Maryland Emergency Department & Acute Care Facility

Opioid Prescribing Guidelines

Supplemental Information for Physicians

**Background**

Emergency Departments (ED) are the largest ambulatory source for opioid analgesic prescriptions with 39% of all opioids prescribed, administered, or continued from an ED. 1 According to the Drug Abuse Warning Network, the estimated number of ED visits for nonmedical use of opioids more than doubled from 2004 to 2008 (from 144,660 to 305,900) in the U.S. 2 As the use of prescription opioids for chronic non-cancer pain has increased, so have unintended consequences related to opioids.

These guidelines are intended to help EDs reduce inappropriate use of opioid analgesics while preserving the mission to treat patients with emergent conditions. They are to be used as guidelines and individual physician judgment should supersede them when appropriate. These guidelines were developed by and revised by the following:

Maryland Chapter American College of Emergency Physicians

Department of Health and Mental Hygiene

 Maryland Poison Center

The Johns Hopkins Department of Emergency Medicine

**GUIDELINES**

***Our emergency department staff understand that pain relief is important when someone is hurt or needs emergency care. However, providing pain relief is often complex. Mistakes or misuse of pain medications can cause serious health problems and are a major cause of accidental death. Our emergency department strives to provide pain relief options that are safe and appropriate.***

***Our main job is to look for and treat an emergency medical condition. Chronic pain is best managed and coordinated outside the emergency department by primary care providers or a pain specialist.***

***We use our best judgment when treating pain, and follow legal and ethical guidelines. For your safety, we will do the following.***

***General principles***

* ***We will recommend that one doctor and one pharmacy provide all the medications used to treat a patient’s chronic pain.***
	+ The American Pain Society recommends that all patients on chronic opioid therapy have one clinician who accepts primary responsibility for their overall medical care.3 The ED physician is not in a position to assess, set goals, modify dose, monitor response, or discontinue use of chronic opioid therapy for chronic pain. All these are routine and important components of Risk Evaluation and Mitigation Strategy (REMS) deemed necessary by the U.S Food and Drug Administration. The absence of these routine practices places the patient at risk for harm from excessive or unnecessary amounts of opioid analgesics. The ED physician’s one-time relationship with the patient does not allow for proper prescribing or monitoring of patients with chronic pain. Also, replacing longitudinal care with repeat ED visits is a counter-therapeutic enabling action that delays patients from seeking appropriate care, pain control, and monitoring.
	+ Patient who visit the ED multiple times for chronic pain instead of visiting their primary care provider need to be re-directed back to the primary care provider. Primary care providers of patients with high ED utilization rates should receive a letter from the ED. This letter can be sent via email using CRISP DIRECT MESSAGING or other means of communication. If the primary care provider agrees, a Treatment Agreement (i.e. Pain Agreement, contract) that includes an ED care plan is started. The patient may be sent a letter to inform him/her of this course of action.
	+ Patients who visit the ED multiple times for chronic pain and do not have a primary care provider need an ED care plan. The ED care plan should stress the importance of seeing a primary care provider for chronic medical conditions and chronic pain management. The ED care plan should be filed into a dedicated section of the electronic health record so that it can be easily accessed when the patient presents to the ED.4
* ***We will often use computers to track patient visits and prescriptions.***
	+ ED physicians are encouraged to use Chesapeake Regional Information System for our Patients (CRISP) and other internal tracking systems to identify patients who have high ED utilization rates. As of 2013, all 46 acute care hospitals in Maryland, some nursing homes and some out-patient radiology facilities participate in CRISP. CRISP collects real-time clinical information regarding: encounters (i.e. ED visits, hospital visits), H&P, discharge summaries, operative notes, consultations, radiology, laboratory. The CRISP portal is a free tool available to clinical staff that allows secure access to CRISP data. Visit [www.crisphealth.org](http://www.crisphealth.org) for more information. Pilot studies show that patients with high ED utilization rates that are identified by databases such as CRISP *may* be suffering from substance abuse/addiction.
	+ The Prescription Drug Monitoring Program (PDMP) will track outpatient pharmacy and practitioner dispensation of controlled substances. The PDMP will be accessed through CRISP. Veterans Administration Hospitals will be included in the PDMP soon. Limitations of the PDMP include: Opioid Treatment Programs (i.e. methadone clinics, some buprenorphine clinics) do not report to PDMP; pharmacies that only serve hospital inpatients, nursing homes, assisted living facilities and facilities treating persons with developmental disabilities do not report to the PDMP; some dispensing to hospices do not report to PDMP; **tramadol** is NOT monitored in PDMP because it is not a controlled substance. Visit <http://adaa.dhmh.maryland.gov/PDMP/SitePages/Home.aspx> or <http://www.hidinc.com/mdpdmp.html> for more information. Lastly, Maryland’s PDMP will be establishing interoperability with neighboring states that have similar programs, including Virginia, Delaware and West Virginia (Pennsylvania will require substantial program changes). Implementation of interstate data sharing is scheduled for 2014. ED physicians should document in the patient’s medical record their query of CRISP for continuity of care.
* ***We will not provide missed doses of methadone or buprenorphine for patients in drug treatment program, except in particular situations.***
	+ Methadone should not be administered to patients who claim they missed their appointment with the opioid treatment program (i.e. methadone clinic) or vomited their dose. Exceptions can be made in cases where the patient missed his/her appointment because he/she was being worked up in the ED, was waiting to be admitted to a bed, was under “observation status” or in the unlikely case of a weather emergency or natural disaster (check ADAA website for declaration of an emergency <http://adaa.dhmh.maryland.gov/SitePages/Home.aspx>). Should one of these exceptions arise in a patient treated with methadone, the observation unit or admitting physician should call the opioid treatment program to verify the patient’s status, dose, and last dose. Always verify self-reported doses beforehand with the program. After administration of methadone, document the dose, date and time clearly. Alternatively, opioid withdrawal can be treated symptomatically with non-opioid analgesics, anti-emetics, or other medications based on the patient’s symptoms. Hospital-specific internal policies may take precedent over these recommendations.
	+ Buprenorphine should not be administered to patients who missed their appointment, vomited their dose or whose prescription was lost, stolen or destroyed. Exceptions should be made in cases where the patient missed his/her appointment because he/she was being worked up in the ED, was admitted and waiting for a bed, was under “observation status” or in the unlikely case of a weather emergency or natural disaster. Should one of these exceptions arise in a patient treated with buprenorphine, the observation unit or admitting physician should call the buprenorphine prescriber. In the event of weather emergency or natural disaster and the patient is discharged from the ED, buprenorphine can be “called in” to the retail pharmacy by the buprenorphine prescriber since it is a CSA schedule III medication.

