CALIFORNIA TECHNOLOGY ASSESSMENT FORUM℠

An Action Guide for the Treatment of Migraine: Next Steps for Clinicians

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ICER
INSTITUTE FOR CLINICAL AND ECONOMIC REVIEW

Introduction

About This Guide

Evidence from clinical research, which informs effectiveness reviews, provides a critical foundation for judgments that patients, clinicians, and health insurers must make about treatment choices and coverage policies. Yet that evidence is often not translated in a way that is helpful to inform health care decisions. This document is a companion action guide designed to help clinicians make use of the results of a recent technology assessment entitled "*Controversies in Migraine Management*" developed by the Institute for Clinical and Economic Review (ICER) and faculty at University of California, San Francisco. This report formed the basis for the deliberations and votes of the California Technology Assessment Forum (CTAF) Panel – an independent committee of medical evidence experts from across California, with a mix of practicing clinicians, methodologists, and leaders in patient engagement and advocacy, who evaluate evidence and vote on the comparative clinical effectiveness and value of medical interventions. All CTAF Panel members meet strict conflict of interest policies.

CTAF held its public meeting on controversies in migraine management on July 11, 2014 in Los Angeles, California. A full report summarizing the discussion and votes taken is available on the CTAF website. We have developed this Action Guide to provide a list of specific evidence-based action steps that clinicians can take to improve patient outcomes and the overall value of treating migraine. This guide serves as a companion to the evidence review and meeting results. The content provided here is for informational purposes only, and it is not designed to replace professional medical advice.

A Note on CTAF Evidence Voting

Each public meeting of CTAF involves deliberation and voting on key questions on the comparative clinical effectiveness and value of the various diagnosis and treatment options discussed. When voting, CTAF Panel members are not provided with prescribed thresholds or boundaries for how to interpret value. Rather, the CTAF Panel members are asked to assume the perspective of a state Medicaid program or a provider organization making resource allocation decisions within a relatively fixed budget.

Action Steps for Clinicians

If you are a clinician treating patients with migraine, the following action steps may help you ensure that patient care is coordinated and incorporates the best available evidence.

1. **Engage with and encourage other clinicians and medical professional societies to support a campaign to reduce the use of opioids to treat migraine pain in the emergency department (ED).**

Nationally, 53% of patients seeking relief from migraine pain in the ED receive opioids, despite strong clinical evidence showing that opioids are not the most effective treatment. Rather, the most effective treatment is combination therapy of dihydroergotamine (DHE) along with either neuroleptics or metoclopramide, or neuroleptic monotherapy. Alternatives that are equally effective as opioids include metoclopramide monotherapy and NSAIDs. While some patients will need opioids to relieve migraine pain, they should be used as a last resort. Opioids carry risks of dependence and misuse, as well as a greater risk of transforming migraines from episodic to chronic compared to triptans, NSAIDs, and acetaminophen. Research on opioids in the ED has focused on Demerol rather than the drug more commonly used to treat migraine, Dilaudid.

Current guidelines related to migraine are available here:
American Academy of Neurology (AAN)
https://www.aan.com/Guidelines/Home/ByTopic?topicId=16
http://www.choosingwisely.org/doctor-patient-lists/american-academy-of-neurology/
http://www.neurology.org/content/78/17/1337.full.html

American Headache Society (AHS)
http://www.americanheadachesociety.org/assets/1/7/How_I_Do_It_Acute_Treatment.pdf
http://www.americanheadachesociety.org/new_guidelines_treatments_can_help_prevent_migraine/
http://www.choosingwisely.org/doctor-patient-lists/american-headache-society/

American Academy of Family Physicians (AAFP) / American College of Physicians (ACP) / American Society of Internal Medicine (ASIM) Joint Guideline
http://annals.org/data/Journals/AIM/20020/0000605-200211190-00014.pdf

Canadian Headache Society / Canadian Journal of Neurological Sciences (CJNS)
http://headachenetwork.ca/wp-content/uploads/Acute-migraine-guideline.pdf
http://headachenetwork.ca/wp-content/uploads/CanadianHeadacheSocietyGuidelineforMigraineProphylaxis.pdf

British Association for the Study of Headache (BASH)
http://www.bash.org.uk/wp-content/uploads/2012/07/10102-BASH-Guidelines-update-2_v5-1-indd.pdf

More information may be found at this link:

- National Institutes of Health: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3663475/pdf/ndt-9-709.pdf

2. Work with patients to help them develop a written treatment plan to guide their care at home and in urgent care and emergency settings.

