

Chronic Pain in the Emergency Department

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ABSTRACT

OBJECTIVE: To describe the experiences of emergency department (ED) use among a population of Rhode Island Medicaid patients with chronic pain and a recent history of frequent ED use, who were eligible to participate in the Rhode Island Medicaid Pain Management program.

METHODS: Qualitative interviews were conducted with twenty-four patients who were either enrolled, or eligible to be enrolled, in a pain management program that is part of a state-funded initiative to reduce ED overuse.

RESULTS: Four main themes describe the experiences of these patients seeking ED care: (1) patients perceive that they use the ED appropriately; (2) frustrations in communication with ED providers; (3) helplessness; (4) changes in beliefs and behaviors with care coordination.

CONCLUSIONS: Patients enrolled, or eligible to be enrolled, in the Rhode Island Medicaid Pain Management program believe they use the ED for true emergencies, but feel helpless and unable to communicate effectively with ED providers.

KEYWORDS: emergency medicine, pain, complementary therapies, Medicaid

INTRODUCTION

Pain is a common complaint in the emergency department (ED), accounting for 38% to 78% of ED visits.^{1,2} ED providers have been criticized for under-prescribing analgesics^{3,4} and sub-optimally managing painful conditions in the ED.⁵ Historically, national organizations have urged providers to more liberally prescribe opioids for painful chronic conditions.⁶

Yet healthcare providers in general, and emergency physicians in particular, are also increasingly experiencing pressure to decrease provision of opioids for pain, and new Centers for Disease Control and Prevention (CDC) guidelines explicitly discourage opioid prescriptions for chronic pain.⁷ Risks associated with opioid use include misuse, addiction, and overdose,⁸ and opioid addiction is driving the current epidemic of drug overdoses.⁹ Although EDs are responsible for the minority of opioid prescriptions in the United States,¹⁰ EDs may treat a population that is particularly at risk for opioid diversion or misuse,^{11,12} with one study reporting indicators of risk of misuse associated

with one in ten ED opioid analgesic prescriptions.¹¹

Given these competing challenges experienced by ED physicians, it is important to understand how chronic pain patients experience their visits to the ED. Many departments of health and EDs are developing guidelines around the provision of opioids for chronic pain syndromes^{13,14} but few studies have examined the perceptions of ED patients with chronic pain.

We sought to understand chronic pain patients' experiences of the ED by interviewing patients enrolled in the Rhode Island Medicaid Pain Management program. The program is offered to members living with chronic pain who have used the ED more than three times in the past year. The program's goals are to connect patients with primary care and to improve pain management. Patients are offered case management and a peer navigator, as well as massage therapy, chiropractic, and/or acupuncture services at no charge to the patients. In 2013, the program targeted 1500 members with chronic pain who are high ED utilizers; 825 patients (55% of those eligible) engaged in the program. As part of a larger analysis of the Pain Management program, we wanted to learn what it is like for these patients when they visit the ED. Rigorously describing these patients' experiences may help inform patient-centered interventions that seek to balance the need for adequate pain relief with concerns about opioid misuse, addiction, and diversion.

METHODS

Design

This study consisted of semi-structured interviews and was approved by the New England and Lifespan/Rhode Island Hospital Institutional Review Boards.

Setting and population

We purposively sampled patients representing a range of engagement in the state Medicaid Pain Management program.

Protocol

Patients were recruited from one of the Lifespan hospitals' emergency departments or by referral from Pain Management program case managers. Inclusion criteria were that patients were eligible to enroll in the Pain Management program during the time interviews were conducted, from May to September 2014.

Measurements

All participants were asked, “Can you describe the last time you visited the ED or an urgent care facility for your pain?” Probes included, “Did the ED meet your needs?” and, “Was the visit typical?” These questions were part of a larger semi-structured interview about pain management. The interview guide was created with input from a community advisory board and was pilot-tested with 4 chronic pain patients.

Two research team members, trained in qualitative research methods conducted the interviews, either at hospital-based offices or at a location convenient for the interviewee (e.g., a coffee shop). Interviews lasted about 60 minutes and were audio recorded and transcribed. Interviewees received \$100 compensation. The research team collected interview data until saturation had been reached; that is, no new themes were emerging from the data.

Data analysis

The coding scheme was created by the research team. We used deductive thematic analysis,¹⁵ in this case, informed by the same preexisting research that informed the larger interview guide.^{16,17} As such, the research team created a coding structure based on the interview guide, which was refined as interviews were completed. Coding was completed in duplicate by five research team members trained in qualitative analysis; each transcript's coding was discussed by the larger research team and discrepancies were resolved with discussion. Data were entered into NVivo software (Version 10).

