

# Opiate Prescribing Guidelines for Vermont Emergency Departments

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## Consensus statement by Vermont ED Directors, 2014

These Guidelines are intended to provide a general approach in the prescribing of opiates and related controlled substances by emergency department providers in the state of Vermont. They are not intended to take the place of clinical judgment, which should always be utilized to provide the most appropriate care which meets the unique needs of each patient.

- 1) **Acknowledgement:** This document represents the summary of recommendations and standards derived from literature review and practice experience by the present working group of Vermont Emergency Department Directors. It incorporates important work and precedents set forth in guidelines from the American College of Emergency Physicians and emergency medicine societies in states such as Ohio and Washington, with consideration for our regional practice environment.
- 2) **Background:** Nationally, opiate prescriptions dispensed by retail pharmacies have tripled since 1991 in response to changing expectations regarding pain management in the US. According to the National Survey on Drug Use and Health, Vermont is the 28th highest of all states in non-medical use of pain relievers among individuals 12 and older. In addition, 6% of teenagers between 12 and 17-year-old and 13.3% of adults between the ages of 18 and 25 have reported nonmedical use of prescription drugs. In 2010 more people were prosecuted in federal court in the state for illicit trafficking of oxycodone and other prescription opioids than for any other drug. Prescription opioids accounted for more than half of the fatal drug overdoses in Vermont for the sixth straight year. Vermont ranks second only to Maine in per-capita admissions for treatment for addiction to prescription opioids and has the most per-capita consumption of buprenorphine in the nation.

Data from the Doctor's Company in review of open claims between 2011 and 2012 indicate that opiates top of the list of prescription medications causing injury to patients at 19% of the total, and 48% of those claims involved acute care settings. Nationally, emergency room visits for misuse and abuse of prescription painkillers doubled to 475,000 over that same time and prescription opiates now cause more overdose deaths than heroin and cocaine combined. To address these growing concerns several institutions in the state have independently enacted their own guidelines on responsible opiate prescribing. Similar guidelines enacted elsewhere in the US have led to a 23% drop in pain medicine overdoses. The current group of Vermont Emergency Medical Directors was tasked with developing a unified plan to ensure quality and consistency between different facilities throughout the state.

Management of ongoing chronic or recurrent-episodic pain should be managed by a single provider – either a primary care physician or pain management specialist. For a variety of reasons, both system-related and personal, patients frequently present to acute care settings for the management of these problems. Acute care settings are highly inappropriate for the ongoing management of long term pain problems. While skilled at handling emergency conditions, most acute care providers are not formally trained to prescribe or monitor long term opiate therapy. In this setting, a provider’s one-time encounter with the patient precludes any possibility of ongoing monitoring which places patients at risk of harm from excess or unnecessary amounts of medication. As such, it is generally recommended that utilization of controlled pain medications in the acute care setting be limited to the minimum effective course of treatment for acute pain problems associated with objective findings of physiologic derangement. An important objective of the guidelines is to help define criteria that practitioners can use to help identify patients at the highest risk of harm. This group may require dosage adjustments when opiate medications are legitimately needed or may benefit from referral to a pain management specialist or substance abuse treatment when they are not.

Many providers are discouraged from appropriately limiting prescription opiates due to concerns regarding EMTALA compliance. The emergency department physician is required by law to evaluate any patient who presents to the emergency department for an emergency medical condition. Subjectively reported severe pain in the absence of any verifiable acute medical abnormality normally expected to cause pain does not by itself represent an emergency medical condition. EMTALA allows the physician to use his/her clinical judgment when treating pain and does not require the use of narcotics. If the physician feels that there is increased risk for harm such that the risk outweighs the expected benefit of treatment, then non-narcotic alternatives are preferred.

### 3) Purpose Statement

- a) Standardize the treatment approach among providers.
- b) Optimize pain control strategies while minimizing risk to patients.
- c) Reduce inappropriate prescribing and use of controlled substances.
- d) Mitigate the societal costs associated with the consequences of prescription drug abuse and addiction.

