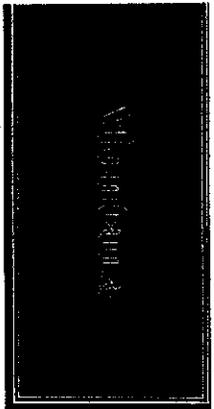


EXHIBIT 3  
DATE 4-6-05  
SI 30



# Montana

**Last Acts  
Evaluation  
of Your State Pain  
Policies  
&  
Other Policies  
Affecting Quality  
End-of-Life Care**

**Last Acts  
Evaluation  
of Your  
State  
Pain  
Policies**

Taken From: Last Acts. "Means to a Better End. A Report  
on Dying in America Today." November, 2002.  
Available via the Internet at:  
<http://www.lastacts.org/files/misc/means0211.pdf>

# MONTANA

Criteria	Measure	Grade
<p><b>State Advance Directive Policies:</b>  <i>Do state policies support good advance care planning?</i>  <b>Quality of state advance directive laws, 2002</b></p>	3.0 on a scale of 0 to 5	C
<p><b>Location of Death:</b>  <i>What proportion of the state's deaths occur at home?</i>  <b>Percentage of state residents who died at home, 1997</b></p>	27.7	D
<p><b>Hospice Use:</b>  <i>Is hospice care widely used in the state?</i>  <b>Percentage of deaths with hospice stays, 2000</b>  <b>Median length of stay in hospice (days), 2001</b></p>	17.5 25.2	D D
<p><b>Hospital End-of-Life Care Services:</b>  <i>Do the state's hospitals offer pain and palliative care services?</i>  <b>Percentage of hospitals self-reporting pain management programs, 2000</b>  <b>Percentage of hospitals self-reporting hospice programs, 2000</b>  <b>Percentage of hospitals self-reporting palliative care programs, 2000</b></p>	24.1 34.5 15.5	D D E
<p><b>Care in ICUs at the End-of-Life:</b>  <i>How many elderly people spend a week or more in intensive care units during the last six months of life?</i>  <b>Percentage of state residents over 65 with seven or more ICU days totaled across all admissions during the last six months of life, 2000</b></p>	6.7	B
<p><b>Pain Among Nursing Home Residents:</b>  <i>How well do the state's nursing homes manage their residents' pain?</i>  <b>Percentage of nursing home residents in persistent pain, 1999</b></p>	48.4	D
<p><b>State Pain Policies:</b>  <i>Do state policies encourage good pain control?</i>  <b>State pain policies' level of support of palliative care, 2001</b></p>	4 on a scale of -3 to 9	C
<p><b>Palliative Care-Certified Physicians and Nurses:</b>  <i>Does the state have enough physicians and nurses who are trained and certified in palliative care?</i>  <b>Percentage of primary care and primary care subspecialty physicians who are certified in palliative care, 2000</b>  <b>Percentage of estimated number of full time equivalent registered nurses who are certified in palliative care, 2000</b></p>	0.97 0.89	A A



# Last acts.

*A national coalition to improve care and caring near the end of life*

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EMBARGOED FOR RELEASE

NOV. 18, 2002, AT 11:30 A.M. EASTERN TIME

## **NATIONAL GROUP GIVES MONTANA MIXED RATINGS ON END-OF-LIFE CARE**

***High Marks for Supply of Trained Physicians and Nurses  
and for Minimal Use of ICU Care; Most Other Findings Disappointing***

WASHINGTON, D.C. (Nov. 18, 2002) – The nation's first state-by-state "report card" on availability and use of care for dying Americans, released today in Washington, D.C., shows that terminally ill and dying residents of Montana are well served in some aspects of end-of-life care, but poorly served in others.

This analysis was produced by *Last Acts*, the nation's largest coalition to improve care and caring near the end of life. Former First Lady Rosalynn Carter is honorary chair of *Last Acts*, which is funded by The Robert Wood Johnson Foundation. The coalition is composed of more than 1,000 Partner organizations, including the American Medical Association, the American Nurses Association, the American Hospital Association, AARP and the NAACP.

On the positive side, *Means to a Better End: A Report on Dying in America Today*, reports that Montana has a relatively low percentage of elderly residents who spend a week or more in the hospital intensive care unit in the last six months of life, possibly receiving overly aggressive care. The state also has a relatively high percentage of nurses and physicians who are trained to provide palliative care. Palliative care controls pain and symptoms while providing emotional and spiritual support to the patient and family, respecting their cultural traditions.

On the down side, a few hospitals in the state report having hospice or palliative care programs. The use of hospice care in Montana is also limited, and several nursing homes in the state do not effectively control the pain of dying residents. These and other findings indicate that the state needs to do more to prepare for the needs of the frail and dying now and in the future, when the number of Americans over the age of 65 will be rapidly increasing.

