The 2022 CDC Clinical Practice Guideline: Context, Overview, Application, and Policy Implications

Maine Independent Clinical Information Service

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Who I Am

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I have no disclosures

Objectives

- Understand the context the CDC 2022 Clinical Practice Guideline for Prescribing Opioids for Pain are built upon, especially the prior 2016 guidelines
- Learn how to apply the updated guidelines to best support our patients and system
- Reduce stigma surrounding patients who require opioids for function
- Increase understanding of both risk and benefit of long-term opioid therapy and refine approach to potential tapering (or not tapering)

Definitions

Legacy patients– patients who have been on longstanding opioid agonist therapy.

- This term does not include clinical scenarios where the risks of opioid treatment outweighs its benefit

Agonist therapy–short for 'full' agonist (oxycodone, morphine) vs '**partial**' agonist– buprenorphine

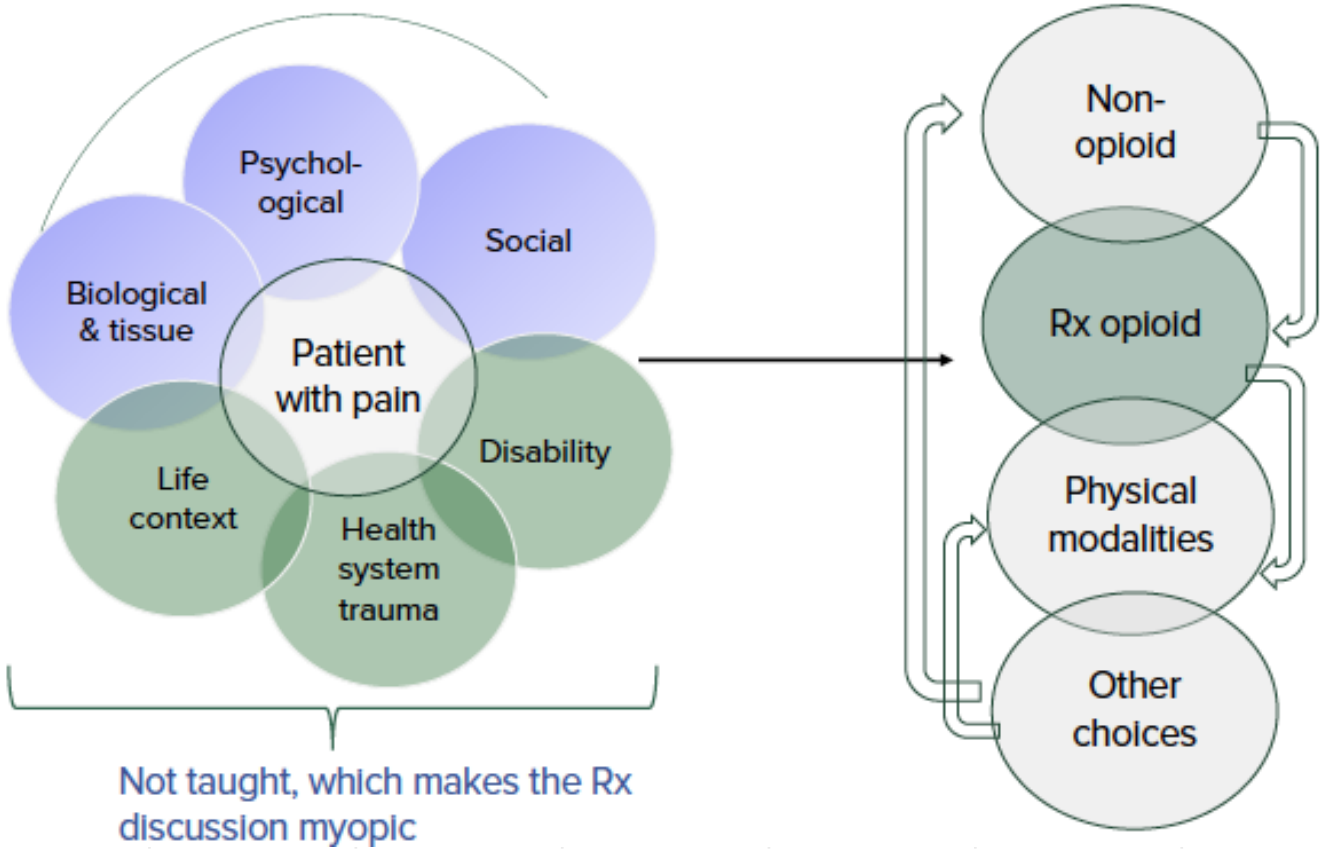
LTOT– Long Term Opioid Therapy

All **pain** discussed in the 2022 (and 2016) CDC guidelines excludes pain associated with active cancer, sickle cell anemia, palliative, or hospice care

Please Note

- This conversation may be uncomfortable to some, given the past 10-15 years of the opioid crisis and its evolution
- What I am NOT asking or even suggesting is a return to the early 00's
- Both CDC guidelines to be discussed are focused on opioid prescribing, not optimal pain care

