NATIONAL HEMOPHILIA FOUNDATION
for all bleeding disorders

MASAC Document #260

MANAGEMENT OF CHRONIC PAIN IN PERSONS WITH BLEEDING DISORDERS: GUIDANCE FOR PRACTICAL APPLICATION OF THE CENTERS FOR DISEASE CONTROL'S OPIOID PRESCRIBING GUIDELINES

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EXECUTIVE SUMMARY:

The Pain Initiative Task Force of the National hemophilia Foundation's Medical and Scientific Advisory Council convened an expert panel to provide guidance for multi-disciplinary healthcare providers who seek to apply the Centers for Disease Control's opioid prescribing guidelines to care provided to individuals with bleeding disorders.

The focus of the panel was to concentrate on situational needs specific to the bleeding disorders community.

The recommendations may be used as a guide for clinics to establish policy documents, modify clinical practices, and address acute and chronic pain.

Recommendations:

Clinics should strongly consider developing clinical worksheets to facilitate pain management. An example of such a worksheet is provided.

All patients with a bleeding disorder and a history of joint bleeding should be screened for both acute and chronic pain, as well as depression and anxiety.

All patients under consideration for opioid treatment, or who already receive opioids, should be assessed for risks of such treatment.

If opioids are initiated for acute pain, the lowest effective dose, in the lowest quantity should be prescribed (three days or less will often be sufficient, rarely > seven days.)

Nonpharmacologic and nonopioid pharmacologic therapy are preferred for chronic pain. Opioids should be initiated only if other methods of pain management are judged insufficient.

Before the initiation of opioid therapy for chronic pain, realistic goals for pain and function should be established, as well as a plan for how opioid therapy would be discontinued if benefits do not outweigh risks.

Using opioids to treat chronic pain is a complex situation that requires frequent evaluation. Re-assessment of benefits and risks of opioid therapy should be completed within 1-4 weeks of initiation, and at least every 3 months thereafter.

All patients treated with opioids should be prescribed naloxone auto-injector, regardless of opioid dosage.

Clinicians should make use of Prescription Drug Monitoring Programs (PDMP), where available, at initiation of opioids and periodically thereafter.

There is no standard opioid tapering schedule suitable for all patients. In general, the longer the duration of opioid use, the more slowly the dosage reduction. Opioid tapering is not indicated for all patients.

INTRODUCTION

Background

Persons with bleeding disorders (PBD) experience both acute and chronic pain associated with bleeding. Bleeding into soft tissues and joints, whether spontaneous or associated with trauma, often causes acute pain. Repeated bleeding events over time can lead to long-term changes in affected tissues, particularly joints. Chronic arthropathy causes disability and reduces quality of life due to chronic pain.[1,2]

Approximately 40-70% of adults with hemophilia A and B experience chronic pain.[2,3] Individuals with other bleeding disorders, including von Willebrand Disease, may also have chronic pain related to sequelae of their bleeding disorder.[4] Prevention and early treatment of bleeding events remain key elements of both preventing and treating pain, but many patients require

other pharmacologic and non-pharmacologic interventions to reduce the negative impacts of pain.

Opioid medications are utilized by up to 50-70% of persons with hemophilia in the U.S. to treat pain; in many cases, these medications are prescribed by their hematology provider.[5] The "opioid crisis" in the United States (U.S.) has contributed to the development of many new opioid management recommendations, guidelines, and regulations. Treatment of chronic pain with opioid medications remains controversial, and the treatment landscape is constantly and rapidly evolving. These changes create an environment that in some settings leads to provider or patient reluctance to treat pain with opioids, due to concerns about safety and to the increased regulatory burden for opioid prescribing.

In 2016, the U.S. Centers for Disease Control and Prevention (CDC) issued the "CDC Guideline for Prescribing Opioids for Chronic Pain" (CDC Guidelines), which focuses on the use of opioid medications for treating pain not due to active cancer or for end-of-life / palliative care.[6] While this document provides a well-reasoned, evidence-based approach to the use of opioids, the recommendations can be difficult to implement in hematology and hemophilia treatment center (HTC) clinics. The practice of mandatory and/or abrupt tapering of opioids based on pre-defined thresholds has been observed across many types of providers and clinics, despite the CDC Guidelines' recommendation that treatment plans be individualized for each patient. In some cases, hematology providers choose to significantly reduce opioid doses, change regimens, or stop prescribing opioids altogether for patients who have been using opioid medications. While these changes are necessary and beneficial in some circumstances, drastic alterations of opioid pain management plans may not always be necessary or indicated in all patients.

