The Role of the Emergency Department in the Opioid Epidemic

Scott G. Weiner, MD, MPH
Department of Emergency Medicine
Brigham and Women’s Hospital
Disclosures

Treasurer, Massachusetts College of Emergency Physicians

Consultant for kaleo Pharma (makers of naloxone auto-injector)
Objectives

Describe the opioid epidemic
Discover the ED’s role in contributing to the epidemic
Discuss ways that EDs can help solve the problem

Along the way: Opioid guidelines, PDMP, PreManage ED, suboxone, naloxone
Accidental Death in the US

[Graph showing trends in accidental deaths from motor vehicle traffic, firearm, and drug poisoning from 1979 to 2011.]
Drug Overdose Deaths by Major Drug Type, United States, 1999–2010

![Graph showing drug overdose deaths by major drug type from 1999 to 2010.]

- Opioids
- Heroin
- Cocaine
- Benzodiazepines

Rates of opioid overdose deaths, sales and treatment admissions increased in parallel (US, 1999-2010)

![Graph showing parallel increases in opioid sales, deaths, and treatment admissions from 1999 to 2010.](image)

**Sources:**
- CDC/National Vital Statistics System
- DEA
- ARCOS System
- SAMHSA’s TEDS System
2001
2005
2006
2009
2011
2012
In 2007, approximately 27,000 unintentional drug overdose deaths occurred in the United States, one death every 19 minutes. Prescription drug abuse is the fastest growing drug problem in the United States. The increase in unintentional drug overdose death rates in recent years (Figure 1) has been driven by increased use of a class of prescription drugs called opioid analgesics (1). Since 2003, more overdose deaths have involved opioid analgesics than heroin and cocaine combined (Figure 2) (1). In addition, for every unintentional overdose death related to an opioid analgesic, nine persons are admitted for substance abuse treatment (2), 35 visit emergency departments (3), 161 report drug abuse or dependence, and 461 report nonmedical uses of opioid analgesics (4). Implementing strategies that target those persons at greatest risk will require strong coordination and collaboration at the federal, state, local, and tribal levels, as well as engagement of parents, youth influencers, health-care professionals, and policy-makers.

Overall, rates of opioid analgesic misuse and overdose death are highest among men, persons aged 20–64 years, non-Hispanic whites, and poor and rural populations. Persons who have

Among patients who are prescribed opioids, an estimated 80% are prescribed low doses (<100 mg morphine equivalent dose per day) by a single practitioner (7,8), and these patients account for an estimated 20% of all prescription drug overdoses (Figure 3). Another 10% of patients are prescribed high doses (≥100 mg morphine equivalent dose per day) of opioids by single prescribers and account for an estimated 40% of prescription opioid overdoses (9,10). The remaining 10% of patients are of greatest concern. These are patients who seek care from multiple doctors and are prescribed high daily doses, and account for another 40% of opioid overdoses (11). Persons in this third group not only are at high risk for overdose themselves but are likely diverting or providing drugs to others who are using them without prescriptions. In fact, 76% of nonmedical users report getting drugs that had been prescribed to someone else, and only 20% report that they acquired the drug from their own doctor (4). Furthermore, among persons who died of opioid overdoses, a significant proportion did not have a prescription in their records for the opioid that killed them; in West Virginia, Utah, and Ohio, 25%–66% of those
Figure 13. Morphine: distribution of consumption, 2012

- United States (5%) 56.5%
- Europe (11.1%) 25.3%
- Canada (0.5%) 7.9%
- Australia and New Zealand (0.4%) 2.4%
- Japan (2%) 0.9%
- Other countries (81%) 7.0%

Note: Percentages in parentheses refer to share of the world population (i.e. total population of all reporting countries).
What is the Role of the ED?
Tragedy of the Commons
The Year was 2005

6 years before the PDMP was available
9 years before Gov. Patrick declared a public health emergency
10 years before MHA and MMS created prescribing guidelines
10 years before Gov. Baker convened opioid task force
11 years before comprehensive opioid bill signed
Canary in the Coal Mine
### Confirmed Unintentional/Undetermined Opioid-related Deaths by Gender: 2015

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1,048</td>
</tr>
<tr>
<td>Female</td>
<td>331</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,379</strong></td>
</tr>
</tbody>
</table>

1. These opioid-related deaths are confirmed as unintentional or undetermined.

#### Gender Distribution

- **Male**: 76% (1,048 deaths)
- **Female**: 24% (331 deaths)
For every 1 opioid overdose death in 2010 there were...

