

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

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# Who I Am

- **Andrew Suchocki, MD, MPH, FAAFP**
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# Objectives

- Understand the context the CDC 2022 Clinical Practice Guideline for Prescribing Opioids for Pain are built upon
- Learn how to apply the guidelines to best support our patients and system
- Reduce stigma surrounding patients who require opioids for function
- Explore how the guidelines formal adoption can support a variety of state-wide professional organizations policy implications



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 new 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 potential 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

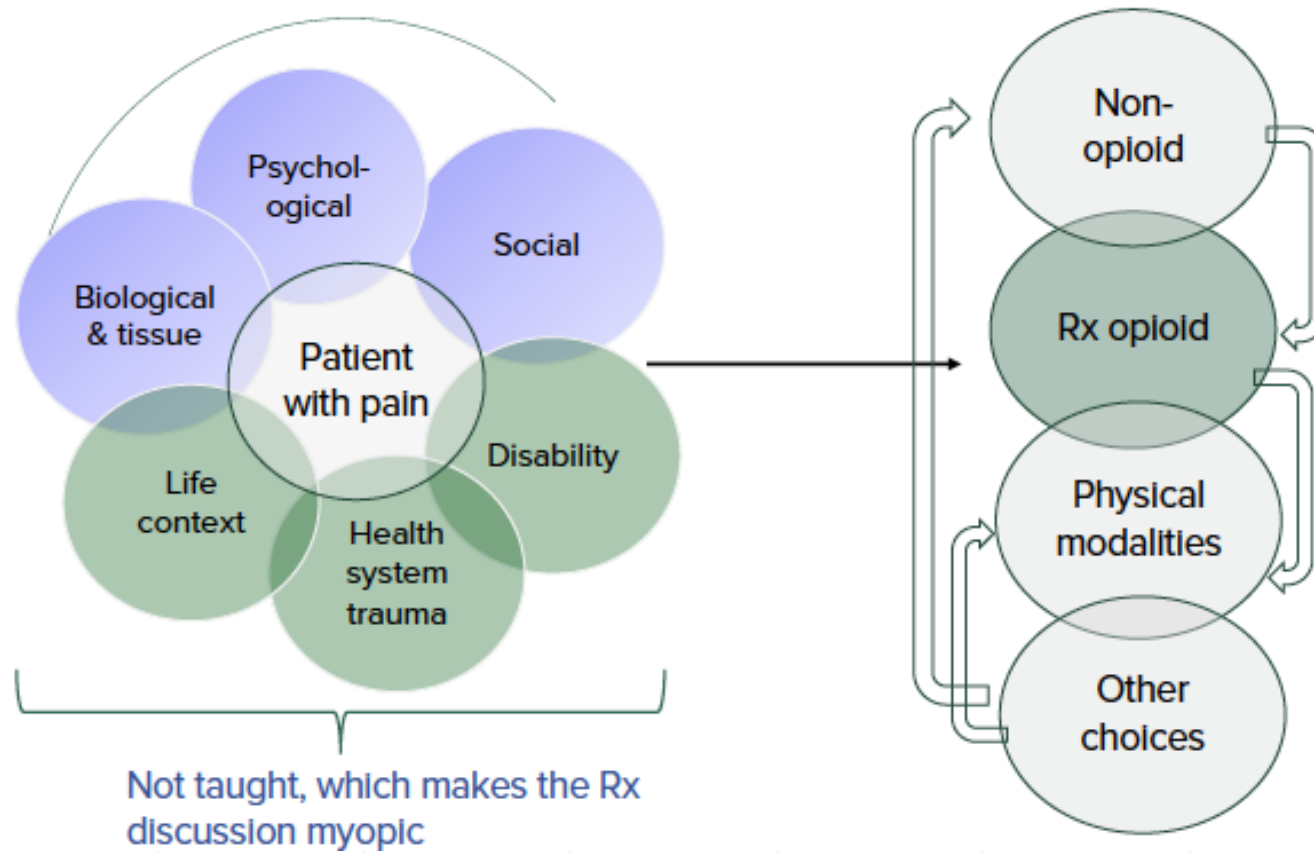
All **pain** discussed in the 2022 (and 2016) CDC guidelines excludes pain associated with active cancer, sickle cell anemia, palliative, or hospice care



