Evaluation Summary: *Oklahoma Emergency Department and Urgent Care Clinic Prescribing Guidelines*

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Table of Contents

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Background

In the United States, and in Oklahoma, unintentional poisoning deaths have risen dramatically over the past decade. Unintentional poisoning is the leading cause of injury death in Oklahoma, surpassing motor vehicle crashes. Of the nearly 3,900 unintentional poisoning deaths in Oklahoma from 2007-2012, 79% involved at least one prescription drug. Prescription painkillers are now the most common class of drugs involved in overdose deaths (87% of prescription drug-related deaths, with 460 opioid-involved deaths in 2012).

In September 2012, the Oklahoma Prevention Leadership Collaborative (OPLC) commissioned a workgroup to develop a state plan, *Reducing Prescription Drug Abuse in Oklahoma*. This workgroup, the Prescription Drug Planning Workgroup, was a multi-disciplinary workgroup composed of doctors, physician assistants, pharmacists, nurse practitioners, law enforcement officials, and community specialists, with representatives from the Oklahoma State Department of Health (OSDH), regulatory boards, Oklahoma Department of Mental Health and Substance Abuse Services, Oklahoma Bureau of Narcotics and Dangerous Drugs Control, Oklahoma Hospital Association, Oklahoma Health Care Authority, state medical associations, Oklahoma Pharmacists Helping Pharmacists, and the Oklahoma Parent Teacher Association. The Workgroup created a comprehensive five-year plan to reduce unintentional overdose deaths involving opioids in Oklahoma by 15% (65 fewer Oklahomans). The recommended seven focus areas are as follows: community/public education, provider/prescriber education, disposal/storage for the public, disposal/storage for providers, tracking and monitoring, regulatory/enforcement, and treatment/interventions. Each of these focus areas have state and community action items. The state action items are very specific with designated completion dates and lead agencies in charge of the work. After the plan was finalized, the Workgroup sought endorsers/supporters of the plan; 37 plan supporters were identified, which included government agencies and other organizations such as AAA, the Oklahoma Safety Council, and the Interfaith Alliance of Oklahoma.

The OSDH was tasked with accomplishing the state action item: “Develop and promote adoption of opioid prescribing guidelines for prescribers by 2013.” The OSDH created a workgroup called the Opioid Prescribing Guidelines Workgroup. This Workgroup was composed of all the organizations represented on the Prescription Drug Planning Workgroup, in addition to practicing medical providers. The Workgroup created two sets of opioid prescribing guidelines: one set for emergency departments and urgent care clinics, and a second set for office-based settings.

Prescribers and dispensers, including physicians, physician assistants, nurse practitioners, pharmacists, nurses, veterinarians, and dentists, all have a role to play in reducing prescription drug abuse/misuse. Some receive little training on the importance of appropriate prescribing and dispensing of opioids to prevent adverse effects, diversion, and addiction. Outside of specialty addiction treatment programs, some healthcare providers have received minimal training on recognizing substance abuse in their patients.

The Prescribing Guidelines Workgroup created the *Oklahoma Emergency Department (ED) and Urgent Care Clinic (UCC) Opioid Prescribing Guidelines* (hereafter referred to as the *Guidelines)* to help reduce the misuse of prescription opioid analgesics while preserving

and supporting the vital role of the ED/UCC provider to treat patients with emergent medical conditions. The definition of UCC, for the purpose of these *Guidelines*, does not include those patient-physician encounters in which longitudinal, either primary or ongoing specialty, care is being provided.

The *Guidelines* were distributed to medical providers across Oklahoma in October 2013 through the following organizations: the Oklahoma Hospital Association, all five regulatory boards, the nursing board, and the Oklahoma Health Care Authority. The *Guidelines* were also posted on the Injury Prevention Service (IPS) website (http://poison.health.ok.gov) and published in *The Journal of the Oklahoma Osteopathic Association* and *The Journal of the Oklahoma State Medical Association.*

Purpose/Methods

In July 2014, the IPS began an outcome evaluation of the *Guidelines*. The purpose of this evaluation was to identify how many Oklahoma hospitals had adopted (as a policy or recommendation) the *Guidelines* and to examine implementation outcomes in ED settings.

In collaboration with the Oklahoma Hospital Association, the IPS developed a 26-item questionnaire to identify how many Oklahoma hospitals adopted the *Guidelines,* assess the acceptability and usefulness of the *Guidelines*, and determine ways to improve recommendations and tools.

