
CDC GUIDELINES IN PAIN MANAGEMENT WHERE ARE WE NOW?

“Improving the Way Opioids are Prescribed for Safer Chronic Pain Treatment”

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Pain Management



Disclaimer: I am on the speaker bureau for Depomed Pharmaceuticals

GOALS



- 1) Better understand why the CDC has developed these opioid prescribing guidelines.
- 2) Look more closely at and better understand the alternatives to opioids proposed by the CDC guidelines.
- 3) Understand how these guidelines affect our workers' compensation patients.

OPIOIDS AND THEIR USE

The CDC's Role



CDC'S MISSION

New CDC Opioid Prescribing Guidelines

Improving the Way Opioids are Prescribed for Safer Chronic Pain Treatment



The problem:

Existing guidelines vary in recommendations, and primary care providers say they receive insufficient training in prescribing opioid pain relievers. It is important that patients receive appropriate pain treatment, and that the benefits and risks of treatment options are carefully considered.



259 million

In 2012, health care providers wrote 259 million prescriptions for opioid pain relievers – enough for every American adult to have a bottle of pills ¹



300% increase

Prescription opioid sales in the United States have increased by 300% since 1999², but there has not been an overall change in the amount of pain Americans report^{3,4}.



2 million

Almost 2 million Americans, age 12 or older, either abused or were dependent on opioid pain relievers in 2013.⁵

