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

Marian Wilson, PhD, MPH, RN-BC
Assistant Professor, Washington State University College of Nursing
Spokane, WA

Terence McCarthy, MD
Immediate Past Chief of Staff, Emergency Physician, Texas Health Harris Methodist Hospital
Head of Emergency Services and Vice Chair Clinical Sciences
Texas Christian University and Texas Health Science Center School of Medicine
Fort Worth, TX
Conflict of Interest Disclosure

Authors Conflicts of Interest:

Marian Wilson, No Conflict of Interest
Terence McCarthy, No Conflict of Interest
INFLUENCES ON PATIENT SATISFACTION AMONG PATIENTS WHO USE EMERGENCY DEPARTMENTS FREQUENTLY FOR PAIN-RELATED COMPLAINTS

Authors: Patricia Newcomb, PhD, RN, CPNP, Marian Wilson, PhD, MPH, RN-BC, Ralph Baine, MD, Terence McCarthy, MD, Nicholas Penny, MCITP-DBA, Carline Nixon, LMSW-IFR, and Justin Orren, BA, Fort Worth, TX, Spokane, WA, Arlington, TX, Pikeville, KY

Contribution to Emergency Nursing Practice
- Patient satisfaction with nursing care in the emergency department overall is dependent on wait time, compared with an age-matched control group (n = 305) of nonfrequent ED users. Patient satisfaction survey responses and electronic medical records were used to model relationships between patient satisfaction and predictor variables.
U.S. Opioid Overdose Deaths 1999–2010

Number of deaths

- 1999: 2,900
- 2007: 11,500
- 2010: 15,500

CDC, 2010
2017: Headed in the wrong direction

115
die every day from an opioid overdose (that includes prescription opioids and heroin).
33,091 U.S. Opioid Overdose Deaths in 2015

Statistically significant drug overdose death rate increase from 2014 to 2015, US states
Heroin use rising as opioid scrutiny increases

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

Pain Care Management in the Emergency Department: A Retrospective Study to Examine One Program’s Effectiveness

Authors: Bat Masterson, RN, and Marian Wilson, MPH, RN-BC, Coeur d’Alene, ID, and Spokane, WA

Major Depressive Disorder symptoms - **54%**

Unresolved Pain

Pain Intensity mean 6.0 (SD 1.6)

Pain Interference mean 7.5 (SD 1.8)

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**Background**

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
- Mental Illness
- Diversion Dishonest

Sift & Sort

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

Emergency Department Opioid Prescribing Guidelines

1. One medical provider should provide all opioids to treat a patient’s chronic pain.

2. Allergies to any opioids or narcotic medication (e.g. Morphine) will preclude administering of any other narcotic.

3. The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbations of chronic pain is discouraged.

4. Emergency medical providers should not provide replacement prescriptions for controlled substances that were lost, destroyed or stolen.

5. Emergency medical providers should not provide replacement doses of methadone for patients in a Methadone treatment program.

6. Long-acting or controlled-release opioids (such as OxyContin®, Fentanyl patches, and Methadone) should not be prescribed from the ED.

7. EDs are encouraged to share the ED visit history of patients with other emergency physicians who are treating the patient using an Emergency Department Information Exchange (EDIE) system.

8. Physicians should send patient pain agreements to local ED’s and work to include a plan for pain treatment in the ED.

9. EDs should coordinate the care of patients who frequently visit the ED using and ED care coordinator program.

10. EDs should maintain a list of clinics that provide primary care for patients of all payer types.

11. EDs should perform screening, brief interventions and treatment referrals for patients with suspected prescription opiate abuse problems.

12. The administration of Dilaudid and Fentanyl in the ED is discouraged.

13. For exacerbations of chronic pain, the emergency medical provider should contact the patient’s primary opioid prescriber or pharmacy. The emergency medical provider should only prescribe enough pills to last until the office of the patient’s primary opioid prescriber opens.

14. Prescriptions for opioid pain medication from the ED for acute injuries, such as fractured bones, in most cases should not exceed 30 pills.

