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Lessons learned for follow-up phone booster counseling calls with substance abusing emergency department patients

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ABSTRACT

Background: Post-visit "booster" sessions have been recommended to augment the impact of brief interventions delivered in the emergency department (ED). This paper, which focuses on implementation issues, presents descriptive information and interventionists' qualitative perspectives on providing brief interventions over the phone, challenges, "lessons learned", and recommendations for others attempting to implement adjunctive booster calls.
Method: Attempts were made to complete two 20-minute telephone "booster" calls within a week following a patient's ED discharge with 425 patients who screened positive for and had recent problematic substance use other than alcohol or nicotine.
Results: Over half (56.2%) of participants completed the initial call; 66.9% of those who received the initial call also completed the second call. Median number of attempts to successfully contact participants for the first and second calls were 4 and 3, respectively. Each completed call lasted an average of about 22 minutes. Common challenges/barriers identified by booster callers included unstable housing, limited phone access, unavailability due to additional treatment, lack of compensation for booster calls, and booster calls coming from an area code different than the participants' locale and from someone other than ED staff.
Conclusions: Specific recommendations are presented with respect to implementing a successful centralized adjunctive booster call system. Future use of booster calls might be informed by research on contingency management (e.g., incentivizing call completions), smoking cessation quitlines, and phone-based continuing care for substance abuse patients. Future research needs to evaluate the incremental benefit of adjunctive booster calls on outcomes over and above that of brief motivational interventions delivered in the ED setting.

1. Introduction

There were over 4.9 million drug-related emergency department (ED) visits in United States in 2010, with nearly half of them (46.8%, or 2.3 million visits) due to drug misuse/abuse (Substance Abuse & Mental Health Services Administration, 2012). ED patients are more likely than either the general population or primary care patients to report drug use (Cherpitel & Ye, 2008; Cunningham et al., 2009; Rockett, Putnam, Jia, & Smith, 2003). It has been recommended that brief interventions be tested with drug-using ED patients (Cunningham et al., 2009). In addition to its potential public health impact (Babor et al., 2007), the implementation of brief interventions targeting drug use may also reduce avoidable health care costs (Rockett, Putnam, Jia, Chang, & Smith, 2005).

An emergency department visit may present a "teachable moment" during which drug-using patients may be more contemplative about the impact that their alcohol or drug use is having on their lives and, as such, they may be more receptive to an intervention addressing those concerns (Minugh et al., 1997; Williams, Brown, Patton, Crawford, & Touquet, 2005). However, such moments, or windows of opportunity, may be less impactful for those who do not see a temporal relationship between their ED visit and their substance use. In fact, those who view their ED visit primarily or exclusively as a medical issue, even if they have a history of alcohol or drug use, may view a brief intervention targeting their substance use as an unrelated and unwelcome intrusion (Longabaugh et al., 2001). Also, the general level of activity, potential lack of privacy, brevity of available time, and degree of chaos during an ED visit may make it difficult to provide an effective intervention in that setting (Bernstein & Bernstein, 2008; Daeppen et al., 2007; Mello, Longabaugh, Baird, Nirenberg, & Woolard, 2008; Mello, Nirenberg, Woolard, Baird, & Longabaugh, 2007; Nilsen et al., 2008). Even if initially successful, the benefits of identifying and intervening with a hazardous drinker or drug user may dissipate somewhat rapidly over time (McCambridge & Strang, 2004, 2005; Williams et al., 2005). Although possibly a teachable moment, it is not clear the extent to which the "lesson" conveyed by the intervention has been learned or retained once the individual leaves the ED.

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Rather than serving as the site for maximal brief intervention effectiveness, the ED setting might more appropriately be seen as one in which patients are motivated to engage in discussions about their substance use at a later point after the immediate medical crisis has been resolved and when they may be more receptive to interventions (Nilsen et al., 2008). Such considerations have led to the recommendation that multi-contact interventions or "booster sessions" be provided, either in person or via phone (Academic ED SBIRT Research Collaborative, 2007; Bernstein & Bernstein, 2008; Bernstein et al., 2009; Longabaugh et al., 2001). As Bernstein and Bernstein state, "A booster session or referral for follow-up sessions outside the confines of a busy ED may be needed in addition to a 10-minute intervention in the course of clinical care" (p. 752).

While the initial brief intervention in the ED may get individuals to focus on and contemplate possibly changing risk-related behaviors, it might not be sufficient to motivate them to develop and implement a change plan. However, a booster session after leaving the ED can remind them of the intervention, encourage and reinforce their commitment to change as well as explore barriers that they may have encountered, and reinforce their putting their change plan into action (Lee et al., 2010; Longabaugh et al., 2001).

