

APPENDIX B



MARYLAND EMERGENCY DEPARTMENT OPIOID PRESCRIBING GUIDELINES

1. Hospitals, in conjunction with Emergency Department personnel, should develop a process to screen for substance misuse that includes services for brief intervention and referrals to treatment programs for patients who are at risk for developing, or who actively have, substance use disorders.
2. When possible, Emergency Department providers, or their delegates, should consult the Maryland Prescription Drug Monitoring Program before writing an opioid prescription.
3. Hospitals should develop a process to share the Emergency Department visit history of patients with other providers and hospitals that are treating the patients by using CRISP, Maryland's health information exchange.
4. For acute exacerbations of chronic pain, the Emergency Department provider should attempt to notify the primary opioid prescriber or primary care provider of the visit and medication prescribed.
5. ED providers should not provide prescriptions for controlled substances that were lost, destroyed or stolen. Further, Emergency Department providers should not provide doses of methadone or buprenorphine for patients in a treatment program, unless the dose is verified with the treatment program and the patient's Emergency Department evaluation and treatment has prevented them from obtaining their scheduled dose.
6. Unless otherwise clinically indicated, Emergency Department providers should not prescribe long-acting or controlled release opioids, such as OxyContin®, fentanyl patches, or methadone.
7. When opioid medications are prescribed, the Emergency Department staff should counsel the patient:
 - to store the medications securely, not share them with others, and dispose of them properly when their pain has resolved;
 - to use the medications only as directed for medical purposes; and
 - to avoid using opioids and concomitant sedating substances due to the risk of overdose.
8. As clinically appropriate and weighing the feasibility of timely access for a patient to appropriate follow up care and the problems of excess opioids in communities, Emergency Department providers should prescribe no more than a short course and minimal amount of opioid analgesics for serious acute pain, lasting no more than three days.

BACKGROUND

As the use of prescription opioids for chronic non-cancer pain has increased, so have unintended consequences related to opioids. Like many other states, Maryland has experienced a rising rate of prescription drug abuse in recent years. Admissions to substance abuse treatment programs related to prescription opioids like oxycodone, hydrocodone and methadone have risen steadily since 2008.¹ Studies and national experience have shown that individuals who abuse prescription opioids are increasingly initiating heroin use, likely contributing to the increase in the number of heroin-related overdose deaths. The number of opioid-related deaths² increased by 22 percent between 2013 and 2014, and by 76 percent between 2010 and 2014.³ The number of heroin-related deaths in Maryland more than doubled between 2010 and 2014. Deaths have increased among all age groups, whites and African Americans, men and women, and in all regions of the State.⁴

The Maryland Hospital Association's Executive Committee in 2015 charged its Council on Clinical and Quality Issues to develop provider-focused guidelines to address the misuse of opioid prescriptions which would be voluntarily adopted across Maryland's hospitals. The guidelines were endorsed by the Maryland Chapter of the American College of Emergency Physicians in August 2015. While recognizing the need to assess the clinical needs of each patient, these recommendations seek to promote a general standard on opioid utilization and prescribing within Maryland hospital emergency departments (ED). To assist with implementation, recommendations are followed by general clinical and operational guidance for hospital staff to consider. Providers should be aware of the following three overarching considerations that are integral to the application of each recommendation:

The recommendations are not intended to interfere with or supersede the professional medical judgment of the treating provider to determine the right course of treatment (including prescribing practices) based on each individual patient's medical condition;

There are instances, documented in the guidance below, where the professional medical judgment of the treating healthcare provider may determine an alternative course of treatment for a specific patient that varies from a recommendation;

Generally, a patient should obtain opioid medications through one medical clinic or provider to ensure continuity of care, safety, and patient progress, however, in certain circumstances it may be appropriate to prescribe opioids in a limited manner from the ED.

While these recommendations are focused on one setting, the hospital ED, it is acknowledged that a comprehensive effort that includes providers beyond emergency medicine is needed to effectively address this problem.

¹ Maryland Department of Health and Mental Hygiene, Alcohol and Drug Abuse Administration, State of Maryland Automated Record Tracking (SMART) system. SMART records patient and treatment information reported by publically-funded, certified substance use disorder treatment providers in Maryland.

