American Society of Anesthesiologists®

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February 20, 2017

The Joint Commission
Standards and Survey Methods
Hospital Pain Assessment and Management Field Review
One Renaissance Blvd.
Oakbrook Terrace, IL 60181

[Submitted Electronically]

The American Society of Anesthesiologists® (ASA), on behalf of our over 52,000 members, is pleased to submit comments on The Joint Commission's Proposed Requirements Related to Pain Assessment and Management for the Hospital Accreditation Program. ASA thanks The Joint Commission (TJC) for the opportunity to comment on these Proposed Requirements and commends TJC on its work on the updated draft. Although ASA offers comments and points of clarification in the following paragraphs, ASA believes less prescriptive accreditation requirements successfully allow institutions to develop robust policies and abide by those policies.

LD.04.05.17 Pain Assessment and Pain Management as an Organization Priority

ASA offers the following comments on LD.04.05.17:

- ASA strongly agrees with TJC that pain assessment and pain management, including safe opioid prescribing, should be an organizational priority. However, ASA is concerned that the development and implementation of the eight Element of Performance for LD.04.05.17 may require significant resources that are unavailable at certain medical centers.

- ASA agrees with and supports Element of Performance #1 that would require the hospital has a leader or leadership team responsible for pain management and safe opioid prescribing. ASA believes that the leadership structure for such an endeavor is unique in that pain management is often compartmentalized within multiple specialties. Anesthesiologists and pain medicine specialists are uniquely positioned to lead this effort.

- We agree that hospitals should promote access to non-pharmacologic pain treatment, however we request that the minimum standard for this be illustrated. For example, will an institution meet this requirement if such treatment is promoted via patient education materials or will specific therapies need to be available at the point of care? In addition, several of these therapies require support from insurance carriers that is not currently covered in many instances. Please note that ASA also promotes interventional, regional and other pain therapies as an alternative for pain management.

- ASA agrees and commends TJC for requesting that disparities in pain care and pain assessment be evaluated on an ongoing basis. However, we request additional clarification on how this might work as a control cohort is often times difficult to identify for comparison. ASA requests additional information on whether this might be an institutional cohort or a national cohort. It would be helpful to know more about how TJC would appropriately measure and define a disparity.

- ASA requests further clarification of what defines "complex pain management needs." For instance, ASA views uncontrolled chronic pain as typically complex but wonders whether this would fall within the scope. Additionally, would acute pain management in patients with psychiatric issues or substance use disorders qualify as complex? We request additional information for clarification of how this might be evaluated. These complex patients would require a multidisciplinary approach for control of the pain.

- ASA requests clarification of another proposal that would require the hospital identify opioid treatment programs that can be used by clinicians for patient referrals. The description "opioid treatment program" is vague and we are unclear of what type of program would qualify. For instance, could these include either a pain center that provides chronic opioid pharmacotherapy or an opioid detox program? Additional information is necessary to determine how these programs would be evaluated by TJC.

- ASA agrees that the hospital could facilitate and encourage practitioners and pharmacists to access Prescription Drug Monitoring Program databases for prescriptions.

- ASA requests further clarification of "hospital provided equipment for clinicians to monitor patients considered high risk of adverse outcomes" from opioid treatment during hospitalization. For example, are available pulse oximetry or pulse oximetry with central monitoring sufficient equipment to meet this element of performance? If so, TJC should develop guidance and specifically state what is required of these elements of performance.

PC.01.02.07 Hospital Assessment and Management of the Patient's Pain

ASA offers the following comments on PC.01.02.07:

- While ASA believes that hospitals should screen patients for pain or the risk of pain at the time of admission, screening tools common to medical and surgical populations may have limited impact upon different patient populations. For example, there are variations between pediatric populations, adult populations, veteran populations and non-veteran populations. ASA requests that TJC provide guidance on how facilities and practices can adequately address the patient variation and use of screening tools.

- A proposed element of performance requires for "patients who have been screened and found to have new, undiagnosed, or worsening pain," that "the hospital conducts an assessment of clinical and psychosocial risk factors that may affect pain assessment, pain management, and the risk of treatment with opioids." ASA believes this proposal may be too broad and should

be limited to chronic or subacute contexts, particularly with respect to psychosocial risk factors.

- The proposed TJC revisions did not suggest any timing language in which implementation of a diagnostic plan would be considered appropriate. Diagnostic plans are often developed and implemented on an outpatient basis and greater clarity on TJC expectations is needed.

- ASA believes the element of performance that requires the hospital to treat the patient's pain or refer the patient for treatment is vague and requires additional context. It is unclear what would constitute the minimum standard for meeting the requirement of referral.

- ASA applauds TJC for including shared-decision making and patient-centered care as a key component in the pain management process. Clinicians will need to receive training in this as it may be outside of their current scope of practice for more complex pain issues. A statement on utilizing consultation of pain specialists to facilitate these conversations and treatment planning may be necessary.

PC.02.01.01 Hospital Compilation and Analyzation of Data

ASA offers the following comments on PC.02.01.01:

- ASA requests additional information on what constitutes a high dose of opioids and the expectation of TJC on the facility or practice. ASA suggests that TJC consider a standard table or equation for opioid conversation, such as the CDC Morphine Milligram Equivalents (MME) dosing chart. At the same time, we recognize that variability may exist in regards to standard conversion ratios affecting the oral morphine equivalents reported. Understandably, developing this code for automated reporting and conversion is challenging and will require significant resources and expertise. Because of these factors, reporting of daily oral morphine equivalents may be one of the most difficult aspects of performance tracking.

We thank TJC for consideration of our comments. If there are issues on which you need additional information or would like further discussion, please contact Ashley Walton, J.D., Pain Medicine and Federal Affairs Manager or Elizabeth Quill, J.D. Senior Regulatory Affairs Specialist at 202-289-2222.

Respectfully submitted,

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