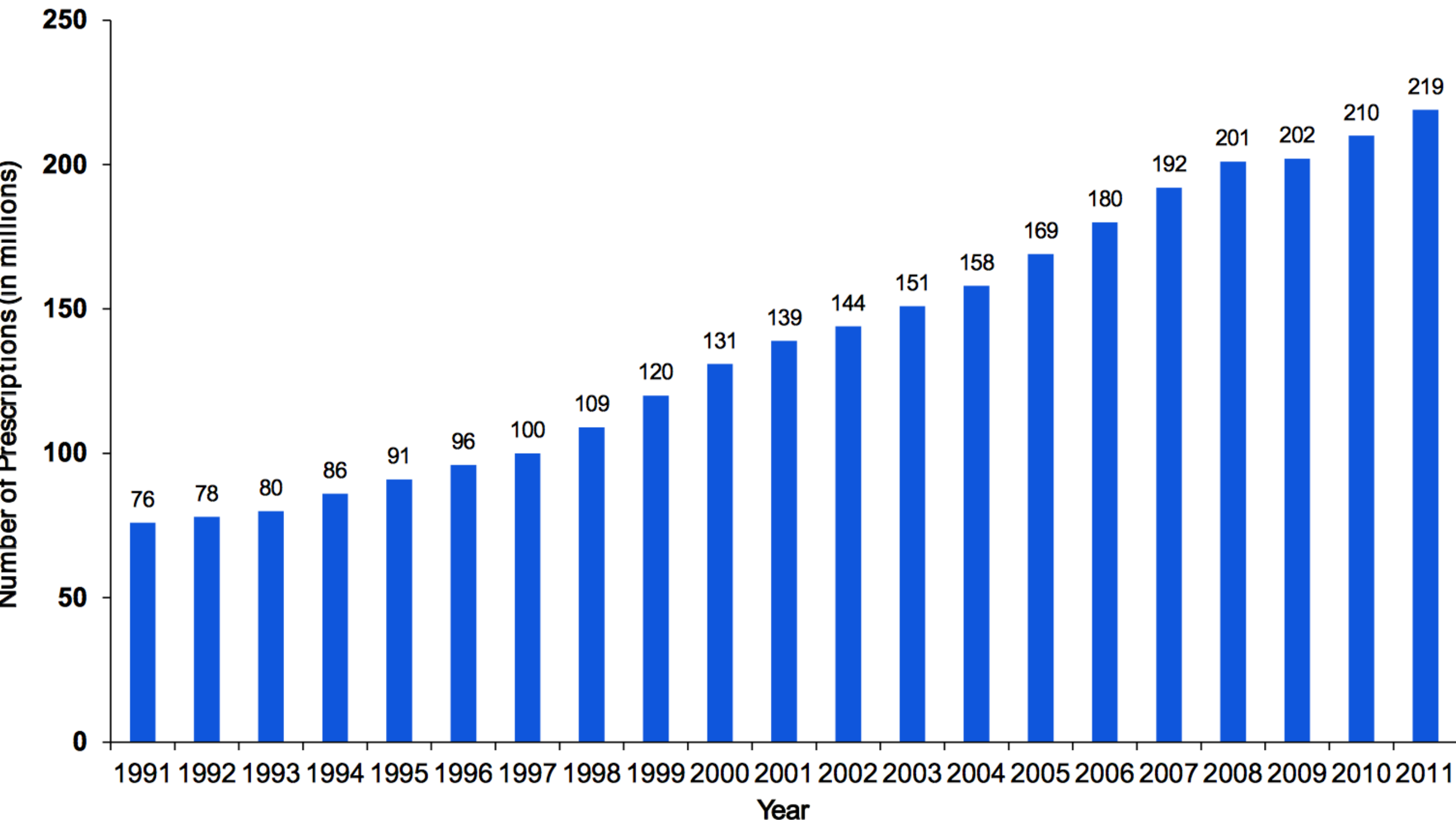


16 thousand

In 2013, more than 16,000 people died in the United States from overdose related to opioid pain relievers, four times the number in 1999.⁶

CDC [works 24/7](#) to protect America from health, safety and security threats, both foreign and in the U.S. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, CDC fights disease and supports communities and citizens to do the same.

Opioid Prescriptions Dispensed by Retail Pharmacies—United States, 1991–2011



ASAM NATIONAL STATISTICS



ASAM American Society of
Addiction Medicine

Opioid Addiction 2016 Facts & Figures

Opioid Addiction

- Opioids are a class of drugs that include the illicit drug heroin as well as the licit prescription pain relievers oxycodone, hydrocodone, codeine, morphine, fentanyl and others.¹
- Opioids are chemically related and interact with opioid receptors on nerve cells in the brain and nervous system to produce pleasurable effects and relieve pain.¹
- Addiction is a primary, chronic and relapsing brain disease characterized by an individual pathologically pursuing reward and/or relief by substance use and other behaviors.²
- Of the 21.5 million Americans 12 or older that had a substance use disorder in 2014, 1.9 million had a substance use disorder involving prescription pain relievers and 586,000 had a substance use disorder involving heroin.³
- It is estimated that 23% of individuals who use heroin develop opioid addiction.⁴

National Opioid Overdose Epidemic

- Drug overdose is the leading cause of accidental death in the US, with 47,055 lethal drug overdoses in 2014. Opioid addiction is driving this epidemic, with 18,893 overdose deaths related to prescription pain relievers, and 10,574 overdose deaths related to heroin in 2014.⁵
- From 1999 to 2008, overdose death rates, sales and substance use disorder treatment admissions related to prescription pain relievers increased in parallel. The overdose death rate in 2008 was nearly four times the 1999 rate; sales of prescription pain relievers in 2010 were

ASAM NATIONAL STATISTICS

four times those in 1999; and the substance use disorder treatment admission rate in 2009 was six times the 1999 rate.⁶

- In 2012, 259 million prescriptions were written for opioids, which is more than enough to give every American adult their own bottle of pills.⁷
- Four in five new heroin users started out misusing prescription painkillers.⁸
- 94% of respondents in a 2014 survey of people in treatment for opioid addiction said they chose to use heroin because prescription opioids were “far more expensive and harder to obtain.”⁹

Impact on Special Populations

Adolescents (12 to 17 years old)

