



# Implementing Prescribing Guidelines in the Emergency Department

April 16, 2013



**OHIO INJURY PREVENTION  
PARTNERSHIP**

*Prescription Drug Abuse Action Group*

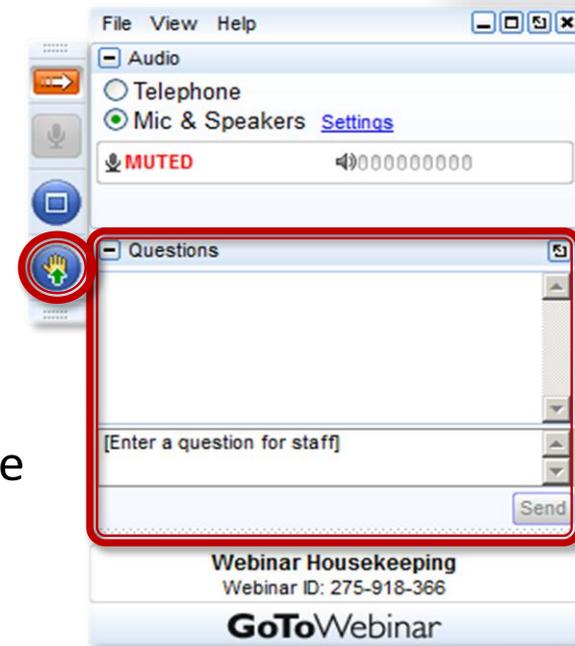
# Housekeeping

**Note:** Today's presentation is being recorded and will be provided within 48 hours.



Two ways to ask questions at the end of the webinar:

- Submit your text questions and comments using the Questions Panel.
- Please raise your hand to be unmuted for verbal questions.



# Governor's Cabinet Opiate Action Team



- Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances (OOCS) Prescribing Guidelines

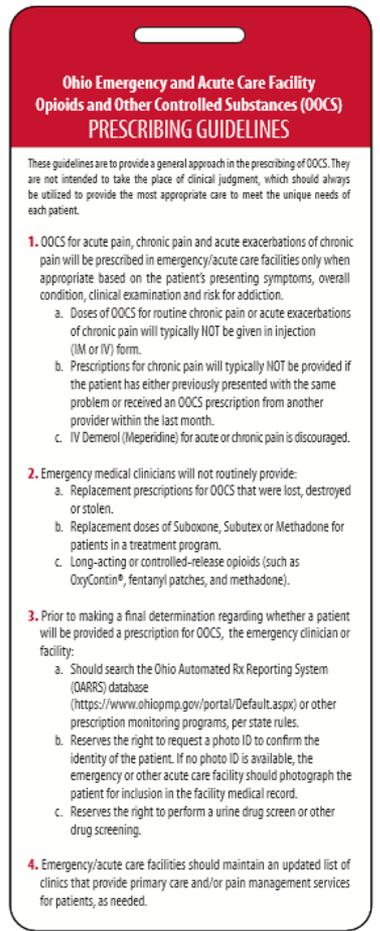
[www.healthyohioprogram.org/ed/guidelines](http://www.healthyohioprogram.org/ed/guidelines)

# Pocket Cards Available



- Limited quantities of pocket cards available.
- To request cards, please email: [HealthyO@odh.ohio.gov](mailto:HealthyO@odh.ohio.gov)
- Include your name, address, quantity requested and reason for your request.

[www.healthyohioprogram.org/ed/guidelines](http://www.healthyohioprogram.org/ed/guidelines)



# Prescription Drug Abuse Action Group



**OHIO INJURY PREVENTION  
PARTNERSHIP**

*Prescription Drug Abuse Action Group*

Next meeting May 10<sup>th</sup> from 1:00 – 3:00 pm

[www.healthyohioprogram.org/vipp/pdaag/pdaag](http://www.healthyohioprogram.org/vipp/pdaag/pdaag)

# Today's Webinar



- Dawn Prall, MD, FACEP
- Bill Quinlan, St. Luke's Hospital

[www.healthyohioprogram.org/ed/guidelines](http://www.healthyohioprogram.org/ed/guidelines)

