Beyond the Opioids: What matters most to people who visit emergency departments for pain-related complaints

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Conflict of Interest Disclosure

Authors Conflicts of Interest:

Marian Wilson, No Conflict of Interest
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Influences on Patient Satisfaction Among Patients Who Use Emergency Departments Frequently for Pain-Related Complaints

2017: Headed in the wrong direction

33,091 U.S. Opioid Overdose Deaths in 2015
Heroin use rising as opioid scrutiny increases

National Overdose Deaths
- Prescription Opiates (left) and Heroin (right)

Trends in ED Pain Care
Percent of ED visits resulting in an opioid prescription

Coinciding with national efforts to improve the quality of pain care, the percentage of ED visits resulting in a prescription for an opioid analgesic for home use increased from 23% in 1993 to 42% in 2005.

Pletcher et al., 2008

2010 ED Pain Care Management Program considered a success!

ED visits for chronic pain reduced 77%:
- 3,689 frequent user visits pre-enrollment
- 852 post-enrollment

2011 ED pilot study: Pain & depression persist after ED encounters

Major Depressive Disorder symptoms - 54%

Unresolved Pain
Pain Intensity mean 6.0 (SD 1.6)
Pain Interference mean 7.5 (SD 1.8)


2013 Emergency Departments struggle with pain practices

Rural Idaho to Dallas

Setting

- Texas Health Harris Methodist Hospital
  - 720 bed
  - Non-profit, urban
  - 100-bed ED
  - 22 ED physicians

- Texas Health Resources
  - 14 hospitals
  - Nursing leadership vision to engage nurses in EBP & research
How to provide appropriate care and meet patient expectations in a brief ED encounter?

Under-treated Pain

Denial Unaware

Sift & Sort

Mental Illness

Frequent ED visitors requesting opioids may have undertreated chronic pain, substance abuse, psychiatric, or psychosocial problems. Grover & Close, 2009

Ongoing efforts based on exemplars

ED physician perspectives on pain satisfaction scores

"I’m scared to not give out those opioids because my patient satisfaction scores will come back poorly."

"Part of my paycheck comes from satisfaction scores."

"So I pay for not giving narcotics with a smaller paycheck."

Internal data does not support concerns

External evidence
- ED practitioners are among the most frequent prescribers of opioids – primary care prescribe most. Volkow, 2009
- ED providers vary considerably in attitudes regarding opioid guidelines and prescribing practices. Kilaru et al., 2014
- Press Ganey pain satisfaction not related to administration of opioids or non-opioid analgesics in 2 New England hospitals. Schwartz et al., 2014
  - Data not available at time of study
  - Needed site-specific data, more convincing evidence

Study purpose
Assess relationships between opioid prescribing practices, patient and ED attributes, and patient satisfaction scores among patients with high utilization of the emergency department for pain relief
Data collected
- De-identified physician information from physician group serving the study ED
- Hospital electronic medical record (EMR), opioid dose, patient data
- Press Ganey surveys of patients visiting study ED in 2013 - linked to physician

Patient satisfaction survey general procedures
- Press Ganey proprietary survey
- Paper survey mailed within a week of ED visit
- Sent only to those discharged home
- Excluded:
  - Left Without Being Seen
  - Against Medical Advice
  - No publicity patients
  - Patients already receiving survey in last 90 days

Population of interest for study cohort
High ED Users:
1. Three visits in 1 month
2. Four visits in 2 consecutive months (Or 2 in 2 months)
3. Seven visits in 12 months

Pain score greater than 0

Excluded:
Children, OB, cognitively impaired, unable to communicate
Persistent pain data

- Full ED Population for 2013 by Admit Date
  - Removed admitted patients
  - 109,280 Encounters
  - 68,145 Patients
- Discharged patients (ED Only)
  - Removed patients under 18
  - 106,421 Encounters
  - 67,971 Patients
- Discharged adult patients
  - Removed low utilizers (less than 2 ED visits)
  - 94,317 Encounters
  - 59,657 Patients
- High utilizer, discharged adult patients
  - Removed encounters with an initial Pain Score of 0
  - 38,968 Encounters
  - 12,224 Patients
- High Utilizer, discharge adult patients with positive pain score
  - 32,890 Encounters
  - 11,528 Patients

Methods

- Groups compared
  - Frequent ED users with pain complaints who returned Press Ganey surveys (N = 304)
  - Age-matched control group, random sample of adult ED patients (not frequent-ED users) with any presenting complaint who returned Press Ganey surveys (N = 304)
- Manual chart audits confirmed:
  - Pain as significant role in multiple ED encounters
  - Patients met the frequency-related definitions of high ED utilization

