

# Oklahoma Emergency Department (ED) and Urgent Care Clinic (UCC) Opioid Prescribing Guidelines

*Note: These guidelines do not replace clinical judgment in the appropriate care of patients. They are not intended as standards of care or as templates for legislation, nor are they meant for patients in palliative care programs or with cancer pain. The recommendations are an educational tool based on the expert opinion of numerous physicians and other health care providers, medical/nursing boards, mental and public health officials, and law enforcement personnel in Oklahoma and throughout the United States. The guidelines are available at <http://poison.health.ok.gov>.*

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. When administering or prescribing opioids, it is suggested that health care providers start with the lowest possible effective dose for the management of pain.
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.
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.)
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.
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.
7. Health care providers should not provide replacement prescriptions for lost, destroyed or stolen controlled substances.
8. Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, suboxone, and methadone) should not be prescribed from the ED/UCC.
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.
10. The administration of intravenous and intramuscular opioids for the relief of exacerbations of chronic pain is discouraged, except in special circumstances.
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.
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.
13. Health care providers are encouraged to consider non-pharmacological therapies and/or referral to specialists for follow-up, as clinically appropriate.
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.
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.

## BACKGROUND

Prescription drug abuse is Oklahoma's fastest growing drug problem. Of the nearly 3,200 unintentional poisoning deaths in Oklahoma from 2007-2011, 81% involved at least one prescription drug.<sup>1</sup> In 2010, Oklahoma had the fourth highest unintentional poisoning death rate in the nation (17.9 deaths per 100,000 population).<sup>2</sup> Prescription painkillers (opioids) are now the most common class of drug involved in overdose deaths in Oklahoma (involved in 87% of prescription drug-related deaths, with 417 opioid-involved overdose deaths in 2011).<sup>1</sup> In a 2010 National Survey on Drug Use and Health report, Oklahoma led the nation in non-medical use of painkillers, with more than 8% of the population age 12 and older abusing/misusing painkillers.<sup>3</sup> Oklahoma is also one of the leading states in prescription painkiller sales per capita.<sup>4</sup>

These guidelines were primarily taken and adapted from the opioid prescribing guidelines of Washington and New York City.<sup>5,6</sup> The Opioid Prescribing Guidelines for Oklahoma Workgroup reviewed and discussed each recommendation in the Washington and New York City ED guidelines in the process of selecting those guidelines most relevant to the practice of medicine in Oklahoma. Prescribing guidelines from Utah and Ohio were also reviewed by Workgroup members.<sup>7,8</sup>

The Workgroup created these guidelines in 2013 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. It is recognized that some UCCs also have longitudinal medical clinics within the same workspace, or in close proximity, and it is not the intention of these guidelines to address patient-physician encounters more closely related to longitudinal care than otherwise. A second set of guidelines for office-based practice of medicine will be forthcoming.



Oklahoma Board of Nursing

Oklahoma Society of Interventional Pain Physicians

## RECOMMENDATIONS

### **1. Consider opioid medications for the treatment of acute pain only when the severity of the pain is reasonably assumed to warrant their use.**

Opioid analgesics should not be considered the primary approach to pain management in patients being discharged from the ED/UCC. Alternative and effective pharmacological interventions for acute pain exist, including non-steroidal anti-inflammatory drugs (NSAIDs), acetaminophen, and nerve blocks (e.g., for dental pain). Non-pharmacological therapies, such as fracture immobilization, may obviate the need for additional pain medications. Short-acting opioid analgesics such as hydrocodone, immediate-release oxycodone, and hydromorphone may be prescribed as adjuncts to relieve acute pain when the severity of the pain warrants their use. They also may be prescribed when non-opioid therapies have not or are reasonably presumed to not provide adequate relief from pain.<sup>7</sup> When prescribing combination preparations of prescription opioid analgesics and acetaminophen, caution the patient about the maximum dose of acetaminophen they should take to avoid toxicity. Risks and benefits, patient allergies, and potential adverse reactions should be considered before using any analgesic medication or modality. The resources of both the patient and the hospital should likewise be considered when determining the best options for treating a patient's pain.

The federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to provide a medical screening examination to determine whether an individual presenting to an ED has an emergency medical condition. If the hospital determines that a patient has an emergency medical condition, the hospital must provide treatment as may be required to stabilize the patient's medical condition.<sup>9</sup> EMTALA, however, **does not** require the use of opioid analgesics to treat pain. ED/UCC providers may apply their professional judgment to determine whether prescribing opioid analgesics for pain is the appropriate course of treatment. Providers should document various therapies considered for their treatment plan, including risks and benefits.

### **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.**

If opioid analgesics are considered for the management of pain after patient discharge from the ED/UCC, start with the lowest possible effective dose. Higher doses increase the risk of adverse events such as respiratory depression and overdose.<sup>10,11,12</sup> These risks are especially pronounced for opioid-naïve patients.

### **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.**

Excessive quantities of opioid analgesics increase the risk of misuse, abuse, or diversion. In addition, initiation of opioid analgesic therapy in opioid-naïve patients may lead to inappropriate long-term use.<sup>13</sup> For most patients with acute pain, a three-day supply is generally sufficient. When considering the quantity of pills prescribed, it is important to take as-needed dosing into

account. For example, a patient taking opioid analgesics “every six hours as needed for pain” may need only one or two doses a day. There may be some acute conditions (e.g. rib fractures) for which severe pain is expected to last more than three days and for which risks of inadequate pain control may exceed risks of a longer supply of opioids. However, if the patient’s acutely painful condition outlasts a three-day supply of opioid medication, a re-evaluation of the condition is likely to be beneficial. Consider expediting follow-up care if the patient’s condition is expected to require more than a three-day supply of opioid analgesics. If follow-up care cannot be expedited, the three-day limit may need to be minimally extended to allow the patient time to see their primary care provider.

**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.)**

The PMP is a real-time database of scheduled prescriptions written to persons who filled a prescription in Oklahoma. The PMP can be accessed at [http://www.ok.gov/obnnd/Prescription\\_Monitoring\\_Program/](http://www.ok.gov/obnnd/Prescription_Monitoring_Program/).

Patients with a history of or current substance abuse are at increased risk of misusing opioids when prescribed.<sup>14,15</sup> Emergency medical providers should ask the patient about a history of substance abuse prior to prescribing opioid medication for the treatment of acute pain. A non-opioid regimen can be offered to ED/UCC patients with acute pain and a history of substance abuse. A history of or current substance abuse should not exclude an ED/UCC patient from being prescribed opioids for acute pain, but it might prompt a discussion with the patient about the potential for addiction. When a patient with a history of opioid addiction presents with acute pain due to an objectively diagnosed clinical or traumatic condition requiring the use of opioids for pain control, very close follow-up is indicated, as the patient is at high risk for misusing opioid medications. The patient’s primary care provider should also be notified, if possible, of the patient’s treatment. Emergency medical providers wishing to perform more extensive screening for the risk of opioid addiction are encouraged to use tools such as the Opioid Risk Tool.<sup>16</sup>

**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.**

Screening, brief intervention, and referral to treatment (SBIRT) has been shown effective in providing brief intervention, brief therapy and treatment referral to substance abusers who frequent EDs/UCCs, with substantial declines in illicit drug abuse ([http://ok.gov/odmhsas/Prevention\\_in\\_Practice.html](http://ok.gov/odmhsas/Prevention_in_Practice.html)).<sup>17</sup> Among high-risk users of prescription opioids in Washington, at six-month follow-up, there was a 41% reduction in days of drug use (from 12.8 to 7.5 days) for individuals who received only a brief intervention, and a 54% reduction (from 14.4 days to 6.6 days) for individuals who received a brief intervention, followed by brief therapy or chemical dependency treatment.<sup>17</sup> With proper training, brief interventions can be delivered in the ED/UCC by nurses, case managers, crisis counselors, social workers, or a

chemical dependency professional. The 2010 National Drug Control Strategy recommends expansion of brief interventions in health care settings.<sup>18</sup>

Patients often find themselves in the ED/UCC after their dependence or addiction has led them to a turning point in their life, such as a traumatic event or “hitting rock bottom.” Without immediate intervention the patient can easily fall back into addiction. The ED/UCC should maintain an easy to understand guide on local addiction recovery resources, including all payer types.

