Emergency Department Practitioner Pain Management Toolkit

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1. INTRODUCTION

Pain is one of the most common complaints among patients visiting the Emergency Department (ED). As the frequency of opioid use for the treatment of pain has increased, there has been a significant increase in the non-medicinal use of opioids, addiction, drug-related emergency department visits, and deaths. These guidelines were developed to provide emergency department providers with recommendations for the safe and effective management of pain in the emergency department setting and are not meant to replace the clinical judgement.

These guidelines were adapted from the American Academy of Emergency Medicine, the Connecticut Hospital Association (CHA), and the Massachusetts Hospital Association (MHA) and are in-line with the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain. Recommendations from other states were reviewed as part of the development of these guidelines.

2. PRESCRIBING GUIDELINES

2.1 Emergency Department Opioid Prescribing Guidelines for the Treatment of Non-Cancer Related Pain

1. Consider short-acting opioids for the treatment of acute pain only as a second-line treatment to other analgesics unless there is a clear indication for the use of opioid medication (e.g. patients with an acute abdomen or long bone fracture).

2. Start with the lowest possible effective dose for the management of pain. Higher doses increase the risk of adverse events such as respiratory depression and overdose. These risks are especially pronounced in opioid-naïve patients.

3. When prescribing opioids for acute pain, prescribe a short course of opioid medication. Most patients require no more than 3 days of pain control for most acute pain conditions. Excessive quantities increase the risk of misuse, abuse or diversion and may lead to long-term use.

4. Consider high dose NSAIDs for acute dental pain along with referral to the Connecticut Dental Health Partnership (CTDHP). Providers can contact CTDHP at 1.855.283.3682.

5. Address exacerbation of chronic pain conditions with non-opioid pharmacologic treatment, non-pharmacologic therapies. Coordinate with the patient’s Primary Care Provider (PCP) for follow-up care.

6. Consult the Connecticut Prescription Monitoring Program (CTPMP) database before writing opioid prescriptions.

7. Ask about a history of current substance abuse prior to prescribing opioids for acute pain. Opioids should be prescribed with great caution in the context of a substance abuse history. Consider assessing for opioid misuse or addiction using a validated screening tool.

8. Consider risk factors for respiratory depression when prescribing opioids. Use caution when prescribing opioid medications to patients currently taking benzodiazepines and/or other opioids. Opioid medications, when combined with other central nervous system depressants or given to patients with underlying medical conditions such as obstructive sleep apnea, can increase the risk for overdose. In addition, patients taking higher doses of opioids, including cumulative doses from more than one source, are at higher risk for respiratory depression.

9. Use extra caution when considering prescribing opioids to patients who do not have proper identification.

10. Provide safety information about opioid medication to patients. Patients should be informed of the risks of taking opioid medication which include: overdose that can lead to death, fractures from falls, drowsiness leading to injury, tolerance, dependence, and addiction. Patients should be informed that respiratory depression is more common with the use of alcohol, benzodiazepines, antihistamines, and barbiturates. In addition, they should be provided with information on the safe storage and proper disposal of unused medications. Consider adding safety information to standard discharge instructions for all patients prescribed opioids as part of an ED visit.

11. Refrain from initiating treatment with long-acting or controlled release opioids. These medications can cause death from respiratory depression even when taken as directed and some are appropriate only for patients who have become tolerant to opioids. Often, community-based providers require patients to agree to and sign a medication contract. In addition, these medications require close monitoring and follow-up care. Due to the nature of the care provided in an emergency department setting, close monitoring on an ongoing basis is generally not possible.

12. Refrain from ordering IV or IM opioids for acute exacerbations of chronic pain. Use of parenteral opioids should be avoided for an acute exacerbation of chronic pain due to their short duration and potential for addictive euphoria. In general, oral opioids are superior to parenteral opioids in duration of action.

13. Avoid replacing prescriptions for lost, stolen, or destroyed opioid prescriptions or for those finished prematurely. Patients misusing controlled substances frequently report their opioid medications as having been lost or stolen. Most written agreements between chronic pain patients and pain management physicians state that prescriptions for opioids will not be replaced.

14. Avoid providing replacement doses for Methadone or Suboxone for patients participating in a Medication Assisted Treatment (MAT) program.

15. Understand Emergency Medical Treatment and Active Labor Act (EMTALA) and its requirements for the treatment of pain. The emergency clinician is required under the EMTALA to evaluate an ED patient reporting pain. However, the law allows the emergency clinician to use clinical judgment when treating pain and does not require the use of opioids.

