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Senate Joint Resolution 28

- ✦ The Montana Pain and Symptom Management Task Force (MPSMTF)
- ✦ Montana Legislature in 2005
- ✦ Senator Carolyn Squires
- ✦ Staffed by American Cancer Society



Senate Joint Resolution 28

- ✦ For two years gathered national and local information on pain management
- ✦ Conducted a convenience sample Community Survey (329 participants, results can be found at www.mtpain.org)



Senate Joint Resolution 28

- ✦ Developed a white paper with 10 recommendations focusing on policy, provider practice improvement, and advocacy (Mailed over 900 white papers to opinion leaders in Montana)
- ✦ Recommended the Development of the Montana Pain Initiative
 - + Move from information gathering to action



MTPI Advisory Council

- ✦ 35 Members representing

Oversite: <ul style="list-style-type: none"> ✦ American Cancer Society ✦ American Cancer Society Cancer Action Network Boards/Associations: <ul style="list-style-type: none"> ✦ Medical ✦ Pharmacy ✦ Nursing 	Organizations: <ul style="list-style-type: none"> ✦ Attorney General's Office ✦ Benefis Healthcare ✦ Billings Clinic ✦ Bozeman Deaconess Hospice and Palliative Care; ✦ Bozeman Deaconess Hospital ✦ Community Medical Center ✦ DPHHS/Medicaid ✦ St. Patrick Hospital and Health Sciences Center ✦ St. Peter's Hospital ✦ St. Vincent Healthcare
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Executive Committee

- Leadership of the MTPI
- + Chair, Randale Sechrest, MD
 - + Vice Chair, Jean Forseth, RN
 - + Medical Director, Kathryn Borgenicht, MD
 - + American Cancer Society Liaison, Kristin Nei
 - + Program Director, Kaye Norris, PhD



Grants

- ✦ Pain Improvement Partnership (Lance Armstrong funding through the Alliance of State Pain Initiatives)
- ✦ Strategic Planning (Lance Armstrong Foundation through the Alliance of State Pain Initiatives)
- ✦ State Pain Activity (American Cancer Society Cancer Action Network)
- ✦ Public Safety Program: Partnering to Improve Pain Management and Reduce Abuse and Diversion (Montana Attorney General's Office)



Getting the Work Done

- ✦ Standing Committees
 - + Public and Institutional Policy
 - + Patient and Public Education & Advocacy
 - + Provider Practice Improvement
- ✦ Work Groups
 - + Addressing Chronic Pain and Addiction
 - + Passage of Prescription Drug Registry



Policy Improvement

- ✦ In 2008-9 Assisted PMP Coalition in drafting Prescription Monitoring Program legislative language which focused on patient safety
- ✦ The bill was defeated in the Human Health and Services Committee
- ✦ In 2010-2011 worked closely with the Montana Attorney General's Office to draft and pass Prescription Drug Registry legislation



Policy Improvement

- ✦ Montana Board of Medical Examiners adopted Model Pain Policy developed by Federation of State Medical Boards
- ✦ Board of Pharmacy revised pain policy based on national standards
- ✦ 13 Facilities (long term care, home health, and critical access hospitals) revised policy and structure to improve pain management



Provider Practice Improvement

Annual Conferences:

- ✦ Politics of Pain: Improving Pain Management Policy in Montana (Missoula, April 2007)
- ✦ Pain Management Policy and Practice: A Balanced Approach (Missoula, September 2008)
- ✦ Practical Approaches to Managing Pain (Bozeman, Sept 2009)



Provider Practice Improvement

Annual Conferences:

- ✦ Navigating the Complexities of Pain (Billings, October 2010)
- ✦ Front Line Pain Management: Neuroplastic Transformation, Interdisciplinary Care, Safe Prescribing (Bozeman, October 2011)
- ✦ Redefining Pain: The Changing Landscape of Pain Management (Missoula, May 2014)

Special Conference:

Addressing Chronic Pain and Addiction: A Community Network Approach (Missoula, May 2010)



Provider Practice Improvement

- Disseminated Scott Fishman's book *Responsible Opioid Prescribing: A Physician's Guide* to over 3000 practicing prescribers (partnered with Attorney General's Office and Board of Medical Examiners)



Research

Developed pain questions for the 2010 Behavior Risk Factor Surveillance Survey



2010 BRFSS Results

Severity Level	Grade 1—Mild	Grade 2—Moderate	Grade 3—Severe
Duration	3 months to 1 year	>1 year to 5 years	>5 years
Frequency	Recurrent Pain: Once/month or less	Persistent pain: Once/week to once/hour	Constant Pain
Intensity (None to 10) Scale	1-3	4-6	7-10
Activity Limitation	None	1 to <14 days per month	≥14 days per month



