EMERGENCY DEPARTMENT MODEL PRACTICES DEALING WITH THE PRESCRIPTION OPIOID EPIDEMIC

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

In recent years, misuse of over the counter and prescription drugs has surpassed the use of illicit drugs as cause of emergency department visits in the US.

EDs account for 5% of opioid prescriptions filled.
INTRODUCTION

1) Discuss our experience at Allegiance Health
2) Discuss developments in primary care and what is coming
3) Discuss Michigan College of Emergency Physicians ED prescribing recommendations
4) Discuss the recent experiences in Washington State
ALLEGIANCE PATIENT
MANAGEMENT PROGRAM

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

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

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

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

The large number of these patients were there for chronic pain and opioid seeking behavior
PMP

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

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

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

Not all patients were notified of this.
PMP

Started to see a dramatic change in prescribing

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

We saw a 62.4% reduction in ED visits

We continue to trend this over time and the visit number has stabilized for most patient
We currently do a 1, 3, and 5 year review based on the success of the program with each individual patient.

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

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

Started meeting with The Center for Family Health (a federally qualified clinic) as a significant number of patients were shared.
COMMON PATHWAYS

The ED developed non-opioid chronic headache pathway and chronic back pain pathway

Developed Migraine order sets for our electronic medical record

Saw a significant decrease in chronic head patients

Saw and improvement in migraine outcomes and decreased ED LOS
PRESCRIBING RECOMMENDATIONS

We developed ED prescribing recommendations in 2010-11 and had them approved at our hospital medical executive committee.
While revamping our prescribing habits in the ED, work was done to change some primary provider habits as well. Allegiance developed a common pain contract. Development of system guidelines for chronic pain assessment and opioid prescribing. Dealing with outlying physicians. System wide mandatory computer based learning for all providers for pain with incentives for PCPs.
Due to the changing environment, and prescription opioids becoming the new gateway drugs, interest started in developing recommendations.

Seen improvement in other states who have them.

Questions from multiple ED department chairs about help in managing this problem.

Allegiance Health, DMC, Sparrow, and Henry Ford Health Systems have all developed own guidelines.
In recent years, misuse of over-the-counter and prescription drugs has surpassed the use of illicit drugs as a cause of ED visits in the U.S.A. Prescription and illicit drug misuse now account for more deaths than motor vehicle accidents.

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

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

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

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

The ED should not prescribe extended release/long-acting pain medications such as OxyContin, MS Contin, Fentanyl patches or Methadone. Instead, patients should be referred to their prescribing health care practitioner for these controlled medications.
Utilization of the Michigan Automated Prescription System (MAPS) is highly encouraged for every patient with a chronic pain condition. This free risk management tool provides an electronic report, usually within minutes, on a patient’s history of Schedule II-V controlled substance use.

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

EDs should provide a list of local clinics, including federally qualified health centers, that provide primary care for patients of all payer types.
Our emergency department (ED) understands that pain relief is important when someone is hurt or needs emergency care. Providing pain relief, however, is often complex; also, there are major risks involved in using pain medications as mistakes or misuse of these powerful medications can cause serious health problems and even death. Our ED, therefore, is committed to providing pain relief that is appropriate and safe for your illness.
MCEP PATIENT EDUCATION

To ensure patient safety:

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

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

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

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

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

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

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

Patient resources on chronic pain:

• American Chronic Pain Association [www.theacpa.org](http://www.theacpa.org) or 1-800-533-3231

• State of Michigan Department of Licensing and Regulatory Affairs (LARA) Pain and Symptom Management website: [www.michigan.gov/pm](http://www.michigan.gov/pm)
MAPS

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

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

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

Developed 7 best practices
WASHINGTON BEST PRACTICES

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

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

Establishing ED awareness of patients who are frequent visitors.

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

Adopt stricter guidelines for prescribing of narcotics in the ED

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

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

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

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

Dr. House recommended!

VICODIN
Fast Relief for Constant Pain

"I use it for aching muscles!"