Opioid Use in Michigan

MiCMRC/MiPCT

Educational Webinar

June 7, 2016

Presenter

- Catherine Reid, MD
- Consulting Physician, Office of Medical Affairs Michigan Dept. of Health and Human Services
- Coordinator for Michigan's Drug Utilization Review Board
  - In her role with MDHHS, Dr. Reid reviews literature regarding best pain management practice (often in coordination with other state Medicaid agencies), formulates policy, prescribing criteria and reviews inappropriate controlled substance cases brought by Licensing and Regulatory Agency (LARA), the attorney general's or inspector general's office.
  - As a coordinator on the Drug Utilization Review Board, she reviews prescribing patterns for opiates, opiates and concurrent use of benzodiazepines or stimulants, length of short acting opiate use, Morphine Equivalent Daily Dose (MEDD) prescribing and MAPS registration among MAT prescribers. These reviews resulted in letters to prescribers and changes in Medicaid policy.

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For technical assistance please e-mail: micmrc-requests@med.umich.edu

Disclosure Statement of Financial Interest

- Catherine Reid, Marie Beisel, Lauren Yaroch, and Betty Rakowski have reported no relevant conflict of interest for the purpose of the MiCMRC/MiPCT Webinar, “Opioid Use in Michigan”
- There is no commercial support for this activity.

Opioid Use in Michigan

Catherine Reid, MD

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Objectives:

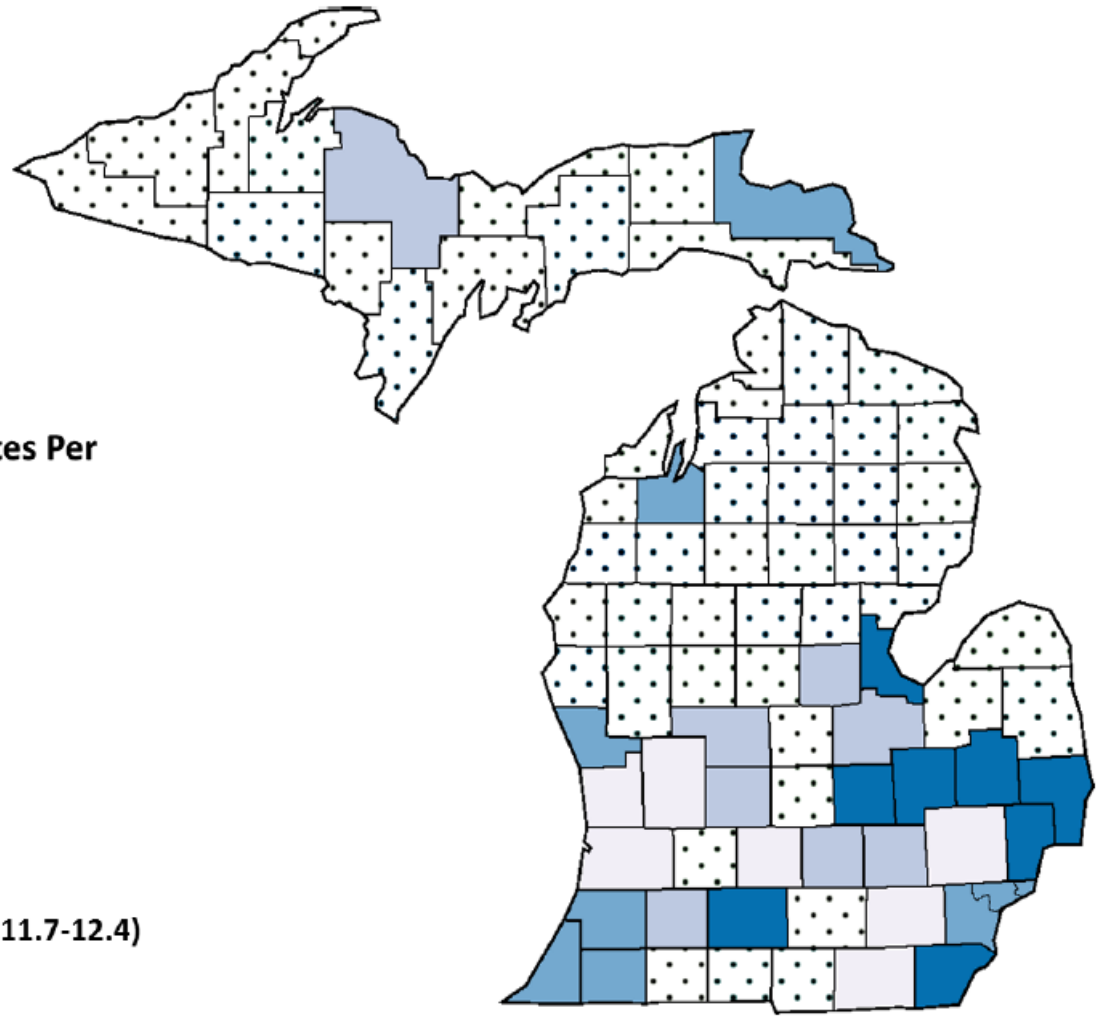
- Learn to recognize the risk involved when prescribing opioids
- Understand the key principles in assessing and treating a patient with pain, both adult and pediatric
- Understand narcotic and non-pharmacologic modalities in an integrated approach to pain management