The survey was emailed to the Chief Executive Officers (CEOs) of all 157 hospitals in Oklahoma. The CEO was instructed to have their Medical Director or equivalent staff complete the survey and submit only one survey per hospital. Data were collected using a web-based questionnaire through SurveyMonkey, with the option of submitting a hard copy instead.

Findings

A total of 49 hospitals out of 157 completed the survey, along with one urgent care clinic, resulting in a 32% response rate (n=50).

The majority of surveys were completed by Medical Directors (66%), followed by physicians (6%), physician assistants (4%), nurse practitioners (4%), and other non-specific ED staff (20%; Table 1). Most respondents rated their knowledge of prescription drug abuse and overdose as “high” (78%) and perceived it as a “widespread problem” in their community (62%; Tables 2 and 3). Respondents from hospitals with prescribing guidelines were more likely to perceive prescription drug abuse as a “widespread problem” than respondents from hospitals without guidelines (Figure 1). Discussing or providing information on prescription drug abuse to patients was “very important” to the majority of respondents (68%; Table 4).

Out of the 50 survey respondents, 38 (76%) knew about the *Guidelines* prior to receiving the survey (Table 5). The majority of responding hospitals had adopted some form of guidelines for opioid prescribing, with 29 (76%) hospitals adopting or in the process of adopting the *Guidelines* and 10 (48%) adopting or in the process of adopting their own set of guidelines (Tables 6 and 7). Seventy-four percent of hospitals with prescribing guidelines used their hospital guidelines as a recommendation or practice guideline and not as a requirement or policy (Table 8).

Of hospitals that had adopted or were in the process of adopting the *Guidelines*, 55% reported adopting all of the recommendations. For hospitals that had not adopted the *Guidelines* in full, the recommendations most commonly excluded were:

- Maintaining a list of local primary care and mental health clinics;
- Querying the Oklahoma Prescription Monitoring Program (PMP);

- Performing Screening, Brief Intervention, and Referral to Treatment (SBIRT);
- Having one health care provider provide all opioid prescriptions; and
- Provide information on the risks of overdose and addiction, safe storage, and safe disposal (Table 9).

For hospitals that had adopted their own set of guidelines, the most common recommendations were:

- Discouraging the replacement of lost, stolen, or destroyed prescriptions;
- Discouraging the replacement of opioid treatment medications;
- Discouraging the use of long-acting opioids;
- Querying the PMP; and
- Setting short supply limits (Table 10).

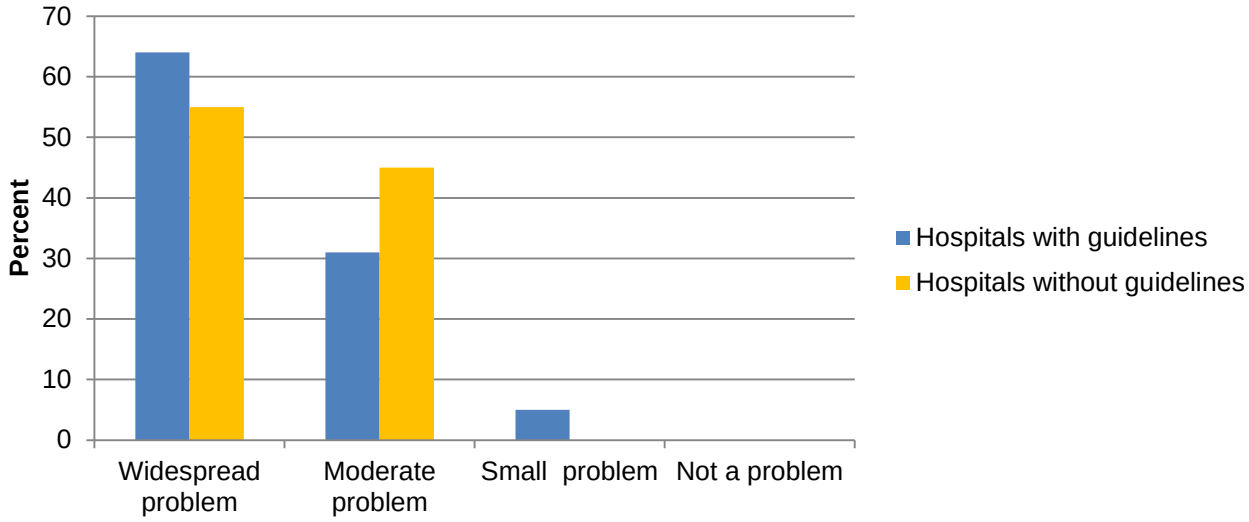
The most commonly reported barrier to implementing the *Guidelines* was fear of lower patient satisfaction survey scores (38%), followed by time (24%). Twenty-eight percent reported no barriers to implementing the *Guidelines* (Table 11).