15. ED patients should be screened for substance abuse prior to prescribing opioid medication for acute pain.

16. The emergency physician is required by law to evaluate an ED patient who reports pain. The law allows the emergency physician to use their clinical judgment when treating pain and does not require the use of opioids.
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

<table>
<thead>
<tr>
<th>Encounter Count</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>109,280</td>
<td>Full ED Population for 2013 by Admit Date</td>
</tr>
<tr>
<td>68,145</td>
<td>Removed admitted patients</td>
</tr>
<tr>
<td>106,421</td>
<td>Discharged patients (ED Only)</td>
</tr>
<tr>
<td>67,971</td>
<td>Removed patients under 18</td>
</tr>
<tr>
<td>94,317</td>
<td>Discharged adult patients</td>
</tr>
<tr>
<td>59,557</td>
<td>Removed low utilizers (less than 2 ED visits)</td>
</tr>
<tr>
<td>38,968</td>
<td>High utilizer, discharged adult patients</td>
</tr>
<tr>
<td>12,224</td>
<td>Removed encounters with an initial Pain Score of 0</td>
</tr>
<tr>
<td>32,890</td>
<td>High Utilizer, discharge adult patients with positive pain score</td>
</tr>
</tbody>
</table>
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>
<thead>
<tr>
<th>Item</th>
<th>Frequent users with pain (n = 304) Mean score (SD)</th>
<th>Infrequent users (n = 304) Mean (SD)</th>
<th>Entire sample (N = 608) Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfaction with nursing care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses’ courtesy</td>
<td>4.45 (0.966), n = 299</td>
<td>4.64 (0.767), n = 300</td>
<td>4.55 (0.876), N = 599</td>
</tr>
<tr>
<td>Nurses’ attention to patient needs</td>
<td>4.37 (1.08), n = 294</td>
<td>4.53 (0.918), n = 298</td>
<td>4.45 (1.00), N = 592</td>
</tr>
<tr>
<td>Nurse informativeness regarding treatments</td>
<td>4.30 (1.09), n = 295</td>
<td>4.50 (0.859), n = 296</td>
<td>4.40 (0.987), N = 591</td>
</tr>
<tr>
<td>Nurses’ concern for privacy</td>
<td>4.44 (0.974), n = 292</td>
<td>4.57 (0.832), n = 295</td>
<td>4.57 (0.906), N = 587</td>
</tr>
<tr>
<td>Nurse took time to listen</td>
<td>4.38 (1.03), n = 295</td>
<td>4.56 (0.799), n = 298</td>
<td>4.47 (0.926), N = 593</td>
</tr>
<tr>
<td>Patient satisfaction with ED nursing care (index)</td>
<td>4.38 (0.972), n = 301</td>
<td>4.53 (0.769), n = 303</td>
<td>4.46 (0.879), N = 604</td>
</tr>
<tr>
<td>Satisfaction with physician care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctor’s courtesy</td>
<td>4.53 (0.890), n = 303</td>
<td>4.58 (0.843), n = 301</td>
<td>4.56 (0.867), N = 604</td>
</tr>
<tr>
<td>Doctor’s concern for comfort</td>
<td>4.40 (0.984), n = 298</td>
<td>4.42 (0.981), n = 299</td>
<td>4.41 (0.982), N = 597</td>
</tr>
<tr>
<td>Doctor informativeness regarding treatment</td>
<td>4.36 (1.012), n = 299</td>
<td>4.43 (0.982), n = 296</td>
<td>4.39 (0.997), N = 595</td>
</tr>
<tr>
<td>Doctor took problem seriously</td>
<td>4.34 (1.119), n = 298</td>
<td>4.46 (0.949), n = 299</td>
<td>4.40 (1.037), N = 597</td>
</tr>
<tr>
<td>Doctor took time to listen</td>
<td>4.40 (0.967), n = 298</td>
<td>4.51 (0.911), n = 298</td>
<td>4.46 (0.940), N = 596</td>
</tr>
<tr>
<td>Patient satisfaction with ED physician care (index)</td>
<td>4.41 (0.923), n = 303</td>
<td>4.48 (0.863), n = 303</td>
<td>4.44 (0.894), N = 606</td>
</tr>
<tr>
<td>Other items</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting time to see doctor</td>
<td>4.26 (1.077), n = 297</td>
<td>4.34 (0.925), n = 296</td>
<td>4.30 (1.004), N = 593</td>
</tr>
<tr>
<td>Informed about delays</td>
<td>4.11 (1.131), n = 277</td>
<td>4.19 (1.087), n = 266</td>
<td>4.15 (1.109), N = 543</td>
</tr>
<tr>
<td>Staff cared about you as a person</td>
<td>4.31 (1.051), n = 293</td>
<td>4.43 (0.939), n = 287</td>
<td>4.37 (0.998), N = 580</td>
</tr>
<tr>
<td>How well pain was controlled</td>
<td>4.17 (1.138), n = 288</td>
<td>4.40 (0.965), n = 265</td>
<td>4.28 (1.064), N = 553</td>
</tr>
<tr>
<td>Cleanliness of emergency department</td>
<td>4.39 (0.908), n = 298</td>
<td>4.41 (0.900), n = 290</td>
<td>4.40 (0.904), N = 588</td>
</tr>
<tr>
<td>Characteristic</td>
<td>Total participants analyzed</td>
<td>ED Over-users with recurrent pain complaints</td>
<td>Infrequent ED Users (general adult ED patient population)</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>-----------------------------</td>
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<td>----------------------------------------------------------</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<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>87 (28.6%)</td>
<td>108 (35.5%)</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>185 (61%)</td>
</tr>
<tr>
<td>Black</td>
<td>139 (22%)</td>
<td>97 (32%)</td>
<td>39 (13%)</td>
</tr>
<tr>
<td>Other</td>
<td>53 (18%)</td>
<td>28 (9%)</td>
<td>80 (26%)</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). ($X^2 = 615$, $p < .0001$).
Black & urban poor are frequent ED users