# Implementing the Emergency Department and Acute Care Pain Management Guidelines

Dawn Prall, MD, FACEP  
April 16, 2013

# Objectives

- Discuss how prescribers can provide good care with regard to controlled substance use and chronic pain management in the acute care setting
- Describe where the acute care setting fits within the scope of chronic pain management
- Review some statistics regarding controlled substance prevalence and accidental overdose death
- Review the guidelines
- Discuss strategies for guideline implementation

# Background

- Pain relief = removing pain
- Pain management = improving one's quality of life which is affected by chronic pain through a multi-disciplinary approach

The focus of chronic pain management should be improving quality of life for people living with chronic pain, not necessarily pain relief.

This requires setting (realistic) quality of life goals and ongoing assessment.

# Background

- Chronic pain – There are many definitions.
  - Disease state characterized by persistence of pain beyond normal expected healing time. Can be complicated by environmental, psychosocial and behavioral factors. Can (and often does) co-exist with other disease.
  - Acute pain is often a SYMPTOM of an underlying problem; chronic pain is a DISEASE PROCESS in and of itself

# Background

- Chronic pain: - several types
  - Chronic benign (or non-cancer) pain – which is the \*\* focus of this discussion and the guidelines\*\*
    - Disease process that has significant impact on quality of life but by definition is not life threatening.
  - Chronic cancer pain
    - Disease process that can have significant morbidity and mortality associated with it. Treatment processes are different than for chronic benign pain syndromes.
  - Other chronic pain (like sickle cell disease)
    - Disease process that has significant morbidity and mortality associated with it. Treatment processes are different than for chronic benign pain syndromes.

# Where the acute care setting fits into chronic pain management

- Ideally, there should be 1 outpatient health care provider coordinating the patient's pain management for safety and monitoring of therapy.
- Providers in the acute care setting should be an extension of this outpatient provider, not the primary chronic pain management providers.
  - Communication and consistent care are keys to successful chronic pain management in the acute care setting.

# How do prescribers prevent inappropriate prescribing and continue to provide good care?

- Continue to be vigilant for life/limb threatening illness/injury
- Be a compassionate provider!
  - Quality of life for many patients with chronic pain is perceived by them as not being very good. Be understanding of this.
- Education (self, patients) about the different types of pain, treatment options and patients' need for active participation in their health care
  - See The American Chronic Pain Association website <http://www.theacpa.org/What-We-Have-Learned> for a good perspective on this.

# How do prescribers prevent inappropriate prescribing and continue to provide good care?

- RISK ASSESSMENT before prescribing
  - Gather background information – usually through EMR, family, outpatient physicians, etc.
  - Use OARRS
  - SBIRT for personal addiction screening and referral
    - <http://www.healthyohioprogram.org/ed/~media/FD00387E09FF494E81DE74239BD776E0.ashx>
  - Screen for mental illness and refer for treatment
    - Usually can glean through conversation
  - Consider asking about family history of addictions
  - Help set up safety plans for those at risk for misuse of prescription medication

# How do prescribers prevent inappropriate prescribing and continue to provide good care?

- Technically, on some level, we violate state medical board rules by prescribing “dangerous drugs” for “intractable pain” without performing a thorough history and physical, including assessment for addiction prior to prescribing. ( ORC 4731-21)
- Do not hesitate to prescribe controlled substances when appropriate – i.e., appropriate situation/injury in a patient with low risk for adverse events who has close follow up for monitoring use.
  - Use a safety plan in a high risk patient with acute injury appropriately treated with controlled substances (e.g., fracture, etc.)

What's the problem?

“Chronic pain affects an estimated 116 million American adults — more than the total affected by heart disease, cancer and diabetes combined.”

Report Release: Relieving Pain in America—A Blueprint for Transforming Prevention, Care, Education and Research.

