What are the key concepts organizations need to understand regarding the pain management requirements in the Leadership (LD) and Provision of Care, Treatment, and Services (PC) chapters?

Any examples are for illustrative purposes only.

Providing staff and licensed practitioners (LP) with educational programs and resources regarding pain management and safe

use of opioid medication

Research and clinical guidance on pain management are evolving. The intent of the requirement is to provide up-to-date information to practitioners who are involved in patient care. Each organization determines what educational resources and programs to have readily available to staff and licensed practitioners, giving consideration to staff needs, services provided, and patient population served. Educational resources available to staff may include online resources and/or clinical guidelines that include content related to safe opioid prescribing, modalities of treatment, multi-modal pain management^, patient assessment and reassessment criteria.

^ Multimodal analgesia may be described as combining 2 or more analgesic agents or techniques that act by different mechanisms to provide analgesia resulting in improved pain relief while use of fewer opioids.

Opioid treatment programs that can be used for patient referrals

Clinicians encountering patients dealing with possible opioid abuse or dependence need readily accessible, accurate information about available resources to which patients can be referred for treatment. It can be challenging for individual clinicians or departments to maintain current information about provider availability in the community, therefore leadership can play a role by identifying community resources, then communicating this information to staff and practitioners. To

assist organizations, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) has a directory of opioid treatment programs.

Compliance may be determined through interviews with leadership, staff, practitioners and patients, review of an organization's discharge and referral processes, discharge information provided to patients to support ongoing care following discharge, etc.

Leadership responsibilities for developing and monitoring performance improvement activities specific to pain management and safe opioid prescribing

Whether an individual 'leader' is assigned this responsibility, or a 'leadership team' model is used, responsible leader(s):

- participate in defining the goals and metrics for performance improvement activities, e.g., on monitoring the use of opioids;
- allocate resources to conduct performance improvement activities;
- review performance improvement data;
- promote improvement in practices and accountability across disciplines and services involved in pain management and opioid prescribing.

Survey activities may include staff interviews, review of applicable meeting minutes, discussions with leadership, practitioners, governing body members, review of performance improvement data, etc.

Providing information to staff and licensed practitioners (LP) on available services for consultation and referral of patients with complex pain management needs

The intent of this requirement is to ensure that staff and LPs are knowledgeable about available services and resources. Available sources for consultation and referral may include 'internal' resources (such as a qualified provider with a specific expertise, an organization's outpatient pain management program or addiction treatment program) or external healthcare services and community resources. Compliance with this requirement is determined through interviews with staff, LPs, patients, etc.

Acceptable non-pharmacologic pain treatment modalities

Organizations are required to provide non-pharmacologic pain treatment modalities relevant to its patient population and assessed needs of the patient. These modalities serve as a complementary approach for pain management and may potentially reduce the need for opioid medication in some circumstances.

Additionally, it is important to have non-pharmacologic pain treatment modalities available for patients that refuse opioids or

for whom physicians believe may benefit from complementary therapies. Non-pharmacologic strategies include, but are not limited to, acupuncture therapy, massage therapy, physical therapy, relaxation techniques, music therapy, cognitive behavioral therapy, etc. The level of evidence for these therapies is highly variable, and it is evolving. Therefore, our standards do not mandate that any specific complementary option(s) is provided, but allow organizations to determine what modality(s) to offer.

Organizations should ensure that patient preferences for pain management are considered, and, when a patient's preference for a safe non-pharmacologic therapy cannot be provided, provide education to patients on where the treatment may be accessed post-discharge. There is not an expectation that the hospital will fulfill any and all requested non-pharmacologic therapies during the inpatient stay.

Practitioner and pharmacist access to the Prescription Drug Monitoring Program (PDMP) databases
Facilitating access to the PDMP means that leadership has implemented systems and processes that support both ease of access for practitioners and consistent access to the PDMP when required by law.
Examples may include:

- Shortcuts on designated computer desktops to the PDMP database

- Links from the organization's intranet site and/or electronic health record (EHR)
- Staff and practitioner education that includes access to and when the PDMP is to be queried
- Demonstration/return demonstration
- Periodic monitoring of compliance as defined
- Periodic refreshers with staff, as defined by the organization
- Creating prompts in an electronic medical record (when state law requires accessing before hospital discharge)

Each organization determines who is responsible for accessing the PDMP. This may vary based on different patient care settings.

The requirement does NOT apply to patients receiving short term opioid medications DURING the hospital encounter (for example, opioids administered for a day or two following a surgical or invasive procedure). During survey, compliance with accessing the PDMP may be evaluated during tracer activities, interviews with staff, practitioners, pharmacists, etc.
NOTE: This requirement is only applicable in states that have a fully functioning Prescription Drug Monitoring Program (PDMP).

Monitoring of post-operative patients on opiates and/or on opiates combined with other pain medications
The Joint Commission requires hospitals to monitor patients at high risk for adverse outcomes related to opioid treatment (for example, patients with sleep apnea, patients receiving continuous

intravenous opioids, patients on supplemental oxygen, etc.) (See PC.01.02.07 EP 6). The intent of this requirement is to ensure adequate monitoring and timely detection of opioid-induced respiratory depression. Decisions on who is at high risk and monitoring requirements are determined by the clinical team responsible for providing care and based on evidence-based guidelines, accepted standards of practice, etc.
In addition, leadership commitment is required to ensure that appropriate equipment is available to monitor patients deemed at high risk for adverse outcomes from opioid treatment (See LD.04.03.13 EP 7). Refer to standards PC.03.01.01 through PC.03.01.07 regarding sedation and anesthesia care, specifically.

Review of evidence-based guidelines will assist leadership and the medical staff in developing policies, protocols, metrics and other quality indicators. During survey, clinicians may be asked to describe how they identify a patient that is high risk and how they would manage and monitor that patient.

Educating the patient and family on discharge related to pain management

It is the responsibility of each organization to determine who is qualified and responsible to educate the patient and family at discharge regarding the pain management plan, side effects of treatment, impact on activities of daily living, and safe use, storage, and disposal of opioids when prescribed. PC.01.02.07 EP 8 requires written documentation that the patient and family

were educated on these topics. Each organization determines where this information will be documented in the medical record.

Screening vs. assessing pain

A 'screening' is a process for evaluating the possible presence of a problem. An 'assessment' gathers more detailed information through collection of data, observation, and physical examination. Assessments are completed by individuals deemed qualified through education, training, licensure, etc., to conduct such evaluations. Pain assessment tools are generally evidence-based and often include, at a minimum, an evaluation of pain intensity, location, quality, and associated symptoms. An accurate pain screening and assessment is the foundation on which an individualized, effective pain management plan is developed.

For example, a pain 'screening' may be used to determine if the patient has pain or not. If the patient answers "yes", a comprehensive pain assessment would be indicated. If the patient answers "no" no further pain assessment would be expected, unless required by organizational policy.

Organizations are 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, and ability to understand and should be evidence-based. For example, adult intensive care unit (ICU) patients who are unable to self-report

and pediatric patients require the use of alternative assessment tools. Hospitals are required to have defined criteria that they will use to screen, assess and reassess pain that are consistent with the patient's age, condition, and ability to understand. Organizations determine where these criteria are located and any documentation requirements when such screenings or assessments are completed.

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