Advisory Committee on Pain and Symptom Management (ACPSM)
2014 Recommendations
to
Michael Zimmer, Acting Director, Dept. of Licensing and Regulatory Affairs
Nick Lyon, Director, Dept. of Community Health

2014: The "State" of Pain in Michigan:

Background:

Pain is a significant public health problem in Michigan and beyond. The American Academy of Pain Medicine reports that in 2011 at least 100 million adult Americans had chronic pain conditions. (1) In Michigan, with a population of about 10 million citizens, up to 3 million persons live with daily chronic pain.

Pain costs society dearly. In 2008, costs to federal and state governments for medical expenditures were $99 billion or an amount equal to $2,000 for everyone living in the US (1). In fiscal year 2013, 813,936 full Michigan Medicaid beneficiaries had at least one claim or encounter that included a primary or secondary diagnosis code involving "pain" (2).

Pain affects more Michigan citizens and Americans than diabetes, heart disease and cancer combined. The chart below depicts the number of chronic pain sufferers compared to other health conditions:

Condition:	Number of Persons with:	Source:
Chronic Pain	100 million Americans	Institute of Medicine of the National Academies (3)
Diabetes	25.8 million Americans (diagnosed and estimated)	American Diabetes Association (4)
Coronary Heart Disease	16.3 million Americans	American Heart Association (5)
Stroke	7.0 million Americans	American Heart Association (5)
Cancer	11.9 million Americans	American Cancer Society (6)

In Michigan annually:

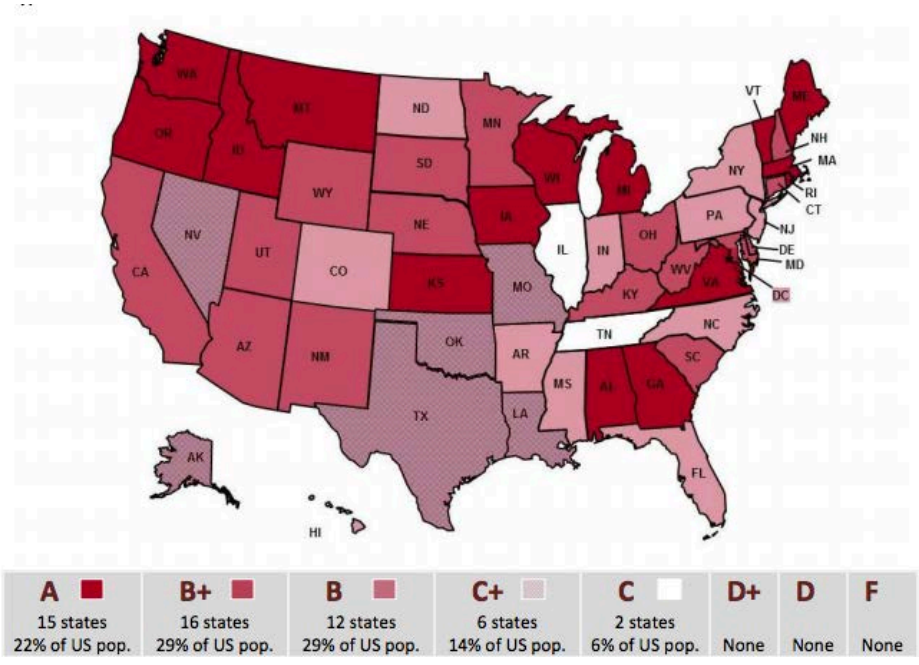
Condition:	Number of MI patients:	Source:
Chronic Pain	~3 million	EPIC-MRA poll, AAPM
Diabetes	730, 630 (9.2% Adults) 500,322 PreDiabetes (6.3%)	MDCH Diabetes in MI Update 2013
Heart Disease	164,696 Hospital discharges	MDCH CVD Fact Sheet
Stroke	158,833 Adults report ever having had a stroke	MI Behavioral Risk Factor Surveillance System
Cancer	52,406 Invasive cancer all sites	MDCH Cancer Brief

In 2012, 73,715 Michigan residents were hospitalized for pain as a primary or secondary diagnosis during admission. Chronic pain diagnoses accounted for 72% of these admissions (52,359 cases). By contrast, Michigan hospital admissions in 2012 for cancer-related pain represented only 5.2% of the total admissions for pain. (7)

Michigan leads in pain policy

There are important ongoing efforts in the U.S. to address simultaneously two major public health crises: the medical under-treatment of pain and the non-medical use of controlled substances, both of which involve the opioid analgesic class of medications.

