

**Ohio Emergency and Acute Care Facility
Opioids and Other Controlled Substances (OOCs) Prescribing Guidelines
Background Document**

ACKNOWLEDGEMENT

The Professional Education Workgroup of the Governor’s Cabinet Opiate Action Team (GCOAT) would like to acknowledge the hard work of the Washington State Emergency Department Provider Workgroup for providing the source material featured in this document. More information on the Washington State prescribing guidelines can be accessed here: <http://www.washingtonacep.org/painmedication.htm>.

BACKGROUND

According to the Centers for Disease Control and Prevention (CDC), the misuse and abuse of prescription painkillers was responsible for more than 475,000 emergency department visits in 2009, a number that nearly doubled in just five years.ⁱ The Drug Abuse Warning Network (DAWN) reports that in 2009, a quarter of all drug-related ED visits and over half of ED visits for drug abuse or misuse, an estimated 1,079,683 ED visits, involved the nonmedical use of prescription drugs, over-the-counter medicines, or other types of pharmaceuticals.ⁱⁱ

As the use of OOCs for chronic non-cancer pain has increased, so have unintended consequences related to this usage. From 1999 to 2010, drug overdose deaths increased 372% 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.ⁱⁱⁱ In addition, on average from 2007-09, there were 19 ED visits each day in Ohio for unintentional drug overdose amounting to nearly 2,000 per year. At least 1 in 5 (19%) of these are related to opioids.^{iv}

Another consequence of OOCs use is the burgeoning need for treatment specific for opioid addiction. According to the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) there has been a more than 300% increase in the number of admissions for substance abuse treatment for opioids in Ohio from 1993 to 2008.^v

These guidelines are intended to help emergency and other acute care facilities reduce the inappropriate use of OOCs while preserving their vital role of treating patients with emergent medical conditions. These guidelines were developed by the Emergency Department Opiate Prescribing Guidelines Committee convened by the Ohio Department of Health and the Ohio Department of Aging under the Professional Education Work Group of the Governor’s Cabinet Opiate Action Team (GCOAT). The Guidelines Committee included

representation of state medical and health care associations, emergency departments, acute care facilities, state agencies and boards, as well as individual physicians, nurses, physician assistants and other clinicians.

INTRODUCTION

Ideally, a primary care provider and/or pain management specialist should provide pain management for a patient. The American Pain Society's guidelines recommend that all patients on chronic opioid therapy should have a clinician who accepts primary responsibility for their overall medical care.^{vi}

Emergency physicians and other emergency clinicians are highly trained to look for and treat emergency medical conditions and use their best judgment when treating pain. However, emergency clinicians are not in a position to monitor the effects of chronic opioid therapy and therefore should generally try to avoid prescribing opioids for the treatment of chronic pain. 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, for a variety of reasons including a patient's lack of insurance and/or access to care, 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.**

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", requires the emergency physician to evaluate every patient who presents to the ED. 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 Center for Medicare Services (CMS) requires the hospital to have policies for accessing a patient's pain and documenting the assessment. Emergency medical clinicians should use their professional judgment when prescribing or withholding opioid treatment. There is no obligation under EMTALA to treat a patient's pain in the emergency facility.

GUIDELINES

1. **OOCs for acute pain, chronic pain and acute exacerbations of chronic pain will be prescribed in emergency/acute care facilities only when appropriate based on the patient's presenting symptoms, overall condition, clinical examination and risk for addiction.**

Screening for risk for addiction:

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. This screening, often called Screening, Brief Intervention and Referral to Treatment (SBIRT), can serve as an early intervention and connect individuals with substance dependence to treatment options. Screening patients including adolescents 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. The CRAFFT^{vii} is recommended as a tool for screening adolescents for potential substance misuse or abuse. **(Screening tool examples – Attachment A)**

The Washington State Screening, Brief Intervention, Referral and Treatment (WASBIRT) Program has proven the effectiveness of providing brief intervention, brief therapy and treatment referral to high-risk substance abusers who frequent hospital EDs, with substantial declines in illicit drug use. Among high-risk users of prescription opioids, at six-month follow-up, there was a 41% reduction in days of drug use (from 12.8 to 7.5 days) for individuals who received only a brief intervention, and a 54% reduction (from 14.4 days to 6.6 days) for individuals who received a brief intervention, followed by brief therapy or chemical dependency treatment.^{viii}

Patients with a history of or current substance abuse are at increased risk of developing opioid addiction when prescribed opioids for acute pain.^{ix x} Emergency medical providers should ask the patient about a history of or current substance abuse prior to prescribing opioid medication for the treatment of acute pain. A non-opioid regime should be offered to emergency facility patients with acute pain and a history of or current substance abuse. A history of or current substance abuse should not exclude an emergency facility patient from being prescribed opioids for acute pain but it should prompt a discussion with the patient about the potential for addiction. Consideration should be given to prescribing a smaller quantity of opioid medication, with follow up opioid monitoring in patients with a history of or current substance abuse. The patient's primary care provider should be notified of their patients' treatment. Emergency medical clinicians wishing to perform more extensive screening for the risk of opioid addiction are encouraged to use tools such as those included in Attachment A.

