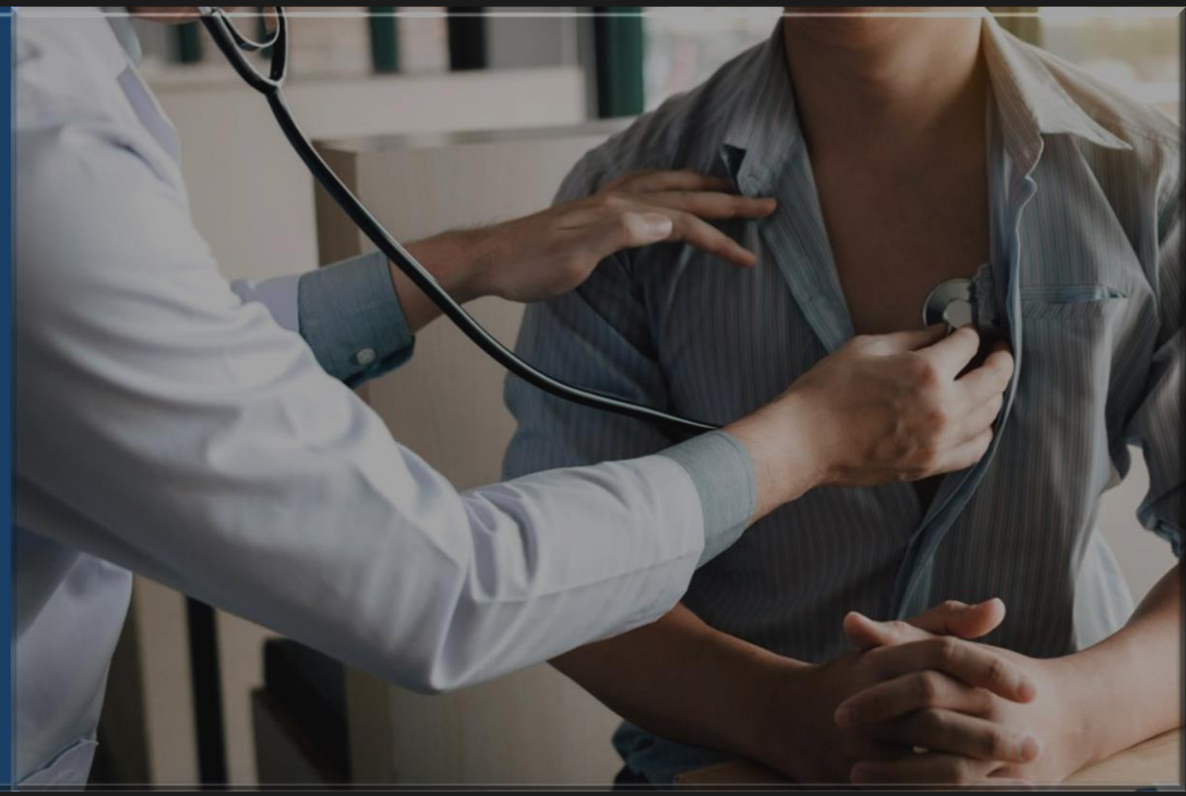


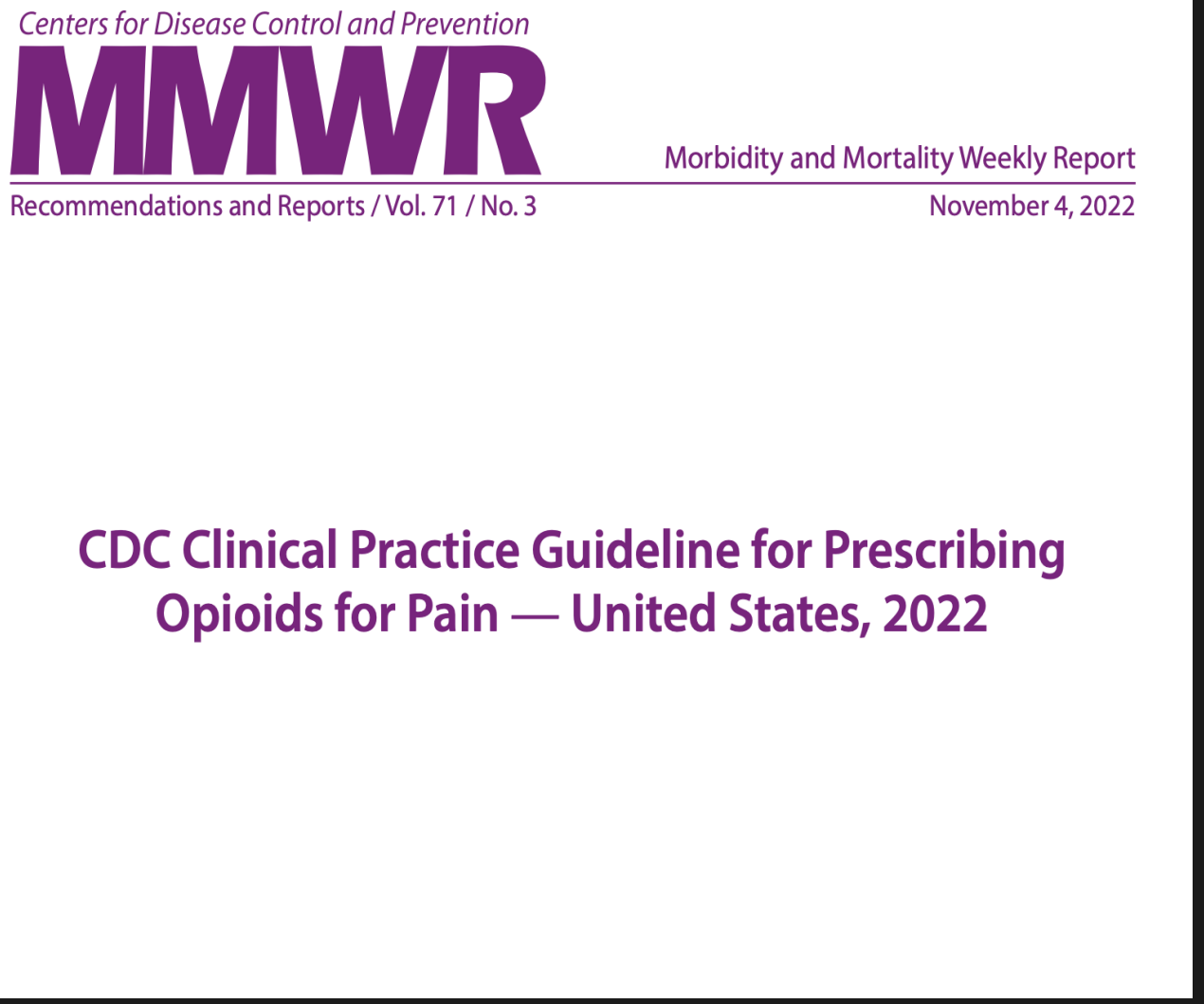
2023 CDC Clinical Practice Guideline: what clinicians need to know