² Opioid-related deaths included deaths related to heroin, prescription opioids, and nonpharmaceutical fentanyl.

³ Maryland Department of Health and Mental Hygiene, Alcohol and Drug Abuse Administration. *2014 Annual Report on Drug- and Alcohol-Related Intoxications Deaths in Maryland.*

⁴ Ibid.

RECOMMENDATIONS

1. Hospitals, in conjunction with Emergency Department personnel, should develop a process to screen for substance misuse that includes services for brief intervention and referrals to treatment programs for patients who are at risk for developing, or who actively have, substance use disorders.

a. ED providers work closely with all patients, including those identified as having a higher risk of, or having a history of, prescription or illicit drug misuse or substance use disorder, to ensure they receive an appropriate medical screening examination and clinically appropriate treatment plan (which may include necessary and suitable medication). Providers should always consider alternatives for pain management, including non-pharmacologic treatment (splinting, etc.) and non-opioid medications. In some situations opioid pain medications may be indicated and should be prescribed even to patients with an identified substance use disorder. In these instances, the provider should talk with the patient about the variety of risks, including the increased risk for substance misuse, addiction, and overdose.

b. To meet the goal of only prescribing opioid pain medication when necessary, and to curb the high incidence of prescription and/or illicit drug misuse and addiction occurring in communities, hospital staff should aim to conduct appropriate screenings of patients for substance misuse, addiction, and overdose concerns. The American Medical Association (AMA) has approved several billing codes that will allow physicians to be reimbursed for providing screening and brief intervention services:

http://www.integration.samhsa.gov/sbirt/Reimbursement_for_SBIRT.pdf

c. Screening tools should be used to assess the patient's risk of substance misuse or use disorder. Screening will help providers make patient-specific treatment decisions and recommendations for follow-up care and/or monitoring. One example of a process used in some hospitals is the SBIRT (Screening Brief Intervention and Referral to Treatment) process. SBIRT aims to identify patients who do not present overtly as moderate or higher risk. General information on this program including links to free training can be found here:

<http://bha.dhmd.maryland.gov/SitePages/SBIRT.aspx>

d. ED providers see patients ranging from occasional substance users to those who have severe substance use disorders. ED providers have a unique opportunity to intervene with patients who present for medical care. To be effective caregivers and increase the chance of patients following through with recommendations, ED providers should offer patients who could benefit from additional services with a list of resources available.

e. While the goal of this recommendation is focused on screening patients who arrive seeking opioid pain medication, the assistance and efforts described above also should be provided to patients who have arrived to the ED due to an overdose of a particular opioid/opiate. Prior to discharge, an ED provider should discuss overdose prevention with the patient. If appropriate, patients should be prescribed naloxone; if someone is accompanying a patient, providers are encouraged to counsel both the patient and the accompanying person that naloxone must be administered by someone other than the person in overdose. Maryland recently changed the law to allow naloxone to be prescribed to someone in addition to the end user, allowing friends and family members to carry and administer it. If a prescription and/or education are appropriate, providers should consider giving the patient and/or others caring for the patient information on

what naloxone is and how to obtain a prescription. Additionally, patients who arrive to the ED due to an overdose should be referred to follow-up services such as counseling, detoxification, and/or other treatment options as appropriate. A DHMH memo on provider prescribing of naloxone is available at

http://bha.dhmh.maryland.gov/OVERDOSE_PREVENTION/Documents/October2014%20Naloxone%20Expansion%20Letter_Primary%20Care.pdf

f. Supporting literature: Madras, et al., *Drug and Alcohol Dependence*, 2009; 99: 280-95;

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2760304/>

2. When possible, Emergency Department providers, or their delegates, should consult the Maryland Prescription Drug Monitoring Program (PDMP) before writing an opioid prescription.

