



NCIPC Board of Scientific Counselors

January 28, 2016

National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
Atlanta, Georgia

CDC Injury Prevention

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
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Eighteenth Meeting: Thursday, January 28, 2016

1600 Clifton Road, N.E.
Building 19, Auditorium B-3
Atlanta, GA 30329

Summary Proceedings

The eighteenth meeting of the National Center for Injury Prevention and Control (NCIPC) Board of Scientific Counselors (BSC) took place on Thursday, January 28, 2016 at the Tom Harkin Global Communications Center on the Clifton Road Campus of the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia. The BSC met in open session in accordance with the Privacy Act and the Federal Advisory Committee Act (FACA). Dr. Stephen Hargarten served as chair.

Call to Order / Roll Call / Introductions / Meeting Logistics

Stephen Hargarten, MD, MPH
Professor and Chair
Department of Emergency Medicine
Medical College of Wisconsin
Chair, National Center for Injury Prevention and Control Board of Scientific Counselors

Dr. Stephen Hargarten called the eighteenth meeting of the NCIPC BSC to order at 9:01 a.m. on Thursday, January 28, 2016.

Mrs. Tonia Lindley conducted a roll call of NCIPC BSC members and *ex officio* members. She asked all members to disclose any conflicts of interest. The meeting attendance is appended to this document as Attachment A. The following conflicts of interest were disclosed by BSC members:

- **Dr. Traci Green** was previously employed at Inflexxion, a small business that conducts Small Business Innovation Research (SBIR) grants and behavioral interventions for pain assessments. She indicated that she would recuse herself from any conversations regarding pain assessments. She provided consultancy to Purdue Pharmaceuticals, a privately-held pharmaceutical company, for designing two overdose prevention brochures for people who use diverted opioids and who inject opioids. That salary support was approximately $3,000.00, and she indicated that she would recuse herself from conversations regarding overdose prevention education materials.
- **Dr. Wilson Compton** reported minimal, long-term stock holdings in General Electric; 3M Corporation; and Pfizer, Incorporated.

Mrs. Lindley confirmed that a quorum was present. She offered housekeeping notes to the meeting participants.

Dr. Hargarten thanked the BSC members and *ex officio* members for attending the meeting and indicated his appreciation for their commitment and thoughtful input. He also thanked the members of the public who were present in person and via teleconference, emphasizing that their interest and voice in the topic of opioids abuse is appreciated, and all public comments are taken into consideration.

He welcomed Dr. Deborah Gorman-Smith, a previous BSC member who was returning to the board. He also welcomed Captain Kelly Taylor, a new *ex officio* member from the Indian Health Service (IHS) and Mindy Chai, an *ex officio* member from the National Institute of Mental Health (NIMH).

The day's agenda, the Opioid Guideline Workgroup observations, and two Power Point presentations are posted on the NCIPC BSC website so that participants on the telephone could more easily follow the presentations. The website is: www.cdc.gov/injury/BSC and the materials are available under the "Meetings" tab. The meeting's written and oral comments and other materials would be posted on the NCIPC BSC website as the official record of the meeting.

Welcome

Stephen Hargarten, MD, MPH
Professor and Chair
Department of Emergency Medicine
Medical College of Wisconsin
Chair, National Center for Injury Prevention and Control Board of Scientific Counselors

Dr. Hargarten reported that the Opioid Guideline Workgroup of the NCIPC BSC was approved during the January 7, 2016 BSC teleconference. Since then, the workgroup has reviewed the draft of the CDC Guideline for Prescribing Opioids for Chronic Pain, supplementary documents, and public feedback. The workgroup has met four times and discussed each of the recommendations in detail. Dr. Christina Porucznik served as chair of the group, and Dr. Traci Green participated as a member of the workgroup.

He explained that the morning's presentation would provide an overview of the Guideline, including background and rationale for each of the guideline recommendations. Dr. Porucznik would then share the workgroup's observations. The day's agenda includes two discussion periods as well as 90 minutes of public comment.

Dr. Hargarten reminded the BSC members and *ex officio* members to remain for the entirety of the meeting in order to maintain quorum. At the end of the day, BSC members would be asked to vote on the workgroup's observations. The results of the BSC vote would be forwarded to CDC and the US Department of Health and Human Services (HHS). The authors of the draft guideline were available to answer questions during the day.

Opioid Overdose Prevention: A CDC Priority [Video]

Thomas Frieden, MD
Director
Centers for Disease Control and Prevention

Via video, **Dr. Tom Frieden** apologized for not attending the meeting in person as he was in Geneva, Switzerland at the World Health Organization (WHO) where he serves as the US representative to the WHO Executive Board.

He emphasized that many people in the US experience chronic pain. There is an obligation to offer safe and effective management of pain and not to increase patients' risk of addiction, overdose, and death. What was not known 20 years ago that is known now, is just how addictive prescription opioids can be. Every day, 78 Americans lose their lives to an opioid overdose. They leave behind devastated families and communities. Deaths from opioid abuses have been increasing rapidly since 1999, and the rates have never been higher. Overdose deaths from prescription opioids, such as oxycodone, hydrocodone, and methadone quadrupled from 1999 to 2013. Rates of all opioid overdose deaths, including all legally-prescribed opioids and illegal drugs such as heroin, increased another 144% from 2013 to 2014 alone.

Addressing the prescription drug overdose epidemic is one of CDC's top priorities. Dr. Frieden thanked the NCIPC BSC for the time, attention, and commitment that they have devoted to this important and urgent issue. He thanked members of the Opioid Workgroup for their efforts to help CDC address the opioid overdose epidemic, and the members of the public who were participating in the meeting in person and on the telephone. CDC has head many voices from the public on this important work. The comments are heard and valued, and they have been a critical part of the process. Prescription drug abuse is an epidemic. The best science must be applied to address it. Observations from the workgroup and recommendations from the NCIPC BSC will enhance CDC's ability to finalize the guidelines and to take effective action.

Dr. Frieden thanked everyone for the work that they had done and would continue to do, and said he looked forward to continuing to work together to protect the public's health.

Guidelines in Public Health

Anne Schuchat, MD, RADM, USPHS
Principal Deputy Director
Centers for Disease Control and Prevention

Dr. Anne Schuchat welcomed and thanked the NCIPC BSC, the Opioid Workgroup, members of the public, and NCIPC staff. She stressed that this issue is extremely important, and guidelines are an important part of CDC's work. She remarked on the sense of convergence at CDC, as part of the agency is working in the Emergency Operations Center (EOC), focused on the Zika virus in the Americas and the urgent need to share information with the public so that they can protect themselves. Her first experience with CDC guidelines was with Group B *Streptococcus* (group B strep, GBS) guidelines. Group B strep is another infectious disease

that can cause severe complications in babies. Today, this group is deliberating lifesaving guidelines to address the best ways to prescribe opiates. The issues of Zika are in the news. Issues of Group B strep are in the past, thanks to the implementation of sound guidelines that have prevented more than 90,000 infections. The Opioid Guideline will have enormous public health impact and will make a difference for patients and clinicians who struggle with these issues.

Dr. Schuchat has worked on a number of CDC guidelines, particularly in her role as the Director of the National Center for Immunization and Respiratory Diseases (NCIRD), which manages the Advisory Committee on Immunization Practices (ACIP). Three times per year, ACIP deliberates on immunization recommendations for the American public. The recommendations have significant impact. The process is helped by following a systematic review of evidence using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system, the same system that has guided the Opioid Guidelines. GRADE helps to coalesce the complex evidence and to recognize that values are a factor in decision-making about preferences.

CDC is committed to several principles related to guideline development. The agency's pledge to the American public is to make the best decisions possible based on the best available evidence, openly and objectively reviewed. The principles of relying on evidence, transparency, and understanding the urgency of the problem are critical to their work.

Prescription opioid abuse and overdose is a significant priority for Dr. Frieden and Dr. Schuchat. They are frequently briefed by Dr. Houry and NCIPC staff. They are pleased that the NCIPC BSC has assembled to help put the pieces together. The nation faces an epidemic of addiction and overdose that is unrelenting. Doctors need, and are asking for, additional guidance on prescribing these drugs safely. Patients need and deserve appropriate, effective, and compassionate care, especially when they face persistent pain. NCIPC is listening to all perspectives, looking at all of the available evidence, and taking care to get this right.

Dr. Frieden, Dr. Schuchat, and the leadership of HHS are fully engaged and committed to the guidelines and to improving the health of all Americans. The guidelines will support effective, safer pain care for all. She thanked the group for the work that they have done, are doing, and will do.

Background: Draft CDC Guideline for Prescribing Opioids for Chronic Pain

Debra Houry, MD, MPH
Director
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Debra Houry greeted the group and thanked Drs. Schuchat and Frieden for their remarks. Their engagement shows the support that CDC has provided NCIPC during the process of creating the draft Opioid Guideline. She also thanked the BSC and the meeting participants, as well as the members of the Opioid Guideline Workgroup and the consultants who joined their discussion for their thoughtful evaluation of the evidence reviews that support the guidelines, the public comments, and each recommendation in the guideline. The workgroup conducted the Herculean task of a complete and fresh review of all relevant materials to the guideline. The

workgroup convened four meetings to generate a report that would be presented to the NCIPC BSC. She said she looked forward to hearing the report and the BSC's discussion.

Guidelines sit at the intersection of public health and clinical practice. Dr. Houry herself is a public health researcher and a practicing emergency physician. At CDC, she sees issues of pain, prescription opioid addiction, and overdose on a macro level with systems-level solutions. As an emergency physician, she sees the issues "one person at a time." From a patient with a fractured arm who needs a short course of pain relief, to a patient in chronic pain issues who needs comfort and referral to a pain specialist, to a patient after an overdose of a prescription opioid or heroin, she has witnessed this epidemic from the front lines. Patient safety and care are her primary concern.

CDC has tracked the rise in opioid overdoses for over a decade. Approximately 10 years ago, CDC epidemiologists noticed a substantial increase in the number of adults dying from unintentional poisoning. Researchers examined the data, and one of CDC's first landmark articles on this emerging issue was a 2006 analysis that studied a dramatic increase in poisoning mortality rates and compared it to sales of opioid analgesics nationwide. The CDC authors noted prevention efforts, stating that "the overall goal should be to identify ways to reduce deaths from opioid analgesics without diminishing the quality of care for patients." Since the early days of working on this issue, CDC has sought to prevent prescription opioid overdoses while supporting quality care for people with chronic pain. This goal continues today.

The problem facing the US is significant. From 2000-2014, nearly half a million people in the US died from drug overdose. By the end of this meeting, 20 people would have died of overdose from a prescription or illegal opioid overdose. Since 1999, the amount of opioids prescribed and filled in the US quadrupled, yet there has not been an overall change in the amount of pain that Americans report. Opioid overdoses from prescription and illicit opioids killed 78 people a day in 2014. More than 28,000 lives were lost to opioids in one year. The problem is not getting better, and it is a problem that the US has faced before.

In November 2015, a historian at the University of North Florida published a perspective in the *New England Journal of Medicine* (*NEJM*) on the history of preventing and treating narcotic addiction in the US. He noted that physicians using morphine injections to treat pain were the most important drivers of the addiction epidemic of the 1870s and 1880s. At that time, physicians and pharmacists then "turned the tide" and succeeded through primary prevention. The historian noted that history offers grounds for optimism that the prescription opioid epidemic in the US can be controlled. There are similar opportunities today.

The approach being discussed during this meeting, CDC's Guideline for Prescribing Opioids for Chronic Pain, was not a panacea for the opioid or pain problem. It represented one important step toward more cautious prescribing of opioids while ensuring that patients who suffer from chronic pain have safer and more effective pain management. There is a need for more research and to build the evidence base on opioid benefits and risks, as well as the effectiveness of other pain treatments. In the meantime, it is important to begin with the available evidence regarding effectiveness and safety.

In all of its work, CDC's strategy is to use the best science to create real-world solutions. CDC's aim with the proposed guideline is to prevent prescription opioid overdose while ensuring that patients have access to safe and effective pain treatment. The guideline is one part of a broader approach.

The public comments received throughout the process of creating the guideline indicate that there are misconceptions about it. Hundreds of comments were received from patients with chronic pain and their families. They expressed that opioids reduce their pain, and they worried about the legal and clinical implications of the guideline. For example, there was fear that the guideline represents a law that would prohibit providers from prescribing opioid pain medication. Because of misconceptions about what guidelines represent, it is important to be clear on these issues.

The purpose of the guideline is to help primary care providers offer safer, more effective care for patients with chronic pain and to help reduce opioid use disorder and overdose. The guideline is a set of recommendations on the use of opioids for treating chronic pain; that is, pain lasting longer than three months or past the time of normal tissue healing. The guideline will help primary care providers determine when to start opioids for chronic pain and provide guidance regarding medication selection, dose, and duration. It will also provide guidance regarding when and how to reassess progress and discontinue medication, if needed. It will help providers and patients work together to assess the benefits and risks of opioid use and to address potential harms.

The audience of the guideline is primary care providers; however, it is acknowledged that providers work within team-based care. Therefore, the guideline refers to and promotes collaborative working relationships with other providers, such as behavioral health providers, pharmacists, and pain management specialists.

The guideline does not apply to patients who are in active cancer treatment or who are receiving palliative or end-of-life care. The guideline is not a rule, regulation, or law. It is not intended to deny access to opioid pain medication as an option for pain management, and it is not intended to take away physician discretion and decision-making. Guidelines guide physicians' practices, and Dr. Houry has found them to be helpful in the majority of cases, but not in all cases. She has chosen other options in collaboration with her patients.

The heart of the guideline is an effort to improve communication between providers and patients regarding the risks and benefits of prescription opioids. Pain must be treated effectively and safely. There is an under-recognition of the risks of opioids over the long-term, and limited evidence of actual benefits of their long-term use for chronic pain. There is insufficient evidence that long-term opioid therapy reduces chronic pain and improves function, and there is growing evidence that non-opioid treatments can be effective with less harm. Given these uncertain benefits in light of substantial risks, the evidence supports, and experts agree, that long-term opioid therapy outside of active cancer, palliative, and end-of-life care, should only be used when the benefits outweigh the risks, and should be used in combination with other treatments to provide greater benefits.

For patients not already taking opioids, opioids should not be first-line or routine therapy for chronic pain. People who have been on opioids long-term and believe that these medications are helping them might be understandably anxious about the idea of reducing or discontinuing opioids. Patients deserve the opportunity to learn about new evidence on the risks of opioids, particularly at higher dosages; to re-evaluate whether continuing their current treatment is the best available option; or to consider changing course if they and their provider together determine that it makes sense to do so. For patients and providers who choose to do so, the guideline will have information regarding the safe reduction or discontinuation of opioids.

CDC was responsive to concerns regarding the guideline development process, and followed a rigorous process using the best and most recent scientific evidence to develop the guideline. The guideline and recommendations were drafted after an extensive review of more than 130 of the most relevant and recent scientific studies about the effectiveness and risks of opioid and other pain treatments. Many have said that more evidence regarding effective pain treatments is needed. CDC agrees, and the recommendations will be refined when better evidence is available. Guidelines are warranted now, however, with the evidence that is currently available. Further, CDC consulted over a dozen of the country's top experts from many different disciplines on the recommendations and evidence. CDC received more than 1500 comments from constituents on the guideline even before the formal public comment period began. This input was helpful in revising the draft guideline. From the beginning, CDC has valued stakeholder and public engagement in a transparent and scientifically rigorous guideline development process. While CDC is dedicated to timely release of the guideline, given the urgent public health need, improvement of prescribing and successful control of the epidemic will require clinical practice changes. Support for these changes will benefit from review and engagement.

In mid-December 2015, the draft guideline was made available for public comment for 30 days. Over 4300 public comments were received, the most of any CDC guideline published on www.regulations.gov to date. Every comment was read. Dr. Houry was touched by the stories of individuals who live with chronic pain and their loved ones who care for them. Pain was described as *unrelenting*, *agonizing*, *profound*, *debilitating*, and *horrific*. Comments were also received from individuals struggling with opioid addiction and from individuals who lost loved ones to overdose. In addition to individual comments, letters were submitted from over 160 organizations, medical professional associations, hospital organizations, pain organizations, consumer groups, and state attorneys general. All feedback on broad themes as well as specific statements is carefully considered.

When the Opioid Guideline Workgroup was convened by the BSC in January 2016, public comments were heard. Dr. Houry thanked the individuals who shared their comments in that meeting and looked forward to the day's public comments after the presentation of the Opioid Guideline Workgroup. The workgroup's thorough review of the guideline and evidence was appreciated, as was their comments.

CDC believes that taking action and issuing guidelines now, based on what is known now, is warranted. The amount of drugs prescribed and sold in the US quadrupled since 1999, and the opioid overdose rate has risen in lockstep with prescriptions. Opioids can help manage some types of pain, but they also carry serious risks of addiction and overdose. Patients deserve to make informed choices about the benefits and risks of treatment options. This guideline is a balanced approach to achieving the goals of helping physicians manage chronic pain better and more safely in partnership with patients.

Overview: Draft CDC Guideline in Prescribing Opioids for Chronic Pain

Debbie Dowell, MD, MPH, LCDR, USPHS
Senior Medical Advisor
Division of Unintentional Injury Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

Dr. Debbie Dowell thanked the group for their attention to these critical issues. She provided an overview of the draft CDC Guideline for Prescribing Opioids for Chronic Pain, emphasizing that the guideline is needed. Many Americans, as many as 11% by one estimate, experience chronic pain. Opioids are frequently prescribed for chronic pain. Approximately 20% of patients seen in physician offices with pain receive a prescription for an opioid. Primary care providers account for approximately 50% of opioid pain medications dispensed. They report concern about opioids and insufficient training in opioid prescribing, and in the management of chronic pain. In her experience as an internal medicine physician, Dr. Dowell recognized that although pain was among the most common problems affecting patients, the medications offered too often failed to address pain adequately. She started a special clinic to assess and manage the most common pain-related conditions, including osteoarthritis, back pain, and musculoskeletal pain. She was quickly overwhelmed by referrals from her colleagues. Satisfying pain management often takes more time than the few minutes that primary care providers have to see a patient.

Over the last few decades, opioids have been prescribed more often and other treatments have been used less often for chronic pain. The quadrupling of opioid prescriptions in the US since 1999 primarily reflects increased use of opioids for the treatment of chronic pain. National guidelines on the prescription of opioids for chronic pain have been published by the US Department of Veterans Affairs (VA), the US Department of Defense (DoD), and the American Pain Society (APS) with the American Academy of Pain Medicine (AAPM). However, these guidelines were published in 2010 or earlier and do not incorporate new evidence published since that time, including several new studies examining the relationship between prescribed opioid dosage and overdose risk.

The new CDC guideline is intended to:

- ❑ Support informed clinical decision-making
- ❑ Help providers offer safer, more effective care for patients with chronic pain
- ❑ Help reduce misuse, abuse, and overdose from opioids
- ❑ Encourage improved communication between providers and patients about the benefits and risks of opioid therapy
- ❑ Improve provider confidence regarding when and how to use opioids in management of chronic pain
- ❑ Benefit patient health

The primary audience for the guideline is primary care providers treating patients 18 years of age and older with chronic pain (e.g., pain lasting more than three months or past the time of normal tissue healing) in outpatient settings outside of active cancer treatment, palliative care, and end-of-life care.

The guideline development process has reached the point of engagement with the NCIPC BSC. The meeting included a presentation on the observations of the BSC Opioid Guideline Workgroup. CDC used the GRADE process to rate the quality of evidence and to determine the recommendation categories. GRADE is a recognized standard for guideline development that supports a transparent approach to conducting systematic reviews, rating evidence quality, and determining the strength of recommendations. GRADE is used by more than 100 organizations, including CDC. Within the GRADE framework, recommendations are based on:

- Quality of evidence
- Balance between benefits and harms
- Values and preferences
- Resource allocation, or cost

Evidence is categorized into four types within the GRADE framework:

- Type 1, or high-quality evidence: Randomized controlled trials (RCTs) or overwhelming evidence from clinical studies

- Type 2, or moderate-quality evidence: RCTs with important limitations, or exceptionally strong evidence from observational studies

- Type 3, or low-quality evidence: Observational studies or RCTs with notable limitations

- Type 4, or very low-quality evidence: Clinical experience and observations, observational studies with important limitations, or RCTs with several major limitations

"Low-quality evidence" does not mean that there is no evidence. Instead, the evidence usually consists of observational studies or RCTs that are not well-designed. Unfortunately, few RCTs directly address decisions that clinicians need to make every day.

The recommendations are categorized using GRADE to convey the extent to which there is confidence that adherence to the recommendation will do more good than harm:

- Category A: Most patients should receive the recommended course of action.

- Category B: Decisions are made on an individual, case-by-case basis. Choices vary based upon patient values and preferences, as well as specific clinical situations. This category is assigned when the advantages and disadvantages of a clinical action are more balanced.

The 12 recommendations of the draft guideline 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

Dr. Dowell presented the 12 recommendations and the rationales for each. Recommendations 1 through 3 address determining when to initiate or continue opioids for chronic pain. Recommendations 4 through 7 address opioid selection, dosage, duration, follow-up, and discontinuation. Recommendations 8 through 12 focus on assessing risk and addressing harms of opioid use.

Recommendation One
Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain. Providers should only consider adding opioid therapy if expected benefits for both pain and function are anticipated to outweigh risks to the patient.

Recommendation Category: A
Evidence Type: 3

Rationale:

- While there is evidence that opioid therapy can reduce pain in the short term, with most trials lasting less than six weeks, there is insufficient evidence to determine whether pain relief, function, or quality of life improves with long-term opioid therapy.
- Long-term opioid use for chronic pain is associated with serious risks, including abuse, dependence and overdose.
- Many non-opioid therapies can improve chronic pain with less risk for harm, including exercise therapy, cognitive behavioral therapy, non-opioid pharmacologic therapies, and multidisciplinary approaches.
- When opioids are used, they are more likely to be effective if combined with other approaches.

Recommendation Two
Before starting opioid therapy for chronic pain, providers should establish treatment goals with all patients, including realistic goals for pain and function. Providers should not initiate opioid therapy without consideration of how therapy will be discontinued if unsuccessful. Providers 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

Rationale:

- It is difficult for providers and patients to predict whether benefits will outweigh risks of long-term opioid therapy. There is weak evidence that some patients experience pain relief long-term, and currently-available risk stratification tools show inconsistent results for ability to predict harms.
- In general, medications should not be continued when harms outweigh benefits.
- Establishing treatment goals in advance will help providers and patients make decisions about continuing or stopping drugs.
- Pain relief, function, and quality of life are all important.

Recommendation Three
Before starting and periodically during opioid therapy, providers should discuss with patients known risks and realistic benefits of opioid therapy and patient and provider responsibilities for managing therapy.

Recommendation Category: A
Evidence Type: 3

Rationale:
- Providers should involve patients in decisions about whether to start opioid therapy.
- Many patients lack information about opioids.
- Essential elements to communicate include:
  - Realistic expected benefits
  - Common and serious harms
  - Expectations for both patients and providers to mitigate risks

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

Recommendation Category: A
Evidence Type: 4

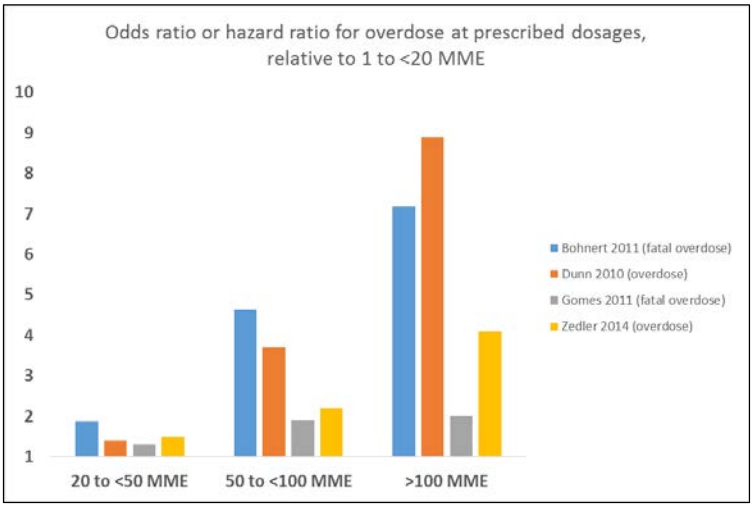
Rationale:
- There is a higher overdose risk among patients initiating treatment with ER/LA opioids than among those initiating treatment with immediate-release opioids.
- The clinical evidence review did not find evidence that continuous, time-scheduled use of ER/LA opioids is more effective or safer than intermittent use of immediate-release opioids.

Recommendation Five
When opioids are started, providers should prescribe the lowest effective dosage.
Providers should use caution when prescribing opioids at any dosage and should implement additional precautions when increasing dosage to 50 or more morphine milligram equivalents (MME)/day, and should generally avoid increasing dosage to 90 MME/day or more.

Recommendation Category: A
Evidence Type: 3

Rationale:
- Risks for serious harms related to long-term opioid therapy increase in a dose-dependent manner.
- In a large, national VA sample, the majority of fatal overdose cases had prescribed dosages above 50 MME. Among patients not experiencing overdose, most had dosages of 50 MME or less.
- The benefits of high-dose opioids for chronic pain are not established. An RCT found no difference in pain or function between more liberal dose escalation, with an average opioid dosage of 52 MME at the end of the study, and maintenance of current dosage, with an average dosage of 40 MME at the end of the study.