- 15 abuse treatment admissions
- 26 emergency room visits
- 115 who abuse/are dependent
- 733 nonmedical users

$4,350,000 in healthcare-related costs
In addition to 978 opioid overdose deaths, there were more than 2,000 hospital stays and more than 4,500 emergency department visits for non-fatal overdoses in 2013.
Yokell MA. Presentation of Prescription and Nonprescription Opioid Overdoses to US Emergency Departments. JAMA Intern Med. 2014 Dec 1;174(12):2034-7

<table>
<thead>
<tr>
<th>Table 2. Charges for Admitted and Nonadmitted Patients by Opioid Typea</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Overdoses</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>No. of ED visits</td>
</tr>
<tr>
<td>No. of ED visits resulting in hospitalizationb</td>
</tr>
<tr>
<td>Mean charges for ED visit for nonadmitted patients, $</td>
</tr>
<tr>
<td>Total ED charges for nonadmitted patients, $</td>
</tr>
<tr>
<td>Mean length of inpatient stay, d</td>
</tr>
<tr>
<td>Total No. of hospital days</td>
</tr>
<tr>
<td>Mean charges of inpatient stay, $</td>
</tr>
<tr>
<td>Total inpatient charges (includes ED charges of admitted patients), $</td>
</tr>
</tbody>
</table>
Something happened along the way...
Attack of the Guidelines!
An Act relative to 72 hour emergency prescribing.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Chapter 94C of the General Laws is hereby amended by adding the following section:—

Section 50. A physician practicing in an emergency room shall not be permitted to provide to a patient seeking emergency care more than 72 hours worth of a controlled substance as defined by this chapter.
The Fifth “Vital Sign”
Complying with Pain Management Standard PC.01.02.07

Pain is an inevitable part of health care. Some patients arrive at an organization in pain, while others may experience pain during care, treatment, or services—such as patients undergoing surgery. Regardless of how his or her pain manifests, every patient hopes his or her health care experience will include interventions that will eliminate or reduce pain.

Unlike other physical indicators like blood pressure and temperature, pain cannot be quantitatively measured. The duration and intensity of pain vary from person to person. Therefore, organizations must have effective and interactive pain assessment and reassessment processes that help identify pain, point to effective treatment, and verify that implemented interventions work.

Provision of Care, Treatment, and Services (PC) Standard PC.01.02.07 directly addresses the “who, what, where, when, and how” of the pain assessment and reassessment processes. (See Sidebar 1 on page 8). “Organizations often struggle to completely comply with this standard,” says Jane Schetter, R.N., M.S.N., senior consultant for Continuous Service Readiness at Joint Commission Resources. “In particular, they have difficulty with reassessment and establishing appropriate

(Continued on page 8)
Statement on pain management from David W. Baker, MD, MPH, FACP, Executive Vice President, Healthcare Quality Evaluation, The Joint Commission:

In the environment of today’s prescription opioid epidemic, everyone is looking for someone to blame. Often, The Joint Commission’s pain standards take that blame. We are encouraging our critics to look at our exact standards, along with the historical context of our standards, to fully understand what our accredited organizations are required to do with regard to pain.
We conclude that ED pain intensity is high, analgesics are underutilized, and delays to treatment are common.

Despite efforts to improve pain management practice, oligoanalgesia remains a problem for emergency medicine.
NHAMCS - Between 2001-2010:
- Painful conditions 47.1% to 51.1%
- Non-opioids 26.2% to 27.3%
- Opioid use increased from 20.8% to 31.0% of all visits
- Use of schedule II 7.6% to 14.5%
Total number of prescriptions dispensed in the U.S. by top 10 prescribing specialties for IR and ER/LA opioids, Year 2009


- GP/FM/DO, and IM were top 2 prescribers for IR and ER/LA opioids
- IR opioid prescribers:
- Dentists and EM specialists accounted for about 18 million and 11 million IR dispensed prescriptions
Compared with office settings, EDs had 17% less MMEs

