FEBRUARY 2019

Volume 35
Number 2

OR Manager
The monthly publication for OR decision makers

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CONFERENCE ISSUE
OR Business Management Conference
January 27-30, 2019
San Diego

OR business

Disruptive innovation in supply chain: Impact of Amazon and technology, Part 1

Supply chain is the lifeblood of the OR, so any disruption in the flow of that lifeblood can lead to outcomes ranging from dissatisfaction with backorders to chaos if a new implant doesn't arrive on time. But disruption also can be a positive force, especially if it supports flow.

When Amazon Business entered the medical supply chain market, Mathew Palcich, MBA, implemented the service at Summit Pacific Medical Center in Elma, Washington. The change reduced time spent on supply procurement by 80% in 1 year and saved money by reducing the operating budget by 15% (through not needing to backfill a position) and cutting annual shipping costs by $10,000.

With supply chain estimated to represent 30% of hospital costs (second only to labor), even small improvements can make big differences. And a 2018

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Patient safety

Follow pain management standards to ensure survey success

Postoperative pain management has always been a major focus of patient care. However, the opioid crisis is increasing the challenges healthcare leaders face because of the call for a national change in modalities of pain management.

Regulatory bodies, specifically, are executing control to confront the opioid epidemic head on, making it increasingly important for OR managers to understand new pain management guidelines from the Joint Commission and Centers for Medicare & Medicaid Services (CMS) and how these changes will affect their survey readiness.

John R. Rosing, MHA, FACHE

At the 2018 OR Manager Conference in Nashville, Tennessee, John R. Rosing, MHA, FACHE, executive vice president and principal of Patton Healthcare Consulting in Naperville, Illinois, shared changes in pain management standards made by the Joint Commission and CMS in 2018. He discussed the emphasis that both organizations will place on these new requirements during accreditation surveys.

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Pain management

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Scale back patients' expectations to reduce pain without 'high-powered' opioids.

Political overtone

"There is a bit of a political overtone to the new Joint Commission standards," Rosing notes. The nationwide opioid crisis is affecting every community, big and small, across the country, and the Joint Commission does not want to be perceived as having contributed to the idea that patients have a right to pain management and a right to not experience pain, he says.

Whether or not the Joint Commission bears any responsibility for the opioid crisis, the organization is clearly resetting its expectations and taking a more conservative approach to pain management.

In the past year, the Joint Commission has deleted some standards that were introduced in the 2000s:

- Educating licensed independent practitioners about pain assessment and managing pain. (MS [Medical Staff])
- The right to pain management. (RI [Rights and Responsibilities of the Individual])
- The comprehensive pain assessment and criteria for reassessment stand alone Elements of Performance (EPs). (PC [Provision of Care])
- The response to pain EP. (PC)

CMS is also involved because it controls the funding through Medicare and Medicaid and, in so doing, forces accrediting organizations that survey on its behalf to adhere to its rules and regulations.

Early salvo

In March 2014, CMS issued a "Survey and Certification Letter" to state survey agency directors that addresses the administration of IV medications and postoperative care using IV opioids.

The letter focused on appropriate patient monitoring and updated guidance for hospital medication administration requirements to:

- Reflect the need for patient risk assessment and appropriate monitoring during and after medication administration, particularly for postoperative patients receiving IV opioid medications, in order to prevent adverse events.
- Emphasize the need for postoperative monitoring of patients receiving IV opioid medications, regardless of where they are in the hospital.

The 2014 letter was an "early salvo" aimed at increasing the safety of using opioids postoperatively, says Rosing. CMS also issued another statement in 2018, but that was directed more at Medicare Advantage organizations than at hospitals.

The 231-page letter summed up by saying that CMS won't authorize payment for more than a 7-day supply of an oral opioid medication, and CMS will no longer consider pain management scores when determining value-based purchasing reimbursement.

New leadership standard

The Joint Commission also released new and revised pain assessment and management standards in 2018. These have overarching statements with EPs under them, and it is the EPs that are scored as compliant and noncompliant, not the standard itself, notes Rosing.

For example, seven new scorable EPs have been added to the new Leadership standard, "LD.04.03.13: Pain assessment and pain management, including safe opioid prescribing, is identified as an organizational priority for the hospital."

EP 1: A leader or leadership team is assigned to implement safe opioid prescribing and to develop and monitor performance improvement activities. Rosing notes that this EP "seems simple enough," but it went into effect January 1. He asks: "If your survey happened today, would you know who that individual or team is? Are these people in place? Have they been meeting? Are there meeting minutes? Is there anybody who can speak to it?"

