New 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain

Clinician Outreach and Communication Activity (COCA) Call

Thursday, November 17, 2022

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Objectives

At the conclusion of today's session, the participant will be able to accomplish the following:

1. List three key updates to 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain.
2. Discuss approaches to maximize benefits and minimize risks when starting, continuing, or discontinuing opioids for pain.

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Today's Presenter

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What's New in the 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain

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November 17, 2022

Why update?

+ **Pain continues to affect the lives of millions of Americans**
+ **Many can’t access the full range of potentially helpful therapies**
  - limited access to treatment modalities
  - lack of clarity around evidence supporting pain treatments
+ **Pain-management disparities persist**
+ **Opioids continue to be commonly used to treat pain**
+ **New scientific evidence supports expanded guidance and specificity**
  - acute and subacute pain treatment
  - opioid tapering
  - treatment modalities for different types of pain

Guideline development

+ **Applied GRADE framework; recommendations based on**
  - systematic review of available scientific evidence
  - benefits and harms
  - values and preferences of patients, caregivers and clinicians
  - resource allocation (e.g., costs to patients or health systems)

+ **CDC sought and considered input from**
  - public comment
  - the Board of Scientific Counselors (BSC) of CDC's Injury Center (NCIPC)
  - federal partners
  - peer reviewers with scientific and clinical expertise

Recommendation categories

+ Category A recommendation

- applies to all persons
- most patients should receive the recommended course of action

+ Category B recommendation

- individual decision-making needed
- different choices will be appropriate for different patients
- clinicians help patients arrive at a decision consistent with patient values and preferences and specific clinical situations

Evidence types

- Type 1 evidence: randomized clinical trials or overwhelming evidence from observational studies
- Type 2 evidence: randomized clinical trials with important limitations or exceptionally strong evidence from observational studies
- Type 3 evidence: observational studies or randomized clinical trials with notable limitations
- Type 4 evidence: clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations

Clinical evidence review findings

- Some noninvasive, nonpharmacologic interventions show sustained improvements in pain, function, or both up to 12 months following treatment and not associated with serious harms
- NSAIDs improve pain and function at least as much as opioids in several common acute conditions
- Nonopioid drugs, including SNRI antidepressants, pregabalin/gabapentin, and NSAIDs, associated with small to moderate improvements in chronic pain and function
- Opioids associated with small improvements in short-term (1 to <6 months) pain and function compared with placebo, with reduced effectiveness over time (3-6 vs. 1-3 months)
- Opioid therapy associated with increased risk of serious harms that increases with opioid dosage
  - No clear threshold below which there is no risk
  - No validated, reliable way to predict which patients will suffer serious harm

Federal Advisory Committee, peer reviewer, and public input

+ **Barriers persist in access to**
  - pain care
  - evidence-based treatment
+ **Shared decision-making is critical**
+ **Discontinuing opioids after extended use can be challenging and harmful**
+ **Communication of recommendation statements requires care**
  - language referencing specific opioid dosages and durations facilitates misapplication
  - clinicians need specific information

Scope of the 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain

- Expanded recommendations on use of opioids for acute pain (duration <1 month)
- Expanded to include subacute pain (duration of 1-3 months)
- Includes chronic pain (duration of >3 months)
- Applicable outpatient settings include clinician offices, clinics, and urgent care centers
- Includes prescribing for pain management when patients are discharged from hospitals, emergency departments, or other facilities
- Does not apply to providing care to patients while hospitalized or in an emergency department or other observational setting

The 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain is

- **A clinical tool to improve communication between clinicians and patients and empower them to make informed, person-centered decisions related to pain care together**

- **Intended for primary care clinicians and other clinicians providing pain care for outpatients aged ≥18 years old with**
  - acute pain (duration <1 month);
  - subacute pain (duration of 1-3 months); or
  - chronic pain (duration of >3 months)

- **Intended to be flexible to enable person-centered decision-making, taking into account an individual's expected health outcomes and well-being**

The 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain is *NOT*

- A replacement for clinical judgment or individualized, person-centered care
- Intended to be applied as inflexible standards of care across patients and/or patient populations by healthcare professionals, health systems, pharmacies, third-party payers, or governmental jurisdictions or to lead to the rapid tapering or abrupt discontinuation of opioids for patients
- A law, regulation, or policy that dictates clinical practice or a substitute for FDA-approved labeling
- Applicable to
  - management of sickle cell disease-related pain,
  - management of cancer-related pain, or
  - palliative care or end-of-life care; or
- Focused on opioids prescribed for opioid use disorder

What’s new?