- a. Doses of OOCs for routine chronic pain or acute exacerbations of chronic pain will typically NOT be given in injection (IM or IV) form.
 - Parenteral opioids should be avoided for the treatment of chronic pain in emergency/acute care facilities because of their short duration and potential for addictive euphoria. Generally, oral

opioids are superior to parenteral opioids in duration of action and provide a gradual decrease in the level of pain control. When there is evidence or reasonable suspicion of an acute pathological process causing the acute exacerbation of chronic pain then parenteral opioids may be appropriate. Under special circumstances intravenous or intramuscular opioids may be administered in the emergency/acute care facility when an emergency care plan is coordinated with the patient's primary care provider.

b. Prescriptions for chronic pain will typically NOT be provided if the patient has either presented with the same problem or received an OPCS prescription from another provider within the last month.

- Chronic pain treatment requires monitoring the effects of the medication on pain levels and patient's level of functioning. The emergency medical provider is not capable of providing this monitoring. The absence of prescription opioid monitoring places the patient at risk for harm from excess or unnecessary amounts of these medications. The emergency medical clinician's one-time relationship with the patient does not allow proper monitoring of the patient's response to chronic opioids.

c. IV Demerol (Meperidine) for acute or chronic pain is discouraged.

- Demerol[®] use has been shown to induce seizures through the accumulation of a toxic metabolite with a long half-life that is excreted by the kidney. Demerol[®] has the lowest safety margin for inducing seizures of any opioid. Numerous reviews of Meperidine's pharmacodynamic properties have failed to demonstrate any benefit to using Meperidine in the treatment of common pain problems.^{xi xii}

2. Emergency medical clinicians should not provide:

a. Replacement prescriptions for OPCS that were lost, destroyed or stolen.

- Patients misusing controlled substances frequently report their prescriptions were lost or have been stolen. Pain specialists routinely stipulate in pain agreements with patients that lost or stolen controlled substances will not be replaced. Most pain agreements between chronic pain patients and physician states that prescriptions will not be replaced. Emergency/acute care facilities should institute a policy not to replace prescriptions that are requested on the basis of being lost, stolen, or destroyed.

b. Replacement doses of Suboxone, Subutex or Methadone for patients in a treatment program.

- Methadone should not be prescribed or administered as opioid substitution therapy from the Emergency/acute care facility. Methadone has a long half-life and patients who are part of a daily methadone treatment program that miss a single dose will not go into opioid withdrawal for 48 hours. Opioid withdrawal is not an emergency medical condition. The emergency medical provider should consider that the patient may have been discharged from a methadone treatment program for noncompliance or is not enrolled. The emergency medical provider or admitting physician should call the methadone treatment program if the patient is admitted to the hospital. The patient's status in the methadone treatment program should be verified and the patient's methadone dose should be documented for continued dosing while hospitalized.

- Suboxone and Subutex are narcotic medications used for the treatment of opioid dependence and are available only by prescription. According to the Medication-Assisted Treatment Policy Statement^{xiii} from the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) these medications must be taken under a doctor's care as prescribed and require monitoring as part of an overall treatment program. Replacement doses of these medications should not be prescribed in an emergency or acute care setting.

c. Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone).

- Long acting opioids should not be prescribed from the emergency/acute care facility because this treatment requires monitoring which the emergency medical provider cannot provide. Methadone and oxycodone are involved in more unintentional opioid overdose deaths than any other prescription opioid.^{xiv}

3. Prior to making a final determination regarding whether a patient will be provided a prescription for OPCS the emergency clinician or facility should:

a. Request a photo ID to confirm the identity of the patient. If no photo ID is available, the emergency or other acute care facility should photograph the patient for inclusion in the facility medical record.