Michigan continues at the top of a growing number of states that enact policy measures that promote the delivery of effective pain management, by enhancing access to pain care, including the use of pain medications, and minimizing potential treatment barriers. The 2013 report, Achieving Balance in State Pain Policy: A Progress Report Card shows the extent that state policies can support pain management and patient care. The University of Wisconsin Pain & Policy Studies Group (PPSG) researchers evaluate the content of state laws and regulatory policies to determine whether they could enhance or impede pain management. Michigan continues to receive a grade of 'A' that reflects the quality of its legislation and regulatory policies as they positively influence patient pain care.



Treatment of Pain in Michigan

There are many therapies utilized in the treatment of acute and chronic pain.

In 2013, in a telephone survey of 1000 persons, 27.7% of Michigan residents reported having sought treatment from a health care professional for an acute pain condition the past year. 27.6% of Michigan residents stated they had been told that they were entitled to have their pain managed as a basic part of their health care. (8)

In the past year, 15.7% of respondents reported having had an acute or chronic pain condition which prevented them from either going to work or doing their job while at work. 25.2% of respondents reported having an acute or chronic pain condition for which they did not seek medical treatment. (8)

89.4% of respondents in 2013 agreed that acute pain can be effectively managed with today's pain medications or other treatments. To the question: "Chronic pain can be effectively managed with today's pain medication or other treatments." the number of individuals who agreed increased from 63.3% in 2009 to 69.0 % in 2013. Respondents reported a pain level of 7.20 (out of a 10 point scale) prior to seeking treatment and a pain level of 3.00 after seeking treatment. (8)

Most respondents commented on the prescription medications prescribed and used to treat their pain. 6.2% of respondents indicated that they had a physician or health care provider show reluctance or refusal to prescribe what the respondents thought was an effective type or amount of pain medication. The respondents indicated the main reason for a physician showing reluctance to prescribe pain medication was the physician's perception that the pain was not bad enough, followed by the physician concern the medication was not being taken as prescribed. (8)

For all surveys to the question: "What type of health care professional treated your pain over the past year?" most respondents answered the family physician or physician's assistant (51%), followed by physical therapists (14.4%) chiropractors (14.0) and massage therapists. The percentage of respondents receiving massage therapy jumped from 7.4% to 11.5% since 2009. Statistically unchanged from 2009 at 4.0% was the use of psychologist, social worker, or a mental health counselor to treat pain; in 2013 at 4.8%. (8)

Prescription Medication Use in Michigan

Prescription medications are the most common form of pain treatment in Michigan and the US. Prescribing and dispensing of medications is monitored by the federal government and our Michigan Automated Prescription System. The use of opioid and other DEA scheduled medications for the treatment of acute and chronic pain has increased across the country.

The table below shows the recent trends in use of these medications in Michigan:

Schedule II and III Drug Use in the State of Michigan‡			
Drug	Units prescribed		
	2011	2012	2013
Schedule II			
Morphine	28,027,786	32,043,014 (↑14%)	33,884,070 (↑6%)
Oxycodone	75,192,984	87,871,391 (↑17%)	91,294,172 (↑4%)
Methadone	31,203,994	30,082,019 (↓4%)	28,597,265 (↓5%)
Meperidine	433,517	383,245 (↓12%)	325,549 (↓15%)
Fentanyl	3,555,035	2,055,587 (↓42%)	4,877,670 (↑137%)
Schedule III			
Hydrocodone	463,552,834	476,940,148 (↑3%)	470,880,776 (↓1%)
Hydromorphone	8,943,492	10,455,022 (↑17%)	10,397,883 (↓1%)
Buprenorphine	8,925,072	9,955,880 (↑12%)	10,894,638 (↑9%)
Oxymorphine			
Tapentadole			
Tylenol with Codeine	1,099,911	884,066 (↓20%)	814,565 (↓8%)

‡Data from the Michigan Automated Prescription System (MAPS) for 2013.

