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Pain Management Study

FINAL REPORT

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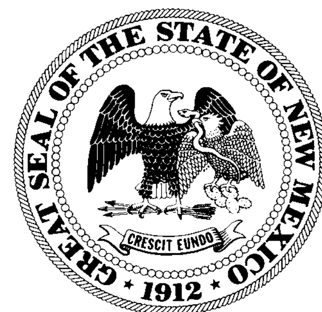

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I. EXECUTIVE SUMMARY

During the 2001 Legislative Session, Senator Mary Jane Garcia sponsored a Memorial that requested the NM Health Policy Commission (HPC) to take the lead in a study of pain management in New Mexico. The Memorial was inspired by anecdotal information that indicated that physicians in the state are concerned about being disciplined or faced with legal action when they prescribe pain medications and that as a result, they routinely under-prescribe for pain. The HPC launched a study of pain management in the state that included a survey of New Mexicans receiving prescription medications, a site survey of the opinions, beliefs and knowledge of health professionals throughout the state, and a Task Force drawn together from a wide array of stakeholders to consider the issues and make recommendations to the Legislature.

While the Task Force made numerous final recommendations, there were two key findings of the study as a whole. The first finding is that there is a dire need for more education about pain and pain management, for both patients and health professionals. Patients often lack a clear language for expressing the extent and nature of their pain in such a manner that their health care provider can understand and respond to appropriately. Furthermore, health professionals in New Mexico have significant limitations to their knowledge about the etiology of pain, the actual risks and benefits of opioids in the treatment of pain, and effective pain management in general. Pain management receives little or no attention in the curricula of the professional schools in the state, there are no competency requirements for pain management that are necessary for licensure, and although there are guidelines available for health care professionals to refer to, few practitioners actually do. The major recommendation the Task Force made in response to this finding is a call for the creation of a State Advisory Council on Pain Management which would be responsible for instituting statewide education efforts for both providers and patients.

The other key finding of the study is that providers continue to be fearful that they make themselves vulnerable to discipline and/or legal action when they prescribe opioids and other narcotics for pain. The Task Force members spent many hours debating the validity of this fear, yet whether it is an unfounded perception or a valid concern, many providers respond by under-prescribing for pain. To address this finding, the Task Force made recommendations for changes in the NM Board of Medical Examiners (BME) disciplinary process, and for the review and updating of BME guidelines on prescribing for pain. These recommendations are meant to make the guidelines more current, and to make the disciplinary process more transparent to providers, both of which should directly address provider fears.

The full set of Task Force recommendations includes other issues, such as a patient bill of rights and establishing in statute the right of all New Mexicans to receive appropriate treatment for pain. In addition, the results of the site survey and the prescription drug survey questions provide interesting and revealing information about the state of pain management in New Mexico today. In short, then, this study and report fully respond to the concerns raised by Senate Memorial 22, and provide both the Legislature and New Mexican citizens with insightful and useful information and recommendations that can be used to develop effective pain management public policy for New Mexico.

II. BACKGROUND

The Issue

Pain is a major healthcare problem in this country, and is the single most common symptom that prompts people to seek medical care. Because pain is subjective, it is hard to develop a single definition that applies under all circumstances. Generally, the working definition of pain is "what the patient says it is." Pain creates discomfort, and it also inhibits normal functioning. More than 50 million workdays per year are lost to pain and pain-related illnesses.[1] Conservative statistics suggest pain is experienced by at least 2% of the adult population at any given time.[2] Despite the prevalence and social and economic significance of pain, however, the line between appropriate prescribing for pain and inappropriate over-prescribing has not yet been conclusively established. This uncertainty often leads physicians and other prescribing practitioners to err on the side of caution and under-prescribe opioids, generally the most effective class of pain-relieving narcotics, to avoid crossing the line and becoming subject to legal prosecution.

There have been many efforts to recognize the legitimate value of narcotics to treat pain. In 1961, the Single Convention on Narcotic Drugs stated that: "the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering… adequate provision must be made [by governments] to ensure the availability of narcotic drugs for such purposes."[3]

The World Health Organization Expert Committee on Essential Drugs has for many years designated morphine, codeine and other opioids as "essential drugs," and in 1986 it

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[1] American Pain Society. 2000. *Position Statement: Pain Assessment and Treatment in the Managed Care Environment*. 2000.
[2] P.F.M. Verhaak, J.J. Kerssens, J. Decker, M.J. Sorbi, and J.M. Bensing. 1998. "Prevalence of chronic benign pain disorder among adults: a review of the literature." *Pain* 77: 231-239.
[3] United Nations. 1961. *Single Convention on Narcotic Drugs, 1961, as amended by the 1972 Protocol Amending the Single Convention on Narcotic Drugs.* UN: New York, NY.

devised and recommended to all governments a simple, medically and scientifically sound approach to treating cancer pain that depends on the availability of these drugs.

The U.S. Federal Food, Drug and Cosmetic Act (FFDCA) also asserts that opioid analgesics are effective, safe and legal to be prescribed for human use, without specifying or recommending dosages or quantity of prescription. The FFDCA does not regulate medical practice, however – it leaves this responsibility to the states. The Federal Controlled Substances Act (CSA) acknowledges that many of the drugs controlled by the Act are "necessary to maintain public health."[4] In October of 2001, the Drug Enforcement Agency went further on the issue, urging policies that protect "the appropriate use of opioid pain relievers for patients who need them, while also preventing abuse and diversion of drugs."[5]

From 1994 to 1998, state medical boards participated in pain management workshops sponsored by the Federation of State Medical Boards of the U.S. (FSMB), which resulted in the development and adoption by FSMB of "Model Guidelines for the Use of Controlled Substances for the Treatment of Pain" in 1998.(4) Since that time, boards have begun adopting guidelines to encourage improved pain management and to dispel physicians' fear of discipline. The NM Board of Medical Examiners adopted its guidelines for physicians on prescribing for pain in 1996.

The Pain Relief Act and Senate Memorial 22

Despite all of the above, the perception persists that physicians who prescribe opioids for pain are vulnerable to legal action even when they do so as part of a legitimate medical course of treatment. Because of this persistent perception of risk, anecdotal evidence suggests that physicians routinely under-prescribe for pain. Under-treatment of pain occurs when the patient remains uncomfortable, and is less functional than could be expected in the absence of pain. In response to growing concern about under-treatment,

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[4] Controlled Substances Act of 1970. Pub L no 91-513, 84 Stat 1242.

[5] U.S. Drug Enforcement Agency. 2001. *Drug Enforcement Administration, 21 Health Groups Call for Balanced Policy on Prescription Pain Medications like Oxycontin*. DEA Press Release. October 23, 2001.

Senator Mary Jane Garcia introduced the Pain Relief Act, which was adopted by the New Mexico Legislature in 1999. The intent of the Pain Relief Act was to provide "Safe Harbor" for providers to prescribe treatment for chronic pain appropriately and without fear of prosecution. The Act prevents disciplinary action from being taken against a health care provider who prescribes, dispenses or administers medical treatment for the therapeutic purpose of relieving intractable pain and who can demonstrate by reference to an accepted guideline that his or her practice substantially complies with that guideline and with the standards of practice. This legislation creates a presumption in favor of doctors and other health care providers that protects them from prosecution for providing pain treatment that falls within guidelines recognized by the New Mexico Board of Medical Examiners.

In 2001, legislation was introduced that would have amended the Pain Relief Act to provide loss recovery to providers who have been sued under the Act. This proposed legislation failed, but the issue continued to be a matter of concern. Senator Garcia next sponsored Senate Memorial 22, which was adopted by the Senate in 2001. The Memorial requested that the New Mexico Health Policy Commission (HPC) work with the New Mexico Board of Medical Examiners, the Board of Nursing and the Department of Health to conduct a study of pain management with particular focus on:

- Patients' rights to be informed about and receive pain management therapies;
- The incidence of under-treatment of pain in New Mexico;
- Pain management standards of care and the education and training necessary for health care professionals to provide an adequate and appropriate level of treatment;
- Regulations and Guidelines provided by the Board of Medical Examiners and the Board of Nursing; and
- The ability of health care professionals to defend themselves and recover costs when wrongly disciplined or prosecuted for providing appropriate pain management that may exceed a board's guidelines.

HPC Response to SM 22

The HPC took several steps to respond to SM 22. The agency began by gathering data on the current state of pain management in New Mexico. A site survey of selected New Mexican health care facilities was conducted to assess statewide standard of care practices and health care provider opinions about pain management. The HPC also added several questions to its on-going prescription drug access survey that specifically addressed access to drugs and treatment for chronic pain.

In addition to gathering primary data, the HPC formed a Pain Management Task Force to gain insight into, and feedback on, pain management in New Mexico from consumers, providers, regulatory agencies and other stakeholders. The Task Force was charged with examining the issues identified by SM 22 and developing recommendations for the Legislature. The Task Force was comprised of representatives from State government, professional associations, health care facilities, health care providers, consumer advocacy organizations and teaching facilities, all of whom were interested and involved in pain management, the provision of quality services and access to treatment for New Mexicans. Subcommittees were formed to examine the four issues requested by the Memorial independently and make policy recommendations that were eventually synthesized by the Task Force into a set of final recommendations.

This report addresses the data, analysis and findings of the study conducted by the HPC from 2001-2002 regarding issues of access to pain treatment for New Mexicans and those initiatives necessary to improve access to pain treatment as requested in SM 22. The one area of the Memorial this report does not address is the request to examine the incidence of under-treatment for chronic pain in New Mexico. After considering the issue, the HPC determined that it could not be addressed due to the significant limitations of available data and information from State agencies, and the lack of resources necessary to collect and analyze appropriate data.

III. THE ENVIRONMENTAL SCAN

In October 2000, the US Senate declared that the "Decade of Pain Control and Research" would begin on January 1, 2001.[6] The announcement focused the attention of federal and state lawmakers on a policy issue, effective pain management, that is extraordinarily complex and difficult to address. For federal and state governments, and their subordinate medical boards, the key issue must be balancing both the comfort and the safety of the patient with the need to ensure providers that they will not be punished for providing appropriate pain care. Public policy can also affect other important aspects of pain management, including end-of-life palliative care and the related and controversial issue of assisted suicide, establishing appropriate standards of care to guide health care providers, and developing educational programs that deliver an adequate amount of training on pain management.

Overview of Recent Federal Activity

Federal legislation to address pain management has been introduced in the last several sessions of the US Congress, but to date none of this proposed legislation has become law. The right to effective treatment of pain has been included in most of the various versions of Patients' Bills of Rights, including HR 3080, the Josephine Butler United States Health Service Act sponsored by Rep. Barbara Lee (referred to subcommittee on March 27, 2002). The Advanced Planning and Compassionate Care Act of 2002, introduced by Senator John Rockefeller IV as S. 2857, addresses end of life issues, and seeks to establish national uniform policy on advance directives and national standards for end of life care (referred to committee on August 1, 2002).

Legislative proposals encompassing a wider array of pain management issues include the Pain Relief Promotion Acts of 1999 (HR 2260) and 2000 (HR 5544). Neither of these

[6] American Academy of Pain Medicine. 2000. *Decade of Pain Control and Research Begins January1, 2001.* Press Release. October 31, 2000.

bills survived the end of their respective congressional sessions, but both engendered serious debate and consideration. The bills each had information and education components – for example, they would have required the Agency for Healthcare Research and Quality to "promote and advance scientific understanding of, and collect and disseminate protocols and evidence-based practices regarding, pain management and palliative care," and the Secretary of Health and Human Services to award funds for the development and implementation of pain management education and training programs.

In addition, the bills had "safe harbor" components, and would have protected medical practitioners by stating that using controlled substances to alleviate pain and discomfort in the usual course of professional practice is a legitimate medical purpose and consistent with public health and safety, even if it may unintentionally increase the risk of death. The bills would have amended the Controlled Substances Act to declare that alleviating pain as part of a course of medical treatment is a legitimate medical purpose for dispensing or administering a controlled substance, even if it might increase the risk of death. Each bill also expressed concerns that legislation not result in investigations into confidential decisions made by a patient and his or her physician, because such investigations would discourage physicians from prescribing controlled narcotics to treat pain.

The *Guide to Evaluation: Achieving Balance in Federal and State Pain Policy*, developed by the Pain and Policy Studies Group at the University of Wisconsin's Comprehensive Cancer Center, has quickly become the national standard for evaluating the effectiveness of federal and state pain policies. The *Guide* proposes **17 specific criteria**, (8 of which potentially enhance pain management and 9 of which potentially impede pain management) which can be used to evaluate any pain management policy or standard. The same 17 criteria can be used as models for developing new and more effective pain management policies. According to the *Guide*, existing federal legislation

and regulations have elements which both enhance and impede effective pain management. For example:

- The Controlled Substances Act (1970) may **enhance** pain management by declaring that many controlled substances have a legitimate medical purpose, and are necessary to maintain public health.
- The Code of Federal Regulations, Food and Drugs (21 CFR 1306.11) may **enhance** pain management by allowing prescriptions to be transmitted by facsimile in a variety of situations, and upon oral authorization by prescribing practitioner in emergency cases.
- The Code of Federal Regulations, Public Health (42 CFR 41.15) may **impede** pain management by perpetuating the belief that the use of opioids hastens death.
- The Code of Federal Regulations, Food and Drugs (21 CFR 291.505 and 1306.07) has four sections identified as possibly **impeding** pain management by: referring to addiction as physiologic dependence; requiring MD's in treatment programs to place patients on three months of probation if they test positive for narcotics without verifying possible prescriptive use; implying that opioids are used as a last resort for intractable pain; and ambiguous provisions confusing physical dependence or tolerance with addiction.[7]

Overview of Recent State Activity

The states have been responding to the issue of effective pain management as well. From 1989 to 2000, there was a significant increase in the total number of state pain policies, including twenty-two statutes, eighteen regulations, thirty-two guidelines and one policy statement. Ten states have adopted Intractable Pain Treatment Acts (IPTAs) that provide legal immunity to physicians when prescribing opioids for pain. However, since 1999, the number of new state pain policies adopted or amended has slowed significantly. Seven states remain without any pain policy, and according to the Pain and Policy

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[7] D.E. Joranson, A.M. Gilson, K.M. Ryan, M.A. Maurer, and J.M. Nelson. 1999. *A Guide to Evaluation: Achieving a Balance in Federal and State Pain Policy, Part I.* The Pain and Policy Studies Group, University of Wisconsin Comprehensive Cancer Center. Madison, Wisconsin.