Joshua Blum MD| October 14, 2023

Agenda

- Review the guideline underpinnings
- Distill recommendations
- Highlight notable statements and identify limitations
- Review harms of weaning and discontinuation for effective shared decision-making conversations

Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95.
DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1



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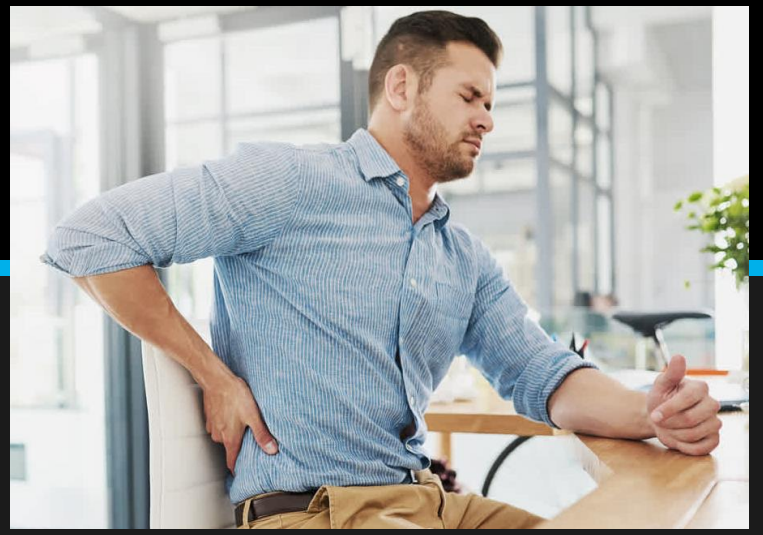


- 46 yo male, chief complaint: “my PCP is making me come here.”
- Longstanding chronic back and knee pain, on LTOT, oxycodone IR 10 mg Q4h
- Other medications: Sertraline 150 mg/d, Buspirone 10 mg TID, Trazodone 200 mg at bedtime
- Divorced, lives alone, on disability. Previously worked as forklift operator

Questions for you

- How many LTOT patients do you care for?
- How frequently do you evaluate them and conduct a risk-benefit assessment?
- How many more patients on LTOT could your practice accommodate?

Ideal opioid prescribing in a single slide

- **Maximize non-opioid tx**, incl non-pharm modalities, non-opioid analgesics, mood, sleep, exercise
- **Assess risk** with a screening tool: ORT, SOAPP
- **Check PDMP and UDT** at initiation and periodically during treatment
  - At least yearly
  - CDC: PDMP monthly
- Use informed consent/**agreement**
- Have realistic **risk-benefit discussion** with patient
- **Initiate with short-acting** opioids
- Use **low or** moderate doses, generally **<50 MME** & definitely **<90 MME**
- Set specific **functional goals**
- **Outline exit strategy** at initiation
- **Don't co-prescribe sedatives, especially BZDs**
- Prescribe **naloxone (esp. MME≥50)**
- Stress safe storage & disposal
- Use an **ongoing monitoring tool** to assess **risk-benefit** incl. pain relief, function, side effects, SUDs
- **Re-evaluate within 1-4 weeks**
- **Ongoing assessment** of risks & benefits at least **every 3 months**
- Address minor red flags with education, more intensive monitoring
- Multiple minor red flags or major red flag should result in cessation
- **Refer for evidence-based SUD treatment for patients with OUDs**
- **Continue to care for patient after weaning off opioids**

