Background for Updating the CDC Guideline for Prescribing Opioids

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CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016


U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
2016 Guideline: purpose, use, and primary audience

• Recommendations for the prescribing of opioid pain medications
  – for patients aged 18 and older
  – in outpatient, primary care settings
  – in treatment for chronic pain
• Not intended for use in active cancer treatment, palliative care, or end-of-life care
• Primary Audience: Primary Care Providers
  – e.g., family practice, internal medicine
  – physicians, nurse practitioners, physician assistants
Development process for 2016 Guideline

**Analyse**
- Systematic Literature Review
- CDC Draft Recommendations
- Core Expert Group Consultation

**Consult**
- CDC Draft Guideline
- Core Expert & Stakeholder Review
- Federal Partner Review
- Peer Review
- Constituent Input (Webinar)

**Comment**
- CDC Revised Guideline
- FRN Public Comment
- Federal Advisory Committee* Review
- Publication of Guideline (March 15, 2016)

*NCIPC Board of Scientific Counselors
Organization of recommendations

- The 12 recommendations were grouped into three conceptual areas:
  - Determining when to initiate or continue opioids for chronic pain
  - Opioid selection, dosage, duration, follow-up, and discontinuation
  - Assessing risk and addressing harms of opioid use
2016 CDC Guideline – 12 recommendations

1. Opioids not 1st line or routine therapy for chronic pain
2. Set goals for pain and function when starting
3. Discuss expected benefits and risks with patients
4. Start with short-acting opioids
5. Prescribe lowest effective dose; reassess benefits and risks when increasing dose, especially to ≥50 MME; avoid or justify escalating dosages to ≥90 MME
6. Prescribe no more than needed for acute pain; 3 days often sufficient; >7 days rarely needed
7. If benefits of continuing opioids do not outweigh harms, optimize other therapies and work with patients to taper
8. Assess risks; consider offering naloxone
9. Check PDMP for other prescriptions, high total dosages
10. Check urine for other controlled substances
11. Avoid concurrent benzodiazepines and opioids whenever possible
12. Arrange medication-assisted treatment for opioid use disorder
2016 CDC Guideline implementation

1. Translation and communication
2. Clinical training
3. Health system implementation
4. Insurer/pharmacy benefit manager implementation
Overall and high-risk opioid prescribing decreased at accelerated rates following 2016 CDC Guideline release

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<tbody>
<tr>
<td>Opioid prescribing rate/100K population</td>
<td>-23.48 (CI, -26.18 to -20.78)</td>
<td>-56.74 (CI, -65.96 to -47.53)</td>
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<td>Patients with overlapping opioid + benzodiazepine Rx (%)</td>
<td>-0.02% (CI, -0.04% to -0.01%)</td>
<td>-0.08% (CI, -0.08% to -0.07%)</td>
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<tr>
<td>High-dosage opioid Rx (≥90 MME/day)/100k population</td>
<td>-3.56 (95% CI, -3.79 to -3.32)</td>
<td>-8.00 (CI, -8.69 to -7.31)</td>
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Some policies and practices attributed to the 2016 Guideline were inconsistent with its recommendations

The 2016 Guideline does not support abrupt tapering or sudden discontinuation of opioids

Misapplication of recommendations

• to impose hard limits or “cutting off” opioids
• to populations outside of the 2016 Guideline’s scope (e.g., to patients with cancer pain or post-surgical pain)
• to patients receiving or starting medication-assisted treatment for opioid use disorder
CDC has addressed misapplication of the guideline beyond its intended scope

CDC 2/28/19 letter to ASCO,* ASH,* and NCCN*:

- The Guideline provides recommendations for prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care
- Guidelines addressing pain control in sickle cell disease should be used to guide decisions
- Clinical decision-making should be based on
  - an understanding of the patient’s clinical situation, functioning, and life context
  - careful consideration of the benefits and risks of all treatment options, including opioid therapy

*American Society of Clinical Oncology (ASCO), American Society of Hematology (ASH), National Comprehensive Cancer Network® (NCCN)
“there are no shortcuts to safer opioid prescribing... or to appropriate and safe reduction or discontinuation of opioid use”
POCKET GUIDE: TAPERING OPIOIDS FOR CHRONIC PAIN

Follow up regularly with patients to determine whether opioids are meeting treatment goals and whether opioids can be reduced to lower dosage or discontinued.

Tapering plans should be individualized and should minimize symptoms of opioid withdrawal while maximizing pain treatment with nonpharmacologic therapies and nonopioid medications. In general:

- **Go Slow**: A decrease of 10% per month is a reasonable starting point if patients have taken opioids for more than a year. A decrease of 10% per week may work for patients who have taken opioids for a shorter time (weeks to months).

  *Discuss the increased risk for overdose if patients quickly return to a previously prescribed higher dose.*

- **Consult**: Coordinate with specialists and treatment experts as needed—especially for patients at high risk of harm such as pregnant women or 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.*

- **Support**: Make sure patients receive appropriate psychosocial support. 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.*

- **Encourage**: Patient collaboration and buy-in are important to successful tapering. Tell patients that improved function and decreased pain after a taper can be expected, even though pain might initially get worse.

  *Tell patients “I know you can do this” or “I’ll stick by you through this.”*

GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

Recommendations focus on pain lasting longer than 3 months or past the time of normal tissue healing, outside of active cancer treatment, palliative care, and end-of-life care.
HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics

Viewpoint

Patient-Centered Reduction or Discontinuation of Long-term Opioid Analgesics

The HHS Guide for Clinicians

Deborah Dowell, MD, MPH; Wilson M. Compton, MD, MPE; Brett P. Giroir, MD
Statement from the 2016 Guideline on potential future update

“CDC will revisit this guideline as new evidence becomes available to determine when evidence gaps have been sufficiently closed to warrant an update of the guideline.”

Requests for CDC to provide recommendations on opioid prescribing for acute pain

Requests from

• Professional specialty societies
• U.S. Senators
• Media
CDC is funding the Agency for Healthcare Research and Quality to conduct five systematic reviews

- Noninvasive nonpharmacological treatments for chronic pain: a systematic review update*
- Opioid treatments for chronic pain*
- Nonopioid pharmacologic treatments for chronic pain*
- Treatments for Acute Pain Systematic Review**
- Treatments for Acute Episodic Migraine**

*anticipated publication spring 2020
**anticipated publication fall 2020
Updated guideline scope

Evidence identified in new systematic reviews *may* allow

- Additional detail on nonpharmacologic and nonopioid pharmacologic therapies for chronic pain
- Updated information on benefits and risks of nonpharmacologic, nonopioid pharmacologic, and opioid therapies for chronic pain
- Expanded guidance on acute pain
- Expanded guidance on opioid tapering
Key steps to facilitate updating the CDC Guideline for Prescribing Opioids

• Review of five systematic evidence reviews

• Request establishment of and input from a Board of Scientific Counselors expert workgroup

• Input from patients, providers, and the public (e.g., opportunities for public comment posted in federal register notices)