Positive outcomes reported by hospitals that had adopted the *Guidelines* or their own set of guidelines included increased use of the PMP, fewer prescriptions written for opioids, reduction in inappropriate opioid prescribing, higher staff satisfaction, higher physician satisfaction, and fewer patients requesting opioids. Twenty-six percent reported "unsure/no notable outcomes" (Table 12).

Negative outcomes included more conflict with patients over opioid prescriptions, lower patient satisfaction, less ability to focus on emergent conditions, and an increase in inappropriate use of the ED. Thirty-six percent reported "unsure/no notable outcomes" (Table 13).

The use of SBIRT was not commonly implemented in the ED, with only 8% of hospitals reporting implementation of the clinical tool (Table 14). Common responses for not using SBIRT were lack of knowledge or familiarity, not having a good referral system, limited treatment services, and lack of time. Assessing patients for substance use/abuse and querying the PMP prior to prescribing opioids were common practices in 84% and 66% of hospitals, respectively (Tables 15 and 16). Hospitals with prescribing guidelines were slightly more likely than hospitals without guidelines to check the PMP and assess history of substance abuse as common practices among their providers. All hospitals that implemented SBIRT were hospitals with guidelines (Figure 2).

Figure 1. Perception of Prescription Drug Abuse in the Community



Overall, the *Guidelines* had been well received by providers in responding hospitals (39% very positive and 34% somewhat positive; Table 17). Ninety-four percent of respondents would recommend that other institutions adopt the *Guidelines* (Table 18). The predominant suggestion for improving the *Guidelines* was adding more tools to support best practices, such as screening and educational tools and a list of treatment services and primary care providers (Table 19).

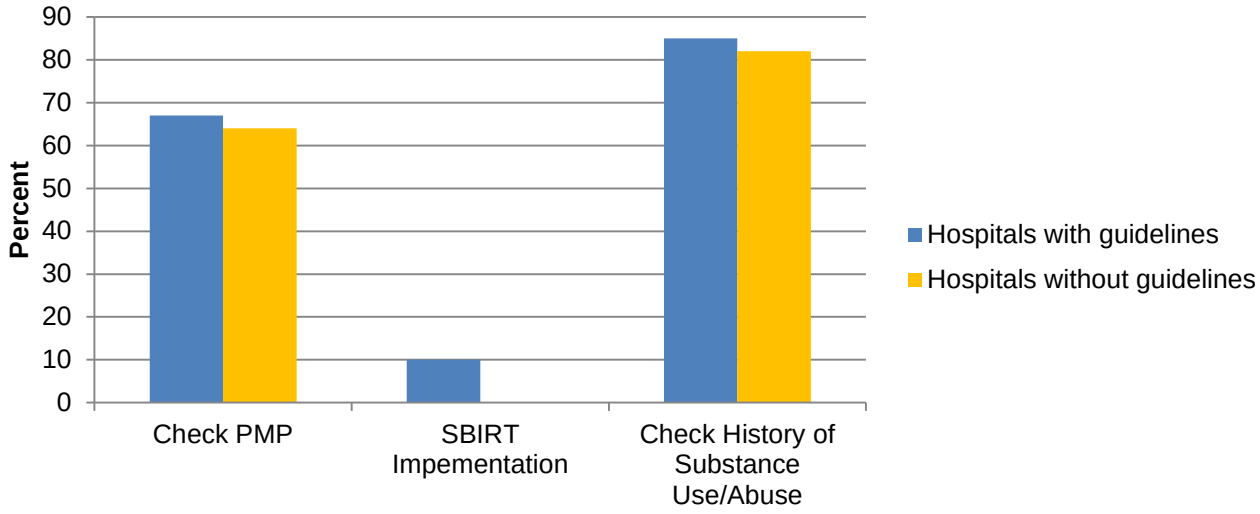
Conclusions

Opioid prescribing practices have changed dramatically over the past 15-20 years, which has led to an increase in the use and distribution of prescription opioids. As a result, drug-related morbidity and mortality has increased in the United States and in Oklahoma. A number of factors are contributing to this epidemic, but one major factor has been prescribing trends. It is still too early to assess to what extent the *Guidelines* have impacted these trends. However, due to the majority of hospitals perceiving prescription drug abuse as a "widespread problem" in their community, the positive feedback provided by Oklahoma hospitals on how the *Guidelines* have been received by providers, and the majority of hospitals recommending the *Guidelines*, there is continued support for the use of the G*uidelines*. The outcomes of this evaluation will help improve future editions of the *Guidelines* and guide strategies to increase and enhance utilization.