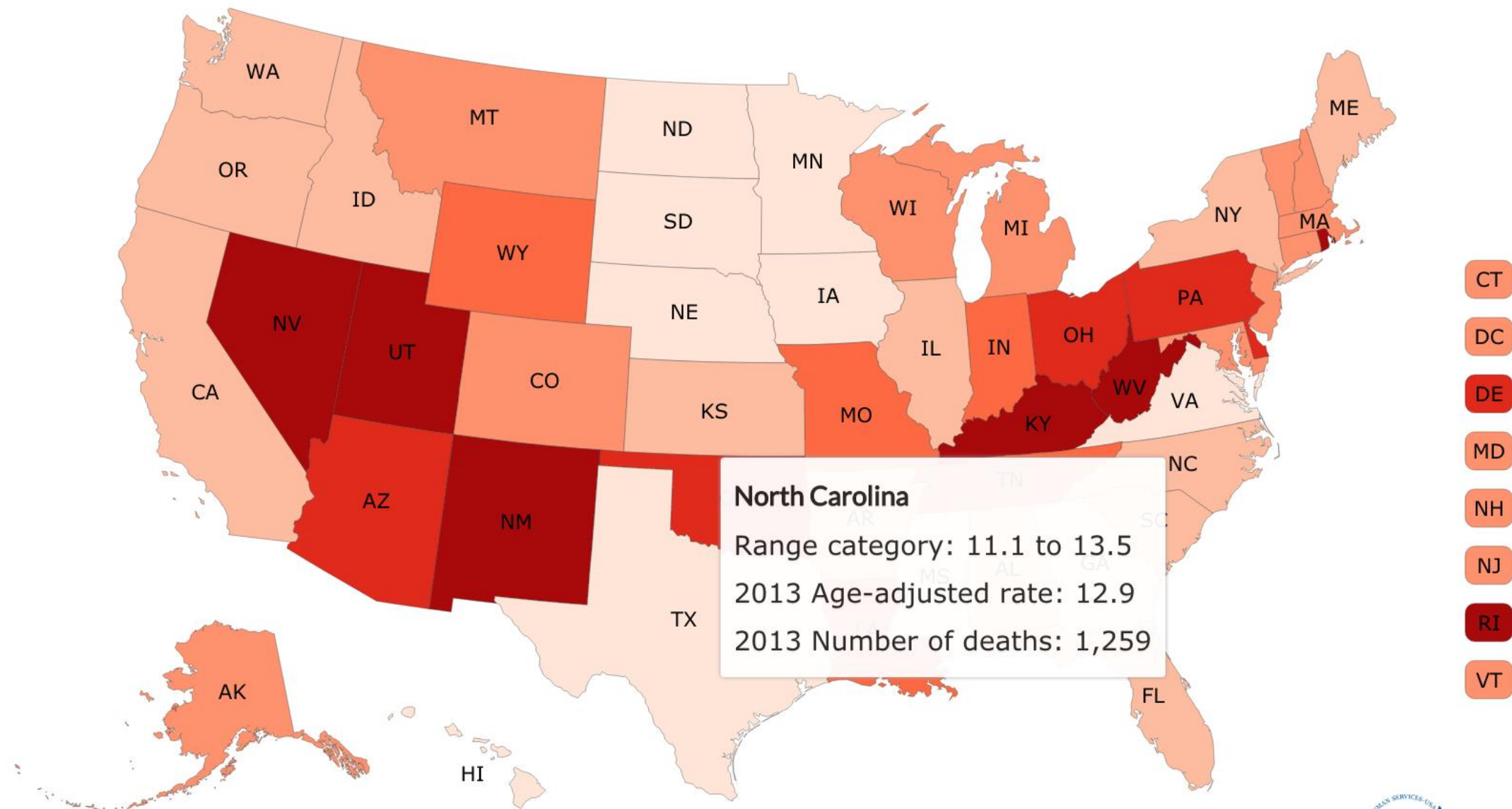
- In 2014, 467,000 adolescents were current nonmedical users of pain reliever, with 168,000 having an addiction to prescription pain relievers.³
- In 2014, an estimated 28,000 adolescents had used heroin in the past year, and an estimated 16,000 were current heroin users. Additionally, an estimated 18,000 adolescents had heroin a heroin use disorder in 2014.³
- People often share their unused pain relievers, unaware of the dangers of nonmedical opioid use. Most adolescents who misuse prescription pain relievers are given them for free by a friend or relative.¹⁰
- The prescribing rates for prescription opioids among adolescents and young adults nearly doubled from 1994 to 2007.¹¹

Women

- Women are more likely to have chronic pain, be prescribed prescription pain relievers, be given higher doses, and use them for longer time periods than men. Women may become dependent on prescription pain relievers more quickly than men.¹²
- 48,000 women died of prescription pain reliever overdoses between 1999 and 2010.¹²

