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Observations of the Opioid Workgroup of the Board of Scientific Counselors of the National Center for Injury Prevention and Control on the Updated CDC Guideline for Prescribing Opioids

Submitted by:

Chinazo Cunningham, MD, MS, Opioid Workgroup Chair

On behalf of the:

Opioid Workgroup Members

Anne Burns, RPh

Wilson Compton, MD, MPE

Beth Darnall, PhD

Frank Floyd, MD, FACP

Neeraj Gandotra, MD

Christine Goertz, DC, PhD

Elizabeth Habermann, PhD, MPH

Joseph Hsu, MD

Marjorie Meyer, MD

Paul Moore, DMD, PhD, MPH

Aimee Moulin, MD, MAS

Mallika Mundkur, MD, MPH

Kate Nicholson, JD

Ted Park, MD, MSc

Jeanmarie Perrone, MD

Travis Rieder, PhD, MA

Stephen Rudd, MD, FAAFP, CPPS

Roberto Salinas, MD, CAQ, (G, HPM)

Doreleena Sammons-Hackett, SM, CPM

Wally Smith, MD

Jennifer Waljee, MD, MPH, MS

Mark Wallace, MD

Designated Federal Officer:

CDR Melanie R. Ross, MPH, MCHES

Observations on CDC Guideline for Prescribing Opioids – United States, 2022

This document outlines the observations of the Opioid Workgroup on the updated CDC Guideline for Prescribing Opioids. CDC recommendations for prescribing opioids for outpatients with pain outside of sickle cell disease-related pain management, cancer pain treatment, palliative care, and end-of-life care. The observations presented here follow the ordering of the draft Guideline.

Overall Observations

Overarching Themes

- Overall, many workgroup members felt that much of the supporting text of the guideline was not balanced and was missing key studies. Many workgroup members felt that the guideline focused heavily on the risks or potential harms of opioids, while less attention was focused on the potential benefits of opioids, or the risk of not taking opioids or undertreating pain. In addition, some workgroup members felt that the language of the recommendation statements or supporting text conveyed more certainty or was more absolute than warranted by the evidence.
- Much of the discussion of the recommendations centered around the concern for misapplication of the guideline. Because of the consequences of misapplication of the 2016 guideline, many workgroup members were concerned about how the recommendation could be misapplied, leading to potential harm to patients. The workgroup discussion thus focused on how best to mitigate against this valid concern while preserving the benefits of the guideline. However, some were concerned that the workgroup may have been over-correcting and so much concern about future misapplication could potentially be detrimental to the greater good.
- Many workgroup members felt the guideline paid too little attention and had minimal discussion about racial/ethnic disparities and inequities in how pain is perceived, valued, and managed, and the potential implications of these disparities on implementation of the guideline, including disparities in access to recommended treatments, along with how the guideline could impact disparities.
- Many workgroup members noted how the guideline has a constant tension between public health benefits versus patient benefits. This issue is minimally addressed in the guideline and comes very late. Workgroup members felt it is important to directly address this tension between risks and benefits to public health versus individual patients, and to contextualize how individual providers should use this guideline in caring for their patients versus considering potential public health consequences. In addition, several workgroup members felt that overall, the guideline was not sufficiently patient-centered.
- Many workgroup members were cautious about including specific opioid dose thresholds in the recommendations. Workgroup members acknowledged the importance of having benchmarks, but many felt that specific opioid doses would be misapplied as absolute cutoffs or thresholds for policies or practices. Many workgroup members felt the specific opioid dose thresholds belonged in the supporting text where the discussion could be more nuanced. In addition, there is no single standard formula for calculating MMEs.
- Many workgroup members noted a sense of exceptionalism throughout the guideline. Specifically, certain conditions were named in the text, while others were not. Naming of specific conditions may lead to interpretation regarding whether pain is “real” or “worthy” of certain types of treatment. In addition, while the guideline states it does not apply to sickle cell disease, cancer, palliative care, or end-of-life care, palliative care is not clearly defined.
- Many workgroup members felt that the recommendation category A was overutilized (11 of the 12 statements had recommendation category A). Members felt that this type of grading likely contributed to the misapplication of the 2016 guideline.
- Many members of the workgroup developed a document that described the workgroup’s guiding principles when providing observations on the guideline. Guiding principles include: minimize bias, ensure scientific integrity, enhance inclusivity, establish patient- and clinician-centered guidance, and mitigate harms from unintended consequences. The document is included as Appendix A.