- Patients who lack picture ID should be photographed. Photographing the patient improves patient safety by providing a means of positive ID of the person treated. Patients who present to multiple emergency/acute care facilities and provide false information to obtain controlled substances often do not provide photo ID. This is done to hide the patient's history of multiple visits from the emergency/acute care facility staff. Photographing patients may dissuade them from providing false information because the photograph provides documentation they presented to the emergency/acute care facility. Triage documentation provided to the emergency clinician should indicate if the patient provided ID.
- Patients abusing or diverting prescriptions sometimes provide a fictitious name when registering in the emergency/acute care facility and receive prescriptions under the fictitious name. Ohio law does not require the patient to present an ID when filling a controlled substance prescription. However, emergency/acute care facility staff members are required pursuant to Ohio Revised Code (ORC) 2921.22(A)(1), to contact local law enforcement if they suspect a felony is being committed: "Except as provided in division (A) (2) of this section, no person, knowing that a felony has been or is being committed, shall knowingly fail to report such information to law enforcement authorities." Attempting to obtain controlled substances by fraud, deceit, or subterfuge is a felony under Ohio Revised Code (ORC) 2925.22 - Deception to obtain a dangerous drug.

<http://codes.ohio.gov/orc/2925.22>

b. Search the Ohio Automated Rx Reporting System (OARRS) database.

<https://www.ohiopmp.gov/portal/Default.aspx>

- OARRS was established in 2006 as a tool to assist healthcare professionals in providing better treatment for patients with medical needs while quickly identifying drug-seeking behaviors. An OARRS Prescription History Report can assist in assuring that a patient is getting the appropriate

drug therapy and is taking their medication as prescribed. Prescribers, pharmacists and officers of law enforcement agencies whose primary mission involves enforcing prescription drug laws can register for an OARRS account. Registered prescribers may also permit delegates to register for an OARRS account in order to request Prescription History Reports on the prescriber's behalf.

House Bill 93 of the 129th General Assembly required professional licensing boards to adopt administrative rules specifying when a health care provider is required to review information in OARRS. These rules can be accessed here:

- Medical Board: <http://codes.ohio.gov/oac/4731-11-11>
- Nursing Board: <http://codes.ohio.gov/oac/4723-9-12>
- Pharmacy Board: <http://codes.ohio.gov/oac/4729-5-20>
- Dental Board: <http://codes.ohio.gov/oac/4715-6-01>

4. Emergency/acute care facilities should maintain a list of clinics that provide primary care for patients, as needed.

- Emergency/acute care facility staff should encourage patients to seek primary care in non-emergent care settings. Emergency clinicians and other emergency/acute care facility staff should counsel over utilizing patients on appropriate venues for their symptoms and provide patients with an up-to-date list of clinic resources. The emergency clinician should not feel compelled to prescribe opioids due to the patient's lack of a primary care provider.

5. Prior to making a final determination regarding whether a patient will be provided a prescription for an OPCS, the emergency clinician is encouraged to do the following, as indicated:

- a. Contact the patient's routine provider who usually prescribes their opioid or other controlled substance.
 - An emergency/acute care facility's care coordination program (if available) should contact the patient's primary care providers to notify them of the patient's over utilization of the emergency/acute care facility and formulate an emergency care plan. Providing prescriptions for OPCS for chronic pain when the primary care provider is not available for a consultation is discouraged. When the patient does not have a primary care provider it is recommended that an emergency care plan be created by the emergency clinician. This plan should stress the importance of seeing a primary care provider for chronic medical conditions and chronic pain management. The emergency care plan should be filed in the patient's medical record.
- b. Request a consultation from their hospital's palliative or pain service (if available) to see the patient in the emergency department.
 - Palliative care focuses on patients of all ages with a chronic disorder – whether an illness, condition, or injury – that adversely affects daily functioning or reduces life expectancy. The main goals of palliative care are to prevent and relieve suffering and to enable the best quality of life possible for patients and their families, no matter what the stage of the disorder, the need for other treatments, or the setting in which care is delivered.^{xv} If an emergency/acute care clinician has access to a palliative or pain service a consultation can provide additional options for patients with chronic pain.

c. Request medical and prescription records from other hospitals, provider's offices, etc.

- The exchange of medical information between emergency medical providers who have treated the patient is HIPAA compliant. Sharing patient visit information between urgent care centers and emergency departments is also encouraged.
- The HIPAA Privacy Rule^{xvi} allows doctors, nurses, hospitals, laboratory technicians, and other health care providers to share protected health information, such as X-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes without the patient's authorization. These treatment communications may occur orally or in writing, by phone, fax, e-mail, or otherwise. This includes sharing the information to consult with other providers to treat a different patient, or to refer the patient. For more information visit:
www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/usesanddisclosuresfortpo.html

d. Request that the patient sign a "pain agreement" that outlines the expectations of the emergency clinician with regard to future prescriptions for OPCS.