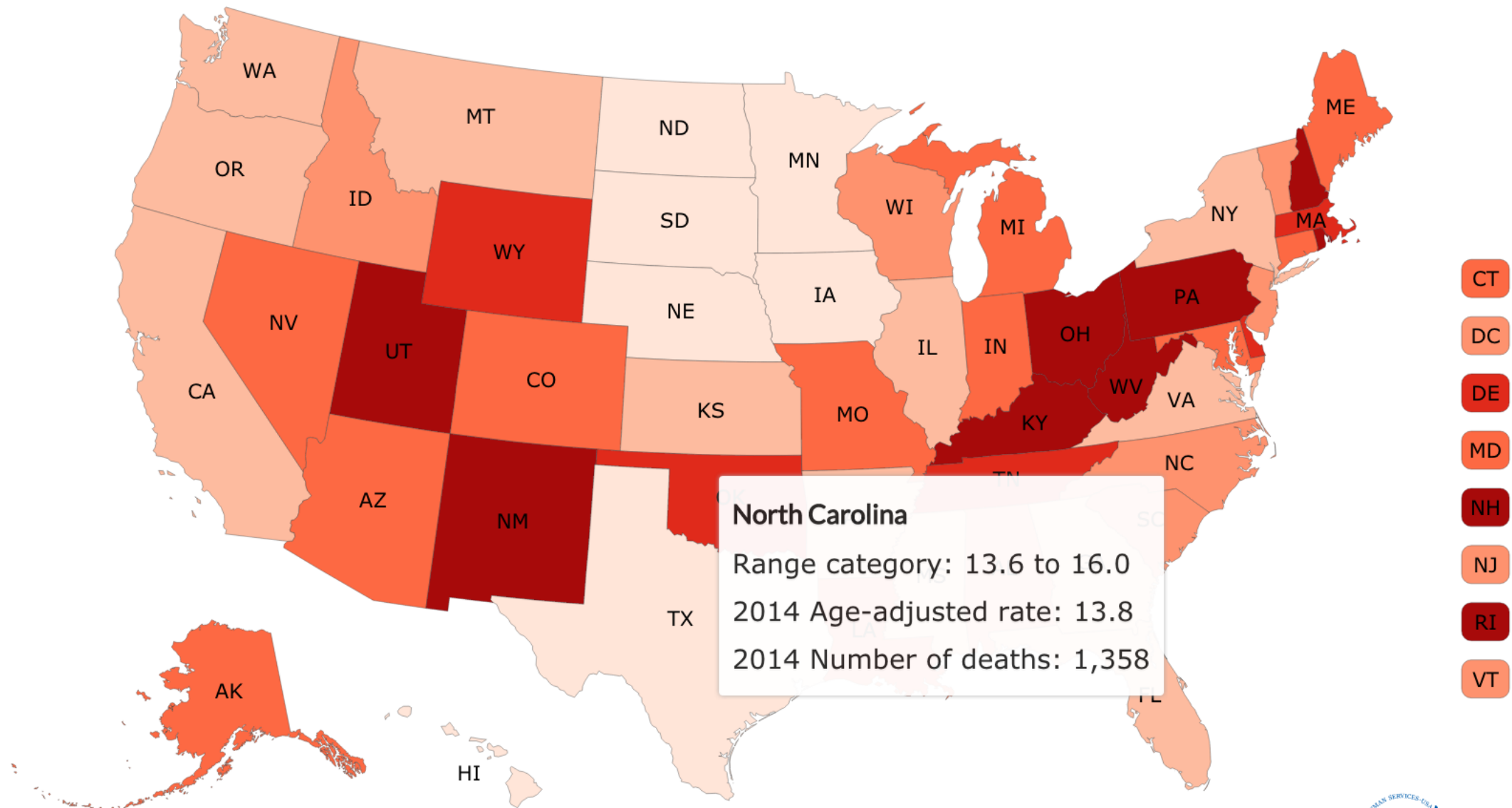
CDC OVERDOSE DATA 2013

Number and age-adjusted rates of drug overdose deaths by state, US 2013



CDC OVERDOSE DATA 2014


Number and age-adjusted rates of drug overdose deaths by state, US 2014



CDC Guidelines

Policy_for_the_Use_of_Opiate x stelprdb5437101.pdf x American Academy of Pain M x CDC Guideline for Prescribing x CDC Know The Risks x

https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

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Morbidity and Mortality Weekly Report (MMWR)


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

Recommendations and Reports / March 18, 2016 / 65(1);1–49

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On March 15, 2016, this report was posted online as an MMWR Early Release.

Please note: An erratum has been published for this report. To view the erratum, please click [here](#).