Recommendation Five is the recommendation for which the most new evidence has accumulated in the last five years. During her medical training in the late 1990s, Dr. Dowell was taught that higher opioid dosages did not put patients at higher risk for overdose as long as the dose was titrated up slowly enough for patients to develop tolerance. This teaching was not based on controlled studies. Since 2010, nine well-designed, case-controlled and cohort studies have been published demonstrating a strong association between prescribed opioid dosage and opioid-related overdose. Four studies that used similar cut points, and therefore could be combined in one chart, are shown here:



Dosages of 50 to 100 MME per day show an increased opioid-related overdose risk of factors from 2 to 5, and dosages of greater than 100 MME per day show an increased opioid-related overdose risk of factors of up to 9. Five additional cohort or case-controlled studies have also shown a similar dose-response relationship between opioid dosage and overdose risk.

Recommendation Six

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, providers should prescribe the lowest effective dose and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three or fewer days will usually be sufficient for most non-traumatic pain not related to major surgery.

Recommendation Category: A
Evidence Type: 4

Rationale:

- ❑ Opioid use for acute pain is associated with long-term opioid use, and greater amount of early opioid exposure is associated with greater risk for long-term use.
- ❑ More than a few days of exposure significantly increases hazards.
- ❑ Fewer days' supply minimizes the number of pills available for intentional or unintentional diversion.
- ❑ In most cases of acute pain, such as acute back pain, not related to major surgery or trauma, pain severe enough to require opioids will subside within three days. If it does not, re-evaluation is generally warranted.

Recommendation Seven
Providers should evaluate benefits and harms with patients within one to four weeks of starting opioid therapy for chronic pain or of dose escalation. Providers should evaluate benefits and harms of continued therapy with patients every three months, or more frequently. If benefits do not outweigh harms of continued opioid therapy, providers should work with patients to reduce opioid dosage and to discontinue opioids.

Recommendation Category: A
Evidence Type: 4

Rationale:
- Risks for opioid overdose highest during the first two weeks after initiation for ER/LA opioids, within the first three days after initiation for methadone.
- Patients who do not experience pain relief with opioids at one month are unlikely to experience pain relief with opioids at six months.
- Continuing opioid therapy for three months substantially increases risk for opioid use disorder.

There is a strong association between continuing opioid treatment for three months and opioid use disorder. Using data from a large medical claims database, Edlund and colleagues showed that patients on more than 90 days of high-dose opioid therapy, defined in the analysis as greater than 120 MME, had a 122-fold increase in the likelihood of being diagnosed with an opioid use disorder compared with no opioid prescription. As a comparison, it should be noted that the odds ratio for lung cancer in current smokers relative to nonsmokers is estimated at 40, and the odds ratio for heart disease in current smokers relative to nonsmokers is estimated at 2. Even at relatively lower dosages of 36 MME or lower for more than 90 days, there is a 15-fold increase in the likelihood of opioid use disorder.

Recommendation Eight
Prior to starting and periodically during continuation of opioid therapy, providers should evaluate risk factors for opioid-related harms. Providers 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, or higher opioid dosages (greater than or equal to 50 MME) are present.

Recommendation Category: A
Evidence Type: 4

Rationale:
- Opioids can worsen central sleep apnea and increase risk for respiratory depression and overdose.
- Reduced renal or hepatic function can result in a smaller therapeutic window between safe dosages and dosages associated with respiratory depression.
- Patients with mental health co-morbidities and histories of substance use disorder are at higher risk for opioid use disorder and overdose.
- Community-based naloxone distribution has been associated with reduced opioid-related overdose death.

Recommendation Nine
Providers 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 dangerous combinations that put him or her at high risk for overdose. Providers 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 three months.

Recommendation Category: A
Evidence Type: 4

Rationale:
- Most fatal overdoses are associated with high total prescribed daily opioid dosages, and/or receipt of opioids from multiple prescribers or pharmacies.
- Both of these risk factors can be assessed by reviewing PDMP data.

PDMP data can predict overdose risk. Using data from Vital Statistics in the Tennessee PDMP in a matched, case-controlled study, Baumblatt and colleagues found that the risk of death from an overdose went up six-fold for patients who received opioids from four or more doctors, or from four or more pharmacies. The risk was 11 times greater for patients on high dosages of more than 100 MME.

Patients with one or more risk factors receiving prescriptions from multiple sources and/or total dosage, accounted for 55% of all overdose deaths. They only comprise 6% of patients not experiencing fatal overdose. In other words, information from a PDMP can predict a high proportion of patients at risk for overdose death.

Recommendation Ten
When prescribing opioids for chronic pain, providers 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

Rationale:
- Urine drug tests can provide useful information about unreported drug use that can increase patients' risk for overdose.
- Factors influencing category B designation include:
- These tests are not always covered by insurance, and particularly when more specific tests are used can result in significant cost burden for patients.
- Urine test results are often misinterpreted by providers.

Recommendation Eleven
Providers should avoid prescribing opioid pain medication for patients receiving benzodiazepines whenever possible.

Recommendation Category: A
Evidence Type: 3

Rationale:
- Concurrent benzodiazepine and opioid prescription are associated with a near quadrupling of risk for overdose death, compared with opioid prescription alone in a case-cohort study.
- Concurrent benzodiazepine use has been found in large proportions of opioid-related overdose deaths in epidemiologic case series.

Recommendation Twelve
Providers should offer or arrange evidence-based treatment, usually medication-assisted treatment (MAT) with buprenorphine or methadone in combination with behavioral therapies, for patients with opioid use disorder.

Recommendation Category: A
Evidence Type: 3

Rationale:
- Prevalence of opioid use disorder, previously referred to as opioid dependence or addiction, among primary care patients on chronic opioid therapy ranged from 3% to 26%.
- Buprenorphine or methadone are effective in preventing relapse among patients with opioid use disorder.

NCIPC followed a rigorous process and used GRADE, which provides a transparent framework for the translation of evidence into recommendations. The supporting text in the draft guideline provides further information about implementation of the recommendations. Dr. Dowell thanked the group for their time and careful consideration of the draft guideline.

Discussion Points

Dr. Hargarten opened the floor for clarifying questions about the draft guideline. Regarding the background and need for the guideline, he noted that Dr. Dowell reported that 11% of Americans experience daily pain. He asked whether that percentage has changed in the last decade or two; that is, is the US as a nation experiencing more chronic pain than ever before, or has the situation been fairly steady?

Dr. Dowell replied that it is difficult to tell whether the number of Americans experiencing daily pain has changed, as different surveys in different populations ask questions in different ways and generate varying ranges. Some ranges are as high as 40% of adult Americans experiencing daily pain, as expressed in the Institute of Medicine (IOM) report, which used the definition of "any back pain, arthritis, neck pain, or headache in the last year." Other estimates are as low as 8%. It is difficult to track what is happening over time. A study from Daubresse and colleagues examined reports of pain in a large database from 2000-2010. That study concluded that the amounts of pain that people reported were relatively constant during that

time period. Interestingly, during that time period, opioid prescribing was increasing as the use of other treatments was decreasing.

Dr. Sherry Lynn Hamby asked about the data presented as rationale for Recommendation Seven. She wondered whether the data were presented in comparison with no opioid use and whether the cell should not have a zero value, as it is not clear how opioid use disorder would be present without opioid use. She also noted that odds ratios are not equivalent to relative risk in many studies and warned that the guideline should take care with that wording. Relative risk could be 122, but that phrasing should not be used to imply an incident rate of over 100%.

Dr. Dowell agreed and clarified that odds ratios are the ratio of one odds to another odds in another group, where relative risk is a ratio of proportions. In terms of the study supporting Recommendation Seven, she indicated that opioid use was compared to no opioid prescription. The study utilized a claims database to determine opioid use. People could have been using opioids that were not prescribed or that were prescribed outside the managed healthcare system.

Report from Opioid Guideline Workgroup

Christina Porucznik, PhD, MSPH
NCIPC BSC member
Chair, Opioid Guideline Workgroup

Dr. Christina Porucznik thanked the group and noted that the Opioid Guideline Workgroup included members who represented a range of specialties, experience, and expertise. The role of the workgroup was to provide observations to the BSC about the draft CDC Guideline for Prescribing Opioids for Chronic Pain, the clinical evidence review, and the contextual evidence review. The group met four times in 2016 by teleconference on January 8, 13, 15, and 18.

During its January 7, 2016 meeting, the NCIPC BSC suggested that the workgroup engage the help of consultants to provide expertise from additional perspectives. The workgroup engaged with consultants from the following additional fields who participated in workgroup discussions as the workgroup identified need for additional information in their specialties:

Consultant Area	Participation
Pediatrics & Anesthesiology	*Ad hoc*, not contacted
Occupational Med & Worker's Comp	*Ad hoc,* not contacted
Obstetrics & Gynecology	Participated 1/15
GRADE methods & cost effectiveness	Participated 1/8, 1/13, & 1/15
Medical Ethics	*Ad hoc*, not contacted
Addiction Psychiatry	Participated 1/15
Physical Medicine & Rehabilitation	Participated 1/13
Addiction Psychiatry	Participated 1/15

The group made overall observations about the guideline. These observations apply either to more than one of the recommendation statements or to the guidelines as a whole rather than to a single statement.

- Workgroup members support efforts reflected in the guideline to encourage integrated care for people with chronic pain. As defined in the draft National Pain Strategy, integrated care is the systematic coordination of medical, psychological, and social aspects of healthcare. It includes primary care, mental health care, and specialist services when needed.

- Workgroup members suggest continued monitoring of Guideline implementation for evidence of their impact and of unintended consequences, and modification of the guideline when warranted by evidence.

- Several workgroup members suggest that pediatric and adolescent populations should be considered for future updates of opioid prescribing guidelines. The current draft guideline is intended for adults over age 18 being managed in primary care for chronic pain.

- Risks and benefits of opioid therapy and chronic pain, and the epidemiology of prescription drug misuse and abuse, are areas of active research. The workgroup suggests that the contextual evidence review may need to be updated more frequently than the clinical evidence review. The workgroup encourages CDC to work with partners to support additional research in this field.

- Workgroup members expressed strong preference for Guideline Recommendations that are framed with positive rather than negative language.

- Several workgroup members observed that they were asked to consider cost feasibility for the recommendations. In general, the group feels that such data are lacking and are subject to great variability. More research is required in this domain in order to have evidence related to cost feasibility that could be evaluated.

- Concerns about access to care, cost, and insurance coverage were raised by several workgroup members in discussion of Guideline Recommendations One, Six, Seven, Eight, Nine, Ten, and Twelve.

- Systematic changes in payment policies will likely be required to support implementation of the guideline. Workgroup members encourage CDC to work with federal partners to support payment policies that are congruent with the guideline.

- Discussions about safe medication storage and disposal are mentioned in several sections of supporting text that accompany the guideline. Workgroup members observed that these discussions are relevant throughout the course of opioid therapy for chronic pain and encourage providers to include patient education on safe storage and disposal of medications as a routine part of therapy along with discussions of risks, benefits, treatment goals, mental health, pain, and function.

- Workgroup members observed that primary care providers may require additional education on approaches integral to implementation of the Guidelines, including education on:
  - Non-pharmacologic and integrated care
  - Offering naloxone to patients with chronic pain
  - Medication-assisted treatment for opioid use disorder

- Workgroup members encourage CDC to work with partners to support and/or provide appropriate education to primary care providers.

The workgroup also offered the following observations about each of the recommendations in the draft guideline:

Recommendation One

- All members of the workgroup agreed with the type and category of evidence for Guideline Recommendation One.
- Workgroup members commend the ordering of statements and agree that the topic of this recommendation should be first.
- Clear wording that opioids are not routine therapy for adults in chronic pain managed in primary care, as well as mention that both pain and function are important, are good messages to present first in the guideline.
- Several workgroup members expressed significant concerns about access to care, particularly for non-pharmacologic therapies mentioned in this recommendation. It was suggested that there should be clear preference for integrated care for chronic pain expressed in Recommendation One and throughout the guideline and supporting text.

Recommendation Two

- All members of the workgroup agreed with the type and category of evidence for Guideline Recommendation Two.
- Workgroup members particularly commend this recommendation for its focus on patient-centered goals for improvement of pain and/or function.
- There was some concern that some providers would interpret the phrasing of "pain and function" to mean that improvements are required in both pain and physical function in order to justify continuation of opioid therapy. Such meaning could be clarified in the supporting text. Spinal cord injury patients, for example, may never walk again; however, continued opioid therapy may be appropriate if it helps manage their pain and improves social or psychological function.
- Many people with chronic pain also experience mental health concerns, such as depression and/or anxiety. There is evidence that treating these co-existing conditions can improve pain outcomes as well. Several workgroup members encouraged the addition of language in the supporting text for Recommendation Two to include evaluation of mood in addition to pain and function.

Recommendation Three

- All members of the workgroup agreed with the type and category of evidence for Guideline Recommendation Three.
- Several members observed that suggesting a safety discussion in response to unexpected findings in the PDMP data or urine drug screen results in the supporting text for this recommendation may suggest to providers that safety discussions are for extreme events, rather than conversations that should occur at initiation of opioid therapy and should continue as a routine matter throughout the duration of therapy.
- Disposal of medications is a complicated situation. Information about safe disposal of medication should be included in the tools accompanying the guideline.
- Several workgroup members suggest that consideration of possible risk to household members from accidental ingestion or diversion of opioids should be included in the discussion of risks and benefits with the patient who will be receiving the opioids.

Recommendation Four

- All members of the workgroup agreed with the type and category of evidence for Guideline Recommendation Four.
- This recommendation is evidence type 4, which includes observational studies and clinical experience. The subject matter experts (SMEs) in the workgroup agreed that this recommendation is consistent with best practices and well-deserves a Category A designation.

Recommendation Five

- This recommendation generated significant discussion about content in addition to the discussion about the recommendation category and evidence type:
  - Six of the nine workgroup members agreed with the category A and evidence type 3 designation.
  - Three workgroup members felt that the evidence type 3 was appropriate, except for the last paragraph of supporting text. If the discussion of tapering in the supporting text was removed, then Category A and evidence type 3 designation was appropriate.
  - Two workgroup members suggested revisions to the statement.
- Most members felt that the evidence for the last paragraph of supporting text, which involves tapering, was type 4 evidence, but would support type 3 evidence for the remaining paragraphs of supporting text.
  - One specific observation was that the last paragraph of the supporting text for this recommendation, regarding patients already taking opioids, does not directly support Recommendation Five itself, which is about initiation of opioid therapy.
- In comparison to contextual evidence for risk and harm for opioid therapy, there are virtually no studies of long-term benefits or improvement in pain and function with opioid therapy. Workgroup members encourage future studies to populate this data gap.
- One member of the workgroup strongly opposes Recommendation Five as it is written. This member stated repeatedly that the current recommendation clearly suggesting dose limits is not supported by any data showing a decrease in benefit-to-risk ratio at the arbitrary number stated in the recommendation. This member expresses concern that the current wording of Recommendation Five will undermine support for the entire guideline from providers and professional organizations.
- The focus on patient pain and function included in the text of Recommendation Two is not similarly included with Recommendation Five. Improvement or decrement of pain and/or function should be the impetus for any change in dose, either increasing or decreasing. Workgroup members observed that this message should be repeated here.

Recommendation Six

- All members of the workgroup agreed with the evidence type for Recommendation Six.
- There was considerable discussion about the category for this recommendation:
  - One member recommended that this recommendation should be Category B.
  - Many members are able to support the Category A designation only if the statement is reworded to include a range for the duration of therapy.
- The duration of therapy was the focus of animated discussion:
  - Many members felt that three days was too limited and preferred a range of values, none of which exceeded seven days.
  - Seven days or fewer: four members
  - Three to seven days: two members
  - Five to seven days: one member
  - Three to five days: one member

- One member was strongly opposed to seven days as too long.
- A specific wording suggestion for this recommendation is, "Avoid prescribing more than three days' supply, unless circumstances clearly warrant additional opioid therapy."
- The supporting text for this recommendation should also include information and tools about safe medication storage and disposal.

Recommendation Seven

- All members of the Workgroup agreed with the type and category of evidence for Recommendation Seven.
- This recommendation should apply to all patients. Several workgroup members expressed concern that the wording of this recommendation applies only to opioid naïve patients.
- Individual workgroup members suggested specific edits to this recommendation, particularly to the final sentence. There was concern that it implies that all patients should be at a dose of zero opioids and fails to suggest what else providers should do regarding other therapies besides eliminating the opioid medication.

Recommendation Eight

- All members of the Workgroup agreed with the type and category of evidence for Recommendation Eight.
- Two members suggest that the recommendation would be stronger with the inclusion of concomitant use of central nervous system (CNS) depressants or sedatives among the listed risk factors in the statement.

Recommendation Nine

- All members of the Workgroup agreed with the type and category of evidence for Recommendation Nine.
- The bulleted information in the supporting text for this recommendation should also apply to patients on high dosages of medications and dangerous combinations, not just patients receiving medications from multiple providers.
- Workgroup members observe that access to PDMP data and the utility of that data vary among states. Issues of data sharing can limit PDMP utility in border areas. CDC and its federal partners are encouraged to support PDMP development and operation across the country and to help to work toward efficient data access and interfaces for all providers of controlled substances.

Recommendation Ten

- All members of the workgroup agreed with the evidence type for Recommendation Ten.
- The majority of workgroup members felt that this recommendation should be a Category A recommendation, rather than Category B.
- The universal recommendation from Category A is perceived to be both more focused on patient safety and less likely to result in urine drug testing being applied selectively among already-stigmatized or stereotyped patients.
- Supporting text for this recommendation should encourage providers to use the simplest urine drug testing appropriate for each patients in order to reduce cost and improve the feasibility of the recommendation.
- Workgroup members emphasized the need for providers to be educated about interpretation of the results of the urine drug testing implemented in their practice settings.
- Research on risks and benefits of urine drug testing is limited, and more such research is encouraged.

Recommendation Eleven

- All members of the workgroup agreed with the type and category of evidence for Recommendation Eleven.
- Risk mitigation in the presence of co-prescription of opioids and benzodiazepines was universally supported by the workgroup.
- Members of the workgroup observed and supported that the intention of this recommendation is to discourage concurrent prescribing of opioids and benzodiazepine medications; however, several members felt that the current language presumes that the benzodiazepine is appropriate and fails to encourage patient-centered decision-making about risks and benefits for each medication.
- Supporting text for this recommendation could include language regarding the importance of the pharmacist in co-prescribing situations and the role for the use of PDMP data to identify concurrent medication use.
- Workgroup members noted that the wording of Recommendation Eleven has changed significantly during the comment and review process.
  - Several workgroup members preferred the original wording.
  - Some workgroup members preferred that this statement be modified to state that "providers should use caution when" prescribing opioids, rather than "providers should avoid" prescribing opioids.
  - Several workgroup members supported the "avoid" wording, and two members strongly preferred the "avoid" wording.
- Discussion about this recommendation surrounded concerns about inter-professional communication; that is, between psychiatrists, who frequently prescribe the benzodiazepine and the primary care providers, who prescribe opioids. The discussion included challenges and the need for providers and patients to jointly discuss the patient's needs, prioritize patient goals, and weigh risk of concurrent benzodiazepine and opioid exposure before deciding upon initiating, continuing to prescribe, or tapering either medication.

Recommendation Twelve

- There was disagreement among the workgroup members regarding the evidence category for this recommendation. One member strongly supported a Category B designation, while the remaining members were comfortable with Category A.
- Workgroup members agreed that the evidence for MAT for opioid use disorder is strong and recommended that the evidence type for this recommendation be upgraded from Type 3 to Type 2.
- Workgroup members commended the wording of this recommendation, particularly the "providers should offer or arrange" clause. The workgroup members felt that this wording will help encourage primary care providers to be proactive about treatment for opioid use disorder and perhaps encourage more providers to acquire training and licensure for buprenorphine prescribing.

The workgroup also reviewed and generated observations on supplemental materials to the draft guideline, including the Clinical Evidence Review, the Contextual Evidence Review, and Comments from Stakeholders, Peer Reviewers, and the Public.

- ❑ The Clinical Evidence Review was thorough and well-done for the specific clinical questions.
- ❑ Workgroup members recommend continued support for future clinical and contextual research on benefits and risks of opioid therapy for chronic pain.
- ❑ Future updates of the Contextual Evidence Review should seek out more information about specific non-pharmacologic therapies for chronic pain, such as exercise therapies, interventional therapies, integrated medicine, and behavioral therapies.
- ❑ Evidence in the Contextual Evidence Review supports that mental health disorders frequently co-occur among people with chronic pain. The supporting text for Recommendations Two and Five, which describe evaluating pain and function, should be modified to include evaluation of patient mood as well.
- ❑ Comments from constituents demonstrated the breadth and variety of positions on the issue of opioid therapy for chronic pain among adults managed in primary care. However, there seemed to be general agreement that guidelines are urgently needed, even if this set of guidelines is only the first step.
- ❑ Comments from patients and family members in particular expressed the desire that patient-centered care is enhanced, rather than reduced, by this guideline. Members of the workgroup felt that the guideline could be implemented in a manner consistent with patient-centered care.

Discussion Points

Dr. Shelly Timmons asked about the extent to which the workgroup took into account the larger context of chronic pain, its diagnosis, separation of pathophysiologies, and the determination of appropriate treatments of chronic pain other than opioids. She noted that Dr. Houry had mentioned that this guideline is part of a larger effort on chronic pain. The guideline has a limited scope for a reason and is only addressing the use of opioid therapies; however, she wondered about the context of the workgroup's formulation of language, particularly in the contextual section. There is some paucity of language in that section that could expand on the problem of diagnosis and pathophysiology, and the selection of appropriate treatments.

Dr. Porucznik replied that the workgroup extensively discussed the difficulty of patient access to non-pharmacologic therapy for chronic pain. Members of the group agreed that it is a great idea for patients to manage chronic pain through means other than opioids, and that opioids should not be a first step of treatment. Members were also in agreement that it is difficult in practice for patients to access other therapies and for providers to get patients into care that does not have a prescription. There was a great deal of concern that because this document focuses on opioids, it may give the impression that opioids are normal and that other therapies are alternative when in reality, the characterizations should be reversed. Opioids should be reserved for cases in which they are the only approach that works. The workgroup realized that this guideline is for the prescription of opioids in primary care.

Dr. Traci Green added that the focus of the guideline was on what to do after an assigned diagnosis of an acute or chronic pain condition, not on what do to before the diagnosis.

Dr. Timmons expressed concern that only alternative therapies that are not medical were being considered. The first step is to decide whether opioid medication is even appropriate for the type of chronic pain that a patient is experiencing. There are surgical therapies and other medications and classifications that could be more appropriate. Headache and back pain, for instance, have multiple etiologies and it is important to work through the range of appropriate and possible approaches. The emphasis on that decision-making process is in a brief paragraph in the draft guideline, but the process may have been given short shrift. More clarifying language on may be needed, if possible.

Dr. Porucznik responded that the workgroup had discussed this issue. There is limited evidence comparing opioids to other therapies. Encompassing the spectrum of evidence is challenging.

Regarding the workgroup response to Recommendation Five and the statement on dosage limits, **Dr. Deborah Gorman-Smith** noted that one workgroup member strongly opposed including specific limits. She assumed that the other workgroup members were not concerned about the dose levels stated in the guideline and asked for more detail about the group's conversation.

Dr. Porucznik said that there was a great deal of workgroup discussion on this point. Other workgroup members did not have as strong a response to the limits as the member with the strong response. There was concern that nearly any specified level chosen could be described as "arbitrary." The available evidence is primarily from large claims databases and related sources. Opioid dosing is not discrete. It is in "chunks of pills." Therefore, it is not possible to look at a uniform distribution and find an inflection point. The other workgroup members were comfortable with the levels presented in the draft guideline.

Dr. Greenspan reminded the participants on the telephone that they could access the workgroup observations document at www.cdc.gov/injury/BSC, under the tab "Meetings."

Dr. Hargarten thanked Dr. Porucznik and the workgroup and congratulated them on a thoughtfully organized summary of their observations.

Lunch Break / Call to Order / Roll Call

Dr. Greenspan dismissed the group for a lunch break at 10:40 a.m. The meeting resumed at 11:30 a.m. **Mrs. Tonia Lindley** conducted a roll call of the BSC members and *ex officio* members and established that a quorum was present.

Discussion of Workgroup Report

Stephen Hargarten, MD, MPH
Professor and Chair
Department of Emergency Medicine
Medical College of Wisconsin
Chair, National Center for Injury Prevention and Control Board of Scientific Counselors

Dr. Hargarten thanked Dr. Porucznik for her leadership of the Opioid Guideline Workgroup, and Dr. Green and the other workgroup members for the time and effort that they dedicated to reviewing the draft CDC Guideline for Prescribing Opioids for Chronic Pain and its supporting documentation. He reminded the participants that the materials were available online. During this session, he opened the floor for questions and comments regarding the content of the Opioid Guideline Workgroup observations and requested that BSC members provide input regarding their priority areas of concern or clarification.

Discussion Points

Dr. Angela Mickalide requested a more engaged discussion regarding safe storage of medications, particularly with the pediatric population, as well as further discussion regarding the lack of Type One and Type Two evidence within GRADE and whether this type of evidence will ever be available moving forward.

Dr. John Allegrante suggested that they discuss professional education and the potential partnerships that will need to be formed for provider education regarding the guideline and regarding the problem of opioid abuse in general. This guideline will be an organic, living document, but he said he hoped to discuss further provider education and the implementation of the guideline.

Dr. Joan Duwve asked for additional conversation regarding urine drug monitoring, especially the availability of specific urine drug tests that are appropriate for office-based use and that are powerful enough to discern the types of information that providers may need to make informed decisions. There may need to be more robust language in the guideline regarding urine drug monitoring. She also hoped for a discussion regarding the workgroup's suggestion that this recommendation should be Category A rather than Category B.

Dr. Samuel Forjuoh observed that there are already too many recommendations and wondered if they could be combined. There may be a way to simplify them, especially given that primary care physicians are already overwhelmed and may be burdened by several recommendations on opioids.