EP 2: The hospital provides nonpharmacologic pain treatment modalities. "What alternative treatments do you have available at your hospital?" asks Rosing. He notes that there is a list of examples of these treatments, and hospitals can pick what they want to do. They don't have to do all of them. Examples include aromatherapy, music therapy, and pet therapy.

EP 3: The 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. This applies to physicians and others who can prescribe medications, such as nurse practitioners and physician assistants, says Rosing. "What education and resources have you provided them?" he asks. Did you create an intranet page or brochure or something else that can be used as guide?"

Rosing notes that when the Joint Commission uses the term "education" in an EP, it can be something as simple as posting an educational piece on the intranet and usually means testing for comprehension is not necessary. When

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using the word "competency," the Joint Commission wants to see validation of acquired knowledge.

EP 4: The hospital provides information to staff and licensed independent practitioners on available services for consultation and referral of patients with complex medical needs. "If a chronic pain patient with probable addiction is admitted for surgery, what consultants are available to assist in patient management? Do you have someone in your organization to provide this assistance?" Rosing asks. "To score well on a survey, you have to be able to answer this question," he says.

EP 5: The hospital identifies opioid treatment programs that can be used for outpatient referrals. "Does the physician do this, does social work do this, is a booklet provided to the patient for

Sharpen pre-existing opioid use disorder assessment processes.

self-referral?" Rosing asks. "We don't know yet what option surveyors want to see, and might not know for some months," he says. Often the Joint Commission will publish a "Frequently Asked Question" on their website that clarifies their intent.

EP 6: The hospital facilitates practitioner and pharmacist access to the Prescription Drug Monitoring Program databases. All states now have a database where known drug-seeking individuals or addicted individuals are labeled. Some states make it mandatory to check this database before giving a patient an opioid prescription; it's optional in others, says Rosing. This standard also asks organizations to facilitate access to that database with a link or an icon that can be used to open it quickly.

EP 7: Hospital leadership works with clinical staff to identify and acquire equipment needed to monitor patients who are at high risk for adverse outcomes from opioid treatment. Rosing notes that this EP goes back to the March 2014 Survey and Certification Letter and asks organizations what they have done to:

- identify those most at risk before treatment, such as patients who are elderly, morbidly obese, have undiagnosed sleep apnea, are opioid naïve, or opioid addicted, and those requiring long surgical procedures
- prescribe guidance on opioid potency and dosing

- educate patients and families
- implement nurse monitoring and use of tools like the Pasero Opioid-induced Sedation Scale
- implement specialized monitoring like capnography for the highest risk patients.

Revised Medical Staff standard includes new EP

The Medical Staff standard, "MS.05.01.03: The organized medical staff has a leadership role in organization performance improvement activities to improve quality of care, treatment, and services and patient safety," already had 17 EPs, and a new EP 18 was added.

EP 18: The medical staff is actively involved in pain assessment, pain management, and safe opioid prescribing through:

- Participating in the establishment of protocols and quality metrics.
- Reviewing performance improvement data.

This EP would not be forced on the entire medical staff, but it could include three or four physicians on the pharmacy and therapeutics committee who look at medication usage over time. It also could be two or three physicians who are on the hospital's quality management committee who study this data," says Rosing.

"If you already had established protocols before January 1, 2018, find out if they focused on inpatients, outpatients, discharges, or high-risk patients," Rosing says.

He also advises leaders to "look at what performance measures have been collected to help you understand adherence to your protocols and new quality metrics."

Many hospitals choose number of doses sent home with a discharged patient or guidelines for dosing based on age. Adverse drug reactions or in-house use of naloxone also could be a part of this.

Changes in Provision of Care standard

In the revised Provision of Care standard, "PC.01.02.07: The hospital assesses and manages the patient's pain and minimizes the risks associated with treatment," the words "and minimizes the risks associated with treatment" were added. One EP was removed, three were revised, and five were added. The standard now includes the following eight EPs.

EP 1 (D): The hospital has defined criteria to screen, assess, and reassess pain. The "D" means there is an expectation that this is to be documented, which means there is a policy and procedure that guides what these screening criteria and assessment criteria are and when to reassess pain, says Rosing. "This is not new," he says, "they just added the words 'screen' and 'reassess.'"

EP 2: The hospital screens patients for pain during emergency department visits and upon admission. "This EP was revised but is not new," notes Rosing.

EP 3: The hospital treats the patient's pain or refers the patient for treatment.

Note: Treatment strategies may include nonpharmacologic, pharmacologic, or a combination of approaches. "This is where the emphasis on alternative treatments comes in," Rosing says, noting that "they don't say which ones you have to include; it's your choice."

EP 4 (D): The hospital develops a pain treatment plan based on evidence-based practices and the patient's clinical condition, past medical history, and pain management goals.

