Implementing Prescribing Guidelines in the Emergency Department

April 16, 2013
Housekeeping

**Note:** Today’s presentation is being recorded and will be provided within 48 hours.

Two ways to ask questions at the end of the webinar:

- Submit your text questions and comments using the Questions Panel.
- Please raise your hand to be unmuted for verbal questions.
Governor’s Cabinet Opiate Action Team

- Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances (OOCS) Prescribing Guidelines

www.healthyohioprogram.org/ed/guidelines
Pocket Cards Available

- Limited quantities of pocket cards available.
- To request cards, please email: HealthyO@odh.ohio.gov
- Include your name, address, quantity requested and reason for your request.

www.healthyohioprogram.org/ed/guidelines
Prescription Drug Abuse Action Group

Next meeting May 10th from 1:00 – 3:00 pm

www.healthyohioprogram.org/vipp/pdaag/pdaag
Today’s Webinar

- Dawn Prall, MD, FACEP
- Bill Quinlan, St. Luke’s Hospital

www.healthyohioprogram.org/ed/guidelines
Implementing the Emergency Department and Acute Care Pain Management Guidelines

Dawn Prall, MD, FACEP
April 16, 2013
Objectives

- Discuss how prescribers can provide good care with regard to controlled substance use and chronic pain management in the acute care setting
- Describe where the acute care setting fits within the scope of chronic pain management
- Review some statistics regarding controlled substance prevalence and accidental overdose death
- Review the guidelines
- Discuss strategies for guideline implementation
Pain relief = removing pain

Pain management = improving one’s quality of life which is affected by chronic pain through a multi-disciplinary approach

The focus of chronic pain management should be improving quality of life for people living with chronic pain, not necessarily pain relief.

This requires setting (realistic) quality of life goals and ongoing assessment.
Chronic pain – There are many definitions.

Disease state characterized by persistence of pain beyond normal expected healing time. Can be complicated by environmental, psychosocial and behavioral factors. Can (and often does) co-exist with other disease.

Acute pain is often a SYMPTOM of an underlying problem; chronic pain is a DISEASE PROCESS in and of itself.
**Background**

**Chronic pain: - several types**

- **Chronic benign (or non-cancer) pain** – which is the **focus of this discussion and the guidelines**
  - Disease process that has significant impact on quality of life but by definition is not life threatening.

- **Chronic cancer pain**
  - Disease process that can have significant morbidity and mortality associated with it. Treatment processes are different than for chronic benign pain syndromes.

- **Other chronic pain (like sickle cell disease)**
  - Disease process that has significant morbidity and mortality associated with it. Treatment processes are different than for chronic benign pain syndromes.
Ideally, there should be 1 outpatient health care provider coordinating the patient’s pain management for safety and monitoring of therapy.

Providers in the acute care setting should be an extension of this outpatient provider, not the primary chronic pain management providers.

Communication and consistent care are keys to successful chronic pain management in the acute care setting.
How do prescribers prevent inappropriate prescribing and continue to provide good care?

- Continue to be vigilant for life/limb threatening illness/injury.

- Be a compassionate provider!
  - Quality of life for many patients with chronic pain is perceived by them as not being very good. Be understanding of this.

- Education (self, patients) about the different types of pain, treatment options and patients’ need for active participation in their health care.
  - See The American Chronic Pain Association website [http://www.theacpa.org/What-We-Have-Learned](http://www.theacpa.org/What-We-Have-Learned) for a good perspective on this.
How do prescribers prevent inappropriate prescribing and continue to provide good care?

- **RISK ASSESSMENT** before prescribing
  - Gather background information – usually through EMR, family, outpatient physicians, etc.
  - Use OARRS
  - SBIRT for personal addiction screening and referral
    - [Link](http://www.healthyohioprogram.org/ed/~/media/FD00387E09FF494E81DE74239BD776E0.ashx)
  - Screen for mental illness and refer for treatment
    - Usually can glean through conversation
  - Consider asking about family history of addictions
  - Help set up safety plans for those at risk for misuse of prescription medication
Technically, on some level, we violate state medical board rules by prescribing “dangerous drugs” for “intractable pain” without performing a thorough history and physical, including assessment for addiction prior to prescribing. (ORC 4731-21)

Do not hesitate to prescribe controlled substances when appropriate – i.e., appropriate situation/injury in a patient with low risk for adverse events who has close follow up for monitoring use.

- Use a safety plan in a high risk patient with acute injury appropriately treated with controlled substances (e.g., fracture, etc.)
What’s the problem?
“Chronic pain affects an estimated 116 million American adults – more than the total affected by heart disease, cancer and diabetes combined.”


Total # of adults in the United States in 2012 = approx. 250 million
There is a strong relationship between increases in exposure to prescription opioids and fatal unintentional overdose rates.