Pain Framework



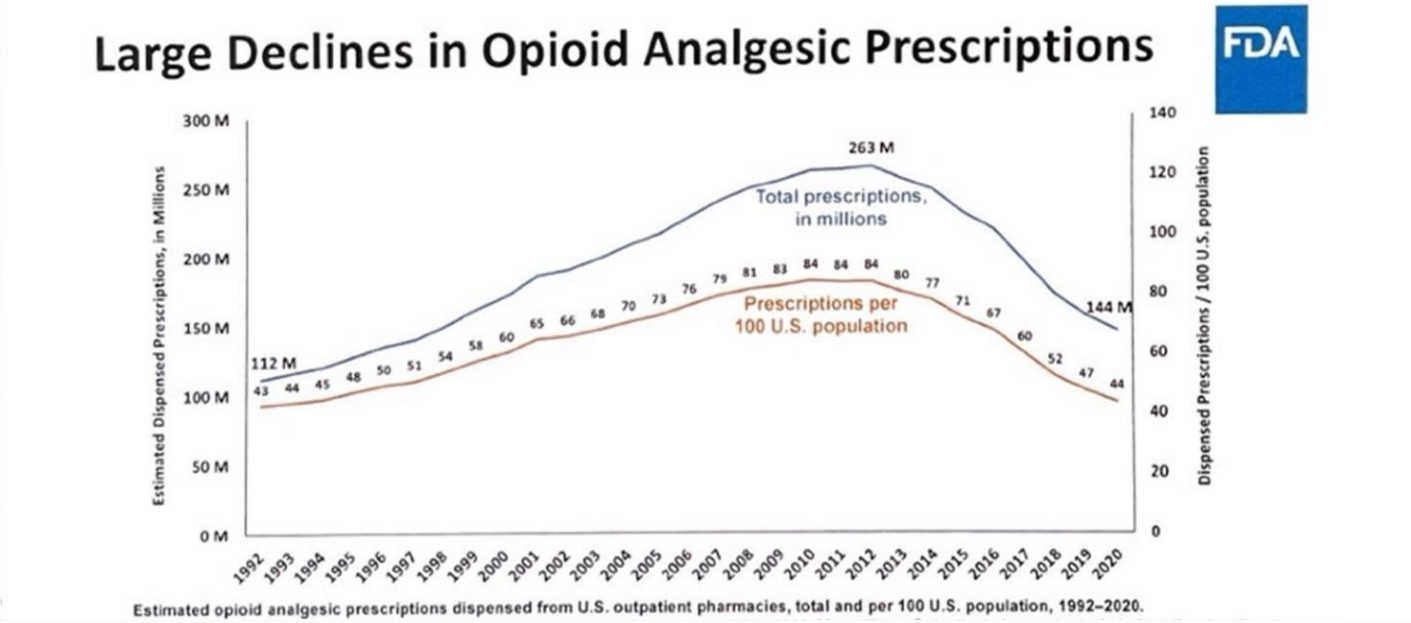
CDC's 2022 Guidline for Prescribing Opioids for Pain: the What and the Why. Kertesz, S.G. February, 2023

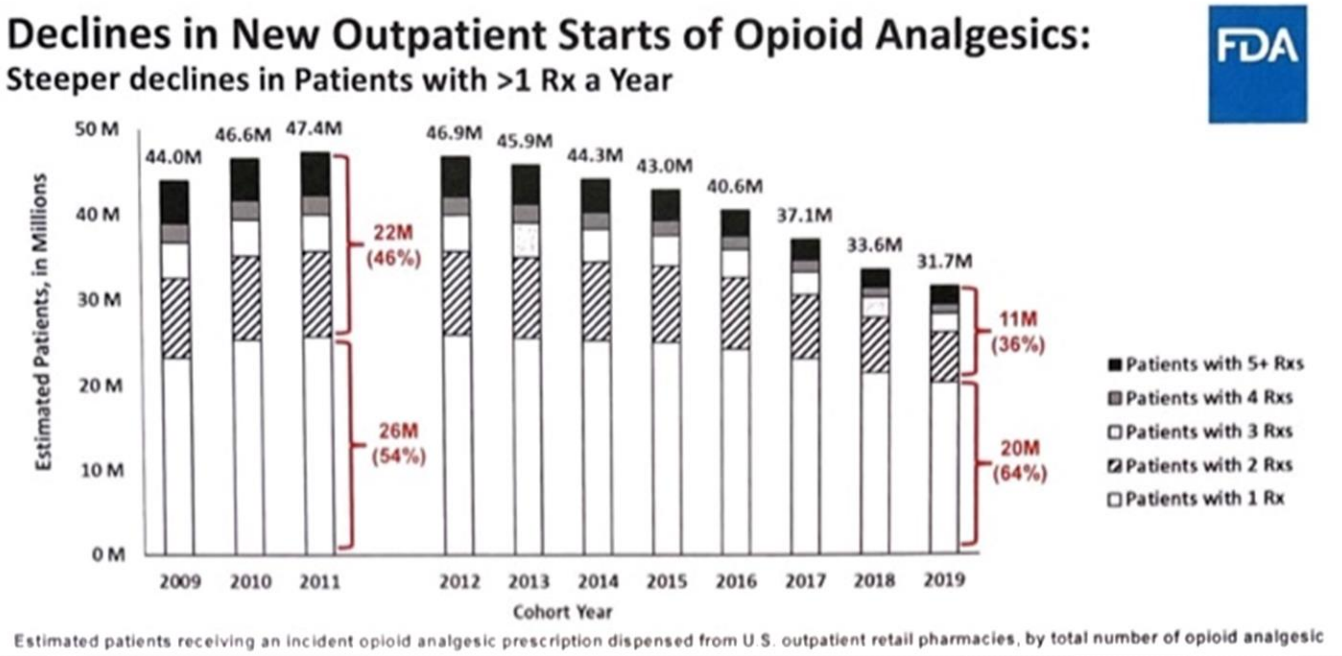
2016 CDC Guidelines: Prescribing Opioids for Chronic Pain

- Non-opioid therapy is preferred for chronic pain, unrelated to acute, cancer, or palliative care
- Opioids are not first-line or routine therapy for chronic pain and for acute pain, '3 days will often be sufficient'
- Use lowest effective dose when starting chronic opiates
- Any opioid treatment should be rooted in functionality with realistic goals for pain relief
- Clinicians should avoid ≥ 90 MME (or carefully justify why if above 90) and taper/discontinue when risks outweigh benefits

2016 CDC: Results of Rapid Application

Depending on what we are measuring or who the audience is, these had a dramatic impact.