a. Clinical access to the PDMP data is available through an active CRISP account that includes the PDMP data feed. Accessing PDMP data through CRISP is a free service that allows healthcare providers to review controlled substance prescription data and more safely manage their patients' use of controlled substances. PDMP data may be viewed by searching for a patient in CRISP's query portal. The *Maryland Emergency Department Opioid Prescribing Guidelines* are not intended to override any Maryland regulatory requirement. Rather, it aims to set a baseline standard when providers should be consulting the PDMP data in CRISP. In short, the PDMP data in CRISP should be checked whenever possible, but not when it would interfere with timely and needed medical care or when other circumstances might dictate deviation.

b. Patterns of concern in the PDMP data include obtaining medications from multiple providers and filling prescriptions at multiple pharmacies, especially when prescriptions are filled in quick succession or on the same day. Other activities that raise concerns include: obtaining prescriptions from providers in multiple (provider or hospital) systems; obtaining large numbers of pills that may not be warranted given the patient's height and weight or condition; and filling prescriptions far from the patient's home address or work address. While these patterns and activities may be concerning, they do not always indicate a misuse issue. Long-term use or high doses do not necessarily indicate a problem, but providers should engage patients to discuss these facts. Patients receiving long-term opioid therapy can develop tolerance, requiring a higher dose of medication.

c. The PDMP data can help providers identify concerning patterns of controlled dangerous substances prescriptions which may put the patient at risk for unintended overdose. Patients with documented, legitimate sources of pain should be prescribed opioids if indicated. In patients about whom a clinician is uncertain whether a presentation represents "drug seeking behavior" it is recommended to err on the side of providing a limited prescription.

d. More information about the PDMP is available at <http://bha.dhmh.maryland.gov/PDMP>.

Register to access PDMP data through a CRISP account at

https://crisphealth.force.com/crisp2_login

e. Supporting literature: Hall, et al., *JAMA*, 2008; 300: 2613-20; Paulozzi, *Pain Medicine*, 2011; 12: 747-754; Haffajee RL, Jena AB, Weiner SG. Mandatory Use of Prescription Drug Monitoring Programs. *JAMA*. Published online January 26, 2015. doi:10.1001/jama.2014.18514.

<http://jama.jamanetwork.com/article.aspx?articleid=2107540>

3. Hospitals should develop a process to share the Emergency Department visit history of patients with other providers and hospitals that are treating the patients by using CRISP, Maryland's health information exchange.

a. CRISP provides a mechanism for clinicians to exchange information about the health care their patients have received from another provider. This core functionality exists today in the ability to search for and access information through the “query portal” where a physician may find a patient’s lab and radiology results, medication history, discharge summaries, history and physicals, operative notes, and consults.

b. A second application provided by CRISP is the encounter notification system. CRISP receives near-real time patient registration feeds directly from all Maryland hospitals, Delaware hospitals, most hospitals in the District of Columbia, and about 40 nursing homes. The registration data is then used to notify primary care physicians and certain health plans of a patient’s hospital visit (admission, discharge or ED)--information that allows the physician to follow up with the patient and manage the person’s care as they transition between settings.

c. In addition to utilizing CRISP, ED providers, based on their individual assessment of each patient, may choose to discuss follow-up care that may include referrals to treatment, referrals to social services, and/or follow-up appointments with appropriate groups (internal or external to the hospital).

d. There is variability in the information that hospitals make available to CRISP that should be considered when determining how to operationalize this recommendation. Information about how your hospital currently participates with CRISP is available at <https://crisphealth.org/FOR-PROVIDERS/Participating-Organizations>

e. Supporting literature: Jena, et al., BMJ, 2014; 348: g1393; <http://www.bmj.com/content/348/bmj.g1393.full.pdf+html>.

