

TOOLKIT: Safe Opioid Prescribing in Emergency Departments



Inland Empire Safe Opioid Prescribing Medical Task Force

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Inland Empire Safe Opioid Prescribing Medical Task Force

Dear Medical Colleagues

Prescription opioid drug dependence, misuse, abuse and drug related overdose deaths have become a public health emergency. By 2009, drug overdose deaths outnumbered deaths due to motor vehicle crashes for the first time in the U.S.ⁱ Opioid analgesics were involved in 30% of drug overdose deaths where a drug was specified in 1999, compared to nearly 60% in 2010.ⁱⁱ Opioid-related overdose deaths now outnumber overdose deaths involving all illicit drugs such as heroin and cocaine combined.ⁱⁱⁱ

The increased morbidity and mortality related to prescription opioid drug usage have led to an exponential increase in emergency department visits. The total number of drug-related ED visits increased 81 percent from 2004 (2.5million) to 2009 (4.6 million).^{iv} **Despite emergency departments prescribing only a fraction of those prescriptions written nationally, ED prescriptions for opioids are reported to account for approximately 45% of those opioids diverted for non-medical use.**^v With pain being one of the most common chief complaints among emergency department patients, the ED is at the forefront of treating and curtailing the propagation of this national epidemic.

The initiative to institute local and national interventions to address this problem based on specific community needs is cropping up everywhere across the country with specific interests in advocating for safe prescribing practices among healthcare providers. From 2000-2007 San Bernardino County's drug use hospitalization rate was similar to the state overall each year and its death rate due to drug use decreased between those same time periods.^{vi} In comparison, Riverside County's data show the drug-related hospitalization rate was higher than the state every year except for 2006 and the death rate due to drug use increased between 2000-2007, which was similar to the statewide rates.^{vii} Both counties have evidence of an increase in adverse outcomes related to opioid abuse.

The Inland Empire Safe Opioid Prescribing Medical Task force has developed this toolkit to turn the tide on this trend, and help physicians protect our community from this blight. Be a part of the solution!



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MISSION STATEMENT

The Inland Empire Safe Opioid Prescribing Medical Task Force will inform and equip hospitals in our community, to help stem the tide of prescription opioid misuse , focusing on safe prescribing practices and providing resources for Emergency Department staff to share with patients and their families.

OBJECTIVES

- Convene as body of Stakeholders from 2015 through 2017 to address this need in the IE
- Identify all hospital Emergency Department Medical and Nursing Directors
- Assess the current community resources for treatment of chronic pain and addiction
- Create a toolkit following the example of those created in San Diego and in Los Angeles
- Distribute that toolkit to every Emergency Department in the Inland Empire
- Distribute flyers to every Emergency Department to use in discussion with their patients
- Explore methods to collect data specifically related to this epidemic in our two-county region
- Host meetings and/or webinars for the ED Directors to facilitate implementation of these tools
- Create a website for all of the above resources, making them available to all providers for reproduction and reference in the effort to improve and maintain safe prescribing.

ⁱ U.S. Department of Health and Human Services. Addressing Prescription Drug Abuse in the United States, Current Activities and Future Opportunities. Developed by the Behavioral Health Coordinating Committee Prescription Drug Abuse Subcommittee 2012.

ⁱⁱ U.S. Department of Health and Human Services. Addressing Prescription Drug Abuse in the United States, Current Activities and Future Opportunities. Developed by the Behavioral Health Coordinating Committee Prescription Drug Abuse Subcommittee 2012.

ⁱⁱⁱ Centers for Disease Control and Prevention. WONDER [database]. Atlanta, GA: US Department of Health and Human Services, Centers for Disease Control and Prevention; 2013

^{iv} National Institute on Drug Abuse. Drug Facts: Drug Related Hospital Emergency Room Visits. May 2011. www.drugabuse.gov

^v American Academy of Emergency Medicine Board of Directors Clinical Practice Statement. Emergency Department Opioid Prescribing Guidelines for the Treatment of Non-Cancer Related Pain. 2013

^{vi} The California Department of Alcohol and Drug Programs with the Center for Applied Research Solutions. Indicators of Alcohol and Other Drug Risk and Consequences for California Counties: San Bernardino County 2010.

^{vii} The California Department of Alcohol and Drug Programs with the Center for Applied Research Solutions. Indicators of Alcohol and Other Drug Risk and Consequences for California Counties: Riverside County 2010

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Safe Prescribing Hospital Participants

Riverside County			
	Hospital	City	Participant
1	Corona Regional Medical Center	Corona	✓
2	Desert Regional Medical Center	Palm Springs	✓
3	Eisenhower Medical Center	Rancho Mirage	✓
4	Hemet Valley Medical Center	Hemet	✓
5	Inland Valley Medical Center	Wildomar	✓
6	JFK Memorial Hospital	Indio	✓
7	Kaiser Permanente – Moreno Valley	Moreno Valley	✓
8	Kaiser Permanente – Riverside	Riverside	✓
9	Loma Linda University Medical Center-Murrieta	Murrieta	✓
10	Menifee Valley Medical Center	Menifee	✓
11	Palo Verde Hospital	Blythe	✓
12	Parkview Community Hospital Medical Center	Riverside	✓
13	Rancho Springs Medical Center	Murrieta	✓
14	Riverside Community Hospital	Riverside	✓
15	Riverside University Health System – Medical Center	Moreno Valley	✓
16	San Geronio Memorial Hospital	Banning	✓
17	Temecula Valley Hospital	Temecula	✓

San Bernardino County			
	Hospital	City	Participant
1	Arrowhead Regional Medical Center	Colton	✓
2	Ballard Rehabilitation Hospital	San Bernardino	✓
3	Barstow Community Hospital	Barstow	✓
4	Bear Valley Community Hospital	Big Bear Lake	✓
5	Canyon Ridge Hospital	Chino	✓
6	Chino Valley Medical Center	Chino	✓
7	Colorado River Medical Center	Needles	

8	Community Hospital of San Bernardino	San Bernardino	✓
9	Desert Valley Hospital	Victorville	✓
10	Hi-Desert Medical Center	Joshua Tree	✓
11	Kaiser Permanente-Fontana	Fontana	✓
12	Kaiser Permanente-Ontario	Ontario	✓
13	Loma Linda University Behavioral Medicine Center	Redlands	✓
14	Loma Linda University Children's Hospital	Loma Linda	✓
15	Loma Linda University Medical Center	Loma Linda	✓
16	Montclair Hospital Medical Center	Montclair	✓
17	Ridgecrest Regional Hospital	Ridgecrest	✓
18	Redlands Community Hospital	Redlands	✓
19	St. Bernardine Medical Center	San Bernardino	✓
20	St. Mary Medical Center	Apple Valley	✓
21	San Antonio Regional Hospital	Upland	✓
22	San Bernardino Mountains Community Hospital	Lake Arrowhead	✓
23	VA Loma Linda	Loma Linda	✓
24	Victor Valley Global Medical Center	Victorville	✓

Safe Opioid Prescribing in Emergency Departments:

Recommendations on the Use of the Patient Handout

The patient handout has been endorsed by more than thirty-nine emergency departments in the Inland Empire. This hand out is also being used in San Diego, Imperial counties and Los Angeles County. It has been endorsed by the Hospital Association of Southern California and the Riverside and San Bernardino County Departments of Public Health. The document has undergone a health literacy test and reads at a sixth-to- seventh-grade level and is available in English and Spanish.

When to Distribute Handouts:

We ask that every emergency department provide a copy of this flyer to every patient at discharge. This can be part of the general discharge instructions given to patients.

How to Distribute Handouts:

We recommend the use of the followingscript. Health Care Provider: "Here is a flyer with information about the rules that our ED follows about pain medicine."

How to Print Handouts:

A PDF of this handout is available on our website: www.hasc.org/safeprescribing

Handouts are 8 ½" x 11", Double-sided (English on one side and Spanish on the other).

SAFE PAIN MEDICINE PRESCRIBING IN EMERGENCY DEPARTMENTS

We care about you. Our goal is to treat your medical conditions, including pain, effectively, safely and in the right way.

Pain relief treatment can be complicated. Mistakes or abuse of pain medicine can cause serious health problems and death.

Our emergency department will only provide pain relief options that are safe and correct.



For your SAFETY, we follow these rules when helping you with your pain.

- 1.** We look for and treat emergencies. We use our best judgment when treating pain. These recommendations follow legal and ethical advice.
- 2.** You should have only ONE provider and ONE pharmacy helping you with pain. We do not usually prescribe pain medication if you already receive pain medicine from another health care provider.
- 3.** If pain prescriptions are needed for pain, we will only give you a limited amount.
- 4.** We do not refill stolen prescriptions. We do not refill lost prescriptions. If your prescription is stolen, please contact the police.
- 5.** We do not prescribe long acting pain medicines such as: OxyContin, MSContin, Fentanyl (Duragesic), Methadone, Opana ER, Exalgo, and others.
- 6.** We do not provide missed doses of Subutex, Suboxone, or Methadone.
- 7.** We do not usually give shots for flare-ups of chronic pain. Medicines taken by mouth may be offered instead.
- 8.** Health care laws, including HIPAA, allow us to ask for all of your medical records. These laws allow us to share information with other health providers who are treating you.
- 9.** We may ask you to show a photo ID when you receive a prescription for pain medicines.
- 10.** We use the California Prescription Drug Monitoring Program called CURES. This statewide computer system tracks opioid pain medications and other controlled substance prescriptions.

If you need help in **Riverside County** call **800-499-3008** and in **San Bernardino County** call **909-421-4601** - ask for information on treatment services for drug use disorders.

Emergency Departments throughout the Inland Empire have agreed to participate in this important program.

To discuss safer and more helpful chronic pain treatment options, please schedule an appointment with your treating physician.



ADMINISTRACIÓN DE MEDICAMENTOS PARA EL DOLOR EN LA SALA DE EMERGENCIAS

Nos preocupamos por su salud y bienestar y por lo mismo, nuestro objetivo es tratar sus condiciones médicas—incluyendo el dolor que sienta—de una manera eficaz, segura y adecuada.

El tratamiento para aliviar el dolor puede ser complicado. Los errores o el abuso de medicamentos con receta para lidiar con el dolor pueden provocar graves problemas de salud y hasta la muerte.

Nuestro departamento de emergencias le proporcionará únicamente opciones de alivio del dolor que sean seguras y adecuadas.



Por su salud, siempre que le brindemos ayuda para lidiar con su dolor, seguiremos estas medidas de seguridad.

1. Determinamos y tratamos emergencias. Usamos nuestro mejor criterio para tratar el dolor. Estas recomendaciones siguen consejos legales y éticos.
2. Nos aseguramos que tenga UN solo proveedor y UNA sola farmacia que le ayuden con su dolor. Normalmente no le recetaremos medicamentos para el dolor si usted ya recibe un medicamento contra el dolor de otro proveedor médico.
3. Si necesita un medicamento recetado para lidiar con su dolor, le daremos una cantidad limitada.
4. No surtimos recetas que fueron robadas ni recetas perdidas. Si le roban su receta de un medicamento contra el dolor, por favor póngase en contacto con su proveedor médico, la policía o el sheriff.
5. No recetamos medicinas para el dolor crónico como: OxyContin, MSContin, Fentanyl (Duragesic), Metadona, Opana ER, Exalgo entre otros.
6. No surtimos dosis perdidas de Subutex, Suboxona ni de Metadona.
7. No solemos proveer inyecciones de alivio rápido para el dolor crónico agudo. De intensificarse el dolor, es posible que se le ofrezca un medicamento oral.
8. Las leyes de protección a la salud, entre ellas HIPAA, nos dan acceso a su expediente médico. Estas leyes nos permiten compartir información con otros proveedores médicos que le brindan atención médica.
9. Podemos pedirle que nos muestre una identificación con fotografía cuando reciba un medicamento recetado para el dolor.
10. Usamos el programa *Controlled Substance Utilization Review and Evaluation System* (CURES en inglés), un sistema electrónico estatal que nos permite tener precaución y monitorear la frecuencia con la cual se receta un medicamento opioide para el dolor entre otras sustancias controladas.

Si necesita ayuda en el condado de Riverside llamada 800-499-3008 y en la llamada Condado de San Bernardino 909-421-4601- pedir información sobre los servicios de tratamiento para los trastornos por consumo de drogas.

Los servicios de urgencias en todo Inland Empire han aceptado participar en este importante programa.

Si desea aprender más sobre sus opciones para lidiar con el dolor crónico de una manera más segura y eficaz, hable con su médico de cabecera acerca de los tratamientos disponibles.



Safe Opioid Prescribing in Emergency Departments:

Pain Management Guidelines

This section of the toolkit includes two evidence-based articles. These articles provide emergency department clinicians with clinical guidance from AAEM and the ACEP as follows:

- Emergency Department Opioid Prescribing Guidelines for the Treatment of Non- Cancer Related Pain. AAEM Board of Directors Nov 12, 2013.
- Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department. Annals of Emergency Medicine Volume 60, No.4: Oct 2012.

Clinical Practice Statement

Emergency Department Opioid Prescribing Guidelines for the Treatment of Non-Cancer Related Pain (11/12/2013)

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Reviewed and approved by the AAEM Board of Directors 11/12/2013.

Executive summary

Pain is one of the most common chief complaints among emergency department patients with a reported rate of over 50%.¹ There is great variability among emergency clinicians in the management of pain, especially with respect to the use of opioid medications.² Importantly, morbidity and mortality have increased as the frequency of opioid use for the treatment of pain has increased.³ This includes a significant increase in non-medical opioid use, addiction, drug-related emergency department visits, and death.^{4,5} The dangers of prescribing opioid medications extend beyond the individual patient and may adversely impact public health.⁶ Approximately 13% of high school seniors have reported non-medical use of prescription opioids. Despite emergency departments prescribing only a fraction of those prescriptions written nationally, ED prescriptions for opioids are reported to account for approximately 45% of those opioids diverted for non-medical use.⁷

These guidelines were developed to provide the emergency clinician with recommendations regarding the safe, effective, and ethical practice of pain management in the emergency department setting. These recommendations may be adopted in whole or in part and should be adapted to address individual hospital policies along with state and local regulations. This document is not meant to replace the judgment of the treating clinician who is in the best position to determine the needs of the individual patient.

Recommendations

In the management of the emergency department patient presenting with acute or chronic pain, the emergency clinician should consider the following when prescribing an opioid medication:

- 1. Administer a short-acting opioid analgesic for the treatment of acute pain as a second-line treatment to other analgesics unless there is a clear indication for the use of opioid medication (Example-patient with acute abdomen, long bone fracture, etc).**
- 2. Start with the lowest effective dose of an opioid analgesic.**

- 3. Prescribe a short course (up to 3 days) of opioid medication for most acute pain conditions.**
- 4. Address exacerbations of chronic pain conditions with non-opioid analgesics, non-pharmacological therapies, or referral to pain specialists for follow-up.**
- 5. Consider assessing for opioid misuse or addiction using a validated screening tool.**
- 6. Consider accessing a centralized prescription network or state-based prescription drug monitoring program, when available, for patient information on recent controlled substance prescriptions.**
- 7. Refrain from initiating treatment with long-acting, or extended-release, opioid analgesics such as methadone.**
- 8. Avoid prescribing opioid analgesics to patients currently taking sedative-hypnotic medications or concurrent opioid analgesics.**
- 9. Refrain from replacing prescriptions for lost, stolen, or destroyed opioid prescriptions.**
- 10. Refrain from refilling chronic opioid prescriptions. Refer the patient to the treating clinician who provided the original prescription.**
- 11. Encourage prescribers to provide safety information about opioid analgesics to patients. This could include information on the risks of overdose, dependence, addiction, safe storage, and proper disposal of unused medications.**
- 12. Following treatment with opioids (in particular the parenteral form) consider an appropriate period of observation and monitoring before a patient is discharged.**
- 13. Understand EMTALA and its requirements for the treatment of pain. The emergency clinician is required under EMTALA to evaluate an emergency department patient reporting pain. The law allows the emergency clinician to use clinical judgment when treating pain and does not require the use of opioids.**

Opioid prescribing is associated with potential misuse and future dependence.^{8,9,10} Though attempts can be made to mitigate this, there are no set of predictors that can determine all patients at risk for opioid abuse.¹¹ This should be reserved for only the most painful conditions using good clinical judgment.

Higher doses of opioids are associated with an increased risk of opioid overdose deaths.^{12,13} In addition, increased doses are also associated with an increased risk of abuse.⁹

Few acutely painful conditions treated in the emergency department require more than a short 3-day course of opioid therapy.¹⁴ Longer courses of opioid treatment are associated with increased risk of abuse⁸ and disability.¹⁵ In addition, opioid use beyond 3 days results in

diminished efficacy and potential increased pain sensitivity.¹⁶ In special circumstances, when longer courses of opioid treatment may be required, an effort should be made to ensure close follow up as an outpatient. In addition, a patient may return to the ED for reassessment if 3 days of opioid treatment was inadequate and/or they were unable to arrange outpatient follow up within that time.

The benefits and safety of opioids for the management of chronic pain remain uncertain.¹⁷⁻¹⁹ Treatment of chronic pain is complicated and requires a thorough assessment and determination of appropriate long-term therapy. Patients with chronic pain are optimally managed by a single long-term provider who can frequently monitor treatment efficacy and safety. Monitoring practices such as patient-prescriber agreements and urine drug testing are not practical in the emergency department setting.²⁰ Importantly, predictors for opioid abuse in chronic pain patients are difficult to assess during an emergency department evaluation.^{11, 21}

Patients with a history of substance abuse are at an increased risk of opioid misuse when prescribed opioid analgesics for acute pain. The single question, "How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?" was found to be 100% sensitive and 73.5% specific for the detection of a drug when the patient answered one or more times.²² Consider alternative therapy in these patients.

Centralized prescription networks provide valuable information on a patient's prescription history. Multiple studies have shown that use of these systems leads to decreases in inappropriate prescribing practices.^{23,24}

Long acting opioids are high risk for respiratory depression and do not have a role in the treatment of acute pain syndromes.^{25, 26} The pharmacokinetics of these medications result in an unpredictable peak effect and increase the risk of respiratory depression. Prescriptions for long acting and extended release opiates are more susceptible to diversion and non-medical opioid use.²⁶

Consider other risk factors for respiratory depression such as obstructive sleep apnea. Prescribing new, or refilling old opioid prescriptions for patients already on opioids or sedative hypnotics have potential life threatening consequences due to respiratory depression and/or trauma secondary to mental status obtundation.

The EMTALA definition of a medical emergency makes reference to severe pain as a symptom that should be investigated; pain may be the result of an emergency medical condition. EMTALA does not state that severe pain is an emergency medical condition. EMTALA does not obstruct the emergency medical provider from applying their professional judgment to withhold opioid treatment of pain for ED patients without an emergency medical condition. ²⁷

Opioid dispensing and administration is fraught with its own intrinsic problems and related morbidity and mortality. A thoughtful approach using this guideline provided will hopefully assist emergency physicians in treating pain ethically without the subsequent consequences associated with their administration.

Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department

From the American College of Emergency Physicians Opioid Guideline Writing Panel

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DISCLAIMER: The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention/the Agency for Toxic Substances and Disease Registry, or the Food and Drug Administration.

Policy statements and clinical policies are the official policies of the American College of Emergency Physicians and, as such, are not subject to the same peer review process as articles appearing in the print journal. Policy statements and clinical policies of ACEP do not necessarily reflect the policies and beliefs of *Annals of Emergency Medicine* and its editors.

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ABSTRACT

This clinical policy deals with critical issues in prescribing of opioids for adult patients treated in the emergency department (ED). This guideline is the result of the efforts of the American College of Emergency Physicians, in consultation with the Centers for Disease Control and Prevention, and the Food and Drug Administration. The critical questions addressed in this clinical policy are: (1) In the adult ED patient with noncancer pain for whom opioid prescriptions are considered, what is the utility of state prescription drug monitoring programs in identifying patients who are at high risk for opioid abuse? (2) In the adult ED patient with acute low back pain, are prescriptions for opioids more effective during the acute phase than other medications? (3) In the adult ED patient for whom opioid prescription is considered appropriate for treatment of new-onset acute pain, are short-acting schedule II opioids more effective than short-acting schedule III opioids? (4) In the adult ED patient with an acute exacerbation of noncancer chronic pain, do the benefits of prescribing opioids on discharge from the ED outweigh the potential harms?

INTRODUCTION

Pain is a major symptom of many patients presenting to the emergency department (ED), with up to 42% of ED visits being related to painful conditions.¹ Pain management has received increased emphasis in the past decade, including The Joint Commission's focus on patient analgesia² and increasing institutional emphasis placed on patient satisfaction surveys

covering pain management. Much literature, including the most recent Institute of Medicine report on this topic, has stressed that health care providers have not done as well as possible in the area of pain management.³ A possible unintended consequence of these efforts is the increase in prescription drug abuse, especially opioid abuse, the fastest-growing drug abuse problem in the United States.⁴

As part of this issue, there has been a startling increase in unintentional drug overdoses and related deaths since the late 1990s.^{5,6} Reported overdose deaths involving opioid analgesics increased from 4,030 in 1999 to 14,800 in 2008.^{7,8} Data from 2008 reveal that drug overdoses were the second leading cause of injury death in the United States, after motor vehicle crashes.⁹ Currently, deaths from opioid analgesics are significantly greater in number than those from cocaine and heroin combined.⁸

The efforts of clinicians to improve their treatment of pain, along with pharmaceutical industry marketing, have been factors in contributing to a significant increase in the sale and distribution of opioids in the United States. For example, the sales of opioid analgesics to hospitals, pharmacies, and practitioners quadrupled between 1999 and 2010.⁸ Drug sales and distribution data of opioids show an increase from 180 mg morphine equivalents per person in the United States in 1997 to 710 mg per person in 2010.^{8,10} This is the equivalent of 7.1

kg of opioid medication per 10,000 population, or enough to supply every American adult with 5 mg of hydrocodone every 4 hours for a month.⁸

The dilemma of treating pain appropriately while avoiding adverse events is further complicated by insufficient data supporting the long-term use of opioids in the treatment of chronic noncancer pain. Although selective use of opioids in the treatment of acute pain is traditionally accepted, the treatment of chronic noncancer pain is more complex. Many authors have begun to question the routine long-term use of opioids for the treatment of chronic noncancer pain.¹¹⁻¹³ Multiple practice guidelines have been developed to address this issue.¹⁴⁻¹⁹ However, most recommendations in this area are of a consensus nature, being based on experiential or low-quality evidence.

Data from 2009 show that there were more than 201.9 million opioid prescriptions dispensed in the United States during that year.²⁰ It is difficult to obtain reliable data concerning the degree to which this is an emergency medicine issue, but during 2009, in the 10- to 19-year-old and 20- to 29-year-old patient groups, emergency medicine ranked third among all specialties in terms of number of opioid prescriptions, writing approximately 12% of the total prescriptions in each age group. In the 30- to 39-year-old group, emergency medicine

ranked fourth. Although these data do not deal with total doses dispensed by specialty, it is commonly postulated that the population served in EDs as a whole is at high risk for opioid abuse.²¹

The significant increase in opioid-related deaths has raised the concern of many.^{5,6,8} This problem has also been observed

in the pediatric population.²²⁻²⁴ Action at the national level includes the recent proposal from the Food and Drug Administration for the establishment of physician education programs for the prescribing of long-acting and extended-release opioids as part of their national opioid risk evaluation and mitigation strategy (the REMS program).²⁵ State efforts to address this issue have included the development of statewide opioid prescribing guidelines, such as those developed by the Utah Department of Health¹⁷ and statewide ED opioid prescribing guidelines, such as those developed in Washington State by the Washington chapter of the American College of Emergency Physicians (ACEP) working with other state organizations.¹⁶ Some individual EDs and emergency physician groups have also promulgated opioid prescribing guidelines. Some of these policies also deal with the necessity of patient education about the safe use and proper disposal of opioid medications. Early data indicate that, in some cases, these guidelines may decrease prescription opioid overdose.²⁶ Anecdotal experience suggests that public policies such as these may change patient perceptions of appropriate prescribing and mitigate complaints arising from more stringent prescribing practices. ACEP has approved related policy statements about optimizing the treatment of pain in patients with acute presentations and the implementation of electronic prescription drug monitoring programs.^{27,28}

This clinical policy addresses several issues believed to be important in the prescribing of opioids by emergency physicians for adult patients treated and released from the ED for whom opioids may be an appropriate treatment modality. Although relieving pain and reducing suffering are primary emergency physician responsibilities, there is a concurrent duty to limit the personal and societal harm that can result from prescription drug misuse and abuse. Because long-acting or extended-release opioids are not indicated for the treatment of acute pain, the aim of this clinical policy is to provide evidence-based recommendations for prescribing short-acting opioids for adult ED patients with painful acute or chronic conditions while attempting to address the increasing frequency of adverse events, abuse, and overdose of prescribed opioid analgesics.

METHODOLOGY

This clinical policy was created after careful review and critical analysis of the medical literature. The critical questions were formulated in the PICO (patient, intervention, comparison, outcome)²⁹ format to strengthen the clarity and scientific rigor of the questions. Searches of MEDLINE, MEDLINE InProcess, and the Cochrane Library were performed. All searches were limited to English-language sources, human studies, adults, and years 2000 to 2011. Specific key words/phrases and years used in the searches are identified under each critical question. In addition, relevant articles from the bibliographies of included studies and more recent articles identified by committee members were included.

This policy is a product of the ACEP clinical policy development process, including expert review, and is based on the literature; when literature was not available, consensus of panel members was used. Expert review comments were received from emergency physicians, toxicologists, pain and addiction medicine specialists, pharmacologists, occupational medicine specialists, and individual members of the American Academy of Clinical Toxicology, American Academy of Family Physicians, American Academy of Pain Medicine, American Chronic Pain Association, American College of Occupational and Environmental Medicine, American College of Osteopathic Emergency Physicians, American College of Physicians, American Pain Society, American Society of Health-System Pharmacists, American Society of Interventional Pain Physicians, Emergency Medicine Resident's Association, and Emergency Nurses Association. Their responses were used to further refine and enhance this policy; however, their responses do not imply endorsement of this clinical policy. Clinical policies are scheduled for revision every 3 years; however, interim reviews are conducted when technology or the practice environment changes significantly. The Centers for Disease Control and Prevention was the funding source for this clinical policy.

All articles used in the formulation of this clinical policy were graded by at least 2 subcommittee members for quality and strength of evidence. The articles were classified into 3 classes of

evidence on the basis of the design of the study, with design 1 representing the strongest evidence and design 3 representing the weakest evidence for therapeutic, diagnostic, and prognostic studies, respectively (Appendix A). Articles were then graded on dimensions related to the study's methodological features: blinded versus nonblinded outcome assessment, blinded or randomized allocation, direct or indirect outcome measures (reliability and validity), biases (eg, selection, detection, transfer), external validity (ie, generalizability), and sufficient sample size. Articles received a final grade (Class I, II, III) on the basis of a predetermined formula, taking into account the design and study quality (Appendix B). Articles with fatal flaws or that were not relevant to the critical question were given an "X" grade and were not used in formulating recommendations for this policy. Evidence grading was done with respect to the specific data being extracted and the specific critical question being reviewed. Thus, the level of evidence for any one study may have varied according to the question, and it is possible for a single article to receive different levels of grading as different critical questions were answered. Question-specific level of evidence grading may be found in the Evidentiary Table included at the end of this policy. Evidence grading sheets may be viewed at <http://www.acep.org/clinicalpolicies/?pg=1>.

Clinical findings and strength of recommendations about patient management were then made according to the following criteria:

Level A recommendations. Generally accepted principles for patient management that reflect a high degree of clinical certainty (ie, based on strength of evidence Class I or overwhelming evidence from strength of evidence Class II studies that directly address all of the issues).

Level B recommendations. Recommendations for patient management that may identify a particular strategy or range of management strategies that reflect moderate clinical certainty (ie, based on strength of evidence Class II studies that directly address the issue, decision analysis that directly addresses the issue, or strong consensus of strength of evidence Class III studies).

Level C recommendations. Other strategies for patient management that are based on Class III studies, or in the absence of any adequate published literature, based on panel consensus.

There are certain circumstances in which the recommendations stemming from a body of evidence should not be rated as highly as the individual studies on which they are based. Factors such as heterogeneity of results, uncertainty about effect magnitude and consequences, and publication bias, among others, might lead to such a downgrading of recommendations.

This policy is not intended to be a complete manual on the evaluation and management of adult ED patients with painful conditions where prescriptions for opioids are being considered, but rather is a focused examination of critical issues that have

particular relevance to the current practice of emergency medicine.

The goal of the ACEP Opioid Guideline Panel is to provide an evidence-based recommendation when the medical literature provides enough quality information to answer a critical question. When the medical literature does not contain enough quality information to answer a critical question, the members of the ACEP Opioid Guideline Panel believe that it is equally important to alert emergency physicians to this fact.

Recommendations offered in this policy are not intended to represent the only management options that the emergency physician should consider. ACEP clearly recognizes the importance of the individual physician's judgment. Rather, this guideline defines for the physician those strategies for which medical literature exists to provide support for answers to the critical questions addressed in this policy.

Scope of Application. This guideline is intended for physicians working in hospital-based EDs.

Inclusion Criteria. This guideline is intended for adult patients presenting to the ED with acute noncancer pain or an acute exacerbation of chronic noncancer pain.

Exclusion Criteria. This guideline is not intended to address the long-term care of patients with cancer or chronic noncancer pain.

CRITICAL QUESTIONS

1. In the adult ED patient with noncancer pain for whom opioid prescriptions are considered, what is the utility of state prescription drug monitoring programs in identifying patients who are at high risk for opioid abuse?

Recommendations

Level A recommendations. None specified.

Level B recommendations. None specified.

Level C recommendations. The use of a state prescription monitoring program may help identify patients who are at high risk for prescription opioid diversion or doctor shopping.

Key words/phrases for literature searches: opioid, drug prescriptions, drug monitoring, drug utilization review, substance abuse detection, drug-seeking behavior, drug and narcotic control, substance-related disorders, physician's practice patterns, program evaluation, emergency service, and variations and combinations of the key words/phrases with exclusion of cancer.

Emergency physicians must balance oligoanalgesia (undertreatment or ineffectual treatment of pain) with concerns about drug diversion* and doctor shopping.^{†30-33} Therefore, the

*Drug diversion: The diversion of drugs for nonmedical use through routes that do not involve the direct prescription of the drug by a provider. Diverted drugs might be provided by family or friends, purchased on the street market, or obtained through fraudulent prescription. Epidemiologic data suggest that most opioids used nonmedically are obtained through these means.

development of mechanisms to address these issues is justified. The expanded use of prescription drug monitoring programs to curb prescription opioid misuse was recommended in the 2011 Prescription Drug Abuse Prevention Plan released by the White House Office of National Drug Control Policy.³⁴ Prescription drug monitoring programs are state-based monitoring programs for certain controlled substances that are prescribed by licensed practitioners and dispensed by pharmacies. Although existing in various forms for more than 3 decades, the first effort to standardize prescription drug monitoring practice was the passage in 2005 of the National All Schedules Prescription Electronic Reporting Act (NASPER). Unfortunately, this federal legislative mandate that intended to harmonize prescription drug monitoring programs across the various states has yet to be fully funded.

Prescription drug monitoring programs ideally serve multiple functions, including identifying patients who engage in doctor shopping, and patients, providers, or pharmacies who engage in diversion of controlled substances and providing information about prescribing trends for surveillance and evaluation purposes. Such information may serve to benefit the patients, the health care system, epidemiologists, policymakers, regulatory agencies, and law enforcement.³⁵ Certain large health care systems, particularly closed prescribing systems such as the Veterans Administration and health maintenance organizations, maintain databases that allow prescribers to view recent prescriptions of enrolled clients or patients. Forty-one states have operational prescription drug monitoring programs of various complexity and capability, with an additional 7 states having prescription drug monitoring program legislation in place but with programs that are not yet operational.³⁶ Most states allow health care providers and pharmacists to access the programs for patients under their care. Other groups such as law enforcement and regulatory boards may also have access. One program tracks only schedule II drug prescriptions, whereas most track drug prescriptions of schedule II to IV or II to V drugs.

Despite prescription drug monitoring programs providing an intuitive perception of benefit for the medical community, there are limited data to indicate any benefit of these programs for improving patient outcomes or reducing the misuse of prescription drugs.³⁷ In part, this relates to the limited optimization of and standardization between the programs and the lack of a mechanism to allow interstate communication.³⁵

†Doctor shopping: The practice of obtaining prescriptions for controlled substances from multiple providers, which is regarded as a possible indication of abuse or diversion. There is no rigorous definition, and various authors have defined it in different ways, from 2 or more prescribers within 30 days, greater than 4 during 1 year, and greater than 5 during 1 year.³⁰⁻³² It has also been defined as the amount of drug obtained through doctor shopping compared with the amount intended to be prescribed.³³ The use of "pill mills," in which a prescriber provides ready access to prescriptions or pills, can be considered a form of doctor shopping.

One study has demonstrated that compared with states without a prescription monitoring program, those with such a program had a slower rate of increase in opioid misuse.³⁸

In an attempt to quantify the effect of a prescription drug monitoring program, Baehren et al³⁹ conducted a prospective study (Class III) of 18 providers who cared for a convenience sample of adult patients with pain in a single Ohio ED. After the clinical assessment of a patient, the researchers queried the providers about 3 patient-specific issues: (1) the likelihood of querying the state's prescription drug monitoring program, called Ohio Automated Rx Reporting System; (2) the likelihood of providing an opioid prescription at discharge; and (3) if yes, which opioid and what quantity. They were then provided with a printout of the patient data from the prescription drug monitoring program and asked to reassess the same questions. Of the 179 patients with complete data, information from the Ohio Automated Rx Reporting System altered prescribing practice in 74 of 179 (41%). The majority (61%) of these patients received fewer or no opioids, whereas 39% received more. The change in management was attributed to the number of previous prescriptions, 30 of 74 (41%); number of previous prescribers, 23 of 74 (31%); number of pharmacies used, 19 of 74 (26%); and number of addresses listed, 12 of 74 (16%). A limitation of this study was that 4 prescribers accounted for almost two thirds of the total patient encounters. In this study, knowledge of the information provided by a prescription drug monitoring program had an important impact on the prescription practices for controlled substances in an ED, although the actual effect of prescription drug monitoring program data on patient outcomes in this study is unknown.

Although not specifically evaluating the benefit of prescription drug monitoring programs on identifying high-risk patients, Hall et al,³² in a Class III study, reviewed characteristics of decedents who died of prescription drugs in West Virginia and reported that opioid analgesics accounted for 93% of deaths. Cross-referencing the medical examiner's detailed analysis of the cause of death with the West Virginia prescription monitoring program, the authors determined the prescription history of the drug associated with each fatality. Patients who had received controlled drugs from 5 or more prescribers in the year before death were defined as engaging in "doctor shopping," whereas those whose death was not associated with a valid prescription were considered to have obtained their drugs through "diversion." Of the 295 deaths that were reviewed, the mean age of patients who died was 39 years, and 92% were between ages 18 and 54 years. Diversion was associated with 186 (63%) of the fatalities, and doctor shopping was associated with 63 (21%) of the fatalities. Of the 295 total decedents, 279 (95%) had at least 1 indicator of substance abuse, and these differed according to whether the drug was obtained through diversion or doctor shopping. Deaths involving diversion were associated with a history of substance abuse (82.3% versus 71.6%; odds ratio [OR] 1.8; 95% confidence interval [CI] 1.0 to 3.4), nonmedical route of

pharmaceutical administration (26.3% versus 15.6%; OR 1.9; 95% CI 1.0 to 3.8), and a contributory illicit drug (19.4% versus 10.1%; OR 2.1; 95% CI 1.0 to 4.9). Patients with evidence of doctor shopping were significantly more likely to have had a previous overdose (30.2% versus 13.4%; OR 2.8; 95% CI 1.4 to 5.6) and significantly less likely to have used contributory alcohol (7.9% versus 19.8%; OR 0.3; 95% CI 0.1 to 0.9). Few patients (8.1%) were involved in both doctor shopping and diversion. The study suggests that the information provided by a prescription drug monitoring program, with correct interpretation and action based on that knowledge, might have prevented some inappropriate prescribing and poor outcomes in this patient population.

In another Class III study, Pradel et al³³ monitored prescribing trends for buprenorphine in a select area of France, using a prescription drug database during a multiple-year period. During this time, a prescription drug monitoring program was implemented, allowing a before-after comparison of the buprenorphine prescribing pattern for more than 2,600 patients. The doctor shopping drug quantity, which was defined as the total drug quantity received by the patient minus the quantity prescribed by an individual provider, increased from 631 g in the first 6 months of 2000 to a peak of 1,151 g in the first 6 months of 2004, equivalent to 143,750 days of treatment at 8 mg/day. The doctor shopping ratio, determined as the ratio of the quantity delivered to the quantity prescribed, increased steadily from early 2000 (14.9% of the grams of drug prescribed) to a peak value in the first 6 months of 2004 (21.7%). After implementation of the prescription drug monitoring program in early 2004, this value decreased rapidly, in fewer than 2 years reaching the value observed in 2000. The points of inflection of the doctor shopping curves (quantity and ratio) coincided with the implementation of the prescription drug monitoring program, suggesting an immediate benefit of this program. The prescribed quantity did not change after the implementation, indicating that access to treatment may not have changed. Eighty percent of the total doctor shopping quantity of buprenorphine was obtained by approximately 200 (8%) of the total patients. However, it is difficult to make any inferences about the effect of a decrease in doctor shopping, given the fractional amount of total prescribing accounted for by this practice.³³ The authors suggested that the doubling in the street price of buprenorphine after the prescription drug monitoring program implementation was an indicator of success.

