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Interdisciplinary Pain Management Programs: The American Academy of Pain Management Model

Alexandra Campbell, PhD, and B. Eliot Cole, MD, MPA

PROMOTING EXCELLENCE IN INTERDISCIPLINARY PAIN MANAGEMENT: THE AAPM APPROACH

The American Academy of Pain Management (AAPM) was founded in 1988 as a nonprofit corporation by Drs. Richard and Kathryn Weiner (now Padgett). The Weiners' vision was that a professional membership organization, designed specifically to meet the educational and professional needs of clinicians in the emerging discipline of inter/multidisciplinary pain management, could best accomplish its goals by offering certification of professionals, continuing education, university-based specialty training, legislative advocacy, pain facility accreditation, and outcomes benchmarking of pain program success. By 2002, when Richard Weiner passed away, the AAPM had become the largest multidisciplinary pain practitioner membership organization in the nation with 6,000 members from many different professional disciplines including medical and osteopathic physicians, chiropractic physicians, podiatrists, dentists, psychologists, social workers, acupuncturists, clergy, nurses, pharmacists, physical and occupational therapists, rehabilitation counselors, massage therapists, and others.

As Richard Weiner (1993) stated:

> The multidisciplinary team approach, as it has evolved within the context of contemporary pain management, has the unique advantage of overlooking paradigmatic blocks, turf barriers, and linear, restricted vision. The multidisciplinary pain management movement is the harbinger of integrated future health care. (p. 201)

The evidence supporting the clinical success and cost-effectiveness of the integrated multidisciplinary approach to pain management continues to mount (Flor, Fydrich, & Turk, 1992; Kee, Middaugh, Pawlick, & Nicholson, 1997), and the AAPM has demonstrated leadership in bringing this approach into the forefront of pain treatment strategies through its approach to pain program accreditation. See Chapter 100 for a detailed discussion of the multi/interdisciplinary approach to pain management.

MULTIDISCIPLINARY PRACTITIONER CREDENTIALING AND EDUCATION

Although not a requirement for pain program accreditation, the obtaining of credentialed status would be an asset to anyone directing or practicing in an interdisciplinary pain treatment program. Establishing a credentialing process was one of the AAPM's earliest goals. In 1991, 151 individuals sat for the first psychometrically validated credentialing exam, which was developed in cooperation with Applied Measurement Professionals. Credentialing by means of passing a specialty examination is a voluntary process that allows practitioners to attest to their commitment to excellence in pain management.

The AAPM credentialing examination covers the following areas: principles of anatomy and physiology; comprehensive patient assessment; developing and implementing an individual treatment plan and specific treatment modalities; education of patients, clinicians, regulators, and payers; professional, ethical, and legal practice; and outcomes measurement. Regardless of the area of professional expertise, multidisciplinary pain practitioners must have a wide range of knowledge about the entire field, including the practices of those from different disciplines. The examination is periodically updated by means of a job analysis to keep it current with the field of pain management, which is constantly evolving (American Academy of Pain Management, 1999). See Appendix C for more information about credentialing, including how to obtain a self-assessment examination to determine readiness to sit for the exam.

Continuing education is available at the AAPM annual clinical meeting and through other mechanisms. University-based postgraduate degrees and certificates in Pain Management are awarded by the AAPM-associated University of Integrated Studies. See Appendix D for more information regarding these services and programs.

PAIN PROGRAM ACCREDITATION

The April 1992 issue of the AAPM member newsletter (Weiner, 1992) announced the creation of a pain facility accreditation program. Numerous drafts of the accreditation application were scrutinized and refined by the contributions of many clinical and academic professionals through a survey of AAPM members conducted by College of Business and Public Administration, at Old Dominion University, the University of the Pacific School of Pharmacy, and the AAPM. At the same time, the creation of a National Pain Data Bank was announced for the collection and processing of pain management outcomes information. Credentialed pain professionals located across the country were recruited to receive training in the onsite facility review process. During the 1-day review process surveyors are dedicated to helping pain programs raise the bar for quality pain management.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO; 2001) adopted standards addressing pain assessment and treatment in 2001, and the Commission on Accreditation of Rehabilitation Facilities (CARF; 2003) also incorporates principles of the interdisciplinary approach to pain treatment in its pain program accreditation standards. JCAHO has published valuable resources on how to improve pain management activities in institutional settings (JCAHO, 2000, 2003). See Chapter 101 in this volume for more information on JCAHO and standards. While JCAHO accredits hospitals and CARF accredits multidisciplinary pain programs of a certain type, the AAPM provides accreditation both for large, comprehensive multidisciplinary treatment programs and for pain management programs offered by smaller networks of solo practitioners and even for syndrome- or modality-oriented clinics.

The purpose of accreditation through the AAPM is to establish credibility for a pain program by demonstrating that patients receive appropriate services in a safe and effective fashion. Pain Program Accreditation (PPA) standards focus on an organization's ongoing business and personnel management, the physical plant (with an emphasis on safety), and the clinical services provided to patients. Much of the following material appears in the AAPM *Pain Program Accreditation Manual* (2001) and in three articles by Dr. Cole (1999a, 1999b, 1999c), which appeared in the AAPM member newsletter.

Two major distinctions are made in the PPA standards. There are *nonclinical standards* and *general clinical standards*, which must be met by all programs, and there are *classification-specific standards*, which must be met only by certain types of programs.

NONCLINICAL ACCREDITATION STANDARDS

There are five *nonclinical standards* concerning the organization's purpose and operation. These standards require a mission statement describing the purpose of the organization and the services available; written policies describing the types of patients served and/or the types of conditions addressed; specifically defined (even if broad) inclusion and exclusion criteria for services (not based on gender, race, color, creed, religion, or national origin, of course); patient education, informational, and marketing materials that truthfully describe the personnel, program, and services provided; and practitioners who possess the appropriate training and experience to provide quality treatment.