Patients are most knowledgeable about their symptoms and how they have been able to achieve relief from pain. An easy-to-reference, written treatment plan that summarizes drugs and other treatments such as lifestyle changes may help patients manage their migraines. For a patient who is in extreme distress from migraine pain and visits urgent care or the ED, a written treatment plan developed with the patient will help ensure that clinicians understand which drugs provide the best pain relief for that individual. As noted above, there are better treatments to relieve migraine pain in the ED, and a patient's treatment plan should say that they do not want to receive opioids in urgent care or the ED except as a last resort. Patients should know that there are risks to treating migraine with opioids. These include the possibility of transforming the headaches from episodic to chronic, developing medication overuse headache, and addiction. Treatment plans should remind patients who visit urgent care or the ED to quickly schedule a follow-up appointment with their primary care provider, headache specialist, and/or neurologist to review the reason for the visit and discuss any potential modifications to their treatment plan.

More information may be found at this link (and in the Appendix):

- San Diego County Medical Society: http://www.sandiegosafeprescribing.org/ http://www.sdcms.org/Portals/18/Assets/Lev%20Docs/SafePrescribingEnglish91113Cropped.pdf (English) http://www.sdcms.org/Portals/18/Assets/Lev%20Docs/SafePrescribingSpanishCropped.pdf (Spanish)

3. Educate patients about migraine triggers and alternative therapies to ensure that patients with migraine get the right treatment in the right place as quickly as possible.

The best time to talk about treating a patient's migraine is when they are not having one. Primary care providers and headache specialists should take the opportunity to talk with patients when they are feeling well to review migraine triggers and lifestyle changes that patients can make to help prevent migraine. Alternative drug therapies to prevent and treat migraine should also be discussed, as well as the pros and cons associated with each drug. In considering treatment alternatives, it may be helpful to try several drugs within one class (e.g., triptans), or to retry a drug that did not previously provide pain relief but was not used for a long enough time to completely assess its effectiveness. It is important to educate patients about treatment options other than opioids as early as possible in their care, ideally in primary or specialty care settings, and to explain the risks of treating acute migraine with opioids (i.e., transformation from episodic to chronic, medication overuse headache, addiction). When possible, use electronic medical record (EMR) technology to coordinate care between primary care, specialty care, urgent care, and ED settings. Transcutaneous electrical stimulation (TENS) and transcranial magnetic stimulation (TMS) devices are under development for prevention and treatment of migraine, and there is great patient interest in non-pharmacological approaches. However, the current state of evidence does not yet support a role for these devices outside of clinical trials.

More information can be found at these links:

- American Headache Society and affiliated organizations:
  http://www.achenet.org/resources/information_for_patients/
  http://www.americanheadachesociety.org/professional_resources/patient_education/
  http://www.americanheadachesociety.org/professional_resources/headache_fact_sheets/
  http://www.americanheadachesociety.org/assets/1/7/Alan_Rapoport_-_Migraine_Prevention_Medications.pdf
  http://www.headachejournal.org/view/0/toolboxes.html
- American Migraine Foundation: http://www.americanmigrainefoundation.org/resources-and-links/

4. **Emergency physicians should work with their departmental leadership to implement evidence-based practice around opioid prescribing for migraine pain relief.**

Emergency medicine clinicians on the Policy Roundtable[1] suggested that a systematic review of charts and EMRs be completed to better understand prescribing practices for patients seeking relief from migraine pain in the ED. After the data are analyzed, feedback can be provided on the extent to which opioids are being used appropriately or inappropriately. It was also suggested that education about evidence-based practice be provided to emergency physicians through academic detailing.

To further encourage appropriate use of opioids to treat migraine pain, emergency physicians and departmental leaders should work together to develop order sets that require explanation or justification before they permit an override to allow opioid use for migraine symptom relief.

5. **Clinicians should partner with purchasers, health plans, and other policymakers to implement quality improvement initiatives to reduce opioid prescribing for migraine pain.**

Clinicians should participate in quality improvement initiatives that involve measurement and reporting of results, with a goal of reducing the use of opioids in the ED. Congruence between patient treatment plans and the actual treatments rendered might be used as a quality improvement metric for EDs.

[1] The Policy Roundtable at the July 11, 2014 CTAF meeting was composed of neurologists and headache specialists, a patient advocate, and payer representatives, all of whom were asked at the meeting to disclose any conflicts of interest.

APPENDIX

SAFE PAIN MEDICINE PRESCRIBING
IN EMERGENCY DEPARTMENTS

We care about you. Our goal is to treat your medical conditions, including pain, effectively, safely and in the right way.

Pain relief treatment can be complicated. Mistakes or abuse of pain medicine can cause serious health problems and death.

