R³ Report | Requirement, Rationale, Reference

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Published for Joint Commission-accredited organizations and interested health care professionals, *R3 Report* provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also may provide a rationale, *R3 Report* goes into more depth, providing a rationale statement for each element of performance (EP). The references provide the evidence that supports the requirement. *R3 Report* may be reproduced if credited to The Joint Commission. Sign up for email delivery.

Pain assessment and management standards for critical access hospitals

Effective Jan. 1, 2019, new and revised pain assessment and management standards will be applicable to all Joint Commission-accredited ambulatory care, critical access hospitals, and office-based surgery organizations. The Joint Commission published new and revised pain assessment and management requirements in January 2018 for the Hospital Accreditation program (see July 2017 issue of *Perspectives*). This project is a continuation of this initiative.

Engagement with stakeholders, customers, and experts

In addition to an extensive literature review and public field review, The Joint Commission sought expert guidance through the following:

- Technical advisory panel (TAP) included practicing clinicians from health care and academic organizations, professional associations, the payor and health technology sectors.
- Primary care panel included experts in chronic non-cancer pain management in the primary care setting, including members of leading health care organizations with ongoing safe prescribing and provider education initiatives.
- Standards review panel (SRP) consisted of representatives from organizations or professional associations who provided a "boots on the ground" point of view and insights into the practical application of the proposed standards.

The prepublication version of the pain assessment and management standards will be available online until the end of 2018. After Jan. 1, 2019, access the standards in the E-dition or standards manual.

Leadership

LD.04.03.13: Pain assessment and pain management, including safe opioid prescribing, is identified as an organizational priority.

Requirement	LD.04.03.13 EP 1: The critical access hospital has a leader or leadership team that is responsible for pain management and safe opioid prescribing and developing and monitoring performance improvement activities. (See also PI.02.01.01, EP 19)
Rationale	Gaps in the evidence on optimal pain management, combined with a substantial rise in opioid use and associated harms over the past two decades, are of great concern for health care organizations and the public. Solutions to these safety and quality problems require the coordination of administrative and physician leadership to promote quality initiatives and allocate resources for safe pain management.
Reference*	National Academy of Medicine (NAM). First do no harm: Marshaling clinician leadership to counter the opioid epidemic. Washington, DC: National Academy of Medicine.
Requirement	LD.04.03.13, EP 2: The critical access hospital provides nonpharmacologic pain treatment modalities.
Rationale	Nonpharmacologic therapies can be effective in managing acute and chronic pain. Major professional organizations and experts agree that chronic pain and perioperative pain are optimally managed when practitioners combine nonpharmacologic and pharmacologic treatments.

Reference*	Qaseem A, et al. Noninvasive treatments for acute, subacute, and chronic low back pain: A clinical practice guideline from the American College of Physicians. *Annals of Internal Medicine*. 2017;166(7):514-30. Skelly AC, et al. Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review. Comparative Effectiveness Review No. 209. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 290-2015-00009-I.) AHRQ Publication No 18-EHC013-EF. Rockville, MD: Agency for Healthcare Research and Quality; June 2018. Nahin RL, et al. Evidence-based evaluation of complementary health approaches for pain management in the United States. Mayo Clinic Proceedings. 2016;91(9):1292-1306. Elsevier. Tick H, et al. Evidence-based nonpharmacologic strategies for comprehensive pain care. The Consortium Pain Task Force White Paper. Dowell D, et al. CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016. *Morbidity and Mortality Weekly Report* Recomm Rep. 2016;65(No. RR-1):1-49. doi: 10.15585/mmwr.rr6501e1. Chou R, et al. Management of Postoperative Pain: A Clinical Practice Guideline from the American Pain Society, the American Society of Regional Anesthesia and Pain Medicine, and the American Society of Anesthesiologists' Committee on Regional Anesthesia, Executive Committee, and Administrative Council. *The Journal of Pain*. 2016;17(2):131-57.
Requirement	LD.04.03.13, EP 3: The critical access hospital provides staff and licensed independent practitioners with educational resources and programs to improve pain assessment, pain management, and the safe use of opioid medications based on the identified needs of its patient population.
Rationale	Provider competence is stressed in clinical practice guidelines, regulations, and by experts in the field. Providers are expected to be knowledgeable about multiple modalities of pain treatment, early identification and prevention of harms of opioid therapy, and management of patients with complex needs. However, providers report insufficient training in pain management and opioid prescribing. The critical access hospital can increase provider competence in pain management by providing access to effective education resources.
Reference*	Mostofian F, et al. Changing physician behavior: What works? The American Journal of Managed Care. 2015;21(1):75-84. Alford DP, et al. SCOPE of pain: An evaluation of an opioid risk evaluation and mitigation strategy continuing education program. *Pain Medicine*. 2016;17(1):52-63.
Requirement	LD.04.03.13, EP 4: The critical access hospital provides information to staff and licensed independent practitioners on available services for consultation and referral of patients with complex pain management needs.