Dr. Wilson Compton asked for discussion regarding evaluating the outcomes of implementing the guideline and assessing its impact both on pain patients, the larger drug abusing community and on overdose rates, which is the main goal of the guideline. There are potential positive impacts, such as reducing opioid misuse, abuse, and overdose. There are also potential benefits and complications for patients that seek pain treatment.

Dr. Hamby suggested that the group discuss the review of state policies and how they figured into the development of the guideline. She encouraged that they consider using the rich data that are available from a number of states that have implemented different guidelines with different features in order to determine which approaches have the biggest impact on overdose. There is an opportunity to advance evidence-based practice. Further, there should be consideration of inclusion of other outcomes and possible adverse effects, such as patients who have had less-successful pain management due to more restricted access to opioids. National guidelines that were released in 2010 apparently had little impact on prescribing practices, which have increased considerably.

Dr. Duwve expressed confusion with respect to Recommendations Eight and Eleven, particularly regarding the workgroup recommendation to include depressants and sedatives in Recommendation Eight. Recommendation Eleven speaks to this point when it refers to the co-prescribing of benzodiazepines. Perhaps the CNS depressants could be added to Recommendation Eleven so that Recommendation Eight remains focused on multiple prescribers for opioids specifically.

Dr. Gerald Gioia asked to hear more discussion regarding non-pharmacologic therapies and the guidance that can be provided to primary care providers to prepare them to inform their patients about those options if they are not actively pursued.

Dr. Timmons emphasized that in addition, surgical therapies may be considered, as well as other, non-opioid pharmacological therapies. The BSC might consider recommending increased language regarding the context. The guideline refers to integrated care for chronic pain, which is a combination of multiple diagnoses. It is important to integrate that conversation at least into the guideline's background materials and to educate primary care providers on choosing therapies appropriately.

Dr. Hargarten noted that some of the BSC's responses addressed the workgroup observations, and others focused on content within the guideline.

Dr. Porucznik addressed Dr. Duwve's observations on Recommendations Eight and Eleven. Recommendation Eight lists different risk factors and times when people should take more caution, including before starting and periodically during continuation of opioid therapy. The workgroup felt that CNS depressants and sedatives represent a real risk factor at this point and should not be left out of this recommendation. The recommendation chiefly refers to benzodiazepines, and it is important for another recommendation to focus on benzodiazepines. The workgroup did not specify benzodiazepines in Recommendation Eight because they did not want to be too specific and possibly imply that other depressants or sedatives are free from risk. There has been a great deal of work on the combined harms of opioids and benzodiazepines, partly because they both appear in PDMP data and it is relatively easy to evaluate them.

Dr. Duwve agreed about the risks of co-prescribing. In Indiana, she hears of people taking the "holy trinity" of a muscle relaxant, benzodiazepines, and opioids to potentiate the effects of the opioids. She had been confused regarding why there were two recommendations, but she agreed that there is sufficient risk to warrant mentioning them twice.

Dr. Porucznik turned to Recommendation Ten and the availability of office-based urine drug testing and the assignation of Category A versus Category B. The workgroup felt that assigning Category B to the recommendation was tantamount to having no recommendation at all. Presently, urine drug testing is used by some providers. It is probably more often used for

patients who are members of more stigmatized populations or in a stereotypical testing. The workgroup felt that assigning Category A to the recommendation for urine testing would strengthen it, systematize it, make testing more part of routine care, and not relegate the testing to an approach that providers use to "fire patients." Regarding the availability for office-based use, there is a wide variety of technologies being used for urine drug testing. The larger concern of the workgroup was that providers may not be aware of the testing that occurs when they call for urine drug screening. There is a corollary of providers who buy expensive machines and conduct office-based testing as a means of generating income. Neither scenario is appropriate. Therefore, the workgroup suggested using language that refers to the "simplest appropriate test." This recommendation incorporates not testing for something that will not change the management, and considering testing in a qualitative rather than a quantitative fashion. Providers should observe the prescribed medications to check for diversion and should ensure that there are no other opioids present. Many primary care providers will need education regarding the appropriate types of testing so that the testing is cost-efficient for patients and useful in practice.

Dr. Duwve agreed that it is difficult for providers to tease out who needs to be tested and who does not. This concept was confirmed in Indiana when a family practice doctor tested all patients in his practice in a small rural community. The results were surprising. Patients who had never violated any of the contractual provisions had no evidence of drug in their urine when tested. Providers can be poor judges about who needs to be tested. There has been a great deal of discussion in Indiana regarding language that is applied to testing. There are many options, and it can be challenging for a busy primary care provider to navigate them. She recommended that the guideline include detailed directions for when to use a test, what its results mean, and more. Indiana uses language that states that "a prescribing physician shall perform or order a drug monitoring test that must include a confirmatory test using a method selective enough to differentiate individual drugs within a drug class." Reducing cost and improving feasibility are worthy goals, but if the test is meaningless, then the approach is not cost-effective.

Dr. Porucznik said that the implementation choices are likely to occur at system levels rather than in individual private offices. CDC can provide tools in the supporting text to the guideline to help the decisions get made.

Dr. Hargarten asked about follow-up plans for education, such as their specificity, instructions, and emphasis.

Dr. Dowell added that the key to the success of the guideline will be provider education and implementation. CDC is not at that stage yet, but there has been a great deal of thinking about the best way to ensure that the guideline is understood and used. Fact sheets and a checklist will be created for providers. In particular, a fact sheet is planned on non-opioid treatments, including non-pharmacologic treatments as well as non-opioid pharmacologic treatments. It will take longer to develop, but it will be important to provide fact sheets on urine drug testing, dosage, and understanding MME. Fact sheets are also planned on PDMP checks and what they mean and do not mean, as well as suggestions to help patients. A mobile app is also planned. In the future, CDC hopes to engage with medical professional societies and clinical decision support mechanisms to help providers follow guidelines, when appropriate, with their patients. Quality improvement (QI) measures may present another avenue, and it may be possible to work with academic institutions that can partner with health systems to develop a QI technical package. Other ideas are welcomed.

Dr. Allegrante said that medical societies are logical partners, given continuing medical education (CME). He suggested partnering with the pharmaceutical industry. It may be controversial, but given the impact that the industry has on prescribing behavior among clinicians, it may be worth consideration.

Dr. Dowell replied that CDC had not yet thought about the pharmaceutical industry, but there is an extensive risk evaluation and mitigation strategy (REMS) program for extended release and long-acting opioids, which is funded by pharmaceutical companies.

Dr. Timmons asked about plans for developing a research agenda for comparative effectiveness research or other types of research on this subject.

Dr. Dowell answered that research is very important and critically needed. This research will also be expensive to do well. There have been discussions with potential funding partners regarding how to prioritize the research.

Dr. Timmons said that one of the benefits of developing guidelines is the light that they shed on where evidence is lacking and to develop and publish a research agenda, even if it is not funded through CDC.

Regarding the co-occurring use of benzodiazepines and other medication, **Dr. Hamby** said she understood that the majority of overdoses are among people who are on multiple medications. It would be worth considering emphasizing this point more in terms of identifying the most at-risk patients. Regarding language, she noted that Indiana uses the phrasing “shall” in reference to certain urine testing, and the workgroup debated whether this point should be Category A or B in the guideline. These questions are empirical and data are already available to address them. Data are available because there is variability in the language used in state prescribing policies. It is possible to examine the differences in rates in urine testing and the more important final outcome of overdose. The best available scientific evidence should be used to craft policy, and this state information is not currently being used to inform the guideline.

Dr. Hargarten noted that the recommendation was to classify selective urine testing as Category A, as opposed to Category B. This change would be consistent with the current understanding of the best approach.

Dr. Hamby pointed out that the workgroup’s conclusion represented a consensus judgment. Actual data could support the classification and allow the language to be strengthened. State data are probably available on increasing the percent of patients are being urine tested and on the type of testing that is offered. With these data, many ideas that are presented as professional judgment calls could be treated as empirical questions with current available data.

Dr. Robert Johnson noted that while evidence is available regarding how frequently people are tested, there is no evidence regarding how urine drug testing impacts outcomes. There is the potential for harm, which was considered by the workgroup, because urine drug tests can be difficult to interpret and many primary care providers are not skilled in interpreting them. The cost issue is complex. Confirmatory tests add $50 to $100 each, and patients may be billed for them. Confirmatory tests may not be needed in all situations, such as when the detected drug was expected. These issues need to be addressed within laboratories and clinic systems. If a confirmatory test is mandated, it may not be based on strong data and the cost-effectiveness is not clear. Some people may be found through this testing who would not be expected;

however, a low-risk person with 10 urine drug tests with expected results may not need to continue being tested. Many questions are not addressed well and supported with evidence.

Dr. Hamby concurred regarding cost issues, which could be incorporated into the products that accompany the guideline. Information is available regarding evidence of the impact on the outcome of overdose, but has not been analyzed. The state policies could be coded for their strength of recommendation, the type of testing, whether it is required or optional, and other factors. Good state-level data are available on overdose rates. It would be a simple matter to code state policies for key issues within the recommendations and determine whether states with stronger wording show fewer overdoses, for instance, or whether the policy does not affect outcome. This point is an example of the states as "laboratories," as a wide range of policies have been implemented. The variability and CDC surveillance could be used to craft guidelines based on the factors that are most correlated with reductions in overdose.

Dr. Johnson pointed out that the data analysis requires resources and time. A larger problem is the number of confounding factors. Most of the states that implement urine drug testing policies are implementing a number of other opioid-related policies. It would be highly challenging to separate the causative factors with any reliability.

Dr. Porucznik replied that this issue relates to the questions of evaluating outcomes and implementation. Her state tried to conduct a project to determine the impact of the guidelines that were promulgated some years ago. Many of the guideline statements were difficult to assess in practice. It was difficult to measure the degree to which the recommendations had been implemented at a statewide, health systems, or practice level and therefore to determine whether there had been changes in practice. Urine drug screening is a discrete practice that could be assessed by billing data, for example, to determine how frequently certain practices and providers order the tests. The same billing data cannot be used to learn what the providers do about the results of the tests, or how they decided to make a request for testing for one patient and not another. She agreed that evaluating implementation and associated outcomes is important, but the work will not be straightforward and it will require a great deal of cooperation not only among state PDMPs, but also among health systems to access medical record data that will include diagnoses, laboratory requests, billing, and other elements. Systems will need to work together in a manner that they presently do not in order to move forward with this implementation.

Dr. Hamby stressed that complete information is almost never available about mediators or mechanisms. Many of these factors could be relatively "low-hanging fruit" for determining indicators of mechanisms. Data have been presented, for example, from Washington State on the year that the guidelines changed and the subsequent overdose rates. A small step beyond this work is to guide the state guidelines and re-run the analyses. Details on implementation, mediators, and mechanisms would be welcomed. However those details are not necessary for global associations that could add a higher degree of confidence in the conclusions in the guideline.

Dr. Porucznik said the question of the availability of Type One and Type Two evidence is worthwhile. She noted that the draft guideline recommendations are based on Type Three and Four evidence, which rely on observational studies, the epidemiological literature, and the contextual evidence review rather than on clinical trials. Clinical trials in this area are highly unlikely. For instance, a long-term clinical trial on more than a year of opioid therapy versus surgery is not likely to occur. Therefore, it is important and valuable that the guideline

incorporates not only a clinical evidence review, but also information from the literature review and contextual evidence review to support its statements.

Dr. Green added that comparative effectiveness work could contribute to the understanding of GRADE Types One and Two.

Dr. Timmons thought that this area needed additional emphasis on the pathophysiology of pain mechanisms. Interventions cannot be compared and providers need context regarding the type of pain that is being treated. This guideline focuses on patients who already have been deemed to have a pain problem or some other problem that is amenable to main. Therefore, it should put these mechanisms into context.

Dr. Porucznik addressed the question of attempting to measure, document, and consider both pain and function. These issues should be based not only on a pain score, but also on consideration of how they are doing and whether the current therapy is helping them live a better life. That discussion should take place between patients and providers regarding the course of action that will get patients to their best point.

Dr. Timmons agreed and supported the guideline's emphasis that function is not only physical. Other factors affect how people function in their daily lives. One therapy versus another will be different for each individual, and these questions should be central to every discussion between a patient and provider.

Dr. Porucznik agreed and added that it can be easy to latch on to something like a pain score or a functional assessment, which is easier to record. If providers only focus on aspects of a patient that are easy to record in simple categories, then important parts of the discussion are missed. CDC hopes to encourage patients to think with their providers about other benefits, such as their ability to play with their children, which are not easy to fill in on a form.

Dr. Gioia pointed out that these issues relate to the bio-psycho-social aspect of pain, which is that mood and mindset should be assessed with function. Mood can be a transient, situation-specific effect or an existing mood or anxiety disorder that now frames the pain experience and potentially the effect of the biological agent that is prescribed to modify the pain response. The close integration of the psychological component is important.

Dr. Porucznik turned to the subject of safe storage, especially as it pertains to the protection of children from accidental ingestion. The workgroup discussed this issue at length, as it is related to safe and reasonable disposal practices so that unused medication is not available for diversion or accidental ingestion. CDC plans to make information about safe storage and disposal available as part of the accompanying tools to the guideline document.

Regarding non-pharmacologic therapies and providing guidance to primary care providers, **Dr. Porucznik** said that partnerships for professional education will be important to help primary care providers implement the recommendations in their practices.

Dr. Gioia commented on discussion in the psychological and psychiatric sciences regarding how to screen patients for a variety of medical disorders related to mood and anxiety, knowing that these disorders can be mediators and moderators of response and even of outcome. To that extent, he wondered about the workgroup's discussion regarding elevating or reinforcing the integrative model and particularly the need to emphasize the assessment of mood and its relationship to the opioid prescription.

Dr. Porucznik said that the workgroup discussions about non-opioid and non-pharmacologic returned to the same perceived barrier of patient access, primarily for insurance coverage for such therapies. The US is a large country with diverse regions, and a comprehensive pain center is not within the reach of everyone. The workgroup was somewhat at a loss with this point, as there was agreement that therapies other than opioids are important to help people manage chronic pain, but there was great concern regarding how people can access those therapies. The workgroup fervently hopes that inclusion of these other therapies within the guideline recommendations may help serve as a "bully pulpit" to encourage payment changes so that patients can potentially access other therapies. Further, the inclusion within the guideline could help providers think about discussing other therapies with their patients. Including information in the tools that accompany the guideline regarding how to have these conversations and about the other potential therapies will be helpful; however, the resources will be different in every individual practice and health system. Therefore, it is not possible to encourage a "one size fits all" strategy. It is not possible to change the curricula of medical schools or to force practitioners to take CMEs in this area, but the guideline can help start the conversation and provide a means for academic and medical partners to address the issue.

Dr. Gioia thanked the workgroup for not allowing the barriers to interfere with making the right decision to include this recommendation. Access will not be advanced until these questions are asked and these problems are defined. It is important to include these issues.

Dr. Porucznik noted that the workgroup had many conversations regarding whether the guideline should reflect the world as it is, or the world that they would like to live in.

Dr. Timmons said that most change in areas such as these comes from patients themselves as they ask questions and advocate for themselves and their family members. She asked about plans for patient education materials on types of pain, types of alternative therapies, and related issues.

Dr. Dowell said that CDC plans patient educational materials.

Dr. Porucznik commented that this issue relates to the idea of a research agenda related to guidelines and the types of professional education opportunities that might make the most difference in providers changing their practices. The effort may not focus on educating individual practitioners, but about educating administrators of health systems.

Regarding the comment that there are "too many recommendations," **Dr. Porucznik** also participated on the Core Expert Group that participated in the initial development of the guideline. At one point, there were approximately 26 recommendations. There has been significant reduction since then. In order to reach practicing physicians effectively, she wondered if the recommendations should be reordered so that the top three that are most likely to be retained are of highest priority. Many of the recommendations will be operationalized at a system level more than in an individual provider's head. For instance, recommendations such as not beginning therapy with a long-acting prescription in a patient who has not had such a prescription could be incorporated into the electronic medical record (EMR).

Dr. Forjuoh said he understood the points, but reiterated that there are too many recommendations. He works with primary care providers who are overwhelmed with recommendations, so he always thinks about how to make their work easier. He suggested that Recommendations Four and Five, which both refer to prescribing the lowest effective dosage, could be combined.

Dr. Porucznik said that the use of checklists could be helpful in provider offices. This issue speaks to the research agenda that will be possible, as well as to the evaluation and implementation phase. It will be important to learn how different health systems operationalize the recommendations and to make comparisons to determine which models are best so that they can be disseminated throughout the country.

Dr. Green commented that the recommendations fall into three conceptual areas: 1) beginning opioid therapy, 2) continuing opioid therapy, and 3) assessing risk. The different areas apply to different types of patients along the care trajectory.

Dr. Porucznik revisited the idea of evaluating outcomes. It is important to think about the kinds of outcomes that might be available for evaluation. They all want to "move the needle" on overdose fatality, but outcomes that are closer on the causal chain should be considered, such as prescription dispensing, studying a reduction in the duration of days of supply or reductions observed in PDMP data of patients having concurrent prescriptions from different providers. She asked the BSC for other suggestions that can help inform the research agenda.

Dr. Hamby suggested measuring unintended consequences, not just reduction in overdose. Reduction in overdose is a desirable outcome, but it is important to meet the needs of the heterogeneous group people with chronic pain. Adverse outcomes could include increased cost and difficulty in accessing pain treatments. There are counties in her region that do not have a physician, much less a massage therapist or acupuncturist. These services are far more expensive and difficult to access. Patients should not be "fired" by their doctors as the providers are under pressure regarding prescribing. Some providers may opt not to treat people with chronic pain. These unintended consequences, or side effects and complications, should be considered. Is healing delayed from the service utilization point-of-view if a three-day prescription is provided rather than a seven-day prescription? In this case, it may be necessary for a practice to accommodate twice as many medical visits for pain patients, and the burden to the practice as well as the cost borne by insurance companies is important. It would be helpful if the guideline shared thinking on these issues, as many people have raised concerns about them.

Dr. Porucznik agreed that measuring unintended consequences will be important. These points cannot be derived from an administrative database. She said she hoped that collaborations could be engaged with qualitative researchers that do not rely on extracting information from medical records in order to measure these impacts. The impacts should be incorporated into the evaluation of the guideline and into future iterations of the guideline. Patients should not die, but they also should not suffer.

Dr. Duwve said that physicians are uncomfortable prescribing opioids because they see the overdoses that present to hospitals and they see the mortality that results from overdose. Several physicians have related that they are more comfortable prescribing within a set of guidelines, as they are more secure knowing that they are prescribing appropriately and safely.

Dr. Tamara Haegerich described some of the proposed translation materials. A Quality Improvement (QI) technical package for health systems could outline specific education for providers, quality metrics for monitoring treatment, and pulling quality metrics from the EHR to monitor average daily dose, whether urine drug screens are conducted, and PDMP checks. Patient outcomes can be included in the EHR to gather this information. The "plan, do, study, act" cycle can be implemented: plan the education and the necessary practice changes to implement the guidelines, measure, reflect and determine whether changes are needed, and engage in the cycle again. CDC envisions creating a package that health plans can adopt and utilize as well as forming groups of health systems that work together in a QI collaborative to share best practices, changes, and adverse and beneficial outcomes. Evaluation at the smaller health systems level is less concerned with confounding factors and can isolate practices.

Dr. Allegrante said that this approach is the operational answer to the pushback on the notion of moving to RCT-type designs too quickly. A focus on implementation and measures related to implementation may be more feasible and perhaps more important as the first part of the research agenda. Regarding outcomes over time, these issues are complex behavioral changes on the part of patients, providers, industries, and insurance companies. There will be so many confounding factors that it will not be possible to point to the guideline's internal validity with any integrity. He supported an investigative approach to evaluation that will draw on historical documentation and anthropologic methods, and the kinds of qualitative methods that may yield a great deal of information about the behavior of this guideline in the hands of various stakeholder groups. The approach proposed by NCIPC is ideal.

Dr. Green observed that there is tremendous opportunity with Recommendation Twelve, especially in the treatment of opioid use disorder. Systems-level change and incorporating MAT into the conversation at the systems-wide level will be important. There has been constrained access to treatment and medications in rural areas. Moreover, payer-based systems have placed many prior authorizations and other challenges to accessing treatment. Discussing non-opioid therapies and non-pharmacological treatment can incorporate ideas regarding access to effective and evidence-based opioid use disorder treatments.

Dr. Timmons supported the idea of incorporating more of the workgroup's thought process into the document, which will have a wide audience of thoughtful, intelligent, and educated people who can help solve the problems. For the document to be received by the audience with credibility, it may be helpful to describe the lines of thinking, such as a discussion of the limitations associated with using an administrative or billing database for drawing conclusions, as they are fraught with problems. If the document outlines the thinking behind the recommendations, the available data or data gaps, and the suggested ways forward, then the living document can help guide and shape future research.

Dr. Porucznik agreed and noted that "science happens in bits" and it is important to start somewhere. When this guideline is put forward, it will start many conversations and spark many scientific questions. They should be glad that the process will lead to more evidence and help to save lives.

Dr. Timmons stressed that the workgroup put a great deal of work and time into conducting thoughtful analyses, and the extent to which this work can be reflected in more detail will be beneficial.

Dr. Hargarten said that the workgroup observations can be advanced by the BSC to inform the guideline. The discussion thus far had highlighted much of the workgroup's deliberations. Evaluation is important and was touched on by the workgroup. The intended consequence of the guideline is, of course, fewer deaths. The unintended consequences that have been discussed are important. It is complicated to implement a federal guideline when many state-based guidelines are being implemented and evaluated.

Dr. Porucznik emphasized that the guideline is a guideline, not legislation. There will be situations in which a health system already has practices in place that are more restrictive than the guideline suggests. Situations such as these should be measured as implementation progresses. The BSC is not putting forward the guideline; rather, the BSC's function is to make a recommendation to CDC regarding moving forward with the guideline, taking the observations from the workgroup and the public into account as the guideline is finalized.

Dr. Holly Hedegaard commented on the layout and presentation of the document, which will have an impact on its acceptance. The documents shared thus far were dense and wordy, with a layout that was not conducive to readers' full understanding. Each recommendation in the guideline could include a section on the clinical analysis and a section on the discussion points that have arisen. The recommendations would be stronger if they were accompanied by not only the scientific thinking behind them, but also the additional factors that were considered in generating them, the additional research that is needed, and potential prioritization.

Dr. Hargarten agreed that the materials should be clear. This guideline is patient-centered and is informed by the best available science to equip providers to make the best decisions for their patients. He noted that Recommendation Five in the guideline spurred a great deal of discussion in the workgroup and asked for the BSC's thoughts.

Dr. Hamby appreciated the work of the workgroup and the opportunity for robust discussion among people of varying opinions. She commented on the range of consensus among the workgroup members and noted that not all of the recommendations had the same level of endorsement or consensus. NCIPC would do well to take the differences into consideration as the guideline is finalized, particularly regarding Recommendations Five and Six. The recommendations may be helped if text is included to describe the thinking behind the establishment of specific dosage ranges and opioid treatment duration. She did not feel that the evidence supported a specific recommendation and that the three-day duration specified in Recommendation Six was somewhat arbitrary. If there were strong feelings about that duration, then the argument should be described clearly. Almost any of the ranges better reflect the quality of the evidence. She appreciated that the workgroup highlighted these issues.

Dr. Porucznik said that the workgroup discussions had a planned agenda, and different recommendations were discussed in different meetings. Some recommendations were expected to be more controversial than others, so they were not discussed on the same day in order to ensure that appropriate time was allotted to discuss all of the issues. Their meetings were via telephone, and some workgroup members spoke up more than others. Before the discussion was closed on each recommendation, a roll call was conducted of all workgroup members to ensure that everyone had a specific time and opportunity to weigh in. This approach enhanced the discussion and captured perspectives from all of the specialties and backgrounds represented in the group. When there was disagreement, it was not the workgroup's role to establish consensus. The workgroup's role was not to edit or change the document. The different observations were captured so that they could be shared with the BSC and CDC.

Regarding Recommendation Six, **Dr. Duwve** appreciated the variety of opinions expressed and the different ranges. There did not appear to be consensus regarding a number of days. The language in the recommendation and the supporting text stated that the prescription should be for no greater quantity than needed for the expected duration of pain severe enough for opioids. The text then stated that three or fewer days will "usually be sufficient." The use of the word "usually" left the number of days to the discretion of the provider. Further, the text stated that providers should consider a default of less than or equal to three days and adjust the duration based on circumstances of the pain syndrome. Therefore, the document gives flexibility to providers to use clinical judgment. The larger message is that 30 days with three refills are not needed. Short durations are appropriate because there is risk beyond a certain amount of time, but the prescription is at the provider's discretion.

Dr. Gorman-Smith addressed Recommendation Five and dosage limits. She asked about the workgroup discussion regarding suggested language, as well as the two recommendations and two levels of evidence regarding tapering that are reflected.

Dr. Porucznik replied that this recommendation was a point of great contention among the group, because workgroup members felt that the last paragraph of supporting text, which focuses on patients who are already on opioid therapy, is important but may not belong where it is placed in the document. The conversation was difficult, because the workgroup did not want to recommend creating an additional recommendation to address tapering for patients who are already on opioid therapy.

Dr. Dowell said that the draft of Recommendation Five reflected earlier discussions during the guideline development process, with numerous levels of feedback, comment, and review. There were concerns regarding this recommendation being applied to both patients starting opioid therapy and patients who are already on high dosages. The initial intent of the recommendation was to address initiation and not reaching high dosages in the first place. The paragraph in question in the supplemental text was added to give providers and patients more flexibility and to acknowledge that the issues are different for patients who are already on high dosages. The text acknowledges that the possibility of dosage reduction could be anxiety-provoking for patients who have been on high dosages for years, and that the risk-benefit equation is different for them. However, these patients should be given the opportunity to reevaluate their continued use of opioids in light of recent evidence. She understood the questions regarding whether this point belonged in Recommendation Five and whether the evidence type was the same as the rest of the recommendation.

