

# New York City Emergency Department Discharge Opioid Prescribing Guidelines

*Note: These guidelines do not replace clinical judgment in the appropriate care of patients nor are they intended to provide guidance on the management of patients while they are in the ED.*

## **In the management of patients with acute or chronic non-cancer pain discharged from an emergency department,**

- 1. Consider short-acting opioid analgesics for the treatment of acute pain only when the severity of the pain is reasonably assumed to warrant their use.**
- 2. Start with the lowest possible effective dose if opioid analgesics are considered for the management of pain.**
- 3. Prescribe no more than a short course of opioid analgesics for acute pain. Most patients require no more than three days.**
- 4. To assess for opioid misuse or addiction, use targeted history or validated screening tools. Prescribers can also access the New York State Controlled Substance Information (CSI) on Dispensed Prescriptions Program for information on patients' controlled substance prescription history.**
- 5. Avoid initiating treatment with long-acting or extended-release opioid analgesics.**
- 6. Address exacerbations of chronic or recurrent pain conditions with non-opioid analgesics, non-pharmacological therapies, and/or referral to specialists for follow-up, all as clinically appropriate.**
- 7. Avoid when possible prescribing opioid analgesics to patients currently taking benzodiazepines and/or other opioids. Consider other risk factors for consequential respiratory depression.**
- 8. Attempt to confirm with the treating physician the validity of lost, stolen, or destroyed prescriptions. If considered appropriate, replace the prescription only with a one-to two-day supply.**
- 9. Provide information about opioid analgesics to patients receiving a prescription, such as the risks of overdose and dependence/addiction, as well as safe storage and proper disposal of unused medications.**

## Background

With increased use of prescription opioid analgesics for the treatment of pain, misuse also has increased, as have the use of medical services and deaths associated with opioid analgesics. From 2002-2003 to 2008-2009, self-reported, non-medical prescription opioid use increased by 40% with four % of New Yorkers aged 12 and older (263,000) reporting misuse. Between 2004 and 2009, the rate of opioid analgesic-related emergency department (ED) visits in New York City doubled, rising from 55 to 110 visits for every 100,000 New Yorkers. In 2009, one in every four unintentional drug poisoning (overdose) deaths (158) in New York City involved prescription opioid analgesics, a 20% increase from 2005.<sup>1</sup>

The New York City Department of Health and Mental Hygiene created these guidelines to help reduce the misuse of prescription opioid analgesics by establishing standards for prescribing from the ED. In developing the guidelines, the Health Department was cognizant of the need to preserve the vital role of the ED in treating patients with painful medical conditions. These guidelines are consistent with the City Health Information bulletin on Opioid Prescribing, "Preventing Misuse of Prescription Opioid Drugs,"<sup>2</sup> and were informed by opioid prescribing guidelines in other jurisdictions.<sup>3,4</sup> They also incorporate input from a panel of New York City ED providers. The guidelines are not meant for patients in palliative care programs or with cancer pain. They do not replace clinical judgment in the appropriate care of patients nor are they intended to provide guidance on the management of patients while they are in the ED.

## Recommendations

### In the management of patients discharged from an emergency department,

1. **Consider short-acting opioid analgesics for the treatment of acute pain only when the severity of the pain is reasonably assumed to warrant their use.**

Opioid analgesics should not be considered as the primary approach to pain management in discharge planning for patients. Alternative and effective pharmacological interventions for acute pain exist, including non-steroidal anti-inflammatory drugs (NSAIDs), acetaminophen, and nerve blocks (e.g., for dental pain). Non-pharmacological therapies, such as fracture immobilization, may obviate the need for additional pain medications. Short-acting opioid analgesics such as hydrocodone, immediate-release oxycodone, and hydromorphone may be prescribed as adjuncts to relieve acute pain when the severity of the pain warrants their use. They also may be prescribed when non-opioid therapies have not or are reasonably presumed to not provide adequate relief from pain.<sup>4</sup> When prescribing combination preparations of prescription opioid analgesics and acetaminophen, caution the patient about the maximum dose of acetaminophen they should take to avoid toxicity.

The federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to provide a medical screening examination to determine whether an individual presenting at an ED has an emergency medical condition. If the hospital determines that a patient has an emergency medical condition, the hospital must provide treatment as may be required to stabilize the patient's medical condition.<sup>5</sup> EMTALA, however, **does not** require the use of opioid analgesics to treat pain. ED prescribers may apply their professional judgment to determine whether prescribing opioid analgesics for pain is the appropriate course of treatment.

