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MOCEP Companion to MHA Opioid Prescription Guidelines

On December 1, 2015, the Missouri Hospital Association (MHA) released a guideline about Emergency Department opioid prescribing practices.[1] Multiple organizations, including the Missouri College of Emergency Physicans (MOCEP) were involved in the development of these guidelines. As this was a collaborative process between six organizations, compromises were necessary to gain support and approval of the guideline from all six organizations. While MOCEP believes the guideline can be a useful tool for emergency physicians, we also believe that a few key points were either excluded or require further elaboration. This companion or addendum serves to add to the guidelines that were released by the MHA and is not intended to replace them.

In other states, hospitals and emergency departments have taken action to reduce the incidence and risk of opioid misuse and abuse among patients.[2-5] The following recommendations are meant to serve as an addendum to the guidelines released by the MHA on December 1, 2015.

- Emergency Department providers should not feel compelled to provide controlled substances to patients in order to improve patient satisfaction ratings.[6] Hospitals should not fault Emergency Department providers for not prescribing narcotics if the provider determines that they are not indicated.

- When possible, non-narcotic treatments should be utilized for non-traumatic tooth pain. This can include utilizing dental blocks, eugenol, and nonsteroidal anti-inflammatory drugs (NSAIDS), in addition to opioids if they are needed to provide effective analgesia. Increased access for non-insured or underinsured patients to dental resources should be encouraged in an effort to alleviate the need to manage non-traumatic tooth pain in the emergency department. Improving reimbursement for dental care may help to increase access to dental care.

- Emergency providers should adequately treat a patient's pain. While the analgesic plan determined by the Emergency Physician should include non-narcotic alternatives, these guidelines are not meant to advocate for oligoanalgesia.

While the guidelines and this companion piece are important, they are only a first step. There is still much work to be done to decrease opioid diversion and the morbidity and mortality associated with opioid use disorders. An emphasis should still be placed on the development of a prescription drug-monitoring program (PDMP).[7] Missouri remains

the only state not to have one. While efforts to create a PDMP remain stalled, MOCEP is still committed to developing a program, as long as it is functional, easy to access, and accessible to emergency physicians in real time.

In addition to the development of a PDMP, other polices should be directed at increasing resources and access to treatment for substance use disorders. While these guidelines and the PDMP will assist in decreasing opioid diversion, they do not fix the underlying addiction disorder. Patients suffering from addiction and substance use disorders often find that both addiction and psychiatric resources are limited and struggle with accessing care. In addition, policies such as Good Samaritan laws that allow providers to prescribe and dispense naloxone to public health organizations, law enforcement and family, and bystanders as an antidote for opioid overdoses should be encouraged.[8] Community naloxone programs have been very successful in other parts of the country.[9] These programs train the public and family members to treat opioid overdoses with naloxone. After receiving appropriate training, those participating in these programs have actually been able to teach others how to identify and treat people dying from opioid overdoses. These programs have decreased mortality from opioids without increasing opioid use or serving as impediments to bystanders calling for medical assistance.[10-12]

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