**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), the 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.**

The emergency health care provider is not in a position to monitor the effects of chronic opioid therapy and therefore should not prescribe opioids for the treatment of chronic pain. Repeated prescribing of opioids from the ED/UCC is a counter-therapeutic, enabling action that delays patients from seeking appropriate pain control and monitoring.

Guidelines for the treatment of chronic pain from the Washington State Agency Medical Directors Group and the Medical Quality Assurance Commission recommend that all pain medicine be prescribed by one practitioner.<sup>19,20</sup> The American Pain Society’s guidelines recommend that all patients on chronic opioid therapy should have only one clinician who accepts primary responsibility for their overall medical care.<sup>10</sup>

Prescribing opioids from the ED/UCC to patients with chronic pain should usually be limited to those situations in which the existence of acute pain can be attributed to a disease process or traumatic injury diagnosed with objective evidence. Opioid treatment of patients with chronic pain requires close monitoring of the patient’s pain and functioning. The emergency medical provider is not capable of providing this monitoring. The absence of prescription opioid monitoring places the patient at risk for harm from excess or unnecessary amounts of these medications. The ED/UCC provider’s one-time relationship with the patient does not allow proper monitoring of the patient’s response to chronic opioid therapy.

**7. Health care providers should not provide replacement prescriptions for lost, destroyed or stolen controlled substances.**

Patients misusing controlled substances frequently report their opioid medications as having been lost or stolen. Pain specialists routinely stipulate in pain agreements with patients that lost or stolen controlled substances will not be replaced. Most written agreements between chronic pain patients and pain management physicians, including the Health Resources and Services Administration (HRSA) toolkit sample pain agreement, state that prescriptions for opioids will not be replaced. EDs/UCCs should institute policies not to replace opioid prescriptions when lost, stolen, or destroyed.<sup>21</sup>

**8. Long-acting or controlled-release opioids (such as OxyContin®, fentanyl patches, suboxone, and methadone) should not be prescribed from the ED/UCC.**

Long-acting opioids should not be prescribed from the ED/UCC because this treatment requires monitoring which the emergency medical provider cannot provide. Methadone and oxycodone are known to be associated with higher incidences of overdose death than any other prescription opioid.<sup>22</sup>

Methadone and/or suboxone should not be prescribed or administered as opioid substitution therapy from the ED/UCC. Methadone and suboxone have a long half-life, and patients who are part of a daily methadone or suboxone treatment program that miss a single dose, will not go into opioid withdrawal for 48 hours. Opioid withdrawal, by itself, is not an emergency medical condition. The emergency health care provider should consider the possibility that the patient may have been discharged from a methadone or suboxone treatment program for noncompliance or is not enrolled. The emergency health care provider or admitting provider should call the methadone or suboxone treatment program if the patient is admitted to the hospital. The patient's status in the methadone or suboxone treatment program should be verified and the patient's methadone or suboxone dose should be documented for continued dosing while hospitalized.

**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.**

Opioid prescriptions for exacerbations of chronic pain from the ED/UCC are discouraged. Chronic pain patients should obtain opioid prescriptions from a single opioid prescriber who monitors the patient's pain relief and functioning. Prescribing pain medicine from the ED/UCC for chronic pain represents unmonitored opioid therapy, which is not safe.

The emergency medical provider should attempt to contact the primary opioid prescriber prior to prescribing any opioids. If the patient's primary opioid provider feels further opioid pain medicine is appropriate, it can be prescribed by that provider during office hours. In exceptional circumstances, although it should not be expected and is not required, the emergency medical provider may choose to prescribe opioid medication for acute exacerbations of chronic pain, when the following safeguards are followed:

1. The patient's primary opioid prescriber is contacted first to approve further opioids for the patient. If approved, a limited prescription can be prescribed from the ED/UCC to last until the patient is able to see their primary opioid prescriber. This reinforces the idea that patients should obtain pain medicine only from the primary opioid provider.
2. Only enough opioid pain medication is prescribed to last until the patient can contact their primary prescriber, with a maximum of a three-day supply of opioids (rather than a quantity sufficient to last until the patient's next scheduled appointment).