Data Analysis

- Multivariable analysis modeled variables expected to influence pain satisfaction including nurse/physician items:
  - Concern for privacy/comfort
  - Courtesy
  - Took time to listen
  - Attention to needs
  - Took problem seriously
TABLE 1. Response to rated items from Press Ganey ED surveys

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Total participants analyzed</th>
<th>ED Over-users with recurrent pain complaints</th>
<th>Infrequent ED Users (general adult ED patient population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample size</td>
<td>608 (100%)</td>
<td>304 (50%)</td>
<td>304 (50%)</td>
</tr>
<tr>
<td>Male</td>
<td>195 (32%)</td>
<td>97 (28.6%)</td>
<td>108 (35.3%)</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>94 (16%)</td>
<td>52 (17%)</td>
<td>42 (14%)</td>
</tr>
<tr>
<td>Race</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>416 (60%)</td>
<td>179 (59%)</td>
<td>161 (53%)</td>
</tr>
<tr>
<td>Black</td>
<td>139 (22%)</td>
<td>97 (32%)</td>
<td>42 (14%)</td>
</tr>
<tr>
<td>Other</td>
<td>53 (18%)</td>
<td>28 (9%)</td>
<td>25 (8%)</td>
</tr>
<tr>
<td>Received Rx for scheduled drug at ED discharge</td>
<td>154 (25%)</td>
<td>140 (46%)</td>
<td>14 (5%)</td>
</tr>
<tr>
<td>Age</td>
<td>Mean 52 (SD = 17.6); range 18-92 years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Main findings: Few frequent ED users return surveys

Satisfaction survey yield = 5% of all encounters.
Surveys from ED frequent-users = 6% of total ED surveys returned, 0.3% of all ED encounters.

ED frequent-users with pain complaints were 75% less likely to yield a PG survey return than other patients (OR = 0.2488; χ² = 615, p < 0.0001).
Black & urban poor are frequent ED users

Black patients were more likely to be identified as ED frequent-users than white patients ($\chi^2 = 29.8, p < 0.0001$).

“Frequent-users with pain” were more likely to report residential addresses in one of the 8 poorest zip codes in the city ($\chi^2 = 50.5, p = 0.0001$).

No relationship between receiving an opioid prescription and satisfaction ratings

Frequent-users with recurrent pain were more likely to leave the ED with a prescription of a scheduled drug than other patients ($\chi^2 = 138, p = 0.0001$).

Receipt of a prescription for a scheduled drug was not significantly associated with Press Ganey ratings of physician behaviors.

Opioid prescription did not determine patient satisfaction

66% of the variance in patient satisfaction with physician behavior was accounted for by 5 variables.

Variables that did not contribute significantly to predicting patient satisfaction with physician behavior included:
- status as a frequent-user of the ED
- receipt of a prescription for scheduled drugs.
Main Findings: What matters most

<table>
<thead>
<tr>
<th>Predictive Variable</th>
<th>Standardized</th>
<th>95% CI</th>
<th>t-value</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient satisfaction with ED nursing care (composite score)</td>
<td>.159</td>
<td>-.067 -.261</td>
<td>3.317</td>
<td>.001</td>
</tr>
<tr>
<td>Waiting time for physician</td>
<td>.122</td>
<td>-.038 -.181</td>
<td>3.006</td>
<td>.003</td>
</tr>
<tr>
<td>Perception that staff cared about respondent as a person</td>
<td>.353</td>
<td>.228 - .415</td>
<td>6.784</td>
<td>.0001</td>
</tr>
<tr>
<td>How well pain was controlled</td>
<td>.146</td>
<td>-.063 -.190</td>
<td>3.918</td>
<td>.0001</td>
</tr>
<tr>
<td>Cleanliness of ED</td>
<td>.154</td>
<td>-.090 -.331</td>
<td>4.484</td>
<td>.0001</td>
</tr>
</tbody>
</table>

Study strengths and weaknesses

- Blinded data extractors
- Inter-rater reliability 96% on 95 randomly selected chart audits
- Low survey yield
- One site

Clinical implications

Nurses and healthcare team can promote a clean, caring environment, prioritize work flow and pain management.

Providers can withhold opioids when appropriate without fear of significant impact on patient satisfaction.

Kindness and compassion matter.
Moving forward

Educated ED physicians and Advanced Practice Clinicians about results of study.