2016 Guideline Rapid Uptake: At What Cost?

Health Professionals for Patients in Pain (2019)[1]

- An early national response addressing numerous instances of poorly applied CDC guidelines including:
  - 90 MME became *de facto* daily dose limit
  - Payer-imposed barriers
  - Explicit tapering plans required for high dose
  - Concerns over professional risk/liability
  - Alternative therapies not covered by many commercial payers (though as of today, less an issue)

A Supportive Reply: CDC Guidelines Authors: NEJM letter June 13, 2019[2]

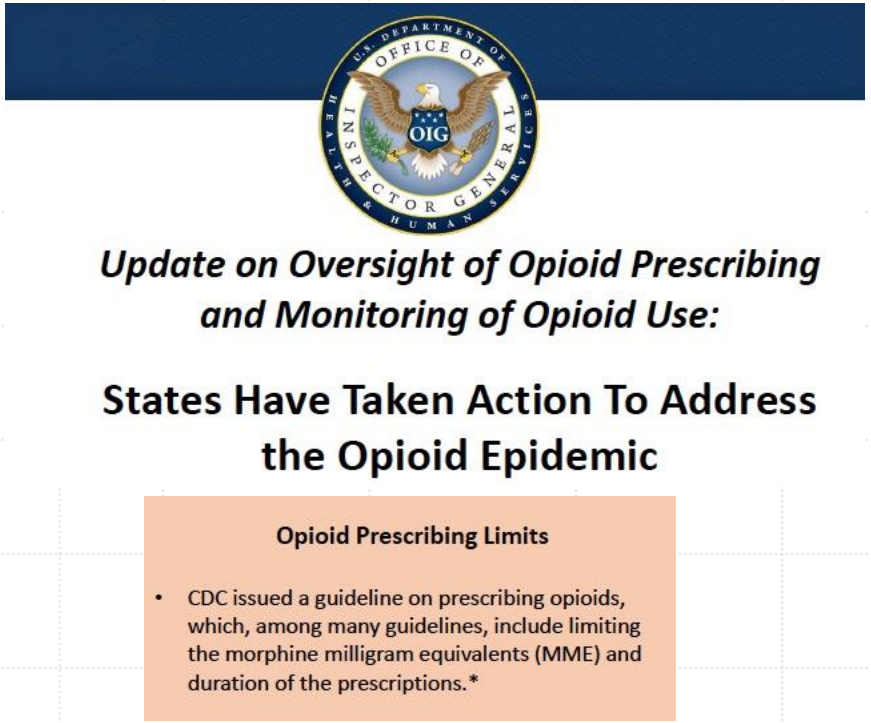
"…Applications were inconsistent and went beyond its recommendations…"

- Misapplication:
  - Toward Populations outside of guidelines, including those receiving *opiates that treat OUD*
  - Via imposing rigid limits and sudden tapers, causing rapid d/c or practice dismissal
- What they (2016 guidelines) *actually* said:
  - If patient is above 90, **justify** the decision
  - The guidelines did **not** support abrupt discontinuation unless safety acutely an issue

[1]https://healthprofessionalsforpatientsinpain.org/the-letter-1

[2]NEJM2019; 380:2285-2287 ``

State Policies: 2020 OIG Report



State-by-State Comparison:
Opioid Prescribing Limits Compared With CDC Guideline (cont.)

Texas

Medicaid policy limits opioid prescriptions to a maximum of 90 MME.

Alabama

Medicaid policy denies opioid claims that exceed a cumulative MME of 250 per day and will gradually decrease the MME limit until it reaches the CDC recommendation of 90 MME per day.