An observational study of opioid-related deaths by Paulozzi et al³⁷ highlights some important considerations in the assessment of the effectiveness of prescription drug monitoring programs. The authors assessed the mortality rate from 1999 to 2005 from schedule II and III prescription opioids in the United States and compared states that had prescription drug monitoring programs with those that did not. They further divided states with prescription drug monitoring programs into those that proactively informed prescribers, generally by mail, of potential

misuse and those that did not. This study found no difference in the mortality rates over time for states with and without a prescription drug monitoring program, nor did states with proactive prescription drug monitoring programs perform better than those with programs that were not proactive. There was a nonsignificantly lower rate of consumption of schedule II opioids and a significantly higher rate of consumption of hydrocodone (schedule III) in states that had a prescription drug monitoring program. A major limitation of this study is that the variability in the prescription drug monitoring program structure, including the ability of health care providers to access the database, was not considered. Current applicability is somewhat limited by substantial changes in the manner in which prescription drug monitoring programs function since the study was conducted, including the extent of physician access and the definition of patient inclusion criteria. Because of the practical limitation of the delay in informing the prescriber of a patient's potential drug misuse, the proactive notification aspect of these programs would have minimal effect on emergency medical practice in states that cannot provide prescription drug monitoring program data in real time.

In conclusion, there are no studies that directly evaluate the effect of real-time, voluntary access to a prescription drug monitoring program on prescribing practices of emergency physicians. In addition, the broader effect of such access on diversion, abuse, doctor shopping, mortality, and the possibility of pain undertreatment remains undefined. Prescription drug monitoring programs have many limitations in their current format, including complex access issues, limitations on access permission, thresholds for patient listing, timeliness, interstate communication, and whether the data are presented to the physician automatically or require physician effort to retrieve. Furthermore, the recent addition of prescription drug monitoring programs in several states and continuing changes in the structure or function of existing programs limit the direct application of even recently published research. Legislation designed to improve prescription drug monitoring program operation (eg, NASPER) has stalled or remained underfunded, and concerns over patient confidentiality have often trumped public health concerns. Until an interstate, frequently updated, multiple-drug-schedule, easily accessible, widely used prescription drug monitoring system is implemented, the likelihood of success is limited.³⁵

2. In the adult ED patient with acute low back pain, are prescriptions for opioids more effective during the acute phase than other medications?

Recommendations

Level A recommendations. None specified.

Level B recommendations. None specified.

Level C recommendations. (1) For the patient being discharged from the ED with acute low back pain, the

emergency physician should ascertain whether nonopioid analgesics and nonpharmacologic therapies will be adequate for initial pain management.

(2) Given a lack of demonstrated evidence of superior efficacy of either opioid or nonopioid analgesics and the individual and community risks associated with opioid use, misuse, and abuse, opioids should be reserved for more severe pain or pain refractory to other analgesics rather than routinely prescribed.

(3) If opioids are indicated, the prescription should be for the lowest practical dose for a limited duration (eg, <1 week), and the prescriber should consider the patient's risk for opioid misuse, abuse, or diversion.

Key words/phrases for literature searches: acute low back pain, opioid, and variations and combinations of the key words/phrases.

Acute low back pain is a common ED presenting complaint. Opioids are frequently prescribed, expected, or requested for such presentations.^{40,41} In a recent study, it was estimated that low back pain–related disorders result in approximately 2.6 million annual ED visits in the United States. Of medications either administered in the ED or prescribed at discharge, the most frequently used classes were opioids (61.7%; 95% CI 59.2% to 64.2%), nonsteroidal anti-inflammatory drugs (NSAIDs) (49.6%; 95% CI 46.7% to 52.3%), and muscle relaxants (42.8%; 95% CI 40.2% to 45.4%).⁴¹ The opioid analgesics most commonly prescribed for low back pain, hydrocodone and oxycodone products, are also those most prevalent in a Government Accountability Office study of frequently abused drugs.⁴² Low back pain as a presenting complaint was also observed in a recent study to be associated with patients at higher risk for opioid abuse.⁴³ Low back pain, although a common acute presentation, is also often persistent and recurrent, with 33% of patients continuing to complain of moderate-intensity pain and 15% of severe pain at 1 year from initial presentation. Symptoms recur in 50% to 80% of people within the first year.⁴⁴ In one study, 19% reported opioid use at a 3-month follow-up.⁴⁰ Emergency physicians, as a specialty, are among the higher prescribers of opioid pain relievers for patients aged 10 to 40 years.²⁰ Recent data show simultaneous increases in overall opioid sales rates and prescription opioid–related deaths and addiction rates and suggest that widespread use of opioids has adverse consequences for patients and communities.⁸

There is a paucity of literature that addresses the use of opioids after ED discharge for acute low back pain versus the use of NSAIDs or the combination of NSAIDs and muscle relaxants. Two meta-analyses published in the last 5 years identified relatively few valid studies that address the use of opioids for low back pain.^{45,46}

In a Class III 2008 Cochrane review, NSAIDs were compared with opioids and muscle relaxants for the treatment of low back pain.⁴⁶ Three studies were reviewed that compared opioids (2 of which are no longer in use) with NSAIDs for treatment of acute low back pain, including 1 study considered by the Cochrane reviewers to be of higher quality.⁴⁷ None of

the individual studies found statistically significant differences in pain relief. A Class III review by McIntosh and Hall⁴⁵ of clinical evidence for treatment of acute low back pain similarly found no evidence for superiority of opioids over other therapies and no direct information to demonstrate that opioids were better than no active therapy; however, the authors concluded that the opioid-related studies were too small to detect any clinically important differences.

A Class III Cochrane review of NSAID treatment for acute low back pain evaluated 65 studies (including more than 11,000 patients) of mixed methodological quality that compared various NSAIDs with placebo, other drugs, other therapies, and other NSAIDs.⁴⁶ The review authors concluded that NSAIDs are slightly effective for short-term symptomatic relief in patients with acute and chronic low back pain without sciatica (pain and tingling radiating down the leg). In patients with acute sciatica, no difference in effect between NSAIDs and placebo was found but moderate efficacy was found for opioids. The systematic review also reported that NSAIDs are no more effective than other drugs (acetaminophen, opioids, and muscle relaxants). Placebo and acetaminophen had fewer adverse effects than NSAIDs, and NSAIDs had fewer adverse effects than muscle relaxants or opioids.

A 2003 Cochrane review of muscle relaxants for low back pain (Class X because it did not address the role of opioids) found that muscle relaxants were effective for short-term symptomatic relief in patients with acute and chronic low back pain.⁴⁸ However, muscle relaxants were associated with a high incidence of adverse effects. This study cited strong evidence in 4 trials involving a total of 294 people that oral nonbenzodiazepine muscle relaxants are more effective than placebo in patients with acute low back pain for short-term pain relief, global efficacy, and improvement of physical outcomes.

Although no superiority has been demonstrated for opioids over other therapies for treatment of acute low back pain, groups have recommended against use of opioids as first-line therapy for treatment of this problem.^{49,50} A guideline for diagnosis and treatment of low back pain endorsed by the American College of Physicians and the American Pain Society recommends opioids only for severe, disabling pain that is not controlled or not likely to be controlled with acetaminophen or NSAIDs.⁴⁹ In their 2007 guidelines, the American College of Occupational and Environmental Medicine stated that routine use of opioids for acute, subacute, or chronic low back pain is not recommended.⁵⁰

Several observational non-ED studies also suggest caution with regard to opioid prescribing for back pain. Franklin et al,⁵¹ in a retrospective study (Class X because of the non-ED patient population), found that workers with acute low back injury and worker's compensation claims who were treated with prescription opioids within 6 weeks of acute injury for more than 7 days had a significantly higher risk for long-term disability. In a subsequent Class III population-based prospective study of opioid use among injured Washington

State workers with low back pain, Franklin et al⁵² observed a strong association between the amount of prescribed opioids received early after injury and long-term use of prescription opioids. A retrospective study of 98 workers with acute low back pain and subsequent disability claims by Mahmud et al⁵³ found that patients whose treatment of new work-related low back pain involved opioid use for 7 days or more were more likely to have long-term disability (relative risk 2.58; 95% CI 1.22 to 5.47); however, the direct applicability of this study (Class X) was limited because most patients were not seen in the ED. In another study that addressed associations of long-term outcome with opioid therapy for nonspecific low back pain, Volinn et al⁵⁴ found that the odds of chronic work loss were 11 to 14 times greater for claimants treated with schedule II ("strong") opioids compared with those not treated with opioids at all. They further observed that the strong associations between schedule II use and long-term disability suggest that for most workers, opioid therapy did not arrest the cycle of work loss and pain. Although this study was also graded as Class X because of the population selected and failure to directly address acute or immediate benefit, the results highlight potential problems of treating acute low back pain with opioids.⁵⁴ Unfortunately, causation cannot be directly inferred from these studies because of possible confounding.

In summary, although opioids currently offer the most potent form of pain relief, there is essentially no published evidence that the prescription of opioid analgesics for acute low back pain provides benefit over other available medications or vice versa. Several observational studies suggest associations of both prescription of "strong" opioids or longer prescription duration (greater than 7 days) and early opioid prescribing with worsened functional outcomes. Additionally, as noted, the overall increased rate of opioid sales has been strongly associated with adverse effects in the community (overdose, addiction, aberrant use, and death).⁸ Therefore, it can be recommended that opioids not be routinely prescribed for acute low back pain but reserved for select ED patients with more severe pain (eg, sciatica) or pain refractory to other drug and treatment modalities. Prescriptions for opioids should always be provided for limited amounts and for a limited period. Extra caution (such as use of prescription drug monitoring programs and seeking of collateral patient information such as patient visit history) may be indicated for patients identified as possibly having an increased risk for substance dependence or abuse.

3. In the adult ED patient for whom opioid prescription is considered appropriate for treatment of new-onset acute pain, are short-acting schedule II opioids more effective than short-acting schedule III opioids?

Recommendations

Level A recommendations. None specified.

Level B recommendations. For the short-term relief of acute musculoskeletal pain, emergency physicians may prescribe short-acting opioids such as oxycodone or hydrocodone

products while considering the benefits and risks for the individual patient.

Level C recommendations. Research evidence to support superior pain relief for short-acting schedule II over schedule III opioids is inadequate.

Key words/phrases for literature searches: opioids, schedule II narcotics, schedule III narcotics, acute pain, acute disease, emergency service, and variations and combinations of the key words/phrases.

Schedules II and III are classifications established by the Comprehensive Drug Abuse Prevention and Control Act of 1970 and determined by the Drug Enforcement

Administration. Among other criteria, classification decisions for specific drugs are based on judgments about the potential for their abuse. Schedule II opioids include morphine (eg, MS Contin), oxymorphone (eg, Opana), oxycodone (eg, Roxicodone) and oxycodone combination products (eg, Percocet, Percodan), as well as hydromorphone (eg, Dilaudid) and fentanyl (eg, Duragesic patch, Actiq). Schedule III opioids include combination products, such as hydrocodone (15 mg or less) combined with acetaminophen (eg, Vicodin, Lortab) or ibuprofen (eg, Vicoprofen), as well as some of the codeine combination products.⁵⁵ Schedule classifications for opioids may change over time in response to a number of factors, including their perceived risk of abuse. Calls to reclassify hydrocodone combination products (eg, Vicodin, Lortab) from schedule III to schedule II have increased in recent years in response to increasing levels of abuse of these substances.

These recommendations address only new-onset acute pain. Long-acting or extended-release schedule II products such as oxycodone ER (OxyContin), methadone, fentanyl patches, or morphine extended-release (MS Contin) are indicated for chronic pain and should not be used for acute pain.⁵⁶ Long-acting and extended-release opioids are for use in opioid-tolerant patients only and are not intended for use as an “as-needed” analgesic. In addition, the immediate-release oral transmucosal formulations of fentanyl are indicated only for breakthrough pain relief in cancer patients who are already taking sustained-release medications and are opioid tolerant. These formulations should not be used for acute new-onset pain.

As part of the decision to prescribe opioids for new onset of acute pain, the care provider can select between short-acting schedule II or III agents (Table). In general, equianalgesic doses of opioids are equally efficacious in relieving pain. Therefore, *a priori*, there is no reason to consider an equianalgesic dose of a short-acting schedule II opioid more effective in providing pain relief than a short-acting schedule III opioid. However, some studies have compared schedule II and III opioids combined with nonopioid analgesics with one another. Two prospective randomized controlled trials have compared the efficacy of short-acting oxycodone, a schedule II drug, with hydrocodone combination products (schedule III) and found them to be equal.^{57,58} In 2005, Marco et al⁵⁷ compared single doses of

Table. Short-acting oral opioid formulations. Dose and interval are recommended starting dosing ranges.

Medication	Initial Dose/Interval	Schedule
Codeine/APAP	30-60 mg* PO Q4-6h PRN	III
Codeine	30-60 mg PO Q4-6h PRN	II
Hydrocodone/APAP	5-15 mg* PO Q4-6h PRN	III
Hydromorphone	2-4 mg PO Q4-6h PRN	II
Morphine	15-30 mg PO Q4-6h PRN	II
Oxycodone/APAP	5-15 mg* PO Q4-6h PRN	II
Oxycodone	5-15 mg PO Q4-6h PRN	II
Oxymorphone	10-20 mg PO Q4-6h PRN	II

APAP, acetaminophen; h, hour; mg, milligram; PO, by mouth; PRN, as needed; Q, every.

*Listed dose is of the opioid component. Note that the acetaminophen component is now limited to 325 mg or less per pill.

oxycodone 5 mg with hydrocodone 5 mg (both combined with 325 mg acetaminophen). In this single-site Class II study of 67 adolescent and adult subjects with acute fractures, no differences in analgesic efficacy were observed at 30 or 60 minutes. Constipation rates were higher for hydrocodone. In a 2002 Class I study, Palangio et al⁵⁸ compared oxycodone 5 mg combined with acetaminophen 325 mg (schedule II) with hydrocodone 7.5 mg combined with ibuprofen 200 mg (schedule III) in a prospective, multicenter, multidose, randomized controlled trial of 147 adults with acute or recurrent low back pain. During an 8-day study period, no differences were found in pain relief, doses taken, global evaluations of efficacy, health status, or pain interference with work. As noted above, equianalgesic doses of opioids have similar efficacy in the treatment of acute pain, no matter their Drug Enforcement Administration classification. Given this understanding, it was not unexpected that 2 randomized controlled trials comparing schedule II with III agents found no differences in analgesic efficacy.

4. In the adult ED patient with an acute exacerbation of noncancer chronic pain, do the benefits of prescribing opioids on discharge from the ED outweigh the potential harms?

Recommendations

Level A recommendations. None specified.

Level B recommendations. None specified.

Level C recommendations. (1) Physicians should avoid the routine prescribing of outpatient opioids for a patient with an acute exacerbation of chronic noncancer pain seen in the ED.

(2) If opioids are prescribed on discharge, the prescription should be for the lowest practical dose for a limited duration (eg, <1 week), and the prescriber should consider the patient's risk for opioid misuse, abuse, or diversion.

(3) The clinician should, if practicable, honor existing patient-physician pain contracts/treatment agreements and

consider past prescription patterns from information sources such as prescription drug monitoring programs.

Key words/phrases for literature searches: opioid, patient

discharge, pain, emergency service, and variations and combinations of the key words/phrases with exclusion of cancer.

Patients with chronic noncancer pain, either already taking opioids or not, commonly present to the ED for treatment of acute exacerbation of their pain. There have been no studies that evaluate the efficacy or potential harms of prescribing opioids specifically for these patients on discharge from the ED. Thus, given the paucity of evidence, this critical question cannot be definitively answered. Despite the biological plausibility that treating any acute exacerbation of pain with parenteral or oral opioids should decrease pain intensity, no studies were found to support this hypothesis.

Only 2 randomized controlled trials were identified that addressed the use of short-acting opioids for the treatment of breakthrough pain in patients taking opioids for chronic noncancer pain; transmucosal fentanyl was the intervention for both trials.^{59,60} Because of methodological problems, valid estimates for efficacy of the intervention could not be determined, but adverse event rates among both treated populations were common and similar (range 63% to 65%) (Class III).

A systematic review of nonrandomized studies by Devulder et al⁶¹ examined the effect of rescue medications on overall analgesic efficacy and adverse events. They examined 48 studies of patients treated with long-acting opioids for chronic noncancer pain and compared the analgesic efficacy and adverse events among those that allowed short-acting opioid rescue medications for breakthrough pain with those that did not allow such rescue medications. Although graded Class X because of lack of randomized studies and the limitation of harms studied to adverse effects only, no significant difference in the analgesic efficacy between the rescue and nonrescue studies was found. There was also no difference between these 2 groups in the incidence of nausea, constipation, or somnolence. Kalso et al,⁶² in a Class III systematic review, found that 80% of patients receiving opioids for chronic noncancer pain had at least 1 adverse event, including nausea (32%), constipation (41%), and somnolence (29%).

Studies of the use of opioids for chronic pain indicate that adverse effects of these drugs are common. Several studies assessed the adverse effects with the use of tramadol with acetaminophen in the treatment of patients with chronic low back pain.⁶³⁻⁶⁵ All of the studies had high dropout rates and reported adverse event rates of nausea, dizziness, and somnolence between 8% and 17%. Allan et al,⁶⁶ in a nonblinded Class III study comparing transdermal fentanyl versus oral morphine, found a constipation rate of 48% in the morphine-treated patients compared with a rate of 31% in the fentanyl-treated patients. Constipation was also the major adverse effect in a Class III study by Hale et al⁶⁷ comparing oxycodone extended release, oxycodone controlled release,

and placebo. Furlan et al,⁶⁸ in a Class II meta-analysis of 41 randomized studies of opioid use in the treatment of chronic noncancer pain, found that constipation and nausea were the

⁶⁹

only significant adverse effects. Holmes et al,⁶⁹ however, in a Class III study, assessed an opioid screening instrument, the Pain Medication Questionnaire, in chronic noncancer pain patients and found that those patients with a higher score were more likely to have a substance abuse problem or request early refills of their opioid prescription. In a retrospective Class III cohort study, Jensen et al⁷⁰ conducted a 10-year follow-up on patients discharged from a pain clinic and found that chronic opioid treatment may put patients at risk for chronic depression. Unfortunately, near-universal shortcomings of these studies include the exclusion of patients with a history of substance abuse, other significant medical problems, or psychiatric disease, and lack of follow-up to detect long-term effects such as aberrant drug-related behaviors, addiction, or overdose. Therefore, studies such as these can be confounded, making the ability to draw conclusions about causality difficult.