## Please Note

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

# Pain Framework







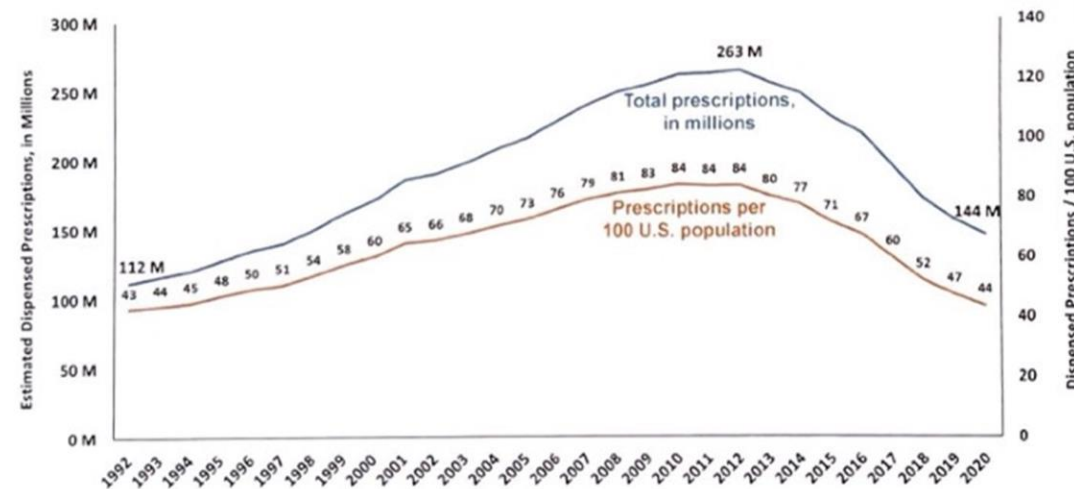
## 2016 CDC Guidelines: Prescribing Opioids for Chronic Pain

- 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  $\geq 90$  MME (or carefully justify why if above 90) and taper/discontinue when risks outweigh benefits

# 2016 CDC: Results of Rapid Application

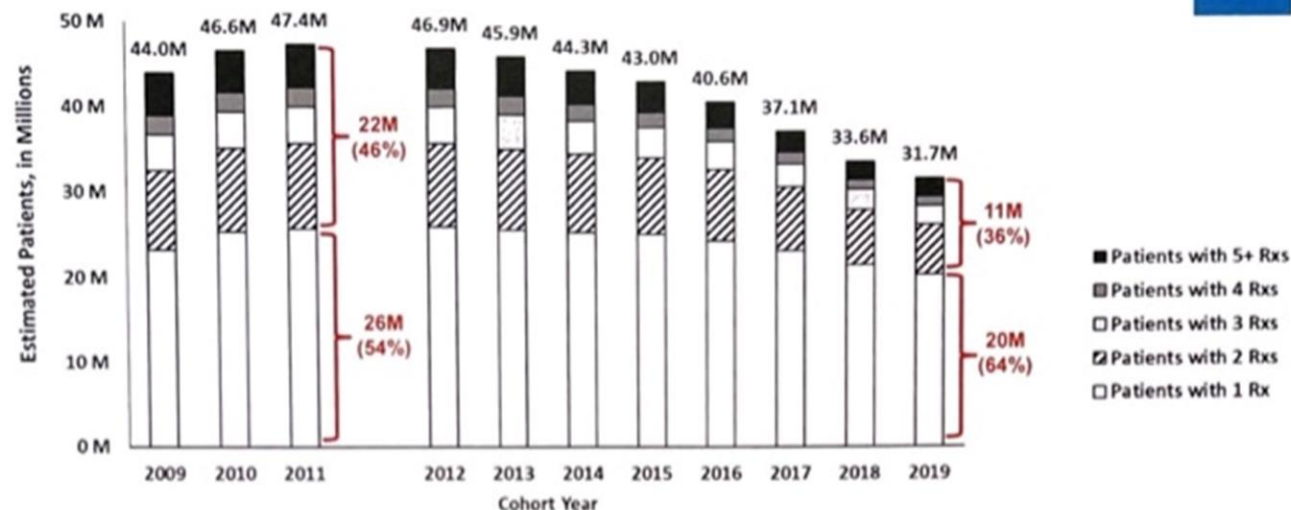
Depending on what we are measuring or who the audience is, these had a dramatic impact.

## Large Declines in Opioid Analgesic Prescriptions



Estimated opioid analgesic prescriptions dispensed from U.S. outpatient pharmacies, total and per 100 U.S. population, 1992–2020.

## Declines in New Outpatient Starts of Opioid Analgesics: Steeper declines in Patients with >1 Rx a Year



Estimated patients receiving an incident opioid analgesic prescription dispensed from U.S. outpatient retail pharmacies, by total number of opioid analgesic

# 2016 Guideline Rapid Uptake: At What Cost?



The NEW ENGLAND  
JOURNAL of MEDICINE

## Perspective

### No Shortcuts to Safer Opioid Prescribing

Deborah Dowell, M.D., M.P.H., Tamara Haegerich, Ph.D., and Roger Chou, M.D.



#### Health Professionals for Patients in Pain (2019)<sup>1</sup>

- 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<sup>2</sup>

“...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

<sup>1</sup><https://healthprofessionalsforpatientsinpain.org/the-letter-1>

<sup>2</sup>NEJM2019; 380:2285-2287 ``

# State Policies: 2020 OIG Report



*Update on Oversight of Opioid Prescribing  
and Monitoring of Opioid Use:*

**States Have Taken Action To Address  
the Opioid Epidemic**

## Opioid Prescribing Limits

- CDC issued a guideline on prescribing opioids, which, among many guidelines, include limiting the morphine milligram equivalents (MME) and duration of the prescriptions.\*

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 ( $\geq 50$  MME)<sup>1</sup>
  - 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 (HD0)
  - Proportion of members 18 years and older who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME]  $\geq 90$ ) for  $\geq 15$  days over the defined year.

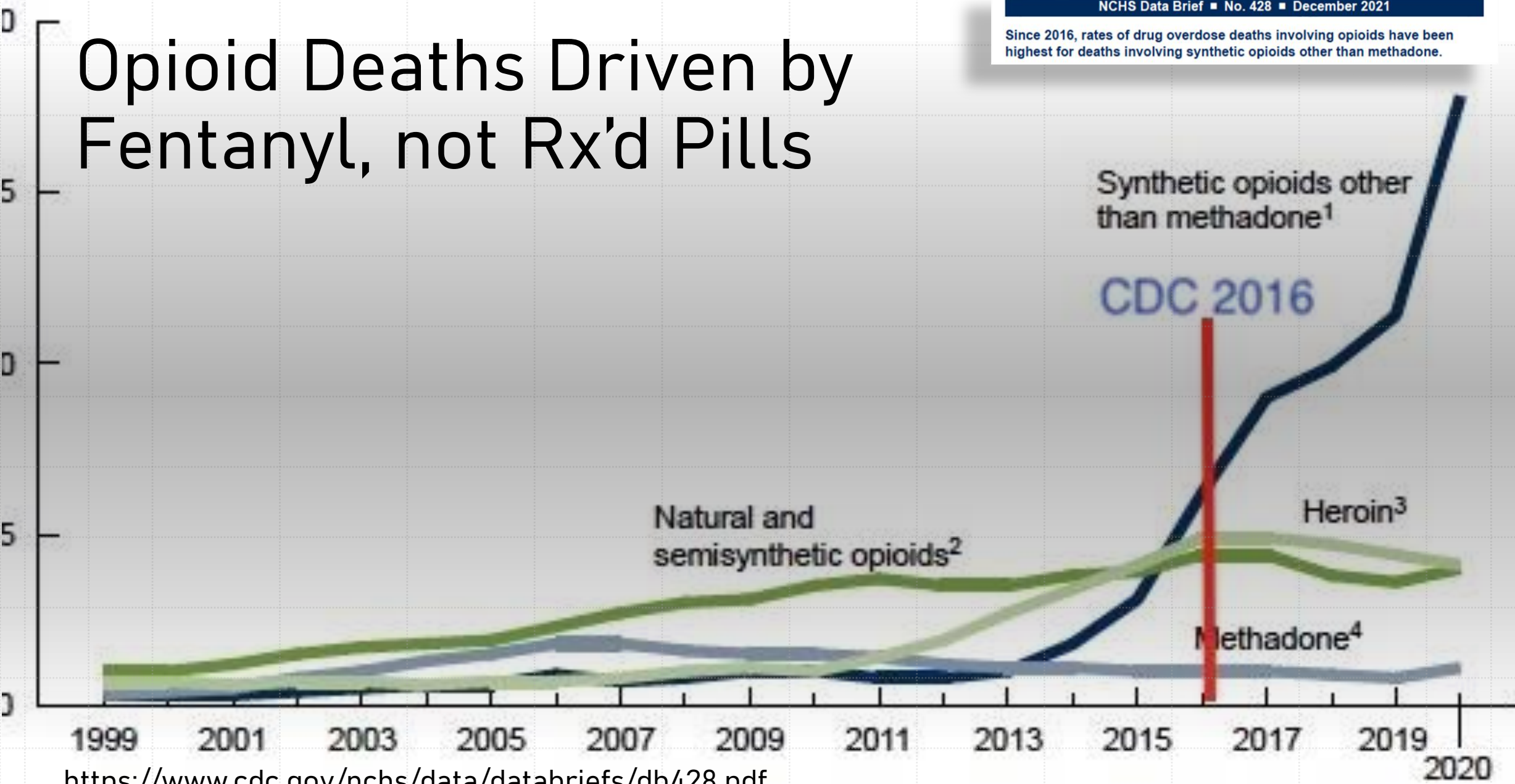


<sup>1</sup><https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2793299>.

# Opioid Deaths Driven by Fentanyl, not Rx'd Pills

NCHS Data Brief ■ No. 428 ■ December 2021

Since 2016, rates of drug overdose deaths involving opioids have been highest for deaths involving synthetic opioids other than methadone.



<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 btwn opioid naïve and the legacy population
- Emphasis on the risk/benefit for long term opioids (esp > 50 MME)
- Done via 12 specific recommendations

## *2016 Guideline Clarifications*

- Removing the 'avoid' for  $\geq 90$  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-pharmacologic & 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

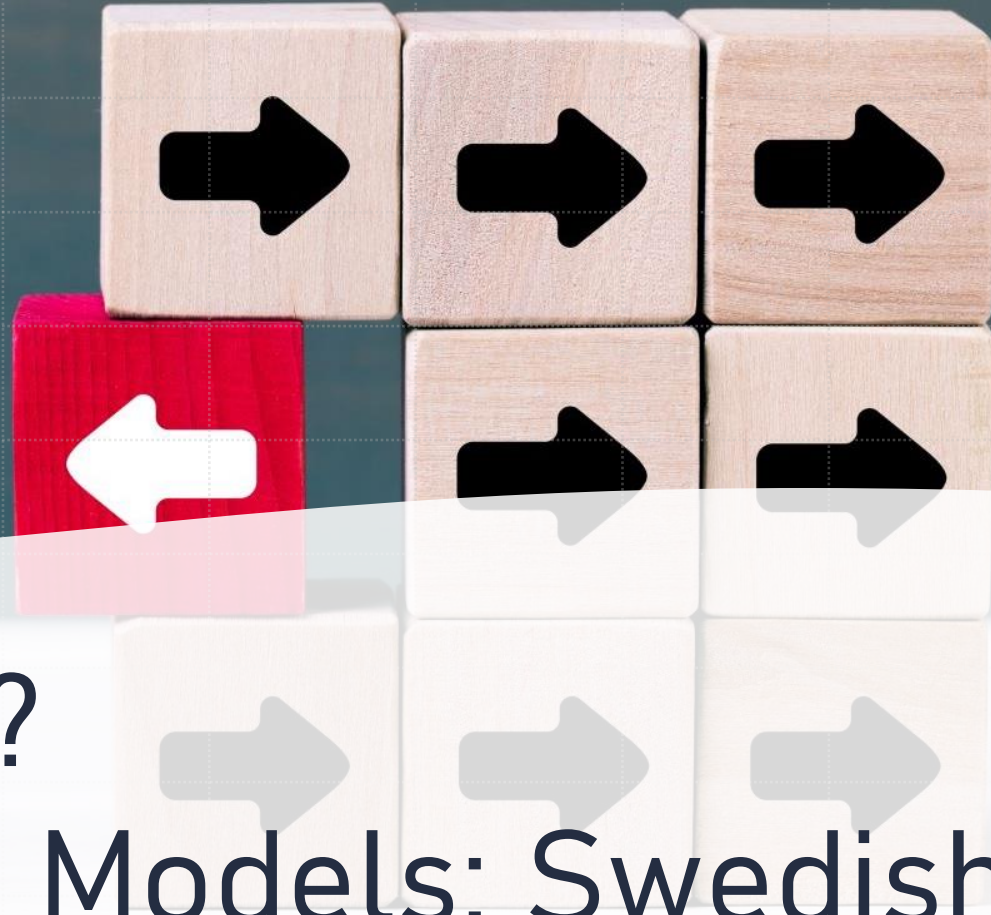
## Recommendation #5

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

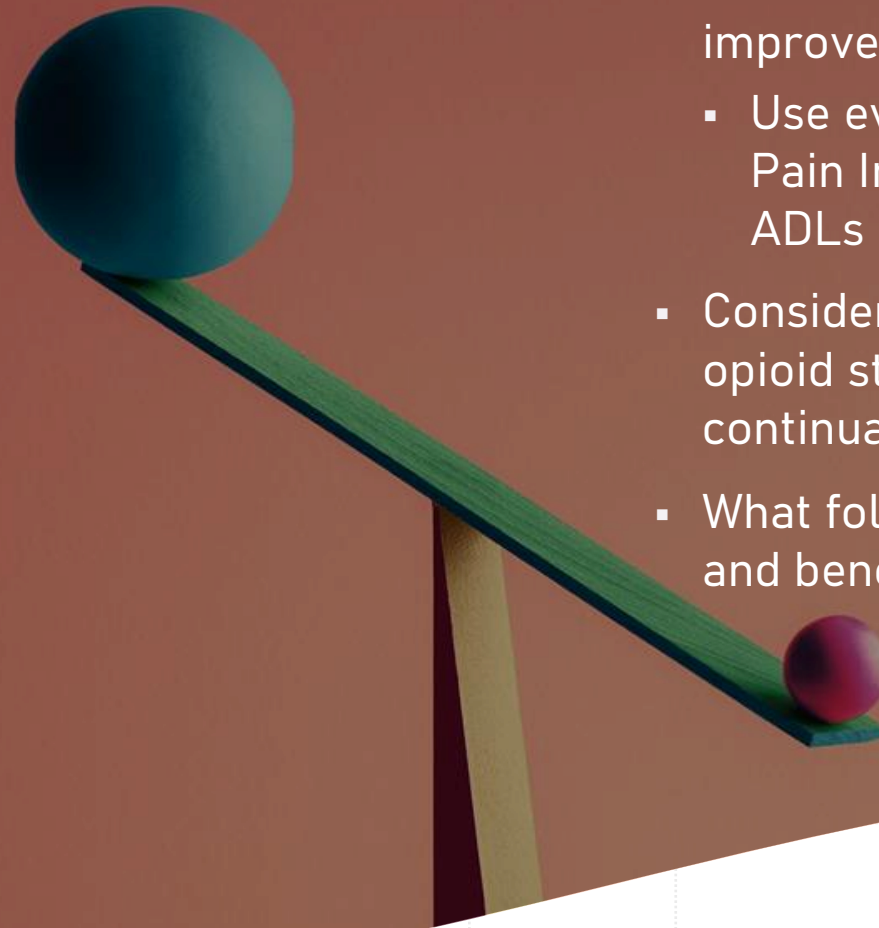




# Risk vs Benefits?

## 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<sup>1</sup>
- What follows are proposed frameworks to risk and benefit of LTOT

<sup>1</sup> <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.	<b>Family Hx of substance abuse</b>		
	Alcohol	<input checked="" type="checkbox"/> 1	<input type="checkbox"/> 3
	Illegal drugs	<input type="checkbox"/> 2	<input type="checkbox"/> 3
	Prescription drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4
2.	<b>Personal Hx of substance abuse</b>		
	Alcohol	<input type="checkbox"/> 3	<input type="checkbox"/> 3
	Illegal drugs	<input type="checkbox"/> 4	<input type="checkbox"/> 4
	Prescription drugs	<input type="checkbox"/> 5	<input type="checkbox"/> 5
3.	<b>Age between 16 &amp; 45 yrs</b>	<input type="checkbox"/> 1	<input type="checkbox"/> 1
4.	<b>Hx of preadolescent sexual abuse</b>	<input type="checkbox"/> 3	<input type="checkbox"/> 0
5.	<b>Psychologic disease</b>		
	ADD, OCD, bipolar, schizophrenia	<input type="checkbox"/> 2	<input type="checkbox"/> 2
	Depression	<input type="checkbox"/> 1	<input type="checkbox"/> 1



# Swedish Risk Model Continued

Medical co-morbidities present?

- COPD, CHF, OSA, Fall Risk, unmanaged psych condition, poor renal/hepatic fxn
  - $\geq 2$  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  $\geq 2$  co-morbidities **or** high-risk Rx present
  - This will grade **up** score
- Final score is either:
  - Low, moderate, or high risk





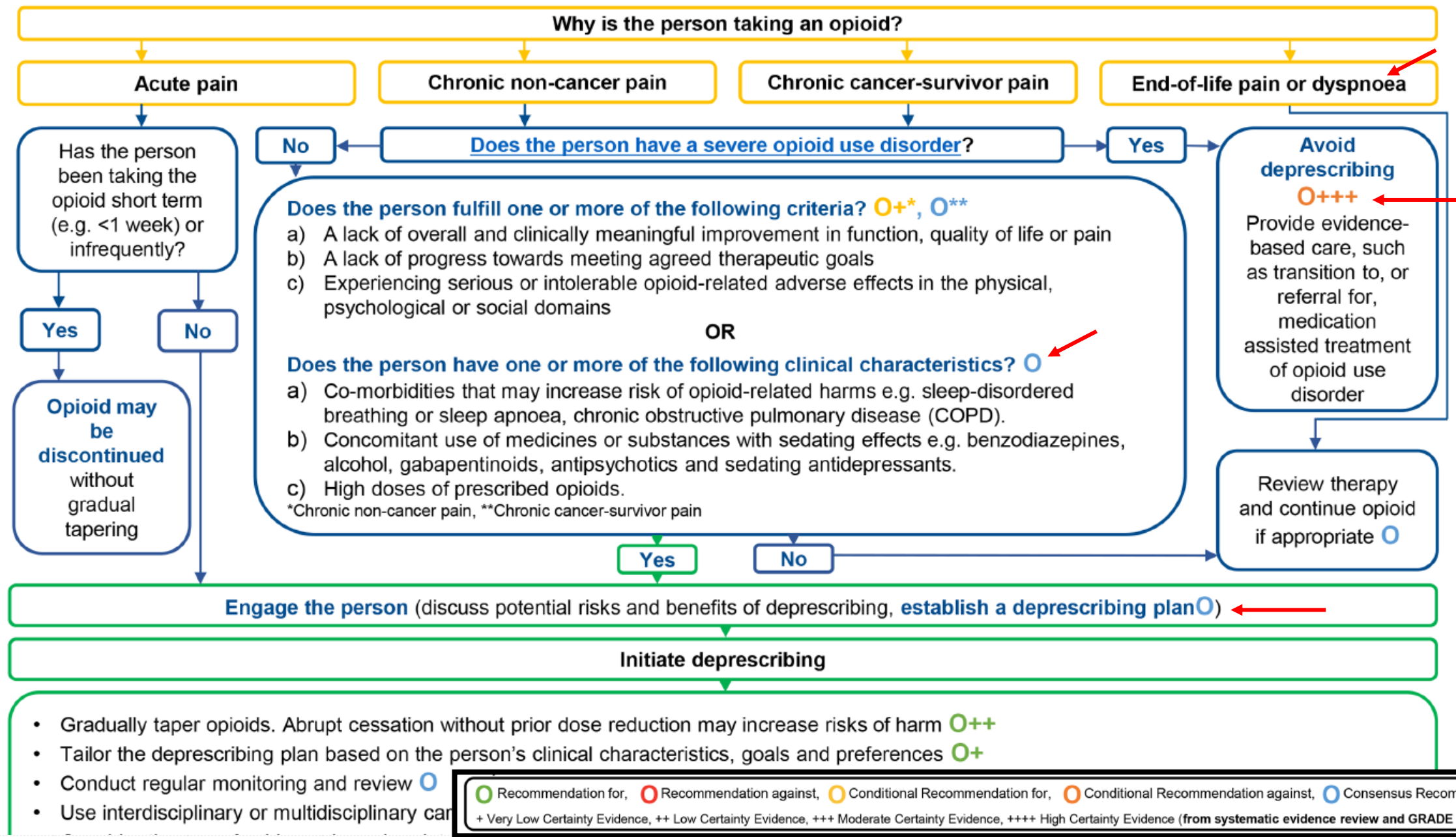
# Australian Deprescribing Guidelines



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

<sup>1</sup>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.

<sup>2</sup>Schünemann H, et al. GRADE handbook [updated Oct 2013]. GRADE Working Group, 2013. <https://gdt.gradepro.org/app/handbook/handbook.html>







# 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 rely 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





# 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 PDMP– 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 PDMP 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)
  - “PDMP-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