2010 BRFSS Results

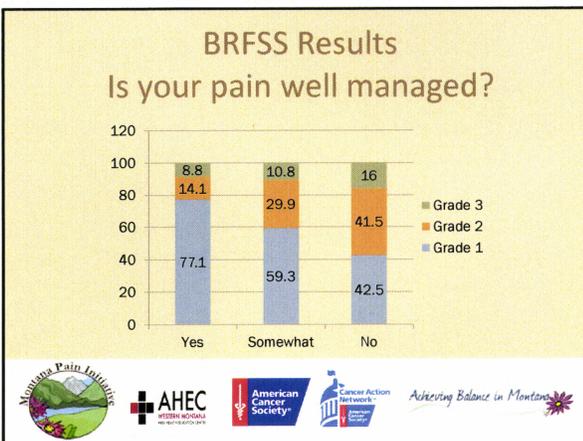
- ✘ 2,607 respondents suffered from chronic pain (33% of total respondents)
- ✘ 90% pain lasted at least 1 year
- ✘ 40% experience pain constantly
- ✘ 50% had other health conditions (asthma, diabetes, cardiovascular disease, mental)



2010 BRFSS Results

- ✘ ~25% rated pain intensity as severe
- ✘ 5% Grade 3—Severe (duration, frequency, intensity, activity limitation)
- ✘ Translated to estimated 40,000 Montanans experience severe pain
- ✘ ~168 days per year lost productivity (each)





Report Conclusion

- ✘ Chronic pain a considerable public health burden in Montana
- ✘ Montanans with most severe chronic pain more likely to be uninsured
- ✘ Montana Healthcare providers may be inadequately treating pain when other health conditions are seen as predominant



Two Competing Public Health Crises

- 1) Epidemic of untreated and undertreated chronic pain:
 - WHO: "undertreated pain is the #1 health problem in America."
 - *Relieving Pain: A Blueprint for Transforming Prevention, Care, Education, and Research (IOM 2011).*
- 2) Epidemic of prescription drug abuse:
 - CDC: 6million Americans are abusing prescription pain killers: more than heroin, cocaine, and hallucinogens combined (increase of 80% in 6 years).



IOM: "Underlying Principles"

1. **A moral imperative. Effective pain management is a moral imperative, a professional responsibility, and the duty of people in the healing professions.**
2. **Chronic pain can be a disease in itself. Chronic pain has a distinct pathology, causing changes throughout the nervous system that often worsen over time. It has significant psychological and cognitive correlates and can constitute a serious, separate disease entity.**

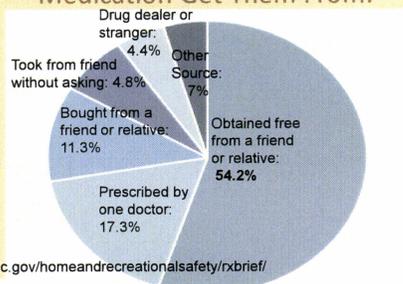


Who is at risk for overdose death?

1. **9 million persons who report long-term medical use of opioids.**
 - + About 3% of U.S. population
2. **6 million persons who report non-medical use of opioids over the last one month.**
 - + About 3% of the adult population over age 12
 - + But about 5% of the 18-25 years age group
3. **CDC: 25-66% of opiate OD fatalities occurred in patients who were never prescribed the implicated drug.**



People Who Abuse Prescription Pain Medication Get Them From:



Source: <http://www.cdc.gov/homeandrecreationalafety/rxbrief/>



Best-Practices

- + Evaluate opioid abuse risk using a validated screening tool such as DIRE or Opioid Risk Tool
- + Establish a chronic pain agreement for long-term use
- + Use urinary drug test when at high risk for abuse
- + Treat and monitor patients at highest risk for abuse
- + Behavioral health needs to be part of assessment and treatment



When is it appropriate to use opioids for persistent pain?

- + After thorough evaluation
- + When opioids have an equal or better therapeutic index than alternative therapies
- + The medical risk of opioids is relatively low
- + The patient is likely to be responsible in using the medication
- + Opioids are part of an overall management plan



Regulation of Prescribing Practice

- ✗ Intention is good
- ✗ Potential unintended consequences:
 - + impede access to necessary medications, and
 - + diminished quality of life of patients who experience persistent pain



Going Forward

- ✗ Healthcare Providers, Regulators, Patient Advocates, Law Enforcement must work together
- ✗ A balanced approach with equal emphasis on pain management and public safety will be the most effective
- ✗ State funding that leverages private and non-profit dollars is necessary to sustain a coordinated effort



Thank You.