Determining Whether or Not to Initiate Opioids for Pain

Recommendation #1: *Nonopioid therapies are preferred for many common types of acute pain. Clinicians should only consider opioid therapy for acute pain only if benefits are anticipated to outweigh risks to the patient. (Recommendation Category: A; Evidence Type: 3)*

Observations:

- Several workgroup members recommended changing the wording of Recommendation #1—remove the second “only”, consider changing “preferred” to “effective”.
- Several workgroup members were concerned about the large and unclear category of acute pain, and felt further clarification is needed. For example, should post-surgical pain be in this category of acute pain? Several workgroup members felt the statement was an oversimplification and there were situations or conditions that should be exceptions. Workgroup members also felt that categorizing pain should be based on pathophysiology or severity, rather than time. Several members noted that it is often unclear when acute pain transitions to subacute pain, and when subacute pain transitions to chronic pain. In addition, there is little attention to acute-on-chronic pain.
- Some workgroup members felt the recommendation does not consider shared decision-making.
- Several workgroup members were concerned that the recommendation could be misinterpreted and translated into bad policy. There was particular concern about limited access to non-opioid pain management modalities, in part due to lack of availability or lack of coverage by payers. Improving access to non-opioid pain management modalities should be a priority.
- Recommendation Category: Most, though not all, workgroup members felt this statement should be graded category B.

Recommendation #2: *Nonopioid therapies are preferred for subacute and chronic pain. Clinicians should only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient. Before starting opioid therapy for subacute or chronic pain, clinicians should discuss with patients known risks and realistic benefits of opioid therapy, should establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. If opioids are used, they should be combined with other therapies as appropriate. (Recommendation Category: A, Evidence Type: 3)*

Observations:

- Several workgroup members voiced appreciation for this statement because of the attempt to be inclusive and comprehensive, take into account pain and function, and be realistic upfront with patients. In addition, the attention to de-prescribing and exit strategies is appreciated.
- Some workgroup members felt shared decision-making should be emphasized here and in other recommendations.
- Several workgroup members noted that certain conditions for which this guideline does not apply feels like exceptionalism in terms of what’s serious pain versus what’s not and may reflect what types of pain conditions receive research funding or other attention.
- Some workgroup members felt the language in this recommendation is somewhat too strong, given problems with some of the cited evidence. Words like “are preferred” might be softened to “may be preferred” or “may be effective”. Although the harms of opioids are very well-defined, the benefits (especially long-term) are not well understood and difficult to study.
- Recommendation Category: Some workgroup members felt the recommendation category should be B.

Opioid Selection and Dosage

Recommendation #3: *When starting opioid therapy for acute, subacute, or chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids. (Recommendation Category: A and Evidence Type: 3)*

Observations:

- Most workgroup members overall agreed with the statement. Some felt the need to define “starting” and opioid-naïve more clearly, particularly given patients’ historical context of prior pain management strategies.
- Several workgroup members appreciated the support text discussion regarding abuse-deterrent formulations.
- Recommendation Category: Most workgroup members agreed with the recommendation category A.

Recommendation #4: *When opioids are started for opioid-naïve patients with acute, subacute, or chronic pain, clinicians should prescribe the lowest effective dosage. If opioids are continued for subacute or chronic pain, 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. (Recommendation Category: A and Evidence Type: 3)*

Observations:

- Many workgroup members voiced concern about the dose thresholds written into the recommendation. Many were concerned that this recommendation would lead to forced tapers or other potentially harmful consequences. Though workgroup members recognized the need to have thresholds as benchmarks, many felt that including these thresholds in the supporting text could serve to de-emphasize them as absolute thresholds, and thus recommended removing the specific MME range from the recommendation. In addition, these thresholds are felt to be arbitrary to some degree and could be calculated differently based on different conversion formulas, but when they appear in the statement, they appear to be authoritative.
- Several workgroup members appreciated the split of recommendations #4 and #5, which differentiated those who were starting opioids from those who were already receiving higher doses of opioids.
- Some workgroup members noted that the term “justify” was concerning, as it reflects legal language. To whom should providers be justifying their management decisions? Terms like “evaluating” benefits seemed more appropriate to the treatment context. In addition, some were concerned about the term “avoid” being too strong as well.
- Recommendation Category: Several workgroup members felt the grading should be a B, but if the specific dose thresholds were removed from the text, then the grade should be an A.

