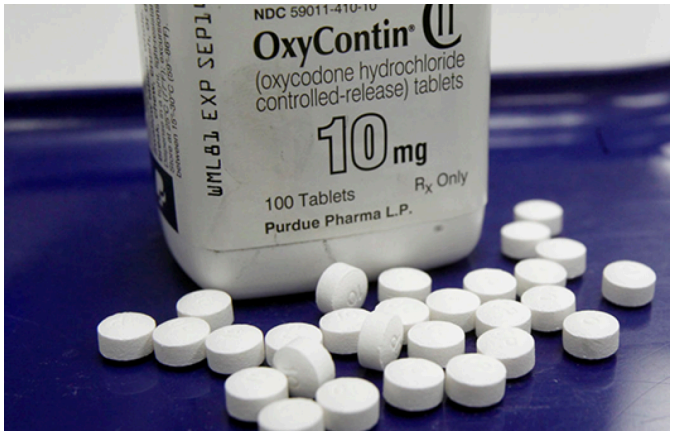
Introduction to the NC ED Pain Management Guidelines

April 12, 2017

Our Agenda

- Overview of Opioid Epidemic
- Our Committee Efforts
- Review of NC ED Pain Management Guidelines
- NCHA Grant Overview



Polling Question

- Does your hospital have ED pain management guidelines in place?

The Opioid Epidemic

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Opioid Facts

The United States has 4.6% of the world's population

- We use 80% of the worlds opioids![1]
- 83% of the world's population has no access to any opioids.

Seya M-J, Gelders SF a M, Achara OU, Milani B, Scholten WK. A first comparison between the consumption of and the need for opioid analgesics at country, regional, and global levels. *J Pain Palliat Care Pharmacother*. 2011;25(1):6-18. doi:10.3109/15360288.2010.536307.

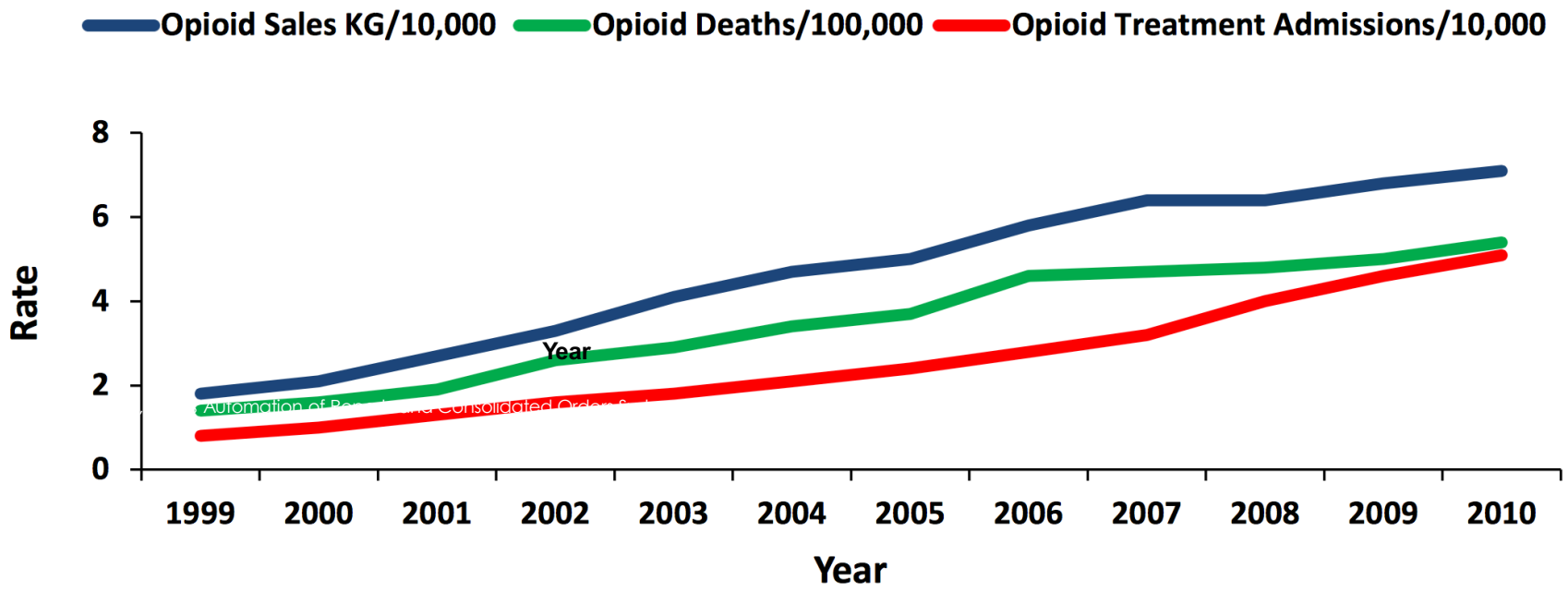
Opioid Increase

Drug distribution through the pharmaceutical supply chain was the equivalent of 96 mg of morphine per person in 1997