To relate Michigan's prescribing practices to other states, in July 2014 the U.S. Center for Disease Control released a comparison of 2012 painkiller prescriptions per state. Michigan ranked in the highest category of prescriptions per person when compared to other states: 107 painkiller prescriptions written per 100 Michigan residents. (9)

Trends and changes in prescribing patterns of these medications have been analyzed by pain and health policy experts within Michigan's Licensing and Regulatory Affairs (LARA) and Community Health (MDCH) departments. The Michigan Advisory Committee on Pain and Symptom Management utilizes this and other important health data in making its recommendations for improvements in pain management.

Prescription Medication Abuse

Prescription drugs are the second-most abused category of drugs in the United States, following marijuana. [10]

Prescription painkillers are considered a major contributor to the total number of drug deaths. In 2007, for example, nearly 28,000 Americans died from unintentional drug poisoning, and of these, nearly 12,000 involved prescription pain relievers. [11]

Nearly one-third (29%) of people age 12 or older who used illicit drugs for the first time in the past year began by using prescription drugs non-medically. [12]

Opioid analgesics (e.g., oxycodone, hydrocodone) are narcotic drugs that are prescribed to relieve pain and were involved in a large number of Michigan's prescription drug overdose deaths. The Michigan Automated Prescription System (MAPS) is a prescription drug monitoring program which reported over 20.9 million prescriptions written for controlled substances in 2012. Hydrocodone remains the highest prescribed drugs since the creation of MAPS in 2003, accounting for 32.2% of all prescriptions in 2012. (13)

In Michigan from 2009 to 2012: The average age-adjusted unintentional or undetermined intent drug poisoning death rate was 12.3 per 100,000 Michigan residents (95% CI: 11.9-12.6). On average, 24% of drug overdose decedents had no prescription in the Michigan Automated Prescription System (MAPS) (13).

1,299 (36%) of overdose decedents in Michigan had at least one prescription filled within the 364 days prior to death and had 5 or more prescribers per year (13).

Among the 930 opioid-related overdose Michigan decedents between 2009 and 2012, 818 (88%) died from opioid without heroin or cocaine and 276 (30%) decedents had no prescription in MAPS for an opioid (13).

In Michigan in 2012, prescription opioids were involved without heroin or cocaine in 153 of the 188 opioid related deaths or 84%. (13)

Michigan opioid-related deaths with evidence of drug diversion (i.e. using a prescription drug without a prescription) were almost two times more likely to have cocaine or heroin in their system at time of death compared to opioid-related decedents with an opioid prescription filled within the 30 days prior to death (13).

Of the 1,422 opioid or benzodiazepine decedents in Michigan from 2009-2012, more than one-third (36%) obtained a prescription for at least one opioid and at least one benzodiazepine within the 30 days prior to death. Of the 826 heroin-related deaths, 148 (18%) had a prescription for an opioid in the 30 days prior to death (13).

Among overdose decedents with opioid prescriptions within the 30 days prior to death, approximately 70% of both men and women obtained a prescription for hydrocodone.
Among men and women, the percent of decedents with a hydrocodone prescription (71%) was almost 4 times greater than the next closest opioid, oxycodone (18%) (13).

State of Michigan Advisory Committee on Pain and Symptom Management (ACPSM)

The Advisory Committee on Pain and Symptom Management (ACPSM) is charged with studying the State of Pain in Michigan and making recommendations to MDCH and LARA with the goal of improving the care of patients in pain. The committee's appointees recognize the importance of providing good pain management to Michigan citizens in pain while balancing this with reduction in the misuse of prescription medications and the health and societal consequences of abuse including lawlessness and death.