Studies Group, many states have policies that may actually interfere with pain management. The *Guide to Evaluation: Achieving Balance in Federal and State Pain Policy* has a state-by-state evaluation of existing pain policies, and is an excellent resource for further information.

New Mexico

The Pain Relief Act requires that physicians follow pain management guidelines developed by nationally recognized health care organizations, providing that those guidelines have been accepted by the New Mexico Board of Medical Examiners.

The NM Board of Medical Examiners (NMBME) adopted the state's current standard of care in 1996. That standard recognizes that "some dangerous (prescription) drugs and/or controlled substances are indicated for the treatment of pain and are useful for relieving and controlling other related symptoms from which patients may suffer."

Utilizing the 17 criteria for evaluating pain-related policies developed by the Pain and Policy Studies Group, the NMBME standard has the potential to **enhance** pain management in five key ways: by acknowledging that both pain management and opioids are part of professional practice, by addressing fears that medical professionals might have of regulatory scrutiny, by extending the use of opioids to all patients whether or not they are addicts, and by stating that prescription amounts are not the only determining factor of legitimate or illegitimate pain treatment. At the same time, the NMBME standard has the potential to **impede** effective pain management by implying that opioids are a last resort for pain treatment, and by requiring that physicians consult about their patients with other health are professionals who have experience with pain management.

NMBME is scheduled to make its guidelines into a rule at a public hearing in November 2002. As a result of the discussions surrounding this Memorial, the NMBME has agreed

to include in the review process leading up to the final rule consideration of any nationally recognized guidelines that were submitted to the Board before July 1, 2002.

Standards of Care

The possibility of expanding the standards of care that are recognized and accepted by the NMBME is an important step towards alleviating provider concerns. There are many existing standards of care for conditions and illnesses that result in chronic pain. These standards have been created by a wide range of national medical professional associations and health care organizations. This report would grow unwieldy very rapidly if we tried to summarize, or even list, all of these standards here. Last Acts, a national coalition for end-of-life care, has put together an excellent publication which summarizes 41 standards from organizations ranging from the American Medical Association to the American Pain Society to the Veteran's Health Administration.[8] The various standards defy easy comparison or analysis as a group – while each addresses the relief of pain, some are very specific and consider not only *when* pain should be alleviated but also precisely *how*, while others are broad policy statements about the quality of care that patients *should* receive, with no specific information about when or how that care should be rendered.

As mentioned above, the *Guide to Evaluation: Achieving Balance in Federal and State Pain Policy* offers a standardized method for comparing and developing pain policies and standards of care. The *Guide*, however, considers only the policies of governmental entities, and does not include standards of care developed by health care organizations. For an all-inclusive (non-comparative or evaluative) data source, look to the web-based National Guideline Clearinghouse (www.ngc.gov), which lists hundreds of guidelines put together by national organizations as well as state agencies and other governmental entities.

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[8] Donald Phillips, Charles Sabatino and Karen Nisley Long.. 2001. *Compendium of Health Care Organization Guidelines and Position Statements on Issues Related to the Care of the Dying.* Last Acts. Chicago, IL.

Current standards for palliative care generally differ from those for chronic pain not due to cancer. The issue of physician-assisted suicide appears to be a significant concern for palliative care providers, and therefore figures prominently in many palliative care standards of care. Physicians managing patients with chronic pain – and standards of care guiding those physicians – are generally more concerned with addiction, drug abuse, and other potential side effects of opioids.

In January 2001 the new standards on pain management by the Joint Commission on Accreditation of Healthcare Organization (JCAHO) went into effect. 19,000 hospitals, nursing homes, and other health care facilities must bring themselves into compliance with these new standards, which explicitly recognize the rights of patients to appropriate pain management. A summary of the JCAHO standards can be found in Appendix I of this report.

Provider Education on Pain Management

Health care providers perceive risk when they prescribe narcotics for pain, but evidence suggests that under-prescribing is not just due to fear: many health care providers lack solid education in effective pain management. In general, what little pain management education exists in most medical and nursing program curriculums is disease-process specific, with no hourly requirement. The Health Policy Commission Site Survey conducted for SM 22 revealed that 100% of providers think that emphasis specific to chronic pain management in medical school is lacking. A 1999 study stated that 97% of physicians surveyed acknowledged that insufficient knowledge and inadequate education contribute to the problem of under-treated pain.[9]

Nurses are on the front-lines of pain management, yet a recent survey of 8,000 nurses demonstrated that while nurse have become more informed about pain, they are still

[9] K.L. Pargeon and B.J. Hailey. 1999. "Barriers to Effective Cancer Pain Management: A Review of the Literature." *Journal of Pain Symptom Management* 18: 358-368.

lacking the basic knowledge to manage pain properly.[10] According to a recent study, pain content accounted for only .5% of the total text content in 50 textbooks used in nursing education; end-of-life care accounted for only 2% of the content.[11] State pain policies are similarly lacking: in a search of Nurse Practice Acts in the U.S., only two states were found to have sections or provisions specific to pain management, Virginia and California.

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[10] M. McCaffrey and B.R. Ferrell. 1999. "Opioids and Pain Management: What do Nurses Know?" *Nursing.* March, 1999: 48-52.
[11] B. Ferrell, R. Virani and M. Grant. 2000. "Analysis of Pain Content in Nursing Textbooks." *Journal of Pain Symptom Management* 19: 216-228.

IV. DATA ANALYSIS AND FINDINGS

As noted above, the HPC gathered primary data regarding pain management in New Mexico in two ways. Questions about access to pain treatment and prescription drugs specifically for chronic pain were inserted into the on-going prescription drug access survey, a random sample telephone survey of New Mexico households. In addition, a site survey of selected New Mexico health care facilities was conducted. This survey used face-to- face interviews to assess statewide standard of care practices and provider opinions.

A. PRESCRIPTION DRUG ACCESS SURVEY

While it would have been useful to conduct a complete and exclusive study on incidence of pain, access to treatment and effectiveness of treatment, SM 22 did not provide the resources necessary for such a substantial survey. However, in response to a different Memorial, HJM 22 (2002), the HPC had already contracted with Burger, Carroll and Associates to conduct a random access telephone survey of New Mexico households to measure access to prescription medications in general. Therefore, the opportunity appeared to insert questions into the survey instrument that would collect data on access to prescription drug treatment specifically for chronic pain. The methodology of the survey and the raw data can be found in Appendix C of this report.

The overall research goal was to better understand how New Mexicans are affected by chronic pain, receiving prescription drug treatment for chronic pain and the potential effectiveness of that treatment. For the purposes of this study, chronic pain was defined as pain of singularly defined origin, etiology and diagnosis recurring over time. It is acknowledged in both literature and by those conducting this study that respondent definitions of chronic pain will vary greatly for cultural, educational and personal reasons.

Findings

The findings would indicate that of the 3,300 randomly selected respondents to the survey, 361 reported having a need for prescription drugs to treat chronic pain. Of these, 82.20% received the medication they needed, while 12.86% did not. Effectiveness of treatment also varied: 23.74% reported that the medication they received *always* adequately controlled their pain, while 65.57% reported that the medication only *sometimes* adequately controlled their pain, and 9.84% reported that the medication received *never* controlled their pain.

These findings should not be interpreted to indicate any measure of either under-treatment for pain or effectiveness of prescription drug treatment for chronic pain. Rather the findings of this study may indicate that of New Mexicans who identify as having chronic pain, most are able to receive the medication prescribed as the result of treatment for that pain and that for most, the medication they received at least sometimes adequately treated their condition.

B. SITE SURVEY

In order to explore and evaluate standards of care in place at various types of health care facilities in New Mexico, as well as how patients are informed of their rights to pain management, the HPC contracted with Maryanne C. Morelos, RNC, to conduct a site survey of selected New Mexico health care facilities. In addition, the survey was designed to provide some information about the perceptions of the incidence of under-treatment for chronic pain by providers in the state; to examine education and training for health care professionals and the most effective way to provide it; and to assess the views of health care professionals on the current climate of pain treatment in New Mexico and nationally, as well as their views on the impact of state guidelines and legislation that influence their practice.

Settings and Participants

The site survey sample of 26 institutions represented major healthcare systems in larger communities and metropolitan areas of the state, encompassing all 4 geographic areas of New Mexico. Sites included hospitals, long term care facilities (LTC), rehabilitation centers, hospice care, nursing homes, pain clinics or ambulatory surgery centers, and chemical dependency treatment units (CDU). Health care professionals surveyed included nurses, physicians, psychologists, pharmacists, and institutional administrators. The methodology of the survey and specific questions and responses can be found in Appendix D of this report.

Survey questions were intended to reflect upon compliance with JCAHO Standards of Care in Pain Management. The standards for pain management (Appendix E) were implemented by the Joint Commission on Accreditation of Healthcare Organizations in the fall of 2000 and affected any institution receiving accreditation surveys after January 1, 2001. Therefore most institutions surveyed were in various stages of reaching compliance with these standards.

Findings: Respondent beliefs

All respondents were asked to express their attitudes or beliefs regarding the current state of pain management in New Mexico. Greater than 90% of those surveyed hold a firm belief that under-treatment of pain does exist. Respondents identified the major barriers to effective pain management as:

- Lack of education and knowledge regarding pain management - this includes being able to differentiate between addiction, dependence, and tolerance in the use of opioids.[12]
- Time consumption for health care providers in the management of these clients;

[12] Addiction is a chronic neurobiological disease, characterized by impaired control over drug use, compulsive use, and/or continued use despite harm. Dependence is a state of adaptation that produces withdrawal symptoms when the drug is abruptly stopped. Tolerance is also a state of adaptation, resulting in diminished effectiveness of the drug over time. (Partners Against Pain. *Understanding Key Terms in Pain Management*. Available at www.partnersagainstpain.com)

- Fear of regulatory scrutiny in the treatment of chronic pain patients;
- Fear of litigation in the treatment of chronic pain patients; and
- Fear of loss of licensure.

100% of responding providers that practice pain management reported a significant increase in the number of clients referred for evaluation and treatment over the past 12 months. Greater than 80% of that group reported that primary care physicians have cited fear of regulatory scrutiny and reprisal as the rationale for referring their patients to pain management specialists, even when the treatment plan developed by the primary care physician has been effective. Many health care providers said they believed that current and ongoing litigation over pain management practices has had a definite and significant negative impact on primary care physicians and family practitioners practicing pain management. Some provider respondents reported primary care physicians making verbal, rather than written, referrals, due to their fear of litigation.

These are important findings and clearly confirm the anecdotal evidence about provider fears that was a major catalyst for this study. Even though regulatory scrutiny may be as apparently benign as a letter from the Board of Medical Examiners (BME) asking the physician to explain his or her prescribing practices, many physicians fear such oversight. In Task Force discussions, BME initially responded to this fear by providing information that it has, in fact, conducted very few reviews of physicians as a result of claims of over-treatment, and that its process for investigating such claims is careful and thorough, taking all factors into account. However, what may seem like a fair and benign approach to BME is clearly not perceived as such by prescribing health care providers, who still fear the arrival of a letter or investigator in their offices. Whether this is a rational fear or not is irrelevant if providers are responding to their perceived fears by under-treating and leaving New Mexicans in pain.

Related New Mexico Studies on Pain Management

A. Las Cruces Study

At Memorial Medical Center in Las Cruces the medical, nursing, and pharmacy staff were given written surveys regarding their knowledge and attitudes about pain management prior to the initiation of pain management education and initiatives to meet JCAHO compliance. A selected sample of questions and answers from this 2000 study can be found in Appendix D.

The Las Cruces study starkly revealed the extent of the need for more and better education about pain management. Respondents were asked a series of true or false questions, and the percent of incorrect answers was alarming, particularly on questions that revealed the extent to which the respondent understood the etiology of pain. For example, when asked if patients can sleep in spite of moderate or severe pain, which is true, only 53% of physicians answered correctly. When asked if patients who can be distracted from the pain must therefore not have as much pain as they report, which is false, only 68% of physicians answered correctly. Interestingly, nurses scored significantly higher on this question, at 75% correct.

Respondents to this survey also showed a lack of knowledge about the effects of opioids themselves. When asked whether opioids (narcotics) act on the central nervous system to decrease the perception of pain, whereas non-opioid analgesics, such as aspirin, act on the peripheral nervous system to decrease the transmission of pain impulses, which is a true statement, only 66% of physicians and 72% of RNs answered correctly. Respondents also demonstrated an unreasonable concern with addiction. Doctors and nurses alike significantly overestimated the likelihood of addiction after a patient has received opioids for pain for 3 – 6 months. The low number of health care providers answering correctly to the question regarding opiate treatment for greater than 3 months (only 13% for physicians) is alarming, and may demonstrate a significant problem in their

comprehension of drug addiction, dependence and tolerance. The results clearly identify a need for health care professional education, including education on pharmacology and the etiology of pain.

B. Rural New Mexico Hospice Network Study

This study was done at University Hospital and involved 50 subjects over age 55. The objective of the study was to evaluate the need for and effectiveness of a palliative care team in the treatment of in-patients admitted at the end of life for care. The study was accomplished through a retrospective chart review. Charts were reviewed as to whether physicians and nurses assessed for ten common symptoms on admission, including addressing pain as a problem and the assessment of pain through use of a standard assessment scale. With only one exception, a physician who used a visual analog scale to assess pain, neither physicians nor nurses used scales to assess symptoms on admission. During the course of admission, physicians addressed the issue of pain only 45.4% of the time, significantly less than nurses, who had a rate of 72.7%.

