



We are a diverse group of pain survivors advocating for a Montana Pain Patient's Bill of Rights. Treatment of our chronic intractable pain conditions is a fundamental human right. We endorse Dr. Forest Tennant's position on the opioid controversy. Dr. Forest Tennant is a world renowned expert who specializes in research and treatment of intractable pain.

My position on the opioid controversy is quite simple and I ask all concerned to consider it:

1. We have a long-standing standard known as the World Health Organization 3 Step Analgesic Ladder (1982). Only when non-opioid treatments fail are opioids used because about everyone knows they have complications.
2. There cannot be a cap on dosages as patients vary. The government should certify or recognize the MDs who will prescribe high dose opioids so patients who need high dosages can get the help they need.
3. Patients who are currently on opioids and doing well should be left on them.

Forest Tennant M.D., Dr. P.H.

The World Health Organization:

WHO'S CANCER PAIN LADDER FOR ADULTS

- 1] If pain occurs, there should be prompt oral administration of drugs in the following order: non-opioids (aspirin and paracetamol);
- 2] Then, as necessary, mild opioids (codeine);
- 3] Then strong opioids such as morphine, until the patient is free of pain.

Another Perspective on Montana Prescription Drug Overdoses

1. In 2014 there were 243 completed suicides in Montana:
 - 81% involved Males
 - 25% of the completed suicides involved Veterans
 - Approximately 9% of suicides involved Native Americans
 - Based on completed reports received by the suicide mortality review team, approximately 40 percent of Montana's completed suicides involved people with severe medical problems, including terminal illness or **chronic pain**

Source: http://missoulian.com/news/state-and-regional/percent-of-montana-suicides-in-were-males-nearly-percent-were/article_c5ab2cdf-0b7f-54/

2. In 2013 there were 109 prescription drug related deaths. For comparison purposes, there were 224 deaths caused by car accidents reported by the Montana Highway Patrol in 2013.

Source: http://missoulian.com/news/state-and-regional/percent-of-montana-suicides-in-were-males-nearly-percent-were/article_c5ab2cdf-0b7f-54af-b2fb-23bb2cd3cd0c.html

Number of Deaths each Year in the United States (2013 CDC Statistics)

- Heart disease: 611,105
- Cancer: 584,881
- Chronic lower respiratory diseases: 149,205
- Accidents (unintentional injuries): 130,557
- Stroke (cerebrovascular diseases): 128,978
- Alzheimer's disease: 84,767
- Diabetes: 75,578
- Influenza and Pneumonia: 56,979
- Nephritis, nephrotic syndrome, and nephrosis: 47,112
- **Intentional self-harm (suicide): 41,149**

Source: <http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm>

NOTE: Preventable Medical Harm, is now the 3rd Leading Cause of Death and kills as many as **440,000** people each year according to a July 2014 Senate Subcommittee on Primary Health and Aging: "Preventable medical errors in hospitals are the 3rd leading cause of death in the United States." The Chairman of this hearing stated: "Medical harm is a major cause of suffering, disability, and death – as well as a huge financial cost to our nation."

STATE OF MONTANA

PAIN PATIENTS BILL OF RIGHTS

The Montana Legislature finds and declares all of the following:

- a) The state has a right and duty to control the illegal use of opiate drugs.
- b) Inadequate treatment of acute and chronic pain originating from cancer or noncancerous conditions is a significant health crisis.
- c) For many patients, pain management is the single most important treatment a medical practitioner can provide.
- d) A patient suffering from severe chronic intractable pain should have unobstructed access to proper treatment of his or her pain within a reasonable time period, understanding that the wellbeing of the patient is at risk if substantial time is permitted to elapse.
- e) Due to the complexity of their problems, many patients suffering from severe chronic intractable pain may require a referral to a medical practitioner with the expertise in the treatment of severe chronic intractable pain. In some cases, severe chronic intractable pain is best treated by a team of clinicians in order to address the associated physical, psychological, social, and vocational issues.
- f) In the hands of knowledgeable, ethical, and experienced medical practitioners, opiates administered for severe acute pain and severe chronic intractable pain can be safe and effective.
- g) Opiates can be an accepted treatment for patients in severe chronic intractable pain who have not obtained relief from any other means of treatment.
- h) A patient suffering from severe chronic intractable pain has the option to request or reject the use of any or all modalities to relieve his or her pain.
- i) A medical practitioner treating a patient who suffers from severe chronic intractable pain may prescribe a dosage deemed medically necessary to relieve pain, in order to put forth every effort for the patient to obtain some measure of "quality of life."
- j) A patient who suffers from severe chronic intractable pain has the option to choose or refuse opiate medication for the treatment of severe chronic intractable pain.
- k) The patient's medical practitioner may refuse to prescribe opiate medication for a patient who requests the treatment for severe chronic intractable pain. However, that practitioner shall inform the patient of those medical practitioners who do treat severe chronic intractable pain with methods that include the use of opiates.