A number of investigators have followed this recommendation and have begun to incorporate booster sessions following the initial ED or trauma center visit as a component of a more extensive intervention. While some of the follow-up boosters have been done through a letter summarizing the session (Gentilello et al., 1999) or as a second face-to-face session (Longabaugh et al., 2001), a larger number of such follow-up sessions have been delivered over the phone (Bernstein et al., 2009, 2010; Bogenschutz et al., 2011; D'Onofrio et al., 2012; Soderstrom et al., 2007; Sommers et al., 2006). As is true for the initial brief interventions (Nilsen et al., 2008), such calls appear to vary along a number of dimensions, such as completion rates and duration; however, there is limited information in the literature about these dimensions as well as their content, implementation, and effectiveness.

Similarly, while attractive as an intervention extender, such booster calls may be difficult to implement within the ED setting (Academic ED SBIRT Research Collaborative, 2007, 2010). Again, however, details about implementation barriers and successes are scarce.

Because booster calls are an attractive and increasingly frequent addition to interventions to help ED-visiting alcohol and drug users, a more detailed exposition of challenges and successes in implementing and conducting booster calls would guide more effective booster calls in future interventions. The purpose of the present paper is to (1) provide descriptive information concerning post-ED visit booster phone calls and interventionists' qualitative perspectives on providing brief interventions over the phone; (2) present information about factors that appear to impede or facilitate implementation of booster calls; and (3) make recommendations if booster calls are to be incorporated into and implemented as part of future research studies or clinical practice.

2. Methods

2.1. Study participants

This study describes the methodology for conducting brief, motivational interviewing (MI) interventions via booster telephone follow-up calls to participants in one arm of a multi-site randomized clinical trial on screening and brief intervention with drug users in six EDs across the United States (Bogenschutz et al., 2011; Donovan et al., 2012). The trial's primary objective was to compare substance use and related outcomes among substance abusing ED patients randomized to either (1) minimal screening only (MSO); (2) screening, assessment and referral to treatment if indicated (SAR); or (3) screening, assessment, and referral plus a brief intervention with two telephone follow-up booster calls (BI-B). The trial was conducted within the National Drug Abuse Treatment Clinical Trials Network, between 2010 and 2012. The current report focuses only on the BI-B arm of the study, and more specifically on the methods employed to organize, implement, and conduct booster follow-up phone calls to 425 adults who had received a brief intervention in the ED.

2.1.1. Booster counselors

Booster calls were conducted by one male and two female counselors. One had a master's degree in social work and had also worked in an emergency department; the other two had master's degrees in counseling. All previously had been certified as MI practitioners and had experience conducting brief MI interventions in both clinical and research settings, with approximately 5–10 years of brief intervention experience. All booster calls were made from the study's centralized Booster Call Center located at the University of Washington in Seattle.

2.1.1.1. Counselor training and supervision. Booster counselors received standardized 2-day training in motivational interviewing and study procedures. Two counselors received this training at a national kick-off meeting with lead investigators and ED counselors, while one (hired part-way through the study) received it via Webinar. Following the training, each counselor completed four booster sessions with "pilot" participants who had consented to participate in the study for training purposes. Each pilot session was audiotaped and reviewed by lead fidelity monitors at the centralized Certification and Monitoring Center at the University of New Mexico in Albuquerque, who coded for adherence to the protocol and to MI principles using the centralized Motivational Interviewing Treatment Integrity (MITI) system (Moyers, Martin, Manuel, Hendrickson, & Miller, 2005). After four sessions in which criteria were met, booster counselors were considered fully certified for the study.

Booster counselors met bi-weekly with a designated supervisor to review and discuss cases. The booster counselor supervisor reviewed 1 audio recording of a booster session per week for each booster counselor (total of 3 sessions/week). Supervision was conducted in a group format. The supervisor provided feedback based on the reviewed audiotaped sessions, and facilitated discussion and problem solving of common challenges that arose in the booster call process over the course of the trial.

As part of the training and certification of the ED counselors in the first two sites to begin the study, ED and booster counselors had to conduct their respective brief interventions with consenting pilot subjects. A major difference in the procedures between this pilot and the main phase of the trial was that pilot participants received $30 remuneration for completing each booster call whereas main trial participants had no such financial incentive. This procedural difference allowed for subsequent analyses to explore whether there were differences in response rates between calls in which an incentive was or was not provided.

2.1.1.2. Fidelity Monitoring. All sessions were audio recorded for fidelity monitoring purposes. Participants were informed of these procedures during their study informed consent process. All participants provided written informed consent with study research staff at their local EDs. All sites, including the centralized Booster Call Center, obtained approval and were overseen by their local institutional review boards. The centralized Certification and Monitoring Center reviewed approximately 5% of booster counselors' sessions on an ongoing basis during the trial, using the MITI and a checklist.

2.1.2. Study participant recruitment

Male and female adult patients were recruited from six geographically diverse EDs across the US (one each from the southwest and midwest, and two each from the southeast and northeast). Potential participants were screened by study research staff for study participation upon admission to the ED for medical treatment. Study inclusion criteria were: (1) registration as a patient in the ED during study screening hours; (2) positive screen (≥ 3) for problematic use of a non-alcohol,