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

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Overall Observations

- Unbalanced - focus on risks of opioids, less attention on potential benefits of opioids or risks of untreated/undertreated pain. Missing key studies
- Concern for misapplication of Guideline, leading to potential harm to patients
- Tension between public health benefits vs. individual patient benefits; not sufficiently patient-centered
- Too little attention to racial/ethnic disparities and inequities in how pain is perceived, valued and managed

Overall Observations (continued)

- Cautious about including specific opioid dose thresholds in the recommendations
- Sense of exceptionalism – certain conditions with "real" pain or warrant specific types of treatment
- Recommendation category A overutilized (11 of 12 recommendations)
- Opioid Workgroup Guiding Principles document

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.

- Change the wording
- Concerned about the large and unclear category of acute pain
- Does not consider shared decision-making
- Concerned recommendation could be misinterpreted and translated into bad policy. Must consider lack of access to non-opioid treatment.
- Most felt graded category should be B

Recommendation #2: Nonopioid therapies are preferred for subacute and chronic pain. Clinicians should only consider 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.

- Appreciate the attempt to be inclusive and comprehensive
- Shared decision-making should be emphasized
- Certain conditions for which this recommendation does not apply = exceptionalism
- Language is too strong
- Some felt graded 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.

- Most agreed with the recommendation
- Need to define “starting” and “opioid-naïve” more clearly
- Appreciate the supporting text regarding abuse-deterrent formulations
- Agree with grading 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.

- Concern about dose threshold in the statement; may lead to forced tapers and other potential harms
- Appreciate splitting recommendations #4 (starting/continuing/increasing) and #5 (reducing/tapering)
- Concern with term "justify" as it reflects legal language
- Should be graded category B, but if dose thresholds removed, then could be category 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.

- Appreciate language that acknowledges the complexity of the situation
- Dose threshold should be removed from the recommendation and included in supporting text
- Recommendation not balanced, does not include risk/benefit calculation of continuing opioids
- More discussion needed on obtaining consent from patients
- Use the term “risk” instead of “harm” as assessing risk is one of the biggest challenges providers face

Recommendation #5 (continued)

- Fuller discussion warranted regarding benefits to society vs. patients
- Supporting text missing key points (risk of tapering, lack of observational studies, never increasing dose after starting taper, assuming goal is 0 MME, not patient-centered)
- Over-correcting for possible misapplication of Guideline
- Grading category B more appropriate, especially when individualization in recommendation

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.

- Concerned about misapplication, which could be reduced by removing the last sentence
- Patients vs. public health outcomes
- Implementation of this recommendation can differential outcomes on patients based on sociodemographic characteristics
- Move the last sentence to the supporting text or add qualifiers (e.g., “In most patients…)
- The first sentence is category A but not the second sentence

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.

- Little evidence to support this recommendation, particularly the specific time frames. However, it is reasonable and reflects common practice.
- Use of "risks" and "harms" in this recommendation is inconsistent
- In supporting text, discussion is about 50 MME, while elsewhere the threshold is 90 MME
- Health disparities and health equity should be more central in the supporting text

Assessing Risk and Addressing Harms of Opioid Use

Recommendation #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), or concurrent benzodiazepine use, are present.

- Concern about naming specific conditions that increase risk
- Concern about opioid dose threshold in the recommendation—arbitrary and inconsistent
- Concern with potential downstream effects of offering naloxone for patients with limited means
- Pregnancy missing as a risk factor
- Buprenorphine has a very high MME, therefore unclear implications

Recommendation #8 (continued)

- Supporting text is unbalanced—focus on risk of opioids, not risk of undertreated pain
- Little consideration of the lack of access to alternative pain treatments
- Naloxone should remain in the recommendation, but a more comprehensive risk mitigation approach is warranted
- Some felt category A is warranted if specific conditions are removed; others felt it is warranted regardless

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, subacute, or chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

- The word "dangerous" may be too strong and too binary
- Conflicting opinions on checking PDMP for acute pain
- Caution regarding potential harms of the PDMP
- Appreciate recommendation that patients are not dismissed due to PDMP information
- Supporting text needs to be re-worked, especially regarding acute pain
- Differing opinions on the appropriate grading category

Recommendation #10: When prescribing opioids for subacute or 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.

- Illicit drugs are not defined
- Interpretation of urine drug test results can be complicated
- Biases and disparities regarding who has urine drug tests should be more central
- Ensure non-stigmatizing language in the supporting text
- Importance of providers' discussing why and how urine drug tests are used

Recommendation #10 (continued)

- Cautious regarding conducting urine drug tests prior to prescribing opioids
- Cautious about patients' potential financial implications of frequent urine drug tests
- Category B is appreciated, though others felt category A could reduce bias and disparities

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.

- The words “avoid” and “whenever possible” can be interpreted as “never”
- Including an entire class of medications is far-reaching and could lead to unintended negative consequences
- Recommendation not appropriate for acute care setting
- Include FDA warnings in the supporting text regarding benzodiazepine use among people prescribed opioids
- Recommend category B

Recommendation #12: Clinicians should offer or arrange treatment with medication for patients with opioid use disorder.

- Agree with the language of the recommendation, specifically the word “should”
- New regulations regarding buprenorphine prescribing should be included in the supporting text
- Supporting text should distinguish opioid agonist vs. antagonist treatment and question whether they are equal options
- Conflation in the supporting text regarding management of problematic opioid use vs. OUD
- Details about OUD treatment inaccurate in the supporting text
- Evidence type should be 1

Introduction and Conclusions Sections

- Discussion regarding disparities and equity comes too late
- Need more explicit statement about being a *clinical* guideline, not a payer or governmental policy
- Authorship issues—few unnamed reviewers, unclear how public input was factored into the Guideline, many references had a lead author who authored the Guideline
- Must acknowledge real-world lack of access to non-opioid pain management