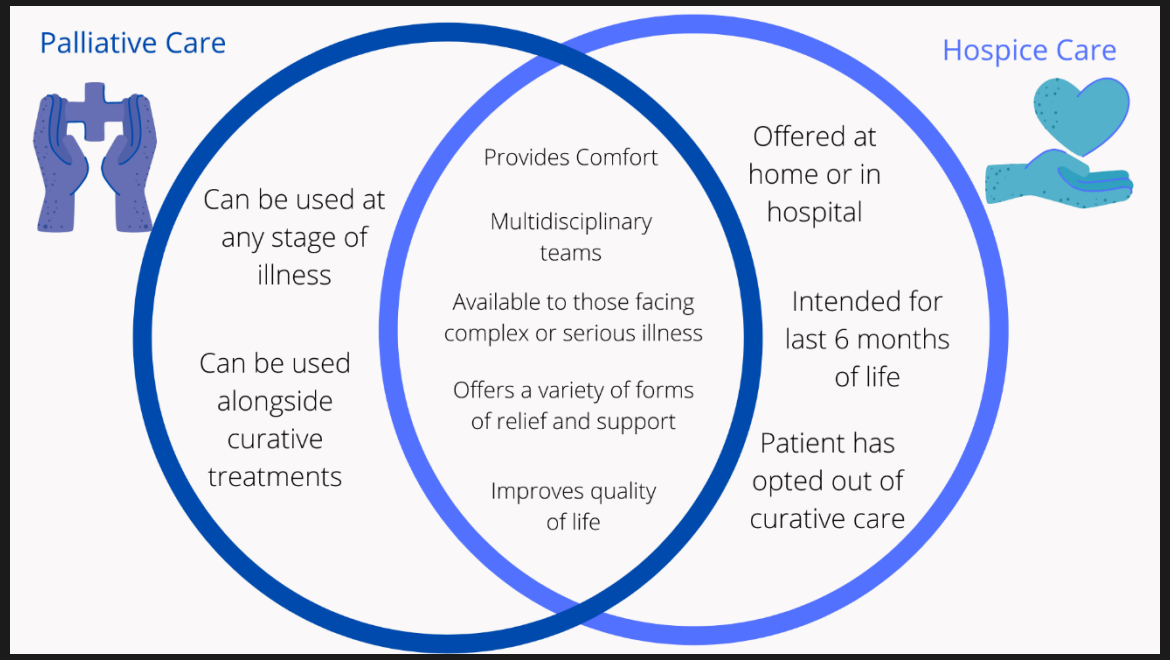
For acute pain: prescribe at low dose for as short a duration as possible: generally ≤3 days and definitely ≤7

Who are the Guidelines for?

- Primary care clinicians *and other clinicians* who prescribe opioids, including oral health care providers working in outpatient settings
  - *Includes hospital discharge*

Which patient populations?

- Adult patients with acute, subacute, or chronic pain
- NOT:
  - Sickle cell pain
  - Cancer pain
  - Palliative care
  - End-of-life care



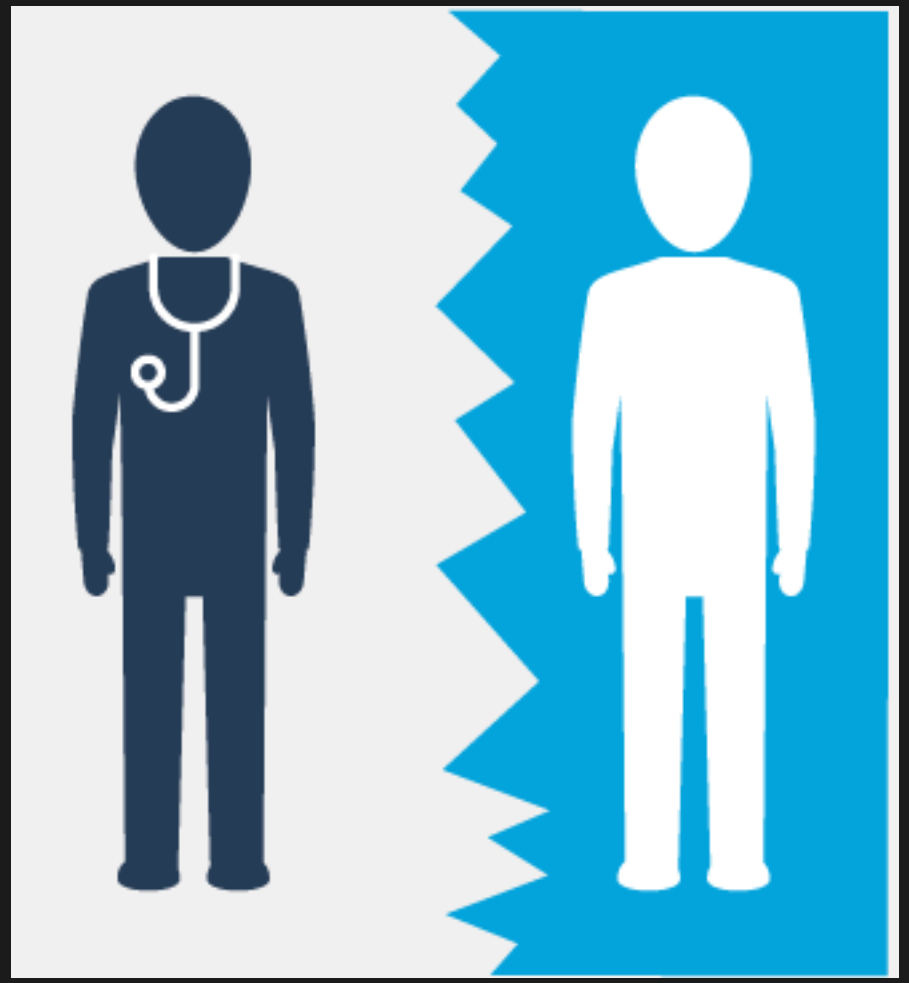
New: pain definitions & distinctions

Acute	<1 month
Subacute	1-3 months
Chronic	>3 months

”High impact” pain: pain on most or every day in the past 3 months that limits life or work activities (1 in 14 U.S. adults)

New: acknowledging disparities in treatment

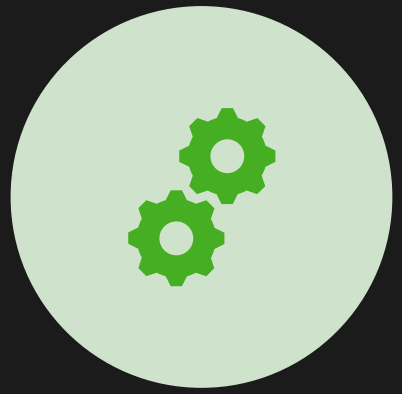
- Black, Hispanic patients
  - Less analgesia for acute pain
  - Fewer post-partum pain assessments
- Rural vs. urban patients more likely to receive opioids
- Prescribing rules enforced more for Black patients (frequency of visits, restriction of early refills)