**The following shall be known as
“THE MONTANA PAIN PATIENTS BILL OF RIGHTS “**

- a) A patient who suffers from severe chronic intractable pain has the option to request or reject the use of any or all modalities in order to relieve his or her pain however, initially each patient should be granted the opportunity to consider receiving any and all benefits which may result from ALTERNATIVE OPTIONS. This would include, but is not limited to: Physical Therapies, Prolotherapy, Neuropathic Medicine, Acupuncture, Chiropractic Medicine, Low-Dose Opiates, etc....
- b) A patient who suffers from severe chronic intractable pain has the option to choose opiate medications to relieve the pain without first having to submit to an invasive medical procedure, which is defined as surgery, spinal injections: such as steroid and/or diagnostic injections, neurostimulators, destruction of a nerve or other body tissue by manipulation, or the implantation of a drug delivery system or device. A medical practitioner cannot dismiss a patient from care for their refusal not to submit themselves to such invasive medical procedures.
- c) The patient’s medical practitioner may refuse to prescribe opiate medication for the patient who requests a treatment for severe chronic intractable pain. However, that practitioner shall inform the patient which medical practitioners who treat pain and whose methods include the use of opiates; and the patient shall be given a copy of their record(s).
- d) A medical practitioner who uses opiate therapy to relieve severe chronic intractable pain may prescribe a dosage deemed medically therapeutic and necessary to relieve a patient’s pain in their endeavor to achieve some measure of “quality of life.”
- e) A patient may voluntarily request that his or her medical practitioner provide an “identifying notice” of the prescription for purposes of emergency treatment or law enforcement identification.
- f) Nothing in this section shall do either of the following:
 - 1) Limit any reporting or disciplinary provisions applicable to medical practitioners and surgeons who violate prescribing practices or other provisions.
 - 2) Limit the applicability of any federal statute or federal regulation or any of the other statutes or regulations of this state which regulate dangerous drugs or controlled substances.

Administration of controlled substances to a person experiencing “intractable pain “

- a) Notwithstanding any other provision of law, a medical practitioner and surgeon may prescribe or administer controlled substances to a person in the course of the practitioners and surgeons treatment of that person for a diagnosed condition or conditions causing intractable pain.
- b) “Intractable Pain,” as used in this section, means a pain state in which the cause of pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending medical practitioner and surgeon and one or more practitioners or surgeons specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain.

- c) No medical practitioner or surgeon shall be subject to disciplinary action by the board for prescribing or administering controlled substances in the course of treatment of a person for intractable pain with the understanding that patient records, patient supplying and purchasing records are strictly kept.
- d) This section shall not apply to those persons being treated by a medical practitioner and surgeon for chemical dependency because of their use of drugs or controlled substances.
- e) This section shall not authorize a medical practitioner and surgeon to prescribe or administer controlled substances to a person the practitioner and surgeon knows to be using drugs or substances for non-therapeutic purposes.
- f) This section shall not affect the power of the board to deny, revoke, or suspend the license of any medical practitioner and surgeon who does any of the following:
 - 1) Prescribes or administers a controlled substance or treatment that is non therapeutic in nature or non-therapeutic in the manner the controlled substance or treatment is administered or prescribed or is for a non-therapeutic purpose in a non-therapeutic manner.
 - 2) Fails to keep the complete and accurate records of purchases and disposals pursuant to, the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970. A medical practitioner and surgeon shall keep records of his or her purchases and disposals of the drugs by the practitioner and surgeon, the name and address of the person receiving the drugs, and the reason for the disposal of or the dispensing of the drugs to the person and shall otherwise comply with all state record keeping requirements for controlled substances.
 - 3) Writes false or fictitious prescriptions for controlled substances scheduled in the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970.
 - 4) Prescribes, administered, or dispenses in a manner not consistent with public health and welfare controlled substances scheduled in the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970.
 - 5) A professional office of a healthcare provider is a "public accommodation" covered under Title III of the Americans with Disabilities Act (ADA). 42 U.S.C. § 12182 (7)(F); 28 C.F.R. § 36.104. Accordingly, doctors are obligated to comply with the requirements of title III of the ADA. 28 C.F.R. § 36.104.