This document aims to provide guidance to hematology providers who prescribe opioids to manage pain, so that they have the tools to discuss with patients the risks and benefits of opioids, confirm efficacy and monitor for adverse effects of pain management strategies, and align clinical practices with regulatory requirements.

Rationale

The purpose of this document is twofold: to supplement the CDC Guidelines by highlighting special considerations for pain management in PBD; and to provide practical advice for hematology practitioners who manage patients with bleeding disorders and chronic pain.

We recognize that multiple guidelines and policies addressing opioid medications have been created by multiple groups. This document specifically refers only to the 2016 CDC Guidelines.

Scope and Audience

This document provides guidance for healthcare providers who manage PBD. While most acute and chronic pain in PBD is due to joint bleeding and damage, we expect the practices described in this document to be applicable to any patient with pain due to bleeding in locations other than joints.

The CDC Guidelines were written to be used specifically in patients aged 18 years or older. Use of opioid medications for the management of chronic pain in children is therefore beyond the

scope of this document. However, while prescribing opioid medications in children requires specific expertise / experience that is not covered here, the principles of screening and monitoring for pain and related disorders may be extended to the pediatric population.

Guidance Development Methods

This guidance document was developed by a multi-disciplinary group of experts in hematology, pain medicine, psychology, nursing, physical therapy, and social work, as well as individuals who have a bleeding disorder. The Pain Initiative Task Force was formed by the National Hemophilia Foundation's Medical and Scientific Advisory Committee (MASAC) leadership to address the issue of pain in the bleeding disorders community.

The Task Force identified several aspects of pain management that are most applicable in PBD and that would potentially benefit from specific guidance statements from MASAC. Members of the Task Force discussed these potential topics and agreed that opioids would be the group's initial focus.

We performed a survey of our expert panel members to define the guidance document's target population and audience, the scope of the document, and the questions to be addressed. We drew from the prior experiences of group members to inform our work. One group member had previously developed standard operating procedures for chronic pain management at her institution, and other group members conducted a narrative review of the medical literature for publications relevant to pain management in PBD.

Individuals in the group were assigned one to three elements of the CDC Guidelines to review independently.[6] Each group member then reported back to the group any special considerations for PBD pertinent to the guideline element, as well as practical advice for implementing the guideline in the clinic. Each CDC Guideline (12 total) was categorized into one of the following headings for this guidance document: 1) screening and risk assessment; 2) determining when to initiate or continue opioids; 3) opioid selection, dosage, duration and other considerations; and 4) opioid monitoring and tapering or discontinuation.

The group as a whole then reviewed and revised the guidance relevant to each guideline, until we reached an informal consensus on each statement. These statements were then summarized in the following document, which was presented for review, discussion, and revision by members of MASAC on 2/28/2020.

The CDC Guidelines statements are quoted verbatim within this document. In each instance, the reproduced statement is followed by a bracketed statement (e.g., [CDC Guideline #1]) and a reference number. All other recommendations in this document were developed by the Task Force.

Although the Task Force performed a narrative review of the literature to inform the group's discussions, evidence on the use of opioids in the bleeding disorders population is limited. This document is not meant to serve as a replacement for existing evidence-based guidelines; rather, this document should be viewed as a guidance document, based on expert consensus and when necessary extrapolation of data from other patient populations, for recommendations specific to PBD.

General recommendations for Hemophilia Treatment Centers and hematology clinics

HTCs and hematology clinics should consider developing and maintaining written policies and procedures on managing opioid therapy for PBD within the individual practice. The following guidance statements may be used to help establish such policy documents and to modify clinical practices to address pain. Clinics should strongly consider developing clinical worksheets or checklists to facilitate pain management discussions and documentation. An example worksheet is included for review in Attachment 1.