Dr. Porucznik said that the workgroup agreed that the conversation is important to have and that the information is important to share, but they concluded that the evidence type was not the same for that paragraph of information. Including that paragraph calls into question the evidence type for all of Recommendation Five. The workgroup observed that keeping Recommendation Five about initiation and finding another place in the document to discuss information about patients who have been on long-term, high dosages would be cleaner and more consistent.

Dr. Compton understood that the 90 MME limit applied to longer durations and not to initiation of opioid therapy. The evidence is for chronic care, not just for initiation. The recommendation mixed initiation and long-term, given its focus on MMEs for initiation and for longer terms of therapy.

Dr. Porucznik replied that views of the length of the initiation process may differ. If a patient is starting therapy and receiving dose escalations, then a provider could still perceive that the patient is in the initiation phase as the dose is escalating, as opposed to a patient the provider "inherited" who is already on opioid therapy.

Dr. Hamby noted that the workgroup's discussion also related to specificity and the provision of a single point of duration. If the research states that three or fewer days is usually sufficient for most non-traumatic pain that is not related to major surgery, it implies that there is evidence that two days is not enough, four days is too many, and seven days is definitely too many. The evidence review does not have that level of specificity regarding the impacts of different dosages. The same point applies to 90 MMEs versus 80 MMEs, as there are not hard scientific data to support the specific dose recommendations. It may be preferable to follow the recommendations of the workgroup and acknowledge that the evidence base does not have that level of specificity and to offer a range, or to word the recommendation so that it does not make a strongly affirmative statement in the absence of specific data. These data are needed in the research agenda, but the guideline may need to be more cautious, given the current state of scientific knowledge.

Dr. Porucznik said that particularly regarding Recommendation Six, the workgroup agreed that "knee-jerk" prescriptions for 30 days should not be written. The workgroup felt that three days was too short but could support ranges. If one fixed number is offered, then there may be a perception that there is something "magical" about it. Offering a range, even if it includes or is centered upon a fixed number, gives a better perception of the uncertainty related to the number.

Dr. Dowell pointed out that even though Recommendation Five was assigned evidence Type 3, this area has had the most new research since the latest guidelines were released. A systematic review of opioid prescribing guidelines published before 2012 considered doses greater than 200 MME confer higher risk. The cut points were arbitrary in order to put patients in categories of dosages. Other studies have showed similar results. A study by Bohnert, et al used a national VA sample to match patient prescriptions with death certificate data. The average dose among overdose decedents was 98.1, and among patients not dying of overdose was 47.7. These findings contribute to the notion that a dosage of 100 is too high. This paper tried to drill down specifically. The median prescribed dosage among patients dying of overdose was 60, with an interquartile range (IQR) of 30-120. Among controls, the median prescribed dosage was 25, with an IQR of 15-45. Initially, the thinking was that stopping and reevaluating at a dosage of 50 made sense. Most patients are under that dosage, although there may be reasons to be on higher dosages. Some of the data suggest that 100 may be too high for safety in most cases. There is not a single cutoff below which opioids are safe and above which they are unsafe, but there is building evidence that risk increases in parallel with dose. There is no robust evidence to suggest that increasing dosages results in greater control of pain.

Dr. Hamby noted that Recommendations Five and Six will apply to a higher percentage of cases, as the recommendations focus on sufficient doses and length of treatment duration for adequate pain control. It is not disputed that the longer a patient is on opioids, and the higher the doses that the patient receives, that the risk of overdose increases. However, that conclusion does not provide direct evidence to support a specific statement such as "three or fewer days is usually sufficient for non-traumatic pain." It is important to describe other outcomes and goals to ensure that pain management is adequate. Millions of people receive

treatment for the management of pain, and a smaller number are at risk for overdose. These distinctions should be made, and the science should be presented carefully.

Public Comments

Stephen Hargarten, MD, MPH
Professor and Chair
Department of Emergency Medicine
Medical College of Wisconsin
Chair, National Center for Injury Prevention and Control Board of Scientific Counselors

Leslie Dorigo
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

During this session, **Dr. Hargarten** opened the meeting for the public comment period. He thanked the members of the public who were participating in the meeting in-person and via teleconference. As described in the *Federal Register* notice announcing the meeting, the public was asked to pre-register in order to provide comments. Comments were to be provided on a first-come, first-served basis. The comment period was scheduled to be open from 1:00 p.m. until 2:30 p.m.

Ms. Dorigo added her welcome and explained the public comment period format. She thanked the individuals and organizations who had pre-registered to make comment, indicating that the commenters would be called in the order in which they pre-registered. The in-person commenters were instructed to speak at the microphone, and those in attendance via telephone were informed that the telephone operator would un-mute their respective lines when it was their turn to speak. Ms. Dorigo indicated that remarks were to be limited to two minutes, and that reminders would be provided when approximately 30 seconds remained in the allotted time. If commenters were not available when their name was called, their name would be called again at the end of the queue. All public comments will be included in the official record of the meeting and posted on the CDC website with the complete meeting minutes at www.cdc.gov/MASO. She indicated that the public comment period would not include questions and answers, but assured participants that any questions posed during the period would be considered by the BSC and CDC.

The teleconference operator provided the commenters on the telephone with instructions for making their comments.

Gary Mendell
Shatterproof

Mr. Gary Mendell introduced himself and explained that he is a father who has experienced the anguish of burying his first-born son, who was addicted to opiates. He is also the founder of Shatterproof, a national organization committed to identifying and implementing solutions to the tragic epidemic of overdose death in the US. Shatterproof is sensitive to the many Americans who suffer chronic pain; however, the draft CDC guideline makes it clear in the first sentence that the guideline is not intended for patients who are undergoing active cancer treatment,

palliative care, or end-of-life care. To reverse this horrific epidemic, the medical community is urgently in need of guidance from CDC. The previous day, the US Senate Judiciary Committee held a hearing that documented unanimous support for the CDC guideline from the administration and bipartisan Senators who advocated with unanimity that over-prescribing of opioids is a root cause of this epidemic, and that better provider education and guidelines are necessary, quickly.

Mr. Mandell has seen first-hand countless wonderful people who have become addicted to prescription painkillers, many of whom have died and left their families torn apart and "shattered" as his was. Those who have died cannot be present to testify. CDC can wait for years for further research, but if it does, tens of thousands of people will die, and tens of thousands of families will be torn apart beyond imagination—not to mention the millions of Americans who lead subpar lives with their families, parents, sons and daughters, as they wait for the phone call that no one wants to receive. In this regard, he urged CDC to disregard all comments made by individuals with financial conflicts of interest and to issue as quickly as humanly possible the guideline that has been prepared for months. As a father of four other children, he and families across America are depending on CDC.

Susan Peschin
Alliance for Aging Research

Ms. Peschin serves as President and CEO of the Alliance for Aging Research. She thanked CDC for the opportunity respectfully to request changes to the draft CDC Guideline for Prescribing Opioids for Chronic Pain. In Recommendation One, the guideline should acknowledge the real-world issues of non-pharmacologic therapy and non-opioid pharmacologic therapy as first-line treatments for chronic pain. While acupuncture, massage, and other types of treatment demonstrate short-term benefits, the primary focus of this guideline is the long-term management of chronic pain. Further evidence is needed before they can be suggested as alternatives to opioids. Most of these treatments are not reimbursed by public and private insurers, so providers should be directed to consider their patients' coverage status before prescribing an unaffordable intervention.

Additionally, the Alliance for Aging Research is concerned about the overuse of over-the-counter (OTC) pain relievers by providers attempting to avoid an opioid prescription, particularly for older persons with multiple chronic conditions. Nonsteroidal anti-inflammatory drugs (NSAIDs) are contraindicated for several diseases that seniors experience concurrently with pain. Acetaminophen also has a maximum daily limit that easily can be exceeded in the pursuit of chronic pain management.

In Recommendation Five, the dosage thresholds are in direct conflict with the US Food and Drug Administration's (FDA) approved product labeling, which deliberately excluded dosage thresholds based on evidence review. A June 2015 piece in the journal *Pain Medicine* found that "dosage levels are not informed by high-quality evidence are arbitrary and may amount to experimentation with increased risk to patients." Recommendation Five is not supported by evidence, and the Alliance for Aging Research urges that it should be removed from the guideline.

Recommendation Six imposes a three-day limit for the prescription of opioids to treat acute pain. The clinical evidence for this recommendation focused on the emergency setting, not on acute pain post-surgery. This recommendation disproportionately impact seniors, since they are 2.6 times more likely to have surgery than younger adults. Ms. Peschin requested that CDC

remove a time or specific pill limit for acute pain treatment. The emphasis of this recommendation should be on prescribing the lowest dose of a short-acting opioid in a number and duration that the provider determines to be clinically necessary.

Opioids may not be the panacea, but they have helped reduce pain and improve function for millions of people. This effort should focus on the need to ensure access while preventing harm.

Gary M. Franklin, MD, MPH
Washington Department of Labor and Industries
Co-chair, Washington State Agency Medical Director's Group (WA AMDG)

Dr. Franklin stated that the over-prescribing opioid epidemic represents the worst man-made epidemic in modem medical history, with over 175,000 deaths from unintentional overdose, many more hundreds of thousands of emergency department and hospital admissions from overdoses, and millions with potential addiction.

The recent paper by Case and Deaton in the Proceedings of the National Academy of Sciences (PNAS) pointed out the shocking increase in mortality among middle-aged, lower-educated whites. A large proportion of this increase in mortality in this very susceptible group of Americans is related to unintentional overdose of prescribed opioids. Dr. Franklin reported the first deaths in the US from unintentional overdose of prescribed opioids in a peer-reviewed journal in 2005. These unintentional overdose deaths primarily occurred among injured workers who had entered the workers compensation system due to a mild musculoskeletal injury. This was the saddest thing he had seen in many years as Medical Director.

By 2006, the public programs in the State of Washington already had over 10,000 citizens on doses of opioids greater than 100 MMEs. By 2008, this translated into 508 deaths from prescribed opioids. More than half of these deaths were in the Medicaid program. In response, the WA AMDG, in full collaboration with a large group of the state's well-respected academic and clinical pain experts, developed the nation's first opioid dosing guideline. WA AMDG has subsequently developed two more guidelines, the most recent in 2015. The result has been a 40% decline in unintentional overdose deaths in Washington state.

WA AMDG strongly supports the CDC guideline, which is consistent with the WA AMDG guidelines.

Don Flattery
Citizen Advocate / Impacted Parent

Mr. Don Flattery lives in Alexandria, Virginia. He is a grieving parent who has suffered the loss of his 26-year-old only son to an opioid overdose sixteen months ago. His talented, highly educated, and loving son became addicted to OxyContin® as a working adult. Like thousands of others, including members of the medical community, he did not fully comprehend the addictive power of opioid drugs, and that misunderstanding led to his demise.

Mr. Flattery strongly believes that the draft CDC guideline is a rational first step in returning to more cautious prescribing of opioids in the US. Moreover, the guideline is urgently needed and cannot wait for more research, more debate, and more deliberation. The imperative to act is now.

Recommendations One, Two, Three, and Seven are much-needed, common sense statements of caution for physicians to consider as they establish long-term treatment goals while also improving communication between doctors and patients regarding the immutable addiction risks associated with opioid therapy, something clearly lacking in today's practice.

Mr. Flattery said he appreciated the focus of several recommendations, especially Recommendation Eight, to the continual evaluation of risk factors, particularly in select populations such as pregnant women, the elderly, patients with existing substance use disorder, and those co-prescribed benzodiazepines. He believes that his son's adolescent exposure to opioids related to a sports injury possibly inculcated him and created a physiological response, making him more susceptible to future opioid addiction. While the guidelines are not aimed at those under the age of 18, prior adolescent use of medically-prescribed opioids should be factored into physician assessments of patient vulnerability to addiction. Such patients are potentially at risk as opioid-prescribed adults.

Mr. Flattery implored CDC to maintain the recommendations that specify dosage and duration. To remove such limits and numerical recommendations would render the guideline meaningless, a potential goal of some outside groups with business or financial interests to protect. Further evidence and future studies could address slight modifications that could be accomplished through future guidance or supplemental documents.

Mr. Flattery encouraged CDC to issue the prescribing guideline as expeditiously as possible. He applauded the creation of a valuable tool that does not impede physician decision-making, but improves patient care and protects public health.

Michael Britt Doyle
Widower of a Wife With Opioid Addiction

Mr. Michael Britt Doyle lives in the San Francisco Bay area and is the father of four. He urged CDC to implement the opioid prescribing guideline. Last year, his wife passed away after a 15-year battle with opioid addiction, starting with her third Caesarian section. In 2000, they did not realize the dangers that opioids presented as they do now. When addiction took hold of his wife, she went to various pharmacies and different doctors all over the area. He heard her say many times, "I'm just following doctor's orders." The response was convenient, but it was also true. She eventually ran out of doctors and pharmacies, but she was taking nearly 50 pills per day and experienced horrible withdrawal for several months. She received prescriptions for other medications, such as Klonopin, Valium, and other benzodiazepines. When she could no longer get those drugs, which she took at a rate of 20-30 pills per day, she turned to alcohol. When she would drink so much that she would be taken to the hospital in an ambulance, the protocol was the same: a 72-hour hold followed by a 28-day substance abuse program. CDC has the possibility to save lives.

Dr. Hargarten noted that the line had dropped and the last of Mr. Doyle's comments were not heard, but his written comments had been submitted for the official meeting record.

Kerilyn Whitehead
Sister of a Brother Who Overdosed

Ms. Kerilyn Whitehead expressed thanks for the opportunity to speak. Many people are not aware of the growing epidemic of addiction. There is a stigma surrounding society that addiction is something that one can control. One can decide whether or not he or she wants to be an addict. People are taught to look at addicts as criminals and deadbeats who deserve the life they have built for themselves. This could not be further from the truth behind addiction.

Further education needs to be given not only to children, adolescents, and teenagers in schools, but to families and medical professionals as well. Addiction is a disease just like diabetes, cancer, Alzheimer's, and Lyme Disease. Addiction affects not only the addict, but also the addict's family, friends, and anyone in the addict's close circle.

April 1, 2015, is a day that Ms. Whitehead will never forget. At about 3:30 in the morning, she awoke to her parents' frightened screams. They were screaming her brother's name from his room in hopes that he would respond. Her 19-year-old brother was lying in his bed, unresponsive. Strange noises came from his mouth and nose. She got out of bed to see what was going on his room and immediately called 911. Her brother had overdosed on opioids and was nearly dead from taking OxyContin®.

Hospitals are not given the proper tools or education they need to treat addicts and addiction or overdoses. Many hospitals do not even want addicts brought into the emergency room; however, they have no other choice. Stamford Hospital did not treat her drug addicted brother properly; however, she was not sure if they actually knew how.

With more than two million Americans age 12 or older abusing or dependent on opioids, all hospitals, doctors, and nurses should know how or what to do with this epidemic. Drug overdose deaths have more than doubled since 2000, with a record of 45,000 deaths in 2014. Six in ten of those deaths involved opioids, such as prescription pain relievers like isocodone and OxyContin®. Getting prescriptions has never been easier. More education, policies, and awareness need to be brought to this growing epidemic, and it needs to happen now.

Dr. Harold Laski
Southside Medical Center
Jacksonville, Florida

Dr. Harold Laski addressed the problem that lies in the unintended consequences that will occur. The guideline states that it is voluntary, but past history shows that state medical boards and others will view these as standards of care.

Recommendation Five states a total daily dose ceiling of opioid, and the addition of the word "generally" does not add to the clarity of the phrase and does not alleviate patients' fear. Physicians will not prescribe higher doses, even when appropriate. It is the CDC's obligation to create a guideline that helps resolve all of the unintended consequences of its action. This task is hard, but if not, chronic pain sufferers will look for other, more dangerous avenues to obtain relief. If just 10% of the 100 million Americans with chronic pain seek treatment, there would be a necessity of 10 million doctor visits a month just for chronic pain. Generalists need to treat the vast majority of chronic pain patients.

The guideline must be created so that only those who merit receiving the controlled medications are able to get them. Mark Twain once said, "There are three kinds of lies: lies, damned lies, and statistics." The statistics that show that controlled substances are often involved in medical cases of morbidity and mortality are misleading. If all cases were removed in which the presence of opioid was inappropriate, such as persons who obtained the drugs illegally and patients who were inappropriately prescribed the medications, only the patients who were appropriately prescribed the correct medication and dose would be left. This group of users statistically shows a very low number of cases of morbidity and mortality.

It is important not to "put our heads in the sand" and ignore chronic pain sufferers. The solution must be part of the guideline and not something that waits for future solutions. Educational requirements for physicians who prescribe, as well as for patients who use controlled substances, should be part of the guideline. Incentives must be given to drug researchers so that every opioid is available only in forms that cannot be abused—not just the branded, long-acting opioids, but all opioids.

The guideline should recommend a national drug database, not just state, to eliminate doctor-shopping and pharmacy-hopping. Physicians and pharmacists have access to full drug information that at this point is not accessible, such as for Methadone clinics in government institutions such as the VA. It is important to do something that helps everyone and does not create unintended consequences.

Barron Joseph Clepp
Father of a Son Who Died of an Overdose
Retired Human Resource Director

Mr. Barron Joseph is a father from Texas with first-hand knowledge of the need for better management of opioid prescribing patterns. Before he retired in 2013, he was Director of Human Resources for a local branch of a large national organization. He supported approximately 1200 working people, mostly between the ages of 19 and 25. In this position, he had complete visibility of terminations, drug testing, medical leave, and performance evaluations. The use of painkillers was a large factor in terminations, medical problems, and poor job performance evaluations.

One worker was a 24-year-old male who was a prescription drug user. He was terminated. He went home and told his mother, who was caring for him, that he was getting a glass of water from the kitchen. He went to the kitchen, took an overdose of painkillers, and killed himself. The Human Resources system could not do anything for these young people. In 2013, over two millions Americans abused or were addicted to opioid painkillers. What could they do? The Human Resources system placed their behavior in their permanent record and forced them to seek another job.

In 2014, 28,000 people in the US died from prescription opioid painkillers and heroin overdoses. Those 28,000 people were real people. Mr. Clepp's son David was addicted to painkillers and alcohol. He fought a long, difficult fight against addiction. He died of a heroin overdose on August 2, 2011 in San Antonio, Texas. He was 27 years old.

"For the public record, I love you, David. Thank you."

Lexi Reed Holtum
Steve Rummler Hope Foundation

Ms. Lexi Reed Holtum stressed that with the 14% increase in opioid overdose deaths in 2014, the highest rate on record with a total of 28,467 opioid overdose deaths, it is clear that active steps must be taken to support prescribers and to change prescribing practices. Ms. Holtum supported the CDC draft guideline.

It is especially frustrating to those who have studied how this problem came about that there was never any scientific evidence that these medicines were safe and effective in the long-term. Further, the data over the last 15 years have seen no proven benefit to those taking these opioid medicines, such as decreased rates of disability for musculoskeletal pain or reduced need for surgery, such as spinal fusion. The incidence of both continues to increase to new heights, with over 11 million recipients of Social Security Disability Insurance (SSDI) in 2014 compared to four million in 1992. In short, there is no evidence of benefit and ample evidence of harm.

Many prescribers have received only limited education on how to treat pain or addiction. How could they be expected to intuitively know how to assess for the dangers in prescribing opioids? The proposed guideline offers a simple and modest formula for prescribers to follow to more safely manage patients' pain. The proposed guideline is not mandatory. It is simply a guideline and does not restrict prescribers' ability to assess individual situations, case-by-case, in order to determine the best outcome. The guideline also supports pain patients by using better care and providing the opportunity to understand the risks of prescribing.

Dee DeLuca-Mattos
Mother of a Son in Recovery From Opioid Addiction

Ms. Dee DeLuca-Mattos introduced herself and said that on January 28, 2012, she and her husband, frightened beyond words, drove their son to the airport so that he could travel to begin treatment for opioid addiction.

In 2013, almost two million Americans aged 12 or older either abused or were dependent on opiates. Her family is part of that number. She supports greater caution in prescribing opioids as a mother of a son in recovery from opioids. His addiction did not start from buying drugs on the streets or from a drug dealer on the wrong side of the tracks, as everyone perceives. His addiction began as a result of an accident after which he was prescribed 60 OxyContin® to go home with, with two refills thereafter.

He was in his last year of college with a bright future when his addiction started spiraling out of control. The family struggled to save him not only from his addiction, but also from the medical professionals who were so recklessly prescribing the opioids to him not for pain, but because he asked for them. Ms. Deluca-Mattos is one of the lucky ones, because today her son is in recovery. But he will have to fight every moment of every day, work a program, and commit himself to sobriety because his addiction will never go away.

Each night Ms. Deluca-Mattos chats with a group of women who have been brought together not by tea or tennis, but who found each other in the darkest of moments—all of their children are addicted to opioids. Most of the women are not as fortunate as she. So for them and for the children whom they have lost, she pledges not only to help in the fight against illegal drugs, but also to stand as a beacon of hope and change. This change needs to happen, because

who needs 60 OxyContin®? Ms. Deluca-Mattos implored CDC to implement change and education so that this epidemic can be eradicated.

Sarah Svoboda
National Safety Council

Ms. Sarah Svoboda said that the National Safety Council (NSC) would like to thank CDC, NCIPC, and the BSC for their work to address the Nation's opioid epidemic and to develop the draft guidelines. NSC is a 100-year-old, Congressionally-chartered nonprofit safety organization with the mission of saving lives by preventing injuries and deaths at work, in homes and communities, and in transportation through leadership, research, education, and advocacy.

After a thorough review of the evidence assembled and the draft recommendations, NSC strongly supports the draft guideline. There is little evidence that chronic opioid therapy (COT) offers effective relief from chronic pain; however, there is abundant evidence about the harms of COT. These recommendations, which provide clear, evidence-based guidance for clinical decision-making, could have saved Bill, a 33-year-old machinist, who died of an unintentional overdose of methadone in July 2006. He had been taking hydrocodone for severe lower back pain relief but developed a tolerance to it. On a Friday phone call, Bill's doctor prescribed methadone, a long-acting opioid. The methadone dose Bill took that weekend led to his death. He left behind a wife and two sons. Recommendation Four specifically cautions that "methadone should not be the first choice for an ER/LA opioid" as methadone's unusual characteristics make the safe prescribing for pain especially challenging.

A number of these recommendations (numbers Seven, Eight, Nine, and Twelve) cite the increased risk of opioid-use disorders when encouraging physicians to re-evaluate COT after three months. Michael, a 20-year old patient with Crohn's disease, became addicted to the opioid painkillers prescribed for this condition. He took his own life while on a waiting list for substance abuse treatment. Recommendation Twelve speaks directly to the life-saving role of physicians and how collaboration with their patients and substance abuse treatment providers can prevent senseless outcomes such as Michael's.

Betts, a chronic pain patient on COT, had concerns about the safety of her high dose and the quality of life. When she asked her physician if she could be addicted, the doctor did not address those concerns, so she found a different physician. Working together to set realistic treatment goals and expectations, her physician helped her taper off of opioid pain medications, obtain counseling for her addiction, and use a variety of non-opioid therapies to better and more effectively manage her pain. The patient-centered principles Betts's physician employed are echoed in the draft guideline.

Lawrence Little
Hunterdon County, New Jersey

Mr. Lawrence Little lives in Hunterdon County, New Jersey, which is the highest-income county in the state, and the fourth-highest-income county in the nation. What is less known is that the county has dark statistics of which it is less proud. Hunterdon County law enforcement reported that overdose cases increased 33% from 2014 to 2015. In 2015, 88% of the overdose cases were due to heroin or opiates, which represented a five-time increase over 2014. In 2015, overdose fatalities increased by 50%, even with the increased use of Narcan™ in the county.

The statistics are not just numbers to Mr. Little, who has witnessed the impact of opioid abuse in his own family. He watched his niece struggle just days after her birth with the opiate withdrawal she inherited from her mother during pregnancy. A local athlete has received prescriptions for opiates for months at a time for sports injuries, with the result of addiction. His life and his family are spiraling out of control.

Mr. Little's wife recently underwent gallbladder surgery. After surgery, the hospital staff insisted that she take Percocet® prior to being released. She explained that she reacts poorly to opioids and did not want to take them. She felt that ibuprofen would be fine. This preference led to a "full-court press," so she relented and took one Percocet®. She regretted this immediately, as it made her nauseated. The hospital insisted that she take a prescription for Percocet®, even when she insisted that she would not fill it. The next day, the hospital followed up with his wife and was incredulous that she had not filled the prescription and was shocked that she was doing fine on ibuprofen alone. Mr. Little and his wife were horrified that the prescription was for a 30-day supply of Percocet® which, for someone less scrupulous, would have been worth considerable money on the street.

The CDC must approve opioid prescription guidelines without delay, and without watering them down. Every day of waiting results in more people becoming addicted or dying.

G. Caleb Alexander, MD, FACP
Johns Hopkins Bloomberg School of Public Health

Dr. Caleb Alexander is a practicing General Internist and Pharmacoepidemiologist. He co-directs the Center for Drug Safety and Effectiveness at the Johns Hopkins Bloomberg School of Public Health. He noted that the draft CDC guideline focuses on a critical area where clinicians need more guidance. Contrary to what some have claimed, the recommendations provide sufficient scientific support to justify their strength and the derivation of "strong" recommendations is entirely consistent with best practices in guideline development. A big part of the problem is that manufacturers have generated much of the "evidence" used to promote opioids, and almost none of it is relevant to chronic opioid use, as has been discussed. Despite how frequently some argue that guidelines like these may hurt patients' access to effective treatments, he is not aware of any high-quality evidence to support these assertions.

