



Greater New York Hospital Association

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TESTIMONY

OF THE

GREATER NEW YORK HOSPITAL ASSOCIATION

ON

PAIN MANAGEMENT LEGISLATION FOR HEALTHCARE PROVIDERS

AT A PUBLIC HEARING HELD BEFORE

THE NEW YORK STATE ASSEMBLY

COMMITTEE ON HEALTH

JANUARY 26, 2005

**Testimony
of the
Greater New York Hospital Association
on
Pain Management Legislation for Healthcare Providers
at a Public Hearing Held Before
The New York State Assembly
Committee on Health
January 26, 2005**

Good morning, I am Terri A. Straub, Vice President for Quality and Patient Safety of the Greater New York Hospital Association. I am a registered nurse with over 15 years of clinical experience in surgical and emergency services and I worked for eight years as the Senior Director of Quality at the Federal quality improvement organization for New York State, IPRO. In my capacity at IPRO I was a lead project director on a statewide project to improve pain management for acute pain in the hospital setting. I am not a pain management expert, but my testimony today will speak to the issue from the perspective of the hospitals represented by GNYHA and also from my many years of leading quality improvement projects, caring for patients, their families, and my own family members. GNYHA represents over 250 hospitals and continuing care facilities in New York, Connecticut, and New Jersey. All of GNYHA's members are either not-for-profit, charitable organizations or publicly sponsored institutions. Together, they provide services that range from state-of-the-art, tertiary care to the most basic primary care, given their roles as safety net providers for the many communities they serve.

GNYHA and its members share with you the goal of this hearing: ensuring that all patients receive the highest quality of care and the most optimal pain management that is available. Indeed, it is the mission of GNYHA's members to provide high quality care to the patients they serve, and healthcare providers undertake extensive efforts to ensure they are doing so.

We welcome the opportunity to appear before you today and commend you on undertaking the important task of ensuring that all patients receive appropriate pain management.

GNYHA would like to focus on the implications the proposed legislation will have for hospitals, and we will defer to the physicians who testify before this Committee to discuss the more clinical aspects. In general, to the extent that the bill proposes to mandate education for physicians and physician assistants, GNYHA members believe this is a role for the medical schools and should be integrated into specialty practice that has board certification oversight. Mandated educational curricula coming from outside the profession are often viewed as ineffectual and may marginalize the efficacy of this type of training. With respect to medical educational curriculum, GNYHA refers the Committee to the November 5, 2004 testimony of Dr. Joseph Fins and believes there is room for enhancing pain management training within the context of non-mandated physician education training, certification programs, and quality improvement programs.

While we support the goals of the legislation, we believe that enhanced patient care is more likely to be achieved through the introduction of quality improvement projects and through continued adherence to current JCAHO standards.

Quality Improvement Opportunities

Quality improvement demonstration projects could provide educational opportunities for a broad spectrum of healthcare providers and could promote systemic changes in healthcare organizations as well. Quality improvement that is driven by a multi-disciplinary team has the potential to not only be sustained, but to also have an impact on a much broader patient population. The quality improvement model is also advantageous because it yields comparative data. Baseline and impact data are continuously collected and analyzed to assess the efficacy of education and system changes. Through ongoing evaluation of the data, healthcare organizations can identify best practice models that can be replicated throughout the hospital and by other healthcare organizations in NYS and throughout the country. Adoption of best practices has been shown to drive system change and improves quality throughout a healthcare organization. Finally, the use of a quality improvement model allows for continuous change to practice as science evolves (rather than every four years).