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[View suggested citation](#)

Summary

This guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. The guideline addresses 1) when to initiate or continue opioids for chronic pain; 2) opioid selection, dosage, duration, follow-up, and discontinuation; and 3) assessing risk and addressing harms of opioid use. CDC developed the guideline using the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework, and recommendations are made on the basis of a systematic review of the scientific evidence while considering benefits and harms, values and preferences, and resource allocation. CDC obtained input from experts, stakeholders, the public, peer reviewers, and a federally chartered advisory committee. It is important that patients receive appropriate pain treatment with careful consideration of the benefits and risks of treatment options.

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CDC'S ROLE IN GUIDELINES

Clinical Practice Guideline Development



“Intended to improve communication between providers and patients about the risks of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including abuse, dependence, overdose and death.”

CDC'S ROLE IN GUIDELINES



Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Guidelines from CDC are intended for *primary care providers* treating chronic pain (>3 months duration or outside of normal tissue healing), *outside* of **ACTIVE CANCER treatment, palliative care and end-of-life care.**

CDC'S ROLE IN GUIDELINES

1. Estimated 20% of patients presenting to physician offices with non cancer pain symptoms or pain related diagnosis receive an opioid Rx.
2. Opioid Rxs per capita increased 7.3% in the five years from 2007 to 2012. Rates increased more for family practice, general practice and internal medicine over that period.
3. Opioid prescriptions written by primary care providers account for nearly half of all dispensed opioids.



CDC'S ROLE IN GUIDELINES

1. When to initiate or continue opioids for chronic pain.
2. Opioid selection, dosage, duration, follow-up, and discontinuation.
3. Assessing risk and addressing harms of opioid use.

CDC'S ROLE IN GUIDELINES

Attempt to communicate to prescribers and curtail *high risk prescribing practices* that contribute to overdose risk.

- ❖ High dose prescribing
- ❖ Overlapping benzodiazepines and opioids
- ❖ ER/LA opioids for acute pain



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WHY DO WE NEED GUIDELINES NOW?

- ❖ Multiple societies with multiple recommendations.
- ❖ Multiple states and medical boards with multiple recommendations.
- ❖ While many similarities, there is much variability on range of dosing thresholds (from 90 to 200 milligrams morphine equivalent -MME/day), audience, use of evidence, and rigor of methods from studies.
- ❖ Recommendations based on most recent scientific evidence, expert opinion, stakeholder and constituent input .

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY(AHRQ)

- ❖ Previously published on the effectiveness and risks of long-term opioids in chronic pain treatment.



<http://www.effectivehealthcare.ahrq.gov/ehc/products/557/1971/chronic-pain-opioid-treatment-report-141007.pdf>2014

SO HOW DID THE CDC DO THIS THING?

1. <http://www.gradeworkinggroup.org>. Looks at types of evidence (1-4) and recommendations come in two flavors (A and B).
2. Types of evidence range from randomized controlled trials all the way to clinical experience and observations.
3. Category A: applies to all persons in a group and indicates most patients should receive recommended course of action.
4. Category B: there should be individual decision making based on different clinical situations.

EVIDENCE EVALUATED

1. Expert opinion and federal partner engagement.
2. Stakeholder comment, peer review, constituent engagement.

5 KEY QUESTIONS

- 1) The effectiveness of long-term opioid therapy versus placebo, no opioid therapy, or nonopioid therapy for long term (> 1year) outcomes related to pain, function, and quality of life, and how effectiveness varies according to type/cause of pain, patient demographics, and patient comorbidities. KQ1



5 KEY QUESTIONS

- 2) The risks of opioids versus placebo or no opioid on abuse, addiction, overdose, and other harms, and how harms vary according to the type/cause of pain, patient demographics, patient comorbidities, and dose. KQ2

5 KEY QUESTIONS

- 3) The comparative effectiveness of opioid dosing strategies (different methods for initiating and titrating opioids; immediate-release versus ER/LA opioids; different ER/LA opioids; immediate-release plus ER/LA opioids versus ER/LA opioids alone; scheduled, continuous versus as-needed dosing; dose escalation versus dose maintenance; opioid rotation versus maintenance; different strategies for treating acute exacerbations of chronic pain; decreasing opioid doses or tapering off versus continuation; and different tapering protocols and strategies) KQ3

