The role of the *2016 CDC Guideline for Prescribing Opioids for Chronic Pain* in addressing patients on long-term opioid therapy

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Patient-Centered Approach to Chronic Opioid Management

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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.

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Centers for Disease Control and Prevention

Special Communication

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

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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.

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Purpose, use, and primary audience

- Recommendations for the prescribing of opioid pain medications
  - for patients 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
  - family practice, internal medicine
  - physicians, nurse practitioners, physician assistants

CDC 2/28/19 letter to ASCO,* ASH,* and NCCN* emphasizing stated Guideline scope:

- 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)

Recommendations most relevant to starting opioids

- Opioids not 1st line or routine therapy for chronic pain
- Establish and measure progress toward goals
- Discuss benefits and risks with patients before starting opioids
- Use immediate-release opioids when starting opioids
- For acute pain, 3 days or less will often be sufficient; more than 7 days will rarely be needed

Recommendations relevant to starting or continuing opioids

- Maximize use of nonopioid treatments
- Use caution when increasing dosages
  - Reassess benefits and risks of increasing dosage to ≥50 MME/day
  - Avoid or justify increasing to high dosages (≥90 MME/day)
- Check PDMP for other prescriptions, high total dosages
- Avoid concurrent benzodiazepines and opioids
- Naloxone for patients at higher risk
- Offer or arrange medication-assisted treatment (MAT) for patients with opioid use disorder

Specific guidance for patients already receiving long-term opioid therapy

- Regularly review benefits and risks of continued opioids
- Provide interested and motivated patients with support to slowly taper opioid dosages
- Establish goals with patients who continue opioid therapy
- Maximize pain treatment with nonpharmacologic and nonopioid pharmacologic treatments

Specific guidance for patients already receiving long-term high-dose opioid therapy

- Empathetically review risks associated with continuing high-dose opioids
- Offer slow taper if benefits don’t outweigh risks
- For patients who agree to taper opioids to lower dosages, collaborate with the patient on a tapering plan
- Closely monitor and mitigate overdose risk for patients who continue to take high-dose opioids

Tapering guidance

- Optimize nonopioid pain management
- Taper slowly enough to minimize opioid withdrawal
- Patients tapering opioids after taking them for years might need very slow opioid tapers (e.g., 10% per month or slower)
- Individualize tapering plans based on patient goals, concerns
- Allow for pauses in the taper

Tapering guidance

- Access appropriate expertise if considering tapering opioids during pregnancy
- Discuss with patients the increased risk for overdose on abrupt return to a previously prescribed higher dose
- Remain alert to signs of anxiety, depression, and opioid use disorder that might be unmasked by an opioid taper
- Optimize psychosocial support for taper-related anxiety

TED Ideas worth spreading

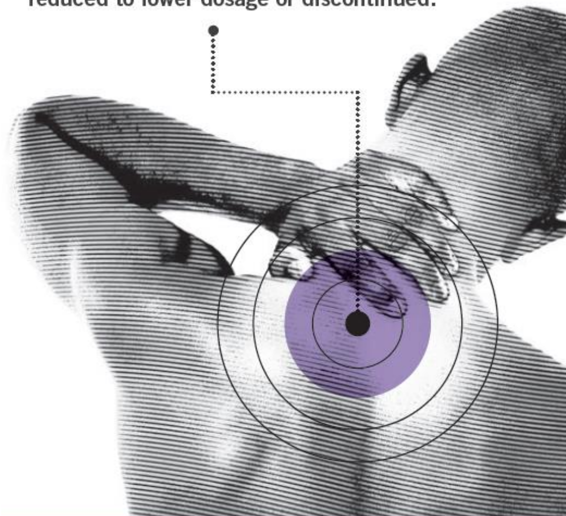
TRAVIS REIDER

The agony of opioid withdrawal and what doctors should tell their patients

Rieder, Travis (2017 October). The agony of opioid withdrawal and what doctors should tell their patients. Retrieved from https://www.ted.com/talks/travis_rieder_the_agony_of_opioid_withdrawal_and_what_doctors_should_tell_patients_about_it?language=en

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.

CDC Guideline implementation

Focus on four priority areas to maximize the uptake and use of the opioid prescribing guideline for chronic pain outside of active cancer, palliative, & end-of-life care

1

Translation and Communication

Develop tools and resources about the guidelines for a variety of audiences – including providers, health systems, and the general public.

2

Clinical Training

Educate providers through medical schools and ongoing continuing medical education (CME) activities.

3

Health System Implementation

Educate providers, integrate into EHRs and other clinical decision support tools, adopt and use quality metrics, and leverage within broader coordinated care activities.

4

Insurer/Pharmacy Benefit Manager Implementation

Proactive improvement in coverage and service delivery payment models – including reimbursement for clinician counseling; coverage for non-pharmacological treatments and medication-assisted treatment; and drug utilization management.

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"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

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For more information, contact CDC
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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.