Risk of Prescribing Narcotics: Current issues with opioids in Michigan

- Michigan is part of the national epidemic of abuse, addiction and overdose due to opioids
- Trend of increased opioid use began in late 1990's as a response to release of first long acting narcotic and a classification of pain as "**the 5th vital sign**" which must be treated
- Fostered a belief that chronic pain could safely be treated without addiction
- Led to increased opioid prescribing for conditions (like arthritis, back pain) with high doses and continuous therapy

Unintentional or Undetermined Intent Poisoning Death Rates, by County of Residence: MI Residents, 2009-2012

(Office of Recovery Oriented Systems of Care, MDCH, December 2013)



Overall MI rate: 12.0 (95% CI: 11.7-12.4)

Michigan statistics

	1999	2014
Number of deaths	460	1762
State Population	9,897,117	9,909,877
Rate per 100,000	4.65	18.04

CDC data March 2016

Pathophysiologic Classification of Pain

A. Nociceptive Pain: injury activates pain receptors, "nociceptors", which then physiologically transmit pain message to brain

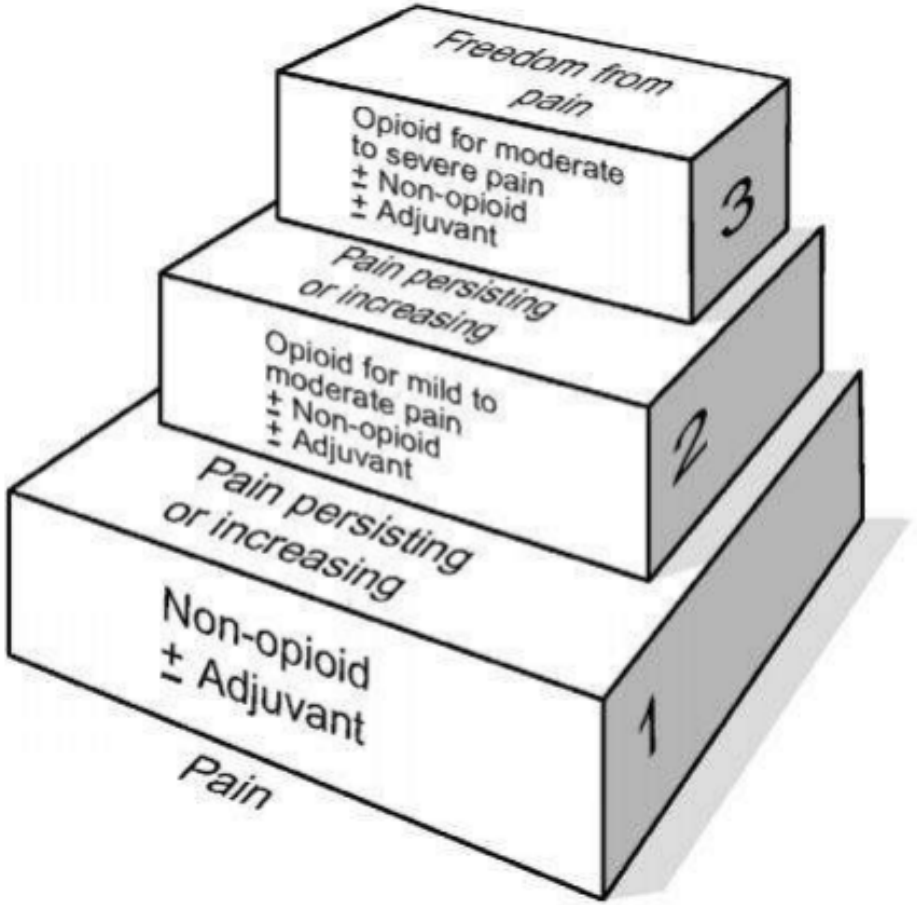
- **Somatic pain**:
  - activation of nociceptors in **surface tissue** (skin, mucosa) or **deep tissue** (muscle, bone, joint)
  - usually well localized
- **Visceral pain**:
  - activation of nociceptors in **viscera** (internal organs)
  - usually not well localized

Pathophysiologic Classification of Pain

B. <u>Neuropathic Pain:</u>

- pain caused by injury to nerve cells from structural damage, compression or dysfunction of brain/spinal cord signal processing
- Peripheral or central nervous system
- Damage can be caused by infection, trauma, ischemia, metabolic or immune conditions
- Burning, shooting, persistent (diabetic nerve pain, neuropathy)

World Health Organization (WHO) ladder



Basic Concepts of Pain Management Adults

Structured approach to evaluating a pain patient

- Determine correct diagnosis
- Type of pain: nociceptive vs neuropathic
- Previous treatment
- Co-morbid conditions

Psychological assessment

- Co-morbid mood disorders, depression
- Sleep patterns
- Risk of abuse or addiction

Tools for screening depression, abuse risk in the office

- Tools are either patient self-reported or clinician administered, average time to complete $\leq$ 5 min
- CAGE – Adapted to Include Drugs (**CAGE – AID**)
- Alcohol Use Disorders Identification Test (**AUDIT**)
- Opioid Risk Tool (**ORT**)
- Patient Health Questionnaire 9 (**PHQ-9**)
- Screener and Opioid Assessment for Patients with Pain (**SOAPP-R**)

Establish treatment goals

- Increase function should be primary goal
- Improved quality of life
- Advise patient that complete relief of pain unlikely

Non-pharmacologic and non-narcotic treatment modalities should be used first

- Weight loss
- Physical therapy
- Cognitive Behavioral therapy and Biofeedback techniques
- Adjuvants: NSAIDS, tricyclic antidepressants, anti-seizure meds (gabapentin, pregabalin, carbamazepine)
- Joint injections, epidural, nerve blocks, spinal stimulators, etc.

If narcotics are started:

- Decision to start narcotics should be made with the patient after discussion of risks/benefits
- Complications and adverse reactions, including possibility of overdose and addiction, part of discussion
- Explanation that complete pain relief is unlikely, set realistic goals that emphasize improved function
- **Lowest dose on a trial basis should be used**
  - Short-acting narcotics should be used first
  - Extended Release (ER) or long acting (LA) version of a narcotic should never be the initial choice, increases overdose potential
- Avoid concurrent benzodiazepine use

Utilize Morphine Equivalent Daily Dose (MEDD) calculations when treating with narcotics, also called "Morphine Mg Equivalent (MME)"

- Converts all opioids to their approximate equivalent in morphine, helps standardize opioid dosing or "Equianalgesic" dose, helps when converting one opioid for another
- Dose calculators are widely available on internet to give equivalent dose (example: Oxymorphone 10mg = 30mg morphine)
- ≥ 100 MEDD is associated with an increased risk of overdose
- ≥ 120 MEDD should be referred to a pain specialist

Frequent re-assessment during treatment

- Complications: Sedation, Constipation
- **Hyperalgesia** – syndrome where opiates sensitize the CNS and actually make pain worse
- **Monitoring MAPS, urine drug screens, pill counts**
- Strategy for stopping narcotics if goals are not met, developed when narcotics are started
- **STOP NARCOTICS IF NO IMPROVEMENT**

Michigan Automated Prescription System (MAPS)

- Michigan's prescription drug monitoring program (PDMP), managed by Dept. of **Licensing and Regulatory Affairs (LARA)**
- **Automated system** that **registers all controlled substances dispensed** to an individual in Michigan
- **Data entered by the pharmacy** that fills prescription
- Collected on **Schedule II-V drugs** and **reported to LARA daily**
- Must be either **law enforcement**, a **Michigan licensed prescriber or pharmacist** *and* **registered with MAPS** to access reports

Controlled Substances and Drug Schedules

Controlled Substances: drugs or chemicals whose use, procession or manufacture are controlled by the government.

Drug Enforcement Agency (DEA) divides controlled substances into 5 “schedules” based on medical use, abuse and addiction potential.

Examples:

Schedule I – heroin, Ecstasy, Marijuana

Schedule II – OxyContin, Percocet, Adderall, Hydrocodone

Schedule III – Suboxone, Tylenol with Codeine

Schedule IV – Xanax, Ambien, Tramadol

Schedule V – Robitussin AC, Phenergan with Codeine

Information in a MAPS Report:

- Chronological **list of all controlled substances prescribed for an individual**, reported by their name and date of birth
- Date prescription was **written**, date it was **filled**
- Lists each **drug, strength and quantity prescribed**
- **Who wrote** the prescription
- **What pharmacy** filled prescription
- **How it was paid for**: private pay (cash), commercial insurance, Medicaid

Example MAPS report (fictional)

