IHM Part 3, Chapter 30 Audit Tool
Chronic Non-Cancer Pain Management Policy
Site:
Date of Review:

This worksheet can be used by IHS facilities and IHS Areas to audit local policy elements and confirm alignment with the IHM Part 3, Chapter 30 policy on chronic non-cancer pain management. Sites should also be aware of other applicable Federal and State laws and accreditation requirements that may identify additional policy requirements for consideration and adoption at the local level. A local Chronic Non-Cancer Pain Management policy is one component of a comprehensive opioid stewardship program.

1. Respect and support the patient's right to optimal pain assessment and management

Policy Requirement (Reference)	Findings	Local Policy Reference (if desired)	Comments
Explicit definition of Chronic Pain	☐Yes ☐No		
Written & Signed Informed Consent for chronic opioid therapy (COT) requirement (3-30.4) - may be combined with Treatment Agreement	☐Yes ☐No		
Standardized Informed Consent specified in local policy (3-30.4, C)	☐Yes ☐No		
Written & Signed Treatment Agreement for COT (3-30.5)	☐Yes ☐No		
Standardized Treatment Agreement specified in local policy (3-30.5, E) - may be combined with Informed Consent. Treatment agreement includes the following: 1. The goals of treatment specified, in terms of pain management, restoration of function, and safety; 2. The patient's responsibility for safe medication use, including not using more medication than prescribed or using the opioid in combination with alcohol or other substances; storing medication in a secure location; and safe disposal of any unused medication; 3. The patient's responsibility to use one physician or practice; 4. The patient's agreement to periodic monitoring (including random and/or scheduled urine drug screens	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No		

(UDS) and pill counts); 5. The provider's responsibility to ensure continuity of care via an alternate prescriber within the practice if needed; 6. The provider's prescribing policies and expectations (including the number and frequency of prescription refills, provider's practices on early refills, and replacement of lost or stolen medication). 7. Specific reasons for which drug therapy may be changed or discontinued (including violation of the policies, practices, and agreements spelled out in the treatment agreement).	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No		
Patient/Family Engagement - Patient Education (3-30.25)	☐Yes ☐No		
Co-prescribed Naloxone Parameters described (3-30.18) (e.g. morphine milligram equivalents (MME) >50)	☐Yes ☐No		

2. Assess and manage patient's pain.

Policy Requirement (Reference)	Findings	Local Policy Reference (if desired)	Comments
Screening for Pain—pain assessment process and local screening tools are clearly described	☐Yes ☐No		
Parameters for recommended pain reassessment described (e.g.: prior to dose escalation, prior to COT initiation)	☐Yes ☐No		
Initial Patient Assessment recommendations specified in policy (3-30.9): 1. Comprehensive review of pain history (onset, location, quality, duration, and intensity), prior pain treatments, diagnostic tests, and functional status assessments, medical history findings, and physical examination; 2. Past psychiatric history including depression, anxiety, and other emotional or personality disorders; 3. Current or prior substance use and abuse; including review of the patient's current psychosocial status, any history of mental health or substance abuse concerns, and assessment for relevant signs of misuse or abuse of	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No		

Policy Requirement (Reference)	Findings	Local Policy Reference (if desired)	Comments
substances; 4. Family and social history including employment, cultural background, and school or social network; 5. Relevant legal history; and 6. Consider assessment for other behavioral patterns of concern, such as impulsive behaviors, through use of validated screening tools (e.g.: Opioid Risk Tool). Other best practice screenings include the following: • Screening for Depression (e.g.: PHQ-9), • Anxiety (e.g.: GAD-7), • suicidality (e.g.: ASQ) and • substance use (e.g.: NIDA quick screen or DAST 10)	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No		
Initiating COT requirements specified in policy (3-30.10): 1. Documentation of appropriate pain diagnosis in the IPL (EHR Integrated Problem List) and past pain treatments with respective treatment failure/success details (including non-pharmacological and non-opioid interventions). 2. Statement surrounding opioid treatment should be presented to the patient as a therapeutic trial or test for a defined period of time (usually no more than 90 days) with specified evaluation points and follow up within 1 to 4 weeks of opioid treatment initiation or dose escalation. 3. Statement surrounding the initiation of the lowest possible dose of medication and subsequently, slowly titrated to desired therapeutic response. 4. Urine drug screening requirements/statement to include actionable steps as a result of unexpected UDS results and documentation requirements. 5. Review of State PDMP data and patient history of controlled substance use to determine whether the	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No		

Policy Requirement (Reference)	Findings	Local Policy Reference (if desired)	Comments
patient is receiving opioid dosages or dangerous combinations that increase the risk for overdose. (align with IHM Part 3, Chapter 32) 6. Documentation requirements when deciding to continue opioid treatment beyond the trial/test period and reflects a careful evaluation of treatment benefits versus adverse events and potential risks. 7. Statement surrounding lack of provider obligation to provide opioid treatment for chronic non-cancer pain when the adverse events and/or potential risks outweigh the benefits. 8. Parameters specifying avoidance of co-prescriptions of opioids with benzodiazepines, and other respiratory or central nervous system depressants whenever possible.	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No		
Ongoing Monitoring and Management (3-30.14)			
Requires documentation of treatment plan review at regular intervals (minimum every 3 months). *Best practice recommendation to use the EHR patient education module.*	☐Yes ☐No		
Functional status assessment and goals documented. *Best practice to use the CPT code as a structured data element to enable reminders and reporting.*	☐Yes ☐No		
Urine drug screen requirements (frequency and documentation requirements) specified at least annually and as needed (3-30.19)	☐Yes ☐No		
Periodic Pill Counting (3-30.20) parameters specified	☐Yes ☐No		

