



# **PARTNERSHIP HEALTHPLAN RECOMMENDATIONS For Safe Use of Opioid Medications**

## **Emergency Department Guidelines**

### **Introduction**

Partnership HealthPlan is a County Organized Health System covering Medical and Mental Health Benefits for Medi-Cal beneficiaries in 14 counties in Northern California. Our mission is to help our members, and the communities we serve, be healthy. In this spirit, we have launched a community-wide initiative to promote safer use of opioid medications.

Why is this important? In the last decade, the death rate from opioid overdose has quadrupled, making opioid overdose as common a cause of death as motor vehicle accidents. For every overdose death, there are 130 people who have a long-term dependence on opioids and 825 non-medical users of opioids (see figure at end of this policy). These numbers originate in prescriptions for opioid pain medications written by health professionals, so health professionals must work together to reverse this trend.

The emergency department has two key roles in helping with community-wide efforts to control opioid overuse: (1) insuring acute pain is treated in a way that decreases the probability of future over-use of opioids and (2) working closely with primary care clinicians to ensure a coherent, safe approach to treating chronic pain. PHC recommends the following to achieve these goals:

### **Recommendations**

- A. Check a CURES report on all patients who will receive opioid medications. If there is a discrepancy, consider contacting the relevant pharmacies to confirm information, as occasionally the CURES data is not accurate.
- B. Limit opioid prescriptions for Acute Pain. Avoid opioids if pain is not severe or if there are risk factors for abuse (including age 16-45). If opioids are prescribed, use low doses for short courses.
- C. Do not prescribe opioids in the ED for chronic non-malignant pain.
- D. Do not prescribe opioids for poorly defined pain (e.g. fibromyalgia, “everything hurts”, pain not fitting any clinical syndrome)
- E. Do not prescribe controlled substances for patients with high risk of abuse or diversion. Examples include:
  - 1. Patient goes to an emergency room outside of the community they live in.
  - 2. Patient paying cash for ED visit.

3. Patient reports they are on a chronic opioid prescribed by an out-of-area prescriber, who cannot be reached.
  4. Patient says their medications were lost or stolen.
- F. Refer patient to PCP instead of prescribing refills of existing opioid medications.
  - G. If the PCP cannot be contacted to do a refill, limit opioid refills to a 4-day supply maximum.
  - H. Notify PCP if an opioid prescription is given, especially if it is a refill.
  - I. Call pharmacy to verify medication history on intoxicated patients.
  - J. Perform a urine toxicology screen on a patient before prescribing a controlled medication, to be sure the result is consistent with the patient's medication history. Consider a confirmatory serum test if the results of a tox screen are unexpected, because false positive and negative screening results are common.
  - K. Prescribe high dose NSAIDs for acute dental pain (studies show opioids are inferior for dental pain, and no more effective than placebo).
  - L. If patients come to the emergency room for severe, breakthrough pain on any regular basis, develop an agreed-upon treatment plan with the Primary Care Physician or usual prescribing outpatient physician to avoid such visits.

### **Other Guidelines for Safe Opioid Prescribing**

Dental Guidelines

Community Pharmacy Guidelines

Primary Care & Specialist Prescribing Guidelines

### **Key Points from these other guidelines**

1. Most experts world-wide advocate a maximum dose of 120 mg oral morphine equivalents daily (MED), to decrease the risk of overdose and opioid-induced hyperalgesia. This does not mean doses should be escalated to this point in all patients. Many are well-controlled at lower doses. PHC recommends this 120 mg MED limit be used as a community standard.
2. Have a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs.
3. Have a signed medication use agreement with the prescriber or prescribing office, renewed yearly.
4. Regularly check the CURES database in all patients being prescribed opioids, preferably each time a prescription is being authorized. At a minimum, the CURES database should be checked annually. If a finding on the CURES report is not consistent with patient history, PHC

recommends contacting the relevant pharmacies to confirm the accuracy of the CURES report, as reporting errors do occur.

5. Have at least three office visits yearly for chronic pain patients using opioids.
6. Limit each opioid prescription to 28 days, writing this on the prescription (e.g. “must last 28 days”). The 28-day refill, scheduled for a Tuesday, Wednesday or Thursday every 4 weeks, is a best practice, to avoid weekends, holidays, and Friday refills.