Expanded recommendations on acute pain

+ **Nonopioid therapies are at least as effective as opioids for many common types of acute pain, including**
  - low back pain
  - neck pain
  - other common musculoskeletal conditions
  - minor surgeries or dental procedures
  - kidney stone pain
  - headaches

+ **Taper when discontinuing opioids following continuous use for more than a few days**

New guidance on subacute pain

+ Ensure potentially reversible causes of chronic pain are addressed

+ Carefully reassess treatment goals, benefits, and risks

+ Continue opioid therapy only as an intentional decision that benefits are likely to outweigh risks
  - after informed discussion with the patient
  - as part of a comprehensive pain management approach

+ Avoid initiating long-term therapy unintentionally

Updated content on benefits and risks of nonopioid treatments for specific chronic pain conditions

- Back pain or osteoarthritis: exercise, physical therapy, weight loss, manual therapies, psychological therapies, mindfulness-based stress reduction, yoga, acupuncture, multidisciplinary rehabilitation, topical NSAIDs, duloxetine, systemic NSAIDs

- Neck pain: mind-body practices (yoga, tai chi, or qigong), massage, acupuncture

- Fibromyalgia: exercise, physical therapy, cognitive behavioral therapy, myofascial release massage, mindfulness practices, tai chi, qigong, acupuncture, multidisciplinary rehabilitation, tricyclic and SNRI antidepressants, NSAIDs (topical diclofenac), pregabalin and gabapentin

- Neuropathic pain: tricyclic, tetracyclic, and SNRI antidepressants; selected anticonvulsants, capsaicin, lidocaine patches

Expanded recommendations on tapering

+ **Emerging data highlight benefits and risks of tapering opioids**

+ **A new recommendation outlines in greater detail how clinicians can work with patients already receiving opioids in determining if and how to taper opioids and emphasizes**
  - patient-centered treatment changes, using empathy and shared decision-making
  - tapers of 10% per month or slower for better tolerability when patients have been taking opioids for longer durations (e.g., ≥1 year)
  - avoiding abrupt discontinuation of opioid therapy or rapid reduction of opioid dosages

New elements to inform implementation

+ **Recommendation statements emphasize general principles rather than specific thresholds to discourage the misapplication of thresholds as inflexible standards**
  - e.g., avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks
  - more specific information, such as data related to dosages, is provided in supporting text with additional considerations to inform clinical decision-making and individualized patient care

+ **Suggested strategies to promote more equitable access and mitigate barriers to quality care**
  - mechanisms for timely access to re-evaluation for patients with unexpectedly continuing pain
  - specific cautions against bias in use and interpretation of PDMP and toxicology test data

+ **Five new guiding principles to inform implementation across recommendations and support appropriate, individualized care**

Guiding principles for implementation of 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain

- 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. Flexibility to meet the care needs and the clinical circumstances of a specific patient are paramount

- A multimodal and multidisciplinary approach to pain management attending to the physical health, behavioral health, long-term services and supports, and expected health outcomes and well-being needs of each person is critical

Guiding principles for implementation of 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain, continued

- Special attention should be given to avoid misapplying this clinical practice guideline beyond its intended use or implementing policies purportedly derived from it that might lead to unintended consequences for patients

- Clinicians, practices, health systems, and payers should vigilantly attend to health inequities, provide culturally and linguistically appropriate communication, and ensure access to an appropriate, affordable, diversified, coordinated, and effective nonpharmacologic and pharmacologic pain management regimen for all persons

Recommendations

The recommendations are grouped into four areas

1. Determining whether or not to initiate opioids for pain
2. Selecting opioids and determining opioid dosages
3. Deciding duration of initial opioid prescription and conducting follow-up
4. Assessing risk and addressing potential harms of opioid use

Determining whether or not to initiate opioids for pain

Recommendation 1
determining whether to initiate opioids for acute pain (duration <1 month)

- Nonopioid therapies are at least as effective as opioids for many common types of acute pain.
- Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient.
- Before prescribing opioid therapy for acute pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy.

- **recommendation category:** B; **evidence type:** 3

Recommendation 2
determining whether to initiate opioids for subacute pain (1-3 months' duration) or chronic pain (duration >3 months)

- Nonopioid therapies are preferred for subacute and chronic pain.
- Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider initiating 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 the realistic benefits and known risks of opioid therapy, should work with patients to establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks.