To achieve these dual and important goals the committee has taken on projects including information gathering cited above and has attempted to educate Michigan citizens and health professionals about pain management and medication diversion and prescription abuse prevention.

The ACPSM achievements in 2013 and 2014 include:

1. Completed work on an ***ACPSM Model Core Curricula on Pain Management for Michigan Medical Schools*** and contacted all of Michigan's medical schools to promote the curricula.
2. Co-sponsorship of the **"Scope of Pain"** conference with Boston University
3. Development of Continuing Education (CE) recommendations for nine Michigan health professional boards and forwarded those CE recommendations to the licensing boards to provide them with guidance on required CE hours and appropriate content for pain and symptom management for competent prescribing
4. Development of **Pain Management Tool Kits** for health care professionals and the public and posted them on the Department of Licensing and Regulatory Affairs website.

Recommendations:

The Advisory Committee on Pain and Symptom Management (ACPSM) supports, plans, and advises action that will better address and relieve the pain many Michigan citizens endure every day. ACPSM advocates for the compassionate and rational treatment of acute and chronic pain and promotes efforts to reduce or eliminate the adverse effects of pain therapies including prescription medication overdose, diversion of pain medications for non-medical use, and the social consequences of addiction and abuse.

Towards those goals, the Committee recommends:

Recommendation 1:

The Directors of the Michigan Departments of Licensing and Regulatory Affairs and Community Health should support the ACPSM Pain Management Continuing Education (CE) recommendations, including quantifying the number of requisite credits; and should promote the Pain Management CE recommendations to the various health professional licensing boards.

The ACPSM continues to support the importance of continuing education on pain and symptom management for health professions and has determined, based on careful review and consideration, the following specific CE/CME targets and content recommendations which comply with the current statute noted below.

> *MCL 333.16204. . . . the appropriate board shall by rule require an applicant for renewal to complete an appropriate number of hours or courses in pain and symptom management. Rules promulgated by a board under section 16205(2)* for continuing education in pain and symptom management shall cover both course length and content and shall take into consideration the recommendation for that health care profession by the interdisciplinary advisory committee created in section 16204a.*

Quantity: The ACPSM recommends the following minimums in pain and symptom management continuing education:

Suggested Minimum CE/CME Hours in Pain & Symptom Management	Total CE/CME Hours Required Per Profession and Licensing Cycle	Examples of Boards for which CE/CME Hours Should Apply
1	1-24	Massage therapy, Nursing home administrators
2	25-49	Nursing (25), Pharmacy (30), Social work (45)
3	50-74	Dentistry (60)
4	75-99	Athletic trainers (80)
5	150 credits per 3 years	Allopathic and Osteopathic Medicine

Content: The ACPSM recommends that the health profession boards, when they open their rules for review, shall consider pain and symptom management content that is appropriate for that health profession. CE course curricula should include as many as possible of the topics listed in the *ACPSM Model Core Curriculum on Pain Management for Michigan Medical Schools* as found Appendix A.

Recommendation 2:

The Directors of the Michigan Departments of Licensing and Regulatory Affairs and Community Health should adopt the *ACPSM Model Core Curriculum on Pain Management for Michigan Medical Schools* and promote its use in Michigan health professional educational schools and centers.

In May 2011, the Bureau of Health Professions brought together curriculum faculty from Michigan's seven medical schools to meet with several members of the Michigan Advisory Committee on Pain and Symptom Management with the goal of drafting a model core

curriculum for medical schools addressing pain and its management. After committee and stakeholder input and several revisions, model core pain curriculum was completed in late 2012.

The *ACPSM Model Core Curriculum on Pain Management for Michigan Medical Schools* is intended to assist faculty with the identification of essential learning objectives for a four year graduate medical school curriculum. The model curriculum is useful in the identification of the gaps that national pain curriculum experts suggest are widespread in the education healthcare professionals, such as content addressing ethics, health policy, and clinical sciences.

