

c. 2003, Florida Academy of Pain Medicine, Inc. All rights reserved. The information contained herein is for informational purposes only and does not constitute legal advice, which should be obtained from competent personal legal counsel.

FAPM PAIN PROGRAM ACCREDITATION STANDARDS

I. Classification Specific Standards

A. Major Comprehensive, Comprehensive and Small Multidisciplinary Pain Centers

1. Organizational:

- a. Governing body authority and delegation of that authority is documented.
- b. The governing body has developed written policy regarding ethical leadership, organizational behavior and expectations for high quality client or patient care
- c. A written organizational chart is available for all staff and interested parties
- d. If the organization is a corporation, a written job-specific description exists for the Chief Executive Officer, detailing the authority and responsibilities delegated to the CEO by the governing body
- e. If the organization is a corporation, the Chief Executive Officer is evaluated on an annual basis by the governing body

2. Business Operation:

- a. Written or electronic records demonstrate that the facility financial affairs are managed on the basis of an annual budget approved by the governing body if one exists
- b. Written or electronic records demonstrate that communication to, from and between treatment team members and support staff is sufficient for facility operation

3. Clinical Operation

- a. Written or electronic records demonstrate that a case manager is identified for each and every client or patient to coordinate the multidisciplinary team approach to care
- b. Written or electronic records demonstrate that the case manager orients the client or patient to the facility program
- c. Written or electronic records demonstrate that program services are provided by a coordinated interdisciplinary team method (i.e. minutes from the regularly scheduled treatment team meetings are maintained)
- d. Written or electronic records demonstrate that treatment goals are updated and modified at case conferences, treatment team meetings or during scheduled client or patient appointments

- e. Written or electronic records demonstrate that case conferences attended by the practitioners involved in the ongoing treatment are held not less than weekly for those clients or patients in daily treatment programs
- f. Written or electronic records demonstrate that case conferences address goal setting, discharge planning, ongoing client or patient education and that modification occurs as treatment progresses
- g. Written or electronic records demonstrate that the case manager coordinates communication between the treatment team and the employer for the client or patient
- h. Written or electronic records demonstrate that the case manager makes arrangements for discharge and after-care follow-up services

4. Personnel Management

- a. Written or electronic records demonstrate that there is an agreement signed by the program's director and each treatment team member who is not an employee (independent contractor) defining the duties and responsibilities, having a defined term, and being current with respect to the term

2. Syndrome or Modality Oriented Pain Clinic

1. Organizational

- a. Written or electronic records demonstrate that the governing body or the facility owner/operator/clinician have administrative authority and to whom any authority has been delegated
- b. Written or electronic records demonstrate that the governing body or the facility owner/operator/clinician is responsible for ethical leadership, establishment of policy and maintenance of high quality care

2. Business Operations

- a. Written or electronic records demonstrate that the facility financial affairs are managed on the basis of an annual budget, approved by the governing body if one exists
- b. Written or electronic records demonstrate that communication to, from and between treatment team members is sufficient for the operation of the program

3. Clinical Operations

- a. Written or electronic records demonstrate that clients or patients have received referrals and/or consultations to specialists having training outside of, or beyond the practitioner's usual scope of practice
- b. Written or electronic records demonstrate close communication with the patient, referral source and any consultants in establishing or modifying the treatment goals

4. Personnel management

- a. Written or electronic records demonstrate that there is an agreement signed by the program's director and each treatment team member who is not an employee (independent contractor) defining the duties and responsibilities, having a defined term, and being current with respect to the term

II. Clinical Operations

- A. Written or electronic records at admission to the program describe the client's or patient's presenting problem or chief complaint, sufficient history about the problem and general medical condition, and the findings from the physical examination
- B. Written or electronic records demonstrate determination of needs regarding functional status, psychological and social well-being during the initial evaluation
- C. Written or electronic records demonstrate working diagnoses and appropriate treatment plans for all clients or patients receiving services
- D. Written or electronic records demonstrate the development of a discharge plan with behaviorally measurable goals at the time of admission
- E. Written or electronic records demonstrate that client or patient input is obtained to develop treatment goals, criteria for discharge, expected time frames for improvement and how the ongoing treatment will be evaluated
- F. Written or electronic records demonstrate individual client or patient evaluations (i.e. consultations, reports, test interpretations), and treatment notes from all of the participating treatment providers
- G. Written or electronic records demonstrate communication between the treatment providers within (i.e. team meeting minutes, letters, chart notations), and from outside of, the facility
- H. Written or electronic records demonstrate the use of a pain intensity scale (i.e. descriptive, numeric or visual analog) utilized throughout the treatment course to document changes in the perceived pain
- I. Written or electronic records demonstrate discharge plans and after-care follow-up arrangements to appropriate support services
- J. Written or electronic records demonstrate the use of a signed, general informed consent for treatment with every client or patient
- K. Written or electronic records demonstrate the use of an invasive or surgical procedure informed consent for each and every invasive procedure performed
- L. Written or electronic records demonstrate that the invasive or surgical procedure informed consent specifically states the type of procedure being performed, upon whom the procedure will be performed, who will be performing the procedure, what are the expected benefits and likely risks, what alternative treatments exist, that the consent may be revoked at any time, and that no guarantees are offered
- M. Written or electronic records demonstrate that a signed, release of information is obtained prior to the release of any client or patient records

- N. Written or electronic records demonstrate that the release of information form utilized specifically states to whom records are being sent, during what period of time, what type of records are being released (i.e. medical, psychological, laboratory or testing results, and chemical dependency), and the intended purpose for the release
- O. Written or electronic records or patient informational materials demonstrate that the treatment costs and billing procedures are communicated to the clients or patients
- P. Written or electronic records are secured and only available to facility employees and staff on a need-to-know basis (i.e. access to clinical information is limited for the clerical staff)
- Q. Written or electronic records are maintained in a common, organized format
- R. Written or electronic records demonstrate the utilization of appropriate equipment and modalities for the type of clients and patients seeking treatment
- S. Written or electronic records, or facility written policy, demonstrate that staff operating therapeutic equipment are properly trained to do so (i.e. training logs in personnel files, certificates from national training organizations)
- T. Written or electronic records demonstrate that in the case of a patient given narcotics for longer than an acute (7-10 day period) period of time, or those with a history of substance abuse, a narcotics agreement has been discussed and signed by the patient or client
- U. The facility utilizes an outcome measurement system and client or patient satisfaction tool

III. Compliance with Florida Law (F.A.C. 64B8-9.013 - Standards for the Use of Controlled Substances for Treatment of Pain)

Summarized, these are (and some are duplicative with I and II of these standards):

- A. A complete medical history and physical examination is performed on every new patient
- B. A written treatment plan is established for each patient. The treatment plan should "state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function.
- C. There is an appropriate informed consent for the treatment, and a written Agreement for Treatment when needed, especially if the patient has a history of addiction of substance abuse.
- D. The treatment plan is periodically modified in response to the changing nature of the pain.
- E. The Facility engages the services of consultants and/or make appropriate referrals.
- F. Appropriate medical records are kept.
- G. The Facility complies with all controlled substances laws and regulations.