### 4) Definitions

- a) Acute Pain: The normal predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically associated with invasive procedure, trauma and disease. It is generally time limited.
- b) Addiction: A primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use and continued use despite harm. Physical

dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

- c) Chronic pain: A state in which pain persists behind the usual course of acute disease or injury, that may or may not be associated with chronic pathological processes that cause continuous or intermittent pain over months or years.
  - d) Controlled substances: The US DEA defines and maintains a list of controlled substances. For the purposes of this guideline, discussion will be limited to schedule II and III and IV substances.
    - i) Schedule II controlled substances: Substances in this list have a high potential for abuse which may lead to severe psychological or physical dependence. Examples include hydromorphone, methadone, meperidine, oxycodone, fentanyl, and morphine.
    - ii) Schedule III controlled substances: Substances in this schedule have a potential for abuse less than substances and schedules I or II. Abuse may lead to moderate or lower physical dependence or high psychological dependence. Examples include hydrocodone, buprenorphine, and Tylenol with Codeine.
    - iii) Schedule IV controlled substances: Substances in the schedule have a low potential for abuse relative to substances in Schedule III. Examples include alprazolam, clonazepam, diazepam, lorazepam, midazolam, temazepam.
  - e) High risk features: features that may be associated with increased risk of addiction or abuse:
    - i) Use of multiple providers or pharmacies to obtain controlled substances.
    - ii) Preoccupation with opiates.
    - iii) Anger, aggression, or threatening response to limiting opiate use.
    - iv) Insistence on specific or rapid onset formulations, or parenteral opiate administration.
    - v) Reporting pain scale greater than 10.
    - vi) Three visits or more in 7 days for pain related complaints.
    - vii) Requests for rapid dose escalation.
    - viii) Evidence of habituation and tolerance in patients without history of opiate use.
    - ix) Noncompliance with recommended non-opioid treatments or evaluations.
    - x) Inability to restrict medications or take them on an agreed upon schedule.
    - xi) History of alcohol or other controlled substance dependence or abuse.
- 5) Adjunctive Treatments
- a) Over-the-counter medications: NSAIDS, acetaminophen, diphenhydramine.
  - b) Topical analgesics: Lidocaine (Lidoderm) patch, diclofenac patch (Flector), capsaicin.
  - c) Partial opioid agonist: Tramadol
  - d) Anticonvulsant Medications: gabapentin, pregabalin.
  - e) Antidepressant Medications: Trazodone, Cymbalta, Effexor, Elavil.
  - f) Physical therapy.

## 6) Guidelines

- a) Triage and initial assessment
  - i) Any patient presenting to an Emergency Department should have a medical screening examination performed to evaluate for an emergency medical condition.
  - ii) Patients should not be discouraged from completing the medical screening examination (MSE). Things that may potentially be considered as forms of discouragement include reviewing care plans or data from the Vermont Prescription Monitoring System with the intent of prohibiting certain treatments prior to formal MSE. Such discussions may be appropriate, but should be deferred for the evaluating provider after the MSE has occurred.
  - iii) Providers are encouraged to review the Vermont Prescription Monitoring System prior to treating or prescribing opiates for patients with high risk features.
  - iv) Signage explaining the purpose of these guidelines may be posted in waiting and treatment areas.
- b) Treatment in the acute care setting
  - i) Any patient receiving parenteral narcotics should be appropriately monitored with inclusion of either pulse oxymetry or capnography. Capnography is preferred for sedated or high risk patients due to the potential for earlier warning of adverse events.
  - ii) Patients presenting to the acute care setting requesting rapid escalation of treatment for chronic pain or requesting parenteral administration of opiates should be considered to be at high risk for injury or abuse. Any escalation of treatment is discouraged and should be appropriately managed by the primary care provider.
  - iii) Patients presenting to an acute care setting who appear to be sedated, intoxicated or under the influence of other psychoactive substances should be considered to be a high risk group. A urine drug screen may be considered prior to initiating treatment, when appropriate, to screen for increased risk. Concurrent use of nonprescribed controlled or illegal substances is considered to be a risk factor for overdose or abuse.
  - iv) Long-acting opiates including fentanyl patch, MS Contin, and oxycontin should generally not be initiated by acute care providers since close monitoring and follow-up are critical to their safe use. Acute care providers should only prescribe scheduled doses of long-acting opiates during the course of treatment in the acute setting as part of an established outpatient plan for chronic pain management.
  - v) Due to low safety margin, drug interaction and risk of seizure, IV Demerol (meperidine) for treatment of acute or chronic pain is discouraged.
- c) General prescribing guidelines
  - i) Acute care providers should not prescribe replacements for narcotics that have been lost, stolen, or destroyed or continuation of treatment for patients who have run out of narcotics early or while their usual provider is off duty.

