



# Arizona's Emergency Department Prescribing Guidelines

Pain is a major symptom of many patients presenting to the emergency department (ED), with up to 42% of emergency department (ED) visits being related to painful conditions. The ED is the largest ambulatory source for opioid analgesics with 39% of all opioids prescribed, administered, or coming from emergency departments. According to the Drug Abuse Warning Network (DAWN), the estimated number of ED visits for nonmedical use of opioid analgesics more than doubled from 2004 to 2008 (from 144,600 to 305,900 visits).

Although relieving pain and reducing suffering are primary emergency care responsibilities, there is a concurrent duty to limit the personal and societal harm that can result from prescription drug misuse and abuse. The use of prescription opioids for chronic non-cancer pain has increased, so have unintended consequences related to opioids. In Arizona, from 2004-2014 there has been a 28 percent increase in the age-adjusted mortality rate due to poisoning among Arizona residents, from 13.9 deaths per 100,000 residents in 2004 to 17.8 deaths per 100,000 residents in 2014.

These guidelines are intended to help EDs reduce the inappropriate use of controlled substances while preserving the vital role of the ED to treat patients with emergent medical conditions. These guidelines were developed by the Emergency Department Work Group sponsored by the Arizona Department of Health Services (ADHS) and the Arizona Chapter American College of Emergency Physicians (AzCEP).

As defined by the Institute of Medicine, guidelines are "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances."

This work group is composed of members representing:

- Arizona Chapter American College of Emergency Physicians
- Arizona Department of Health Services Office of Injury Prevention
- Arizona Department of Health Services Behavioral Health Services
- Arizona Emergency Nurses Association
- Indian Health Services
- Over 50 attendees representing Arizona Hospital Emergency Departments

*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 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.*

# RECOMMENDATIONS

## Arizona Guidelines for Emergency Department Controlled Substance Prescribing

### **1: When possible, one medical provider should provide all controlled substances to treat a patient's chronic pain.**

*Rationale:* The emergency physician/provider is not in a position to monitor the effects of chronic opioid (or other controlled substances) therapy and therefore should not prescribe opioids for the treatment of chronic pain. Repeated prescribing of opioids (or other controlled substances) from the ED is a counter-therapeutic enabling action that delays patients from seeking appropriate pain control and monitoring.

The American Pain Society's guidelines<sup>4</sup> 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 Controlled Substances Prescription Monitoring Program should be checked prior to prescribing controlled substances.**

*Rationale:* The primary function of the Controlled Substances Prescription Monitoring Program is to provide a central repository of all prescriptions dispensed for Schedule II, III, and IV controlled substances in Arizona. It allows the prescriber access to a database to identify patients who might be doctor-shopping to feed a drug addiction and assist in treating patients, identifying and deterring drug diversion.<sup>5, 6</sup>

### **3: The administration of intravenous and intramuscular controlled substances in the ED for the relief of acute exacerbations of chronic pain is discouraged.**

*Rationale:* 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 care provider.

#### **4: Emergency medical providers should not provide replacement prescriptions for controlled substances that were lost, destroyed, or stolen.**

*Rationale:* 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.<sup>7</sup> Most pain agreements between chronic pain patients and physician, 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.**

*Rationale:* 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.**

*Rationale:* 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.<sup>8</sup>

#### **7: Prescriptions for controlled substances from the ED should state the patient is required to provide a government issued picture identification (ID) to the pharmacy filling the prescription.**

*Rationale:* Patients diverting prescriptions can provide a fictitious name when registering in the ED and receive prescriptions under the fictitious name. The Arizona State Board of Pharmacy does require through rule that the patient present an ID when filling a controlled substance prescription. (A.A.C. R4-23-402)

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 identifying information when registering in the ED. Attempting to obtain controlled substances by fraud, deceit, or subterfuge is a felony under Arizona Revised Statute §13-3407.

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 automobile crash, and their identification was destroyed or lost.

### **8: EDs are encouraged to photograph patients who present for pain related complaints without a government issued photo ID.**

*Rationale:* 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 EDs and provide false information to obtain controlled substances often do not provide photo ID. 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 ID.

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

*Rationale:* 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 clinics that provide pain management and primary care for patients of all payer types.**

*Rationale:* 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 or controlled substances due to the patient's lack of a primary care physician.

## **11: EDs should perform screening, brief interventions and treatment (SBIRT) referrals for patients with suspected prescription abuse problems.**

*Rationale:* Emergency departments remain the healthcare safety net. By default, individuals do seek “primary care” in the ED. SBIRT has the potential to reach many individuals who may not realize they have patterns and habits that put them at significant risk for alcohol-related illness and serious injury.<sup>9</sup>

## **12: The administration of Demerol® (Meperidine) in the ED is discouraged.**

*Rationale:* 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.<sup>10,11</sup>

## **13: For exacerbations of chronic pain, the emergency medical provider should attempt to contact the patient's primary controlled substances prescriber or pharmacy. The emergency medical provider should only prescribe enough pills to last until the office of the patient's primary controlled substances prescriber opens.**

*Rationale:* Opioid prescriptions for exacerbations of chronic pain from the ED are discouraged. 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 or other controlled substance therapy which is not safe. In exceptional circumstances, the emergency medical provider may prescribe opioid or controlled substance medication for acute exacerbations of chronic pain, when the following safeguards are followed:

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

If the primary provider cannot be reached, then the patient's pharmacy should be contacted. The pharmacy should verify recent prescriptions for pain medication from the primary prescriber and not from multiple prescribers. The ED physician should confirm that recent opioid or controlled substance prescriptions reported by the pharmacy match what the patient reports. No opioids or controlled substances should be prescribed if the patient misrepresents the prescriptions. Providing false information in an effort to obtain prescription opioids or other controlled substances is an aberrant medication taking behavior that can signal an addiction problem.

