PARTNERSHIP HEALTHPLAN RECOMMENDATIONS For Safe Use of Opioid Medications

Emergency Department Guidelines

Introduction

Partnership HealthPlan is a County Organized Health System covering Medical and Mental Health Benefits for Medi-Cal beneficiaries in 24 counties in Northern California. Our mission is to help our members, and the communities we serve, be healthy. In this spirit, we have community-wide guidelines to promote safer use of opioid medications.

Effective Jan. 1, 2027, Partnership will operate a Centers for Medicare & Medicaid Services (CMS)-approved Dual-Eligible Special Needs Plan (D-SNP) in specific counties as described in the Department of Health Care Services (DHCS) CalAIM Dual Eligible Special Needs Plan Policy Guide. This line of business will be known as Partnership Advantage and will be a Medicare Advantage plan offered to all full-benefit, dual-eligible beneficiaries 21 years of age or older who reside in the applicable counties. Therefore, federal guidelines are cited throughout this policy attachment.

The emergency department has two key roles in helping with community-wide efforts to control opioid overuse: (1) insuring acute pain is treated in a way that decreases the probability of future over-use of opioids and (2) working closely with primary care clinicians to ensure a coherent, safe approach to treating chronic pain. The Emergency Department (ED) can be a critical access point for members with Substance Use Disorder (SUD). ED personnel should consider screening for SUD and initiating medication-assisted treatment (MAT). Partnership recommends the following to achieve these goals:

Recommendations

A. Check a Controlled Substance Utilization Review and Evaluation System (CURES) report on all patients who will receive opioid medications, and also those patients who will receive other Schedule I-IV controlled medications. If there is a discrepancy, consider contacting the relevant pharmacies to confirm information, as occasionally the CURES data is not accurate.

B. Limit opioid prescriptions for Acute Pain to no more than 4 days. Avoid opioids if pain is not severe, and consider non-opioid analgesic options preferentially. If there are risk factors for SUD (e.g., contextual or individual risk factors, such as history of abuse/trauma, personal history of SUD, family history of SUD, poverty, other mental health conditions, family rejection of sexual orientation or gender identity), carefully consider balancing the need for adequate analgesia against the risks of controlled substance misuse and/or SUD behavioral destabilization. If opioids are prescribed, use low doses for short courses with all patients. Refer also to the CDC Reducing Health Risks Among Youth.

C. Avoid prescribing opioids for chronic pain not associated with the cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease.

D. Avoid prescribing opioids for poorly defined pain (e.g., pain not fitting any clinical syndrome after appropriate medical work up).

E. In patients with a suspected or documented history of substance misuse or SUD, take a careful history and after appropriate medical work up; if opioid analgesia is indicated, carefully balance the need for adequate analgesia against the risks of controlled substance misuse and/or SUD behavioral destabilization. Potential indicators of substance misuse behaviors include:
   1. Patient goes to an emergency room outside of the community they live in (or multiple) with suspected aim to secure opioid analgesic medications
   2. Patient paying cash for ED visit.
   3. Patient reports they are on a chronic opioid prescribed by an out-of-area prescriber, who cannot be reached.
   4. Patient reports that their medications were lost or stolen.
   5. CURES report reveals multiple controlled substance prescribers in multiple locations.
   6. Collateral sources indicate a history of maladaptive behaviors in relation to controlled substances.

F. Refer patient to primary care provider (PCP) instead of prescribing refills of existing opioid medications.

G. If the PCP cannot be contacted to do a refill, limit opioid refills to a 4-day supply maximum.

H. Notify PCP if an opioid prescription is given, especially if it is a refill.

I. Call pharmacy to verify medication history on intoxicated patients.

J. Perform a urine toxicology screen on a patient before prescribing a controlled medication, to be sure the result is consistent with the patient's medication history. Consider a confirmatory test if the results of a tox screen are unexpected, because false positive and negative screening results are common. Ensure that the urine toxicology screen adequately captures the substances of interest (e.g., often urine toxicology screens for "opiates" will not detect fully synthetic opioids such as methadone or fentanyl).