Policy Requirement (Reference)	Findings	Local Policy Reference (if desired)	Comments
Reassessment requirement at each pain visit specified and includes evidence based standards (e.g.: 6As of pain management) to determine medication effectiveness and need for treatment modification	☐Yes ☐No		
Evaluation for conversion to a long-acting opioid analgesic specified	☐Yes ☐No		
Statement requiring "Clinicians will use caution and evaluate individual benefits and risks when increasing dosage to ≥ 50 MME/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day." *Recommend verbatim with QA review*	☐Yes ☐No		
Continuation or modification of therapy includes a risk benefit analysis, reassessment parameters, and treatment goals	☐Yes ☐No		
Medication Refills and Proxy Dispensing (3-30.27) Local policies and procedures must outline the management of medication refills for lost or stolen prescriptions, early or missed refills, and proxy medication dispensing.	☐Yes ☐No		

Policy Requirement (Reference)	Findings	Local Policy Reference (if desired)	Comments
Continuum of Care (3-30.16)			
1. Statement surrounding patient management (receive chronic pain management from one consistent provider);	☐Yes ☐No		
2. In cases where an appointment with the primary pain management provider is not available, patients may be assessed and treated by alternate medical providers in the same facility. Under these circumstances, opioid treatment is based on the alternate provider's medical evaluation and clinical judgment.	☐Yes ☐No		
3. An alternate provider may prescribe some, all or none of the opioid medications for up to 30 days or until an appointment with the primary pain management provider is available, whichever comes first.	☐Yes ☐No		
4. In some instances, an alternate provider may be unfamiliar with a patient or uncomfortable with the current treatment regimen. At such times, the alternate provider may request more frequent visits or re-evaluations for continued pain management until an appointment with the primary pain management provider is available.	☐Yes ☐No		
5. Whenever possible, primary pain management providers will attempt to coordinate care with alternate providers for their foreseen absence.	☐Yes ☐No		
6. Treatment of chronic pain in urgent care or emergency room settings is inappropriate in most circumstances and should be avoided.	☐Yes ☐No		
7. Contract or locums clinicians should be discouraged from the initiation of chronic opioid treatment. Consultation with the facility Clinical Director or multi-disciplinary pain management team by contract or locums providers will occur prior to initiation of chronic opioid treatment.	☐Yes ☐No		

3. Facility providers practice evidence-based and best clinical practices for the use of pharmacologic and non-pharmacological modalities and non-opioid therapies to treat pain.

Policy Requirement (Reference)	Findings	Local Policy Reference (if desired)	Comments
Policy has a clear statement on Fentanyl (3-30.12)—including required REMS training	☐Yes ☐No		
Policy has a clear statement on Marijuana (3-30.13)	☐Yes ☐No		
Referral mechanisms for patients to pain management specialists	☐Yes ☐No		
Co-occurring disorders. Process to assess behavioral health and substance use with referral to specialty behavioral health services when needed	☐Yes ☐No		
Specifies safeguards to minimize the risk and improve detection of misuse and diversion of opioid analgesics and other controlled substances (3-30.21)	☐Yes ☐No		
Recognize the signs and symptoms of Opioid Use Disorder; opioid induced hyperalgesia; and consider opioid de-prescribing when clinically appropriate.	☐Yes ☐No		
De-prescribing (3-30.22): Specifies parameters, patient assessment requirements, and criteria for opioid tapers. 1. Opioids should not be tapered rapidly or discontinued abruptly due to risk of significant opioid withdrawal 2. If opioid treatment is discontinued, the patient who has become physically dependent should be provided with a safely structured individualized taper regimen in addition to care coordination and alternate treatment modalities as available. 3. Withdrawal management plan recommended 4. Specification of referral and pain management plan 5. Patient education including increased risk for overdose on abrupt return to a previously prescribed higher dose.	☐Yes ☐No		

New Provider Orientation (3-30.29) 1. All new provider staff will complete an orientation on associated local policies and guidelines 2. A copy of IHM, Part 3, Chapter 30, "Chronic Non-Cancer Pain Management," will be provided to all new clinical staff before or at the orientation 3. Mandatory training (IHS Essential Training in Pain and Addictions) (3-30.30-3-30.31)	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No		

4. Establish multidisciplinary pain management teams for review of processes for treatment plans and patient management.

Policy Requirement (Reference)	Findings	Local Policy Reference (if desired)	Comments
Describes the interdisciplinary team, communication processes, meeting frequency, and emphasis on integrative pain management approaches.	☐Yes ☐No		
Responsibility and oversight in restarting COT (3-30.23)	☐Yes ☐No		
Quality Monitoring (3-30.28) 1. Statement regarding policy compliance and oversight as part of opioid stewardship best practices 2. Statement surrounding allegations of inappropriate pain management by a provider will be investigated and addressed at the local level in accordance with the established Medical Staff Bylaws 3. Mortality and morbidity review process for the review and investigation of deaths related to internally prescribed and managed opioids	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No		
Best or promising practices: *1. Pain management team assists with creation of opioid stewardship plan* *2. Pain management team assists with design of peer review criteria and OPPE, FPPE, and/or QAPI studies* *3. Pain management team utilizes a patient registry to*			

Policy Requirement (Reference)	Findings	Local Policy Reference (if desired)	Comments
track patients and population health outcomes (iCare) 4. *Pain management team assists with the interpretation of unexpected UDS results, provides recommendations on treatment plans secondary to unexpected UDS results, and reviews clinical documentation regarding UDS results*			