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

“Frequent-users with pain” were more likely to report residential addresses in one of the 8 poorest zip codes in the city ($X^2 = 50.5$, $p = 0.0001$).
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 ($X^2 = 138, p = 0.0001$).

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 Beta Coefficient</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 - .231</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

START LOW. GO SLOW.

Guideline for Prescribing Opioids for Chronic Pain

www.cdc.gov
Screenings can be incorporated into ED waiting areas

https://www.mdcalc.com

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

Marian Wilson¹, Casey Hewes², Celestina Barbosa-Leiker¹, Anne Mason¹, Katherine A. Wuestney¹, Jessica A. Shuen³, and Michael P. Wilson³
“...striking the right balance of not contributing to addiction woes...while also not under treating 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?
Public Health Impact of Opioid Analgesic Use

For every 1 overdose death there are

- Abuse treatment admissions: 9
- ED visits for misuse or abuse: 35
- People with abuse/dependence: 161
- Nonmedical users: 461

Treatment admissions are for primary use of opioids from Treatment Exposure Data set.
Emergency department (ED) visits are from DAWN. Drug Abuse Warning Network, https://dawninfo.samhsa.gov/default.
Abuse/dependence and nonmedical use in the past month are from the National Survey on Drug Use and Health.
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
  ◦ Oxycodone, hydrocodone, hydromorphone

• Use state prescription monitoring systems
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
    • Unilogo anomic dysphasia
    • Lost/stolen meds

• Flagging
  • FYI Column
  • “Chronic Pain Disorder”
Societal interventions -
Partner with communities

• Naloxone programs
• “Lock-in” programs: one provider/pharmacy
• Drug take back programs
• Triplicate prescription/E-prescribing
• Referrals and warm hand-offs
  • Case Manager/Social Work
  • PCPs
  • Pain Management Specialists
  • Addiction Medicine Specialists
  • Rehab facilities
  • Chaplain
Prescribing Pain medication in the Emergency Department

Our emergency department staff understands that pain relief is important when someone is hurting. However, providing pain relief is often complex. Mistakes or misuse of pain medication can cause serious health problems and even death. Our emergency department will only provide pain relief options that are safe and appropriate.