K. Prescribe high dose NSAIDs for acute dental pain. (Studies show opioids are inferior for dental pain, and no more effective than placebo.)

L. If patients come to the emergency room for severe, breakthrough pain on any regular basis, develop an agreed-upon treatment plan with the Primary Care Physician or usual prescribing outpatient physician to avoid such visits.

M. For patient safety, intramuscular and intravenous opioids should not be administered for chronic pain not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease related pain.

N. For patients reporting current methadone maintenance for opioid use disorder, immediately contact their Narcotic Treatment Program (NTP) to verify dosing and standing with their program. Do not adjust or discontinue methadone dosing without consultation with the patient's NTP. Methadone maintenance dosing (e.g., daily) will not adequately provide analgesia for acute pain and these patients will often require additional analgesia (sometimes additional opioid medications) to obtain adequate analgesia.

O. For patients presenting with acute pain who are on buprenorphine-containing products or naltrexone treatment for opioid use disorder, achieving analgesia may present unique challenges. Consider consulting available resources for analgesia strategies and protocols for these individuals in an emergency situation (e.g., CA Bridge Program.

P. For all patients with identified opioid use disorder, offer initiation of medications for addiction treatment (MAT; e.g., buprenorphine-naloxone/buprenorphine, methadone, naltrexone). Example protocols and strategies can be found through CA Bridge website: https://bridgetotreatment.org/addiction-treatment/ca-bridge/.

1. Linkages to community MAT providers can be facilitated through consulting (Substance Abuse and Mental Health Services Administration) SAMHSA Treatment locator (https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator), or for patients who reside in Humboldt, Mendocino, Shasta, Siskiyou, Solano, Lassen, Modoc, contact Carelon Behavioral Health for treatment options: (855) 765-9703. Members who reside in counties **other than** Humboldt, Mendocino, Shasta, Siskiyou, Solano, Lassen, or Modoc should be referred to their home county's behavioral health access number.

Other Guidelines for Safe Opioid Prescribing

Dental Guidelines
Community Pharmacy Guidelines
Primary Care & Specialist Prescribing Guidelines

Key Points from these other guidelines

1. According to the Centers for Disease Control (CDC) 2022 Guidelines, additional dosage increases beyond 50 MME/day are progressively more likely to yield diminishing returns in benefits relative to risks to patients as dosage increases further. Clinicians should carefully evaluate a decision to further increase dosage based on individualized assessment of benefits and risks and weighing factors such as diagnosis, incremental benefits for pain and function relative to risks with previous dosage increases, other treatments and effectiveness, and patient values and preferences.

2. Request a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs.

3. Consider a signed medication use agreement with the prescriber or prescribing office, renewed yearly.

4. Regularly check the CURES database in all patients being prescribed opioids at each time a prescription for a controlled substance (Schedule I-IV) is being authorized. Consider checking

a CURES report when prescribing Schedule V controlled substances, as well. If a finding on the CURES report is not consistent with patient history, Partnership recommends contacting the relevant pharmacies to confirm the accuracy of the CURES report, as reporting errors do occur.

5. Schedule at least three office visits yearly for chronic pain patients using opioids.

6. Limit each opioid prescription to 28 days, writing this on the prescription (e.g., "must last 28 days".) The 28-day refill, scheduled for a Tuesday, Wednesday or Thursday every 4 weeks, is a best practice, to avoid weekends, holidays, and Friday refills.

7. Offer to prescribe naloxone for all patients being offered opioid prescriptions, of any duration. California law permits prescribing naloxone to patients taking opioids (legal or illegal) for use in an emergency to prevent accidental death. See http://prescribetoprevent.org/ for details. Intranasal naloxone is available at a pharmacy without a prescription, but a prescription is required to obtain Medi-Cal or Medicare coverage for naloxone.

8. If present, consider offering prescribing naloxone for family members, friends, close contacts of those who are at high risk of opioid overdose (e.g., those with a history of opioid overdose.)

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