MISSOURI ACADEMY OF FAMILY PHYSICIANS

MAOPS established 1897 — Missouri Association of Osteopathic Physicians & Surgeons

Missouri College of Emergency Physicians — MoCEP

Missouri Dental Association

MHA Missouri Hospital Association

MSMA Missouri State Medical Association

OPIOID USE IN MISSOURI:
Strategy for Reduced Misuse and Abuse

POLICY RECOMMENDATION — *Effective December 2015*

- A focused pain assessment prior to determination of treatment plan; if the patient's pain prohibits a comprehensive assessment, then judicious use of opioids to alleviate pain is suggested. While the pain assessment should include risk factors for addiction and the incorporation of non-narcotic analgesics, a specific written, comprehensive assessment is not required.[i, ii, iv]
- Diagnoses based on evidence-based guidelines and appropriate diagnostics whenever possible.[ii]
- Non-narcotic treatment of symptomatic, non-traumatic tooth pain should be utilized when possible.[ii]
- Treatment of patients with acute exacerbation of existing chronic pain should begin with an attempt to contact the primary opioid prescriber or primary care provider, if circumstances are conducive.[i, ii, iii]
- Opioid analgesic prescriptions for chronic conditions, including acute exacerbation of existing chronic pain management, should be limited to no more than 72 hours, if clinically appropriate and assessing the feasibility of timely access for follow-up care.[i, ii, iii]
- For new conditions requiring narcotics, the length of the opioid prescription should be at the provider's discretion. The provider should limit the prescription to the shortest duration needed that effectively controls the patient's pain. Outpatient access to follow-up care should be taken into consideration regarding the length of the prescription.[ii, iv]
- Emergency department physicians and providers should not provide prescriptions for controlled substances that are claimed to be lost or destroyed.[ii, iii]
- Unless otherwise clinically indicated, emergency department physicians and providers should not prescribe long-acting or controlled release opioids. If indicated, prescribers should provide tamper-resistant, or abuse deterrent, forms of opioids.[i, ii, iii, iv]
- When narcotics are prescribed, emergency department staff should counsel patients on proper use, storage, and disposal of narcotic medications.[iii, iv]
- Beyond the emergency department, health care providers should encourage policies that allow providers to prescribe and dispense naloxone to public health, law enforcement and family as an antidote for opioid overdoses.[i, iii]

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[i] Cantrill, S., et al. (2012). Clinical policy: critical issues in the prescribing of opioids for adult patients in the emergency department." *Annals of Emergency Medicine, 60*(4), 499-525. doi:http://dx.doi.org/10.1016/j.annemergmed.2012.06.013

[ii] Agency for Healthcare Research and Quality. (2014). Acute pain assessment and opioid prescribing protocol. Health care protocol. *National Guideline Clearinghouse. Guideline Summary NGC-10206*. Retrieved from http://www.guideline.gov/content.aspx?id=47765&search=opioid

[iii] Maryland Hospital Association. (2015). Maryland emergency department opioid prescribing guidelines. Retrieved from http://www.mhaonline.org/resources/opioid-resources-for-hospitals

[iv] The New York City Emergency Department Discharge Opioid Prescribing Guidelines Clinical Advisory Group. (n.d.). Retrieved from http://www.nyc.gov/html/doh/downloads/pdf/basas/opioid-prescribing-guidelines.pdf

[v] The Agency Medical Directors' Group. (n.d.). Retrieved November 22, 2015 from http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

[vi] The Washington College of Emergency Physicians. (n.d.). Retrieved from http://www.washingtonacep.org/postings/tm_acep_letter_final.pdf

[vii] The Network for Public Health Law. (n.d.). Retrieved from https://www.networkforphl.org/_asset/qz5pvn/network-naloxone-10-4.pdf