Beginning in 2013, the ACPSM has refocused their efforts on dissemination of the model core curriculum to begin the wider distribution of curricular materials to other schools educating healthcare professionals in the Michigan including Schools of Pharmacy, Nursing, and Allied Health. This broader distribution of the curriculum is driven by the recognition of the importance of the team of healthcare professions in the effective diagnosis and management of acute and chronic pain.

The purpose is to ensure comprehensive, essential content on pain education that is consistent across all of Michigan's medical schools.

Recommendation 3:

The Directors of the Michigan Departments of Licensing and Regulatory Affairs and Community Health should promote the use of Michigan's electronic prescription monitoring program (MAPS), should encourage emergency room (EMR) interconnectivity with MAPS, should develop MAPS prescribing and dispensing thresholds to trigger further evaluation of the prescriber, and should regularly review MAPS data to facilitate more specific monitoring of Physicians, Pharmacists, and Health Plans use, including sending reports to the users, to ensure pain management and limit misuse and diversion of scheduled medications.

The Michigan Automated Prescription System (MAPS) is a free risk management tool that generates reports on a patient's access (by prescription and dispensing) of opiate pharmaceuticals classified as schedule II-V controlled substances. By Michigan statute effective in 2002, the system was developed to coordinate patient care, to limit the overuse and misuse of scheduled medications and to allow better tracking of these important drugs.(14) MAPS provides valuable statistical information about prescribing and dispensing of outpatient medications to Michigan pharmacists, doctors, citizens, and regulatory officials. MAPS data can be used collectively to analyze healthcare trends and assess public healthcare policy or used individually to improve pain medication management and limit misuse and overuse of medications by healthcare providers and dispensers.

Only pharmacists, veterinarians, and dispensing prescribers are required to enroll in MAPS and report the dispensing of schedule II-V controlled substances. No other physician prescriber is required to report on the prescribing of schedule II-V controlled substances. Any Michigan prescriber can enroll in MAPS. Enrollment does not require the physician to report on prescribing, but allows the physician the benefit of being able to check on the medications dispensed to a patient prior to writing a prescription for the patient.

The ACPSM urges the Directors of the Michigan Departments of Licensing and Regulatory Affairs and Community Health to encourage healthcare provider and pharmaceutical dispensers to enroll as MAPS users, by going to: www.michigan.gov/miMAPSinfo. The ACPSM suggests that the Directors highlight the importance of physician enrollment and use of MAPS in their professional capacities whenever addressing health care related forums. The Directors are also encouraged to advertise and distribute the State of Michigan DVD on *MAPS and Effective Pain Management*.

Triggers:

The ACPSM recommends that the Directors return to and review any previous plan to develop thresholds for prescribing and dispensing. In general, the plan proposed that a prescriber or dispenser exceeding the threshold would trigger further evaluation of the prescribing practice. The thresholds proposed at the time of the MAPS regulation process were:

- **three of the same medications in the same mount for an individual patient,**
- **three different prescribers in the same month for the same patient, or**
- **three different dispensers in the same month for a patient.**

A recent joint project between the Michigan Department of Community Health and the Michigan Department of Licensing and Regulatory Affairs compared MAPS data to information on the death certificates of Michigan residents from 2009 through 2012. One key finding was that 36% of drug overdose decedents (unintentional or undetermined intent) with at least one prescription filled within the 364 days prior to death, had five or more prescribers per year. It is the consensus of the ACPSM that with physician use of MAPS prior to prescribing the schedule II through V controlled substances for new patients, or patients suspected of diversion or doctor shopping, the incidence of overdose for persons who had five or more prescribers per year could be reduced. Similarly, having connectivity between MAPS and emergency departments could aid in physicians making more informed decisions when a patient presents at the emergency department seeking controlled substances.

Exceeding the thresholds identified above would not necessarily mean that a prescriber or dispenser would be reprimanded; rather that a designated Department pharmacy investigator, the MI Board of Pharmacy, or MI law enforcement would further investigate. The intent behind the development of a MAPS threshold is to identify early and limit bad prescribers, bad dispensers, “doctor shopping” and diversion.