RESULTS

Characteristics of participants

Twenty-four patients participated in the study, ranging in age from 21 to 64; 62% were female, 64% White, and 26% Latino/ Hispanic, and other. All patients reported musculoskeletal pain; eight also reported concomitant pain-related systemic illnesses (e.g., cancer, diabetic neuropathy). All patients were eligible to participate in the Pain Management program and nineteen patients identified as currently participating. Representative quotes for each theme are listed in **Table 1**.

Main results

We identified four themes describing the experiences of patients seeking ED care: (1) Patients perceive that they use the ED appropriately and avoid going to the ED unless they are having a true emergency; (2) Frustrations in communication with ED physicians; (3) Helplessness, and (4) Change in beliefs and behaviors with care coordination.

Study participants often reported reluctance to go to the ED, but if they did go, it was within the bounds of what they, or primary care physicians (PCPs), perceived to be an emergency. An emergency tended to be defined as unbearable pain which left patients with no choice but to seek

immediate pain relief at the ED. One patient described: *“I try to toughen it up and not even go to them, but if it’s at the point where I’m falling on the floor and I’m twitching cuz I’m in so much severe pain, or I’m crying, then, yes, I will go to the urgent care or I will go the emergency room”*.

– Patient (PA) 26. Many patients expressed in various ways that they felt they were following prescribed rules for when to visit the ED. For example, one patient described that she would only visit the ED of one hospital: *“I don’t float around from hospital to hospital, which I go to [named] Hospital and that’s it. It ain’t like I’m lookin’ for anythin’ and I’m not lookin’ for them to fill any prescriptions.”* —PA01.

A second theme was that patients did not feel that their needs were recognized or acknowledged by ED physicians and nurses. Many patient interviewees expressed frustration that ED providers seemed to suspect them of drug seeking, as expressed by one patient: *“I ain’t gonna sit there and beg you for ‘em [opioid medications] and overdose on ‘em. I’m just doin’ it just for my back.”* He’s like, *“I understand, but there’s a lot of people overdosin’ on ‘em.”* I’m like, *“Dude, I ain’t gonna sit there and overdose.”* —PA03. More generally, patients expressed that they wanted someone to address the underlying cause of their pain, but that the ED providers were not taking this desire seriously. One patient described her frustration: *“They say they do, but I think they take the same tests over and over and over. Why they keep taking the same test? Try different tests. It may cost a little bit of money. I understand the insurance don’t wanna pay for these tests. How the hell you supposed to know what’s wrong with the person, then, if you don’t even test that person for that other – them other possibilities?”* —PA15.

A third theme suggested that, overwhelmingly, the chronic pain patients felt helpless. They repeatedly expressed that they were not active participants in decisions about their own healthcare. One patient described how the medications he was given were not working, expressing little confidence that he would be prescribed something that would ease his pain: *“Well, I was hoping they’d, I don’t know, give me something for the pain while I was there [at the ED], trying to get it to subside a little bit, and give me something that would actually work...”* —PA09. For some, helplessness was experienced because of being on the receiving end of swift changes in opioid prescribing habits. One patient described her experience: *“There’s things going on where the kids are getting hold of them [opioid medications], people abuse them. Nobody likes to give them no more. I’ve got high blood pressure and they said like NSAIDS are no good for people with high blood pressure because you can have a heart attack. I tried to explain that to them but they think that I just want the Vicodin.”* —PA23. Despite the frustration expressed by many, some patients appreciated the ED staff’s efforts to educate patients about opioid risks. One patient said that the ED was the first place to tell her that opioids could cause harm: *“Or you end up in the emergency room and the emergency room is the one that told me, “You*