Much of the opposition to the guideline has been based on a faulty premise; namely, that the recommendations will somehow jeopardize the care of those living with pain. This is a false dilemma that presupposes that there are only two options: reducing opioid use or maintaining patients' access to beneficial treatments. There are multiple options for doing both. High-quality care for those in pain is not jeopardized by guidelines such as these; in fact, it requires them.

The Bloomberg School of Public Health recently released a comprehensive set of recommendations entitled "The Prescription Opioid Epidemic: An Evidence-Based Approach." The document was submitted to the docket. In addition to supporting prescribing guidelines such as those proposed in the CDC draft guideline, the Bloomberg School of Public Health also recommends targeting other points along the spectrum of prescription drug production, distribution, prescribing, dispensing, and use. Comprehensive and coordinated approaches to opioid-related injury, addiction, and death offer the greatest promise for reducing the incredible morbidity and mortality from these products. Dr. Alexander expressed his gratitude for the consideration of these matters.

Joan Peters-Gilmartin, PA-C, MHP
Mother of a Son Who Died from a Heroin Overdose
Nauset Family Practice, Orleans, MA
The Open Door of Cape Cod, North Eastham, MA

Dr. Joan Peters-Gilmartin is not only a primary care provider in family medicine, but also she represents a family of loss, having lost her son to heroin overdose in 2014. His opioid abuse disorder began with prescription pills.

Most of the general public have no idea about the history of pain management that was promulgated to health care providers over the last 20 years and how we got to where we are today with a widespread, full-blown epidemic of opioid overdose deaths across all ages and demographics. Healthcare providers are just as poorly trained in assessing pain as they are in treating it, and there have never been evidence-based guidelines for using long-term opioids for chronic pain until recently. New neuro-biological research indicates, in fact, that we have been doing it wrong for decades, unwittingly following the pressures of big Pharma and medical board warnings that pain was being under-treated. In fact, we have often made chronic pain worse with long-term opioid use, driving the patient request for increased doses by creating the condition of hyperalgesia.

Given that the USA is the largest consumer of opioid prescriptions, it also is time to look at this issue and ask why that is the case. In part, prescribers were driven this way because insurance companies refused to cover, or limited access to coverage for, other modalities for chronic pain management that can be efficacious and that other countries use first-line, such as acupuncture, myotherapy / massage, chiropractic or osteopathic manipulation, biofeedback, yoga, et cetera. Or, they limit access. Additionally, insurance has limited access to mental health to deal with the psychodynamic alterations that accompany chronic pain and are known to exacerbate it or alter the perception of pain. People living with chronic pain need to have a treatment plan that includes teaching them how to live with some level of pain and not to have that pain define their existence, which Dr. Peters-Gilmartin sees so often in clinical practice. Primary care practitioners need to receive better training in the use of opioids and the management of chronic pain syndromes, as it often takes weeks or months in regional areas to get a patient referral to a Chronic Pain Management Specialist. Practitioners need to be mandated to use a PDMP, but first that program needs to be uniform, nationalized, and simplified. The ability to renew a US Drug Enforcement Administration (DEA) license to prescribe controlled substances should be tied to demonstrated use of the PDMP in the future in addition to proof of continuing education hours devoted to not only Pain Assessment and Management, but Addiction Management as well.

No one is saying never to use opioids for chronic pain, and nowhere is it suggested never to treat post-surgical, malignant, or end-of-life pain and suffering. The new proposed guideline from CDC is very sensible and practical. Now that we recognize the breadth and depth of the wrong that we as a medical community have been part of, we have a moral and ethical responsibility to fix it. Because we have done something wrong for so long is no reason to continue to do so. As a medical provider, a parent of loss, and an addiction recovery advocate, Dr. Peters-Gilmartin supports the urgent passage of the draft CDC guideline.

Dr. David Juurlink
University of Toronto and American College of Medical Toxicology

Dr. David Juurlink commended CDC for taking action to address the prescription opioid crisis. He also expressed concern that focusing on the problems of mortality, addiction, heroin, and other harms associated with prescription opioids will lead to an overlooking of the other harms that opioids cause, particularly over the long-term.

How many falls, fractures, and head injuries are caused by these drugs, particularly in patients on high doses of them? The answer is not known. How many cases of delirium result from these drugs each year, and how many patients suffer and die from opioid-induced constipation? No one knows. There is a cascade of effects of opioid-induced disruptions of sleep architecture, particularly when a doctor wanting to help prescribes a sedative. How many cases of depression are caused by these drugs? How many patients suffer from testosterone depression or from opioid-induced hyperalgesia, with patients worsened by the drugs? How many people are harmed or are killed by opioid-related car accidents?

No one knows the answers to these questions, but clearly millions have been harmed by these phenomena, which are dose-related and offer strong support for CDC's proposed dose thresholds. The harms of opioids should be weighed against the benefits, and while there can be increased quality of life from low-dose opioids, it must be acknowledged that the evidence base is terrible, and the determination of effectiveness is based solely on anecdote. This point is important, as physical dependence is a near-universal consequence of COT. When doses are reduced or missed, symptoms of withdrawal ensue, and patients realize quickly that all it takes to feel better is to resume the drug. Understandably, this effect is perceived as an ongoing need for opioids.

As CDC reviews feedback from patients regarding pain, Dr. Juurlink urged that the phenomenon of physical dependence, which is another form of harm, be considered. The drugs are easy to continue and difficult to stop, even when there are analgesic effects.

Dr. Rebecca Cunningham
Emergency Physician & Injury Researcher
University of Michigan

Dr. Rebecca Cunningham emphasized that the enormous impact of the current epidemic and the need for public health response simply cannot be overstated, and CDC is to be commended for taking the large action that can impact the nation's public health. In her 20 years of practice in emergency medicine, she was first trained that opioids were dangerous medications to be used with great care. Then the pendulum swung to widespread opioid prescribing for many patients. With that swing, she has watched first-hand the river of patients brought into hospitals who have overdosed, and the anguishing and increasing calls by 911 providers seeking medical guidance who are unable to revive teens and young adults often who are overdosing in the community and are too late for help. There is urgent need for public health action.

As a clinician-educator of student doctors, Dr. Cunningham sees great need for guidance on best practices given the complete current vacuum of such guidance and wide disparity in daily and individual practices. Clinicians are currently working almost blindly on how to care best for their patients' pain. They are confused at the best action and do not want to see their patients in pain, but without clear guidance such as being proposed by CDC, they cannot make safer

prescribing decisions. Physicians need immediate guidance on how best to align care with safer prescribing. Only then can physicians begin to have difficult conversations with patients and to aid the next generation of doctors in safer prescribing. There is a widespread lack of understanding of the benefits and potential harms of the typical options, and there is tremendous physician variability. Every day that medicine is practiced with this much variability and not guided by current science is another day the next generation of student doctors is taught potentially harmful practices, and patients are failed by the lack of provision of safer options to ameliorate their pain.

The state of the science around opiate use is fairly extensive, and it is very convincing regarding harms and the need for action relative to other practice guidelines. Although GRADE 1 evidence is the gold standard, this is not level of evidence that drives most change in practice. Many such practice guidelines are typically based on observational data such as used in this guideline, as the science of rigorous RCTs is often fundamentally cost-prohibitive and, more importantly, not ethical when studying outcomes that include death from overdose. Finally, the time lag to obtain the highest ideal of ideal evidence is arguably not ethical, given the national epidemic of overdose. There are many times in medicine that doing nothing is not ethical. In this case, waiting for the gold standard, RCT, longitudinal study while there is evidence that current practice is harmful is not ethical. In addition, the grade of evidence provided in the draft CDC guideline is well in-keeping with other evidence-based changes suggested across medical care. The grade of evidence provided in this guideline is more than sufficient. Specifically, the dosage guidelines should not be altered.

Ms. Ada Guidice-Tompson
Mother of a Son Who Died from an Opioid Overdose

Ms. Ada Guidice-Tompson said that if the draft CDC guideline had been in effect in 2002, her son Michael would still be alive today. His pain would have been consciously treated without addictive opioids, and he would not have been given a prescription for a month's supply. Michael is a clear example of how the medical use of opioids for acute pain quickly leads to their prolonged and chronic use, and over-prescribing.

Ms. Guidice-Tompson's son died within two years of his first opioid prescription, while under the care of one doctor. Many prescribers and patients believe opioids are helping relieve pain and fail to link the drug's impact on overall mood and pain in the long-term. Tolerance, dependence, opioid-induced hyperalgesia, withdrawal, and substance use disorder are inter-related and common among medical and non-medical users. Pain is often a surrogate for addiction, and the two are not mutually exclusive.

Informing patients that opioids are pharmaceutical-grade heroin would make it clear that these drugs do not have to be misused or abused in order to cause harm and would educate patients who might then be less likely to accept even a three-day prescription for a short-term opioid. Looking at the increase in babies born with neonatal abstinence syndrome (NAS) to mothers prescribed opioids for pain should have made us stop and take notice. Prescribers cannot change the inherent properties of opioids, and using opioids as prescribed for pain does not protect patients. Relying on REMS and other external measures to mitigate harm is important; however, the natural physiological reaction within a human body cannot be stopped or prevented when an individual ingests an opioid, even an abuse-deterrent one.

Pharma marketing, misinformation, conflict of interest, and weak regulatory controls have manipulated science and downplayed the inherent risks of opioids within a legally sanctioned system. Both patients and clinicians have been operating under impaired choices. Patients need pain relief that is safe, does not reduce their quality of life, and does not cut their lives short. Patients who are already on opioids should not be abandoned. The CDC guideline is urgently needed to end the epidemic caused by inappropriate and over-prescribing of opioids. To save lives and protect people, this guideline and its resulting impact must be independent of opioid manufacturers and their lobby groups.

Dr. Mark Roberts
American College of Occupational and Environmental Medicine

Dr. Mark Roberts expressed his gratitude for the opportunity to speak. He is the President of the American College of Occupational and Environmental Medicine (ACOEM), which focuses on the protection of workers and their families. ACOEM supports the CDC's proposed recommendations for the safer and more effective use of opioids for chronic, non-cancer pain.

The rationales supporting the recommendations are well-reasoned and supported by the best available evidence and expert consensus. Guidance from an unbiased, authoritative source such as the CDC is especially important in light of the continued absence of quality evidence of effectiveness of opioids for chronic, non-cancer pain treatment. The proposed CDC recommendations are consistent with ACOEM's 2014 update of its guidelines for opioid use, based on an extensive systematic review of published material.

Physicians seek accurate and unbiased guidance for the treatment of chronic, non-cancer pain, according to more than 40 surveys of US, United Kingdom (UK), and Canadian physician organizations. In these surveys, physicians noted minimal education in pain management at all levels. They felt that many patients' perceptions of pain were confounded by untreated or inadequately treated psychiatric disorders or emotional distress. Physicians were concerned about addiction, dependence, diversion, and side effects associated with opioid use. Many physicians felt uncomfortable prescribing opioids for chronic, non-cancer pain in the absence of objective findings or specific diagnoses. In most cases, the specific pathophysiological aspects of chronic, non-cancer pain are not known, so the target of treatment must be unknown. Chronic, non-cancer pain does not fit the pathophysiological model that is used in modern medicine.

Prescriptions without quality evidence represent a return to eminence-based medicine. Reliance on clinical judgment alone results in the variation of care. Wide variations in the rates of prescription of opioids and overdose and deaths have been demonstrated. Clinical judgment must be guided by the best available evidence to achieve improvements in the appropriate use of opioids. Public education and physician education are needed due to the general poor health knowledge about the benefits and risks of opioids. Many people believe that opioids are safe if they are prescribed by a physician. People often view opioids as a first choice for chronic pain, rather than more effective and less dangerous alternatives such as exercise, cognitive-behavioral therapy, and other modalities. Physicians have stated that they need and will use guidelines to create boundaries for patients demanding opioids. This situation is a classic public health problem, when hazards in the community are associated with increased adverse effects.

Howard Techau
Individual

Mr. Howard Techau expressed his gratitude for the opportunity to speak and expressed condolences to those who have lost loved ones due to overdoses. Many chronic pain patients are suffering more now due to the restrictions that are already in place. Some are seen as drug-seekers, but only approximately 5% of chronic pain patients are addicts. There need to be limits on prescription opioids for people who have sustained sports or work-related injuries. But for those who are in chronic pain, such as fibromyalgia patients, opioids have a great effect.

Many opioid overdoses are due to fentanyl, which is cheaper than heroin. Another aspect of this issue is that many chronic pain patients are depressed and may commit suicide by overdosing on prescription or illicit drugs. One study examined people who were thought to have died due to heroin; however, many of them died due to suicide.

Mr. Techau recommended the creation of a federal database similar to the mechanism that is in place for Sudafed. He expressed the hope to take the pressure off of doctors who prescribe opioids responsibly, and the pharmacies that fill the prescriptions. If the CDC guideline is not law, then why are pharmacies denying patients opioids that they have been prescribed, saying that they are over the limit? He agreed with the need for a database to stop doctor-shopping and pharmacy-shopping. He said he hoped that chronic pain patients are not overlooked when this guideline is implemented.

David Laws
Father of a Daughter Who Died from An Accidental Overdose
Georgia Overdose Prevention

Mr. David Laws asked the group to indicate, by a show of hands, how many know someone who is either affected by or lost a life to opioids. Mr. Laws is a father of three. He urged CDC to remain steadfast in taking action for safer opioid prescribing and managing practices. His first child, daughter Laura Hope, was prescribed opioid-based medication at age 14 after she broke her jaw in a soccer game. She was a freshman in high school, and she never made it to her senior year. He received the call that her senior photographs were ready to be picked up in the limousine on the way to her memorial service.

Opioid addiction took over, and the Laws family lost Laura to an accidental overdose on November 27, 2013 at the age of 17 ½. As a result of her death, Mr. Laws joined club that he would never want to be a member of—a lonely, growing club of grieving parents whose children have been lost to opioid addiction.

CDC made recommendations with the right balance between over-prescription of opioids that can be highly addictive, while allowing pain management to continue for deserving patients. Balance is needed, as shown by recent government successes in cracking down on “pill mills.” It is time now to take action on the well-thought-out, balanced guidelines presented by CDC. Delay means that more lives will be lost needlessly. Every day that the CDC delays issuing the guidelines as recommended, there is a chance that another young person might unintentionally get on a road that is difficult to get off of. As a result, there can be lifelong struggles, or as with Laura, a life that is much too short.

Mr. Laws applauded CDC for listening to real stories of real people and families that have been forever affected by irresponsible opioid prescribing practices. He urged CDC to be strong, fair, and fearless in issuing guidelines that are as strong as the recommendations of last year. If we can change a heart, we can change a mind; if we can change a mind, we can change a life. His life has been changed forever.

Pete William Jackson
Father of a Daughter Who Died From One OxyContin® Pill
Advocates for Reform of Prescription Opioids (ARPO)

Mr. Pete William Jackson, President of Advocates for the Reform of Prescription Opioids (ARPO), conveyed on behalf of ARPO strong support of the CDC Opioid Prescribing Guidelines. ARPO represents many people who have been harmed by opioid medications, a majority of whom are, or were, pain patients who became involved with opioids through a legitimate prescription for pain, only to become addicted after prolonged use.

Mr. Jackson became involved in advocating for more reasonable prescribing practices after losing his 18-year-old daughter, Emily, to one OxyContin® pill. She was three days from her first day in college. Her tragedy underscores how terribly potent these opioid medications are. How can somebody die from consuming one pill?

With the recent news from CDC that opioids were involved in over 28,000 deaths in 2014, the proposed guideline could not come at a more critical time. People know about opioids being restricted, but Americans continue to consume more opioids, not fewer. Yet, there are forces within the opioid industry and their paid lobbyists and pain organizations pushing back mightily, for a variety of reasons, which collectively threaten to undermine the public health benefits of these reasonable, long-overdue guidelines. ARPO urges the CDC not to allow the profit-driven pressure from the opioid industry to delay further the adoption of this important guideline.

Mr. Jackson emphasized that we are all pain patients at one time or another. It is accepted that these medications have an important role in healthcare. No one, especially pain patients, is well-served by the overly aggressive prescribing practices that have been well-documented by the CDC. The CDC guideline will save many lives and will also result in better healthcare for people who suffer from pain. Doctors need to prescribe more cautiously. The bottom line is this: everyone benefits from sound, evidence-based prescribing guidelines, including pain patients. Please adopt this guideline as soon as possible so that more people can live and enjoy better healthcare. Thank you for protecting American lives!

Ms. Carolyn Noel
Chronic Pain Sufferer
Pain Action Alliance to Implement a National Strategy (PAINS)

Ms. Carolyn Noel introduced herself and said that she has lived with chronic pain for 13 years. She was present to speak on behalf of Pain Action Alliance to Implement a National Strategy (PAINS), a national alliance of professional societies, patient advocacy groups, and ethics and policy organizations. PAINS is a program of the Center for Practical Bioethics in Kansas City, Missouri. PAINS was organized for the purpose of promoting cultural transformation in the way that pain is perceived, judged, and treated as called for in the IOM report entitled, “Revealing Pain in America.”

PAINS strongly encourages this community to align its efforts with recommendations made in the IOM report and recommendations that are in the forthcoming National Pain Strategy Report, developed for the implementation of those recommendations. Those reports move away from a biomedical pain care model, to a bio-psycho-social approach. Clearly, the intent of the proposed guideline is to reduce the abuse of opioids. PAINS supports that intent and is committed to working with CDC and with others focused on this issue.

However, it must be acknowledged that the guideline will also have tremendous impact on those who struggle to live with chronic pain. Pain is individualized, and formulaic approaches will not work or are likely to harm patients. Today, PAINS asks CDC to answer three questions before publishing the opioid prescribing guideline:

- Will they improve function and quality of life for those who live with this dreadful disease?
- Will they allow physicians to fulfill their ethical duties and obligations to chronic pain patients?
- Can they be justified with evidence that exists today?

Carol Thornton
Safe States Alliance

On behalf of the Safe States Alliance, **Ms. Carol Thornton** offered the group's support to CDC for its leadership in the development of Guidelines for Prescribing Opioids for Chronic Pain. Safe States Alliance is a national nonprofit 501c(3) organization and professional association with the mission of strengthening the practice of injury and violence prevention. Among its diverse membership are state health departments and injury and violence prevention programs. These programs are vital partners in CDC's Prescription Drug Overdose Boost for State Prevention, which provides financial resources and scientific and technical assistance to support state prevention efforts to maximize PDMPs, improve public insurance mechanisms to protect patients, and evaluate policies to identify prevention that works. Many of these state programs are actively involved in the development, dissemination, and evaluation of state-level prescribing guidelines.

Safe States Alliance is strongly supportive of providing physicians with tools that can be used, along with their personal clinical judgment, to assess and develop a plan to appropriately address acute and chronic pain for patients in the most appropriate and safe way possible. The scientific review conducted by the expert panel provides the best available evidence. The guideline will be an incredibly useful resource for states in the development, review, and updating of state-specific guidelines.

Safe States Alliance thanks CDC for its leadership in providing strong scientific analyses and guides to support states and communities in addressing this public health crisis.

Dr. Jane Ballantyne
Anesthesia Pain Specialist
President of Physicians for Responsible Opioid Prescribing
University of Washington

Dr. Jane Ballantyne has been an anesthesia pain specialist since 1990. She is the President of Physicians for Responsible Opioid Prescribing. When she began practicing, opioids were rarely used for chronic pain because they were thought to be ineffective or unsafe. In the following 20 years, opioid prescribing increased four-fold in the US and is still rising. Many factors produced this increasing, but most important is the new teaching that came largely from palliative care and industry. This teaching aimed to establish the right of chronic pain patients to receive opioids; change the belief that chronic opioids were neither effective nor safe; and encourage open-ended dosing according to the stated pain level. The result of this shift was that both the number of people receiving opioids and the doses they were receiving increased exponentially, and a whole culture changed.

By the end of the 1990s, Dr. Ballantyne and her colleagues began to question the basis of the teaching they had received, and their own practice. Patients receiving high doses of opioids typically reported high pain levels and rarely showed the expected improvements in function and quality of life. Dr. Ballantyne and her colleagues searched the literature and found no evidence to support their practice. They published their findings and began teaching more rational approaches, but nothing seemed to stem the tide of increased and unsafe prescribing. There is now growing evidence that opioid prescribing for pain has harmed both society and pain patients and has not relieved the nation's burden of chronic pain, yet there is a reluctance to act on the basis that more scientific research is needed—research that will take years to complete, if it ever gets done at all.

The CDC guideline is urgently needed. The guideline was created using the best available evidence, expert review, and input from a broad and balanced group of stakeholders. It recommends precautions that very few people would argue. The suggested duration limitations for new patients are suggested on the basis that lower doses have been shown to be more effective and safer. The guideline does not suggest taking opioids away from people who have already become dependent, does not suggest taking opioids away from people have already become dependent, nor anything that would compromise pain relief.

Dr. Ballantyne expressed hope that the BSC would appreciate the urgent need for action, the reality of the limited state of the evidence, and the care with which the guideline was crafted.

Andrew Kolodny, MD
Chief Medical Officer
Phoenix House Foundation

Dr. Andrew Kolodny is the Chief Medical Officer of Phoenix House. He commended CDC for the work to address the opioid addiction epidemic, and he voiced strong support for issuing guidance to the medical community on opioid prescribing. Primary care has contributed to an epidemic of overdose deaths and addiction by over-prescribing opioids. Over-prescribing was not done out of malicious intent, but because of a desire to treat pain more compassionately. To bring this public health crisis under control, doctors must prescribe much more cautiously.

The increase in opioid prescribing was not in response to new evidence, but in response to an industry-funded campaign that minimized the risk of addiction and other adverse effects and exaggerated the benefits of using opioids in the long-term for chronic pain. The medical community was misinformed.

Primary care needs guidance on opioid prescribing that is free of industry bias. The CDC guideline accomplishes this. Evidence shows that the widespread use of opioids for chronic pain is harming more people than it is helping. Many patients on long-term opioids continue to suffer from significant pain and dysfunction. The field has also come to realize that addiction and other serious side effects are common. CDC has demonstrated a strong association between increased opioid sales and overdose deaths and other adverse public health effects. Aggressive prescribing is harmful to everyone, including people with chronic pain. Dr. Kolodny urged CDC to accept and release the guideline as quickly as possible. Appropriate pain care is not jeopardized by the guideline: it demands it.

Judy Rummler
Mother of a Son Who Died of An Opioid Overdose
FED UP! Coalition
Steve Rummler Hope Foundation

Ms. Judy Rummler expressed her thanks for the opportunity to present comments on this important issue. She is chair of the FED UP! Coalition, a grassroots movement of individuals and organizations from across the country. The group holds rallies and advocates for change in public policy that will help pain patients and those suffering with the disease of addiction. The group is fed up with the failure of the FDA to take action that could end the over-prescribing of opioids and save thousands of lives. FED UP! applauds CDC for creating this draft guideline which will lead to more cautious opioid prescribing and reverse the trend of ever-increasing overdose deaths. Many of FED UP!'s members and partners have friends and family members who have died from opioid overdoses. The voices of these lost loved ones have been silenced, but their stories need to be told.

Ms. Rummler's story, similar to thousands of others, is about the loss of her son Steve Rummler. If Steve had had the opportunity to present to the BSC five years ago, he would have said that he had intractable chronic pain due to his back injury. He would have said that he needed his opioids in order to any have any quality of life. He had become addicted to the opioid painkillers that were being prescribed to him for his chronic pain, and he would have been terrified at the thought of losing access to his pills. Steve died of an accidental overdose on July 1, 2011. Among his belongings was a note referring to his prescription that said, "At first it was a lifeline. Now it is a noose around my neck."

As the mother of a son who suffered with chronic pain and the founder of the Steve Rummler Hope Foundation, Ms. Rummler has compassion for pain patients. Their voices are being heard in this discussion and they have posted many comments. But there are more than 200,000 Americans who have tragically died from the opioid epidemic, and these mothers, fathers, sons, and daughters are unable to post comments or otherwise participate in this discussion. These are people who had faith in their doctor's knowledge of the risks associated with opioids and who were not expecting that something bad would happen to them.

She urged the CDC and the BSC to consider these silenced voices when evaluating the need to release the guideline. What would they say about a guideline that could have saved their lives? This proposed guideline, including guidance on dosage, duration, and increased access to integrative care, is long overdue as a way to prevent pain patients from getting started on a cycle of opioid use that can lead to more pain, the disease of addiction, and overdose death.

Dr. Asokumar Buvanendran
Pain Medicine Specialist, Rush University Medical Center
Vice-Chair, American Society of Anesthesiologists (ASA)

Dr. Asokumar Buvanendran is a Pain Medicine Specialist at Rush University Medical Center. He is also the current Vice-Chair of the American Society of Anesthesiologists (ASA) Committee on Pain Medicine. ASA supports the federal government's efforts to reduce opioid overdose deaths and supports the majority of recommendations in the CDC Guideline. ASA has two primary concerns with the recommendations in the draft guideline.

ASA is concerned that the draft guideline inaccurately portrays the effectiveness and risks of interventional procedures, which is particularly concerning since interventional pain procedures are a key non-opioid therapy to treat chronic pain. When performed by a pain medicine physician, there are an extremely small number of complications associated with interventional therapies, such as epidural injections, radiofrequency denervation, and spinal cord stimulation, and the complication rate is far lower than the complication rate for chronic opioid therapy for chronic pain. To make the available non-opioid options clear to the prescribing physician, ASA proposes that CDC revise Recommendation One to include examples of non-pharmacological and non-opioid pharmacological therapies, which should include interventional pain procedures.

ASA is concerned that the guideline would curtail the ability of perioperative physicians, including physician anesthesiologists, surgeons, and co-managing internists or hospitalists, to treat patients' acute pain after surgery. Any recommendations made by CDC need to balance the over-prescription of opioids for acute pain with perioperative physicians' imperative to treat post-surgical pain. In Recommendation Six, the ASA recommends that CDC revise the statement:

> "When opioids are used for acute pain, providers should prescribe the lowest effective dose of short-acting opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three or fewer days will usually be sufficient for non-traumatic pain not related to surgery."