<http://www.iom.edu/Reports/2011/Relieving-Pain-in-America-A-Blueprint-for-Transforming-Prevention-Care-Education-Research/Report-Release.aspx>

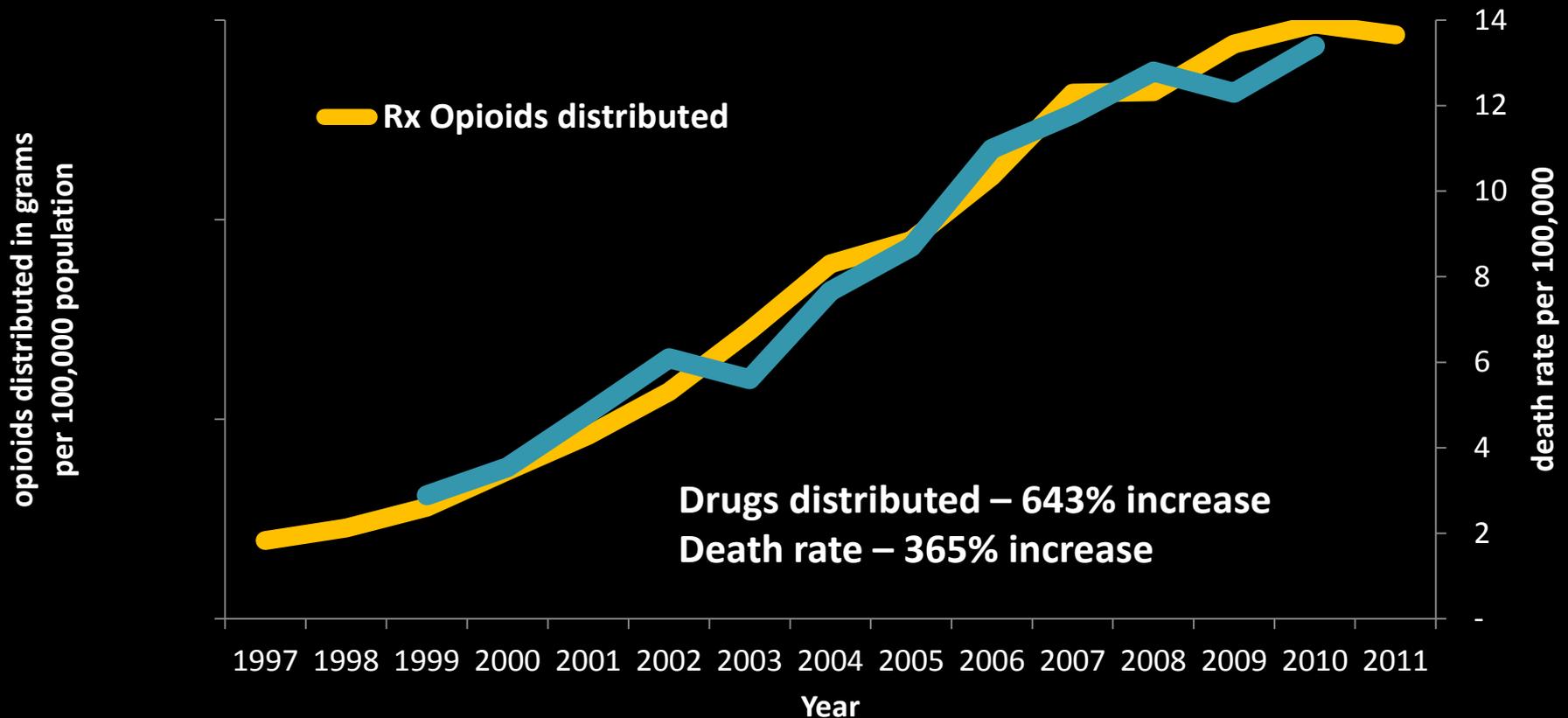
**Total # of adults in the United States in 2012 = approx. 250 million**

## CONTRIBUTING FACTORS:

# Ohio Data

There is a *strong* relationship between increases in exposure to prescription opioids and fatal unintentional overdose rates.