3. If the primary opioid provider cannot be reached, then the Oklahoma PMP should be queried. The ED/UCC provider should confirm that recent opioid prescriptions reported by the PMP match what the patient reports. If the Oklahoma PMP reveals recent opioid prescriptions from multiple prescribers, the provider should not prescribe an opioid. Likewise, no opioids should be prescribed if the patient misrepresents a personal history of opioid use; providing false information in an effort to obtain prescription opioids is behavior that can signal opioid addiction or misuse.

Urine drug testing for illicit and prescribed substances requires a working knowledge of the potential for false positive and false negative results and the need for confirmatory testing. A discussion on the limitations of urine testing is beyond the scope of these guidelines. Other chronic pain guidelines address urine drug testing in detail.<sup>19</sup> Urine drug testing has the potential to identify patients using illicit drugs or not taking medications they report being prescribed. Both of these situations are grounds for denying further opioid prescriptions. Clinicians knowledgeable in interpretation of urine drug testing results are encouraged to perform urine drug tests before prescribing opioids for exacerbations of chronic pain.

**10. The administration of intravenous and intramuscular opioids for the relief of exacerbations of chronic pain is discouraged, except in special circumstances.**

Parenteral opioids should be avoided for the treatment of chronic pain in the ED/UCC because of their short duration and potential for addictive euphoria. Generally, oral opioids are superior to parenteral opioids in duration of action and provide a gradual decrease in the level of pain control. When there is evidence or reasonable suspicion of an acute pathological process causing the acute exacerbation of chronic pain then parenteral opioids may be appropriate. Under special circumstances, some patients may receive intravenous or intramuscular opioids in the ED/UCC when this treatment plan is coordinated with the patient's primary care provider.

**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.**

Opioid analgesics, when combined with other central nervous system depressants or given to patients with certain underlying medical conditions, can increase the risk for overdose, especially in older patients. Avoid the combination of benzodiazepines and opioid analgesics as much as possible.<sup>10</sup> In Oklahoma, about one-third of unintentional opioid overdose deaths involve a benzodiazepine, most commonly alprazolam (Xanax®).<sup>1</sup> In addition, patients taking higher doses of opioids, including cumulative doses from more than one source, are at higher risk for respiratory depression. The Centers for Disease Control and Prevention estimates that the 20% of patients receiving opioids who were prescribed a combination of 100 or more morphine equivalents per day account for 80% of opioid overdoses, with half of these among patients with opioids from more than one prescriber.<sup>23</sup> Opioid analgesics should be used with caution in older patients and those with sleep-disordered breathing, such as obstructive sleep apnea, obesity, or congestive heart failure.<sup>24</sup> Doses may have to be adjusted in patients with renal or liver disease due to decreased clearance of the drug.

**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.**

Patients should be informed of the risks of taking opioid analgesics and be reminded to take them as prescribed, not more frequently or in greater quantities. Risks of opioid analgesics include, but are not limited to: overdose that can slow or stop their breathing and even lead to death; fractures from falls in patients aged 60 years and older; drowsiness leading to injury; tolerance; and dependence. Respiratory depression is more common with use of alcohol, benzodiazepines, antihistamines, and barbiturates. Patients should be reminded to avoid medications that are not part of their treatment plan because they may worsen side effects and increase the risk of overdose.

Nearly three-fourths (71%) of people aged 12 and older who have used opioid analgesics for non-medical purposes reported obtaining them for free or buying them from family or friends.<sup>3</sup> Patients should be told how to minimize risks to others by keeping their medication in a secure location, preferably locked; not sharing medication with anyone; and promptly disposing of unused opioids.