Key findings on the status of end-of-life care in Montana:

- **Palliative Care-Certified Physicians and Nurses:** The state received A grades for the percentage of physicians and nurses trained to provide palliative care. This suggests that, compared to that of other states, the health care workforce is doing a good job in preparing for current and future needs of the frail elderly and dying.
- **Care in ICU at the End-of-Life:** Montana received a B grade for the small percentage of elderly residents (7 percent) who spent a week or more in intensive care units during the last six months of life. This suggests that health care providers in the state are avoiding overly aggressive care that does not take the patient's treatment wishes into consideration.
- **Hospital End-of-Life Care Services:** Hospitals in Montana offer low levels of pain management, hospice and palliative care services. The state earned the lowest possible grade – an E – for the small percentage of hospitals (16 percent) reporting palliative care programs. Montana earned the second lowest grade of D for the percentage of hospitals reporting pain management programs (24 percent), and the percentage of hospitals offering hospice programs (35 percent).
- **Location Of Death:** A majority of Montanans do not die at home, although most Americans say they prefer to be at home in comfortable surroundings with their loved ones. The state earned a D grade from *Last Acts* on this measure.
- **Pain Among Nursing Home Residents:** Nursing homes in Montana do a poor job of managing patients' pain, earning a D grade from *Last Acts*. The rate of persistent pain in nursing home residents is 48 percent.
- **Hospice Use:** Hospice care is not widely used in Montana. Only 18 percent of people over age 65 who died in the state used hospice in the last year of life. Moreover, the median length of stay in hospice care in the state was 25 days, which is less than the 60 days considered necessary for the maximum benefit from the program.

End-of-life care advocates in Montana include:

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# Pain & Policy Studies Group Evaluation of Your State Pain Policies

Taken from: Joranson DE, Gilson AM, Ryan KM, Maurer MA, Nischik JA, Nelson JM. *Achieving balance in federal and state pain policy: A guide to evaluation*. The Pain & Policy Studies Group, University of Wisconsin Comprehensive Care Center. Madison, Wisconsin; July 2000. Available at: <http://www.medsch.wisc.edu/painpolicy/eguide2000/index.html>

Pain & Policy  
Studies  
Evaluation  
of Your  
State Pain  
Policies

# MONTANA

## POLICIES EVALUATED

### Statutes

UNIFORM CONTROLLED SUBSTANCES ACT *(No provisions found)*  
Title 50. Health and Safety; Chapter 32. Controlled Substances

MEDICAL PRACTICE ACT *(No provisions found)*  
Title 37. Professions and Occupations; Chapter 3. Medicine

PHARMACY PRACTICE ACT *(No provisions found)*  
Title 37. Professions and Occupations; Chapter 7. Pharmacy

INTRACTABLE PAIN TREATMENT ACT  
*No policy found*

### Regulations

CONTROLLED SUBSTANCES REGULATIONS *(No provisions found)*  
Title 8. Department of Commerce; Chapter 40. Board of Pharmacy; Sub-Chapter 12. Dangerous Drug Act

MEDICAL BOARD REGULATIONS *(No provisions found)*  
Title 8. Department of Commerce; Chapter 28. Medical Examiners

PHARMACY BOARD REGULATIONS *(No provisions found)*  
Title 8. Department of Commerce; Chapter 40. Board of Pharmacy

### Other Governmental Policies

#### MEDICAL BOARD GUIDELINE

Montana Board of Medical Examiners. "Statement on the Use of Controlled Substances in the Treatment of Intractable Pain, Guidelines for Prescribing Opioid Analgesics for Chronic Pain." *Montana Medical Association Bulletin*. Vol. 51, No. 1, pp. 3-4. June, 1996. Effective: March 15, 1996.

# MONTANA

## POLICIES THAT MAY ENHANCE PAIN MANAGEMENT

	1	2	3	4	5	6	7	8
Criteria	Controlled substances are necessary for public health	Pain management is part of medical practice	Opioids are part of professional practice	Encourages pain management	Addresses fear of regulatory scrutiny	Prescription amount alone does not determine legitimacy	Physical dependence or analgesic tolerance are not confused with "addiction"	Other provisions that may enhance pain management
<b>Statutes</b>								
Controlled Substances Act <sup>1</sup>								
Medical Practice Act <sup>1</sup>								
Pharmacy Practice Act <sup>1</sup>								
Intractable Pain Treatment Act <sup>2</sup>								
<b>Regulations</b>								
Controlled Substances <sup>1</sup>								
Medical Board <sup>1</sup>								
Pharmacy Board <sup>1</sup>								
<b>Other Governmental Policies</b>								
Medical Board Guideline				!	!			