This EP is all new and has a "D" for documentation.

"If taken literally, this means your care plan or treatment plan as well as the physician or licensed independent practitioner medication orders must be based on evidence-based practices, clinical condition, and past history," Rosing says. "This drills down to the patient who is opioid naïve or opioid tolerant and focuses attention toward creating a treatment plan that recognizes preexisting conditions."

EP 5: The hospital involves patients in the pain management treatment planning process through:

- Developing realistic expectations and measurable goals that are understood by the patient for the degree, duration, and reduction of pain. "We struggle with this one a little because in the past, patient involvement meant: What are your limits of pain? What is your postoperative pain goal? Do you want to be pain free? Can you accept a pain of five?" he says. "Now we have to be more pronounced in telling patients that we're probably not going to be able to accomplish pain free unless we use high-powered opioids. We have to almost negotiate with patients to scale back their expectations and scale back their treatment plans to accomplish the needed degree, duration, and reduction of pain," Rosing says. This EP will again likely require some "Frequently Asked Questions" to find out what the surveyors are really looking for, he says.
- Discussing the objectives used to evaluate treatment progress, for example, pain relief and improved physical and psychosocial function.
- Providing education on pain management and treatment options and safe use of opioid and nonopioid medications when prescribed. "This EP could entail hard work requiring a lot of thought and individualization. It's not just a self-reported pain scale any longer," says Rosing. He suggests trying to tie treatment plan goals to this EP.

EP 6: The hospital monitors patients identified as being high risk for adverse reactions related to opioid treatment.

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"This could include your use of the Pasero Scale, capnography findings, drug use evaluation, audits for recognition of high-risk patients, and monitoring of reversal agent use," he says.

EP 7 (D): The hospital reassesses and responds to the patient's pain through:

- Evaluation and documentation of response to pain interventions.
- Progress toward pain management goals, including functional 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.

This EP includes a "D" for documentation, which in this case refers to documentation in the medical record; it's not a policy and procedure, Rosing says.

"It means the surveyors want to see if the hospital reassesses and responds to the patient's pain via evaluation and documentation of response to pain interventions in the hospital record," he explains.

EP 8 (D): The hospital educates the patient and family on discharge plans regarding pain management, including:

- Pain management plan of care.
- Side effects of pain management treatment.
- Activities of daily living, including the home environment, which 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.

"We have not seen a lot of scoring on this Provision of Care standard yet," notes Rosing. "When heavy scoring begins, it will probably be on the "D" EPs 1, 4, 7, and 8 because on tracer, the surveyors can ask for you to show them your documentation. If you don't have it, you will be scored."

Additions to Performance Improvement standard

Two EPs were added to the 17 EPs of Performance Improvement standard, "PI.02.01.01: The hospital compiles and analyzes data."

EP 18: The hospital analyzes data collected on pain assessment and pain management to identify areas that need change to increase safety and quality for patients. Rosing advises picking clinically relevant measures, such as identification of high-risk patients, appropriate use of capnography, and lower dosing for high-risk patients to comply with this EP.

EP 19: The 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.

This is aimed at getting "a handle" on ordering patterns for inpatients and outpatients, says Rosing. He suggested creating a chart of what the orthopedic surgeons, for example, are ordering for inpatients postoperatively and at the time of discharge, revealing the norm within the group as well as showing the outliers.

"Over time physicians typically accept the norm and follow the evidence-based guidelines," he says. Any persistent noncompliance can be taken up the chain to a department chair or higher to convince them to get in line. He also noted that if outpatient prescriptions are being ordered though the hospital's computer system, that data can be mined and used to monitor duration of outpatient opioid use.

Practical steps to take now

It is important to sharpen pre-existing opioid use disorder assessment processes. When a patient is a user, clinicians should consider a plan to taper opioids before surgery. Intraoperatively and immediately postoperatively, there is an emerging process of multimodal pain management, which includes regional anesthesia, IV ketorolac, and IV acetaminophen.

Postoperative pain management also can include massage, acupuncture, guided imagery, heat or cold therapy, music therapy, and aroma therapy, as well as past processes of repositioning, ice pack, conversation, and hand holding.

"Most important, we have to set realistic expectations for patients and their families," says Rosing. "This is a big challenge given where we have been and what these new standards are going to require." ✣

—Judith M. Mathias, MA, RN

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Related Content

For more on this topic, see these OR Manager articles:

- *OR leaders feel the pain of the opioid crisis (May 2018; 1, 13-16)*
- *Opioid prescriptions drop after orthopedic team changes protocol (June 2018; 15-17)*
- *Evidence-based practice supports adopting ERAS protocols (May 2017; 15-19)*