Wexford County Opioid Toolkit

WEXFORD/CRAWFORD
PHYSICIAN HOSPITAL
ORGANIZATION

Prevention

Screening for Risk of Addiction

Administering an addiction screening tool before prescribing opioids is great way for clinicians to assess a patient's relative risk of addiction. After an extensive review of the available screening tools, The Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R) was a clear choice when compared to its competitors. The SOAPP-R...

- Has 24 items.
- Takes 5 minutes to administer and score.
- Allows the patient to self-report.
- Provides excellent discrimination between high and low risk patients [1].
- Is cross-validated [2].
- Was developed specifically for pain patients [3].
- Is easily understood by patients, takes little time to administer/score, and taps information believed by professionals to be important [2].
- Appears to better predict potential opioid abuse than the Opioid Risk Tool (ORT), Pain Medication Questionnaire (PMQ), or Diagnosis Intractability Risk and Efficacy inventory (DIRE) score [4,5].
- Is copyrighted.
- Alternative is the ORT
  - Free
  - Five minute duration
  - Individualized scoring

Adverse Childhood Experiences (ACEs)

- The CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study is one of the largest investigations of childhood abuse and neglect and later-life health and well-being.
- The ACE Score is the number of categories of ACEs.
- ACEs have a dose-response relationship with many health problems.
- Incredibly common, but largely unrecognized.
  - Almost 40% of the original Kaiser sample reported 2 or more ACES.
  - 12.5% experienced 4 or more [6].

Prevention

- An individual with an ACE score of 1 is 1.7 times more likely to have used illicit drugs than an individual without any ACEs [7].
    - An individual with a score of 2, 3, or 4 is 2.9, 3.6, and 4.7 times as likely, to have used illicit drugs, respectively [7].
- A male child with an ACE score of 6, compared to a score of 0, has a 46-fold (4,600%) increase in the likelihood of becoming an injection drug user sometime later in life [8].
- Each of the 10 categories of ACEs are associated with a 2- to 4-fold increase in the likelihood of illicit drug use by age 14 and increased the risk of use into adulthood [9].
- Record familiarity with trauma-informed care.
- Consider documenting ACEs score in chart for all patients.

Resiliency

- Resilience refers to positive adaption, or the ability to maintain or regain mental health, despite experiencing adversity [10].
- The good news is that the brain is plastic, and continually changes its wiring in response to the environment [12].
- If the toxic stress stops and is replaced by practices that build resilience, the brain can slowly undo many of the stress induced changes and return to baseline [12].
- It can take just one adult to shield a child from adversity by creating a microenvironment of safety and predictability amid family distress, poverty, discrimination or violence [12].
- Clinical and public health interventions each have a role in improving the chances of resilience among children and adults affected by severe adversity [11].
- Interventions across the lifespan include support for parents of infants, early childhood intervention programs, school-based interventions, workplace and unemployment programs, and activity programs for older adults [11].
- Clinical implications include renewed emphasis on the value of a clinician taking a good history, a strong therapeutic alliance, and the reinforcement of attitudes and behaviors known to facilitate resilient outcomes [11].
- Consider additional opportunities to foster resiliency in the community, at schools, coaching, and church groups.

Prescribing for Acute Pain

Best Practices

Opioid abuse and addiction often starts with the treatment of acute pain. It is imperative that clinicians prescribe the lowest effective dose of immediate release opioids for the shortest therapeutic duration. This time frame is often 3 days or less.

- Implement MAPS.
- Screen using ORT.
- Prescribe non-opioids first.
- If progression to opioids, choose the lowest dosage and shortest duration.

ER/Surgery Recommendations

Before prescribing opioids for a patient in the ER or for post-op:

- Check MAPS.
- Be aware of existing scripts and pain contracts for each patient.
- Limit the amount of opioids prescribed (3 days or less).
- Refer the patient back to their primary care physician as soon as surgical blank is stabilized.
- Consult pharmacy about inpatients.
- Make an extra effort to inform PCPs about discharge pain medications.

Non-Opioid Choices

Options may include...