While pain is being addressed by some physicians and nurses on admission, it is even less often addressed during the hospitalization. Although pain scales were printed on daily nursing flow sheets, they were not used. The development and use of a palliative care team was supported by this and other data obtained from this study. These conclusions could also support the theory held by many medical professionals that an incidence of under-treatment of pain does exist in New Mexico. It further indicates the need for education of health professionals on pain management and poses the question of how to effect change within the institution regarding pain management. An examination of the barriers affecting organizational change may support an increase in competency of pain management for the health care professional.

Alternative Treatments for Pain

Because the specific areas of concern within SM 22 were the incident of under-treatment of pain and issues of provider liability, the HPC study focused on issues around opioids and pain management. There are, of course, many other alternative methods for treating pain, including chiropractic, acupuncture, massage and a host of other modalities. However, if health care providers are so lacking in education and understanding of conventional methods, it seems unlikely that they are better informed about the relative effectiveness of alternative methods.

V. TASK FORCE ISSUES

As noted above, the HPC's response to SM 22 included gathering a broad array of the health care community into a Pain Management Task Force to gain insight into, and feedback on, pain management in New Mexico from consumers, providers, regulatory agencies and other stakeholders. The Task Force was charged with examining the issues identified by SM 22 and developing recommendations for the Legislature. The Task Force was comprised of representatives from State government, professional associations, health care facilities, health care providers, consumer advocacy organizations and teaching facilities, all of whom were interested and involved in pain management, the provision of quality services and access to treatment for New Mexicans. Subcommittees were formed to examine the four issues requested by the Memorial independently and make policy recommendations that were eventually synthesized by the Task Force into set of final recommendations.

A. Subcommittee on a Patient's Right to be Informed and Receive Pain Management Therapies

The complete report of the findings and recommendations of this subcommittee can be found in Appendix E.

This subcommittee determined that its task was to address the following questions:

1. Do New Mexicans have access to financial means, appropriate providers, and education necessary to obtain adequate treatment for chronic pain? Including:
   a) Do all health plans in the state *(e.g.,* individual*,* state employee health plans, Medicaid and managed care organizations*)* provide coverage for pain management?
   b) Do all health plans in the state offer access to specialists, hospice and home care?
   c) How is information about pain management coverage provided to consumers?
   d) Does Medicaid cover pain management, regardless of the diagnosis?
   e) What resources are available to the uninsured or those who don't have coverage?

2. How do providers inform patients as to the treatment standards and options?
3. How are patients informed of their rights with regard to pain management?
   a) What appeals processes are available?
   b) What avenues are available to patients?
4. How can consumers become educated in describing pain to their health practitioners?

The subcommittee used several means to address these questions, including: a review of videos demonstrating interviews with people living with chronic pain and how they are managing their pain; inviting a legal representative to address appeals processes and legal avenues consumers may take in relation to their medical pain management; and a review of seven New Mexico health plans to determine levels of pain management coverage. Additionally, subcommittee members shared brochures, articles and other information that are used to provide consumer information on patients' rights to pain management. One of the members provided a perspective on the bureaucratic channels that the average consumers must often go through to get the information they need to even begin getting the help they think they may need.

A key concern of this subcommittee was the dilemma that arises when patients and physicians have different definitions and criteria for pain. The subcommittee determined that patient education in the language of pain – learning to recognize and accurately describe pain symptoms, as well as to self-advocate in the face of physician uncertainty – is as important as provider education in the effective management of pain. Toward this end, the subcommittee determined that leadership should be taken by the Department of Health in educating the public on how to describe pain and access treatment for pain, as well as on a patient's right to treatment for pain.

Another major concern of the subcommittee was the absence of clear definitions of the extent of coverage for pain management in health plan materials, which makes it difficult for health care consumers to fully understand their rights. In response, the subcommittee

recommended that health plans make their materials more informative, and that health plans, hospitals, clinics and other providers develop and post in an obvious location a Consumer Pain Bill of Rights and policies that support consumer information and education about pain treatment. There are many of these policies available and JCAHO guidelines require education of the patient and the patient's family concerning treatment for pain and the rights of the patient.

B. Subcommittee on Provider Education in Pain Management

The complete report of the findings and recommendations of this subcommittee can be found in Appendix F.

This subcommittee determined that its task was to address the following questions:

1. Are New Mexico providers trained in current standards of care for pain?
2. What educational resources are available?
3. What current research is available concerning pain treatment?
4. What guidelines are available for providers with regard to treatment of pain by NM licensing boards?
5. What educational resources should be made available that are not currently available?
6. Are New Mexico providers applying current standards of care for pain appropriately with their patients?

The subcommittee used several means to address these questions. Surveys containing the above questions were sent to and answered by education professionals from New Mexico's medical and nursing schools, numerous clinical professionals in practice, members of the committees of the Pain Initiative Task Force, and the Board of Nursing. Also factored into the results are the survey of health professionals in Las Cruces and the Lee survey at the University of New Mexico Health Sciences Center. Additionally, a review of curricula at the University of New Mexico Health Sciences Center was conducted. A number of members of various professional boards were consulted as to

their initiatives in developing pain standards for their states.

This subcommittee determined that the Las Cruces survey, the survey by Lee at the University and its own survey clearly revealed that a pain educational mandate must be instituted in New Mexico. In the professional schools in New Mexico there are very few opportunities afforded the students to learn about the causes of pain and its treatment. While there is an effort to address the topic of diversion, most of the other knowledge required to treat pain is not included in curricula. Applicants for physician licenses are required to listen to a lecture on the subject of pain management, but there are no requirements to be proficient in the area. Although guidelines from the Agency for Health Care Policy and Research (AHCPR) and the NM Pain Relief Act are available, this subcommittee found that few, if any, practitioners have instituted these in their daily practice.

C. Subcommittee on Legal and Regulatory Issues for Providers and Regulatory Agencies

The complete report of findings and recommendations by this Subcommittee can be found in Appendix G.

This subcommittee determined that its task was to address the following questions:

1. What will it cost the State to regulate pain treatment, and how does that cost compare to the costs engendered by a lack of access to appropriate pain treatment?
2. What guidelines and policies are available to providers with regard to treatment for pain by New Mexico licensing boards?
3. How are guidelines developed, followed and kept current by New Mexico licensing boards?
4. How can New Mexico licensing boards improve regulatory guidelines to better serve patients and providers? Are uniform guidelines appropriate?

5. Do Board of Medical Examiners (BME) guidelines serve other health professional licensing boards adequately and appropriately?
6. Does the New Mexico Controlled Substances Act recognize the essential medical uses of controlled substances, including their use for pain?
7. Is there a current rationale for existing State laws, regulations or agency policies regarding prescribing and dispensing of controlled substances that are more restrictive than federal law?
8. Do the New Mexico medical, pharmacy and nursing boards have statements of policy that encourage pain management and recognize that the use of opioids for the treatment of pain is a legitimate medical practice?
9. What liabilities, real or perceived, do providers face with regard to pain treatment?
10. What recourse do providers have when charged with violating licensing board regulations concerning treatment for pain?
11. How can provider liabilities and subsequent recourse and recovery be addressed fairly?

The subcommittee used several means to address the questions. It began its work with a process of identifying general subject areas derived from the questions posed that warranted further discussion by the group in order to develop recommendations, but would require further research. Various committee members took on the task of further developing these areas through various means to better inform the subcommittee on the issues. The committee members tasked with each issue provided findings at subsequent subcommittee meetings in a variety of ways including literature research, the formation of smaller focused discussion groups, and reports by outside experts on the issues. By these means, the subcommittee decided to focus on the following set of issues:

- Costs related to pain management or lack thereof;
- Pain management guidelines;

- Issues of provider liability;
- Board remediation; and
- Law enforcement.

Essentially the group was dealing with livelihoods and vested interests, the responsibility of the State to its citizens, and standards to ensure that providers know what they are doing. The subcommittee determined that it was beyond its scope and ability to address the cost of under-treatment of pain, because of the complexity of the issue and the lack of available data.

D. Subcommittee on Standards of Care in Pain Management

The complete report of findings on Standards of Care can be found in Appendix H.

This subcommittee was tasked by the Task Force to consider the following questions:

1. What are the current standards of care with regard to treatment for conditions or illnesses resulting in chronic pain?
2. Are New Mexico providers trained in current standards of care for chronic pain?
3. What are the professional requirements for education in pain treatment and standards of care?
4. What educational resources are available to practitioners concerning pain treatment and standards of care?
5. Do practitioners when treating patients for chronic pain apply a written standard of care consistently?
6. Do different standards of care for chronic pain and for palliative care apply and should they be addressed separately with regard to regulation?

Unfortunately, the members of this subcommittee were unable to meet to pursue these issues. HPC staff conducted a literature review on the topic of standards of care, which was distributed to the other subcommittees to assist in informing their discussions.

VI. RECOMMENDATIONS TO THE NEW MEXICO LEGISLATURE

A. FINAL SM 22 TASK FORCE RECOMMENDATIONS

The following are the recommendations agreed to by the entire SM 22 Pain Management Task Force. It should be noted that there was a good deal of controversy about some of these issues, and that final recommendations were reached through the hard work, open communication and willingness to compromise of all the members of the Task Force. As befits a group this large and diverse, considering such a wide array of issues, these recommendations cover a broad range of changes the Task Force thinks need to happen to improve pain management in New Mexico, and include, but are not limited to, potential actions by the Legislature. It should also be noted that the NM Board of Medical Examiners (BME) has already taken several steps to respond to the concerns raised by the SM 22 Task Force, and these steps are highlighted below. (* All recommendations that refer to or are related to the JCAHO guidelines are marked with an asterisk.)

- **AMEND PAIN RELIEF ACT**
  - A policy statement should be developed as a preamble to the Pain Relief Act stating the following: "Every New Mexican shall receive appropriate treatment for pain."
  - The NM Board of Medical Examiners will be responsible for establishing acceptable pain management guideline standards that will remain applicable to all regulatory boards appropriate to prescribing providers until such time as those boards establish their own guidelines for pain management. The Pain Relief Act should be amended by adding the following language to Section 24-2D-2 Definitions, part A., "accepted guideline: or guidelines established and accepted by licensing boards appropriate to other prescribing providers."

- Amend the Pain Relief Act, Section 24-2D-2, Definitions, part F., from "intractable pain" to simply "pain."
- Amend the Pain Relief Act, Section 24-2D-3, Disciplinary action; evidentiary requirements, to remove language, part A., "if no currently acceptable guidelines are available, rules" from the statute.
- See also "Board of Medical Examiners Basis for Disciplinary Action," below.
- See also "Board of Medical Examiners Guidelines for Prescribing for Pain," below.

- **STATE ADVISORY COUNCIL ON PAIN MANAGEMENT**
    - An interdisciplinary council comprised of health care consumers, health professional boards, providers, educators and health plans, should be established to institute pain management education for all health care professions as well as consumers, and to advise boards as to appropriate educational requirements and competencies for each discipline. This organization, known as the State Advisory Council on Pain Management, should be located within the Governor's Office. The Advisory Council shall be responsible for instituting statewide education efforts concerning the diagnosis and treatment of pain, including, but not limited to:

        - Health care professionals:
            - Medical School Curriculum (see recommendation below.)
            - Continuing Medical Education for health professionals (see recommendation below.)
            - Community based programs (e.g., promatoras, community health workers, SET, personal care, advocacy groups) to develop and implement a pain management curriculum for consumers on how to describe and communicate with providers about pain.

- Health providers should consistently consider pain as the standard 5th vital sign assessment throughout a patient's care, either as an outpatient or in-patient, giving patients the opportunity to talk about their pain if they have any.

- Health providers should be sensitive to patients who may have difficulty expressing their pain due to a developmental or other disability.

- Consumers:
  - Consumer access to pain management information and treatment may be dependent on many variables, such as: a patient's ability to verbalize her pain, cultural differences, a health provider's sharing of information and asking the appropriate questions, the amount of information given in informational pamphlets or health plans, consumer understanding of legal rights for appeal and financial ability to pursue an appeals process. Educating consumers on pain management care is necessary to reduce or control pain. The Advisory Council shall take on a leadership role to plan and conduct an educational program to encourage and instruct consumers/patients in understanding and describing pain with the particular focus on:

    a) The expectation that the consumer/patient will be able to describe his/her pain.

    b) Accurate observation and description of pain.

    c) Consideration of the consumer/patient's orientation such as, but not limited to, values, religion, philosophy, habits of thinking, personality, attitude, prior education, expectation,

fear of illness, support system or lack thereof.

d) The language of pain, including different domains with a wide range of descriptors and recognition of related conditions such as sleeplessness, discomfort, etc. This language of pain should be taught at an early age, so that children may become adults who can articulate their pain. Teachers and parents should be included in this training.

e) The rationale and significance, as well as the techniques of vital signs, with pain being the fifth vital sign.

f) The right to receive information and monitored treatment without fear of becoming addicted.

g) The Advisory Council should be responsible for developing model language concerning pain management as required by JCHAO that can be added to existing Patient Bill of Rights documents.*

- **UNDER-TREATMENT OF PAIN**
  - The Task Force finding that it is necessary to create a positive legal duty to effectively treat pain and suffering: Doctors (MD, DO, DMD, DPM, nurse specialists, etc) have the duty to effectively treat the pain and suffering of a patient. Under-treatment for pain as well as over treatment will be considered cause for disciplinary action. This information should be marketed to providers and applicants by licensing boards and professional associations, and it should be made clear to providers that complaints of under-treatment by providers will be investigated and disciplined as rigorously as those for over treatment. This position assumes that a Board-recognized standard of care exists.
    - Recommendation: All boards that have authority over health care professionals and/or providers who administer and/or distribute

controlled substances shall include language in their practice act that makes clear that under treatment for pain is grounds for disciplinary action. This recommendation for statutory change should be put into effect by each board this year at Sunset Review.

- **NOTE:** *BME has already addressed this recommendation by including this language in its proposed 2003 changes to the Medical Practice Act. No other boards have done so, however.*

- **HEALTH PLAN COVERAGE**
  - The Superintendent of Insurance shall assure that both private and public health plans make their policies and provisions regarding coverage of pain treatment and management easily understandable and available to all consumers.