Recommendation #5: *For patients already receiving higher opioid dosages (e.g., >90 MME/day), clinicians should carefully weigh benefits and risks and exercise care when reducing or continuing opioid dosage. 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. (Recommendation Category: A and Evidence Type: 4)*

Observations:

- Many opioid workgroup members appreciated the language that acknowledged the complexity of the situation.
- Similar to the observations noted for recommendation #4, many workgroup members felt that the threshold dose should be removed from the statement and included in the supporting text.
- Several workgroup members noted that the framing of this recommendation is not balanced – that it does not include the risk/benefit calculation of continuing opioids. For example, a more balanced approach is to have one sentence about continuing opioids and one sentence about tapering opioids in terms of risk/benefit analyses. Also,

not fully acknowledged is that continuing opioids and not tapering opioids avoids risks of poor analgesia, worsening functioning, and suffering, and potentially illicit opioid use.

- Some workgroup members felt more discussion is needed regarding working with patients or obtaining consent from patients when prior to initiating and prior to tapering opioids, and limiting involuntary tapering. Others felt that consent should occur prior to initiating opioids, and that it may not be feasible to obtain consent at each point in which clinical management is changed.
- Some workgroup members noted that the supporting text for recommendation #5 and other areas of the guideline document flips back and forth between “harm” and “risk”. Some felt that the document should use “risk”, as assessing risk is one of the biggest challenges providers face.
- Several workgroup members felt an explicit and fuller discussion regarding benefits to society versus individual patients was warranted with this recommendation.
- Many workgroup members appreciated the supporting text. However, there were some specific issues that were noted as concerning by some members, these included: never going back up in dosage during opioid tapering; lack of inclusion of observational studies showing potential dangers of tapering; minimal discussion about risk of tapering; role of patient-centeredness approach; representing the role of buprenorphine as established rather than emerging; an explicit discussion of goals of tapers is needed, particularly related to public health versus individual patient outcomes; there seems to be an underlying assumption that the goal is to get to zero MME, but perhaps it should be to get to a safer dose or better symptoms or function; a section on iatrogenic harms of tapering may be warranted.
- Some workgroup members were concerned that much of the discussion was about over-correcting for possible misapplication of the guideline, which could lead to the detriment of the greater good.
- Recommendation Category: Many workgroup members felt that grade B is more appropriate. In addition, several noted that there is a bit of a mismatch in grading. For example, when there are several caveats and individualization in the language in the statement, how can it be recommended for all people?

Opioid Duration and Follow-Up

Recommendation #6: *When opioids are used for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. One to three days or less will often be sufficient; more than seven days will rarely be needed. (Recommendation Category: A and Evidence Type: 4)*

Observations:

- Several workgroup members were concerned about the potential application of this recommendation. Some felt that removing the last sentence would reduce risk of misapplication and questioned the evidence supporting the statement (evidence type = 4). The challenges of defining acute pain were noted again (see observations for statement #1 - e.g., it is not a diagnosis, it does not reflect pathophysiology), and some workgroup members felt many potential exceptions may require more than 3 days of opioids (and that “rarely” doesn’t seem accurate). However, others felt differently, and did not want to water down this statement so much that it doesn’t help improve excess opioid prescribing that exists.
- Some workgroup members wanted clarification and discussion in the text about the goal of this statement—whether it is about patients versus public health outcomes.
- Some workgroup members discussed how implementation of this guideline can have differential outcomes on patients based on their sociodemographic characteristics. For example, some patients will navigate the health care system to get refills as needed, while for others it will be impossible, thereby leading to potential different consequences.
- Several workgroup members recommended moving the last sentence into the supporting text rather than the recommendation (e.g., not including 3-7 days in the statement), or adding qualifiers like “most patients” or “many patients” or “initial prescription”, and felt that doing so would allow for more flexibility and patient centeredness.

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- **Recommendation Category:** Several workgroup members felt that the first sentence was category A, but not the second sentence. And that category A for the second sentence was out of step with the evidence type 4, and the qualifiers that are necessary to describe the exceptions.