Questions of opioid effectiveness involve the assessment of reduction in pain and improvement in function for the patient, potential patient adverse effects, and the potential harm to the community (eg, opioid diversion and abuse) from the drugs

³²

prescribed. Hall et al,⁷¹ in a Class III retrospective analysis of 295 unintentional prescription overdose deaths, found that 93% were due to opioids, 63% represented pharmaceutical drug diversion, 21% of the patients had engaged in doctor shopping, and 95% of the patients had a history of substance abuse. Although no studies have addressed the effects related to dose and duration of prescribed opioids in this specific patient population, 2 general studies have shown a correlation between high daily opioid dose and overdose death.^{71,72}

Patient assessment tools such as the Screener and Opioid Assessment for Patients with Pain (SOAPP), Opioid Risk Tool (ORT), Diagnosis, Intractability, Risk, and Efficacy (DIRE), and others to assess the risk of prescription opioid misuse and abuse have yet to be fully validated in the ED in terms of sensitivity, specificity, and utility.⁷³ Many, however, believe that use of these tools, as imperfect as they are, represents a beginning in the ability to better quantify potential risks related to opioid prescribing for outpatients.

Many patients undergoing treatment for chronic noncancer pain have pain contracts/treatment agreements with their primary care providers. These should be honored if possible in treating any acute exacerbation of their pain.^{74,75} As discussed in critical question 1, use of prescription drug monitoring programs may also assist the emergency physician in making appropriate clinical decisions about the use of outpatient opioid prescriptions for these patients.

FUTURE RESEARCH

Provider pain management practices related to opioids are highly variable. In part, this variability reflects the lack of evidence to guide many of these therapeutic decisions.⁷⁶

Although there is high-quality research assessing the treatment of acute pain with opioid analgesics during the ED encounter, there is a paucity of studies assessing the benefits of prescribing opioids for discharged ED patients with acute pain and chronic noncancer pain, especially in comparison to other analgesic drugs and pain treatment modalities. Therefore, clinical decisions and practice recommendations must rely on practice experience and consensus rather than research evidence.

ED populations typically include patients with unmet substance abuse treatment needs and psychiatric comorbidities, and many of these patients present with acute pain.⁷⁷ In almost all pain studies, these patients are excluded, leaving clinicians with little evidence-based guidance for their pain management. There are also significant research gaps in clearly understanding the long-term harms of opioids, including drug abuse and addiction, aberrant drug-related behaviors, and diversion. As mentioned above, further research and validation is needed on ED patient abuse and addiction-related assessment tools. Additional studies to characterize individual patient-related risks for opioid abuse are also greatly needed.

Although there has been recent widespread adoption of prescription monitoring programs, there remains a dearth of evidence about the effectiveness of these programs in altering physician prescribing patterns or diminishing the adverse effects of opioids in the community. For research in this area to advance, further refinement of prescribing metrics (quantity, duration, and frequency) and public health measures is required. Comparison of the functionality and effectiveness of the various state prescription drug monitoring program models may provide additional insight into developing best practices that could be adopted nationally, including the sharing of data between states. Important distinctions among the states, such as immediate online prescriber access to the prescription monitoring program, should be examined for their relative contributions. However, this type of analysis must consider baseline variability among states for prescription opioid misuse (versus heroin or methadone, for example) and other state-specific issues (such as prescription-writing regulations).

With respect to the treatment of acute low back pain in the ED, there is a need for quality studies comparing the effectiveness of the more commonly prescribed opioids (hydrocodone and oxycodone congeners and other semisynthetic opioids) and nonopioid therapies, with attention to confounding variables such as depression or other psychopathology. Further study is needed to validate or refute the reported associations of early or potent opioid prescribing with increased rates of disability.⁵¹ Given the frequency of acute low back pain as an ED presentation and its association with perceived drug-seeking behavior,⁷⁸ and with apparent higher risk for misuse,⁴³ more attention needs to be paid to discriminatory historical or physical factors that may be predictive of drug-seeking or abuse to allow better matching of treatment modality for individual patients.

Future studies should include additional multiple-dose analgesic protocols to better understand the postdischarge experience of patients with acute pain and what would constitute optimum patient follow-up provisions. Investigators should include clinically relevant study periods (days to weeks), which vary by diagnosis; thus, trials should be stratified by specific presenting complaints, pain site, discharge diagnosis, and classification of pain type, ie, nociceptive, neuropathic, and visceral pain. In addition to measuring pain and adverse effects, functional outcomes, such as return to work or pain-related quality-of-life measures, should be included.⁷⁹ Straightforward observational studies are needed to determine the relative duration of different acute pain presentations, thus informing decisions to prescribe an appropriate number of opioid doses per prescription. Current prescribing practice often involves a “one size fits all” pattern that is encouraged by electronic prescribing software. Prescribing practices that ignore variable durations of acute pain syndromes will predictably result in undertreatment for some patients and overtreatment for others. The latter increases the likelihood that unused opioids will be diverted into nonmedical use in communities at risk.

Additional research should include evaluation of the appropriateness of patient satisfaction as a quality metric as related to patient expectations of opioids and the prevalence of providers reporting pressure through low patient satisfaction scores or administrative complaints to provide opioids when the providers believe these drugs are not medically indicated. This issue may gain increased importance with the institution of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, which may tie some reimbursement to patient satisfaction scores. Additional work is needed to investigate what constitutes an appropriate educational curriculum in both medical school and residency for physician education concerning safe, appropriate, and judicious use of opioids.

Research addressing the treatment of chronic noncancer pain would be enhanced by the use of accepted case definitions, standardized definitions of adverse events, and validated pain measurements. Case definitions should use a similar definition of chronic, nociceptive (musculoskeletal or visceral) versus neuropathic pain, or pain by disease type (headache, low back pain, etc). Research reporting also requires more refined descriptions of opioid potency and routes of administration.

Although opioids represent a treatment modality that has long been used in patient care, it is clear by the paucity of definitive answers to the questions posed in this document and the significant number of future research issues that much work remains to be done to clarify the best use of opioids in the care of patients.

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American Chronic Pain Association and has previously been a consultant to the pharmaceutical industry.

Relevant industry relationships are those relationships with companies associated with products or services that significantly impact the specific aspect of disease addressed in the critical questions.

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Evidentiary Table.

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Hall et al ³²	2008	Retrospective, population based, observational study	Comparison of West Virginia medical examiner data with patient data from the state prescription monitoring program and opioid abuse treatment program records	Behaviors of those who died of a pharmaceutical overdose; diversion; doctor shopping; substance abuse history; type of drug	295 deaths; 67% male; 92% aged 18-54 y; 63% pharmaceutical diversion; 21% doctor shopping; 95% substance abuse history; 93% opioids	Actual source of opioids involved in death not known; single state; not validated definitions; retrospective	III
Pradel et al ³³	2009	Database	Review of prescription drug database (not prescription monitoring program) to identify amount of buprenorphine delivered, prescribed, and obtained by doctor shopping; extension of 2004 study, used multiple time period comparisons; evaluation of trends in doctor shopping over time	Determined prescribed quantity of buprenorphine, delivered quantity, and the doctor shopping quantity	Although there was some variation over time, the trend for prescribing stayed constant overall and doctor shopping decreased after 2004, associated with the change in the mechanism by which prescriptions are monitored	Reasons for multiple providers or overlapping or interrupted prescriptions unclear; did not examine risk factors for abuse	III
Baehren et al ³⁹	2010	Prospective, uncontrolled	Physicians prescribing analgesics for nonacute pain were asked details about the patient's prescription and then again after being informed of the prescription monitoring program search result for that patient	Change in prescription for the specific patient	179 enrolled; management changed in 41%; 61% received fewer opioids, 39% received more	Convenience sample; majority of data from 4 prescribers	III

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
McIntosh and Hall ⁴⁵	2011	Review of randomized controlled trials, systematic reviews, and observational studies found searching MEDLINE 1966-12/2009, EMBASE 1980 to 12/2009, and Cochrane database up to 12/2009; 49 studies met inclusion criteria	Multiple treatment modalities for acute low back pain, including oral drugs, local injections, and nondrug treatment	Clinical improvement of low back pain	NSAIDs shown to effectively improve symptoms compared with placebo, but use associated with gastrointestinal adverse effects; musclerelaxants may reduce pain and improve clinical assessment but are associatedwith adverse effects including drowsiness, dizziness, nausea	The studies examining the effects of analgesics such as acetaminophen or opioids were generally too small to detect any clinically important differences	III

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Roelofs et al ⁴⁶	2008	Cochrane review: search of MEDLINE, EMBASE, and Cochrane central registry of controlled trials up to 7/2007; 65 trials qualified for review	NSAIDs and COX-2 inhibitors administered to treat low back pain	Clinical improvement of low back pain	Review authors found NSAIDs are not more effective than other drugs (acetaminophen, opioids, and muscle relaxants); placebo and acetaminophen had fewer adverse effects than NSAIDs, although the latter had fewer adverse effects than muscle relaxants and opioids; the new COX-2 NSAIDs do not seem to be more effective than traditional NSAIDs but are associated with fewer adverse effects, particularly stomach ulcers, although other literature has shown that some COX-2 NSAIDs are associated with increased cardiovascular risk	7 studies reported on acute low back pain, 5 of which, including 1 higher-quality study, did not find any statistical differences between NSAIDs and opioids or muscle relaxants; there is moderate evidence that NSAIDs are not more effective than other drugs for acute low back pain	III
Videman et al ⁴⁷	1984	Double-blind parallel study	70 patients; comparative trial of meptazinol vs diflunisal for up to 3 wk	Patients examined at 1-wk intervals for task capability, range of motion, and subjective pain self-assessment	Both regimens produced marked improvement in most parameters, similar adverse effect profiles	No mention of patient randomization	III

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Franklin et al ⁵²	2009	Prospective cohort; Washington State workers with back injury; n=1,883	Prospective cohort of workers with back injuries interviewed at 18 days (medial) and 1 y after injury; pharmacy data obtained from computerized records; analyzed for demographic and covariates	Injury severity, pain, function, and quantities of opioids used	For long-term users total number of medications increased significantly ($P=.01$) from the first to the fourth quarter; after adjustment for baseline pain, function, and injury severity, the strongest predictor of longer-term opioid prescriptions was total number of medications in the first quarter; receipt of ≥ 10 mg/day medicine in first quarter more than tripled the odds of receiving opioids long term, and receipt of ≥ 40 mg/day medicine in first quarter had 6-fold odds of receiving long-term opioids; amount of prescribed opioid received early after injury predicts long-term use	Addressed progression to long-term use according to initial treatment and continuation of same	III

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Marco et al ⁵⁷	2005	Single site; prospective; double blind; randomized controlled trial; concealment method described; ED patients with fractures	Single dose of oxycodone 5 mg/acetaminophen 325 mg schedule II vs hydrocodone 5 mg/acetaminophen 325 mg schedule III	Primary outcomes were numeric pain scores (0-10) at 30 and 60 min	88 subjects evaluated, 73 enrolled, 67 completed ED study period, 35 to oxycodone, 32 to hydrocodone; no baseline differences, no differences in outcomes at 30 min: -0.6 (95% CI -1.8 to 0.5); 60 min -0.5 (95% CI -2.0 to 1.0); adverse effects higher for constipation with hydrocodone (21% vs 0%; (95% CI 3% to 39%))	Small sample size powered to address acute pain during the first 30 to 60 min in the ED; study also assessed adverse effects during a longer period of time; excluded history of alcohol or opioid or other substance abuse; limited time period	II
Palangio et al ⁵⁸	2002	Prospective multicenter (18 sites), randomized controlled trial, sequential assignment by computer-generated randomization schedule	Hydrocodone 7.5 mg/ibuprofen 200 mg (schedule III) vs oxycodone 5 mg/acetaminophen 325 mg (schedule II)	Primary outcome was mean daily pain relief score at endpoint (day 8 or day of discontinuation), study period up to 8 days, intention-to-treat analysis	147 subjects enrolled (75 hydrocodone/ibuprofen, 72 oxycodone/acetaminophen), adults with acute or recurrent low back pain requiring opioids, 85% completed study in both groups, mean days to endpoint 6.5 vs 6.9 days, no baseline differences, no differences in pain relief, number of pills, global evaluations, SF-36, pain interference with work, adverse events	Excluded drug or alcohol abuse, concealment methods described	I

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Portenoy et al ⁵⁹	2007	Randomized, double blind, placebo controlled	Fentanyl buccal tablet for breakthrough pain in chronic low back pain patients	Pain before treatment and for 2 h after treatment	Fentanyl buccal tablet effective for breakthrough pain in chronic low back pain; adverse effects in 65%; 34% during double-blind phase	Severe selection bias in initial screening; industry sponsored	III for adverse effects
Simpson et al ⁶⁰	2007	Randomized, double blind, placebo controlled	Fentanyl buccal tablet for breakthrough pain in chronic pain patients	Pain before treatment and for 2 h after treatment	Fentanyl buccal tablet effective for breakthrough pain; adverse effects in 63%; 22% dropout	Severe selection bias in initial screening; industry sponsored	III for adverse effects
Kalso et al ⁶²	2004	Systematic review	Randomized trials in chronic noncancer pain comparing potent opioids with placebo	Pain intensity outcomes	15 randomized trials were included; 11 studies compared oral opioids for 4 wk; pain intensity decrease was 30% compared with placebo; only 44% were taking opioids by mo 7 to 24; 80% of patients experienced at least 1 adverse event: constipation (41%), nausea (32%), somnolence (29%)	4-wk duration on average; differing causes of pain; open label in many of the studies; limited power calculations; concealment not maintained in some studies	III

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Peloso et al ⁶³	2004	Prospective, randomized, blinded study	Tramadol/acetaminophen vs placebo; patients with chronic low back pain requiring daily medication for at least 3 mo	Pain VAS; pain relief rating scale; Short Form Magill Pain Questionnaire SF-36; 3-mo trial	336 patients randomized; improved mean final pain scores (47 vs 63; $P<.001$), adverse effects: nausea 12%, dizziness 11%, constipation 10%, somnolence 9%	35%-40% dropout rate; pharmaceutical-sponsored research	II
Ruoff et al ⁶⁴	2003	Prospective, randomized, blinded study	Tramadol/acetaminophen vs placebo; patients with chronic low back pain requiring daily medication for at least 3 mo	Pain VAS; pain relief rating scale; Short Form Magill Pain Questionnaire SF-36; Roland Disability Questionnaire	318 patients randomized; tramadol improved pain VAS ($P=.15$) and final Pain Relief Rating Scale ($P<.001$); adverse effects: nausea 13%, somnolence 12%, constipation 11%, dizziness 8%	153 of 318 dropped out; pharmaceutical-sponsored research	II

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Schnitzer et al ⁶⁵	2000	Prospective, randomized, blinded study	Tramadol/acetaminophen vs placebo; patients with chronic low back pain requiring daily medication for at least 3 mo	Time to discontinuation because of inadequate pain relief; Short Form Magill Pain Questionnaire; Roland Disability Questionnaire	380 patients in open-label phase; 254 entered into blinded phase; time to therapeutic failure was greater in the placebo group ($P<.0001$); other parameters showed improvement; adverse effects: nausea 17%, dizziness 15%, somnolence 14%, headache 12%	The dropout rate was the primary outcome; pharmaceutical-sponsored research	III

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Allan et al ⁶⁶	2005	Nonblinded, randomized comparison of 2 treatments in patients with chronic low back pain	Transdermal fentanyl vs sustained-release oral morphine; 680 total patients; dose titrated to effect; followed for 13 mo; outpatient setting; not applicable to ED	Pain relief (VAS scale); bowel function (validated questionnaire); quality of life (SF-36); disease, progression (3-point scale), days not working, adverse events all during 13 mo	Comparable pain relief, noninferior, VAS score for fentanyl (56) vs morphine (55); fentanyl had lower constipation rate: fentanyl (31%) vs morphine (48%)	Both groups had half of the participants drop out; vague definition of chronic low back pain; not blinded	III

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Hale et al ⁶⁷	2005	Randomized trial, blinded	Comparison of oxymorphone extended-release vs oxycodone controlled release vs placebo in patients with chronic low back pain who were taking a stable dose of opioids	VAS of pain score 4 h after morning dose; use of breakthrough pain medications; categorical pain intensity, pain intensity, global assessment, adverse events	Opioids were superior to placebo at reducing VAS for pain compared with placebo, oxymorphone (-27), oxycodone (-36); oxymorphone was comparable to oxycodone in pain efficacy and adverse effects; sedation and constipation were more common with opioids (35% vs 29% vs 11%)	Only 22 of 75 patients in the placebo group completed the study; included only patients receiving stable opioids and then randomized to opioids or placebo; baseline characteristics between groups not specified; pharmaceutical-sponsored research	III

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Furlan et al ⁶⁸	2006	Meta-analysis	Study included randomized trials of any opioid for chronic noncancer pain (defined as pain for longer than 6 mo) vs placebo or some other nonopioid treatment	41 randomized studies with 6,019 patients evaluated for effectiveness and adverse effects; most (80%) had nociceptive pain	81% of the studies were believed to be of high quality; dropout rates were 33% in the opioid group and 38% in the placebo group; opioids improved pain and functional outcomes compared with placebo in nociceptive and neuropathic pain; strong opioids were superior to naproxen and nortriptyline for pain relief; weak opioids were not superior; constipation and nausea were the only significant adverse effects observed	Average duration of the study was 5 wk (range 1-16 wk); adequate random patient assignment in only 17 of 41 trials; 90% of trials were pharmaceutical-sponsored research	II

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Holmes et al ⁶⁹	2006	Prospective cohort	Convenience sample of patients who were new at a pain clinic; Pain Medication Questionnaire was administered; patients were treated with interdisciplinary treatment and/or medications alone, depending on the results of an initial evaluation	Beck Depression Inventory; Confidential Pain questionnaire; SF-36; Million VAS; Oswestry Disability Questionnaire; Physician Risk Assessment; VAS	271 patients, divided into low-, medium-, and high-score pain medication questionnaire; high-score group was more likely to have a known substance use problem (OR 2.6), request early refills (OR 3.2), or drop out of treatment (OR 2.3)	Only 26% of patients completed the full treatment program; heterogeneous types of pain diagnosis; differing treatment plans	III

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Jensen et al ⁷⁰	2006	Retrospective review of cohort	Patients who were treated and discharged from a pain clinic 10y ago; medical records were abstracted and questionnaires were sent to willing participants	Demographics, health care utilization, SF-36; Hospital Anxiety and Depression Scale; Coping Strategy Questionnaire; CAGE* test	160 patients; 60% of patients were still taking long-acting opioids; dose escalation was unusual; chronic users had lower health-related quality of life and higher occurrence of depression	160 of 279 possible patients participated; no control group	III

COX-2, cyclooxygenase-2; *ED*, emergency department; *h*, hour; *mg*, milligram; *min*, minute; *mo*, month; *NSAID*, nonsteroidal anti-inflammatory drug; *OR*, odds ratio; *SF-36*, Short-Form Health Survey; *VAS*, visual analog scale; *vs*, versus; *wk*, week; *y*, year.

*CAGE (Cutting down, Annoyed, Guilty, Eye-opener) test is a method of screening for alcoholism.

