Virginia Hospital Emergency Department Opioid Prescribing Guidelines

BACKGROUND

The VHHA Board of Directors in January 2016 established a Task Force on Prescription Opioid Abuse that was charged with finding ways to combat opioid abuse, and developing prescribing recommendations to guide hospital emergency departments. Representatives from VHHA member organizations and the Virginia College of Emergency Physicians jointly developed 14 recommendations that provide a general standard on opioid prescribing within Virginia hospitals' emergency departments.

GUIDELINES

1. A dedicated provider outside the emergency department should provide all opioids to treat any patient's chronic pain.
2. Administering intravenous or intramuscular opioids in the emergency department for the relief of acute exacerbation of chronic pain is generally discouraged.
3. Prescriptions for opioids from the emergency department should be written for the shortest duration appropriate. In cases of diagnostic uncertainty or chronic conditions, this generally should be for no more than three days, as is consistent with national guidelines.
4. Hospitals, in conjunction with emergency department personnel, should develop a process to screen for substance misuse. Those protocols should include services for brief intervention and referrals to treatment programs for patients who are at risk for developing, or who actively have, substance use disorders.
5. When patients present with acute exacerbations of chronic pain, it is recommended that a summary of the emergency department care, including any medication prescribed, is communicated to the primary opioid prescriber or primary care provider.
6. Emergency department providers should not dispense prescriptions for controlled substances that were lost, destroyed, stolen, or finished prematurely.
7. Emergency department providers should use extra caution when considering prescribing controlled substances to patients who do not have proper photo identification.
8. Emergency department providers, or their designees, are encouraged to consult the Prescription Monitoring Program (PMP) before writing opioid prescriptions for acutely painful conditions.
9. Emergency department providers, in general, should not provide replacement doses of methadone or buprenorphine for patients participating in an opioid treatment program.
10. Unless otherwise clinically indicated, emergency department providers should not prescribe long-acting or controlled release opioids, such as oxycodone, fentanyl patches, or methadone.
11. Emergency department providers are strongly discouraged from prescribing or dispensing buprenorphine products.
12. Hospitals are encouraged to support physicians' decisions when it is their clinical judgment that an opioid should not be prescribed even if a patient has requested a prescription.
13. Emergency departments are encouraged to coordinate the care of patients who frequently visit the emergency department for evaluation of acute exacerbations of chronic pain. When possible, care coordination should include development of a patient-specific care plan involving the emergency department, hospital, and the primary care provider treating the patient's pain-inducing condition. Such care plans may include patient-specific policies or treatment plans, and should include treatment referrals for patients with suspected prescription opioid abuse problems.
14. Nothing in these recommendations is intended to supersede state or federal laws or regulations. Emergency departments should consider posting signs that notify patients that staff consults the PMP prior to prescribing controlled substances as is required by law.

Virginia College of Emergency Physicians

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