Chronic pain management is a complex endeavor. We recommend that HTCs and hematology clinics implement whenever possible a multimodal and multidisciplinary approach for treating pain. This recommendation is not meant to discourage hematology providers from addressing pain, even when resources are limited.

We strongly encourage HTCs and hematology clinics to measure and document pain and other relevant clinical outcomes using established patient-reported outcome (PRO) measures to assess pain and monitor the effects of pain management therapy. A list of some of these measures is also included in Attachment 1. We suggest using measures of pain interference (the degree to which pain prevents one from completing tasks / activities) and functional status in addition to measures of pain intensity (the degree of severity of pain).

A. SCREENING AND RISK ASSESSMENT

Rationale: Acute and chronic pain are common in PBD, particularly those with a history of joint bleeding.[2,3] Mental health conditions such as depression and anxiety are also seen in PBD, and treatment of these disorders is often an essential aspect of pain management.[7]

1. All patients with bleeding disorders, particularly those with a history of joint bleeding, should be screened for acute and chronic pain. This includes both acute pain due to bleeding and chronic pain due to arthropathy.

Practice implications: Incorporate pain assessment into routine clinical practice. Pain should be evaluated at least annually for all patients and at every visit for those who have chronic pain managed by the HTC or hematology clinic. Use of measures of function and/or pain interference are strongly encouraged, rather than solely measuring or focusing on assessment of pain intensity. Results of PRO measures of pain should be discussed with the patient during the clinic visit when the assessments are made.

2. All PBD with chronic pain should be evaluated for depression and anxiety. Consider also screening those who do not have chronic pain.

Practice implications: Use of standardized PRO measures of depressive symptoms and anxiety is encouraged, such as the Physicians' Health Questionnaire 9-item (PHQ-9) scale and the Generalized Anxiety Disorder 7-item (GAD-7) scale.[8,9] The PHQ-4 also screens for both anxiety

and depressive symptoms.[10] Clinics should develop clinical pathways to assess patients with elevations in anxiety and depressive symptoms, and, if warranted, provide appropriate mental health interventions or referrals to other providers who treat these disorders.

3. All patients who are being considered for or who already receive opioid treatment for acute and/or chronic pain should be assessed for risks associated with opioid use. [CDC Guideline #8][6]

Practice implications: The Opioid Risk Tool (ORT: 5 questions) or the Screener and Opioid Assessment for Patients with Pain – Revised (SOAPP-R: 24 questions) may be used prior to initiating opioid therapy to screen for risk of opioid misuse.[11,12] In addition to screening for depression and anxiety, clinics should also identify patients who have a history of other conditions that may increase the risks associated with opioids, including personality disorders (Axis II conditions), post-traumatic stress disorder, alcohol or substance use disorder, or other psychiatric diagnoses.[13] Patients should also be assessed during the clinical history for presence of sleep-disordered breathing (including sleep apnea), hepatic or renal insufficiency, history of substance use disorder or prior nonfatal overdose, and pregnancy. Review of available data from the state Prescription Drug Monitoring Program (PDMP) for any patient in whom opioids are being considered is also recommended, to establish documentation of the patient's history of opioid medication use. In many locations, review of the PDMP is required when prescribing opioids; medical providers should familiarize themselves with their local requirements for PDMP use.

Special considerations: All patients who are treated with opioids should be prescribed naloxone intranasal spray (preferred) or auto-injector, regardless of the opioid dosage used.[14,15]

B. DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS

Rationale: Given the risks associated with opioid use, clinicians should include patients in a shared decision-making process when considering using opioids to treat pain.

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate. [CDC Guideline #1][6]

Practice implications: Opioids should only be initiated if other methods of pain treatment have been tried and judged to be insufficient. Non-opioid pharmacologic and non-pharmacologic methods for treating pain in PBD should continue to be used even if opioids are prescribed. Multimodal treatment of pain is more effective than using medications alone.[16] Alternative and/or complementary medicine therapies and exercise are important components of multimodal pain management. Physical therapy and behavioral health interventions should be included in pain management plans for all PBD. As such, HTCs and hematology clinics should strive to involve physical therapists and mental health providers in the care of all patients with pain.