These standards are drawn from the AAPM Code of Ethics. The intent of the first five standards is to establish a commitment to pain management, to provide services in an ethical manner, and to provide services within a consistent model. When surveying a program, onsite reviewers actually look for the presence of a code of ethics and patient bill of rights (these may be adapted from the AAPM documents, see Appendices A and B); they read written policies about the services provided, patients or conditions treated; check the truthfulness of marketing and educational materials; check to see if there is evidence of appropriate training and experience for the program pain professionals (usually by reviewing curriculum vitae); and verify that the program director has the requisite skills to lead a multidisciplinary team. If appropriate, materials for special populations need to be made available to patients (e.g., non-English speaking, visually/hearing impaired). Since the Health Insurance Portability and Accountability Act of 1996 (HIPAA; Department of Health and Human Services, 2004) was signed into law and portions of this

law became enforceable in April 2003 (Privacy Rule) and October 2003 (Transactions and Code Sets Rule), pain programs are now asked if they are in compliance HIPAA. The surveyor records the answer that is given by the facility and may look for Notice of Privacy Policies, but accreditation by the AAPM does *not* certify HIPAA compliance. All programs are expected to abide by any and all federal and state/local laws that apply to them. The AAPM provides all surveyed facilities with a written notice that it abides by HIPAA rules in its dealings with surveyed pain programs and will sign business associate contracts if necessary.

Five *nonclinical standards* are in place to assess the business practices of the program. These documentation standards require written administrative policies that are reviewed and updated annually, written patient care policies that are reviewed and updated annually, necessary legal documents to engage in practice; and proof of general liability insurance, and proof of professional liability insurance. Reviewers determine that the administrative and patient care policies for the day-to-day operation of the program are adequate, and then check for creation and review dates. Having a system in place to document that staff annually reviews policies and procedures is crucial, in addition to circulating and documenting review of any new policies and procedures that may be instituted between regular annual reviews. Surveyors check for current business licenses, certificates of occupancy, fire marshal inspection certificates, professional licenses, and similar documents. Numerous insurance certificates are screened for general liability, directors and officers insurance, and professional liability. The intent of this section is to determine if the pain program is operating lawfully and that adequate patient and staff safeguards exist. The exact content of the administrative and patient care policies is not mandated, to allow each unique program the opportunity to develop the policies needed to operate. Specific insurance limit recommendations are not made except for professional liability (recommend minimum: $500,000/$1,000,000). The reviewer takes into account local variations in the business climate that may affect the types and amounts of insurance policies maintained by the program and its personnel.

Personnel management standards require job-specific descriptions for employees and independent contractors; annual performance evaluations reflecting the job-specific descriptions; written personnel policy; and properly maintained personnel files demonstrating necessary education, experience, and skills required for work. Surveyors review personnel files to see if job-specific descriptions and annual reviews exist for all employees and independent contractors.

Surveyors determine that these descriptions have been updated within the past year. Job descriptions need to be current to accurately reflect current performance. Surveyors review personnel files looking for up-to-date resumes or curriculum vitae, copies of licenses, documentation of training, and diplomas. To understand employee and employer expectations, surveyors read the program's personnel policy manual. Procedures for resolving grievances, dress codes, duty hours, and assignments are examples of what the surveyors looks for. Employee orientation to workplace regulations needs to be documented with the employees' signatures. Annual documentation of review of personnel policies by all employees is ideal.

Surveyors tour the building and all clinical treatment areas to make a determination about patient and staff safety. The physical plant standards require that the facility be safe for patients and staff by meeting applicable OSHA requirements; is compliant with local codes regarding access for challenged patients consistent with the Americans with Disabilities Act (ADA); has adequate ventilation and is maintained at a comfortable temperature; has written annually updated policies describing the proper handling of waste and the proper handling, storage, and disposal of medications, needles, and soiled linen; maintains electrical equipment free of obvious hazards; has emergency exits that are clearly marked and free of obstructions; has adequate regular and handicapped parking available; has an operating fire detection, warning, and suppression system; has written policies about fire drills and expected employee actions in the event of fire or other emergency situations (e.g., natural disaster, terrorist attack); and complies with local fire codes. Evidence that fire drills and other simulated emergency evacuations are carried out at least annually is important to have on file. Onsite reviewers must walk throughout the building to determine the overall level of cleanliness, ability of challenged patients to get around in the office, appropriateness of ventilation, and observance of policies about hazardous waste management. Reviewers are asked to imagine themselves in the office during different types of emergency situations including possible natural disasters or terrorist attacks. Could employees and patients exit the building without assistance? If they had challenges, could they still get out of the building? Because AAPM reviewers are not usually from the same town where the program is located, seeing a current fire marshal certificate or similar document usually resolves the issue about compliance with local fire codes. Reviewers want to see smoke detectors, fire extinguishers, and sprinkler systems if required by local codes. Reviewers do not test these items; they just determine if they are available.

Some may wonder why there are so many standards having little to do with actual patient care. These *nonclinical standards* have everything to do with ethical business practices; efficiency of practice; and the health, safety, and welfare of employees and patients. Standards have evolved over many years and have been tailored to meet the needs of pain practitioners in a wide variety of practice situations. While many are very specific, most require the

judgment of the surveyor to determine compliance. It is the goal of the AAPM to improve the programs being surveyed and to provide consultative advice during the accreditation survey process. Rather than just question the programs and their staff, PPA surveyors strive to gradually raise the overall quality of pain management services in the United States through a collegial process.