Under title III of the ADA, no person who owns or operates a place of public accommodation may discriminate against an individual on the basis of disability in the full and equal enjoyment of goods, services, privileges, advantages, or accommodations, and must provide auxiliary aids and services when necessary to ensure effective communication. 42 U.S.C. §§ 12182(a), 12182(b)(1)(A)(ii), 12182(b)(2)(A)(iii); 28 C.F.R. §§ 36.201(a), 36.202, 36.303. Ensuring that medical care providers do not discriminate on the basis of disability is an issue of general public importance. *The U.S. Department of Justice is authorized to investigate alleged violations of title III of the ADA and to bring a civil action in federal court in any case that involves a pattern or practice of discrimination or that raises issues of general public importance.*

If a doctor is open to receive patients and has been contacted to become the Pain Patient's Primary Care Provider (PCP) and to help with disability-related pain management and treatment but is refused care and the physician failed to consult with the patient, to legitimately determine whether or not any of the doctors could provide the treatment that was sought. In failing to meet and consult with the patient, the doctor denied the patient a full and equal opportunity to participate in and benefit from the goods, services, facilities, privileges, advantages, or accommodations offered by these medical practices within the meaning of 42 U.S.C. §§ 12182(a), 12182(b)(1)(A)(ii), 12182(b)(2)(A)(iii) and 28 C.F.R. §§ 36.202, 36.303. Essentially, if when the

doctors learned that the patient received pain management treatment, and that they would be referring him or her to other specialists regarding the disability-related pain, if they immediately denied service or refused to take one in as a patient without any explanation. This is an issue.

The ADA also provides "defenses" to public accommodations when the business, or in this case the doctors, determine that they are unable to provide services or that they must refuse services to a prospective or current patient based on an individual's disability. For example, the doctors would have had to show that treating the patient would have posed a "direct threat" to the health or safety of others (see 42 U.S.C. § 12182(b)(3)). A determination that an individual poses a direct threat to the health or safety of others must be made through an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, not on generalization or stereotypes. 42 U.S.C. §12182(b)(3); 28 C.F.R. § 36.208(b). However, since the pain patient's condition is neither contagious nor of the type that poses a direct threat to others should a doctor elect to provide treatment, the direct threat defense does not apply in this case.

- g) Nothing in this section shall be construed to prohibit the governing body of a hospital from taking disciplinary actions against a medical practitioner or surgeon.

DRAFT

Montana Pain Patients Rebuttal to Montana Know Your Dose Statistics

November 22, 2015

In 2014 there were 243 completed suicides in Montana:

- 81% involved Males
- 25% of the completed suicides involved Veterans
(most common age group, Veteran suicides was 55-64 years old, or 51 suicides)
- Approximately 9% of suicides involved Native Americans
- 40% of Montana's completed suicides involved patients with severe medical problems including terminal illness or **CHRONIC PAIN**

Poisoning Deaths quoted in MT Know Your Dose statistics included intentional suicides:

<u>Year of Death</u>	<u>Total Deaths</u>	<u>Accidents</u>	<u>Suicides</u>	<u>Homicides</u>	<u>Undetermined Intent</u>
2009	139	91	30	0	18
2010	115	60	32	0	23
2011	135	86	21	0	28
2012	109*	72	19	0	18

*NOTE: There were 89 poisonings (109 minus 19) of accidental or undetermined intent. It is not appropriate to tally up suicides in the "overdoses" as this skews the statistics shared by the Know Your Dose campaign. According to our research, some coroners will accommodate grieving families and categorize the cause of death as accidental since suicide typically voids most insurance benefits. We agree there is a problem with addiction in the youth which includes other substances such as alcohol, meth, and now heroin in Ravalli County (2015). Addiction problems affecting Montana's youth should be addressed separately from chronic pain patients suffering from combat injuries, bad backs, arthritis, etc. For instance, back pain is a leading cause of disability impacting Montanans in the prime of their life and careers.