Tenets of care

Holistic	Compassionate	Person-centered
Trust	Identify potentially reversible or treatable causes	Establish Dx

Treatment outcomes



OPTIMIZE FUNCTION

OPTIMIZE QUALITY OF LIFE

MEASURABLE

Shared goals: 2016 and 2022

Improve provider-patient communication around benefits & risks

Improve pain, function, quality of life for patients with pain

Improve pain treatment effectiveness and safety

Reduce risks associated with opioid use and other treatments for pain

- OUD
- Opioid overdose
- Rx opioid-related adverse events

Acknowledgement of misapplication

- Intentions:
  - Voluntary
  - Flexible
  - ”Support, not supplant” individualized care
- Misapplications:
  - Extension to excluded populations
  - Mandated, rapid tapers
  - Abrupt discontinuations
  - Rigid dosage thresholds
  - Duration limits (insurers and pharmacies)

Acknowledgement of misapplication

- Following 2016 Guidelines release:
  - 527 State and Federal policies enacted
  - 170 imposed opioid dosing limits
  - 35 directly referenced the Guidelines

Duensing K et al. *J Pain Res* 2020

Acknowledgement of harm

- Patient dismissal
- Patient abandonment
- Untreated/under-treated pain
- Withdrawal symptoms
- Psychological distress
- Overdose
- Suicidal ideation and suicide

Worlds apart

- Patients being considered for ***initial*** treatment
- Patients already receiving opioids as part of ***ongoing*** pain management

Thorough vetting and feedback

- 5 systematic evidence reviews
- Independent federal advisory committee review
- peer reviewers
- Public comment with revision
- Virtual conversations 2020: additional insights from patients, caregivers and clinicians

What we were told:

1. Opioids are highly effective for acute and chronic pain
2. Opioids are safe
3. Opioids are easy to discontinue

Evidence

- Opioids are not more effective than other things that work for acute, subacute, and chronic pain:
  - **Non-invasive, non-pharmacologic therapies**
    - Exercise, psychological interventions
  - **Non-opioid medications**
    - NSAIDs
    - SNRIs
    - Neuropathic agents

The evidence is minimal for long-term improvement of pain or function with ANY chronic pain treatment

Evidence

- Opioids are associated with significant risks, including
  - Dry mouth, N/V, constipation, confusion, somnolence
  - Dizziness, falls and fractures
  - Hypogonadism
  - Depression
  - Long-term use, tolerance, physical dependence
  - Opioid use disorder
  - Overdose

What the evidence shows

- Weaning and/or discontinuation is difficult for patients and providers
  - Requires substantial support, reassurance
- May be harmful to patients
  - Increased risk of suicidality, cardiovascular events
  - Harms may persist for months or years
- Abrupt discontinuation especially harmful
- Discontinuation of opioids not evidence-based for OUD

Recommendations

Considerations

- 4 main considerations:
  - Quality of evidence
  - Balance between desirable and undesirable effects
  - Values and preferences
  - Resource allocation (cost to patients and/or health systems)
- Other considerations:
  - Feasibility
  - Acceptability
  - Impact on health equity

GRADE-ing the evidence

Evidence type

1: RCTs, overwhelming evidence from observational studies

2: RCTs with important limitations, exceptionally strong evidence from observational studies

3:Observational studies or RCTs with notable limitations

4: Clinical experience, limited observational studies

Rating

1: High confidence that the true effect is close to the estimate

2: True effect likely to be close to estimate, but with uncertainty

3: Limited confidence in effect estimate, moderate uncertainty

4: Very little confidence in the effect estimate, high uncertainty

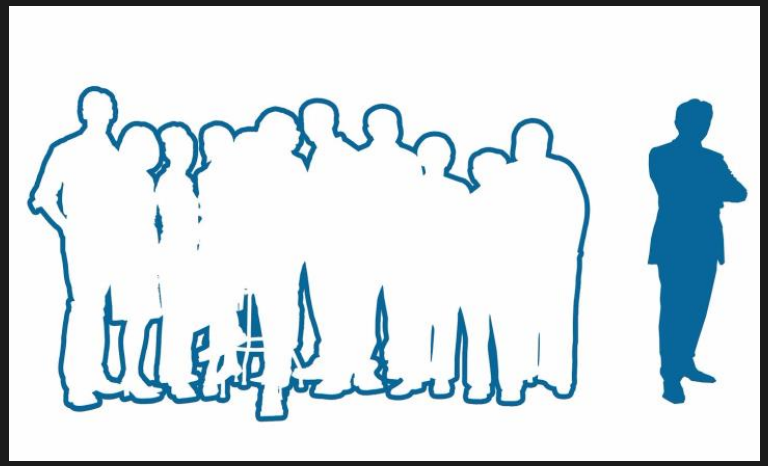
Categorizing the recommendations

- Category A:

Applies to all persons; most should receive the recommended course of action

- Category B:

Individual decision-making needed, with different choices appropriate for different patients



12 recommendations, 4 categories

1. Opioid initiation (1-2)
2. Opioid selection and dosage (3-5)
3. Duration of initial Rx & conducting follow up (6-7)
4. Assessing risk and potential harms (8-12)

Recommendation 1: Acute Pain (B3)

- Maximize non-pharmacologic and non-opioid modalities
- Consider opioid therapy for acute pain only if benefits anticipated to outweigh risks
- Before prescribing, discuss “realistic benefits and known risks”