- Pain relievers such as acetaminophen, ibuprofen, and naproxen.
- Some medications that are also used for depression or seizures.
- Physical therapy, exercise, and early activation.

See relative strengths guide.

Prescribing for Chronic Pain

Best Practices

In most cases, opioids should not be used as a first resort for treating chronic pain (exceptions can be made for patients with active cancer, palliative care, or end-of-life care). If an opioid prescription is deemed necessary, take the following actions before prescribing for chronic pain...

1. Assess pain and function using a validated pain scale and document results.
2. Consider non-opioid therapies where appropriate, including pain clinic and physical therapy.
3. Talk to the patient about the risks of treatment using opioids and document results.
4. Independently evaluate the patient's risk of harm and misuse.
5. Obtain a signed narcotic contract.

Take these following actions when prescribing opioids for chronic pain...

1. Start with the lowest dose of immediate release opioids for the shortest therapeutic duration possible.
2. Avoid prescribing over 90 Morphine Milligram Equivalents per day.
3. When prescribing over 50 Morphine Milligram Equivalents per day, increase follow-up frequency and consider prescribing naloxone.

After initiating opioid therapy for chronic pain, take the following actions...

1. Reassess the benefits and risks of opioid therapy with the patient within 1 - 4 weeks of the initial assessment.
2. Assess pain and function and compare it to the baseline and reassess pain and function every three months.
3. Only continue therapy after confirming clinically meaningful improvements in pain and function without significant risks or harm.
4. If over-sedation or overdose risk occurs, reduce the opioid dosage by 10% per week until the desired dosage is reached and monitor for symptoms of withdrawal.

Prescribing for Chronic Pain

Opioid Contracts

The opioid epidemic has popularized the use of opioid contracts between patients and doctors. The primary objectives of opioid contracts are to...

- Foster adherence to an opioid therapy plan.
- Gain the informed consent of the patient.
- Provide legal risk management for the prescribing practice.
- Increase the efficiency of the prescribing practice.

See samples of narcotic contracts.

Drug Screening

A 3-year study was conducted on behavioral monitoring and urine drug testing in patients receiving long-term opioid therapy for pain.

- Their findings suggest that random drug testing of all patients receiving opioids for pain may be warranted.
- The researchers found that urine drug testing was much more effective than behavioral monitoring alone in identifying patients who were taking drugs other than the prescribed opioid.
- For example, 72 percent of patients with a positive test result did not have any behavioral indicators considered useful for screening.
- When combined with a patient's history, collateral information from a spouse or other family member (obtained with permission of the patient), questionnaires, biological markers, and a practitioner's clinical judgment, drug testing provides information that...
    - Can affect clinical decisions about pharmacotherapy, especially with controlled substances.
    - Increases the safety of prescribing medications by identifying the potential for overdose or serious drug interactions.

Prescribing for Chronic Pain

- Helps clinicians assess patient use of opioids for chronic pain management or compliance with pharmacotherapy for opioid maintenance treatment for opioid use disorders.
- Helps the clinician assess the efficacy of the treatment plan and the current level of care for chronic pain management and substance use disorders (SUDs).
- Aids in screening, assessing, and diagnosing an SUD, although drug testing is not a definitive indication of an **SUD.**
- Monitors abstinence in a patient with a known SUD.
- Verifies, contradicts, or adds to a patient's self-report or family member's report of substance use.
- Identifies a relapse to substance use.

Abuse and Addiction

Identifying Opioid Use Disorder

Catching opioid use disorder in its early stages before the behavior changes from being classified as abuse to addiction can be extremely important to the future health and well-being of the patient. The most recent addition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) classifies opioid use disorder as the presence of two or more of the following within a period of one year...

- Opioids are often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- Craving, or a strong desire or urge to use opioids.
- Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
- Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
- Important social, occupational, or recreational activities are given up or reduced because of opioid use.
- Recurrent opioid use in situations in which it is physically hazardous.
- Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- Tolerance, as defined by either of the following...
    - A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
    - A markedly diminished effect with continued use of the same amount of an opioid.