Table 1. Themes and representative quotations

Theme	Representative quotes
Theme 1: Chronic pain patients perceive that they use the ED appropriately and avoid the ED unless they are having a true emergency.	"I would always bring my MRI report with me. My written MRI report. Things like that. They knew I wasn't in there just, "Hey, can I have some pain meds?" kinda deal. They knew there was an actual issue." —PA10
	"I'm not the type of person at all, "Well, I don't feel good today. Oh, I'm in a little bit of pain. I'm gonna go." No, if I go to the hospital, it's because I'm in severe pain...I don't play this, "I'll go if I'm not in pain." I go if I'm in severe pain, and that's it. That's the only time that I go to the hospital". —PA26
	"Unfortunately sometimes it just gets too bad and I try to call my primary doctor or whatever doctor that's on-call. I'll explain to them the situation and they'll say, "Well, if you need to go to the emergency room, go." —PA01
	"Then I had to go straight to the hospital. I had to see what they could do for me with the pain cuz my prescription ran out. The doctor said, "I don't wanna give you no more of this and that," and I said, "Dude, what do you want me to do?" I'm cryin' on the phone. She's like, "If you're hurt that bad, go right to the hospital." —PA03
Theme 2: Frustrations in communication with ED physicians	"Cuz I'm sitting here. I'm sweating. I'm dehydrated. They see all this stuff going on. They don't see no heroin marks or no nothing in my skin. I'm butt naked. They got me undressed. For real, why you asking me these stupid questions?" —PA15
	"A lot of my initial pain, for some reason – I don't know why – is more like the evening time or nighttime. I don't know why. It just is, and trying to get an appointment to see a doctor when you're in pain – everybody wants you to take – they want you to keep takin' pills. Take pills, take pills, take pills, so you don't get to that point where it's so bad you hafta' go to the emergency room. If I don't hafta' take a pill, I don't wanna take a pill" —PA01
	"[T]hey were just like a drug factory. Then they would up the medicine—amitriptyline—until my eyes dried out and I had to go to the ER. It was, like, "It's not working." "Oh, take more. Take more. Take more." I'm at a point in my life where I don't want to take medicine. I wanna find a way to make myself work." —PA19
Theme 3: Helplessness	"I'm on Medicaid. I had been to the emergency room more than four times in one year. They sent me a letter. I was very upset cuz it said in the letter that you have to have new doctors and all this stuff. I had already spent the better part of six years gaining a rapport with my surgeons, with my doctors, with my nurse practitioner and everybody else. I panicked. I called the number. I said, "I can't get—you can't give me new doctors. This is ridiculous." I said, "It's taken a lot for me to trust these people." —PA06
	"This last time I went to Hospital 2, because they didn't wanna take me to Hospital 1...Yeah. Sometimes the emergency room doesn't—the emergency guys, they don't wanna take you down there". —PA12
	"Yeah. They just started hand 'em [opioid medication] to me, but now my doctor said he don't even wanna give 'em to me no more". —PA03
Theme 4: A change in beliefs and behaviors with care coordination.	"Well, they don't want me to go to the emergency room unless it's a true emergency. I called them [primary care providers (PCP)] when I hurt my ribs. They said that they couldn't see me. They couldn't see me for a couple of days. I said, "Listen, I might've broken my ribs....That's the only time I ever go to the emergency room, is when they can't see me. I understand that. I don't go to the emergency room unless I have to." —PA16
	"Yeah, cuz I don't go as much no more cuz I'll sit there with the pain. I'll just call cuz they say, "Call your primary first before you come running over to the hospital." I'll be calling 'em. "I need to come in there today." He be like, "Okay. Come in at this time." —PA13

need to try to cut down on 'em. You're takin' too many. They're gonna be bad for your liver and there's so many other side effects that could happen." —PA01

A final theme from the interviews suggested that patient beliefs and behaviors associated with the ED changed because of being enrolled in the state Pain Management program which has the goal of connecting patients to services, including primary care. One patient described that she had learned to try other sources of care before visiting the ED: *"That's because she told me basic cold or basic little things. If you got a splinter just per se, if you've got*

something like that, go to the doctor instead of going to the emergency room. I tried it. I'd rather do that. I'll call her in the morning, and they'll give me an appointment either that same mornin' or that afternoon. Then I'll go." —PA14. Other patients gave examples of how they now work with primary care to manage their health. As an example: *"They suggested I do the Communities of Care [Pain Management program] to help manage the pain. Since they put me in physical therapy, I don't get the episodes that used to put me in the hospital."* —PA07

DISCUSSION

The aim of the current study was to understand the lived experiences of ED use by patients with chronic pain and a history of frequent ED use. The desperation, frustration and helplessness described by the patients with chronic pain in our study help to illuminate a population with complex needs. High-needs patients with chronic pain such as those enrolled in the Chronic Pain program are likely to need some form of behavioral intervention in addition to treatment of their pain syndrome.^{18, 19}

Our study is one of many to describe communication difficulties between patients with chronic pain and physicians.²⁰ To our knowledge, however, it is the first to describe this tension in the ED setting. We detected one area of strain that centered on communication around pain medication. Patients felt defensive in the ED and believed they were suspected of diverting or misusing pain medication; yet patients – sometimes the same patients – also reported that medication was being pushed on them at the expense of finding an underlying problem.

The patients in our study were eligible to be enrolled in the state Pain Management program. One of the goals of the program is to better integrate patients into the health-care system so that they rely less on the ED. Some patients reported that since being enrolled in the program, they had visited a PCP or urgent care center rather than the ED for a health concern. Initiatives like the Pain Management program may be useful for redirecting some to urgent care and connecting others to primary care; however, further quantitative evaluation of such programs is needed. An extensive evaluation of the Rhode Island Pain Management program is currently underway.

While the intention of our study is to report the experiences of a select population in great need, a limitation of our study is that the sample size, while appropriate for the goals of our study, was small, and knowledge gained might not generalize to other people, other settings, or other states.

In summary, patients with chronic pain who frequently use the ED believe they do so for true emergencies, but feel helpless and unable to communicate effectively with ED providers. Improved communication, particularly around opioids, may be helpful. Some patients report that the Pain Management program has led them to think differently about appropriate ED use but further evaluation of the program will be informative.

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