GENERAL CLINICAL ACCREDITATION STANDARDS

The National Institutes of Health (NIH) Consensus Conference entitled, "The Integrated Approach to the Management of Pain" (1986), concluded that while there are a multitude of pharmacological and nonpharmacological treatment approaches for pain, "no single treatment modality is appropriate for all or even for most individuals suffering from pain" (p. 12). Hence, the AAPM's program standards do not dictate which specific modalities must be present in a treatment program. Typically, however, multi/interdisciplinary approaches usually incorporate pharmacological, psychological/behavioral, and physical/rehabilitative components with interventional/surgical and complementary non-allopathic methods (such as acupuncture and massage) possibly being present as well (National Pharmaceutical Council, 2001). Many published clinical guidelines exist that outline the standards of care for acute and chronic pain management. These should be consulted and new publications should be monitored so that appropriate clinical practice standards can be maintained over the years that a pain program is in operation. McCaffery and Pasero (1999) have updated their extremely useful nursing education manual that discusses the mechanisms, assessment, and pharmacological and nonpharmacological treatment of all types of acute and chronic pain problems in adults, infants, and the elderly population, and during pregnancy and childbirth. Also see Chapters 101 and 103 in this volume for more information on implementing and running a pain management program.

Marketdata Enterprises (2003), in its survey of the most commonly used techniques for the treatment of chronic pain, noted a somewhat disturbing trend: the use of nerve blocks increased from 79% of pain practices surveyed in 2001 to 82% in 2003, while physical therapy use dropped from 85% in 2001 to 71% of programs in 2003. The multidisciplinary approach also declined in use from 81% of programs in 2001 to 77% in 2003. This occurred despite the evidence that questions the efficacy of interventionalist strategies and that supports the use of the multidisciplinary approach (Clark, 2000; Okifuji & Turk, 1998; Turk & Okifuji, 1997, 1998), especially where long-standing chronic pain of uncertain pathophysiology is present. Reasons for this alarming reversal of the trend to establish multi/interdisciplinary pain care include reimbursement issues and economic pressures.

General clinical standards address the core elements of patient care necessary for all pain programs. During an onsite inspection for Pain Program Accreditation, after touring the facility and addressing the nonclinical issues, the reviewer focuses on the scope and quality of care being provided. Reviewers will want to know the schedule of team meetings, and usually staff tries to schedule a meeting for the day of the survey so that the reviewer can observe the team in action and interview each treatment provider and administrative person briefly and informally to get a sense of how they view the workings of the program. Meeting and individually speaking with the treatment team members gives the surveyor a chance to assess how the program actually works on a day to day basis. Sometimes staff will provide useful feedback for improving the program that they have not yet had a chance to communicate to management. The surveyor can then give the suggestions for change to upper management during the out-briefing at the end of the survey day.

Chart review is another crucial element in program evaluation. The reviewer needs to examine a sufficient number of clinical records to adequately address the 20 general clinical standards. Usually, at least 10 randomly chosen clinical records, representing both open and closed cases, are reviewed to answer the questions raised in the general clinical standards. If full compliance with the general clinical standards is not immediately evident, the reviewer examines 5 additional records (or more) to resolve the concerns. Reviewers may ask the facility representative to show them where in the chart necessary documentation exists demonstrating how the program is able to meet the general clinical standards. Reviewers note how many of the charts they review are in compliance with the standards and how many are missing required elements.

Necessary elements of the chart include the presence of a well-documented presenting problem with a thorough history and physical. If this has been done by the referring physician, with a more focused assessment done upon admission to the pain program, a copy of the more thorough examination report needs to be obtained by the program.

The needs of the whole patient should be addressed during the initial assessment process through adequate documentation of functional and psychosocial status. Patient interviews, exams, diagnostic laboratory tests, and scores on validated psychosocial assessment instruments should be used to develop a multidimensional conceptualization of the biopsychosocial processes that are contributing to the patient's pain problem. Individualized assessments by providers from different disciplines (when indicated) need to be clearly formulated with working diagnoses and signed notes. Initial therapeutic goals

should be formulated in clearly behavioral and specific terms with a treatment plan that the patient agrees to and signs. (AAPM provides examples of controlled substance agreements, pharmacy agreements, and treatment attestation forms to help protect prescribing physicians on its Web site.) Over time, charting should reflect progress toward these goals and/or adjustment of the goals themselves. At admission, a discharge plan with measurable goals should be formulated so that progress can be assessed more objectively. Expected timeframes for improvement and the method for evaluating treatment progress should be clearly spelled out from the beginning of treatment.

All charts need to contain an area for consultations, reports, and results of laboratory tests in addition to ongoing treatment notes from all treatment providers that discuss the relevant clinical information. Written evidence that the different treatment providers both within and from outside the facility (as when referrals are made) communicate with each other is a critical charting element. Particularly when invasive procedures are used, documentation of pain levels pre- and post-procedure through the use of a verbal or numerical rating scale provides basic outcomes information. A discharge summary documents the patients' strengths and weaknesses at the time when the bulk of treatment has been delivered and describes any specific limitations and recommendations for activity levels, employment, diet, etc. Referrals to appropriate aftercare or follow-up services should be documented. Some programs follow patients indefinitely and do not have clear discharge dates. If patients continue to be seen on a maintenance follow-up basis (for example, to prevent relapse of chronic pain behaviors), this needs to be appropriately documented as well. Sometimes individuals are designated as "program" patients during an initial period of more intensive interdisciplinary treatment, and later, after a significant portion of the expected degree of improvement in pain and functioning has been accomplished, converted to "clinic" patient status for follow-up medication management or cognitive-behavioral "booster" individual or support group sessions.

