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**ADVISORY COMMITTEE MEMBERS**

<b><u>MEMBER</u></b>	<b><u>REPRESENTING</u></b>
<b>Melanie Brim, M.H.A., Chairperson*</b>	Michigan Department of Community Health
<b>Ruth Ann Brintnall, R.N., M.S.N., Ph.D.</b>	Michigan Board of Nursing
<b>Michael D. Chafty, M.D., J.D.</b>	Pain Specialist, Michigan Board of Medicine
<b>Daniel J. Clauw, M.D. *</b>	University of Michigan School of Medicine
<b>Dennis W. Dobritt, D.O.</b>	Pain Specialist, Michigan Board of Osteopathic Medicine and Surgery
<b>Ahmed ElGeneidy, D.D.S.</b>	Michigan Board of Dentistry
<b>Jean Friend*</b>	Public Member
<b>Ralph A. Geraci, PA-C</b>	Michigan Task Force on Physician's Assistants
<b>Alan Lewandowski, Ph.D.</b>	Michigan Board of Psychology
<b>Jeanne Lewandowski, M.D.</b>	Michigan Board of Medicine
<b>Frenchie D. McCall, LMSW*</b>	Chronic Pain Sufferer
<b>William Morrone, D.O.</b>	Michigan Board of Osteopathic Medicine and Surgery
<b>Lawrence L. Prokop, D.O.*</b>	Michigan State University College of Osteopathic Medicine
<b>Steven Roskos, M.D.*</b>	Michigan State University College of Human Medicine
<b>Claire Saadeh, Pharm.D., BCOP</b>	Michigan Board of Pharmacy
<b>Maria J. Silveira, M.D., M.A., M.P.H.*</b>	Michigan Hospice and Palliative Care Association
<b>Michael A. Stellini, M.D.*</b>	Wayne State University School of Medicine

**\* Appointed by the Governor**

# **FY 2009 Annual Report of the Advisory Committee on Pain & Symptom Management**

## **I. Executive Summary**

The Pain and Symptom Management Advisory Committee consists of representatives from health professional licensing boards and the Task Force on Physician's Assistants, Michigan universities, a professional hospice association, the Michigan Department of Community Health, and the public. It was established under the Occupational Regulation Sections of the Michigan Public Health Code, P.A. 421 of 1998, which took effect April 1, 1999. The first interdisciplinary advisory committee was established in 1995 under P.A. 232 of 1994.

The committee was charged with addressing issues related to pain and symptom management by holding a public hearing to gather information from the general public and make recommendations.

Three subcommittees were formed to focus on the following areas:

1. Public Education
2. Professional Education
3. Public Policy

A public hearing was held on June 20, 2000. Based on the public hearing testimony, the advisory committee identified the following pain and symptom management issues to be of utmost concern to the public:

- Lack of education and training in pain and symptom management for health care professionals
- Lack of "pain and symptom management" curriculum in medical, dental, pharmacy, psychology and nursing programs in Michigan health professions educational institutions
- Lack of awareness of pain and symptom management among patients, family members, insurers and state agencies
- Lack of access and coverage for treatment for pain and symptom management
- Fear of addiction and misinformation regarding Schedule II drugs and lack of availability of Schedule II drugs in pharmacies
- Physicians' reluctance to prescribe Schedule II drugs for fear of disciplinary action
- Patients' difficulty in proving disability to insurers

The following 18 recommendations were made by the sub-committees:

1. *Michigan Department of Consumer and Industry Services (MDCIS) should develop and implement a website on pain and symptom management for the following:*

- A. *Healthcare professionals:*

- The website should address the issues of state law and related administrative rules, education and continuing education, provider issues, pharmacy issues and links to professional associations and other resources on pain and symptom management.*

- MDCIS should publish information about the website and access to the website in "Health Alert." MDCIS staff should be responsible for updating the website with information received from the advisory committee, from professional associations and newsletters.*

- B. *General public:*

- To increase the public awareness regarding pain management, the website should cover topics such as the definition of pain, causes of pain, frequently asked questions, current news concerning pain issues in Michigan and across the country, policy statements, bibliography and topics of interest. The website should be linked to other user-friendly pain and symptom management websites such as the American Pain Society, the International Association for the Study of Pain, the American Pain Foundation, etc. The website should also have a "contact us" feature where the public can express their concerns related to pain and symptom management to the committee, department and legislature.*

2. *The legislature should amend all statutes to eliminate the use of the term "intractable pain." The term "intractable pain" should either be eliminated in these statutes or amended to read "pain," as appropriate.*
3. *MDCIS in consultation with the Department of Community Health shall develop, publish, and distribute an informational booklet on pain including acute pain, chronic pain and malignant pain, and the use of pharmaceuticals (including opioids and other controlled substances) as well as non-pharmacologic modalities for the control of pain and symptoms.*
4. *MDCIS should develop and publish brochures and prepare videos in consultation with the pain and symptom management advisory committee members for the benefit of patients / patient families and care givers regarding pain, the causes of pain, the emotional needs of the patients and their families, and treatment and health care coverage.*
5. *MDCIS should develop and disseminate guidelines similar to the Joint Commission on Accreditation of Healthcare Organizations requirements for "pain standards" as*

6. *MDCIS should disseminate curricula developed by or similar to the International Association for the Study of Pain (IASP) model core curricula regarding pain and symptom management to the Michigan institutions that provide health care education and continuing education, and should integrate pain and symptom management into the customary practice of health care.*
7. *The State legislature should establish a grant program to facilitate the integration and implementation of the model curricula into appropriate educational programs in Michigan institutions so as to encourage Michigan institutions educating health professionals to implement the model core curricula. The impact of implementing model core curricula in pain management can be further evaluated and reassessed to determine the effectiveness.*
8. *MDCIS should formulate the language for an administrative rule through the respective boards to address continuing education as a condition for license renewal of health professionals in support of the existing statute (333.16204) regarding pain and symptom management. Continuing medical education in pain and symptom management for health care professionals shall be for a minimum of 1 hour per licensing cycle and include materials on indications and use of controlled substances.*
9. *MDCIS should encourage the hospitals to increase the medical and nursing staff's knowledge by providing the guidelines for the required curricula in pain and symptom management to be covered through their organized educational programs.*
10. *MDCIS should encourage professional associations to address education and training in pain and symptom management for those health professionals who are not required by the statute to have continuing education to assure that all health professionals maintain a current understanding of pain and symptom management.*
11. *MDCIS should establish guidelines similar to the "Model guidelines for the use of controlled substances for the treatment of pain" (See Appendix B) published by the Federation of State Medical Boards of the United States (FSMB), in collaboration with the licensing boards and their respective professional associations.*
12. *The state legislature should replace the current Official Prescription Program with a simplified electronic monitoring system to balance availability of safe and effective drugs for pain and symptom management and deter the diversion of prescription drugs for illegitimate use. The new system should be an on-line interactive system that will be able to provide data sets for providers. Until such a system is in place, MDCIS should educate health professionals about Michigan's Official Prescription Program with an emphasis on the intent to facilitate appropriate care and give providers access to information regarding patient drug use patterns.*
13. *The Public Policy Subcommittee supports the Commission on End of Life Care's recommendation that the State Legislature should amend the Policy on Patient and*

14. *MDCIS should promote Health Maintenance Organizations, Medicaid, Medicare and other insurers to provide access to and coverage for the care provided or recommended by a multidisciplinary team including alternative therapies and procedures such as acupuncture, behavioral management, therapeutic massage and musculoskeletal manipulation/treatment.*
15. *MDCIS should encourage pharmacies within communities or among pharmacy chains to share information and carry an adequate supply of Schedule II medications to meet the needs of the patients/communities by ensuring that pharmacies are aware of supply and demand issues.*
16. *MDCIS should promulgate rules that require pharmacies to assist patients in finding adequate supplies of medications within a reasonable time when the pharmacy is unable to fill a valid prescription as presented.*
17. *The state legislature, MDCIS and MDCH should work to minimize the state regulatory impediments to access to effective pain medications under Schedule II to assure appropriate care in pain management. These include:*
  - a. Lengthening the time limit for filling prescriptions from five (5) days to 90 days*
  - b. Lengthening the period from 72 hours to 14 days for completely filling a prescription that is only partially filled*
18. *MDCIS and the practice boards should adopt and publicize statements of principle that under-treatment is as serious an offense as any other form of inappropriate treatment of pain under the practice acts applicable to physicians, dentists, nurses, and pharmacists. This is consistent with the grounds for violation under the Michigan Public Health Code 333.16221.*

From November 2002, when the Committee's first report was issued, through May 2006 there were a number of circumstances that limited the full operation of the ACPSM. The terms of several of the Governor appointees expired without replacements. In addition, the responsibility for the committee was transferred from the Department of Labor and Economic Growth to the Department of Community Health, resulting in a period when regular committee meetings were not held. Nevertheless, several of the 18 recommendations from the 2002 report were partially or completely implemented between 2002 and 2006.

Appointments were made in May 2006, allowing the committee to reconvene. In 2007 and 2009, new appointments and reappointments were made to conform with the two-year terms required by statute. Since November 2006, the Committee has met 12 times. The Committee met once in 2006, four times in 2007, four times in 2008, and three times in 2009.

Eight of the original 18 recommendations have been completed. Seven of the recommendations have been partially completed, and four of the recommendations were determined to be either accomplished through alternative actions or were not considered feasible and have not been completed.

The most recent meetings of August 2009 and October 2009 focused on developing new recommendations to be implemented in FY 2010 and FY 2011. The following recommendations were identified for completion over the next two years:

1. Convene a Summit of representatives from Michigan medical schools and postgraduate medical education programs to explore ways to improve pain management education in both the medical school curriculum as well as the residency experience.
2. Present 5-10 comprehensive trainings on pain management to be offered to health care professionals and pre-professionals at key Michigan locations. The state should also make available such training as an online module and seek CME/CE sponsorship to make the training widely accessible.
3. Improve pain and symptom management of the elderly and those with advanced illnesses by providing education to health professionals, as well as patients and their families. This will include such efforts as providing training opportunities for health professionals and the development of written materials and outreach to patients and their families.
4. Increase the use of MAPS by health professionals and make the MAPS data and information regarding the use of controlled substances more available to health professionals.
5. Introduce a bill to establish a program to promote remediation of health care providers failing to appropriately prescribe or dispense controlled substances.
6. The MDCH Bureau of Health Professions should fully utilize its communication resources to disseminate pain management information to health care professionals, such as the FSMB Model Guidelines on pain management, MAPS information, state-sponsored pain management trainings, and other resource information.
7. Develop and implement strategies designed to improve the public's knowledge, attitudes and practices regarding pain and symptom management.
8. The Department of Community Health, together with the Boards of Medicine and Osteopathic Medicine and Surgery, should determine that the practice of Interventional Pain Management is the practice of medicine. The Boards should determine what specific practices of interventional pain management can be delegated to other health professionals.