Recommended Areas of Focus

- Expand awareness of the *Guidelines* and increase the number of hospitals adopting them.
- Increase the number of providers that follow the *Guidelines*.
- Identify ways to alleviate the fear of patient satisfaction scores among providers and improve patient satisfaction, while maintaining appropriate prescribing.
- Increase the number of providers that regularly perform SBIRT.
- Increase the number of providers that regularly query the PMP prior to prescribing opioids.
- Increase the number of providers that regularly assess patients for substance abuse history prior to prescribing opioids.
- Include useful clinical tools for providers in the *Guidelines*.

Figure 2. Common Practice in the Emergency Department Prior to Prescribing Opioids



Appendix A: Data Tables of all Survey Questions

(Sample size varies by question due to skip logic in the survey)

Table 1: Role in the ED

What is your role in the Emergency Department (ED)? (n=50)	Frequency	Percentage
Medical Director or Officer	33	66
Physician	3	6
Physician Assistant	2	4
Nurse Practitioner	2	4
Other*	10	20

*Includes ED Nurse, Pharmacist, ED Manager, Chief Operating Officer, Chief Executive Officer, and Director of Nursing

Table 2: Prescription drug abuse knowledge

How would you rate your knowledge of prescription drug abuse and overdose? (n=50)	Frequency	Percentage
Expert	7	14
High	39	78
Medium	4	8
Low	0	0

Table 3: Perception of prescription drug abuse

What is your perception of prescription drug abuse in your community? (n=50)	Frequency	Percentage
Widespread problem	31	62
Moderate problem	17	34
Small problem	2	4
Not a problem	0	0

Table 4: Importance of discussing with patients

How would you rate the importance of discussing or providing information on prescription drug abuse to patients in your hospital? (n=50)	Frequency	Percentage
Very important	34	68
Important	14	28
Somewhat important	2	4
Not important	0	0

Table 5: Aware of the *Guidelines* prior to the survey

Prior to this survey, were you aware of the *Oklahoma Emergency Department (ED) and Urgent Care Clinic (UCC) Opioid Prescribing Guidelines*? (n=50)	Frequency	Percentage
Yes	38	76
No	12	24

Table 6: Adopted the *Guidelines*

Has your hospital adopted any portion of the *Oklahoma ED/UCC Opioid Prescribing Guidelines*? (n=38)	**Frequency**	**Percentage**
Yes	21	55
No	9	24
In the process of adopting	8	21

Table 7: Adopted their own set of guidelines

Does your hospital currently have its own set of opioid prescribing guidelines or an opioid prescribing policy? (n=21)	**Frequency**	**Percentage**
Yes	4	19
No	11	52
In the process of adopting	6	29

Table 8: Recommendation or policy

If your hospital has adopted or is in the process of adopting opioid prescribing guidelines/policy, is this a: (n=39)	**Frequency**	**Percentage**
Recommendation or practice guideline	29	74
Requirement or policy	2	5
Not sure	8	21