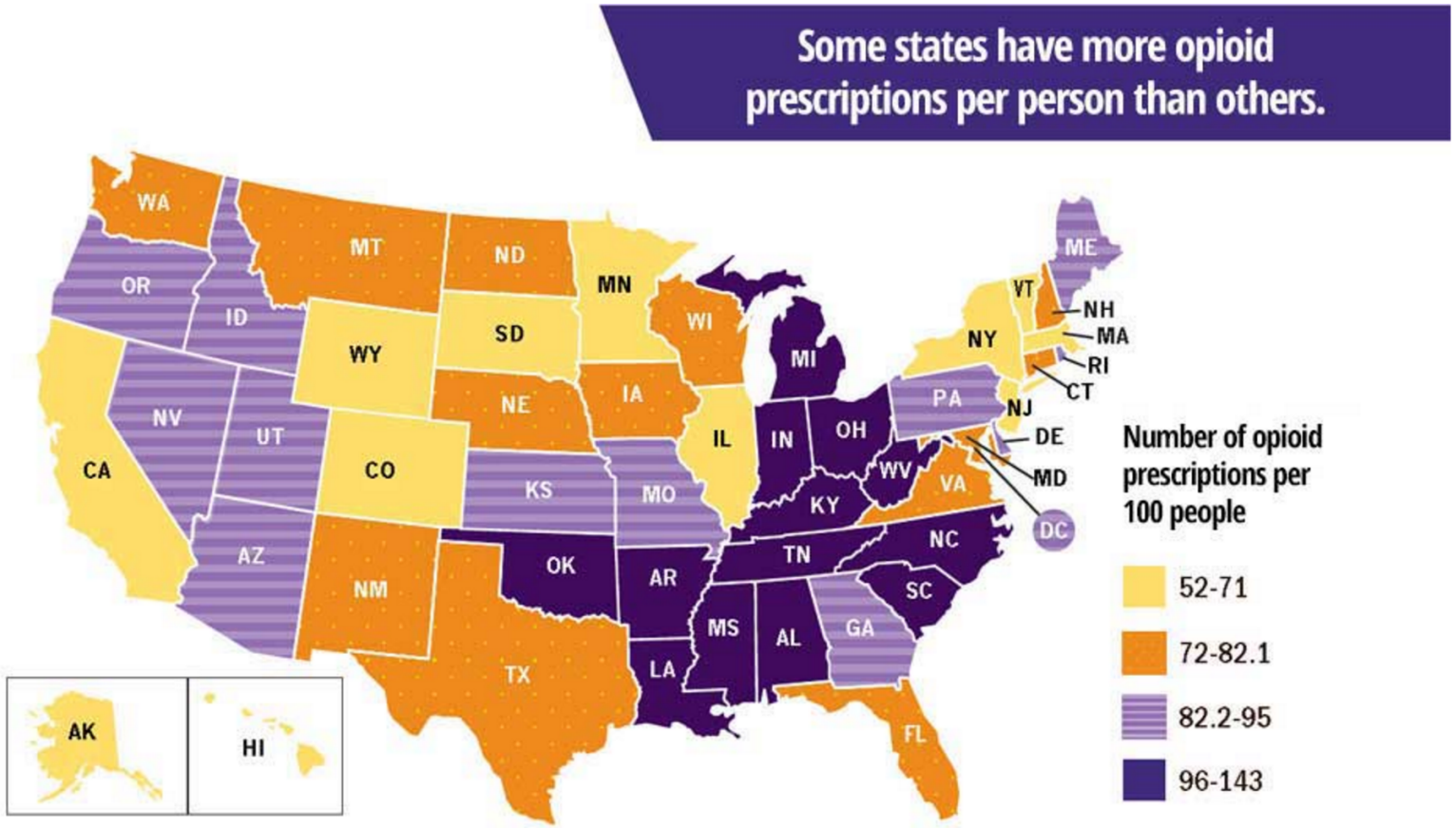
and approximately 700 mg per person in 2007, an increase of >600%.