Unintentional fatal drug poisoning rates and distribution rates of prescription opioids in grams per 100,000 population by year, Ohio, 1997-2011 (2010 for deaths)

Drugs distributed – 643% increase
Death rate – 365% increase

CONTRIBUTING FACTORS:

Sources:
1. Ohio Vital Statistics
2. DEA, ARCOS Reports, Retail Drug Summary Reports by State, Cumulative Distribution Reports (Report 4) Ohio, 1997-2007
3. Calculation of oral morphine equivalents used the following assumptions: (1) All drugs other than fentanyl are taken orally; fentanyl is applied transdermally. 2) These doses are approximately equianalgesic: morphine: 30 mg; codeine 200 mg; oxycodone and hydrocodone: 30 mg; hydromorphone: 7.5 mg; methadone: 4 mg; fentanyl: 0.4 mg; meperidine: 300 mg; 4. US Census Bureau, Ohio population estimates 1997-2007
5. preliminary data for 2007-2011
We see a lot of people with chronic pain in the acute care setting. Chronic pain is best managed with coordinated care through 1 outpatient provider.

Though we do not prescribe a majority of the controlled substances in our country, we do interface with a lot of people at risk for misuse.

- We have an opportunity to provide patients education about the risks of these medications.
Why do we need guidelines?

- When we write prescriptions, we cannot monitor their effectiveness due to lack of follow up with the actual prescriber inherent in the acute care setting.

- More people die from accidental drug overdose than car accidents now. It is now the state and national #1 cause of accidental death.

- We all are part of the problem and need to be part of the solution.

We need to be more responsible prescribers!
The Acute Care Pain Management Guidelines
The Acute Care Pain Management Guidelines

What are they?
- They are a set of guidelines meant to provide guidance to both patients as well as health care providers in the acute care setting regarding chronic benign pain management, controlled substance prescribing and use in the acute care setting.

What specifically can or do the guidelines cover?
- The function of the acute care setting in management of chronic pain
- Why restrictions on controlled substance prescribing are in place (i.e., safety)
- Controlled substance med refills (or lack of)
- The importance of outpatient management of chronic pain
- Coordination of care
- What to expect during the evaluation (safe, appropriate care)
- Getting help for addiction
Risk Screening
Addiction risk screening before prescribing controlled substances

- There are many tools available:
  - SBIRT
  - CAGE-AID
  - DAST-10
  - Many others

- It can be as simple as asking about tobacco, alcohol and drug use.

- Ideally, risk screening should be done for every controlled substance prescription that is written.
  - Check Photo ID or some biometric identification
  - OARRS checking – though NARxCHECK can help make checking OARRS an faster (automatic) process.
Risk screening for mental illness is helpful as well. Addiction and diversion risk is higher for those with uncontrolled mental illness.
My Experience
The Journey...

- Insight
  - Good ideas for years with too much resistance
  - Washington state program

- Local
- System-wide
- Regional
- State
Helpful tips for implementation

- **Program champion**
- **Administrative support**
  - Tends to be easier with urgent cares than with hospital systems
- **Prescribers who are willing to provide quality, compassionate care that is safe**
- **Coordination of care with outpatient providers and resources**
  - Can use direct communication (less welcome or helpful after hours) and/or pre-determined, written care plans within the chart that are as objective as possible
Helpful tips for implementation

- Consistent care across prescribers within the group
  - Care plans can be helpful with this.
  - If available, place copies of outpatient pain agreements in the acute care setting medical records.
  - Insurance companies can sometimes be helpful with this through care plan development, lock-in programs, etc.

- Prescriber education and support THROUGHOUT THE GROUP
  - **CONSISTENT CARE on every visit IS THE CRUX OF THIS PROGRAM’S EFFECTIVENESS**

- Consistent care across neighboring health systems is also very helpful.
Helpful tips for implementation

- Community support

- Overall EDUCATION and AWARENESS
  - Involves patients, health care providers and administrators
  - Education should include basics of chronic non-cancer pain management and why these guidelines are important

- Patience and persistence!

- Program Maintenance
Potential obstacles

- Administrators
- Health care system issues
- Risk management
- Providers
- Patients

Basically, everyone and everything you will encounter.
“Buy in” and education of all parties is key to successful implementation.

Education is ongoing.

Focus on providing good AND compassionate care.
  - Remember that chronic pain, addiction and mental illness are all diseases. They need to be treated as such.

Understand the risks and benefits of what you are prescribing or recommending to patients.

Always be vigilant for life threatening disease.

Do not hesitate to prescribe when appropriate but screen for risk before you prescribe!
  - Use OARRS and check identification
  - Cautious prescribing controlled substances to those with uncontrolled mental illness
  - Use safety plans when appropriate
Lessons Learned: Implementing Prescribing Guidelines in the Emergency Department
St. Luke’s Hospital
Managing Chronic Pain in the ER

• Planning began in 2009 when the ED physician leadership requested help.
• St. Luke’s had become known as the place to go to get drugs – “Patient testimonial”
• Physicians and staff asked to identify frequent flyers
• Ten patients had over 22 visits (average 38 visits) in 2008 totaling 379 visits.
• One patient had 80 visits.
• 19 patients were identified as “drug seeking”
Critical Issue

Physicians must be signed up to request OARRS reports.

Nurses or clerks should also be signed up to request OARRS reports.

OARRS reports should be requested on any patient with chronic pain issues or if the physician is suspicious of drug seeking behavior.