16. Utilize the HUSKY Health Intensive Care Management (ICM) program to assist you with care coordination. ICM team members will assess a patient's health status, barriers, and strengths;

develop a patient centered care plan; identify gaps in care; coordinate with specialists; coordinate with the CT Behavioral Health Partnership (CT BHP); conduct patient visits, coordinate transportation; and provide appointment reminders. To refer patients to the ICM program, providers can call 1.800.440.5071, Monday through Friday 8:00 a.m. - 6:00 p.m. and select the prompt for Intensive Care Management or complete the ICM Referral Form and fax to 866.361.7242.

17. Maintain a list of local primary care and MH clinics that provide follow-up care for patients.

2.2 Exacerbation of Chronic Pain Conditions

Address exacerbation of chronic pain conditions with non-opioid pharmacologic treatment, non-pharmacologic therapies, or referral to pain specialists for follow-up. Opioid analgesics should not be considered the initial approach to pain management in patients being discharged from the ED. Alternative and effective interventions exist. Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred first line treatments for chronic pain.

The HUSKY Health Pharmacy program covers the following non-opioid pharmacologic treatment:

- Acetaminophen
- Non Steroidal Anti Inflammatory Drugs (NSAIDs)
- Gabapentin/Pregabalin
- Tricyclic antidepressants and serotonin/norepinephrine reuptake inhibitors
- Topical agents (lidocaine, capsaicin, NSAIDs)

The HUSKY Health program also covers the following non-pharmacologic therapies including:

- Physical and occupational therapy
- Naturopath services
- Transcutaneous Electrical Nerve Stimulation (TENS) units
- Chiropractic manipulation
- Acupuncture

2.3 Connecticut Prescription Monitoring Program (CTPMP)

The Connecticut Prescription Monitoring Program collects prescription data for Schedule II through Schedule V drugs into a central database, the Connecticut Prescription Monitoring and Reporting System (CPMRS). Providers and pharmacists use the data from the (CPMRS) for the active treatment of their patients.

While most ED patients legitimately seek pain relief treatment occurring from injury or exacerbations of chronic pain conditions, some patients seek opioid medications for inappropriate use or diversion. The CTPMP is intended to collect and make available prescription histories so that Connecticut providers may treat and counsel patients appropriately.

When consulting the CTPMP, the following should raise concerns:

- Obtaining medications from multiple providers, provider groups or hospital systems
- Obtaining large numbers of pills that may not be warranted given the patient’s condition

- Filling prescriptions at multiple pharmacies especially when prescriptions are filled in quick succession or on the same day
- Filling prescriptions far from the patient's home address or work address

NOTE: When methadone is dispensed from a methadone maintenance program, it will not appear in the CTPMP database.

2.4 Opioid Risk Assessment

It is recommended that prior to prescribing opioid medications, providers screen for potential opioid misuse, and consider the following features that may be associated with increased risk of addiction or abuse:

- Use of multiple providers or pharmacies to obtain controlled substances
- Preoccupation with opioids more so than underlying pain conditions
- Anger, aggression, or threatening response to limiting opioid use
- Insistence on specific or rapid onset formulation or parenteral opioid administration
- Requests for rapid dose escalation
- Evidence of habituation and reported tolerance in patients without history of opioid use
- Noncompliance with recommended non-opioid treatments or evaluations
- Inability to restrict medications or take them on agreed upon schedule
- History of alcohol or other controlled substance dependence or abuse

2.5 Opioid Risk Assessment Tools

There are various standardized opioid risk assessment tools that can be used to evaluate a patient's risk of aberrant drug-related behavior. HUSKY Health recommends the use of the following risk assessment tools.

The Screener and Opioid Assessment for Patients with Pain – Revised (SOAPP – R)
SOAPP-R is a quick and easy-to-use 24-item questionnaire designed to help providers evaluate the patient's relative risk for developing problems when placed on long-term opioid therapy. Patients are assigned a risk category based on the level of risk for opioid misuse with related treatment considerations for each category.

The Drug Abuse Screening Test (DAST – 10)
The DAST-10 is a 10-item brief screening tool that can be administered by a clinician or self-administered. This tool assesses drug use in the past 12 months.