Abuse and Addiction

- Withdrawal, as manifested by either of the following ...
  - The characteristic opioid withdrawal syndrome (refer to Criteria A and B of the criteria set for opioid withdrawal).
  - Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.

Once the diagnosis of opioid use disorder has been reached, an intervention or professional help may be necessary for the patient to achieve full remission.

Abuse and Addiction

Tapering

Consider tapering to a reduced opioid dosage or tapering and discontinuing opioid therapy when your patient...

- Requests dosage reduction.
- Does not have clinically meaningful improvement in pain and function (e.g., at least 30% improvement on the 3-item PEG scale).
- Is on dosages greater or equal to SO MME/ day without benefit or opioids are combined with benzodiazepines.
- Shows signs of substance use disorder (e.g. work or family problems related to opioid use, difficulty controlling use).
- Experiences overdose or other serious adverse event.
- Shows early warning signs for overdose risk such as confusion, sedation, or slurred speech.

Keys to tapering include...

- Going slow.
- A decrease of 10% of the original dose per week is a reasonable starting point.
    - Some patients who have taken opioids for a long time might find even slower tapers (e.g., 10% per month) easier.
  - Discuss the increased risk for overdose if patients quickly return to a previously prescribed higher dose.
- Consulting
  - Coordinate with specialists and treatment experts as needed-especially for patients at high risk of harm such as patients with an opioid use disorder.
  - Use extra caution during pregnancy due to possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal.
- Supporting
  - Make sure patients receive appropriate psychosocial support.

Abuse and Addiction

    - If needed, work with mental health providers, arrange for treatment of opioid use disorder, and offer naloxone for overdose prevention.
  - Watch for signs of anxiety, depression, and opioid use disorder during the taper and offer support or referral as needed.

- Encouraging
  - Let patients know that most people have improved function without worse pain after tapering opioids.
    - Some patients even have improved pain after a taper, even though pain might briefly get worse at first.
  - Tell patients "I know you can do this" or "I'll stick by you through this".

Items to consider...

- Adjust the rate and duration of the taper according to the patient's response.
- **Do not reverse the taper**; however, the rate may be slowed or paused while monitoring and managing withdrawal symptoms.
- Once the smallest available dose is reached, the interval between doses can be extended and opioids may be stopped when taken less than once a day.

Intervention

If tapering is unsuccessful or if a patient continues to exhibit signs of opioid use disorder, an intervention involving their loved ones may be a necessary motivator to seek professional help. An intervention...

1. Provides specific examples of destructive behaviors and their impact on the abusing or addicted person and their loved ones.
2. Offers a prearranged treatment plan with clear steps, goals and guidelines.
3. Defines how each person will act if a loved one refuses to accept treatment.

Abuse and Addiction

Every intervention is unique, but most include the following steps...

1. Make a Plan.
2. Gather Information.
3. Form the Intervention Team.
4. Decide on Specific Consequences.
5. Make Notes on what to Say.
6. Hold the Intervention Meeting.
7. Follow Up.

Refer and Partner

- Added pressure from payers.
- Pain Clinic is not just for medication prescribing.