#### **14: Prescriptions for controlled substance pain medication from the ED for acute injuries, such as fractured bones, in most cases should not exceed 30 pills with no refills.**

*Rationale:* 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 such as fractured bones, the emergency medical provider should not prescribe more than 30 pills. 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. Some fractures, such as a fractured ribs or fractured clavicle, often heal within 30 days without further medical evaluation; the emergency provider is discouraged from prescribing more than 30 opioids or other controlled substances. The patient should have a medical evaluation if they require opioid or other controlled substances therapy beyond 30 pills. Infrequently and in exceptional cases, it may be necessary to prescribe more than 30 opioid or controlled substance pills.

Opioid medications should be used only after determining that alternative therapies do not deliver adequate pain relief. The lowest dose of opioids or other controlled substance 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 opioids.<sup>12</sup>

#### **15: ED patients should be screened for substance abuse prior to prescribing controlled substance medication for acute pain.**

*Rationale:* Patients with a history of or current substance abuse are at increased risk of developing opioid addiction when prescribed opioids for acute pain.<sup>13,14</sup> Emergency medical providers should ask the patient about a history of or current substance abuse prior to prescribing opioid or controlled substance medication for the treatment of acute pain. A non-opioid regime should be offered to ED patients with acute pain and a history of or current substance abuse. A history of or current substance abuse should not exclude an ED patient from being prescribed opioids or other controlled substances 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 or other controlled substance medication, with follow up monitoring in patients with a history of or current substance abuse. The patient's primary care physician should be notified of their patients' treatment.

**16: The emergency physician is required by law to evaluate an ED patient who reports pain. The law allows emergency physicians to use their clinical judgment when treating pain and does not require the use of controlled substances.**

*Rationale:* 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 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. 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 obstruct the emergency medical provider from applying their professional judgment to withhold opioid treatment of pain for ED patients without an emergency medical condition.



## REFERENCES

<sup>i</sup>Pletcher MJ, Kertesz SG, Kohn MA, et al. Trends in opioid prescribing by race/ethnicity for patients seeking care in US emergency departments. *JAMA*. 2008;299:70-78.

<sup>ii</sup>National Center for Health Statistics. Medication therapy in ambulatory medical care: United States, 2003-04. *Vital and Health Statistics, Series 13*, number 163, December, 2006. Accessed on 10/22/12 at [http://www.cdc.gov/nchs/data/series/sr\\_13/sr13\\_163.pdf#page=26#page=26](http://www.cdc.gov/nchs/data/series/sr_13/sr13_163.pdf#page=26#page=26)

<sup>iii</sup>Cai R, Crane E, Poneleit K, Paulozzi L. Emergency Department Visits Involving Nonmedical Use of Selected Prescription Drugs --- United States, 2004--2008. *MMWR Morb Mortal Wkly Rep* 2010;59(23):705-709. Accessed on 10/22/12 at: [http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5923a1.htm?s\\_cid=mm5923a1\\_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5923a1.htm?s_cid=mm5923a1_w).

<sup>iv</sup>American Pain Society--American Academy of Pain Medicine Opioids Guidelines Panel. Clinical Guidelines for the Use of Chronic Opioid Therapy in Chronic Noncancer Pain. *J Pain*, 2009; 10(2):113-120. Accessed on 10/22/12 at: [http://www.jpain.org/article/S1526-5900\(08\)00831-6/abstract](http://www.jpain.org/article/S1526-5900(08)00831-6/abstract).

<sup>v</sup>Arizona State Board of Pharmacy. Accessed on 10/23/12 at: [http://www.azpharmacy.gov/CS-Rx\\_Monitoring/aboutpmp.asp](http://www.azpharmacy.gov/CS-Rx_Monitoring/aboutpmp.asp)

<sup>vi</sup>American College of Emergency Physicians. Policy statement. Critical issues in the prescribing of opioids for adult patients in the emergency department. *Ann Emerg Med*. 2012;60:499-525

<sup>vii</sup>Opioid Agreements/Contracts. Assessed on 10/23/12 at: <http://www.aapainmanage.org/literature/Articles/OpioidAgreements.pdf>

<sup>viii</sup>CDC - Injury - Poisoning in the United States - Issue Brief. Accessed on 10/23/12 at: <http://www.cdc.gov/homeandrecreationalafety/rxbrief/index.html>

<sup>ix</sup>Madras, B., Wilson, C., et al. Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and six months. *Drug Alcohol Depend*. 2009; 99:280-295. Accessed on 10/29/12 at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2760304/>

<sup>x</sup>Chalverus, CA. Clinically significant meperidine toxicities. *J Pharm Care in Pain & Symptom Control* 2001; 9(3):37-55.

<sup>xi</sup>Latta, KA, Ginsberg, B, Barkin, RL. Meperidine: A critical review. *Am J Therapeutics*, 2002, 9:53-68.

<sup>xii</sup>Unintentional Drug Poisoning in the United States, CDC Issue Brief, July 2010, accessed May 27, 2011 at <http://www.cdc.gov/HomeandRecreationalSafety/pdf/poison-issue-brief.pdf>

<sup>xiii</sup>Braden J, Russo J, Fan M, Edlund M, Martin B, DeVries A, Sullivan MD. Emergency department visits among recipients of chronic opioid therapy. *Arch Intern Med* in press.

<sup>xiv</sup>Edlund MJ, Fan M, DeVries A, Braden J, Martin B, Sullivan MD. Trends in use of opioids for chronic non-cancer pain among individuals with mental health and substance use disorders: the TROUP study. *Clin J Pain* 2010;26:1-8.