- **recommendation category:** A; **evidence type:** 2

Selecting opioids and determining opioid dosages

Recommendation 3

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

- **recommendation category:** A; **evidence type:** 4

Recommendation 4

+ When opioids are initiated 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 evaluate individual benefits and risks when considering increasing dosage, and should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients.

+ **recommendation category:** A; **evidence type:** 3

Recommendation 5

- For patients already receiving opioid therapy, clinicians should carefully weigh benefits and risks and exercise care when changing opioid dosage.
- If benefits outweigh risks of continued opioid therapy, clinicians should work closely with patients to optimize non-opioid therapies while continuing opioid therapy.
- If benefits do not outweigh risks of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages or, if warranted based on the individual clinical circumstances of the patient, to appropriately taper and discontinue opioids.
- Unless there are indications of a life-threatening issue, such as warning signs of impending overdose, (e.g., confusion, sedation, or slurred speech), opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages.

- **recommendation category:** B; **evidence type:** 4

Deciding duration of initial opioid prescription and conducting follow-up

Recommendation 6

- When opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.

- **recommendation category:** A; **evidence type:** 4

Recommendation 7

- Clinicians should evaluate benefits and risks with patients within 1 - 4 weeks of starting opioid therapy for subacute or chronic pain or of dosage escalation.
- Clinicians should regularly re-evaluate benefits and risks of continued opioid therapy with patients.

- **recommendation category:** A; **evidence type:** 4

Assessing risk and addressing potential 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 work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone.

- **recommendation category:** A; **evidence type:** 4

Recommendation 9

- When prescribing initial opioid therapy for acute, subacute, or chronic pain, and periodically during opioid therapy for chronic pain, 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 combinations that put the patient at high risk for overdose.

- **recommendation category:** B; **evidence type:** 4

Recommendation 10

- When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and non-prescribed controlled substances.

- **recommendation category:** B; **evidence type:** 4

Recommendation 11

- Clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants.

- **recommendation category**: B; **evidence type:** 3

Recommendation 12

- Clinicians should offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder.
- Detoxification on its own, without medications for opioid use disorder, is not recommended for opioid use disorder because of increased risks for resuming drug use, overdose, and overdose death.

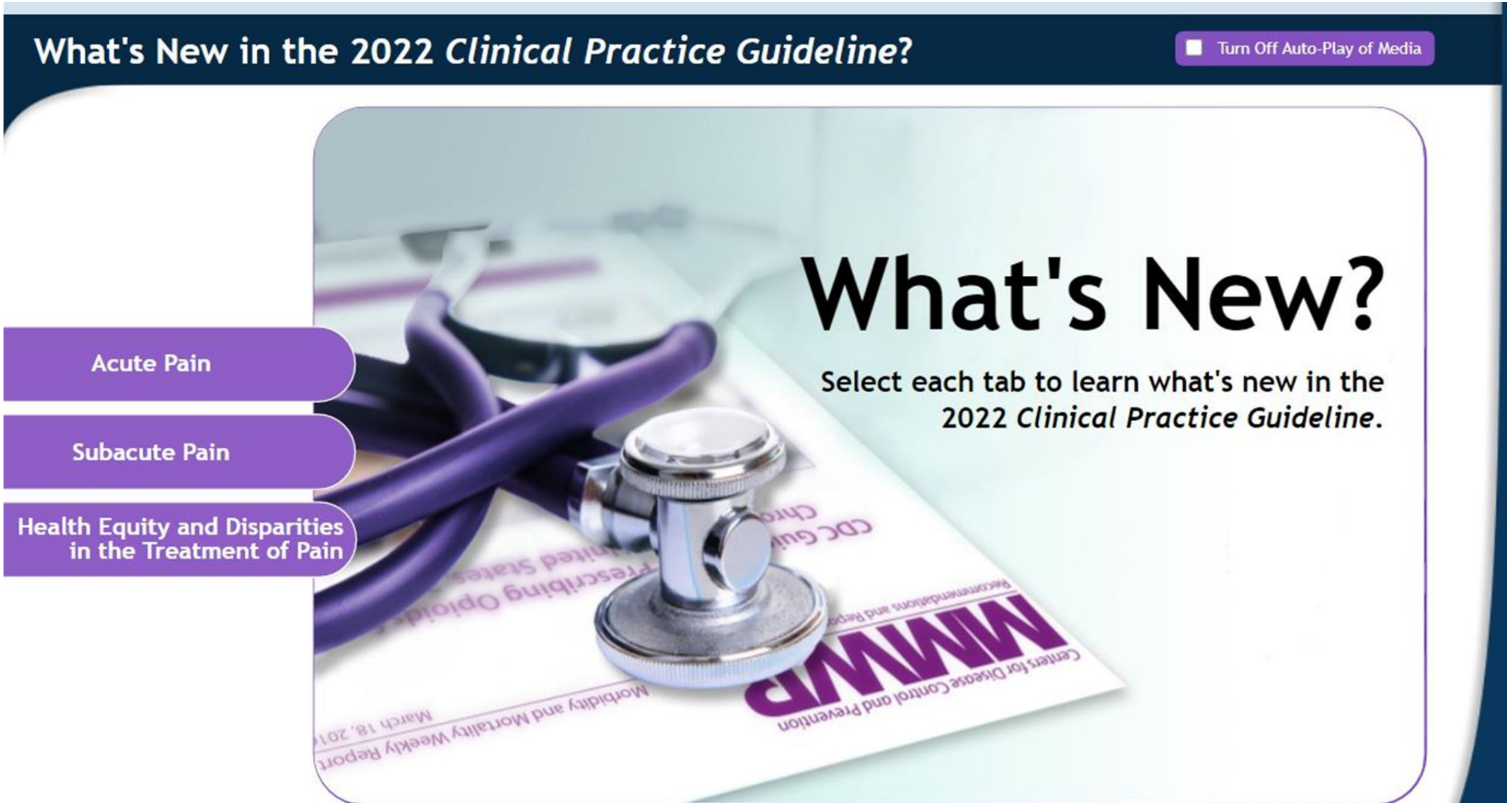
- **recommendation category:** A; **evidence type:** 1

