Approved: February 2, 2006
Date

MINUTES OF THE HOUSE HEALTH AND HUMAN SERVICES COMMITTEE

The meeting was called to order by Chairman Jim Morrison at 1:30 P.M. on February 1, 2006, in Room 526-S of the Capitol.

All members were present except Representatives Watkins and Kilpatrick, both of whom were excused.

Committee staff present:
Melissa Calderwood, Kansas Legislative Research Department
Mary Galligan, Kansas Legislative Research Department
Renae Jefferies, Revisor of Statutes' Office
Gary Deeter, Committee Secretary

Conferees appearing before the committee:
Phyllis Zorn, Hays, citizen
Miranda Zorn, citizen
Robert Twillman, LIFE Project Pain management and Public Policy Task Forces
Chip Wheelen, Executive Director, Kansas Association of Osteopathic Medicine
Jerry Slaughter, Executive Director, Kansas Medical Society

Others attending:
See attached list.

The minutes for 1-31 were approved.

The Chair opened the hearing on **HB 2649.**

Phyllis Zorn, Hays, told a personal story about her daughter's surgery, a sequence of events that accelerated from an infection to an abscess to surgery without adequate anesthesia. (Attachment 1) She learned that doctors sometimes undertreat for pain, fearing repercussions from the Board of Healing Arts for over-prescribing.

Miranda Zorn, the daughter in the story above, further related the ordeal of enduring surgery with inadequate pain medication. (Attachment 2) She encouraged members to pass the bill.

Robert Twillman, LIFE Project Pain management and Public Policy Task Forces, spoke as a proponent. (Attachment 3) He said poor pain management is a significant public health concern, costing the American economy $110 billion per year as estimated by the National Institutes of Health, an unnecessary financial and human cost. He noted that sections 2 and 3 of the bill express rights already extant, that no new rights are created in these sections. He said section 5, by deleting a reference to the principle of double effect, which is intended to reassure physicians that pain management will not be construed as assisted suicide, actually perpetuates the inaccurate idea that patients are in danger of inadvertently being

killed by proper pain medication. He recommended eliminating those clauses. Regarding section 6 of the bill, he commented that the intent is to clarify unprofessional conduct regarding the prescribing of drugs; he suggested an amendment to section six stating that an inadequate prescription is as unprofessional as an excessive prescription.

Deanne Bacco, Executive Director, Kansas Advocates for Better Care, provided written testimony as a proponent. (Attachment 4)

Chip Wheelen, Executive Director, Kansas Association of Osteopathic Medicine, said the physicians he represents endorse the principle of the bill and appreciate the organizations that seek to promote a better quality of life for those dealing with pain. (Attachment 5) He identified three categories of pain patients: those who have been injured or undergone surgery, those who must endure long-term pain, and those who try to manipulate physicians to obtain opiates; he stated that the first and second categories have legitimate need for proper pain medication. Commenting on sections of the bill, he said section 2 is an acceptable statement of public purpose as long as it does not create a new cause of action for litigation. He suggested reshaping the language of sections 2 and 3 to eliminate the possibility of creating a new right. He also suggested that section 3 should state what is not intended by the bill. Offering amendments which he said would clarify the intent of the bill, he suggested language that would protect physicians from disciplinary action if they followed the guidelines of the Board of Healing Arts. He also commended the language provided by Jerry Slaughter. (See Attachment 6)

Jerry Slaughter, Executive Director, Kansas Medical Society, offered written testimony with recommended language to strengthen the bill. (Attachment 6) Representative Bethell, stating that the proposed amendments increased the effectiveness of the bill, said that he had prepared a balloon amendment for the committee's consideration.

Answering questions, Mr. Wheelen said avenues of redress are available with or without the bill: filing a complaint with the Board of Healing Arts and, if a person suffers damages, recovering those damages through a lawsuit; he noted that the bill attempts to protect physicians from unnecessary disciplinary action. To another question, he said if the bill passes, all those licensed to prescribe medications would need to adjust the statutory language in their practice acts to accommodate the bill. He replied that the bill would not create a new standard of care.

A fiscal note on **HB 2649** was included for members. (Attachment 7)

The Chair closed the hearing and asked members for bill introductions.

Representative Kiegerl requested a bill that would bring Kansas into compliance with federal law regarding a baby inadvertently delivered alive during an abortion procedure. The motion was made, seconded and passed to accept the bill as a committee bill.

Representative Bethell requested a bill that would require reporting to the Board of Nursing the employment and termination dates of licensed nurses. The committee accepted sponsorship of the bill.

The Chair requested three bills on behalf of the Kansas Sheriff's Association: (1) extending the current statute prohibiting the unlawful sale or distribution of controlled substances within 1000 feet of school to include licensed day-care centers, public parks, playgrounds, and premises or structures used by a public school district; (2) extending the current law prohibiting the unlawful sale or distribution of depressants, stimulants, or hallucinogenic drugs within 1000 feet of school to include licensed day-care centers, public parks, playgrounds, and premises or structures used by a public school district; and (3) adjusting the sentencing guidelines grid to reflect the changes in the criminal code. A motion was passed sponsor all three bills.

Staff Melissa Calderwood gave a briefing on **HB 2678**, which she said repeals the present law regarding free-standing renal dialysis facilities dispensing drugs. She noted that a similar bill **(HB 2225)** went through the committee and the House in 2005 and was sent to the Senate Public Health and Welfare Committee, which held hearings but took no action on the bill.

A fiscal note was provided for members. (Attachment 8)

Staff Mary Galligan briefed the committee on **SB 263**. She said the bill changes the composition of the Board of Emergency Medical Services to require one of three members active in the profession to be an administrator. She said because of Senate amendments, the fiscal note was no longer applicable. The number of members would not change, only the composition of membership.

