Washington ED Opioid Abuse Work Group

Guidelines to Prevent Prescription Drug Abuse from the Emergency Department

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 rooted 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.

1. 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 for the relief of acute exacerbations of chronic pain is discouraged.

3. Emergency medical providers should abstain from providing replacement prescriptions for controlled substances that were lost, destroyed or stolen.

4. Emergency medical providers should not provide replacement doses of methadone for patients in a methadone treatment program who have missed a dose.

5. Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, and methadone) should not be prescribed for acute pain.

6. Emergency departments are encouraged to share the ED visit history of a patient with other emergency physicians who are treating the patient using the Emergency Department Information Exchange (EDIE).

7. Physicians should send pain agreements they make with patients to the local emergency departments and develop the agreements in cooperation with the ED to include a plan for pain treatment in the ED.

8. Prescriptions for controlled substances from the emergency department should state the patient is required to provide a government issued picture identification (ID) to the pharmacy filling the prescription.

9. Emergency departments are encouraged to photograph patients who present for pain related complaints without a government issued photo ID.

10. Emergency Departments should coordinate the care of patients who frequently visit the ED using an ED care coordination program. This includes recording an ED care plan in a dedicated section of the hospital electronic health record.

11. Emergency departments should maintain a list of clinics that provide primary care for patients of all payer types.

12. Emergency departments should perform screening, brief interventions, and referral to treatment for patients with suspected prescription opiate abuse problems. Emergency medical providers should refer patients to have a chemical dependency assessment and maintain a list of local chemical dependency treatment resources.

13. The administration of Demerol® (Meperidine) in the emergency department is discouraged due to its side effect of lowering the seizure threshold.

14. For exacerbations of chronic pain the emergency medical provider should attempt to
contact the patient’s primary opioid prescriber or pharmacy and prescribe only enough pills to last until the office of the patient’s primary opioid prescriber opens.

15. No more than 30 pills of opioid medication for acute injuries, such as fractured bones, should be prescribed from the emergency department in most circumstances.

16. ED patients should be screened for a history of substance abuse prior to prescribing opioids for acute pain.

17. The emergency physician is required by law to evaluate an ED patient with 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**

The emergency department (ED) is the largest ambulatory source for opioid analgesics with 39% of all opioids prescribed, administered, or continued coming from emergency departments. According to the Drug Abuse Warning Network (DAWN), approximately 324,000 emergency department visits in 2006 in the U. S. involved the nonmedical use of pain relievers (including both prescription and over-the-counter pain medications). As the use of prescription opioids for chronic non-cancer pain has increased, so have adverse effects related to opioids. In Washington from 1995-2007, there has been a 17 fold increase in unintentional poisoning deaths and a 7 fold increase in poisoning hospitalizations related to prescription opioids. There has been a 4 fold increase in admissions state-funded substance abuse treatment for prescription opiates in Washington from 2003-2008.

These guidelines are intended to help EDs reduce the inappropriate use of prescription drugs while preserving the vital role of the emergency department to treat patients with emergent medical conditions. These guidelines were developed by the Emergency Department Opioid Abuse Work Group sponsored by the Washington State Department of Health (DOH). This work group is composed of members representing:

- Washington State Department of Health
- Washington State Department of Social and Health Services
- Washington Department of Labor and Industries
- Washington Chapter of the American College of Emergency Physicians
- Washington Poison Center
- Washington Emergency Physicians
- Washington Pain Physicians
- Washington State Emergency Nurses Association

The Washington Chapter of the American College of Emergency Physicians and the Interagency Workgroup to Prevent Opioid Abuse, Misuse and Overdose has endorsed these guidelines as a framework for reducing prescription drug abuse related to emergency department usage. [PENDING]

**Recommendations**

1. 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 emergency department is a counter-therapeutic enabling action that delays patients from seeking appropriate pain control and monitoring.
Guidelines for the treatment of chronic pain from the Washington State Agency Medical Directors Group\(^6\) and the Medical Quality Assurance Commission\(^7\) recommend that all pain medicine be prescribed by one practitioner. The American Pain Society’s guidelines\(^8\) 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 emergency department 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 treatment on pain levels and the 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 the ED physician to properly monitor the patient’s response to chronic opioids and the patient’s functioning.