- **PATIENT BILL OF RIGHTS**
  - All public and private health care providers and health plans should have a Patients Bill of Rights, should assure that it includes the right to effective pain management. These Bills of Rights should be posted in health care facilities and offices where appropriate, included in health plan literature, and made easily available to consumers.*

- **PATIENT NOTIFICATION**
  - Patient Education requirements should be included in practice guidelines and should state that the patient has the right to receive pain treatment. Practice guidelines should require a formal process by which this information is provided to the patient. All boards should add the required pain management patient notification by providers the practice act at sunset review.*

- **CONSUMER ADVOCACY**
  - Existing appropriate consumer advocacy groups are encouraged to address the issue of pain management, and to provide information and support to health care consumers. These organizations are also encouraged to advocate on the issue of pain management, and to help consumers with informal legal issues and concerns, particularly when a consumer may have little or no financial means to pay for legal fees stemming from appeals.

- **MEDICAL SCHOOL CURRICULUM**
  - All health care and allied health care professionals meet a level of competency in the diagnosis, causes and treatment of pain. A minimal amount of time in professional schools must be mandated for the subject of pain management. The Task Force recommends that all healthcare educational and training schools redesign their curricula to prepare their students to be competent in the "Basic Learning Issues" (attached document) to the degree appropriate to their practice. The discretion of each professional discipline should be used to suggest that this subject be more or less a greater portion of their curriculum.

  - The Joint Commission of Hospital Accreditation has recently begun requiring that patients be asked about pain as well as having their pain treated. The Task Force urges that this initiative become a requirement in all medical settings.*

  - Information about pain and pain management should be readily available. The Task Force recommends that professional libraries have special sections concerning this topic.

  - The Task Force recognizes that each discipline will apply these learning issues differently. It is not the intent of this Task Force to "prescribe" curriculum. However, we would encourage the incorporation of these learning

issues into curricula such that every practitioner is able to demonstrate pain management competence (not just knowledge) within the scope of his/her practice.

1. Pain history interviewing:
    1. Know how to ask questions about pain symptoms in a manner that considers the cultural background of the patient.
    2. Distinguish the types of pain by history.
    3. Understand the physical/psychological/age issues that influence the reporting of pain.
    4. Understand the psychosocial/spiritual issues that influence the reporting of pain.
    5. Understand the issues in confronting abuse of opioids, when interviewing a person. These include:
        a. Use, misuse, abuse, dependence, addiction including abstinence vs. sobriety
        b. Pseudo-addiction [13]
        c. Iatrogenic dependence
        d. Diversion
    6. Comprehend the concept of total pain.

2. Pain level scoring:
    1. Obtain from the patient a pain score using a tool that is specific for the patient's group (pediatrics, adult, mentally impaired).

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[13] Pseudo-addiction refers to" patient behaviors that may occur when pain is under-treated. Patients with unrelieved pain may become focused on obtaining medications, may clock-watch and may otherwise seem inappropriately "drug seeking." Can be distinguished from true addiction because the symptoms resolve when the pain is effectively treated. Pseudo-tolerance is the need to increase dosage not due to a heightened tolerance, but rather due to disease progression, drug interaction, new disease, or other factors. (Partners Against Pain. *Understanding Key Terms in Pain Management.* Available at : www.partnersagainstpain.com)

2. Use this tool to assign a numerical number to the level of (pain as the 5th vital sign).
3. Record the above in the patient's medical record.

3. Common treatment approaches to pain:
   1. Monitor response to drug treatments.
   2. Utilize non-pharmacological treatments.
   3. Offer appropriate and timely referrals to specialists in pain management.
   4. Work on an interdisciplinary team.

4. Pharmacology of pain treatment:
   1. Understand analgesic classification.
   2. Identify routes and appropriate use of analgesics.
   3. Understand the pharmacokinetics of common analgesic agents including absorption, distribution, metabolism and excretion.
   4. Recognize and treat common adverse reactions.
   5. Use an equivalent dose regimen for the opioids.
   6. Understand the principles of "opioid rotation."
   7. Understand the common side effects of the opioids and the approach to their treatment.

5. Legal issues:
   1. Understand the Federal and State laws regulating the use and distribution of controlled substances.
   2. Understand how the State Board of Pharmacy acts as a resource in identifying substance misuse and diversion.
   3. Understand the mission of licensing Boards, the enforcement of their respective Practice Acts, their reporting procedures and their willingness

to assist licensees who find themselves in trouble with controlled substances.

- **CONTINUING MEDICAL EDUCATION**

  CME requirements in pain management should be developed for all prescribing providers, and be required for obtaining /maintaining licensure for physicians, nurses, pharmacists and dentists. These CMEs should be based on an interdisciplinary concept of educating providers and applied to appropriate providers at the discretion of each licensing board. Licensing boards should recognize that concerns of patient well-being must out weigh the concerns of the provider.

  The Task Force recognizes that there is a need for the flexibility of the licensing boards with regard to mandating and enforcing these requirements. Being aware that too many educational mandates may increase the cost to the State and limit the flexibility of individual license holders and of the licensing agency, individual boards should determine which of their providers would require this education and establish requirements and procedures for assuring compliance.

  The members of the Board of Nursing have taken no formal position on discontinuing the continuing education requirement. An advisory committee to the board, the Nursing Practice Advisory Committee has been discussing the issue of the continuing education requirement. A majority of state Boards of Nursing across the country has discontinued this requirement for continued licensure since it has been demonstrated that continuing education does not assure continuing competence. The advisory committee has made no formal recommendation to the Board of Nursing at this time.

The SM 22 Task Force recommends that:

1. Educational programs should be implemented by the health professional licensing boards with regard to current pain management standards, accepted guidelines and regulatory policy.

2. The Boards of Medicine, Nursing and Pharmacy should require that each applicant for re-licensure in New Mexico have a minimum of training in pain management. Boards should have the flexibility to determine number of training hours as appropriate for each profession.

3. Pain management curriculum should be mandated in State-supported health professional programs: Schools of Medicine, Pharmacy, Nursing, PA and Allied Health. State-supported health professional programs should include interdisciplinary education programs that address legal and regulatory issues concerning pain management.

4. Intensive educational programs in pain management be conducted for State medical, pharmacy, nursing, allied health board members, staff, attorneys and investigators to update their knowledge and views about pain management including under-treatment and review of regulatory policy.

- **BOARD OF MEDICAL EXAMINERS GUIDELINES ON PRESCRIBING FOR PAIN**
    - Review, update and replace if necessary, the New Mexico Board of Medical Examiners Guidelines on Prescribing for Pain, (1996) with current national guidelines. The use of an open, inclusive, ongoing annual process to review evolving pain relief national standards of care and guidelines for pain management (public input, interdisciplinary committee review, public hearing, periodic review) by the Board of Medical Examiners.

- This Task Force is very pleased that the Board of Medical Examiners has taken the steps to institute an annual review of national standards for pain management for rule making on guidelines for pain management. Language establishing annual responsibility for the process within the Board procedures should be added by amendment to the Pain Relief Act.
  - **NOTE:** *BME has already addressed this recommendation by proposing a new rule, titled Management of Chronic Pain with Controlled Substances, 16.10.14 NMAC.*

- **BOARD OF MEDICAL EXAMINERS BASIS FOR DISCIPLINARY ACTION**
  - Proposed changes to the Pain Relief Act with regard to Section 24-2D-3 Disciplinary Action: evidentiary requirements should include:

  A. No medical prescribing decision may proceed a notice of contemplated action solely based upon any of the following:

  1. Patient characteristics: age, diagnosis, prognosis, history of drug abuse;
  2. Lack of consultation to pain specialist; or
  3. Quantity of medication prescribed or dispensed.

  B. The Board(s) will judge the validity of prescribing based on the health care professional's treatment of the patient and on available documentation, as well as on the quantity and timing of prescription. The goal is to control the patient's pain for its duration while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors

- **BOARD OF MEDICAL EXAMINERS ADMININSTRATIVE PROCESS FOR DISCIPLINARY ACTION**
  - When appropriate, the practitioner should be contacted prior to beginning a Board investigative process and prior to any legal action by the Board. When appropriate, the Board should provide a process in which initial contact is in the form of an informal peer review committee and provider monitoring, followed by a process of rehabilitation and education, upon sufficient investigative findings by the peer review committee, and prior to initiating a legal action to discipline.
  - To address issues concerning what may be perceived as potentially unfair practices in the administrative practices of disciplinary actions by the Board of Medical Examiners, it should be considered that as an alternative course of action that the State may provide independent federal and administrative law judges would hear professional licensing cases.

- **PHYSICIAN EXPENSES IN DISCIPLINARY ACTIONS – AMEND UNIFORM LICENSING ACT AND MEDICAL PRACTICES ACT**
  - Section 61-1-4(g) of the Uniform Licensing Act should be repealed.
  - Section 61-6-15(f) of the Medical Practices Act should be repealed.
    - **NOTE:** *BME has already addressed this recommendation by including this language in its proposed 2003 changes to the Medical Practice Act.*

B. NEW MEXICO HEALTH POLICY COMMISSION RECOMMENDATIONS

The Commissioners of the NM Health Policy Commission applaud the work of the SM 22 Pain Management Task Force, and the thorough and comprehensive recommendations the Task Force has put forward. While the HPC has no additional recommendations, the Commission strongly supports all of the Task Force recommendations as presented, with one exception. Regarding the creation of a State Advisory Council on Pain Management, the HPC recommends that the enabling legislation for the Advisory Council include a clear sunset clause, and that the Advisory Council not be located within the Governor's Office.

APPENDICES

APPENDIX A: Senate Memorial 22

SENATE MEMORIAL 22

45th legislature - STATE OF NEW MEXICO - first session, 2001

INTRODUCED BY
Mary Jane Garcia

A MEMORIAL

REQUESTING THE NEW MEXICO HEALTH POLICY COMMISSION TO CONDUCT A STUDY, IN CONJUNCTION WITH THE NEW MEXICO BOARD OF MEDICAL EXAMINERS, THE BOARD OF NURSING AND THE DEPARTMENT OF HEALTH ON PAIN MANAGEMENT, AND TO REPORT ITS FINDINGS TO THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE.

WHEREAS, many people experience severe pain and suffering not only when close to death but also chronically over a period of time and throughout an illness; and

WHEREAS, patients may not receive appropriate and consistent pain management and may, as a result, suffer episodically or chronically; and

WHEREAS, medical and nursing schools have only recently begun to create or expand training and practice programs to address the needs of patients suffering from severe acute or chronic intractable pain; and

WHEREAS, health care professionals have legitimate legal and ethical concerns about what constitutes adequate pain management; and

WHEREAS, patients have legitimate fears about addiction or side effects due to pain management therapies; and

WHEREAS, it is the policy of the state to improve the quality of life and to assure that basic health services are available, accessible and acceptable; and

WHEREAS, the purpose of the New Mexico health policy commission is to provide a forum for the discussion of complex and controversial health policy and planning issues and for the creative exploration of ideas, issues and problems surrounding health policy and planning;

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE OF THE STATE OF NEW MEXICO that the New Mexico health policy commission, in conjunction with the New Mexico board of medical examiners, the board of nursing and the department of health, conduct a study on pain management with particular focus on:

A. a patient's right to be informed about and receive pain management therapies;

B. the incidence of under-treatment of pain and the necessary education and training for health care professionals to provide an adequate and appropriate level of treatment;

C. the guidelines provided by the New Mexico board of medical examiners and the board of nursing; and

D. the ability of a health care professional to defend himself and to recover costs when wrongly disciplined or prosecuted for providing an appropriate level of pain management that may exceed a board's guidelines; and

BE IT FURTHER RESOLVED that the New Mexico health policy commission present its findings and recommendations to the legislative health and human services committee by October 1, 2002; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the New Mexico health policy commission, the New Mexico board of medical examiners, the board of nursing, the department of health and the legislative health and human services committee.

APPENDIX B: SM 22 Task Force Members

Stephen Abram, MD	UNM Department of Anesthesia
Josephine Arguello	UNM HSC – PERT Project
Debbie Armstrong	NM Agency on Aging
Mike Batt	NM Division of Insurance
David Bennahum, MD	UNM HSC – PERT Project
Wanda Borges, RN , CNP	Memorial Medical Center
Maureen Boshier	NMHS
Debra Brady, RN	NM Board of Nursing
Annette Brooks Ph.D.	Veterans Administration Medical Center
Marvin Call, MD	
Carol Capitano	UNM SALUD
Sister Linda Chavez	S.E.T.
Angela Corbett	Purdue Pharma
Kris Coughenour	Sandia Hospice
Virginia Crenshaw	Consumer
Andra Davis, RN	St. Joseph Health Services
Rena DiGregorio	NM Hospital & Health Systems Association
Virginia Doucet	Las Vegas Medical Center
Katherine Esterheld, RN	Sandia Hospice
Walter Forman, MD, FACP, CMD	UNM HSC – PERT Project
Susan Fox RN, PhD	UNM College of Nursing
John Flores, MD	Memorial Medical Center
Gary Frank, MD	St. Vincent Hospital
Mary Jane Garcia	NM State Senate
Pat Gaylor	DOH Office of Facility Management
Mary Louise Giron	AARP
Joie Glenn	NM Association for Home Care
Christine Glidden	New Mexico Board of Medical Examiners
David Goldstein, MD	Four Corners Ambulatory Surgery Center
Marily Griffin	Presbyterian Home Health Care
Linda Grisham	New Mexico Division of Insurance
Robin Hermes, MD	
Gail Hitson, RN	Memorial Medical Center
Mary Hoke, MD	NMSU Department of Nursing
Katherine Huffman	NM Drug Policy Institute
Allen Hurt	NM State Senator
Jim Jackson	New Mexico Protection and Advocacy Systems
Dan Jaco MA, MSPH	New Mexico Medical Review Association
Joe Jimenez	Purdue Pharma
GTS Khalsa	New Mexico Board of Medical Examiners
Charlotte Kinney	New Mexico Board of Medical Examiners
Karen Kinsman	New Mexico Health Care Association
Judith Kitzes, MD	UNM HSC
Allison Kuper	Senate Majority Leadership Staff

SM 22 Task Force Members, cont.