Unintentional fatal drug poisoning rates and distribution rates of prescription opioids in grams per 100,000 population by year, Ohio, 1997-2011 (2010 for deaths)



Sources: 1. Ohio Vital Statistics; 2. DEA, ARCOS Reports, Retail Drug Summary Reports by State, Cumulative Distribution Reports (Report 4) Ohio, 1997-2007

[http://www.deadiversion.usdoj.gov/arcos/retail\\_drug\\_summary/index.html](http://www.deadiversion.usdoj.gov/arcos/retail_drug_summary/index.html); 3. Calculation of oral morphine equivalents used the following assumptions: (1) All drugs other than fentanyl are taken orally; fentanyl is applied transdermally. 2) These doses are approximately equianalgesic: morphine: 30 mg; codeine 200 mg; oxycodone and hydrocodone: 30 mg; hydromorphone; 7.5 mg; methadone: 4 mg; fentanyl: 0.4 mg; meperidine: 300 mg; 4. US Census Bureau, Ohio population estimates 1997-2007; 5. preliminary data for 2007

# Why do we need guidelines?

- We see a lot of people with chronic pain in the acute care setting. Chronic pain is best managed with coordinated care through 1 outpatient provider.
- Though we do not prescribe a majority of the controlled substances in our country, we do interface with a lot of people at risk for misuse.
  - We have an opportunity to provide patients education about the risks of these medications.

# Why do we need guidelines?

- When we write prescriptions, we cannot monitor their effectiveness due to lack of follow up with the actual prescriber inherent in the acute care setting.
- More people die from accidental drug overdose than car accidents now. It is now the state and national #1 cause of accidental death.
- We all are part of the problem and need to be part of the solution.

**We need to be more responsible prescribers!**

# The Acute Care Pain Management Guidelines

# The Acute Care Pain Management Guidelines

- What are they?
  - They are a set of guidelines meant to provide guidance to both patients as well as health care providers in the acute care setting regarding chronic benign pain management, controlled substance prescribing and use in the acute care setting.
- What specifically can or do the guidelines cover?
  - The function of the acute care setting in management of chronic pain
  - Why restrictions on controlled substance prescribing are in place (i.e., safety)
  - Controlled substance med refills (or lack of)
  - The importance of outpatient management of chronic pain
  - Coordination of care
  - What to expect during the evaluation (safe, appropriate care)
  - Getting help for addiction

# Risk Screening

# Addiction risk screening before prescribing controlled substances

- There are many tools available:
  - SBIRT
  - CAGE-AID
  - DAST-10
  - Many others
- It can be as simple as asking about tobacco, alcohol and drug use.
- Ideally, risk screening should be done for every controlled substance prescription that is written.
  - Check Photo ID or some biometric identification
  - OARRS checking – though NARxCHECK can help make checking OARRS an faster (automatic) process.

- Risk screening for mental illness is helpful as well. Addiction and diversion risk is higher for those with uncontrolled mental illness.

# My Experience

# The Journey...

- Insight
  - Good ideas for years with too much resistance
  - Washington state program
- Local
- System-wide
- Regional
- State

# Helpful tips for implementation

- Program champion
- Administrative support
  - Tends to be easier with urgent cares than with hospital systems
- Prescribers who are willing to provide quality, compassionate care that is safe
- Coordination of care with outpatient providers and resources
  - Can use direct communication (less welcome or helpful after hours) and/or pre-determined, written care plans within the chart that are as objective as possible

# Helpful tips for implementation

- Consistent care across prescribers within the group
  - Care plans can be helpful with this.
  - If available, place copies of outpatient pain agreements in the acute care setting medical records.
  - Insurance companies can sometimes be helpful with this through care plan development, lock-in programs, etc.
- Prescriber education and support THROUGHOUT THE GROUP
  - \*\*CONSISTENT CARE on every visit IS THE CRUX OF THIS PROGRAM'S EFFECTIVENESS\*\*
- Consistent care across neighboring health systems is also very helpful.

# Helpful tips for implementation

- Community support
- Overall EDUCATION and AWARENESS
  - Involves patients, health care providers and administrators
  - Education should include basics of chronic non-cancer pain management and why these guidelines are important
- Patience and persistence!
- Program Maintenance

# Potential obstacles

- Administrators
- Health care system issues
- Risk management
- Providers
- Patients

Basically, everyone and everything you will encounter.