Potential benefits

- Similar or decreased effectiveness for pain and function vs NSAIDs across several acute pain conditions
- Small improvements in short-term (1-6 months) pain and function compared with placebo
- Attenuated pain reduction over time (3-6 months vs 1-3 months)

Reviewing risks- acute and chronic use

- Typical opioid side effects
- Risk of safe vehicle operation
- Risk to household members
- Safe storage & disposal
- Risk of combining with other CNS depressants
- Respiratory depression and overdose
- OUD
- All-cause death

Recommendation 2: Subacute/Chronic Pain (A2)

Same as for acute pain, plus:

Consider how opioid therapy will be discontinued if benefits do not outweigh risks

Opioid risks- chronic pain

- Unknown/attenuated benefit with prolonged use
- Importance of periodic reassessment
- Functional goals
- Exit strategy
- Risk mitigation

Recommendation 3 (A4)

When initiating opioid therapy for all pain durations, use IR opioids

Use caution with ER/LA opioids

Don't use as intermittent/prn, don’t use methadone, review metabolism & drug interactions

Use ER/LA only in opioid-tolerant individuals

Recommendation 4 (A3)

- Initiate opioids at lowest effective dosage
- For subacute or chronic pain, use caution, carefully evaluate individual risk-benefit when considering dose increase
- Avoid increasing dosage above levels likely to yield diminishing returns in benefit relative to risks
- Outside of life-threatening risk (e.g., impending overdose) do not discontinue or reduce opioid dosages rapidly

Recommendation 5 (B4)

For patients on COT, carefully weigh benefits & risks when changing dosage

Continue to optimize non-opioid modalities

If risks>benefits, work with patient to gradually taper and discontinue

Details

- Potential benefits include avoiding the risks of tapering!
- “At times, clinicians and patients might not be able to agree on whether or not tapering is necessary. When patients and clinicians are unable to arrive at a consensus on the assessment of benefits and risks, clinicians should acknowledge this discordance, express empathy, and seek to implement treatment changes in a patient-centered manner while avoiding patient abandonment.”
- ”Payers, health systems, and state medical boards should not…set rigid standards…and should ensure that policies do not penalize clinicians for accepting new patients who are using prescribed opioids for chronic pain, including those receiving high dosages…or for refraining from rapidly tapering patients.”

Indications for taper/discontinuation

- Patient request
- No significant improvement in pain or function
- Unclear benefit compared to risks after prolonged treatment
- No improvement with higher dosages
- Side effects impairing function or quality of life
- Opioid misuse
- Overdose or other serious event
- Medications or medical conditions that increase risk for adverse event
- Consider transition from full-agonist opioid to buprenorphine for pain to reduce risk of overdose

Limits of shared decision making

- Evidence of benefit insufficient/absent
- Impaired capacity to understand options
- Wider (societal) interests overrule individual wishes
- “Profound existential uncertainty”

Sullivan MD, Linder JA *JAMA Int Med* 2023

Recommendation 6 (A4)

When needed for acute pain, prescribe no greater quantity than needed for expected duration of pain severe enough to require opioids

Details

- ”A few days” is usually sufficient
- Evaluate patients continuing to receive opioids for acute pain at least every 2 weeks
- Leftover opioids for acute pain common; 52-68% of all opioid tablets
- Many surgical interventions have established ranges for opioid rxs
- Limiting duration of opioids prescribed can minimize need for taper
- If opioids used continuously for more than a few days, clinicians should prescribe a brief taper

Recommendation 7 (A4)

Evaluate benefits and risks within 1-4 weeks of initiation or dose escalation of opioid therapy for subacute or chronic pain.

Regularly reevaluate benefits and risks of continued opioid therapy

Details

- Assess more frequently when initiating ER/LA opioids or with dosage ≥50 MME
- Regularly assess all patients receiving CLTOT, suggested interval 3 months “or more frequently for most patients.”
  - Reevaluate patients at risk for overdose or OUD more frequently
- “…establish treatment goals, including functional goals, for continued opioid therapy” in legacy patients
- Review pain, function, goals, side effects, serious adverse events
- Optimize treatment for depression, anxiety, or other psychological co-morbidities
- Continue to maximize non-opioid and non-pharmacologic therapies

Recommendation 8 (A4)

Before starting and periodically during continuation of COT, evaluate risk for opioid-related harms and discuss with patients

Incorporate strategies to mitigate risk, including offering naloxone

Details

- Use validated tools to screen and assess MH and SUDs
- Optimize MH conditions, consult behavioral health specialists when needed
- Offer naloxone, especially to patients with:
  - Hx of overdose
  - SUD
  - Sleep-disordered breathing
  - ≥MME daily dose
  - Opioid + benzodiazepine use
  - Age >65, renal disease, hepatic disease

Recommendation 9 (B4)

Review PDMP data to determine if the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose

Details

- At a minimum, before initial Rx then Q3 months
- PDMP-generated risk scores not validated
- Don’t dismiss patients from practice based on PDMP information
- Discuss unexpected results with patient, including safety concerns
- Communicate with other clinicians and coordinate care
- When diversion likely, consider toxicology testing to determine if opioid rx can be discontinued without risk of withdrawal

2018-2019 CO PDMP State Audit

- 18% of prescribers not PDMP registered
- 8,700 patients received Rxs from ≥10 prescribers
- 85 prescribers prescribed >3,000 Rxs each (26x average)
- PDMP staff did not follow up on “problematic trends”

Recommendation 10 (B4)

Consider the benefits and risks of toxicology testing to assess for prescribed medications and other prescribed and non-prescribed controlled substances