***Acute pain:***

1. ***We will start with the safest medication.***

Consider educating the patient on the role of neurotransmitters and pain. The following example can be used: ask the patient to think back to his/her childhood and recall how long it took for the severe pain of a skinned knee to subside. This discussion may help set the framework and expectations for the ED management of their acute pain.

Non-pharmacologic treatments such as lifestyle changes (weight, exercise) should be considered. Other non-pharmacologic treatment such as physical therapy should be considered as well.

The Centers for Disease Control recommend the use of non-opioid analgesics for most cases of acute pain (e.g. toothache, migraine headaches,...) and recommends opioids for serious fractures and cancer pain only.4 National ACEP Opioid Guidelines Panel stated that, given a lack of evidence of superior efficacy of either opioid or non-opioid analgesics for low back pain, opioids should be reserved for severe pain refractory to other analgesics.6

ED physicians should prescribe codeine and tramadol with caution. **Codeine** exerts its analgesic action via CYP 2D6 conversion to morphine and this enzymatic conversion is extremely variable, potentially leading to under-treatment and overdosing.7 **Tramadol** has a narrow therapeutic index, potentially causing seizures at doses only slightly higher than therapeutic doses (500 mg); this is especially important if the patient is likely to self-escalate the dose or has a history of nonmedical use of opioids.8 Tramadol-related deaths are on the rise from 2007 to 2011 in Maryland.9 **Meperidine** should be avoided for risk of seizures as well. **Extended release/long acting** opioids should not be prescribed from the ED.