Only 0.3% ED Rx were for >100 MME per day vs. 2.6% in office setting
POSED Study

19 Hospitals, national sample
12% of all adult patient visits result in an opioid prescription
Vast majority were oxycodone and hydrocodone, immediate release, 5 mg
Mean number of pills was 17/prescription
<table>
<thead>
<tr>
<th>Specialty</th>
<th>Oxycodone</th>
<th>Hydrocodone</th>
<th>Hydromorphone</th>
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<tbody>
<tr>
<td>Family Medicine</td>
<td>90 &lt;50-120&gt;</td>
<td>60 &lt;30-120&gt;</td>
<td>60 &lt;30-120&gt;</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>75 &lt;30-120&gt;</td>
<td>60 &lt;30-120&gt;</td>
<td>60 &lt;30-120&gt;</td>
</tr>
<tr>
<td>Anesthesiology/Pain</td>
<td>90 &lt;60-120&gt;</td>
<td>90 &lt;60-120&gt;</td>
<td>90 &lt;60-120&gt;</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>60 &lt;40-80&gt;</td>
<td>40 &lt;30-60&gt;</td>
<td>60 &lt;30-89&gt;</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>20 &lt;12-20&gt;</td>
<td>15 &lt;12-20&gt;</td>
<td>20 &lt;12-30&gt;</td>
</tr>
<tr>
<td>Surgery</td>
<td>40 &lt;30-60&gt;</td>
<td>30 &lt;20-50&gt;</td>
<td>40 &lt;30-85&gt;</td>
</tr>
<tr>
<td>Specialty</td>
<td>No. of Rx</td>
<td>Cumulative %</td>
<td>Mean Pills/Rx</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------</td>
<td>--------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>1,971,401</td>
<td>18.6%</td>
<td>88.8</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>1,611,049</td>
<td>15.2%</td>
<td>84.4</td>
</tr>
<tr>
<td>Anesthesiology/Pain</td>
<td>593,825</td>
<td>5.6%</td>
<td>95.6</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>546,849</td>
<td>5.2%</td>
<td>58.4</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>407,553</td>
<td>3.8%</td>
<td>26.5</td>
</tr>
<tr>
<td>Surgery</td>
<td>374,700</td>
<td>3.5%</td>
<td>49.9</td>
</tr>
<tr>
<td>Other</td>
<td>1,548,603</td>
<td>14.6%</td>
<td>69.8</td>
</tr>
<tr>
<td>Missing</td>
<td>3,563,374</td>
<td>33.6%</td>
<td>67.6</td>
</tr>
</tbody>
</table>
However...
Ohio PDMP

Median morphine milligram equivalent (MMEs) per prescription was 100 (IQR 75-125)

Only 12,639 prescriptions (0.04%) were for extended release formulations
Opioid Prescribing in Emergency Departments
The Prevalence of Potentially Inappropriate Prescribing and Misuse

Joseph Logan, PhD, MHS, Ying Liu, PhD, Leonard Paulozzi, MD, MPH, Kun Zhang, MS, and Christopher Jones, PharmD, MPH

Objective: Emergency departments (EDs) routinely provide care for patients seeking treatment for painful conditions; however, they are also targeted by people seeking opioid analgesics for non-medical use. This study determined the prevalence of indicators of potential ED opioid misuse and inappropriate prescribing by ED providers in a large, commercially insured population.

Research Design and Indicators: A Health MarketScan® Research Database analysis of enrollees aged 18 and older who received an opioid prescription during two 1-year periods was performed. The study population was stratified by sex.

Results: We identified 400,288 enrollees who received at least one ED opioid prescription. At least one indicator applied to 10.3% of enrollees: 7.7% had high daily doses; 2.0% had opioid overlap; 1.0% had opioid-benzodiazepine overlap. Among LA/ER opioid prescriptions, 21.7% were for acute pain, and 14.6% were overlapping. Females were more likely to have at least one indicator.

Conclusions: Improving opioid prescribing in emergency departments might not be optimal in terms of minimizing the risk of their misuse. Guidelines for the cautious use of opioid analgesics in EDs and timely data from prescription drug monitoring programs could help EDs treat patients with pain while reducing the risk of nonmedical use.