Table 9: Excluded recommendations for those that adopted the *Guidelines*

If your hospital adopted or is in the process of adopting the *Oklahoma ED/UCC Prescribing Guidelines* but elected to exclude any of the 15 recommendations, please select which recommendations have NOT been adopted. (n=29)	**Frequency**	**Percentage**
Not applicable, we adopted all recommendations	16	55
14. EDs/UCCs should maintain a list of local primary care and mental health clinics that provide follow-up care for patients of all payer types.	4	14
4. Providers should query the Oklahoma Prescription Monitoring Program (PMP) for patients presenting with acute pain, prior to prescribing opioid medication. (In circumstances where a patient's pain is resulting from an objectively diagnosed disease process or injury, a clinician may prudently opt not to review the Oklahoma PMP.)	3	10
5. In patients suspected of opioid addiction, abuse, or diversion, health care providers should check the Oklahoma PMP and perform screening, brief intervention, and referral to treatment, if indicated.	3	10
6. In patients who routinely take opioids for chronic pain, it is ideal that one health care provider provide all opioid prescriptions, with rare exception. When an exception occurs and another provider deems it necessary to prescribe opioids (i.e., a new, acute injury or objectively diagnosed disease process/injury), Oklahoma PMP data should be reviewed, and only enough pills prescribed, if indicated, to last until the office of the patient's primary opioid prescriber opens.	3	10
12. Provide information about opioid medications to patients receiving an opioid prescription, such as the risks of overdose and addiction, as well as safe storage and proper disposal of unused medications.	3	10
1. Consider opioid medications for the treatment of acute pain only when the severity of the pain is reasonably assumed to warrant their use.	2	7
2. When administering or prescribing opioids, it is suggested that health care providers start with the lowest possible effective dose for the management of pain.	2	7
3. When prescribing opioids for acute pain, prescribe no more than a short course, except in special circumstances. Most patients require opioids for no more than three days of pain control, with a maximum of 30 pills in most cases.	2	7
10. The administration of intravenous and intramuscular opioids for the relief of exacerbations of chronic pain is discouraged, except in special circumstances.	2	7
11. Always consider risk factors for respiratory depression when prescribing opioids. Use caution when prescribing opioid medications to patients currently taking benzodiazepines and/or other opioids.	2	7
13. Health care providers are encouraged to consider non-pharmacological therapies and/or referral to specialists for follow-up, as clinically appropriate.	2	7
15. Emergency health care providers are required by law to evaluate an ED patient who reports pain. The law allows emergency providers to use their clinical judgment when treating pain and does not require the use of opioids when the risks of opioid therapy outweigh the benefits.	2	7
7. Health care providers should not provide replacement prescriptions for lost, destroyed or stolen controlled substances.	1	3
8. Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, suboxone, and methadone) should not be prescribed from the ED/UCC.	1	3
9. For exacerbations of chronic pain, it is suggested that the emergency health care provider attempt to notify the patient's primary opioid prescriber that the patient is under evaluation at the ED/UCC. The emergency health care provider should only prescribe enough pills to last until the office of the patient's primary opioid prescriber opens.	1	3
Not sure	1	3

Table 10: Included recommendations for hospitals with their own guidelines

Select the recommendations that are/will be included in your hospital's opioid prescribing guidelines/policy. (select all that apply) (n=10)	**Frequency**	**Percentage**
Discourage providing replacement prescriptions for lost, destroyed or stolen controlled substances	10	100
Discourage providing replacement doses of opioid treatment medications (e.g., suboxone, methadone)	10	100
Discourage prescribing long-acting or controlled-release opioids (e.g., methadone, OxyContin®, fentanyl)	10	100
Recommend checking the Prescription Monitoring Program (PMP)	10	100
Set or recommend limits on days supply (e.g., 3 days) prescribed from the ED	10	100
Use caution when prescribing opioid medications to patients currently taking benzodiazepines and/or other opioids	9	90
Recommend starting with the lowest possible effective dose of opioids for the management of pain	8	80
Recommend that patients leaving the hospital with an opioid prescription be provided with information about the risks of overdose and addiction, as well as safe storage and proper disposal of unused medications	8	80
Discourage administration of intravenous and intramuscular opioids for the relief of exacerbations of chronic pain	7	70
Maintain a list of local primary care and mental health clinics that provide follow-up care for patients of all payer types	6	60
Other*	2	20

*Includes one provider for pain management and discourage providing chronic pain control in the ED

Table 11: Barriers to implementing the *Guidelines*

Which of the following were barriers to implementing the *Oklahoma ED/UCC Opioid Prescribing Guidelines*? (select all that apply) (n=29)	**Frequency**	**Percentage**
Fear of lower patient satisfaction survey scores	11	38
Time	7	24
Lack of familiarity with the PMP	2	7
Support from physicians	2	7
Support from leadership	1	3
Level of knowledge and training	1	3
Guidelines are too confusing or cumbersome to use	0	0
Lack of consensus on what recommendations should be adopted	0	0
Other barriers	4	14
No barriers	8	28

Table 12: Positive outcomes

Have there been any positive outcomes resulting from adoption of the *Oklahoma ED/UCC Opioid Prescribing Guidelines* or your hospital's own prescribing guidelines/policy? (select all that apply) (n=39)	**Frequency**	**Percentage**
Increased use of the PMP	17	44
Fewer prescriptions written for opioids	14	36
Reduction in inappropriate opioid prescribing	11	28
Reduction in inappropriate use of the ED	9	23
Higher staff satisfaction	8	21
Higher physician satisfaction	8	21
Fewer patients requesting opioids	7	18
Less conflict with patients over opioid prescriptions	6	15
Ability to focus more on emergent conditions	2	5
Higher patient satisfaction	0	0
Other	4	10
Unsure/no notable outcomes	10	26

