WEST VIRGINIA HOSPITAL ASSOCIATION

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Guidance for Use and Prescribing of Opioids in Emergency Departments

Background

The opioid crisis is affecting communities across the country with an estimated 2.1 million people in the United States (U.S.) suffering from a substance use disorder related to prescription opioid pain medication.[1] The amount of opioids dispensed in the U.S. has quadrupled between 1999 and 2013[2], despite no change in the amount of pain that Americans reported.[3] The consequences of this epidemic are devastating to families and communities with the misuse of prescription painkillers estimated to cost over $50 billion a year in lost productivity (46%), healthcare costs (45%), and criminal justice costs (9%).[4]

Research has shown that risk factors for prescription painkiller abuse and overdose, include:

- Overlapping prescriptions from multiple providers and pharmacies, including overlap of painkiller and benzodiazepine prescriptions;
- High daily doses of prescription painkillers;
- Long-acting or extended release painkillers prescribed for acute pain;
- A history of mental illness or alcohol/substance abuse;
- Living in rural areas and having low income; and
- Having Medicaid insurance –one study found 40% of Medicaid enrollees had at least one indicator of potentially inappropriate use or prescribing.[5]

West Virginia has one of the highest opioid and benzodiazepine prescribing rates in the country, which is a leading contributor to the opioid epidemic and unlikely to be explained by differences in the health status of the population alone.[6] West Virginia has the third highest prescribing rate per 100 persons for opioid pain relievers (137.6 per 100 persons) and has the highest prescribing rate for benzodiazepines in the country (71.9 per 100 persons) – both rates are more than two standard deviations above the mean.[7] West Virginia also has the highest drug overdose mortality rate in the nation.[8]

Emergency departments (EDs) are a major source of opioid prescriptions and must balance the use of opioid pain medication in legitimate pain control with the responsibility of safe prescribing in light of the potential for misuse by patients. This is an increasingly difficult task with emergency department visits associated with pharmaceutical misuse or abuse increasing 114 percent between 2004 and 2011.[9]

Opioid prescribing practices are one of three targeted priorities by the U.S. Department of Health and Human Services to reduce opioid use disorders and overdose.[10] The use of clinical practice guidelines can assist providers in providing safe, effective treatment while reducing the potential for misuse, abuse, or overdose from opioids.[11]

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Position

The West Virginia Hospital Association (WVHA) acknowledges the devastating impact of the inappropriate use of controlled substances; specifically opioids and benzodiazepines, by the public and are recommending the following guidelines for use and prescribing of opioids in the ED. WVHA recognizes that ED clinicians are committed to evaluate every emergent complaint and to determine a specific treatment plan for that patient encounter. We encourage providers in the Emergency Department to follow these guidelines, but the individual's clinical judgement in any specific case supersedes any guideline. Therefore, it is recommended that the following action be taken as part of a comprehensive use and prescribing of opioids program in every emergency department in West Virginia.

Action

Through the work and coordination of the WVHA Emergency Department Taskforce, the WVHA Quality Committee, and the partnership with the West Virginia Chapter of the American College of Emergency Physicians, it is recommended that hospitals review current policy/practice on use and prescribing of opioids in the ED and if necessary take action to align your hospital's current policy (or create one if none exists) with the recommended guidelines. Hospitals should also take steps to educate staff about the new/revised policy for use and prescribing of opioids.

[1] Substance Abuse and Mental Health Services Administration, *Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013. Available at: http://archive.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/Index.aspx. Accessed October 7, 2015.

[2] Centers for Disease Control and Prevention (CDC). Injury Prevention & Control: Prescription Drug Overdose – What States Need to Know about the Epidemic. Available at: http://www.cdc.gov/drugoverdose/epidemic/states.html. Accessed October 7, 2015.

[3] CDC. Injury Prevention & Control: Prescription Drug Overdose – Data Overview. Available at: http://www.cdc.gov/drugoverdose/data/index.html. Accessed October 7, 2015.

[4] Birnbaum HG. Societal costs of prescription opioid abuse, dependence, and misuse in the United States. *Pain Medicine*, 12: 657-667, 2011.

[5] CDC. Injury Prevention & Control: Prescription Drug Overdose – Risk Factors for Prescription Painkiller Abuse and Overdose. Available at: http://www.cdc.gov/drugoverdose/epidemic/riskfactors.html. Accessed October 7, 2015.

[6] CDC. Injury Prevention & Control: Prescription Drug Overdose – Prescribing Data. Available at: http://www.cdc.gov/drugoverdose/data/prescribing.html. Accessed October 7, 2015.

[7] Paulozzi LJ. Vital Signs: Variation among States in Prescribing of Opioid Pain Relievers and Benzodiazepines – United States, 2012. *MMWR*, 63(26); 563-568. July 4, 2014.

[8] Trust for America's Health and the Robert Wood Johnson Foundation. The Facts Hurt: A State-by-State Injury Prevention Policy Report. 2015. Available at: http://www.healthyamericans.org/reports/injuryprevention15/. Accessed October 7, 2015.

[9] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality The DAWN Report: Highlights of the 2011 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits. Available at: http://www.samhsa.gov/data/sites/default/files/DAWN127/DAWN127/sr127-DAWN-highlights.htm. Accessed October 7, 2015.

[10] Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. Opioid Abuse in the US and HHS Actions to Address Opioid-Drug Related Overdoses and Deaths. March 26, 2015. Available at: http://aspe.hhs.gov/basic-report/opioid-abuse-us-and-hhs-actions-address-opioid-drug-related-overdoses-and-deaths. Accessed October 7, 2015.

