EMERGENCY DEPARTMENT MODEL PRACTICES DEALING WITH THE PRESCRIPTION OPIOID EPIDEMIC

RAMI R KHOURY, MD, FACEP
ASSISTANT MEDICAL DIRECTOR
EMERGENCY CARE
ALLEGIANCE HEALTH
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I see you are back in the ER again with a severe case of Hypodilaudidism~
INTRODUCTION

1) Discuss the current state of the Opioid Epidemic
2) Discuss our experience at Allegiance Health
3) Discuss Michigan College of Emergency Physicians ED prescribing recommendations
4) Discuss the recent experiences in Washington State
In recent years, misuse of over the counter and prescription drugs has surpassed the use of illicit drugs as cause of emergency department visits in the US.

EDs account for 5% of opioid prescriptions filled.
OPIOID EPIDEMIC


1) Distribution of opioids in 2010 was enough to supply every American adult with 5mg of hydrocodone every 4 hours for a month.

2) In 2009, there was more than 201.9 million opioid prescriptions in the US.

3) In 2009, the ED ranked 3rd among all specialties in terms of number of opioid prescriptions in the 10-19, 20-29, and 30-39 age groups.
According to K.H. Todd, in his article “Pain and Prescription Monitoring Programs in the Emergency Department”:

1) Prevalence of pain in ED patients is 78%.

2) Among those with pain presentation, 40% have underlying chronic pain.
“Epidemiology of Emergency Department Visits of Opioid Overdose: A Population Based Study,” published in Mayo Clinical Proceedings in March 2014 found that frequent ED visits for opioid overdoses were associated with a higher likelihood of future hospitalizations and near-fatal events.
Each day, 46 people die from an overdose of prescription painkillers* in the US.

Health care providers wrote 259 million prescriptions for painkillers in 2012, enough for every American adult to have a bottle of pills.

10 of highest prescribing states for painkillers are in the South.
CDC VITAL SIGNS

Number of painkiller prescriptions per 100 people

Lowest

AZ 82
NE 79
WA 77
ND 75
TX 74
IA 73
CT 72
CO 71
NJ 63
NY 60
MN 62
HI 52
CA 57

Average

NC 97
OH 100
VA 78
WI 76
MD 74
NM 74
FL 73
NH 72
MA 71
VT 67
IL 68
AK 65
SD 66

Highest

SC 102
DE 91
KS 94
RI 90
PA 88
OR 89
DC 86
UT 86
ME 85
ID 86
MS 120
AR 116
LA 118
MI 107
IN 109

State Abbreviation — GA 91 — Number of painkiller prescriptions per 100 people

AL 143
TN 146
WV 138
KY 126
OK 128
Some states have more painkiller prescriptions per person than others.
MICHIGAN AS OF 2013

1) No law regulating Pain Clinics which puts us in the red according to CDC for not following a best practice

2) MAPS is in the yellow per the CDC: It does 1) providing prescribers and dispensers access to MAPS, 2) interoperability with MAPS and at least one other state or the District of Columbia, but not 3) proactively reporting findings to law enforcement and regulatory agencies

3) Our overdose death rate per 100,000 is higher than national average

4) Our recreational use rate for people 12 years or older is higher than the national average
The Joint Commission’s standards do not require physicians to prescribe pain medication or opioids.

The standards do require pain to be assessed, managed and if necessary “treated.”

The standards do not mandate any specific approach to treating pain.

The Joint Commission’s standards are meant to draw attention to pain management, not prescribe the treatment.
ALLEGIANCE PATIENT MANAGEMENT PROGRAM

Program has been around since 2002
Became more intensive in 2009
Initially was a document detailing some patient history and visit information
In 2009, due to the amount of opioid requests coming in from patients in the ER, as well as a variety of patients visiting the department from different parts of the state for Vicodin, the format changed.
PATIENT MANAGEMENT PROGRAM

Developed ED complex patient committee with 2 ED physicians, ED nurse, case management, and a member from ACCESS (mental health team)

Goal was to help expedite care for patients with rare disease as well as address our own ED super-utilizer problem

Looked at all patients with 5 or more visits in a rolling 3 month period

The large number of these patients were there for chronic pain and opioid seeking behavior
PATIENT MANAGEMENT PROGRAM

Changed the format of the PMPs (care plans) to have a physician recommendation as well as past medical history and psychiatric recommendation.