Key Words: opioid analgesics, inappropriate prescribing, ED opioid prescriptions

In some instances, the prescribing of opioid analgesics in EDs might not be optimal in terms of minimizing the risk of their misuse. Guidelines for the cautious use of opioid analgesics in EDs and timely data from prescription drug monitoring programs could help EDs treat patients with pain while reducing the risk of nonmedical use.

“Whenever I wonder whether I should or shouldn’t be giving a dose of pain medication, I always remember this: I’ve never created an addict by giving one shot of pain meds, and I’ve never cured an addict by withholding it. These are complex issues and I can’t always sort them out in the emergency department.”
59 patients reporting heroin or nonmedical opioid use. 35 (59%) reported first exposure was legitimate. For 10 of 35 (29%), the prescription came from the ED. "Although short-term opioid administration by EPs is unlikely to cause addiction by itself, ED opioid prescriptions may contribute to the development of addiction in some patients."
4801 patients with minor painful condition over 1 yr
52% opioid naïve (no prescription in the year prior to visit)

299 (12%) of opioid naïve patients went on to have recurrent use

“Opioid naïve ED patients prescribed opioids for acute pain are at increased risk for additional opioid use at 1 year.”
2,887 ED patients with acute onset low back pain
349 (12%) received an early opioid prescription

After multivariable adjustment, early opioids associated with higher long-term use of opioids (22% vs 16%).

“Early opioid prescribing in the ED for uncomplicated LBP increased long-term opioid use and medical costs, and should be discourage.”
Own It

Be the experts at opioid prescribing
Use screening tools
Counsel on risks of opioids
Use guidelines
Set the example for other specialities
Be the safety net
Clinical Policy: Critical Issues in the Prescribing of Opioid
Adult Patients in the Emergency Department

Clinical Practice Statement

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

Chair: Steven Rosenbaum, MD FAAEM
Authors: David Cheng, MD FAAEM
Nima Majlesi, DO FAAEM
Co-Authors: Mitchell Heller, MD FAAEM
Steve Rosenbaum, MD FAAEM
Michael Winters, MD FAAEM

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%. There is great variability among emergency clinicians in the management of pain, especially with respect to the use of opioid medications. Importantly, morbidity and mortality have increased as the frequency of opioid use for the treatment of pain has increased. This includes a significant increase in non-medical opioid use, addiction, drug-related emergency department visits, and death. The dangers of prescribing opioid medications extend beyond the individual patient and may adversely impact public health. 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.

New York City Emergency Department Discharge Opioid Prescribing Guidelines

Note: These guidelines do not replace clinical judgment in the appropriate care of patients nor are they intended to provide guidance on the management of patients while they are in the ED.

In the management of patients with acute or chronic non-cancer pain discharged from an emergency department,

1. Consider short-acting opioid analgesics for the treatment of acute pain only when the severity of the pain is reasonably assumed to warrant their use.
2. Start with the lowest possible effective dose if opioid analgesics are considered for the management of pain.
3. Prescribe no more than a short course of opioid analgesics for acute pain. Most patients require no more than three days.
4. To assess for opioid misuse or addiction, use targeted history or validated screening tools. Prescribers can also access the New York State Controlled Substance Information (CSI) on Dispensed Prescriptions Program for information on patients’ controlled substance prescription history.
5. Avoid initiating treatment with long-acting or extended-release opioid analgesics.
6. Address exacerbations of chronic or recurrent pain conditions with non-opioid analgesics, non-pharmacological therapies, and/or referral to specialists for follow-up, all as clinically appropriate.
7. Avoid when possible prescribing opioid analgesics to patients currently taking benzodiazepines and/or other opioids. Consider other risk factors for consequential respiratory depression.
8. Attempt to confirm with the treating physician the validity of lost, stolen, or destroyed prescriptions. If considered appropriate, replace the prescription only with a one-to-two day supply.
9. Provide information about opioid analgesics to patients receiving a prescription, such as the risks of overdose and dependence/addiction, as well as safe storage and proper disposal of unused medications.
1. Hospitals, in conjunction with ED personnel, should develop a process to screen for substance misuse.

2. When possible, consult the PDMP before writing an opioid prescription.

3. Hospitals should develop a process to share the ED visit history of patients with other providers and hospitals that are treating the patients in the Emergency Department by using a health information exchange system.
Screening tools

SOAPP-R
ORTH
NIDA 1:

“In the past year, have you used prescription drugs for non-medical reasons or any illegal drugs?”
1. Hospitals, in conjunction with ED personnel, should develop a process to screen for substance misuse.