Conclusions

- **The 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain is intended to**
  - improve clinician and patient communication about benefits and risks of pain treatment
  - improve the effectiveness and safety of pain treatment
  - mitigate pain
  - improve function and quality of life for patients with pain
  - reduce risks associated with opioid pain therapy
- **Evidence to guide optimal pain management remains limited**
- **Patient-clinician communication about benefits and risks of opioids remain central to treatment decisions**
- **This updated guideline can help inform those decisions**

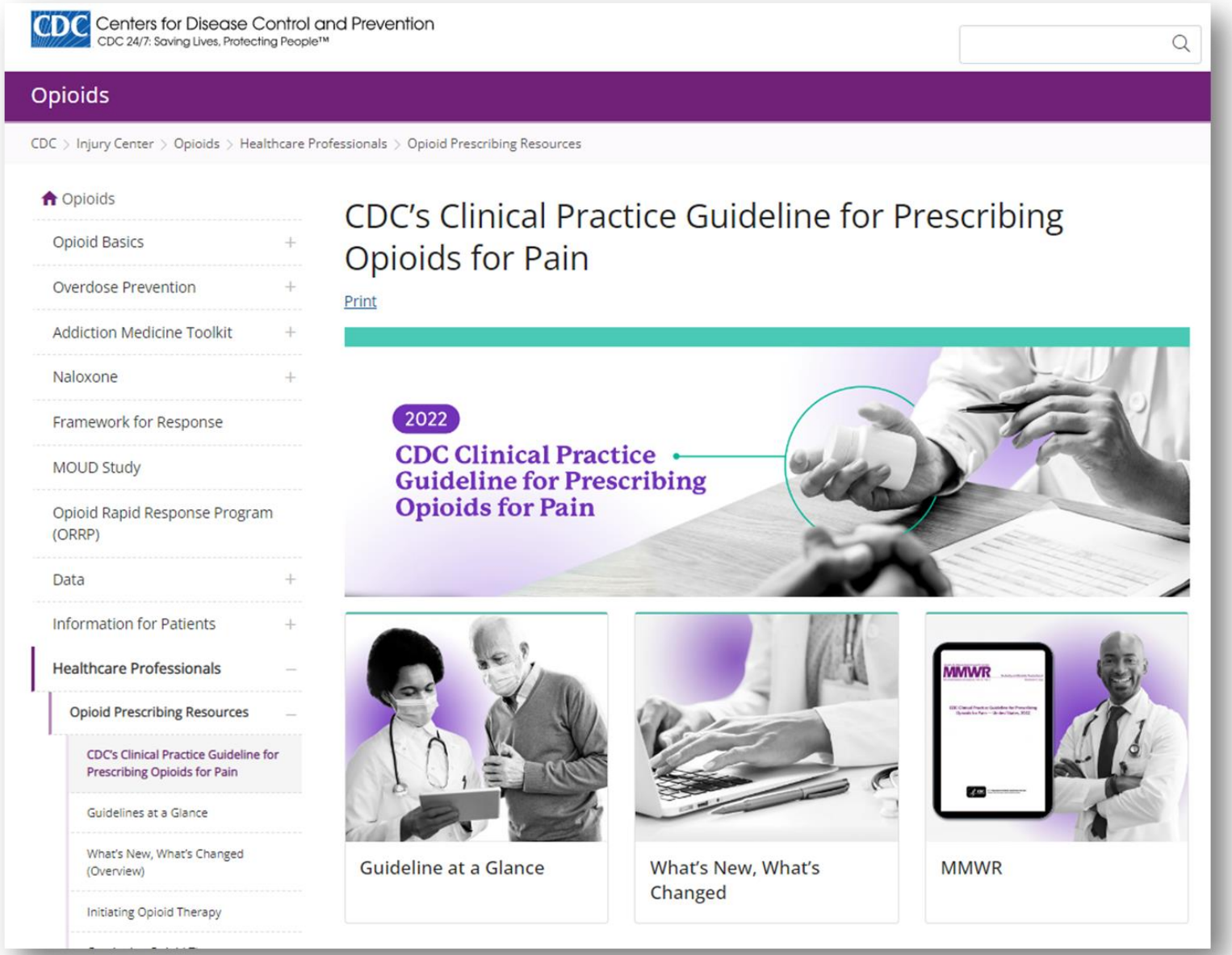
Resources

Resources


What's New in the 2022 Clinical Practice Guideline?
Turn Off Auto-Play of Media
Acute Pain
Subacute Pain
Health Equity and Disparities in the Treatment of Pain
What's New?
Select each tab to learn what's new in the 2022 Clinical Practice Guideline.
MMWR
Centers for Disease Control and Prevention
Morbidity and Mortality Weekly Report

New Webpages

New Webpages



Additional Resources

CDC Clinician Resources

Addiction Medicine Toolkit

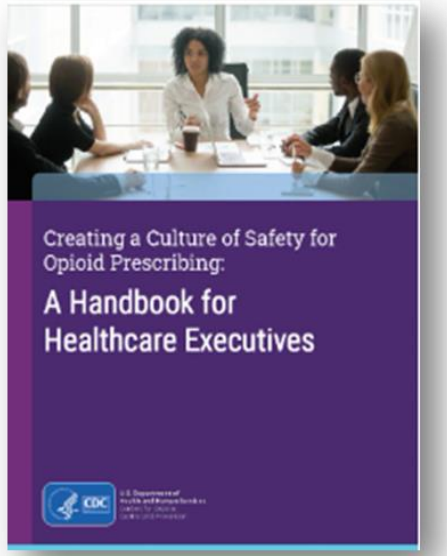
https://www.cdc.gov/opioids/addiction-medicine/index.html

Naloxone

https://www.cdc.gov/opioids/naloxone/index.html

Electronic Clinical Decision Support Tools

https://www.cdc.gov/opioids/healthcare-admins/ehr/index.html



Handbook for Healthcare Executives

https://www.cdc.gov/opioids/healthcare-admins/executive-handbook.html

Knowledge Check

Knowledge Check

Use of which of the following therapies is associated with improvements in pain and function that are sustained up to 12 months following completion of treatment and are not associated with serious harms?

A. Noninvasive, nonpharmacologic interventions (such as exercise and psychological therapies)

B. Nonsteroidal anti-inflammatory drugs (NSAIDs)

C. Opioids

D. Pregabalin and gabapentin

E. All of the above

Knowledge Check: Answer

Use of which of the following therapies is associated with improvements in pain and function that are sustained up to 12 months following completion of treatment and are not associated with serious harms?

A. Noninvasive, nonpharmacologic interventions (such as exercise and psychological therapies)

B. Nonsteroidal anti-inflammatory drugs (NSAIDs)

C. Opioids

D. Pregabalin and gabapentin

E. All of the above

Thank you!

For more information, contact CDC:

1-800-CDC-INFO (232-4636)

TTY: 1-888-232-6348

opioids@cdc.gov

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