Note: A dot indicates that one or more provisions were identified

<sup>1</sup> No provisions found in this policy

<sup>2</sup> No policy found

# MONTANA

## POLICIES THAT MAY IMPEDE PAIN MANAGEMENT

	9	10	11	12	13	14	15	16	17
Criteria	Implies opioids are a last resort	Implies opioids are not part of professional practice	Perpetuates belief that opioids hasten death	Physical dependence or analgesic tolerance confused with "addiction"	Medical decisions are restricted	Length of prescription validity is restricted	Practitioners are subject to additional prescription requirements	Other provisions that may impede pain management	Provisions that are ambiguous
<b>Statutes</b>									
Controlled Substances Act <sup>1</sup>									
Medical Practice Act <sup>1</sup>									
Pharmacy Practice Act <sup>1</sup>									
Intractable Pain Treatment Act <sup>2</sup>									
<b>Regulations</b>									
Controlled Substances <sup>1</sup>									
Medical Board <sup>1</sup>									
Pharmacy Board <sup>1</sup>									
<b>Other Governmental Policies</b>									
Medical Board Guideline	!							!	

Note: A dot indicates that one or more provisions were identified

<sup>1</sup> No provisions found in this policy

<sup>2</sup> No policy found

OTHER GOVERNMENTAL POLICY  
Medical Board Guideline

STATEMENT ON THE USE OF CONTROLLED  
SUBSTANCES IN THE TREATMENT OF INTRACTABLE PAIN,  
GUIDELINES FOR PRESCRIBING OPIOID ANALGESICS FOR  
CHRONIC PAIN

STATEMENT ON THE USE OF CONTROLLED SUBSTANCES IN  
THE TREATMENT OF INTRACTABLE PAIN

The Montana Board of Medical Examiners continues to be concerned about the use of controlled substances by individuals who seek them for their mood-altering and addictive potential rather than legitimate medical reasons. However, the Board is also concerned about adequate pain management. The Board recognizes that pain from whatever cause is often under treated. The Board is aware that there are a number of factors that continue to interfere with effective pain management. These include exaggerated fears of opioid side effects including addiction, fear of legal consequences when controlled substances are used, low priority of proper pain management in our health care system, and the lack of integration of current knowledge concerning pain management into medical education and clinical practice.

(+) CRITERION 5:  
ADDRESSES FEAR OF  
REGULATORY SCRUTINY

(-) CRITERION 9:  
IMPLIES OPIOIDS ARE A  
LAST RESORT

→ The Board seeks to assure that no Montanan requiring narcotics for pain relief is denied them because of a physician's real or perceived fear that the Board of Medical Examiners will take disciplinary action based solely on the use of narcotics to relieve pain. While improper use of narcotics, like any improper medical care, will continue to be a concern of the Board, the Board is aware that treatment of malignant and especially nonmalignant pain is a very difficult task. The Board does not want to be a hindrance to the proper use of opioid analgesics. → Treatment of chronic pain is multifactorial and certainly treatment with modalities other than opioid analgesics should be utilized, usually before long term opioids are prescribed. Use of new or alternative types of treatment should always be considered for intractable pain periodically, in attempts to either cease opioid medications or reduce their use.

(+) CRITERION 4:  
ENCOURAGES PAIN  
MANAGEMENT

(-) CRITERION 16:  
OTHER PROVISIONS THAT  
MAY IMPEDE PAIN  
MANAGEMENT  
  
Comment: "Drug holidays" are  
no longer recognized as  
appropriate medical practice.

The proper use of opioid analgesics for chronic pain must involve certain elements, which are also consistent with any quality medical care. The following guidelines will help assure the proper use of these medications for chronic pain and minimize the improper use:

GUIDELINES FOR PRESCRIBING OPIOID ANALGESICS FOR  
CHRONIC PAIN

1. Thorough history and physical examination. Included in the history is assessment of the etiology of pain, physical and psychological function of the patient, substance abuse history, other treatments that have been attempted to control the patient's level of pain, identification of underlying or coexisting diseases or conditions and, as much as possible, statements by all treating physicians that the patient's pain is intractable and not controlled by other than the use of opioid analgesics.

(CONTINUED ON NEXT PAGE)

## OTHER GOVERNMENTAL POLICY

## Medical Board Guideline

(CONTINUED)

2. Treatment plan. A thoroughly documented, written treatment plan should be established and should include how treatment success will be evaluated, such as pain relief and improved physical or psychological functioning. Several treatment modalities should be utilized in most cases and should be done concurrently with the use of opiates. Periodic review by the physician should be accomplished to determine that there are no other appropriate treatment methods that would then be of additional benefit to the patient.

3. Informed consent. The physician should discuss the risks and benefits of the use of controlled substances with the patient and/or guardian and this should be accomplished on an ongoing basis, not just at the initiation of treatment.

4. Appropriate referral. If treatment objectives are not being realized or if patients appear to be at risk for misuse of medications, referral should be made to appropriate specialists including addiction specialists and chronic pain specialists.

5. Documentation. All the above recommendations and guidelines should be recorded accurately and completely in the patient's medical record.

We hope that the above statements and guidelines will help reverse the trend of under treatment of intractable pain, and that they will facilitate the more appropriate use of controlled substances by duly licensed practitioners with prescriptive authority in the State of Montana.