This report meets the regulatory requirements of the Public Health Code, Article 15 on Occupations, Part 161 on General Provisions, Section 333.16204(a)(4)(f)(i – iii), which states that the committee should:

*Annually report on the activities of the advisory committee and make recommendations on the following issues to the director of the department of consumer and industry services (community health):*

- i. Pain management educational curricula and continuing educational requirements of institutions providing health care education.*
- ii. Information about the impact and effectiveness of previous recommendations, if any, that have been implemented, including, but not limited to, recommendations made under subdivision (d).  
(Subdivision (d): Develop recommendations to the licensing and registration boards and the task force created under this article on integrating pain and symptom management into the customary practice of health care professionals and identifying the role and responsibilities of the various health care professionals in pain and symptom management.)*
- iii. Activities undertaken by the advisory committee in complying with the duties imposed under subdivisions (c) and (d).  
(Subdivision (c): Develop and encourage the implementation of model core curricula on pain and symptom management.)*

This report is the first report completed since the initial 2002 report. The committee will begin issuing annual reports following each fiscal year to comply with this statute.

## **II. The Importance of Pain Management**

Pain is a universal problem that affects millions of people regardless of social, economic and cultural considerations. A 2009 estimate by the American Academy of Pain Medicine indicates that over 76 million Americans suffer from serious chronic and/or acute pain each year. This translates to an estimated 2.5 million Michigan citizens with serious pain. In a 1997 survey of Michigan residents sponsored by the Pain Education Fund at Chelsea Community Hospital, one in five Michigan adults reported experiencing some form of chronic pain, and 40% of people with chronic pain say that pain affects their ability to live a normal life.

In spite of the ongoing work of the committee to remove policy barriers to effective pain management by the Michigan Legislature and state licensing boards (Appendix C), Michigan studies and surveys continue to show that pain remains largely untreated or undertreated (Appendix B). The work of the Advisory Committee on Pain & Symptom

Management helps the Michigan Department of Community Health develop policies to promote access to safe and effective pain management for every Michigan citizen.

A number of health care and human costs are associated with pain. Studies have shown that untreated or undertreated pain can result in longer hospital stays, slower rates of healing and recovery, increased rates of re-hospitalization, increased outpatient visits, and decreased ability to function fully (Appendix B). Unrelieved pain also often leads to an inability to work and thus maintain health insurance. The American Academy of Pain Medicine suggests that the annual cost of untreated pain among Americans may be as high as \$100 billion each year, or an estimated \$3.3 billion annually for Michigan. Appendix K contains a number of facts identified by the Alliance of State Pain Initiatives which indicate the seriousness of this health care issue.

Michigan's severely strained economy in recent years has only added to the issue of the cost of untreated or undertreated pain. At the end of 2009, the Michigan Department of Labor and Economic Growth reported an unemployment rate of close to 15%, the highest in the nation. Unemployment has resulted in a reduction of health care insurance coverage for many Michigan residents. Under a strained economy, Michigan pain sufferers are forced to either try to live with their pain or seek treatment in hospital emergency departments- adding to the overall cost of health care. Furthermore, as Michigan's population ages and residents live longer, the number of people that will need help managing their pain will continue to increase.

Pain is not, however, just a Michigan problem. The Centers for Disease Control's *Health United States 2006* Report's lead author, Amy Bernstein, has stated "We chose to focus on pain in this report because it is rarely discussed as a condition in and of itself – it is mostly viewed as a byproduct of another condition. We also chose this topic because the associated costs of pain are posing a great burden on the health care system, and because there are great disparities among different population groups in terms of who suffers from pain."

In spite of the many challenges today associated with safely and effectively managing pain, it is both the commitment and expectation of the Advisory Committee on Pain and Symptom Management to help bring about changes that will result in 1) more health care professionals who are adequately educated around pain and practice high quality pain and symptom management, and 2) an empowered public that understands it has the right to have pain fully assessed and adequately treated, and will proactively work with their health care provider to develop an appropriate treatment plan.

### **III. Background of the Advisory Committee on Pain and Symptom Management**

Dating back to the 1990's, there was broad agreement that untreated and undertreated pain was a widespread public health problem that must be addressed. It was during that period that the Michigan Commission on End of Life Care was formed to address the important components of care at the end of life, including and especially pain and symptom management. Many of the members of the Commission became members of

the Advisory Committee on Pain and Symptom Management, and some of the recommendations of the Commission's final 2002 report were among the Advisory Committee on Pain and Symptom Management's 2002 recommendations as well. A copy of the Executive Summary of the 2002 Michigan Commission's report can be seen in Appendix F.

In 1994, P.A. 232 was enacted and became effective on June 30, 1994. P.A. 232 established the first pain and symptom management committee, which was called the Interdisciplinary Advisory Committee on Pain and Symptom Management.

The Interdisciplinary Advisory Committee on Pain and Symptom Management of 1994 accomplished the following:

- Held a public hearing
- Formed four subcommittees (following review of the hearing transcripts)
  - Health care integration
  - Continuing education
  - Core curricula
  - Publication development

As part of these activities, the committee developed a number of recommendations that were designed to provide a balance between providing the public with greater access to effective pain medication while at the same time recognizing the need to control the improper use of these pain medications. No significant progress was made on many of the initial recommendations issued in 1995. Pain and symptom management continued to be a growing concern in Michigan throughout the rest of the 1990s, resulting in a second wave of pain management legislation.

#### **A. Creation of the Advisory Committee on Pain and Symptom Management**

In 1998, the Public Health Code was amended by P.A. 421, which took effect on April 1, 1999. The amendment maintained most of the original duties of the committee but required that the committee be renamed to the Advisory Committee on Pain and Symptom Management. Though renamed, the Advisory Committee on Pain and Symptom Management retained its important charge of identifying and addressing issues in Michigan that pose barriers to effective pain and symptom management, and to make appropriate recommendations to address these barriers. This committee, similar to the first committee, was represented by a wide array of health care professionals.

After the appointments were made to this committee, three subcommittees were formed:

- Public education
- Professional education
- Policy

On June 20, 2000 another public hearing was held. Issues brought up in oral written testimony were referred to one of the three subcommittees to be addressed. In November 2002, the committee issued a report of its findings and its 18 recommendations. This report can be found on the current MDCH pain and symptom management website at [www.michigan.gov/pm](http://www.michigan.gov/pm) under the committee section. Appendix A includes a list of the committee's current members, subcommittee members, and other committee information. It should be noted that the three original subcommittees that were formed in 1999, as identified above, were dissolved after the November 2002 Advisory Committee on Pain and Symptom Management report was issued. Only a website subcommittee currently remains.

### **B. Committee Activities November 2002 – Spring 2006**

During this time period, there were a number of circumstances that limited the full operation of the committee. The terms of several of the Governor appointees expired without replacements. The responsibility for the committee was transferred from the Department of Labor and Economic Growth to the Department of Community Health, resulting in a period when regular committee meetings were not held.

Nevertheless, several of the 18 recommendations from the 2002 report were partially or completely implemented between 2002 and 2006. Among the several significant steps taken during this period were the following:

- Administrative rules were amended for the Boards of Nursing, Dentistry, Optometry, Social Work, and Chiropractic to require pain and symptom management continuing education for license renewal. In 2007, the Board of Pharmacy amended their rules to add this requirement, and between 2010 and 2012 several more boards with continuing education requirements will be adding this requirement of at least 1 hour of CE in pain and symptom management.
- The Boards of Medicine, Osteopathic Medicine and Surgery, Nursing, and Pharmacy promulgated guidelines on the use of controlled substances for the treatment of pain in 2007 the Board of Dentistry promulgated their guidelines.
- Statutes were enacted that 1) eliminated the use of the term “intractable” pain, 2) established adequate and appropriate pain management as the right of every Michigan resident, and 3) minimized regulatory impediments to accessing Schedule 2 pain medications.
- An electronic prescription monitoring system referred to as the Michigan Automated Prescription Systems (MAPS), was developed and implemented allowing physicians, pharmacists, dentists and veterinarians to track their patient or customer's use of controlled substances (Schedule II – V), with the goal of preventing or reducing abuse and diversion.

- The Bureau of Health Professions posted pain and symptom management information on their website.
- The Bureau of Health Professions disseminated information on pain and symptom management through their newsletter *HealthLink*.

For more detailed information on what was accomplished during this time period, see Appendix G. This appendix organizes the 18 recommendations by those that are completed, partially completed, and incomplete.

#### **IV. Committee Activities Spring 2006 – September 2009**

In May 2006, the Governor's office made several appointments to the Advisory Committee on Pain and Symptom Management, allowing for the reconvening of regular committee meetings. Since the fall of 2006, three staff from the newly created Workforce Development, Research and Evaluation Section within the MDCH Bureau of Health Professions began attending committee meetings and assisting in the implementation of committee recommendations. Due to the increasing focus of the section on professional practice issues, such as pain management, the section was renamed the Professional Practice Section in 2009.

In July 2008, the Bureau hired a full time Pain Management and Palliative Care Coordinator who, in addition to managing the new MDCH pain management program, now serves as the lead support staff for the committee. The MDCH administration approved the establishment of this new pain management in 2008 as a result of some findings from a 2004 report of the Michigan Cancer Consortium. This report showed that in spite of nearly 15 years of state efforts to improve pain and symptom management, caregivers of cancer and non-cancer patients reported that their loved ones were still dying with significant pain. Between 2006 and 2009, the Cancer Section has twice presented findings from this "caregiver" study to the committee.

As a result of the Michigan Cancer Consortium findings, the Michigan Department of Community Health authorized the establishment of a new Pain Management and Palliative Care Program in the Bureau of Health Professions. The purpose of the program is to develop, implement, and evaluate the impact of strategies to improve pain and symptom management for all Michigan residents. The Committee will continue to assist in the development of survey tools to establish baseline data, develop impact strategies to improve pain management. The Committee will be used to help prioritize efforts by the Bureau to appropriate, safe and effective pain and symptom management in Michigan.

The committee has met 12 times since November 2006. The agenda and approved minutes for each of these quarterly meetings are posted on the pain and symptom management website at [www.michigan.gov/pm](http://www.michigan.gov/pm) under the committee section. Appendix

H includes a list of the dates of the meetings, and the main topics covered during these meetings. Appendix I includes a list of the meeting dates planned for calendar year 2010.