4. For acute exacerbations of chronic pain, the Emergency Department provider should attempt to notify the patient’s primary opioid prescriber or primary care provider of the visit and the medication prescribed.

a. ED providers should use caution in prescribing opioids for acute exacerbations of chronic pain, except when clinically appropriate based on the patient’s individual medical condition. Providers understand the dangers of drug-to-drug interactions and the importance of knowing if patients have medication(s) in their system or access to other medication(s) prior to prescribing additional medication(s); this may be especially true for chronic pain patients, as they often already have strong pain medication(s) available to them from a primary prescriber. There may be rare occasions where it is clinically appropriate to treat a chronic pain patient with a short-acting opioid medication in the ED during an episode of severe pain. EDs should develop policies to inform the primary opioid prescriber or primary care provider in these circumstances. Opioid therapy should generally be managed through a primary care provider. There may be circumstances, however, where the provider’s professional medical judgment supports a different opioid medication to treat an episode of acute pain that is not responding to the patient’s usual treatment regimen.

b. Supporting literature: Jena, et al., BMJ, 2014; 348: g1393; Hall, et al., JAMA, 2008; 300: 2613-20.

5. Emergency Department providers should not provide prescriptions for controlled substances that were lost, destroyed, or stolen. Further, Emergency Department providers should not provide doses of methadone or buprenorphine for patients in a treatment program, unless the dose is verified with the treatment program and the patient's Emergency Department evaluation and treatment has prevented them from obtaining their scheduled dose.

a. The goal of this recommendation is to help control against patients who are misusing controlled substances and 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." The ED should institute a similar recommendation to not replace prescriptions for opioid analgesics requested based solely on the patient description of the drug being lost, stolen, or destroyed. ED providers, using professional medical judgment, may prescribe or offer an on-site dispensing of a single medication dose as a reasonable option. While this should be rare, in such a scenario ED providers should document that they confirmed the need directly with the patient's primary provider. Pursuant to this recommendation, ED providers should not replace these prescriptions if they are unable to obtain this confirmation.

b. This recommendation's goal should be for the ED provider or the admitting physician to call the methadone treatment program or the buprenorphine product provider prior to administering certain narcotics or before the patient is admitted to the hospital.

i. In the majority of cases, for treatment of opioid use disorder, methadone and buprenorphine products are prescribed to be taken once daily. For patients who are on this daily regimen, the withdrawal symptoms are not expected to start before 24 hours after the last dose. ED providers should know that opioid withdrawal is not generally recognized as an emergency medical condition, but missing daily maintenance dose can cause cravings and lead to relapse. The ED providers may also be aware that there may be a small group of patients who take these medications twice a day for various clinical reasons as directed by their providers. When ED providers call the treatment programs to confirm dose, they should also verify the directions of usage for these medications.

ii. Please be aware that most patients in a methadone treatment program must receive their dose daily and in person, supervised at the clinic. Some patients who are in sustained remission and compliant with treatment are allowed to have take-home privileges, meaning they may have a few days' worth of methadone at home. The ED providers should take this fact into consideration when planning for aftercare.

c. When an ED provider sees a pattern of opioid pain medications for a patient that rises to a level of concern, the provider should engage the patient in a conversation about his or her prescription history in a non-accusatory conversation. A pattern of concern does not always equate to substance misuse. Providers are encouraged to seek training on having difficult conversations with patients.

d. Information about the Maryland Board of Physicians CME mandate is available at <http://www.mbp.state.md.us/pages/overdose.html>. This page includes information on Board-approved resources. One free resource is SCOPE of Pain, a CME/CNE web-based 3-module activity to help providers manage the prescribing of pain medications and treatment of chronic pain patients, available at: <https://www.scopeofpain.com/>.

e. Supporting literature: Chabal, et al., Clin. J. Pain 197; 13: 150-55; Wu, et al., J. of Pain and Symptom Management, 2006; 32: 342-46

6. Unless otherwise clinically indicated, Emergency Department providers should not prescribe long-acting or controlled-release opioids, such as OxyContin®, fentanyl patches, and methadone.

a. Often the most appropriate treatment may be to refer a patient with chronic and complex pain to a pain specialist. However, there may be instances where an ED provider's professional medical judgment indicates deviation from this recommendation given a specific patient's circumstance and medical condition. Although expected to be rare, if the treating ED provider believes that long-acting or controlled-release opioids are necessary to stabilize a patient's severe pain, there are considerations that may influence the length of prescription. These considerations may include the patient's medical condition or certain circumstances (e.g. state of emergencies, certain weather conditions, etc.) where it may be difficult to obtain follow up care within a few days. Providers should consider all relevant information about the patient and his or her situation in deciding on a course of treatment and/or prescription length.

b. Supporting literature: Hall, et al., JAMA, 2008; 300: 2613-20; Paulozzi, Am. J. Pub. Health, 2006; 96: 1755-1757.; Dhalla, et al., CMAJ, 2009, 181; 2: 891-896.