A fiscal note (Attachment 9) and a supplemental note (Attachment 10) were also available to members.

The meeting was adjourned at 2:44 p.m. The next meeting is scheduled for Thursday, February 2, 2006.

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

HOUSE HEALTH AND HUMAN SERVICES COMMITTEE
GUEST LIST

DATE: February 1 2006

NAME	REPRESENTING
Robert Twillman	LIFE Project
Lindsey Douglas	Hein Law Firm
Miranda Zorn	constituent/proponent
Pat Terich	Cerebral Palsy Research
Tom Brown	Life Project
Chip Wheelen	Asn of Osteopathic Med
Mark Stafford	Bd of Healing Arts
Jerry Slaughter	KMS
Dan Morin	KMS
David Klepper	KC STAR
Marty Heilman	Conlee Consulting Grp, Inc.
Janelle Williamson	Washburn School of Nursing
Wendy Dronan	Lincoln County EMS
Cori Dodds	Wichita State University
Fred Lucky	Kansas Hosp Assn.
Phyllis Zorn	Constituent / proponent
Jerry Jo Deckert	GRANT CO. EMS-ULYSSES, KS.
[illegible]	American Heart Assn
Terri Roberts	Kansas State Nurses Association

Testimony in support of the Pain Patient's Bill of Rights

Phyllis Zorn

On Dec. 26, 2004, I took my daughter, Miranda Zorn, to the emergency room at Hays Medical Center for treatment of what we suspected was strep throat. Diagnosing a viral infection, the attending physician ordered an injection of SoluMedrol to ease Miranda's symptoms.

The injection intended to usher in relief for Miranda instead ushered in the nightmare that brings us to speak to you today. The needle was unsterile and within only a few days an abscess developed that later proved to be a staph aureus infection. The abscess was 8 centimeters across. That is the size of the entire palm of my hand.

On Saturday, Jan. 8, after one return trip to the emergency room and two visits to her physician's office, the abscess began oozing pus. We returned to the emergency room to have the drainage cultured.

On Monday, Jan. 10, Miranda's physician read the preliminary lab results, canceled her appointment with him and scheduled her to see his partner, an infectious disease specialist. Thus the partner took over her treatment for the abscess.

That afternoon, the doctor lanced and drained the abscess. According to his records, he anesthetized only the incision area in preparation for the operation. He did not anesthetize deep tissue. His records note that about 100 cc of pus was drained from the incision. The abscess cavity, which was measured the following day in the first of 18 visits to the hospital's special nursing unit, was 3 ½ centimeters deep, a centimeter long and a half-centimeter wide.

Attachment 1
HHS 2-1-06

I want to emphasize that **only** the incision area had been anesthetized. Although Miranda felt only pressure as the initial incision was made, when the doctor made a second cut to be able to reach deeper into the abscess, that cut was made without any anesthesia. Also done without anesthesia was the process of repeatedly reaching inside the abscess with his finger to pull out pus and dead tissue.

The process was extremely painful for Miranda, particularly since the area of inflammation was so large. In reaction to the pain, Miranda first complained, then began to cry. She cried throughout the procedure and pleaded with the doctor to make the pain stop. I asked him if there was something more he could do to ease her pain, but he told me there wasn't because the abscess had already been cut open.

It wasn't until months later, in speaking to another doctor for an article about under-treatment of pain and the reasons doctors are overly cautions about treating pain, that the other doctor explained all the options that existed in Miranda's specific circumstances. Those options included additional injections, intravenous pain medications, bringing in an anesthesiologist and taking her to the operating room for general anesthesia if lesser measures were unsuccessful. Twice the doctor being interviewed told me that what happened that day, as well as the following day when Miranda's regular doctor directed the nurse to unpack, clean, measure and repack the wound without administering pain medication (a directive the nurse refused to follow), "did not comply with the standards of care." He further said under-treatment of pain is a disciplinary issue with the Kansas Board of Healing Arts.

I understand completely the threat a staph aureus abscess presents. In 1995, one week before Christmas, my best friend, an otherwise healthy 34-year-old mother of four little girls, died from septicemia brought on by a staph aureus infection.

Knowing the threat Miranda's abscess posed, I comforted her throughout the operation so that she would comply with the procedure. Although there is no doubt in my mind the ordeal was worse for Miranda than it was for me, those of you who are parents will understand the depth of my own agony in watching my child suffer that day. I suppose the ordeal lasted about 10 minutes, but the after-effect was much longer. There was no reason for her to suffer so much.

The doctor noted in his records that "the patient tolerated the procedure well."

I disagree.

I am grateful to the doctor for treating the abscess and I am thankful to have Miranda beside me today, but I have come here in the interest of doing what I can to make sure no one else's child undergoes such a painful procedure without adequate measures taken to relieve the pain.

I thank Representatives Bob Bethell and Jim Morrison for their encouragement to share our story with you, and I thank you for listening to us today. Together we can change scenarios where patients suffer needless pain.

Testimony in favor of "The Pain Patients Bill of Rights"

Miranda Zorn

Today I'm here to tell you my story.

On December 26, 2004, I went to the emergency room for what I thought was strep throat. Cultures were run, along with a sinus X-Ray, and it was determined that I had a virus. I was given a shot to make me feel better.

On January 2, I was seen in the ER again because the injection site had become severely painful, swollen and red in color. I was put on Keflex and warned about what might be to come. A week later, the abscess started to drain, and a third visit to the ER was needed to run a culture. I was told to schedule an appointment with my physician on Monday.