Recommendation #7: *Clinicians should continue opioid therapy for subacute or chronic pain only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for subacute or chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. (Recommendation Category: A, Evidence Type: 4)*

Observations:

- Overall, many workgroup members felt ok with the statement in general and the recommendation category. They noted that there is little evidence to support it, particularly the specific time frames of 1-4 weeks and 3 months; however, it was reasonable and reflects common practice.
- As mentioned in overall themes, several group members observed that the use of “risks” and “harms” in this recommendation is inconsistent and recommend more careful and consistent consideration of these terms. Several members felt that using the term risk would be more appropriate than harms, as harms are typically not currently present.
- In the supporting text, there is discussion about 50 MME, while in other places the threshold is 90 MME. 50 MME as a threshold to increase the frequency of visits is a bit arbitrary.
- As mentioned in overall themes, many workgroup members noted that the issue of health disparities and health equity should be more central in the supporting text for this recommendation. These issues, including social determinants of health, are important and have real consequences when recommending frequent visits. For example, the duration of prescriptions or the frequency of visits may need to be guided more by social determinants of health or payer issues (e.g., co-pays) than by opioid dose.

Assessing Risk and Addressing Harms of Opioid Use

Recommendation Statement #8: *Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss with patients. Clinicians should incorporate into the management plan strategies to mitigate risk, including offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present. (Recommendation Category: A, Evidence Type: 4)*

Observations:

- Several workgroup members noted concern about naming specific conditions that increase risk; it suggests a parity among them. There is concern that listing these conditions implies that they carry equal risk, and that other conditions that are not listed carry less risk. In addition, specifying the 50 MME dose threshold is concerning, and conveys similar risk as the other conditions. The dose threshold is arbitrary and inconsistent with other sections of the guideline (50 vs. 90 MME). As noted in overarching themes, many members recommended that these specific conditions be removed from the recommendation.
- A few members noted concerns with potential downstream effects of offering naloxone for patients of limited means, with concerns specifically about the cost of purchasing naloxone (e.g., in some areas, patients were required to fill and pay for naloxone).
- Some members noted specific conditions that were concerning:
 - Pregnancy seems to be missing as a risk factor, though there is a different framework for pregnant women with OUD. There is concern about the framing that benefits outweigh risks for pregnant patients receiving MOUD, but not those with pain, despite the fact that not prescribing opioids could lead to withdrawal. In addition, pregnancy statements were overgeneralized, and there was concern that with the supporting text, pregnant women undergoing procedures could be at risk of not receiving adequate treatment.

- Because buprenorphine has a very high MME, it's not clear what the implications would be.
- Many workgroup members noted that the supporting text was not balanced, and a full discussion of risks and benefits are needed – that address risk/benefits of prescribing opioids and of not prescribing or limiting opioids. For example, the discussion about older adults focuses on risks of opioids, but there is no discussion about risks of untreated or undertreated pain in this population (e.g., potential worsening of blood pressure, mood, cognition). A similar point was made regarding individuals with psychiatric conditions, and the possibility of destabilization with untreated or undertreated pain. Likewise, the discussion about people with substance use disorders was unbalanced, with little discussion regarding the challenges of pain management (and buprenorphine's analgesic effect was missing). This issue of an unbalanced discussion in the supporting text is noted as an overall theme throughout the guideline.
- Some workgroup members noted that there is little consideration about the problem of lack of access to alternative pain treatments.
- While many workgroup members noted that naloxone should remain in the recommendation, some felt that taking a more comprehensive risk mitigation approach is warranted.
- Recommendation Category: Several workgroup members noted that evidence category A was appropriate if the list of conditions were removed. However, if the list of conditions remains in the recommendation statement, then the recommendation category should be B. Some workgroup members disagreed and felt the evidence category should remain A regardless of the list of conditions.

Recommendation #9: *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 acute or chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months. (Recommendation Category: A, Evidence Type: 4)*

Observations:

