CDC Guideline for Prescribing Opioids for Chronic Pain

Clinician Outreach and Communication Activity (COCA) Call
June 22, 2016
Accreditation Statements

CME: The Centers for Disease Control and Prevention is accredited by the Accreditation Council for Continuing Medical Education (ACCME®) to provide continuing medical education for physicians. The Centers for Disease Control and Prevention designates this live activity for a maximum of 1.0 AMA PRA Category 1 Credit™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

CNE: The Centers for Disease Control and Prevention is accredited as a provider of Continuing Nursing Education by the American Nurses Credentialing Center’s Commission on Accreditation. This activity provides 1.0 contact hour.

IACET CEU: The Centers for Disease Control and Prevention is authorized by IACET to offer 1.0 CEU’s for this program.

CECH: Sponsored by the Centers for Disease Control and Prevention, a designated provider of continuing education contact hours (CECH) in health education by the National Commission for Health Education Credentialing, Inc. This program is designed for Certified Health Education Specialists (CHES) and/or Master Certified Health Education Specialists (MCHES) to receive up to 1.0 total Category I continuing education contact hours. Maximum advanced level continuing education contact hours available are 0. CDC provider number 98614.

CPE: The Centers for Disease Control and Prevention is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. This program is a designated event for pharmacists to receive 0.1 CEUs in pharmacy education. The Course Category: This activity has been designated as knowledge-based. Once credit is claimed, an unofficial statement of credit is immediately available on TCEOnline. Official credit will be uploaded within 60 days on the NABP/CPE Monitor.

AAVSB/RACE: This program was reviewed and approved by the AAVSB RACE program for 1.0 hours of continuing education in the jurisdictions which recognize AAVSB RACE approval. Please contact the AAVSB RACE Program at race@aavsb.org if you have any comments/concerns regarding this program’s validity or relevancy to the veterinary profession.

CPH: The Centers for Disease Control and Prevention is a pre-approved provider of Certified in Public Health (CPH) recertification credits and is authorized to offer 1 CPH recertification credit for this program.
Continuing Education Disclaimer

CDC, our planners, presenters, and their spouses/partners wish to disclose they have no financial interests or other relationships with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters, with the exception of Dr. David Tauben. Dr. Tauben would like to disclose that his employer, the University of Washington, received a contract payment from the Centers for Disease Control and Prevention.

Planners have reviewed content to ensure there is no bias.

This presentation will include discussion of the off-label use of medications with evidence-based indications for pain.
Objectives

At the conclusion of this session, the participant will be able to:

- Describe what is known about effectiveness and risks of long-term opioid therapy for chronic pain.
- Discuss how to determine when opioids should be initiated or continued for chronic pain, and when should they be discontinued.
- Discuss recommendations for opioid selection and dosage for chronic pain.
- Describe strategies that can be used to assess risk and address harms of opioid use.
## Save-the-Dates

Mark your calendar for the upcoming opioid prescribing calls

<table>
<thead>
<tr>
<th>Call No.</th>
<th>Date</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>June 22</td>
<td>Guideline for Prescribing Opioids for Chronic Pain</td>
</tr>
<tr>
<td>2</td>
<td>July 27</td>
<td>Non-Opioid Treatments</td>
</tr>
<tr>
<td>3</td>
<td>August 3</td>
<td>Assessing Benefits and Harms of Opioid Therapy</td>
</tr>
<tr>
<td>4</td>
<td>August 17</td>
<td>Dosing and Titration of Opioids</td>
</tr>
</tbody>
</table>
TODAY’S PRESENTER

Tamara Haegerich, PhD
Deputy Associate Director for Science
National Center for Injury Control and Prevention
Centers for Disease Control and Prevention
Deborah Dowell, MD, MPH
Senior Medical Advisor
National Center for Injury Control and Prevention
Centers for Disease Control and Prevention
TODAY’S PRESENTER

