

patients rotating through time and time again.

“When you are in the trauma room for months at a time and you are taking care of gunshot and stab wounds, and heaven knows what else, you rapidly learn that most of this is caused by substances,” observes **Gail D’Onofrio**, MD, FACEP, chair of the Department of Emergency Medicine at Yale University School of Medicine in New Haven, CT.

Not content to just keep placing a bandage on the situation, D’Onofrio has spent the past decade working with colleagues to fine tune a method for intervening with these types of patients so they stand a chance of actually making the kind of changes that will prevent a repeat visit to the ED. Her tool, the Brief Negotiation Interview (BNI), uses motivational interviewing techniques to try and elicit from patients reasons why they need to drink less, stop using harmful drugs, or to admit to themselves that they need to get help for an addiction.

This is the kind of thing that many emergency providers feel is beyond the scope of their practice to provide, but a research team led by D’Onofrio has shown use of the BNI by practitioners in the ED can bring about positive changes in problem drinkers.¹ And D’Onofrio says the same approach can be used with respect to drug abuse and other harmful behaviors that have health consequences.

D’Onofrio has, in fact, been using the technique for years, and she is well aware of the constraints that emergency physicians face. She is also accustomed to objections from busy providers that they simply don’t have the time to conduct the BNI, which takes about seven minutes to carry out.

EXECUTIVE SUMMARY

Researchers have found that the Brief Negotiation Interview (BNI), a tool developed at Yale School of Medicine in New Haven, CT, can curb harmful drinking in patients when the tool is used with these patients in the emergency setting. Further, by using the same motivational interviewing techniques employed in the tool, experts say providers can help patients curb other harmful behaviors as well.

- The BNI consists of a series of questions that take about seven minutes to discuss with patients.
- The tool prompts patients to come up with their own reasons for changing harmful behaviors.
- To implement the BNI, emergency providers need training and constant reinforcement.
- Ideally, experts say the motivational interviewing techniques employed in the BNI need to become routine to have a lasting impact on patient care.

“One of the strengths that I have is that I work in an ED that is horribly busy and chaotic, and people can see me do my job well and also be able to integrate some intervention into my care,” she says. “I am very reasonable. There are times when you can’t do the whole intervention. There are times when you can only do 30 seconds or a minute, but you can do part of it, and then you give patients referrals or handouts.”

Furthermore, D’Onofrio sees attitudes changing among emergency physicians who want to do more than just patch people up without making any attempt to address the underlying issues. “Emergency physicians like myself see this revolving door of problems,” she says. “And if you can do anything to get people into treatment or just raise their awareness that these things could be resulting from alcohol or drug use, then in the end, it is a benefit to emergency physicians. I think more and more people are learning that, and we are finding creative ways to deal with this.”

Ask for permission

It takes practice to engage in effective motivational interviewing, but D’Onofrio has observed that providers become adept at the practice relatively quickly. “Emergency physicians learn incredibly complex skills like putting chest tubes in, intubating people, and putting in central lines,” she says. “This is a skill like any other.”

The payback is that you can see patients start to switch on and listen to what the provider has to say, says D’Onofrio. To give an example of how motivational interviewing works, D’Onofrio uses the case of a patient who has been involved in a car wreck. The first step for the provider is to ask the patient for permission to discuss his alcohol use. “When you ask for permission, the patient almost always says yes — even if they say it grudgingly,” she says. The conversation can then proceed something like this:

Provider: Do you see a connection between your car crash today and your drinking?

Patient: *Look how bad the weather is tonight. See how bad it is?*

Provider: It is a bad night, so you can imagine what would happen if there is anything that is distracting you. Do you know that one drink for anybody decreases your reaction time? Is it possible that you didn’t see that car coming because of this?

Patient: *Well it is possible, I guess.*

Provider: OK, on a scale of 1 to 10, how likely are you to change any aspect of your drinking?

Patient: *I would say 3 or 4.*

Provider: That’s great. Thirty percent ready to change. Tell me some reasons why you didn’t choose a lower number? You must have had some reason to change.

Patient: *Because I got in this crash.*

Provider: This must be difficult for you with no car and a broken hand. What other reasons do you have to change?

Patient: *I am spending a lot of money on alcohol, and my girlfriend is mad at me. Also, when I am drinking I yell at my grandmother. I don’t like to yell at her. It upsets me.*

Look for opportunities to engage

Once the patient unveils his or her own reasons for changing, the provider can then lead the conversation toward meaningful steps the patient can take toward positive change. “We know that 7% of the time just having a physician advise a patient to do something will prompt that patient to do it, so just offering advice has some effect,” says D’Onofrio. “However, the key to this is asking the patient to identify reasons to change.”

Sometimes you will have patients tell you that they have no reason to change, but there is usually something you can use to focus the conversation, says D’Onofrio. “You listen to the patient and then you turn it around,” she says. “Sometimes people come in with a sexually transmitted disease, and my resident will ask them if it is possible that they didn’t use a condom because they were drinking. The reply is usually “of course.” This gives the resident an opening to discuss some reasonable limits that will enable the patient to make better choices, she explains.

Such conversations can generally be completed in a just a few minutes, says D’Onofrio, noting that providers need to take advantage of opportunities. “If you are putting a splint on or suturing, that is a great time to start talking to them while you are doing the procedure,” she says. “You can double-dip on your time.”

D’Onofrio realizes that there are times when the practitioner may have to make judgment calls about which patients to engage in this type of questioning, but she stresses that the goal should be to make it a routine task. “We want to normalize the fact that providers are asking about substance use and doing brief interventions as much as they

would ask about tetanus [shots],” she says. “That is such a normalized process that it is embedded in [an emergency provider’s] everyday life.”