Appendix A. Literature classification schema.*

Design/Class	Therapy [†]	Diagnosis [‡]	Prognosis [§]
1	Randomized, controlled trial or meta-analysis of randomized trials	Prospective cohort using a criterion standard or meta-analysis of prospective studies	Population prospective cohort or meta-analysis of prospective studies
2	Nonrandomized trial	Retrospective observational	Retrospective cohort Case control
3	Case series Case report Other (eg, consensus, review)	Case series Case report Other (eg, consensus, review)	Case series Case report Other (eg, consensus, review)

Downgrading	Design/Class		
	1	2	3
None	I	II	III
1 level	II	III	X
2 levels	III	X	X
Fatally flawed	X	X	X

Safe Opioid Prescribing in Emergency Departments: Talking Points

Discussions with CMO's, CNO's and CEO's

As you implement the Safe Pain Medication Prescribing guidelines in your ED, you may need to have a discussion with the CMO, CNO or CEO of your hospital. They may have concerns regarding EMTALA, the Joint Commission or Patient Satisfaction. We summarize the key points about these key issues below.

Background on the Opioid Epidemic in the United States The United States is experiencing a major problem with prescription opioids. Opioid prescriptions have increased across the country and deaths from opioid overdoses have increased right along with it. We as Emergency Physicians, feel we need to do our share to curtail this problem. Safe Pain Medication Prescribing guidelines state that a patient with chronic pain should have one provider who can safely administer high risk pain medications that have the potential for addiction or diversion to other people. This means that Emergency Departments and Urgent Care centers must focus on supporting that by not refilling high risk medications like opioids, not rewriting for lost or stolen prescriptions, and not prescribing long-acting opioid medications among other things.

EMTALA The Emergency Medical Treatment and Active Labor Act (EMTALA) mandates that all patients arriving to an Emergency Department receive a medical screening examination. This includes patients with chronic pain. Pain is a potential sign of an emergency medical condition that must be considered when a provider performs a medical screening examination. EMTALA does not regulate nor mandate the actual treatment of pain. EMTALA only mandates the evaluation of pain as a possible symptom of an emergency medical condition. (A) Recently, CMS provided an opinion on the hanging of signs in triage areas describing safe pain medication prescribing guidelines and they ruled against hanging of such signs in triage. They were concerned that these signs might be a deterrent to patients seeking emergency medical care. Information such as brochures or signage can be handed out or can be made visible only after the medical screening exam has been completed. (B) For more information, see Tab 6 (EMTALA).

Joint Commission The Joint Commission mandates a pain assessment and then either treatment or referral for treatment. Treatment does not necessitate opioids. The Joint Commission has no mandate that requires ED physicians to provide pain medication in the ED or write for pain medication upon discharge. (A)

Patient Satisfaction Safe Opioid Prescribing guidelines have already been implemented in EDs across the country including in Washington and Ohio states and most recently San Diego County, Imperial County, Los Angeles County and Kaiser-Permanente Southern California facilities. San Diego and Imperial Counties implemented the use of the patient handout in March 2013; Kaiser's EDs and Urgent Care Centers began using the handouts in January 2014, Los Angeles County implemented the use of patient handout in September 2014. In both San Diego, Kaiser and Los Angeles, patient satisfaction scores were unaffected by the implementation of the guidelines in the EDs. In San Diego, no hospital reported a change in patient satisfaction score based on the Safe Prescribing guidelines. And in Kaiser, there have been very few patient complaints and no changes in patient satisfaction of ED physician care as of April 2014.

We hope that this letter in addition to the other attachments in the Toolkit will allow the adoption of and implementation of these guidelines to run smoothly in your ED. Please let us know if there is anything else we might do to help you along this path.

References:

- (A) ACEP April 1, 2013 Robert Bitterman M.D., member ACEP Medical Legal Committee, Is *“Severe Pain” considered an Emergency Medical Condition under EMTALA?*
- (B) ACEP eNow January 22, 2014 Kevin Klauer DO, EJD, FACEP, Medical Editor in Chief and Richard Wild MD, JD, MBA, FACEP, CMS Chief Medical Officer for the Atlanta Regional Office (Region 4) *ED Waiting Room Posters on Prescribing Pain Medications May Violate EMTALA*

Discussions with EMTALA and the Joint Commission

This document is to aid Emergency Department Medical Directors in their adoption of the *Inland Empire Counties Safe Pain Prescribing in Emergency Departments* patient handout and how it reconciles with EMTALA and the Joint Commission.

EMTALA and Pain

Many misconceptions exist regarding EMTALA and the evaluation and treatment of patients with pain as a complaint. EMTALA regulations state that any patient who presents to a Medicare receiving hospital with a complaint of pain, including severe pain, must be provided an appropriate medical screening examination (MSE) to determine if an emergency medical condition exists. The MSE may include any resources available in your hospital to determine if an Emergency Medical Condition exists, including laboratory testing and imaging.

The requirement for an MSE includes patients with chronic pain conditions who present to the Emergency Department with a complaint of pain. The MSE will determine if the complaint of pain is a result of an emergency medical condition. An emergency medical condition is defined as a medical condition such that the absence of immediate medical treatment could result in (1) placing the individual's (or unborn child's) health in serious jeopardy, (2) serious impairment of bodily function, or (3) serious dysfunction of any organ or part. Pain alone is not considered by the EMTALA regulations to be an emergency medical condition. (A, E) In a recent review on the topic, Dr. Robert Bitterman MD, JD, FACEP, a nationally recognized physician-attorney expert specializing in EMTALA compliance issues, uses the example of a patient with chronic low back pain complaining of severe pain. He explains that the patient does not have an emergency medical condition unless that pain is related to, for example, an aortic aneurysm rupture or a herniated disc causing neurological dysfunction where immediate treatment is necessary to avoid the imminent danger of death or serious disability. (A) Once an emergency medical condition is determined to not exist, the Medical Screening Examination is complete.

EMTALA also does not regulate nor mandate the actual treatment of pain. EMTALA only mandates the evaluation of pain as a possible symptom of an emergency medical condition. (A)

Joint Commission and Pain

The Joint Commission does have its own regulations regarding the evaluation and treatment of pain. The Joint Commission mandates a pain assessment and then either treatment of the patient's pain or referral of the patient for treatment. The Joint Commission does not mandate that a patient's pain be treated with opiate medications. (B) In Dr. Bitterman's back pain example, the ED physician may, after the MSE, decide the best treatment options include bed rest, heat packs, and referral back to the patient's primary care provider. The Joint Commission has no regulations requiring ED physicians to provide pain medications in the ED or write pain prescriptions upon discharge. (A)

EMTALA and Signage referring to Safe Opioid Prescribing Guidelines

Hospitals and State Departments of Health all across the country are developing guidelines for prescribing opioid medications in the Emergency Department for chronic pain patients. These guidelines have included patient brochures to be handed out and posters explaining the guidelines that have been hung in the waiting rooms or treatment rooms of the Emergency Departments. The intention of the posters, by well-meaning Emergency Departments, was to inform patients regarding the ED's controlled prescription policy.

Recently the CMS Atlanta Regional Office in South Carolina (Region 4) stated an opinion regarding the use of “pain posters” in EDs. Although the CMS National Office in Baltimore has not specifically addressed this issue, other CMS Regional Offices have also concurred with the recent Atlanta Regional Office’s rulings. The Region 4 opinion was also based on consultation with the CMS National Office directly. Because of the interest, it is expected that the CMS National Office may issue a national memorandum on the topic of prescription opioid signage. (C) CMS’ opinion is based on EMTALA compliance. The following bullet points are a summary of the CMS Atlanta Office’s rulings (D):

- Signage indicating a patient’s right to a Medical Screening Examination must be prominently displayed.
- Signage that refers to “Prescribing Pain Medication in the Emergency Department” or any similar language, which the hospital might choose to post in patient waiting rooms or treatment rooms, **might be considered to be coercive or intimidating to patients who present to the ED with painful medical conditions**, thereby **violating both the language and the intent of the EMTALA statute and regulations.**” (D)
- CMS is concerned that “pain posters” in the ED may discourage a patient from staying for a medical screening exam or discourage a patient from seeking care in the future.
- CMS is also concerned that a “pain poster” would also raise the question of whether or not a hospital would provide stabilizing treatment for an emergency medical condition when opioids may be appropriate.
- Hospitals that use such signage, or any signage that may have the real or perceived effect of discouraging an individual from seeking care, are at risk for being found EMTALA non-compliant.
- CMS does not appear to have an issue with the actual development of opiate prescription guidelines nor the education of patients as long as any education is done after the Medical Screening Exam has been completed.
- “It is within the bounds of reasonable professional judgment and discretion for a physician or other licensed healthcare practitioner to provide or withhold opioids and/or other methods of pain control, depending on the specific clinical circumstances of an individual’s presentation”.(D)
- “It is left to the judgment of the provider as to how best to give specific patient-centered education, including handouts, policies, and institutional protocols. But again, it is emphasized that patient education should take place after a patient focused medical screening exam is completed and not by posting general policies and procedures or displaying such materials in the waiting area.” (D)

Summary

All patients who present to the ED should have a medical screening examination to determine if an emergency medical condition exists. Any information regarding an ED’s policy about controlled substances, whether as brochures or posters, should only be given to or seen by the patient after the medical screening examination has been completed.

A. ACEP April 1, 2013 Robert Bitterman M.D., member ACEP Medical Legal Committee, *Is “Severe Pain” considered an Emergency Medical Condition under EMTALA?*

B. Joint Commission Standard PC.01.02.07: The hospital assesses and manages the patient’s pain.

C. Ohio Hospital Association Statement *Emergency Department Opiate Prescribing Guidelines* January 15, 2014

D. ACEP eNow January 22, 2014 Kevin Klauer DO, EJD, FACEP, Medical Editor in Chief and Richard Wild MD, JD, MBA, FACEP, CMS Chief Medical Officer for the Atlanta Regional Office (Region 4) *ED Waiting Room Posters on Prescribing Pain Medications May Violate EMTALA*

E. AAEM Clinical Practice Statement *Emergency Department Opioid Prescribing Guidelines for the Treatment of Non-Cancer Related Pain* 11/12/2013

Controlled Prescriptions: Questions and Answers

April 2014
Roneet Lev, MD

As emergency physicians we feel the responsibility to be the ultimate patient advocate, the safety net, the one doctor who can fix things when no one else can. We are always there, 24/7, ready to solve problems. If patients can't get their prescriptions from their clinic, we are there to help. If the psychiatrist can't be reached and the patients need their medications, we are there. If medications are stolen, we are there.

Unfortunately, sometimes when we write prescriptions we are harming patients, not helping them. Prescription Drug Abuse is an epidemic with 105 lives lost per day nationwide according to the Centers of Disease Control. All of these deaths are preventable.

We prescribe 10 times more pills now than we did 10 years ago. There is a high street value for many of the controlled substances, and diversion of medications is a serious problem. We need to follow the Goldilocks rule: not too much, not too little, but just right. The quantities of pills need to help, without leftover for potential diversion or waste.

It is much harder to say no to patients than to say yes. The "Yes" doctors are quickly identified as the "candy man" in the community. The "Yes" emergency departments are the "candy land." Word gets out quickly.

Hopefully this article will help you to say "No," to do it in a nice way, and to realize that you are helping your patient with your decision. You are the ultimate patient advocate, and that is why you must prescribe safely.

These are general recommendations based on my experiences and those of my colleagues. I chair the prescription drug abuse medical task force in San Diego, with California ACEP, and work with the medical and community at large to curb the prescription drug abuse epidemic. You may like some suggestions and not others. That's not a problem. With time and practice you will develop the best language that works for you.

Helpful Prescribing Tips:

- CURES is your friend. It is a valuable tool, like checking old records. It makes you a better doctor. I had a patient who said, "I don't have a doctor." I checked CURES, and they did have a doctor. "Oh, that's not my doctor, that's just my pain doctor." You will also find out when patients really need a prescription and couldn't get it. CURES will help you prescribe smarter.
- There are many patient advocates who are appalled by the number of prescriptions that we write for. We generally hear the complaints when we do not give prescriptions that patients are demanding. However, there are an equal number of people who are angry that doctors are over-prescribing. "I can't believe that the doctor gave me 30 Percocet after a simple cyst was removed!" I have seen a prescription of Vicoprofen given after a dental cleaning! The prescription was given to the wife of a prescription drug abuse advocate. Now it is a permanent exhibit in the anti-drug lectures.
- Opioid withdrawal is uncomfortable, but not dangerous. New patients who present to the pain specialist are not immediately given whatever meds they state they need. The specialist first does research - CURES report, drug screen, reviews old records - and it may be 2 weeks before the patient is placed on a regular regimen. Do not feel badly if you are sending a patient home without a pain prescription in someone who has already received one in the past month from a different provider.

- Chronic Pain Medication refill principles are really the same for all patients. The underlying diagnosis does not matter - cancer, sickle cell anemia, spinal stenosis, fibromyalgia. If the patient has prescriptions from other doctors, then the ED should not be giving more prescription.
- Benzodiazepine withdrawal, unlike opioid withdrawal can be dangerous. Xanax is a frequently requested medication. However the half-life is short and abuse potential is high. According to the San Diego Coroner report, the deaths from Xanax equal the deaths from oxycodone. If you need to prescribe a benzodiazepine, give ativan or librium.
- For alcohol withdrawal, there is no point in writing a prescription for librium if the patient plans on continuing to drink. Ask the patient what his or her intention is. If they want to try and stop, then by all means, write a prescription. The alcohol treatment programs recommend that you write the prescription "prn", so if your patient goes to a treatment program it can be given as needed instead of round the clock. Usually no more than 10 pills are needed.
- If a patient already has pain pills at home, they usually do not need more pills from you. A patient with kidney stone or humerus fracture, who already is on Percocet for back pain, usually does not need extra pills. Treat the acute pain in the ED, but the patient may not need another prescription.
- Patients on chronic pain medications should have a pain contract with their doctor. Chronic pain means needing opioids for 3 months or more. The Medication Agreement states that medications will not be refilled in the emergency department, that lost prescriptions will not be refilled, and that the patient should make appointments with his or her doctor before he or she runs out of their medication. Having such a patient come to the ED for a prescription is like a child asking the mother for permission to go out after the father said no. (For my kids this is a crime with the highest level of punishment). You are not helping the patient by filling such a prescription.
- Patients should not mix opioids and benzodiazepines. Patients should not mix opioids with illegal drugs. Pain specialists as part of their practice make patients choose between opioids and benzodiazepines. There are unfortunate patients who have a legitimate pain condition, but refuse to stop abusing meth or heroin, and therefore the clinics will not refill pain prescription. Giving a controlled prescription to a patient who is a known addict is a DEA violation and can jeopardize your license.
- Don't prescribe Soma (Carisoprodol). This is a highly abused medication that is supposed to work as a muscle relaxant, but in fact is metabolized to meprobamate, a horse tranquilizer that is no longer available in Canada, Sweden, and Norway. If you are prescribing a muscle relaxant, use Flexeril (cyclobenzaprine) instead. Soma is part of the "Holy Trinity": Oxycodone, Xanax, and Soma. Some pharmacies have a red flag warning to call a physician for a written justification for all patients on the "Holy Trinity." It's much easier to just not write for Soma than to fill out paperwork explaining why the patient needs it.
- In a hurry? Don't want confrontation? It is a lot easier to say "yes" and just give a few pills. It is much harder to say "no", look at CURES and check prior records. How bad can a few pills be? A few pills can mean continued addiction, drug diversion, avoiding getting help, and even death. The yes doctor is the "candy man." You need to follow the well know rule of medicine: "Physician do no harm".

Helpful Patient Answers

PATIENT COMPLAINT: "Back Pain or Headache with multiple previous visits."

PROVIDER ACTION: "Listen carefully; get a full history, physical, and medication history."

Don't make the mistake of jumping to conclusions because the patient is there again and again for the same complaint. Don't start rolling your eyes and label the patient a "drug seeker."

The first thing to do is to treat this patient like any other patient. EMTALA mandates that even if a patient presents with a chronic condition, you need to do a full screening to make sure the patient does not have an emergency medicine condition. Sit down, take a good history and include a very detailed medication history. Do a thorough physical examination. Check the old chart. Do your homework even more than you would a different patient. See if something was missed on previous visits.

I am sure you have seen a patients like this example. Chief complaint: "headache," and the nurses said "he is here all the time - he just wants drugs." I smiled, thanked them for the heads up, put blinders on to what was implied, and took the time to do a careful assessment. This patient was in hospital a month ago for headache with a negative work up. There was an explanation of why the admitting team did not think an LP was warranted. Teaching point - someone didn't want to do a test that = I have to do it. And of course, this man had meningitis. Not just any meningitis, but TB meningitis. We all know that revisits to the ED are opportunities to find the real diagnosis.

PATIENT REQUEST: "Can I have something for pain?"

This is a common request from many patients with various chief complaints.

PROVDIER ANSWER: "Yes, let me check your medical record for the best choice."

You will generally offer pain medications to many patients before they even ask. You may not need the part about "let me check your records." Even with patients who are drug seeking, you will often want to offer pain relief, even if it is a non-opioid choice. Then go to the chart, to CURES, and do some research for the best plan.

PATIENT REQUEST: A patient requests a pain prescription when medical records or CURES show that they already receive a prescription from a different provider.

PROVIDER ANSWER: "I will treat your pain now, but your doctor needs to write for any additional prescriptions."

"I see that you already have prescriptions from Dr. X. For your safety all of your pain medications need to be regulated by a single doctor and pharmacy." **Although I cannot write for a pain prescription, I can certainly help with your pain today."**

Usually that does the trick. However if you need, you can use the followinglines:

"These medications are controlled by the DEA, which has strict rules for both the doctor and the patient. You have to get any new prescriptions from your doctor or clinic."

"We practice safe medicine and therefore all prescriptions and care should be coordinated with your doctor."

And finally, you can simply say, **"I am sorry, we follow the safe prescribing guidelines, which means all your narcotic prescriptions have to come from one doctor and one pharmacy."**

PATIENT COMMENT: "But my doctor is out of town, my insurance changed, I couldn't get an appointment"

PROVIDER ANSWER: "I'm sorry that happened. We can help you with your pain in the emergency department, but for your safety you will need to contact your doctor for any additional prescriptions."

Like with talking to small children, try to avoid the word, "no", and make statements in the positive.

Look at the CURES report. You will see if the patient has received medications from the same clinic on a monthly basis. If this is the case, then it should be part of their pain contract not to get additional prescription from the ED. If the patient is doctor shopping, then you should not be part of that.

"Your doctor would want us to honor the pain contract, so I would want to follow your doctor's recommendations."

I have had a patient tell me "But I made sure I did not sign the contract, so that I can get more medication." Well... just because she didn't sign it doesn't mean we should not be following the pain contract.

PATIENT COMPLAINT: "None of the other medicines work for me"

Patients frequently say, "I tried ibuprofen", "I tried Vicodin", and "Those don't work for me. What I really need is Dilaudid 2 mg IV with Benadryl 50 mg and Phenergan."

PROVIDER ANSWER - "Can you please tell me how you take the prescription?"

There are some reasonable patients who really tried the ibuprofen and Vicodin, but you need to find out exactly how they used it.

You need to ask: **"Tell me how are you taking your medication."** Find out the dose and the timing.