After scheduling my appointment, the doctor's office called and said that I had been transferred from my regular physician to the infectious disease specialist for this. Upon arriving, we were taken right in. The nurse looked me over. She left and the doctor came in a couple of minutes later. He was unsure of why my appointment had been switched to him; we told him the lab results were to have come in that morning. He went to fetch them and was back within two minutes. He said the results showed a "staph-like infection," which was immediately followed by: "I can't prove it was the needle."

He then looked me over and told me that it had to be drained right away. There was still far too much infection under there for me to just keep taking the antibiotics. I grimaced and told him I wasn't looking forward to that. He and the nurse both assured

Attachment 2
HHS 2-1-06

me that the worst part of the surgery was going to be the shot to numb everything. I smiled and told him that I was glad.

When they prepped me for surgery, I remember thinking how glad I was that my mom had come with me; I wasn't sure if I'd have been able to drive myself home. Then, as it turned out, driving myself home was to be the least of my worries.

The shot hurt a bit, as expected. And with the incision, there was a bit of pressure, but no pain. So far, so good, I thought to myself. Then came the draining.

At first, it just hurt from the pressure of the doctor draining the abscess, and that was okay. Then, slowly, the pain became sharp and no longer just from the pressure. I held my breath, trying to keep from crying, which didn't work. I start crying anyway. The pain became unimaginable. I thought the shot was going to be the worst part! That was nothing compared to this. It was worse than I can even put into words. As I was lying on the table sobbing, the doctor behind me asked "Oh, does it hurt?" Since I was sobbing too much to answer, my mother answered, "Do you think she would be crying if it didn't hurt?" The doctor said nothing back, just kept going. My mom asked if there was something else he could do, another shot maybe. He said there was nothing; since the incision had already been made, the field was unsterile and another shot would just start the whole cycle over again. So Mom just held my hand tighter and told me it was going to be over soon. Just then, when I thought the pain couldn't get any worse, I felt like I was being cut with a dull knife with no anesthetic at all. It felt like something was being ripped out of me. I screamed out, and the doctor said, "I'm sorry, I'm sorry, I'm sorry." And while he sounded sincere, it did no good for me – it didn't make the pain go away, nor did it lessen it any. And just when I thought for sure that that had to have been

the worst of it, I felt the same ripping feeling again, only this time it was worse. It was pure torture. I don't know how else to describe it. This time, as I screamed out, the doctor again apologized and said that was almost done. True to his word, he was. A few minutes later, he told me that he was done draining it and all he had left was packing and dressing. I breathed a sigh of relief between sobs, thinking to myself that packing can't be too bad.

Since the pain was lessened, I tried to quit crying. (Really, all I did was go from screaming down to mildly sobbing.) As I was trying to recover, the nurse was getting the dressing and packing ready. The doctor explained to my mom that what he had done at the end was reach his finger in to pull out some of the infection, and then showed her why it was so important that he do it.

Once they were all ready to pack and dress, he warned me they were going to start again. I nodded my head as I sobbed to let him know I understood. At first, the packing wasn't so bad. Then, the more he packed, the more it hurt, and it quickly escalated to hurting so badly that I was again screaming. The only consolation was that at least the packing was much quicker that the surgery itself.

After I was packed, the doctor explained that the packing was not to be changed by us; he would call down to Special Nursing Services and arrange for them to change the packing and dressing everyday starting tomorrow, but that the dressing was going to need changed 3 or 4 times before my appointment. He asked the nurse to show Mom how to change the dressing so he could call down to Special Nursing Services and to the pharmacy. The nurse showed my mom how to change the dressing as I slowly started to cry less, and then she stayed with me while mom went to call work to tell them she would

not be back that day. (She also signed papers to have the records released.) The nurse came over and brought me facial tissue and asked how I was doing. I told her better; she said, "Better, but not really?" and I laughed a little bit. She told me I could stay in the room until I was ready, to take my time getting dressed.

By the time my mom came back, I had quit crying almost altogether. The doctor came back in and said that he had called the pharmacy and prescribed more Keflex and another antibiotic, along with Loritab. He also said that Special Nursing Services would be calling us that night to set up an appointment for the next day. He, also, told me to take my time getting around if I needed to.

When the doctor and nurse left, I slowly started sitting up. Every move I made hurt, and I started crying a little again. It took what felt like hours to sit up and get off of the table, but probably only took five minutes. The doctor came back in to check on me as I was getting dressed. He said the pharmacy would have my pills ready when we got there. He said the painkiller should be plenty strong enough, but if it wasn't, I could also take aspirin. He told me that for having the abscess repacked, the pills should also be enough.

The pills were fine for getting me through the rest of the day and the morning on Tuesday. And, like I was instructed, I just made sure to take my pills on schedule.

I arrived at my appointment at Special Nursing Services at 1:30. I had taken my pain pill at 12:30. When the nurse took the packing out, it hurt so bad I about flew off of the cot. At least it was quick and I didn't cry. She told me to relax; she'd get me a blanket and a pop and call up to my doctor to get something else prescribed for while she was changing the packing. She brought my pop and blanket and then left for a while.

She came back ten minutes later and said that the doctor treating my infection wasn't in, but she spoke to his partner, my regular physician. He had initially said that I was to receive no more pain medication, that those pills should be plenty. She told him that she would not repack it without more pain control. He then, reluctantly, told her that I could have 12.5 mg of Demerol, and that if after ten minutes I still needed more, to give me the other 12.5 mg. She said that should could either give me a shot, at which point I made a sour face, or she could put in an IV. I said I was a little leery of another shot and I'd rather have an IV. She said that was her pick, too. So, she explained to me what was going to do since I'd never had an IV before. She found a good vein, gave me a shot to numb the area and then put in the IV. She called down the wound care specialist to help her decide what to pack and dress with. I was initially given just 12.5 mg of Demerol as instructed. When the wound was being measured it still hurt terribly, so the nurse got ready to give me the rest of the Demerol. (The wound measured at 3.6 cm deep, 2 cm long and 1 cm wide.) The wound care specialist worked very quickly, and by the time the other 12.5 mg of Demerol had gotten into my blood, she was already done.

