VIEWPOINT

History of The Joint Commission's Pain Standards
Lessons for Today's Prescription Opioid Epidemic

David W. Baker, MD, MPH
Division of Healthcare Quality Evaluation, The Joint Commission, Oakbrook Terrace, Illinois.

Supplemental content

Corresponding Author: David W. Baker, MD, MPH, Division of Healthcare Quality Evaluation, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181 (dbaker@jointcommission.org).

In 2000, as part of a national effort to address the widespread problem of underassessment and undertreatment of pain, The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations [JCAHO]) introduced standards for organizations to improve care for patients with pain (eAppendix in the Supplement). After initial positive responses and small studies showing the benefits of following the standards, reports emerged about adverse events from overly aggressive treatment of pain. A 2002 report from the Institute for Safe Medication Practices (ISMP) asked, "[I]n our noble efforts to alleviate pain, has safety been compromised?"[1] In response, the standards and related materials were changed to address the problems.

Today, the United States is in the midst of a prescription opioid epidemic. Numerous interventions have been advocated to address the problem. Although these efforts are well intentioned, there are concerns that the pendulum will swing too far in the opposite direction, reversing the country's gains in pain management. This Viewpoint briefly reviews the history of The Joint Commission standards and the lessons learned to help inform efforts to address the prescription opioid crisis.

Call to Improve Pain Assessment and Treatment

In 1990, Max[2] decried the lack of improvement in pain assessment and treatment over the previous 20 years and called for a different approach that included the following: make pain "visible"; give physicians and nurses bedside tools to guide use of analgesics; ensure patients a place in the communications loop; increase clinician accountability by developing quality assurance guidelines; improve care systems; assess patient satisfaction; and work with narcotics control authorities to encourage therapeutic opiate use. Max reiterated the conventional wisdom of the day that "therapeutic use of opiate analgesics rarely results in addiction,"[2] although this was based on a single publication from 1980 that lacked detail about the study methods.[3] The American Pain Society subsequently developed quality assurance standards for relief of acute pain and cancer pain that followed the recommendations Max had outlined.

The Joint Commission's First Pain Standards

In 2000, The Joint Commission announced standards for pain management (eAppendix in the Supplement). The standards emphasized the need for organizations to perform systematic assessments using quantitative measures of pain (eg, place pain on a 10-point scale), as recommended by the Institute of Medicine in 1987.[4] The Joint Commission also provided examples of implementation describing how organizations had successfully demonstrated compliance with a standard, stressing that these were only examples and not required ways to meet a standard.

Early Responses and Successes

The Joint Commission standards were supported by pain management specialists. In one study that made a numerical pain scale mandatory in the postanesthesia care unit (PACU) and required an acceptable pain score for discharge from the PACU,[5] the mean consumption of opiates per patient increased from 40.4 mg (morphine equivalents) in 2000 to 46.6 mg in 2002 with no increase in length of stay, naloxone use, or nausea and vomiting. The standards' recommendation to use patients' self-reported pain according to numerical scales was supported by a study that found emergency department nurses significantly underestimated patients' pain compared with patients' self-report (mean scores of 4.2 vs 7.7, respectively, on a 10-point scale).[6]

Negative Reactions and Unintended Consequences

The Joint Commission standards raised concerns that requiring all patients to be screened for the presence of pain and raising pain treatment to a patients' rights issue could lead to overreliance on opioids. Nurses expressed concerns about statements on The Joint Commission website that implied organizations could no longer use PRN (as needed)–range analgesic orders without specific implementation protocols. The Joint Commission clarified that the issue was not the use of PRN orders per se, but rather PRN orders that were written ambiguously; fixed algorithms for adjusting pain medications were not needed or recommended.

Signals appeared suggesting that some clinicians had become overzealous in treating pain. In a 2003 survey of 250 adults who had undergone surgical procedures, almost 90% of patients reported they were satisfied with their pain medications. Nevertheless, the authors concluded that "many patients continue to experience intense pain after surgery"[7] and "[a]dditional efforts are required to improve patients' postoperative pain experience."[7] Health care organizations implemented treatment policies and algorithms based on patients' responses to numerical pain scales. Concerns about this practice increased after a report that the incidence of opioid oversedation increased from 11.0 to 24.5 per 100 000 inpatient hospital days after the hospitals implemented a numerical pain treatment algorithm.[8] The ISMP linked overaggressive pain management to a substantial increase in oversedation and fatal respiratory depression events.

Copyright 2017 American Medical Association. All rights reserved.

Downloaded From: http://jamanetwork.com/pdfaccess.ashx?url=/data/journals/jama/0/ by a University of Colorado - Denver HSL User on 02/23/2017

Changes to Standards and Examples of Implementation

In response to these concerns, The Joint Commission made multiple changes. The 2001 example of implementation that said "Pain is considered a 'fifth' vital sign in the hospital's care of patients" was changed in 2002 to say "Pain used to be considered the fifth vital sign," and by 2004 this phrase was deleted from the accreditation standards manual. The standard that pain be assessed in all patients was eliminated in 2009 except for patients receiving behavioral health care. In response to criticisms that the standards encouraged opioid use, The Joint Commission added a note to its standards in 2011 emphasizing that both pharmacologic and nonpharmacologic strategies have a role in the management of pain and listing examples of nonpharmacologic strategies (eg, acupuncture, chiropractic therapy, and cognitive behavioral therapy).