Since the reconvening of the committee in 2006, the committee has brought in numerous speakers who presented on a variety of pain and symptom management issues. As noted above, the three original subcommittees formed in 1999 to develop recommendations (Public Education, Professional Education, and Policy) were disbanded thereafter. The membership list (Appendix A) identifies members of a website subcommittee, which is the committee's only current subcommittee. The website subcommittee meets periodically to update the structure and content of the Bureau's pain management website. The committee may convene other subcommittees in the future to review documents, surveys, reports, or policy issues, as needed.

Over 20 non-member stakeholders frequently attend the committee's quarterly meetings. These non-member attendees come from a wide array of stakeholder agencies, including the Michigan Hospice and Palliative Care Organization, Michigan Health and Hospital Association, Wayne State University's Center to Advance Palliative Care Excellence, Right-to-Life of Michigan, Michigan Center for Rural Health, Michigan's Medicare Improvement Organization, Michigan Cancer Consortium, Michigan health professional training programs, professional trade associations, patient advocacy organizations, and a number of other interested health care organizations and professionals. In addition, five staff members of the Bureau's Professional Practice Section regularly attend all quarterly committee meetings and help implement the committee recommendations.

As identified above, a number of the recommendations were accomplished between 2002 and 2006. However, a number of the 18 recommendations had not been completed, or were only partially completed by the end of 2006. Between 2006 and 2009, the Committee took action to address the remainder of its uncompleted 2002 recommendations. Considerable progress has been made to complete the remaining recommendations. The following is a summary of the progress made between 2006 and 2009:

- *Supportive of recommendations 1A and 1 B.* In 2007 a Bureau of Health Professions pain and symptom management website for health professionals and the public was established with its own URL ([www.michigan.gov/painmanagement](http://www.michigan.gov/painmanagement) or [www.michigan.gov/pm](http://www.michigan.gov/pm)).
- *Supportive of Recommendation #1 and several of the recommendations related to professional and public education.* Several promotional strategies were developed and implemented to increase the number of visitors to the pain management website and to add subscribers to the Bureau's newsletters, *HealthLink* and *Public Forum*, which frequently contain pain management information.
- *Supportive of several of the recommendations related to professional and public education.* Several articles regarding pain management topics were written for

issues of the Bureau of Health Profession's *HealthLink* newsletter for health professionals, for the *Public Forum* newsletter for the public, and for other publications.

- *Recommendation #3.* In 2009, in lieu of the Bureau developing, publishing, and distributing an informational booklet on pain, the Bureau customized the Federation of State Medical Boards booklet *Responsible Opioid Prescribing: A Physician's Guide*. The booklet was printed with a message from the Michigan Boards of Medicine and Osteopathic Medicine and Surgery, and was mailed to all Michigan-based physicians, physician's assistants, advanced practice nurses, dentists, and pharmacists (approximately 58,000 health care professionals).
- *Recommendation #3.* In 2009, the development of a new Michigan Automated Prescription System DVD began. This new training DVD will be an updated MAPS training video from a previous 2004 VHS distributed to physicians, and will contain updated MAPS information and a special section on pain management assessment and treatment issues. The DVD is to be completed and distributed to all eligible MAPS users in 2010.
- *Generally supportive of all 18 recommendations.* In FY 2008 and FY 2009, staff from the Bureau's Professional Practice Section gave numerous presentations to the various boards on the activities and recommendations of the Committee and various Pain Management Program activities.
- *Generally supportive of all 18 recommendations.* The Bureau staff distributed the customized booklet *Responsible Opioid Prescribing: A Guide for Michigan Physicians* to the boards from September through December 2009. The distribution of the booklet to the boards will continue into 2010, as will consultations with the boards on various pain management issues.
- *Recommendation #5.* In 2009, in lieu of developing and disseminating guidelines, a link was posted on the pain management website to the National Guidelines Clearinghouse and the Cochrane Library, where there are hundreds of evidence-based guidelines on pain and symptom management.
- *Recommendation 6.* In 2007, the International Association for the Study of Pain's *Model Core Curriculum Guidelines* were distributed to every professional training school in Michigan in the fields of medicine, nursing, psychology, pharmacy, dentistry, physical therapy and occupational therapy (106 training programs). Follow up email communication resulted in about 36% of recipients of those guidelines confirming they received the guidelines.
- *Supportive of #8.* In 2009, the Professional Practice Section staff discussed the statute requirement that boards with continuing education requirements must add language to their administrative rules on continuing education in pain and

- *Supportive of #12.* In 2009, a number of activities were undertaken to increase the numbers of users of MAPS (newsletter articles, MAPS promotion in the Responsible Opioid Prescribing booklet, presentations, and various stakeholder meetings). The result was an increase of 44% in MAPS usage by those who are eligible to use MAPS (from 16% to 23% between November 2008 and November 2009).
- *Supportive of #14.* In 2009, a meeting was held with Medicaid to discuss reimbursement for treatment of pain using alternative and complementary methods such as acupuncture and massage therapy. Medicaid responded that they do cover a number of such treatments, and that the key to providing reimbursement is that there be scientific evidence of efficacy for such treatments.
- *Supportive of #15.* In 2009, a survey was sent out to independent, small-chain, and large-chain pharmacies asking 1) if they carried Schedule II's, and 2) if they did carry Schedule II's, would they be willing to be put on a confidential list of pharmacies that carry Schedule II's. The list would be made available to all licensed Michigan pharmacies, allowing referrals to be made. At the time of this report, the list is still being compiled, to be distributed in FY 2010.
- *Supportive of several recommendations related to professional education.* The Bureau of Health Professions began participation in a project funded by the Centers for Disease Control and the Federation of State Medical Boards. The goal of the project was to collect the email address of every licensed physician in the state and was targeted for completion in 2009. Such an email database would have greatly enabled communication with physicians around vital professional practice issues, including pain and symptom management. In 2009 the CDC withdrew funding for this national project, which remains on hold.

As Appendix G shows, eight of the initial 18 recommendations from the 2002 committee initial report have been completed. Seven of the 18 recommendations have been partially or nearly completed, or completed differently from the original intention. Although four of the 18 recommendations remain largely incomplete, some of these have been deemed not feasible by the committee or will be completed in FY 2010.

## **V. FY 2009 Committee Activities and Development of New Recommendations**

In addition to completing the 2002 recommendations and continuing to develop new recommendations around pain and symptom management, the Committee will serve throughout FY 2010 and beyond in an advisory capacity as the Bureau implements its

state Pain Management and Palliative Care Program. The following are some of the activities in which the Committee has participated:

*FY 2009 physician survey.* In October 2008, the Committee assisted the Bureau of Health Professions by providing input on the development of pain management questions to be included in a physician survey sent out annually to physicians during license renewal. Eighteen questions were added to the FY 2009 survey to assess physicians on their knowledge, attitudes, and behavior related to pain management, including questions regarding end of life care. The survey results revealed a number of significant findings, which will be used to both develop pain management strategies and as baseline data to track the success of the Bureau's efforts. The survey will be repeated in FY 2010 and 2011.

*FY 2009 public survey.* In December 2008, the Committee assisted the Bureau by providing input on a public survey on pain management wherein the public was assessed regarding knowledge, attitudes, and behavior related to pain management. The survey was conducted in March 2009 and revealed a number of significant findings, which will be used to both develop pain management strategies aimed at public education and will serve as baseline data to track the success of our efforts. The survey will be repeated in FY 2010 and 2011.

*Establishment of the Bureau's Pain Management and Palliative Care Program.* While the Bureau's Pain Management and Palliative Care Program, launched in FY 2008, is a separate operation from the Committee, the coordinator of this program serves as the lead support staff to the Committee and facilitates coordination between the Committee and the Pain Management and Palliative Care Program. Following the findings of the 2004 Michigan Cancer Consortium 2004 Report, the MDCH administration decided to house this program at the Bureau for three reasons: 1) the Advisory Committee on Pain and Symptom Management has been administered by the Bureau since its inception, 2) the Professional Practice section of the Bureau was already focused on this practice issue, and 3) a *Pain Management Education and Controlled Substances Electronic Monitoring and Anti-diversion fund* was already established through controlled substance licensing fees administered by the Bureau, and was available for pain management program activities.

*Distribution of a Booklet on Opioid Prescribing.* The Bureau began working with the Federation of State Medical Boards (FSMB) in FY 2008 to customize their publication *Responsible Opioid Prescribing: A Physician's Guide* and distribute it to all Michigan-based physicians, residents, physician's assistants, advanced practice nurses, dentists and pharmacists in 2009. Although this is part of the strategic plan of the Bureau's Pain Management and Palliative Care Program, this project has also served to address recommendation #3 of the 2002 Committee Report regarding distribution of an information booklet on pain (see Appendix G).

*Communication and Coordination of Efforts with Internal and External Stakeholders.* The Bureau staff will continue to work with members and affiliates of the Committee, a

recently formed MDCH Palliative Care Steering Committee for state government stakeholders, health professional organizations and associations, and health care facilities to advance the Committee's recommendations as well as the Bureau's Pain Management and Palliative Care Program. On behalf of the Committee, Bureau staff will continue to consult annually with appropriate health profession boards, as specified in the statute establishing the duties of the Committee (Appendix E).

In addition to these important activities, the Committee has developed the following eight new recommendations for the two-year period including FY 2010 and FY 2011:

1. Convene a Summit of representatives from Michigan medical schools and postgraduate medical education programs to explore ways to improve pain management education in both the medical school curriculum as well as the residency experience.
2. Present 5-10 comprehensive trainings on pain management to be offered to health care professionals and pre-professionals at key Michigan locations. The state should also make available such training as an online module and seek CME/CE sponsorship to make the training widely accessible.
3. Improve pain and symptom management of the elderly and those with advanced illnesses by providing education to health professionals, as well as patients and their families. This will include such efforts as providing training opportunities for health professionals and the development of written materials and outreach to patients and their families.
4. Increase the use of MAPS by health professionals and make the MAPS data and information regarding controlled substances use more available to health professionals.
5. Introduce a bill to establish a program to promote remediation of health care providers failing to appropriately prescribe or dispense controlled substances.
6. The MDCH Bureau of Health Professions should fully utilize its communication resources to disseminate pain management information to health care professionals, such as the FSMB Model Guidelines on pain management, MAPS information, state-sponsored pain management trainings, and other resource information.
7. Develop and implement strategies designed to improve the public's knowledge, attitudes and practices regarding pain and symptom management.

8. The Department of Community Health, together with the Boards of Medicine and Osteopathic Medicine and Surgery, should determine that the practice of Interventional Pain Management is the practice of medicine. The Boards should determine what specific practices of interventional pain management can be delegated to other health professionals.

The Committee will regularly hold quarterly meetings over the next two fiscal years to focus on implementation of these seven recommendations.