1. ***We will start with the safest effective dose if pain medications are used.***

Prescribing opioids should be limited to only the immediate treatment of acute exacerbations of pain associated with objective findings of uncontrolled pain. If opioid analgesics are prescribed for the management of pain, start with the lowest and safest dose. For example: oxycodone 5 mg; hydrocodone 5 mg (2.5 mg strengths are available but are not easily found at retail pharmacies). Higher doses increase the risk of adverse events such as respiratory depression and overdose. For example, the administration of one single dose of an opioid (e.g. 10-15 mg oxycodone) at nighttime can precipitate central sleep apnea in patients who otherwise do not display sleep-related breathing disorders. 10

1. ***We will prescribe no more than a short course of pain medications. Generally, most patients require no more than 3 days.***

Excessive supplies of opioids increase the risk of misuse, abuse, and diversion. Initiation of opioid analgesics in opioid-naïve patients may lead to inappropriate long term use. In addition, there is a large body of evidence demonstrating that injured workers treated with opioids have low levels of return to work.

There may be some acute conditions (e.g. rib fractures, long bone fractures) for which severe pain is expected to last more than 3 days and for which risks of inadequate pain control may exceed risks of a longer supply of opioids. If the patient’s acutely painful condition is expected to outlast a three-day supply of opioid medication, a re-evaluation of the condition is recommended. Consider expediting the follow-up care when these conditions are met.

1. ***We will avoid prescribing multiple medications at the same time.***

Opioid analgesics, when combined with other central nervous system depressants or given to patients with certain underlying conditions, can increase the risk for overdose, including overdose related death.

In Maryland, approximately 80% of opioid overdose deaths involve at least one additional sedative medication such as:

* benzodiazepines (alprazolam Xanax®, clonazepam Klonopin®)
* muscle relaxants (carisoprodol Soma®)
* anti-emetics (promethazine Phenergan®)
* diphenhydramine (Benadryl®, Tylenol PM®)

Avoid the combination of benzodiazepines and opioid analgesics as much as possible. Consider the following: one patient with pain = one prescription.

Opioid analgesics should be used with caution in patients with sleep-disordered breathing, such as obstructive sleep apnea, obesity or congestive heart failure. Furthermore, central sleep apnea can be induced by opioids in patients with no evidence of pre-existing sleep apnea.10 Consequently, consider modifying discharge instructions for qhs doses in patients at risk for central sleep apnea.

1. ***We may ask about drug use problems before prescribing medications.***

Patients with past or present substance use problems are at increased risk of developing opioid addiction when prescribed opioids for chronic pain, depending on the substance(s) abused.11,12 ED physicians should target their history to ask the patient about substance use disorders prior to prescribing opioid medication for the treatment of chronic pain. Past or present substance use problems should not exclude an ED patient from being prescribed opioids for chronic pain, but it should prompt a discussion with the patient about the potential for addiction. If drug misuse or addiction is identified, the physician will attempt to refer to substance use disorder treatment services.  Either direct referral to a treatment program or referral to 2-1-1 is appropriate. Consideration should be given to prescribing a smaller quantity of opioid medication and expediting follow up with the primary care provider or specialty referral. Attempts should be made to enlist a reliable family member or friend to assist in monitoring the proper use of the opioid.

***Chronic pain:***

***1. We may call your primary care doctor or pharmacy or follow the pain contract between you and your primary care doctor.***

Opioid prescriptions for exacerbations of chronic pain from the ED are discouraged. Chronic pain patients should obtain opioid prescriptions from a single provider that monitors the patient’s pain relief and functioning. The ED physician’s one-time relationship with the patient does not allow for proper monitoring of patients with chronic pain, it is a form of unmonitored opioid therapy that is not safe. It is important to keep in mind that exacerbations of pain in patients who suffer from chronic pain may be associated with affective disorders or other medical problems which may need to be addressed. In exceptional circumstances, the ED physician may prescribe opioid medication for exacerbations of chronic pain, when the following safeguards are followed:

1. Only prescribe enough opioids to last until the patient can contact their primary care provider, with a maximum of a 3-day supply (rather than a quantity sufficient to last until the next appointment). The ED physician should attempt to contact the primary opioid prescriber prior to prescribing any opioids. If the patient’s primary provider feels further opioid pain medication is appropriate, it can be prescribed by that provider, during office hours.
2. The patient’s primary opioid provider is contacted first to approve further opioids for the patient. If approved, a limited supply to last until the patient is able to see his/her primary care provider can be prescribed from the ED. This reinforces the idea that patients should obtain pain medications from the primary opioid provider only.