7. When opioid medications are prescribed, the Emergency Department staff should counsel the patient:

- **to store the medications securely, not share them with others, and dispose of them properly when their pain has resolved;**
- **to use the medications only as directed for medical purposes; and**
- **to avoid using opioids and concomitant sedating substances due to the risk of overdose.**

a. Providers should always discuss with patients the generally known risks and benefits associated with treatment and self-care post-discharge.

b. Issues to consider for the discussion include:

i. Patients can be high risk for substance misuse or addiction for multiple reasons. One reason may be drug interactions with other medications they are taking, including but not limited to those patients who have co-morbidities (psychiatric and/or somatic) and those who are on benzodiazepines.

ii. The ED staff should ensure that prior to prescribing opioid medication, patients are thoroughly informed of the potential risks and benefits of the proposed opioid treatment, other alternative treatment(s), and no treatment.

iii. Patients should be counseled that the medication should be used only as directed and only until other non-opioid pain medication can be used to treat their pain.

iv. Once the patient can treat the pain with non-opioid medication, any remaining medication should be disposed of properly.

1. The FDA's guidance on safe disposal is available at:

<http://www.fda.gov/downloads/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/UnderstandingOver-the-CounterMedicines/ucm107163.pdf>

2. A patient-friendly sheet from the EPA is available at:

<http://water.epa.gov/scitech/swguidance/ppcp/upload/ppcpflyer.pdf>

3. The Maryland Department of Health and Mental Hygiene provides a list of prescription drop boxes where anyone can deposit unused medications safely:

http://bha.dhmh.maryland.gov/OVERDOSE_PREVENTION/SitePages/Rx%20Disposal.aspx

4. Also, most retail pharmacies sell special containers (e.g. envelopes) in which patients can mail unused medications to a licensed, secure facility where they are safely destroyed.

c. Supporting Literature: Dart, et al., *Annals of Emergency Medicine*, 2009; 53: 419-424; Wolf, et al., *J. Forensic Sciences* 2004; 49: 1-4.

8. As clinically appropriate and weighing the feasibility of timely access for a patient to appropriate follow-up care and the problems of excess opioids in communities, Emergency Department providers should prescribe no more than a short course and minimal amount of opioid analgesics for serious acute pain, lasting no more than three days.

a. While this recommendation aims to set a general standard of prescribing opioid pain medication, no recommendation can override a provider's professional medical judgment to determine the right course of treatment (including prescribing practices), based on a patient's medical condition and circumstances surrounding the ED visit.

b. 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 the risks of a longer supply. In addition, there are certain circumstances (e.g., weather conditions, state or national disasters/emergencies, among others) that may warrant the prescribing of medication for a longer period of time due to the inability of the patient to access a pharmacy or to make an appointment with his or her primary care provider. Similarly, providers may consider regional wait times for certain specialists or primary care especially if the patient does not have a current primary provider, along with other factors, in determining adequate quantity of medication.

c. Supporting literature: Dhalla, et al., *Canadian Family Physician*, March 2011, 57: 3:e92- e96; Alam, et al., *Arch. Intern. Med.*, 2012, 172(5): 425-430; Bohnert AB, Valenstein M, Bair MJ, et al., *Association Between Opioid Prescribing Patterns and Opioid Overdose Related Deaths*. *JAMA*. 2011;305(13):1315-1321. doi:10.1001/jama.2011.370.

