Opioid Guideline Workgroup

Observations presented to the National Center for Injury Prevention and Control's

Board of Scientific Counselors

Preparatory material for Board of Scientific Counselors meeting on

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Submitted by:

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In addition to the identified members of the Workgroup additional consultation was arranged for specific content areas.

Consultant Area	**Participation**
Pediatrics & Anesthesiology	*Ad hoc*, available for questions, not contacted
Occupational Medicine & Worker's Compensation	*Ad hoc*, available for questions, not contacted
Obstetrics & Gynecology	Participated in meeting on 1/15/16
GRADE methodology & cost effectiveness	Participated in meetings on 1/8, 1/13, and 1/15
Medical Ethics	*Ad hoc*, available for questions, not contacted
Addiction Psychiatry	Participated in meeting on 1/15/16
Physical Medicine & Rehabilitation	Participated in meeting on 1/13/16
Family member affected by loss of a loved one to opioid overdose	Participated in meeting on 1/13/16

Overall Observations

- Workgroup members support efforts reflected in the Guidelines — specifically in the supporting text and statements of Guideline Recommendations # 1, 9, 11, and 12 — to encourage integrated care for people with chronic pain. As defined in the Draft National Pain Strategy, "*Integrated care* is the systematic coordination of medical, psychological and social aspects of health care and includes primary care, mental health care, and, when needed, specialist services." (http://iprcc.nih.gov/docs/DraftHHSNationalPainStrategy.pdf, p.9)
- Workgroup members suggest monitoring of Guideline implementation for evidence of impact and unintended consequences and modification of Guidelines when warranted by evidence.
- Several workgroup members suggest that pediatric and adolescent populations should be considered for future updates of opioid prescribing guidelines.
- Risks and benefits of opioid therapy in chronic pain and the epidemiology of prescription drug misuse and abuse are areas of active research, so the Workgroup suggested that the contextual evidence review may need to be updated more frequently than the clinical evidence review. We encourage CDC to work with partners to support additional research in this field.
- Workgroup members express strong preference for Guideline Recommendations that are framed with positive rather than negative language.
- Several workgroup members observed that we were asked to consider cost feasibility for the recommendations and in general feel that such data are lacking and subject to great variability. More research is required in this domain in order to have evidence relating to cost feasibility that could be evaluated.
- Concerns about access, cost, and insurance coverage were raised by several workgroup members in discussion about Guideline Recommendations #1, #6, #7, #8, #9, #10, and #12. Systematic changes in payment policies will likely be required to support implementation of the

Guidelines. Workgroup members encourage CDC to work with federal partners to support payment policies congruent with the Guidelines.

- Discussions about safe storage and disposal are mentioned in several sections of supporting text. Workgroup members observe that these discussions are relevant throughout the course of opioid therapy for chronic pain and encourage providers to include patient education on safe storage and disposal of medications as a routine part of therapy along with discussion of risks, benefits, treatment goals, mental health, pain, and function.
- Workgroup members observe that primary care providers may require additional education on approaches integral to implementation of the Guidelines, including education on non-pharmacologic and integrated care, offering naloxone to patients with chronic pain, and medication assisted treatment for opioid use disorder. Workgroup members encourage CDC to work with partners to support and/or provide appropriate education.

Observations Specific to Guideline Recommendation Statements

The observations presented here follow the ordering of the Guidelines.

> **GUIDELINE RECOMMENDATION #1:** *Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain. Providers should only consider adding opioid therapy if expected benefits for both pain and function are anticipated to outweigh risks to the patient. (Recommendation category: A; Evidence type: 3)*

All members of the Workgroup agreed with the type and category of evidence for Guideline Recommendation #1.

- Workgroup members commend the ordering of statements and agree that the topic of Guideline Recommendation #1 is first. Clear wording that opioids are not routine therapy for adults in chronic pain managed in primary care as well as mention of both pain and function are good messages.
- Several workgroup members expressed significant concerns about access to care, particularly for non-pharmacologic therapies mentioned in Guideline Recommendation #1 and suggestion that there should be clear preference for integrated care for chronic pain expressed in Guideline Recommendation #1 and throughout the Guidelines.

> **GUIDELINE RECOMMENDATION #2:** *Before starting opioid therapy for chronic pain, providers should establish treatment goals with all patients, including realistic goals for pain and function. Providers should not initiate opioid therapy without consideration of how therapy will be discontinued if unsuccessful. Providers should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety. (Recommendation category: A; Evidence type: 4)*

All members of the Workgroup agreed with the type and category of evidence for Guideline Recommendation #2.