At GNYHA, we have seen such models function successfully. Two models that have generated success include:

- **IPRO Pain Management Quality Improvement Collaborative.** In 1996, IPRO launched a collaborative quality improvement initiative to enhance pain management. Forty-five hospitals across the State volunteered to participate in the initiative, and over the course of one year, there were dramatic improvements and systemic changes in the administration of acute pain management in the hospital setting. Improvements were seen in education, evaluation, and assessment of pain for patients, postoperative pain management, and utilization of standardized pain management assessment tools. It is the belief of GNYHA that this is the kind of initiative that might more effectively meet the goals of the proposed legislation, especially considering that with the State's support, ours would be a wider, and better-funded project. GNYHA is happy to support such an initiative and work with the legislature to move it forward.
- **The Pittsburgh Regional Healthcare Initiative-** In the Pittsburgh area, over forty hospitals and other healthcare stakeholders have voluntarily developed a quality improvement coalition to improve healthcare in the region. Their first successful quality improvement initiative was to reduce infections in hospital intensive care units. The success was driven by practice changes that incorporated standardizing the materials used for procedures, the use of data to drive improvement, and ongoing education using the data to support the didactic programs. This initiative is fast becoming a national model for making improvements to healthcare.

It is not merely coincidence that the two successful programs above did not incorporate mandatory education; on the contrary, there is data proving that education mandates are not an effective way to achieve quality improvement. For example, education mandates for infection control training had little or no impact on improving infection rates. Instead, healthcare organizations that have achieved success in reducing infection rates have implemented multi-disciplinary quality improvement projects that require system changes that cannot be circumvented. To that end, GNYHA and the United Hospital Fund (UHF) have partnered to

explore opportunities to reduce infections using a quality improvement model. Through a voluntary collaborative effort, the first project will focus on reducing hospital-acquired infections for patients treated in the intensive care unit of the hospital. GNYHA and UHF will be inviting hospitals to volunteer to participate in the project and commit to making improvements and systems changes. The success of the project will be determined through ongoing data collection, system changes, and evaluation of participating hospitals.

Joint Commission on Accreditation of Healthcare Organizations

We would also like to draw your attention to the current Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards for pain management referenced earlier in this testimony. GNYHA and its members support JCAHO standards - standards that clearly outline appropriate pain management practices for ambulatory care facilities, behavioral health care facilities, health care networks, home care, hospitals, and long-term care organizations. GNYHA members believe that the JCAHO standards alleviate the need for separate legislation, as they comprehensively assure that timely and optimal pain management is offered to all patients. These standards call upon healthcare organizations to:

- Recognize the right of patient to appropriate pain management
- Screen for the presence and assess the nature of pain in all patients
- Record the results of the assessment in a way that facilitates regular reassessment and follow-up
- Determine and ensure staff competency in pain assessment and management, and address pain assessment and management in the orientation of all new clinical staff
- Establish policies and procedures that support the appropriate prescribing and ordering of pain medications
- Ensure that pain does not interfere with a patient's participation in rehabilitation
- Educate patients and family members about the importance of effective pain management
- Address patient needs for symptom management in the discharge planning process
- Incorporate pain management into performance review activities

GNYHA believes that these standards provide hospitals with the framework to develop pain management guidelines, protocols, and educational initiatives that are customized to the patient populations they serve. JCAHO standards are not limited to training physicians and physician assistants. JCAHO standards actually guide healthcare organizations on the assessment and management of pain; they provide an impetus for healthcare organizations to support system changes that improve pain management and ensure accountability. As a result, healthcare organizations and practitioners have embraced these standards as part of their overall quality and patient safety agenda.

Unintended Consequences of Proposed Legislation

We believe that education mandates can have very negative consequences, however unintentional. Specifically, this legislation has the potential to limit the pool of qualified practitioners who can provide pain management and palliative care. Without concomitant funding, the legislation's requirement that physicians and physician assistants obtain education in pain management every four years, in order to practice pain management, may prompt physicians to opt out of the practice of pain management altogether, thereby limiting the pool of qualified physicians. This unintended consequence will ultimately limit patients' ability to seek pain management and will undermine the original intentions of the bill.