Rationale	Many patients in hospital and ambulatory settings have complex pain management needs and require multidisciplinary care. Access to specialists through consultation, referral, or use of in-house experts reflects best practice. For example, consultation or referral to a pain specialist is advised when it is necessary to develop a perioperative pain management plan for the patient with opioid tolerance or a history of substance abuse. Cost, lack of transportation, and low availability of services may hinder the use of nonpharmacologic treatments. A barrier also could be the provider's limited knowledge about available networks of nonpharmacologic care providers in the community. Critical access hospital leaders can support access by providing information about local resources for patient referral.
Reference*	Chou R, et al. Management of postoperative pain: A clinical practice guideline from the American Pain Society, the American Society of Regional Anesthesia and Pain Medicine, and the American Society of Anesthesiologists' Committee on Regional Anesthesia, Executive Committee, and Administrative Council. *The Journal of Pain*. 2016;17(2):131-57.
Requirement	LD.04.03.13, EP 5: The critical access hospital identifies opioid treatment programs that can be used for patient referrals.
Rationale	When a patient is suspected of having an opioid use disorder, clinicians need information for referring him or her for opioid use disorder treatment. Critical access hospital leadership should identify up-to-date resources. The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) website provides a directory of opioid treatment programs and related provider resources.
Resources	U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) Directory of Opioid Treatment Programs
Requirement	LD.04.03.13, EP 6: The critical access hospital facilitates practitioner and pharmacist access to the Prescription Drug Monitoring Program databases. Note: This element of performance is applicable in any state that has a Prescription Drug Monitoring Program database, whether querying is voluntary or is mandated by state regulations for all patients prescribed opioids.
Rationale	Prescription Drug Monitoring Programs (PDMPs) aggregate prescribing and dispensing data submitted by pharmacies and dispensing practitioners. When used together with other assessment strategies and tools, PDMPs can assist providers in preventing misuse and diversion of prescription medications. A link on the homepage of the electronic health record (EHR) to all relevant PDMPs in the geographic areas served by the organization would facilitate access. The Joint Commission does not mandate that organizations use PDMPs prior to prescribing an opioid because of the limited availability of current databases in many locations. However, some states (e.g., Massachusetts) require use of PDMPs prior to prescribing an opioid; critical access hospitals will be assessed on compliance with state law.
Reference*	Substance Abuse and Mental Health Services Administration (SAMHSA). Prescription drug monitoring programs: A guide for healthcare providers. The Pew Charitable Trusts. Prescription drug monitoring programs: Evidence-based practices to optimize prescriber use 2016.
Requirement	LD.04.03.13, EP 7: Critical access hospital leadership works with its clinical staff to identify and acquire the equipment needed to monitor patients who are at high risk for adverse outcomes from opioid treatment. (See also PC.01.02.07, EP 6)

