Background for Updating the CDC Guideline for Prescribing Opioids

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

Continuing Education Examination available at http://www.cdc.gov/mmwr/cme/conted.html.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Special Communication

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

Deborah Dowell, MD, MPH; Tamara M. Haegerich, PhD; Roger Chou, MD

IMPORTANCE Primary care clinicians find managing chronic pain challenging. Evidence of long-term efficacy of opioids for chronic pain is limited. Opioid use is associated with serious risks, including opioid use disorder and overdose.

OBJECTIVE To provide recommendations about opioid prescribing for primary care clinicians treating adult patients with chronic pain outside of active cancer treatment, palliative care, and end-of-life care.

PROCESS The Centers for Disease Control and Prevention (CDC) updated a 2014 systematic review on effectiveness and risks of opioids and conducted a supplemental review on benefits and harms, values and preferences, and costs. CDC used the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework to assess evidence type and determine the recommendation category.

EVIDENCE SYNTHESIS Evidence consisted of observational studies or randomized clinical trials with notable limitations, characterized as low quality using GRADE methodology. Meta-analysis was not attempted due to the limited number of studies, variability in study designs and clinical heterogeneity, and methodological shortcomings of studies. No study evaluated long-term (≥1 year) benefit of opioids for chronic pain. Opioids were associated with increased risks, including opioid use disorder, overdose, and death, with dose-dependent effects.

RECOMMENDATIONS There are 12 recommendations. Of primary importance, nonopioid therapy is preferred for treatment of chronic pain. Opioids should be used only when benefits for pain and function are expected to outweigh risks. Before starting opioids, clinicians should establish treatment goals with patients and consider how opioids will be discontinued if benefits do not outweigh risks. When opioids are used, clinicians should prescribe the lowest effective dosage, carefully reassess benefits and risks when considering increasing dosage to 50 morphine milligram equivalents or more per day, and avoid concurrent opioids and benzodiazepines whenever possible. Clinicians should evaluate benefits and harms of continued opioid therapy with patients every 3 months or more frequently and review prescription drug monitoring program data, when available, for high-risk combinations or dosages. For patients with opioid use disorder, clinicians should offer or arrange evidence-based treatment, such as medication-assisted treatment with buprenorphine or methadone.

CONCLUSIONS AND RELEVANCE The guideline is intended to improve communication about benefits and risks of opioids for chronic pain, improve safety and effectiveness of pain treatment, and reduce risks associated with long-term opioid therapy.

Editorials
Author Audio Interview at jama.com
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JAMA. doi:10.1001/jama.2016.1464
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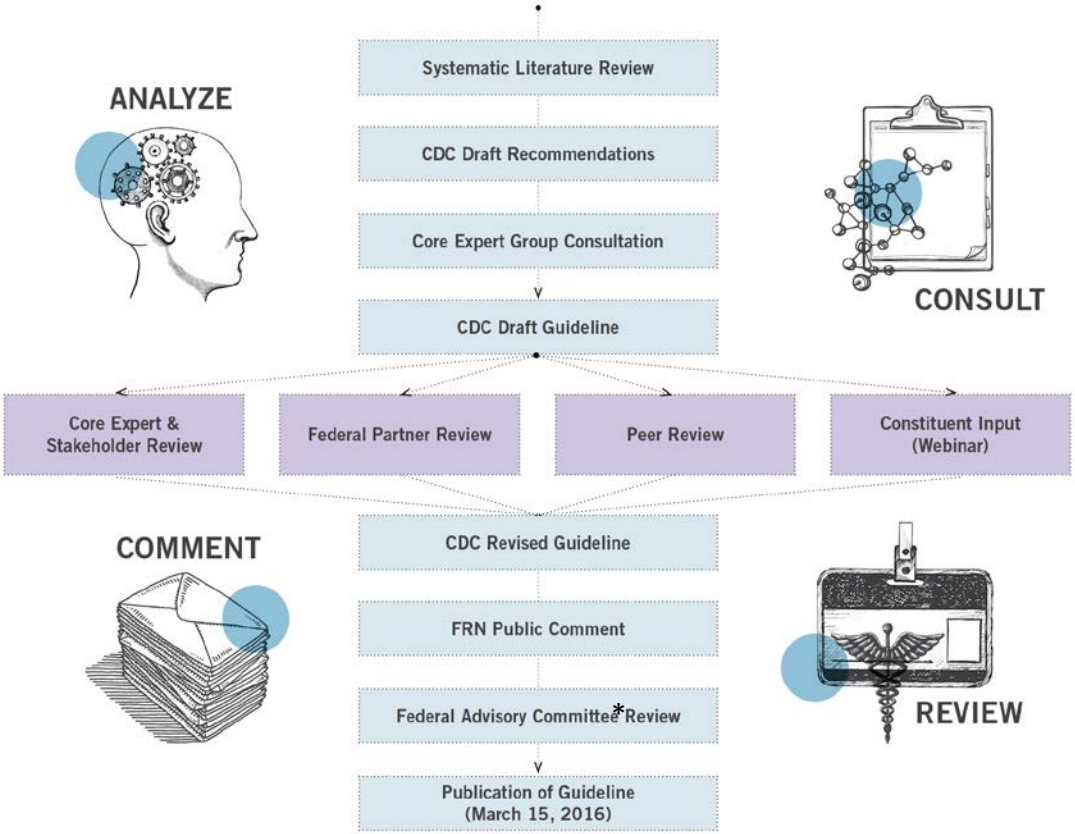
2016 Guideline: purpose, use, and primary audience