Paulozzi LJ, Baldwin G. CDC Grand Rounds: Prescription Drug Overdoses — a U.S. Epidemic. *MMWR*. 2012;61(1):10-13.

Rates of Opioid Overdose Deaths, Sales and Treatment, Admissions, US, 1999-2010.

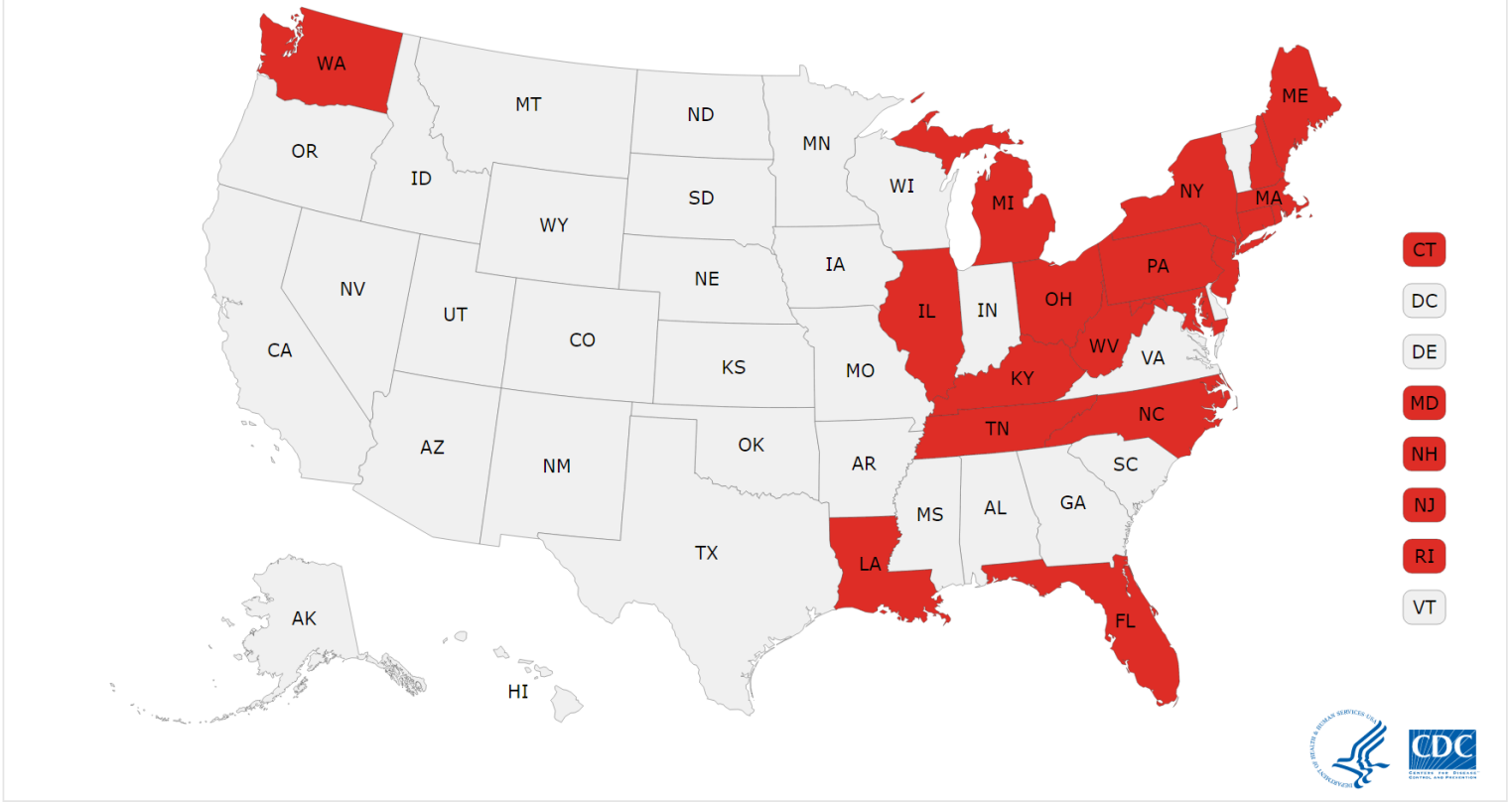


National Vital Statistics System, DEA's Automation of Reports and Consolidated Orders System, SAMHSA's TEDS