The presence of a general informed consent for the patient to be treated in the program, in addition to specific consents for individual procedures, may be useful, especially for the legal protection of the program. This general consent covers the patient who is going through the evaluation process and may have to attend several appointments before a complete treatment plan is generated and begun. It is also necessary to have unique consent forms for every type of invasive/surgical procedure patients may receive that name the procedure, note the person performing the procedure, and state that no specific guarantees are being made to the patient about the outcome of the procedure. The patient's name should appear on the consent form and the patient's signature confirms that the patient has been informed of the common risks and benefits of the procedure and has been informed of any treatment alternatives that may be available, and that all of the patient's questions regarding the procedure have been answered to the patient's satisfaction. AAPM recommends that all of a patient's questions and the answers given be documented in order to provide extra legal protection for treatment providers. The patient needs to be further informed that consent may be revoked at any time.

Medical releases of information should be specific regarding the purpose of the disclosure and time-limited, with separate releases (even if on the same form) for treatment-related information pertaining to mental health services, substance abuse treatment information, and HIV status.

Printed patient materials that explain financial responsibilities and how third-party payers are handled can be helpful in making billing policies clear, especially for those programs where self-payment may constitute a significant proportion of program revenues.

Provision needs to be made for the secure storage of medical records, preferably in a centralized location. Access to the records needs to be restricted to appropriate staff, and there should be a designated person who is responsible for maintaining and securing the medical records on a continuous basis. HIPAA guidelines give specific recommendations for record security and these must be followed.

The importance of having a practical, consistent format for the organization of the medical chart cannot be underestimated. The medical record basically "tells the story" of the patient's journey through the treatment program, and it should be able to be "read" by the surveyor with little or no direction from staff. Clearly labeled chart tab dividers that separate elements of the chart are commonly used. A system for alerting providers to the presence of any known allergies should be conspicuous. An alert sticker can be placed on the outside of the chart, with the specific allergies listed on the inside cover, in line with health information privacy requirements.

The chart review is not intended to be a draconian process. It is a practical review of treatment records, looking for the elements necessary to accomplish the assessment, complete evaluation, and appropriate treatment of the patient with pain. Obtaining informed consent and permission to release medical records to outside entities, and establishing goals for treatment with the patient are required elements for any successful program.

Several accreditation standards cannot usually be answered in the clinical records, but can be resolved through the examination of other materials. Specialized treatment equipment and all necessary emergency equipment need to be regularly checked and certified by the appropriate state or local authority. Documentation of the certifications may be kept in an easily accessible log book.

The 510k documents for certain medical devices must also be on file. Documentation that staff has the ongoing training necessary to operate the equipment is necessary (this may be accomplished through training logs and training certificates kept in personnel files).

The final general clinical standard that is applicable to all pain programs addresses the need for the facility to be utilizing some type of outcomes measurement strategy. As this is such an important topic, it is covered thoroughly below.

CLASSIFICATION-SPECIFIC ACCREDITATION STANDARDS

The unique standards for each of the distinct classification types of pain programs are now discussed. To explain the need for the *classification-specific standards* a review of the AAPM organizational history regarding accreditation is in order.

Many years ago the leadership of the AAPM decided to offer program accreditation to all types and sizes of pain programs using different designations depending on the type and scope of services offered. It was determined not to be in the interest of the field of pain management, or to the patients served, to exclude any program that was interested in becoming accredited. Instead of accrediting only the larger university- and hospital-based programs, the AAPM developed a methodology to allow all pain programs to apply for accreditation, whether they were inpatient or outpatient in focus, large or small, or involved just a single practitioner, syndrome, or treatment modality. To meet the diverse needs of the AAPM membership and to be able to provide patient safeguards through the accreditation process, six types of pain programs were identified: major comprehensive multidisciplinary, comprehensive, small and network multidisciplinary, and syndrome and modality oriented (International Association for the Study of Pain, 1990). IASP, definitions for pain center classifications are somewhat different from those of the AAPM.)

Each classification of pain program had specific standards developed. The most detailed standards were written for the three largest and most complex types of programs. For the smaller, less-formalized programs, realistic standards were written to motivate solo practitioners and practitioners in syndrome- or modality-oriented programs to address the multidisciplinary needs of patients. A detailed definition of each type of program classification follows.

- Major comprehensive multidisciplinary pain program: Manages various types of painful conditions, conducts education/research programs, and involves a minimum of six disciplines operating within the same organization.
- Comprehensive multidisciplinary pain program: Manages various types of painful conditions, may conduct educational or research programs, and involves a minimum of four disciplines operating within the same organization.
- Small multidisciplinary pain program: Manages various types of pain conditions and involves a minimum of two disciplines operating within the same organization.
- Network multidisciplinary pain program: Generally involves a solo practitioner or group of clinicians all of the same discipline who manage various types of pain conditions by utilizing a network of closely coordinated independent professionals of varying disciplines.
- Syndrome-oriented pain program: Manages a single type of pain syndrome (e.g., back pain, complex regional pain syndrome, headache, temporomandibular joint dysfunction) utilizing one or more clinicians of the same or different disciplines.
- Modality-oriented pain program: Manages one or more pain syndromes by utilizing a single modality (e.g., acupuncture, biofeedback, counseling, hypnosis, nerve blocks, or transcutaneous electrical nerve stimulation).

Unlike the Commission on Accreditation of Rehabilitation Facilities (2003), which requires that all accredited programs have a board-certified medical director and a psychologist on staff, the AAPM system allows for programs that may be headed by a qualified multidisciplinary pain practitioner from other disciplines. The AAPM will accredit smaller syndrome- or modality-oriented programs as long as the treatment philosophy of the multi/interdisciplinary approach can be shown to be approximated through appropriate consultation and referral.