- 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



*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

	1/2012	Monthly decline prior to Guideline release (1/2012-2/2016)	Monthly decline following Guideline release (4/2016-12/2017)
Opioid prescribing rate/100K population	6577	-23.48 (CI, -26.18 to -20.78)	-56.74 (CI, -65.96 to -47.53)
Patients with overlapping opioid + benzodiazepine Rx (%)	21.04%	-0.02% (CI, -0.04% to -0.01%)	-0.08% (CI, -0.08% to -0.07%)
High-dosage opioid Rx (≥90 MME/day)/100k population	683	-3.56 (95% CI, -3.79 to -3.32)	-8.00 (CI, -8.69 to -7.31)

From Bohnert ASB, Guy GP Jr, Losby JL. Opioid Prescribing in the United States Before and After the Centers for Disease Control and Prevention's 2016 Opioid Guideline. Ann Intern Med. 2018 Sep 18;169(6):367-375

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)

The NEW ENGLAND JOURNAL of MEDICINE

"there are no shortcuts to safer opioid prescribing… or to appropriate and safe reduction or discontinuation of opioid use"

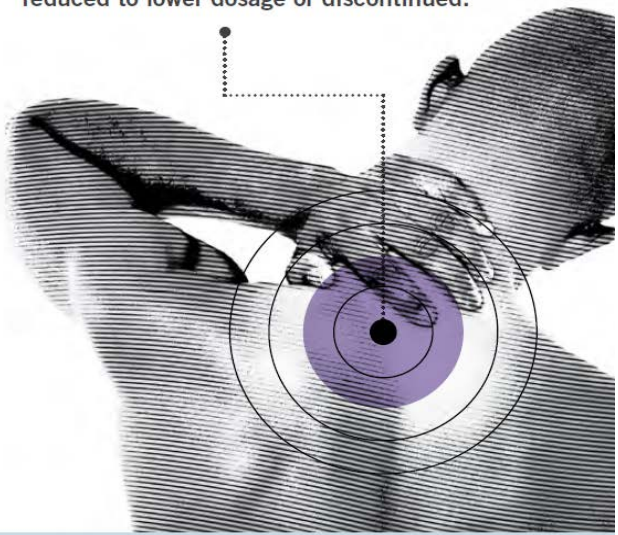
Perspective

No Shortcuts to Safer Opioid Prescribing

Deborah Dowell, M.D., M.P.H., Tamara Haegerich, Ph.D., and Roger Chou, M.D.

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.



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.

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

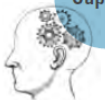
A decrease of 10% per month is a reasonable starting point if patients have taken opioids for more than a year. A decrease of 10% per week may work for patients who have taken opioids for a shorter time (weeks to months).

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."

HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics

This *HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics* provides advice to clinicians who are contemplating or initiating a reduction in opioid dosage or discontinuation of long-term opioid therapy for chronic pain. In each case the clinician should review the risks and benefits of the current therapy with the patient, and decide if tapering is appropriate based on individual circumstances.

Viewpoint

October 10, 2019

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

The HHS Guide for Clinicians

Deborah Dowell, MD, MPH[1]; Wilson M. Compton, MD, MPE[2]; Brett P. Giroir, MD[3]

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."

Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain—United States, 2016. *MMWR Recomm Rep*. 2016;65(RR-1):1-49.

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)

For more information, contact CDC
1-800-CDC-INFO (232-4636)
TTY: 1-888-232-6348 www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.