**Subject: Chronic Opiate and Sedative Management in the Emergency Department**

**Guideline Implemented: Page:** 1 of 3

**Revised: Revised:**

**Purpose:**

To institute an emergency department guideline regarding the administration, dispensing, and prescribing of controlled substances to patients with chronic pain and subjective pain syndromes.

# Background:

In an effort to address concerns regarding the potential abuse and diversion of controlled substances, the emergency physicians and advanced practice providers at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have adopted this best practice guideline in the Emergency Department (ED) to guide treatment of patients with chronic opiate and sedative use, and for patients with chronic pain syndromes (e.g., back and dental pain, headaches).

This practice guideline also specifies the administration of, and prescriptions for, opiates and sedatives to patients with chronic pain and subjective pain syndromes.

Opiates and sedatives include but are not limited to: codeine, hydrocodone/acetaminophen (Vicodin, Lortab, Norco), oxycodone/acetaminophen (Percocet, Roxicet, Endocet), morphine, hydromorphone (Dilaudid), oxycodone (Roxicodone, OxyContin), lorazepam (Ativan), diazepam (Valium), clonazepam (Klonopin).

Additionally, hydromorphone (Dilaudid), a Schedule II controlled substance, is six-and-a-half times more potent than morphine, thus it has an increased likelihood for adverse events. Other opiates (for example, fentanyl and morphine) are equally effective for the treatment of pain with less risk for patient harm.

# GOALS:

* Reduce sedative and opioid-related overdoses and controlled substance diversion.
* Optimize treatment of chronic pain
* Improve access to appropriate opioid analgesic and sedative use

# INCLUSION CRITERIA:

* Patients that present to the ED more than 2 times in 1 month or more than 6 times per rolling 12 month period for a pain or sedative related complaint.
* Patients that have had opiate or sedative prescriptions dispensed from 2 or more providers per 12 month following period, as reflected in the Ohio Prescription Monitoring Program.
* Discharge from a pain clinic for breaking a controlled substance agreement.
* History of controlled substance abuse or withdrawal.
* Prior controlled substance conviction.
* History of controlled substance overdose.
* Presentation consistent with chronic pain syndrome without evidence of acute injury or inflammation, e.g., back or dental pain, headache

# EXCLUSION CRITERIA:

* Sickle Cell disease: May be eligible for an individual pain contract
* Active cancer, crippling rheumatologic disease, life-threatening condition, or other terminal diagnoses (e.g., liver failure)
* Acute significant trauma to include, but not limited to, fracture, dislocation, etc.
* Acute significant medical illness to include, but not limited to, appendicitis, CT/US-proven ureteral stone, pancreatitis, etc.

# GUIDELINES:

1. All patients will receive a medical screening exam performed with compassion and empathy.
2. Prescriptions for lost, stolen or expired controlled substances should not be refilled or re-issued, even if a police report has been filed.
3. Patients who have received opiate or sedative prescriptions from two or more different providers, as determined by the OH PMP/NarxCheck, should not be prescribed opiates.
4. Intramuscular and intravenous medications will be avoided.
   1. IM/IV Dilaudid should be reserved for patients with metastatic cancer/palliative care and end-stage renal disease.
   2. If the oral route cannot be used, all other patients should be treated with other opiates, e.g., fentanyl or morphine.
   3. Letters from primary care physicians containing pain control instructions (“opiate cocktails”) for chronic pain should not be honored.
5. Providers should use their clinical judgment and discretion as to whether patients who are managed by a pain clinic will receive opiates or sedatives in the emergency department.
   1. Providers may choose to manage acute exacerbations of chronic pain with non-opiate therapies
6. Oral opiates ordered in the emergency department
   1. Norco (acetaminophen and hydrocodone) 5mg tablets should be the oral opiate drug of choice in the ED.
   2. Oral oxycodone, morphine, and hydromorphone should not be ordered.
7. For acute conditions, providers should follow these guidelines when prescribing controlled substances:
   1. Norco should be the prescriptive opiate of choice.
   2. Oxycodone, fentanyl, morphine, hydromorphone, etc should not be prescribed.
   3. Prescriptions should be written for a maximum of 10 pills with no refills.
   4. Only one opiate prescription should be given per 6 months.
   5. Government issued ID is required prior to the receipt of an opiate or sedative prescription.
   6. . Providers should avoid prescribing controlled substances for chronic pain, including requests for bridging prescriptions after normal office hours or on weekends.
   7. Physicians should review each patient’s prescription history in the Ohio PMP/NarxCheck to guide treatment decisions.
8. Patients who have acute exacerbations of chronic pain should only receive non-opiate prescription medications.
9. In rare instances, a provider may prescribe controlled substances to a patient with chronic pain or a subjective pain syndrome, but only after direct contact with their primary care provider. If prescribed, the number should be the minimum necessary for the patient to get a refill on the next office day, e.g., on Saturday night the patient would get the minimum number necessary for Monday morning.
10. Patients presenting with chronic or acute on chronic back pain should be offered the following:
    1. An NSAID, acetaminophen, and/or non-benzodiazepines muscle relaxant
    2. No opiates should be ordered.
    3. No opiates should be prescribed.
    4. A prescription for non-opiate pain medication, for example, an NSAID, acetaminophen, and/or non-benzodiazepines muscle relaxant.
11. Patients presenting with chronic or acute on chronic headache should be offered the following:
    1. IV/IM/PO anti-emetics, e.g., metoclopramide, prochlorperazine, promethazine, ondansetron
    2. IV/IM NSAID, e.g., Toradol
    3. IV fluids
    4. PO non-opiate analgesics, e.g., NSAID, acetaminophen
    5. No opiates should be ordered.
    6. No opiates should be prescribed.
    7. A prescription for non-opiate analgesic, for example but not limited to, NSAID, acetaminophen, sumatriptan.
12. Patients present with dental pain or a simple dental infection should be offered the following:
13. A dental block for immediate pain control
14. No more than 2 Norco 5mg pills should be administered prior to discharge.
15. No opiates should be prescribed.
16. Antibiotics, if there are signs of an infection
17. A prescription for non-narcotic pain medication

These guidelines are meant to discourage opiate negotiations, i.e., the practice of appeasing patients with IV or IM medications. Most pain specialists believe that intermittent IV or IM doses of opiates are counterproductive to their patients and it is rare to get a 50% reduction in the pain scale for chronic pain patients.

Providers need to understand that patients with chronic pain and subjective pain syndromes may have a very high opiate tolerance. Due to this tolerance, their pain may not be fully controlled during their visit. Providers will attempt to control their pain with non-opiate and sedative therapies.

These patients should be referred for appropriate follow-up care. Case Mangers and or Social Workers are available to assist the patient in establishing relationships with local primary care providers, specialists, and/or pain management clinics as patients with chronic pain or opiate dependence are best managed by a primary care provider not ED visits. Chronic pain treatment is multi-factorial and often requires combinations of antidepressants, counseling, physical and alternative therapies that are not available in the ED .

NOTE: The individual provider’s clinical judgment will always determine the appropriate treatment plan.

**REFERENCES:**

1. American Chronic Pain Association: https://theacpa.org/Going-to-the-ER
2. American College of Emergency Physicians Opioid Guideline Writing Panel. Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department, <http://www.acep.org/workarea/DownloadAsset.aspx?id=88197>
3. Drug poisoning deaths in the United States, 1980-2008. Warner M1, Chen LH, Makuc DM, Anderson RN, Miniño AM.
4. US Food and Drug Administration. Fact Sheet – FDA Opioids Action Plan. 2/5/16.