GNYHA also feels that the bill is too narrow in another significant regard, and thus could limit not only the number of prescribing practitioners but also the number of disciplines involved with the assessment and referral process for seeking pain management. Pain management is a much more comprehensive process than prescribing medications. The legislation, as written, only addresses the direct management of pain through opiates. However, there are many more steps involved in the provision of responsible pain management. For example, there is the step of initially identifying and assessing the patient for pain. There is the step where patients are referred for alternative levels of care at the appropriate point of hospitalization or home care. And there is the step of transitioning patients from home care or the hospital to hospice care. Nurses, discharge planners, social workers and others all play a central role in this series of steps,

yet they are not considered in the current version of the bill. This may have the unintended effect of limiting their involvement, which would break down the pain management cycle.

Management of Pain for the Dying, Acute Pain, Chronic Non-Terminal Pain

Another concern that has been voiced by GNYHA members is that the proposed legislation groups pain management training and guidelines for acute and end-of-life pain together. In fact, there are vast differences in the practices of end-of-life pain management, acute pain management, and chronic non-terminal pain management. Although the legislation acknowledges various levels of pain management training, it does not acknowledge these necessary distinctions in the type of pain management a patient may require. This leaves the door open to having a broad interpretation of practice parameters for physicians and therefore could potentially create confusion with the hospital credentialing process for physicians. We have concerns about adopting legislative education mandates, but if they were to be adopted, it would be critical that end-of-life care be considered under separate legislation.

Immunization of Physicians against Punitive Corrective Actions

The law rightly attempts to immunize the medical profession against punitive corrective actions; so long as patients are being appropriately treated with pain medications, however high the dose. But at the same time, it includes a disciplinary clause to be added to New York States Education law, once again subjecting physicians to disciplinary intervention. This is precisely what has led to the under treatment of pain – the fear of legal reprisals for the use of pain medications. This punitive education law clause now pushes the balance in the opposite direction – causing a fear of under treatment that will lead to over treatment. It is a value judgment as to whether over treatment is preferable to under treatment, but clearly appropriate treatment is the best.

Patient and Family Expectations

As an aside, it has been brought to the attention of GNYHA that quite often the patient and family members' perception of managing pain may be diametrically opposed. Our member

institutions comply with and support the JCAHO pain management standards that require hospitals to teach patient and family members about pain management and treatment options. That said, however, at times, even in the event of ongoing education, patients refuse pain management medications either because they perceive they cannot tolerate pain medication because of past negative reactions or because they want to stay fully alert throughout the course of treatment due to fear of not being in control of their own care. Quite often, a patient's refusal is perceived by family members as the care giver not managing pain correctly, prompting well-intentioned family members to advocate for more medication for the patient, even if this is against the patient's will. These experiences, although they tend to be the exception, may be cast as hospitals not caring for a patient. While GNYHA believes that enhanced pain management can better be achieved through quality improvement projects and adherence to JCAHO standards, if legislation is to be enacted, GNYHA would like to see any proposed legislation acknowledge this unfortunate but understandable reality and protect the hospital and primary caregivers in such situations.

Summary

GNYHA members have an unwavering commitment to providing high quality and safe patient care. Included in this commitment is a willingness to learn the latest and most effective treatments for managing pain. In the complex environment of healthcare, the challenge faced by practitioners is the ability to disseminate information and implement changes to practice. There is little or no data that supports that physician continuing medical education (CME) drives changes to practices and it is disconcerting to think we might be depending on mandated CME to make improvements. Physicians will ultimately perceive the mandate for training as another administrative headache to have to fulfill with no compensation or foreseeable benefits for the patient, and therefore very few physicians may fulfill the mandate and thereby compromise patient care to a greater extent.

GNYHA supports bills that improve patient care. However as expressed in this testimony, GNYHA has many concerns that this bill is narrow in scope and has too strong a focus on opiate over or under prescribing and physician CME. Rather than focus on the bill as proposed, I ask,

on behalf of GNYHA members, that we work collaboratively to identify effective quality improvement models to drive changes in practice for acute, chronic, and palliative care pain patients.

On behalf of GNYHA members, I thank you for giving us the opportunity to testify before this Committee and offer to assist in developing a quality improvement demonstration proposal if this is a direction the committee would like to pursue.