According to more recent statistics from MT Department of Public Health and Human Services, Montana is gaining the upper hand on prescription drug abuse. The number of prescription drug-related deaths in **Montana numbered 109 in 2013**, according Montana DPHHS. The number of people prosecuted for prescription drug crimes in Yellowstone County has fallen 70 percent from 2011 to 2013.

References: JUDY can you help me out here and put in a format so all this fits on one page???

http://missoulian.com/news/state-and-regional/percent-of-montana-suicides-in-were-males-nearly-percent-were/article_c5ab2cdf-0b7f-54af-b2fb-23bb2cd3cd0c.html

<http://dphhs.mt.gov/Portals/85/publichealth/documents/Epidemiology/MTHDDS/Special%20Reports/Drugdeathshosps.pdf>

http://m.missoulian.com/news/state-and-regional/montana-struggles-to-combat-prescription-drug-abuse-drug-registry-ineffective/article_6bbcefd4-20b6-11e4-a7d3-001a4bcf887a.html

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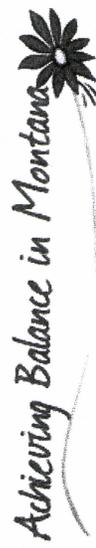


Kaye Norris, PhD
Program Director, Montana Pain Initiative
Assistant Director, Western Montana Area
Health Education Center



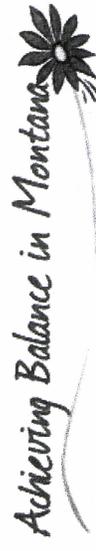
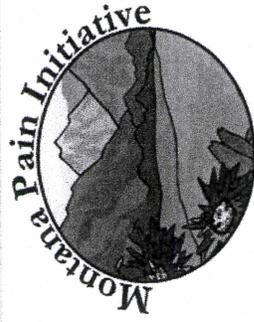
Senate Joint Resolution 28

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



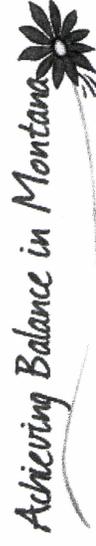
Senate Joint Resolution 28

- × 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:

- × American Cancer Society
- × American Cancer Society Cancer Action Network

Boards/Associations:

- × Medical
- × Pharmacy
- × Nursing

Organizations:

- × 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



Executive Committee

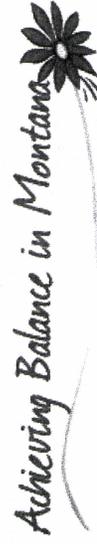
Leadership of the MTPI

- + Chair, Randal 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)



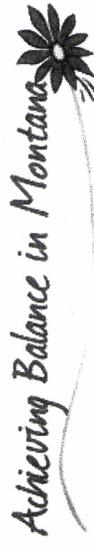
Getting the Work Done

- × 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



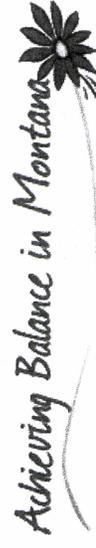
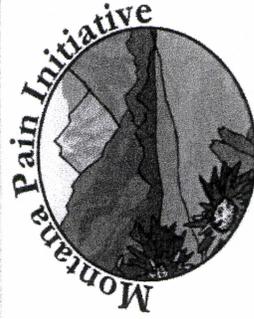
Policy Improvement

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



Policy Improvement

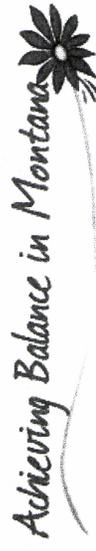
- × Montana Board of Medical Examiners adopted Model Pain Policy developed by Federation of State Medical Boards
- × Board of Pharmacy revised pain policy based on national standards
- × 13 Facilities (long term care, home health, and critical access hospitals) revised policy and structure to improve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