2. The administration of intravenous and intramuscular opioids in the emergency department for the relief of acute exacerbations of chronic pain is discouraged.
   Parenteral opioids should be avoided for the treatment of chronic pain in the emergency department 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 more 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 coordinated with the patient’s primary care provider is in place.

3. Emergency medical providers should abstain from providing replacement prescriptions for controlled substances that were lost, destroyed or stolen.
   Patients misusing controlled substances frequently report their prescriptions are lost or have been stolen. Pain specialists routinely stipulate in pain agreements with patients that lost or stolen controlled substances will not be replaced. Emergency departments should institute a policy not to replace prescriptions that are requested on the basis of being lost, stolen, or destroyed. Most pain agreements between chronic pain patients and physician, including the HRSA toolkit sample pain agreement\(^9\), state prescriptions will not be replaced.

4. Emergency medical providers should not provide replacement doses of methadone for patients in a methadone treatment program who have missed a dose.
   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 the patient is not enrolled in a methadone treatment program. The emergency medical provider or admitting physician should call the methadone treatment program when 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 in order to continue dosing while hospitalized.

5. Long-acting or controlled-release opioids (such as OxyContin\(^\circ\), fentanyl patches, and methadone) should not be prescribed for acute pain.
   Long acting opioids should not be prescribed from the ED for the treatment of acute pain. The treatment of pain with long acting opioids requires close follow up which the emergency medical provider can provide.
Methadone and oxycodone have caused more unintentional opioid overdose deaths than any other prescription opioid.\(^{10}\)

6. **Emergency departments are encouraged to share the ED visit history of a patient with other emergency physicians who are treating the patient using the Emergency Department Information Exchange (EDIE).**

The ED Opioid Abuse Work Group is coordinating the creation of an ED monitoring program similar to the prescription monitoring programs used in over 30 states.\(^{11}\) The ED monitoring program is titled the Emergency Department Information Exchange (EDIE) and is being operated by Collective Medical Technology. EDIE will allow hospitals to send ED patient demographic information to a central database when the patient presents to a participating ED. The patient's name is then checked for ED visits at other participating EDs. If the patient is found to have a significant number of visits to other emergency departments the patient's ED visit history is faxed or sent electronically to the ED for use by the emergency physician. The EDIE can identify patients, while they are still in the ED, who present to multiple EDs to obtain controlled substances so further prescribing can be prevented. Providing the ED visit history from all ED's in the region, or preferably the state, to the ED physician has the potential to reduce prescription drug abuse. This exchange of medical information between emergency medical providers who have treated the patient is HIPAA compliant. The sharing of visit information between urgent care centers and the emergency department is also encouraged.

7. **Physicians should send pain agreements they make with patients to the local emergency departments and develop the agreements in cooperation with the ED to include a plan for pain treatment in the ED.**

By having a record of the patient's pain agreement on hand the emergency physician can have a more complete picture of the patient's request and the expectations of the provider prescribing long term opioids for the patient.

8. **Prescriptions for controlled substances from the emergency department should state the patient is required to provide a government issued picture identification (ID) to the pharmacy filling the prescription.**

Patients diverting prescriptions can provide a fictitious name when registering in the emergency department and receive prescriptions under the fictitious name. Washington law does not require the patient to present an ID when filling a controlled substance prescription.

Emergency physicians should contact local law enforcement to report patients who provide false information in an attempt to obtain controlled substances. Local law enforcement should prosecute patients who provide false personally identifying information when registering in the emergency department. Attempting to obtain controlled substances by fraud, deceit, or subterfuge is a felony under RCW 69.50.403. The ED physician should report patients that provide false information to obtain controlled substances. Reporting this crime is specifically permitted under RCW 69.50.403 which states “Information communicated to a practitioner in an effort unlawfully to procure a controlled substance or unlawfully to procure the administration of such substance, shall not be deemed a privileged communication.”