By having a record of the patient’s pain contract (i.e. treatment agreement), the ED physician can have a more complete picture of the patient’s request and the prescribing provider’s expectations. Treatment Agreement templates are available on-line to help primary care providers in this regard. Many EDs in Maryland started following Treatment Agreements in 2012-2013. They report success in limiting repeat visits to the ED and prescribing of opioids for chronic pain patients.

1. ***We will provide referral to a primary care doctor, if needed.***

Self-explanatory

***Repeat: We may ask about potential substance use problems and provide information on referral to treatment as appropriate before prescribing medications.***

Patients with past or present substance use problems are at increased risk of developing opioid addiction when prescribed opioids for chronic pain, depending on the substance(s) abused.11,12 ED physicians should target their history to ask the patient about substance use disorders prior to prescribing opioid medication for the treatment of chronic pain. Past or present substance use problems should not exclude an ED patient from being prescribed opioids for chronic pain, but it should prompt a discussion with the patient about the potential for addiction. If drug misuse or addiction is identified, the physician will attempt to refer to substance use disorder treatment services.  Either direct referral to a treatment program or referral to 2-1-1 is appropriate. Consideration should be given to prescribing a smaller quantity of opioid medication and expediting follow up with the primary care provider or specialty referral. Attempts should be made to enlist a reliable family member or friend to assist in monitoring the proper use of the opioid.

***3. We will not typically give out prescriptions for pain medications that were lost, stolen, or destroyed.***

Patient missing controlled substances frequently report their prescriptions were lost or stolen. Pain specialists routinely stipulate in pain treatment agreements with their patients that lost or stolen controlled substances or prescriptions will not be replaced. Most pain treatment agreements between chronic pain patients and physicians state that prescriptions will not be replaced. EDs should institute a policy locally to NOT replace prescriptions that are requested on the basis of being lost, stolen, or destroyed.

***4. We will not typically prescribe extended release/long acting opioid pain medications such as methadone, oxycodone, or fentanyl skin patches.***

Extended release/Long acting (ER/LA) opioids should not be prescribed from the ED. Dosing of ER/LA opioids must be titrated to individual response. Response may vary depending on tolerance, age, renal and hepatic function, incomplete cross-tolerance, other conditions, drug interactions, and genetics. Methadone and oxycodone are involved in more unintentional overdose deaths than any other prescription opioid in Maryland and nationwide.4,9

***Pain medications are associated with risks of overdose and addiction.***

Patients should be informed of the risks of taking opioid analgesics and be reminded to take them as directed, not more frequently or in greater quantities. Risks of opioid analgesics include, but are not limited to: overdose that can cause respiratory depression even lead to death; drowsiness leading to injury; fractures from falls; tolerance; and dependence. These risks are often underestimated. Respiratory depression is more common with co-use of alcohol, benzodiazepines, muscle relaxants, antihistamines and barbiturates. Patients should be reminded to avoid medications that are not part of their treatment plan because they may worsen side effects and increase the risk of overdose death.

***We can refer you to a drug treatment program. Or you can call the Help Line 2-1-1- or*** [***www.211md.org***](http://www.211md.org)

If drug misuse or addiction is identified, the physician will attempt to refer to substance use disorder treatment services.  Either direct referral to a treatment program or referral to 2-1-1 is appropriate. Consideration should be given to prescribing a smaller quantity of opioid medication and expediting follow up with the primary care provider or specialty referral. Attempts should be made to enlist a reliable family member or friend to assist in monitoring the proper use of the opioid.

***Safe storage info: www.fda.gov/lockitup***

Proper storage includes child-resistant packaging, keeping medications out of reach, and using a lock box if small children or teenagers are in the house. Proper disposal of medications includes flushing the medications down the toilet and taking advantage of community-sponsored drug take-back days.

**Disclaimer**

*This document should not be used to establish any standard of care. No legal proceeding, including medical malpractice proceedings or disciplinary hearings, should reference a deviation from any part of this document as constituting a breach of professional conduct. These guidelines are only an educational tool. The following recommendations are not founded in evidence-based research but are based on promising interventions and expert opinion. Additional research is needed to understand the impact of these interventions on decreasing unintentional drug poisoning and on health care costs. All of the following recommendations should be implemented in concert and collaboration with public health entities and other relevant stakeholders.*

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