Major Comprehensive, Comprehensive, and Small Multidisciplinary Clinical Accreditation Standards

Major comprehensive, comprehensive, and small multidisciplinary programs have the same *classification-specific standards*. Organizational requirements address the purpose and business structure of these larger programs. Documentation of the structure of the governing body, usually in the form of a clear organizational chart, is very helpful to the surveyor as he or she needs to quickly grasp the lines of communication and authority that exist. This chart should be made available to key employees as well. Minutes of the governing body's meetings should be kept as well as written policy that describes how authority is delegated throughout the organization. Documentation demonstrating commitment to principles of ethical leadership, how policies are determined, and institutional com-

mitment to high-quality patient care are minimal elements the surveyor will want to ascertain are in place through discussion or viewing of relevant documents. Corporations need to have a written job description for the chief executive officer (CEO) detailing the authority and responsibilities delegated to the CEO by the governing body. The CEO should be evaluated on job performance annually by the governing body.

Documentation of the business operations of the larger multidisciplinary programs needs to show that the financial affairs of the organization are managed on the basis of an annual budget that is approved by the governing body. Evidence of adequate communication between key administrative staff members should be present and may take the form of interoffice memoranda or e-mail, for example.

Clinical operations of large multidisciplinary programs can be complex, but if well-thought-out policies and procedures are in place and are clear to all staff, even the largest programs can operate quite smoothly and efficiently. During the onsite survey, the reviewer will want access to written documentation that identifies a case manager for every client/patient to coordinate true interdisciplinary care. Some programs use a patient-care coordinator instead of a nurse case manager, and of course there is flexibility with this and other of the clinical standards. What is necessary is that the program has an effective way of accomplishing its mission to provide integrated patient care and that this is clear to the reviewer. Chart notes reflecting that all patients are properly oriented to the program need to be in evidence in addition to documentation of a coordinated team-approach to treatment.

Documentation of meetings and case management chart notes indicating how treatment goals are updated and modified by the team and communicated to the patient (with their input and agreement) must be present. Staffings need to take place not less than weekly for clients in daily treatment programs. The case manager is responsible for ensuring that the necessary communication between practitioners takes place, and there needs to be a provider designated to make any final treatment decisions especially when there is disagreement between practitioners about how to proceed. Documentation needs to show that care is coordinated. Case conferences need to address goal setting, discharge planning, ongoing patient care, and modifications to the treatment plan. The tracking and modifying of goals with patient input needs to be obvious in the chart. The case manager (or another designee) is also responsible for ensuring appropriate and timely communication between the program and the patient's employer if necessary, with accurate and timely documentation of these contacts and any work-related goals present in the chart. The final duty of the case manager (or other designee) is to ensure that adequate plans are made for discharge. Follow-up appointments, any home-based services needed, along with recommendations and limitations should be documented and present in the discharge summary.

As mentioned above in the section on *nonclinical* accreditation standards, if a major comprehensive, comprehensive, or small multidisciplinary program utilizes regular consultants or independent contractors to accomplish any treatment components, written agreements between the program director and the consultants/contractors that describe the specific duties and responsibilities of the nonstaff team members should be present. A length of time that the agreement is in effect should be specified so that the agreement can be reviewed and updated regularly. A personnel file should include this agreement, a copy of the consultant/contractor's license to practice, and any other documentation necessary (e.g., Drug Enforcement Administration certificate, pharmacy registration) for practice in addition to evidence of malpractice insurance in adequate amounts. An annual performance review for the independent contractor or consultant will help ensure that high standards of care are being upheld and will alert management when there is a need to consider altering or ending the relationship.

Network Multidisciplinary Clinical Accreditation Standards

Network multidisciplinary programs involve groups of independent practitioners working together to provide interdisciplinary care. In most instances, leadership for a network multidisciplinary program is provided by a solo-practice clinician. This clinician often carries the dual responsibilities of administration and patient care. It is desirable for network multidisciplinary pain program services to be provided by a coordinated interdisciplinary team; however, it is not required that the program actually employ all of the treatment team members. In most network multidisciplinary pain programs, it is common that the other team members are serving as consultants to, or independent contractors for, the primary practitioner providing care. Hence, the standard regarding personnel management for independent contractors described above applies to this type of program as well.

Organizational and business operation standards for network multidisciplinary and syndrome- or modality-oriented programs are quite similar and are in place to ensure adequate documentation of the governing body or owner/operator's policies and procedures regarding delegation of authority, commitment to ethical leadership, establishment of policy, and maintenance of high quality patient care. The governing body or person should operate with an annual budget, and communication needs to be adequate between the treatment team members and support staff (usually through documented phone contact, e-mail, and interoffice memoranda).

Clinical standards include documentation of patient orientation, and most importantly, there should be at least monthly treatment conferences (weekly, if possible) attended by team members caring for active patients engaged in regular (possibly daily) treatment. As this ideal is not always attainable when practitioners do not work in close proximity with each other, phone contact and other means of communication and records sharing may sometimes have to suffice. Network multidisciplinary programs have to be able to show the reviewer that communication between team members and the documentation of this communication is sufficient to provide truly integrated care. Patients may or may not be involved in the team meetings, and the documentation of the team meetings should be the responsibility of a designated staff member. The chart needs to show that individual case management reflects input from the team members and the patient regarding goal setting, discharge planning, patient education, and the modification of goals as treatment progresses.

Syndrome- and Modality-Oriented Clinical Accreditation Standards

Syndrome- or modality-oriented pain programs are also usually operated by a solo practice clinician, carrying the dual responsibilities of administration and patient care. With respect to patient care, the clinician carries the responsibility for obtaining consultations or referrals when services required by the patient are outside the scope of the clinician's training and experience, and for coordinating these referrals and consultations to effect, as much as possible, a multi/interdisciplinary treatment approach. Again, in terms of personnel management, consultant agreements are a critical component for the success of this type of program and allow for owner/operator monitoring and quality control.