Opioid Risk Tool (ORT)
The Opioid Risk Tool (ORT) is a brief, self-report screening tool designed for use with adults to assess for risk of future opioid abuse among individuals prescribed opioids for the treatment of chronic pain.

2.6 Morphine Equivalent Dose

The CDC recommends that when initiating opioid therapy for chronic pain outside of active cancer, palliative, and end-of-life care.

- Clinicians should prescribe the lowest effective dosage
- Clinicians should use caution when prescribing opioids at any dosage
- Clinicians should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day

Risks for serious harm related to opioid therapy especially increase at higher opioid dosage, may increase motor vehicle accidents, opioid use disorder, and overdose. Information on calculating total daily dose of opioids is available on the CDC website.

For additional information, the full CDC Guideline for Prescribing Opioids for Chronic Pain is available here.

2.7 Medication Assisted Treatment (MAT)

Medications in combination with counseling and behavioral therapies can provide a holistic, patient approach to the treatment of opioid dependency. The HUSKY Health program covers a number of medications used in the treatment of opioid use disorders.

The following medications are currently covered:

- Buprenorphine HCL tablet (sublingual)
- Methadone
- Naltrexone (oral)
- Suboxone film (sublingual)
- Vivitrol (extended release naltrexone injectable)

Additional information on MAT is available on the MAT page of the CT BHP website. The MAT page includes a variety of helpful resources including a search tool providers may use to locate CMAP providers offering MAT services. Providers may search by provider, town, or treatment modality.

Providers should be aware of the specific regulatory requirements for the administration of methadone and buprenorphine products for the treatment of opioid use disorder. ED clinicians should avoid providing replacement doses for Methadone or Suboxone for patients participating in a MAT program unless the dose is verified with the treatment program and the patient's ED visit has prevented administering of their scheduled dose.

3. NON-OPIOID SERVICES & TREATMENTS FOR CHRONIC PAIN

3.1 Care Coordination

To the extent possible, hospitals should develop a process to coordinate the care of patients who frequently visit the ED. Recommendations include the following:

- Developing an internal process to identify and provide notice to the patient's PCP that the patient was prescribed or sought opioid medications or was treated for an overdose. If appropriate, the ED should notify the PCP of a positive screening for opioid misuse or opioid use disorder as well as the information provided to the patient
- Discussing follow up care with the patient that may include referrals to treatment, referrals to community support programs and/or follow-up appointments with appropriate providers
- Maintaining a list of local primary care and mental health clinics that provide follow-up care for patients

3.2 HUSKY Health Emergency Department Care Management Program

The Emergency Department Care Managers (EDCM) receives instant notification for HUSKY members that go to the EDs with certain trigger diagnoses. Claims and Electronic Medical Records (EMR) are reviewed to identify utilization, ED care and medications. The EDCM will speak to the hospital Care Managers in the ED for members that are difficult to contact in the community. For members with identified behavioral health or substance abuse diagnoses, the EDCM will collaborate with CTBHP staff dedicated to 5 Connecticut EDs (Hartford, St Francis, Yale, Bristol and Backus). Members are asked to sign a release of information form for the Community Care Team (CCT). The members discussed at these meetings are provided strong support in the community from the behavioral health support team, providers, and peers.

If the member is able to speak to the EDCM, the engagement process is started while the member is in the ED. For members discharged from the ED a telephonic outreach call is made to members with numerous ED visits in a rolling 12 month period. The EDCM will complete a telephonic assessment and work with the member to schedule a follow-up appointment for their PCP post ED visit. If a member does not have a PCP, the EDCM will work with the member to locate a PCP and schedule an appointment. If the member needs a specialist or pain management provider they are referred to ICM. Members are also referred to ICM for further assistance with coordination of care and access to services. ICM will also provide education on medical conditions.

3.3 HUSKY Health Member Engagement Services and Escalation Unit

For further clarification of covered medical benefits or for assistance with locating a CMAP enrolled medical provider providers may contact the HUSKY Health Member Engagement Services and Escalation Unit. The representatives are available to ease the coordination of care for patients with chronic pain by locating and providing appointment assistance and helping with referrals to pain management specialists. Providers can "***Reach for Escalation***" by calling 1.800.440.5071, Monday through Friday, 8:00 a.m. - 6:00 p.m. or by completing the online "***Reach for Escalation***" form available on the HUSKY Health website at www.ct.gov/husky. To download this form click here.