Because MAPS has data entered at the point of dispensing, and before the medications are distributed, it is an ideal place to add the proposed threshold "hard stops" into the electronic system. It is recommended that the system include a hard stop which would be given a swift evaluation to ensure that the health practitioners who are legitimately prescribing or dispensing would not have their treatment therapy interrupted or extraordinarily delayed.

Recommendation 4:

The Directors of the Michigan Departments of Licensing and Regulatory Affairs and Community Health should encourage efforts to prevent and reduce the misuse, abuse, and diversion of pain medications, address proper storage and disposal, and caution against engaging in activities such as driving or caring for children while taking certain medications. These efforts can be accomplished with adoption of best practices, and a commitment to coordinating monitoring and enforcement actions among the state departments, the Michigan Attorney General and law enforcement.

Best Practices:

ACPSM recognizes the obligation of pain medication providers and regulators to promote a balanced approach to medication management including efforts to limit drug diversion. The ACPSM endorses for adoption by the Directors the following best practices for prescribing pain medications:

Balancing the need to relieve symptoms, to improve function and to assure safety: Chronic pain and acute pain are different illnesses that require different approaches to effective treatment. The management of chronic pain encompasses much more than the prescription of controlled medications, but instead, requires a biopsychosocial approach such that it is the patient with pain that is being treated rather than merely prescribing to treat pain. Balancing the need to relieve subjective symptoms, improve objective function and assure safety for the patient, his/her family or visitors who may access the medications, is critical. The prescription of opioids (and benzodiazepines) carry associated risks that must be addressed. However, it is often more expedient in the current healthcare system, to issue a prescription than to provide the optimal physician-patient visit time, address insurance coverage issues or arrange access to physical, social and psychological therapies. These pressures to effective healthcare delivery for pain sufferers increases the risk for iatrogenic opioid use disorder in the patient and risk to family, friends and the community.

Require a documented objective illness, an absence of contraindications and an ability to comply with treatment plan: Patients requiring treatment with controlled pain medications should have an objective illness (supported by objective exam findings, imaging or other testing results), an absence of contraindications (uncontrolled psychological, social, or substance abuse disorder) and the ability to comply with all treatments, including attend follow-up appointments. Local pain generators should be

treated, so that use of systemic opioids may be minimized. Ever increasing doses of opioids is unjustified when the prescriber understands that overdose or diversion risk increase, while opioid-induced hyperalgesia (more pain) increases.

Number of pills prescribed closely matched to the present need: Results from the 2010 National Survey on Drug Use and Health (NSDUH) demonstrate that prescription drugs are most commonly acquired for free from friends or relatives. Therefore, the home is a point of access for prescription drug abuse. Adults are often ill-informed about how accessible their prescriptions are to their family, friends, babysitters, and visitors. The Directors should promote to the professional boards of medicine, dentistry, and pharmacy, and to health care insurers, a shift in the mindset that pain medications need to be prescribed and dispensed for a full 30 day (or in a number of cases 90 days) supply. By limiting the dispensing to a quantity more accurately reflecting the medical procedure or patient's symptom reduces the amount of medications that are not needed and are laying around in medicine cabinets across Michigan or in the community with potential for diversion, abuse, or misuse. An example of a solution to this problem is the situation where a teenager's oral surgeon or dentist prescribes a 30 day supply of pain medicine after a wisdom teeth retraction or other dental procedure. The ACPSM instead urges that the standard prescribing practice in this situation be a prescription for four days of pain medicine with an option for the parent to request a refill if necessary. By tailoring the number of pills to a customary length of need reduces the unused number of pills available to other members of the household for misuse, and to the teenager and his or her friends, for abuse, misuse, and diversion. In the dental procedure example the excess is 24 days of drugs known to be highly abused.