The syndrome- and modality-oriented program standards covering organization, business practices, and clinical operations are similar to those discussed in the section above for network multidisciplinary programs. In addition, there needs to be evidence that the primary treatment provider makes the necessary referrals and/or seeks consultation when it is clear from the assessment that the patient will benefit from integrated multidisciplinary pain management services outside the scope of training of the primary provider. There should be close communication between the primary provider and any outside consultants and treating providers. This communication must be evident in the medical record, especially in terms of setting and modifying treatment goals.

OUTCOMES MEASUREMENT AND PERFORMANCE IMPROVEMENT

Defining, measuring, and disseminating relevant treatment outcomes information is something even the smallest pain program must do in order to remain viable in today's health care climate of increased demand for evidence-based practice and cost-containment accountability. Patients, payers, and providers are all stakeholders in the pain management process and are looking for results in terms of the outcomes variables that are important to them. Reduced pain, functional recovery, reduced need for medication, improved quality of life, and patient satisfaction with treatment are important to patients and providers. Providers, employers, and insurance companies are interested in functional rehabilitation (as evidenced by return to work) and containing the cost of treatment (as evidenced by settled disability claims and reduced health care utilization) (Okifuji & Turk, 1998). Every pain management program needs to use outcomes measurement to improve performance and address the needs of stakeholders or risk becoming obsolete as competing providers are able to prove their worth. Both JCAHO and CARF have outcomes measurement requirements for the hospitals and pain programs they accredit. *The Wisconsin Resource Manual* (Gordon, Dahl, & Stevenson, 2000), entitled *Building an Institutional Commitment to Pain Management,* outlines the steps necessary to improve pain management in different types of health care settings based on guidelines published by the Agency for Healthcare Research and Quality (1994) and the American Pain Society (1995).

Because the AAPM accredits different classifications of pain programs, the requirement for outcomes measurement must be realistically assessed in the context of the type of program being reviewed. The goal of adequately assessing treatment success and using the information gained through tracking outcomes to affect treatment quality is best viewed as a being on a continuum ranging from the use of a comprehensive multidimensional outcomes assessment instrument, such as the National Pain Data Bank, which only the larger, comprehensive multidisciplinary pain management programs may have the financial resources and workforce available to employ, to the simple use of a Numerical Rating Scale or Visual Analogue Scale (VAS) of pain intensity obtained whenever the patient is seen or before and after invasive procedures, which even the smallest program can be expected to have minimally in place. The AAPM goal is to help all pain programs raise the bar for quality care through improving and effectively utilizing outcomes assessment tools and techniques. The information gained must be useful to all stakeholders including patients, providers, and payers and be presented in a clear, concise, understandable format.

In spite of the obvious need for outcomes research in order for pain programs to stay in business, the market survey of chronic pain management programs cited above (Marketdata Enterprises, 2003) contained a shocking finding. The number of pain programs that claimed they could document outcomes data declined since 2001

from 67 to 59% in 2003. The authors stated that the main reason for the decline may be due to the increase in number of solo anesthesiologists practicing pain management. Although 87% of true multidisciplinary pain programs could document outcomes in 2003, only 40% of anesthesia-based modality-oriented programs could. This represents a decline from 1999 when fully 77% of all pain programs surveyed reported that they could document outcomes data. This trend must be reversed for the field of pain management to remain at the forefront of the integrated health care movement and to continue in its leadership role for the rest of the health care industry. See Chapter 9 for a more in-depth discussion of the importance of quality assurance and outcomes measurement in pain management.

THE NATIONAL PAIN DATA BANK

In response to the different service delivery models current in the field of pain management, the AAPM has created outcomes measurement tools that can fit the needs of different types of pain programs. Much of the following information appears in the AAPM *Pain Outcomes Profile Instruction Manual* (2004). The AAPM created the National Pain Data Bank (NPDB) outcomes measurement system in the early 1990s, as national policy makers began insisting on the use of standardized outcomes measurement approaches to assess the quality of health care. Outcomes measurement was made a requirement for the AAPM Pain Program Accreditation in 1992, and by the end of 2002 the NPDB had collected data from approximately 100 pain management programs and tracked more than 13,000 patients. The purpose of the data bank was to provide comparison benchmarks for successful treatment outcomes that could be used by the solo practitioner as well as by the large multidisciplinary treatment program. The NPDB became an important tool in helping pain management programs comply with pain outcomes measurement standards imposed by national accrediting agencies (Cole, 2000).

The NPDB measurement system consists of three separate questionnaires that a patient completes at intake, discharge, and follow-up. In addition to subscale and total scores, narrative reports may be generated at intake giving a summary description of the patient's pattern of responding on crucial dimensions of the pain experience including pain intensity, functional status, and emotional health. These are three domains recognized as crucial in determining outcomes by the IASP. Other important outcomes data such as disability status, medical resource utilization, patient satisfaction, diagnosis, and treatment modalities used are included in the NPDB questionnaires, making it a complete outcomes measurement system. Subscribing pain programs collect data and submit the data on diskette to the AAPM. Quarterly reports are generated comparing the performance of programs that are similar in size and in the scope of treatments offered.