**13. Health care providers are encouraged to consider non-pharmacological therapies and/or referral to specialists for follow-up, as clinically appropriate.**

Opioids are just one of the numerous, therapeutic pain control options for most causes of chronic illness or injury. Opioid prescriptions from the ED/UCC for exacerbation or progression of chronic pain, not associated with palliative/end of life care, are discouraged in general. Patients with chronic pain who require opioid analgesics should obtain opioid prescriptions from a single prescriber who monitors the patient's pain relief and function. Prescribing opioid analgesics from the ED/UCC for chronic pain is a form of unmonitored opioid therapy that is not optimal for patient care. In exceptional circumstances, the provider may consider prescribing short-acting opioid analgesics for patients with acute worsening of chronic pain. Similarly, changing the opioid a patient is using chronically in an effort to improve pain relief (i.e., opioid rotation) is complicated and generally should not be done in the ED/UCC.<sup>25</sup>

**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.**

EDs/UCCs should encourage patients to seek primary care in non-emergent care settings. ED/UCC providers and staff should counsel over-utilizing patients on appropriate venues for their symptoms and provide patients with an up-to-date list of clinic resources. The emergency health care provider should not feel compelled to prescribe opioids due to the patient's lack of a primary care provider.



**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.**

The Emergency Medical Treatment and Active Labor Act (EMTALA) does not require the emergency health care provider to provide pain relief for patients who do not have an emergency medical condition. Once a medical screening exam determines that a patient does not have an emergency medical condition, there is no obligation under EMTALA to treat a patient's pain in the ED. The EMTALA definition of a medical emergency makes reference to severe pain as a symptom that should be investigated that may be resultant to an emergency medical condition. EMTALA does not state that severe pain is an emergency medical condition. The Center for Medicare Services (CMS) requires the hospital to have policies for assessing a patient's pain and documenting the assessment. EMTALA does not obstruct the emergency health care provider from applying their professional judgment to withhold opioid treatment of pain for ED/UCC patients without an emergency medical condition.

Emergency health care providers working in EDs/UCCs should be supported by administrators when opioids are not administered or prescribed because prudent, clinical judgment dictates that the risks of opioid therapy outweigh the benefits.

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***Disclaimer:** This document should not be used to establish any standard of care. 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. These guidelines are only an educational tool. Clinicians should use their own clinical judgment and not base clinical decisions solely on this document. The recommendations are not founded in evidence-based research but are based on promising interventions and expert opinion. Additional research is needed to understand the impact of these interventions on decreasing unintentional drug poisoning and on health care costs. These guidelines should be considered by clinicians, hospitals, administrators, public health entities, and other relevant stakeholders.*

## References

1. Oklahoma State Department of Health, Injury Prevention Service. Unintentional Poisoning Fatality Surveillance System. [Data file].
2. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2012). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved from [http://webappa.cdc.gov/sasweb/ncipc/dataRestriction\\_inj.html](http://webappa.cdc.gov/sasweb/ncipc/dataRestriction_inj.html). Accessed September 11, 2013.
3. Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health*. Retrieved from <http://oas.samhsa.gov/2k8state/AppB.htm>. Accessed September 11, 2013.
4. Centers for Disease Control and Prevention. (2011). *Prescription Painkiller Overdoses in the U.S.* Retrieved from <http://www.cdc.gov/vitalsigns/painkilleroverdoses/>. Accessed September 10, 2013.
5. Washington State Department of Health. (n.d.). *Washington Emergency Department Opioid Prescribing Guidelines*. Retrieved from <http://washingtonacep.org/Postings/edopioidabuseguidelinesfinal.pdf>. Accessed September 10, 2013.
6. The New York City Department of Health and Mental Hygiene. (n.d.). *New York City Emergency Department Discharge Opioid Prescribing Guidelines*. Retrieved from <http://www.nyc.gov/html/doh/downloads/pdf/basas/opioid-prescribing-guidelines.pdf>. Accessed September 10, 2013.
7. Utah Department of Health. (2009). *Utah Clinical Guidelines on Prescribing Opioid Analgesics for Treatment of Pain*. Retrieved from <http://health.utah.gov/prescription/pdf/guidelines/final.04.09opioidGuidlines.pdf>. Accessed September 10, 2013.
8. Ohio Department of Health (n.d.). *Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances (OOCs) Prescribing Guidelines*. Retrieved from <http://www.healthyohioprogram.org/ed/~media/7496C0B75BD740E7A6BBF57306DF1E22.aspx>. Accessed September 10, 2013.
9. Centers for Medicare and Medicaid Services. (1986). *Emergency Medical Treatment and Labor Law Act (EMTALA)*. Retrieved from <https://www.cms.gov/EMTALA>. Accessed September 10, 2013.
10. Chou, R., Fanciullo, G.J, Fine, P.G., Adler, J.A., Ballantyne, J.C., Davies, P., . . . Miaskowski, C. (2009). Clinical guidelines for the use of chronic opioid pain therapy in chronic noncancer pain. *Journal of Pain, 10*(2), 113-130.
11. Dunn, K.M., Saunders, K.W., Rutter, C.M., Banta-Green, C.J., Merrill, J.O, Sullivan, M. . . . Korff, M.V. (2010). Opioid prescriptions for chronic pain and overdose: a cohort study. *Annals of Internal Medicine, 152*(2), 85-92.
12. Bohnert, A.S., Valenstein, M., Blair, M.J., Ganoczy, D., McCarthy, J.F., Ilgen, M.A., & Blow, F.C. (2011). Association between opioid prescribing patterns and opioid overdose-related deaths. *Journal of the American Medical Association, 305*(13), 1315-1321.