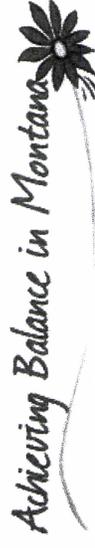
Provider Practice Improvement

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



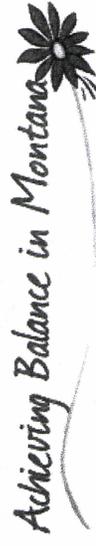
2010 BRFSS Results

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



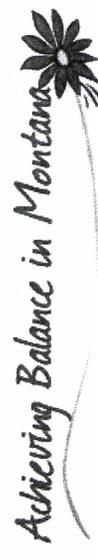
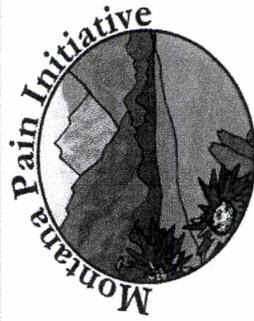
2010 BRFSS Results

- × 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)



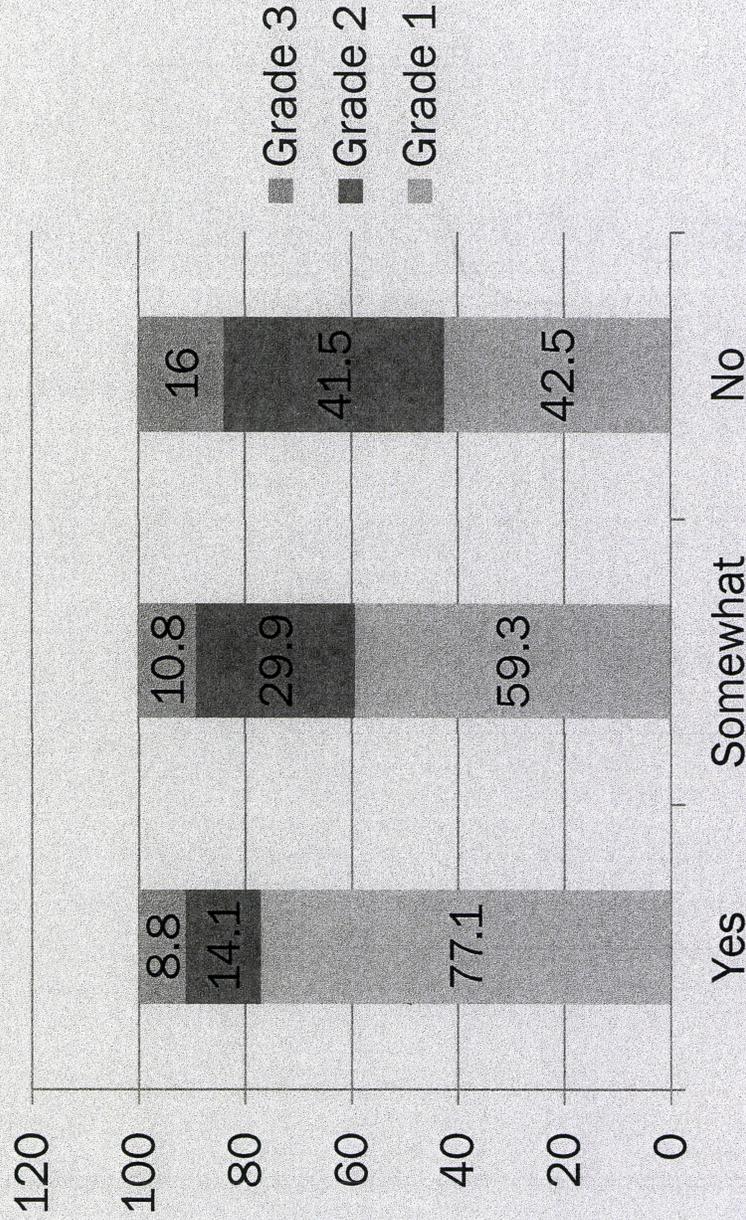
2010 BRFSS Results

- × ~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)



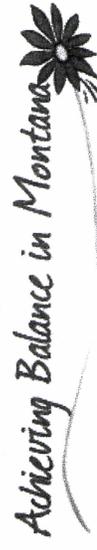
BRFSS Results

Is your pain well managed?



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



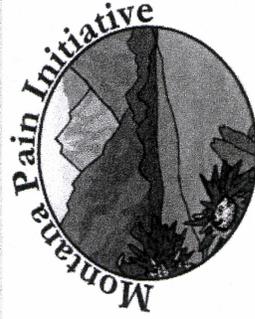
Two Competing Public Health Crises

- 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).