Address barriers

There is no question that emergency providers are overwhelmed with responsibilities. “We are the front line, and the health care system is broken, so we do everything,” acknowledges D’Onofrio. “So one of the huge barriers [to implementing BNI-style interventions] is that physicians will say that if they identify something and it is really bad, they won’t have time to deal with it, so it is almost better not to bring it up.”

To counter such arguments, EDs need to have resources in place that providers can rely on to help with patients who have severe problems, says D’Onofrio. For example, the ED at Yale New Haven Hospital has health promotion advocates available who can help to connect patients directly with the care and services they need. “Physicians can do tons of this themselves when someone is harmful and hazardous, but not severe. When the patients are severe, you need someone who can help get them into a specialized treatment center, which is not easy,” says D’Onofrio. “You have to know what is available in your community, and you have to partner with these centers.”

Kerry Broderick, MD, FACEP, a staff physician in the ED at Denver Health Medical Center, and medical director of Screening Brief Intervention & Referral to Treatment (SBIRT) Colorado, has championed use of the BNI by both nurses and physicians, and she notes that having one or two health educators on hand is extremely helpful, especially if there is not a social worker involved or strong buy-in from the nursing staff and leadership. “Providers are afraid to get into [the BNI] without having someone to hand-off to,” she says. “Practicing a ‘tight’ BNI is also very important. Two minutes of some feedback may be all you can get from staff.”

Emergency providers commonly complain that there are no specialized centers in their community to deal with substance abuse problems, says D’Onofrio, noting that she has heard this specific argument often in her own ED in New Haven, CT. But she insists there are always some resources. “We have tons of centers in New Haven. People just need to get out there, and that is what health promotion advocates can help with,” she says. “Everyone has Alcoholics Anonymous and Narcotics Anonymous, at the very least. It is just a matter of trying to find them.”

Provide continuous reinforcement

Motivational interviewing techniques are not just useful with respect to substance abuse; they can be used effectively to discuss almost any type of behavior with patients, says D’Onofrio. Instead of scolding a diabetic who is not adhering to his medical routine, physicians might have more success asking the patient about his reasons for non-adherence, she says. “Then it will get better,” adds D’Onofrio.

However, for a BNI-based intervention to remain in place in the ED, there needs to be constant reinforcement. “Until it becomes normalized you need great opinion leaders and role models that do it,” observes D’Onofrio. “You always need those, no matter what. It is true of anything you do in the ED.”

Broderick agrees that delivering education and training in how to use the BNI is just a first step. “Initially we conducted two- to three-hour training sessions, but they were not sustainable, so then we built a web-based module that we could assign to people,” she says. “We also do booster training for the nurses on a semi-annual basis.”

Emergency department leaders that are interested in making use of the BNI should first make sure they have an acceptable screening tool in place for substance use first, says Broderick. “Having an [electronic medical record] that has [the screening tool] built in would be the easiest way to do this,” she says. ■

Editor’s note: For training videos and more information on Screening Brief Intervention & Referral to Treatment — a process that includes use of the Brief Negotiation Interview (BNI), visit the Yale School of Medicine Web site at: <http://medicine.yale.edu/sbirt/index.aspx>.

REFERENCE

1. D’Onofrio G, Fiellin D, Pantalon M, et al. A Brief intervention reduces hazardous and harmful drinking in emergency department patients. *Ann Emerg Med.* 2012;60:181-192.

COMING IN FUTURE MONTHS

- Using the split-flow model to improve throughput
- Preventing traumatic injuries in young patients
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SOURCES

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CNE/CME OBJECTIVES

1. Apply new information about various approaches to ED management.
2. Discuss how developments in the regulatory arena apply to the ED setting.
3. Implement managerial procedures suggested by your peers in the publication. ■

CNE/CME QUESTIONS

1. According to **James Eckman**, MD, sickle cell patients are often not believed when they present to the ED for care. Why is this the case?

- A. ED providers lack experience in dealing with sickle cell patients.
- B. Sickle cell patients often exhibit delusional behavior.
- C. Sickle cell patients visit the ED frequently.
- D. These patients are primarily presenting with extreme pain, but no other physical findings or lab changes.

2. **Matthew Lyon**, MD, RDMS, developed a specialized protocol for sickle cell patients in order to:

- A. educate providers about sickle cell disease
- B. save costs related to excess utilization
- C. eliminate treatment delays and improve management of patients
- D. A and C

3. Eckman says that one of the reasons why ED use tends to spike among sickle cell patients as they reach adulthood is:

- A. Sickle cell disease tends to act up in patients during the late teens and early 20s.
- B. Adult sickle cell patients prefer to access their care in the ED.
- C. ED providers have more expertise in sickle cell disease than internal medicine physicians.
- D. Sickle cell patients have trouble navigating the health care system.

4. What is the Prescription Monitoring Program in Washington state?

- A. a process whereby the state regularly reviews and comments on provider behavior
- B. a database designed to facilitate the identification of patients with narcotic-seeking behavior
- C. a pharmacy-driven effort aimed at eliminating medication errors
- D. a method for making sure that patients are taking their medicines as directed

5. According to **Gail D'Onofrio**, MD, FACEP, when engaging in motivational interviewing with a patient who has an alcohol problem, the first step for a provider is to ask the patient:

- A. for permission to discuss his or her alcohol use
- B. if he or she is ready to make positive changes
- C. why he or she continues to drink
- D. if he or she is open to getting help for a drinking problem

6. According to D'Onofrio, roughly what percentage of the time does the patient follow through with the instruction when a provider advises the patient to do something?

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- B. 7%
- C. 10%
- D. 3%