https://oig.hhs.gov/oas/reports/region9/92001000.pdf

The 2016 Legacy– Ongoing Impact

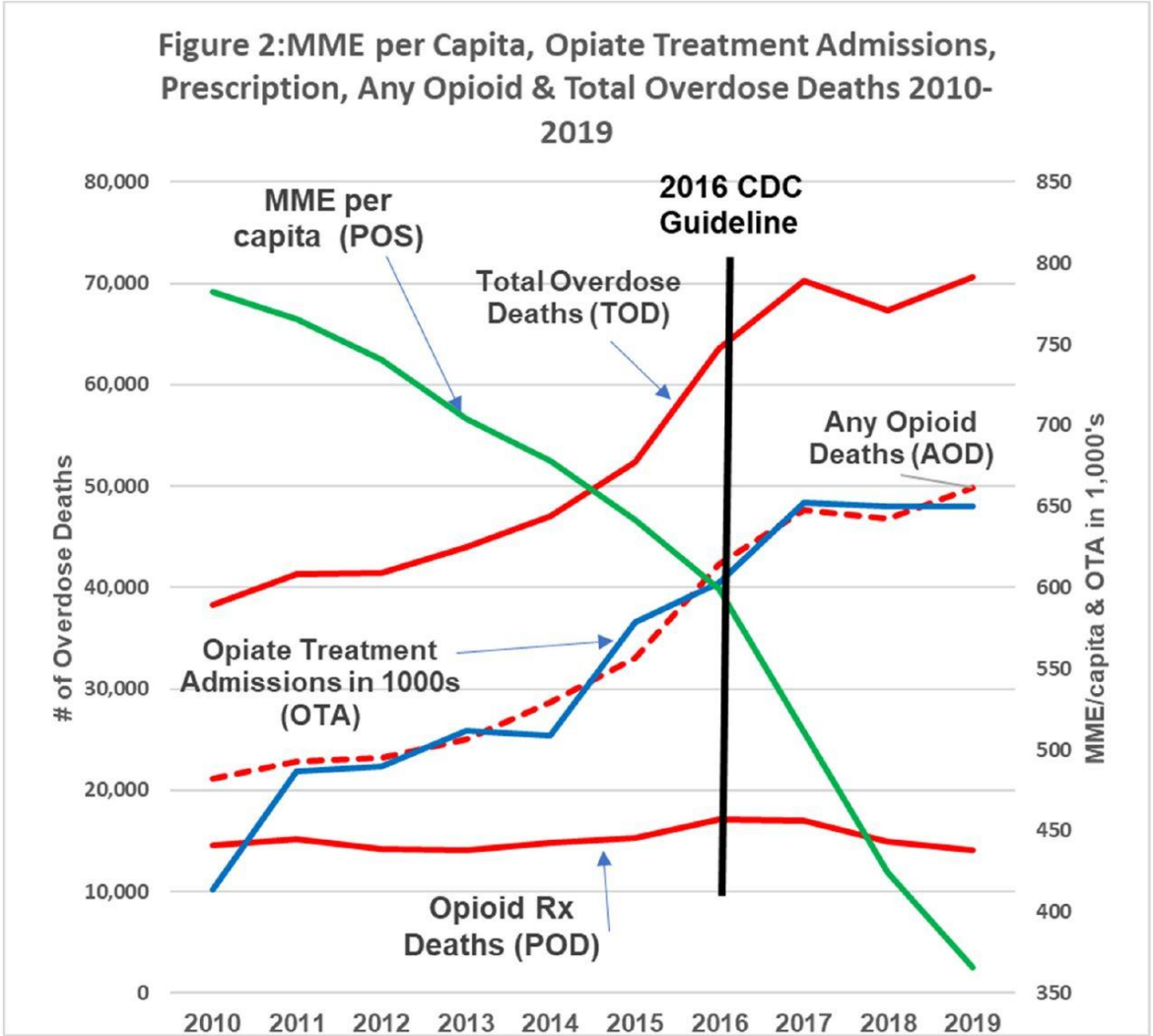
- Forced tapering's burden on mental health: Recent JAMA study showed tapering patients on chronic, higher dose therapy (≥50 MME)[1]
  - Nearly doubled the risk of precipitating a mental health crisis
  - Significantly increased the risk of overdose

- Current HEDIS Measure: Use of Opioids at High Dosage (HDO)
  - Proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 days over the defined year.

[1]https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2793299.

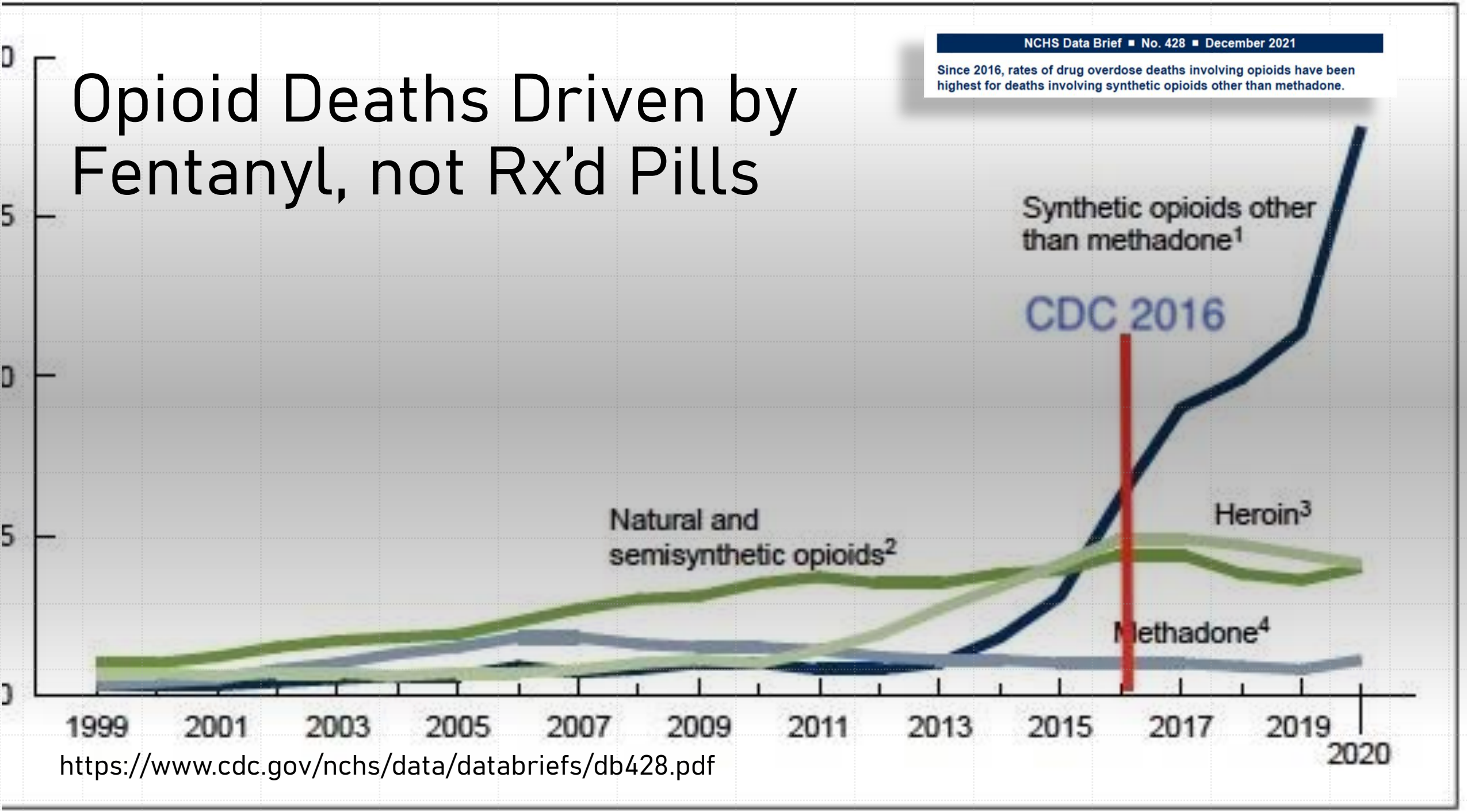
NCQA
Measuring quality.
Improving health care.