# Summary

- “Buy in” and education of all parties is key to successful implementation.
- Education is ongoing.
- Focus on providing good AND compassionate care.
  - Remember that chronic pain, addiction and mental illness are all diseases. They need to be treated as such.
- Understand the risks and benefits of what you are prescribing or recommending to patients.
- Always be vigilant for life threatening disease.
- Do not hesitate to prescribe when appropriate but screen for risk before you prescribe!
  - Use OARRS and check identification
  - Cautious prescribing controlled substances to those with uncontrolled mental illness
  - Use safety plans when appropriate



**Lessons Learned : Implementing Prescribing Guidelines in the  
Emergency Department**

## St. Luke's Hospital Managing Chronic Pain in the ER

- Planning began in 2009 when the ED physician leadership requested help.
- St. Luke's had become known as the place to go to get drugs – “Patient testimonial”
- Physicians and staff asked to identify frequent flyers
- Ten patients had over 22 visits (average 38 visits) in 2008 totaling 379 visits.
- One patient had 80 visits.
- 19 patients were identified as “drug seeking”

## St. Luke's Hospital Managing Chronic Pain in the ER

### Critical Issue

Physicians must be signed up to request OARRS reports.

Nurses or clerks should also be signed up to request OARRS reports.

OARRS reports should be requested on any patient with chronic pain issues or if the physician is suspicious of drug seeking behavior.

OARRS are stored in the medical record, read only.

## St. Luke's Hospital Managing Chronic Pain in the ER

Physicians requested one page form with history of pain treatment in the ED.

Form was developed with chief pain complaint, demographics, encounters, and number of CT scans, and nine questions to screen for drug seeking behavior.

# Pain Treatment History form

Includes demographics:

Date form completed

Patient name and DOB

PCP and specialists seen

Allergies

Chief pain complaint

Abdominal, migraine/headache, back/neck,  
toothache, other

# Pain Treatment History form

Encounter and x-ray information:

Number of ED visits two previous years

Number of inpatient stays

Number of imaging studies

CT scans

Other imaging

# Pain Treatment History form

## Screening questions:

History of multiple visits to other local ED's?

Requests a specific drug?

Requested specific physician?

Did the patient get agitated if drugs not given?

Security involvement?

AMA after being denied opioid?

Is there a pain management contract with any physician?

Was an OARRS report requested?

# Pain Treatment History form

Pain Treatment History forms are completed retrospectively for all patients identified as having chronic pain or suspected of being drug seekers.

ED nurses complete forms in “spare” time!

Completed forms are stored in medical record in a “Universal” folder that is accessible without opening an encounter record.



St. Luke's Hospital  
Maumee, Ohio

Pain Treatment History - Emergency Department  
History form completion date 10-6-09



Patient name [redacted] FOR 1-28-79

Medical record # [redacted] Family physician Ø

Specialist upon [redacted]

Allergies ASA, AMPICILLIN, CODEINE, ULTRAM, ULTRACET, NUBAIN  
DEMEROL

Chief Pain Complaint:

- Abdominal pain # 7
- Migraine/Headache # \_\_\_\_\_
- Back/Neck pain # 4
- Sorethroat/Jaw pain # \_\_\_\_\_
- Sickle Cell pain # \_\_\_\_\_
- Other FALL 71