[11] CDC. Common Elements in Guidelines for Prescribing Opioids for Chronic Pain. Available at: http://www.cdc.gov/drugoverdose/prescribing/common-elements.html. Accessed October 7, 2015.

West Virginia College of Emergency Physicians
ADVANCING EMERGENCY CARE

West Virginia Hospital Association

Guidelines for Use and Prescribing of Opioids in Emergency Departments

1. In compliance with the West Virginia Medical Practice Act, one medical provider should provide all opioids (narcotics) to treat a patient's chronic pain. For exacerbations of chronic pain, the emergency medical provider should attempt to contact the patient's primary opioid provider or pharmacy. It is recommended that a summary of the ED care be sent to the primary opioid provider.

2. A prescription for a controlled substance should not be given to a patient without a government issued photo ID.

3. The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbation of chronic pain is not in the patient's best interest and is discouraged.

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

5. Emergency medical providers should not provide replacement doses of methadone for patients in a methadone program without consultation with the methadone program.

6. The ED will not prescribe or dispense suboxone. The ED will not prescribe opioid pain pills to those identified as enrolled in a suboxone clinic without consultation with the suboxone clinic, except in the case of an acute injury or illness such as a broken bone.

7. Long-acting or controlled-release opioids should not be prescribed in the ED, with the rare exceptions of some hospice patients, and only after consultation with hospice.

8. Prescriptions for opioids from the ED for acute injuries, such as broken bones, will cover the shortest appropriate time. If the emergency provider does elect to provide pain medication for chronic pain, it will only be enough to cover until the next business day.

9. The ED may coordinate the care of patients who frequently visit the ED to establish a patient specific policy/treatment plan, which should include treatment referrals for patients with suspected prescription opioid abuse problems.

10. Hospital emergency department providers, or their delegates, should consult the West Virginia Controlled Substance Automated Prescription Program (CSAPP) before writing a controlled substance prescription.

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Action Checklist

- ☐ Make a commitment to improve how patients in your emergency department receive care related to the use and prescribing of opioids.

- ☐ Convene an improvement team that consists of at least an ED physician, pharmacy, nursing, and risk management to review your current policy/practice in comparison to the recommended guidelines.

- ☐ Using the provided Gap Analysis worksheet make a final status determination on action.

- ☐ If necessary, modify your policy/practice to create alignment with the recommended guidelines on the use and prescribing of opioids.

- ☐ Educate staff on the new policies/practices.

Gap Analysis for Use and Prescribing of Opioids Guidelines for the Emergency Department

Recommended Guideline	Current Status	Final Status
(1) In compliance with the West Virginia Medical Practice Act, one medical provider should provide all opioids (narcotics) to treat a patient's chronic pain. For exacerbations of chronic pain, the emergency medical provider should attempt to contact the patient's primary opioid provider or pharmacy. It is recommended that a summary of the ED care be sent to the primary opioid provider.		☐ Consistent with current policy ☐ Adopt with no changes ☐ Will not adopt ☐ Will adopt with the following modifications:
(2) A prescription for a controlled substance should not be given to a patient without a government issued photo ID.		☐ Consistent with current policy ☐ Adopt with no changes ☐ Will not adopt ☐ Will adopt with the following modifications:

Recommended Guideline	Current Status	Final Status
(3) The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbation of chronic pain is not in the patient's best interest and is discouraged.		☐ Consistent with current policy ☐ Adopt with no changes ☐ Will not adopt ☐ Will adopt with the following modifications:
(4) Emergency medical providers should not provide replacement prescriptions for controlled substances that were lost, stolen, destroyed or finished prematurely.		☐ Consistent with current policy ☐ Adopt with no changes ☐ Will not adopt ☐ Will adopt with the following modifications:
(5) Emergency medical providers should no provide replacement doses of methadone for patients in a methadone program without consultation with the methadone program.		☐ Consistent with current policy ☐ Adopt with no changes ☐ Will not adopt ☐ Will adopt with the following modifications:

Recommended Guideline	Current Status	Final Status
(6) The ED will not prescribe or dispense suboxone. The ED will not prescribe opioid pain pills to those identified as enrolled in a suboxone clinic without consultation with the suboxone clinic, except in the case of an acute injury or illness such as a broken bone.		☐ Consistent with current policy ☐ Adopt with no changes ☐ Will not adopt ☐ Will adopt with the following modifications:
(7) Long-acting or controlled-release opioids should not be prescribed in the ED, with the rare exceptions of some hospice patients, and only after consultation with hospice.		☐ Consistent with current policy ☐ Adopt with no changes ☐ Will not adopt ☐ Will adopt with the following modifications:
(8) Prescriptions for opioids from the ED for acute injuries, such as broken bones, will cover the shortest appropriate time. If the emergency provider does elect to provide pain medication for chronic pain, it will only be enough to cover until the next business day.		☐ Consistent with current policy ☐ Adopt with no changes ☐ Will not adopt ☐ Will adopt with the following modifications:

Recommended Guideline	Current Status	Final Status
(9) The ED may coordinate the care of patients who frequently visit the ED to establish a patient specific policy/treatment plan, which should include treatment referrals for patients with suspected prescription opioid abuse problems.		☐ Consistent with current policy ☐ Adopt with no changes ☐ Will not adopt ☐ Will adopt with the following modifications:
(10) Emergency Department providers, or their delegates, should consult the West Virginia Controlled Substance Automated Prescription Program (CSAPP) before writing a controlled substance prescription.		☐ Consistent with current policy ☐ Adopt with no changes ☐ Will not adopt ☐ Will adopt with the following modifications: