

MipainManagement

Department of Community Health

Bureau of Health Professions

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Special Points of Interest

- Pharmacy Directory
- MAPS Program Updates
- State Program Updates
- Upcoming Michigan Conferences

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Volume 2, Issue 1

Spring 2011

Bureau of Health Professions



Melanie Brim, Director
Bureau of Health Professions,
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Community Health

In the fall of 2010 the Bureau of Health Professions launched *MipainManagement* - an electronic newsletter for health care professionals in Michigan. This second issue is being distributed by mail to every Michigan health professional that received a new license since fall of 2010. We are also sending this issue electronically to all who have subscribed to it in the past 6 months. *MipainManagement* includes useful information regarding pain and symptom management, including best practices in Michigan, current state and federal pain management policy and legislation, results from state and national pain surveys, and much more. You are invited to contribute to this newsletter by contacting the bureau's Professional Practice Section at 517-335-6557.

MipainManagement is free to anyone subscribing to it, so I encourage you to take advantage of this offer and complete the enclosed mailer to subscribe to this newsletter. If you are receiving it electronically, please encourage your colleagues to subscribe to it by visiting our pain management website at www.michigan.gov/pm. On behalf of the Michigan Department of Community Health, I hope you enjoy this newsletter and consider contributing to it in the future.

Pharmacy Directory Available for Patient Referral

In 2002, the State of Michigan's Advisory Committee on Pain and Symptom Management recommended the development of strategies to ensure patients who suffer from chronic pain have reliable and on-going access to a pharmacy that can fill valid prescriptions for Schedule 2 controlled substances. In response to this recommendation, the Pain Management and Palliative Care Program and the Michigan Automated Prescription System (MAPS) surveyed Michigan pharmacies in an effort to compile a confidential list of pharmacies that stock supplies of Schedule 2 controlled substances. The Bureau received an excellent response to the survey, as many Michigan pharmacies were willing to be included in the confidential list, or *Pharmacy Directory*. The Pharmacy Directory will be provided to practitioners, which will enable them to refer their patients to pharmacies in their geographical area that supply Schedule 2 controlled substances. This will help ensure the patient has access to medication that is required for pain relief.

The Pharmacy Directory will be available to practitioners only through MAPS Online. MAPS is the electronic prescription monitoring program for the State of Michigan used to identify and prevent drug diversion at the prescriber, pharmacy and patient levels by collecting Schedule 2-5 controlled substance prescription data dispensed by pharmacies and practitioners.

Collection of prescription information through MAPS allows practitioners to query this database for patient-specific reports which allow a review of the patient's Schedule 2-5 controlled substance prescription records. This enables the practitioner to determine if patients are receiving controlled substances from other providers. MAPS provides practitioners with ease of mind when prescribing controlled substances for their patients. It is instrumental for those physicians who treat patients with chronic and long term pain conditions and assists with effective pain management.

The Pharmacy Directory link is located on the MAPS user home page, and is a confidential list which may only be used by practitioners. For those practitioners who are not currently registered with MAPS, please visit the MAPS website at www.michigan.gov/mimapsinfo for registration information or email MAPS staff at mapsinfo@michigan.gov.

Interventional Pain Management

By Michael Chafty, M.D.
Member, Michigan Advisory Committee on Pain & Symptom Management

Interventional Pain Management, as defined by the American Society of Interventional Pain Physicians (ASIPP), is a “discipline of medicine devoted to the diagnosis and treatment of pain related disorders”. It utilizes a multidisciplinary approach, in which a team of professionals work together to evaluate, diagnose, and formulate a treatment plan to manage chronic, often debilitating pain. The physician-led team includes psychologists, nurses, and physical therapists. The goal is to control pain, improve patient quality of life, and increase daily function without reliance on medications alone. Injections are one component of multidisciplinary pain management, which also includes therapy, medications, and counseling.

Interventional pain management utilizes invasive techniques, such as fluoroscopy, CT scans, and ultrasound to safely guide injections. Examples of blocks that are used include epidurals, facets, rhizotomy (nerve ablation), celiac plexus, spinal cord stimulator implants, intrathecal pumps, and many others. These procedures are complicated, and because of the risk to the nervous system, require intensive training. Physicians must complete residency after medical school, and many complete a fellowship program devoted solely to pain management. There are advanced certification examinations offered by the American Board of Anesthesiology, and other specialties, to qualified physicians who have completed pain management fellowships.

