UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
ADULT EMERGENCY DEPARTMENT MANUAL

SUBJECT: Adult Emergency Department Controlled Substance Policy	ADMINISTRATIVE APPROVAL:
EFFECTIVE: 04/11 REVISED:	J. D. McCourt, MD - Medical Director, Adult ED
POLICY #:	Kim Voss RN: Associate Administrator of Clinical Intervention and Quality Management
AFFECTS: UMC Adult ED physicians and Mid-level providers;	Evelyn Lundell, RN, MSN Clinical Manager Adult Emergency Department

POLICY STATEMENT:
Due to the recent increase in prescription medication addiction, overdose and deaths, the UMC Adult ED has developed the following guidelines regarding the administration and prescribing of controlled substances.

UMC Adult ED physicians and Mid-level providers responsibility:

- UMC Adult ED physicians and Mid-level providers have a professional responsibility to prescribe controlled substances appropriately, guarding against abuse while ensuring patients have the medications available when they require them.
- UMC Adult ED physicians and Mid-level providers have a responsibility to protect our practice from becoming an easy target for drug diversion.
- UMC Adult ED physicians and Mid-level providers have a legal and ethical responsibility to uphold the law and help protect our patients and community from drug abuse and drug diversion.

PURPOSE:
To establish guidelines for the UMC Adult ED physicians and Mid-level providers regarding the appropriate administration and prescribing of controlled substances.

PERFORMED BY:
UMC Adult ED physicians and Mid-level providers

Guidelines:
Suggested *guidelines* to be followed when administering and prescribing controlled substances to UMC emergency department patients:

1. **A medical screening exam (MSE) will be available to all patients requiring or requesting a controlled substance.**
2. **Acute pain**
   A. Acute pain conditions will be treated at the emergency clinician's discretion.
   B. Exacerbations of intermittent but chronic conditions, such as sickle cell crisis, will be treated at the emergency clinician's discretion.
   C. Acute on chronic exacerbations of malignant pain will be treated at the emergency clinician's discretion.

3. **Chronic Pain**
   A. Strict non-narcotic pain policy is recommended for patients with documented chronic pain
      I. **Exclusions examples:** Malignancy, sickle cell anemia, or patients determined by the ED clinician to be exhibiting acute pain.
      II. **Inclusions examples:** Diagnosed chronic pain syndromes, chronic headache (including migraines), chronic back pain, non-acute dental pain, neuropathic pain

4. **Chronic Pain: Patients with established pain management specialist**
   A. Patients must have a letter from a physician describing the protocol.
   B. Letter from the physician should attempt to be verified by phone conversation with the pain specialist.
   C. No controlled substance will be prescribed or administered without pain specialist verification.
   D. Non-opioid prescriptions will be offered if pain specialist verification cannot be established.
   E. It is at the discretion of the treating ED clinician to consider controlled substance bridge therapy, allowing for enough medication to last to the next business day. The patient is to be informed that under no circumstances will this process be repeated by a repeat emergency department visit.

5**. Chronic Pain: Patients without established pain management specialist**
   A. ED clinicians will treat pain at their discretion. Non-opioid medications are recommended.
   B. Referral to a primary care physician, neurologist and or pain management specialist will be provided as indicated.
   C. Prescription for non-opioid medications can be provided.
   D. It is at the discretion of the treating ED clinician to consider controlled substance bridge therapy allowing for enough medication to last to the next business day. The patient is to be informed that under no circumstances will this process be repeated by a repeat emergency department visit.

6. Rewriting controlled substance prescriptions
   A. Lost, stolen, misplaced prescriptions for controlled substances will not be rewritten.
   B. Request to rewrite prescriptions from other facilities for controlled substances will not be Honored
   C. It is at the discretion of the treating ED clinician to consider a controlled substance bridge therapy allowing for enough medication to last to the next business day. The patient is to be informed that under no circumstances will this process be repeated by a repeat emergency department visit.
   D. Methadone Maintenance Therapy: The prescribing of methadone for patients with chronic opioid dependence is not an emergent issue, and UMC Adult ED physicians and Mid-level providers should not provide patients prescriptions for missed doses.

7. Controlled substance abuse / Suspicious drug seeking behavior
   A. It is the responsibility of all UMC Adult ED physicians and Mid-level providers to make every effort to accurately identify patients who may be misrepresenting them selves or providing misleading information for the intent purpose of obtaining and misusing controlled substances.
   B. All UMC Adult ED physicians and Mid-level providers are encouraged to make a good faith effort to identify this group of patient,s using any of the following recourses:

I. Request a valid picture ID/ social security #
II. Check the patient's profile report on the online Nevada Prescription Monitoring Program (https://rpt.pmp.relayhealth.com/nv/)
III. Check previous medical records
IV. Contact the patient's physician, and/or other prescribers
V. Check for "alerts" placed on the patient's EmSTAT ED record

C. Patients with a high likelihood of controlled substance abuse / suspicious drug seeking behavior should not be prescribed controlled substances, and the following is recommended:
I. Provision of appropriate medical screening examination and stabilizing treatment
II. Recommended use of alternative modes of pain management, such as local nerve blocks, physical therapy, etc.
III. Referral for counseling, if drug abuse or misuse is suspected.
IV. Clear communication with the patient about the fact that they are exhibiting Drug Seeking Behavior, their treatment plan, the amount of narcotic medication that is necessary in the provider's opinion (if any), the fact that the amount or type of medication they are seeking is not necessary or advisable, and education about the fact that refusal to prescribe narcotics is not a refusal of care.
V. A final diagnosis of "**Drug Seeking Behavior**" should be avoided (unless there are strong objective findings recorded in the health record to support the diagnosis).
VI. UMC Adult ED physicians and Mid-level providers are encouraged to place an "alert" on the patient's health record to heighten awareness of potential **Drug Seeking Behavior**. The decision to place an "alert" on the patient's health record shall be made by the patient's provider after identification efforts outlined in section 7B are followed.

References:

1. Braden JB, Russo J, Fan MY, et al. Emergency Department Visits Among Recipients of Chronic Opioid Therapy. *Arch Intern Med*. 2010;170:1425-1432.
2. Wilsey BL, Fishman SM, Tsodlov A et al. Psychological Comorbidities Predicting Prescription Opioid Abuse among Patients in Chronic Pain Presenting to the Emergency Department. *Pain Med*. 2008;9:1107-1117.
3. Trescot AM, Boswell MV, Atluri AL, et al. Opioid Guidelines in the Management of Chronic Non-Cancer Pain. *Pain Physician*. 2006;9:1-40.
4. Svenson JE, Meyer TD. Effectiveness of nonnarcotic protocol for the treatment of exacerbations of chronic nonmalignant pain. *Am J Emerg Med*. 2007;25:445-449.
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6. Zednich AD, Hedges JR. Community-wide emergency department visits by patients suspected of drug-seeking behavior. *Acad Emerg Med.* 1996;3(4):312–7.
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8. A Guide to Prescribing, Administering and Dispensing Controlled Substances in Missouri, January 1999.