

Emergency and Acute Care Facility Opioid and Other Controlled Substances Prescribing Guidelines (ED Guidelines) *Frequently Asked Questions*

What are the Emergency and Acute Care Facility Opioid and Other Controlled Substances (OOCs) Prescribing Guidelines (ED Guidelines)?

Under the leadership of the Governor's Cabinet Opiate Action Team (GCOAT) Professional Education Workgroup (PEW), Emergency Department Opiate Prescribing Guidelines Committee, the *Emergency and Acute Care Facility Opioid and Other Controlled Substances Prescribing Guidelines (ED Guidelines)* were developed to help emergency and other acute care facilities reduce inappropriate prescribing of opioid pain medication while preserving their vital role of treating patients with emergent medical conditions. They are intended to provide appropriate clinical guidance for the prescribing of opioids and other controlled substances in the unique acute care environment where the treatment of pain is frequently indicated without the benefit of an established patient-doctor relationship.

Why focus on Opioid Prescribing?

From 1999 to 2010, drug overdose deaths increased 372 percent in Ohio from 327 to 1,544, the highest number on record. This is equivalent to 4 Ohioans dying every day or one Ohioan dying every 6 hours. Unintentional drug overdose continues to be the leading cause of injury-related death in Ohio, ahead of motor vehicle traffic crashes, suicide and falls. Prescription drugs are involved in most of the unintentional drug overdoses and have largely driven the rise in deaths. Prescription opioids (pain medications) are associated with more fatal overdoses than any other prescription or illegal drug including cocaine and heroin combined. Nearly half (45 percent) of fatal unintentional overdoses involved prescription opioids in Ohio in 2010, compared to 39 percent in 2009.

Why focus on Emergency Departments/Acute Care Facilities?

The PEW decided to address the emergency and acute care setting first because of the positive attitude of its clinicians in wanting to get a more consistent approach to pain management in the EDs across Ohio, and because of its more controlled setting and operation. In addition, of the 374,891 ED visits in the U.S. during 1993-2005, 42 percent were related to pain and nearly one-third (29 percent) of patients received an opioid. The overall number of opioid prescriptions written during ED visits for pain increased 14 percent during this time period. Overall, 23 percent of these patients received a prescription for an opioid analgesic in 1993 compared to 37 percent in 2005. (*Source: JAMA, Trends in Opioid Prescribing by Race/Ethnicity for Patients Seeking Care in US EDs, 2008*)

Treatment of pain is frequently indicated in the emergency/acute care setting, but without the benefit of an established doctor-patient relationship. It is also often conducted in an environment of limited resources including prescriber time and diagnostic information.

In Ohio, **16 percent** of fatal overdose victims in 2008 had a history of *doctor shopping* (filled prescriptions from at least five different prescribers per year) in the two years prior to their death. (Source: OAARS & ODH Vital Statistics). Doctor shopping often occurs in the ED setting. The closure of “pill mills” associated with HB 93 in 2011 may result in increased drug seeking behavior (e.g. doctor shopping) at EDs. For these reasons, the Professional Education Workgroup identified the ED/acute care setting as a critical first step in addressing responsible opioid prescribing practices.

The emergency clinician is not in a position to monitor the effects of chronic opioid therapy and therefore should prescribe opioids for the treatment of chronic pain only in very limited circumstances. Repeated prescribing of OPCS from the emergency department/acute care facility is a counter-therapeutic enabling action that delays patients from seeking appropriate pain control and monitoring. Prescribing OPCS for chronic pain from the emergency department/acute care facility should be limited to only the immediate treatment of acute exacerbations of pain associated with objective findings of uncontrolled pain. Chronic pain treatment requires monitoring the effects of the medication on pain levels and patient’s level of functioning. The emergency clinician’s one-time relationship with the patient does not allow proper monitoring of the patient’s response to chronic opioids. The absence of prescription opioid monitoring places the patient at risk for harm from excess or unnecessary amounts of these medications. However, as emergency departments and other acute care facilities routinely serve patients seeking relief from acute pain or exacerbation of chronic pain the recommended practices set forth in this document are intended as guidance for staff members in emergency departments and acute care facilities in their provision of patient care. **These guidelines are not intended to take the place of clinical judgment, which should always be utilized in order to provide the most appropriate care to meet the unique needs of each patient.**

How were the Guidelines developed in Ohio?