## **VI. Conclusion**

Between November 2002 and September 2009, excellent progress was made on the recommendations of the committee. This work helped Michigan to become one of only five states that received an “A” rating from the University of Wisconsin’s Pain and Policy Studies Group (Appendix D). This “A” rating recognizes that Michigan excels in balancing its advocacy of pain management with its attention to issues of patient safety and drug diversion.

However, as measured by the surveys, studies and reports described above, the prevalence of untreated and undertreated pain remains a significant health care problem in Michigan. The Committee intends to continue its advocacy work and advisory role with the Department as the eight new recommendations are addressed. The Committee will also assist the Bureau in implementing Pain Management and Palliative Care Program activities that address the Committee’s recommendations. It is recognized that simply developing recommendations and implementing strategies to improve pain management in Michigan is not an end in itself- MDCH must also measure the impact of these efforts. The Committee will utilize the public and physician surveys of the Bureau to measure the impact of implementing the recommendations. The Committee continues to be committed to changing the knowledge, attitudes and clinical practices of health care providers regarding pain and symptom management, and to helping the public understand their right to safe, adequate and appropriate pain and symptom management as a basic part of their health care.

## Appendix A

### Advisory Committee on Pain and Symptom Management Members

#### Statutory requirements for the Advisory Committee on Pain Symptom Management / Composition of the Advisory Committee on Pain and Symptom Management

PA 232 of 1994, which was enacted on June 30, 1994, required the establishment of a committee, to be called the Interdisciplinary Advisory Committee on Pain and Symptom Management, and prescribed what types of members should be appointed to the committee.

PA 421 of 1998 amended PA 232 of 1994, and was enacted on April 1, 1999. It created the current committee, which is called the Advisory Committee on Pain and Symptom Management. The committee consists of 17 members appointed by the Governor or the various licensing boards, as well as the Director of the Michigan Department of Community Health or her designee.

#### Roster

*A current listing of the Advisory Committee on Pain and Symptom Management roster is maintained on the MDCH Bureau of Health Professions Pain Management website at [www.michigan.gov/pm](http://www.michigan.gov/pm).*

#### Member (with statutory basis and appointing authority)

**Melanie Brim, M.H.A., Chairperson \***  
MDCH/Bureau of Health Professions

**Ruth Ann Brintnall, R.N., M.S.N., Ph.D.**  
Michigan Board of Nursing

**Michael D. Chafty, M.D., J.D.**  
Michigan Board of Medicine

**Daniel J. Clauw, M.D. \***  
University of Michigan School of Medicine

**Dennis W. Dobritt, D.O.**  
Michigan Board of Osteopathic Medicine and Surgery

**Ahmed ElGeneidy, D.D.S.**  
Michigan Board of Dentistry

**Jean Friend \***  
Public Member

**Ralph A. Geraci, PA-C**  
Michigan Task Force on Physician's Assistants

**Alan Lewandowski, Ph.D.**  
Michigan Board of Psychology

**Jeanne Lewandowski, M.D.**  
Michigan Board of Medicine

**Frenchie D. McCall, LMSW \***  
Chronic pain Sufferer

**William Morrone, D.O.**  
Michigan Board of Osteopathic Medicine and Surgery

**Lawrence L. Prokop, D.O. \***  
Michigan State University College of Osteopathic Medicine

**Steven Roskos, M.D. (replaced Karen Ogle, M.D. in April 2010)\***  
Michigan State University College of Human Medicine

**Claire Saadeh, Pharm.D., BCOP**  
Michigan Board of Pharmacy

**Maria J. Silveira, M.D., M.A., M.P.H. \***  
Michigan Hospice and Palliative Care Organization

**Michael A. Stellini, M.D. \***  
Wayne State University School of Medicine

**\* Appointed by the Governor**

### **Website Advisory Subcommittee Members**

*This subcommittee was formed in early 2007, following the official launch of the pain management website. It met quarterly the first year, and currently meets twice a year, or as needed to develop structural or content changes to the website. The subcommittee is comprised of Committee members, Bureau staff, and non member stakeholders.*

Susan Affholter, MDCH BHP staff

Steve Creamer, MDCH BHP staff

Doreen Lyman, MDCH BHP staff

Janet Massoglia, non-member Committee affiliate

Chris Patterson, R.N., non-member Committee affiliate

Lawrence Prokop, D.O., Committee member

Claire Saadeh, R.Ph., Committee member

Jeff Towns, non-member Committee affiliate

## Appendix B

### Pain Studies

#### Michigan

Michigan Department of Community Health Cancer Prevention and Control Section. (2004). *End of Life in Michigan: Needs Assessment Report*. This report can be retrieved from the Michigan Cancer Consortium website under the resources for its end-of-life priority: [www.michigancancer.org](http://www.michigancancer.org)

Michigan Department of Community Health Cancer Prevention and Control Section. (2002, 2004, 2006, 2008). *Michigan Special Cancer Behavioral Risk Factor Survey*. The surveys, which include questions on pain and symptom management, can be retrieved from the Michigan Cancer Consortium website under the resources for its end-of-life priority: [www.michigancancer.org](http://www.michigancancer.org)

Michigan Department of Community Health Bureau of Health Professions. (2008-9). *Physician Survey*. This survey, which includes questions on pain management, can be retrieved from the Bureau's pain management website: [www.michigan.gov/pm](http://www.michigan.gov/pm)

Michigan Department of Community Health Bureau of Health Professions. (2009). *Public Survey on Pain*. This survey can be retrieved from the Bureau's pain management website: [www.michigan.gov/pm](http://www.michigan.gov/pm)

Miller, Lisa Renee, M.A.; Cano, Ann Marie, M.A., PhD. Chronic Pain Prevalence in Michigan. *Journal of Pain*, Vol. 9, Issue 4, p. 70, April 2008. Can be retrieved from [www.jpain.org](http://www.jpain.org)

#### National

Centers for Disease Control. (2006). *Health, United States, 2006*. This report includes a special feature on pain, and can be ordered (GPO stock number 017-022-01602-8) from: [www.cdc.gov/nchs](http://www.cdc.gov/nchs)

## Appendix C

### Michigan's Pain Legislation and Guidelines

An abbreviated listing of Michigan's pain-related legislation and guidelines is posted to the professional side of the Bureau's pain management website at [www.michigan.gov/pm](http://www.michigan.gov/pm). For more complete information, visit the Michigan Legislature website at [www.mi.legislature.gov](http://www.mi.legislature.gov). In addition, for specific continuing education information, refer to the administrative rules for each of the licensing boards at [www.michigan.gov/mdch](http://www.michigan.gov/mdch).

#### A. Legislation

The following are highlights from Michigan's pain legislation.

#### **Michigan Public Health Code, Article 5 on Prevention and Control of Diseases and Disabilities, Part 56A on Terminal Illness**

*Part 56A is known as the Michigan Dignified Death Act.*

§ 333.5655(d). That the patient or the patient's surrogate or patient advocate acting on behalf of the patient may choose adequate and appropriate pain and symptom management as a basic and essential element of medical treatment.

§ 333.5658. Prescription of controlled substance; immunity from administrative and civil liability.

#### **Michigan Public Health Code, Article 7, Controlled Substances**

Article 7 is completely devoted to controlled substances. Here, however, are a few highlights from Article 7:

§ 333.7303. License required [for a person who manufactures, distributes, prescribes, or dispenses a controlled substance . . .]; renewal; scope of authority; etc.

§ 333.7303a. Licensed prescriber; administering or dispensing controlled substance without separate license; use of other controlled substances; recording response; etc.

§ 333.7333. "Good faith" defined; dispensing controlled substances included in schedule 2; prescription form; emergency; filling and refilling prescription; dispensing

#### **Michigan Public Health Code, Article 15 on Occupations, General Provisions**

§ 333.16204. Completion of continuing education as condition for license renewal; completion of hours or courses in pain and symptom management; rules; certain individuals excluded [sanitarians; veterinarians]

§ 333.16204a. Advisory committee on pain and symptom management; creation; members; compensation; expenses; terms; duties; review of guidelines.

§ 333.16204b. Treatment of pain; enactment of legislation. The legislature finds that the treatment of pain is an appropriate issue for the legislature to consider, and that the citizens of this state would be well served by the enactment of legislation. . .

§ 333.16204c. **Medical treatment of pain**; use of controlled substances; legislative findings; treatment by licensed health professionals; electronic monitoring system; "controlled substance" defined.

§ 333.16204d. Information booklet on pain; educational program for health professionals.

§ 333.16315. Pain management education and controlled substances electronic monitoring and anti-diversion fund. The department shall use the pain management education and controlled substances electronic monitoring and anti-diversion fund only in connection with programs relating to pain management education for health professionals, preventing the diversion of controlled substances, and development and maintenance of the electronic monitoring system for controlled substances data .

**Michigan Public Health Code, Article 17 on Facilities and Agencies, Part 201 on General Provisions**

*Known as patient rights.*

§ 333.20201(2)(o). A patient or resident is entitled to adequate and appropriate pain and symptom management as a basic and essential element of his or her medical treatment.

**B. Guidelines from the Michigan Boards of Medicine, Osteopathic Medicine and Surgery, Nursing, and Pharmacy**

The Michigan Boards of Medicine, Osteopathic Medicine & Surgery, Nursing, and Pharmacy recognized the need for the people of Michigan to have access to appropriate and effective pain relief, and in late 2003 adopted the *Guidelines for the Use of Controlled Substances for the Treatment of Pain*. These guidelines were based on the influential Federation of State Medical Boards' 1998 *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain*.

It is anticipated that the above boards will, in the near future, adopt the Federations' updated 2004 *Model Policy for the Use of Controlled Substances for the Treatment of Pain*, which is largely identical to the 1998 *Model Guidelines* but with an emphasis on the inappropriate treatment of pain (including under treatment) as a divergence from acceptable medical practice. These guidelines are posted under the Bureau's website at [www.michigan.gov/mdch](http://www.michigan.gov/mdch).

## Appendix D

### Michigan's "A" Ratings on Balanced Pain Policies

The legislative work of both the initial advisory committee established in 1994 and the current ACPSM, established in 1999, earned the highest "A" rating among all states for balanced pain policies from the University of Wisconsin's Pain & Policy Studies Group (PPSG). The principle of balance refers to being able to effectively treat pain while at the same time preventing and reducing the abuse and diversion of prescription controlled substances.

Over an eight year period and five evaluations, Michigan has received the following ratings:

<u>Evaluation Year</u>	<u>Rating</u>
2000	B
2003	A
2006	A
2007	A
2008	A

The overall purpose that the PPSG has for conducting these evaluations of pain policies is to motivate individuals, organizations, and state governments to improve pain management by preventing and reducing drug abuse, regulating professional practice, and improving patient care. It can also be added that by allowing comparisons across states, these assessments have created some competition, and, thereby, some incentive to make improvements. To read the entire 2008 report, go to [www.painpolicy.wisc.edu](http://www.painpolicy.wisc.edu).