You will be surprised how many patients used 400 mg of ibuprofen twice a day and it was not enough. Or they took one pill of Vicodin last night and now 8 hours later they are in the ED with pain again without taking anything in between.

Depending on the description of how the medications are being taken, your answer could be: **"That's the right dosing, good job, you should continue."** Or **"That's not quite giving the medications a chance to work."** Let's try having you take the medication with a good dose. If you take Vicodin 4 times a day and add ibuprofen 4 times a day, you can alternate and have something to take 8 times a day. The combination works well."

The unreasonable patient will give you a vague answer like: "I have tried it in the past, so I know it doesn't work," or "I am allergic to everything." This is a red flag for you to check CURES and old records. The answer is: **"I need to review your records to find out what the best options are."** Go to the records, do the research, find out the allergies and what they received before, and return with a plan.

PATIENT COMPLAINT: "My prescriptions were lost"

Patients will come to the ED and ask for a refill of a prescription because they lost it. We have heard all the reasons: "I forgot them on the bus," "My back pack was stolen," "I flushed them down the toilet because I thought I didn't need them," "they fell in the pool," and "I lost them at Disneyland."

PROVIDER ANSWER: "I can give you something for pain now, but it is best for your doctor to coordinate any additional prescription."

If the patient says that the prescriptions were stolen, then the answer is easy:

"Did you file a police report?" These are highly abused medications that are sold illegally. If a prescription were stolen then the DEA or police would want to know about it.

With a lost or stolen prescription, you need to listen to the story and use your judgment. Pain Agreements state that patients should not lose their medications and keep them safe. Some pain agreements allow for one lost prescription a year. The primary care doctor should be aware of the missing prescription. It is probably best to have lost or stolen prescriptions refilled by the primary care provider who can take account of all the prescriptions. Check a CURES report and see if there is a bigger problem.

Make sure that you document on the patient's discharge instructions and in your dictation: **"Please obtain all pain medications from single doctor or clinic. No refills will be provided by the emergency department."** This should be a message for doctors coming after you that the patient has received information on safe prescribing.

PATIENT QUESTION: "I need some codeine for my cough."

Phenergan with codeine cough syrup is a highly abused medication. There are cultures that put this medication in their drink and sip it all day. There have been pharmacies in some parts of town that received a fine for excessive

loads of Phenergan with codeine. I've seen funny hidden camera videos showing pharmacy techs sneaking sips of codeine while at work.

PROVIDER ANSWER: "The best medicine for your cough is an inhaler."

"The inhaler opens your lungs and gets the junk out. A cough syrup just prevents the cough reflex and keeps the junk in. That's why I don't prescribe the cough syrup and use the inhaler instead".

PATIENT QUESTION: "My tooth hurts."

PROVIDER ANSWER: "Would you like a shot to stop the pain?"

One of my favorite patients is a dental patient, and not because my husband is a dentist. It's because these are the most grateful patients. Do a dental block with Marcaine and get 100% relief for 6 hours. When I ask "Do you want a shot like the dentist for your pain that will numb up your tooth?" Patient with true dental pain will say: "Anything, just get rid of the pain." You should never give an IM injection of Dilaudid for dental pain. If the patient is "scared" of a shot (dental block), then you can offer a couple Vicodin in the ED and check a CURES report to see if you should be writing a prescription or not.

PATIENT QUESTION: "I know my rights!"

There are patients who are angry no matter what we do or how nice we are. They threaten to sue you and want to talk to a manager.

PROVIDER ANSWER: "I am happy to refer you to our manager."

Remember that you are on stage when you talk to patients. Your conversation is not just for the patient, but also for the big audience of other patients and staff who are listening in on the interesting loud interaction. The listeners want to root for you.

I have used the same language to one patient who is so thankful that someone took the time to explain the dangers of the medications, and another who gets angry and called administration.

If you are referring the patient to hospital administration, hopefully they understand and are educated about safe prescribing. If not, you should provide some educational background and refer them to the various web sites that explain the prescription drug abuse epidemic and safe prescribing. (CaliforniaACEP.org or SanDiegoSafePrescribing.org).

There are several lines you can use in difficult situations:

"I am sorry you feel this way, and I am happy to refer you to our manager."

"This is the same treatment I give my own family."

PATIENT MEDICATION HISTORY: " Vicodin, Ambien, Xanax, Soma, Neurontin, ..."

PROVIDER ANSWER: "I see that your medications have some drug interactions."

I am sure you have reviewed patient medication lists that go on for pages. Use this as an opportunity to alert the patient to polypharmacy or for opioid and sedative interactions. A patient may present with a fall, but the fall is because of all the medications.

"Wow, that's a long list of medications!"

"I see from the list that you are taking pain medications and anxiety medications together. That could be a dangerous combination."

"I don't want to make changes to your medications, but you should discuss this with your doctor, and at least do not take the oxycodone and xanax at the same time."

"You seem very sleepy from these medications."

"Could it be that you fell down because of your medications?"

One family member of a patient I saw agreed with my explanation and said, "We don't want a Michael Jackson."

PATIENT PRESENTATION: Abdominal pain with multiple negative work ups.

PROVIDER ANSWER: "How often do you use marijuana?"

The first thing to do is a good history, physical, and make sure that a different diagnosis has not been overlooked. After that, think marijuana.

Marijuana these days is not the marijuana of the 1970s. California marijuana can have 25% THC or more, while in the 70's marijuana was 3% THC. There is a new surge of chronic abdominal pain patients who have had multiple CT scans, endoscopies, colonoscopies, and ultrasounds, all with negative results, but with a history of daily marijuana use. The treatment for THC associated cyclic vomiting syndrome is to get off the marijuana, and not to get more and more Dilaudid. Treating marijuana toxicity with opioids is creating a second addiction on top of the first one. This is difficult to explain to patients, because they were told marijuana helps nausea rather than causing it. If you can convince the patient to stop marijuana for several months (not just a few days), they will be grateful later.

PATIENT PRESENTATION: Musculoskeletal pain in a Patient who is in recovery.

PROVIDER ANSWER: "You did such a good job being clean, it's not a good idea to trade one drug for another."

You see patients in recovery that is proud of their recovery, but have a new pain condition. They understand addiction. Explain to them that using Motrin and Tylenol and limiting opioids will help them prevent a new addiction.

PATIENT COMPLAINT: Pain

PROVIDER DISCHARGE INSTRUCTION: "I will give you a prescription for Norco. Please realize that this is a medication that can be abused. Keep it secure, take it only as prescribed, and do not drive if not fully alert."

The prescription drug abuse advocates request that physicians warn their patients about the seriousness of controlled medications. A quick warning in the ED can go a long way.

PATIENT PRESENTATION: Clear Doctor Shopping

PROVIDER ANSWER: "I am concerned as your medications can be addicting. Would you like me to refer you to someone who can help with this?"

As with everything, you have to use your judgment. Most patients who are in the ED are not ready to admit that they have an addiction, but sometime their family members are around and realize that there is a problem. **Use family and friends to highlight a prescription problem.**

This is the language recommended for the primary care provider when they need to discontinue opioid treatment because of prescription drug abuse: **"The medication no longer appears to be as beneficial as it once was. As the benefits of the opioids no longer outweigh the risks, we need to discontinue this approach and together find a safer and more effective means of dealing with your pain".**

Some patients have very overt doctor shopping and you may want to contact the DEA. Getting the DEA involved can force patients into court mandated drug rehab and save someone's life.

Words at a Glance

PATIENT	PROVIDER ANSWER
Anything	Remember you are on stage. Your words not just for the patient, but for the staff and patients who are also listening.
Can I have something for pain?	"Yes, let me check your medical record for the best choice"
The medicines don't work	"Can you please tell me how you take the prescription?"
Lost Rx Rx from other Sources	I can give you something for pain now, but it is best for your doctor to coordinate any additional prescription".
Stolen Rx	Did you file a police report?
Patient with chronic pain	"Your doctor would want us to honor the pain contract, so I would want to follow your doctor's recommendations".
I need codeine cough syrup	"The best medicine for your cough is an inhaler.
Dental Pain	"Would you like a shot to stop the pain?"
Abdominal Pain with negative work ups	"How often do you use marijuana?"
Previous Recovery History	"You did such a good job being clean, it's not a good idea to trade one drug for another".
Opioids and Sedatives	"I see that your medications have some drug interactions"
Clear Doctor Shopping	"I am concerned as your medications can be addicting. Would you like me to refer you to someone who can help with this?"
Angry Patient	"I am sorry you feel this way. I will try to treat your pain now, but your doctor needs to coordinate any further prescriptions."

Further Suggestions

Medscape has a free CME program on "Managing Pain Patients Who Abuse Prescription Drugs." This has video examples of how a primary care provider talks to his patient. You will need a Medscape username and password. www.medscape.org/viewarticle/770440

If you have further tips and suggestions that should be included in the next version of this document, please contact Roneet Lev via email at roneet@cox.net.

Safe Opioid Prescribing in Emergency Departments:

Referrals for Substance Use Disorder Treatment

This section of the toolkit provides guidance for the referral of patients to treatment of substance use disorders (addiction) services.

Who should be referred for treatment of substance use disorder?

Individuals who have addictions to alcohol or other substances should be referred for treatment.

How to assess/screen for substance use disorder?

Use the four CAGE Questions as a screening test for Alcohol Dependence (Note: two “yes” responses indicate that the possibility of alcoholism should be investigated further).

- Have you ever felt you needed to **C**ut down on your drinking?
- Have people **A**nnoyed you by criticizing your drinking?
- Have you ever felt **G**uilty about drinking?
- Have you ever felt you needed a drink first thing in the morning (**E**ye-opener) to steady your nerves or get rid of a hangover?

Additional substance use screening and assessment tools are located in the Resources section (Tab 10) titled “Chronic Pain Screening and Monitoring Tools.”

Where should I refer the patient?

- Contact your hospital Social Worker for assistance.
- Find out if the patient has health insurance: refer to the patient’s health plan.
- Review the following pages for Riverside and San Bernardino County’s Substance Use and Drug and Alcohol Services hotlines.

Substance Use Administration Office Prevention and Treatment Services

**3525 Presley Avenue
Riverside, CA 92507
(951) 782 - 2400 Phone
(951) 683 - 4904 FAX**

**Substance Use
Community Access, Referral,
Evaluation, and Support Line
(SU CARES)**

**1 - 800 - 499 - 3008
Responds 24 / 7 / 365**

Se habla Español

DRINKING DRIVER PROGRAMS (DDP) LOCATIONS AND HOURS

INDIO

83-912 Avenue 45, Suite 9
Indio, CA 92201
(760) 863-8471
M-F, 8am to 5pm

RIVERSIDE

2085 Rustin Avenue, #3
Riverside, CA 92507
(951) 955-7350
M-F, 8am to 5pm

Services Available at all below RUHS Behavioral Health Clinics

- Walk-in Screening, Assessment, and Placement Services
- Individual and Family Prevention Services
- Substance Use Treatment Services, Various Modalities

Clinic Locations and Hours

BANNING

1330 W. Ramsey Street
Banning, CA 92220
(951) 849-7142
M-F, 8am to 5pm

BLYTHE

1297 W. Hobsonway
Blythe, CA 92225
(760) 921-5000
M-F, 8am to 5:30pm

CATHEDRAL CITY

68615 Perez Road, Suite 6A
Cathedral City, CA 92234
(760) 770-2286
M-Th, 8AM to 5pm
Fri., 8am to 4:30pm

CORONA

623 N. Main Street, Suite D11
Corona, CA 92880
(951) 737-2962
M-F, 8am to 5pm

DESERT HOT SPRINGS

14320 Palm Drive
Desert Hot Springs, CA 92240
(760) 770-2264
M-F, 8am to 5pm

INDIO

83-912 Avenue 45, Suite 9
Indio, CA 92201
(760) 347-0754
M-F, 8am to 5pm

LAKE ELSINORE

31764 Casino Drive, Suite 200
Lake Elsinore, CA 92530
(951) 471-4649
M-F, 8am to 5pm

SAN JACINTO

1370 S. State St., Suite A
San Jacinto, CA 92583
(951) 791-3350
M-Th., 8am to 5pm
Fri., 8am to 4:30pm

RIVERSIDE

2085 Rustin Avenue, #3
Riverside, CA 92507
(951) 955-2105
M-F, 8am to 5pm
Fri. 8am to 4:30pm

TEMECULA

40925 County Center Drive, Suite 200
Temecula, CA 92591
(951) 600-6360
M-Th, 8am to 5pm

**Substance Use Community Access,
Referral, Evaluation, and Support Line
(SU CARES) 1 - 800 - 499 - 3008**

(SU CARES) Guidance and assistance is just a phone call away! We provide substance abuse prevention and treatment service information for individuals and families, screening and placement services, and direct referrals for consumers of Riverside County communities seeking help with substance use difficulties or questions.

Pregnant or know someone who is and wants treatment? Immediate access to treatment for pregnant and parenting women. Call today and ask about our peri-natal programs.



SAN BERNARDINO COUNTY ALCOHOL AND DRUG SERVICES

SCREENING, ASSESSMENT AND REFERRAL CENTER (SARC)

SARC offers confidential assessments for substance use treatment and recovery services. With the assistance of staff, treatment options are discussed and coordinated with provider agencies. Treatment services available include: detoxification, residential, adult outpatient drug free, adolescent outpatient drug free, narcotic treatment program, perinatal, recovery centers and case management.

850 E. Foothill Boulevard
Rialto, CA 92376
(909) 421-4601
Fax (909) 421-9466

ACCESS UNIT

The Access Unit is a call center comprised of mental health professionals that provide widespread linkages ranging from referrals to DBH clinics and/or fee-for-service providers to authorizations for outpatient services. This unit is available 24 hours a day, 7 days a week.

303 E. Vanderbilt Way
San Bernardino, CA 92415
(888) 743-1478 or (909) 386-8256
Fax (909) 890-0353 or (909) 890-0175

Safe Pain Medicine Prescribing in Emergency Departments:

Controlled Substance Utilization Review and Evaluation System (CURES)

The Controlled Substance Utilization Review and Evaluation System (CURES) is the name of California's Prescription Drug Monitoring Program (PDMP). CURES provides an opportunity for providers to review the prescription drug history of their patients and identify those who may be abusing prescription drugs. We recommend that all ED providers use one or more of the following options:

1. Access CURES for each patient seen in your ED to review their recent prescription drug history.
2. Ask for assistance from your hospital pharmacy staff to access CURES for each patient seen in your ED.
3. Invite the Department of Justice (DOJ) to visit your institution and register your staff for access to CURES.

CURES 2.0

REGISTRATION TIPS TO ~~X~~ SUCCESSFULLY REGISTER

MEDICAL DOCTORS

License Type

Your license type is the letter in front of your license number on your license wallet card.

For example, if your wallet card reads G12345,
select "Medical Doctor (MD) - Type G" as your license type.

OSTEOPATHIC DOCTORS

License Type

Your license type is "Osteopathic Doctor (DO) – Type A."

License Number

The prefix "20A" reflects your license type. It is not part of your license number and should not be included in the license number field.

For example, if your wallet card reads 20A1234,
enter "1234" as your license number.

PODIATRIC DOCTORS

License Board

**Select the "Board of Podiatric Medicine" as your licensing board,
NOT "Medical Board of California."**

NURSE MIDWIVES / NURSE PRACTITIONERS

License Number

Make sure to register using your Nurse Midwife Furnishing license number or your Nurse Practitioner Furnishing license number and NOT your Registered Nurse license number.

The Nurse Midwife Furnishing license or Nurse Practitioner Furnishing license is your
qualifying license for access to the CURES database.

PHYSICIAN ASSISTANTS

License Board

**Select the "Physician Assistant Committee" as your licensing board,
NOT "Medical Board of California."**

ALL APPLICANTS

Social Security Number (SSN) and Individual Tax Identification Number (ITIN)

Choose between these options based upon **what is on file with your licensing board**.

To be approved, the information you enter into the CURES online registration form must **EXACTLY** match records on file with your licensing board.

A business ITIN number should never be used, because it will not match records on file for you.

Prescriber Name Validation

For prescribers to be approved, their last name, as entered into the CURES online registration form, must match their name on file with the Drug Enforcement Agency.

Security Questions and Answers

Please make a note of your security question answers for later retrieval.

The answer **CANNOT** be part of the question (a word, part of a word, or a single letter.)

For example, if the security question contains the word **PET**, an answer of **PET** will not be accepted.

If the security question contains the word **WHERE**, an answer of **ER** will not be accepted.

Do not use abbreviations or single letter answers.

Reapplying after Denial

Once denied, applicants must reapply.

The CURES program cannot edit information submitted by applicants.

Upon receipt of a denial, review your User Registration Confirmation page printout for accuracy and compliance with these tips before reapplying.

If the information you entered is correct, contact your licensing board to verify that the date of birth and SSN or ITIN it has on file for you is accurate.

Approval/Denial Timeframe

Applicants should receive an approval or denial within 48 hours.

If you have not received an email by then, check your spam/junk email folder before contacting the CURES program.

FIRST-TIME LOGIN TIPS

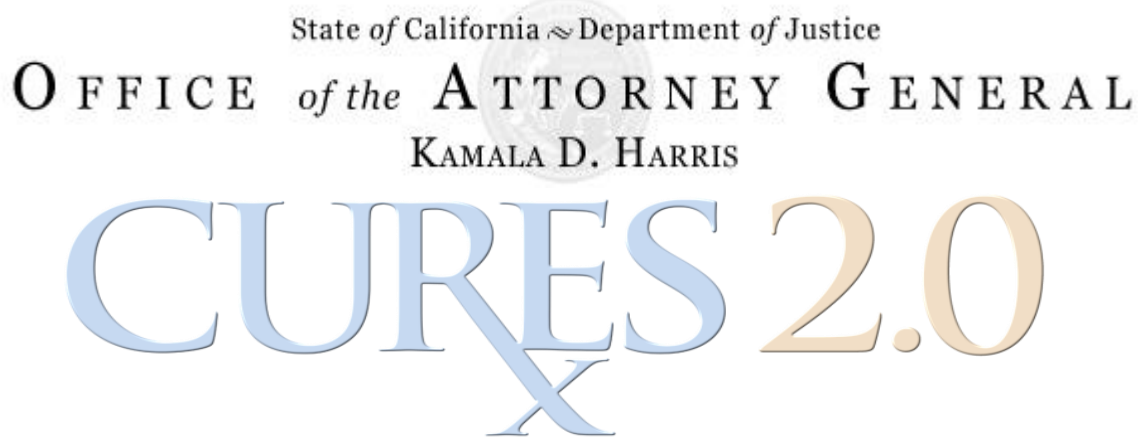
Entering Primary Address

To enter the address, **CLICK THE PENCIL ICON**.

After inserting address, **CLICK THE CHECKMARK** to confirm address entry.

Entering Phone Type – (Required Field)

Make sure to select phone type (home, office, or cell.)