After we received the records, we learned what the doctor had done to numb the area before he drained. His records show he numbed only the skin with lidocaine and not the deep tissue. This explains why draining out the abscess hurt so badly. We have since learned that there were several other things that could have been done to give me more pain control when we asked for it. For example, I could have been given a shot in my arm; I could have been given a fast acting pill; I could have had an IV put in my hand. One doctor said that he, upon seeing the extent of the abscess, would have stopped surgery and called a surgeon and an anesthesiologist.

As I read a copy of the proposed bill, I was delighted to see that one of the points outlines that a patient is to be given options of how to treat his or her pain. Having been given options in Special Nursing Services, I can't even convey to you how nice it was to have the nurse listening to what I wanted. Most of the time doctors and nurses simply do what they feel is best and have no regard for what that patient wants. I don't believe that is right any more that I believe it's acceptable to be in that amount of pain. I know that doctors are afraid of over-prescribing, but I have to tell you, I believe that chances of that are pretty slim. I was given 25 mg of Demerol for 8 days. The first day I was in too much pain; the second day I felt drunk. By the last day, I just couldn't sit still. And on that day, the nurse and I decided that I no longer needed the Demerol; I had hardly felt that packing the day before. (I only had it on that last day because the wound had to be measured.) It was as much my choice as it was hers. If pain medication is used simply for pain control, then I don't think there will be a problem with it being abused.

There are doctors who have said that this bill should not be passed – that doctors have enough restrictions as it and don't need anymore. However, I feel that if this bill didn't need to be passed, this would not have happened to me. Several of the people I know have told me that this 'is just all about getting revenge" for what happened, but it's not. I came through it with just a scar and some bad memories. But, I survived. This is about making sure it doesn't happen to anyone else in the future.

Living Initiatives For End-Of-Life Care

Helping Kansans with advanced chronic and terminal illness live with dignity, comfort and peace

Testimony on HB2649
House Health and Human Services Committee
Robert Twillman, Ph.D.
LIFE Project Pain Management and Public Policy Task Forces
February 1, 2006

It is my pleasure to speak to you today in support of HB2649, the Pain Patient's Bill of Rights, submitted by Representative Bethell. It is my belief that this bill represents a significant addition to existing public policy related to pain management in Kansas. Experts who evaluate public policy related to pain management have consistently given Kansas high marks for its policies, and I believe that the additions proposed in this bill will produce a rating that is second to no other state's.

As I testified when I last spoke with you two weeks ago, poor pain management is a significant public health concern. For a variety of reasons, patients with pain experience great difficulty in receiving adequate treatment from their physicians and other healthcare providers, resulting in serious decrement to their quality of life. Uncontrolled pain causes disability, anxiety, anger, depression and despair, and, in the most extreme cases, suicide. The National Institutes of Health estimate that the cost of unrelieved pain to the American economy is approximately $110 billion each year. To put that into a more local perspective, if this cost is distributed evenly across the population of the United States, the share for Kansas each year is slightly over $1 billion.

This extreme financial and human cost is unnecessary. Research has demonstrated that approximately 90% of individuals with pain can achieve adequate pain control using oral and intravenous pain medications, along with non-drug interventions. We do not approach this level of success in common medical practice. The failure of the healthcare system to provide adequate pain relief to individuals with pain can be traced to a number of sources. From the perspective of healthcare professionals, some of the barriers include inadequate assessment of patients' pain reports; an unwillingness to accept patients' reports of pain as being valid or reliable; fear that prescribing appropriate pain medications will result in addiction or other untoward side effects; inadequate knowledge of available options for treating pain; fear of being sued for overprescribing; and fear of sanction by regulatory and law enforcement agencies. In fact, it is quite possible to obtain adequate education on pain assessment and treatment, given the prevalence of continuing education opportunities available today; addiction as a consequence of pain treatment is a truly rare complication, one that physicians can be taught to prevent, detect, and treat appropriately; physicians are increasingly being sued for undertreatment of pain; and, at least in Kansas, the regulatory and law enforcement communities have demonstrated a commitment to evaluating pain treatment appropriately, such that physicians who make an honest effort to provide good treatment and document that effort appropriately are not subject to sanction.

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Still, despite our superb public policy and supportive regulatory boards, available statistics indicate that the quality of pain management in Kansas is below average.

HB2649 seeks to improve pain care for Kansans by making a strong positive statutory statement on the subject, while simultaneously eliminating the few negative features of our public policy identified by experts in this subject area. Sections 2 and 3 of this bill outline a Pain Patient's Bill of Rights, stating in simple terms the basic right of patients to have their pain reports heard, believed, and acted upon appropriately. This recognition of the rights of individuals with pain is consistent with statements from the Joint Commission on the Accreditation of Healthcare Organizations and numerous other professional organizations. The LIFE Project's Pain Management Task Group has used the specific content of this Bill of Rights in its campaign and, as such, it has been reviewed and approved by a variety of our partner organizations, as we jointly try to improve the care of patients with life-limiting illnesses. It also closely mirrors the content of a Pain Patient's Bill of Rights developed by the American Pain Foundation. HB2649 puts this right into practical terms, outlining the type of treatment individuals with pain should expect when they see a healthcare professional. Interestingly, everything in sections 2 and 3 is already available and appropriate for individuals with pain. No new right is created here; rather, by stating these rights in this form, they are given statutory authority, and it is made perfectly clear that patients with pain should expect competent and compassionate treatment.