In spite of Michigan's early work around pain policy, such policy in itself does not always translate into improvements in the medical practice of pain management. Michigan's early work around pain issues focused on more effectively treating acute pain, chronic pain, cancer pain, and pain at the end of life. Fortunately, former Governor John Engler had a personal interest in and commitment to end-of life issues. Governor Engler established the Michigan Commission on End-of-Life Care by Executive Order 1999-4, issued on June 11, 1999. The Commission was charged with issuing a report that would identify what needed to be done to improve end-of-life care in Michigan. The Commission was also charged to coordinate its efforts with other groups, such as the Advisory Committee on Pain and Symptom Management.

In spite of Michigan's success promulgating effective pain policies, surveys of the public continue to show that the actual medical practice of pain management has not improved. Furthermore, suffering from pain continues in spite of the availability of effective methods for controlling most pain, including both pharmacological and non-pharmacological methods.

\* These ratings (shown above) reflect a reassessment of state ratings considering new criteria beginning in 2006. The initial assessment of state ratings for balanced pain policies which did not contain the new criteria resulted in lower ratings for most states. Michigan's initially assessed ratings in 2000 are shown below:

<u>Evaluation Year</u>	<u>Rating</u>
2000	D+
2003	C+
2006	A
2007	A
2008	A

## Appendix E

### Statutory Requirements of the Advisory Committee on Pain and Symptom Management

**333.16204(a)(4).** The advisory committee shall do all of the following, as necessary:

- a. At least once annually consult with all of the following boards to develop an integrated approach to understanding and applying pain and symptom management techniques:
  - i. All licensure boards created under this article, except the Michigan board of veterinary medicine.
  - ii. The Michigan board of social work created in section 18505.
- b. Hold a public hearing in the same manner as provided for a public hearing held under the administrative procedures act of 1969, within 90 days after the members of the advisory committee are appointed under subsection (1) to gather information from the general public on issues pertaining to pain and symptom management.
- c. Develop and encourage the implementation of model core curricula on pain and symptom management.
- d. Develop recommendations to the licensing and registration boards and the task force created under this article on integrating pain and symptom management into the customary practice of health care professionals and identifying the role and responsibilities of the various health care professionals in pain and symptom management.
- e. Advise the licensing and registration boards created under this article on the duration and content of continuing education requirements for pain and symptom management.
- f. Beginning in January of 2000, annually review any changes occurring in pain and symptom management.

**333.16204(a)(5).** In making recommendations and developing written materials under subsection (4), the advisory committee shall review guidelines on pain and symptom management issued by the United States department of health and human services.

## Appendix F

### Executive Summary of Recommendations from the Michigan Commission on End of Life Care Report to the Governor August 2001

*Many of these recommendations were made in response to barriers to care the Commission identified early in its study of end-of-life care.*

#### **General.**

1. The Governor and the Legislature should adopt these principles in formulating public policy for end-of-life care:
  - a) The end of life is an important time in the life cycle of all Michigan citizens. People facing the end of their life should have optimal comfort and support.
  - b) All Michigan citizens should be encouraged to engage in caring conversations with their loved ones concerning their expectations and wishes for end-of-life care, and to plan for their financial, emotional, legal, and spiritual needs at the end of life.
  - c) A model of palliative care should be integrated into treatment modalities, beginning at diagnosis of a life-limiting condition and continuing throughout the course of illness and beyond, regardless of outcome.
  - d) Children living with life-threatening or terminal conditions deserve intensive symptom management, palliative care, and respite programs that meet their special needs.
  - e) People who live with advanced severe illness and die in long-term care settings are a uniquely vulnerable population whose interests at the end of life must be defined, protected, and advanced.
  - f) The lack of effective pain and symptom management is a public health issue that requires the highest level of professional and regulatory attention.
2. The Governor, the Michigan Department of Community Health (MDCH) and the Michigan Department of Consumer and Industry Services (MDCIS) should initiate a state wide awareness and educational campaign for the public and for health care professionals. This campaign should be culturally sensitive and should recognize varying approaches to end-of-life care based on spiritual and cultural beliefs and life experiences. The topics of this campaign should include:

- a) Awareness of all aspects of medical decision-making, including the importance of designating a patient advocate and fully exploring all options for treatment and care
  - b) Laws concerning the designation of patient advocates, guardians, and other surrogates
  - c) The principles of pain and symptom management
3. MDCH should nurture an ongoing coalition of public and private stakeholders that will reshape health care delivery systems to provide appropriate and competent curative and palliative care services. These services should be designed around the needs of patients and families rather than those of the providers of services, should eliminate barriers to access, and should realign financial incentives as appropriate.
4. MDCH and MDCIS should develop public policy and draft regulations for end-of-life care based on standards developed by experts in the field in order to promote competent and appropriate care for Michigan residents living and dying with advanced illness.

**Professional Education.**

1. Health professional schools or educational programs should include in their core curricula content on end-of-life care appropriate to each discipline, including knowledge, skills, and attitudes. They should:
- a) Charge at least one faculty member with developing this curriculum
  - b) Regularly assess and evaluate both didactic and experiential curriculum content, consider the professional expertise of faculty involved in end-of-life care education, support faculty development and draw on the experience of community professionals
  - c) Work collaboratively with other schools within each discipline and within the larger educational institution to enhance instruction in end-of-life care
  - d) Develop new models of education that incorporate adult learning principles and interactive learning to improve the abilities of physicians and other professionals as they care for people who are dying

2. MDCH should take a leadership role in exploring options for end-of-life care education innovation grants to support curriculum assessment, development, and evaluation by individual schools and educational programs; and for development of interdisciplinary and inter institutional efforts to improve end-of-life education.

3. MDCH, MDCIS, and all applicable health profession licensing boards should promote and advance the art and science of end-of-life care in education of all health professionals at all levels and should promote palliative care as a defined area of expertise, education, and research, all to the end of attaining the best possible end-of-life care for all Michigan citizens.

### **Pain and Symptom Management.**

1. MDCIS should adopt licensing requirements for health facilities and agencies that promote service- and unit-specific education programs for all health professionals on effective pain and symptom management.

2. In order to effect institutional change, MDCIS and MDCH should adopt by regulation and monitor the progress of licensed health facilities and agencies in implementing the requirements for treatment of pain of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) so that facilities demonstrate effective and acceptable assessment and treatment of pain for each patient in an individual and timely manner.

3. All applicable health profession licensing boards should adopt and disseminate the “Model Guidelines for the Use of Controlled Substances for the Treatment of Pain,” promulgated by the Federation of State Medical Boards, and adopt policy declaring that under treatment and inappropriate treatment of pain will be scrutinized.

4. The Legislature should add a subsection to the Policy on Patient and Resident Rights and Responsibilities within the Public Health Code, stating that all patients have the right to adequate pain and symptom management and palliative and hospice care.

5. The Legislature should amend the Michigan Dignified Death Act (MDDA) to eliminate the terminology “life expectancy of less than six months” and replace it with language to require physicians who identify a patient with limited life expectancy due to advanced illness to provide the patient with information about options for management of pain and symptoms. Such information should be provided regardless of whether the patient continues on a course of curative medical care or combines this with or chooses palliative care or hospice care. MDCH and MDCIS should take a leadership role in disseminating information about the MDDA to professionals and the public because it is little known among physicians and is largely disregarded by them.

6. The Legislature should amend all statutes to eliminate the use of the term “intractable pain” or amend it to read “pain” as appropriate.

7. The Legislature should repeal the Official Prescription Program (OPP) because in its current form the OPP impairs access to effective pain management without a corresponding benefit in the control of prescription drug diversion or quality of pain management.

8. The Legislature should replace the current OPP with a system that supports electronic monitoring; is balanced in its approach to high-quality pain management and its desire to limit prescription drug diversion; requires no additional special prescription form; is efficient and invisible to the patient and practitioner; and provides information that is well understood and available to all those who need it.

9. The Legislature, MDCH, and MDCIS should work to minimize state regulatory impediments to effective pain medications and should work with the Michigan Congressional delegation and federal officials to minimize federal regulatory impediments concerning prescriptions, including the time limits for filling them, prohibitions on refills, telephone orders, and electronic transfer of prescriptions.

10. MDCIS should develop a system and promulgate rules that require pharmacies to help patients find adequate supplies of pain medications when the pharmacy is unable to fill a valid prescription as presented.

11. MDCH and the MDCIS Office of Financial and Insurance Services should encourage health plans and payers to minimize co pays, deductibles and other restrictions on reimbursement for opioids prescribed for pain and symptom management.

12. MDCH, MDCIS and the Department of Environmental Quality should explore ways to improve disposition of pharmaceuticals when no longer required for home use, such as by requiring that in settings that have a central point of control such as a nursing facility, hospital, or hospice program, unused pharmaceuticals be retrieved and redistributed to other patients with legitimate prescriptions. This will limit waste of medical resources and reduce costs. The Department of Environmental Quality should advise on the effects of pharmaceutical waste on the environment and methods to minimize any detrimental effect.

### **Reimbursement.**

1. MDCH should assess and validate existing Michigan data to determine how to optimize care at the end of life by analyzing, redistributing, and redesigning incentives in order to provide more options concerning types and settings of care.

2. The Governor, MDCH and MDCIS should work with the Michigan Congressional delegation and federal agencies to further understand and explore current or proposed federal laws and regulations for Medicare and Medicaid, to determine the impact, particularly in Michigan, and make changes where appropriate, in the following areas:

- a) Development of an outlier formula for hospice programs that serve a large number of patients who need higher-cost services or require such services in settings where significant transportation costs exist
  - b) Managed care organizations, health plans, and other payers should be encouraged to include medical-record documentation of physicians' discussions with patients as a quality indicator for physician practice.
2. Michigan driver licenses and other identification cards should clearly denote when a person has executed a do-not-resuscitate order and whether a person has an advance directive (and where it can be found).
  3. The State Court Administrator's Office should take a leadership role in seeing that courts, court personnel, guardians *ad litem*, and others are well prepared to administer, enforce, and provide education about the guardianship reform laws passed in 2000.
  4. The MDCH director should establish a working group of advocates, interested parties, and health care professionals to work toward assessing the numerous issues associated with end-of-life decision-making for persons in Michigan who have never been competent and who are terminally ill.

**Family Issues.**

1. To promote the health and well-being of all Michigan citizens, the Governor and MDCH should encourage provision of competent respite care to reduce caregiver burden and should encourage health plans and other payers to provide adequate reimbursement for such service.