David J. Tauben, MD, FACP
Clinical Associate Professor and Chief
Department of Anesthesia and Pain Medicine
University of Washington
Disclaimer

The findings and conclusions in this presentation are those of the author(s) and do not necessarily represent the views of the Centers for Disease Control and Prevention/the Agency for Toxic Substances and Disease Registry
CDC Guideline for Prescribing Opioids for Chronic Pain

Tamara Haegerich, PhD
Deborah Dowell, MD, MPH

June 22, 2016
Chronic Pain and Prescription Opioids

• 11% of Americans experience daily (chronic) pain
• Opioids frequently prescribed for chronic pain
• Primary care providers commonly treat chronic, non-cancer pain
  – account for ~50% of opioid pain medications dispensed
  – report concern about opioids and insufficient training
The amount of opioids prescribed has **QUADRUPLED** from 1999-2014, but the pain that Americans report remains **UNCHANGED**.
Since 1999, there have been more than 165,000 deaths from overdose related to prescription opioids.
Purpose, Use, and Primary Audience

• Primary Care Providers
  – Family medicine, Internal medicine
  – Physicians, nurse practitioners, physician assistants
• Treating patients ≥18 years with chronic pain
  – Pain longer than 3 months or past time of normal tissue healing
• Outpatient settings
• Does not include active cancer treatment, palliative care, and end-of-life care
Guideline Development Process

• Guideline Development Process: The main steps are analyze, consult, comment, and review. The detailed steps are Systematic Literature Review, CDC Draft Recommendations, Core Expert Group Consultation, CDC Draft Guideline, Core Expert and Stakeholder Review, Federal Partner Review, Peer Review, Constituent Input (Webinar), CDC Revised Guideline, FRN Public Comment, Federal Advisory Committee Review, and Publication of Guideline (March 15, 2016)
GRADE Method

- Standard for guideline development
- Transparent approach for conducting systematic review, rating quality of evidence, and determining strength of recommendations
- Used by > 100 organizations
- Recommendations based on:
  - Quality of evidence
  - Balance between benefits and harms
  - Values and preferences
  - Cost
GRADE Evidence Types

- Evidence Types:
  - Type 1: Randomized controlled trials (RCTs); overwhelming observational studies
  - Type 2: RCTs (limitations); strong observational
  - Type 3: RCTs (notable limitations); observational
  - Type 4: RCTs (major limitations); observational (notable limitations) clinical experience
GRADE Recommendation Categories

- Recommendation categories:
  - Category A: applies to all patients; most patients should receive recommended course of action
  - Category B: individual decision making required; providers help patients arrive at decision consistent with values/preferences and clinical situation
Clinical Evidence Summary

• No long-term (> 1 year) outcomes in pain/function; most placebo-controlled trials < 6 weeks
• Opioid dependence in primary care: 3%-26%
• Dose-dependent association with risk of overdose/harms
• Inconsistent results for different dosing protocols; initiation with LA/ER increased risk of overdose
• Methadone associated with higher mortality risk
• No differences in pain/function with dose escalation
• Risk prediction instruments have insufficient accuracy for classification of patients
• Increased likelihood of long-term use when opioids used for acute pain
Effective nonpharmacologic therapies: exercise, cognitive behavioral therapy (CBT), interventional procedures

Effective nonopioid medications: acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), anticonvulsants, antidepressants

Opioid-related overdose risk is dose-dependent

Factors that increase risk for harm: pregnancy, older age, mental health disorder, substance use disorder, sleep-disordered breathing

Providers lack confidence in ability to prescribe safely and are concerned about opioid use disorder

Patients are ambivalent about risks/benefits and associate opioids with addiction
Organization of Recommendations

- The 12 recommendations are grouped into three conceptual areas:
  - Determining when to initiate or continue opioids for chronic pain
  - Opioid selection, dosage, duration, follow-up, and discontinuation
  - Assessing risk and addressing harms of opioid use
Determine when to initiate or continue opioids for chronic pain
Opioids not first-line or routine therapy for chronic pain

- Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain.
- Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient.
- If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

(Recommendation category A: Evidence type: 3)
Establish and measure progress toward goals

- Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks.
- Clinicians 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)
Discuss benefits and risks with patients

- Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

(Recommendation category A: Evidence type: 3)
Opioid selection, dosage, duration, follow-up, and discontinuation
Use immediate-release opioids when starting

- When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

(Recommendation category A: Evidence type: 4)

Additional cautions for
- Methadone
- Transdermal fentanyl
- Immediate-release opioids combined with ER/LA opioids
Use caution at any dose and avoid increasing to high dosages

- When opioids are started, clinicians should prescribe the lowest effective dosage.
- Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when 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.

(Recommendation category A: Evidence type: 3)
Prescribe no more than needed

• Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians 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.

• 3 days or less will often be sufficient; more than 7 days will rarely be needed.

(Recommendation category A: Evidence type: 4)
Offer a taper if opioids cause harm or are not helping

• Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation.

• Clinicians 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, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

(Recommendation category A: Evidence type: 4)
Assessing risk and addressing harms of opioid use
Evaluate and address risks for opioid-related harms

• Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms.

• Clinicians 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, higher opioid dosages (>50 MME/day), or concurrent benzodiazepine use, are present.

(Recommendation category A: Evidence type: 4)
Check PDMP for high dosages and dangerous combinations

• Clinicians should review the patient’s history of controlled substance prescriptions using state PDMP data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him/her at high risk for overdose.

• Clinicians 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)
Test urine for prescribed opioids and other drugs

• When prescribing opioids for chronic pain, clinicians 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)
Avoid concurrent opioid and benzodiazepine prescribing

- Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

(Recommendation category A: Evidence type: 3)
Treat patients for opioid use disorder (OUD) if needed

- Clinicians 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: 2)
Implementation Resources
Resources

- Fact sheets
  - New Opioid Prescribing Guideline
  - Assessing Benefits and Harms of Opioid Therapy
  - Prescription Drug Monitoring Programs
  - Calculating Total Daily Dose of Opioids for Safer Prescribing
  - Pregnancy and Opioid Pain Medications
Checklist for prescribing opioids for chronic pain

**Checklist**

**When CONSIDERING long-term opioid therapy**
- Set realistic goals for pain and function based on diagnosis (e.g., walk around the block).
- Check that non-opioid therapies tried and optimized.
- Discuss benefits and risks (e.g., 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 (e.g., PEG scale).
- Schedule initial reassessment within 1-4 weeks.
- Prescribe short-acting opioids using lowest dosage or 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 (e.g., PEG), compare results to baseline.
- Evaluate risk of harm or misuse:
  - Observe patient for signs of overdose or overdose risk.
  - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (e.g., 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 ≥250 MME/day total (≥60 mg hydrocodone, ≥30 mg oxycodone), increase frequency of follow-up; consider offering multidisciplinary care.
  - 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 well supported by evidence.
- Short-term benefits overall to moderate for pain, nonaspirin 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:
- Nonopioid medications (e.g., NSAIDs, TCAs, SNRIs, anti-epileptics).
- Physical treatments (e.g., exercise therapy, weight loss).
- Behavioral treatment (e.g., CBT).
- Procedures (e.g., intrathecal catheters).

**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 (e.g., depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

**Urinary 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 of 3 individual question scores
(10% improvement from baseline is clinically meaningful)

1. What number from 0-10 best describes your pain in the past week?
   - 0 = “no pain”; 10 = “worst pain you can imagine”
2. 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”
3. 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”
CDC Guideline for Prescribing Opioids for Chronic Pain

FEASIBILITY for PRIMARY CARE PROVIDERS

David Tauben, MD, FACP
Clinical Professor and Chief
UW Division of Pain Medicine
Hughes M & Katherine G Blake Endowed Professor
Depts of Medicine and Anesthesia & Pain Medicine
University of Washington, Seattle WA
IS IT POSSIBLE TO CHANGE YOUR PRACTICE?