**2. Start with the lowest possible effective dose if opioid analgesics are considered for the management of pain.**

If opioid analgesics are considered for the management of pain after patient discharge from the ED, start with the lowest possible effective dose. Higher doses increase the risk of adverse events such as respiratory depression and overdose.<sup>6,7,8</sup> These risks are especially pronounced for opioid-naïve patients.

**3. Prescribe no more than a short course of opioid medication for acute pain. Most patients require no more than three days.**

Excessive quantities of opioid analgesics increase the risk of misuse, abuse, or diversion. In addition, initiation of opioid analgesic therapy in opioid-naïve patients may lead to inappropriate long term use.<sup>9</sup> For most patients with acute pain, a three-day supply is generally sufficient. When considering the quantity of pills prescribed, it is important to take as-needed dosing into account. For example, a patient taking opioid analgesics “every six hours as needed for pain” may need only one or two doses a day. There may be some acute conditions, e.g. rib fractures, for which severe pain is expected to last more than three days and for which risks of inadequate pain control may exceed risks of a longer supply of opioids. However, if the patient’s acutely painful condition outlasts a three-day supply of opioid medication a re-evaluation of the condition is likely to be beneficial. Consider expediting follow-up care if the patient’s condition is expected to require more than a three-day supply of opioid analgesics.

**4. To assess for opioid misuse or addiction, use targeted history or validated screening tools. Prescribers can also access the New York State Controlled Substance Information (CSI) on Dispensed Prescriptions Program for information on patients’ recent controlled substance prescription history before prescribing controlled substances.**

Patients with histories of substance use disorders are at increased risk of developing opioid addiction when prescribed opioid analgesics for acute pain.<sup>10,11</sup> Validated screening tools include the 10-item Drug Abuse Screening Test (DAST-10).<sup>12</sup> Alternatively, the single question “How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?” (with an answer of one or more considered positive) was found to be 100% sensitive and 73.5% specific for the detection of a drug use disorder compared with a standardized diagnostic interview.<sup>16</sup> A history of substance use disorder should not exclude an ED patient from being prescribed opioid analgesics for acute pain. It should, however, prompt a discussion with the patient about the increased risk for addiction. If necessary, refer for treatment of opioid dependence or addiction.

Prescription databases such as the CSI contain information on patients’ controlled substance prescription history that can inform prescribing decisions. Emergency Department physicians using the Ohio Automated Rx Reporting System for patients presenting with painful conditions changed their opioid prescription plan for 41% of patients after reviewing the patients’ prescription history. Among patients whose prescriptions were changed, 61% received fewer and 39% received more opioids than originally planned.<sup>13</sup>

The New York State CSI on Dispensed Prescriptions program is a database accessible via the Internet that contains information on patients’ controlled substance prescriptions.<sup>14</sup> Changes to New York State law in 2012 will make a patient’s entire controlled substance history (rather than only history meeting specific criteria) available to prescribers through the CSI. The law also will require New York State

prescribers, including ED prescribers writing controlled substance prescriptions for more than five days, to check the patient’s history in the CSI before issuing a controlled substance prescription.<sup>15</sup> Prescribers should register with the [New York State \(NYS\) Health Commerce System health.ny.gov/professionals/narcotic/practitioners/online\\_notification\\_program/](http://health.ny.gov/professionals/narcotic/practitioners/online_notification_program/) ) to gain access. Consider the possibility that a patient is misusing opioid analgesics if the system indicates that the patient has multiple prescriptions for opioid analgesics by multiple providers or filled at multiple pharmacies.

**5. Avoid initiating treatment with long-acting or extended-release opioid analgesics.**

Long-acting and extended-release opioid analgesics are not indicated in the management of acute or intermittent pain. This class of opioid analgesics may cause fatal respiratory depression when administered to patients not previously exposed to opioids, even when used as directed. Patients being treated with long-acting and sustained or extended-release opioid analgesics for the treatment of pain require close follow-up that cannot reasonably be provided by ED prescribers.