➤ Our main job is to look for and treat an emergency medical condition. We use our best judgment when treating pain, and follow legal and ethical guidelines.

➤ We will ask you to show a photo ID (such as a driver’s license) when you check into the emergency department to receive a prescription for pain medication.

➤ We will ask you about a history of pain medication use or substance abuse before prescribing any pain medication.

➤ We will only provide enough pain medication to last until you can contact your doctor. We will prescribe pain medication with a lower risk of addiction and overdose when possible.

➤ We will gather information regarding previous prescriptions and pain related visits to Emergency Department.

➤ It is against the law to solicit multiple Emergency Departments or healthcare providers for narcotic pain medications.

➤ If you are allergic to any opioids or narcotics (for example: morphine) we will not treat you with any other narcotics (for example: Dilaudid).

➤ For your safety, we do not:

  ▪ Give opioid (i.e. morphine, Dilaudid) shots for sudden increases in chronic pain.

  ▪ Refill stolen or lost prescriptions for pain medication.

  ▪ Prescribe missed methadone doses.

  ▪ Prescribe long-acting pain medication such as OxyContin, MS Contin, Fentanyl patches, or methadone for chronic, non-cancer patients.

  ▪ Prescribe pain medication if you already received pain medication from another doctor or emergency department. An exception may be made after contacting your doctor during normal office hours.

Revised 9/20/2012
Why are there emergency department guidelines for prescribing pain medication?

The guidelines were created to help reduce the recent rise in abuse, addiction, overdose, and death from prescription pain medication. Our emergency department follows them to help protect your health by making sure your pain is treated safely and properly.

Why are there pain medications I can’t get in the emergency department?

The emergency department does not prescribe pain medication to people already prescribed pain medication or who have chronic pain. This is to help make sure they do not receive unsafe amounts. Only one doctor should prescribe you pain medication.

Having your personal doctor prescribe pain medication, follow your care, and address your needs is the best way to control your pain safely. Your doctor knows your pain management plan and if you have medical conditions or take prescription medicines that can be dangerous when using pain medication other than he/she prescribed.

What are the dangers when pain medication is not taken as prescribed?

If too large of a dose is taken, it can slow breathing so much that it results in death. It can also cause a seizure or coma. Some medical conditions, prescription medicines, and drugs increase the chance of accidentally overdosing while on prescription pain medication.

What problems have prescription pain medications been causing?

- Deaths from prescription pain medication overdose have reached an epidemic level in the past decade.
- Most overdose deaths are an accident.
- Pain medications are highly addictive. Over 2 million people are currently addicted to them.
- Deaths from overdose are four times higher nationally than in 1999.
- In 2011, there were 167 deaths from accidental drug overdose in Tarrant County.
- Prescription pain medication has been involved in more deaths than cocaine and heroin combined since 2003, with 15,597 deaths in 2009.
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13. For exacerbations of chronic pain, the emergency medical provider should contact the patient's primary opioid prescriber or pharmacy. The emergency medical provider should only prescribe enough pills to last until the office of the patient's primary opioid prescriber opens.

14. Prescriptions for opioid pain medication from the ED for acute injuries, such as fractured bones, in most cases should not exceed 30 pills.

15. ED patients should be screened for substance abuse prior to prescribing opioid medication for acute pain.

16. The emergency physician is required by law to evaluate an ED patient who reports pain. The law allows the emergency physician to use their clinical judgment when treating pain and does not require the use of opioids.
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..."
Contact Marian Wilson, PhD, MPH, RN-BC marian.wilson@wsu.edu
Terence McCarthy, MD terencemccarthy@texashealth.org
**PCSS** is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with:

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<td>Addiction Technology Transfer Center</td>
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