5 KEY QUESTIONS

- 4) The accuracy of instruments for predicting risk for opioid overdose, addiction, abuse, or misuse; the effectiveness of risk mitigation strategies (use of risk prediction instruments); effectiveness of risk mitigation strategies including opioid management plans, patient education, urine drug testing, prescription drug monitoring program data (PDMP), monitoring instruments, monitoring intervals, pill counts, and abuse-deterrent formulations for reducing risk for opioid overdose, addiction, abuse, or misuse; and the comparative effectiveness of treatment strategies for managing patients with addiction.
- KQ4

5 KEY QUESTIONS

- 5) The effects of prescribing opioid therapy versus not prescribing opioid therapy for acute pain on long-term use. KQ5



GUIDELINE RECOMMENDATIONS

12 Total Recommendations in the Three Different Key Areas

1. When to initiate or continue opioids for chronic pain
2. Selection, dosage, duration, follow up and discontinuation
3. Assessing risk and addressing harms of opioid use

RECOMMENDATIONS FROM THE CDC

When to initiate or continue opioids for chronic pain:

- ❖ Only consider opioids if expected benefits are not outweighed by risks. Use all other treatments options/modalities when possible.
- ❖ Before starting opioids for chronic pain, establish treatment goals and have an exit plan. Only continue when clinically meaningful improvement in pain and function is achieved.
- ❖ Before starting opioids for chronic pain, discuss risks and realistic benefits and the responsibilities of the patient and the provider.

RECOMMENDATIONS FROM THE CDC

Opioid selection, dosage, duration, follow-up, and discontinuation:

- ❖ Start with immediate release (IR) opioids for chronic pain, not extended release (ER/LA).
- ❖ Prescribe the lowest effective dose, and caution when dosing greater than or equal to 50 morphine milligram equivalents (MME)/day. Generally avoid increasing dosage to greater than or equal to 90 MME/day.

RECOMMENDATIONS FROM THE CDC

Opioid selection, dosage, duration, follow-up, and discontinuation:

- ❖ Use lowest effective dose of immediate release opioids for acute pain, CDC recommending three or fewer days for non-traumatic pain not related to major surgery.
- ❖ Evaluate benefits and harms within 1-4 weeks of starting opioids for chronic pain. Evaluate going forward every three months or more frequently and evaluate benefits versus risks every visit. Consider tapering or discontinuing opioids if warranted.

RECOMMENDATIONS FROM THE CDC

Assessing risk and addressing harms of opioid use:

- ❖ Before starting and periodically during chronic opioid therapy consider risk mitigation strategies including prescribing naloxone.
- ❖ Review prescription drug monitoring program (PDMP) data when starting and periodically (at least every three months) during any chronic opioid therapy for chronic pain.

RECOMMENDATIONS FROM THE CDC

Assessing risk and addressing harms of opioid use:

- ❖ When prescribing opioids for chronic pain, urine drug testing (UDT) should be used before starting therapy and at least annually during therapy.
- ❖ Avoid prescribing opioids for patients on benzodiazepines (or vice-versa?) if possible.
- ❖ We should offer or arrange evidenced-based treatment (methadone or buprenorphine in combo with behavioral therapies) for patients with opioid use disorder.

ASA-American Society of Anesthesiologists Concerns



- ❖ Possibility of promoting curtailment of perioperative pain management.
- ❖ Downplaying the role of interventional procedures as a non-opioid therapy.

WHAT WE CAN DO

- ❖ Safe Opioid prescribing classes.
- ❖ Set limits.
- ❖ Understand and communicate the limitations and dangers of opioids.



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FELLOWSHIP IN A NUTSHELL

CHECKLIST

When **CONSIDERING** long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
 - Discuss risk factors with patient.
 - Check prescription drug monitoring program (PDMP) data.
 - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If **RENEWING** without patient visit

- ☐ Check that return visit is scheduled ≤ 3 months from last visit.

When **REASSESSING** at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
 - Observe patient for signs of over-sedation or overdose risk.
 - If yes: Taper dose.
 - Check PDMP.
 - Check for opioid use disorder if indicated (eg, difficulty controlling use).
 - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
 - If ≥ 50 MME/day total (≥ 50 mg hydrocodone; ≥ 33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
 - Avoid ≥ 90 MME/day total (≥ 90 mg hydrocodone; ≥ 60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤ 3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores (30% improvement from baseline is clinically meaningful)

Q1: *What number from 0–10 best describes your **pain** in the past week?*

0 = “no pain”, 10 = “worst you can imagine”

Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*

0 = “not at all”, 10 = “complete interference”

Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*

0 = “not at all”, 10 = “complete interference”

❖ Recommendations,
NOT RULES.