Special considerations: Non-steroidal anti-inflammatory drugs (NSAIDs) should typically be avoided in PBD, particularly higher doses over extended durations, due to risks of potential short-term interference with platelet function and of GI ulcer formation. Selective COX-2 inhibitors (e.g., celecoxib) appear to be associated with decreased risk of anti-platelet effects and ulcer formation when compared to non-selective NSAIDs and may be considered.[17] In patients with increased risk of developing gastrointestinal ulcers, concomitant use of a gastroprotective agent with a COX-2 inhibitor may further reduce the risk of ulcer formation.[18]

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety. [CDC Guideline #2][6]

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy. [CDC Guideline #3][6]

Practice implications: Clinicians should assist patients in setting measurable goals for pain management, placing particular emphasis on goals related to function. Goals should be recorded in the patient's words. Periodic review and monitoring of progress toward achievement of these goals should be used to determine the perceived benefit of opioid medications. Opioids should only be continued if a clear benefit of their use outweighs the associated potential risks of the medications.

Prior to initiating opioid therapy, clinicians must discuss with patients the known risks and potential benefits of using opioids for pain. Patients should also be made aware of the continuous process of evaluating and re-evaluating the risk to benefit ratio of opioids. Clinicians should explicitly state that opioids will be discontinued if the risks associated with their use are judged to outweigh the benefits of opioid therapy. This discussion should include the practices for monitoring for evidence of opioid misuse and addiction, conditions which necessitate cessation of opioid therapy. Consider using the phrase, "Our overall goal is to treat your pain while ensuring that the treatments we use are as safe as possible. If at any point I judge that opioids are no longer safe for you to use because they potentially endanger your health or the health of others, the medication will be decreased over time and then stopped. If this happens, we will not stop treating your pain and will continue to work with you to find other avenues for pain management."

Risks associated with opioid use that should be discussed explicitly with patients include development of tolerance and dependence, addiction, opioid misuse, respiratory depression, and death. Common side effects include constipation, somnolence, lethargy, confusion, sexual dysfunction, and itching. Opioid-induced hyperalgesia (increasing pain despite increased dosages) may occur and central sensitization may develop in patients exposed to opioid medications for an extended period of time.[19]

C. OPIOID SELECTION, DOSAGE, DURATION AND OTHER CONSIDERATIONS

Rationale: Clinical practices for using opioids to treat pain are constantly evolving, based on emerging evidence of the risks and benefits of pain management using these medications.

1. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids. [CDC Guideline #4][6]

2. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day. [CDC Guideline #5][6]

Practice implications: We suggest that all patients who initiate opioids be prescribed short-acting medications only, to be used on an as-needed basis for treatment of acute bleeding-related pain or exacerbations of chronic arthropathy-related pain. Short-acting pain medications may also be used for prevention of pain that is anticipated to occur due to planned physical activity.

We suggest that clinicians develop familiarity with using two to three short-acting opioids (e.g., for adult patients: oxycodone, hydrocodone, tramadol) and limit opioid prescriptions to these medications whenever possible.

Conversion of opioid dosages to morphine milligram equivalents (MME) should be accomplished using the same conversion values over time to ensure consistency. We recommend avoiding prescribing at any time 90 MME/day or greater and attempting to reduce opioid dosage to below 50 MME/day when benefits of continuing opioids do not clearly outweigh the risks.

Special considerations: Reducing opioid doses to 50 – 90 MME/day may not be possible in all patients, particularly those who have required higher doses for an extended period of time for treatment of chronic joint pain. Clinicians should weigh the potential benefits of reducing opioid doses against the risk of reduced efficacy of pain management with each patient receiving higher than recommended opioid doses.

3. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed. [CDC Guideline #6][6]

Practice implications: Clinicians should review the treatment of acute bleeds with patients and expectations for opioid use during the time of bleed. If using chronic opioids, define and discuss the clinic's policy for providing "extra doses" of opioids for acute pain, and discuss the acceptable indications for and appropriate use of opioids for treatment of acute pain.