- Workgroup members commend Guideline Recommendation #2 in particular for its focus on patient-centered goals for improvement of pain and/or function. There was some concern that some providers would interpret the phrasing of "pain and function" to mean that improvements were required in both pain and physical function in order to justify continuation of opioid therapy. Such meaning could be clarified in the supporting text. Spinal cord injury patients, for example, may never walk again, but continued opioid therapy may be appropriate if it helps manage their pain and improves social or psychological function.
- Many people with chronic pain also experience mental health concerns such as depression and/or anxiety, and there is evidence that treating these co-existing conditions can improve pain outcomes as well. Several workgroup members encourage addition of language in the supporting text to include evaluation of mood in addition to pain and function.

GUIDELINE RECOMMENDATION #3*: Before starting and periodically during opioid therapy, providers should discuss with patients known risks and realistic benefits of opioid therapy and patient and provider responsibilities for managing therapy. (Recommendation category: A; Evidence type: 3)*

All members of the Workgroup agreed with the type and category of evidence for Guideline Recommendation #3.

- Several members observed that suggesting a safety discussion in response to unexpected findings in the PDMP or urine drug screen in the supporting text for Guideline Recommendation #3 may suggest to providers that safety discussions are for extreme events rather than conversations that should occur at initiation of opioid therapy and continue as a routine matter throughout the duration of therapy.
- Some members suggested that the supporting text for Guideline Recommendation #3 could be strengthened by moving information about consideration of risk to household members from opioid exposure or improper storage in the home (e.g. pediatric poisoning events) from the last bullet to higher in the text.
- Disposal of medications is a complicated situation. Information about safe disposal of medication should be included in the tools accompanying the Guidelines.
- Several members suggest that consideration of possible risk to household members from accidental ingestion or diversion of opioids be included in the discussion of risks and benefits with the patient.

GUIDELINE RECOMMENDATION #4*: When starting opioid therapy for chronic pain, providers should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids. (Recommendation category: A; Evidence type: 4)*

All members of the Workgroup agreed with the type and category of evidence for Guideline Recommendation #4.

- Guideline Recommendation #4 is evidence type 4. This recommendation is consistent with best practices and well-deserves Category A designation.

GUIDELINE RECOMMENDATION #5*: When opioids are started, providers should prescribe the lowest effective dosage. Providers should use caution when prescribing opioids at any dosage, should implement additional precautions when increasing dosage to 50 or more morphine milligram equivalents (MME)/day, and should generally avoid increasing dosage to 90 or more MME/day. (Recommendation category: A; Evidence type: 3)*

This statement generated significant discussion about content in addition to the discussion about recommendation category and type of evidence.

- Six of the nine Workgroup members agreed with the category A and evidence type 3 designation. Three members felt that the evidence type 3 was appropriate except for the last paragraph of supporting text and if the discussion of tapering in the supporting text was removed then the category A and evidence type 3 designation was appropriate. Two Workgroup members suggested revisions to the statement.
- One specific observation was that the last paragraph of the supporting text for Guideline Recommendation #5, regarding patients already taking opioids, does not directly support Guideline Recommendation #5 which is about initiation of opioid therapy.
- In comparison to contextual evidence for risk and harm from opioid therapy there are virtually no studies of long-term benefits or improvement in pain and function with opioid therapy. Workgroup members encourage future studies to populate this data gap.
- One member of the Workgroup strongly opposes Guideline Recommendation #5 as it is written. This member stated repeatedly that the current recommendation clearly suggesting dose limits is not supported by any data showing a decrease in benefit/risk ratio at the arbitrary numbers stated in the recommendation. This member expresses concern that the current wording of Guideline Recommendation #5 will undermine support for the entire Guidelines from providers and professional organizations.
- The focus on patient pain and function included in the text of Guideline Statement #2 was not similarly included with Guideline Statement #5. Improvement or decrement of pain and/or function should be the impetus for any change in dose, either increasing or decreasing, and members observed that it should be repeated here.
- There was not agreement about the evidence type for this statement, in part because of the inclusion of the last paragraph of supporting text. Most members felt that the evidence for the last paragraph of supporting text was type 4 but supported type 3 evidence for the remaining paragraphs of supporting text.
- Individual Workgroup members suggested specific edits to the text which are included here for information. The reworded statements alleviated more general concerns about perceptions of limit setting, implications of safe dosing below those limits, and observation that all of the evidence presented is about risk and harm rather than potential benefits or risk/benefit ratios associated any with dosing levels.
    - "When opioids are started, providers should prescribe the lowest effective dosage. Prescribers should be aware that risk of opioid-associated harm is greater with higher dose opioid therapy and should, therefore, carefully justify a decision to titrate opioids beyond 90 MME/day. In this regard, providers should use caution

when prescribing opioids at any dosage but should implement additional precautions when increasing dosage to > 50 MME/day."