The Michigan Department of Education asked two questions for the first time in school year 2009-10 regarding prescription drug use on the Michigan Profile of Healthy Youth (MiPHY). According to the results of that MiYRBS, illegal drugs were offered, sold, or given on school property to 30% of students within the prior year. Six percent of 9th through 12th graders admitted to having taken barbiturates without a doctor's prescription in the prior 30 days. The students described "Pharming Parties" as a recreation.

Disposal: In an effort to encourage proper disposal techniques and remove from the community unwanted and unused prescription drugs the DEA initiated Nationwide Prescription Drug Take-Back Days to of across communities in all 50 states. In recent years the Michigan State Police have partnered with the DEA to sponsor take back sites throughout the state. Information about the date and location for the Michigan prescription take back day is located on the Michigan State Police website and the State of Michigan website under the "Health" heading. The Michigan Pharmacists Association also sponsors a medication disposal event on the State Capitol lawn in Lansing each year. The Directors of the Michigan Departments of Licensing and Regulatory Affairs and Community Health are urged to promote the Prescription Take Back day and similar events on each home page for the 30 days prior to the annual events to raise public awareness of the opportunity.

RECOMMENDATION 5

The Directors of the Michigan Departments of Licensing and Regulatory Affairs and Community Health should support the continued outreach and educational uses of their department websites, social media, and public service announcements. The Directors should post a website link on each website's home page to the LARA pain and symptom management website and the MDCH Chronic Disease and Injury Control webpage.

The ACPSM recognizes that a person experiencing acute or chronic pain might not be aware of the resources available for them to manage their pain symptoms or to deal with the life changes posed because of the pain symptoms. The ACPSM is aware that often these individuals feel isolated, frustrated, or hopeless. The ACPSM notes that one of the most important tools to enable a person to continue with the important activities of his or her life is information about the medical professional treatment of pain as well as techniques for self-management of pain symptoms and coping.

To aid in providing educational information critical to individuals experiencing pain, the ACPSM health consumer education subcommittee developed a health consumer's pain toolkit available on the Michigan Department of Licensing and Regulatory Affairs, ACPSM website. The health consumer's pain toolkit includes:

a) Listings of health care professionals and other resources by county (where possible)
b) List of self-management tools with recommended website links for counseling/psychotherapy, exercise, stretching/yoga, bio-feedback, and other evidence based, non-pharmacologic treatments
c) Condition-specific listings with links to helpful resources

LARA's pain and symptom website, www.michigan.gov/pm, includes toolkits for health consumers and health professionals which contain wide-ranging critical topics from how to self-manage chronic disease with physical, social, and psychological measures, to state and national guidelines for treating pain.

The ACPSM recommends to the Directors that a link to LARA's pain and symptom website be placed on the homepages of the Michigan Department of Community Health and the Michigan Department of Licensing and Regulatory Affairs, so that a person experiencing acute or chronic pain can easily navigate to the public pain toolkit resource. Similarly the homepage link will quickly direct health care professionals seeking nationally recognized guidelines or data.

The ACPSM Health Consumer Education Sub-Committee recognized that a person who approached living with chronic pain with a positive attitude often had a positive outcome; an ability to continue work or return to work, to participate in the daily activities that brought meaning or fulfillment, and to avoid or mitigate depression. With this recognition the health consumer education subcommittee focused its efforts on gathering and making

accessible information on disease self-management. The subcommittee developed daily messages to broadcast through social media during September Pain Awareness month which feature a theme of taking control of managing one's pain in order to achieve a positive life outcome. The messages direct a person to LARA's pain and symptom website for additional information.

With regard to fostering a patient's desire for taking initiative to manage an acute or chronic pain condition, the ACPSM applauds the Michigan Department of Community Health Personal Action Toward Health program (PATH) program, recommends the continuation of the program and recommends tailoring a portion of the program to persons living in Michigan with chronic pain. (15) The PATH program is modeled after Stanford University's Disease Self-Management Program. The program is a series of workshops given over a period of six weeks, in community settings such as senior centers, churches, libraries and hospitals.