Rationale	The most dangerous adverse effect of opioid analgesics is respiratory depression, and monitoring for respiratory depression is sometimes appropriate. However, there are no controlled trials of monitoring to help determine the optimal strategy. Therefore, this decision should be left to the treating clinical team. The leadership team should work with clinician leaders to ensure equipment is available to monitor patients deemed highest risk (e.g., patients with sleep apnea, those receiving continuous intravenous opioids, or those on supplemental oxygen).
Reference*	Chung F, et al. Society of Anesthesia and Sleep Medicine Guidelines on Preoperative Screening and Assessment of Adult Patients with Obstructive Sleep Apnea. *Anesthesia & Analgesia*. 2016;123(2):452. Lam KK, et al. Obstructive sleep apnea, pain, and opioids: Is the riddle solved? *Current Opinion in Anaesthesiology*. 2016;29(1):134. Lam T, et al. Continuous pulse oximetry and capnography monitoring for postoperative respiratory depression and adverse events: A systematic review and meta-analysis. *Anesthesia & Analgesia*. 2017;125(6):2019-29.

Medical Staff

MS.05.01.01: The organized medical staff has a leadership role in organization performance improvement activities to improve patient safety and the quality of care, treatment, and services.

Requirement	MS.05.01.01, EP 18: The medical staff is actively involved in pain assessment, pain management, and safe opioid prescribing through the following: - Participating in the establishment of protocols and quality metrics - Reviewing performance improvement data
Rationale	The medical staff have responsibility for organizationwide pain management and should play a significant role in defining organizational management and prescribing practices, in addition to relevant quality improvement metrics.
Reference*	National Academy of Medicine (NAM). First do no harm: Marshaling clinician leadership to counter the opioid epidemic. Washington, DC: National Academy of Medicine.

Provision of Care, Treatment, and Services

PC.01.02.07: The critical access hospital assesses and manages the patient's pain and minimizes the risks associated with treatment.

Requirement	PC.01.02.07, EP 1: The critical access hospital has defined criteria to screen, assess, and reassess pain that are consistent with the patient's age, condition, and ability to understand.
Rationale	Critical access hospitals need to develop systems for pain screening and assessment in order to support appropriate individualized pain treatment and perioperative pain management. The hospital is responsible for ensuring that appropriate screening and assessment tools are readily available and used appropriately. The tools required to adequately assess pain may differ depending on a patient's age, condition, ability to understand, and whether pain is acute or chronic. For example, chronic pain generally requires more extensive patient assessment, including various domains of physical and functional impairment.

Reference*	Miller RM and Kaiser RS. Psychological characteristics of chronic pain: A review of current evidence and assessment tools to enhance treatment. *Current Pain and Headache Reports*. 2018;22(3):22. Reid MC, et al. Management of chronic pain in older adults. *British Medical Journal*. 2015;350(7995):1-0. Stanos S, et al. Rethinking chronic pain in a primary care setting. *Postgraduate Medicine*. 2016;128(5):502-15. Tobias JD. Acute pain management in infants and children—Part 1: Pain pathways, pain assessment, and outpatient pain management. *Pediatric Annals*. 2014;43(7):e163-8. Core Curriculum for Pain Management Nursing, Third Edition. (Eds. M. Czarnecki & H. Turner). Elsevier, 2018.
Requirement	PC.01.02.07, EP 2: The critical access hospital screens patients for pain during emergency department visits and at the time of admission.
Rationale	Barriers to pain assessment exist, including provider, healthcare system, and patient-related barriers. Screening patients for pain at the time of admission helps in pain identification and treatment.
Reference*	Core Curriculum for Pain Management Nursing, Third Edition. (Eds. M. Czarnecki & H. Turner). Elsevier, 2018.
Requirement	PC.01.02.07, EP 3: The critical access hospital treats the patient's pain or refers the patient for treatment. Note: Treatment strategies for pain include nonpharmacologic, pharmacologic, or a combination of approaches.
Rationale	Referral may be necessary for patients who need more extensive assessment or require treatments and monitoring that exceed the clinical expertise and capabilities of the individual provider. This may include patients with complex pain management requirements, pediatric patients with chronic nonmalignant pain disorders, or patients with advanced perioperative needs related to opioid tolerance.
Reference*	Becker WC, et al. Evaluation of an integrated, multidisciplinary program to address unsafe use of opioids prescribed for pain. *Pain Medicine*. 2017:pnx041. Chou R, et al. Management of postoperative pain: A clinical practice guideline from the American Pain Society, the American Society of Regional Anesthesia and Pain Medicine, and the American Society of Anesthesiologists' Committee on Regional Anesthesia, Executive Committee, and Administrative Council. *The Journal of Pain*. 2016;17(2):131-57. Palermo T, et al. Assessment and management of children with chronic pain. *American Pain Society*, 2012;4.
Requirement	PC.01.02.07, EP 4: The critical access hospital develops a pain treatment plan based on evidence-based practices and the patient's clinical condition, past medical history, and pain management goals.
Rationale	Differences in the experience of acute or chronic pain may be caused by pain pathophysiology, risk factors, comorbidities, and psychosocial characteristics. These individual variations support an individualized model of pain management, as well as responsible transition of care across care settings to support ongoing care needs. In some instances, an individualized approach to treatment and monitoring is necessary and safe because insufficient clinical guidance exists in areas such as evidence on postoperative opioid tapering protocols.