Current Efforts

In early 2016, The Joint Commission began a project to revise its pain standards and address the opioid epidemic. Draft standards were released for public comment in January 2017.[9] The new standards recommend that pain assessment include identification of psychosocial risk factors that may affect self-report of pain; involve patients to develop their treatment plan and set realistic expectations and measurable goals; focus reassessment on how pain impairs physical function (eg, ability to turn over in bed after surgery); monitor opioid prescribing patterns; and promote access to nonpharmacologic pain treatment modalities. Changes to promote safe opioid use during and after hospitalization and to prevent diversion include the following: identify high-risk patients; have equipment available to monitor high-risk patients; facilitate clinician access to prescription drug monitoring program (PDMP) databases and encourage PDMP use prior to prescribing opioids; and educate patients and families regarding the safe use, storage, and disposal of opioids.

Lessons Learned

Several conclusions from this history could serve as lessons for addressing the current prescription opioid epidemic. First, engage all stakeholders when creating standards and not just those who passionately favor action. Advocates may be less able to see the possible unintended consequences than other stakeholders. Similarly, although the current opioid epidemic has resulted in calls for immediate actions, it is necessary to carefully acknowledge concerns that patients with chronic, painful conditions may be undertreated and stigmatized if they need adjunctive opioid therapy.

Second, try to anticipate unintended consequences and have monitoring programs in place from the start. Many of the unintended consequences of The Joint Commission standards were, in retrospect, predictable, and the need for changes may have been identified earlier if there had been prospective monitoring of adverse consequences. Addressing the opioid epidemic will require a national plan to monitor both the salutary and negative effects of currently proposed policies to counteract prescription opioid abuse.

Third, pay close attention to what programs and procedures organizations implement to meet new requirements. For example, the algorithms organizations used to guide treatment based on numerical pain scores should have immediately raised concern. The Joint Commission developed examples of implementation to try to help organizations address the new standards. These examples may not have been as rigorously developed, vetted, or consistently disseminated to The Joint Commission surveyors as they should have been. Similarly, many recently proposed guidelines (eg, Centers for Disease Control and Prevention chronic pain guidelines) and policies (eg, requirements that all physicians receive education on pain management) to address the opioid epidemic lack sufficient detail to ensure that they are actually beneficial with minimal adverse consequences. Work-arounds are likely to be common.

Fourth, carefully review the primary literature on issues of critical importance and do not simply repeat the claims of experts in previous articles. The 1980 letter to the editor by Porter and Jick[3] suggesting that addiction is rare in patients treated with narcotics has been cited almost 1000 times. Yet the report is so brief, methodologically vague, and unlikely to be generalizable to recent medical practice that its finding should never have been disseminated without cautionary notes and calls for research.

Concerns about unintended consequences should not serve as a deterrent from pursuing "noble" goals. The original pain standards of The Joint Commission were a bold attempt to address widespread underassessment and undertreatment of pain. As The Joint Commission and other organizations across the country work to address the prescription opioid problem, it will be important to proceed not only with these lessons in mind but also with the confidence that effectively counteracting the opioid epidemic represents a necessary and worthy goal.

ARTICLE INFORMATION

Published Online: February 23, 2017. doi:10.1001/jama.2017.0935

Conflict of Interest Disclosures: The author has completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

REFERENCES

1. Institute for Safe Medication Practices. Pain scales don't weigh every risk. July 24, 2002. https://www.ismp.org/newsletters/acutecare/articles/20020724.asp. Accessed February 7, 2017.

2. Max MB. Improving outcomes of analgesic treatment: is education enough? *Ann Intern Med*. 1990;113(11):885-889.

3. Porter J, Jick H. Addiction rare in patients treated with narcotics. *N Engl J Med*. 1980;302(2):123.

4. Osterweis M, Kleinman A, Mechanic D, eds; Institute of Medicine Committee on Pain, Disability, and Chronic Illness Behavior. *Pain and Disability: Clinical, Behavioral, and Public Policy Perspectives*. Washington, DC: National Academy Press; 1987.

5. Frasco PE, Sprung J, Trentman TL. The impact of the Joint Commission for Accreditation of Healthcare Organizations pain initiative on perioperative opiate consumption and recovery room length of stay. *Anesth Analg*. 2005;100(1):162-168.

6. Puntillo K, Neighbor M, O'Neil N, Nixon R. Accuracy of emergency nurses in assessment of patients' pain. *Pain Manag Nurs*. 2003;4(4):171-175.

7. Apfelbaum JL, Chen C, Mehta SS, Gan TJ. Postoperative pain experience: results from a national survey suggest postoperative pain continues to be undermanaged. *Anesth Analg*. 2003;97(2):534-540.

8. Vila H Jr, Smith RA, Augustyniak MJ, et al. The efficacy and safety of pain management before and after implementation of hospital-wide pain management standards: is patient safety compromised by treatment based solely on numerical pain ratings? *Anesth Analg*. 2005;101(2):474-480.

9. The Joint Commission. Pain management. https://www.jointcommission.org/topics/pain_management.aspx. Accessed February 13, 2017.

Copyright 2017 American Medical Association. All rights reserved.

Downloaded From: http://jamanetwork.com/pdfaccess.ashx?url=/data/journals/jama/0/ by a University of Colorado - Denver HSL User on 02/23/2017