Northern Michigan Resources for Opioid Treatment

- Drug-Free Northern Michigan
  - (800) 834-3393
  - Informational resource list can be found here.
- American Addiction Centers Helpline
  - (877) 735-0158.
  - Insurance can cover up to 100% of treatment expenses.
  - Accepts most insurance.
- Michigan State Police (MSP) Angel Program
  - 7711 US-131 BUS, Cadillac, MI 49601.
  - (231) 779-6040.
  - Individuals seeking support for opioid weaning/termination must approach the state police department, pass a warrant/sex offender screening, and complete an informational packet. Subsequently, the individual is matched with a volunteer in the community to provide transportation to a treatment facility.
  - Wexford County is a participant in the MSP Angel Program.
- Munson Medical Center
  - 1105 Sixth St., Traverse City, MI 49684.
  - Inpatient Mental Health Center
    - **(231) 935-5000** or **1-800-847-8474.**
  - Outpatient services are also available.
  - Accepts most insurance.
- Pine Rest Christian Mental Health Services- Traverse City Location
  - 1050 Silver Drive, Traverse City, MI 49684.
  - Clinic Phone: (231) 947-2255.
  - Emergency Phone: (231) 922-4800.
  - Inpatient and outpatient detox, rehabilitation, and counseling services. Telemedicine options available.
  - Accepts most insurance.
- Addiction Treatment Services
  - 747 E Eighth St, Traverse City, MI 49686.
  - (231) 346-5216.
  - Inpatient and outpatient detox, rehabilitation, and counseling services.
  - Accepts most insurance.
- Well-Spring Psychiatry, PC
  - 13310 S.W. Bayshore Dr., Traverse City, MI 49684.
  - (231) 922-9625.
  - Outpatient counseling services.
  - ‘Recovery Services’ are a cash-only treatment option.
  - Accepts most commercial insurance.
- Catholic Human Services
  - 421 South Mitchell Street, Cadillac, MI 49601.
  - (231) 775-6581.
  - Physical, mental, and emotional support.
  - Treatment:
    - 12 step Narcotics Anonymous (NA).
    - Individual and group counseling.
    - Family Services.
    - Acupuncture.
  - Accepts most insurance.

- NA Meetings
    - First Covenant Church
        - 315 E Pine St, Cadillac, MI 49601.
        - 7:00pm on Thursdays.
    - Wayne's Garage
        - 515 N Shelby St, Cadillac, MI 49601.
        - 7:00pm on Tuesdays.
- Family-Based Therapy and Support
    - Lakeshore Community Counseling Services
        - 9116 E 13th St., Ste. B, Cadillac, MI, 49601.
        - (231) 878-3059.
        - Could not contact for insurance inquiry.
    - Bridges of West Michigan
        - 107 N Mitchell St, Cadillac, MI 49601.
        - (231) 468-2550.
        - Could not contact for insurance inquiry.
    - Life Skills Psychological Services, PC
        - 805 S Carmel St, Cadillac, MI 49601.
        - (231) 775-6517.
        - Individual/Group therapy.
        - Accepts most commercial insurance.
- Trina Paddock Professional Counselor
    - 201 N Mitchell St #204, Cadillac, MI 49601.
    - (231) 884-0028.
    - Family, drug use therapy.
    - Accepts most commercial insurance.
- Best Drug Rehabilitation Inc.
    - Center in Manistee, MI: 300 Care Center Drive, Manistee, MI 49660.
    - Call (877) 475-7382 for treatment options a patient's local area.
    - Accepts some commercial insurance.
    - Offices in:
        - Baldwin- Family Healthcare, West MI Community Mental Health Services: 1090 North Michigan Avenue, Baldwin, MI 4 9304. (800) 992-2061.
        - Big Rapids- Ten Sixteen Recovery Network, Nova Counseling Associates.
        - Other locations are: Traverse City, Reed City, Leland, Glen Arbor, Pentwater, Ludington, Oak Hill, and Eastlake.
- Bright Heart Health
    - Treatment programs morning, afternoon, and night.
    - Telemedicine counseling sessions.
    - Accepts most insurance.
- Look to other options/locations in Michigan for more inclusive access to care – Bay City, Saginaw, Grand Rapids, Detroit, etc.