OARRS are stored in the medical record, read only.
Physicians requested one page form with history of pain treatment in the ED.

Form was developed with chief pain complaint, demographics, encounters, and number of CT scans, and nine questions to screen for drug seeking behavior.
Pain Treatment History form

Includes demographics:
  Date form completed
  Patient name and DOB
  PCP and specialists seen
  Allergies
  Chief pain complaint
    Abdominal, migraine/headache, back/neck, toothache, other
Pain Treatment History form

Encounter and x-ray information:
  Number of ED visits two previous years
  Number of inpatient stays
  Number of imaging studies
    CT scans
    Other imaging
Pain Treatment History form

Screening questions:
History of multiple visits to other local ED’s?
Requests a specific drug?
Requested specific physician?
Did the patient get agitated if drugs not given?
Security involvement?
AMA after being denied opioid?
Is there a pain management contract with any physician?
Was an OARRS report requested?
Pain Treatment History form

Pain Treatment History forms are completed retrospectively for all patients identified as having chronic pain or suspected of being drug seekers.

ED nurses complete forms in “spare” time!

Completed forms are stored in medical record in a “Universal” folder that is accessible without opening an encounter record.
Patient name: 
Medical record #: 
Specialist name: 
Allergies: ASA, AMERICAN, CODEINE, VITAMIN, ALUMINUM, DEMEROL

Chief Pain Complaint: 
Abdominal pain #
Toothache/Jaw pain #
Muscle/Back pain #
Back/Neck pain #

Questions
Is there a history (physician dictation) of multiple visits to other hospitals? Date: 7-05-07
Has the patient requested a specific pain medication? Medication(s) requested: PERCOCET DILOPIDO (4-6/8OS)
Has patient requested a specific physician? Date: 5-14-07
Was this patient agitated if the requested medication is not given? 5-14-08 / 7-16-07
Was security notified? Comments: 
Has the patient ever indicated a prescription was lost, stolen, damaged or not received? 3-20-07
"SOMEONE IS STEALING MY IDENTIY" ON CAR
Has the patient ever left the ED AMA after being denied an opioid? Date: 3-14-08
Has the patient ever presented to hospital with an alias name? Date: 5-14-07
Is there a pain management contract with any physician? Date: 1-28-07
Ohio Automated RX Reporting System (OARX) Check completed? Date: 7-05-07 5-14-07 3-20-07
Social Service consultation ordered? Date: 1-28-07
Pain specialist consultation ordered? Date: 1-28-07

Number of SLH ED visitor: 2009 10 2008 0 2007 0 2009
Number of SLH inpatient visits: 2009 0 2008 1 2009
Number of imaging studies at SLH: 2009: CT scan 1 MRR 6 RAD imaging 4 Other
2008: CT scan 1 MRR RAD imaging 2 Other
Pattern of ED visits by time of day: [ ] Days [ ] Evenings [ ] Nights
Name of person completing form

*HAS CALLED 911 X2 FROM AFTER UNSAT. TX IN
Individualized Treatment Plans

Next step:

To provide consistency, individualized treatment plans were developed.
Each plan contains specific medication choices based on the patient’s history.
Physicians are requested to follow plan when the patient presents with “typical” presentation.
Physicians are free to ignore plan.
Individualized Treatment Plans

**Individualized ED Pain Care Plan**

**USE this plan once it is established that this is a typical presentation for this patient.**

Date Plan Established: ____________________________

Patient’s Name: __________________________________

Allergies: Refer to pain history and review current list in MEDHOST.

Current Medications list in MEDHOST/ChartMaxx.

Typical Presentation/Complaints: ____________________________

______________________________________________

______________________________________________

Treatment Recommendations: ____________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________
Individualized Treatment Plans

Treatment plans are developed by ED physicians.

Plans are stored with the pain history in the Universal folder of the medical record.

Physicians are encouraged to share the plan with the patient.

Patient input is requested and welcomed.
St. Luke’s Hospital
Managing Chronic Pain in the ER

Process:

Alert is entered into A/D/T system that history and treatment plans are available.

Nursing notified by registration clerk and then print history and treatment plan.

Nurse or physician prints OARRS.

Information is available to physician either before or after initial visit.
“List”
19 in 2008  289 in 2009  1234 current
1056 with OARRS on file
695 with histories
106 with treatment plans

17 patients known to have expired
Results

Visits by Top 10

- 2008: 350
- 2009: 300
- 2010: 250
- 2011: 200
- 2012: 100
- 2013: 0
## Number of Visits in 2012 (All Patients on list)

<table>
<thead>
<tr>
<th>Visits Range</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>0 (zero)</td>
<td>46%</td>
</tr>
<tr>
<td>&lt;5</td>
<td>93%</td>
</tr>
<tr>
<td>&lt;10</td>
<td>98%</td>
</tr>
<tr>
<td>&gt;=10</td>
<td>2%</td>
</tr>
</tbody>
</table>

Highest number of visits by one patient in 2012 - 17
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Questions?

Two ways to ask questions:

- Submit your text questions and comments using the Questions Panel.
- Please raise your hand to be unmuted for verbal questions.
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