Grant LaFarge, MD	New Mexico Board of Medical Examiners
Harvey Licht	NM DOH
Michelle Lujan Grisham	NM Agency on Aging
Aroop Mangalik, MD	UNM Cancer Center
Randy Marshall	New Mexico Medical Society
Randy Mayhew, MD	
Barbara McAneny, MD	UNM School of Medicine
Joe Menapace	NM Dental Association, Government Liaison
Mary Merrill, RN	NM Board of Nursing
Jerry Montoya	NM Board of Pharmacy
Maryanne Morelos, RNC	UNM College of Nursing; HPC Contractor
Julie Murley	ENMSU
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Ellen Pinnes	Consultant
Fred Pintz, MD	DOH Office of Facility Management
Phyllis Ratliff, RN	NM Board of Nursing
David Roddy	NM Primary Care Association
John Romine, MD	New Mexico Board of Medical Examiners
Paul Roth, MD	UNM Health Sciences Center
Brandon Rotty	
John Saiki, MD	UNM Cancer Center
Rob Schwartz, PhD	UNM Law School
Glenn Smith	NM Office of the Attorney General
Ginger Stubbs, RN	ENMMC
Don Trigg	NM Office of the Attorney General
Cesar Velarde, MD	Memorial Medical Center
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APPENDIX C: HPC Prescription Drug Access Survey Methodology and Responses

Survey interviews were conducted using a computer –assisted telephone interviewing system. 15% of all respondents reported having chronic pain.

The survey methodology was conducted as follows:

- Sample size: 2500
- 250 Pre-test interviews
- Sample stratified at county level
- Each of 33 counties represented according to population share
- Random Digit Dialing
- Published and unpublished numbers

The survey collected data on:

- Measurement of respondents seeking care for chronic pain.
- Measurement of those respondents who reported receiving a prescription drug as treatment for chronic pain.
- A measure of the effectiveness of that treatment.

Responses to Chronic Pain Questions

NMHPC Drug Access Study

Question: Have you been able to get prescription medications for the chronic pain?

			Cumulative	
Med for Pain	Frequency	Percent	Frequency	Percent
Yes 1	296.8519	82.20	296.8519	82.20
No 2	46.43735	12.86	343.2893	95.05
Don't Know 3	14.30092	3.96	357.5902	99.01
Won't Say 4	3.564487	0.99	361.1547	100.00

Question: Did the prescription medication you were prescribed adequately control your pain?

			Cumulative	
Med Control Pain	Frequency	Percent	Frequency	Percent
Always 1	70.47276	23.74	70.47276	23.74
Sometimes 2	194.6514	65.57	265.1241	89.31
Never 3	29.20364	9.84	294.3278	99.15
Don't Know 4	2.524174	0.85	296.8519	100.00

Frequency Missing = 64.302749295

APPENDIX D: HPC Site Survey Methodology and Results and Select Questions and Responses from the Las Cruces Study

I. HPC SITE SURVEY

Methodology

A selective survey sample was designed to represent major healthcare systems within Albuquerque and the surrounding areas. A total of 26 sites were surveyed including the Albuquerque Area Indian Health Services facilities and Veteran's Hospital Systems. The survey sample was stratified to include all 4 geographic areas of the state and major centers in surrounding counties. Face to face interviews were conducted with management level staff and direct service providers by a single interviewer adhering to the standard questions. The same interviewer was used for each site survey and adhered to the standard questions developed by the surveyor and reviewed by the project manager**.** Although chemical dependency units (CDUs) and facilities were included in the survey, for the purpose of data analysis they were not incorporated into the statistics. Pain assessment has only recently received priority in the creation of institutional care standards, and CDU's would not be expected at this time to meet or surpass other health care facilities efforts at compliance.

Analysis of Survey Questions and Findings

The following is a summary of the findings and the intent of the questions, as well as an examination of the existing data made available for the purposes of supporting a possible incidence of under-treatment in the state.

Question: Does the Institution have a written standard of pain management?

Question one examined the institution's possession of a written standard of pain management including assessment, planning, intervention, and evaluation

The respondents replied: 56% yes, 9% no, and 35% in process. The response of in process indicates that the institution is in the process of researching, developing, approving or implementing an institutional standard of pain management.

Question: Are there documented unit specific policies on pain management?
Question 2 examines whether the standard of care in place is generic or unit specific. Unit specific policies are not a JCAHO requirement and frequently may not provide for assessment of every client admitted to the institution. In some cases, such as out patient areas, unit specific policies may be required in addition to the institutional standard as the means for planning, intervention, and evaluation may differ from the rest of the institution. Respondents in 26% of the institutions had unit specific policies, 22% did not, 13% were in process, the question was not applicable to an additional 39%. The not applicable response refers to the fact that unit specific policies were unnecessary.

Question: Is the staff trained on pain management, inclusive of practitioners?
Question 3 is an inquiry into whether or not the staff both clinical and medical has been specifically trained in pain management. Institutions responded that for the clinical staff (nursing and disciplines other than medicine), 44% had received some type of training in pain management, 26% had not, and 39% of institutions were in process of creating, or providing education on pain management. For the medical staff 35% of the respondents had received specific training in pain management, 39% had not, and only 36% were in the process of educating the medical staff.

Question: Are clients informed of a treatment standard in writing?
Question 4 addresses the issue of informing clients of the pain treatment standard for the institution or unit in writing. Of those surveyed, 48% of institutions are providing a written form of the standard to clients, 26% are not, and 26% are in process of developing a written version of the standard for clients. Most institutions responding yes to providing a written standard do so through a statement of patient rights.

Question: Is there a standard method of client pain evaluation and who is responsible?

Question 5 refers to whether or not there is a standard measurement used for assessment of pain by all staff. The most common measurements utilized for this are a standard analog scale consisting of a 1-10 rating assigned to pain by the client with a rating of 1 as the least severe and 10 as the most severe. In addition to this measurement, the Wong-Baker Faces Scale is most commonly used by institutions and physicians surveyed for both children and clients who are unable verbally to assign pain a numerical rating. Other measurements cited for use were a visual analog scale, the FLACC (face, legs, activity, cry, and consolability) scale is used in some institutions and is designed for use in neonates, pediatric patients <3years of age, and cognitively impaired adults. While most all respondents use one or both of the most common measurements for pain, not all reported their use as standard. In particular, physicians or practitioners reported not having a standard measure identified for use in assessment. Respondents answered 87% yes to having a standard measurement, 4% no, and 9% were in the process of standardizing a tool. This question also intended to address who is responsible for the initial client assessment and follow up assessments. The responsibility for assessment was designated 65% RN, 13% an MD or RN, 9% by the MD, 4% by the RN or other clinical staff such as physical or occupational therapists, 5% did not identify responsibility for assessment and 4% are in the process of identifying responsibility.

Question: Who is responsible for the pain management treatment plan?

Question 6 serves to identify responsibility for a treatment plan once pain is assessed as a problem. Planning for clients with pain is identified as the responsibility of 22% RN, 35% by an interdisciplinary team, 35% solely by the MD or in collaboration with an interdisciplinary team, and 13% were in the process of designating responsibility for development and revision of the treatment plan. Approximately 70% of those surveyed have the pain treatment plan incorporated into the standard nursing care plan as opposed to a separate plan of care.

Question: Is there a standard documented method of treatment evaluation and who is responsible?

Question 7 refers to outcome measures, if any used to evaluate pharmacological or other interventions that demonstrate improvement or need for revision of the treatment plan. Most all respondents report that evaluation does occur. However, it is not necessarily occurring at standard intervals or by use of outcome measurement other than a client self report of improvement. It also serves to identify the primary responsibility for evaluation of outcome. Respondents replied that 61% use standard outcome measurements, 17% do not, and 22% are in process of developing or implementing standard outcome measurements for evaluation. The responsibility for evaluation rests 61% on the RN, 13% on the MD, and 9% on an interdisciplinary team evaluation. 13% of respondents are in the process of designating responsibility and 4% did not identify responsibility.

Question: Who assumes care upon discharge and who is responsible for discharge teaching and referrals? Is the family included in this process?

Question 8 inquires as to the assumption of care upon discharge, inclusion of the family in the discharge process, and responsibility of education on pain management. The focus of discharge education is identified as continued assessment of effective treatment, the plan of care at time of discharge, and any follow up or referrals indicated. Respondents report that if discharged from service, clients are returned to the referring primary care physician (PCP). Frequently clients may be referred to an identified pain management specialist for the sole purpose of collaboration on their PCP's existing treatment plan or for the failure of treatment previously attempted by the PCP. Often, clients who are unable to achieve pain relief in the care of the PCP are referred with the expectation of long-term treatment assumed by the pain management specialist. 100% of respondents report resumption of care by the PCP upon discharge, with consultation as needed. 100% of respondents report inclusion of the family in education. However, less than 50% of respondents actually have required family involvement as a standard. The primary factor identified as affecting family involvement is availability at the time of discharge. The

responsibility for discharge education is assumed 39% by the RN, 30% by the interdisciplinary team, and 13% the sole responsibility of the MD. 13% of respondents are in the process of delegating written responsibility and 5% did not identify responsibility.

Question: Are there institutional requirements of continuing education in pain management for all staff?

Question 9 addresses institutional requirements of education in pain management for the healthcare professional. In general, most all institutions use OSHA guidelines for educational requirements for infection control and safety. Some institutions have additional requirements for HIV education and other areas such as child abuse and neglect reporting. These requirements may be met upon employment or annually. For clinical staff respondents replied that 26% do require education on pain management, 39% do not currently, and 35% are in process of developing or implementing required education in this area. For the medical staff, only 9% reported requiring continuing education, 74% do not currently, and 17% are in the process of requiring this. None of the respondents reporting no current requirement in this area have a plan to make this a requirement.

Question: Does the institution provide continuing education in this area?

Question 10 refers to the provision of ongoing education in pain management by the institution. This could be through continuing education units (CEU's) for clinical staff or continuing medical education (CME) offerings. For clinical staff, respondents reported 48% do provide CEU or other offerings, 17% do not, and 26% are in process, and 9% have provided offerings of this type but not on a routine basis. For medical staff, 35% report provision of CME, 17% do not, 22% are in process, and 26% periodically but not routinely provide this type of CME. Frequently, the surveyed healthcare professional trained in pain management was found to be providing the education for the institution.

Question: Is there a documented delineation in management of acute vs. chronic pain?

Question 11 refers to the presence of a documented delineation between the presence of chronic or acute pain management. This is evident when treatment is for an acute injury or in post-operative care. However, the focus of this question was on the assessment and planning for pain management. Of those surveyed, 57% demonstrate a documented difference between the assessment of and planning for pain that is chronic or acute in nature, 26% do not, 13% are in process, and 4% were not applicable. The 4% designated as not applicable refer to the fact only clients with chronic pain would be treated, negating the need for delineation.

Question: Is the client informed of recourse on inefective pain management?

Question 12 reflects provision to the client in writing of their recourse and responsibility should management of their pain be ineffective. Of institutions responding yes, this provision may be in the form of the statement of patient rights, postings in patient areas, and/or in admission packets or paperwork. 65% of respondents provide the client awareness of recourse, 17% do not, and 18% are in process of developing or implementing this type of provision.

Question: Are there quality assurance efforts in this area?

Question 13 sought to identify the percentage of institutions with quality assurance monitors in place for pain management. Greater than 50% of those surveyed report use of patient satisfaction surveys at or after discharge that include at least one question on pain management. There are many institutions using standard patient satisfaction surveys developed in-house or by outside agencies. The intent of this question was to examine the methods being utilized to monitor assessment, planning, intervention, and evaluation of pain management that would reflect compliance with current JCAHO or other accrediting organizations' standards. Therefore patient satisfaction surveys were not included as monitors. 26% of respondents report quality assurance monitors in place,

22% do not, and 52% are in process of developing or implementing quality assurance monitoring.

Question: Are there educational resources available for clients?

Question 14 relates to client access to educational information on pain management. Such information would include education on the etiology of various types of pain, available treatment and/or medications, the difference in drug dependence vs. addiction or tolerance and expected outcomes of treatment. The range of educational information varies by those institutions having learning centers or library materials available to clients, and those providing standard pamphlets, books, or video materials for client use. 35% of respondents do provide clients with educational materials, 26% do not, and 39% are in process of developing these resources for clients.

Question: What is frequency of client litigation related to this area?

Question 15 refers to the known presence of litigation relating to either under-treatment or over-treatment of pain. Only 9% of those surveyed report knowledge of any litigation previously or currently pending. One of the current cases relates to over-dosage with medication and it is not known if this was a medication error or is the result of inappropriate treatment.

Question: Is there required reporting on the methods and evaluation of pain management? If so, to whom? Frequency?

Question 16 reflects the dissemination of compiled quality assurance monitoring data within the institution and the frequency of this reporting. 17% of those surveyed report there is required reporting of this data, 31% do not require reporting on this data or do not compile this data, and 52% are in the process of requiring reporting. Of those currently reporting or in process of mandating reporting, 100% replied that reporting is or will be done on a quarterly basis. 100% of those currently reporting on this data make reports to

the Chief Medical Officer, Chief Nursing Officer, and/or some type of executive committee for review.

Question: Is the institution familiar with the new JCAHO standards that include initial assessment, regular re-assessment, provider, client education and pain assessment of all patients?

Question 17 pertains to knowledge of the new JCAHO standards released in 2000 and affecting institutions surveyed after the January 1, 2001. 91% of respondents including those not accredited by JCAHO reported awareness of the new standards. Only 9% report that they are still in process of obtaining information regarding the new standards and none reported not having knowledge of their release.

Question: What is currently being done to meet compliance for the standards?

Question 18 refers to the current institutional activities regarding pain management as well as the rationale for them. 70% of institutions report that most all activities currently ongoing or accomplished are a direct result of the release of the standards. 9% report being in process of developing activities to meet compliance and 21% report that the standards are not applicable to their institution or organization.