Post- 2010 Data: Prescription opioids deaths are stable



Aubrey, L., Carr, T. Relationships of Prescription Opioid Sales to Opiate Treatment Admissions and Overdose Deaths: A Reanalysis of Relationships-United States 2010-2019, *Frontiers in Pain Research.* 1 March 2022. https://doi.org/10.3389/fpain.2022.884674

Opioid Deaths Driven by Fentanyl, not Rx'd Pills



https://www.cdc.gov/nchs/data/databriefs/db428.pdf

Guiding principles for Implementation of the CDC 2022 Recommendations

- Acute, subacute, and chronic pain needs to be appropriately assessed and treated **independent of whether opioids** are part of a treatment regimen.
- Recommendations are **voluntary and are intended to support, not supplant**, individualized, person-centered care.
- A **multimodal and multidisciplinary** approach to pain management attending to the physical health, behavioral health, long-term services and supports, and expected health outcomes
- **Avoid misapplying** this clinical practice guideline beyond its intended use or implementing policies….that might lead to unintended and potentially harmful consequences for patients.
- **All parts of the health care system should vigilantly attend to health inequities….**ensure access to an appropriate, affordable, diversified, coordinated, and effective nonpharmacologic and pharmacologic pain management regimen for all persons.

2022 CDC Guidelines

What they provide

- A clinician-patient empowerment tool to help make informed, collaborative decisions
- Guidance for all outpatient clinicians treating acute, subacute, or chronic pain (> 18 y/o pts)
- Framework to allow pt centered decisions taking into account pt well-being and expected health outcomes
- Differentiation between opioid naïve and the legacy population
- Emphasis on the risk/benefit for long term opioids (especially > 50 MME)
- Done via 12 specific recommendations

2016 Guideline Clarifications

- Removing the 'avoid' for ≥90 MME
- Changed 3 day acute Rx to Inflexible standards to be applied broadly **especially** if they lead to abrupt discontinuation or rapid tapering
- Provides more resources RE treating OUD including those w/ concurrent chronic pain
- These are **not** a roadmap to **treating pain**: the focus is on best practice **opioid prescribing**.

What the 2022 CDC Guidelines Address

Determining	Determining whether or not to initiate opioids for pain (acute or chronic)
Selecting	Selecting opioids and determining opioid dosages
Deciding	Deciding duration of initial opioid prescription and conducting follow-up
Assessing	Assessing risk and addressing potential harms of opioid use

Determining Whether or not to Initiate Opioids for Pain

Recommendation #1

- Non-opioids are at least as effective as opioids for many types of acute pain
- Maximize non-Rx and non-opioid strategies first, and **only** Rx opioids if benefits>risks
- Before opioid Rx: discuss realistic benefits & known risks of opioids

Recommendation #2

- Non-opioid therapies are preferred for subacute and chronic pain
- Maximize non-pharmalcolog & non-opioid Rx first
- Only consider opioids if expected benefits for pain and function > risks
- Before starting opioids, establish tx goals for pain and function and discuss how opioids will be d/c'd if the benefits are outweighed by risks

Selecting Opioids and Determining Dosages

Recommendation #3

Independent of pain type (acute, subacute, chronic):

- Prescribe immediate release (IR) opioids instead of extended release (ER)
  - IR have a faster onset and shorter duration of action vs ER

Recommendation #4

- When initiating opioids for naïve patients independent of pain type: always start w/ the lowest effective dose
- If opioids *are* continued, evaluate risks and benefits when increasing dose is a consideration