Details

- Toxicology is not a punitive intervention
- Informs and improves patient care
- Not grounds for patient dismissal
- Aim to minimize bias
- Consider testing prior to initiation and at least annually
- Ask about and review in non-judgmental manner
- Clinicians must understand how to interpret results
- Use results to improve safety (rx naloxone, increase monitoring), inform risk-benefit assessment, or identify SUDs

Recommendation 11 (B3)

Use particular caution when prescribing concurrent opioids and benzodiazepines

Consider whether benefits outweigh risks of concurrent prescribing of opioids and other CNS depressants

Details

- Case-cohort study: 4x risk of death[1]
- Risk greater with unpredictable use, higher dose opioids, higher dose benzodiazepines, or a combination
- Taper benzodiazepines gradually as indicated; stopping can be destabilizing
- Treat anxiety with evidence-based treatments
- Communicate and coordinate with other treating clinicians

[1]Park et al. *BMJ* 2015

Recommendation 12 (A1!)

Offer or arrange treatment with evidence-based medications to treat patients with OUD

Detoxification alone is not recommended

Increased risks for resuming drug use, overdose, overdose death

Details

- OUD is a treatable disease
- Discuss concerns with patients in nonjudgmental manner
- Use DSM-5 criteria
- Do not dismiss patients from practice because of OUD
- MOUDs save lives; opportunity for life-saving intervention
- Offer as early as possible in pregnancy
- If unable to provide, arrange referral
- Identify a network of referral options
- Provide ongoing pain management

Notable quotes

Define Voluntary

“This voluntary clinical practice guideline provides recommendations only and is intended to support, not supplant, clinical judgment and individualized, person-centered decision-making. This clinical practice guideline should not be applied as inflexible standards of care across patient populations by health care professionals; health systems; pharmacies; third-party payers; or state, local, or federal organizations or entities.”

Greatest understatement of the guideline

"Despite their favorable benefit-to-risk profile, noninvasive nonpharmacologic therapies are not always covered or fully covered by insurance."

Heyward et al, *JAMA Network Open* 2018

Opioids still first-line

“Opioids therapy has an important role for acute pain related to severe traumatic injuries (including crush injuries and burns), invasive surgeries typically associated with moderate to severe postoperative pain, and other severe acute pain when NSAIDs and other therapies are contraindicated or likely to be ineffective.”

Palliative opioids

“In some clinical contexts (e.g., serious illness in a patient with poor prognosis for return to previous level of function, contraindications to other therapies, and clinician and patient agreement that the overriding goal is patient comfort), opioids might be appropriate regardless of previous therapies used.”

“Palliative care can begin early in the course of treatment for any serious illness that requires advanced management of pain or other distressing symptoms.”

Notable statements

”Payers, health systems, and state medical boards should not…set rigid standards…and should ensure that policies do not penalize clinicians for accepting new patients who are using prescribed opioids for chronic pain, including those receiving high dosages…or for refraining from rapidly tapering patients.”

Don’t back in to LTOT

- “…clinicians should ensure that…opioid prescribing for acute [or subacute that start as acute] pain does not unintentionally become long-term opioid therapy simply because medications are continued without reassessment. Continuation of opioid therapy…might represent initiation of long-term opioid therapy, which should occur only as an intentional decision that benefits are likely to outweigh risks after discussion between the clinician and patient and as part of a comprehensive pain management approach.”

Initial Rx total MME	Odds Ratio
1-140	2.08
>450	6.14

Webster et al. *Spine* 2007

Screening for SUDs: everyone's job

- "Nonprescribed drugs and alcohol are listed as contributory factors on a substantial proportion of death certificates for prescription opioid-involved overdose deaths. Clinicians should ask patients about their drug and alcohol use. Single screening questions can be used. For example, the question *'How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?'* was found in a primary care setting to be 100% sensitive and 73.5% specific for detection of a drug use disorder compared with a standardized diagnostic interview."

Most importantly

“Unless there are indications of a life-threatening issue such as warning signs of impending overdose (e.g., confusion, sedation, or slurred speech), opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages (recommendation category: B; evidence type: 4).”

“Clinicians should avoid abrupt discontinuation of opioids, especially for patients receiving high dosages of opioids, should avoid dismissing patients form care, and should ensure (provide or arrange) appropriate care for patients with pain and patients with complications from opioid use (e.g., opioid use disorder).”

Opioid discontinuation- risks

- Overdose
  - OR =1.44 (no OUD)
  - OR = 3.18 (OUD)
- Suicide
  - Risk of overdose or suicide 1.28% vs 0.96%
- Mental Health Crisis
  - OR = 1.74
- ED visits for withdrawal

Kennedy MC et al *PLOS Medicine* 2022
Oliva EM et al *BMJ* 2020
Agnoli A et al *JAMA* 2021
Fenton JJ et al *JAMA Netw Open* 2022
Larochelle MR et al *JAMA Netw Open* 2022
DiPrete B et al *JAMA Netw Open* 2022
Kertesz SG et al *JAMA Netw Open* 2022

JAMA Network Open

Original Investigation | Pharmacy and Clinical Pharmacology

Long-term Risk of Overdose or Mental Health Crisis After Opioid Dose Tapering

Joshua J. Fenton, MD, MPH; Elizabeth Magnan, MD, PhD; Irakis Erik Tseregounis, PhD; Guibo Xing, PhD; Alicia L. Agnoli, MD, MPH, MHS; Daniel J. Tancredi, PhD