- Several workgroup members felt that the word “dangerous” may be too strong and too binary. Some felt “high-risk” may be more appropriate, noting that there are nuances to deciding whether specific combinations of medications put individuals at risk. In addition, some workgroup members noted that it would be important to check the PDMP for risks that are broader than overdose.
- There were conflicting opinions regarding checking the PDMP for acute pain. Some workgroup members felt that prior to prescribing opioids for a small number of days, checking the PDMP may not be warranted or feasible, and therefore, the word “acute” should be removed or a qualifying term like “when possible” should be added. Others disagreed and felt acute pain should remain in the recommendation statement.
- Some workgroup members expressed caution regarding potential harms of the PDMP, particularly when algorithms are used to create risk scores that lack evidence without qualifications. Some mentioned the cost to the patient-provider relationship; however, others discussed that when protocols are standardized, there is less risk to negatively impacting the patient-provider relationship and less risk of bias.
- Some workgroup members appreciated the recommendation that patients are not dismissed due to PDMP information. Perhaps this declaration should be more prominent, given this real risk to patients.
- Some workgroup members felt the supporting text needs to be re-worked, especially regarding acute pain.
- Recommendation Category: The workgroup was split regarding the recommendation category. Some felt that category A is appropriate. Others felt category A is appropriate only if acute pain were removed and/or if there were qualifying language like “when possible” or “when available”. As with several other recommendation statements, several members of the workgroup felt it was difficult to assign a recommendation category to the statement while recommending changes to the statement. It becomes unclear if the category would/should be applied to a modified statement or the existing statement.

Recommendation #10: *When prescribing opioids for chronic pain, clinicians should use drug testing before starting opioid therapy and consider drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.*

(Recommendation Category: B, Evidence Type: 4).

Observations:

- Illicit drugs are not defined, which is particularly problematic for cannabis. The issues around cannabis create challenges for providers, which vary by state. Perhaps cannabis should be approached similarly to alcohol, which is not routinely tested among individuals taking opioids. However, providers may not have control over the specific panels of tests, and often fentanyl might not be included. This could lead to false assurance. A discussion of these nuances of urine drug tests is warranted.
- Interpretation of urine drug tests results can be complicated, and many providers lack this knowledge, which can lead to inappropriate negative consequences. In addition, because most urine drug tests are screening tests, false positive or false negative tests are not uncommon. Such inaccurate tests could lead to punitive action. Confirmatory testing is important but can also lead to financial issues for patients. Several workgroup members felt these potential harms are not fully addressed in the supporting text. In addition, the concept of a screening test should be included (e.g. with false positives and negatives).
- As mentioned in the overall themes, there are biases and disparities in which patients have urine drug tests. Several workgroup members felt that this issue should be more centrally addressed, as the recommendation statement could have substantial disproportionately negative consequences among Black and Latinx patients.
- Because substance use is associated with serious stigma, some workgroup members recommended reviewing the supporting text to ensure non-stigmatizing language is warranted (e.g., should the term recreational drug be used instead of illegal drug?).
- Several workgroup members discussed the importance of providers' discussing why and how urine drug tests are used, and not taking a punitive approach. There is a potential ethical tension if the role of the provider is to police the patient behavior, as the provider's duty is to the individual patient, and the policy makers' duty is to the public.
- Some workgroup members were cautious regarding conducting urine drug tests prior to prescribing opioids, especially if this were to delay care. Some also felt that the recommended frequency of urine drug tests and the use of opioid dose to guide the frequency were arbitrary.
- Some workgroup members were cautious about patients' potential financial implications of frequent urine drug testing and confirmatory drug testing.
- Recommendation Category: Category B is appreciated, though others felt that a category A could potentially reduce bias and disparities in which patients' clinicians order urine drug tests.

Recommendation #11: *Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants. (Recommendation Category: A, Evidence Type: 3)*

Observations:

- Several workgroup members felt the words "avoid," and "whenever possible" are problematic as they can be interpreted as "never". Some proposed that a more appropriate phrase may be to use extreme caution. In specific situations, benzodiazepines can be beneficial, and stopping benzodiazepines can be destabilizing. Additionally, benzodiazepines may serve as a marker for risk of overdose due to underlying conditions. It's also important to differentiate between chronic stable prescribed use versus erratic unpredictable non-prescribed use.
- Some workgroup members felt including an entire class of medications (central nervous system depressants) was far-reaching and could lead to unintended negative consequences.

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- Some workgroup members felt that this recommendation statement is not appropriate for the acute care setting.
- Including the FDA warnings regarding benzodiazepine use among people prescribed opioids and among people with opioid use disorder should be included in the supporting text.
- Recommendation Category: Several workgroup members recommended a recommendation category B.