❖ Emphasize
thoughtful
prescribing.

New law requires continuing education in controlled substances

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New law requires continuing education in controlled substances

The recently approved NC budget appropriations act includes a new requirement for licensed physicians and physician assistants and other licensed medical professionals to complete at least one hour of the total continuing education hours required in controlled substances prescribing. The Board will consider the new law and discuss how to implement it at its January meeting.

[Read an excerpt from the budget that describes the new requirement.](#)



Notices

December, 2015

October, 2015

September, 2015

August, 2015

July, 2015

June, 2015

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SAFE OPIOID PRESCRIBING COURSES

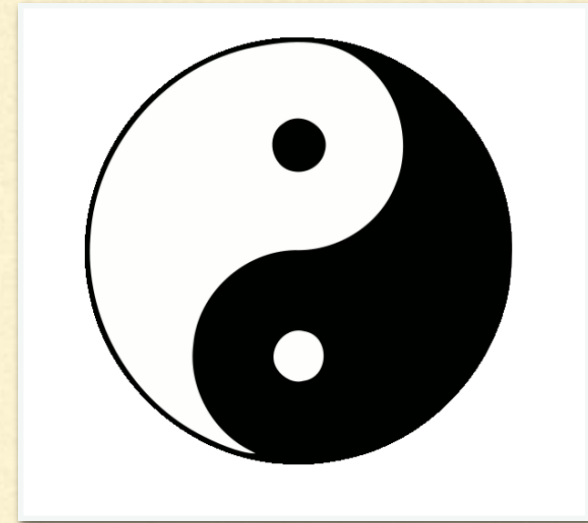


- ❖ PSOC SAFE Opioid Prescribing Course
- ❖ opiodprescribing.org
- ❖ samhsa.org



SET LIMITS AND GOALS

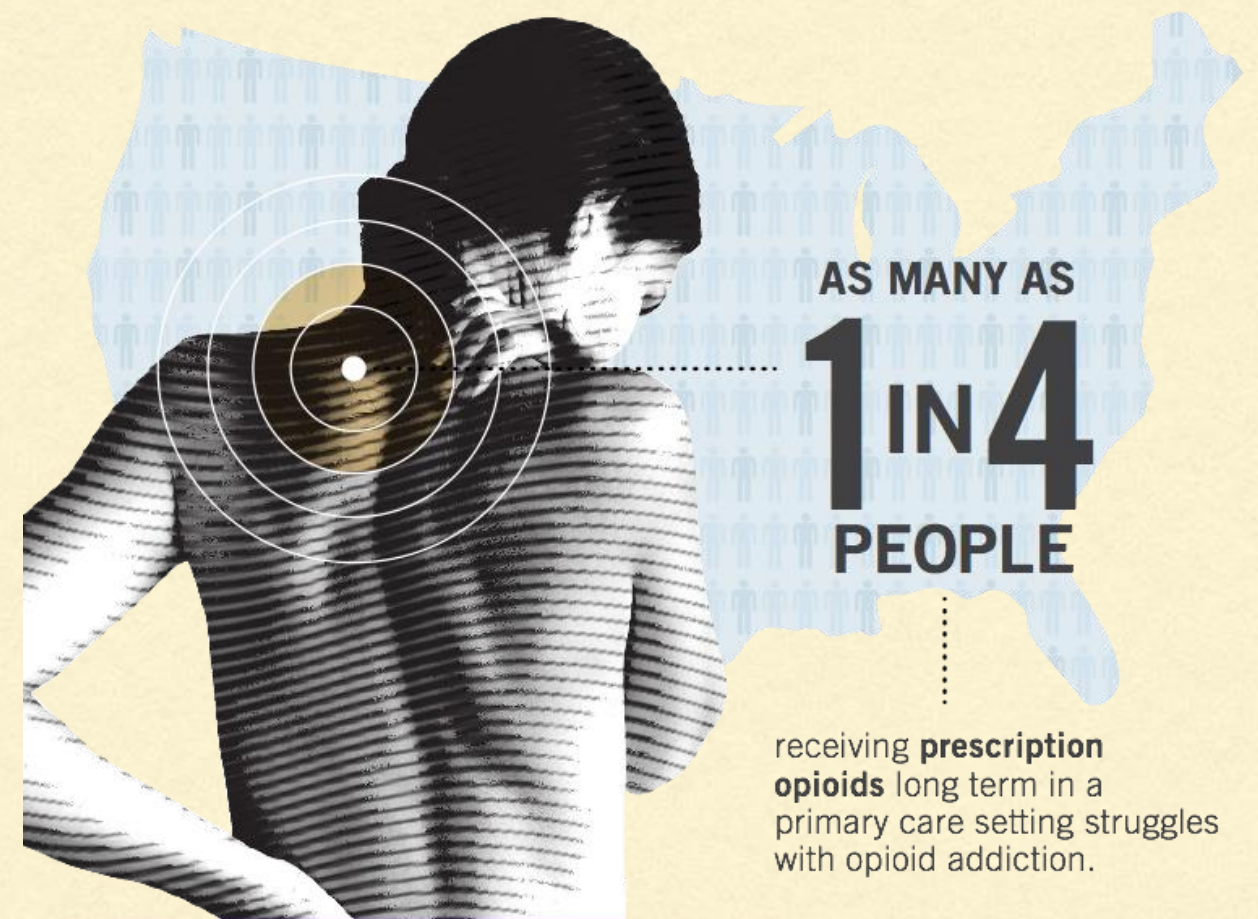
- ❖ Quantity
- ❖ Doses- 50MME? 90MME?
- ❖ Length of time to try opioids- 3 months? 6 months?