• Feasible
  o Capable of being done or carried out;
  o Capable of being used or dealt with successfully;
  o Reasonable
  o Likely
    – Merriam Webster Dictionary

• Imperative
  o “Above all, do no harm” – Hippocrates

• Practical
  o “Vision without execution is hallucination” – Thomas Edison
This line graph shows the age-adjusted rates (per 100,000) of unintentional prescription opioid involved overdoses (both deaths and non-fatal hospitalizations) in Washington State, from 1995 to 2014.

WASHINGTON STATE’S SUCCESS

Source: Jennifer Sabel PhD Epidemiologist, WA State Department of Health, May 2016
KEY ELEMENTS

Guideline Compliant Care

• Team approach with pain champion(s)
• Shared clinic policies and assessment tools
  o Consensus for a pain “standard of care”
  o Focus on functional gains
  o Address opioid safety and efficacy
• Emphasis on a multimodal treatment approach
• Address substance use disorders and have referral options with a defined referral process
• Patient self-management classes and support
• Longer visits
• After visit care with Case or Care managers
• Web-based program with Tele-mentoring and E-consults

Courtesy of Dr. Melissa Weimer, OHSU
1. Highstreet Medical Center, Springfield, MA
2. Boston Medical Center’s TOPCARE, MA
3. Community Hospital of the Monterey Peninsula, CA
4. Duke University Health System, NC
5. Group Health (Seattle) Learning Health Systems, WA
6. Kaiser Permanente’s Southern California Medical Group
7. Lancaster General Health/Penn Medicine, PA
8. Medford Oregon’s Opioid Prescribing Group, OR
9. Oregon Health & Science University’s PROPEL clinic, OR
10. Priority Health (HMO), Lansing, MI
11. Rhode Island/Miriam Hospitals
12. Temple University Hospital Systems, PA
13. VA/DoD Health systems nationwide: Connecticut, Minneapolis, Indianapolis, Seattle/Puget Sound
14. University of Washington and its UW Neighborhood Clinics

Will you add your clinical practice here: __________________?
AN URGENCY

Guideline Compliant Care

- Epidemic in America
  - Influenza Pandemic (1918: 500,000)
  - HIV (1981-2005: 550,000)
  - Prescription Opioid ODs (1999-2014: 165,000, and counting)
- Families and communities are suffering from opioid-related accidental deaths and addictions
- Health care expenses can be reduced with multidisciplinary chronic pain care:
  - Reduce direct costs 70%
  - Reduce disability costs 40%

1Gatchel 2006
Understand Safe & Effective Chronic Pain Treatments

1. For Clinicians
   • **CDC Guidelines**, & your state’s guidelines
   • UW’s “COPE REMS”  [www.coperems.org](http://www.coperems.org)

2. For Patients and Families
   • YouTube: “Understand Pain”, “Brainman Stops His Opioids”
   • Stanford’s: Chronic Pain Self Management Program
   • U. Michigan’s: fibroguide.com
   • American Chronic Pain Association

3. For Policymakers and Payers
   • National Pain Strategy
   • IOM 2011 Report: Relieving Pain in America
Step 2: Assess

✔ Does your practice:

- Use registries and regular review based on dose (MME)
- Measure and track function (e.g. PEG) and mood (e.g. PHQ’s, GAD, PC-PTSD) when prescribing chronic opioids
- Screen for Misuse/Addiction Risks (e.g. ORT, SOAPP, DIRE)*
- Adhere to monitoring policies and procedures: PDMP, UDT
- Enter Care Agreements & Informed Consent re benefits & harms
- Screen for Medical Risks: e.g. sleep apnea, benzodiazepine use
- Follow protocols for OD high risk/naloxone prescribing
- Have Buprenorphine licensees? And actually prescribe?
- Process for interprofessional referrals? (CBT, PT/OT, Rehab, Addiction)

*widely used, though poor predictive validity
• **You**, confident of your care provider relational skills, compassion, and capacity to learn and deliver best-practice pain care.