3.4 HUSKY Health Intensive Care Management Program

The HUSKY Health Intensive Care Management (ICM) Program can assist providers with coordinating care for patients with chronic pain by assessing the patient's health status, barriers and strengths; developing a patient centered care plan; identifying gaps in care; coordinating with specialists; coordinating with the CT BHP; conducting patient visits, coordinating transportation; and providing appointment reminders. To refer patients to the ICM program, providers can call 1.800.440.5071,

Monday through Friday, 8:00 a.m. – 6:00 p.m. and select the prompt for Intensive Care Management or complete the ICM Referral form available on the HUSKY Health website at www.ct.gov/husky and fax to: 866.361.7242. To download this form click here.

3.5 Behavioral Health Services

Under the CT BHP the following services are covered:

- MAT including methadone maintenance, buprenorphine and naltrexone
- Ambulatory Detoxification
- Inpatient Detoxification
- Outpatient Detoxification
- Outpatient Counseling
- Intensive Outpatient Treatment
- Partial Hospitalization
- HUSKY D has services for Residential Substance Abuse Rehab covered by Advanced Behavioral Health which can be reached at 1.800.606.3677, Monday through Friday 8:30 a.m. – 5:00 p.m.

For further clarification of covered benefits or assistance with locating a CMAP enrolled behavioral health provider offering one or more of the above services, providers may contact the CT BHP at 1.877.552.8247, Monday through Friday, 9:00 a.m. – 7:00 p.m.

3.6 Dental Health Services

Pain management remains a significant consideration in dental care and patient management. For assistance with locating a dental provider, providers may contact the CTDHP, at 1.855.283.3682, Monday through Friday, 8:00 a.m. - 5:00 p.m.

CTDHP representatives will:

- Assist providers with locating a dental provider
- Coordinate dental care
- Provide case management
- Assist with obtaining additional resources

Under the CTDHP the following services are covered:

- Exams
- Dentures
- Cleanings
- Crowns
- Root Canals
- X-rays
- Fillings
- Oral Surgery
- Extractions

- Orthodontia

Additional information is available at www.ctdhp.com.

3.7 Screening, Brief Intervention, and Referral to Treatment (SBIRT)

EDs are encouraged to develop a process to screen for patient substance misuse risk that includes services for brief intervention and referrals to treatment programs for patients who are at risk for developing or who actively have substance use disorders. Opioids should be prescribed with great caution in the context of a substance abuse history. All patients for whom ED providers are considering writing an opioid prescription should be screened.

Screening tools should be used to assess the patient's risk of opioid misuse or use disorder. Screening will help providers make patient-specific treatment decisions and recommendations for follow-up care. The SBIRT process is used in a number of hospitals.

SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur. The components of SBIRT are:

- **S**creening to quickly assess the severity of substance use and to identify the appropriate level of treatment.
- **B**rief **I**ntervention which focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change and which includes non-judgmental conversations about an individual's substance use
- **R**eferral to **T**reatment in order to provide those identified as needing more extensive treatment with access to specialty care

Providers may access additional information on SBIRT on the Substance Abuse and Mental Health Services Administration (SAMHSA) website at https://www.samhsa.gov/sbirt/about

Connecticut Department of Social Services (DSS) Provider Bulletin PB 2015-79 "Screening, Brief Intervention, and Referral to Treatment (SBIRT) in Primary Care", published in October 2015, notifies providers of the availability of reimbursement for SBIRT services. Guidance related to coding, claims submission, and referral and supportive resources is included in the bulletin.

An SBIRT App

The SBIRT App for Screening, Brief Intervention, and Referral to Treatment for substance use provides users with detailed steps to complete an SBIRT intervention with patients or clients. The app is designed for use by physicians, other health workers, and mental health professionals and can be used with patients and clients 12 years and older. The app provides evidence-based questions to screen for alcohol, drugs, and tobacco use. If warranted, a screening tool is provided to further evaluate the

specific substance use. The app also provides steps to complete a brief intervention and/or referral to treatment for the patient based on motivational interviewing.

Integrated within the app are three screening instruments for substance use: the Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) assesses substance use in adolescents, the Alcohol Use Disorders Identification Test (AUDIT) assesses alcohol use in adults, and the Drug Abuse Screening Test (DAST) assesses drug use in the adults.

The app was developed as a part of a SAMHSA-funded grant project at Baylor College of Medicine (BCM).

To download this app to your smartphone, visit your app store.