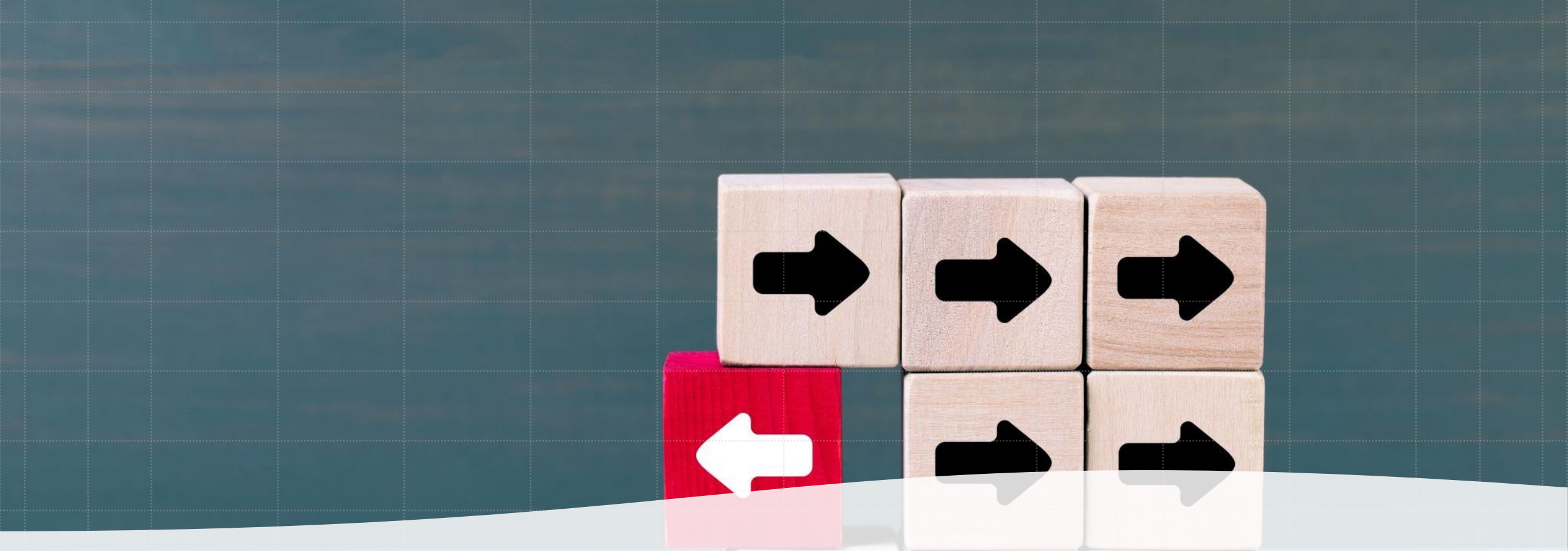
Selecting Part Two: Patients Already on Chronic Opioids

Recommendation #5

Carefully weigh benefits v risks & exercise care when changing opioid dosage

- Benefits > risks? Continue opioids but maximize non-opioid modalities/therapies
- Risks < benefits? Optimize non-pharmacologic therapies and work w/ pts in gradually tapering opioids

Unless provider concerned of impending OD, do **not** abruptly stop opioids or rapidly taper them



Risk vs Benefits? Conceptual Risk Models: Swedish and Australia

Conceptualizing Risk v Benefit

- 2022 CDC Guidelines rely on risk v benefit w/ respect to Rx initiation, continuation, and titration
  - No validated tool capturing this in a tidy way
- We should root **benefit** in evidence of improvement in pain-related functioning
  - Use evidence-based tools such as the Brief Pain Inventory or even an inventory of how ADLs are affected
- Consider **"harm-harm"** framework: the harm of opioid stoppage / taper vs the harm of continuation for a patient already on opioids[1]
- What follows are proposed frameworks to risk and benefit of LTOT

[1] https://journals.sagepub.com/doi/10.1177/08897077231190697

Conceptualizing **Risk-** Providence Swedish Epic Framework

First: Morphine Daily Dose

- < 50 Low
- 50-90 Medium
- >90 High

Third: Combine them

- If #1 is HIGH, ORT score has no effect
  - But, if ORT is > then #1 (i.e. #1 is low and ORT is mod-high), risk goes to mod or HIGH

Second: Adjust with Opioid Risk Tool

Mark each box that applies		Female	Male
1.	**Family Hx of substance abuse**		
	Alcohol	☒ 1	☐ 3
	Illegal drugs	☐ 2	☐ 3
	Prescription drugs	☐ 4	☐ 4
2.	**Personal Hx of substance abuse**		
	Alcohol	☐ 3	☐ 3
	Illegal drugs	☐ 4	☐ 4
	Prescription drugs	☐ 5	☐ 5
3.	**Age between 16 & 45 yrs**	☐ 1	☐ 1
4.	**Hx of preadolescent sexual abuse**	☐ 3	☐ 0
5.	**Psychologic disease**		
	ADD, OCD, bipolar, schizophrenia	☐ 2	☐ 2
	Depression	☐ 1	☐ 1

Credit James Babington, MD, Swedish Pain Services, Program Director, Medical Spine

Swedish Risk Model Continued

Medical co-morbidities present?

- COPD, CHF, OSA, Fall Risk, unmanaged psych condition, poor renal/hepatic fxn
  - ≥2 is suggested to indicate a 'yes'

Concurrent high-risk medications?