Section 5 of this bill seeks to delete a reference to what is known as the Principle of Double Effect, now contained in our laws prohibiting assisted suicide. The statement of this principle, intended here to reassure physicians that appropriate pain management will not be construed to be assisted suicide, in fact provides no actual protection, and instead reinforces the inaccurate notion that patients are at grave risk of being inadvertently killed when pain is managed appropriately. Current medical research refutes this notion. Eliminating the clauses indicated in the bill does absolutely nothing to change the meaning and enforceability of the existing laws; in both cases, it is still the *intent* of the physician that is the crux of the matter.

Finally, section 6 of the bill is an attempt to provide a clearer, more objective definition of unprofessional conduct as it relates to prescribing, dispensing, administering, or distributing medications, especially with respect to the controlled substances used to treat pain. After discussion with the executive director and the general counsel for the Kansas State Board of Healing Arts, I would like to offer an amendment to the language of HB2649, as it relates to K.S.A. 65-2837(b)(23). The text of this amendment follows at the end of this document, and has been distributed for your reference. This revision reflects the sentiments expressed in guidelines for the use of controlled substances in the treatment of pain, as issued by not only the Kansas State Board of Healing Arts, but also by the Kansas State Board of Nursing, and jointly by the Boards of Healing Arts, Nursing, and Pharmacy. Note that the proposed amendment not only defines "excessive" by referencing "all the medical facts relating to the patient", but it further expands the ability of the Board of Healing Arts to hold physicians accountable for "inadequate" treatment of pain. The importance of insuring that healthcare professionals understand that undertreatment of pain carries the same potential professional consequences as the overtreatment of pain can not be overstated, and it reflects language contained in both the joint statement of the licensing boards referenced earlier, and the recent Model Policy for the Use of Controlled Substances in the Treatment of Pain, as issued by the Federation of State Medical Boards. With respect to this amendment, please note that the full Board of Healing Arts has not been able to discuss it at a meeting; the next meeting of the board is scheduled for February 10.

It is my sincere hope that you will carefully consider this important topic and act to promote the relief of pain for all Kansans by adopting HB2649. Thank you very much for the opportunity to speak to you in support of it today.

Text of Proposed Amendment

K.S.A. 65-2837(b)(23): Prescribing, dispensing, administering, *or* distributing a prescription drug or substance, including a controlled substance, *that is inadequate,* ~~in an~~ excessive, improper or inappropriate *given all the medical facts relating to the patient, is not for a legitimate medical purpose*, ~~manner or quantity~~ or *is* not in the course of the licensee's professional practice.

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HB 2649, "pain patient's bill of rights"

January 31, 2006

Honorable Chairman Morrison
and Committee Members:

Kansas Advocates for Better Care is supportive of HB 2649.

Kansas Advocates for Better Care (KABC) is a statewide non-profit organization of consumers that advocates for quality long-term care. It has been assisting/guiding consumers for more than 30 years as they try to understand and make use of the complex long-term care system of services.

Residents in long-term care settings are only part of the population that is concerned with pain relief. The prevalence of pain in frail elders living in nursing homes has been a recognized indicator of quality for several years by the federal government Centers for Medicare and Medicaid Services. The following facts are from their Quality Indicators identified on their website. On January 25, 2006 they showed that the average percent of nursing home residents in Kansas who have moderate to severe pain was 9% while the national average was 6%. As well, the percent of short-stay nursing home residents in Kansas who had moderate to severe pain was 26% while the national average was 23%.

In the early 2000s the Robert Wood Johnson Foundation supported a major national effort to educate the population about pain and pain management.

Kansas has a recognized expert on pain management, Dr. Robert Twillman, who has spent countless hours making presentations across the state to help Kansans understand pain and how to get pain relief.

HB 2649 provides a final confirmation for Kansans that their pain should be acknowledged and taken seriously by health care professionals, family members or other legally authorized persons.

Thank you for this opportunity to testify in support of HB 2649.
Deanne Bacco, Executive Director

Attachment 4
HHS 2-1-06

Kansas Association of Osteopathic Medicine
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Topeka, Kansas 66612
Phone (785) 234 5563
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Testimony on House Bill 2649
To The
House Health and Human Services Committee
By Charles L. (Chip) Wheelen
February 1, 2006

Thank you for the opportunity to express some concerns about the provisions of HB 2649. We generally support the intent of the bill; including the statement of public purpose contained in new section two. We assume that new section two is not intended to create a new cause of action and result in civil lawsuits against physicians. We are concerned, however, about language in sections three and four of the bill.

Item (3) under subsection (a) of new section three does not seem to make sense. Perhaps the word "or" in line 36 of page one should instead say "of other." This would mean that if the patient's physician is for some reason reluctant to prescribe a narcotic drug, the physician would have a duty to refer the patient to another physician who would prescribe narcotics. Unfortunately, there are not many physicians who sub-specialize in pain management, and in many communities there just aren't very many physicians at all. Item (3) could create an impractical requirement that simply cannot be met.

We respectfully request that all the language in new section three be deleted and the following be inserted in lieu thereof.

New Sec. 3. K.S.A. 65-2838 is hereby amended to read as follows: 65-2838. (a) The board shall have jurisdiction of proceedings to take disciplinary action authorized by K.S.A. 65-2836 and amendments thereto against any licensee practicing under this act. Any such action shall be taken in accordance with the provisions of the Kansas administrative procedure act.

