

Delaware Emergency Department Opioid Prescribing Guidelines

This guideline is intended for physicians working in hospital-based Emergency Departments (EDs) and free-standing emergency centers in the state of Delaware, in regards to adult patients presenting to the ED with acute noncancer pain or an acute exacerbation of chronic noncancer pain.

1. Ideally, one medical provider should provide all opioids to treat a patient's chronic pain.
2. The administration of intravenous and intramuscular opioids in the Emergency Department (ED) for the relief of acute exacerbations of chronic noncancer pain should be carefully considered.
3. The administration of Demerol® (Meperidine) in the ED is discouraged.
4. Emergency medical providers should not provide replacement prescriptions for controlled substances that were lost, destroyed or stolen.
5. Emergency medical providers should not provide replacement doses of methadone for patients in a methadone treatment program.
6. Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone) should not be prescribed from the ED.
7. Patients who are found to receive prescriptions for controlled substances from multiple providers should not receive additional prescriptions for controlled substances from the ED.
8. Emergency medical providers should attempt to coordinate care with primary care and pain management physicians for patients presenting to the ED with acute exacerbations of chronic pain.
9. EDs should coordinate the care of patients who frequently visit the ED using an ED care coordination program.
10. EDs should maintain a list of primary care providers for patients of all payer types.
11. Prescriptions for opioid pain medication from the ED for acute injuries, such as fractured bones, or acute painful conditions, such as kidney stones, in most cases should not exceed a 72-hour supply. If the provider prescribes greater than a 72-hour supply of opiates, the Delaware Prescription Monitoring Program should be accessed as per Delaware law.
12. The emergency physician is required by law to evaluate an ED patient who reports pain. The law allows the emergency physician to use their clinical judgment when treating pain and does not require the use of opioids.

BACKGROUND

These guidelines are intended to help EDs reduce the inappropriate use of opioid analgesics while preserving the vital role of the ED to treat patients with emergent medical conditions. These guidelines were developed by the Delaware chapter of the American College of Emergency Physicians based in large part on the work of the Washington State Chapter of the American College of Emergency Physicians.¹ These guidelines were approved by the Physician Advisory Committee for Controlled Substances (PACCS) of the Medical Society of Delaware and the Delaware Healthcare Association.²

RECOMMENDATIONS

1. Ideally, one medical provider should provide all opioids to treat a patient's chronic pain.

The emergency physician is not in a position to monitor the effects of chronic opioid therapy and therefore should not prescribe opioids for the treatment of chronic pain. Repeated prescribing of opioids from the ED is a counter-therapeutic, enabling action that delays patients from seeking appropriate pain control and monitoring.

The American Pain Society's guidelines³ recommend that all patients on chronic opioid therapy should have a clinician who accepts primary responsibility for their overall medical care.

Prescribing pain medicine for chronic pain from the ED 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 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 ED physician's one-time relationship with the patient does not allow proper monitoring of the patient's response to chronic opioids.

2. The administration of intravenous and intramuscular opioids in the ED for the relief of acute exacerbations of chronic noncancer pain should be carefully considered.

Parenteral opioids should be avoided for the treatment of chronic pain in the ED 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 some patients may

receive intravenous or intramuscular opioids in the ED when an ED care plan is coordinated with the patient's primary opioid provider.

3. The administration of Demerol® (Meperidine) in the ED 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.^{4, 5}

4. Emergency medical providers should not provide replacement prescriptions for controlled substances 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 physicians, including the HRSA toolkit sample pain agreement⁶, states that prescriptions will not be replaced. EDs should institute a policy not to replace prescriptions that are requested on the basis of being lost, stolen, or destroyed.

5. Emergency medical providers should not provide replacement doses of methadone for patients in a methadone treatment program.

Methadone should not be prescribed or administered as opioid substitution therapy from the ED. 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 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.

6. Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone) should not be prescribed from the ED.

Long-acting opioids should not be prescribed from the ED 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.⁷

7. Patients who are found to receive prescriptions for controlled substances from multiple providers should not receive additional prescriptions for controlled substances from the ED.

Accessing tools such as the DHIN (Delaware Health Information Network) or the SureScripts Database will allow participating hospitals to share patient visit information to a central database enabling emergency medicine providers to identify patients with multiple ED visits and thus appropriately tailoring their medical therapies while working to prevent drug seeking behavior.

8. Emergency medical providers should attempt to coordinate care with primary care and pain management physicians for patients presenting to the ED with acute exacerbations of chronic pain.

By having a conversation with the patient's primary opioid prescriber, the emergency physician can have a more complete picture of the patient's request and the prescribing provider's expectations.

9. EDs should coordinate the care of patients who frequently visit the ED using an ED care coordination program.

ED care coordination programs should contact the patient's primary care physician to notify them of the patient's ED over utilization and formulate an ED care plan. When the patient does not have a primary care provider an ED care plan should be created by an ED physician. This 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 hospital electronic health record.

10. EDs should maintain a list of primary care providers for patients of all payer types.

EDs should encourage patients to seek primary care in non-emergent care settings. ED physicians and 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 physician should not feel compelled to prescribe opioids due to the patient's lack of a primary care physician.

Patients often find themselves in the ED after their dependence or addiction has led them to a turning point in their life, such as a traumatic event, relationship collapse, or bout of severe depression (or hitting rock bottom). Such moments provide an opportunity to intervene in regards to the addiction. (Without immediate intervention the patient can easily fall back into addiction.) The ED should maintain an easy to understand guide on local addiction recovery resources, including all payer types. A list of chemical dependency service providers certified by the Division of Professional Regulation can be found online.⁸

11. Prescriptions for opioid pain medication from the ED for acute injuries, such as fractured bones, or acute painful conditions, such as kidney stones, in most cases should not exceed a 72-hour supply. If the provider prescribes greater than a 72-hour supply of opiates, the state database should be accessed as per Delaware law.

Patients should receive only enough opioid medication prescribed from the ED to last them until they see a physician for follow-up. For acute injuries with objective findings the emergency medical provider should not prescribe more than a 72-hour supply of opiates. 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. Infrequently and in exceptional cases, it may be necessary to prescribe more than a 72hr supply. Opioid medications should be used only after determining that alternative therapies do not deliver adequate pain relief. The lowest dose of opioids that is shown to be effective should be used. A trial of schedule III (e.g. hydrocodone) opioids should be prescribed before prescribing schedule II opioids⁹.

12. The emergency physician is required by law to evaluate an ED patient who reports pain. The law allows the emergency physician to use his clinical judgment when treating pain and does not require the use of opioids.

The Emergency Medical Treatment and Active Labor Act (EMTALA) does not require the emergency medical provider to provide pain relief for patients that do not have an emergency medical condition. Once a medical screening exam determines that a patient does not have an emergency medical condition, there is no obligation under EMTALA to treat a patient's pain in 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.

REFERENCES

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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. 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.