13. Alam, A., Gomes, T., Zheng, H., Mamdani, M., Juurlink, D., & Bell, C. (2012). Long-term analgesic use after low-risk surgery: a retrospective cohort study. *Archives of Internal Medicine*, 172(5), 425-430.
14. Braden, J., Russo, J., Fan, M., Edlund, M., Martin, B., DeVries, A., & Sullivan, M.D. (2010). Emergency department visits among recipients of chronic opioid therapy. *Archives of Internal Medicine*, 70(16), 1425-1432.
15. Edlund, M.J., Fan, M., DeVries, A., Braden, J., Martin, B., & Sullivan, M.D. (2010). Trends in use of opioids for chronic non-cancer pain among individuals with mental health and substance use disorders: the TROUP study. *Clinical Journal of Pain*, 26, 1-8.
16. Partners Against Pain. (2013). *Opioid Risk Tool*. Retrieved from [http://www.partnersagainstpain.com/printouts/Opioid\\_Risk\\_Tool.pdf](http://www.partnersagainstpain.com/printouts/Opioid_Risk_Tool.pdf). Accessed April 19, 2013.
17. Washington State Department of Social and Health Services. (2008). *Washington State Screening, Brief Intervention, Referral and Treatment Project*. Retrieved from <http://www.dshs.wa.gov/pdf/dbhr/WASBIRTPrelim091908.pdf> . Accessed April 19, 2013.
18. Office of National Drug Control Policy. (2010). *National Strategy*. Retrieved from [http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/ndcs2010\\_0.pdf](http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/ndcs2010_0.pdf). Accessed April 19, 2013.
19. Agency Medical Director's Group. (2010). *Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain*. Retrieved from <http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf>. Accessed April 19, 2013.
20. Washington State Department of Health, Medical Quality Assurance Commission. (2011). *Adopted Pain Management Rules, May 2011 (effective 1/2/12)*. Retrieved from <http://apps.leg.wa.gov/WAC/default.aspx?cite=246-919-850>. Accessed April 19, 2013.
21. Washington State Health Care Authority. (2009). *HRSA Toolkit*. Retrieved from <http://www.hca.wa.gov/medicaid/pharmacy/pages/toolkit.aspx>. Accessed on October 23, 2009.
22. Centers for Disease Control and Prevention. (2010). *Poisoning in the United States – Issue Brief*. Retrieved from <http://www.cdc.gov/homeandrecreationalafety/rxbrief/>. Accessed on April 19, 2013
23. Centers for Disease Control and Prevention. (2012). *CDC Grand Rounds: Prescription Drug Overdoses – a U.S. epidemic. Morbidity and Mortality Weekly Report (MMWR) 61(01):10-13 (January 13, 2012)*. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6101a3.htm>. Accessed on September 10, 2013.
24. Yue, H.J. & Guilleminault, C. (2010). Opioid medication and sleep-disordered breathing. *Medical Clinics of North America*, 95, 435-446.
25. Webster, L.R. & Fine, P.G. (2012). Review and critique of opioid rotation practices and associated risks of toxicity. *Pain Medicine*, 13(4), 562-70.