Statement on Pain Management: Understanding How Joint Commission Standards Address Pain

By David W. Baker, MD, MPH, FACP, Executive Vice President, Healthcare Quality Evaluation, The Joint Commission

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The Joint Commission in April 2016 released this statement on pain management, written by David Baker, MD, MPH, FACP.

In the environment of today's prescription opioid epidemic, everyone is looking for someone to blame. Often, The Joint Commission's pain standards take that blame. We are encouraging our critics to look at our exact standards, along with the historical context of our standards, to fully understand what our accredited organizations are required to do with regard to pain.

The Joint Commission first established standards for pain assessment and treatment in 2001 in response to the national outcry about the widespread problem of undertreatment of

pain. The Joint Commission's current standards require that organizations establish policies regarding pain assessment and treatment and conduct educational efforts to ensure compliance. The standards **DO NOT** require the use of drugs to manage a patient's pain; and when a drug is appropriate, the standards do not specify which drug should be prescribed.

Our foundational standards are quite simple. They are

- The hospital educates all licensed independent practitioners on assessing and managing pain.
- The hospital respects the patient's right to pain management.
- The hospital assesses and manages the patient's pain.

Requirements for what should be addressed in organizations' policies include the following:

1. The hospital conducts a comprehensive pain assessment that is consistent with its scope of care, treatment, and services and the patient's condition.
2. The hospital uses methods to assess pain that are consistent with the patient's age, condition, and ability to understand.
3. The hospital reassesses and responds to the patient's pain, based on its reassessment criteria.
4. The hospital either treats the patient's pain or refers the patient for treatment. Note: Treatment strategies for pain may include pharmacologic and nonpharmacologic approaches. Strategies should reflect a patient-centered approach and consider the patient's current presentation, the health care providers' clinical judgment, and the risks and benefits associated with the strategies, including potential risk of dependency, addiction, and abuse.

Despite the stability and simplicity of our standards, misconceptions persist, and I would like to take this opportunity to address the most common ones:

Misconception #1: *The Joint Commission endorses pain as a vital sign.*

The Joint Commission does not endorse pain as a vital sign, and this is not part of our standards. Starting in 1990, pain experts started calling for pain to be "made visible." Some organizations implemented programs to try to achieve this by making pain a vital sign. The original 2001 Joint Commission standards did not state that pain needed to be treated like a vital sign. The only time that The Joint Commission standards referenced the fifth vital sign was when The Joint Commission provided examples of what some organizations were doing to assess patient pain. In 2002 The Joint Commission addressed the problems in the use of the fifth vital sign concept by describing the unintended consequences of this approach to pain management and describing how organizations had subsequently modified their processes.

Misconception #2: *The Joint Commission requires pain assessment for all patients.*

The original pain standards stated "Pain is assessed in all patients." This was applicable to all accreditation programs (for example, Hospital, Nursing Care Center, Behavioral Health Care). This requirement was eliminated in 2009 from all programs except Behavioral Health Care Accreditation. Patients in behavioral health care settings were thought to be less able to bring up the fact that they were in pain and, therefore, required a more aggressive approach. The current Behavioral Health Care Accreditation standard says, "The organization screens all individuals served for physical pain."

The current version of the standard for hospitals and programs other than behavioral health care says "The hospital assesses and manages the patient's pain." This standard allows organizations to set their own policies regarding which patients should have pain assessed based on the population served and the services delivered. Joint Commission surveyors determine whether such policies have been established and whether there is evidence that the organization's own policies are followed. Some organizations may still follow the old standard and require pain assessment of all patients.

Misconception #3: *The Joint Commission requires that pain be treated until the pain score reaches zero.*

There are several variations of this misconception, including that The Joint Commission requires that patients be treated by an algorithm according to their pain score. In fact, throughout our history we have advocated for an individualized patient-centric approach that does not require zero pain. The introduction to the "Care of Patients" functional chapter in 2001 started by saying that the goal of care is "to provide individualized care in settings responsive to specific patient needs."