Patients who were seen as high opioid users or seekers, and those with chronic pain had a recommendation of “no narcotics unless confirmable pathology.”

These plans were sent to the PCP as well to notify them.

Not all patients were notified of this.
PATIENT MANAGEMENT PROGRAM

Started to see a dramatic change in prescribing

We looked at the ED visit numbers for all PMP patients who have an opioid restriction recommendation in their care plan comparing 2009 and 2010

We saw a 62.4% reduction in ED visits for these patients

We continue to trend this over time and the visit number has stabilized.

Currently have over 1000 patients with plans
PATIENT MANAGEMENT PROGRAM

We currently do a 1, 3, and 5 year review based on the success of the program with each individual patient.

In instances when the plan didn’t decrease visits, we sent the patient a certified letter outlining their ED care.

We also sent the letter to the PCP if they have one.

We also communicate with The Center for Family Health (a federally qualified clinic) as a significant number of patients were shared.
In 2010, we saw an increase of heroin overdoses.

Reiterates that prescription opioids are the new gateway drugs.

Heroin is cheaper

We have now seen a stabilization in the number of heroin overdoses
COMMON PATHWAYS

The ED developed non-opioid chronic headache, chronic back pain and dental pain pathways

Developed Migraine order sets for our electronic medical record

Saw a significant decrease in chronic headache patients

Saw an improvement in migraine outcomes and decreased ED LOS

Saw a decrease of chronic dental pain patients as well as chronic back pain patients
FUTURE GOALS

Enhance the current plans

Merge outpatient documentation with our care plans

Develop pocket guide for our residents and providers consistent with the Ingham County Community Plan of Care Guidelines for Emergency Department Treatment of Chronic and Dental Pain
We developed ED prescribing recommendations in 2010-11 and had them approved at our hospital medical executive committee.
While revamping our prescribing habits in the ED, work was done to change some primary provider habits as well.

Allegiance developed a common pain contract.

Currently developing system guidelines for chronic pain assessment and opioid prescribing.

Dealing with outlying physicians.

System wide mandatory computer based learning for all providers for pain with incentives for PCPs.
Due to the changing environment, and prescription opioids becoming the new gateway drugs, interest started in developing recommendations. Seen improvement in other states who have them. Questions from multiple ED department chairs about help in managing this problem. Allegiance Health, DMC, Sparrow, and Henry Ford Health Systems have all developed own guidelines.
Michigan College of Emergency Physicians (MCEP) Emergency Department (ED) Opioid Prescribing Recommendations

In recent years, misuse of over-the-counter and prescription drugs has surpassed the use of illicit drugs as a cause of ED visits in the U.S.A. Prescription and illicit drug misuse now account for more deaths than motor vehicle accidents.

The following recommendations were developed by the MCEP to assist EDs across Michigan in reducing inappropriate use of opioid analgesics while preserving the vital role of the ED to treat patients with emergent medical conditions.
The emergency health care practitioner is required by law to evaluate patients who report pain. Clinical judgment should be used with regard to treatment options which do not necessarily mandate the use of opioids.

Only one health care practitioner should provide prescriptions for controlled medications for chronic pain.

Parenteral opioids —administered IM, IV, or SC— should not be ordered in the ED for the relief of acute exacerbations of non-cancer, non-terminal, chronic pain. Furthermore, the use of Demerol should be avoided.
ED health care practitioners should not refill prescriptions that have been lost, destroyed, or stolen.

ED prescriptions for controlled medications for acute injuries should be a short course (days).