Recommendation #12: *Clinicians should offer or arrange treatment with medication for patients with opioid use disorder. (Recommendation Category: A, Evidence Type: 2)*

Observations:

- Many workgroup members agreed with the language of the recommendation, specifically the word “should”.
- New regulations regarding buprenorphine prescribing should be included in the supporting text.
- Several workgroup members noted that the supporting text should better distinguish opioid agonist versus opioid antagonist treatment and questioned the framing as the medications being equal options. Opioid agonist treatment has stronger evidence for better outcomes, doesn’t require abstinence, has less challenges with inductions, and is much more widely utilized.
- Some workgroup members noted a conflation regarding management of problematic opioid use versus OUD in the supporting text. Reassessing pain is important prior to deciding whether to taper or discontinue opioids.
- Several specific details about OUD treatment were felt to be inaccurate in the supporting text, and additional review by an OUD expert is warranted.
- Some workgroup members felt the evidence type should be 1.

Introduction and Conclusions Sections of the Guideline

Observations:

In addition to the overarching comments at the beginning of this document, additional comments, and observations specific to the introduction and conclusions sections are as follows:

- The discussion regarding health equity and disparities isn’t until the end of the document. Many workgroup members recommended that this discussion be much earlier in the guideline. In addition, attention to health equity and disparities should be throughout the entire document, and a discussion about how the recommendation may impact equity and disparities is warranted.
- Many workgroup members felt there should be an explicit statement that the guideline is a *clinical* guideline, and not payer or governmental policies. Similarly, the tension between risks and benefits for individual patients versus the public health should be explicitly addressed. A patient-centered approach should be strongly encouraged.
- A few workgroup members noted issues with authorship and reviewers. Specifically, there are a small number of peer reviewers who are not identified, input from patients and providers was solicited but it was not clear how their input was factored into the guideline, and many of the included references have a lead author who is also an author of the guideline. In addition, providing the areas of expertise of the opioid work group members is suggested.
- When describing benefits and harms, it is important to recognize real-world patients’ lack of access to many non-opioid pain management strategies.

Appendix A: Opioid Workgroup Guiding Principles

Background

As described in the Opioid Workgroup (OWG) Roster document (<https://www.cdc.gov/injury/bsc/opioid-workgroup-2019.html>), the Opioid Workgroup (OWG) under the Board of Scientific Counselors, National Center for Injury

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Prevention and Control (BSC/NCIPC), Centers for Disease Control and Prevention (CDC) will be supplied draft text in March 2021. The OWG is tasked with performing the following activities with respect to the draft guideline:

1. Reviewing the quality and implications of clinical and contextual evidence reviews.
2. Reviewing each guideline recommendation statement and accompanying rationale.
3. Considering for each recommendation:
 - a. The quality of the evidence supporting the recommendation (assessing the accuracy of the evidence quality rating; i.e., evidence "type");
 - b. The balance of benefits and risks associated with the recommendation (including the degree to which the benefits of issuing the recommendation can be anticipated to outweigh the harms);
 - c. The values and preferences of clinicians and patients related to the recommendation (including the degree to which there is variability or uncertainty in values and preferences);
 - d. The cost feasibility of the recommendation (including the degree to which implementation is anticipated to be feasible for health systems and patients financially); and
 - e. The category designation of the recommendation (whether Category A or Category B is justified). Category A recommendations apply to all patients; Category B recommendations require individual decision making where different choices will be appropriate for different patients so that clinicians must help patients arrive at a decision consistent with patient values and preferences and specific clinical situations.
4. Developing a summary report, including points of agreement and disagreement, of the workgroup's observations associated with items #1-3 above for the draft updated/expanded 2022 Guideline.

Purpose of the OWG Guiding Principles

The intention of the Guiding Principles document is to provide a procedural framework to approach the tasks described above, as well as to aid in the completion of the work, whereby ethics, principles and priorities are outlined. This document is intended to facilitate the OWG members in comprehensively addressing the draft materials, in completing the assigned tasks; and for guiding group discussion, deliberation, and creation of recommendations and the final summary document. The Guiding Principles may also serve as a public document and reference on the general process and principles by which the OWG approached their assigned tasks.

PRINCIPLE 1: MINIMIZE BIAS

Goal: Identify potential bias in the following:

- A. Evidence reviews
 - i. Authors
 - ii. Studies that have been included or excluded within a review
- B. CDC draft guideline
 - i. Authors
 - ii. Algorithms, methods, and grading metrics used to determine inclusion or exclusion of studies/evidence, or applied to evaluate and determine the strength of evidence.
 - iii. Decisions to consider or not consider various types of evidence (outside of evidence reviews). Minimize bias by ensuring that clinical evidence and various data from real-world patients and real-world practice is weighted appropriately within the broader guiding principles framework.