https://www.cdc.gov/drugoverdose/data/prescribing.html

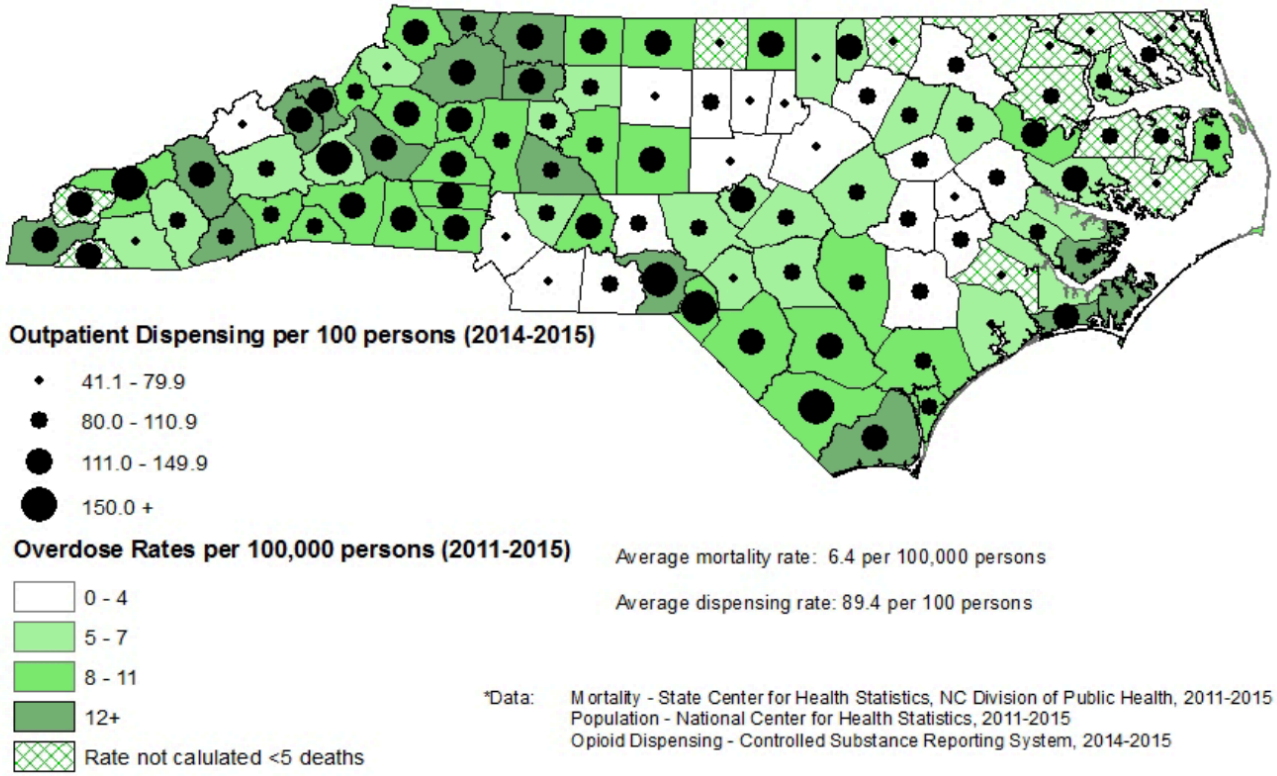
Statistically significant drug overdose death rate increase from 2014 to 2015, US states



https://www.cdc.gov/drugoverdose/data/statedeaths.html

Rate of Unintentional/Undetermined Prescription Opioid Overdose Deaths and Rate of Outpatient Prescriptions Dispensed for Opioids