Misconception #4: *The Joint Commission standards push doctors to prescribe opioids.*

As stated above, the current standards do not push clinicians to prescribe opioids. We do not mention opioids at all:

The note to the standard says: Treatment strategies for pain may include pharmacologic and nonpharmacologic approaches. Strategies should reflect a patient-centered approach and consider the patient's current presentation, the health care providers' clinical judgment, and the risks and benefits associated with the strategies, including potential risk of dependency, addiction, and abuse.

Misconception #5: *The Joint Commission pain standards caused a sharp rise in opioid prescriptions.*

This claim is completely contradicted by data from the National Institute on Drug Abuse. The graph on page 12 (Figure 1 in the report) shows the number of opioid prescriptions filled at commercial pharmacies in the United States from 1991 to 2013 and shows the rate had been steadily increasing for 10 years prior to the standards' release in 2001.

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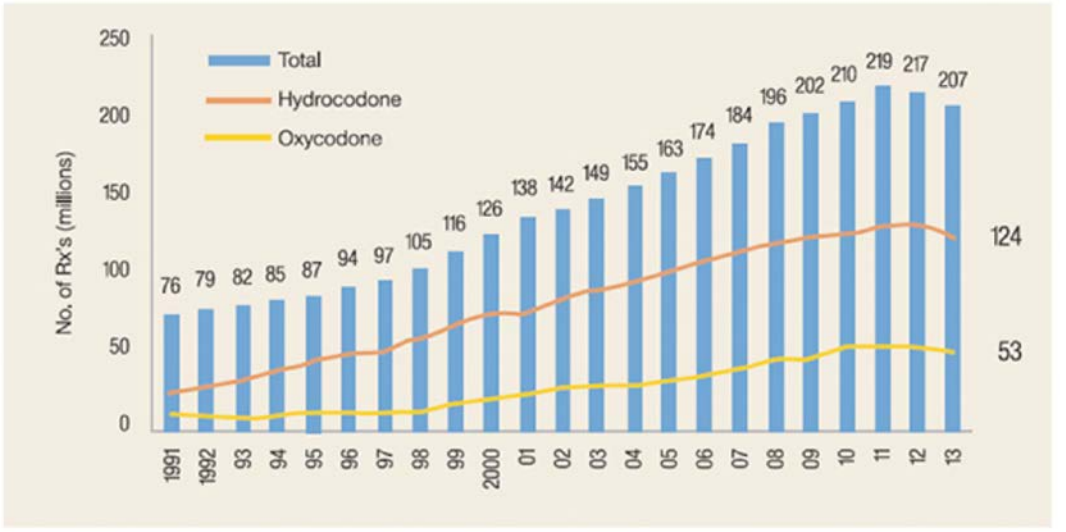
It is likely that the increase in opioid prescriptions began in response to the growing concerns in the United States about undertreatment of pain and efforts by pain management experts to allay physicians' concerns about using opioids for nonmalignant pain. Moreover, the standards do not appear to have accelerated the trend in opioid prescribing. If there was an uptick in the rate of increase in opioid use, it appears to have occurred around 1997–1998, two years prior to release of the standards.

The Joint Commission pain standards were designed to address a serious, intractable problem in patient care that affected millions of people, including inadequate pain control for both acute and chronic conditions. The standards were designed to be part of the solution. We believe that our standards, when read thoroughly and correctly interpreted, continue to encourage organizations to establish education programs, training, policies, and procedures that improve the assessment and treatment of pain without promoting the unnecessary or inappropriate use of opioids.



Opioid Prescriptions Dispensed by US Retail Pharmacies IMS Health, Vector One: National, years 1991-1996, Data Extracted 2011. IMS Health, National Prescription Audit, years 1997-2013, Data Extracted 2014.

Figure 1. Response to Surveys

The Joint Commission is committed to working to dispel these misunderstandings and welcomes dialogue with the dedicated individuals who are caring for patients in our accredited organizations.