- Benzodiazepenes, muscle relaxants, 'z' drugs, barbituates
  - Any = yes

- Calculating Final Risk Score:
  - Take Score from previous slide
  - Factor in
    - Medical co-morbidities?
    - Concurrent high-risk Rx?
  - If no co-morbidities or high-risk Rx:
    - This will **lower** score
  - If ≥ 2 co-morbidities **or** high-risk Rx present
    - This will grade **up** score
  - Final score is either:
    - Low, moderate, or high risk

Australian Deprescribing Guidelines

- Highly focused on tapering opoids, yet does provide framework created to guide risk/benefit decisions[1].
- Rooted in GRADE[2]: recommendations for/against, conditional recommendation for/against, and consensus recommendation
- Evidence-based, ranging from very low-high certainty

[1]Langford, et al. Clinical Practice Guidelines for Deprescribing Opioid Analgesics: Summary of Recommendations. Med J Aust. 2023 Jul 17;219(2):80-89. doi: 10.5694/mja2.52002. Epub 2023 Jun 25. PMID: 37356051.
[2]Schünemann H, et al. GRADE handbook [updated Oct 2013]. GRADE Working Group, 2013. https://gdt.gradepro.org/app/handbook/handbook.html

Opioid Deprescribing Guideline Algorithm

THE UNIVERSITY OF SYDNEY

2022

Why is the person taking an opioid?

- **Acute pain**
  - Has the person been taking the opioid short term (e.g. <1 week) or infrequently?
    - **Yes** → **Opioid may be discontinued** without gradual tapering
    - **No** → **Engage the person** (discuss potential risks and benefits of deprescribing, **establish a deprescribing plan** O)
- **Chronic non-cancer pain**
- **Chronic cancer-survivor pain**
- **End-of-life pain or dyspnoea**

Does the person have a severe opioid use disorder?

- **Yes** → **Avoid deprescribing** O+++
  Provide evidence-based care, such as transition to, or referral for, medication assisted treatment of opioid use disorder
  → Review therapy and continue opioid if appropriate O
- **No**

Does the person fulfill one or more of the following criteria? O+*, O**

a) A lack of overall and clinically meaningful improvement in function, quality of life or pain
b) A lack of progress towards meeting agreed therapeutic goals
c) Experiencing serious or intolerable opioid-related adverse effects in the physical, psychological or social domains

OR

Does the person have one or more of the following clinical characteristics? O

a) Co-morbidities that may increase risk of opioid-related harms e.g. sleep-disordered breathing or sleep apnoea, chronic obstructive pulmonary disease (COPD).
b) Concomitant use of medicines or substances with sedating effects e.g. benzodiazepines, alcohol, gabapentinoids, antipsychotics and sedating antidepressants.
c) High doses of prescribed opioids.

*Chronic non-cancer pain, **Chronic cancer-survivor pain

- **Yes** → **Engage the person** (discuss potential risks and benefits of deprescribing, **establish a deprescribing plan** O)
- **No** → Review therapy and continue opioid if appropriate O

Initiate deprescribing

- Gradually taper opioids. Abrupt cessation without prior dose reduction may increase risks of harm O++
- Tailor the deprescribing plan based on the person's clinical characteristics, goals and preferences O+
- Conduct regular monitoring and review O
- Use interdisciplinary or multidisciplinary car

O Recommendation for, O Recommendation against, O Conditional Recommendation for, O Conditional Recommendation against, O Consensus Recommendation

+ Very Low Certainty Evidence, ++ Low Certainty Evidence, +++ Moderate Certainty Evidence, ++++ High Certainty Evidence (**from systematic evidence review and GRADE approach**).

Considerations for LTOT Patients w/ RF-

More on Consensus Recommendation to Begin Deprescribing

- …Consider clinical outcomes when making decisions about the appropriateness of opioid deprescribing in populations at increased risk of opioid-related harms…including the person's response to opioids in terms of their function, quality of life, pain, and adverse effects. Optimize medical management of comorbid conditions…*This may involve reducing or stopping other substances such as benzodiazepines or alcohol in addition to, or instead of, opioid deprescribing.*
- Ensure mental health connection/co-management/collaboration during this process
- When deprescribing opioids for a person taking concomitant medicines, *ensure that opioid deprescribing does not result in increased use of other substances with detrimental effect.*

Benefits- Harm vs Harm

- Benefits- when considered, provider and patient may have divergent views
  - Evidence supports harm/lack of benefit of opioids and also supports the harm done with forced tapers
  - We reply upon pt self-assessment when assessing for benefits
  - Is physiologic dependence preventing pt objectivity RE appraising benefits?

Proposal: weighing harms v harms instead of risk v benefits would guide individualized decisions, minimizing negative consequences

This Photo by Unknown Author is licensed under CC BY-SA

[1] Kertesz, S; Lagiseety, P. Harms v Harms: Rethinking Treatment for Patients on Long-Term Opioids. ttps://journals.sagepub.com/doi/10.1177/08897077231190697

Deciding Duration of Initial Opioid Rx and Follow-up Interval

Recommendation #6

For acute pain, Rx no greater amount than needed for the expected duration of pain severe enough to warrant opioids

- Avoid prescribing additional opioids to *just in case* pain continues longer than expected.
- Patients should be evaluated at least every 2 weeks if they continue to receive opioids for acute pain

Recommendation #7

Evaluate risks v benefits w/ patients within 1-4 weeks of starting opioids for *subacute or chronic pain*, or of dosage escalation.