Controlled Substance Utilization Review and Evaluation System

California's Prescription Drug Monitoring Program

CURES 2.0 (Controlled Substance Utilization Review and Evaluation System) is a database of Schedule II, III and IV controlled substance prescriptions dispensed in California serving the public health, regulatory oversight agencies, and law enforcement. CURES 2.0 is committed to the reduction of prescription drug abuse and diversion without affecting legitimate medical practice or patient care.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and confidentiality and disclosure provisions of California law cover the information contained in CURES 2.0.

Access to CURES 2.0 is limited to licensed prescribers and licensed pharmacists strictly for patients in their direct care; and regulatory board staff and law enforcement personnel for official oversight or investigatory purposes.

CURES Registration Requirements

California law (Health and Safety Code Section 11165.1) requires all California licensed prescribers authorized to prescribe scheduled drugs to register for access to CURES 2.0 by July 1, 2016 or upon issuance of a Drug Enforcement Administration Controlled Substance Registration Certificate, whichever occurs later. California licensed pharmacists must register for access to CURES 2.0 by July 1, 2016, or upon issuance of a Board of Pharmacy Pharmacist License, whichever occurs later.

Prescriber and dispenser registration to access CURES 2.0 is simple and fully automated. Prescribers and dispensers can register to access CURES by clicking [here](#).

Submission of Controlled Substance Data

California Health & Safety Code Section 11165(d) requires dispensing pharmacies, clinics, or other dispensers of Schedule II through IV controlled substances to provide specified dispensing information to the Department of Justice on a weekly basis in a format approved and accepted by the DOJ. Currently, the ASAP 2009 Version 4.1 is accepted.

Direct Dispense Reporting Application

The DOJ, in coordination with Atlantic Associates, Inc. (AAI), allows direct dispense prescribers and entities, including pharmacies filling less than 25 prescriptions per month, to electronically report dispensing data to the DOJ. The direct dispense application can be accessed on the Direct Dispense website located at www.aaicures.com. Also available at this website are instructions on how to apply for an account and submit dispense data. Please note that the DOJ no longer accepts paper direct dispense reports.

To access the secured direct dispense site, dispensers must first complete the application at <http://aaicures.com/register.for.access.php>. Once an application has been submitted, an email confirmation from AAI will provide approved users with a username and temporary password. If an email confirmation is not received within 48 hours of submitting the application, please contact AAI at CACures@aainh.com or (800) 539-3370.

For additional information concerning controlled substance prescription data reporting, please contact AAI at CACures@aainh.com or (800) 539-3370.

PRESCRIPTION FORMS (FOR PRESCRIBERS)

Obtain Security Prescription Forms

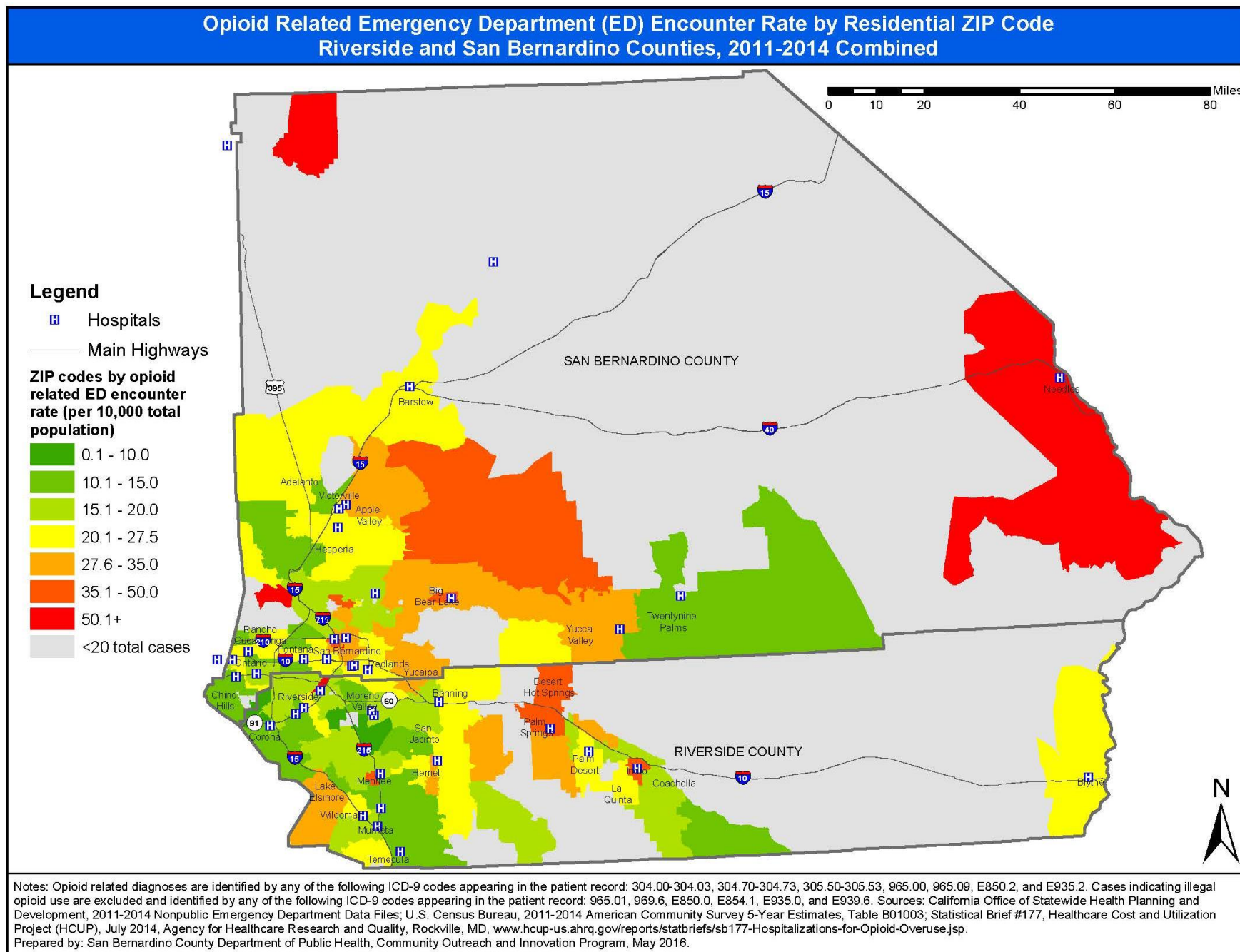
California law requires prescribers of any Schedule II through V controlled substance to obtain and use tamper-resistant prescription forms ordered only from state-approved security printers. To order tamper-resistant prescription forms, please refer to the Approved List of Security Prescription Printers for vendors authorized by the DOJ and their contact information.

Report Lost or Stolen Prescription Forms

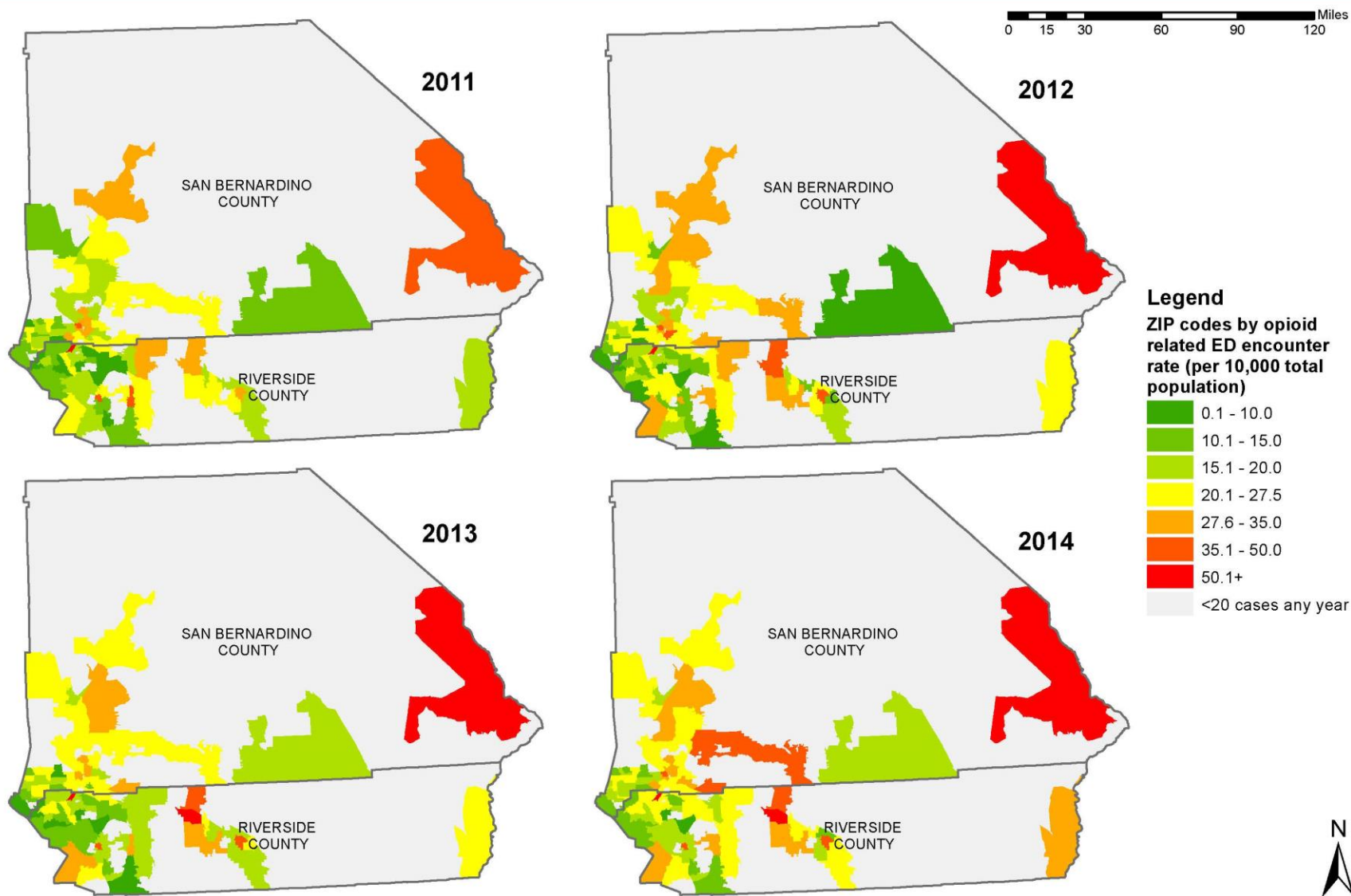
Reports of lost or stolen prescription forms or pads must be reported to local law enforcement and the PDMP. Users registered with CURES can electronically report their lost or stolen prescription forms or pads online when logged into their CURES account. A law enforcement agency report number is required when submitting a report of lost or stolen prescription forms to the PDMP.

For questions concerning how to report lost or stolen prescription pads or forms, please contact the Security Prescription Printer Program at SecurityPrinter@doj.ca.gov.

Opioid Overuse by Zip Code



Opioid Related Emergency Department (ED) Encounter Rate by Residential ZIP Code Riverside and San Bernardino Counties, 2011-2014



Notes: Opioid related diagnoses are identified by any of the following ICD-9 codes appearing in the patient record: 304.00-304.03, 304.70-304.73, 305.50-305.53, 965.00, 965.09, E850.2, and E935.2. Cases indicating illegal opioid use are excluded and identified by any of the following ICD-9 codes appearing in the patient record: 965.01, 969.6, E850.0, E854.1, E935.0, and E939.6. Sources: California Office of Statewide Health Planning and Development, 2011-2014 Nonpublic Emergency Department Data Files; U.S. Census Bureau, 2011-2014 American Community Survey 5-Year Estimates, Table B01003; Statistical Brief #177, Healthcare Cost and Utilization Project (HCUP), July 2014, Agency for Healthcare Research and Quality, Rockville, MD, www.hcup-us.ahrq.gov/reports/statbriefs/sb177-Hospitalizations-for-Opioid-Overuse.jsp. Prepared by: San Bernardino County Department of Public Health, Community Outreach and Innovation Program, May 2016.

The Status of Prescription Opioid Drug Abuse in the Inland Empire: 2009 – 2014 Scorecard

Prescription drug abuse has become one of the fastest-growing public health concerns in the United States and the Inland Empire. The number of deaths from prescription opioids now exceeds the combined number of deaths involving heroin and cocaine. Health care providers can play a significant role in addressing this growing problem. Thus, the Inland Empire Safe Opioid Prescribing Medical Task Force, a multi-disciplinary coalition, was formed to develop common principles among all Inland Empire Emergency Departments on the safe use of opioid pain medications.

This Score Card reviews the scale of the prescription drug abuse problem in the Inland Empire by looking at multiple factors and data points over the last six years. Readers are encouraged to look at all of the information as well as the direction of the trends over time.

Riverside Prescription Drug Abuse 2009-2014

		2009	2010	2011	2012	2013	2014
1.	Population	2,158,399	2,194,933	2,222,403	2,248,311	2,264,173	2,294,333
2.	RX Opioid Deaths Rate per 100,000	75 3.5	66 3.0	79 3.6	78 3.5	69 3.0	
3.	Heroin Deaths Rate per 100,000	38 1.8	33 1.5	31 1.4	37 1.6	57 2.5	
4.	Total Opioid Deaths Rate per 100,000	126 5.8	116 5.3	108 4.9	120 5.3	129 5.7	
5.	ED Visits Rate per 100,000	325 15.1	343 15.6	401 18.0	424 18.9	419 18.5	434 18.9
6.	Opioid Hospitalizations Rate per 100,000	200 9.3	216 9.8	223 10.0	231 10.3	265 11.7	254 11.1

Source: California Department of Public Health (2016), *Alcohol and other drug consequences*

Retrieved from EpiCenter: California Injury Data Online:

<http://epicenter.cdph.cagov/ReportMenus/AlcoholDrugTable.aspx>

San Bernardino Prescription Drug Abuse 2009-2014

		2009	2010	2011	2012	2013	2014
1	Populations	2,022,318	2,039,040	2,053,786	2,065,705	2,075,160	2,096,123
2	RX Opioid Deaths Rate per 100,000	60 3.0	48 2.4	43 2.1	39 1.9	33 1.6	
3	Other Narcotics Rate per 100,000	9 0.4	11 0.5	11 0.5	2 0.1	9 0.4	
4	Heroin Deaths Rate per 100,000	7 0.3	11 0.5	10 0.5	19 0.9	18 0.9	
5	Total Opioid Deaths Rate per 100,000	76 3.8	70 3.4	64 3.1	60 2.9	60 2.9	
6	ED Visits Rate per 100,000	264 13.1	298 14.6	337 16.4	302 14.6	325 15.7	362 17.3
7	Opioid Hospitalizations Rate per 100,000	210 10.4	195 9.6	232 11.3	184 8.9	211 10.2	213 10.2

Source: California Department of Public Health (2016), *Alcohol and other drug consequences*
Retrieved from EpiCenter: California Injury Data Online:
<http://epicenter.cdph.ca.gov/ReportMenus/AlcoholDrugTable.aspx>

Riverside and San Bernardino County Core Opioid Safety Measures: 2010-2013 (from CURES Data)

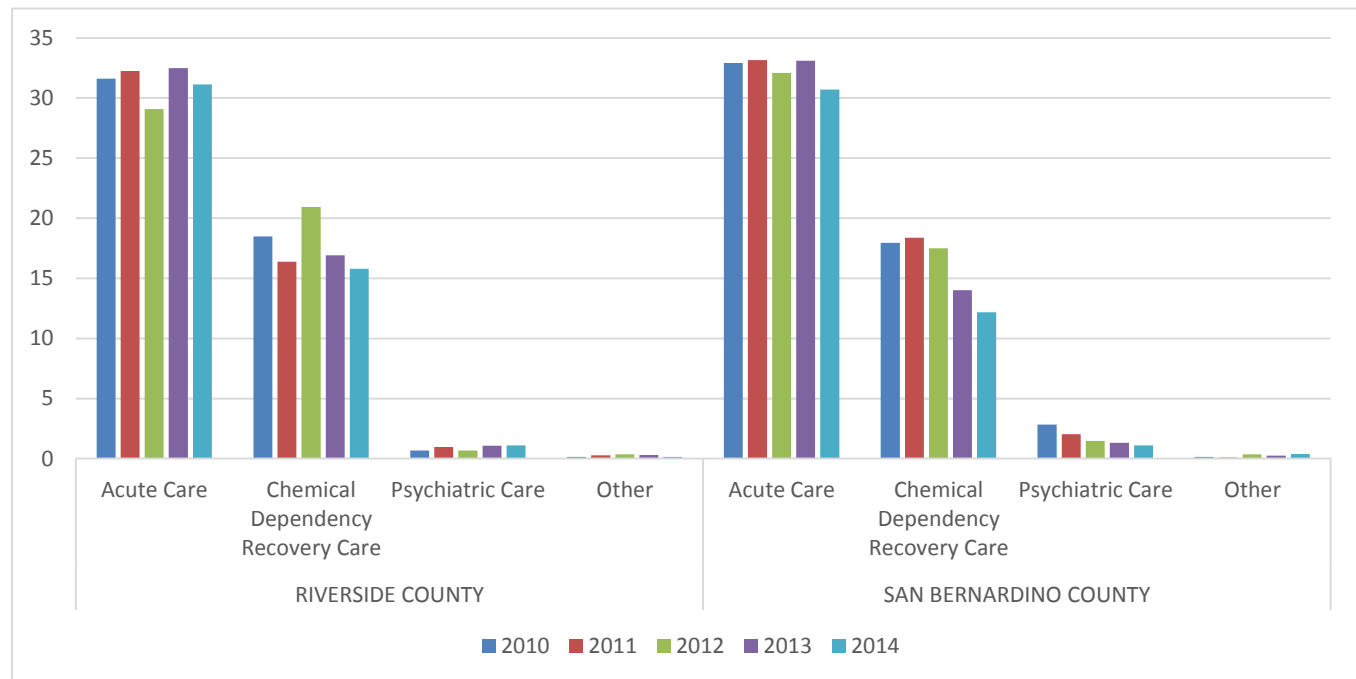
Measure Type	Measure	City	Year			
			2010	2011	2012	2013
Prescription Volume (Buprenorphine not included)	Opioid prescriptions per 1,000 residents	Riverside	583.0	583.0	589.0	569.0
		San Bernardino	608.6	603.2	611.7	576.0
	Morphine milligram equivalents (MME) per resident	Riverside	685.0	620.0	630.0	615.0
		San Bernardino	667.8	636.1	646.8	606.9
	Hydrocodone (Norco 5mg equivalent) per resident	Riverside	137.0	124.0	126.0	123.0
		San Bernardino	133.6	127.2	129.4	121.4
CURES Alert	Residents per 1,000 on >100 mg MME daily (for ≥ 30 days)	Riverside	9.0	9.2	8.8	9.0
		San Bernardino	8.4	9.1	8.9	8.6
	Residents per 1,000 on >40 mg methadone daily (for ≥ 30 days)	Riverside	2.1	2.0	1.8	1.7
		San Bernardino	1.2	1.2	1.2	1.2
	Residents per 1,000 on combo opioids/benzos (for ≥ 30 days)	Riverside	10.0	10.6	11.0	11.3
		San Bernardino	10.2	11.1	11.9	12.1
	Residents per 1,000 on 90 sequential days of opioids	Riverside	10.3	10.3	10.9	10.6
		San Bernardino	11.0	11.1	11.9	11.4
	Residents per 1,000 using six or more prescribers or pharmacies in six months	Riverside	1.5	1.5	1.5	1.5
		San Bernardino	1.6	1.3	1.4	1.3
Buprenorphine	Buprenorphine prescriptions per 1,000 residents	Riverside	6.0	6.1	6.6	8.3
		San Bernardino	4.3	3.6	4.1	6.1
	Number of waived buprenorphine prescribers	Riverside	71.0	77.0	82.0	86.0
		San Bernardino	55.0	61.0	66.0	72.0
	Number of actively prescribing waived buprenorphine prescribers	Riverside	43.0	47.0	52.0	53.0
		San Bernardino	31.0	29.0	34.0	32.0

Source: California Health Care Foundation, *Opioid Safety Coalitions Network - Understanding the Epidemic Through Data*, <http://www.chcf.org/oscn/data> (accessed 4/13/2016).

