Self-Audit Quick Reference Card
Using Controlled Substances to Treat Pain
(August 2015)

History and Physical Evaluation

- □ Take a general patient medical history.
- □ Take a specific patient pain history, including past treatments for pain, such as medications/surgeries/other treatments. Get the names of treating physicians OR review a recent (within the last past 30 days) report from a credible source and document your review and impressions.
- □ Obtain the patient's self-report about current pain: nature, intensity of pain, pain levels, and descriptive terms; document the patient's initial reports.
- □ Perform a condition-appropriate physical examination* OR, if your state permits, review a recent report (within the past 30 days) from a credible source.
- □ Get records of past treatments for pain directly from prior providers. Review them and document review via initials or stamp. Communicate with these providers, as appropriate.
- □ Perform patient risk assessment inquiry by asking patient about (1) his/her history of substance abuse, including alcohol, illegal drugs, and prescribed controlled drugs; and (2) all first-degree family members' substance abuse, including alcohol, illegal drugs, and prescribed controlled drugs. Also evaluate the patient for other high-risk medical issues, such as morbid obesity, use of tobacco, co-existing psychiatric disorders. Communicate with addiction and mental health professionals, as appropriate.
- □ Consider whether to use an early consult/referral for pain condition, abuse issues, psychiatric disorders, etc. NOTE: Some states require an evaluation by a specialist for pain condition if long-term use of controlled substances is contemplated under the "intractable pain" statute.*
- □ Use at least one validated, objective risk assessment tool, such as the Brief Risk Interview (Jones) or Screener and Opioid Assessment for Patients with Pain−Revised (SOAPP-R), to identify patient risk potential tied to controlled substance use. Also consider using assessment tools, such as Snore Score (sleep apnea), Generalized Anxiety Disorder 7-Item Scale (GAD-7) (mood), and Patient Health Questionnaire-9 (PHQ-9) (anxiety). Use of these tools is critical to legitimate medical purpose and monitoring/supervision using a treatment plan and follow-up care schedule.
- □ Perform an assessment of patient's potential risk for opioid overdose using Substance Abuse and Mental Health Services Administration (SAMHSA) Overdose Prevention Toolkit and clinical literature.
- □ Order an initial urine drug test (comprehensive) to corroborate patient's self-report and to establish baseline clinical issues.* Obtain information from the Prescription Drug Monitoring Program (PDMP) database.*

Treatment Plan

Clearly document your rationale for the treatment selected and create a written plan of care. Document all factors leading to your decision to prescribe controlled substances, including specific drugs. Adjust the treatment plan to the individual patient. *Document a working diagnosis and the pain state in a written treatment plan*. In the treatment plan:

- □ State whether you plan other diagnostic tests, labs, etc.
- □ Document clinical rationale for any medications prescribed. Document medical necessity for use of controlled substances and other treatments.
- □ Establish goals for treatment (functional, psychosocial, etc.); goals may include going back to work/staying employed, etc.
- □ Establish goals for acceptable functional and pain levels. Modify as changes occur.
- □ Establish objective methods for measuring patient's accomplishment of treatment plan goals and use periodic review to determine whether met (set actual dates).
- □ Establish length between office visits and how frequently the patient will see physician versus mid-level practitioners. It is important for the physician to consider whether more frequent MD visits during the initial months of treatment will benefit the patient. Some states may require this.
- □ Document a "drug trial" if the patient is new to medications or is switching medications. NOTE: Some states may require a trial of non-addictive modalities or a statement on why the same is not appropriate for the patient.*
- □ Decide how to address common/known side effects, like constipation (prophylactic approach); educate the patient on these issues in the Informed Consent.
- □ Determine whether there is a reason to communicate with the patient's primary care physician about the treatment plan and use of controlled substances.

Informed Consent

Informed Consent is not the same as a treatment agreement (aka, Narcotics Contract). Informed Consent is a process (and not just a piece of paper) by which the physician explains the treatment options and recommendations to the patient and gives the patient information on treatment risks, expected benefits, treatment alternatives, and special issues, such as side effects. It is best to use a written Informed Consent form and make sure it covers the following topics in clear and simple terms:

- □ Discuss risks of using medication prescribed (prolonged use of short- or long-acting medications, side effects, addiction, physical dependence, tolerance).
- □ Discuss benefits of using medications prescribed.
- □ Discuss alternative treatments available to the patient in lieu of medications prescribed.
- □ Discuss special issues re: use of medication prescribed (eg, driving, operating heavy machinery, carrying a weapon, working in a coal mine, driving a school bus). Discuss the potential risk for overdose and educate the patient about overdose prevention. Consider whether the patient is a candidate for a naloxone kit, especially if the patient meets overdose risk criteria established by SAMHSA.