- A pain agreement is a signed document between a medical provider and a patient that includes conditions under which a patient is prescribed OPCS for chronic pain. The agreement typically identifies patient responsibilities and explains the potential for and consequences of misuse and addiction. **(Example Pain Agreements– Attachment B)**

6. Emergency/acute care facilities should use available electronic medical resources to coordinate the care of patients who frequently visit the facility, allowing information exchange between emergency/acute care facilities and other community care providers.

Information sharing regarding visits to emergency/acute care facilities can identify patients with multiple emergency/acute care facility visits. This allows the emergency clinician to appropriately treat the patient and work to prevent drug-seeking behavior. See HIPAA information above in 5c.

7. Except in rare circumstances, prescriptions for OPCS should be limited to a three-day supply. Most conditions seen in the emergency/acute care facility should resolve or improve within a few days. Continued pain needs referral to the primary care provider or specialist for re-evaluation.

Large prescriptions promote a longer period of time to elapse before the patient's pain control and function can be evaluated by a physician. Large prescriptions also increase the potential for diversion and abuse. Opioid prescriptions for exacerbations of chronic pain from the emergency/acute care facility are discouraged. Chronic pain patients should obtain opioid prescriptions from a single opioid prescriber that monitors the patient's pain relief and functioning. Prior to prescribing opioids an OARRS search should be conducted to determine the patient's prescription history and to verify recent prescriptions for pain medications are from the patients primary opioid prescriber and not from multiple prescribers (see Section 3b. above). If OARRS is unavailable, the patient's pharmacy should be contacted to determine the prescription history. No opioids should be prescribed if the patient misrepresents the opioid prescriptions. Providing false information in an effort to obtain prescription opioids is an aberrant medication taking behavior that can signal an addiction problem. Such misrepresentation is unlawful in Ohio ([ORC 2925.22](#)).

Prescribing pain medicine from the emergency/acute care facility for chronic pain is a form of unmonitored opioid therapy, which is not safe. Opioid medications should be prescribed only after determining that alternative therapies do not deliver adequate pain relief. In exceptional circumstances, the emergency medical provider may prescribe opioid medication for acute exacerbations of chronic pain, when the following safeguards are followed:

- a. Only prescribe enough opioid pain medication to last until the patient can contact their primary prescriber, with a maximum of a three day supply of opioid (rather than a quantity sufficient to last until the patient's next scheduled appointment). The emergency medical clinician should attempt to contact the primary opioid prescriber prior to prescribing any opioids. If the patient's primary opioid provider feels further opioid pain medicine is appropriate, it can be prescribed by that provider, during office hours.
- b. The patient's primary opioid prescriber is contacted first to approve further opioids for the patient. If approved, a limited prescription can be prescribed from the emergency/acute care facility to last until the patient is able to see their primary opioid prescriber. This reinforces the idea that patients should obtain pain medicine only from the primary opioid provider.

Urine drug testing for illicit and prescribed substances requires a working knowledge of the potential for false positive and false negative results and the need for confirmatory testing. A discussion on the limitations of urine testing is beyond the scope of this guideline. Other chronic pain guidelines address urine drug testing in detail.^{xvii} Urine drug testing has the potential to identify patients using illicit drugs or not taking medications they report being prescribed. **Both of these situations are grounds for denying further opioid prescriptions.** Clinicians knowledgeable at interpreting the results of the urine drug testing are encouraged to perform urine drug testing before prescribing opioids for exacerbations of chronic pain.

- 8. Each patient leaving the emergency/acute care facility with a prescription for OPCS should be provided with detailed information about the addictive nature of these medications and the potential dangers of misuse. This information may be included in the Discharge or Follow-Up Care Instructions or another handout.**

Discharge/Follow-Up Care instructions can serve both as guidance and as a warning to patients regarding the addictive nature of these medications and the importance of proper use. These instructions should include information about the dangers of sharing medications, combining medications and combining medications with alcohol. A statement should also be included about the proper storage and disposal of narcotics and other controlled medications. **(Example Discharge/Follow-Up Care Instructions – Attachment C)**

- 9. Emergency/acute care facilities should provide a patient handout that reflects the above guidelines and clearly states the facility position regarding the prescribing of opioids and other controlled substances.**

In order to help reduce improper utilization of emergency/acute care facilities and to clearly inform patients of the facility's position regarding the prescription of OPCS, facilities are encouraged to provide the patient handout to patients after the medical screening to explain under what circumstances OPCS will and will not be provided. For a sample patient hand out please visit:

<http://www.healthyohiprogram.org/ed/guidelines.aspx>.

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. Clinicians should use their own clinical judgment and not base clinical decisions solely on this document.

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