## References

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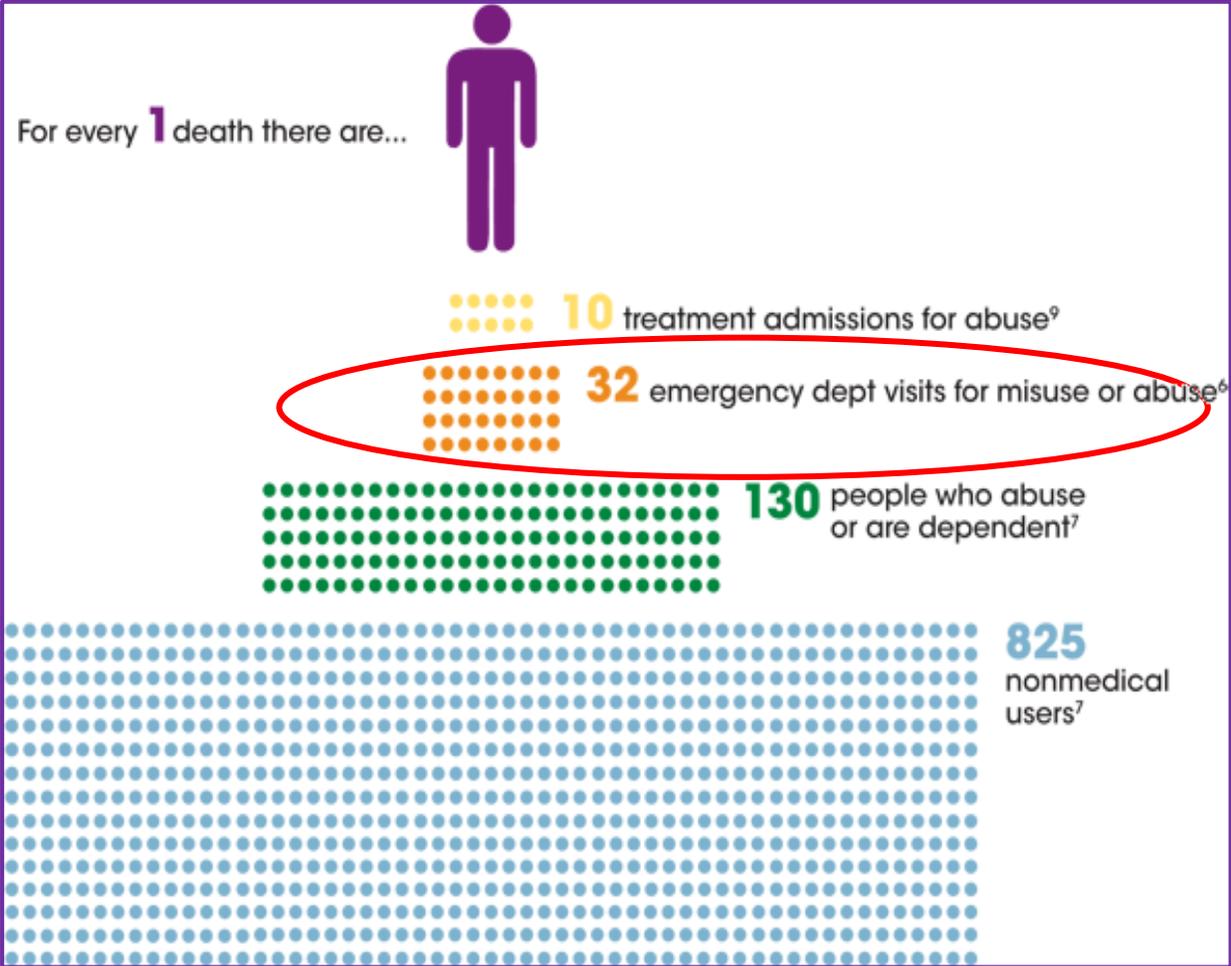
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CDC Statistics (2008)

**Why we have shared responsibility to ensure safe opioid prescribing!**