**TABLE 1. Prescription Opioid analgesics: Short Acting and Long Acting or Extended Release\*<sup>16</sup>**

<b>Short Acting</b>	<b>Long Acting/Extended Release</b>
<b>Codeine</b>	<b>Oxycodone</b> (Sustained Release) OxyContin®
<b>Oxycodone</b> (Immediate Release) Percocet® Percodan®	<b>Methadone</b> Dolophine®
<b>Hydrocodone</b> Vicodin® Lorcet® Lortab® Norco®	<b>Morphine</b> (Sustained Release) MS Contin® Avinza® Kadian® Oramorph SR®
<b>Morphine</b> (Immediate Release)	<b>Fentanyl transdermal</b> Duragesic®
<b>Hydromorphone</b> Dilaudid®	<b>Oxymorphone</b> (Extended Release) Opana ER®
<b>Oxymorphone</b> (Immediate Release)	<b>Hydromorphone</b> (Extended Release) Exalgo ER®

\*This is not a comprehensive list of all available products.

**6. Address exacerbations of chronic or recurrent pain conditions with non-opioid analgesics, non-pharmacological therapies, and/or referral to specialists for follow-up, all as clinically appropriate.**

Opioid prescriptions from the ED for exacerbation or progression of chronic pain not associated with palliative/end of life care are discouraged in general. Patients with chronic pain who require opioid analgesics should obtain opioid prescriptions from a single prescriber who monitors the patient's pain relief and function. Prescribing, and particularly initiating, sustained-release or long-acting opioid analgesics from the ED for chronic pain is a form of unmonitored opioid therapy that is not optimal for patient care. In exceptional circumstances, the ED prescriber may consider prescribing short-acting opioid analgesics for patients with acute worsening of chronic pain. Similarly, changing the opioid a patient is using chronically in an effort to improve pain relief (i.e., opioid rotation) is complicated and generally should not be done in the ED.<sup>17</sup>

**7. Avoid when possible prescribing opioid analgesics to patients currently taking benzodiazepines and/or other opioids. Consider other risk factors for consequential respiratory depression.**

Opioid analgesics, when combined with other central nervous system depressants or given to patients with certain underlying medical conditions, can increase the risk for overdose, especially in older patients. Avoid the combination of benzodiazepines and opioid analgesics as much as possible.<sup>6</sup> In New York City, about half of unintentional opioid drug poisoning overdose deaths involve a benzodiazepine;<sup>18</sup> most commonly alprazolam (Xanax®).<sup>19</sup> In addition, patients taking higher doses of opioids, including cumulative doses from more than one source, are at higher risk for respiratory depression. The CDC estimates that the 20% of patients receiving opioids who were prescribed a combination of 100 or more morphine equivalents per day account for 80% of opioid overdoses, with half of these among patients with opioids from more than one prescriber.<sup>20</sup> Opioid analgesics should be used with caution in older patients and those with sleep-disordered breathing, such as obstructive sleep apnea, obesity, or congestive heart failure.<sup>21</sup> Doses may have to be adjusted in patients with renal or liver disease due to decreased clearance of the drug.

**8. Attempt to confirm with the treating physician the validity of lost, stolen, or destroyed prescriptions. If considered appropriate, replace the prescription only with a one to two day supply.**

Patients misusing controlled substances may report their prescriptions as having been lost or stolen in an attempt to obtain more pills. The American Pain Society's Agreement for Long-term Controlled Substances Therapy for Chronic Pain stipulates that "medications may not be replaced if they are lost, get wet, are destroyed, etc."<sup>6</sup> EDs should institute a policy to not replace prescriptions for opioid analgesics that are requested on the basis of having been lost, stolen, or destroyed. On-site dispensing of a single dose may be a reasonable option. In those rare instances where this may be warranted, ED providers should document that they confirmed the need directly with the patient's physician. ED providers should not replace these prescriptions if they are unable to obtain this confirmation.

**9. Provide information about opioid analgesics to patients receiving a prescription, such as the risks of overdose and dependence/addiction, as well as safe storage and proper disposal of unused medications.**

Patients should be informed of the risks of taking opioid analgesics and be reminded to take them as prescribed, not more frequently or in greater quantities. Risks of opioid analgesics include, but are not limited to: overdose that can slow or stop their breathing and even lead to death; fractures from falls in patients aged 60 years and older; drowsiness leading to injury; tolerance; and dependence. Respiratory depression is more common with use of alcohol, benzodiazepines, antihistamines, and barbiturates. Patients should be reminded to avoid medications that are not part of their treatment plan because they may worsen side effects and increase the risk of overdose.

Nearly three quarters (71%) of people aged 12 and older who have used opioid analgesics for nonmedical purposes reported obtaining them free or buying them from family or friends.<sup>22</sup> Patients should be told how to minimize risks to others by keeping the medication in a secure location, preferably locked, not sharing medication with anyone, and promptly disposing of unused opioid analgesics by flushing them down the toilet.

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