With the help of Applied Measurement Professionals, the University of California at San Diego, and the Department of Veterans Affairs, several reliability and validity studies were carried out demonstrating adequate psychometric properties of select subscales of the NPDB questionnaires (Clark & Gironda, 2000; Gironda, Azzarello, & Clark, 2002). One drawback to the use of the NPDB is its length. Some smaller pain programs and solo practitioners have found it challenging to allocate the staff for its proper administration, while others have been limited by budgetary constraints. Use of the NPDB was mandatory for Pain Program Accreditation in the past; however, it is no longer required. Accredited programs may create their own outcomes measurement systems. The NPDB remains a helpful tool for larger pain programs and institutions dedicated to clinical research. A modified, somewhat shorter, Web-based version of the NPDB may be available in the future. As discussed above, the decline in the number of practitioners who are incorporating outcomes measures in their pain practices may be due to a lack of clinically useful, validated, brief outcomes measures. The AAPM responded to the need for a brief measure by continuing to work with psychologists at the Tampa Veteran's Hospital.

THE PAIN OUTCOMES PROFILE

Further psychometric analysis of items from the NPDB allowed Drs. Clark, Gironda, and Young, Jr., at the Tampa Veteran's Hospital, to determine which ones had the greatest psychometric strength. They eliminated weaker items and added several new questions to create a brief pain outcomes measurement instrument that the AAPM (2004) has published under the name "Pain Outcomes Profile" (POP). The Veteran's Hospital version is called the Pain Outcomes Questionnaire–VA Short Form.

The POP is a 23-item self-report questionnaire that uses 11-point, 0 to 10, numerical rating scales to assess a number of relevant dimensions in the patient's pain experience. The POP assesses three domains of a patient's pain experience: pain perception, perceived physical impairment due to pain, and several aspects of emotional functioning. These domains are assessed using two pain intensity scales, three self-report of functional impairment scales, and two scales that address self-reported emotional functioning (seven scales total).

The POP includes 19 items that are identical to the primary pain outcomes items that appear on the POQ–VA Short Form. However, the POP contains two numerical rating scales to assess the patient's experience of pain intensity *right now* and *pain on the average during the last week*. The POQ–VA Short Form contains only one rating of *pain intensity on average during the last week*.

The POP includes the *pain right now* item as it is believed to have clinical utility. Also, in finalizing the POP, the order of the items on the instrument was rearranged so that questions from the different content scales appear in a counterbalanced fashion.

There are three scales in the domain of perceived functional impairment due to pain: Mobility, Activities of Daily Living (ADLs), and Vitality. The Mobility scale contains four items that rate a patient's perception of pain-related interference with the ability to walk, carry or handle everyday objects, and climb stairs, and whether pain requires the use of assistive devices (e.g., a walking aid or wheelchair). ADLs are assessed with four items that inquire about pain-related interference with the ability to bathe, dress, use the bathroom, and manage personal grooming. The patient's subjective feeling of a lack of Vitality is assessed with three items rating the ability to perform physical activities, feelings of overall energy, and strength and endurance. Self-reported emotional functioning is assessed with two scales. The Negative Affect scale contains five items asking the patient to rate the degree to which pain affects self-esteem, feelings of depression, feelings of anxiety, ability to concentrate, and feelings of subjective tension. The Fear scale contains two items that rate how much worry is experienced about reinjury due to increasing activity and feelings of safety exercising.

The POP can be quickly scored and a cumulative patient scoring record can be placed in the chart. This form allows for tracking of POP scale scores across repeated administrations of the measure (e.g., at intake, several times during active treatment, at discharge).

Although not a complete outcomes measurement system, the POP does provide for the assessment of seven core functional pain outcomes domains that are of interest to patients, providers, and payers. Other important outcomes that should be assessed include patient satisfaction, disability/litigation status, and medical resource utilization.

POP scores and scores on these other important outcomes variables can be placed into a computer database. Program staff should be able to perform at least basic tabulations of scores from the beginning to the end of treatment. Benchmarking outcomes against its own previous performance can at least give a pain program a sense of whether quality improvement is occurring over time.

Clark, Gironda, and Young (2003) trace the development of the final brief pain outcomes questionnaire in the 5-year, cooperative VA–AAPM project that originated with the NPDB long forms. They conclude that the new instrument is reliable, valid, and clinically useful in evaluating the effectiveness of treatment for veterans experiencing chronic noncancer pain. When comparing results from the POQ–VA Short Form and the POP for research purposes, it is important to examine only the 19 items that the two instruments share. Additional research needs to be completed to validate the measure in different populations of patients with various types of pain diagnoses. The future of multidisciplinary pain management depends on the ability to provide the best combination of treatments for the proper duration and intensity to obtain the most cost-effective results with the appropriate patients (Chapman, 2000). The AAPM is currently partnering with several independent pain programs across the country, gathering data to further document the psychometric properties of the POP, to establish norms with different patient samples, and to help programs using the POP document and publish treatment successes. Also, the POP has been translated into Spanish and is available for field-testing and research with a Spanish-speaking population.

With the coming shift toward a "person-centered" health system (Foundation for Accountability, 2003), we hope the 21st century will see a much better educated public taking a greater role in health care decisions, practicing more effective health maintenance behaviors, and gaining a better understanding of health care financing. As patients become savvier in terms of managing their personal health information, they will begin to demand access to quality ratings of different treatment modalities based on evidence for all health conditions, not just chronic or acute pain. Somewhat akin to how *Consumer Reports* magazine publishes ratings and information regarding quality of all kinds of products for the general public, agencies responsible for maintaining standards in health care (such as the Agency for Healthcare Research and Quality) may eventually publish treatment success/cost-effectiveness information designed for the general public concerning treatments for many illnesses and disease conditions. To put it more bluntly, the need and demand for outcomes data for pain management programs of all stripes will not go away anytime soon! If anything, the need to appropriately disseminate quality information will only increase, and this information will need to be presented in different formats for different consumer groups (e.g., the lay public, payers, and health care professionals). Performance improvement and clinical outcomes research should go hand in hand. Pain practitioners need to design performance improvement projects that will lead to publication of articles in peer-reviewed journals so that the evidence base for successful multidisciplinary pain management can continue to grow. These articles can then be summarized in language appropriate for the general public and be published in relevant consumer health publications. Funding for these activities will no doubt be problematic, but strategic research partnerships between membership organizations such as the AAPM and its accredited programs may lead the way.