JAMA Network Open

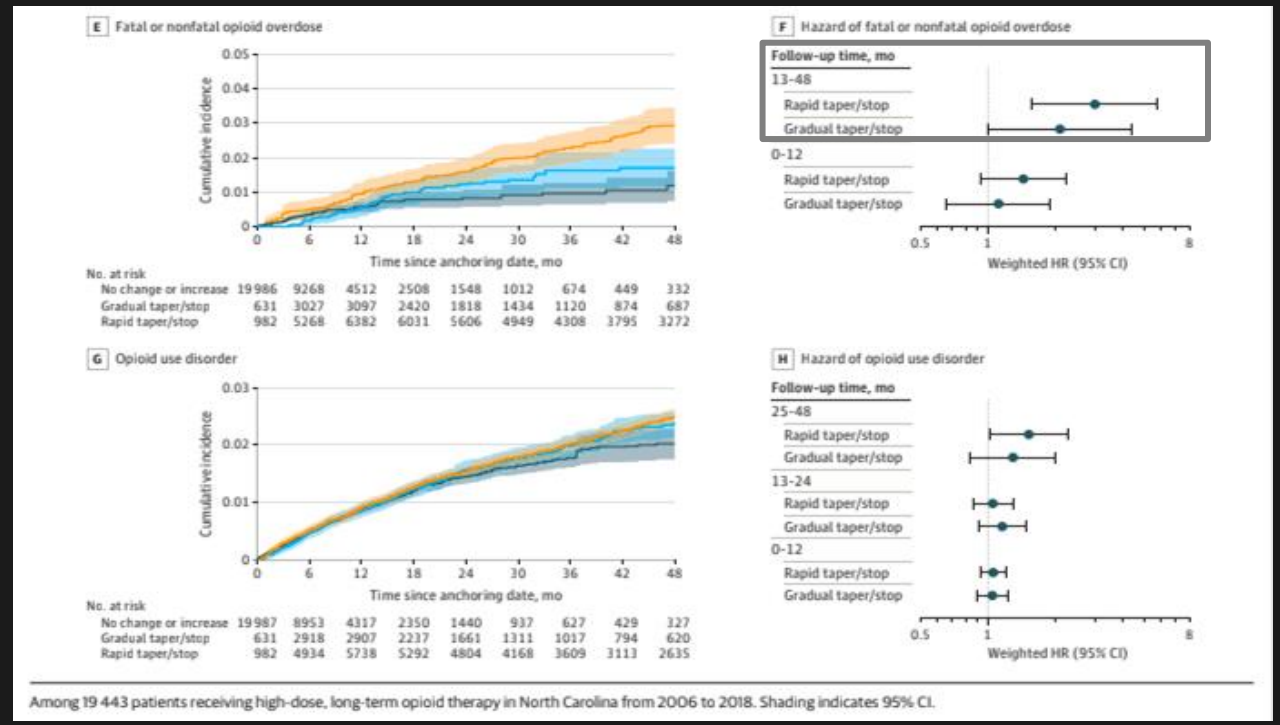
Original Investigation | Public Health

Association of Opioid Dose Reduction With Opioid Overdose and Opioid Use Disorder Among Patients Receiving High-Dose, Long-term Opioid Therapy in North Carolina

Bethany L. DiPrete, PhD, MSGH; Shabbar I. Ranapurwala, PhD, MPH; Courtney N. Maierhofer, MPH; Naoko Fulcher, MS; Paul R. Chelminski, MD, MPH; Christopher L. Ringwalt, DrPH; Timothy J. Ives, PharmD, MPH; Nabarun Dasgupta, PhD, MPH; Vivian F. Go, PhD; Brian W. Pence, PhD

Table 3. Adjusted IRRs of Overdose or Mental Health Crisis in the Postinduction Compared With the Pretaper Period by Patient or Period Subgroups[a]

Patient or period subgroup	Overdose or withdrawal		Overdose		Mental health crisis	
	IRR (95% CI)	*P* value[b]	IRR (95% CI)	*P* value[b]	IRR (95% CI)	*P* value[b]
Baseline dose, MME[c]						
50-89	1.24 (0.98-1.58)	.01	1.04 (0.75-1.44)	.15	1.26 (0.97-1.63)	<.001
90-149	1.54 (1.24-1.90)		1.43 (1.08-1.91)		1.18 (0.93-1.49)	
150-299	1.47 (1.23-1.75)		1.40 (1.11-1.76)		1.49 (1.21-1.82)	
≥300	2.03 (1.67-2.47)		1.71 (1.31-2.24)		2.54 (1.95-3.30)	
Postinduction achieved dose vs baseline[d]						
Discontinued	1.09 (0.88-1.36)	<.001	0.86 (0.62-1.20)	<.001	1.17 (0.91-1.50)	.13
1%-49%	1.32 (1.08-1.61)		1.07 (0.82-1.39)		1.58 (1.26-1.97)	
50%-84%	1.93 (1.61-2.32)		1.86 (1.46-2.37)		1.77 (1.43-2.19)	
85%-114%	2.16 (1.71-2.73)		1.93 (1.43-2.62)		1.59 (1.23-2.06)	
≥115%	1.56 (1.00-2.43)		1.64 (0.94-2.87)		1.28 (0.76-2.16)	
Early vs later in postinduction period						
Early (months 13-16)	1.56 (1.32-1.84)	.94	1.32 (1.05-1.67)	.53	1.56 (1.28-1.89)	.77
Later (months 17-24)	1.57 (1.41-1.75)		1.42 (1.24-1.64)		1.51 (1.33-1.71)	



Among 19 443 patients receiving high-dose, long-term opioid therapy in North Carolina from 2006 to 2018. Shading indicates 95% CI.