Topics of Stanford's chronic pain self-management program include:

1) techniques to deal with the common chronic pain related difficulties of frustration, fatigue, isolation, and poor sleep,
2) appropriate exercise for maintaining and improving strength, flexibility, and endurance,
3) appropriate use of medications,
4) communicating effectively with family, friends, and health professionals,
5) nutrition,
6) pacing activity and rest, and,
7) how to evaluate new treatments.

Information about the PATH program can be found on the MDCH Chronic Disease and Injury Control webpage, a webpage rich in resources for optimally living with chronic illnesses and preventing injury. The Directors should more prominently place links on main webpages directing traffic to the MDCH Chronic Disease and Injury Control webpage in order to raise awareness of the availability of the valuable self-management and injury prevention information.

RECOMMENDATION 6

The Directors of the Michigan Departments of Licensing and Regulatory Affairs and Community Health should promote health practitioner and health plan referrals to pain specialists, and for non-pharmacological and non-surgical alternatives to pain management such as physical therapy, occupational therapy, counseling, manipulation/massage therapy, palliative care, and hospice.

The ACPSM Health Consumer Education Sub-Committee noted that a person who first tried non-surgical and non-pharmacological treatments, or used non-surgical and non-pharmacological treatments along with surgery or medications had better and longer sustained functional and satisfaction outcomes. For patients in specific circumstances,

consulting with a pain specialist brought a more effective and satisfactory outcome than prolonged treatment with a general practitioner.

Patient comments gleaned during the 2013 telephone survey indicated that a significant reason for not seeking a pain specialist or non-medical alternatives was health insurer reluctance to cover the care. (8) A noted complaint of patients experiencing pain is that their gatekeeper doctor did not inform them of standard non-medical alternatives to managing pain or did not make a referral to a pain specialist or alternative modalities.

The Directors of the Michigan Departments of Licensing and Regulatory Affairs and Community Health have occasion to communicate with health insurers or health practitioners and their representative organizations. The ACPSM recommends to the Directors that they encourage Michigan health insurers to cover pain self-management tools such as referrals to pain specialists and alternative pain treatment methods including counseling/psychotherapy, physical therapy, occupational therapy, manipulation/massage therapy, palliative care, and hospice.

Conclusion:

The Michigan Advisory Committee on Pain and Symptom Management advocates for the continued study of the State of Pain in Michigan and for improvements to policy and practice that encourage a balanced approach to medication use and diversion prevention, better education and practice of excellent pain management by all Michigan health professionals, increased attention to best practice for pain management by the Michigan health professional practice boards, and better consumer and health professional education on all aspects of pain experience and management to improve the health status of our state and its communities. We believe that adoption of the recommendations above will assist in reaching that goal.

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APPENDIX A

ACPSM Model Core Curricula on Pain Management for Michigan Medical Schools

The recommended curricula* are as follows:

1. Public health burden of pain
    a. Prevalence,
    b. Impact on health system
    c. Costs
2. Ethics and health policy as related to pain
    a. Michigan pain and controlled substance laws
3. Definitions of Pain
4. Basic sciences as related to pain
    a. Pharmacology of pain
    b. Psychology of pain
    c. Neuroanatomy
    d. Neuroembryology
    e. Evolutionary Biology
    f. Neurophysiology
    g. Pathophysiology of pain
    h. Biochemistry of pain
5. Clinical sciences as related to pain
    a. Specific pain conditions
    b. Pain in special contexts/settings
6. Clinician-patient communications as related to pain
7. Management of pain
    a. Evaluation of pain and documentation of findings
    b. Treatment of pain using non-pharmacological and pharmacological management
    c. Physical medicine and related approaches
    d. Psychotherapeutic and behavioral approaches
    e. Pharmacologic approaches
    f. Interventional approaches
    g. Complementary and alternative medicine/ integrative medicine
    h. Follow-up and reassessment
8. Ensuring quality pain care (standards of care)
9. Michigan programs and resources relevant to pain

**Content is derived from the table of contents of the ACPSM Model Core Curriculum on Pain Management for Michigan Medical Schools.*