Connecticut Emergency Department Opioid Prescribing Guidelines

The following guidelines are an educational tool to assist emergency medical providers (EMPs) in addressing the care needs of patients who come to the Emergency Department (ED), and who have a pain condition that may require the use of opioids.

Specific Considerations for Emergency Departments:

The ED should coordinate the care of patients who frequently visit the ED, using an ED care coordination program, to the extent possible.

Alternative, non-opioid therapies should be administered or prescribed for ED patients with pain whenever possible, in order to minimize the use of opioids and their associated risks. EMPs should review whether the patient has a “voluntary non-opioid directive form” or similar advance directive or instruction.

ED opioid prescriptions for acute pain should be in an amount that will last until the patient is reasonably able to receive follow-up care for the injury. In general, these opioid prescriptions should be for three days or less.

ED patients should be asked about a history of current substance abuse prior to prescribing opioids for acute pain. Opioids should be prescribed with great caution in the context of a substance abuse history.

EMPs generally should not order IV or IM opioids for acute exacerbations of chronic pain.

EMPs generally should not provide replacement prescriptions for controlled substances that were lost, destroyed, or stolen.

EMPs generally should not provide replacement doses for Methadone or Suboxone, but special consideration may be given in the event of natural disasters or other exigent circumstances.

EMPs generally should not prescribe long-acting opioids (e.g. Oxycontin, Fentanyl patches, methadone) for acute pain management.
EMPs should exercise caution when considering prescribing opioids for ED patients in situations in which the identity of the individual cannot be verified.

Patient care is optimized when one medical provider (primary care or specialist) coordinates all prescribed opioids to treat a patient’s chronic pain, to the extent possible.

EMPs should follow their facility’s policy and instruction regarding electronic prescribing of controlled substances.

**Specific Legal, Oversight, and Policy Considerations**

CT state law requires that a provider review a patient’s records in the Connecticut Prescription Monitoring and Reporting System before prescribing more than a 72 hour supply of a controlled substance to that patient.

CT state law prohibits prescribers from issuing an opioid prescription for more than a seven day supply to an adult for the first time for outpatient use, or five day supply to a minor, except when the drug is required to treat the person’s acute medical condition, chronic pain, cancer-associated pain, or for palliative care.

CT state law requires a discussion with the patient (or responsible person for minors, as applicable) about the risks of addiction and overdose associated with opioid drug use, the dangers of opioid drug use with alcohol, benzodiazepines and other CNS depressants, and why an opioid prescription is necessary.

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires patients who present at the hospital seeking care to be screened for any emergency medical condition. This includes patients who present with reports of pain. If an emergency medical condition is present, EMTALA requires that the patient be stabilized prior to transfer or discharge. EMTALA allows an EMP to use his or her clinical judgment in treating pain, and does not expressly require the use of opioids.

The Joint Commission has various standards, statements and guidelines relating to pain management that hospitals should review when assessing pain management and opioid policies.

To the extent that these guidelines are expressly adopted by hospital policy, EMPs should be supported and should not be subject to adverse considerations when following these guidelines.

Original guidelines adopted January 20, 2015; Revised February 2018.
Disclaimer: These guidelines are an educational tool. Clinicians should use clinical judgment in making treatment decisions and not base clinical decisions solely on this document. This document does not establish any standard of care. Deviation from it will occur when clinical situations dictate. No legal proceeding, including medical malpractice proceedings or disciplinary hearings, should reference a deviation from any part of this document as constituting a breach of professional conduct.