- "When opioids are started, providers should prescribe the lowest effective dosage. There is no safe dosage of opioids, but risks of serious harms rise with increasing dosages. Providers should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and potential harms when considering increasing dosage to ≥50 MME/day, and should generally avoid increasing dosage to ≥90 MME/ day."

GUIDELINE RECOMMENDATION #6: *Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, providers should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three or fewer days usually will be sufficient for most non-traumatic pain not related to major surgery. (Recommendation category: A; Evidence type: 4)*

All members of the Workgroup agreed with the evidence type for Guideline Recommendation #6.

There was considerable discussion about the Category rating for Guideline Recommendation #6. One member recommends that Guideline Recommendation #6 be Category B. Many members are able to support the Category A designation only if the statement is re-worded (see suggestions below).

- The duration of therapy was focus for animated discussion. Many members felt that three days was too limited and preferred a range of values, none of which exceeded seven days. Four members preferred seven days or fewer. Two members preferred a range of 3–7 days. One preferred a range of 5–7 days. One preferred a range of 3–5 days. One member was strongly opposed to seven days as "too long".
- Specific wording suggestions for Guideline Recommendation #6 follow.
  - "Avoid prescribing more than three days supply, unless circumstances clearly warrant additional opioid therapy."
- The supporting text for Guideline Recommendation #6 should also include information and tools about safe medication storage and disposal.

GUIDELINE RECOMMENDATION #7*: Providers should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Providers should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, providers should work with patients to reduce opioid dosage and to discontinue opioids. (Recommendation category: A: Evidence type: 4)*

All members of the Workgroup agreed with the type and category of evidence for Guideline Recommendation #7.

- Guideline Recommendation #7 should apply to all patients. Several Workgroup members expressed concern that the wording suggested that Guideline Recommendation #7 applied only to opioid naïve patients.

- Individual workgroup members also suggested specific edits to Guideline Recommendation #7, particularly the final sentence. There was concern that it implied that all patients should be at a dose of zero opioids (…and discontinue) and failed to suggest what else providers should do besides eliminating opioid dose.

  The majority of members would prefer that the last clause be either:

  1. "…providers should work with patients to reduce opioid dosage OR discontinue opioids AND IMPLEMENT OTHER THERAPIES."
  2. "…providers should work with patients to reduce opioid dosage and discontinue opioids IF INDICATED, AND IMPLEMENT OTHER THERAPIES."

Alternately, a completely revised last sentence in Guideline Recommendation #7 could read:

- "If harms outweigh the benefits of opioid therapy, clinicians must work with patients to seek alternative or adjunctive therapies for pain as part of a careful reduction or discontinuation of opioid dosage."
- '….If harms outweigh the benefits of opioid therapy, providers should work with patients to seek alternative or adjunctive therapies for pain as a careful reduction of opioid dosage or discontinuation (if necessary) of opioid therapy.'

GUIDELINE RECOMMENDATION #8: *Before starting and periodically during continuation of opioid therapy, providers should evaluate risk factors for opioid-related harms. Providers should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, or higher opioid dosages (≥50 MME), are present. (Recommendation category: A; Evidence type: 4)*

All members of the Workgroup agreed with the type and category of evidence for Guideline Recommendation #8.

- Two members suggest that Guideline Recommendation #8 would be stronger with the inclusion of concomitant use of central nervous system (CNS) depressants or sedatives among the listed risk factors.

GUIDELINE RECOMMENDATION #9*: Providers 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 high opioid dosages or dangerous combinations that put him or her at high risk for overdose. Providers should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months. (Recommendation category: A; Evidence type: 4)*

All members of the Workgroup agreed with the type and category of evidence for Guideline Recommendation #9.

- The first bullet of the supporting text for Guideline Recommendation #9 implies that pharmacists are solely responsible for inaccurate data entry, to correct that, the phrase "if a pharmacist" should be deleted.
- The bulleted information in the supporting text for Guideline Recommendation #9 should also apply to patients on high dosages and dangerous combinations, not just patients receiving medications from multiple providers.
- Workgroup members observe that PDMP access and utility varies among states. Issues of data sharing can limit PDMP utility in border areas. CDC and its federal partners are encouraged to support PDMP development and operation across the country and help work towards efficient data access and interfaces for all providers of controlled substances.