Reference*	Stanos S, et al. Rethinking chronic pain in a primary care setting. *Postgraduate Medicine*. 2016;128(5):502-15. Gordon DB, et al. Research gaps in practice guidelines for acute postoperative pain management in adults: Findings from a review of the evidence for an American Pain Society Clinical Practice Guideline. *The Journal of Pain*. 2016;17(2):158-66. Cornelius R, et al. Acute Pain Management in Older Adults. *Journal of Gerontological Nursing*. 2017;43(2):18-27. Chou R, et al. Management of postoperative pain: A clinical practice guideline from the American Pain Society, the American Society of Regional Anesthesia and Pain Medicine, and the American Society of Anesthesiologists' Committee on Regional Anesthesia, Executive Committee, and Administrative Council. *The Journal of Pain*. 2016;17(2):131-57.
Requirement	PC.01.02.07, EP 5: The critical access hospital involves patients in the pain management treatment planning process through the following: - Developing realistic expectations and measurable goals that are understood by the patient for the degree, duration, and reduction of pain - Discussing the objectives used to evaluate treatment progress (for example, relief of pain and improved physical and psychosocial function) - Providing education on pain management, treatment options, and safe use of opioid and non-opioid medications when prescribed (See also RI.01.02.01, EPs 2-4; RI.01.03.01, EP 1)
Rationale	The Joint Commission's technical advisory panel on pain management emphasized the importance of discussions between the patient and the provider/care team about realistic goals and expectations for the trajectory of pain, especially when the outcomes of pain treatment are uncertain. It is important to identify domains of function or quality of life issues that the patient values, and prioritize improvement in these areas to increase satisfaction with treatment progress.
Reference*	O'Brien EM, et al. Patient-centered perspective on treatment outcomes in chronic pain. *Pain Medicine*. 2010;11(1):6-15.
Requirement	PC.01.02.07, EP 6: The critical access hospital monitors patients identified as being high risk for adverse outcomes related to opioid treatment. (See also LD.04.03.13, EP 7)
Rationale	The most dangerous adverse effect of opioid analgesics is respiratory depression, and monitoring for respiratory depression is sometimes appropriate. However, there are no controlled trials of monitoring to help determine the optimal strategy. Therefore, this decision should be left to the treating clinical team. The leadership team should work with clinician leaders to ensure equipment is available to monitor patients deemed highest risk (e.g., patients with sleep apnea, those receiving continuous intravenous opioids, or those on supplemental oxygen).
Reference*	Chung F, et al. Society of Anesthesia and Sleep Medicine Guidelines on Preoperative Screening and Assessment of Adult Patients with Obstructive Sleep Apnea. *Anesthesia & Analgesia*. 2016;123(2):452. Lam KK, et al. Obstructive sleep apnea, pain, and opioids: Is the riddle solved? *Current Opinion in Anaesthesiology*. 2016;29(1):134. Lam T, et al. Continuous Pulse Oximetry and Capnography Monitoring for Postoperative Respiratory Depression and Adverse Events: A Systematic Review and Meta-analysis. *Anesthesia & Analgesia*. 2017;125(6):2019-29.