Questions	Yes	No
Is there a history (physician dictation) of multiple visits to other hospitals? Date: <u>7-05-07 3-27-09</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Has the patient requested a specific pain medication? Medication(s) requested: <u>PERCOCET DILAUDID(4-6 DOSES)</u> <u>XANAX FOR ANXIETY</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Has patient requested a specific physician? Date: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has this patient become agitated if the requested medication is not given? <u>5-14-08   7-16-09</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Was security notified? Comments _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Has the patient ever indicated a prescription was lost, stolen, damaged or not received? <u>3-20-09 MULTIPLE NAMES</u> <u>"SOMEONE IS STEALING MY IDENTITY" -&gt; ON CARS</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Has the patient ever left the ED AMA after being denied an opioid? Date: <u>5-14-08</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Has the patient ever presented to hospital with an alias name? Date: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Is there a pain management contract with any physician? Date: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Ohio Automated RX Reporting System (OARRS) check completed? Date: <u>7-05-07 5-14-08 3-20-09</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Social Service consultation ordered? Date: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Pain specialist consultation ordered? Date: _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Number of SLH ED visits: 2009 6 2008 6 2007 1  
 Number of SLH inpatient visits: 2009 0 2008 1 2007 \_\_\_\_\_  
 Number of imaging studies at SLH:  
 2009: CT scan: 1 MRI \_\_\_\_\_ RAD imaging 2 Other \_\_\_\_\_  
 2008: CT scan: 1 MRI \_\_\_\_\_ RAD imaging 8 Other 1 GAUSS 10BECHD  
 Pattern of ED visits by time of day:  Days  Evenings  Nights  
 Name of person completing form Altogether

\*HAS CALLED 911 X2 FROM [redacted] AFTER UNSAT. TX IN



# Individualized Treatment Plans

Next step:

To provide consistency, individualized treatment plans were developed.

Each plan contains specific medication choices based on the patient's history.

Physicians are requested to follow plan when the patient presents with “typical” presentation.

Physicians are free to ignore plan.

# Individualized Treatment Plans



St. Luke's Hospital  
Maumee, Ohio

## Individualized ED Pain Care Plan

**USE this plan once it is established that this is a typical presentation for this patient.**



Date Plan Established: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Allergies: Refer to pain history and review current list in MEDHOST.

Current Medications list in MEDHOST/ChartMaxx.

Typical Presentation/Complaints: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Treatment Recommendations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Individualized Treatment Plans

Treatment plans are developed by ED physicians.

Plans are stored with the pain history in the Universal folder of the medical record.

Physicians are encouraged to share the plan with the patient.

Patient input is requested and welcomed.

## St. Luke's Hospital Managing Chronic Pain in the ER

Process:

Alert is entered into A/D/T system that history and treatment plans are available.

Nursing notified by registration clerk and then print history and treatment plan.

Nurse or physician prints OARRS.

Information is available to physician either before or after initial visit.

## St. Luke's Hospital Managing Chronic Pain in the ER

“List”