ED prescription pads and computer generated printed prescriptions should be printed to require photo ID for controlled substances. Exception to this recommendation should be granted in rare circumstances where the patient sustained a traumatic event, such as an auto crash, where their identification was destroyed or lost.
9. **Emergency departments are encouraged to photograph patients who present for pain related complaints without a government issued photo ID.**

Patients who lack picture identification should be photographed. Photographing the patient improves patient safety by providing a means of positive identification of the person treated. Patients who present to multiple EDs and provide false information to obtain controlled substances often do not provide photo identification. This is done to hide the patient’s history of several ED visits from the ED staff. Photographing patients may dissuade them from providing false information because the photograph provides documentation they presented to the ED. Triage documentation provided to the emergency physician should indicate if the patient provided identification. Patients may be more inclined to provide false information regarding their identity as programs to track ED visits across the state, such as the Emergency Department Information Exchange (EDIE) recommended in these guidelines, are implemented.

10. **Emergency Departments should coordinate the care of patients who frequently visit the ED using an ED care coordination program. This includes recording an ED care plan in a dedicated section of the hospital electronic health record.**

ED care coordination programs should contact the patient’s primary care physician to notify them of the patient’s ED over utilization and formulate a plan of care the emergency medical provider can reference when the patient presents to the ED. When the patient does not have a primary care provider an ED care plan should be created by a physician from the emergency department. This plan does not reinforce the patient’s addictive behavior and stresses the importance of seeing a primary care provider for chronic medical conditions and chronic pain management. The Consistent Care program operated by Providence Sacred Heart Medical Center in Spokane and the Emergency Department Consistent Care program operated by Providence St. Peter Hospital in Olympia are two successful programs in Washington. These programs have demonstrated a 50% reduction in ED visits among enrolled frequent ED users.

Because the ED physician may not have time to read dictations from multiple previous ED visits the ED care plan should be filed into a dedicated section of the hospital electronic health record so the emergency physician can quickly ascertain if the patient has an identified pattern of suspected prescription drug abuse.

11. **Emergency departments should maintain a list of clinics that provide primary care for patients of all payer types.**

Emergency departments should encourage patients to seek primary care in settings for non-emergent care. 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.

12. **Emergency departments should perform screening, brief interventions, and referral to treatment for patients with suspected prescription opiate abuse problems. Emergency medical providers should refer patients to have a chemical dependency assessment and maintain a list of local chemical dependency treatment resources.**

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 emergency rooms, with substantial declines in illicit drug use. Among high-risk users of prescription opiates, 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. Besides being delivered by chemical dependency professionals, with proper training, brief interventions can be delivered in emergency rooms by nurses, case managers, crisis
counselors, social workers, or other professionals. The 2010 National Drug Control Strategy recommends expansion of brief interventions in health care settings.

Patients often find themselves in the ED after their dependence or addiction has led them to a turning point in their life, such a traumatic event or hitting rock bottom. Without a direction from the ED on where to obtain further addiction assessment and counseling, the patient can easily fall back into their addiction. ED's often do not have information on addiction resources readily available. The ED should maintain an easy to understand guide on local addiction recovery resources. Because the type of recovery services available to the patient usually depends upon how the patient pays for their health care the guide should list the types of payer sources each resource accepts. A list of chemical dependency service providers certified by the Division of Behavioral Health and Recovery can be found online.\textsuperscript{13}

13. **The administration of Demerol\textsuperscript{®} (Meperidine) in the emergency department is discouraged due to its side effect of lowering the seizure threshold.**

Demerol\textsuperscript{®} use has been shown induce seizures through the accumulation of a toxic metabolite with a long half life that is excreted by the kidney. Demerol\textsuperscript{®} 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.\textsuperscript{14,15}

14. **For exacerbations of chronic pain the emergency medical provider should contact the patient’s primary opioid prescriber or pharmacy and prescribe only enough pills to last until the office of the patient's primary opioid prescriber opens.**

Opioid prescriptions for exacerbations of chronic pain from the ED are discouraged in general. Chronic pain patients should obtain opioid prescriptions from a single opioid prescriber that monitors the patient’s pain relief and functioning. Prescribing pain medicine from the ED for chronic pain is a form of unmonitored opioid therapy which is not safe. In exceptional circumstances the emergency medical provider may prescribe opioids for acute exacerbations of chronic pain when the following safeguards are followed.