Question: Are there any current studies being done within the institution and any aggregate data available?

Question 19 sought to identify the existence of any data that could be used to support an incidence of under-treatment of pain within the state. 9% of those surveyed reported any existing data, 9% reported current ongoing or anticipated data collection and 82% reported none.

II. SELECTED QUESTIONS AND RESPONSES FROM THE LAS CRUCES STUDY

The survey done by Wanda Borges, RN, Clinical Nurse Specialist, at Memorial Medical Center in Las Cruces utilized a written survey instrument, and included a survey sample of 74 MDs, 9 Advanced Practice Nurses, 203 RNs, and 10 Pharmacists. The following are a selection of the true-false questions and the percentages of MDs, Advanced Practice Nurses (APNs), RNs, and pharmacists (RPhs) answering the questions correctly.

Question: Patients can sleep in spite of moderate or severe pain. **Correct answer**: true
Percent answering correctly: MDs-53% APNs-44% RNs-56% RPhs-50%
Question: If the patient can be distracted from the pain, he or she does not have as high intensity from the pain as he or she reports. **Correct Answer:** False
Percent answering correctly: MDs-68% APNs-89% RNs-75% RPhs-90%

Question: Opioids (narcotics) act on the central nervous system to decrease the perception of pain, whereas non-opioid analgesics, such as aspirin, act on the peripheral nervous system to decrease the transmission of pain impulses. **Correct answer:** True
Percent answering correctly: MDs-66% APNs-78% RNs-72% RPhs-30%
Question: If a patient's pain is relieved by the administration of a placebo, the pain is not real. **Correct Answer:** False
Percent answering correctly: MDs-16% APNs-100% RNs-83% RPHs-100%

Question: Beyond a certain dose, increases in the dose of an opioid (narcotic) analgesic, such as morphine, will not increase pain relief. **Correct answer:** False
Percent answering correctly: MDs 58% APNs 44% RNs-44% RPhs-80%
Question: When opioids (narcotics) are used for pain relief in the following situations, what percent of patients are likely to develop opioid (narcotic) addiction?
Correct answer for all 3 situations: <1%
Situation & percent answering correctly:

a. all patients – overall MDs-58% APNs-56% RNs-68% RPhs-60%

b. Pts. who receive opioids 1-3 days MDS-80% APNs-56% RNs-72% RPhs-90%

c. Pts. who receive opioids 3-6 months MDs-13% APNs-22% RNs-12% RPhs-20%

APPENDIX E: Findings And Recommendations Of The Subcommittee On A Patent's Right To Be Informed And Receive Pain Management Therapies

Charge to this committee by Senate Memorial 22:

Question 1: Do New Mexicans have access to financial means, appropriate providers, and education necessary to obtain adequate treatment for chronic pain? Including:
a) Do all health plans in the state *(e.g.,* individual*,* state employee health plans, Medicaid and managed care organizations*)* provide coverage for pain management?
b) Do all health plans in the state offer access to specialists, hospice and home care?
c) How is information about pain management coverage provided to consumers)
d) Does Medicaid cover pain management, regardless of the diagnosis?
e) What resources are available to the uninsured or those who don't have coverage?

Question 2: How are patients informed as to the treatment standards and options by providers?

Question 3: How are patients informed of their rights with regard to pain management?
a) What appeals processes are available?
b) What avenues are available to patients?

Question 4: How can consumers become educated in describing pain to their health practitioners?

Several means were taken to address the questions, including: a review of videos demonstrating interviews with people living with chronic pain and how they are managing their pain; inviting a legal representative to address appeals processes and legal avenues consumers may take in relation to their medical pain management; a review of seven New Mexico health plans to determine levels of pain management coverage; inviting the HPC economist to discuss the questions relating to access to chronic pain medications being asked on a Pharmaceutical Drug Cost study. Additionally, committee members shared brochures, articles and other information that are used to provide consumer information on patients' rights on pain management. One of our members provided a perspective on the bureaucratic channels that the average consumers must often go through to get the information they need to even begin getting the help they think they may need.

Findings

I. Relating to Question 1

The committee wanted to find out several things from New Mexico health plans:

- Is pain assessment and management mentioned as part of health plan coverage?

- Are alternative services, such as acupuncture, chiropractic, massage, offered for patients seeking pain relief other than or complementary with conventional methods?

Seven health care plans were evaluated to determine coverage for pain management. "Pain management" as a category was not specifically identified in any of the health plans in terms of allowable medication or service.

All health care plans emphasized that they covered "medically necessary" care. A health plan may decide that a service is not "medically necessary" even though the patient's physician has recommended that service. Some plans will only cover the costs of medical treatments and medicines "that have been shown to work."

Acupuncture and chiropractic services to alleviate pain on a short-term basis with annual capped financial coverage were offered by three health care plans. Two plans excluded acupuncture and chiropractic services. One health plan listed acupuncture as an excluded service. One health plan offered a whole package of alternative services as a longer-term coverage.

There are various degrees of coverage within each health plan and this committee reviewed only the Basic Coverage Plans. Due to shortage of time, the committee was unable to go back and ask the private health plan contact persons if such "pain management" coverage is available. According to the Medicaid Salud information found on the Medicaid website, managed care organizations "must ensure that members have adequate access to specialty services", include "home health services" and include "hospice services." Basically, without going into further research, the Medicaid eligibility criteria limit such services to pregnant women, children, disabled persons, the elderly, and to those meeting certain income criteria.

According to the New Mexico Division of Insurance and Human Services Department (HSD) SALUD representatives, there have not been any complaints about the lack of access to pain care. The Insurance Division stated that while there have been complaints about lack of access to specialists; those haven't dealt with treatment of pain. Likewise, HSD reported that there has historically been a shortage of specialists, which subsequently results in long waiting periods to receive care. There have been no complaints regarding access to hospice or homecare by either agency.

It is difficult to determine how consumers receive information and the type of information regarding pain management without hard data. Other than anecdotal information, there is little more that this committee can provide. However, Mr. Jackson, based on his professional experience working with Protection and Advocacy, provided information on the challenges, bureaucratic and otherwise, that consumers face when trying to get assistance for pain management or other medical issues. The full report is found in the attachments of this report. In summary, newly-diagnosed pain management

consumers should be well equipped to have information and knowledge on availability of services and coverage through their insurance plan or other means, understanding how to present their case to health providers, seeking support from advocacy or self-help groups, and the bureaucracy. Unfortunately, this is rarely the case.

Community Health Clinics, Public Health Clinics, University Hospital and emergency rooms treat patients regardless of ability to pay. The treatment may be for acute diagnosis only, and rehabilitation or follow-up may not always be available. County Indigent Funds may be available to provide coverage.

II. Relating to Question 2

Without a survey and further research, the committee cannot determine what treatment options are available to consumers, and if consumers are being given that information. Based on anecdotal evidence and the experience of members on this committee, the belief is that patients may not be getting the information they need.

III. Relating to Question 3

According to our legal issues speaker, appeal avenues are there for consumers, but a barrier may be financial access. Lawyers, legal proceedings and other fees may be the financial responsibility of the consumer. In which case, consumers may choose not to press the issue if they feel they cannot afford to do so.

The Health Plans reviewed by this committee offer similar consumer options for processing a complaint. The amount of detail given in the health coverage handbooks varies.

All but three health plans specify strict deadlines, or windows of opportunity, to file complaints and begin grievance processes. Generally, an internal review process is available for clients to take their complaints. External review is not mentioned in two Health Plans but this does not mean it is not available.

Four health plans specifically state that clients are responsible for hiring and paying for personal legal consult. Some plans will charge their clients for administrative tasks and any research that they must do on the perceived complaint issue.

IV. Relating to Question 4

The committee recognizes the multiple challenges of pain management, including how consumers may describe their pain and health providers understanding or listening to the consumers' pain issues. Differences in cultural backgrounds, medical training on the assessment of pain, education, and awareness play a part in making pain management a difficult issue to handle.

The Joint Commission of Accreditation of Healthcare Organizations (JCAHO) has implemented standards of care in relation to pain management. The results of those pain management surveys may bring better documentation and understanding regarding the prevalence of pain and its management in the medical field. See attached for a copy of JCAHO's "Examples of Implementation."

Recommendations:

Consumer access to pain management information and treatment may be dependent on many variables, such as: a patient's ability to verbalize her pain, cultural differences, a health provider's sharing of information and asking the appropriate questions, the amount of information given in informational pamphlets or health plans, consumer understanding of legal rights for appeal and financial ability to pursue an appeals process. We offer the following recommendations to improve consumer access to pain management information and treatment.

1. Educating health providers and consumers on pain management care is necessary to reduce or control pain. Based on their previous experience and expertise in implementing successful health care promotional programs, we recommend that the New Mexico Department of Health take on a leadership role to plan and conduct an educational program to encourage and instruct consumers/patients in understanding and describing pain with the particular focus on:

   a) The expectation that the consumer/patient will be able to describe his/her pain;
   b) Accurate observation and description of pain;
   c) Consideration of the consumer/patient's orientation such as, but not limited to, values, religion, philosophy, habits of thinking, personality, attitude, prior education, expectation, fear of illness, support system or lack thereof;
   d) The language of pain including different domains with a wide range of descriptors and recognition of related conditions such as sleeplessness, discomfort, etc;
   e) The rationale and significance, as well as the techniques of vital signs, with pain being the fifth vital sign;
   f) The right to receive information and monitored treatment without fear of becoming addicted.

2. A consumer-oriented organization should be funded to provide information and support to health care consumers. The organization might also include advocacy and support to help with informal legal issues and concerns, particularly when a consumer may have little or no financial means to pay for legal fees stemming from appeals. The group would not have to focus only on pain management issues, but should include this expertise. A less desirable alternative would be to provide funding and responsibility for this purpose to a relevant, existing state agency. Funding could come from the state general fund, foundation support, and contributions from the health care industry, or some combination of the above. Client fees should be

avoided as a revenue source because they will significantly limit accessibility and utilization.

3. Providers and health plans should adopt a Consumer Pain Bill of Rights policy, post it where appropriate, listing contact names and numbers. This information should be widely provided by insurance plans, hospitals, health clinics, and all other healthcare professionals for consumers.
4. Health providers should consistently consider pain as the standard 5th vital sign assessment throughout a patient's care, either as an outpatient or in-patient, giving patients the opportunity to talk about their pain if they have any.
5. Health providers should be sensitive to patients who may have difficulty expressing their pain due to a developmental or other disability.
6. The "language of pain" should be taught at an early age, so that children may become adults who can articulate their pain. Teachers and parents should be included in this training.
7. Community based programs (e.g., promatoras, SET, personal care) should incorporate a pain management curriculum to teach people how to describe their pain.
8. Health plans should have a clear definition of the pain management coverage they offer.

Members of the subcommittee:
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Pat Gaylor, DOH Office of Facility Management
Mary Louise Giron, AARP
Marily Griffin
Jim Jackson, NM Protection and Advocacy Services
Dan Jaco, NMMRA
Joe Jimenez, Purdue Pharma
Ellen Pinnes, Consultant

Letty Rutledge, Health Policy Commission

APPENDIX F: Findings And Recommendations Of The Subcommittee On Provider Education In Pain Management

Charge to the Education Committee by Memorial 22:

1. Are New Mexico providers trained in current standards of care for pain?
2. What educational resources are available?
3. What current research is available concerning pain treatment?
4. What guidelines are available for providers with regard to treatment of pain by NM licensing boards?
5. What educational resources should be made available that are not currently available?
6. Are New Mexico providers applying current standards of care for pain appropriately with their patients?

Methods:

Surveys containing the above questions were sent to and answered by education professionals from New Mexico medical and nursing schools, numerous clinical professionals in practice, members of the committees of the Pain Initiative Task Force, and the Board of Nursing. Also factored into our results are the survey of health professionals in Las Cruces and the Lee survey at the University of New Mexico Health Sciences Center. Additionally, a review of curricula at the University of the New Mexico Health Sciences Center was conducted. A number of members of various professional Boards were consulted as to their initiatives in developing pain standards for their States. The results that we are presenting are in our opinion a consensus of those that participated in this effort. We strongly recommend that the educational recommendations be reviewed, approved and introduced into the various State health professional boards for their consideration for adoption.

It is obvious from the Las Cruces survey, the survey by Lee at the University and our own survey that a pain educational mandate be instituted in our State. In professional schools in our State very few opportunities are afforded the students to learn about the causes of pain and its treatment. However, there is an effort to note that the topic of diversion is addressed.

However, most of the other knowledge required to treat pain are not. Applicants for physician licenses are required to listen to a lecture on the subject. However, there are no requirements to be proficient in the area of pain management. Although guidelines from the Agency for Health Care Policy and Research (AHCPR) and our State Pain relief Act are available, we could find few if any practitioners instituting these in their daily practice.

Recommendations:

All health care and allied health care professionals need to be competent in the causes and treatment of pain. Of course each professional discipline might have needs that would suggest that this subject be more or less a greater portion of their curriculum. We would offer the following, as a beginning to institute pain management and its treatment in our professional schools.

1. A minimal amount of time in professional schools must be mandated for the subject of pain management. We suggest that all healthcare educational and training schools redesign their curricula to prepare their students to be competent in the "Basic Learning Issues" (attached document) to the degree pertinent to their practice.

2. The Boards of Medicine and Nursing should require that each applicant for re-licensure in New Mexico have a minimum of training in pain management. We would recommend 6 hours for re-certification/re-licensure in our State.

3. The Joint Commission of Hospital Accreditation has recently begun requiring that patients be asked about pain as well as having their pain treated. We would urge that this initiative become a requirement in all medical settings.

4. Obtaining information about pain and its management should be readily available. We suggest that professional libraries have special section concerning this topic.

5. An interdisciplinary team should be established to institute pain management education for all professionals and to advise Boards as to appropriate knowledge for each discipline. This team should be known as the State Advisory Council on Pain Management. A Statewide effort for education about the diagnosis and treatment of pain should be instituted. We would offer suggest that our State Telehealth System could be utilized in this effort.

