

Managing Acute Pain With Opioids in the Emergency Department: A Teachable Moment?

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 See also Meisel et al., p. S45.

Acute pain is one of the most common reasons patients come to the emergency department (ED). For patients and family members who come to the ED acute pain is a crisis. The expectation is that the pain will be evaluated and treated effectively, ideally with medications (such as opioids) that eliminate or substantially reduce pain. For health care providers in the ED, using opioids to manage common acute pain conditions (e.g., musculoskeletal pain) is challenging for several reasons. First, a patient presenting with an episode of acute musculoskeletal pain often has a long history of pain characterized by waxing and waning of pain symptoms. Although periodic flares in acute pain may trigger visits to the ED, one needs to keep the history and trajectory of pain symptoms when prescribing analgesics. Second, in some patients seen in the ED, particularly those given prescriptions for higher doses of opioids, a prescription for an opioid, meant to provide a short-term strategy for managing acute pain, may lead to long-term opioid use. Patients given prescriptions for higher doses of opioids at the time of their ED visit^{1,2} and those who have a history of

skeletal, back, or neck pain or were prescribed benzodiazepines³ are at greater risk for persistent opioid use. There is heightened recognition of the adverse effects and risks of long-term opioid use, and the risks of prescribing opioids for acute pain (e.g., opioids prescribed in the ED or after surgery). There is also growing interest in strategies for reducing these risks.

In this issue of *AJPH*, Meisel et al. (p. S45) explore a novel approach to managing acute pain episodes in two conditions that can cause chronic pain (musculoskeletal pain and kidney stones.) Their approach fits nicely with the notion that an ED visit for acute pain can serve as a potential “teachable moment” (i.e., a situation where one may be open to change and motivated to adopt health-related behaviors). Theory and research suggest that a teachable moment is most likely to occur when a health encounter affects one’s perception of risk, heightens emotional distress and anxiety, and affects their self-concept.⁴ All of these conditions are present in an ED visit for pain. As pointed out by Meisel et al., in the ED usual care for acute episodes of musculoskeletal or renal colic pain involves

providing generic written information about opioid risks but does not effectively engage patients in active discussions about the personal benefits and costs of short- and long-term opioid use. These usual care approaches clearly fail to capitalize on a potential teachable moment.

Meisel et al. tested two novel interventions for conveying information about opioids. The first, a visual Opioid Risk Tool, provided individualized, easy-to-read and understand information on the patient’s risk of opioid misuse and overall risk category. This tool is interesting, not only because it provides a more open and thorough communication about the potential benefits and harms of opioid analgesics, but also because it represents a more tailored approach to highlighting each patient’s individual opioid-related risks. The second intervention combined this visual tool with an opportunity to view brief (1–3 minutes) professionally made videotapes of real patients discussing their experiences using opioids for pain including problems related to opioid misuse. The rationale for these narratives is compelling. Stories of real-life experiences related to the management of pain with opioids can be highly salient and engaging. The stories may elicit an emotional response from patients because they may identify with and feel validated by the storytellers. Importantly, as Meisel et al. note, narratives may be particularly effective in influencing decision-making in patients with low education and health literacy, a group that is less likely to be responsive to generic written information typically provided to ED patients.

Both interventions tested by Meisel et al. fit nicely with a public health approach to the opioid crisis. Both are brief, standardized, and can be

integrated into a busy ED setting. Thus, both interventions have the potential to reach a large group of patients with pain seen in the ED who are at risk for opioid-related problems. These communication risk interventions also are notable in that they were developed and refined using extensive input from key stakeholders—both patients and providers.

Several questions arise when considering this study. First, are such brief approaches for communicating opioid risk effective? Meisel et al. found several short-term benefits. First, patients receiving both risk communication interventions appeared to be more aware of the risks of opioids in that 39% to 47% accurately recalled their risk category on the Opioid Risk Tool 14 days after their ED visit. Risk recall was better in both groups. Interestingly, patients in the group receiving both the visual tool and narrative were less likely to report a preference for opioids, greater satisfaction with treatment, and higher levels of shared decision-making. Longer-term benefits in terms of reducing self-reported opioid use (90 days after the ED visit), however, were not evident. Taken together, these findings indicate that novel brief communication interventions can affect patient perceptions of their opioid risks and of their treatment in the ED.

Second, who is most likely to benefit from such brief interventions? Interestingly, Meisel et al. found that among those patients at highest risk for opioid misuse, accuracy of recall (a key primary outcome) was higher among those receiving the visual tool plus narratives than the visual tool alone. Learning at the time of an ED visit that one is at higher risk may heighten the salience and impact of viewing patient narratives and enhance recall of risk

status. It should be noted, however, that patients at particularly high risk for opioid misuse were excluded from this study (e.g., those under the influence of illicit drugs or alcohol, deemed to be drug seeking, or taking opioids in the 30 days prior to their visit). Thus, the results may not generalize to the group of patients that are particularly challenging to ED health care providers (i.e., those at very high risk for problems with opioid treatments).

A disappointing aspect of this study is that the communication risk interventions had no effect on reports of opioid use 14 and 90 days after the ED visit. A major reason for the appeal of brief interventions is their potential to change key health behaviors (e.g., daily opioid use for pain). Changing the recall of risk perceptions and perceptions of care may represent a first step in the behavior change process—a step that both raises patient awareness and helps them contemplate the benefits of adopting a health behavior (i.e., appropriate use of opioids to manage an acute pain episode). However, in patients with pain conditions that are likely to be chronic, improved strategies for conveying information about opioid-related risks may not be sufficient to achieve the ultimate goal of reducing the harms of long-term opioid use. What strategies could be used to supplement such strategies? Patients with persistent pain who are at risk for problems with opioids also appear to benefit from mindfulness-based interventions.⁵ In addition, there is evidence that a more consensual patient-centered approach to voluntary opioid tapering that provides patients with control over the pace and timing of their opioid dose can reduce opioid intake without leading to increased pain.⁶ Finally, there is growing interest

in brief motivational interviewing techniques to enhance the motivation and commitment of patients with chronic pain to reduce their intake of opioids, although evidence for their effectiveness is inconclusive.^{7,8}

Is there a risk that communication tools such as those developed by Meisel et al. could be misused (e.g., to deny certain patients access to opioid treatments)? Research has shown that Black and Hispanic patients are less likely to receive opioids for management of their pain in the ED and less likely to be given a prescription for opioids during their ED visit.^{9,10} Meisel et al. make a point that their communication tools were developed and outcomes chosen with input from patients with diverse backgrounds and, thus, reflected their preferences. The population they studied also was diverse (38% Black, > 10% Hispanic). Nevertheless, their study failed to examine whether patients randomized to receive either one of their communication tools showed any racial or ethnic differences on measures such as opioids given in the ED or self-reported opioid use at follow-up. Future research is needed to examine the impact of such communication tools on racial and ethnic disparities in opioid treatments for pain.

In summary, it is increasingly clear that the ED is at the nexus of the opioid and pain crises. The study by Meisel et al. is important in reminding us that a visit for treatment of acute pain can provide an important opportunity for addressing these dual crises. One hopes that this study has a heuristic effect on the field stimulating even more research that capitalizes on the ED as a teachable moment for patients at risk for problems related to chronic pain and long-term opioid use. **AJPH**

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CONFLICTS OF INTEREST

The author has no conflicts of interest to declare.

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