2. When possible, consult the PDMP before writing an opioid prescription.

3. Hospitals should develop a process to share the ED visit history of patients with other providers and hospitals that are treating the patients in the Emergency Department by using a health information exchange system.
MassPAT

- <24 hr reporting
- Data sharing with up to 41 states
- Improved matching of patients
- EMR integration
1. Hospitals, in conjunction with ED personnel, should develop a process to screen for substance misuse.

2. When possible, consult the PDMP before writing an opioid prescription.

3. Hospitals should develop a process to share the ED visit history of patients with other providers and hospitals that are treating the patients in the Emergency Department by using a health information exchange system.
PreManage ED ALERT 04/13/2015 14:18 PM Mouse, Mickey (DOB: 10/01/1928)

This patient has registered at the Ford Medical Center Emergency Department. You are being notified because this patient has recommended Care Guidelines. For more information visit: Please login to EDIE and search for this patient by name.

**Care Providers**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Type</th>
<th>Phone</th>
<th>Fax</th>
<th>Service Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>John K SMITH MD</td>
<td></td>
<td>(801) 856-8575</td>
<td>(855) 343-7671</td>
<td>Current</td>
</tr>
</tbody>
</table>

**ED Care Guidelines from Ford Medical Center**

Last Updated: Wed Feb 17 10:35:40 MDT 2015

**Care Recommendation:**

**Pain contract and scheduled substance prescribing:** Patient had a controlled substance agreement with Dr. Smith but Dr. Jamison. **Dr. Jamison prescribes regular 1 mg Clonazepam, 1 mg Lorazepam, and hydrocodone as needed.** Please do not use controlled substances in the ER unless there are new objective findings.

**Additional Information:**

1. No opiates in the ED for chronic pain or opiate withdrawal. No opiate or benzodiazepine prescriptions at discharge.
2. Strongly encourage or assist Pt in making a PCP appointment prior to d/c.

These are guidelines and the provider should exercise clinical judgment when providing care.

**Care Histories**

**Behavioral**

03/4/2015 Ford Medical Center
- **AXIS I:** Bipolar disorder, type I, hypomanic.
- History of PTSD
- **AXIS II:** Borderline personality features.

**Radiation History**

- 15 CT scans on record from 2007 through 2/6/15, as well as numerous radiology exams.

**Security Events**

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Type</th>
<th>Specifics</th>
<th>Security Events (18 Mo.)</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/03/2014</td>
<td>Ford Medical Center</td>
<td>Verbal</td>
<td>Patient was verbally abusive towards care providers, staff or patient.</td>
<td>Verbal</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Total</td>
<td>1</td>
</tr>
</tbody>
</table>
# Washington PDMP Report

## Rx Details (6 Mo.)

<table>
<thead>
<tr>
<th>Fil Date</th>
<th>Drug Description</th>
<th>Qty</th>
<th>Prescriber</th>
<th>CS</th>
<th>MED</th>
<th>Rx Summary (12 Mo.)</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015-02-18</td>
<td>HYDROCODONE-ACETAMINOPHEN 7.5-325</td>
<td>30</td>
<td>John Smith, MD</td>
<td>3</td>
<td>60.0</td>
<td>CS II-V Rx</td>
<td>0</td>
</tr>
<tr>
<td>2015-01-31</td>
<td>HYDROCODONE-ACETAMINOPHEN 7.5-325</td>
<td>30</td>
<td>John Smith, MD</td>
<td>3</td>
<td>60.0</td>
<td>CS-II Rx</td>
<td>0</td>
</tr>
<tr>
<td>2015-01-10</td>
<td>HYDROCODONE-ACETAMINOPHEN 7.5-325</td>
<td>15</td>
<td>John Smith, MD</td>
<td>3</td>
<td>60.0</td>
<td>Quantity Dispensed</td>
<td>480</td>
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<tr>
<td>2014-12-18</td>
<td>HYDROCODONE-ACETAMINOPHEN 7.5-325</td>
<td>30</td>
<td>John Smith, MD</td>
<td>3</td>
<td>60.0</td>
<td>Unique Prescribers</td>
<td>2</td>
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<tr>
<td>2014-11-29</td>
<td>HYDROCODONE-ACETAMINOPHEN 5.0-250</td>
<td>30</td>
<td>John Smith, MD</td>
<td>3</td>
<td>60.0</td>
<td>Unique Pharmacies</td>
<td>1</td>
</tr>
<tr>
<td>2014-10-31</td>
<td>HYDROCODONE-ACETAMINOPHEN 5.0-250</td>
<td>30</td>
<td>John Smith, MD</td>
<td>3</td>
<td>60.0</td>
<td>Benzos</td>
<td>1</td>
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<tr>
<td>2014-10-02</td>
<td>HYDROCODONE-ACETAMINOPHEN 5.0-250</td>
<td>30</td>
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<td>3</td>
<td>60.0</td>
<td>Opioids</td>
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</tbody>
</table>