Recommendations for basic learning issues in pain management for health care professionals in New Mexico

We recognize that each discipline will apply these learning issues differently. It is not the intent of this document to "prescribe" curriculum. However, we would encourage that

these learning issues be incorporated into curricula such that every practitioner demonstrate pain management competence within the his/he scope of practice. Knowledge base to include:

I. PAIN HISTORY INTERVIEWING

a. Know how to ask questions about pain symptoms in a manner that considers the cultural background of the patient
b. Distinguish the types of pain by history
c. Understand the physical/psychological/age issues that influence the reporting of pain
d. Understand the psychosocial/spiritual issues that influence the reporting of pain
e. Understand the issues in confronting abuse of opioids, when interviewing a person. These include:
    - Use, misuse, abuse, dependence, addiction including abstinence vs. sobriety
    - Pseudo-addiction
    - Iatrogenic dependence
    - Diversion
f. Comprehend the concept of total pain

II. PAIN LEVEL SCORING

a. Obtain from the patient a pain score using a tool that is specific for the patient's group (pediatrics, adult, mentally impaired)
b. Use this tool to assign a numerical number to the level of (pain as the 5th vital sign)
c. Record the above in the patient's medical record

III. COMMON TREATMENT APPROACHES TO PAIN

a. Monitor response to drug treatments
b. Utilize non-pharmacological treatments
c. Offer appropriate and timely referrals to specialists in pain management
d. Work on an interdisciplinary team

IV. PHARMACOLOGY OF PAIN TREATMENT

a. Understand analgesic classification
b. Identify routes and appropriate use of analgesics
c. Understand the pharmacokinetics of common analgesic agents including absorption, distribution, metabolism and excretion
d. Recognize and treat common adverse reactions
e. Use an equivalent dose regimen for the opioids
f. Understand the principles of "opioid rotation"
g. Understand the common side effects of the opioids and the approach

to their treatment.

V. LEGAL ISSUES

a. Understand the Federal and State Laws regulating the use and distribution of controlled substances
b. Understand how the State Board of Pharmacy acts as a resource in identifying substance misuse and diversion
c. Understand the mission of licensing Boards, the enforcement of their respective Practice Acts, their reporting procedures and their willingness to assist licensees who find themselves in trouble with controlled substances.

CITATIONS:

1. Borges, RN, Wanda. 2000. *Pain Knowledge and Attitudes Survey.* Memorial Hospital, Las Cruces, New Mexico.

2. Lee,MY and Forman,WB. 2001. *Symptom Assessment at the End of Life for the Geriatric Patient in a Hospital Setting*. AGS May,2001

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APPENDIX G: Findings And Recommendations Of The Subcommittee On Legal And Regulatory Issues In Pain Management For Providers And Regulatory Agencies

CHARGE TO THE LEGAL AND REGULATORY COMMITTEE

In August of 2001 at the first Task Force meeting for Senate Memorial 22 the Legal and Regulatory Subcommittee was formed to address questions and issues raised by the Memorial with regard to regulating pain treatment in New Mexico and legal issues for health care providers regarding the treatment of chronic pain.

The Subcommittee was given the following set of questions derived from the findings and resolutions in Senate Memorial 22:

1. What will it cost the State to regulate pain treatment vs. lack of access to appropriate pain treatment?
2. What guidelines and policies are available to providers with regard to treatment for pain by NM licensing boards?
3. How are guidelines developed, followed and kept current by NM licensing boards?
4. How can NM licensing boards improve regulatory guidelines to better serve patients and providers? Are uniform guidelines appropriate?
5. Do Board of Medical Examiners (BME) guidelines serve other health professional licensing boards adequately and appropriately?
6. Does the Sate Controlled Substances Act recognize the essential medical uses of controlled substances, including their use for pain?
7. Is there a current rationale for existing State laws, regulations or agency policies regarding prescribing and dispensing of controlled substances that are more restrictive than federal law?
8. Do the State medical, pharmacy and nursing boards have statements of policy that encourage pain management and recognize that the use of opioids for the treatment of pain is a legitimate medical practice?
9. What liabilities do providers face with regard to pain treatment? Real or perceived?
10. What recourse do providers have when charged with violating licensing board regulations concerning treatment for pain?
11. How can provider liabilities and subsequent recourse and recovery be addressed fairly?

The Process Described

The subcommittee began the with a process of identifying general subject areas derived from the questions posed that warrant further discussion by the group in order to develop recommendations, but would require further research. Various committee members took

on the task of further developing these areas through various means to better inform the subcommittee on the issues. The committee members tasked with each issue provided findings at subsequent subcommittee meetings in a variety of ways including: literature research, the formation of smaller focused discussion groups, and reports by outside experts on the issues.

An overview of the issues identified for further research and discussion, committee members, and findings follows:

ECONOMIC COSTS TO STATE – *Health Policy Commission and Board of Medical Examiners.* (See Attachment A)
Information presented by: Shaun Meeks, Senior Economist - Health Policy Commission

1) Does under treatment of pain and/or regulation of pain treatment present costs to the State in terms of:
2) The workforce and chronic pain –
   a) Cost of labor lost and replacement labor.
   b) Disability entitlement costs.
3) Licensing and disciplinary costs to boards and resulting regulatory costs to the state.
4) Cost of pain management CME requirements by licensing agencies.

NEW MEXICO PAIN TREATMENT GUIDELINES AND POLICIES – *Attorney Generals Office, UNM School of Law, Board of Medical Examiners, NM Agency on Aging.*

1) NM PAIN RELIEF ACT
   a) Is the pain relief statute, “The Pain Relief Act,” necessary and desirable as a means of ensuring that New Mexicans will receive adequate treatment for pain?
      i) If yes, legislation should cause providers of pain treatment to behave appropriately and treat patients effectively.
      ii) If yes, it is necessary to compare NM law with University of Wisconsin Report identifying federal regulations and pain management policy and guidelines in other states.
   b) Board of Medical Examiners (BME) procedures for establishing and maintaining appropriate guidelines or rules with regard to pain treatment.
      i) Are BME prescribing liberties or restrictions well defined to providers?
      ii) Current procedural action by the NM Board of Medical Examiners on the issue of developing a procedure for reviewing and accepting pain treatment guidelines by rule:
         - The Board adopted Guidelines for Pain Management in 1996. These Guidelines will be reviewed and made into a rule at a public hearing on November 15, 2002. To prepare for that hearing, the Board will consider any nationally recognized guidelines that are submitted to the Board prior to July 1, 2002.

- The process for developing a new Pain Management rule will be the appointment of an advisory committee at the May Board meeting. This committee will review all guidelines that are submitted for consideration and make recommendations to the Board.
- A proposed rule will be drafted for consideration at the August 2002 Board meeting based on the recommendations of the advisory committee.
- Upon approval of the proposed rule by the Board, the rule will be made available for public comment.
- The final decision will be made following the rule hearing at the November Board meeting.

iii) Under the Pain Relief Act, BME guidelines bind all agencies and respective providers that prescribe pain medications. Should other boards have their own guidelines?

c) Is the statutory term "intractable pain" appropriate or clear ?

i) University of Wisconsin study addresses appropriate language.

BOARD OF MEDICAL EXAMINERS ADMINISTRATIVE PROCESS- *Board of Medical Examiners, Attorney Generals Office, UNM School of Law.*

1) What is the process involved when a providers prescribing practice is brought into question by the Board of Medical Examiners? How does it begin and where does it go from there?

a) In compliance with the Uniform Licensing Act, BME procedures are as follows:

i) The Board investigates providers only in response to complaints.

ii) When a complaint is received from a pharmacy, caretaker, family member or other source:

- A complaint committee is formed made up of the BME attorney, 2 Board members.
- An outside peer (expert) from a similar community is engaged as the complaint investigation progresses towards potential action.
- A subpoena may be issued to review the provider records.
- Upon record review, the committee determines whether or not a hearing is necessary and takes the complaint findings to the Board.

iii) If the Board agrees with the recommendation of a potential violation of the Medical Practice Act, a Notice of Contemplative Action (NCA) is issued using processes defined by the Uniform Licensing Act to conduct a hearing. The complaint committee members do not participate in the hearing or decision process.

iv) Prior to the hearing, full disclosure of information is provided to both parties, anyone can be subpoenaed and a full hearing comes before the Board or a hearing officer appointed by the Board.

v) After reviewing all the evidence provided at the hearing, if the Board finds one or multiple violations of law, the provider may be disciplined. All disciplinary actions against licensed providers fall under the guidelines of the Uniform Licensing Act.

2) Does the BME investigative process create an adversarial relationship between the Board and physicians treating chronic pain?

a) Provider perceptions vs. Board practices and procedures –Has the process actually created a chilling effect on prescribing practices by physicians that is resulting in under treatment for pain?
b) Is the existing process equitable?
   i) Is the use of "triggers," to begin an investigation of a provider, i.e., pharmacy reports to BME based on the quantity of a controlled substance a provider prescribes, appropriate?
   ii) Are all providers treated equally in practice? Primary care providers vs. pain specialists.

2. Are there alternatives to the current process?
   a) Objective peer review processes prior to Board action.
   b) Board contact with the provider prior to issuing a subpoena for records review.
   c) Other states have different procedures for disciplinary actions.

PROVIDER LIABILITIES AND RECOURSE – *NM Medical Society, Board of Medical Examiners, Attorney Generals Office, UNM School of Law.* Information presented by: Teri Beach - Miller Law Firm, John Anderson - NM Medical Society (NMMS) and Jeff Haisley - A.P. Capital Liability Insurance

1) If the State defines accepted guidelines, it may make defense more difficult.
   a) Nationally the treatment guidelines are varied and changing rapidly.
   b) Broadening the scope of Board approved nationally accepted guidelines would ease the burden of liability on the provider.
2) Legislation could cause insurance companies to defend physicians against Board allegations, increasing costs to the State whether or not the doctors prevail.
3) Legislation resulting in law suits will also increase malpractice rates and overall medical costs.
4) Should providers have the right to recover legal costs should they prevail in Board actions?

MANAGED CARE AND PAIN MANAGEMENT – *Division of Insurance, NM Medical Society.* Information presented by: Jeannette Velarde, Medical Director - Lovelace Health Plan, Ernest Dole, Clinician Pharmacist - Lovelace Health Plan and Shawn Quinn, Pharmacy Director - Presbyterian Health Plan

- How do they develop formularies regarding pain management?

- Prescription management, provider education and peer review.
- How are standards of care for pain management set?

THE ROLE OF PHARMACIES- *Attorney Generals Office, NM Board of Pharmacy, Division of Insurance, Board of Medical Examiners.* Information presented by Jerry Montoya, NM Board of Pharmacy.

1. State and federal authority under the Controlled Substances Act.
    a. Prevention of the diversion of illegal drugs to the streets.
    b. Regulation of certain drugs.
2. The use of quantitative "triggers" by pharmacies to initiate a provider investigation.
    a. What defines the quantity necessary to report a provider to a licensing board for over prescribing of opiates? Policies vary by pharmacy, there is no regulation by the Board of Pharmacy.
    b. Pharmacy responsibility and liability in filling prescriptions.
3. Board of Pharmacy regulations and procedures for providers and pharmacies.

This discovery process resulted in very comprehensive discussions that allowed the subcommittee to narrow the subject matter to a single set of issues on which the group agreed to make recommendations with or without consensus. The issues agreed upon for subcommittee final recommendation included:

- Provider investigation triggers
- Under treatment by providers
- Physician expenses in disciplinary actions
- The administrative process for disciplinary action
- Provider Education
- Patient Notification
- Other Health Professional Boards
- Pain Relief Act
- BME Guidelines Process

SUBCOMMITTEE FINAL RECOMMENDATIONS

I. Subcommittee Recommendations Reached by Consensus

- Under treatment by providers

Recommendation: It is necessary to create a positive legal duty to effectively treat pain and suffering: Doctors (MD, DO, DMD, DPM, nurse specialists, etc) have the duty to effectively treat the pain and suffering of a patient. Under treatment for pain as well as over treatment will be considered cause for disciplinary action. This information should

be marketed to providers and applicants by licensing boards and professional associations, and it should be made clear to providers that complaints of under treatment by providers will be investigated and disciplined as rigorously as those for over treatment.

This position assumes that a Board-recognized standard of care exists.

- Investigation Triggers

Recommendation: Provider investigation triggers, including pharmacy reporting, should be limited. Proposed changes to the Pain Relief Act with regard to Section24-2D-3 Disciplinary Action: evidentiary requirements include:

1. No medical prescribing decision may be investigated solely based upon any of the following:
   a. patient characteristics: age, diagnosis, prognosis, history of drug abuse
   a. lack of consultation to pain specialist, or
   b. quantity of medication prescribed or dispensed.
2. The Board(s) will judge the validity of prescribing based on the physician's treatment of the patient and on available documentation, rather than on the quantity and timing of prescription. The goal is to control the patient's pain for its duration while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors (Kansas Medical Board.)

An Alternative view was expressed by the Board of Medical Examiners on this issue. The Board is in agreement that quantity alone should not always be used as the only criterion to begin an investigation. However, the Board's position is that there are circumstances when the quantity of prescriptions or dosage of medication alone is an appropriate trigger and that these situations are differentiated by the Board when reviewing a complaint.

- Patient Notification

Recommendation: Patient Education requirements should be included in BME practice guidelines and should state that the patient has the right to pain treatment and should require a formal process by which this information is provided to the patient. All boards should require pain management patient notification by providers in the sunset review requirements.

a. Health Professional Board Guidelines

Recommendation:

Amendment to the Pain Relief Act as follows:

- The NM Board of Medical Examiners will be responsible for establishing acceptable pain management guideline standards that will remain applicable to all regulatory boards appropriate to prescribing providers until such time as those boards establish their own guidelines for pain management. The statute

should be amended by adding the following language to section 24-2D-2 Definitions, part A., "accepted guideline: " or guidelines established and accepted by licensing boards appropriate to other prescribing providers."

Other amendment Recommendations include:

- Change section 24-2D-2, Definitions, part F., "intractable pain" to simply "pain".