STEPS TO GAINING AAPM PAIN PROGRAM ACCREDITATION

A PPA brochure, manual order form, and articles describing the standards can be found on the AAPM Web site at www.aapainmanage.org. Once the decision is made to become accredited (after the program has been in operation for at least 6 months), the program director/manager completes the self-assessment found in the manual to see which areas of business, clinical, or personnel operations meet the AAPM standards already and which need to be improved before submitting the application. Facilities are encouraged to contact the Pain Program Accreditation Director with any questions or concerns during the application process for clarification. The mission of the AAPM is to come alongside each program and help the program to raise the bar for quality pain management through the consultative accreditation process. The application and self-assessment are submitted (in duplicate) with the appropriate fees along with the required program documents (also in duplicate). These consist of the patient history and physical exam forms used, consent for treatment forms (invasive procedure and/or general treatment), program description, mission statement, patient education materials and program brochures, code of ethics and bill of patient rights (both of which can be easily adapted from the AAPM documents), release of information forms, current research protocols (if any), and copies of outcome measurement and patient satisfaction tools. Resumes or curriculum vitae for all licensed professionals and clerical or support staff members that have patient contact are also requested.

Once the completed application and supporting documents have been received and processed, a surveyor is selected by the Pain Program Accreditation Director, usually near the facility in terms of geographical area. The AAPM has a highly skilled group of accomplished clinician–surveyors whose goal it is to provide expert consultative services during the 1-day review. The surveyor examines all program documents, previous accreditation reports, and resumes before the actual onsite review, thus saving valuable consultation time.

Each pain program accredited by the AAPM must pass all of the *general standards* and one of the sets of *classification-specific standards*. The period of accreditation is for 3 years if all of the standards for accreditation are met. If there are any standards not found to be in compliance, remediation is attempted immediately to bring the program into compliance. If this cannot be accomplished fairly quickly, these programs are likely to receive a 1-year provisional status. To then become fully accredited for 3 years, these provisional programs must have a second (abbreviated) onsite survey and demonstrate full compliance with the accreditation standards. Over the years that the AAPM PPA service has been available, revisions of the pain program standards and changes in the specific items surveyors are to note during their visits to pain programs have improved the overall accreditation process. The process of accreditation has become much more objective. Along with practitioner credentialing and outcomes measurement, program accreditation provides pain practitioners with another link in the "quality" pain management chain.

FUTURE CHANGES AND ADDITIONS TO PPA STANDARDS

The AAPM accreditation manual is periodically updated and revised in response to advancements in the field of pain management and new legal and ethical requirements that arise. Some areas for future revision may include

- Critical incident reporting-medication errors, equipment-related and other patient or staff injuries, incidents of workplace violence, etc.
- Corporate compliance
- Consumer involvement in performance improvement and outcomes measurement activities
- Better dissemination of outcomes data and incorporation of data into patient education materials
- Internet service security and accessibility standards
- Grievance policies for clients
- Background checks for personnel
- External financial audits
- Risk management policies and procedures

THE VALUE OF PAIN PROGRAM ACCREDITATION

Voluntary accreditation through the AAPM demonstrates to peers, payers, and patients that the pain program has submitted to rigorous scrutiny of its policies and procedures, clinical, business, and personnel practices; has met peer-established quality standards; and is committed to excellent patient care and continuous performance improvement.

In addition to the invaluable consultation that takes place during the survey process, all accredited pain programs receive an engraved plaque for display in the facility and use of the AAPM accredited pain program logo for marketing efforts. Each facility is listed on the AAPM Web site with a detailed program description and photographs of the facility and staff. The AAPM receives many calls per week directly from patients seeking treatment, and while not able to provide direct referrals, AAPM staff does direct people to its Web site to view listings of accredited pain programs and credentialed members. A link

directly to the accredited facility's own Web site can also be created if appropriate. If requested, a press release printed on AAPM letterhead will be provided to any accredited program. Programs are invited to submit updated information to the Pain Program Accreditation Director for periodic new press releases. Assistance creating clinical forms, policies, and procedures and for choosing outcomes measures is also freely given.

Future services include the availability of the Pain Outcomes Profile Plus, a computer version of the POP that gives the user instant access to individual patient data graphically displayed, which can be transferred to statistical analysis software for program-wide outcomes assessment. This computer software will also include a module that will enable physicians to document controlled substance prescribing and relevant patient treatment parameters. Other future services may include an Internet forum for accredited program staff members to provide a mechanism for networking and the sharing of information to improve pain management practices, a periodic e-newsletter for program directors/managers and staff, policies and procedures manuals (general or tailored to an individual pain program's needs), topical Web-based articles addressing such issues as practitioner burnout and patient drug-seeking behavior, downloadable examples of excellent chart documents (e.g., discharge summaries), and marketing assistance such as downloadable patient information and education brochures that increase consumer understanding regarding the benefits of seeking treatment at an AAPM-accredited facility.

The AAPM remains committed to being an invaluable resource to multidisciplinary pain practitioners and seeks to be responsive to its members' needs. Contact AAPM at 13947 Mono Way, Suite A, Sonora, CA 95370, (209) 533-9744, to learn more about the many services and tools available to multidisciplinary pain practitioners including accreditation, credentialing, education, and outcomes measurement, and to have your questions and concerns addressed.

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