(b) Either before or after formal charges have been filed, the board and the licensee may enter into a stipulation which shall be binding upon the board and the licensee entering into such stipulation, and the board may enter its findings of fact and enforcement order based upon such stipulation without the necessity of filing any formal charges or holding hearings in the case. An enforcement order based upon a stipulation may order any disciplinary action authorized by K.S.A. 65-2836 and amendments thereto against the licensee entering into such stipulation.

(c) The board may temporarily suspend or temporarily limit the license of any licensee in accordance with the emergency adjudicative proceedings under the Kansas administrative procedure act if the board determines that there is cause to believe that grounds exist under K.S.A. 65-2836 and amendments thereto for disciplinary action authorized by K.S.A. 65-2836 and amendments thereto against the licensee and that the licensee's continuation in practice would constitute an imminent danger to the public health and safety.

(d) The Board shall not take disciplinary action against any licensee for prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice. The Board shall consider prescribing, ordering,

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administering or dispensing controlled substances for pain to be for a legitimate medical purpose if based on sound clinical grounds. The Board shall adopt guidelines for the use of controlled substances for the treatment of pain. In the event a licensee's use of controlled substances has been questioned by another regulatory or enforcement agency and such licensee has prescribed, dispensed or administered controlled substances, including opioid analgesics, in accordance with guidelines adopted by the Board, the Board shall support the licensee in response to the other regulatory or enforcement agency.

New section four of the bill attempts to reiterate public policies that are already a matter of law, but in doing that, it creates inconsistencies. For example, item (1) under subsection (c) restates a definition of unprofessional conduct contained in the Healing Arts Act, but the language differs. If you compare this item (1) with item (25) under subsection (b) of section 6 in line 37 of page 4, which is current law, the language is not the same. Similarly, item (2) under subsection (c) of new section four should be consistent with current law at item (23) under subsection (b) of section six in line 28 of page 4, but it is not. In other words, new section four of HB2649 is probably unnecessary and could be problematic because of inconsistent legal standards for physicians.

We respectfully request that all the language in new section four be deleted and the following be inserted in lieu thereof.

New Sec. 4. *Nothing in this act shall be construed to prohibit disciplinary action by the state board of healing arts or interfere with the investigative authority of any law enforcement agency.*

This language would be concise and straightforward, and would compliment and clarify our requested amendment in section three.

We endorse the amendments to current law contained in sections five and six. These changes would improve clarity of meaning and expression of legislative intent.

Assuming adoption of the above amendments to sections three and four, HB 2649 would be consistent with the existing guidelines for use of controlled substances (narcotics) adopted by the Kansas Board of Healing Arts in 1998. A copy of that document follows. We consider these guidelines to be the standard of care for all physicians licensed to practice in Kansas.

Thank you for your consideration of our concerns. We respectfully request adoption of our proposed amendments prior to your Committee action on HB2649.

Guidelines for the Use of Controlled Substances for the Treatment of Pain

Approved by the Kansas State Board of Healing Arts October 17, 1998.

Section I: Preamble

The Kansas State Board of Healing Arts recognizes that principles of quality medical practice dictate that the people of the State of Kansas have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. The Board encourages physicians to view effective pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially important for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about effective methods of pain treatment.

Inadequate pain control may result from physicians' lack of knowledge about pain management or an inadequate understanding of addiction. Fears of investigation or sanction by federal, state and local regulatory agencies may also result in inappropriate or inadequate treatment of chronic pain patients. Accordingly, these guidelines have been developed to clarify the Board's position on pain control, specifically as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

The Board recognizes that controlled substances, including opioid analgesics, may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. The medical management of pain should be based on current knowledge and research and include the use of both pharmacologic and non-pharmacologic modalities. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity and duration of the pain. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not synonymous with addiction.

The Kansas State Board of Healing Arts is obligated under the laws of the State of Kansas to protect the public health and safety. The Board recognizes that inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Physicians should be diligent in preventing the diversion of drugs for illegitimate purposes.

Physicians should not fear disciplinary action from the Board for prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the usual course of professional practice. The Board will consider prescribing, ordering, administering or dispensing controlled substances for pain to be for a legitimate medical purpose if based on sound clinical grounds. All such prescribing must be based on clear documentation of unrelieved pain and in compliance with these guidelines. If such prescribing meets these criteria, the Board will support physicians whose use of controlled substances has been questioned by another regulatory or enforcement agency.

Allegations of improper prescribing of controlled substances for pain will be evaluated on a case- by-case basis. The board will not take disciplinary action against a physician for failing to adhere strictly to the provisions of these guidelines, if good cause is shown for such deviation. The physician's conduct will be evaluated to a great extent by the treatment outcome, taking into account whether the drug used is medically and/or pharmacologically recognized to be appropriate for the diagnosis, the patient's individual needs including any improvement in functioning and recognizing that some types of pain cannot be completely relieved.

The Board 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 chronicity of prescribing. 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. The following guidelines are not intended to define complete or best practice, but rather to communicate what the Board considers to be within the boundaries of professional practice.

Section II: Guidelines

The Board has adopted the following guidelines when evaluating the use of controlled substances for pain control:

1. **Evaluation of the Patient**

The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

2. **Treatment Plan**

The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

3. **Informed Consent and Agreement for Treatment**

The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is incompetent. The patient should receive prescriptions from one physician and one pharmacy where possible. If the patient is determined to be at high risk for medication abuse or have a history of substance abuse, the physician may employ the use of a written agreement between physician and patient outlining patient responsibilities, including

- urine/serum medication levels screening when requested;
- number and frequency of all prescription refills; and
- reasons for which drug therapy may be discontinued (i.e., violation of agreement).