Our emergency department will only provide pain relief options that are safe and correct.

For your SAFETY, we follow these rules when helping you with your pain.

1. We look for and treat emergencies. We use our best judgment when treating pain. These recommendations follow legal and ethical advice.
2. You should have only ONE provider and ONE pharmacy helping you with pain. We do not usually prescribe pain medication if you already receive pain medicine from another health care provider.
3. If pain prescriptions are needed for pain, we will only give you a limited amount.
4. We do not refill stolen prescriptions. We do not refill lost prescriptions. If your prescription is stolen, please contact the police.
5. We do not prescribe long acting pain medicines such as: OxyContin, MSContin, Fentanyl (Duragesic), Methadone, Opana ER, Exalgo, and others.
6. We do not provide missed doses of Subutex, Suboxone, or Methadone.
7. We do not usually give shots for flare-ups of chronic pain. Medicines taken by mouth may be offered instead.
8. Health care laws, including HIPAA, allow us to ask for all of your medical records. These laws allow us to share information with other health providers who are treating you.
9. We may ask you to show a photo ID when you receive a prescription for pain medicines.
10. We use the California Prescription Drug Monitoring Program called CURES. This statewide computer system tracks opioid pain medications and other controlled substance prescriptions.

If you need help, please call 2-1-1 and ask for information on treatment services for drug use disorders.

Emergency Departments throughout Los Angeles County have agreed to participate in this important program.

To discuss safer and more helpful chronic pain treatment options, please schedule an appointment with your treating physician.

County of Los Angeles Public Health

Health Services Los Angeles County

California ACEP American College of Emergency Physicians

Los Angeles County Medical Association

Hospital Association of Southern California

Kaiser Permanente

ADMINISTRACIÓN DE MEDICAMENTOS PARA EL DOLOR

EN LA SALA DE EMERGENCIAS

Nos preocupamos por su salud y bienestar y por lo mismo, nuestro objetivo es tratar sus condiciones médicas—incluyendo el dolor que sienta—de una manera eficaz, segura y adecuada.

El tratamiento para aliviar el dolor puede ser complicado. Los errores o el abuso de medicamentos con receta para lidiar con el dolor pueden provocar graves problemas de salud y hasta la muerte.

Nuestro departamento de emergencias le proporcionará únicamente opciones de alivio del dolor que sean seguras y adecuadas.

Por su salud, siempre que le brindemos ayuda para lidiar con su dolor, seguiremos estas medidas de seguridad:

1. Determinamos y tratamos emergencias. Usamos nuestro mejor criterio para tratar el dolor. Estas recomendaciones siguen consejos legales y éticos.
2. Nos aseguramos que tenga UN solo proveedor y UNA sola farmacia que le ayuden con su dolor. Normalmente no le recetaremos medicamentos para el dolor si usted ya recibe un medicamento contra el dolor de otro proveedor médico.
3. Si necesita un medicamento recetado para lidiar con su dolor, le daremos una cantidad limitada.
4. No surtimos recetas que fueron robadas ni recetas perdidas. Si le roban su receta de un medicamento contra el dolor, por favor póngase en contacto con su proveedor médico, la policía o el sheriff.
5. No recetamos medicinas para el dolor crónico como: OxyContin, MSContin, Fentanyl (Duragesic), Metadona, Opana ER, Exalgo entre otros.
6. No surtimos dosis perdidas de Subutex, Suboxona ni de Metadona.
7. No solemos proveer inyecciones de alivio rápido para el dolor crónico agudo. De intensificarse el dolor, es posible que se le ofrezca un medicamento oral.
8. Las leyes de protección a la salud, entre ellas HIPAA, nos dan acceso a su expediente médico. Estas leyes nos permiten compartir información con otros proveedores médicos que le brindan atención médica.
9. Podemos pedirle que nos muestre una identificación con fotografía cuando reciba un medicamento recetado para el dolor.
10. Usamos el programa *Controlled Substance Utilization Review and Evaluation System* (CURES en inglés), un sistema electrónico estatal que nos permite tener precaución y monitorear la frecuencia con la cual se receta un medicamento opioide para el dolor entre otras sustancias controladas.

Si necesita ayuda, por favor llame al 211 y pida información sobre los servicios de tratamiento para los trastornos por consumo de drogas.

Todos los departamentos de emergencia del Condado de Los Ángeles han aceptado participar en este importante programa.

Si desea aprender más sobre sus opciones para lidiar con el dolor crónico de una manera más segura y eficaz, hable con su médico de cabecera acerca de los tratamientos disponibles.

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