North Carolina Residents, 2011-2015



Average mortality rate: 6.4 per 100,000 persons

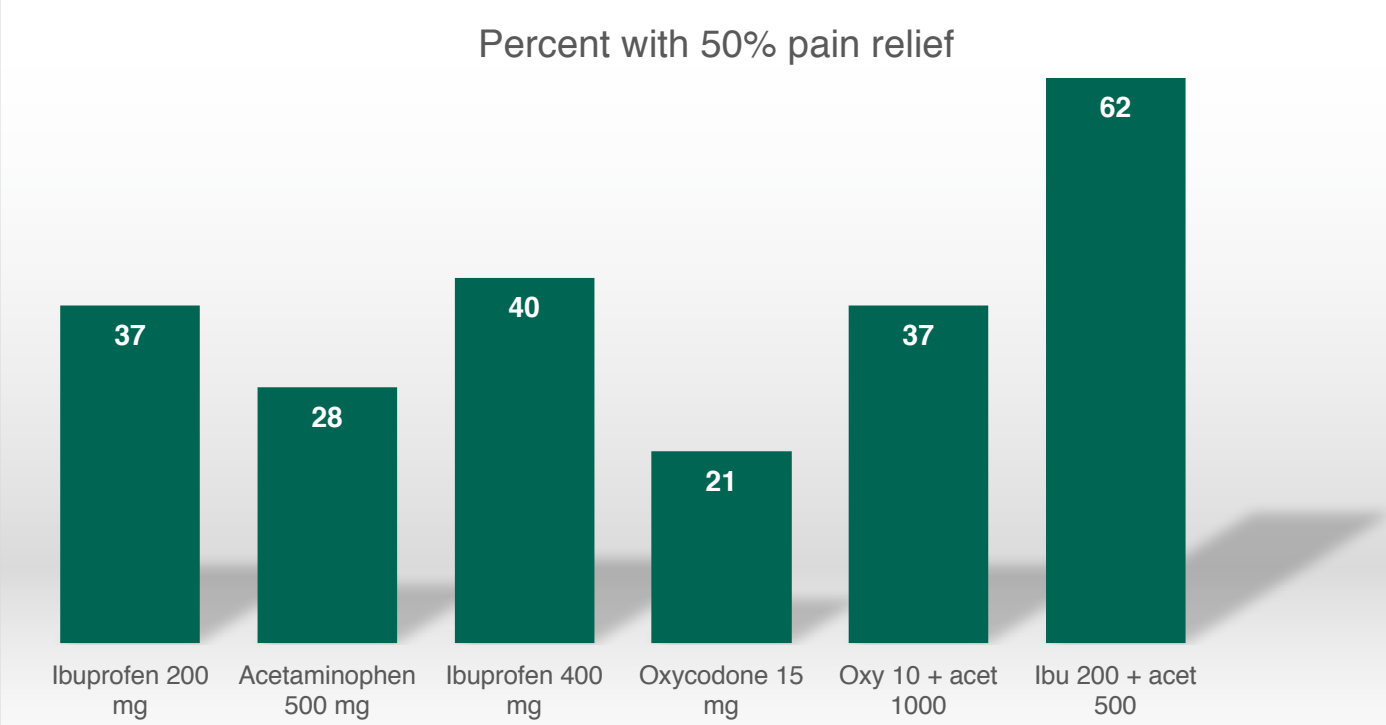
Average dispensing rate: 89.4 per 100 persons

*Data: Mortality - State Center for Health Statistics, NC Division of Public Health, 2011-2015
Population - National Center for Health Statistics, 2011-2015
Opioid Dispensing - Controlled Substance Reporting System, 2014-2015