References

1. Passik SD, Kirsh KL, Casper D. (2008) "Addiction-related assessment tools and pain management: instruments for screening, treatment planning and monitoring compliance." *Pain Med*; 9: S145-S166.
2. Butler SF, Fernandez K, Benoit C, et al. (2008) "Validation of the Revised Screener and Opioid Assessment for Patients in Pain (SOAPP-R)."J *Pain*; 9: 360-372.
3. Butler SF. (2008) "Evidence of Co-occurring Alcohol and Prescript ion Opioid Abuse in Clinical Populations: Implications for Screening." *Tufts Health Care Institute, Program on Opioid Risk Management: Conference on Co-Ingestion of Alcohol with Prescription Opioids*.
4. Jones T, et al. (2012). *Clin J Pain*; 28(2):93-100.
5. Moore TM, et al. *Pain Med.* 2009; 10(8):1426-1433.
6. Felitti VJ, Anda RF, Nordenberg D, Willamson DF, Spitz AM, Edwards V, Koss MP, and Marks JS. (1998). "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults." *American Journal of Medicine*; 245-258.
7. Safe Kids Pennsylvania. (2013). "Adverse Childhood Experiences." *Center for Schools and Communities*. Retrieved from http://www.pasafekids.org/documents/2013-05-01_1445-1600_Witherspoon.pdf
8. Felitti VJ. (2003). "The Origins of Addiction: Evidence from the Adverse Childhood Experiences Study." *Practice of Children's Psychology and Child Psychiatry*; 52:547-559.
9. Dube SR, Felitti VJ, Dong M, Chapman DP, Giles WH, and Anda RF. (2003). "Childhood Abuse, Neglect, and Household Dysfunction and the Risk of Illicit Drug Use: The Adverse Childhood Experiences Study." *Pediatrics*; 111(3): 564-572
10. Wald J, Taylor S, Asmundson GJG, et al. (2006)."Literature review of concepts: psychological resiliency." *Toronto (ON): Defense R&D Canada*
11. Herrman, H., Stewart, D. E., Diaz-Granados, N., Berger, E. L., Jackson, B., & Yuen, T. (2011). "What is resilience?" *The Canadian journal of Psychiatry,* 56(5), 258-265.
12. Delude, Cathryn. (2015, Dec 23). "Scars That Don't Fade." *Proto.*

Sample Patient Agreement Forms

Introduction

This resource includes two sample patient agreement forms that can be used with patients who are beginning long-term treatment with opioid analgesics or other controlled substances. These documents contain statements to help ensure patients understand their role and responsibilities regarding their treatment (e.g., how to obtain refills, conditions of medication use), the conditions under which their treatment may be terminated, and the responsibilities of the health care provider. These documents can help facilitate communication between patients and healthcare providers and resolve any questions or concerns before initiation of long-term treatment with a controlled substance.

Pain Treatment with Opioid Medications: Patient Agreement*

I,______________________________, understand and voluntarily agree that
(initial each statement after reviewing):

______I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

______I will participate in all other types of treatment that I am asked to participate in.

______I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

______I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

______I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

______I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

______I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

______I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

______I will sign a release form to let the doctor speak to all other doctors or providers that I see.

______I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

______I will use only one pharmacy to get all on my medicines:______________________________
Pharmacy name/phone#

______I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (klonopin, xanax, valium) or stimulants (ritalin, amphetamine) without telling a member of the treatment team **before I fill that prescription**. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

*Adapted from the American Academy of Pain Medicine
http://www.painmed.org/Workarea/DownloadAsset.aspx?id=3203

______I will not use illegal drugs such as heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment may be stopped.

______I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.

______I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.

______I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Pain Treatment Program Statement

We here at______________________are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

We will help you schedule regular appointments for medicine refills. If we have to cancel or change your appointment for any reason, we will make sure you have enough medication to last until your next appointment.

We will make sure that this treatment is as safe as possible. We will check regularly to make sure you are not having bad side effects.

We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.

We will help connect you with other forms of treatment to help you with your condition. We will help set treatment goals and monitor your progress in achieving those goals.

We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.

We will work with your medical insurance providers to make sure you do not go without because of paperwork or other things they may ask for.

If you become addicted to these medications, we will help you get treatment and get off of the medications that are causing you problems safely, without getting sick.

______________________	______________________	______________________
Patient signature	Patient name printed	Date
______________________	______________________	______________________
Provider signature	Provider name printed	Date

*Adapted from the American Academy of Pain Medicine
http://www.painmed.org/Workarea/DownloadAsset.aspx?id=3203

Patient Agreement Form

Patient Name:
Medical Record Number:

Addressograph Stamp:

AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

The use of____(print names of medication(s)) may cause addiction and is only one part of the treatment for:______________________________(print name of condition—e.g., pain, anxiety, etc.).

The goals of this medicine are:

☐ to improve my ability to work and function at home.