- Clinicians should regularly re-evaluate benefits v risks of ongoing opioid therapy

Assessing Risk and Addressing Potential Harms of Opioid Use

Recommendation #8

- Before starting and during ongoing opioid therapy, evaluate risk for opioid-related harms and discuss these w/ patients
- Clinicians should work w/ patients to integrate risk mitigation strategies, including naloxone
- Use validated mental health and drug and alcohol screening tools or consult w/ behavioral health specialists
- Use Urine toxicology and PMP- see recommendation 9 and 10

Recommendation #9

- When starting opioids for any type of pain, and periodically during ongoing opioid therapy, review the patient's PMP report, looking for combinations or actions that increase a patient's risk for overdose (or indicate a use disorder- author's note, not in CDC guidelines)
  - "PMP-generated risk scores have not been validated against clinical outcomes such as overdose and should not take the place of clinical judgment"

Assessing Risk and Addressing Potential Harms of Opioid Use

Recommendation #10

- When prescribing opioids for subacute or chronic pain, consider the benefits v risks of toxicology testing to assess for Rx'd medications along with other prescribed and nonprescribed controlled substances
- "Do a UDS before starting a controlled substance, and do it periodically in an ongoing fashion so long as it is prescribed"

Recommendation #11

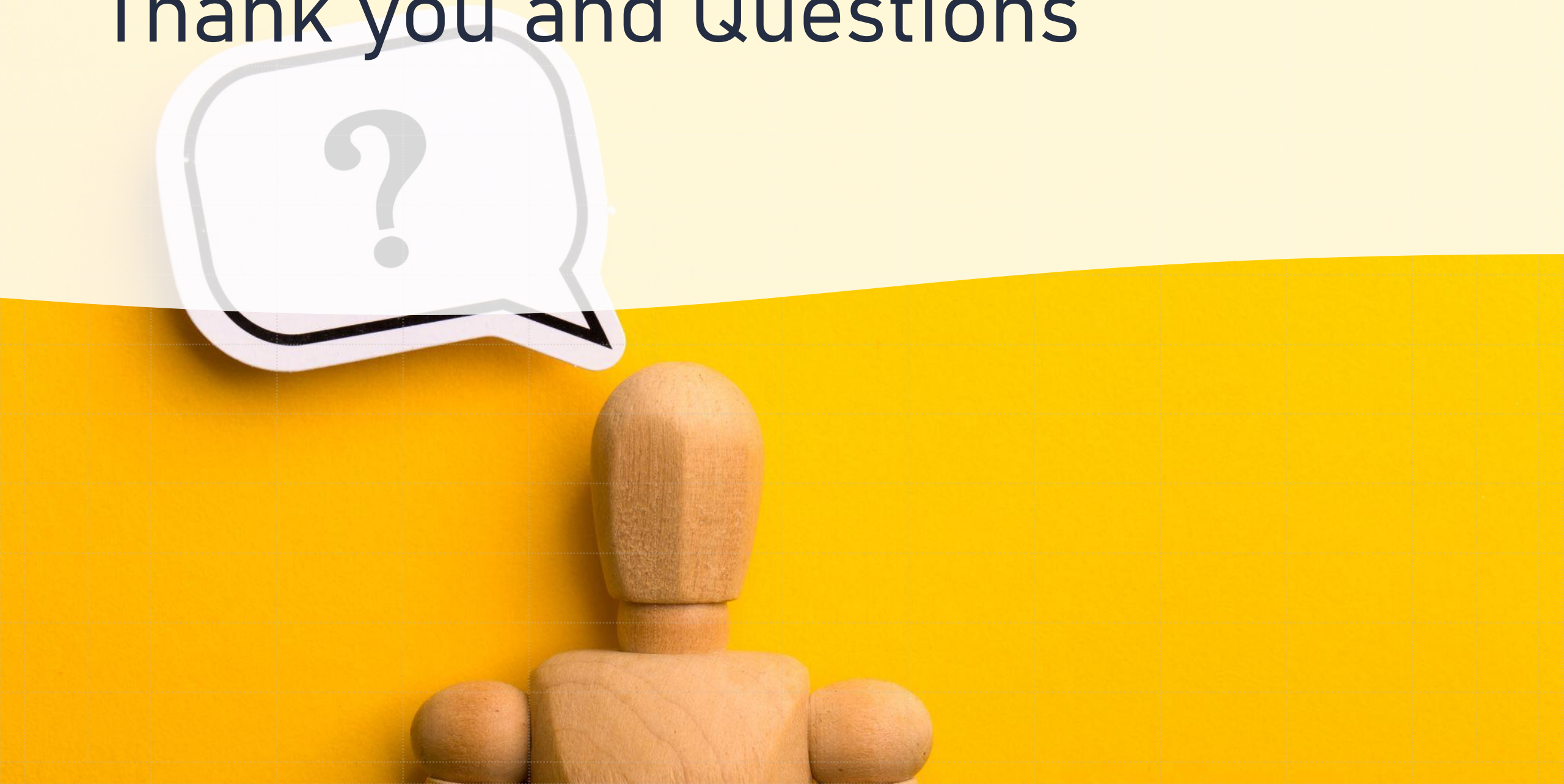
- Use particular caution when prescribing opioids and benzodiazepines concurrently
- Consider if the benefits > risks of concurrent opioid prescribing and other central nervous system depressants

Assessing Risk and Addressing Potential Harms of Opioid Use

Recommendation #12

- Offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder (OUD)
- For patients with OUD, detoxification on its own, w/o medications for OUD, is not recommended given increased risks for resuming use, overdose, and overdose death

Warnings and Recommendations

- Avoid temptation to apply an OUD diagnosis on a patient where it is not clear
- Consider adopting Complex Persistent Opioid dependence – no exact ICD-10 term- closest ***may*** be F11.2 (OUD is F11.10), though inform patient and be mindful of potential misapplication

Thank you and Questions