Make sure to give the patient an opportunity to ask questions, and document this effort. Obtain the patient's signature, give him or her a copy of the form, and retain the original in the medical record. Periodically **REVIEW and RENEW the Informed Consent when you undertake a substantial change in the treatment plan,** ie, prescribe different medication, add in medication, or substantially increase medication dosage.

Legend

*Requirements depend on state licensing board requirements and standards of care.
†Federation of State Medical Boards *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain (July 2013).*

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Agreement for Treatment

Use the Agreement for Treatment to set boundaries with patients regarding use of controlled substances and treatment plan compliance. This document is distinct from the Informed Consent. The Agreement for Treatment should emphasize patient responsibilities.

- □ Decide whether to use the agreement with all of your patients or only high-risk patients.* Your state may require use versus discretionary use.
- □ Typical terms include: (1) one physician/one pharmacy, (2) no use of other controlled substances (CS) without advising you, (3) no purchase of CS through the Internet, (4) agree to urine tests *as requested*, (5) agree to medication counts as requested, (6) agree to designation of a family member/friend as accountability partner, (7) agree to naloxone kit, (8) participate in family conference as requested,* (9) report emergency room and outpatient visits within 24 hours of discharge, (10) agree to store and handle drugs safely at home, (11) specific Health Insurance Portability and Accountability Act (HIPAA) consent for necessary disclosures, and (12) understand consequences if violated (specify consequences), including discontinuation of CS therapy or discharge from the practice.
- □ Address accountability issues for use of "PRN" medication (breakthrough and rescue medication) and consider the patient's compliance during periodic review sessions.
- □ Obtain the patient's signature, give him or her a copy of the form, and retain the original in the medical record.
- □ REVIEW periodically and renew if circumstances relating to the patient's behavior/clinical situation change.

Periodic Review

Assess the patient periodically, based on the individual circumstances of the patient's case (including reference to patient's risk assessment level—low, moderate, or high risk potential for abuse and diversion of controlled substances) and according to standards of care and state licensing board guidelines and regulations. Remember that the physician must see the patient at times during the periodic review process,* and the timing of the physician's participation should be based on the patient's individual circumstances, the complexity of the case, and the patient's risk potential, including medical risk for potential overdose. Consider the following for periodic review:

- □ Use the "Five A's": Assess the patient's Activity, Analgesia, Adverse Events, Affect, and Aberrant Drug-Related (or Non-Compliant) Behavior.† Consider using RxProLogic® software or a Legal Side of Pain® form designed to capture critical information.
- □ Document whether the patient is meeting treatment plan goals.
- □ Consider whether the patient is more functional or maintaining functional level. Is the patient improving in the area of activities of daily living (ADL)?
- □ Is pain control improving? If so, document rationale for continued use of medications. If not, make necessary adjustments to the treatment plan.
- □ Are there psychological issues to address? Use a questionnaire like the Current Opioid Misuse Measure (COMM®). Consider whether other assessment tools are needed. Consider whether to refer the patient for behavioral health intervention. Consider whether medication changes are necessary.
- □ Is the patient handling the prescribed medications responsibly? Is there a need for a medication count? Check the PDMP database.* Another urine drug test? Referral?
- □ If the patient's function is not improving or if the patient has demonstrated aberrant drug-related behaviors, consider whether it is time to revise the treatment plan or discontinue meds. Likewise, consider whether to obtain a consultation or make a referral—if so, do it and document it.

Consultations and Referrals

- □ Consider whether a consultation or a referral is appropriate at any time during the physician–patient relationship.
- □ If the patient has symptoms or history of depression or other psychological problem, consider a mental health consult and document efforts and results.
- □ You may need to use a consultation or referral early in the treatment plan if the patient has a history of substance abuse or coexisting psychiatric disorder.
- □ Document your efforts and the results; document corresponding changes/modifications to the treatment plan.
- □ Make sure that you obtain reports from consultations and referrals and file the reports according to appropriate documentation standards.*

Legend
*Requirements depend on state licensing board requirements and standards of care.
†Federation of State Medical Boards *Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain (July 2013)*.