The Guidelines were developed through a multidisciplinary effort headed by the Professional Education Workgroup of the Governor’s Cabinet Opiate Action Team (GCOAT), which involved state medical and health care associations, emergency departments and acute care facilities, state agencies and boards, as well as individual health care professionals. The Professional Education Workgroup is tasked to address provider education around pain management and opioid use, which continues to be a significant need

A subgroup of the Professional Education Workgroup was formed to develop the guidelines. Endorsing organizations are listed on the final ED Guidelines on the ODH website at <http://www.healthyohioprogram.org/ed/guidelines.aspx> however the Professional Education Workgroup is an even broader group of interested health care professionals and stakeholders. This group used Washington State’s ED opioid prescribing guidelines as a starting point and then provided Ohio-specific information, expertise and feedback. The Guidelines were developed and approved through consensus.

Who has officially endorsed the Guidelines?

The guidelines are endorsed by Ohio American College of Emergency Physicians, Ohio Association of Health Plans, Ohio Association of Physician Assistants, Ohio Bureau of Workers' Compensation, Ohio Hospital Association, Ohio Osteopathic Association, Ohio Pharmacists Association, Ohio State Medical Association, and Ohio Bureau of Workers' Compensation and facilitated by the Ohio Departments of Health and Aging.

Are the ED Guidelines to be considered clinical requirements or standards of care?

The ED Guidelines are not intended to be protocols or requirements for care. They are guidelines. The Guidelines take into account that they are unable to address the myriad circumstances and challenges that may present in the emergency/acute care setting, especially with chronic pain patients and/or individuals impacted by opioid-addiction. Clinical judgment is still the determining factor in prescribing practices. There is growing professional recognition however, that current opioid prescribing practices for chronic pain may not only be ineffective, but may actually have a damaging long-term impact on patients. For example, injured workers who are on long-term or high dose opioid therapy have longer recovery times and resulting workers' compensation costs than those on lower dose/short-term opioid use or alternative pain management care (Source: Pain Pills Add Cost and Delays to Job Injuries, New York Times, June 3, 2012). In conjunction with the Guidelines, the Professional Education Workgroup recommends ongoing continuing education for emergency/acute care providers who prescribe opioids.

What do we do in rural areas where there are no pain management specialists and/or primary care physicians will no longer take pain patients?

These guidelines are not intended to take the place of clinical judgment, which should always be utilized in order to provide the most appropriate care to meet the unique needs of each patient. While it is generally recognized that a primary care provider or pain management specialist *should* provide chronic pain management for a patient instead of the emergency/acute care provider, the Professional Education Workgroup recognizes that PCPs or pain specialists are not always available or willing to take on new chronic pain patients. To that end, the guidelines provide an option for the treatment of pain by ED and acute care physicians through the use of pain agreements. These pain agreements typically identify patient responsibilities and explain the potential for and consequences of misuse and addiction. The corresponding ED Guidelines background paper provides more information for clinicians regarding the treatment of chronic pain in the ED/acute care facility including sample pain agreements. This information is posted to the Ohio Department of Health's web site: <http://www.healthyohioprogram.org/ed/guidelines.aspx>.

With the closing of Ohio pill mills, won't the ED Guidelines hurt chronic pain patients who are uninsured or who have no other options for pain management?

The ED Guidelines are not intended to shut the door on people in need of help. They are intended to provide uniform guidance to emergency/urgent care providers about appropriate use of these powerful, highly addictive substances in this specialized care setting that *generally* does not have the

benefit of a well-established physician/patient relationship. The goal is to break the cycle and prevent additional problems through updated opioid prescribing practices.