NC Opioid Overdose Deaths

- 2013 – 790
- 2014 – 913
- 2015 – 1,110

Efficacy of Pain Mediations
Acute Pain

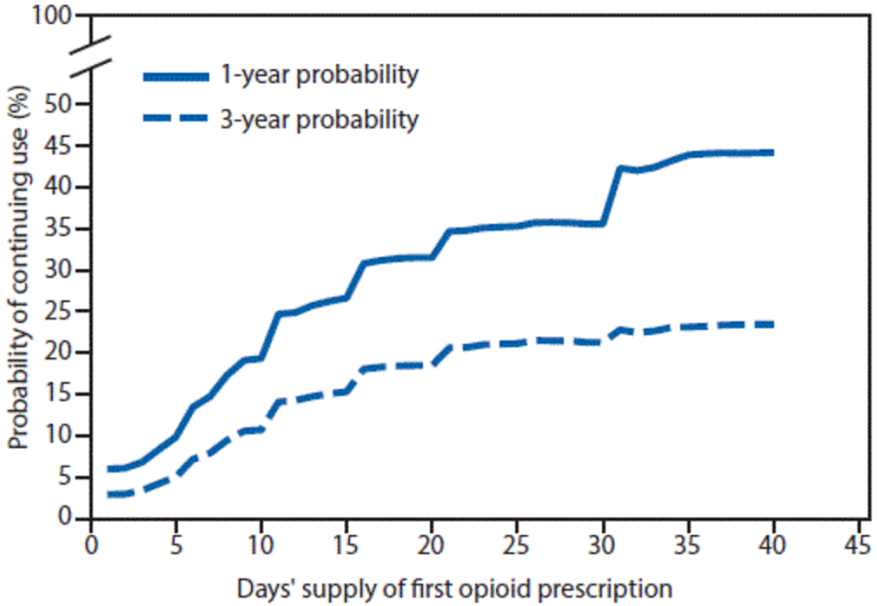


Teater D. *Evidence for the Efficacy of Pain Medications*. Itasca, Illinois; 2014. www.nsc.org/painmedevidence.
Moore RA, Derry S, McQuay HJ, Wiffen PJ. Single dose oral analgesics for acute postoperative pain in adults. *Cochrane Database Syst Rev*. 2011;9(9):CD008659. doi:10.1002/14651858.CD008659.pub2.

Acute Rx Leads to Long-term Use

Duration of acute use:

- 1 day - 6% chance of still using that drug a year later
- 8 days - 13.5%
- 31 days - 29.9%



www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm?s_cid=mm6610a1_e

New Jersey hospital emergency room becomes first in U.S. to end use of opioid painkillers

POSTED 6:23 PM, MARCH 28, 2016, BY CHRISTIE DUFFY

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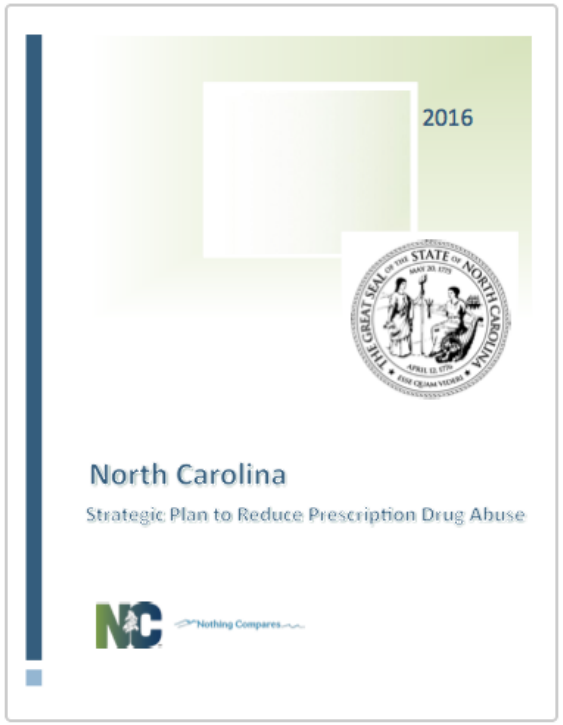
PATERSON, N.J. -- St. Joseph's Regional Medical Center announced it has become the first hospital in the country to implement a program that will manage patients' pain in the emergency room without the use of opioid painkillers.

NC Strategic Plan to Reduce Prescription Drug Abuse



I. Prevention and Public Awareness
II. Intervention & Treatment
III. Professional training and coordination
IV. Identification of core data

Our Opioid Stewardship Advisory Committee

Member	Affiliation
Steven Jarrett, PharmD	Medication Safety Officer Carolinas Healthcare System
Bridget Bridgman, PharmD, CPPS	Director, Medication Safety Novant Health
Chris Griggs, MD, MPH	Emergency Room Carolinas Healthcare System
Jeff Gadsden, MD, FRCPC, FANZCA	Chief, Division of Orthopaedic, Plastic and Regional Anesthesiology Duke University Medical Center
Carol Labadie, PharmD	Medication Safety Officer Vidant Medical Center
Barry Bunn, MD	ED Medical Director/Chief of Staff Vidant Edgecombe Hospital
Nancy Schanz	NCHA, NCQC PSO
Don Teater	Meridian Behavioral Health Services Teater Health Solutions

NC Guidelines for Opioid Management in Emergency Departments

Across the country and in NC, hospitals are working to reduce the opioid epidemic using a multitude of strategies to fight this serious public health problem in their communities. Specific regions of our state have both high rates of prescription opioid sales and overdoses. In 2015 there were 738 prescription opioid overdose deaths in NC and opioid over-prescribing increases the possibility for dependence, abuse, overdose, and diversion. At current rates, unintentional poisonings will surpass motor vehicle crashes as the leading cause of injury death in NC by the end of 2017.