## Appendix G

### Status Report on the November 2002 Advisory Committee on Pain and Symptom Management Report Recommendations

Recommendation No. / Regarding	Recommendation	Action Taken
<p><b>1A</b> - - Website for health care professionals</p>	<p><u>2002 Recommendation</u></p> <p>MDCIS should develop and implement a website on pain and symptom management. The website should address the issues of:</p> <ul style="list-style-type: none"> <li>• state law</li> <li>• related administrative rules</li> <li>• education</li> <li>• continuing education</li> <li>• provider issues</li> <li>• pharmacy issues</li> <li>• links to professional associations</li> <li>• links to other resources on pain and symptom management</li> </ul> <p>MDCIS should publish information about the website and access to the website in “Health Alert”.</p> <p>MDCIS staff should be responsible for updating the website with information received from the advisory committee, from professional associations and newsletters.</p>	<p><u>Completed.</u></p> <p><a href="http://www.michigan.gov/pm">www.michigan.gov/pm</a></p> <p><u>Completed and on-going.</u> In addition to “Health Alert,” the website has been promoted by using many other channels.</p> <p><u>Completed and on-going.</u></p>
<p><b>1B</b> - - Website for the public.</p>	<p><u>2002 Recommendation</u></p>	<p><u>Completed.</u> See 1A above.</p>

Recommendation No. / Regarding	Recommendation	Action Taken
	<p>MDCIS should develop and implement a <u>website for educating the public</u> on pain and symptom management. The website will cover topics such as:</p> <ul style="list-style-type: none"> <li>• definition of pain</li> <li>• causes of pain</li> <li>• frequently asked questions</li> <li>• current news concerning pain issues in Michigan and across the country</li> <li>• policy statements</li> <li>• bibliography</li> <li>• topics of interest</li> </ul> <p>The website should be linked to other user-friendly pain and symptom management websites such as:</p> <ul style="list-style-type: none"> <li>• American Pain Society</li> <li>• International Association for the Study of Pain</li> <li>• American Pain Foundation</li> </ul> <p>The website should also have a “contact us” feature where the public can express concerns related to pain and symptom management to the committee, department and legislature.</p>	<p><u>Completed and ongoing.</u></p> <p><u>Completed.</u></p>
2 – Policy issue	<p><u>2002 Recommendation</u></p> <p>The legislature should amend all statutes to eliminate the use of the term “intractable pain”. The term “intractable pain” should either be eliminated in these statutes or amended to read “pain”, as appropriate.</p>	<p><u>Completed.</u></p> <p>Public Acts 234, 235, 241 and 242, effective January 3, 2002, and January 8, 2002, either eliminated the term “intractable pain” or amended the statutes to read “pain,” as appropriate. Codes affected:</p>

Recommendation No. / Regarding	Recommendation	Action Taken
		a) the Insurance Code b) the Nonprofit Health Care Corporation Reform Act c) the Public Health Code
<b>5 - - Patient rights</b>	<u>2002 Recommendation</u>  MDCIS should develop and disseminate guidelines similar to the Joint Commission on Accreditation of Healthcare Organizations requirements for “pain standards” as the standard of care for all health providers, in collaboration with the licensing boards and their respective professional associations.	<u>Completed.</u> Since many guidelines have already been developed, in 2009 the ACPSM decided to post links on the pain management website to the National Guideline Clearinghouse and the Cochrane Review. Hundreds of evidence-based guidelines can be located at the two sites. There was no need to develop additional guidelines.
<b>6 - - Core curricula</b>	<u>2002 recommendation</u>  MDCIS should disseminate curricula developed by or similar to the International Association for the Study of Pain (IASP) model core curricula regarding pain and symptom management to Michigan institutions that provide health care education and continuing education, and should integrate pain and symptom management into the customary practice of health care.	<u>Completed.</u>  1. In 2007 the Committee had three of the four Michigan medical schools present their pain management curriculum to the committee and discuss potential areas of improvement.  2. In March 2008, the Bureau sent all Michigan training programs a letter advocating the use of the IASP Curriculum Guidelines. For their reference, a copy of the guidelines was included in the letter.  Training programs (n = 105 schools):  Dentistry Medicine Nursing Occupational Therapy

Recommendation No. / Regarding	Recommendation	Action Taken
		<p>Pharmacy Physical Therapy Psychology</p> <p>In July of 2008, a follow up email was sent to all training schools to see if the letter was received, and to request their feedback about the guidelines.</p> <p>3. The pain and symptom management website, under the professional section, links to the IASP model core curricula.</p>
<p><b>11</b> - - State prescription program</p>	<p><u>2002 Recommendation</u></p> <p>MDCIS should establish guidelines similar to the <i>Model Guidelines for the Use of Controlled Substances for the Treatment of Pain</i> published by the Federation of State Medical Boards (FSMB) of the United States, in collaboration with the licensing boards and their respective professional associations.</p>	<p><u>Completed.</u></p> <p>The following boards established guidelines: in 2003, Medicine, Osteopathic Medicine and Surgery, Nursing, and Pharmacy; in 2007, Dentistry.</p>
<p><b>12</b> - - State prescription program</p>	<p><u>2002 Recommendation</u></p> <p>The state legislature should replace the current Official Prescription Program (OPP) with a simplified electronic monitoring system to balance availability of safe and effective drugs for pain and symptom management and deter the diversion of prescription drugs for illegitimate use. The new</p>	<p><u>Completed.</u></p> <p>Public Acts 231 and 232 of 2001, effective January 3, 2002, provided for the establishment of an electronic monitoring system, subsequently referred to as the Michigan Automated Prescription System (MAPS), to replace the Official Prescription Program (OPP).</p>

<b>Recommendation No. / Regarding</b>	<b>Recommendation</b>	<b>Action Taken</b>
	system should be an on-line interactive system that will be able to provide data sets for providers.	
<b>17a</b> - Prescription filling in community pharmacies	<p><u>2002 Recommendation</u></p> <p>The state legislature, MDCIS and MDCH should work to minimize the state regulatory impediments to access to effective pain medications under Schedule II to assure appropriate care in pain management. These include:</p> <p>a) Lengthening the time limit for filling prescriptions from five (5) days to ninety (90) days.</p>	<p><u>17a has been completed.</u> In regards to 17(a), the Michigan Legislature introduced a bill in 2001 which was subsequently enacted as Public Act 231 of 2001, effective January 3, 2002. PA 231 of 2001 amended the Public Health Code to:</p> <ul style="list-style-type: none"> <li>• Lengthen the period of time to fill Schedule II prescriptions from five (5) days to sixty (60) days.</li> <li>• The act also provided for prescriptions to be partially filled incrementally for sixty (60) days for terminally ill patients.</li> </ul>
<b>17b</b> - - Prescription filling in community pharmacies	<p><u>2002 Recommendation</u></p> <p>The state legislature, MDCIS and MDCH should work to minimize the state regulatory impediments to access to effective pain medications under Schedule II to assure appropriate care in pain management. These include:</p> <p>b) Lengthening the period from 72 hours to 14 days for completely filling a prescription that is only partially filled.</p>	No further action can be taken on this as it would put the State of Michigan in conflict with federal law, specifically CFR 21 1306.13

**Recommendations - - Actions Taken but Incomplete: 3, 4, 8,  
13, 14, 15, 16**

Recommendation Number	Recommendation	Action Taken
3 - - Publications	<p><u>2002 recommendation</u></p> <p>MDCIS in consultation with the Department of Community Health shall develop, publish, and distribute an informational booklet on pain including [the following contents]:</p> <ul style="list-style-type: none"> <li>• acute pain</li> <li>• chronic pain</li> <li>• malignant pain</li> <li>• use of pharmaceuticals (including opioids and other controlled substances)</li> <li>• use of non-pharmacologic modalities for the control of pain and symptoms</li> </ul>	<p>Due to state budget constraints that discouraged the printing and mailing of publications, no action was taken to develop, publish, and distribute an informational booklet.</p> <p>Further, with advances in technology, the concept of an informational booklet has changed.</p> <p>Given technological changes, alternative actions have been taken to address the educational intent of the recommendation. For example, information on pain and symptom management was posted to the Bureau's website in 2004; in 2007, a URL was assigned and the Bureau's pain and symptom management website was launched and includes all of the information that was to have been in the booklet.</p> <p>Furthermore, in September and October 2009, the FSMB's booklet, <i>Responsible Opioid Prescribing</i>, booklet was customized and mailed to all Michigan-based physicians, residents, physician's assistants, advance practice nurses, pharmacists, and dentists. In winter 2010, booklets will be mailed to Michigan-based podiatrists and optometrists. This Responsible Opioid Prescribing booklet,</p>

Recommendation Number	Recommendation	Action Taken
		which was written for health professionals, covered the proposed content of the recommendation.
4 - - Publications	<p><u>2002 Recommendation</u></p> <p><u>Patient / Patient’s Family / Caregivers Brochures and videos.</u> MDCIS should develop and publish brochures and prepare videos in consultation with the pain and symptom management advisory committee members for the benefit of patients/patient families and care givers regarding [the following content]:</p> <ul style="list-style-type: none"> <li>• pain</li> <li>• causes of pain</li> <li>• emotional needs of the patients and their families</li> <li>• treatment</li> <li>• health care coverage</li> </ul>	The pain and symptom management website’s public section partially satisfies this recommendation. The public side is populated with the described content (perhaps less populated on health care coverage).
8 - - Continuing education	<p><u>2002 Recommendation</u></p> <p>MDCIS should formulate the language for an administrative rule through the respective boards to address continuing education as a condition for license renewal of health professionals in support of the existing statute (333.16204) regarding pain and symptom management. Continuing medical education in pain and symptom management for health care professionals shall be for a minimum of 1 hour per licensing cycle and include materials on indications and use of controlled</p>	<p>MDCH formulated language to add 1 hour of pain management continuing education as a condition for license renewal.</p> <p>Rules were promulgated for the Boards of:</p> <ul style="list-style-type: none"> <li>• Nursing, December 19, 2003</li> <li>• Dentistry, June 15, 2004</li> <li>• Optometry, January 20, 2005</li> <li>• Social Work, June 24, 2005</li> <li>• Chiropractic, May 3, 2006</li> <li>• Pharmacy, July 1, 2007</li> </ul>

