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[Submitted via eCOM Tracker JIRA website](#)

**Date:** July 29, 2016

**Re: Safe Use of Opioids—Concurrent Prescribing measure**

Dear Mr. Decker:

On behalf of more than 34,000 members of the American College of Emergency Physicians (ACEP), thank you for the opportunity to comment on the proposed measure “Safe Use of Opioids - Concurrent Prescribing.” The American College of Emergency Physicians applauds the attempt to improve opioid prescribing in the US. We see first-hand the increasing numbers of patients who are taking opioids, and the tragic result of unintended opioid overdoses. We believe that a measure such as the one proposed may be useful, but will be problematic for the emergency provider. While the measure provides a rationale for safe prescribing/use of opioids, which is laudable, the amount of opioids/benzodiazepines prescribed from the emergency department pales in comparison to the outpatient setting. While the physician still bears ultimate responsibility, we believe the practicing pharmacist should provide the final safeguard before dispensing an opiate or benzodiazepine combination. However, most EDs do not have a pharmacist available 24/7.

ED providers do not choose their patient population, and per EMTALA, are required to care for all patients who present for care. ED providers are not primary care physicians and do not have control over the medications that the patients have been prescribed prior to arrival to the emergency department. ED providers deliver episodic care and are not in a position to disrupt an established physician-patient relationship that the patient has with their primary care physician, and as such are not in a position to stop medications that patients are being prescribed by their primary care physician. Therefore, performance on this measure is largely outside of the control of ED providers, especially when they present to the ED with active opioid and benzodiazepine prescriptions.

Regarding “Whether the prescriber should be held accountable if a patient has concurrent, active prescriptions for opioids or opioids and benzodiazepines prior to intake and maintains that prior regimen after discharge” the answer is categorically no. The emergency physician or other emergency provider should not be held accountable for medications s/he does not prescribe, and should not be held responsible to modify a treatment regimen that was established prior to the patient’s ED visit.

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The measure is heavily reliant upon PDMP data. At this time not all states have an optimally functional PDMP. Common problems with the PDMP system include that trustworthiness is highly variable, it can be cumbersome, may not contain real time data, and the information can be unreliable. In addition, patients may cross state lines for care and not all states are part of InterConnect to share information interstate about dispensed prescriptions. Until a coordinated system is in place, this measure should not advance as part of a quality and patient safety initiative for emergency physician scoring.

While the combination of a benzodiazepine and opioid in large doses can be problematic, there is concern that patients on small doses of a benzodiazepine for a chronic problem (anxiety, insomnia) might not be able to be given opioids if they have an acute injury or fracture. There is also a real threat of creating withdrawal in a patient who has been on long standing opioids with concurrent benzodiazepines. Suddenly stopping one of the medications will often cause withdrawal, which can be life-threatening in some cases. Weaning from medication is done over protracted periods of time, and not in the scope of care of an emergency physician.

Another challenge for emergency physicians is that we do not always have access to a list of a patient's medications. In an ideal world, we should know the patient's medications, but our experience is that often the patients themselves do not know their medications. Most of the information available from the EMR represents the last inpatient visit, and medications may, and do, change with subsequent outpatient visits.

If this measure is adopted, we recommend that several groups be excluded. These include Hospice patients, those with cancer and those with sickle cell disease. These groups generally require a baseline opioid with additional, often different, opioid for breakthrough pain. We suggest this measure be limited to large quantities of medications. This would provide the option for emergency physicians to continue a patient's multiple opioid or opioid/benzodiazepine regimen for a 5 day period.

Thank you for the opportunity to share our concerns and comments. We look forward to working with your staff on any future revisions. If you have any questions, please do not hesitate to contact, Sandra Schneider MD FACEP, Director of Director, EM Practice at 1800-798-1822 ext. 3234 or [sschneider@acep.org](mailto:sschneider@acep.org)

Sincerely,

A handwritten signature in black ink, appearing to read "Jay Kaplan". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Jay Kaplan, MD, FACEP

President, ACEP