## Recent Visit Summary

<table>
<thead>
<tr>
<th>Visit Date</th>
<th>Location</th>
<th>Type</th>
<th>Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>03/24/2015</td>
<td>Ford Medical Center</td>
<td>Inpatient</td>
<td>Fever, unspecified</td>
</tr>
<tr>
<td>02/21/2015</td>
<td>Ford Medical Center</td>
<td>Surgery</td>
<td>Malignant neoplasm of liver, secondary</td>
</tr>
<tr>
<td>04/13/2015</td>
<td>Ford Medical Center</td>
<td>Emergency</td>
<td>Headache</td>
</tr>
<tr>
<td>03/30/2015</td>
<td>Murray Medical Center</td>
<td>Emergency</td>
<td>Fever, unspecified</td>
</tr>
<tr>
<td>03/18/2015</td>
<td>Ford Medical Center</td>
<td>Emergency</td>
<td>Long-term (current) use of other medications</td>
</tr>
<tr>
<td>03/03/2015</td>
<td>Providence Centralia Hospital</td>
<td>Emergency</td>
<td>Other chronic bronchitis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Fever, unspecified</td>
</tr>
</tbody>
</table>

## E.D. Visit Count (1 Yr.)

<table>
<thead>
<tr>
<th>Location</th>
<th>Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providence Centralia Hospital</td>
<td>4</td>
</tr>
<tr>
<td>Ford Medical Center</td>
<td>37</td>
</tr>
<tr>
<td>Murray Medical Center</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
</tr>
</tbody>
</table>

Note: Visits indicate total known visits.

Note: Visits indicate total known visits.

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The above information is provided for the sole purpose of patient treatment. Use of this information beyond the terms of Data Sharing Memorandum of Understanding and License Agreement is prohibited. In certain cases not all visits may be represented. Consult the aforementioned facilities for additional information.
4. Hospitals should develop a process to coordinate the care of patients who frequently visit EDs.

5. For acute exacerbations of chronic pain, the ED provider should notify the patient’s primary opioid prescriber or PCP of the visit and the medication prescribed.
6. ED providers should not provide prescriptions for controlled substances that were lost, destroyed, or stolen (and no methadone unless confirmed)

7. Unless otherwise clinically indicated, ED providers should not prescribe long-acting or controlled-release opioids.
MHA Guidelines

8. When opioid medications are prescribed, counsel:
   - to store the medications securely, not share them with others, and dispose of them properly when their pain has resolved
   - to avoid using the medications for non-medical purposes
   - to avoid using opioids and concomitant sedating substances due to the risk of overdose.

9. No more than a short course and minimal amount of opioid analgesics for serious acute pain, lasting no more than five days.
Scott’s Guidelines

Just say no (unless really, really, really needed)
Acetaminophen 650-1000 mg q6
Ibuprofen 400-600 mg q6
The only pain level of 0 is death
If you do give, SDM, 3 days and flush (or properly dispose)

Table 2. Sources of diverted prescription pain medication among Ontario students in grades 7 to 12 who used opioids nonmedically in the past year: 
N = 624.