Recommendation Number	Recommendation	Action Taken
	substances.	
13 - - Patient rights	<p><u>2002 Recommendation</u></p> <p>The Public Policy Subcommittee supports the Commission on End of Life Care’s recommendation that the State legislature should amend the policy on Patient and Resident Rights and Responsibilities (MCL 333.20201(2)) to add a new subsection to the effect that patients have the right to adequate P&amp;SM as an essential element of medical treatment, and to be informed of that right.</p>	<p>In regard to amending the policy, the Michigan Legislature introduced a bill in 2001 which was subsequently enacted as Public Act 240 of 2001, effective January 8, 2002.</p> <p>Subsection (o) was added:</p> <p>MCL 333. 20201. (2)(o). A patient or resident is entitled to adequate and appropriate pain and symptom management as a basic and essential element of his or her medical treatment.</p> <p>Public Act 240 of 2001 can be found on the pain management website or on the Michigan Legislature website.</p> <p>The second part of the recommendation - - “to be informed of that right” - - needs to be addressed.</p> <p>To obtain baseline data on whether or not people have been informed of this right, Question 3 in the Bureau’s March 2009 Public Survey on Pain stated: <i>Have you ever heard or been told that as a Michigan resident or patient you are entitled to have your pain managed as a basic part of your health care?</i> Response: 24.3% responded “yes.”</p>
14 - - Reimbursement for pain management	<p><u>2002 Recommendation</u></p> <p>MDCIS should promote Health Maintenance Organizations,</p>	<p>Following the November 20, 2008 meeting, links were posted to the pain management website related to resources for</p>

<b>Recommendation Number</b>	<b>Recommendation</b>	<b>Action Taken</b>
services	Medicaid, Medicare and other insurers to provide access to and coverage for the care provided or recommended by a multidisciplinary team including alternative therapies and procedures such as acupuncture, behavioral management, therapeutic massage and musculoskeletal manipulation/ treatment.	<p>finding osteopaths and medical acupuncturists.</p> <p>In 2009, the Bureau met with Medicaid and was informed that Medicaid does cover many of the therapies recommended by the Committee. If they cover treatments, health plans that accept Medicaid patients would also cover those treatments. The key to coverage is that the treatment modalities should be evidence-based.</p>
<b>15 - -</b> Prescription filling in community pharmacies	<p><u>2002 Recommendation</u></p> <p>See recommendation #16.</p> <p>MDCIS should encourage pharmacies within communities or among pharmacy chains to share information and carry an adequate supply of Schedule II medications to meet the needs of the patients / communities by ensuring that pharmacies are aware of supply and demand issues.</p>	<p>See recommendation #16.</p> <p>A representative from the Michigan Pharmacists Association presented information about this issue at the May 2008 Committee meeting confirming that a number of barriers affect the willingness of Michigan’s 2500 pharmacies to carry larger amounts of scheduled medication.</p> <p>For example, pharmacies have expressed concern that sharing information about Schedule II medications may compromise the security of their pharmacy or increase the risk of forged prescriptions.</p> <p>Also, in regards to robberies of pharmacies in Michigan for Schedule II medications, from 01/2007 – 05/2008 there were 50 break-ins and 10 armed</p>

Recommendation Number	Recommendation	Action Taken
		<p>robberies of pharmacies.</p> <p>To address the recommendation, in 2009 a survey was sent to Michigan pharmacies asking 1) if they carried Schedule II, and 2) if so, would they be willing to be put on a confidential list of pharmacies that carry Schedule II. In early 2010, the survey data was entered. In winter 2010, the confidential list is expected to be distributed to Michigan pharmacies.</p>
<p><b>16 - -</b> Prescription filling in community pharmacies</p>	<p><u>2002 Recommendation</u></p> <p>See recommendation #15.</p> <p>MDCIS should promulgate rules that require pharmacies to assist patients in finding adequate supplies of medications within a reasonable time when the pharmacy is unable to fill a valid prescription as presented.</p>	<p>See recommendation #15.</p> <p>In 2003, the Michigan Board of Pharmacy issued their Guidelines on the Use of Controlled Substances for the Treatment of Pain. They added language regarding patient referrals: <i>When a patient presents with a prescription for a controlled substance that is not stocked in the pharmacy, the pharmacist should make every effort to refer the patient to another proper source of care to help assure the patient finds access to medication required for symptom relief.</i></p> <p>In May 2008, a representative from the Michigan Pharmacists Association gave a presentation to the Committee. He thought that most pharmacies are already assisting customers in finding supplies of their medication, and that promulgating rules would do little to increase this practice.</p>

Recommendation Number	Recommendation	Action Taken
		Another consideration: if administrative rules (versus the above guidelines) were promulgated, they would be difficult to enforce.

**Recommendations - - No Action Taken: 7, 9, 10, 18**

Recomm. Number	Recommendation	Action Taken
<p>7 - - Core curricula</p> <p>See also #6</p>	<p><u>2002 Recommendation</u></p> <p>#7 follows recommendation #6 - - see below for reference</p> <p>The State Legislature should establish a grant program to facilitate the integration and implementation of the model curricula into appropriate education programs in Michigan institutions so as to encourage Michigan institutions educating health professionals to implement the model core curricula. The impact of implementing model core curricula in pain management can be further evaluated and reassessed to determine the effectiveness.</p> <p>#6 recommendation for reference:</p> <p>MDCIS should disseminate curricula developed by or similar to the International Association for the Study of Pain (IASP) model core curricula regarding pain and symptom management to the Michigan institutions that provide</p>	<p>Based on discussion at the November 20, 2008 committee meeting, it appears highly unlikely that the legislature would establish a grant program given the current economic climate.</p> <p>See “action taken” for recommendation # 6.</p> <p>The Committee, after reviewing various curricula in 2007, approved sending out the IASP model curricula for various health professions to all training schools in Michigan. This mailing was done in 2008. There were positive responses to this mailing, but no data to evaluate the impact of this mailing or to find out who is implementing, or who is planning to implement the IASP curricula.</p>

	health care education and continuing education, and should integrate pain and symptom management into the customary practice of health care.	
<b>9 - -</b> Continuing education	<u>2002 Recommendation</u>  MDCIS [MDCH] should encourage the hospitals to increase the medical and nursing staff's knowledge by providing the guidelines for the required curricula in pain and symptom management to be covered through their organized educational programs.	No action taken.
<b>10 - -</b> Continuing education	<u>2002 Recommendation</u>  MDCIS [MDCH] should encourage professional associations to address education and training in pain and symptom management for those health professionals who are not required by the statute to have continuing education to assure that all health professionals maintain a current understanding of pain and symptom management.	No action taken. From 2010 – 2011, however, several of the remaining boards will be opening up their rules, and will be adding language to their administrative rules on pain and symptom management continuing education.
<b>18 - -</b> Policy	<u>2002 Recommendation</u>  MDCIS [MDCH] and the practice boards should adopt and publicize statements of principle that undertreatment of pain is as serious an offense as any other inappropriate treatment of pain under the practice acts applicable to physicians, dentists, nurses, and pharmacists. This is consistent with the grounds for violation under the Michigan public health code 333.16221.	See recommendation #11.  No action taken. The Bureau, however, did customize the Federation of State Medical Board's booklet <i>Responsible Opioid Prescribing</i> , and distributed it to those health professionals with controlled substance licenses and professionals who work closely with them. The booklet emphasized that undertreated pain was as serious a problem as drug diversion.

## Appendix H

### Advisory Committee on Pain and Symptom Management 2006—2009 Meetings

Date	Topics / Activities / Highlights
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*Note: All meeting dates, agendas, minutes, and electronic presentations or handouts are available on the pain management website at [www.michigan.gov/pm](http://www.michigan.gov/pm).*

November 2006	<p>This was the first meeting of the reconvened Committee since appointments were made earlier in 2006.</p> <p>Melanie Brim will be Director Janet Olszewski's designee on the Committee.</p> <p>M. Brim reviewed the role of the Committee and its responsibilities and requirements; she also reviewed the recommendations from the committee's 2002 report.</p> <p>In regard to Continuing Education (CE), which are recommended, M. Brim talked about the evolution of CE from traditional CE to Continuing Professional Development (CPD). CPD would allow for a more individualized educational plan.</p>
February 2007	<p>Bureau of Health Professions Pharmacy Section gave a presentation on the Michigan Automated Prescription System (MAPS), which was implemented in 2003</p> <p>Kay Presby, consultant for MDCH's Cancer Section / Michigan Cancer Consortium, presented on data from a 2004 End of Life Assessment Report and the 2004 Special Cancer Behavioral Risk Factor Survey. A lowlight: during the last three months of life, about 38% of respondents reported pain levels as being severe to excruciating.</p> <p>Dr. Karen Ogle, member of the Committee and the MI Commission on End-of-Life Care, reported on her study (n = 188) of postgraduate medical training in pain management. A lowlight: 43% reported receiving no training in pain management.</p>
May 2007	<p>A major requirement of the ACPSM is to look at what is offered by training schools on pain management.</p>

Committee reviewed a summary of Michigan pharmacy schools offerings on pain management.

Also reviewed was professional training CE for dentistry, medicine, osteopathic medicine, nursing, and social work.

The new pain management website was launched. A subcommittee was formed to provide oversight and to recommend content.

The Committee recommendations were reviewed.

August 2007

Wayne State University Medical School and Michigan State University College of Human Medicine gave presentations on its pain management curricula.

It was announced that the Governor's Office approved the MDCH proposal on Continuous Professional Development (CPD).

The Cancer Prevention and Control Section / Michigan Public Health Institute updated the ACPSM on the 2006 Special Cancer Behavioral Risk Factor Survey data. Essentially, about 90% of the population dies in moderate to severe pain, with 42% in severe pain. Most recognize the word hospice; almost 100% do not recognize the word palliative.

November 2007

Michigan State University College of Osteopathic Medicine gave a presentation on its pain management curriculum.

University of Michigan provided a handout on its pain management curriculum.

It was concluded that overall the curriculum from the four medical schools seems adequate, though it could improve. Medical students report, however, that once they are out in the field they are not taught to practice what they were learned in medical school about pain management. A much more cautious and professionally vigilant approach seems to be encouraged, especially in rural areas.

Presentation was given on several legal cases resulting from the under treatment of pain.

The Committee recommendations were reviewed.

Committee approved the distribution of the International Association of the Study of Pain's curricula to all appropriate Michigan training schools. [Curricula were mailed in spring 2008.]

Committee members agreed that boards should adopt the Federation of State Medical Boards' 2004 Model Policy for the Use of Controlled Substances for the Treatment of Pain, which supersedes its 1998 Model Guidelines for the . . . The Model Policy emphasizes that the inadequate or under treatment of pain is a divergence from acceptable medical practice.

February 2008

Reviewed Committee recommendations that had not been completed.

Bureau of Health Professions Pharmacy staff gave a presentation on the Michigan Automated Prescription System (MAPS)

May 2008

Membership on the Committee was completed when additional appointments were made by the Board of Medicine, the Board of Osteopathic Medicine and Surgery and the Task Force for Physician Assistants.

Michigan Pharmacy Association's Director of Governmental Affairs, Greg Baron gave a presentation related to the issue of keeping supplies of controlled substances in stock.

The Department's Medical Services Administration explained new requirements related to refilling controlled substances.

It was announced that the IASP guidelines on pain curriculum were sent out to educational institutions with medicine, nursing, pharmacy, dentistry, OT, PT, and psychology programs.