- ii) Acute care providers should not provide replacement doses of Suboxone, Subutex or methadone.
  - iii) Acute care providers should not initiate outpatient treatment for chronic pain using long-acting opiate preparations.
  - iv) Acute care providers should avoid IV/IM narcotics for routine treatment of chronic pain or exacerbations of chronic pain.
  - v) When possible, Schedule III medications should be prescribed preferentially over Schedule II medications because of their lower risk of addiction and misuse. Schedule II medications have not been proven to be more effective for pain control than equivalent doses of Schedule III medications in multiple studies.
  - vi) When narcotics are prescribed for acute injuries they are best managed with an initial course of treatment followed by a rapid taper. Three days is the recommended maximum duration for treatment prescribed from the acute care setting, depending on the condition and clinical judgment.
  - vii) Consider dosage adjustment:
    - (1) in patients with underlying pulmonary disease such as COPD or sleep apnea,
    - (2) children, patients over age 65, and patients with low GFR, or
    - (3) patients on other potentiating medications such as benzodiazepines.
  - viii) Opiate use should be avoided for conditions where they have been shown to be of limited effectiveness or potentially harmful. These include routine dental pain, chronic back pain, neuropathic pain, chronic abdominal pain and vomiting, and migraine headaches.
- d) Discharge and Referral
- i) All patients prescribed an opiate should be provided with appropriate counseling and information regarding the signs and symptoms of adverse reactions such as respiratory depression and the risks of engaging in hazardous activities, such as driving.
  - ii) All patients prescribed an opiate should be assessed for potential drug interactions which could potentiate the respiratory depression effects.
  - iii) Acute care providers are encouraged to share the visit history with the primary care provider, other acute care providers, and pain management or other specialists managing the patient's pain. The HIPAA privacy rule allows doctors, nurses, hospitals, laboratory technicians and other healthcare providers to share protected health information for treatment purposes without the patient's authorization.
  - iv) Consider social services consultation, when appropriate, to assist in coordinating outpatient treatment, referral to primary care or pain management resources, or addiction and rehabilitation services.
- 7) Disclaimer
- a) In recognition of the fact that there may arise circumstances in which adherence to these guidelines is not possible or may otherwise result in suboptimal care, physicians may exercise discretion in deviating from these guidelines when

deemed necessary. Deviations from these guidelines are expected and in no way imply improper care.

8) Administration

- a) If the patient's primary care provider or pain management specialist deems it necessary for the patient to occasionally receive narcotics in the acute care setting for acute exacerbations of a chronic pain condition which would otherwise contradict the principles of this guideline, a patient-specific plan of care may be arranged outlining treatment objectives and parameters.
- b) In order to improve compliance, providers should be protected, whenever possible, from adverse consequences of negative patient perceptions, complaints or actions resulting solely from judicious opioid prescribing adherent to the principles outlined in these guidelines.