Emergency providers (EP) are well situated to prevent new cases of opioid abuse and initiate appropriate treatment for individuals with opioid addiction. The North Carolina Hospital Association (NCHA) and the North Carolina Chapter of the American College of Emergency Physicians (NCCEP) encourage hospitals to review their policies and procedures to ensure opioids are prescribed properly throughout their organization, especially in the Emergency Department (ED). This document serves as a guideline and is not meant to replace the individual judgment of the medical provider who is in the best position to determine the needs of the individual patient, knowing that treating pain does not require the use of opioids.

Hospitals should review their current policy/practice on the use and prescribing of opioids in the ED. It is recommended that hospitals take action to align their current policy (or create one if none exists) with these guidelines. Hospitals can then develop an action plan to implement these best practices and prevent new cases of opioid addiction.

Review of NC Guidelines for Opioid Management in the ED

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Department of Emergency Medicine

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NC Guidelines for Opioid Management in the ED

- Goal: Balance the duty to treat pain and decrease the risk of opioid dependence, addiction, and diversion in the emergency medicine population

- Context: The increase use of opioids in the past two decades for management of acute and chronic pain has led to abuse, addiction, and death in our communities.

- Hospital and Emergency Departments should review this guideline and create hospital and departmental policies that improve pain management while decreasing the use of opioids

Concepts required to interpret these guidelines:

- Acute pain: Pain caused by tissue injury or inflammation that lasts less than 3 months.
- Chronic pain: Pain without identifiable tissue injury or lasting past the time of normal tissue healing, usually greater than 3 months.
- Malignant/Cancer pain: Pain resulting from chronic inflammatory or tissue destroying process. Examples: Metastatic cancer, sickle cell disease, crippling rheumatoid condition

1. **One medical provider should prescribe all opioid pain medicines to treat a patient's chronic pain.**

   - Chronic pain is defined as pain lasting longer than 3 months
   - According to the CDC guidelines and medical literature, there is poor evidence for the effectiveness of opioids in treating chronic pain.
   - In cases where opioids are used to treat chronic pain, one medical provider with an ongoing relationship with the patient is required, which is not possible in the emergency medicine setting.

2. **Emergency Providers should use their judgment and other resources to provide the best and safest care to patients. Hospitals should support the EP's decision when it is their clinical judgment that an opioid should not be prescribed even if a patient has requested a prescription.**

   - The treatment of pain does not require opioid medications

   - EPs should provide their patients a plan and strategies for managing pain

3. Prescriptions for acute pain/injuries should be written for the shortest duration and lowest effective dose appropriate – no more than 3 days on average. CDC guidelines recommend less than 3 days as sufficient for most acute pain and rarely will more than 5 to 7 days of opioids be required.

- Acute pain is defined by pain related to injured or inflamed tissue. In most cases it lasts days to weeks and is expected to resolve before 3 months.

- If EPs decide to give an opioid prescription, a 3 day prescription is recommended as the average standard prescriptions

4. Hospitals and EDs should develop policies to integrate the use of the NC Controlled Substance Reporting System (NC CSRS) into provider workflows when opioids are prescribed. Additionally, hospitals should work to integrate the NC CSRS into current hospital electronic medical records to provide efficient review of patient profiles without the need to repeatedly access a web portal.

5. The NC CSRS report should be interpreted within the clinical context of the patient presentation. Ultimately, the decision to prescribe opioids requires the professional judgment of the EP, weighing the risks of abuse, diversion, or addiction with the risk of failing to treat severe pain.

6. **Non-opioid therapies should be prioritized over opioid analgesics in the relief of acute and chronic pain. This includes the use of NSAIDS, acetaminophen, heat/cold therapy, positions of comfort, physical therapy, and other multimodal therapies.**

   - Hospitals and emergency departments should increase access to and prioritize opioid sparing pain management strategies.

   - The above list are examples and is not an exhaustive list of possible therapies.

7. Only in *rare* circumstances should a short prescription (< 3 days) be provided for a patient on chronic opioid therapy for chronic non-cancer pain. The decision to prescribe for these patients should occur in coordination with the primary prescriber and information regarding the encounter should be communicated to the primary prescriber when possible.

- Ideally, patients in chronic pain should not be introduced to opioids in the emergency department.