Special considerations: Prevention of bleeding is key to reducing the possible need for opioids to treat acute bleeding episodes. Frequent use of "extra doses" of opioids for pain associated with acute bleeds may indicate need to re-evaluate hemophilia treatment or other factors related to bleeding frequency (e.g., physical activity level, adherence to prophylactic medications, etc.). In-person visits to the HTC or hematology clinic may be necessary to fully evaluate a patient for bleeding management and prevention.

4. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible. [CDC Guideline #11][6]

Practice implications: Avoid prescribing both types of medications concurrently. Explain to patients that this combination of medications increases the risk of potentially fatal overdose. Any patient who is prescribed a medication in both of these classes should also be prescribed and taught how to use a naloxone auto-injector (including family members).

D. OPIOID MONITORING AND TAPERING OR DISCONTINUATION

Rationale: The risks of using opioids to treat chronic pain must be reviewed and updated periodically in all patients. Clinics need to identify methods to safely taper and/or discontinue opioids when risks outweigh benefits.

1. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids. [CDC Guideline #7][6]

2. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months. [CDC Guideline #9][6]

3. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs. [CDC Guideline #10][6]

4. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder. [CDC Guideline #12][6]

Practice implications: Clinicians should make clear to patients at each visit how they are evaluating the risks and benefits of continued opioid therapy. Clinics may consider using a

written document to explain the circumstances under which reducing or stopping opioids is indicated- sometimes referred to as medication agreements.

Monitoring of benefits and harms of opioid therapy should ideally occur at least once every 3 months. In situations where distance to the clinic or other factors prevent patients from being seen this often, we suggest that all possible options for follow up be utilized to allow for re-evaluation of opioid therapy, including telephone and/or telehealth, when possible.

Methods for accessing PDMP data vary by state. All clinicians who prescribe opioids should seek out access to their local PDMP and use this resource each time they prescribe or refill an opioid medication.

If urine drug testing (UDT) is utilized to monitor patients receiving opioid medications, we encourage hematology providers to partner with laboratory, pharmacy, toxicology, or other colleagues with sufficient expertise to ensure accurate interpretation of the results of these tests.

The goal of using the PDMP and UDT for monitoring opioid therapy is to more safely prescribe opioids, not to be punitive or to justify discharging patients from practice.

HTCs and hematology clinics should identify pathways for patients with opioid use disorder to access medication-assisted treatment programs.

Special considerations: There is no standard opioid weaning schedule suitable for all patients, but in general the longer a patient has been regularly using opioids, the more slowly doses should be decreased over time. Decisions about opioid tapering should be made in cooperation and after careful discussion with patients. Tapering opioids over time is expected to require increasing existing or adding new pain treatments, including but not limited to physical therapy, exercise, adjunctive non-opioid pain medications, mental health support including behavioral therapy, surgical treatments, and alternative / complementary pain management approaches.

Tapering opioid doses may not be appropriate for all patients, particularly for those with severe joint disease who have been treated with stable doses of opioids for extended periods of time and who are judged to be at low risk for adverse effects. For those who choose to taper to lower doses, a support program may be beneficial.[20]

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APPENDIX

The following worksheet is provided by the Pain Initiative Task Force as a resource to be utilized by clinicians who manage individuals with bleeding disorders who have pain. The tool can be modified by clinicians to fit the specific needs of their patients. It is not meant to be fully comprehensive of all aspects of chronic pain management, but to provide reminders for potential discussion points during pain management encounters and to facilitate documentation. When using this worksheet in clinical practice, members of our group have noted that describing pain's impact using the patient's words and setting achievable goals for pain management are two particularly useful components of this worksheet.

The links on the reverse side of the worksheet are provided to guide practitioners to assessment tools that may be useful. While the choice of measure for various outcomes will likely be based on factors specific to each clinician, clinic, or patient population, we suggest that the same measure be used for each patient as pain is monitored over time.

Patient:	Provider:	Date:

PAIN ASSESSMENT and TREATMENT GOALS

Impact of pain on patient's well-being: (use patient's words / quotes when possible)	Patient's goals for pain management: (specific, measurable, achievable) 1. 2. 3.

Pain measurement(s): Pain intensity scale, pain interference scale, etc.