☐ to help my____________________(print name of condition—e.g., pain, anxiety, etc.) as much as possible without causing dangerous side effects.

I have been told that:

1. If I drink alcohol or use street drugs, I may not be able to think become sleepy and risk personal injury.
   I may get addicted to this medicine.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, must do it slowly or I may get very sick.

I agree to the following:

I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else's medicine.
I will not increase my medicine until I speak with my doctor or nurse.
My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
I will keep all appointments set up by my doctor (e.g., primary care, physical therapy, mental health, substance abuse treatment, pain management)
will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
agree to give a blood or urine sample, if asked, to test for drug use.

Refills

Refills be made only during regular office hours—Monday through Friday, 8:00AM-4:30 PM. No refills on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. **No exceptions will be made**. I will not come to Primary Care for my refill until I am called by the nurse.

I must keep track of my medications. No early or emergency refills may be made.

Pharmacy

I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines.
The name of my pharmacy is ______________________________

Prescriptions from Other Doctors

If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to Primary Care in the original bottle, even if there are no pills left.

Privacy

While I am taking this medicine, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medicine. be asked to sign a release at that time.

Termination of Agreement

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way.

I have talked about this agreement with my doctor and understand the above rules.

Provider Responsibilities

As your doctor, I agree to perform regular checks to how well the medicine is working.

I agree to provide primary care for you even you are no longer getting controlled medicines from me.

____________________________ ____________
Patient's signature Date

____
Resident Physician's signature

____
Attending Physician's signature

☐ This document has been discussed with and signed by the physician and patient. (A signed copy stamped with patient's card should be sent to the medical records department and a copy given to the patient.)

Opioid Risk Tool

Introduction

The Opioid Risk Tool (ORT) is a brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high-risk are at increased likelihood of future abusive drug-related behavior. The ORT can be administered and scored in less than 1 minute and has been validated in both male and female patients, but not in non-pain populations.

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Questionnaire developed by Lynn R. Webster, MD to asses risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med. 2005; 6 (6) : 432

Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP®-R)

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	o	o	o	o	o
2. How often have you felt a need for higher doses of medication to treat your pain?	o	o	o	o	o
3. How often have you felt impatient with your doctors?	o	o	o	o	o
4. How often have you felt that things are just too overwhelming that you can't handle them?	o	o	o	o	o
5. How often is there tension in the home?	o	o	o	o	o
6. How often have you counted pain pills to see how many are remaining?	o	o	o	o	o
7. How often have you been concerned that people will judge you for taking pain medication?	o	o	o	o	o
8. How often do you feel bored?	o	o	o	o	o
9. How often have you taken more pain medication than you were supposed to?	o	o	o	o	o
10. How often have you worried about being left alone?	o	o	o	o	o
11. How often have you felt a craving for medication?	o	o	o	o	o
12. How often have others expressed concern over your use of medication?	o	o	o	o	o

SAMPLE

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Pain

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	o	o	o	o	o
14. How often have others told you that you had a bad temper?	o	o	o	o	o
15. How often have you felt consumed by the need to get pain medication?	o	o	o	o	o
16. How often have you run out of pain medicatio early?	o			o	o
17. How often have others kept you from getting what you deserve?	o	o	o	o	o
18. How often, in your lifetime, have you had legal problems or been arrested?	o	o	o	o	o
19. How often have you attended an AA or NA meeting?	o	o	o	o	o
20. How often have you been in an argument that was so out of control that someone got hurt?	o	o	o	o	o
21. How often have you been sexually abused?	o	o	o	o	o
22. How often have others suggested that you have a drug or alcohol problem?	o	o	o	o	o
23. How often have you had to borrow pain medications from your family or friends?	o	o	o	o	o
24. How often have you been treated for an alcohol or drug problem?	o	o	o	o	o

SAMPLE

Please include any additional information you wish about the above answers.
Thank you.