<table>
<thead>
<tr>
<th>SOURCE</th>
<th>%</th>
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</thead>
<tbody>
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<td>From home</td>
<td>72.4</td>
</tr>
<tr>
<td>From a friend</td>
<td>6.0</td>
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<tr>
<td>From someone I know</td>
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<td>From the “street”</td>
<td>&lt;0.5</td>
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<tr>
<td>Other sources not listed</td>
<td>8.8</td>
</tr>
<tr>
<td>Do not remember</td>
<td>9.7</td>
</tr>
</tbody>
</table>

Adapted from Reuben Strayer, SMACCUS 2015
Examples
Naproxen 500 mg bid x 10 days
+ placebo OR
+ cyclobenzaprine 5-10mg q8 prn OR
+ oxycodone/APAP 5-10mg q8 prn
No difference in functional outcome or pain at 1-week follow-up.
Alternatives to Opioids (ALTO)

Non-opioids:
- Acetaminophen + ibuprofen
- Droperidol, ketamine, dexmedetomidine, propofol
- Anticonvulsants, gabapentin
- Local/regional anesthesia
- Nitrous oxide

New Jersey hospital emergency room becomes first in U.S. to end use of opioid painkillers

Combating addiction: NJ emergency room is first in US to avoid using opioid painkillers

St. Joseph’s Regional Medical Center in Paterson says 75 percent of patients in new program have done fine with less powerful meds
Project ASSERT: SBIRT in Emergency Care

Project ASSERT (Alcohol & Substance Abuse Services, Education, and Referral to Treatment) is a team of peer educators performing "in-reach" at the Boston Medical Center Emergency Department. By collaborating with hospital staff, the health promotion advocates (HPAs) offer screening, brief intervention, information and health resources at the point of service in the hospital environment, rather than conducting "out-reach" in the community setting. Project ASSERT provides comprehensive care and prevention by putting substance abuse in the context of other health and safety needs.

Project ASSERT HPAs affirm the dignity of patients and their cultural backgrounds, beliefs, and values during their hospital visit by establishing a relationship with patients based on emotional support and advocacy. The encounter with HPAs provides patients with the opportunity to explore change through a non-judgmental conversation combined with increased access to various health and treatment services if desired.

Project ASSERT

- Hours: 8am to 12:30 am, 7 days a week and holidays.
- Contact: 617-414-4388

Project ASSERT brochure
Opioid Education and Nasal Naloxone Rescue Kits in the Emergency Department

Kristin Dwyer, MD*
Alexander Y. Walley, MD, MSc†
Breanne K. Langlois, MPH*
Patricia M. Mitchell, RN†
Kerrie P. Nelson, PhD, MS†
John Cromwell†
Edward Bernstein, MD§

*Boston University School of Medicine, Boston Medical Center, Department of Emergency Medicine, Boston, Massachusetts
†Boston University School of Medicine, Boston Medical Center, Department of Medicine, Boston, Massachusetts
‡Boston University School of Public Health, Department of Biostatistics, Boston, Massachusetts
§Boston University School of Public Health, Department of Community Health Sciences, Boston, Massachusetts

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Introduction: Emergency departments (EDs) may be high-yield venues to address opioid deaths with education on both overdose prevention and appropriate actions in a witnessed overdose. In addition, the ED has the potential to equip patients with naloxone kits as part of this effort. We evaluated the feasibility of an ED-based overdose prevention program and described the overdose risk knowledge, opioid use, overdoses, and overdose responses among participants who received overdose education and naloxone rescue kits (OEN) and participants who received overdose education only (OE).

Methods: Program participants were surveyed by telephone after their ED visit about their substance use, overdose risk knowledge, history of witnessed and personal overdoses, and actions in a witnessed overdose including use of naloxone.

Results: A total of 415 ED patients received OE or OEN between January 1, 2011 and February 28, 2012. Among those, 51 (12%) completed the survey; 37 (73%) of those received a naloxone kit, and 14 (27%) received OE only. Past 30-day opioid use was reported by 35% OEN and 36% OE, and an overdose was reported by 19% OEN and 25% OE. Among 53% (27/51) of participants who witnessed another individual experiencing an overdose, 95% OEN and 88% OE stayed with victim, 74% OEN and 33% OE called 911, 26% OEN and 25% OE performed rescue breathing, and 32% OEN (n=6) used a naloxone kit to reverse the overdose. We did not detect statistically significant differences between OEN and OE-only groups in opioid use, overdose or response to a witnessed overdose.