- Should a patient managed on chronic opioid for chronic pain have an exacerbation of pain, a short course of opioids may be required in rare circumstances.

8. Long acting or extended release narcotic agents such as OxyContin, extended release morphine or fentanyl patches should only be prescribed in consultation with the primary opioid prescriber.

   - Long acting agents carry a higher risk of overdose and should not be prescribed from the emergency department without coordination occurring with a primary prescriber.

9. **Controlled substance prescriptions that were lost, stolen, destroyed or finished prematurely should not be replaced. ED providers should not provide replacement doses of methadone or buprenorphine for patients participating in a treatment program without consulting the treatment program or primary opioid prescriber.**

- Replacement doses of methadone should only occur in consultation with prescribing clinic or primary prescriber

- Buprenorphine may be used to stabilize patients in acute opioid withdrawal in the emergency department. Prescriptions for outpatient buprenorphine should only be provided in concert with an outpatient treatment program and a replacement dose should only occur with communication to the patient's outpatient treating provider.

10. Administration of IM or IV opioids for the relief of acute exacerbations of chronic non-cancer pain is not in the patient's best interest and should be discouraged.

- IM and IV opioids act faster than oral opioids and cause greater euphoria and dopamine release in the limbic system. Starting with oral opioids in patients that require further opioid therapy for chronic pain should be prioritized.

11. **Patients who are identified with a substance use disorder or at risk for substance use disorder should be referred to an addiction program or primary care provider for evaluation and treatment.**

- Routine screening for tobacco, alcohol, and illicit substance abuse should occur in patients you are considering treating with opioids.

- The abuse of other substances increases the risk of longer term opioid dependence and abuse. Consider alternative pain management strategies in theses patients or shorter courses of opioids if you feel they are required.

- All those who screen positive for a substance abuse disorder should be referred to treatment.

12. Hospitals and out-patient networks should develop policies to coordinate the care of patients who frequently visit the ED for evaluations of acute exacerbations of chronic pain. A patient specific care plan involving the ED, hospital, and provider treating the patient's pain-inducing condition should be developed that includes patient-specific policies or treatment plans, including referrals for patients with suspected prescription opioid abuse problems.

13. Patients prescribed opioids should be counseled to:
    a. Know risks, side effects and benefits of opioid use,
    b. Store medications securely, not share them with others and dispose of them properly when their pain is resolved,
    c. Use the medications as directed for medical purposes only, and
    d. Avoid using opioids with alcohol, sedatives, muscle relaxants or hypnotics due to the risk of overdose.

- High risk opioid users should receive education about naloxone and a prescription for nasal or IM naloxone.

Another Polling Question…

Which best practices will be most challenging to your facility?

1. Developing facility policies to integrate these best practices.
2. Offering non-opioid multi-modal therapies to patients.
3. Integrating the use of NC CSRS into provider workflow when opioids are prescribed.
4. Referring high risk patients or those with substance use disorders to their PCP or treatment programs.
5. Coordinating the care of patients who frequently visit the ED for evaluations of acute exacerbations of chronic pain.

Resources


NONOPIOID TREATMENTS FOR CHRONIC PAIN
NORTH CAROLINA College of Emergency Physicians
PROMOTING SAFER AND MORE EFFECTIVE PAIN MANAGEMENT
ONIC PAIN TREATMENT
UNDERSTANDING PRESCRIPTION OPIOIDS
PRESCRIPTION OPIOIDS: WHAT YOU NEED TO KNOW
PRESCRIPTION DRUG MONITORING PROGRAMS (PDMPs)
Checking the PDMP: An Important Step to Improving Opioid Prescribing Practices

The Injury and Violence Prevention Branch at the Division of Public Health in partnership with the North Carolina Hospital Association is looking at how to improve care pathways to prevent patients from succumbing to Opioid Addiction and for those suffering with Opioid Use Disorder at a hospital and health system level.

The Coalition for Model Opioid Practices in Health Systems

Phase 1
- Current State Analysis

Phase 2
- Protocol Alignment

Phase 3
- Resource Mapping

Phase 4
- Implementation Support

What Will be Involved?

Prevention:	Response:	Diversion:	Systems:
• Prescribing Practices	• Overdose/Substance Use Disorder Response	• Prevention of diversion by health system practitioners and employees	• Hospital leadership/in-house systems to make all of the above happen

Your Thoughts and Questions?