Requirement	PC.01.02.07, EP 7: The critical access hospital reassesses and responds to the patient's pain through the following: - Evaluation and documentation of response(s) to pain intervention(s) - Progress toward pain management goals including functional ability (for example, ability to take a deep breath, turn in bed, walk with improved pain control) - Side effects of treatment - Risk factors for adverse events caused by the treatment
Rationale	Reassessment should be completed in a timely manner to determine if the intervention is working or if the patient is experiencing adverse effects. Unidimensional reassessment based on numeric pain scales alone is inadequate. The Joint Commission's technical advisory panel stressed the importance of reassessing how pain affects function and the ability to make progress toward treatment goals. For example, after major abdominal surgery, the goal of pain control may be the patient's ability to take a breath without excessive pain. Over the next few days, the goal of pain control may be the ability to sit up in bed or walk to the bathroom without limitation due to pain.
Reference*	Stanos S, et al. Rethinking chronic pain in a primary care setting. *Postgraduate medicine*. 2016;128(5):502-15. Core Curriculum for Pain Management Nursing, Third Edition. (Eds. M. Czarnecki & H. Turner). Elsevier, 2018.
Requirement	PC.01.02.07, EP 8: The critical access hospital educates the patient and family on discharge plans related to pain management including the following: - Pain management plan of care - Side effects of pain management treatment - Activities of daily living, including the home environment, that might exacerbate pain or reduce effectiveness of the pain management plan of care, as well as strategies to address these issues - Safe use, storage, and disposal of opioids when prescribed
Rationale	Patients perceive good patient-provider communication and education as indicators of high quality care. Discharge education is an opportunity for the provider/care team to engage the patient in a discussion on the pain management plan and opioid safety.
Reference*	Mohammed K, et al. Creating a patient-centered health care delivery system: A systematic review of health care quality from the patient perspective. *American Journal of Medical Quality*. 2016;31(1):12-21.

Performance Improvement

PI.01.01.01: The critical access hospital collects data to monitor its performance.

Requirement	PI.01.01.01, EP 40: The critical access hospital collects data on pain assessment and pain management including types of interventions and effectiveness.
Rationale	Organization-level pain assessment and pain management data are important for evaluating organizationwide practices and setting performance improvement goals.
Reference*	National Quality Partner Playbook: Opioid Stewardship. National Quality Forum, Washington D.C.

PI.02.01.01: The critical access hospital compiles and analyzes data.

Requirement	PI.02.01.01, EP 18 The critical access hospital analyzes data collected on pain assessment and pain management to identify areas that need change to increase safety and quality for patients.
Rationale	Organizations have successfully used quality improvement projects to improve in-hospital pain management practices, for example, to improve care coordination within the facility and to decrease opioid use during post-operative hospital stays.
Reference*	Walters TL, et al. Design and implementation of a perioperative surgical home at a veterans affairs hospital. *Seminars in Cardiothoracic and Vascular Anesthesia*. 2016;20(2):133-140). Sage, CA: Los Angeles, CA: SAGE Publications. Alvis BD, et al. Creation and execution of a novel anesthesia perioperative care service at a Veterans Affairs Hospital. *Anesthesia & Analgesia*. 2017;125(5):1526-31.
Requirement	PI.02.01.01, EP 19: The critical access hospital monitors the use of opioids to determine if they are being used safely (for example, the tracking of adverse events such as respiratory depression, naloxone use, and the duration and dose of opioid prescriptions). (See also LD.04.03.13, EP 1)
Rationale	Cautious opioid prescribing for chronic and acute pain is promoted in clinical practice guidelines and regulatory policies. Critical access hospitals can define metrics related to the use of opioids to identify priority areas for practice improvement and resource allocation.
Reference*	Midboe AM, et al. Measurement of adherence to clinical practice guidelines for opioid therapy for chronic pain. *Translational Behavioral Medicine*. 2011;2(1):57-64. Parchman ML, et al. Primary care clinic re-design for prescription opioid management. *The Journal of the American Board of Family Medicine*. 2017;30(1):44-51.

*Not a complete literature review.