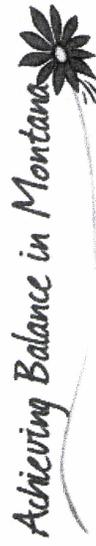
IOM: “Underlying Principles”

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.*

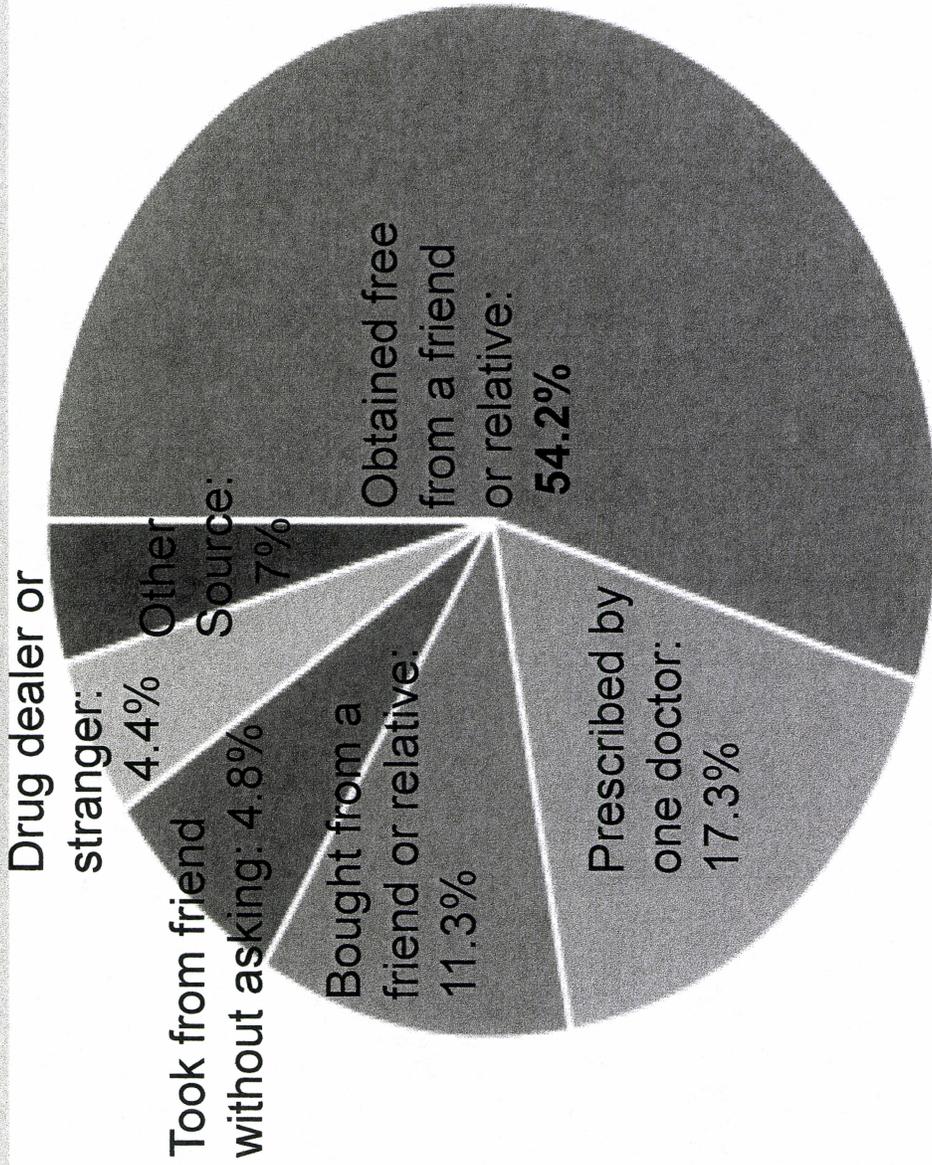


Who is at risk for overdose death?

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.**

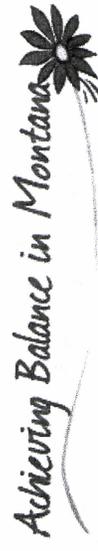


People Who Abuse Prescription Pain Medication Get Them From:



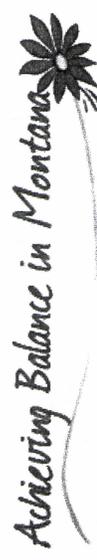
Best-Practices

- + 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.