August 2008

A presentation on the disease of fibromyalgia was given by Committee member Dr. Dennis Dobritt, D.O. and Sharon Ostalecki, Ph.D.

Committee provided input on pain questions for the physician survey that would go out with FY 2009 physician license renewals.

November 2008

The Committee reviewed the recommendations that have not been completed. Committee provided input on the questions for the public survey of pain

February 2009

No meeting due to weather conditions resulting in a lack of quorum.

May 2009

M. Brim gave a presentation on the Michigan Medical Marijuana Program.

Results from the 2009 public survey on pain were presented and discussed.

In lieu of creating and disseminating guidelines (Recommendation #5) the Committee decided to post links on the pain management website to the National Guideline Clearinghouse and to the Cochrane Review, both of which list evidence-based guidelines on pain and symptom management. S. Affholter updated the Committee on a pharmacy survey that is in the field for the purpose of identifying those Michigan pharmacies who carry Schedule II controlled substance and who are willing to be on a confidential list. The list, once completed, would be sent to all Michigan-based pharmacies allowing those who do not carry Schedule II controlled substances to refer to pharmacies that do carry Schedule II controlled substances.

S. Affholter updated the committee on the efforts being made to increase the number of MAPS users.

August 2009

New members/appointees to the Committee were introduced. The term of office is from July 1, 2009 to June 30, 2011.

M. Wissel, the Bureau of Health Professions' Pharmacy Manager, gave a presentation on the Michigan Automated Prescription System (MAPS).

For the majority of time, the Committee identified potential recommendations to be worked on from 2010 – 2011.

October 2009

The entire meeting was spent developing potential recommendations to be worked on from 2010 – 2011.

## **Appendix I**

### **Advisory Committee Pain and Symptom Management 2010 Meetings**

*Note: All meeting agendas, approved minutes, and electronic presentations or handouts will be posted to the pain management website at [www.michigan.gov/pm](http://www.michigan.gov/pm). For more information, contact the Bureau of Health Professions at 517-373-8068.*

The Advisory Committee on Pain and Symptom Management will meet in regular session for 2010 as listed below:

Thursday, April 29, 2010, 9:30 a.m. – 12 p.m., Michigan Health Council  
Thursday August 19, 2010, 9:30 a.m. – 12 p.m., Room 1  
Thursday, November 04, 2010, 9:30 a.m. – 12 p.m., Room 1

LOCATION:  
OTTAWA BUILDING  
611 W. OTTAWA STREET  
UPPER LEVEL CONFERENCE CENTER  
LANSING, MI

## **Appendix J**

### **2009 Advisory Committee on Pain and Symptom Management Recommendations for FY 2010 – 2011**

1. Convene a Summit of representatives from Michigan medical schools and postgraduate medical education programs to explore ways to improve pain management education in both the medical school curriculum as well as the residency experience.
2. Present 5-10 comprehensive trainings on pain management to be offered to health care professionals and pre-professionals at key Michigan locations. The state should also make available such training as an online module and seek CME/CE sponsorship to make the training widely accessible.
3. Improve pain and symptom management of the elderly and those with advanced illnesses by providing education to health professionals, as well as patients and their families. This will include such efforts as providing training opportunities for health professionals and the development of written materials and outreach to patients and their families.
4. Increase the use of MAPS by health professionals and make the MAPS data and information regarding controlled substances use more available to health professionals.
5. Introduce a bill to establish a program to promote remediation for health care providers failing to appropriately prescribe or dispense controlled substances.
6. The MDCH Bureau of Health Professions should fully utilize its communication resources to disseminate pain management information to health care professionals, such as the FSMB Model Guidelines on pain management, MAPS information, state-sponsored pain management trainings, and other resource information
7. Develop and implement strategies designed to improve the public's knowledge, attitudes and practices regarding pain and symptom management.
8. The Department of Community Health, together with the Boards of Medicine and Osteopathic Medicine and Surgery, should determine that the practice of Interventional Pain Management is the practice of medicine. The Boards should determine what specific practices of interventional pain management can be delegated to other health professionals.

## **Appendix K**

### **Pain Facts from the Alliance of State Pain Initiatives**

#### **Pain Facts**

##### ***Did you know that?***

##### **Pain is a national public healthcare crisis**

- Approximately 50-75 million Americans suffer with persistent (chronic) pain. The number of people suffering with chronic pain is higher than, and includes, those with breast cancer, AIDS, and nearly all other serious or terminal illnesses. Yet, unlike those major illnesses, most chronic pain is untreated or under-treated, and this is particularly true for African Americans, Hispanics, and other underserved groups. (The Pain Survey, Louis Harris & Associates, 1999)

##### **Pain takes a toll on almost every aspect of a person's life**

- Two in five pain sufferers (42%) experience such severe pain that they are unable to work, and three in five (63%) are unable to engage in routine activities of daily living. (The Pain Survey, Louis Harris & Associates, 1999)

##### **Effective pain care is hard to find**

- The majority of those suffering with severe chronic pain do not have it under control. For those who do, it took 50% of them over a year to get their pain under control. (*Chronic Pain in America*, the American Pain Society and the American Academy of Pain Medicine, 1999)
- Chronic pain sufferers have difficulty finding doctors who can treat their pain. Almost one-fourth of respondents saw more than three doctors. The reasons they cite are: doctors are unwilling to treat pain aggressively; doctors lack knowledge about pain treatment; doctors do not take their pain seriously. (*Chronic Pain in America*, the American Pain Society and the American Academy of Pain Medicine, 1999)

##### **Pain takes an enormous toll on the US economy**

- Lost productive time from common pain conditions among active workers costs an estimated \$61.2 billion per year. (Stewart WF, Ricci JA, Chee E, Morganstein D, Lipton R., JAMA. 2003 Nov 12)

- The National Institutes of Health estimates that pain costs the American public over \$100 billion per year in medical expenses, lost wages and other costs. (*NIH Guide: New directions in pain research I*, National Institutes of Health, 1998)

### **Back Pain**

- Back pain is the leading cause of disability in Americans under 45 years old. Over 26 million Americans between the ages of 20 and 64 experience frequent back pain, and two thirds of American adults will have back pain during their lifetime.

### **Cancer**

- Over 70% of those with cancer experience pain, yet only 50% of advanced-stage cancer patients, who are undergoing active treatment, get adequate pain treatment. In addition, 89% of children with cancer suffer “a lot” or a “great deal” in the last month of life. Less than 30% has successful treatment of their pain. (Cleeland CS, Gonin R, et. al. *N Engl J Med* 1994; 330: 592-596. Wolfe J, Grier HE, Klar N, et al. *N Engl J Med* 2000; 342:326-333.)

### **Headache**

- More than 45 million Americans get chronic, recurring headaches, while 28 million suffer from migraines (The National Headache Foundation: [www.headaches.org](http://www.headaches.org))

### **Osteoarthritis and Rheumatoid Arthritis**

- Pain is a major determinant of quality of life for people with osteoarthritis and rheumatoid arthritis that affect more than 20 million and 2.5 million Americans, respectively. (National Institutes of Health)

### **Reflex Sympathetic Dystrophy Syndrome (RSD), also known as Complex Regional Pain Syndrome (CRPS)**

- RSD / CRPS is a chronic neurological syndrome that is often characterized by disabling pain. It is estimated to affect more than 1.5 million people in the United States. (The Reflex Sympathetic Dystrophy Syndrome Association; [www.rsds.org](http://www.rsds.org))

### **Other Causes of Pain**

- The National Institute of Dental and Craniofacial Research of the National Institutes of Health reports that 10.8 million US residents suffer from TMJ at any given time (TMJ Association: [www.tmj.org](http://www.tmj.org))
- The American College of Rheumatology ([www.rheumatology.org](http://www.rheumatology.org)) estimates that between 3-6 million Americans, most of whom are women, are affected by fibromyalgia, a complex condition that includes widespread pain.

## **End of Life**

- More than half of all hospitalized patients experience pain in the last days of their lives. (The SUPPORT Principle Investigators. A controlled trial to improve care for seriously ill hospitalized patients: the study to understand prognoses and preferences for outcomes and risk of treatments (SUPPORT). *JAMA* 1995; 274:1591-1598)
- Half of almost 500 terminally ill persons had moderate to severe pain. (Weiss SC, Emanuel LL, Fairclough DL, Emanuel, EJ. Understanding the experience of pain in terminally ill patients. *Lancet* 2001; 357: 1311-1315)

## **Older Americans and Pain**

- Pain is common among nursing home residents. It is estimated that 45% to 80% of them have substantial pain that is undertreated. (Ferrell BA. Pain evaluation and management in the nursing home. *An Intern Med* 1995; 123:681-687. Bernabei R, Gambassi G, Lapane K et al. Management of pain in elderly patients with cancer. SAGE Study Group (Systematic Assessment of Geriatric Drug use via Epidemiology) *JAMA* 1998; 279: 1877-1882.
- Two in three older Americans say that pain prevents them from engaging in routine activities (cooking, housework, hobbies, gardening). (*The Study of Pain and Older Americans*, Louis Harris & Associates for The National Council on Aging, 1997)
- Despite the fact that most older people say that they believe their doctors give them enough information about pain, more than one in three said their doctors do not provide important information (such as negative interaction with other drugs). (*The Study of Pain and Older Americans*, Louis Harris & Associates for The National Council on Aging, 1997)

## **Addiction and Dependence to Pain Medications**

- Addiction is believed to rarely occur in patients who receive pain medications for a medical reason and have no history of drug abuse or addiction. (*Prescription Pain Medications: Frequently Asked Questions and Answers for Health Care Professionals and Law Enforcement Personnel*; A consensus document from the Drug Enforcement Administration and health care experts; [http://www.deadiversion.usdoj.gov/faq/pain\\_meds\\_faqs.pdf](http://www.deadiversion.usdoj.gov/faq/pain_meds_faqs.pdf))
- Physical dependence to pain medication is not addiction. Persons with pain regularly treated with opioid analgesics will develop physical dependence and they will experience withdrawal if they abruptly stop taking the drugs. Proper tapering of the dose can prevent withdrawal symptoms. (*Definitions Related to the Use of Opioids*)

*for the Treatment of Pain*. A consensus document from the American Academy of Pain Medicine, American Pain Society and the American Society of Addiction Medicine. ([www.ampainsoc.org/advocacy/opioids2.htm](http://www.ampainsoc.org/advocacy/opioids2.htm))

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The American Alliance of Cancer Pain Initiatives and the American Pain Foundation as part of the *Power Over Pain* public awareness campaign prepared this document (Alliance of State Pain Initiatives <http://aspi.wisc.edu/documents/pdf/painfacts.pdf>)