Scale:	Scale:	Scale:
Score:	Score:	Score:

Pain location	% pain at this location	Impact on function / activities of daily living

TREATMENT PLAN

Medication	Dose	Frequency, # / month	Patient Report of Effectiveness
			0 +1 +2 +3
			0 +1 +2 +3
			0 +1 +2 +3
			0 +1 +2 +3
			0 +1 +2 +3

Orthopedic consultations / questions:
N/A Yes:

Intervention	**Recommended**	**Participating**
Physical therapy	Y / N	Y / N
Exercise	Y / N	Y / N

Other **non-pharmacologic** pain treatments:

	Disorder	**History?**	**Current assessment**	**Current treatment**
Behavioral Health	Depression	Y / N	None / Mild / Mod / Severe	
	Anxiety	Y / N	None / Mild / Mod / Severe	
Consults/Evals:	EtOH use disorder	Y / N	N/A / Active / Remission	
	Other problems impacting pain management decisions (circle if present):			
	Personality disorder	PTSD	Substance use disorder	Other:

OPIOID MANAGEMENT and MONITORING

Opioid Risk Tool Score: **0 – 3 low risk** **4 – 7 moderate risk** **8+ high risk**

Follow up	In-person: every ___ months Phone: every ___ months	**Rx refills**	Electronic Paper (mail or in-person)

DISCUSSION / INFORMED CONSENT		Side effects: somnolence, constipation, itching	□
Prescription Drug Monitoring Program	□	Risk of dependence, addiction, central sensitization	□
Urine drug screens and illicit drugs	□	Risk of death due to overdose	□
Secure medications; do not share / sell	□	Risk of concurrent opioids and benzodiazepines	□
Single prescriber	□	Policy for dose changes, criteria for weaning opioids	□

Questionnaires useful for screening and/or risk assessment in the context of pain management

The links below are provided to aid practitioners in identifying useful resources, but the websites are not maintained by nor affiliated with the National Hemophilia Foundation. Whether and how to use these measures to guide clinical decisions must be decided by providers based on an individual patient's clinical situation.

PHQ-4 (depression, anxiety): https://www.midss.org/content/patient-health-questionnaire-4-phq-4 Kroenke, K., Spitzer, R. L., Williams, J. B. W., Löwe, B. (2009). An ultra-brief screening scale for anxiety and depression: the PHQ-4 Psychosomatics, 50, 613-621.
PHQ-9 (depression): https://www.mdcalc.com/phq-9-patient-health-questionnaire-9 Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001 Sep;16(9):606-13.
GAD-7 (anxiety): https://www.mdcalc.com/gad-7-general-anxiety-disorder-7 Spitzer RL, Kroenke K, Williams JB, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7.
Opioid Risk Tool: https://www.mdcalc.com/opioid-risk-tool-ort-narcotic-abuse Webster LR, Webster RM. Predicting aberrant behaviors in opioid-treated patients: preliminary validation of the Opioid Risk Tool. Pain Med. 2005 Nov-Dec;6(6):432-42.
Guide to implementing screening for at-risk alcohol behavior (CDC): https://www.cdc.gov/ncbddd/fasd/documents/alcoholsbiimplementationguide.pdf *Appendix F: Single question screening.* Smith PC et al. Primary care validation of a single-question alcohol patients. J Gen Intern Med. 2009 Jul; 24(7):783-8. *Appendix G: AUDIT 1-3 questionnaire.* Babor TF et al. Brief Interventions for at-risk drinking: patient outcomes and cost-effectiveness in managed care organizations. Alcohol 2006 Nov–Dec; 41(6): 624–31.
Compendium of useful tools: https://www.oregonpainguidance.org/tools/
U.S. Department of Health and Human Services Safe Opioid Prescribing: https://www.hhs.gov/opioids/prevention/safe-opioid-prescribing/index.html
Patient-reported outcome measures of pain: *Brief Pain Inventory* (use requires permission and/or fee) - https://www.mdanderson.org/research/departments-labs-institutes/departments-divisions/symptom-research/symptom-assessment-tools/brief-pain-inventory.html *NIH PROMIS Measures* (publicly available) - http://www.healthmeasures.net/explore-measurement-systems/promis