19 in 2008      289 in 2009      1234 current

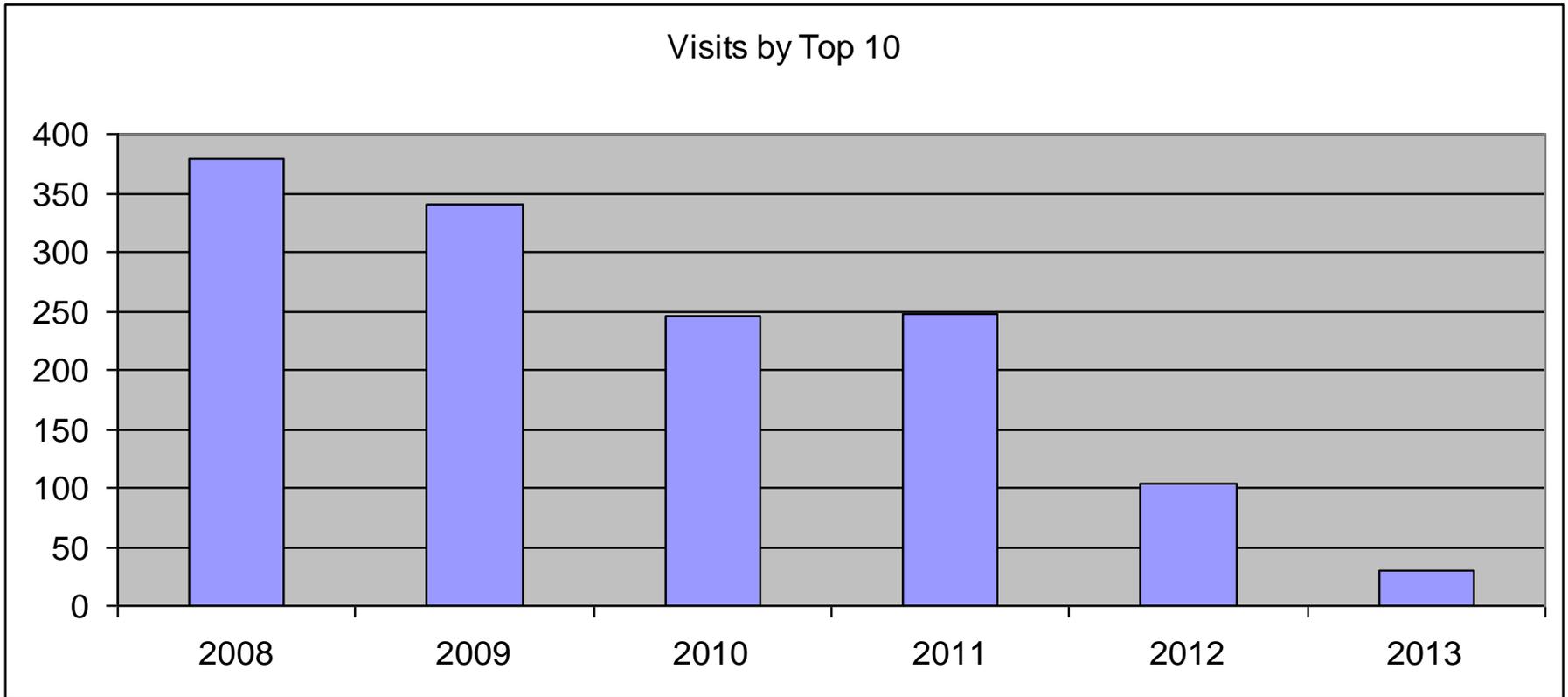
1056 with OARRS on file

695 with histories

106 with treatment plans

**17 patients known to have expired**

# Results



## Number of Visits in 2012 (All Patients on list)

46%

zero

93%

<5

98%

<10

2%

>=10

Highest number of visits by one patient in 2012 - 17

**St. Luke's Hospital**  
**Managing Chronic Pain in the ER**

Bill Quinlan

Risk Manager

419-893-5906

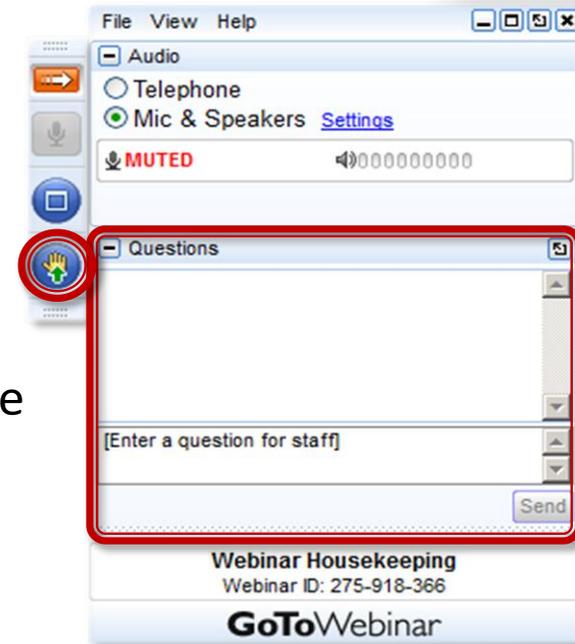
[william.quinlan@promedica.org](mailto:william.quinlan@promedica.org)

# Questions?



Two ways to ask questions:

- Submit your text questions and comments using the Questions Panel.
- Please raise your hand to be unmuted for verbal questions.





Cameron McNamee  
Injury Prevention Policy Specialist  
[cameron.mcnamee@odh.ohio.gov](mailto:cameron.mcnamee@odh.ohio.gov)



**OHIO INJURY PREVENTION  
PARTNERSHIP**

*Prescription Drug Abuse Action Group*