4. **Periodic Review**

At reasonable intervals based on the individual circumstances of the patient, the physician should review the course of treatment and any new information about the etiology of the pain. Continuation or modification of therapy should depend on the physician's evaluation of progress toward stated treatment objectives, such as improvement in patient's pain intensity and improved physical and/or psychosocial function, i.e., ability to work, need of health care resources, activities of daily living and quality of social life. If treatment goals are not being achieved, despite medication adjustments, the physician should reevaluate the appropriateness of continued treatment. The physician should monitor patient compliance in medication usage and related treatment plans.

5. **Consultation**
The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those pain patients who are at risk for misusing their medications and those whose living arrangement pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a co-morbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

6. **Medical Records**
The physician should comply with and meet the requirements of K.A.R. 100-24-1 in the maintenance of an adequate record for each patient.

7. **Compliance With Controlled Substances Laws and Regulations**
To prescribe, dispense or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations.

Section III: Definitions
For the purposes of these guidelines, the following terms are defined as follows:

"Acute pain" is the normal, predicted physiological response to an adverse chemical, thermal or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time-limited and is responsive to opioid therapy, among other therapies.
"Addiction" is a neuro-behavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Addiction may also be referred to by terms such as "drug dependence" and "psychological dependence." Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.
"Analgesic tolerance" is the need to increase the dose of opioid to achieve the same level of analgesia. Analgesic tolerance may or may not be evident during opioid treatment and does not equate with addiction.
"Chronic pain" is a pain state which is persistent and in which the cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.
"Pain" is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.
"Physical dependence" on a controlled substance is a physiologic state of neuro-adaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered. Physical dependence is an expected result of opioid use. Physical dependence, by itself, does not equate with addiction.
"Pseudoaddiction" is a pattern of drug-seeking behavior of pain patients who are receiving inadequate pain management that can be mistaken for addiction.
"Substance abuse" is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.
"Tolerance" is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect, or a reduced effect is observed with a constant dose.

To: House Health and Human Services Committee

From: Jerry Slaughter
Executive Director

Subject: HB 2649; concerning the pain patient's bill of rights

Date: January 31, 2006

The Kansas Medical Society appreciates the opportunity to submit the following comments today on HB 2649, the pain patient's bill of rights. While we support greater awareness and education on the treatment of pain by both health care providers and patients alike, we do have some concerns about the bill.

First, we would like to point out to the committee that there already exists two clear statements of policy on this topic that serve as guidance for the health care professions. In 1998 the Kansas State Board of Healing Arts adopted the *Guidelines for the Use of Controlled Substances for the Treatment of Pain,* which can be found at the following link: http://www.ksbha.org/misc/painmgmt.html . Then, in 2002 the Boards of Healing Arts, Nursing and Pharmacy adopted the *Joint Policy Statement of the Boards of Healing Arts, Nursing and Pharmacy on the Use of Controlled Substances for the Treatment of Pain,* which may be accessed at: http://www.ksbha.org/misc/jointpainmgmt.html . Both statements represent reasoned, clinically appropriate guidelines for health care professionals who take care of patients with pain.

We have some concerns with the language in New Sections 2 and 3 of this bill, in that it could be interpreted as conferring legal rights, and imposing legal duties. Our concern is that the well-intentioned language could create problems that would make providing appropriate care to patients with pain even more difficult. Our fear is that the language in these sections of the bill could result in health care professionals not knowing what their legal obligations and duties actually are in this area of practice, which would discourage them from being willing to take patients with pain into their practices. Obviously, that would not be an outcome that anyone desires. Our suggested language would combine these two sections into a statement of legislative intent or purpose, which conveys the importance of the matter without creating legal rights and duties.

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We respectfully request that all of New Sections 2 and 3 be deleted, and the following inserted therein:

New Section 2. The Legislature finds and declares the following:

(a) A person suffering from pain should expect their report of pain to be taken seriously, and should expect to be treated with respect by health care professionals.

(b) A person suffering from pain should have access to and expect proper assessment and treatment of his or her pain, while retaining the right to refuse treatment.

(c) A person's health care professional may refuse to prescribe opiate medication for a patient who requests treatment for pain. However, that health care professional shall inform the patient that there are physicians who specialize in the treatment of pain with methods that include the use of opiate medication.

(d) A person suffering from pain may request that his or her physician provide an identifying notice of such person's prescription for purposes of emergency treatment or law enforcement identification.

(e) A health care professional treating a person who suffers from pain may prescribe opiate medications in a dosage deemed medically necessary to relieve such person's pain.

(f) A person suffering from pain has the option to request or reject the use of any or all modalities to relieve his or her pain, including the use of opiate medications to relieve pain without first having to submit to an invasive medical procedure such as surgery, destruction of a nerve or other body tissue by manipulation, or the implantation of a drug delivery system or device.

Our concerns with New Section 4 of the bill are that virtually everything in this section is already current law. However, the language in this section is slightly different from existing provisions in the healing arts act, which will create problems for not only compliance, but enforcement. How will physicians know which provision governs their practice if they are inconsistent? We would urge you to delete New Section 4 because it is unnecessary and already covered by existing law, and also because it will create a conflict in statute with inconsistent legal standards. In discussing this provision with Chip Wheelen of the Kansas Association of Osteopathic Medicine, he shared the KAOM's proposed language for this section with us. We would support their proposed amendment.

Our suggested amendments, and those of the KAOM, will make this legislation consistent with the guidelines for the treatment of pain which have previously been adopted by the licensing agencies. We urge you to adopt the amendments described above. Thank you for considering our comments.

February 1, 2006

The Honorable Jim Morrison, Chairperson
House Committee on Health and Human Services
Statehouse, Room 143-N
Topeka, Kansas 66612

Dear Representative Morrison:

SUBJECT: Fiscal Note for HB 2649 by House Committee on Health and Human Services

In accordance with KSA 75-3715a, the following fiscal note concerning HB 2649 is respectfully submitted to your committee.