Michigan Automated Prescription System

Selected Prescription Detail Report

Patient Name: Patient P DOB: 00/00/0000

Patient Name Address	Birth Date Issue Date Fill Date	Medication Form / Qty Strength	Rx Type Auth Refills	Rx Number Transmission Form Payment Type	Practitioner Name Practitioner DEA# Practitioner Address	Dispenser Name Dispenser DEA# Dispenser Address
Patient P Address	00/00/0000 00/02/0000 00/02/0000	Morphine ER 60.00 30 MG	Original 0	xxxxxxx1 Written prescription Commercial PBM Ins	Doctor #1, MD DEA# Address	Pharmacy #1 DEA# Address
Patient P Address	00/00/0000 00/02/0000 00/12/0000	Morphine ER 60.00 30 MG	Original 0	xxxxxxx2 Written prescription Private pay	Doctor #2, MD DEA# Address	Pharmacy #2 DEA# Address
Patient P Address	00/00/0000 00/14/0000 00/14/0000	Hydrocodone Tab 120.00 10/325 MG	Original 0	xxxxxxx3 Written prescription Private pay	Doctor #3, MD DEA# Address	Pharmacy #3 DEA# Address

Basic Concepts Pain Management Pediatrics

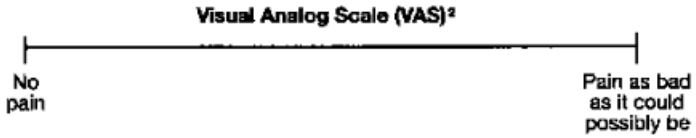
Barriers to treating pediatric pain: identified by Am Academy of Pediatrics (AAP) and the American Pain Society (APS)

- Myth: Children don't feel pain the way adults do
- Lack of both appropriate initial pain assessment and then reassessment
- Difficulty conceptualizing, quantifying pain child is experiencing
- Lack of knowledge of how to treat the pain
- Addressing pain takes too much time
- Fear of using pain meds due to their adverse effects

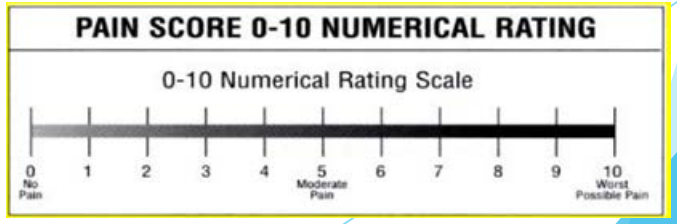
Pain Assessment: adapt for child's ability to communicate

- **Infants**: Face, Legs, Activity, Cry and Consolability (FLACC) scale (birth to 7yo), CRIES
- **Younger children**: Faces Pain Scale

- **Older children (> 8yo), adolescents**:
  - Visual Analog Scale (VAS)



  - Numeric Rating Scale (NRS)



Nonpharmacotherapy measures

- Physical comfort measure: hot/cold compresses, massage, repositioning, physical therapy
- Psychological comfort measures: imagery, distraction, relaxation techniques

Pharmacotherapy

- Topical formulations
- Acetaminophen, NSAIDS
- Opioids: still best choice for moderate to severe pain
- Codeine products used more frequently in children (not necessarily safer)
- Combination NSAIDS with opioids can have dose limiting effect on amount of opioid needed

Procedure related pain

- Children and parents should receive info on what to expect
- May need systemic agents: Blocks, Deep sedation, Anesthesia
- Quiet environment, calm adults, clear instructions

Acute illness:

- Treatment determined by severity of pain and type of illness
- NSAIDS, acetaminophen, distraction, relaxation, physical therapy

Pediatric Pain Management Recommendations

- **Expand knowledge** about pediatric pain and management principles
- Provide **calm environment** for procedures to reduce stress
- Use appropriate **pain assessment tools**
- **Anticipate predictable pain experiences** and intervene/monitor accordingly
- **Multimodal and multidisciplinary approach** to pain management
- **Involve families** and tailor intervention to individual

Conclusion

- **Pain is a complex problem and needs an integrated, multimodal approach**
- **Treatment with opioids has risks: diversion, misuse, addiction, overdose, death**

- Managing pain in both adults and children requires a **structural approach**
  - **Assessment** of pain (type, risk of abuse or addiction) and *children need assessment based on their communication ability*
  - Establishing treatment **goals** (quality of life and improved function)
  - Establishing treatment **plan and re-assessment strategy**:
    - Non-pharmacologic
    - Pharmacologic
    - Non-narcotic, adjuvant
    - Opioids: type, dose, monitoring, stopping if no improvement

- Practitioners should **register for MAPS** and use when prescribing controlled substances

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