GUIDELINE RECOMMENDATION #10*: When prescribing opioids for chronic pain, providers should use urine drug testing before starting opioid therapy and consider urine 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)*

All members of the Workgroup agreed with the evidence type for Guideline Recommendation #10.

The majority of Workgroup members felt that Guideline Recommendation #10 should be a Category A recommendation rather than Category B. The universal recommendation is perceived to be both more focused on patient safety and less likely to result in urine drug testing being applied selectively among already stigmatized or stereotyped patients.

- Supporting text for Guideline Recommendation #10 should encourage providers to use the simplest urine drug testing appropriate for each patient to reduce the cost and improve the feasibility of this recommendation.
- Supporting text for Guideline Recommendation #10 should emphasize the need for providers to be educated about interpretation of the results of the urine drug testing implemented in their practice settings.
- Research on risks and benefits of urine drug testing is limited, and more such research is encouraged.

GUIDELINE RECOMMENDATION #11*: Providers should avoid prescribing opioid pain medication for patients receiving benzodiazepines whenever possible. (Recommendation category: A; Evidence type: 3)*

All members of the Workgroup agreed with the type and category of evidence for Guideline Recommendation #11.

- Workgroup members observe and support that the intention of Guideline Recommendation #11 is to discourage concurrent prescribing of opioids and benzodiazepine medications, however, several members felt that the current language presumes that the benzodiazepine prescription is appropriate and fails to encourage patient-centered decision making about risks and benefits for each medication.

- Supporting text for Guideline Recommendation #11 could include language about the importance of the pharmacist in co-prescribing situations and the role for use of prescription drug monitoring programs (PDMP) for identifying concurrent medication use.
- Workgroup members noted that the wording of Guideline Recommendation #11 has changed significantly during the comment and review process. Several workgroup members preferred the original wording.
- Some Workgroup members preferred that this statement be modified to say, "Providers should USE CAUTION WHEN prescribing opioids…" rather than, "Providers should AVOID prescribing opioids." Several Workgroup members supported the "AVOID" wording; two members strongly preferred the "AVOID" wording.
    - Discussion surrounded concerns about inter-professional communication (i.e., psychiatrists, primary care physicians) challenges and the need for providers and patients to jointly discuss the patient's needs, prioritize patient goals, and weigh risks of concurrent benzodiazepine and opioid exposure before deciding upon initiating, continuing to prescribe, or tapering either medication.
- Risk mitigation in the presence of co-prescription was universally supported by the Workgroup.

GUIDELINE RECOMMENDATION #12*: Providers should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder. (Recommendation category: A; Evidence type: 3)*

There was disagreement among the Workgroup members with regards to the Category for Guideline Recommendation #12. One member felt strongly that this should be a Category B. The remaining Members were comfortable with Category A.

- Workgroup members commend the wording of Guideline Recommendation #12, particularly the "Providers should offer or arrange…" clause because they felt it would help encourage primary care providers to be proactive about treatment for opioid use disorder and perhaps encourage more providers to acquire training and licensure for buprenorphine prescribing.
- Workgroup members were in agreement that the evidence for medication assisted treatment for opioid-use disorder is strong and recommend that the evidence type for Guideline Recommendation #12 be upgraded from type 3 to type 2.

Review of Supplemental Materials: Clinical Evidence Review, Contextual Evidence Review, and Comments from Stakeholders, Peer-Reviewers, and the Public

- The Clinical Evidence Review was thorough and well-done for the specific clinical questions.
- Workgroup members recommend continued support for future clinical and contextual research on benefits and risks of opioid therapy for chronic pain.

- Future updates of the Contextual Evidence Review should seek out more information about specific non-pharmacologic therapies for chronic pain, such as exercise therapies, interventional therapies, integrative medicine, and behavioral therapies.
- Evidence in the Contextual Evidence Review supports that mental health disorders frequently co-occur among people with chronic pain. The supporting text for Guideline Recommendations #2 and #5 which describe evaluating pain and function should be modified to include evaluation of patient mood as well.
- Comments from constituents demonstrated the breadth and variety of positions on the issue of opioid therapy for chronic pain among adults managed in primary care. There seemed to be a general agreement, however, that guidelines are needed, even if this set of guidelines is only the first step.
- Comments from patients and family members, in particular, expressed the desire that patient-centered care is enhanced rather than reduced by these Guidelines. Members felt that the guidelines could be implemented in a manner consistent with patient-centered care.