In Summary

- 2016 Guideline got things right; interval evidence has supported the core recommendations
- Acknowledges difficulty and harms of tapering or discontinuing LTOT
- Focus on non-pharmacologic, non-invasive, non-opioid therapies

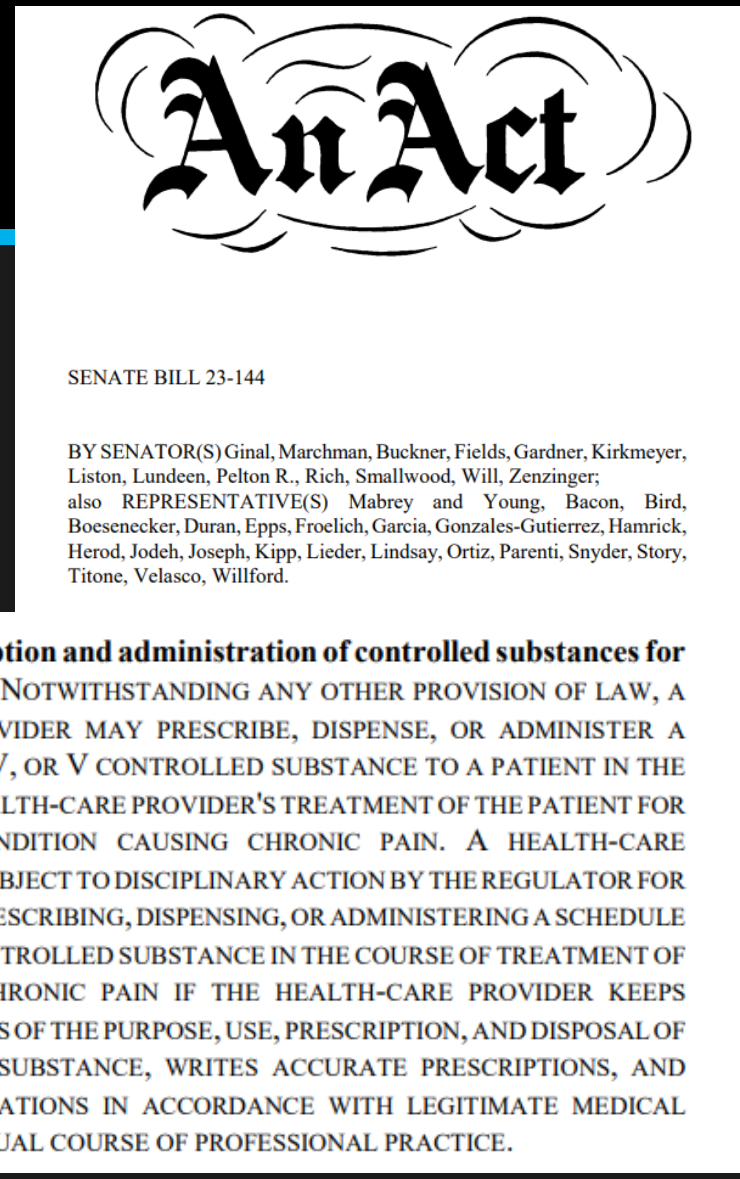
Missed opportunities of the Guidelines

- No clarification of when/how/why to taper LTOT
- Dosing limits maintained in the fine print
- No reference to the Inter-Agency Task Force Report and other references
- Minimal initial impact on patient obstacles, provider protections

Peachman RR *JAMA* 2022

Colorado SB 23-144: protections for health care providers

- No discipline for HCPs who:
  - Prescribe opioids for chronic pain “in accordance with legitimate medical purpose” and with appropriate documentation
  - Prescribe opioids above thresholds specified in state or federal guidelines or policies
- No requirement to taper down to predetermined MME thresholds if patient is “stable and compliant with treatment plan and not experiencing serious harm.”
- No policies for pharmacies or medical practices to refuse patients based solely on MME



An Act

SENATE BILL 23-144

BY SENATOR(S) Ginal, Marchman, Buckner, Fields, Gardner, Kirkmeyer, Liston, Lundeen, Pelton R., Rich, Smallwood, Will, Zenzinger;
also REPRESENTATIVE(S) Mabrey and Young, Bacon, Bird, Boesenecker, Duran, Epps, Froelich, Garcia, Gonzales-Gutierrez, Hamrick, Herod, Jodeh, Joseph, Kipp, Lieder, Lindsay, Ortiz, Parenti, Snyder, Story, Titone, Velasco, Willford.

(3) **Prescription and administration of controlled substances for chronic pain.** (a) NOTWITHSTANDING ANY OTHER PROVISION OF LAW, A HEALTH-CARE PROVIDER MAY PRESCRIBE, DISPENSE, OR ADMINISTER A SCHEDULE II, III, IV, OR V CONTROLLED SUBSTANCE TO A PATIENT IN THE COURSE OF THE HEALTH-CARE PROVIDER'S TREATMENT OF THE PATIENT FOR A DIAGNOSED CONDITION CAUSING CHRONIC PAIN. A HEALTH-CARE PROVIDER IS NOT SUBJECT TO DISCIPLINARY ACTION BY THE REGULATOR FOR APPROPRIATELY PRESCRIBING, DISPENSING, OR ADMINISTERING A SCHEDULE II, III, IV, OR V CONTROLLED SUBSTANCE IN THE COURSE OF TREATMENT OF A PATIENT FOR CHRONIC PAIN IF THE HEALTH-CARE PROVIDER KEEPS ACCURATE RECORDS OF THE PURPOSE, USE, PRESCRIPTION, AND DISPOSAL OF THE CONTROLLED SUBSTANCE, WRITES ACCURATE PRESCRIPTIONS, AND PRESCRIBES MEDICATIONS IN ACCORDANCE WITH LEGITIMATE MEDICAL PURPOSE IN THE USUAL COURSE OF PROFESSIONAL PRACTICE.

Will the new guidelines protect patients?
Will they protect us?

END

Thank you
Joshua.blum@dhha.org