While it is generally recognized that a primary care provider or pain management specialist *should* provide chronic pain management for a patient when necessary instead of the emergency/acute care provider, the Professional Education Workgroup recognizes that PCPs or pain specialists are not always available or willing to take on new chronic pain patients. To that end, the guidelines provide an option for the treatment of pain by ED and acute care physicians through the use of pain agreements. These pain agreements typically identify patient responsibilities and explain the potential for and consequences of misuse and addiction. The corresponding ED Guidelines background paper provides more information for clinicians regarding the treatment of chronic pain in the ED/acute care facility including sample pain agreements. This information is posted to the Ohio Department of Health's web site: <http://www.healthyohiprogram.org/ed/guidelines.aspx>.

What is SBIRT?

SBIRT is Screening, Brief Intervention and Referral to Treatment. Conducting a brief (three to five questions) screening for risk for addiction can serve as an early intervention and reduce risky alcohol and drug use before it leads to more severe consequences or dependence. SBIRT can serve as an early intervention and connect individuals with substance dependence to treatment options. Screening patients in emergency settings makes it possible to use their substance use-related injury or illness as motivation to change. There are many evidence based SBIRT screening tools available which can be adapted easily to almost any health or specialty setting. With proper training, brief interventions can be delivered in emergency settings by physicians, nurses, case managers, crisis counselors, social workers, or a chemical dependency professional. Sample tools are available at: <http://www.healthyohiprogram.org/ed/guidelines.aspx>

Doesn't EMTALA require emergency providers to treat a patient's pain in the ED?

The emergency physician is required by law to evaluate an emergency/acute care facility patient who reports pain. The law allows the emergency clinician to use their clinical judgment when treating pain and does not require the use of opioids. The Emergency Medical Treatment and Active Labor Act (EMTALA), passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1986, also referred to as "the COBRA law", does not require the emergency medical clinician to provide pain relief for patients that do not have an emergency medical condition. Once a medical screening exam determines patient does not have an emergency medical condition, there is no obligation under EMTALA to treat a patient's pain in the emergency facility. The EMTALA definition of a medical emergency makes reference to severe pain as a symptom that should be investigated that may be resultant to an emergency medical condition. EMTALA does not state that severe pain is an emergency medical condition. The Centers for Medicare and Medicaid Services (CMS) requires the hospital to have policies for accessing a patient's pain and documenting the assessment. EMTALA does not obstruct the emergency medical clinician from applying their professional judgment to withhold opioid treatment of pain for emergency/acute care facility patients without an emergency medical condition.

What are the next steps for the Professional Education Workgroup now that the ED Guidelines are completed?

The next task of the Professional Education Workgroup is to develop consensus-based guidance for responsible opioid prescribing for non-cancer, non-hospice care in more general prescribing settings. This may involve the work of setting a threshold or trigger at which point a specialist referral or additional prescriber training would be required prior to proceeding. This work will assist primary care physicians in knowing when they should treat chronic pain and when a referral to a pain medicine specialist is required. The group is meeting monthly and meetings are open to the public. Should you wish to attend meetings of the Professional Education Workgroup, please contact the Ohio Department of Aging.

What is the Governor’s Cabinet Opiate Action Team?

The Governor’s Cabinet Opiate Action Team (GCOAT) was established under the leadership of the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) in the fall of 2011 to address the continuing epidemic of misuse and abuse and overdose from prescription opioids. The GCOAT consists of five working groups: (1) Treatment--includes Medication Assisted Treatment; (2) Professional Education; (3) Public Education; (4) Enforcement; and (5) Recovery Supports.

What is being done through the GCOAT to assist those who are already addicted to prescription opioids?

The GCOAT's Treatment Workgroup (TW) is also working to address the treatment needs of opioid addicted Ohioans. Recognizing that the relapse rates for individuals addicted to opioids ranges from 80 – 95 percent without medication assisted treatment, the TW is working to expand effective treatment options for opioid addicted Ohioans. Under the leadership of ODADAS, the TW has developed and is implementing low-dose medication-assisted treatment protocols for the treatment of opioid addiction. More information regarding these protocols and the work of the Treatment Workgroup can be accessed here:

<http://www.odadas.ohio.gov/public/ContentLinks.aspx?SectionID=e7c37d02-288f-4c68-a51d-3807c218a0a1>

For more information on substance abuse treatment, please contact ODADAS at: 1-800-788-7254.