1. Only enough opioid pain medicine should be prescribed to last until the patient can contact their primary prescriber with a maximum of a two day supply of opioid. A quantity sufficient to last until the patient’s next scheduled appointment with the primary opioid prescriber is discouraged. The emergency provider should attempt to contact the primary prescriber to approve further opioids for the patient. If the patient’s primary opioid provider feels further opioid pain medicine is appropriate it can be prescribed during office hours. Patients may state they have an appointment with their primary prescriber several days after their ED visit and request pain medicine to last until then. Emergency medical providers should refrain from this practice because it contributes to unmonitored opioid therapy.

2. The patient’s primary opioid prescriber is contacted first to approve further opioids for the patient. If approved, a small prescription should be given from the ED to last until more can be prescribed during office hours from the primary opioid prescriber. This reinforces the patient to solicit pain medicine only from the primary opioid provider.

If the primary opioid provider cannot be reached, then the patient’s pharmacy should be contacted. The pharmacy should verify the patient was recently prescribed pain medication from the primary opioid prescriber and not from multiple prescribers. The physician should confirm the recent opioid prescriptions reported by the pharmacy match what the patient reports. No opioid prescription should be given if the patient misrepresented the opioid prescriptions. Providing false information in an effort to obtain prescription opioids is an aberrant medication taking behavior that signals an addiction problem. Such misrepresentation is against the law in Washington (RCW 69.50.403).

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. Urine drug testing has to potential to identify patients using illicit drugs and patient 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.

15. No more than 30 pills of opioid medication for acute injuries, such as fractured bones, should be prescribed from the emergency department in most circumstances.

Patients should receive only enough opioid pain medicine prescribed from the ED to last them until they see a physician in follow-up. For acute injuries with objective findings such as fractured bones the emergency provider should not prescribe more than 30 pills. Prescriptions for larger quantities promote a longer period of time to elapse before the patient’s pain control and functioning can be evaluated by a physician. Prescriptions with large numbers dispensed increase the potential that medicine will go unused and will be available for abuse. Even though some fractures, such a fractured ribs or fractured clavicle, often heal on their own within 30 days without further medical evaluation, the emergency provider is discouraged from providing more than 30 pills of prescription pain medication. The patient needs to have a medical evaluation for further opioid pain therapy beyond 30 pills even if their injury does not require further evaluation. This evaluation can be done over the phone or in person by the patient’s primary care provider or primary prescriber.

In exceptional circumstances left to the clinical judgment of the emergency medical provider it may infrequently be necessary to prescribe more than thirty pills. In these cases the provider should attempt to provide no more than 3 days of pills when the thirty pill limit is exceeded because the patient should be re-evaluated soon when taking high doses of opioids for an acute injury.

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 (eg hydrocodone) opioids should be prescribed before prescribing schedule II opioids.

16. ED patients should be screened for a history of substance abuse prior to prescribing opioids for acute pain.

Patients with a history of substance abuse are at increased risk of developing opioid addiction when prescribed opioids for acute pain. Emergency medical providers should ask the patient about a history of substance abuse prior to prescribing opioids for the treatment of acute pain. A history of substance abuse should not exclude an ED 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 with sooner follow up to allow for close opioid monitoring in patients with a history of substance abuse. A non-opioid regime should be offered to ED patients with acute pain and a history of substance abuse. The patient’s primary care physician should be notified that their patient has been started on opioids so they can assure close follow up and look for signs of addiction.

Emergency medical providers wishing to perform more extensive screening for the risk of opioid addiction are encouraged to use tools such as the Opioid Risk Tool.
17. The emergency physician is required by law to evaluate an ED patient with 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.

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 the ED 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 as causing 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. EMTALA does not block the emergency medical provider from applying their professional judgment to withhold opioid treatment of pain for ED patients without an emergency medical condition.

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5 Washington State Department of Social and Health Services (DSHS), Division of Behavioral Health and Recovery, Treatment Report and Generation Tool.