• **Your multidisciplinary/interprofessional pain care team**...

• …Enabled and enlarged by policies and processes that **your organization’s medical and administrative leadership** will need to support.

• **Your patients and families**, since successful chronic pain treatment requires patient engagement and self-management.
Transformation is a process, it doesn’t happen all at once

- **Start** with a *sense of urgency*
- **Identify** your team and its champions
- **Engage & communicate** goals within your group and throughout the larger organization
- **Prioritize** internal and external obstacles, and introduce steps that overcome initial barriers
- **Get** quick wins
- **Build** IT and other resources needed to support change
- Regularly **review** and **sustain** processes
1. AHRQ Quality Measures: Assessment and management of chronic pain

   www.agencymeddirectors.wa.gov


To Ask a Question

- **Using the Webinar System**
  - “Click” the Q&A tab at the top left of the webinar tool bar
  - “Click” in the white space
  - “Type” your question
  - “Click” ask

- **On the Phone**
  - Press Star (*) 1 to enter the queue
  - State your name
  - Listen for the operator to call your name
  - State your organization and then ask your question
Thank you for joining!
Please email us questions at coca@cdc.gov

Centers for Disease Control and Prevention
Atlanta, Georgia
http://emergency.cdc.gov/coca
Today’s webinar will be archived

When: A few days after the live call

What: All call recordings (audio, webinar, and transcript)

Where: On the COCA Call webpage

http://emergency.cdc.gov/coca/calls/2016/callinfo_062216.asp
Continuing Education guidelines require that the attendance of all who participate in COCA Conference Calls be properly documented. All Continuing Education credits/contact hours (CME, CNE, CEU, CECH, ACPE, CPH, and AAVSB/RACE) for COCA Conference Calls/Webinars are issued online through the CDC Training & Continuing Education Online system (http://www.cdc.gov/TCEOnline/).

Those who participate in the COCA Conference Calls and who wish to receive CE credit/contact hours and will complete the online evaluation by July 21, 2016 will use the course code WC2286. Those who wish to receive CE credits/contact hours and will complete the online evaluation between July 22, 2016 and June 21, 2018 will use course code WD2286. CE certificates can be printed immediately upon completion of your online evaluation. A cumulative transcript of all CDC/ATSDR CE’s obtained through the CDC Training & Continuing Education Online System will be maintained for each user.
## Save-the-Dates

Mark your calendar for the upcoming opioid prescribing calls

<table>
<thead>
<tr>
<th>Call No.</th>
<th>Date</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>June 22</td>
<td>Guideline for Prescribing Opioids for Chronic Pain</td>
</tr>
<tr>
<td>2</td>
<td>July 27</td>
<td>Non-Opioid Treatments</td>
</tr>
<tr>
<td>3</td>
<td>August 3</td>
<td>Assessing Benefits and Harms of Opioid Therapy</td>
</tr>
<tr>
<td>4</td>
<td>August 17</td>
<td>Dosing and Titration of Opioids</td>
</tr>
</tbody>
</table>
Upcoming COCA Call
registration is not required

Identification and Care of Patients with Hantavirus Disease

- Date: Thursday, June 30, 2016
- Time: 2:00 – 3:00 pm (Eastern)
- Presenters:
  - Dr. Barbara Knust – CDC
  - Dr. Gregory Mertz – University of New Mexico
  - Dr. Michelle Harkins – University of New Mexico

http://emergency.cdc.gov/coca
Join Us on Facebook

CDC Facebook page for clinicians! “Like” our page today to learn about upcoming COCA Calls, CDC guidance and recommendations, and about other health alerts.

CDC Clinician Outreach and Communication Activity
https://www.facebook.com/CDCClinicianOutreachAndCommunicationActivity