<http://jama.jamanetwork.com/article.aspx?articleid=896182>

Operational Considerations:

- Some hospitals in Maryland have already or are planning to adopt more restrictive operational versions of the eight recommendations. Such efforts are consistent with the goals of these guidelines. Hospitals are encouraged to assess their own population needs and to implement more restrictive policies if necessary. The objective of these guidelines is to ensure responsible and appropriate prescribing by all hospitals.
- It should be recognized that no recommendation can anticipate all circumstances. As described above, there may be circumstances where clinical information and provider professional judgment would dictate deviance. Examples of special circumstances that would warrant different application includes:
 - During situations of declared national, state, or local emergencies, providers may need to follow a different approach to some or all of the eight recommendations based on their professional medical judgment or because they must follow legal/regulatory mandates. For example, a provider may prescribe a larger dose of medication due to the patient's inability to access a pharmacy or make a primary care appointment, stemming from the emergency.
- Each ED should identify a champion(s) who ensures that ED providers are educated and trained on the recommendation.
- Good communication is essential between ED and inpatient providers. Where the patient will be admitted, the ED and inpatient providers should coordinate so that patient expectations are managed and treatment protocols are consistent throughout the patient's hospital encounter. Hospitals appreciate that some providers may feel pressure to prescribe medications to a patient for fear of complaints and impacts to patient satisfaction scores. Having all EDs in Maryland adopt this recommendation will establish a common practice that, if adhered to, will normalize any anticipated ramifications from not prescribing certain medications. Additionally, current research demonstrates that patient satisfaction scores are not based on whether the patient is provided or prescribed pain medications (opioid or otherwise). Other factors are more important. Hospitals should equip providers with training and resources to have difficult conversations with patients relating to opioid medications.
- The Maryland Board of Physicians maintains a list of Board-approved resources at <http://www.mbp.state.md.us/pages/overdose.html>. One such resource is SCOPE of Pain, a CME/CNE web-based 3-module activity to help providers manage the prescribing of pain medications and treatment of chronic pain patients, available at: <https://www.scopeofpain.com/>. SCOPE of Pain has a list of clinical resources ranging from videos to pain medication information to assessment tools and those are available at: <https://www.scopeofpain.com/tools-resources/>.
- If any documentation is shared with the patients, additional policies and procedures should be implemented to avoid the risk that the material will be prematurely presented to the patient causing the patient to feel intimidated or leave the ED prior to screening and stabilization. It is recommended that you do not discuss any prescribing policies with ED patients until after they have received a medical screening examination.

Legal Consideration:

To ensure the appropriate adoption of these guidelines, hospital staff should discuss with their medical staff, clinical leadership, and legal counsel the potential impact it may have on hospital EMTALA obligations – the federal Emergency Medical Treatment and Active Labor Act. EMTALA requires an appropriate medical screening examination for any individual who presents at a hospital with an ED and when a request is made for examination or treatment of a medical condition. If the hospital determines that a patient has an emergency medical condition, the hospital must provide either treatment as may be required to stabilize the patient’s medical condition or transfer to another medical facility pursuant to the EMTALA laws and regulations. As part of the EMTALA guidance from the federal government, it is important to note that an emergency medical condition includes severe pain. However, EMTALA *does not* mandate the use of any particular treatment modality, including opioid medication, and the law still provides that it is up to the professional medical judgment of the ED provider in recommending treatment decisions that are required to stabilize the emergency medical condition. As in other areas of medical practice, it is sometimes appropriate for medical professionals (in the exercise of that judgment) to develop (individually or collectively) consistent approaches to common problems, including the appropriate use and management of opioid medication. CMS has acknowledged, that a discussion of any opioid management can appropriately occur during or after the medical screening examination. To meet this concern and to reiterate the point made above, it is recommended that hospitals not post any statements that would be seen as refusing to provide patients with opioid medications if they present with severe pain, thereby causing the patient to leave the ED prior to receiving a medical screening exam and stabilization.

Nothing in this document is intended to interfere with or supersede the professional medical judgment of the provider, nor the clinical and administrative policies of the hospital. Rather, this is intended to provide guidance to clinical staff when seeking to provide the best and safest care to patients within the ED.

***Disclaimer:** This document should not be used to establish any standard of care. No legal proceeding, including medical malpractice proceeding 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. All of the following recommendations should be implemented in concert and collaboration with hospital counsel, public health entities and other relevant stakeholders.*