Conclusion: This is the first study to demonstrate the feasibility of ED-based opioid overdose prevention education and naloxone distribution to trained laypersons, patients and their social network. The program reached a high-risk population that commonly witnessed overdoses and that called for help and used naloxone, when available, to rescue people. While the study was retrospective with a low response rate, it provides preliminary data for larger, prospective studies of ED-based overdose prevention programs. [West J Emerg Med. 2015;16(3):381–384.]
Emergency Department Naloxone Distribution

Key Considerations and Implementation Strategies

Elizabeth A. Samuels, MD MPH¹, Jason Hoppe, DO², Joan Papp, MD FACEP³,
Lauren Whiteside, MD MS⁴, Ali S. Raja, MD MBA MPH⁵, Edward Bernstein, MD FACEP⁶

¹ Department of Emergency Medicine, Alpert Medical School of Brown University, Providence, RI, USA
² Department of Emergency Medicine, University of Colorado School of Medicine, Denver, CO, USA
³ Department of Emergency Medicine, Case Western Reserve University, School of Medicine, Cleveland, OH, USA
⁴ Division of Emergency Medicine, University of Washington School of Medicine, Seattle, WA, USA
⁵ Department of Emergency Medicine, Massachusetts General Hospital, Harvard Medical School, Boston, MA
⁶ Department of Emergency Medicine, Boston Medical Center, Boston University School of Medicine, Boston, MA, USA
Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence
A Randomized Clinical Trial

Gail D’Onofrio, MD, MS; Patrick G. O’Connor, MD, MPH; Michael V. Pantalon, PhD; Marek C. Chawarsi, PhD; Susan H. Busch, PhD; Patricia H. Owens, MS; Steven L. Bernstein, MD; David A. Fiellin, MD

IMPORATANCE  Opioid-dependent patients often use the emergency department (ED) for medical care.

OBJECTIVE  To test the efficacy of 3 interventions for opioid dependence: (1) screening and referral to treatment (referral); (2) screening, brief intervention, and facilitated referral to community-based treatment services (brief intervention); and (3) screening, brief intervention, ED-initiated treatment with buprenorphine/naloxone, and referral to primary care for 10-week follow-up (buprenorphine).

DESIGN, SETTING, AND PARTICIPANTS  A randomized clinical trial involving 329 opioid-dependent patients who were treated at an urban teaching hospital ED from April 7, 2009, through June 25, 2013.

INTERVENTIONS  After screening, 104 patients were randomized to the referral group, 111 to the brief intervention group, and 114 to the buprenorphine treatment group.

MAIN OUTCOMES AND MEASURES  Enrollment in and receiving addiction treatment 30 days after randomization was the primary outcome. Self-reported days of illicit opioid use, urine testing for illicit opioids, human immunodeficiency virus (HIV) risk, and use of addiction treatment services were the secondary outcomes.

RESULTS  Seventy-eight percent of patients in the buprenorphine group (89 of 114 [95% CI, 74.5%-99.0%]) completed the treatment vs 31% (34 of 111 [95% CI, 23.7%-45.5%]) in the brief intervention group and 26% (28 of 104 [95% CI, 18.4%-39.5%]) in the referral group (p<0.001).
Own It
Finding 4: Opioid medications must be safely managed by prescribers, pharmacists, and patients

RECOMMENDATIONS OF THE OPIOID WORKING GROUP
MASSACHUSETTS DOCTORS DISCUSS THE RISKS OF PRESCRIPTION PAINKILLERS WITH PATIENTS LESS THAN DOCTORS IN OTHER PARTS OF THE COUNTRY

In a 2015 survey, individuals who, in the past 2 years, HAD taken a strong prescription painkiller, such as Percocet, OxyContin, or Vicodin that was prescribed by a doctor for more than a few days, were asked the following question:

“Before or while you were taking these strong prescription painkillers, did you and your doctor talk about the risk of prescription painkiller addiction, or haven’t you talked about that?”

Only 36% of Massachusetts residents said “yes”, compared to 61% nationally.

Finding 4: Opioid medications must be safely managed by prescribers, pharmacists, and patients

Source: Boston Globe and Harvard T.H. Chan School of Public Health, Prescription Painkiller Abuse: Attitudes among Adults in Massachusetts and the United States
Questions and Discussion

sweiner@bwh.harvard.edu
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