Emily Brunner, MD
Hazelden Betty Ford Foundation

Dr. Brenner expressed her thanks for addressing this important topic. She is a physician at the Hazelden Betty Ford Foundation, where she treats patients affected by opioid addiction on a daily basis. She voiced strong support for the proposed draft recommendations and the CDC Guideline for Prescribing Opioids for Chronic Pain.

The Hazelden Betty Ford Foundation has seen a pronounced increase in the number of patients with opioid use disorders. Opioid dependence among residential treatment admissions in the youth program, for example, increased from 15% in 2001 to 42% in 2014. The foundation works with countless families who have been devastated by opioid addiction, and far too many have lost loved ones to the disease.

This is a crisis that demands attention and commitment, and at the center of this problem is over-prescribing. To be sure, doctors did not start over-prescribing opioids out of malicious intent, but out of a desire to relieve pain more compassionately. However, years of misinformation and, frankly, a lack of education on addiction led doctors to underestimate the risks of these medications.

It does not help that the number-one reason people visit a physician is pain, or that physician visits are increasingly shorter. Pressure to make decisions and provide quick solutions adds to the doctor's dilemma. Reimbursement tied to patient satisfaction surveys also intensifies the pressure to prescribe opioid painkillers in hospital emergency departments. Often it is easier for a physician to write a prescription to maintain the status quo than to ask the difficult question, "Should I change how I am treating this patient?"

Physicians need to limit opioid medication to the treatment of moderate to severe acute pain, and rarely use them for chronic pain. Mistakes made with these drugs can be lethal. As a result, there is a responsibility to be as cautious as possible in prescribing them.

The proposed guideline would encourage more and better physician-patient conversations and help both parties by encouraging alternative interventions and treatment strategies when appropriate. The national crisis around opioid addiction and overdoses deserves the attention CDC is providing and requires a substantial response not only from the federal government, but also from all of medicine as well. Every day that meaningful action is delayed, more people's lives and families are endangered.

This is not about taking needed medications away from those who need them; instead, it is about changing the culture around prescribing opioids so the next generation of pain patients receives the best and least risky treatments possible. Contrary to the claims of opponents, CDC has put forth a rather modest proposal. It is not a mandate. It includes no black-and-white requirements, and it does not apply to active cancer treatment, palliative care for other serious illnesses, or end-of-life care. The proposal is more likely to bring about a balanced approach than to swing the pendulum too drastically. Dr. Brunner and the Hazelden Betty Ford Foundation thank CDC for its leadership and backs the agency's efforts.

Faye Roscoe
Mother of a Son Prescribed Vicodin® Against Her Request

Ms. Faye Roscoe expressed her gratitude for the opportunity to provide comments on the guideline. She supports the original proposal. Twelve years ago, Ms. Roscoe's son, then age 23, had knee surgery. At the time of release from the hospital, the physician prescribed Vicodin® against her request to prescribe a non-narcotic drug due to his existing drug issues. Had stricter guidelines been in place, such as discussing other alternatives for pain medication, she believes that Vicodin® would not have been prescribed.

The goal of the guideline is not to ban opioid medications, but to enact stricter guidelines for healthcare providers who provide people with medication. While pain medication is necessary for many, opioid medication, by default, is not. The lack of concern to best prescribe the correct pain medication has fueled a drug addiction epidemic and skyrocketed overdoses and deaths. CDC has data indicating that 259 million prescriptions were written in 2012 for opioid pain medications. Why are these prescriptions being written for children as young as 12, when 2 million Americans either abused or were dependent on these pain relievers in 2013? It is

imperative that CDC acts immediately. Lives are lost daily to prescription opioid abuse. It could be anyone's family member.

Dr. Daniel Carr
Professor of Public Health & of Anesthesia and Medicine, Tufts University
President-Elect, American Academy of Pain Medicine (AAPM)

Dr. Daniel Carr is the President-Elect of AAPM and is a Professor of Public Health as well as Anesthesia and Medicine at Tufts University, where he directs the program in Pain Research, Education and Policy. AAPM has participated in educational programs on the safe and effective use of opioids. The group's upcoming annual meeting will feature education for primary care providers. AAPM is devoted to patients with pain and offers comments on the stigmatization of patients with pain in several aspects of the draft guideline. AAPM agreed with and supports many of the recommendations that have been put forth. In particular, many comments have indicated that there is no evidence that opioids are effective in the long-term for chronic, non-cancer pain. The review of the literature was of the "best available evidence." On the other hand, to say that there is "no evidence" is a misstatement. The same methodologic group who performed the literature review for the draft guideline already performed prior reviews in 2009, in part supported by AAPM with the APS, and also in the Cochrane library, which has a review to this point in Issue One of 2016. Therefore, the statement that there is no evidence to support the chronic use of opioids is a misstatement and does not reflect a "best available evidence" approach.

The evidence must be made transparent, which does not weaken the compelling account of tragedy of people who have misused, abused, or otherwise overdosed on opioids. It is important to increase the evidence from clinical trials. This work can be conducted by a sensitivity analysis, which will assess the effects upon the conclusions of the literature review by including studies of various durations. Dr. Carr and his colleagues have conducted this analysis, using the roster of studies that were excluded from the CDC's literature review because of their duration. They analyzed these studies and found a considerable amount of evidence.

In a recent issue of *NEJM*, there is a balanced editorial by a specialist in pain aggregation in Boston. The bottom line is to recognize that there is evidence, and the evidence extends to individual variability in the response to opioids, which weakens the logic for setting firm dosage thresholds as the basis for policy. It is known that very often, the nuances of recommendations are lost by insurers and other regulators. AAPM is concerned that the patients who are already stigmatized because of their chronic pain will be further stigmatized.

Jonathan Fielding, MD, MPH, MBA
Professor, Fielding School of Public Health
University of California, Los Angeles School Public Health

Dr. Jonathan Fielding thanked the group for this important opportunity for CDC and for the nation. He is a Professor at the Fielding School of Public Health, a former Health Officer for Los Angeles County, and the Director of Public Health for Massachusetts. He chairs the US Preventive Services Task Force (USPSTF), an independent, nonfederal, unpaid panel of public health and prevention experts that provides evidence-based findings.

Certainly, opioids offer pain relief to many suffering patients and are an important treatment option, when medically indicated; however, it is clear from prescribing data and related addiction treatment admission and overdose death that the medical community has over-relied on opioids to treat pain. Prescription opioid sales in the US have increased by over 300% since 1999, while opioid-related overdose deaths nearly quadrupled. To reverse this horrific epidemic of opioid drug overdose deaths and to prevent opioid-related morbidity, the medical community is urgently in need of guidance from CDC, because aggressive opioid prescribing is harming pain patients and fueling an unprecedented epidemic of addiction and overdose deaths.

Dr. Fielding applauded the CDC scientific committee and the rigorous process they undertook to develop this guideline to improve the dialogue between primary care physicians and patients surrounding the benefits and the risks associated with these medications for the treatment of chronic, non-malignant, and non-terminal pain. This guideline will improve the way opioids are prescribed and can ensure that patients have access to safer, more effective chronic pain treatments while reducing the number of people who misuse, abuse, or overdose from these powerful medications.

The CDC guideline is based upon an unbiased, exhaustive analysis of the best available research. Critics have suggested that there is not definitive evidence to support the guideline related to levels of dosage and duration of use recommendations; however, Dr. Fielding believes that the CDC guideline has sufficient evidence to provide clinical guidance to physicians and that further delays will cause more American lives to be lost unnecessarily, not to mention the millions of Americans who will lead subpar lives. Dr. Fielding has read the draft guideline and strongly urged CDC to release the guideline without revision as quickly as possible.

Dr. Hargarten thanked all participants for providing input and commentary in person and via telephone, and reiterated that the commentaries would become a part of the official record.

Discussion and BSC Recommendations

Stephen Hargarten, MD, MPH
Professor and Chair
Department of Emergency Medicine
Medical College of Wisconsin
Chair, National Center for Injury Prevention and Control Board of Scientific Counselors

Dr. Hargarten observed that the day had been extraordinary, with extraordinary discussion and input from a variety of perspectives, including the BSC and the public. They had held constructive and thoughtful discussion on the workgroup's observations and recommendations. The next step is to further advance the workgroup's recommendations. He opened the floor for discussion and BSC recommendations.

Discussion Points

Dr. Duwve thanked the commenters for the wisdom, stories, and insight that they provided. She recommended that CDC consider the observations made by the workgroup. There was strong support in the day's testimony for integrated care and pediatric and adolescent populations to be considered in future updates to the guideline. She moved that the CDC adopt the workgroup recommendations that had unanimous support or were supported by the majority of workgroup members, and that the CDC continue to consider the variety of recommendations made by the workgroup when there was not consensus.

Dr. Hargarten called for discussion of the three parts of Dr. Duwve's motion to adopt the workgroup's observations.

Ms. Amy Peeples specified that the workgroup was not tasked with making recommendations, only observations and considerations. That role informed the way the report was structured and written.

Dr. Hargarten clarified that the motion was to support the observations made by the workgroup; to support the workgroup observations on the recommendations that had unanimous and majority support; and to support the additional suggestions and observations made by the workgroup that will further inform CDC's efforts to formulate and structure the guideline.

Dr. Duwve and **Dr. Forjuoh** agreed with the description.

Dr. Hamby felt that the motion was appropriate, but asked for Dr. Porucznik's comments if her role permitted her to do so.

Commenting as a BSC member, **Dr. Porucznik** noted that she was the chair of the workgroup because the chair had to be a member of the BSC. The workgroup executed its charge to review the evidence and guideline recommendation statements, and to provide observations that were presented to BSC. With this motion, the BSC would be approving the report as the completion and fulfillment of the workgroup charge and moving that CDC take the observations into consideration as the final version of the guideline is created. The motion was consistent with what the BSC requested in its January 7, 2016 meeting. The BSC was not creating the guideline, but was BSC recommending to CDC that the final version of the guideline should take the workgroup observations into account.

Motion / Vote

Dr. Duwve formally stated her motion: 1) CDC should support the observations made by the workgroup; 2) CDC adopts the workgroup observations that were unanimous or where there was a majority consensus; and 3) CDC further considers the variety of observations made by the workgroup when there was not consensus. **Dr. Forjuoh** seconded the motion. The motion passed unanimously with no abstentions.

Conclusion and Adjourn

Stephen Hargarten, MD, MPH
Professor and Chair
Department of Emergency Medicine
Medical College of Wisconsin
Chair, National Center for Injury Prevention and Control Board of Scientific Counselors

Dr. Hargarten expressed his gratitude for an extraordinary day and a process that was conducted in a professional, science-driven, thoughtful manner. He said he was honored to be part of the work.

Dr. Greenspan expressed her appreciation to the BSC and to Dr. Porucznik and Dr. Green for spending so much time to meet and develop the workgroup report. She thanked Dr. Hargarten for chairing the meeting and the BSC members and *ex officio* members for their participation, and expressed her appreciation for the dedication of all participants in the meeting. She proposed that the next BSC meeting be convened on June 15-16, 2016 in order to coincide with the secondary review process.

With no additional discussion, Dr. Hargarten officially adjourned the meeting at 2:44 p.m.

Certification

I hereby certify that to the best of my knowledge, the foregoing minutes of the January 28, 2016 NCIPC BSC meeting are accurate and complete:

3/11/16
Date

Stephen Hargarten, MD, MPH
Chair, NCIPC BSC

Attachment A: Meeting Attendance

BSC Members

Joan Marie Duwve, M.D., M.P.H.
Associate Dean for Practice
Indiana University

Samuel Forjouh, MD, MPH, DrPH, FGCP
Department of Family and Community Medicine
Texas A&M Health Science Center College of Medicine

Gerard Gioia, Ph.D
Chief, Division of Pediatric Neuropsychology
Children's National Medical Center

Sherry Lynne Hamby, PhD
Department of Psychology
Sewanee, The University of the South

Stephen Hargarten, MD, PhD
Professor and Chair
Department of Emergency Medicine
Medical College of Wisconsin

Robert L. Johnson, M.D.
Dean, University of Medicine and Dentistry
New Jersey Medical School

Angela D. Mickalide, PhD, MCHES
Executive Director
Emergency Medical Services for Children's National Resource Center
Children's National Medical Center

Sherry D. Molock, PhD
Associate Professor
Department of Psychology
The George Washington University

Christina A. Porucznik, PhD, MSPH
Assistant Professor
Department of Family and Preventive Medicine
University of Utah

Maria Testa, PhD
Senior Research Scientist
Research Institute on Addictions
University at Buffalo

Shelly D. Timmons, MD, PhD, FACS
Director of Neurotrauma
Department of Neurosurgery
Geisinger Medical Center

Ex-Officio

Melissa Brodowski, Ph.D., M.S.W., M.P.H.
Senior Policy Analyst
Administration for Children and Families

Iris Mabrey-Hernandez, M.D., M.P.H.
Medical Officer
Agency for Healthcare Research and Quality

Dawn Castillo, MPH
Director
Division of Safety Research
National Institute for Occupational Safety and Health

Elizabeth A. Edgerton, MD, MPH
Branch Chief
EMSC and Injury Prevention
Maternal and Child Health Bureau
Health Resources and Services Administration

Thomas E. Feucht, PhD
Executive Senior Science Advisor
National Institute of Justice

Holly Hedegaard, M.D., M.S.P.H.
Senior Service Fellow
National Center for Health Statistics

Jane L. Pearson, PhD
Associate Director for Preventive Interventions
Division of Services and Intervention Research
National Institute of Mental Health

Lyndon Joseph, Ph.D.
Health Scientist Administrator
National Institutes on Health
National Institute on Aging

Valerie Maholmes, Ph.D., C.A.S.
National Institutes on Health
National Institute of Child Health and Human Development

Wilson Compton, M.D., M.P.H.
Deputy Director
National Institutes on Health
National Institute on Drug Abuse

Jinhee Lee, PharmD
Senior Public Health Advisor
Substance Abuse and Mental Health Service Administration

Thomas Schroeder, M.S.
Director
U.S. Consumer Product Safety Commission

CDC Staff

Adeyelu Asekun, M.S., M.B.A.
Grant Baldwin, Ph.D., M.P.H.
Mick Ballesteros, Ph.D.
Sara Bacon, Ph.D.
Jeneita Bell, M.D., M.P.H.
Mark Biagioni, M.P.A.
Sandy Bonzo, M.L.S., B.S.
Daniel N. Cameron, B.S.
Ted Castellanos, M.P.H., B,A,
Gwendolyn Cattledge, Ph.D., M.S.E.H.
Kristen Cincotta, Ph.D.
LaShundra Cordier
Charmaine N Crabaugh, M.P.H.
Kari Cruz, M.P.H.
Melissa Cyril
Linda Dahlberg, Ph.D.
Leslie Dorigo
Deborah Dowell, M.D., M.P.H.
Patrice Davis-Duncan
Hilary Eiring
Corrine Ferdon, Ph.D
Curtis Florence, Ph.D,
Derek Ford, Ph.D.
Beverly Fortson, Ph.D.
Arlene Greenspan, Dr.P.H., M.P.H.
Juliet Haarbauer Krupa, Ph.D.
Tamara Haegerich, Ph.D.
Jeffrey Herbst, B.A., Ph.D.
Susan Hillis, M.S.N., Ph.D
Dan Holcomb, B.S.
Lisa Holman
Phyllis Holditch Niolon, Ph.D.
Debra Houry, M.D., M.P.H
Robin M. Ikeda, M.D., M.P.H.
Aesa Johannason

Helen T Kuykendall
M. Chris Langub, Ph.D.
Kinzie Lee
Robin Lee, Ph.D.
Courtney Lenard,
Gladys Lewellen, M.B.A., M.P.A.
Sara Lewis, M.H.S.
Tonia Lindley
Jan Losby
Karin Mack, Ph.D.
Angela Marr, M.P.H.
Pedro Martinez, M.P.H.
Greta Massetti, Ph.D.
Melissa Merrick, Ph.D.
Patricia Mitchell, B.S., M.P.H.
Sue Neurath, Ph.D.
Rita Noonan, Ph.D.
Nimeshkumar Patel, M.S.
Cha-kara Parkman-Wimberly, B.S.P.H.
Amy Peeples, M.P.A.
Katie Ports
Emily Robinson
Rose A. Rudd, M.S.P.H.
Erin Sauber-Schatz, M.P.H., Ph.D.
Anne Schuchat, M.D., B.A.
Puja Seth, Ph.D., M.A.
Elizabeth Solhtalab, M.P.A.
Tom Simon, Ph.D.
David Sleet, Ph.D.
L. Shakiyla Smith, M.P.H.
Cassie Sheldon
Jane Suen, Dr.Ph,, M.S.
Mildred Williams-Johnson, Ph.D., D.A.B.T.
Joann Yoon,
Chao Zhou

Other Attendees

Kendra Cox, Cambridge Communications
Tess Benton, National Safety Council
Might Fine, APHA
David Laws, G.O.P.
Gary Mendell, Shatterproof
Carolyn Noel, PAINS
Sarah Svoboda, NSC
Shelly Timmons, Geisinger
Stephen Liguh, Shatterproof

Attachment B: Acronyms Used in this Document

Acronym	
AAPM	American Academy of Pain Medicine
ACIP	Advisory Committee on Immunization Practices
ACOEM	American College of Occupational and Environmental Medicine
APS	American Pain Society
ARPO	Advocates for Reform of Prescription Opioids
ASA	American Society of Anesthesiologists
BSC	Board of Scientific Counselors
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CME	Continuing Medical Education
CNS	Central Nervous System
COT	Chronic Opioid Therapy
DEA	(United States) Drug Enforcement Administration
DOD	(United States) Department of Defense
EMR	Electronic Medical Record
EOC	Emergency Operations Center
ER/LA	Extended-Release/Long-Acting
FACA	Federal Advisory Committee Act
FDA	(United States) Food and Drug Administration
GRADE	Grading of Recommendations Assessment, Development and Evaluation
HHS	(United States Department of) Health and Human Services
IHS	Indian Health Service
IOM	Institute of Medicine
IQR	Interquartile Range
MAT	Medication-Assisted Treatment
MME	Morphine Milligram Equivalents
NAS	Neonatal Abstinence Syndrome
NCIPC	National Center for Injury Prevention and Control
NCIRD	National Center for Immunization and Respiratory Diseases
NEJM	*New England Journal of Medicine*
NIMH	National Institute of Mental Health
NSAID	Nonsteroidal Anti-Inflammatory Drug
NSC	National Safety Council
OTC	Over-the-Counter
PAINS	Pain Action Alliance to Implement a National Strategy
PDMP	Prescription Drug Monitoring Program
PNAS	Proceedings of the National Academy of Sciences
QI	Quality Improvement
RCT	Randomized Controlled Trial
REMS	Risk Evaluation and Mitigation Strategy
SBIR	Small Business Innovation Research
SME	Subject Matter Expert
SSDI	Social Security Disability Insurance
USPSTF	United States Preventive Services Task Force
VA	(United States Department of) Veterans Affairs
WA AMDG	Washington State Agency Medical Director's Group
WHO	World Health Organization

Opioid Guideline Workgroup

Observations presented to the National Center for Injury Prevention and Control's Board of Scientific Counselors

Preparatory material for Board of Scientific Counselors meeting on January 28, 2016

Submitted by:

Christina Porucznik, PhD, MSPH, Workgroup Chair

Workgroup Members:

Anne Burns, RPh

Penney Cowan

Chinazo Cunningham, MD, MS

Katherine Galluzzi, DO

Traci Green, PhD, MSc

Mitchell Katz, MD

Erin Krebs, MD MPH

Gregory Terman, MD, PhD

Mark Wallace, MD

Designated Federal Official:

Amy B. Peeples, MPA

In addition to the identified members of the Workgroup additional consultation was arranged for specific content areas.

Consultant Area	**Participation**
Pediatrics & Anesthesiology	*Ad hoc*, available for questions, not contacted
Occupational Medicine & Worker's Compensation	*Ad hoc*, available for questions, not contacted
Obstetrics & Gynecology	Participated in meeting on 1/15/16
GRADE methodology & cost effectiveness	Participated in meetings on 1/8, 1/13, and 1/15
Medical Ethics	*Ad hoc*, available for questions, not contacted
Addiction Psychiatry	Participated in meeting on 1/15/16
Physical Medicine & Rehabilitation	Participated in meeting on 1/13/16
Family member affected by loss of a loved one to opioid overdose	Participated in meeting on 1/13/16

Overall Observations

- Workgroup members support efforts reflected in the Guidelines — specifically in the supporting text and statements of Guideline Recommendations # 1, 9, 11, and 12 — to encourage integrated care for people with chronic pain. As defined in the Draft National Pain Strategy, "*Integrated care* is the systematic coordination of medical, psychological and social aspects of health care and includes primary care, mental health care, and, when needed, specialist services." (http://iprcc.nih.gov/docs/DraftHHSNationalPainStrategy.pdf, p.9)
- Workgroup members suggest monitoring of Guideline implementation for evidence of impact and unintended consequences and modification of Guidelines when warranted by evidence.
- Several workgroup members suggest that pediatric and adolescent populations should be considered for future updates of opioid prescribing guidelines.
- Risks and benefits of opioid therapy in chronic pain and the epidemiology of prescription drug misuse and abuse are areas of active research, so the Workgroup suggested that the contextual evidence review may need to be updated more frequently than the clinical evidence review. We encourage CDC to work with partners to support additional research in this field.
- Workgroup members express strong preference for Guideline Recommendations that are framed with positive rather than negative language.
- Several workgroup members observed that we were asked to consider cost feasibility for the recommendations and in general feel that such data are lacking and subject to great variability. More research is required in this domain in order to have evidence relating to cost feasibility that could be evaluated.
- Concerns about access, cost, and insurance coverage were raised by several workgroup members in discussion about Guideline Recommendations #1, #6, #7, #8, #9, #10, and #12. Systematic changes in payment policies will likely be required to support implementation of the

Guidelines. Workgroup members encourage CDC to work with federal partners to support payment policies congruent with the Guidelines.

- Discussions about safe storage and disposal are mentioned in several sections of supporting text. Workgroup members observe that these discussions are relevant throughout the course of opioid therapy for chronic pain and encourage providers to include patient education on safe storage and disposal of medications as a routine part of therapy along with discussion of risks, benefits, treatment goals, mental health, pain, and function.
- Workgroup members observe that primary care providers may require additional education on approaches integral to implementation of the Guidelines, including education on non-pharmacologic and integrated care, offering naloxone to patients with chronic pain, and medication assisted treatment for opioid use disorder. Workgroup members encourage CDC to work with partners to support and/or provide appropriate education.

Observations Specific to Guideline Recommendation Statements

The observations presented here follow the ordering of the Guidelines.

> **GUIDELINE RECOMMENDATION #1:** *Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain. Providers should only consider adding opioid therapy if expected benefits for both pain and function are anticipated to outweigh risks to the patient. (Recommendation category: A; Evidence type: 3)*

All members of the Workgroup agreed with the type and category of evidence for Guideline Recommendation #1.

- Workgroup members commend the ordering of statements and agree that the topic of Guideline Recommendation #1 is first. Clear wording that opioids are not routine therapy for adults in chronic pain managed in primary care as well as mention of both pain and function are good messages.
- Several workgroup members expressed significant concerns about access to care, particularly for non-pharmacologic therapies mentioned in Guideline Recommendation #1 and suggestion that there should be clear preference for integrated care for chronic pain expressed in Guideline Recommendation #1 and throughout the Guidelines.

> **GUIDELINE RECOMMENDATION #2:** *Before starting opioid therapy for chronic pain, providers should establish treatment goals with all patients, including realistic goals for pain and function. Providers should not initiate opioid therapy without consideration of how therapy will be discontinued if unsuccessful. Providers 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)*

All members of the Workgroup agreed with the type and category of evidence for Guideline Recommendation #2.

- Workgroup members commend Guideline Recommendation #2 in particular for its focus on patient-centered goals for improvement of pain and/or function. There was some concern that some providers would interpret the phrasing of "pain and function" to mean that improvements were required in both pain and physical function in order to justify continuation of opioid therapy. Such meaning could be clarified in the supporting text. Spinal cord injury patients, for example, may never walk again, but continued opioid therapy may be appropriate if it helps manage their pain and improves social or psychological function.
- Many people with chronic pain also experience mental health concerns such as depression and/or anxiety, and there is evidence that treating these co-existing conditions can improve pain outcomes as well. Several workgroup members encourage addition of language in the supporting text to include evaluation of mood in addition to pain and function.

GUIDELINE RECOMMENDATION #3*: Before starting and periodically during opioid therapy, providers should discuss with patients known risks and realistic benefits of opioid therapy and patient and provider responsibilities for managing therapy. (Recommendation category: A; Evidence type: 3)*

All members of the Workgroup agreed with the type and category of evidence for Guideline Recommendation #3.

- Several members observed that suggesting a safety discussion in response to unexpected findings in the PDMP or urine drug screen in the supporting text for Guideline Recommendation #3 may suggest to providers that safety discussions are for extreme events rather than conversations that should occur at initiation of opioid therapy and continue as a routine matter throughout the duration of therapy.
- Some members suggested that the supporting text for Guideline Recommendation #3 could be strengthened by moving information about consideration of risk to household members from opioid exposure or improper storage in the home (e.g. pediatric poisoning events) from the last bullet to higher in the text.
- Disposal of medications is a complicated situation. Information about safe disposal of medication should be included in the tools accompanying the Guidelines.
- Several members suggest that consideration of possible risk to household members from accidental ingestion or diversion of opioids be included in the discussion of risks and benefits with the patient.