Patient Engagement

1. CDC HANDOUTS
2. ONLINE GUIDES FOR MANAGING PAIN AND OPIOIDS
3. MAKE SURE THE RISKS ARE EXPLAINED “INFORMED CONSENT”

KNOW THE RISKS



MANAGE YOUR PAIN, MINIMIZE YOUR RISK.

Chronic pain can be devastating, and effective pain management is essential to get your life back. Talk to your doctor about ways to manage your pain that don't involve prescription opioids, such as:

- Non-opioid pain relievers, such as acetaminophen (Tylenol®), ibuprofen (Advil®), or naproxen (Aleve®)
- Physical therapy and exercise
- Cognitive behavioral therapy
- Certain antidepressants and anticonvulsants



**GUIDELINE FOR PRESCRIBING
OPIOIDS FOR CHRONIC PAIN**

COMMUNICATE

- ❖ Tell patients how potentially dangerous opioids can be!
- ❖ Explain their role in preventing misuse and diversion!

CVS/Pharmacy offering naloxone prescription free

Posted: Jan 11, 2016 5:56 AM EST
Updated: Jan 15, 2016 12:48 PM EST

By: Stacey Pinno [CONNECT](#)



CVS/Pharmacy officials said they expect to be distributing Naloxone prescription free by the end of March. (Source: WECT)

NORTH CAROLINA (WECT) - CVS/pharmacy is getting on board the fight against the nationwide epidemic of prescription drug abuse.

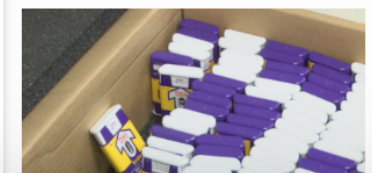
CVS/pharmacy has expanded its availability of Naloxone, an opioid overdose reversal medicine, to people who are not prescribed to it.

"Over 44,000 people die from accidental drug overdoses every year in the United States and most of those deaths are from opioids, including controlled substance pain

medication and illegal drugs such as heroin," said Tom Davis, RPh, vice president of pharmacy professional practices at CVS/pharmacy in a recent press release. "Naloxone is a safe and effective antidote

MORE

Brunswick deputies will carry Naloxone to help save those overdosing on heroin



RECOMMENDATIONS FROM THE CDC IN SUMMARY



Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

1. No evidence for long-term benefit of opioids in pain and function for chronic pain.
2. Plenty of evidence for harms from opioids.
3. Extensive evidence that versus long-term opioids, many other treatments have much less harm.

SAFE(ER) OPIOID PRESCRIBING IN REVIEW



1. Make sure we use all available nonopioid treatments first if possible.
2. We AND patients must understand limits and possible harms of opioids.
3. We must be better at saying no to opioids and explaining why.

REFERENCES

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

<http://www.effectivehealthcare.ahrq.gov/ehc/products/557/1971/chronic-pain-opioid-treatment-report-141007.pdf>2014.



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