NC Guidelines for Pain 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.

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

2. EPs 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.

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.

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.

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.

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.

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.

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.

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.

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.

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

Resources

CDC Guideline for Prescribing Opioids for Chronic Pain
Non-Opioid Treatments for Chronic Pain
Promoting Safer and More Effective Pain Management
Prescription Opioids: What You Need To Know
Prescription Drug Monitoring Programs

References

CDC Guideline for Prescribing Opioids for Chronic Pain – United Stated, 2016
NC Prescription and Drug Overdoses