The Joint Commission

February 26, 2018

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Chairman Hatch and Ranking Member Wyden:

The Joint Commission commends the Senate Committee on Finance for its commitment to combatting the opioid epidemic. We thank the Committee for soliciting policy recommendations related to addressing the root causes of opioid use disorder (OUD) and other substance use disorders (SUDs), prevention of OUD and SUDs, and improving access to and quality of treatment. The Joint Commission shares the Committee's goal of addressing the opioid epidemic. We would like to take this opportunity to 1) highlight some of our current efforts to help health care organizations improve pain assessment and management while minimizing opioid misuse and harm to patients and communities and 2) provide recommendations for your consideration that would strengthen and build upon our new standards. (For more information about The Joint Commission, see the attachment at the end of this letter).

To ensure that The Joint Commission's accreditation standards reflect current science and emerging health care issues for health care organizations, we continually develop and update our standards. In early 2016, The Joint Commission began a comprehensive project to review and revise The Joint Commission's pain assessment and management standards and to add new standards designed to address opioid overuse and misuse. This work included an extensive literature review, learning visits at hospitals to research leading practices in pain assessment and management and the safe use of opioids, convening a technical advisory panel of experts in pain assessment and management, and an open public commentary period (field review). The Joint Commission published revised pain assessment and management standards for acute care hospitals in July 2017, and these went into effect in January 2018. We are currently evaluating expansion of the standards to other healthcare settings. The new hospital standards and a brief explanation of the rationale for each are available at: https://www.jointcommission.org/assets/1/18/R3_Report_Issue_11_Pain_Assessment_2_9_18_REV_FINAL.pdf

The Joint Commission
Washington, DC Office
601 13th St. NW Suite 560 South
Washington, D.C. 20005
202 783 6655

We believe that these new standards are important because they call for a renewed commitment of hospital leadership to improve pain control. Our leadership standard states that: *Pain assessment and pain management, including safe opioid prescribing, is identified as an organizational priority for the hospital.* Several of the many critical performance expectations for this leadership standard may be of particular interest to the Committee as recommendations for further action. They:

- Emphasize the need for a leader or leadership team: *The hospital has a leader or leadership team that is responsible for pain management and safe opioid prescribing and develops and monitors performance improvement activities.* We believe this new requirement will have an important salutary effect at Joint Commission accredited hospitals, and that the Committee should consider ways to support similar requirements for all hospitals that will promote good stewardship programs.
- Emphasize facilitated referral of patients to opioid treatment programs: *The hospital identifies opioid treatment programs that can be used for patient referrals.* There is a critical shortage of treatment providers, and often hospitals do not have programs nearby. Therefore, we recommend that the committee continue to look at how to rapidly expand the pool of trained providers (e.g., nurse practitioner training programs) and the availability of providers through telehealth.
- Emphasize the importance of detecting patients who are misusing opioids: *The hospital facilitates practitioner and pharmacist access to the Prescription Drug Monitoring Program databases.* We did not go farther and require that physicians check PDMPs prior to prescribing opioids because of the limitations and burdens of using PDMPs in many states. The Committee should support the development of a national database that has up-to-date information and can be fully integrated into electronic health records at low cost to healthcare organizations.

In addition, it is critically important for hospitals to monitor prescribing patterns of opioids to identify overuse and to provide education to clinicians to bring their prescribing practices in line with their peers. One of the new Performance Improvement standards states:

- *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).*

Based on recent studies showing the benefit of tracking prescribing patterns, we believe this will be one of the more important of our new requirements. However, we have already heard from some hospitals that it is difficult and expensive to extract prescribing information from their electronic health record. We recommend that the Committee explore ways to encourage electronic health record vendors to provide tools to allow all hospitals to monitor prescribing patterns easily.

The Joint Commission also recommends that the Committee work with others in Congress to remove the current restrictions on sharing SUD diagnosis and treatment information among providers. There is an urgent need to align the Substance Abuse and Mental Health Services Administration's 42 CFR Part 2 requirements with those of the Health Insurance Portability and Accountability Act of 1996 to ensure that clinicians can properly and safely treat patients. The current restrictions carry very well-noted opportunities for medical errors and increased patient risks whenever a clinician is unaware of a patient's SUD history. Having a separate system for SUD information also maintains a stigmatization of certain medical conditions that negatively and inappropriately affects individuals with these disorders.

The Joint Commission

Our final recommendation is that the Committee consider how to ensure that any rapid expansion of needed treatment facilities and services meet at least minimal quality standards. It is critical that we address the shortages of acceptable treatment services through training, incentives, and reimbursement policies. At the same time, we must ensure that any rapidly assembled programs provide credible, effective services by competent individuals. Through its long history of offering both accreditation and certification programs in behavioral and mental health services, including opioid treatment programs, The Joint Commission appreciates the necessary infrastructure to carry out effective programs in SUD and OUD care. We extend to the Committee our willingness to be a resource in this area. Further, we stand ready to engage in a dialogue about how The Joint Commission can also establish new standards or certification programs to foster the availability of telehealth while simultaneously ensuring that patients receive high quality, safe, effective care.

The Joint Commission appreciates the Committee's consideration of our comments. We welcome the opportunity to assist the Committee with its work to develop bipartisan policies to help communities address the opioid epidemic, and we are pleased to answer any questions you may have. Please do not hesitate to contact Kathryn Spates, Director of Federal Relations, at 202-783-6655 or kspates@jointcommission.org.

Sincerely,

Margaret VanAmringe, MHS
Executive Vice President for Public Policy & Government Relations

The Joint Commission

ABOUT THE JOINT COMMISSION

The Joint Commission is an independent, not-for-profit organization founded in 1951, which seeks to continuously improve health care for the public in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. The Joint Commission accredits and certifies more than 21,000 health care organizations and programs in the United States. The Joint Commission evaluates health care organizations across the continuum of care, including most of the nation's hospitals. In addition, our programs encompass office-based surgery facilities, behavioral health care, home care, hospice, and long-term care organizations. The Joint Commission's work crosses a wide-range of health care settings and plays a significant role in health care delivery in these settings.

Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. Although accreditation is voluntary, a variety of federal and state government regulatory bodies, including the Centers for Medicare and Medicaid Services (CMS), recognize and rely upon The Joint Commission's decisions and findings for both Medicare and licensure purposes. Stakeholders throughout the health care field recognize The Joint Commission's standards as next-level protections that drive quality and safety improvements in health care.