GUIDELINE RECOMMENDATION #4*: When starting opioid therapy for chronic pain, providers should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids. (Recommendation category: A; Evidence type: 4)*

All members of the Workgroup agreed with the type and category of evidence for Guideline Recommendation #4.

- Guideline Recommendation #4 is evidence type 4. This recommendation is consistent with best practices and well-deserves Category A designation.

GUIDELINE RECOMMENDATION #5*: When opioids are started, providers should prescribe the lowest effective dosage. Providers should use caution when prescribing opioids at any dosage, should implement additional precautions when increasing dosage to 50 or more morphine milligram equivalents (MME)/day, and should generally avoid increasing dosage to 90 or more MME/day. (Recommendation category: A; Evidence type: 3)*

This statement generated significant discussion about content in addition to the discussion about recommendation category and type of evidence.

- Six of the nine Workgroup members agreed with the category A and evidence type 3 designation. Three members felt that the evidence type 3 was appropriate except for the last paragraph of supporting text and if the discussion of tapering in the supporting text was removed then the category A and evidence type 3 designation was appropriate. Two Workgroup members suggested revisions to the statement.
- One specific observation was that the last paragraph of the supporting text for Guideline Recommendation #5, regarding patients already taking opioids, does not directly support Guideline Recommendation #5 which is about initiation of opioid therapy.
- In comparison to contextual evidence for risk and harm from opioid therapy there are virtually no studies of long-term benefits or improvement in pain and function with opioid therapy. Workgroup members encourage future studies to populate this data gap.
- One member of the Workgroup strongly opposes Guideline Recommendation #5 as it is written. This member stated repeatedly that the current recommendation clearly suggesting dose limits is not supported by any data showing a decrease in benefit/risk ratio at the arbitrary numbers stated in the recommendation. This member expresses concern that the current wording of Guideline Recommendation #5 will undermine support for the entire Guidelines from providers and professional organizations.
- The focus on patient pain and function included in the text of Guideline Statement #2 was not similarly included with Guideline Statement #5. Improvement or decrement of pain and/or function should be the impetus for any change in dose, either increasing or decreasing, and members observed that it should be repeated here.
- There was not agreement about the evidence type for this statement, in part because of the inclusion of the last paragraph of supporting text. Most members felt that the evidence for the last paragraph of supporting text was type 4 but supported type 3 evidence for the remaining paragraphs of supporting text.
- Individual Workgroup members suggested specific edits to the text which are included here for information. The reworded statements alleviated more general concerns about perceptions of limit setting, implications of safe dosing below those limits, and observation that all of the evidence presented is about risk and harm rather than potential benefits or risk/benefit ratios associated any with dosing levels.
    - "When opioids are started, providers should prescribe the lowest effective dosage. Prescribers should be aware that risk of opioid-associated harm is greater with higher dose opioid therapy and should, therefore, carefully justify a decision to titrate opioids beyond 90 MME/day. In this regard, providers should use caution

when prescribing opioids at any dosage but should implement additional precautions when increasing dosage to > 50 MME/day."

- "When opioids are started, providers should prescribe the lowest effective dosage. There is no safe dosage of opioids, but risks of serious harms rise with increasing dosages. Providers should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and potential harms when considering increasing dosage to ≥50 MME/day, and should generally avoid increasing dosage to ≥90 MME/ day."

GUIDELINE RECOMMENDATION #6: *Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, providers 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. Three or fewer days usually will be sufficient for most non-traumatic pain not related to major surgery. (Recommendation category: A; Evidence type: 4)*

All members of the Workgroup agreed with the evidence type for Guideline Recommendation #6.

There was considerable discussion about the Category rating for Guideline Recommendation #6. One member recommends that Guideline Recommendation #6 be Category B. Many members are able to support the Category A designation only if the statement is re-worded (see suggestions below).

- The duration of therapy was focus for animated discussion. Many members felt that three days was too limited and preferred a range of values, none of which exceeded seven days. Four members preferred seven days or fewer. Two members preferred a range of 3–7 days. One preferred a range of 5–7 days. One preferred a range of 3–5 days. One member was strongly opposed to seven days as "too long".
- Specific wording suggestions for Guideline Recommendation #6 follow.
  - "Avoid prescribing more than three days supply, unless circumstances clearly warrant additional opioid therapy."
- The supporting text for Guideline Recommendation #6 should also include information and tools about safe medication storage and disposal.

GUIDELINE RECOMMENDATION #7*: Providers should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Providers 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, providers should work with patients to reduce opioid dosage and to discontinue opioids. (Recommendation category: A: Evidence type: 4)*

All members of the Workgroup agreed with the type and category of evidence for Guideline Recommendation #7.

- Guideline Recommendation #7 should apply to all patients. Several Workgroup members expressed concern that the wording suggested that Guideline Recommendation #7 applied only to opioid naïve patients.

- Individual workgroup members also suggested specific edits to Guideline Recommendation #7, particularly the final sentence. There was concern that it implied that all patients should be at a dose of zero opioids (…and discontinue) and failed to suggest what else providers should do besides eliminating opioid dose.

  The majority of members would prefer that the last clause be either:

  1. "…providers should work with patients to reduce opioid dosage OR discontinue opioids AND IMPLEMENT OTHER THERAPIES."
  2. "…providers should work with patients to reduce opioid dosage and discontinue opioids IF INDICATED, AND IMPLEMENT OTHER THERAPIES."

Alternately, a completely revised last sentence in Guideline Recommendation #7 could read:

- "If harms outweigh the benefits of opioid therapy, clinicians must work with patients to seek alternative or adjunctive therapies for pain as part of a careful reduction or discontinuation of opioid dosage."
- '….If harms outweigh the benefits of opioid therapy, providers should work with patients to seek alternative or adjunctive therapies for pain as a careful reduction of opioid dosage or discontinuation (if necessary) of opioid therapy.'

GUIDELINE RECOMMENDATION #8: *Before starting and periodically during continuation of opioid therapy, providers should evaluate risk factors for opioid-related harms. Providers 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, or higher opioid dosages (≥50 MME), are present. (Recommendation category: A; Evidence type: 4)*

All members of the Workgroup agreed with the type and category of evidence for Guideline Recommendation #8.

- Two members suggest that Guideline Recommendation #8 would be stronger with the inclusion of concomitant use of central nervous system (CNS) depressants or sedatives among the listed risk factors.

GUIDELINE RECOMMENDATION #9*: Providers 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 high opioid dosages or dangerous combinations that put him or her at high risk for overdose. Providers 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)*

All members of the Workgroup agreed with the type and category of evidence for Guideline Recommendation #9.

- The first bullet of the supporting text for Guideline Recommendation #9 implies that pharmacists are solely responsible for inaccurate data entry, to correct that, the phrase "if a pharmacist" should be deleted.
- The bulleted information in the supporting text for Guideline Recommendation #9 should also apply to patients on high dosages and dangerous combinations, not just patients receiving medications from multiple providers.
- Workgroup members observe that PDMP access and utility varies among states. Issues of data sharing can limit PDMP utility in border areas. CDC and its federal partners are encouraged to support PDMP development and operation across the country and help work towards efficient data access and interfaces for all providers of controlled substances.

GUIDELINE RECOMMENDATION #10*: When prescribing opioids for chronic pain, providers 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)*

All members of the Workgroup agreed with the evidence type for Guideline Recommendation #10.

The majority of Workgroup members felt that Guideline Recommendation #10 should be a Category A recommendation rather than Category B. The universal recommendation is perceived to be both more focused on patient safety and less likely to result in urine drug testing being applied selectively among already stigmatized or stereotyped patients.

- Supporting text for Guideline Recommendation #10 should encourage providers to use the simplest urine drug testing appropriate for each patient to reduce the cost and improve the feasibility of this recommendation.
- Supporting text for Guideline Recommendation #10 should emphasize the need for providers to be educated about interpretation of the results of the urine drug testing implemented in their practice settings.
- Research on risks and benefits of urine drug testing is limited, and more such research is encouraged.

GUIDELINE RECOMMENDATION #11*: Providers should avoid prescribing opioid pain medication for patients receiving benzodiazepines whenever possible. (Recommendation category: A; Evidence type: 3)*

All members of the Workgroup agreed with the type and category of evidence for Guideline Recommendation #11.

- Workgroup members observe and support that the intention of Guideline Recommendation #11 is to discourage concurrent prescribing of opioids and benzodiazepine medications, however, several members felt that the current language presumes that the benzodiazepine prescription is appropriate and fails to encourage patient-centered decision making about risks and benefits for each medication.

- Supporting text for Guideline Recommendation #11 could include language about the importance of the pharmacist in co-prescribing situations and the role for use of prescription drug monitoring programs (PDMP) for identifying concurrent medication use.
- Workgroup members noted that the wording of Guideline Recommendation #11 has changed significantly during the comment and review process. Several workgroup members preferred the original wording.
- Some Workgroup members preferred that this statement be modified to say, "Providers should USE CAUTION WHEN prescribing opioids…" rather than, "Providers should AVOID prescribing opioids." Several Workgroup members supported the "AVOID" wording; two members strongly preferred the "AVOID" wording.
    - Discussion surrounded concerns about inter-professional communication (i.e., psychiatrists, primary care physicians) challenges and the need for providers and patients to jointly discuss the patient's needs, prioritize patient goals, and weigh risks of concurrent benzodiazepine and opioid exposure before deciding upon initiating, continuing to prescribe, or tapering either medication.
- Risk mitigation in the presence of co-prescription was universally supported by the Workgroup.

GUIDELINE RECOMMENDATION #12*: Providers 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: 3)*

All members of the Workgroup agreed with the evidence type for Guideline Recommendation #12.

There was disagreement among the Workgroup members with regards to the Category for Guideline Recommendation #12. One member felt strongly that this should be a Category B. The remaining Members were comfortable with Category A.

- Workgroup members commend the wording of Guideline Recommendation #12, particularly the "Providers should offer or arrange…" clause because they felt it would help encourage primary care providers to be proactive about treatment for opioid use disorder and perhaps encourage more providers to acquire training and licensure for buprenorphine prescribing.
- Workgroup members were in agreement that the evidence for medication assisted treatment for opioid-use disorder is strong and recommend that the evidence type for Guideline Recommendation #12 be upgraded from type 3 to type 2.

Review of Supplemental Materials: Clinical Evidence Review, Contextual Evidence Review, and Comments from Stakeholders, Peer-Reviewers, and the Public

- The Clinical Evidence Review was thorough and well-done for the specific clinical questions.
- Workgroup members recommend continued support for future clinical and contextual research on benefits and risks of opioid therapy for chronic pain.

- Future updates of the Contextual Evidence Review should seek out more information about specific non-pharmacologic therapies for chronic pain, such as exercise therapies, interventional therapies, integrative medicine, and behavioral therapies.
- Evidence in the Contextual Evidence Review supports that mental health disorders frequently co-occur among people with chronic pain. The supporting text for Guideline Recommendations #2 and #5 which describe evaluating pain and function should be modified to include evaluation of patient mood as well.
- Comments from constituents demonstrated the breadth and variety of positions on the issue of opioid therapy for chronic pain among adults managed in primary care. There seemed to be a general agreement, however, that guidelines are needed, even if this set of guidelines is only the first step.
- Comments from patients and family members, in particular, expressed the desire that patient-centered care is enhanced rather than reduced by these Guidelines. Members felt that the guidelines could be implemented in a manner consistent with patient-centered care.

Gary Mendell, Shatterproof

My name is Gary Mendell. Related to my qualifications, I am a father who has had the anguish of having to bury his first born son, who was addicted to opioids. I am also the founder and CEO of Shatterproof, a national organization committed to preventing as many of our loved ones as possible from becoming addicted to prescription drugs, illicit drugs and alcohol. Our organization has brought together as advisors many of the preeminent experts in the field, and is focused on identifying and helping to implement solutions to the tragic epidemic of overdose deaths shattering families across our country.

I and several of my advisors have read every word of the Proposed 2016 Guideline for Prescribing Opioids for Chronic Pain ("CDC Guideline") and offer the following:

I and my advisors are very sensitive to the many Americans who suffer with chronic pain. We note that the CDC Guideline makes clear it is not intended for those "patients undergoing active cancer treatment, palliative care, or end-of-life care because of the unique therapeutic goals, ethical considerations, opportunities for medical supervision, and balance of risks and benefits with opioid therapy in such care". It also notes: "It is important that patients receive appropriate pain treatment with careful consideration of the benefits and risks of treatment options. This guideline is intended to improve communication between providers and patients about the risks and benefits 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."

To reverse this horrific epidemic of opioid drug overdose deaths and prevent opioid-related morbidity, the medical community is urgently in need of guidance from the CDC because aggressive opioid prescribing is harming pain patients and fueling an unprecedented epidemic of addiction and overdose deaths.

I and many at Shatterproof have seen firsthand countless wonderful people who have become addicted to prescription painkillers, many of which have died, leaving their families torn apart. And countless others who are living subpar lives in clutches of active addiction.

As all of you know, the CDC Guideline is not based on public opinion, or conflicts of interest related to the profits of opioid sales. Rather, they are based upon an unbiased, exhaustive analysis of the best available research. The CDC can wait for years for further research, but if it does, tens of thousands of our loved ones will die, and tens of thousands of families will be torn apart beyond imagination. Not to mention the millions of Americans who will lead subpar lives, with they and their families agonizing, waiting for that call that no parent, sibling, or child every wants to receive.

In this regard:

1. I strongly urge the CDC to revise Recommendation #1 be strengthened by listing specific chronic conditions for which opioids should be avoided.
2. I strongly urge the CDC to <u>not</u> revise Recommendation #5 related to levels of dosage.
3. I strongly urge the CDC to <u>not</u> revise Recommendation #6 related to duration of dose.
4. I strongly urge the CDC to <u>not</u> revise any other of the recommendations.
5. I strongly urges the CDC to release the CDC Guideline as quickly as possible.

It is time, in fact well past time, for the CDC Guideline, as recommended above, be issued and implemented without any further delay. I as a father of four other children and families all across America are depending on this.

Andrew Kolodny, MD
Chief Medical Officer
Phoenix House Foundation

Draft of oral comments for CDC meeting on proposed opioid guideline

Primary care clinicians have contributed to an epidemic of overdose deaths and addiction by overprescribing opioids. We didn't do this out of malicious intent. For most of us, it was a desire to treat pain more compassionately that led to overprescribing. To bring this public health crisis under control, doctors must prescribe more cautiously.

In response to an industry-funded campaign, sales for opioids increased exponentially. Doctors were taught that unrealistic fear of addiction was resulting in needless suffering and that opioids would provide long-term relief of chronic pain. Doctors were misinformed.

Primary care clinicians need guidance on opioid prescribing that is free of industry bias.

Prescribing opioids short-term for acute pain and in palliative care is not controversial. But their widespread use for chronic pain may actually harm more people than it helps. Many patients on long-term opioids continue to suffer from significant pain and dysfunction. We have also come to realize that addiction and other serious side effects are common.

Overprescribing of opioids isn't just bad for patients. As opioids have become readily available in our medicine chests and classrooms, teenagers are experimenting with them. Unaware that these pills are similar to heroin, many recreational users are becoming addicted and dying from overdoses.

The Centers for Disease Control has demonstrated a strong association between increased opioid sales and overdose deaths. This suggests that prescribing needs to be reduced. Opioid manufacturers, and the pain advocacy organizations they fund, do not agree with this approach. They argue that opioids are still underused for chronic pain and that prescribing needs to increase. And they work against efforts to promote cautious use. The most recent example has been successful effort to delay the release of the CDC's guideline.

For doctors to prescribe more cautiously, an accurate appreciation of risks and benefits is required. The CDC's proposed guideline helps accomplish this.

Untreated chronic pain is a serious problem. But opioids are rarely the answer. Chronic pain patients need and deserve compassionate care and evidence-based treatment.

Susan Peschin, Alliance for Aging Research

My name is Sue Peschin and I serve as president and CEO of the Alliance for Aging Research, the leading non-profit organization dedicated to accelerating the pace of science to improve aging and health. Thank you for the opportunity to comment on the draft CDC Guideline for Prescribing Opioids for Chronic Pain. I am speaking today to respectfully request modifications to this draft guideline in order for healthcare providers to deliver appropriate care to aging pain suffers.

Research shows that older adults are the highest risk age group for persistent pain, yet they are too often undertreated or do not receive the appropriate therapy. Psychosocial factors, like the tendency of older adults to underreport their pain and lower adherence rates to prescribed pain medications often results in increased hospital stays, disability, interference with activities of daily living, sleep disturbances, depression, and suicidal thoughts and suicide.

There has been significant controversy about the guideline development process itself. What has been lost in the mix is the real controversy—that there is a limited or weak evidence base for almost all of these recommendations and that we need significant federal investment in clinical research to fill these key knowledge gaps. Who are the chronic pain patients for whom long-term opioid treatment would be most effective? Who is physiologically at higher risk of physical dependence on opioids? And, which patients will experience reduced tolerance while on long-term opioid treatment? Such gaps should be identified in the introductory statement.

In recommendation 1, the guideline should acknowledge the real-world concerns that accompany non-pharmacologic therapy and non-opioid pharmacologic therapy as first-line treatments for chronic pain. While approaches such as acupuncture, massage, CBT, and exercise demonstrate short-term benefits, the primary focus of this guideline was designed for the long-term management of chronic pain, so further evidence on them is needed before they can be suggested as an alternative to opioids. Most of these treatments are not reimbursed by public and private insurers, so providers should be directed to consider their patient's coverage status before prescribing an unaffordable intervention. Additionally, we are concerned about the potential overuse of acetaminophen and NSAIDs by older adults for chronic pain management and that the risks associated with them may be underestimated by providers attempting to avoid the prescription of an opioid—particularly for older adults who have multiple chronic conditions. NSAIDS are contraindicated for several diseases that seniors often experience concurrently with pain. Acetaminophen also has a maximum daily limit that can be exceeded in the pursuit of chronic pain management without proper education.

The dosage thresholds in recommendation 5 are in direct conflict with the FDA and its approved product labeling, which deliberately chose to exclude dosage thresholds based on evidence review. A June 2015 piece in the journal *Pain Medicine* found that "The lack of dosage uniformity and regulatory approaches across the United States raises the concern that dosage levels are not informed by high-quality evidence, are arbitrary, and may amount to experimentation with increased risk to patients." Recommendation 5 is not supported by existing evidence. We urge that this recommendation be removed from the list entirely.

Recommendation 6 of the draft guideline attempts to limit opioid overuse by imposing a 3-day limit for prescription of opioids to treat acute pain. Comments submitted to you by the AMA highlighted that the clinical evidence provided in the evidence review for this recommendation focused largely on the emergency setting and that there is a lack of evidence to support this recommendation for use in treatment of acute pain post-surgery, which will disproportionately impact older patients. Adults over age 65 are 2.6 times more likely to have surgery than those than those ages 45-64. We urge the modification of Recommendation 6 to remove a time or specific pill limit for acute pain treatment. The emphasis of this recommendation should be on healthcare providers prescribing the lowest dose of a short-acting opioid in a number and duration that the provider determines to be clinically necessary.

Disabling pain in older adults is a significant quality of life issue that creates a huge burden for patients, family caregivers, and society—and we would greatly appreciate more acknowledgement of this side of the discussion as this process moves forward. Opioids may not be the panacea, but they have helped reduce pain and improve function for millions of people. Future efforts and reforms should continue to focus on balance and the need to ensure access while preventing harm, rather than advocating for only one solution to a very complex problem.

Jane Ballantyne, University of Washington

Ballantyne Comments on CDC Guideline

January 9, 2016

I am an anesthesia pain specialist and have been since 1990. In the 1990s through 2008, I was the chief of an academic pain program in Boston. Throughout that span, the prescribing of opioids for chronic pain in the United States quadrupled, and it continues to rise. Whereas opioids were rarely used for chronic pain because they were thought to be ineffective or unsafe, more recently they have been used in up to 7% of chronic pain cases[1] and rising[2], and chronic pain rates are steadily increasing along with improved survivals and an aging population. There are numerous factors that produced the rise in opioid prescribing for chronic pain, but most importantly, there was new teaching that came largely from palliative care and industry.[3] This teaching aimed to 1) establish the right of chronic pain patients to receive opioids and the duty of clinicians to prescribe, 2) change the belief that opioids were not effective for chronic pain, 3) change the belief that opioids were not safe and 4) encourage open ended dosing on the basis that opioid pain relief was best obtained if opioids were dosed according to the stated pain level. The result was that both the number of people receiving opioids, and the doses they were receiving, increased exponentially. And a whole culture changed.

By the end of the 1990s, my colleagues and I began to question the basis of the teaching we had received, and our own practice. Patients receiving high doses of opioids typically reported high pain levels despite the opioid they were receiving, and they rarely experienced the improvements in function and quality of life we had hoped for. We searched the literature and found no evidence to support our practice, and we turned to the laboratory to try and explain the paradox of increasing pain despite increasing opioid doses.[4] We published our findings, we lectured, we presented to the FDA, we wrote guidelines, but nothing seemed to stem the tide of increased and unsafe prescribing. We find ourselves now, over 20 years later, with growing epidemiological evidence that shows clearly that unfettered opioid prescribing for pain has harmed both society and pain patients, and has not relieved the nation's burden of chronic pain.[5-7] Yet there is a reluctance to act on the basis that "more research is needed" – research that will take years to complete, if it ever gets done at all.

The CDC guideline is urgently needed. The guideline was very carefully crafted using the best available evidence, expert opinion from a group of individuals with extensive experience of writing practice guidelines, and stakeholder input from a broad and balanced group of stakeholders. The guideline suggests precautions that very few people would argue, precautions that are identical to those in all previous chronic opioid guidelines, both national and international. In an attempt to move practice away from what has clearly been shown to be ineffective and unsafe – continuous long term high dose opioid treatment - two new changes are suggested: lower standard doses, and shorter duration of treatment for uncomplicated acute pain. The guideline does not suggest taking opioids away from people who have already become dependent, does not suggest taking opioids away from people who can benefit, does not suggest anything that would harm pain patients. Yet it has produced a barrage of criticism, often based on an irrational fear of opioid restrictions. It is that criticism that brings us to the table today. I hope that the Board of Scientific Counselors will appreciate the urgent need for action, the reality of the limited state of the evidence, and the care with which the CDC guideline was crafted.

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Judy Rummler, FED UP! Coalition

Comments for January 28th presentation (for print and oral version)

from Judy Rummler, Chair of the FED UP! Coalition and Founder of the Steve Rummler Hope Foundation

Thank you for the opportunity to present comments on this very important issue.

I am Judy Rummler, Chair of the FED UP! Coalition. The FED UP! Coalition is working to find ways to prevent our children, spouses, parents, and friends from becoming addicted to opioids and to eliminate opioid overdose deaths. FED UP! is a grass roots coalition of individuals and organizations from across the country. We hold rallies and advocate for change in public policy that will help pain patients and those suffering with the disease of addiction. We are fed up with the failure of the FDA to take action that could end the overprescribing of opioids and save thousands of lives. We applaud the CDC for creating this proposed guideline which would lead to more cautious opioid prescribing and reverse the trend of ever-increasing overdose deaths.

Many of our members and partners have friends and family members who have died from opioid overdoses. The voices of these lost loved ones have been silenced, but their stories need to be told.

My story, similar to thousands of others, is about the loss of my son Steve Rummler. If Steve had had the opportunity to present to you five years ago, I am sure that he would have said that he had intractable chronic pain due to his back injury. He would have said that he needed his opioids in order to any have any "quality of life." He had become addicted to the opioid painkillers that were being prescribed to him for his chronic pain, and he would have been terrified at the thought of losing access to his pills. Steve died of an accidental overdose on July 1, 2011. Among his belongings we found a note referring to his prescription that said: "At first it was a lifeline - Now it is a noose around my neck."

As the mother of a son who suffered with chronic pain and the founder of the Steve Rummler Hope Foundation, I have compassion for pain patients. Their voices are being heard in this discussion and they have posted many comments. But there are more than 200,000 Americans who have tragically died from the opioid epidemic, and these mothers, fathers, sons and daughters are unable to post comments or otherwise participate in this discussion. These are people who had faith in their doctor's knowledge of the risks associated with opioids and who were not expecting that something bad would happen to them. I urge the CDC and this Workgroup to consider these silenced voices when evaluating the need to release this guideline. What would they say about a guideline that could have saved their lives?

This proposed guideline is long overdue as a way to prevent pain patients from getting started in a cycle of opioid use that can lead to more pain, the disease of addiction and overdose death.

Thank you!
Judy Rummler,
Chair, FED UP! Coalition
Founder, Steve Rummler Hope Foundation

Gary Franklin, WA State Dept of Labor and Industries

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Medical Director, WA Dept of Labor and Industries, Olympia, WA and Research Professor, Depts of Environmental and Occupational Health Sciences, Neurology, and Health Services, University of Washington, Seattle

Testimony for the Washington State Agency Medical Director's Group, representing all of the public health agencies in WA state (Medicaid, public employees benefits, workers compensation, Dept of Health, Corrections), in strong support of the draft CDC Guideline for Prescribing Opioids for Chronic Pain

I am Gary Franklin, Medical Director of the WA Department of Labor and Industries, and Research Professor at the University of Washington. I am also co-chair of the Washington Agency Medical Director's Group (AMDG), representing all of the public agencies in WA that purchase or regulate health care. The opioid epidemic represents the worst man-made epidemic in modern medical history: over 175,000 deaths from unintentional overdose, many more hundreds of thousands of emergency department and hospital admissions from overdoses, severe adverse events such as neonatal abstinence syndrome, and millions with severe dependence or addiction from taking prescribed opioids for chronic non-cancer pain. The recent paper by Case and Deaton (PNAS, 2015) pointed out the shocking increase in mortality among middle-aged lower educated whites-a large proportion of this increase in mortality in a very susceptible group of Americans is related to unintentional overdose of prescribed opioids.