Due to patient safety concerns, many states are now recognizing interventional pain management as the practice of medicine. The injections must be performed by a physician because of the potential risk to patients. In its 2009 recommendations (www.michigan.gov/documents/mdch/ACPSM2009ReportApril2010_343109_7.pdf), the Michigan Advisory Committee on Pain & Symptom Management recommended that Interventional Pain Management be recognized as the practice of medicine.

Interventional pain management is an exciting new area of medicine, offering hope to patients with complicated pain while maintaining strict adherence to patient safety. At one time, there was little hope for relief from cancer pain or even chronic back pain, except for the reliance on medications. Through these new approaches, physicians are now able to block or lesion nerves to provide effective pain relief to a patient, and eliminate the scourge of pain.

New MAPS Weekly Reporting Requirement to be Implemented in 2011

The Michigan Automated Prescription System (MAPS), is a program which allows prescribers and dispensers of Schedule 2 – 5 controlled substances to get information on a patient’s use of these medications. Since 2007, pharmacies have been required to report prescription data to the Bureau of Health Professions twice a month (on the 1st and the 15th). Prior to that, prescription data had to be reported once a month.

MAPS reporting requirements will change from twice monthly to **weekly reporting** in an effort to provide more accurate and up-to-date prescription information to health professionals. Although the weekly reporting requirement will be implemented by mid to late 2011, daily submissions of prescription data are also accepted. For information about the 2011 reporting requirements, go to www.michigan.gov/mimapsinfo and watch for updates.

Michigan Pain Management and Palliative Care Program Update

In FY 2011, the Pain Management and Palliative Care Program (PMPCP) will conduct its third physician survey and second public pain management survey and distribute the *Responsible Opioid Prescribing: A Michigan Physician’s Guide* to new licensees. An exciting new endeavor of the program is the completion of a DVD on the Michigan Automated Prescription System (MAPS) and Effective Pain Management. The DVD will be mailed out this spring to health professionals who prescribe and dispense controlled substances.

Important FY 2011 collaborative efforts with stakeholders include sponsoring a rural pain management survey with the *Michigan Center for Rural Health* and sponsoring statewide pain management training for nursing home professionals with the *Michigan Local Area Network of Excellence (LANE) of Advancing Excellence in America’s Nursing Homes*. The PMPCP is also sponsoring a summit of medical schools in Michigan to explore improvements in medical school curricula around pain management. This was one of the 2009 recommendations of the Michigan Advisory Committee on Pain and Symptom Management, which will be facilitating the curriculum summit on May 16, 2011.

To learn more about the PMPCP and our other ongoing activities, please visit our website at www.michigan.gov/pm or contact Susan Affholter at 517-373-7303.

The Causal Relationship between Pain and Delirium

By Raymond D. Hobbs, M.D., FACP
Henry Ford Hospital, Detroit, Michigan

“... pain is perfect misery, the worst of evils, and excessive, overturns all patience.”
John Milton, *Paradise Lost*

Two of the most frustrating medical conditions facing the physician, nurse or health care practitioner are the conditions of pain and delirium, which are frequently related to one another and often undertreated and misdiagnosed.

Pain is frequently mismanaged and undertreated, especially at the end of life where numerous studies have shown that many of our patients are suffering needlessly at a time when health professionals can effectively treat most pain conditions. Because there is no blood test or radiologic test for pain, we need to listen to our patients or their caregivers and heed what they tell us. One of the complications of undertreated pain is *delirium*. This is particularly the case as people age into their sixties and beyond. Many health care practitioners, however, are not aware of the relationship between undertreated pain and delirium.

Delirium complicates hospital stays for at least 20 percent of the 12.5 million patients 65 years of age or older who are hospitalized each year in the U.S. It increases the costs of a hospital stay by \$2,500 per patient, and has a mortality rate as high as is found in sepsis or heart attack. And, yet, as common as it is, we frequently fail to diagnose and treat it. Instead, we often erroneously diagnose delirium as dementia.

Misdiagnosing delirium as dementia is a significant mistake, since delirium can be treated, whereas dementia is incurable. The key to making the diagnosis is realizing that there has been a recent change in the patient's thinking and attention. Delirium develops quickly and affects attention, whereas dementia develops slowly and affects memory. Delirium can occur within hours or days whereas dementia progresses over months or years. The key diagnostic question, therefore, is this: “*What was he or she like before now?*” If the change has been sudden, then delirium is the likely diagnosis.

The causes of delirium are numerous and range from a reaction to medications, infections, or recent operations to poorly controlled pain. Delirium caused by poorly controlled pain can set up a repeating cycle. For example, the doctor or nurse may avoid giving pain medications to the patient under the assumption that the medications alone are causing the delirium, thus worsening the delirium because the pain is not being adequately treated. It should be noted that although pain medication may be a cause of delirium, it is much more likely that the delirium is being caused by the undertreatment of pain.

In regards to adequately treating pain through the use of pain medications, most pain medications last for four hours, not the “four to six hours” that health practitioners are usually taught. Furthermore, when treating a patient with ongoing active pain it is more effective to give pain medications around the clock rather than intermittently. That is, it takes far less pain medication to keep continuously managed pain under control than the higher doses it takes to halt uncontrolled pain.

In summary, because pain is such a common condition, it is important for health care professionals to proactively assess for pain and to adequately treat it. By doing so, the incidences of delirium caused by inadequately treated pain should be markedly reduced, resulting in improved patient care and a lessening of human suffering.

Michigan Center for Rural Health Conducts Rural Pain Care Study

In FY 2010, the Michigan Department of Community Health provided funding to the Michigan Center for Rural Health to conduct a pain management survey of rural health care professionals across rural Michigan. The survey, which was administered with the assistance of the MSU's College of Osteopathic Medicine/Family and Community Medicine, was sent to 600 rural Michigan physicians, nurse practitioners, and physician assistants. One hundred sixty-eight (168) surveys were completed and returned.



Survey results indicate that the number one concern of providing pain management among these health professionals is patient prescription drug abuse, followed by patient addiction and the legal complications associated with substance abuse. Other key findings show that sixty-one percent (61%) of respondents do not have written protocols on pain management and 41% do not use a pain management assessment tool with their patients.

In FY 2011, MCRH will be following up the survey with educational programs designed to address issues indicated by the survey. In order to accommodate rural areas, the programs will be delivered via webinar. The first three sessions will feature 1) MAPS training and education, 2) alternative behavioral health programs, and 3) a physician expert on palliative care. Please visit the MCRH web site at <http://www.mcrh.msu.edu> for more information on these educational opportunities.



COMING SOON

MAPS and Pain Management DVD to be Distributed to Health Professionals Across Michigan

The Bureau of Health Professions will soon be distributing a DVD that provides information about the Michigan Automated Prescription System (MAPS) and explores important issues regarding pain management. It is intended as a resource for health care providers who prescribe/dispense pain medication and the providers who work closely with them.

Part I of this DVD describes the use of MAPS, assisting health providers to confidently prescribe safe and effective pain medication. A number of Michigan healthcare professionals describe how the use of MAPS has improved their practice. A demonstration of how to use MAPS is also included.

In Part II of this DVD, an array of health professionals provide information regarding the importance of managing pain and related symptoms, and offer insights into effectively managing pain.

The content of this hour-long DVD represents a collaborative effort between the MAPS program and the Pain Management and Palliative Care Program located within the Bureau of Health Professions, Michigan Department of Community Health.

We believe that health professionals involved in the management of pain and related symptoms will find this DVD to be a useful resource. It is targeted for early spring distribution to physicians, podiatrists, dentists, pharmacists, physician assistants, optometrists and advance practice nurses. If you have questions regarding the content or distribution of this DVD, please contact the bureau's Professional Practice Section office at 517-335-6557.

Upcoming Michigan Conferences

MHPCO 2011 Annual Conference
Mon., Apr. 18, 2011 – Wed., Apr. 20, 2011
 Soaring Eagle Resort
 Mt. Pleasant, Michigan
<http://www.mihospice.org>

**Advancing Excellence in Pain Management
 Pain and Consistent Assignment in Nursing Homes**
Wednesday, June 15, 2011
 Marriott Hotel
 East Lansing, Michigan
<http://www.hcam.org>

2011 Pain and Palliative Care Assembly
Friday, September 16, 2011
 Johnson Center at Cleary University
 Howell, Michigan
<http://www.mihospice.org>

Conference on Pain
Tuesday, October 25, 2011
 Inn at St. John's
 Plymouth, Michigan
<http://www.nursing.msu.edu/continuing.asp>

**Palliative Care Collaborative
 Fifth Annual Regional Conference**
Friday, October 28, 2011
 Dearborn Inn
 Dearborn, Michigan
<http://capewayne.med.wayne.edu>

Michigan Cancer Consortium Annual Meeting
Wednesday, November 9, 2011
 James B. Henry Center for Executive Development
 Lansing, Michigan
www.michigancancer.org



Evaluation and Treatment of Chronic Pain in a Primary Care Setting: An Organizational Perspective

By Karel Schram, P.A., and Wayne Kohn, D.O.
Hackley Community Care Center



“With the support of key leadership, a committed, intentional and purposeful program to address the complex issue of chronic pain evaluation and treatment can be achieved.”

Chronic pain is pervasive throughout our society, yet it remains one of the most challenging, complex and confusing pathologies to manage and treat in a primary care clinic. Hackley Community Care Center is a Federally Qualified Health Center (FQHC) located in Muskegon, Michigan. It has 17 primary care practitioners serving approximately 15,000 low income and/or uninsured patients. This is an abbreviated account of our efforts to provide good pain care to our high risk population while at the same time medically managing the risks of using controlled substances for treating pain.

Several years ago the Joint Commission required that practitioners assess all patients for pain. This requirement became known as the “fifth vital sign.” At the same time, HMOs began to challenge their health care organizations and practitioners to keep patients out of emergency departments. Since many of the emergency department visits involved pain to some degree, we felt it was time to commit to and become intentional about developing an organizational approach to addressing the chronic pain dilemma.

We were fortunate to find and hire a practitioner - physician assistant - who had years of experience working in a pain clinic, and who also possessed a personal passion for treating pain. Our physician assistant developed initial guidelines and became an internal referral source for patients with complicated pain conditions. By having an internal pain resource, we were able to develop a structured, consistent approach to addressing pain. We were also able to eliminate the prolonged office visit resulting from the patient’s usual last question: “What about my pain?”

Following these developments, we confronted the next challenge of any pain treatment program: preventing and reducing the incidences of controlled substance misuse, abuse, and diversion. From our experience, it would have been very easy at this point to abandon any structured effort and allow individuals to determine what level of treatment versus risk they were willing to assume. However, from the beginning, it was our intention to both treat pain adequately and control/minimize the risk of substance misuse, abuse and diversion – thereby achieving a balance.

The diversity of opinions regarding this issue reveals that most practitioners will place emphasis on one side or the other of this equation. This can lead to some very passionate discussions. Leadership, therefore, must assume a guiding role through these discussions. We subsequently developed a pain management workgroup which provided a forum that helped us to reach a consensus. With the understanding that a consensus does not mean total agreement, we were able to address most of the concerns of all and develop even more structure in our pain program.

By using the tools and references found on the State of Michigan’s pain management website (www.michigan.gov/pm), we developed a tier system for stratifying patients according to their risk level. We developed procedures for using the Michigan Automated Prescription System, or MAPS (www.michigan.gov/mimapsinfo), which is a free system that issues reports on a patient’s use of controlled substances. We established protocols for urine drug screens, and now have tools for measuring functionality. We also have an integrated behavioral health staff that is immediately available for consult.

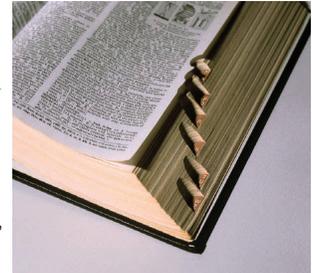
Today, we still see that there is much work to do, but we also contend that we are well on our way to providing a more effective, purposeful, and satisfying pain management experience for both practitioner and patient.

In summary, organizations must be intentional about and committed to developing a quality chronic pain management program with quality defined as minimizing variation in care. Unfortunately, at present there is extreme variation in care in the complex area of chronic pain management. To reduce variations in how pain care is delivered and to improve patient outcomes, resources must be employed, opinions of the health care team must be solicited and respected, and patients must be given the best evidence-based, guideline-driven treatments to alleviate pain and suffering while at the same time medically managing the risks associated with any opioid therapy.

Important Definitions Regarding Opioid Treatment for Pain: What is Addiction, Pseudoaddiction, Dependence, Tolerance, and Substance Abuse?

According to the Bureau of Health Profession's 2009 Public Survey on Pain, approximately 61% of respondents agreed that people do not seek treatment for pain because they fear becoming addicted to pain medications. This survey result reflects widespread misinformation about opioid use for the treatment of pain, and clearly acts as a barrier to those seeking treatment for legitimate pain conditions.

The Federation of State Medical Boards, in its 2004 *Model Policy on the Use of Controlled Substances for the Treatment of Pain*, provides clear definitions on addiction, pseudoaddiction, opioid physical dependence, opioid tolerance, and substance abuse. The bureau would like to present these definitions as a resource for health practitioners who manage pain:



Addiction - Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

Pseudoaddiction—The iatrogenic syndrome resulting from the misinterpretation of relief seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief seeking behaviors resolve upon institution of effective analgesic therapy.

Physical Dependence—Physical dependence is a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

Tolerance—Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

Substance Abuse—Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

Evidence-based Guidelines on Treating Pain

The Michigan Advisory Committee on Pain and Symptom Management has long supported the use of evidence-based guidelines for treating pain. They have identified the National Guideline Clearinghouse at www.guideline.gov and the Cochrane Reviews at www.cochrane.org as having excellent resources on treating pain (acute, chronic, cancer, terminal, etc.).

In 1998 The Federation of State Medical Boards (FSMB) created its *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain*, and in 2004 updated its guidelines in the *Model Policy for the Use of Controlled Substances for the Treatment of Pain* to emphasize the public health issue of undertreated and untreated pain. These guidelines can be found under their policy section at www.fsmb.org.

In furtherance of the Federation's guidance, the Michigan Boards of Medicine, Osteopathic Medicine, Pharmacy, Nursing, and Dentistry developed guidelines for their professions on the use of controlled substances for the treatment of pain. These guidelines can be found under each profession's licensing board at www.michigan.gov/healthlicense.

The booklet *Responsible Opioid Prescribing: A Guide for Michigan Physicians*, which operationalizes the FSMB guidelines mentioned above, has been distributed by the Bureau of Health Professions to all Michigan-based prescribers and dispensers of controlled substances since 2009.

Bureau Newsletters

The first publication of *MipainManagement* newsletter included a subscription postcard to complete and return to our office if you wanted to receive future electronic issues. This issue also includes the postcard. However, you also have the option of signing up to receive the newsletter online at www.michigan.gov/pm. There is a link in the center of the page to subscribe.

Many of the health professionals that receive this newsletter were also interested in receiving our *Public Forum* newsletter. The *Public Forum* newsletter has been in publication since 2007 and includes a wide variety of information that is of interest to the general public as well as health care professionals. To view previous issues of this newsletter, or to sign up online to receive it, go to www.michigan.gov/healthlicense. Scroll down to the *Spotlight* box to subscribe.

Links to both publications can also be found in the *Spotlight* box on our bureau homepage at www.michigan.gov/healthlicense.



Southwest Michigan Initiative Targets Opioid Use Risk Reduction

By Richard M. Tooker, M.D., M.P.H.
Manager, Southwest Michigan Opioid Medication Risk Reduction Initiative

Kalamazoo County Community Mental Health and Substance Abuse Services started a broad-based evaluation of opioid use in October of 2010, the *Southwest Michigan Opioid Medication Risk Reduction Initiative*. The effort is a result of a climbing number of opioid related deaths in the region. As a result, there is now a plan to improve the integration of medical care providers, substance abuse prevention, substance abuse treatment and community mental health services.

According to project manager Richard Tooker, M.D., this initiative is a comprehensive approach to all aspects of opioid use, misuse, diversion, addiction and unintended deaths. Dr. Tooker's efforts will seek to assure responsible opioid prescribing and access to treatment for patients requiring pain management. At the same time, efforts will be expanded to educate providers and the public about opioid diversion and abuse- especially among teens and young adults.

Increased collection of unused opioid medications is underway and planning has begun to increase addiction treatment services for uninsured and underinsured individuals, which is especially important for individuals who have a co-occurring mental health diagnosis.

For further information contact Richard M. Tooker M.D., MPH at 269-673-5411 or rtooker@allegancounty.org.

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This newsletter is a periodic publication of the Department of Community Health, Bureau of Health Professions.

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Introducing MIpainManagement



Michigan's second biannual pain management newsletter for health professionals contains:

- **Clinical information**
- **State policy updates**
- **State Pain Management and Palliative Care Program activities**
- **Activities of the State Advisory Committee on Pain & Symptom Management**
- **National and state pain management events**
- **Much more**

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