PRINCIPLE 2: SCIENTIFIC INTEGRITY

Goal: Ensure the strength of recommendations are appropriate for the level of supporting evidence

- A. Review draft content and evidence grades given.

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- B. Review evidence to support MME classifications and other latent factors that could distort outcomes for primary opioid science (genetics and CYP enzymes, drug metabolism, and variability in bioavailability).
- C. Examine the grounds given for strength of each recommendation, noting especially any role played by values in the GRADE methodology.

PRINCIPLE 3: ENHANCE INCLUSIVITY

Goal: Identify ways in which the *current lens* is too narrow and therefore excluding key populations; find opportunities to extend the lens to enhance inclusivity

- A. Types of studies included in published evidence reviews
 - i. Identify the limits of their generalizability to outlying populations such as rare diseases.
 - ii. Recommend additional types of information that should be included to ensure broad representation of all patients and circumstances.
 - iii. Incorporation of supporting evidence even in the absence of direct evidence to ensure inclusion of marginalized populations.
- B. Defining the target population.

Chronic pain is not a monolith; it includes diverse conditions, etiologies, pain types, and severities. Appreciation of the diversity and complexity of chronic pain is required. We recognize a need to protect outliers, such as persons with rare diseases or progressive, degenerative conditions, who may not otherwise be captured in assessments of aggregate benefit vs. harm.
- C. Considering the input of those whose lives are likely to be most affected and views that might be under-represented in the process.

This type of inclusivity is important to both our internal processes and to ensuring adequate input of affected persons once the guideline is published in draft form. (Recognizing that the guideline is not subject to formal rulemaking requirements but, given the likely policy implications, robust provisions for notice and comment and efforts to include the viewpoints patients, providers and likely under-represented populations are important norms to follow before final adoption of the guideline by the agency).

PRINCIPLE 4: PATIENT AND CLINICIAN CENTERED

Goal: Establish patient and clinician centered care guidance that is accessible, comprehensive, and integrated.

- A. Patient-Centeredness
 - i. Identify barriers to care access including potential financial burden to the patient, use of internet-based medical records, and increased patient-provider communication via telephone or e-mail.
 - ii. Treatment recommendations, whether pharmacologic or non-pharmacologic, must be *meaningfully accessible* to the individual patient when creating care plans. Citing efficacy evidence alone is insufficient.
 - iii. Encourage providers to consider patient needs, desires, and limitations and avoid stigma when making treatment recommendations.
 - iv. Recommend additional training and educational materials for providers on guideline concordant conservative care options.
 - v. Establish strong interdisciplinary relationships, especially between providers with shared patient base.
 - vi. Engage patients in the development of their care plans.
- B. Clinician-Centeredness
 - i. Guidelines should support optimal patient care and shared decision-making for individual adjustment of all medications.
 - ii. Variation from guidelines should be expected for patient centered opioid prescribing. Variation from prescribing guidelines alone should not be considered evidence of suboptimal care.

PRINCIPLE 5: HISTORICAL CONTEXT

Goal: Mitigate harms from unintended consequences

- A. Appreciate the historical context of the initial Guideline and its consequences into deliberations and recommendations, with a goal of preventing injury/harm in current and future patients.
 - i. Recognize that all Guidelines have the potential for causing unintended side effects.
 - ii. Incorporate lessons learned from the various misinterpretations of the 2016 Opioid Prescribing Guidelines in order to prevent similar unintended consequences.
 - iii. Overreach of the guideline to exempted populations (e.g., patients with cancer, sickle cell disease, OUD).
 - iv. Inflexible application of certain key recommendations, which were particularly problematic given the low evidence base to support them.
 - v. Concreteness of the provision -- recommendations which could easily be lifted and enforced. While intended as supply and dosage recommendations, stated numbers were misapplied to define standards of care and policies. Despite the CDC's clarification, these numbers continue to define policies and drive inflexible care that is not patient-centered and has been shown to harm.
 - vi. *Communication science* must be applied to ensure the conclusions of the Guideline are clear, without ambiguity, and with minimal ability to distort the information or create misunderstand, especially as it could pertain to local, state, or national policy.