The ED should not prescribe extended release/long-acting pain medications such as OxyContin, MS Contin, Fentanyl patches or Methadone. Instead, patients should be referred to their prescribing health care practitioner for these controlled medications.
MCEP RECOMMENDATIONS

Utilization of the Michigan Automated Prescription System (MAPS) is highly encouraged for every patient with a chronic pain condition. This free risk management tool provides an electronic report, usually within minutes, on a patient’s history of Schedule II-V controlled substance use.

EDs should provide alternative treatment strategies or referral information for patients who frequently visit the ED for chronic pain conditions.

EDs should provide a list of local clinics, including federally qualified health centers, that provide primary care for patients of all payer types.
Michigan College of Emergency Physicians (MCEP)
Patient Education
Prescribing Pain Medications in Emergency Departments in Michigan

Our emergency department (ED) understands that pain relief is important when someone is hurt or needs emergency care. Providing pain relief, however, is often complex; also, there are major risks involved in using pain medications as mistakes or misuse of these powerful medications can cause serious health problems and even death. Our ED, therefore, is committed to providing pain relief that is appropriate and safe for your illness.
To ensure patient safety:
Only one health care practitioner should provide prescriptions for controlled medications for chronic pain.

Our ED will not give injections for pain management for sudden increases in non-cancer, non-terminal, chronic pain.

Prescriptions that are lost, destroyed, or stolen will not be refilled in our ED.

Our ED will continue to assess and treat acute pain issues that are not related to a chronic pain condition.

Patients will be referred to their prescribing health care practitioner for extended release/long-acting pain medications such as OxyContin, MS Contin, Fentanyl patches or Methadone.
MCEP PATIENT EDUCATION

Our ED may ask the patient about his or her pain medication usage and/or review the Michigan Automated Prescription System (MAPS) to ensure patient safety and to prevent/reduce the risk of patient misuse of pain medications.

If the patient does not have a primary health care practitioner, our ED will seek to make a referral to an appropriate health care practitioner.

Patient resources on chronic pain:
• American Chronic Pain Association [www.theacpa.org](http://www.theacpa.org) or 1-800-533-3231
• State of Michigan Department of Licensing and Regulatory Affairs (LARA) Pain and Symptom Management website: [www.michigan.gov/pm](http://www.michigan.gov/pm)
MAPS

Michigan Automated Prescription System
Has gotten better in recent years
Can access multiple states
Recommended use in MCEP recommendations as well as multiple hospital guidelines
STATE OF WASHINGTON

Have had prescribing guidelines with posters for patients in EDs for a few years

Have revamped their state system to cut down cost and decrease opioid misuse

Developed 7 best practices
WASHINGTON BEST PRACTICES

Electronic system to exchange patient information between emergency departments. 98% of hospitals in state are on this system

Patient education to help clients understand the difference between emergencies and non-emergencies

Establishing ED awareness of patients who are super-utilizers (5 or more visits in a year)

Implementing systems that effectively refer non-emergencies to primary care providers within 3-4 days
WASHINGTON BEST PRACTICES

Adopt stricter guidelines for prescribing of narcotics in the ED

Enrolling at least 90% of the prescribers into the state’s Prescription Monitoring Program

Making sure hospital ER staff get regular feedback reports and take appropriate action when those reports show utilization problems
OUTCOMES AT 13 MONTHS

Rate of ED visits declined by 9.9%
Rate of “super utilizers” (5 or more visits annually) dropped by 10.7%
Rate of visits resulting in a scheduled drug prescription fell by 24%
Rate of visits for a less serious diagnosis decrease by 14.2%

This was a joint effort by Washington State Health Care Authority, Washington State Hospital Association, Washington Chapter of the American College of Emergency Physicians, and Washington State Medical Association
QUESTIONS?
SOURCES

1) CDC.Gov
2) Washington State Chapter of the American College of Emergency Physicians
4) “Pain and Prescription Monitoring Programs in the Emergency Department” Annals of Emergency Medicine, Vol. 56, Issue 1, P24-26
5) “Epidemiology of Emergency Department Visits for Opioid Overdose: A Population-Based Study” Mayo Clinic Proceedings 2014 Apr; 89(4): 462-71