"Beyond the Opioids: What Matters Most to People Who Visit Emergency Departments for Pain-Related Complaints"

Presented by:
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on March 21, 2018

Webcast Questions and Answers
*(Answers are in **bold**)*

Questions:

1. Could you please comment on the lack of reimbursement for many of the more behavioral or complementary means of addressing persistent pain. Many of these patients cannot afford much if any out of pocket expense. (i.e. CBT, acupuncture, etc.)?
    a. **This is a problem and we can advocate to policy makers to ask that equal reimbursement is made for non-opioid pain relief options. We can also, as community members and health care professionals, work to create options to help close the gaps in care. For example, many clinics are adopting shared medical appointment models that are a billable service with a provider present. Pain self-management and CBT content can be delivered this way in small groups, or using online programs. Churches, senior centers, and clinics can offer low or reduced cost yoga, tai chi, exercise classes. There is a great need for affordable, accessible programs that can help people learn to adopt new strategies for pain management. (MW)**
2. Marian Wilson, Any thoughts about increasing survey responses? (e.g., phone calls after ER visit)
    a. **Phone calls are certainly a good idea. I have heard of some hospitals adding scripting at discharge to remind patients that their feedback is important to the organization. (MW)**
3. I missed all the things that you can prescribe for ...Cancer, herpes, burns, kidney stones is all I got down.
    a. **Five diagnoses for hydrocodone prescriptions are: Orthopedic fractures, burns, kidney stones, herpes/shingles, and cancer pain. (TM)**
4. What education was provided to staff?
    a. **In developing our guidelines, we had multidisciplinary participation, including RNs, techs, pharmacists, physicians, social workers, case managers etc. All these different disciplines were responsible for educating their respective colleagues about the prescribing guidelines and the other components of the program (emphasis on referrals, etc.). (TM)**

5. Thoughts about sickle cell pain?
    a. **Sickle Cell patients – great question, I should have mentioned this. We decided early on that sickle cell patients would specifically not be included in this program. Practically speaking though, as our prescribing patterns changed to reflect the guidelines, sickle cell patients were treated the same as other patients. (TM)**
6. I am curious to hear more about locking a member/patient to a single prescriber and how that was determined or works. We have a pharmacy Home program that seems to be effective (Arizona).
    a. **This is a good question with not a lot of published literature I am aware of despite that so many guidelines promote this strategy. The communities I am aware of that do this successfully use prescription monitoring programs and try to coordinate efforts between providers and emergency department case managers – patients are told they need to find a primary care provider and they will no longer get opioids from the ED. It may require stakeholder groups in the community willing to coordinate and work together. (MW)**
7. Will a physician be sentenced to death for prescribing medications for pain? When Norco and oxycodone did became heroin?
    a) **No death sentences have been adjudicated... at least as of yet. To re-emphasize a point: these guidelines are guidelines only, and bedside clinician judgement always overrides any guideline. Thus, if a physician decides that only Dilaudid or hydrocodone will do for a particular patient, then they are free to prescribe these medications. This rarely happens though.**
    b) **As to your question about when Dilaudid and hydrocodone became heroin- ironically, this is often exactly the path that leads opiate abusers to heroin. They graduate from hydrocodone, to oxycontin, to heroin because of increasing potency and decreasing cost. (TM)**
8. Our facility is doing the MAT, on using the naltrexone injection, I just want to clarify if the patient should be detoxing for 10 days? What if the patient just took morphine few hours prior to getting a shot?
    a. **Naltrexone will reverse the effects of any opioids given within MAT – opioids have varying durations of effects. (MW)**
9. How do patients react to not receiving their drug of choice?
    a. **The reaction of patients to not receiving their drug of choice has overwhelmingly been surprisingly muted. I almost never get an argument, because I explain it is our ER's policy, rather than my individual decision. (TM)**

10. I would like the information on the websites for pain alternatives. Where would I send my email address?
    a) **I am happy to share here some information I have compiled and can discuss more if you email marian.wilson@wsu.edu. I recommend providers create a list of local resources that patients can access and stress that this will often require some**

trialing of options in order to find the best pain self-management options for the individual. Many resources and good information can be found online such as the following:

b) **www.painaction.com**
c) **https://nccih.nih.gov/**
d) **http://theacpa.org**
e) **http://pami.emergency.med.jax.ufl.edu/**
f) **https://www.selfmanagementresource.com/programs/small-group/chronic-pain-self-management/**
g) **https://www.ucdmc.ucdavis.edu/nursing/Research/INQRI_Grant/Long-Term%20Non-Surgery%20Pain%20Management%20Strategies%20Booklet%20WebFINAL082311.pdf**

11. Some hospitals "brag" about being Dilaudid free in ED; your take on this?
    a) **Not sure what question is – but if it is should ER's brag about being Dilaudid free: Not sure that's the word I would use, but I would say they can be free to share knowing that they are at least trying to help stem opiate abuse. (TM)**
    b) **It was explained in the presentation that morphine is just as effective if dosed appropriately and seems less associated with a euphoric high. (MW)**
12. What non-pharmacological resources do you have available in the ED and community?
    a. **There are many listed on our second to last slide that can be suggested by providers. Some that are easy to deliver in ED are ice, warm packs, deep breathing, diversion/distraction, and massage. There are varying degrees of evidence for such techniques, yet much data supports yoga, tai chi, cognitive behavioral therapy, physical therapy and self-management programs. This article describes a New Jersey hospital with some innovative approaches: https://www.nytimes.com/2016/06/14/health/pain-treatment-er-alternative-opioids.html**
    b. **Here is a comprehensive white paper on the topic of evidence-based non-pharmacological pain management options:: http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Resources/opioids/Evidence_Based_Nonpharmacologic_Strategies_for_Comprehensive_Pain_Care_White_Paper.pdf (MW)**
13. Do you ask or look on the electronic health record for a pain med contract?
    a. **We do ask about pain contracts, and search the EMR for them, and honor them when in place. I find patients often volunteer this information, because they do not want to violate the terms of the contract. (TM)**