- In Section 24-2D-3. Disciplinary action; evidentiary requirements, remove language, part A., "if no currently acceptable guidelines are available, rules" from the statute.

- BME Guidelines on Prescribing for Pain:

Recommendation: Review, update and replace if necessary, the New Mexico Board of Medical Examiners Guidelines on Prescribing for Pain, 1996 with current national guidelines. The use of an open, inclusive, ongoing annual process to review evolving pain relief national standards of care and guidelines for pain management (public input, interdisciplinary committee review, public hearing, periodic review) by the Board of Medical Examiners.

This committee is very pleased that the Board of Medical Examiners has taken the steps to institute an annual of review of national standards for pain management for rule making on guidelines for pain management. Language establishing annual responsibility for the process within the Board procedures should be added by amendment to the Pain Relief Act.

Final Recommendation to the Legislature:

Recommendation: A Policy Statement be developed as a preamble to the Pain Relief Act stating the following: "That no New Mexican shall be under treated for pain and no New Mexican shall be over treated for pain."

II. Subcommittee Recommendations Reached Without Consensus

Physician expenses in disciplinary actions

Recommendation – without consensus:

- If practitioner prevails, the practitioner should be able to recover costs from the Board.
- If the Board prevails, the practitioner is not required to pay costs to the Board as required under the Uniform Licensing Act.

If the assessment of costs and fees does not bring balance to all parties in the process, another way to achieve balance must be found.

Other views on this recommendation held that:

- There is no budget to support recovery of legal costs and this change would therefore, increase costs to the State.
- The practice of cost recovery is not supported by the basic tenets of American law – civil, criminal or administrative – recovering costs is only allowed in extraordinary cases.

<u>The administrative process for disciplinary action</u>

Recommendation – without consensus: Some members of this subcommittee are concerned that the disciplinary process and procedures instituted by the Board of Medical Examiners has resulted in a "chilling effect" on prescribing practices for pain. We applaud the openness demonstrated by the Board of Medical Examiners throughout the discussion of this matter and it is the desire of some members of this subcommittee that the Board continue to review and discuss the effectiveness of the existing process.

Some members of this subcommittee recommend that the practitioner be contacted prior to beginning a Board investigative process and prior to any legal action by the board, and that the Board provide a process in which initial contact be in the form of an informal peer review committee and that provider monitoring, followed by a process of rehabilitation and education be required upon sufficient investigative findings by the peer review committee, prior to initiating a legal action to discipline.

Other views on this recommendation hold that:

- The "chilling effect" is a perception and not based in real practice by the board and it is recognized that this perception, not board practices, needs to be changed through education of providers about the process.
- The objectivity of the current process is sufficient in that a peer review process, including a non-board member, is part of the initial investigative process and that records are reviewed prior to the issuance of a NCA.
- The current process of issuing a subpoena to initiate the process of records review by the Board is necessary, as some providers object to the records review process and may be less than cooperative.

Recommendation – without consensus: To address issues concerning what may be perceived as potentially unfair practices in the administrative practices of disciplinary actions by the Board of Medical Examiners, it should be considered that as an alternative course of action, independent federal and administrative law judges would hear professional licensing cases.

Other views on this recommendation held that the current BME process of engaging "independent experts" in the investigative process constitutes an objective and balanced approach.

Regulated provider education

Recommendation – without consensus:

The development of CME requirements in pain management for prescribing providers. Licensing boards should recognize that concerns of patient well-being must out weigh the concerns of the provider.

- Educational programs should be implemented by the health professional licensing boards with regard to current pain management standards, accepted guidelines and regulatory policy.

- CME requirements for obtaining /maintaining licensure for physicians, nurses, pharmacists, dentists: An interdisciplinary concept of educating providers should be developed and applied to appropriate providers at the discretion of each licensing board.

- This subcommittee recognizes that there is a need for the flexibility of the licensing boards with regard to mandating and enforcing those requirements. Being aware that too many educational mandates may increase the cost to the State and limit the flexibility of individual license holders and of the licensing agency, individual boards should determine which of their providers would require this education and establish requirements and procedures for assuring compliance.

- Mandatory pain management curriculum should be mandated in State supported health professional programs: Schools of Medicine, Pharmacy, Nursing, PA, Allied Health Care. State supported health professional programs should include interdisciplinary education programs that address legal and regulatory issues concerning pain management.

- Intensive educational programs for state medical, pharmacy, nursing, allied health board members, and staff, attorneys and investigators to update their knowledge and views about pain management including under treatment and regulatory policy. (North Carolina and Alabama medical Boards held educational workshops)

Other Views on this recommendation held that licensing boards are lacking in information system tracking mechanisms for mandated CME requirements as some other states have.

The NM Board of Nursing is considering eliminating all CME requirements as a condition of licensure due to the volume of nurses, but agreed that voluntary CME's for prescribing nurses only might be possible.

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APPENDIX H: Report On Standards Of Care On Pain Management

Question 1: What are the current standards of care with regard to treatment for conditions or illnesses resulting in chronic pain?

Nationwide

There are many existing standards of care for conditions and illnesses that result in chronic pain. These standards have been created by a wide range of national medical professional associations and health care organizations. This report would grow unwieldy very rapidly if we tried to summarize, or even list, all of these standards here. Last Acts, a national coalition for end-of-life care, has put together an excellent publication which summarizes 41 standards from organizations ranging from the American Medical Association to the American Pain Society to the Veteran's Health Administration (Compendium of Health Care Organization Guidelines and Position Statements on Issues Related to the Care of the Dying, July 2001). The various standards defy easy comparison or analysis as a group – while each addresses the relief of pain, some are very specific and consider not only *when* pain should be alleviated but also precisely *how*, while others are broad policy statements about the quality of care that patients *should* receive, with no specific information about when or how that care should be rendered.

The *Guide to Evaluation: Achieving Balance in Federal and State Pain Policy*, developed by the Pain and Policy Studies Group at the University of Wisconsin's Comprehensive Cancer Center, has quickly become the national standard for evaluating the effectiveness of federal and state pain policies. The *Guide* proposes 17 specific criteria, (8 of which potentially enhance pain management and 9 of which potentially impede pain management) which can be used to evaluate any pain management policy or standard. The same 17 criteria can be used as models for developing new and more effective pain management policies.

The *Guide*, however, considers only the policies of governmental entities, and does not include standards of care developed by health care organizations. For an all-inclusive (non-comparative or evaluative) data source, look to the web-based National Guideline Clearinghouse (www.ngc.gov), which lists hundreds of guidelines put together by national organizations as well as state agencies and other governmental entities.

New Mexico

The Pain Relief Act (1999) requires that physicians follow pain management guidelines developed by nationally recognized health care organizations, providing that those guidelines have been accepted by the New Mexico Board of Medical Examiners.

The NM Board of Medical Examiners (NMBME) adopted the state's current standard of care in 1996. That standard recognizes that "some dangerous (prescription) drugs and/or

controlled substances are indicated for the treatment of pain and are useful for relieving and controlling other related symptoms from which patients may suffer." Utilizing the 17 criteria for evaluating pain-related policies developed by the Pain and Policy Studies Group at the University of Wisconsin, the NMBME standard has the potential to *enhance* pain management in five key ways: by acknowledging that both pain management and opioids are part of professional practice, by addressing fears that medical professionals might have of regulatory scrutiny, by extending the use of opioids to all patients whether or not they are addicts, and by stating that prescription amounts are not the only determining factor of legitimate or illegitimate pain treatment. At the same time, the NMBME standard has the potential to *impede* effective pain management by implying that opioids are a last resort for pain treatment, and by requiring that physicians consult about their patients with other health are professionals who have experience with pain management.

NMBME is scheduled to make its guidelines into a rule at a public hearing on November 15, 2002. As a result of the discussions surrounding this Memorial, the NMBME has agreed to include in the review process leading up to the final rule consideration of any nationally recognized guidelines that are submitted to the Board before July 1, 2002.

Question 2: Are New Mexico providers trained in current standards of care for chronic pain?

Defer to Education Subcommittee. This question not addressed by Standards of Care Subcommittee or Legal and Regulatory Subcommittee.

Question 3: What are the professional requirements for education in pain treatment and standards of care?

Defer to Education Subcommittee. This question not addressed by Standards of Care Subcommittee or Legal and Regulatory Subcommittee.

Question 4: What educational resources are available to practitioners concerning pain treatment and standards of care?

Defer to Education Subcommittee.

The initial SM 22 Environmental Scan includes this information on Provider Education on Pain Management:

- Pain Management education is integrated and disease process specific in medical and nursing program curriculums with no specific hourly requirement.
- The recent Health Policy Commission Institutional Survey revealed that 100% of providers stating that emphasis specific to chronic pain management in medical school is lacking.

- The same survey cited current provider training by institutions at 44% for clinical staff and 35% for medical staff.
- A survey of 8000 nurses that compared to earlier surveys demonstrated that while nurse have become more informed about pain, they are still lacking the basic knowledge to manage pain properly.
- According to a recent study, pain content accounted for only 0.5% of the total text content in 50 textbooks used in nursing education; end-of-life care accounted for only 2% of the content.
- Another study stated that a majority (97%) of physicians acknowledged that insufficient knowledge and inadequate education contribute to the problem of under-treated pain.

Question 5: Do practitioners, when treating patients for chronic pain, apply a written standard of care consistently?

Defer to Task Force. This question not addressed by Standards of Care Subcommittee or Legal and Regulatory Subcommittee.

Question 6: Do different standards of care for chronic pain and palliative care apply, and should they be addressed separately with regard to regulation?

Defer to Task Force. This question not addressed by Standards of Care Subcommittee or Legal and Regulatory Subcommittee.

Current standards for palliative care do generally differ from those for chronic pain not due to cancer. The issue of physician-assisted suicide appears to be a significant concern for palliative care providers, and therefore figures prominently in many palliative care standards of care. Physicians managing patients with chronic pain – and standards of care guiding those physicians – are generally more concerned with addiction, drug abuse, and other potential side effects of opioids.

APPENDIX I: JCAHO Standards On Pain Management

Summary of JCAHO Standards with regard to Pain Management

Hospitals, home care agencies, nursing homes, behavioral health facilities, outpatient clinics and health plans will be called upon to:

- recognize the right of patients to appropriate assessment and management of pain;
- assess the existence and, if so, the nature and intensity of pain in all patients ;
- record the results of the assessment in a way that facilitates regular reassessment and follow-up;
- determine and assure staff competency in pain assessment and management, and address pain assessment and management in the orientation of all new staff;
- establish policies and procedures which support the appropriate prescription or ordering of effective pain medications;
- educate patients and their families about effective pain management; and
- address patient needs for symptom management in the discharge planning process.

The new standards explicitly acknowledge that pain is a co-existing condition with a number of diseases and injuries, and requires explicit attention. For example, a patient with breast cancer should effectively be treated not only for the actual illness but also for any associated pain.

The new pain management standards--along with examples of compliance--are being included in 2000-2001 standards manuals for the affected Joint Commission accreditation programs. The standards will first be scored for compliance in 2001.

JCAHO Standard Citations

Standard RI.1.2 Patients are involved in all aspects of their care.
Patients are involved in at least the following aspects of their care:

- Making care decisions, including managing pain effectively;

Standard RI.1.2.8 Patients have the right to appropriate assessment and management of pain.

Intent of RI.1.2.8

Pain can be a common part of the patient experience; unrelieved pain has adverse physical and psychological effects. The patient's right to pain management is respected and supported. The organization plans, supports, and coordinates activities and resources to assure the pain of all individuals is recognized and addressed appropriately. This includes:

- initial assessment and regular reassessment of pain;

- education of relevant providers in pain assessment and management;
- education of patients, and families when appropriate, regarding their roles in managing pain as well as the potential limitations and side effects of pain treatments; and
- after taking into account personal, cultural, spiritual, and/or ethnic beliefs, communicating to patients and families that pain management is an important part of care.

Standard RI.1.2.7 The hospital addresses care at the end of life.
The hospital's framework for addressing issues related to care at the end of life provide for managing pain aggressively and effectively;
Effective pain management is appropriate for all patients, not just for dying patients (see standards RI.1.2.8 and PE.1.4).

Standard PE.1.4 Pain is assessed in all patients.

Intent of PE.1.4
In the initial assessment, the organization identifies patients with pain. When pain is identified, the patient can be treated within the organization or referred for treatment. The scope of treatment is based on the care setting and services provided. A more comprehensive assessment is performed when warranted by the patient's condition. This assessment and a measure of pain intensity and quality (eg, pain character, frequency, location, duration), appropriate to the patient's age, are recorded in a way that facilitates regular reassessment and follow up according to criteria developed by the organization.

Standard PI.3.1 The organization collects data to monitor its performance.
Data that the organization considers for collection to monitor performance include the appropriateness and effectiveness of pain management.

APPENDIX J: Study Criteria Of *The Guide To Evaluation: Achieving Balance In Federal And State Pain Policy*, Pain And Policy Studies Group Of The University Of Wisconsin Comprehensive Cancer Center

The criteria used in this study to evaluate public policies are based on the Central Principle of "Balance." Within the *Guide*, the criterion are elaborated on as they are applied to each policy.

Criteria that identify provisions of policies that may *enhance* pain management:

1. Controlled substances are recognized as necessary for public health
2. Pain management is recognized as part of general medical practice
3. Medical use of opioids is recognized as legitimate medical practice
4. Pain management is encouraged
5. Practitioners' concerns about regulatory scrutiny are addressed
6. Prescription amount alone is recognized as insufficient to determine legitimacy of prescribing
7. Physical dependence or analgesic tolerance are *not* confused with "addiction"
8. Other provisions that may enhance pain management

Criteria that identify provisions of policies that may impede pain management:

9. Opioids are implied to be a last resort
10. Medical use of opioids is implied to be outside legitimate professional practice
11. The belief that opioids hasten death is perpetuated
12. Physical dependence or analgesic tolerance are confused with "addiction"
13. Medical decisions are restricted
14. Length of prescription validity is restricted
15. Practitioners are subject to additional prescription requirements
16. Other provisions that may impede pain management
17. Provisions that are ambiguous

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