Ongoing work to improve ED pain management.

Personalize care = individually-tailored diagnoses, treatments, and clinical decisions based on a patient's own data leads to more holistic view.

Best practices for ED pain care – Determine true needs

Screen and Refer

- Depression/Anxiety
  PHQ-9, GAD
- Substance use/misuse
  SOAPP, COMM, Hx
- Pain interference
  PEG, BPI

Screenings can be incorporated into ED waiting areas

https://www.mdcalc.com

Note

Engaging Adults With Chronic Disease in Online Depressive Symptom Self-Management

Marian Wilkus, Casey Melvick, Catherine Boudreaux-Lubiner, Jamie Merri, Katherine A. Wisniewski, Jessica A. Stover, and Michael P. Wilkus
"...striking the right balance of not contributing to addiction woes...while also not undertreating those who have genuine pain...remains one of the most difficult tasks in medicine."

To Err on Side of Over-Prescribing is Humane...

- Compassion
- Sensitivity vs Specificity
- Speed
- Conflict Avoidance
- Patient Satisfaction
- Or is it?
Joint Commission Standards

- Require pain is assessed, and “if necessary” treated
- Does not require opioids
- Alternative options are mentioned:
  - NSAIDS
  - Physical therapy
  - Alternative medicines
  - Referrals to specialist

Joint Commission Standards

“recognizes and stresses the importance of the individual physician judgment”

“meant to draw attention to pain management, not prescribe the treatment”

American Academy of Emergency Medicine
Model ED Chronic Pain Treatment Guidelines

- One provider, not multiple
- Discourage opioid injections and long-acting agents
- Do not replace lost/stolen prescriptions
  - For acute illness or injury - not more than 7 days worth
- Be aware of high abuse potential
  - Oxycodeone, hydrocodone, hydromorphone
- Use state prescription monitoring systems
American College of Emergency Physicians

PAIN MANAGEMENT CLINICAL POLICY

Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department

1. Utility of state prescription monitoring systems
2. Acute low-back pain: use caution, no benefit to opioids
3. Acute exacerbation non-cancer pain – indications for opioids
4. In the adult ED patient with an acute exacerbation of chronic pain, do the benefits of prescribing opioids on discharge outweigh the harms?

THFW Chronic Pain/Opiate Abuse Team
Guiding Philosophy

Not “Just Say No”

• Get patients the help they need (not necessarily the help they want)
• Deliver message with compassion, empathy and respect
• Tough love

THFW Chronic Pain/Opiate Abuse Program

• Continuous Improvement Team
• Identify Patients
• Educate Patients
• Physician Driven Interventions
• Referrals, referrals, referrals
Identification of Patients

- Visit history
  - 3 pain-related visits within month or 8 within year
- Prescription Access Texas Use
  - Red flags
    - Allergies: Toradol, Ultram, Morphine
    - Feigned pronunciation difficulties
    - Unilateral anomic dysphasia
    - Lost/stolen meds
- Flaging
  - FYI Column
  - "Chronic Pain Disorder"

Societal interventions - Partner with communities

- Naloxone programs
- "Lock-in" programs: one provider/pharmacy
- Drug take back programs
- Triple prescription/E-prescribing
- Referrals and warm hand-offs
  - Case Manager/Social Work
  - PCPs
  - Pain Management Specialists
  - Addiction Medicine Specialists
  - Rehab facilities
  - Chaplain
It looks like you have received a number of narcotic prescriptions from a number of different doctors, which concerns me. I want to help you today, but I do not feel comfortable treating you with Dilaudid. I want to make you feel better and can offer you a number of different treatment options, but none of them will involve giving you Dilaudid.

Usually, it is not possible to completely eliminate chronic pain, so our goal today is to reduce it to a more tolerable level.

The emergency department is not the best place to receive treatment for chronic pain – it’s not what we do best here.

Apply, educate & research non-pharmacological interventions

- Ice/Heat
- Diversion/Distraction
- Osteopathic Manipulative Medicine
- Massage/Therapeutic touch
- Physical therapy, exercise, stretching, yoga, Pilates
- Ergonomics/posture
- Biofeedback
- Cognitive behavioral therapies/self-management
- Aromatherapy
- Support groups

Challenges

- EMTALA
- Patient Satisfaction
- Inertia/Regression to Mean
- Consistency/Compliance
"...high wire act, between cracking down on prescription drug abuse and diversion...and treating those who legitimately need pain medicine..."