Primary Opiate Inpatient Discharges by Bed License Type Riverside County and San Bernardino County Residents, 2010-2014

County	Year	Total Population	Type of Bed License							
			Acute Care		Chemical Dependency Recovery Care		Psychiatric Care		Other	
			#	Rate	#	Rate	#	Rate	#	Rate
Riverside	2010	2,109,464	667	31.6	390	18.5	14	0.7	3	0.1
	2011	2,154,844	695	32.3	353	16.4	21	1.0	6	0.3
	2012	2,192,982	638	29.1	459	20.9	15	0.7	8	0.4
	2013	2,228,528	724	32.5	377	16.9	24	1.1	7	0.3
	2014	2,266,899	706	31.1	358	15.8	25	1.1	3	0.1
San Bernardino	2010	2,005,287	660	32.9	360	18.0	57	2.8	3	0.1
	2011	2,023,452	671	33.2	372	18.4	41	2.0	2	0.1
	2012	2,041,029	655	32.1	357	17.5	30	1.5	7	0.3
	2013	2,056,915	681	33.1	288	14.0	27	1.3	5	0.2
	2014	2,078,586	638	30.7	253	12.2	23	1.1	8	0.4

*Counts and Crude Rates per 100,000 Total Population



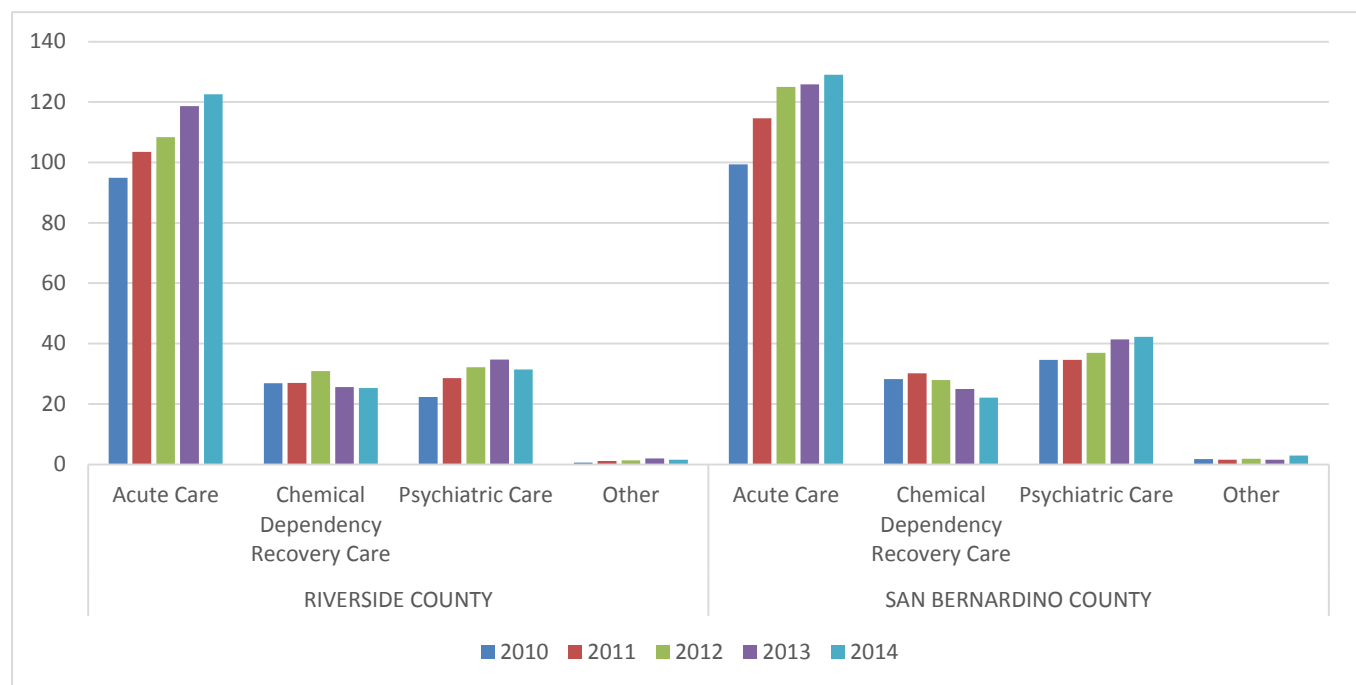
Note: Primary opiate inpatient discharges are identified by principal diagnosis among ICD-9 codes 304.0, 304.7, 305.5, 965.00, 965.01 and 965.09, and/or principal E-code among E850.0, E850.2, E935.0 and E935.2.

Sources: California Office of Statewide Health Planning and Development, 2010-2014 Non-Public Patient Discharge Data Files; U.S. Census Bureau, American Community Survey 5-Year Estimates, Table B01003.

Opiate-Related Inpatient Discharges by Bed License Type Riverside County and San Bernardino County Residents, 2010-2014

County	Year	Total Population	Type of Bed License							
			Acute Care		Chemical Dependency Recovery Care		Psychiatric Care		Other	
			#	Rate	#	Rate	#	Rate	#	Rate
Riverside	2010	2,109,464	2,002	94.9	566	26.8	471	22.3	13	0.6
	2011	2,154,844	2,230	103.5	581	27.0	616	28.6	24	1.1
	2012	2,192,982	2,376	108.3	677	30.9	706	32.2	30	1.4
	2013	2,228,528	2,645	118.7	571	25.6	773	34.7	43	1.9
	2014	2,266,899	2,779	122.6	574	25.3	712	31.4	36	1.6
San Bernardino	2010	2,005,287	1,993	99.4	567	28.3	695	34.7	36	1.8
	2011	2,023,452	2,319	114.6	610	30.1	700	34.6	31	1.5
	2012	2,041,029	2,551	125.0	571	28.0	755	37.0	37	1.8
	2013	2,056,915	2,588	125.8	514	25.0	852	41.4	31	1.5
	2014	2,078,586	2,683	129.1	460	22.1	877	42.2	60	2.9

*Counts and Crude Rates per 100,000 Total Population



Note: Opiate-related inpatient discharges are identified by the presence of any of the following ICD-9 codes in any of 30 diagnosis/E-code fields: 304.0, 304.7, 305.5, 965.00, 965.01, 965.09, E850.0, E850.2, E935.0 and E935.2.

Sources: California Office of Statewide Health Planning and Development, 2010-2014 Non-Public Patient Discharge Data Files; U.S. Census Bureau, American Community Survey 5-Year Estimates, Table B01003.

California Healthy Kids Survey (CHKS)

The California Healthy Kids Survey (CHKS) is a tool for use in Grades 5-12 that help schools and districts accurately identify areas of student and school strengths and weaknesses and address related needs. It has led to a better understanding of the relationship between students health behaviors and academic performance. The data listed below represents Riverside and San Bernardino County.

Riverside: Lifetime Use of Prescription Pain Killers

Indicator	2007-2009			2008-2010			2009-2011			2010-2012			2013-2015		
Rx Pain Killer Use Among Students	Grade 9	Grade 11	NT	Grade 9	Grade 11	NT	Grade 9	Grade 11	NT	Grade 9	Grade 11	NT	Grade 9	Grade 11	NT
0 times	86%	80%	64%	86%	79%	59%	86%	79%	59%	87%	81%	64%	89%	84%	68%
1 time	4%	5%	6%	4%	5%	7%	4%	5%	8%	4%	4%	6%	3%	4%	6%
2 to 3 times	4%	6%	10%	4%	6%	11%	4%	6%	11%	4%	5%	9%	4%	5%	8%
4 or more times	5%	9%	20%	6%	10%	23%	6%	10%	23%	5%	9%	20%	4%	7%	19%
# of Respondents	16,396	13,510	2,911	20,545	16,295	2,407	20,547	16,443	2,369	18,483	15,897	2,514	16,318	13,515	2,300

Riverside: Lifetime Use of Heroin

Indicator	2007-2009			2008-2010			2009-2011			2010-2012			2013-2015		
Heroin Use Among Students	Grade 9	Grade 11	NT	Grade 9	Grade 11	NT	Grade 9	Grade 11	NT	Grade 9	Grade 11	NT	Grade 9	Grade 11	NT
0 times	96%	96%	93%	96%	96%	90%	96%	96%	91%	97%	97%	93%	Lifetime heroin use no longer measure on CHKS		
1 time	1%	1%	3%	1%	1%	2%	1%	1%	2%	1%	1%	2%			
2 to 3 times	1%	1%	2%	1%	1%	3%	1%	1%	3%	1%	1%	2%			
4 or more times	2%	2%	3%	2%	2%	4%	2%	2%	4%	1%	1%	3%			
# of Respondents	16,396	16,510	2,911	20,545	16,295	2,407	20,547	16,443	2,369	18,483	15,897	2,514			

California Healthy Kids Survey (CHKS) – cont’d

San Bernardino: Lifetime Use of Prescription Pain Killers

Indicator	2008			2009			2010			2011			2012		
Rx Pain Killer Use Among Students	Grade 9	Grade 11	NT	Grade 9	Grade 11	NT	Grade 9	Grade 11	NT	Grade 9	Grade 11	NT	Grade 9	Grade 11	NT
0 times	86%	81%	66%	87%	82%	67%	84%	79%	65%	84%	79%	65%	N/A	N/A	N/A
1 time	4%	5%	6%	4%	5%	6%	5%	5%	6%	5%	5%	6%	N/A	N/A	N/A
2 to 3 times	4%	5%	9%	4%	5%	9%	5%	6%	11%	5%	6%	11%	N/A	N/A	N/A
4 or more times	6%	9%	18%	5%	9%	17%	6%	10%	18%	6%	10%	18%	N/A	N/A	N/A

San Bernardino: Lifetime Use of Heroin

Indicator	2008			2009			2010			2011			2012		
Heroin Use Among Students	Grade 9	Grade 11	NT	Grade 9	Grade 11	NT	Grade 9	Grade 11	NT	Grade 9	Grade 11	NT	Grade 9	Grade 11	NT
0 times	96%	96%	93%	96%	96%	93%	95%	96%	91%	95%	96%	91%	N/A	N/A	N/A
1 time	1%	1%	2%	1%	1%	1%	1%	1%	3%	1%	1%	3%	N/A	N/A	N/A
2 to 3 times	1%	1%	2%	1%	1%	3%	1%	1%	2%	1%	1%	2%	N/A	N/A	N/A
4 or more times	2%	2%	3%	2%	2%	3%	2%	2%	4%	2%	2%	4%	N/A	N/A	N/A

*NT = Non-traditional schools. This includes continuation, community day, and other alternative school types

*Source: Riverside County, California Healthy Kids Survey (CHKS) for cycles 2007-2009, 2008-2010, 2009-2011, 2010-2012, 2013-2015
West Ed Health and Human Development Program for the California Department of Education

*San Bernardino County, California Health Kids Survey (CHKS) 2007/08-2009/11: Main Report San Francisco; WestEd Health and Human Development Program for the California Department of Education.

*Please note that Riverside County did not receive a county level report for cycles 2011-2013 and 2012-2014 due to insufficient participation of districts needed to generate a statistically significant report

Additional Information on Prescription Drug (Rx) Indicators

Drug Retail Price

A large variety of pills are sold and the price often depends on the amount bought. Overall the average prices remain stable: Vicodin 10 mg per tablet sold for \$1-5 in 2008 and \$3 in 2013. Xanax 4 mg per pill sold \$1-2 in 2012 and \$2-5 in 2013. However, the price of the Oxycontin pill (80mg) dropped significantly from \$80 in 2009 to \$10-14 in 2013. This may be because of an effort to capture existing Oxycontin users, and prevent them from switching to Black Tar Heroin, which is cheaper than a single Oxycontin pill.

Heroin Addendum

Heroin abuse is growing nationwide. Heroin seizures increased in 2008-2010 and heroin treatment admission increased in 2012. There is speculation that the prescription drug abuse epidemic may be contributing to this trend, as users switch to the cheaper heroin after prescription opioids become harder to find and more expensive. Mexican Black Tar heroin prices have dropped slightly starting since the spring of 2012. This is believed to be the Mexican Drug Trafficking Organizations' efforts to expand their heroin market by appealing to former Oxycontin Users in affluent areas.

Looking Forward

The Inland Empire Safe Opioid Prescribing Medical Task Force will continue collecting data to inform priorities for action. The Task Force has developed the safe opioid pain medication prescribing guidelines and language and communication tools for patients (handouts and poster) and will also track implementation of the use of handouts and outcomes (e.g., number of opioid prescriptions, patient satisfaction). This county-wide approach is intended to decrease doctor and Emergency Department shopping, increase provider and patient education, and ensure that safer care is provided for patients suffering from chronic pain.

Becoming Involved in Keeping the Inland Empire Healthy

You can make a difference!

- ✓ Safely dispose of your old prescriptions by contacting your local police station for safe drug drop off boxes.
- ✓ More info on disposal → http://www.deadiversion.usdoj.gov/drug_disposal/index.html
- ✓ Keep track of your medicine and secure it.
- ✓ Don't share your own medications, or use medication prescribed to someone else.
- ✓ Share this information and talk to your family members and neighbors about the risks involved with the misuse of prescription drugs.

Additional Resources

- **Chronic Pain Screening and Monitoring Tools**
- **Controlled Prescriptions Questions and Answers**
- **Online Continuing Medical Education (CME) on Pain Management**
 - Boston University School of Medicine -- SCOPE of Pain: Safe and Competent Opioid Prescribing Education. Offered in collaboration with the Council of Medical Specialty Societies (CMSS) and the Federation of State Medical Boards (FSMB), this program addresses the FDA mandate to manufacturers of extended release/long-acting (ER/LA) opioid analgesics, by providing comprehensive prescriber education in the safe use of these medications.
<http://www.scopeofpain.com/>
 - American Society of Addiction Medicine - ER/LA Opioid REMS: Achieving Safe Use While Improving Patient Care
<http://www.softconference.com/asam/slist.asp?C=5383>
 - American College of Physicians - Safe Opioid Prescribing
<http://www.pri-med.com/PMO/Featured/Pain%20Management/Default.aspx>
 - AAFP training resource (1 hour) aafp.org/webcast/chronic-pain
 - AAFP (4 hour with Completer status for this ER/LA Opioid REMS, and includes webcast, CME bulletin, and interactive components) aafp.org/rem-s-online
 - <http://www.drugabuse.gov/opioid-pain-management-cmesces>
 - In the near future, the California Medical Board will be offering a 3-hour, web-based CME specific to chronic pain management.
- **Visit our website at www.hasc.org/safeprescribing**
 - Taskforce updates, presentation schedule, and more information

Chronic Pain Screening and Monitoring Tools

Below is a list of Risk Assessment Tools and Ongoing Assessment and monitoring tools from www.opioidrisk.com.

Risk Assessment Tools: ORT, DIRE, SOAPP-R, SOAPP and SISAP

ORT: Opioid Risk Tool

<http://www.painknowledge.org/physiciantools/ORT/ORT%20Patient%20Form.pdf>

Description: This questionnaire developed by Dr. Lynn Webster, to be filled out by the patient, allows health care professionals to determine risk of addiction to prescription opioid medication.

DIRE: Information Guide

<http://www.opioidrisk.com/node/942>

Description: Detailed informational page on the DIRE: Diagnosis, Intractability, Risk, Efficacy. This page includes links to information about the risk assessment tool, as well as development and use of the assessment tool in clinical practice.

SOAPP: Information Guide

<http://www.opioidrisk.com/node/940>

Description: Detailed informational page on the Screener and Opioid Assessment for Patients with Pain (SOAPP). This page includes links to information about the risk assessment tool, as well as development and use in clinical practice.

SOAPP-R: Information Guide

<http://www.opioidrisk.com/node/941>

Description: Detailed informational page on the Screener and Opioid Assessment for Patients in Pain - Revised (SOAPP-R). This page includes links to information about the risk assessment tool, as well as development and use of the tool in clinical practice.

SISAP: Information Guide

<http://www.opioidrisk.com/node/895>

Description: Detailed informational page on the Screening Instrument for Substance Abuse Potential (SISAP). This page includes links to the assessment tool, as well as information about the development and use in clinical practice.

Ongoing Assessment and Monitoring Tools: COMM, ABC, Chabal 5-Point Checklist, PMQ, PDUQ, and PADT.

COMM: Current Opioid Misuse Measure

<http://www.opioidrisk.com/node/946>

Description: Brief, self-report measure designed to assess current aberrant behaviors. Unlike measures that aim to identify risk potential for substance abuse, the COMM asks patients to describe how they are currently using their medication

ABC: Information Guide

<http://www.opioidrisk.com/node/947>

Description: Detailed informational page on the Addiction Behaviors Checklist (ABC). This page includes links to information about the assessment tool, as well as development and use in clinical practice.

Chabal 5-Point Prescription Opiate Abuse Checklist

http://www.ncbi.nlm.nih.gov/pubmed/9186022?ordinalpos=6&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_DefaultReportPanel.Pubmed_RVDocSum

Description: Authors Chabal C, Erjavec MK, Jacobson L, Mariano A, and Chaney E discuss a five-point questionnaire that assesses the risk of opioid abuse through evaluation of behaviors that are consistent with opioid abuse rather than answers to specific questions.

PMQ: Information Guide

<http://www.opioidrisk.com/node/943>

Description: Detailed informational page on the Pain Medication Questionnaire (PMQ). This page includes links to information about the assessment tool, as well as development and use in clinical practice.

PDUQp: Information Guide

<http://www.opioidrisk.com/node/945>

Description: Detailed informational page on the Prescription Drug Use Questionnaire Self-Report (PDUQp). This page includes links to information about the ongoing assessment tool, as well as development and use in clinical practice.

Pain Assessment and Documentation Tool

http://caresalliance.com/Resources/CAA0-011_CaresAlliance_PainAssessment_090110.pdf

Description: Pain Assessment and Documentation Tool (PADT) is a clinician directed interview and form for recording responses.