HB 2649 would establish the Pain Patient's Bill of Rights. The bill would allow patients who suffer from moderate to severe pain to request or reject the use of any or all methods of pain relief, including opiate medications, without first having to submit to an invasive medical procedure such as surgery; choose from treatment options available; receive information regarding physicians who are qualified to treat severe pain; and receive an identifying notice of a prescription from a physician for the purposes of emergency treatment or law enforcement identification.

The bill would also require that patients be treated with dignity and respect by doctors, nurses, and other health care professionals. This would include having their pain thoroughly assessed and promptly treated, and having their pain reassessed regularly and their treatment adjusted if their pain has not been eased. A physician who uses opiate therapy to relieve moderate to severe pain would be allowed to prescribe a dosage deemed medically necessary to relieve the pain.

HB 2649 would not expand the scope of practice for any licensed physician or limit the disciplinary actions that could be brought against any physician. Specific acts that would result in disciplinary action would include writing false prescriptions, dispensing pharmaceuticals in a

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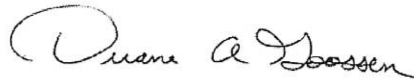
way that violates the federal Comprehensive Drug Abuse Prevention and Control Act of 1970, diverting medications prescribed for a patient for the physician's personal use, and causing or assisting in the suicide or euthanasia of any individual.

The bill would also amend current statutes regarding professional incompetency, by prohibiting the prescribing, dispensing, administering, or distributing a controlled substance for other than a legitimate medical purpose. Current law prohibits the prescribing, dispensing, administering, or distributing a controlled substance in an excessive, improper, or inappropriate manner or quantity.

The Board of Healing Arts and the Board of Nursing have indicated that the passage of HB 2649 would not have a fiscal effect on agency operations.

Sincerely,



Duane A. Goossen
Director of the Budget

cc: Cathy Brown, Healing Arts
Aaron Dunkel, KDHE
Debra Billingsley, Board of Pharmacy
Mary Blubaugh, Board of Nursing

January 31, 2006

The Honorable Jim Morrison, Chairperson
House Committee on Health and Human Services
Statehouse, Room 143-N
Topeka, Kansas 66612

Dear Representative Morrison:

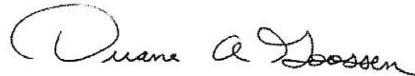
SUBJECT: Fiscal Note for HB 2678 by House Committee on Health and Human Services

In accordance with KSA 75-3715a, the following fiscal note concerning HB 2678 is respectfully submitted to your committee.

HB 2678 would repeal the provision in the Kansas Pharmacy Act that requires free-standing renal dialysis facilities that dispense drugs to consumers to be licensed with the Board of Pharmacy.

The Board of Pharmacy states that none of the free-standing renal dialysis facilities are currently licensed. Therefore, passage of HB 2678 would have no fiscal effect.

Sincerely,



Duane A. Goossen
Director of the Budget

cc: Debra Billingsley, Board of Pharmacy

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February 25, 2005

The Honorable Pete Brungardt, Chairperson
Senate Committee on Federal and State Affairs
Statehouse, Room 143-N
Topeka, Kansas 66612

Dear Senator Brungardt:

SUBJECT: Fiscal Note for SB 263 by Senate Committee on Federal and State Affairs

In accordance with KSA 75-3715a, the following fiscal note concerning SB 263 is respectfully submitted to your committee.

SB 263 would increase the number of members on the Board of Emergency Medical Services from 13 to 15 members. The additional members would be appointed by the Governor from administrators of ambulance services.

Estimated State Fiscal Effect				
	FY 2005 SGF	FY 2005 All Funds	FY 2006 SGF	FY 2006 All Funds
Revenue	--	--	--	--
Expenditure	--	--	--	$6,385
FTE Pos.	--	--	--	--

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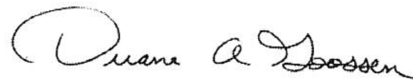
Enactment of SB 263 would require estimated expenditures of $6,385 from the Emergency Medical Services Fee Fund in FY 2006. The costs are for the additional board members' expenses in mileage, lodging, and subsistence. Any fiscal effect resulting from this bill would be in addition to amounts included in *The FY 2006 Governor's Budget Report*.

Sincerely,



Duane A. Goossen
Director of the Budget

cc: Mary Mulryan, Emergency Medical Services

SESSION OF 2005

SUPPLEMENTAL NOTE ON SENATE BILL NO. 263

As Amended by Senate Committee on
Federal and State Affairs

Brief*

SB 263 would amend the membership of the Emergency Medical Services Board to require that at least one member of the three members who are actively involved in emergency medical service shall be an administrator for an ambulance service. The number of members on the Board is not increased by this bill.

Background

A representative from Labette County Emergency Medical Services testified in support of the bill, and a representative from American Medical Response submitted written testimony in support of the bill. The Director of Emergency Medical Services provided neutral testimony on the bill. No opponents testified.

SB 263, as introduced, would have increased the size of the Emergency Medical Services Board from 13 to 15 members to provide that two administrators of ambulance services be included on the Board. The Committee amended the bill to require that at least one member of the three members who are actively involved in emergency medical service shall be an administrator for an ambulance service.

The fiscal note from the Director of Budget was based upon the bill as introduced which would have increased the Board membership by two people. The fiscal note indicates that the passage of the bill would have increased the expenditure of the Emergency Medical Services Fee Fund by an estimated $6,385.

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*Supplemental notes are prepared by the Legislative Research Department and do not express legislative intent. The supplemental note and fiscal note for this bill may be accessed on the Internet at http://www.kslegislature.org

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