Table 13: Negative outcomes

Have there been any negative outcomes resulting from adoption of the *Oklahoma ED/UCC Prescribing Guidelines* or your hospital's own prescribing guidelines/policy? (n= 39)	**Frequency**	**Percentage**
More conflict with patients over opioid prescriptions	11	28
Lower patient satisfaction	11	28
Less ability to focus on emergent conditions	2	5
Increase in inappropriate use of the ED	1	3
Lower physician satisfaction	1	3
More patients requesting opioids	0	0
Lower staff satisfaction	0	0
Increase in inappropriate opioid prescribing	0	0
More prescriptions written for opioids	0	0
Other	4	10
Unsure/no notable outcomes	14	36

Table 14: Implemented SBIRT

Has your ED implemented SBIRT (Screening, Brief Intervention, and Referral to Treatment)? (n=50)	**Frequency**	**Percentage**
Yes	4	8
No	33	66
Unsure	13	26

Table 15: Assessing history of substance use/abuse

Prior to prescribing opioids, is it common practice in your hospital to assess patients for history of substance use/abuse? (n=50)	**Frequency**	**Percentage**
Yes	42	84
Sometimes	8	16
No	0	0

Table 16: Checking the PMP

Prior to prescribing opioids, is it common practice in your hospital to check the Prescription Monitoring Program (PMP)? (n=50)	**Frequency**	**Percentage**
Yes	33	66
Sometimes	13	26
No	3	6
No response	1	2

Table 17: How the *Guidelines* have been received

Overall, how have the *Oklahoma ED/UCC Opioid Prescribing Guidelines* been received by providers in your hospital? (n=38)	**Frequency**	**Percentage**
Very positive	15	39
Somewhat positive	13	34
Neutral	6	16
Somewhat negative	1	3
Very negative	0	0
Unsure	2	5
No response	1	3

Table 18: Recommend *Guidelines*

Would you recommend that other institutions adopt the *Oklahoma ED/UCC Opioid Prescribing Guidelines*? (n=50)	**Frequency**	**Percentage**
Yes	47	94
No	2	4
No response	1	2

Table 19: How to improve the *Guidelines*

How could the *Oklahoma ED/UCC Opioid Prescribing Guidelines* be improved for future editions? (n=50)	**Frequency**	**Percentage**
Additional tools to support best practices	16	32
Less detail	3	6
More descriptive	3	6
Additional recommendations	2	4
Fewer recommendations	2	4
More detail	1	2
Less descriptive	1	2
Guidelines are not technical enough	1	2
Guidelines are too technical	0	0

Table 20: Who made respondent aware of the *Guidelines*

How were you made aware of the *Oklahoma ED/UCC Opioid Prescribing Guidelines*? (n=38)	**Frequency**	**Percentage**
Hospital administration	13	34
One of the regulatory boards	9	24
Article in a state medical journal	8	21
Another physician or other staff	5	13
ED Medical Director or Officer	4	11
Other*	11	29

*Includes Oklahoma Bureau of Narcotics and Dangerous Drugs Control website, Oklahoma State Department of Health, Oklahoma Hospital Association, conference, and state prescribing course.

Table 21: Patient handout

Has your hospital adopted the patient information handout included with the *Oklahoma ED/UCC Opioid Prescribing Guidelines*? (n=50)	**Frequency**	**Percentage**
Yes	6	12
No – We developed our own patient handout	5	10
No – We do not use a patient handout on opioids	32	64
Unsure	7	14

Table 22: How patient handout was disseminated

How is the patient handout being provided to patients? (n=18)	**Frequency**	**Percentage**
Given with discharge instructions to patients leaving with an opioid prescription	7	44
Given at the discretion of the provider	5	28
Given to all patients at registration or discharge	1	6
Given to any patient requesting opioids	0	0
Not sure	3	17

Table 23: Prior knowledge of the unintentional poisoning website

Prior to this survey, were you aware of the Oklahoma State Department of Health (OSDH) website dedicated to unintentional poisonings, http//poison.health.ok.gov? (n=50)	**Frequency**	**Percentage**
Yes	24	48
No	26	52