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Pain

Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 ________

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 ________

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 ________

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 ________

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 ________

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 ________

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 ________

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 ________

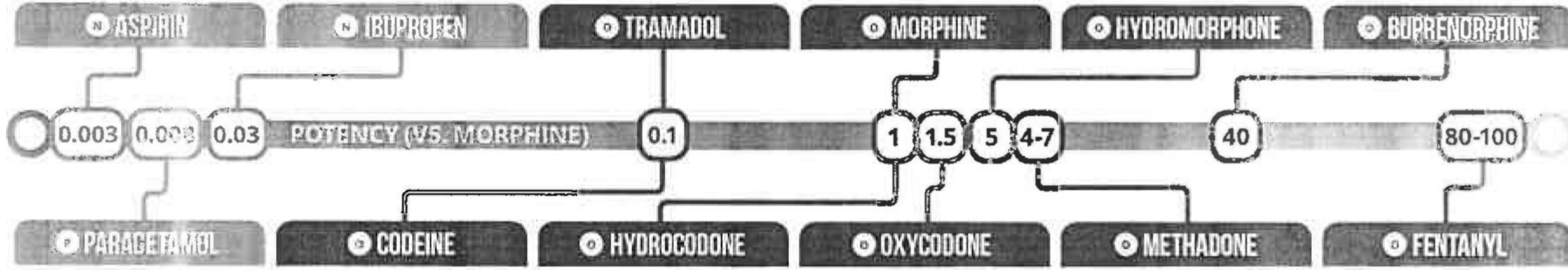
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 ________

10. Did a household member go to prison?
    Yes No If yes enter 1 ________

Now add up your "Yes" answers: ________ This is your ACE Score

A BRIEF GUIDE TO SELECTED COMMON PAINKILLERS

THERE ARE TWO MAIN CLASSES OF PAINKILLERS - PARACETAMOL IS AN EXCEPTION. *Key:* (N) NON-STEROIDAL ANTI-INFLAMMATORY DRUGS (P) PARACETAMOL (O) OPIOID ANALGESICS



Note: Potency values are for oral administration. Numeric measures of potency are variable; the figures given are merely general approximations, and can be affected by a number of factors.

PEG SCORE

Average 3 individual question scores (30% improvement from baseline is clinically significant)

Q1: What number from 0-10 best describes your pain in the past week? 0= no pain, 10=worst you can imagine

Q2: What number from 0-10 best describes how, during the past week, pain has interfered with your enjoyment of life?

0= not at all, 10= complete interference

Q3: What number from 0-10 describes how, during the past week, pain has interfered with your general activity?

0= not at all, 10= complete interference

CHECKLIST FOR SAFE PRESCRIBING

Before starting

____ Document indication

____ List non-narcotic medications tried if any

____ MAPS

____ ORT done and in chart

____ Document safety concerns discussed (addiction, abuse, overdose)

____ Expectations for duration discussed and documented

____ Baseline pain scale (PEG) documented

____ Follow-up plan documented and no refills given without F/U

BEFORE REFILLING

____ Repeat pain scale and document

____ Describe reasons for prolonged use

____ Consider more detailed risk tool (SOAPP_R)

CHECKLIST FOR SAFE PRESCRIBING

CHRONIC USE

___ Document clinical indication

___ ORT done and in the chart

___ Consider more detailed risk assessment (SOAPP-R)

___ Consider ACES assessment

___ MAPS done and in chart

___ Consider a baseline UDS

___ A narcotic contract is signed and in the chart

___ Non-opioid therapies tried are documented along with response

___ Baseline pain scale (PEG) is documented

___ Safety concerns were discussed and documented (abuse, addiction, overdose)

___ Clear expectations for duration of use are documented

___ Consider Rx for naloxone if over 50mg MS equivalent

___ Follow-up expectations, refill policy discussed and documented

___ Consider referral for co-management with BH or Pain specialist

REASSESSMENT

____ Repeat PEG, document improvement if any

____ MAPS

____ Assess for symptoms of risk or harm (over-sedation, overuse)

____ Determine co-therapies are maximized

____ Discuss and document plan for dose adjustment incl. weaning plan

____ Document need for co-management

____ Follow-up frequency no less than every 3 months

____ UDS if indicated or random, at least yearly