I reported the first deaths in the US from unintentional overdose of prescribed opioids in a peer reviewed journal (2005, Am J Ind Med). These unintentional overdose deaths primarily occurred among injured workers who had entered the workers compensation system due to a mild musculoskeletal injury. This was the saddest thing I had seen in many years as Medical Director.

By 2006, the public programs in Washington already had over 10,000 citizens on doses of opioids greater than 100 mg/day morphine equivalents, and by 2008, this translated into 508 deaths from prescribed opioids. More than half of these deaths were in the Medicaid program. In response, the WA AMDG, in full collaboration with a large group of the state's well respected academic and clinical pain experts, developed the nation's first opioid dosing guideline in 2007 to guide effective use of opioids and reduce the risk to our citizens. The AMDG followed up with increasingly comprehensive revisions to the guideline in 2010 and 2015. The most recent edition (June 2015, URL: http://www.agencymeddirectors.wa.gov/guidelines.asp) is highly consistent with the Draft CDC Guidelines. Two separate published statewide surveys of primary care prescribers showed that 85% supported the dosing threshold (120 mg/day MED) in the WA guidelines, and felt that the 120 threshold was too high or just about right.

How in the world did all this happen? The important thing to recognize is that much of the teaching and lobbying that led to out of control opioid prescribing was based on no credible scientific evidence: 1. There is no ceiling on dose- This specific teaching led to law changes in more than 20 states that included language such as ,"No doctor shall be sanctioned for any amount of opioid written" (WA regulations). We now know that there is a very strong dose dependent relationship between average daily dose and overdose poisonings and death. 2. The way to treat tolerance is to keep increasing the dose. The only randomized trial done to date demonstrates that increasing the dose has no beneficial impact on any primary pain or function outcome (Naliboff et al, J Pain, 2011). 3. Addiction is rare, less than 1%. Recent studies (Degenhardt, Lancet Psychiatry, 2015) have shown that severe dependence and opioid use disorder occur in up to 30% of those receiving opioids chronically. In additionto the more serious adverse outcomes related to opioids, there is emerging evidence that even modest opioid use for acute low back pain can double the risk of long term disability-this was a Class I prospective study of risk factors in nearly 2000 low back cases (Franklin et al. Am J Ind Med, 2008). In other words, it is highly likely that opioids are contributing to the initiation and persistence of disability in our workers' compensation systems, and to these workers entering the Social Security Disability and Supplemental Security Income systems.

The CDC Guideline has been criticized for coming up with medium-high recommendations that in some cases are based on lower level evidence. This is the same methodology used by the American Pain Society/American Academy of Pain Medicine evidence-based guideline published in 2009 (J Pain 10:113-130). The same organizations that are now criticizing this aspect of the Draft CDC guideline came up with 25 recommendations, 18/25 (72%) of which were "Strong" recommendations based on "Low" level evidence. The evidentiary underpinning of the draft CDC guideline is very strongly done, with both a formal evidence assessment and a supplementary contextual evidence review.

The federal government found insufficient evidence on long term effectiveness of opioids to reach any conclusion, but there was strong evidence supporting dose dependent risk for serious harm related to chronic opioid use (Chou et al, Ann Int Med,2015). In the face of this evidence, and the points raised above, the public agencies in Washington State strongly support and applaud the CDC's draft guideline.

Don Flattery, Citizen advocate/Impacted parent

I am participating in this public process to implore the CDC to issue the draft opioid prescribing guidelines as soon as possible. The epidemic of opioid prescription drug and heroin addiction the country is facing is a public health crisis which continues to worsen rather than diminish despite considerable expenditure of vast local, state and federal resources. More importantly, the horrific loss of life continues to climb as public health practitioners, medical personnel, researchers and public policy analysts continue deliberations over strategies to address the issue. **We can not wait for more research, deliberation and debate - the imperative to act is now.**

My name is Don Flattery and I live in Fairfax County, Virginia. I am a recently retired federal manager, an appointed member of the Virginia Governor's Task Force on Prescription Drug and Heroin Abuse, and I am an active participant in the development of a strategic plan for community action on opioid and heroin use in Fairfax County. But I am not writing today in any of those roles. I am addressing the Board solely as a grieving parent, someone who has suffered the loss of his 26 year old and only son to an opioid overdose sixteen months ago. My beautiful, talented, highly educated and loving son became addicted to OxyContin as a working adult pursuing his career passion in the film industry. Like thousands of others, including members of the medical community, he did not fully comprehend the addictive power of opioid drugs and that misunderstanding led to his demise.

The curve of prescribed opioids over the last two decades has gone exponential and with 259 million opioid prescriptions written as recently as 2012, opioid painkillers are ubiquitously available and present in our communities, workplaces, schools and medicine cabinets. There is a direct, immutable nexus between opioid prescribing and the explosion of opiate addiction and overdose deaths. Until we can "bend the curve" of the number of prescribed opioid pain relievers, we will continue to swim in place and all the federal, state and community resources we can bring to bear for education, prevention, and treatment will be for naught. **We must ensure more cautious prescribing of opioid drugs in this country and CDC's guidelines are a commonsense, first step in doing so.**

Without question, the millions of opioid prescriptions in the US contributes enormously to their availability for non medical purposes but the crisis before us is not just a matter of (mostly young) people abusing otherwise "safe as prescribed" medications. That characterization ignores the significant role and pathway to opioid addiction and mortality that medically prescribed opioids play in this crisis. The fastest rate of prescription opioid drug overdose deaths is occurring in the 55 to 64 year old age group - these are not people snorting crushed opioid pain relievers after a high school social event - they are people who became dependent and then addicted to their prescribed narcotics. Moreover, the incidence of non medical OPR use has declined from 2.7 million users in 2002 to 1.8 million non medical users in 2012. Despite contrary assertions that will be made to the Board through this process, it is a fact that medically prescribed opioids are directly implicated and a primary cause of the addiction and mortality crisis before us.

In other forum and policy discussions, the lack of physician training regarding addiction has been widely discussed and recognized as a "gap" in medical education. A gap sadly filled through prior information campaigns from opioid manufacturers. CDC's voluntary opioid prescribing guidelines will provide a commonsense tool for informing prescriber decisions regarding opioids and associated risks. **A tool that does not impede physician decision making but one that improves patient care and protects public health.**

Michael Britt Doyle

I would like to share the reasons that I support greater caution in prescribing opioids:

My wife, Wynne Doyle, passed away 10 months ago. When we met 22 years earlier, Wynne was an incredibly beautiful, vibrant woman. We married in 1995 and had three children over the following five years. She had been a cheerleader, homecoming queen, marathon runner, and world traveler. Post-partum depression and the extended use of high doses of opiate-derived pain medication that accompanied a third C-section birth were not something either of us paid attention to because no one discussed the dangers openly at the time. The internet was not the information source it is now, so we relied on the various doctors we saw and the medication regimens they ordered.

It wasn't until Andrea Yates drowned her children in 2006 that the world began to take post-partum depression seriously, and it wasn't until recently that people started taking notice of the massive problem our country has with opiate addiction. According to a recent Time Magazine article titled Why America Can't Kick Its Painkiller Problem , 4 out of 5 new heroin addicts started with prescription opiates.

Wynne drew the line at "street drugs." She never would have tried heroin because, above all else, she considered herself a lady. I'm convinced that the pain she was in during withdrawal when she couldn't refill a prescription is what drove her to alcohol more than anything else.

An average of 46 Americans die from opioid overdoses every day. This epidemic has seemingly gained momentum under the radar for several years and has become almost socially acceptable by the mere fact that the drug comes in pill form that a doctor prescribes. I don't even know how many times I heard Wynne say "I'm just following the doctor's orders!"

The worst part for me over the years was watching Wynne come home from several substance abuse programs or hospital visits with what seemed like as many prescriptions of other drugs like Klonopin, Suboxone, Lorazepam, Tramadol, and many others that could easily become addictions as well. I tried very hard to understand the logic and asked the doctors at the facilities why they needed to give her more prescriptions as she left, but I was never fully satisfied with the answers I got because it seems so incredibly illogical to me[.

I still find it incredible that the hospital that removed Wynne's massive kidney stone in the final week of her life sent her home with heavy, opiate-based pain medication prescriptions even though they had 15 years of files on her countless visits to their emergency room where they did medical detoxification to save her life.

I felt truly helpless for the past 15 years while Wynne's addiction ripped our family apart both emotionally and financially. I am working with Shatterproof as an ambassador to get the word out, and am also writing a book about our experiences because I can't imagine what we went through can't serve as a warning for others.

Thank you for your consideration.

Best,
Britt
Britt Doyle
Founder
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Kerilyn Whitehead

Educating about Addiction and Overdoses as the Numbers Rise.

Many people are not aware of the growing epidemic of addiction. There is a stigma surrounding society that addiction is something one can control; one can decide whether or not he wants to be an addict. People are taught to look at addicts as criminals and deadbeats who deserve the life they have "built" for themselves. This could not be further from the truth behind addiction. Further education needs to be given not only to children, adolescents, and teenagers in schools, but families and medical professionals as well.

Addiction is a disease just like diabetes, cancer, Alzheimer's and Lyme's disease. Addiction not only affects the addict, but the addict's family, friends and anyone in the addicts close circle. These caregivers have to be educated how to take care of themselves as well as treating the loved one in their life with the disease.

April 1, 2015 is a day I will never forget. At about 3:30 in the morning, I awoke to my parents' frightened screams. They were screaming my brother's name from his room in hopes he would respond. My nineteen year old brother was lying in his bed, unresponsive. Strange noises came from his mouth and nose. I got out of bed to see what was going on his room and immediately called 911.

One of the last instructions I can remember is the dispatcher asking me to put my phone to my brothers mouth and as soon as I said "okay…" the dispatcher said, "Okay ma'am, I can hear the weird noises you were talking about." The dispatcher told me that she suspected the weird noises my brother was making was "ineffective breathing". I had no idea what that meant but I knew it did not sound good. Next thing I knew, she was telling me I had to give my brother CPR until help arrived. I had been certified in CPR my whole life but have never actually had to use on anyone before. I was hesitant and started screaming at the woman on the phone that I just could not do it. She told me I had to. I did not have a choice. I could hear the severity of the situation in her tone. I nervously began administering CPR to my brother. My baby brother – the one person in my life I share an irreplaceable bond with. When the EMTs arrived they immediately took over, sending me and my parents downstairs to wait while they administered Narcan, oxygen, and whatever else needed to get my brother breathing again. We later learned his respiratory rate was at a 4 (a normal respiratory rate is a 12). He was almost dead. Waiting downstairs for news from the EMTs felt like an eternity. When they finally came down to let us know they had revived him, I felt like I could breathe again, too. They told us that they were going to ask him a few questions and then they put him in the ambulance to take him to the Emergency Room. During that time, my brother told them he had taken Vyvanse, Adderall, and five or six OxyContin (20mg) pills throughout that day. My mother had found two OxyContin (20mg) pills in his wallet as soon as he was taken out on the stretcher and handed them over to the EMTs. My brother was admitted to the Emergency Room and released after two short hours with a diagnosed "drug overdose."

Hospitals are not given the proper tools or education they need to treat addicts and addiction or overdoses. Many hospitals do not even want addicts brought into the emergency room however, they have no other choice. Stamford Hospital did not treat my drug addicted brother properly however, I'm not sure if they actually knew how. With more than 2 million Americans, age 12 or older, abusing or dependent on opioids all hospitals, doctors, and nurses should know how or what to do with this epidemic. Instead, doctors, nurses, and hospitals are the ones sued and blamed for many addictions and overdoses. Getting prescriptions has never been easier! More education and awareness needs to be brought to this growing epidemic and it needs to happen now!

Harold Laski, Southside Medical Center

I applaud the CDC for its efforts and intent. The problem is in the unintended consequences that are sure to occur, including the fear of physicians who appropriately treat those patients whose pain does not respond sufficiently to other pain relief modalities so that they can lead improve their quality of life. The guidelines state that they are voluntary but the past has shown us that State Medical Boards and others will take these as Standards of Care and doctors will fear for their licenses. Guideline 5 which originally read "should prescribe the lowest possible effective dosage" was changed to "the lowest effective dosage." leaving out the word "possible". More importantly the phrase "should avoid increasing dosages to 90" was changed by simply adding the word "generally" so that the phrase now reads "should generally avoid increasing dosage to 90 MME." The legal definitions of the word "generally" includes "normally" and "usually". Does the addition of this word really give physicians more leeway to prescribe medication dosing than the previous draft did? And will physicians and State Boards see it as such? How does the term "generally" make the difference in that sentence that the majority of critics of Guideline 5 requested? And not to be a stickler, but the phrase "should generally avoid increasing dosage to 90 MME or greater than 90 MME is redundant. Maybe I am a stickler, but that is just what physicians fear of the State Boards and anyone else who controls how physicians treat patients. Changes still have to be made so that physicians who do treat chronic pain appropriately will feel comfortable that their practice will not be constrained by the Guidelines. It is the CDC's obligation to create a Guideline that takes into account the unintended consequences of its actions. Is this hard? You bet it is. But it is their obligation to do this so that those patients who do rely on their doctors for pain relief can get what they deserve and that is the best medical treatment available at the time such that their quality of life improves sufficiently. But there are over 100 million Americans with some degree of Chronic Pain. If even 10% seek treatment that means that there would be a necessity of ten million doctors visits a month just for chronic pain. With only about 3500 pain specialists this would mean that each specialist would have to see over 100 patients a day. We need the generalists and family practitioners to treat the vast majority of chronic pain patients. Hampering them will have those intended consequences come to light. And to quote an old proverb, "Don't throw the child out with the bathwater." Don't make those patients that will suffer due to these unintended consequences be left with a life that is incomplete and rife with depression, pain, and suffering. The guideline must be created so that ONLY those that merit receiving the controlled medications are able to get them. Mark Twain once said "There are three kinds of lies: lies, damned lies, and statistics." Statistics show that controlled substances are often involved in medical cases of morbidity and mortality. However, this can be misleading If we removed all those cases where the presence of the opioid was inappropriate such as in those persons who were not prescribed the medications at all (family members and friends of persons prescribed the medications, and those procuring the medication through illegal means such as theft or coercion), those patients who were inappropriately prescribed the medications (such as those who were prescribed higher doses than needed and those that were given prescriptions for the wrong medication for their diagnosis) then we are left with only those patients who were appropriately prescribed the correct medication and dose of that medication, and this group of users statistically shows a very low number of cases of morbidity and mortality. This all means that physicians who appropriately prescribe the medications should not feel in any way fearful of prescribing them to their patients who merit them. The wording of the guideline must be carefully changed so that physicians are not fearful. So, the guidelines must mandate a specific protocol that physicians can feel comfortable following and doctors must be required to take whatever educational courses would be necessary for them to understand the protocol. Maybe there should be a requirement for any patient who is to receive controlled substances for chronic pain also be given some kind of required education on the use and abuse of the controlled substances. Incentives must be given to companies that manufacture these medications so that every opioid available is only available in forms that cannot be abused. Not just the branded long acting opioids, but all opioids. Physicians and pharmacists must be able to get drug database information from anywhere in the United States and not just there home state. And physicians and pharmacists must have access to drug information that at this point is not accessible, such as Methadone use at Methadone clinics and all opioids that are prescribed and distributed to patients from government institutions such as the VA. There are other unintended consequences such as Pharmacies that have increased the prices of the opioids 500 to 1000% or require cash payments for the opioids And finally there must be included in the guidelines stipulations that stop pharmacists from requiring from 1-6 non opioid prescriptions before they will fill the opioid prescriptions. So the guideline must cover all of these factors if we are to actually control the effects that the guideline would have otherwise it becomes useless. Let's do something that actually helps and does not create those unintended consequences that I started this letter off describing.

Barron Joseph Clepp

Before I retired in November of 2013, I was a Director of Human Resources for a large organization in Houston, Texas. In this position I had complete visability of terminations, drug testing, and performance evaluations for a working population of 1,200 people. My thinking is that the use of "pain killers" is a large factor in people being terminated for cause or performance, failing drug test, and having poor evaluations. It was common knowledge in our working population of 19-25 year olds the that if you got a prescription for pain killers you could feel better at work and not get caught.

There were two people in my department, in their 50's that had back problems for years. It was clear they used hydrocodone /acetaminophen (Vicoden) and oxycodone/acetaminophen (Percocet). They used the drugs to stop moderate pain, but also to feel better at work. Their work performance was up and down and their attendance was not good. Their addiction was clear if you just looked under their polish act of deception.

I have also seen the same blurry-eyed acceptance of "pain killers" away from the workplace. My son was an alcoholic and like so many alcoholics also took pain pills.

He died of a heroin overdone on August 2, 2011. He was 27 years old-Just another statistic to report.

I have read that Opioids make a dramatic difference for moderate to severe pain and are safe as long as you use them safely and follow the doctor's instructions carefully.

This maybe true, but primary care doctors do not control them, HR departments do not control them and the people that get hooked on them do not control them.

We need new prescribing guidelines with strong directions for follow-up and discontinuation of opioids.

Lexi Reed Holtum, Steve Rummler Hope Foundation

Comments from Lexi Reed Holtum

I am speaking to you today on behalf of the Steve Rummler Hope Foundation to express our support for the recent effort by the Centers for Disease Control and Prevention to introduce prescribing guidelines for opioid pain medicines in an effort to combat the epidemic of opioid addiction and overdose death which has caused so much devastation to patients and families over the last 15 years.

Our involvement in this public health issue began like so many – with personal tragedy. My fiancé, Steve, died of a heroin overdose in July of 2011 at the age of 43. However, while heroin may have been the immediate cause of his death, what brought him to that dark place began years earlier with a back injury which became chronic - again, a story very familiar to many Americans. He sought the help of medical professionals who put him on opioid pain medicine in 2005. Initially this brought great relief , but over time he needed to take more and more and it was increasingly ineffective. Ultimately, after a failed attempt at treatment and unable to find enough opioids through prescriptions, he turned to heroin on the night he died. We at the Foundation have been trying to save lives and raising awareness of this problem ever since. One of our proudest achievements was the passing of Steve's Law in 2014 which will put the opioid antidote, naloxone, into the hands of first responders here in Minnesota. This effort is already saving lives by reversing the effects of prescription opioids and heroin in acute overdose. But we realize that to truly stop the tragic loss of life on the scale we are experiencing right now we must begin "upstream" with the pattern of liberal opioid prescribing that has characterized American medicine beginning in the late 90s. It has been this change in prescribing culture that starts so many down the path to misery like it did with Steve. And it is a path that begins in the doctor's office.

The United States now consumes over 80% of the world's opioids despite having just 5% of the world's population. And with the increase in sales has come increased overdose deaths from 4,030 in 1999 to 18,893 in 2014, an increase of over 400%. Rising alongside opioid overprescribing has been the use of heroin, which, being an opioid itself, is frequently turned to by users of prescriptions when access to pills becomes limited. The number of heroin deaths has also climbed tragically from 1,842 in 2000 to 10,574 in 2014. Of note, the year 2011 saw 4,397 Americans die from heroin overdose. My fiancé was one of those.

What is especially frustrating to those of us who have studied how this problem came about was that there was never any scientific evidence that these medicines were safe and effective in the long term. Further, the data over the last 15 years have seen no proven benefit to those taking these opioid medicines such as decreased rates of disability for musculoskeletal pain or reduced need for surgery such as spinal fusion. The incidence of both continues to increase to new heights with over 11 million recipients of SSDI in 2014 compared to 4 million in 1992. In short, we have no evidence of benefit and ample evidence of harm.

As the fiancée of someone who suffered with chronic back pain, let me be the first to say how much I sympathize with chronic pain patients. And to family members of those with a loved one in such a circumstance, let me also say I understand how desperate one can feel looking for answers to provide relief to those we love. I myself suffer from chronic back pain, but I have learned that these medicines are not the answer and have found alternative treatments that work. For too few do they safely and predictably provide lasting relief, and for too many they result in ruin. For that reason I applaud the efforts of the CDC and believe that they constitute the beginning of a reversal of this trend of overprescribing and will prevent patients from starting down a path that leads to despair.

Asokumar Buvanendran, American Society of Anesthesiologists

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ASA Testimony before the National Center for Injury Prevention and Control Board of Scientific Counselors
January 28, 2016

My name is Asokumar Buvanendran, and I am a pain medicine specialist at Rush University Medical Center and the Vice-Chair of the American Society of Anesthesiologists Committee on Pain Medicine. ASA supports the federal government's efforts to reduce opioid overdose deaths, and supports the majority of recommendations in the CDC Guideline. Today, I would like to address ASA's two primary concerns with the recommendations in the Guideline.

First, ASA is concerned that the Guideline inaccurately portrays the effectiveness and risks of interventional procedures, which is particularly concerning since interventional pain procedures are a key non-opioid therapy to treat chronic pain. When performed by a pain medicine physician, there are an extremely small number of complications associated with interventional therapies, such as epidural injections, radiofrequency denervation, and spinal cord stimulation, and the complication rate is far lower than the complication rate for chronic opioid therapy for chronic pain. To make the available non-opioid options clear to the prescribing physician, we propose that CDC revise Recommendation #1 to include examples of nonpharmacological and non-opioid pharmacological therapies, which should including interventional pain procedures.

Second, ASA is concerned that the Guideline would curtail perioperative physicians', which includes physician anesthesiologists, surgeons, and co-managing internists or hospitalists, ability to treat patients' acute pain after surgery, and any recommendations made by CDC need to balance the overprescribing of opioids for acute pain with perioperative physicians' imperative to treat post-surgical pain. In recommendation 6, the CDC should remove the reference to "major" surgery because even minor surgery may require opioids for more than three days. We recommend that the CDC revise the Guideline to state:

> When opioids are used for acute pain, providers should prescribe the lowest effective dose of short-acting opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three or fewer days will usually be sufficient for non-traumatic pain not related to surgery.

Thank you.

Dee DeLuca-Mattos

My name is Dee DeLuca-Mattos, I support greater caution in prescribing opioids because simply I am a mother of a son in recovery from opioids. My son was the poster child for a clean, healthy, active life. Catholic school boy, athlete, good student, out-going, friendly, loving and more important would not take an aspirin. His addiction did not start from buying drugs on the streets, from a drug dealer on the wrong side of the tracks as everyone perceives. His started from an accident, in which he was prescribed 60 Oxycontin to go home with. 6.0, Sixty,.
He was in his last year of college, when his addiction started and he, we, our family struggled to save him not only from his addiction, but we tried to save him from the medical professionals that were so recklessly prescribing them to him. This went I for 4 years desperately trying to understand his addiction, trying to learn as we were fighting to keep our son alive, costly rehabs, out patient, then the same doctors prescribing the opioids are the same doctors prescribing suboxone. You will never understand until you walk in the darkness of addiction, the anguish, pain and struggle of watching someone slowing deteriorating in front of your eyes. I am one of the lucky ones, because today, my son is in recovery but he will have to fight every moment of everyday, work a program and commit himself to sobriety because his addiction, will never go away. My fear! Is that he does have a car accident and the medical professional ignores the simple words as: Allergies: opioids, is ignored (as so commonly is) what can happen. Image, that worry.

When you have a child that is an addict your embark on a journey , one that pushes you to search for answers to questions you never thought in a million years you would have to know. Your alone, in the dark, and fighting a ticking bomb. Each night I speak with a group of women who have all been brought together not by tea, or tennis, but we found each other in the darkest of moments, all of our children are addicted to opioids, most are not as fortunate as I and so for them and the children they have lost I pledge to help in the fight not only against drugs but to stand as a beacon of hope and change. I will not state the statistics from opioid overdose, or go into the lack of education within the medical community on how highly addictive this drug category is instead I will tell you, that behind ¾ of every oxycontin, Percocet or vicoden is a story of a mother struggling to save her child from death, not trying to save her child from Pain.

Sarah Svoboda, National Safety Council

The National Safety Council (NSC) would like to thank the Centers for Disease Control and Prevention, the National Center for Injury Prevention and Control, and the Board of Scientific Counselors for their work to address our Nation's opioid epidemic and to develop these draft guidelines.

NSC is a 100-year-old Congressionally chartered nonprofit safety organization whose mission is to save lives by preventing injuries and deaths at work, in homes and communities, and in transportation through leadership, research, education, and advocacy.

After a thorough review of the evidence assembled and the draft recommendations, NSC strongly supports these guidelines. There is little evidence that chronic opioid therapy (COT) offers effective relief from chronic pain. However, there is abundant evidence about the harms of COT.

These recommendations – which provide clear, evidence-based guidance for clinical decision-making – could have saved Bill, a 33-year old machinist, who died of an unintentional overdose of methadone in July 2006. He had been taking hydrocodone for severe lower back pain relief but developed a tolerance to it. On a Friday phone call, Bill's doctor prescribed methadone, a long-acting opioid. The methadone dose Bill took that weekend led to his death. He left behind a wife and two sons. Recommendation #4 specifically cautions that "methadone should not be the first choice for an ER/LA opioid" as methadone's unusual characteristics make safe prescribing for pain especially challenging.

A number of these recommendations (numbers 7, 8, 9 and 12) cite the increased risk of opioid-use disorders in encouraging physicians to re-evaluate COT after three months. Michael, a 20-year old patient with Crohn's disease, became addicted to the opioid painkillers prescribed for this condition. He took his own life while on a waiting list for substance abuse treatment. Recommendation #12 speaks directly to the life-saving role of physicians and how collaboration with their patients and substance abuse treatment providers can prevent senseless outcomes such as Michael's.

Betts, a chronic pain patient on COT, had concerns about the safety of her high dose and the quality of life. When she asked her physician if she could be addicted, the doctor dismissed her concerns. Betts looked for and found a different physician willing to help. Working together to set realistic treatment goals and expectations, her physician helped her taper off opioid pain medications, obtain counseling for her addiction, and use a variety of non-opioid therapies to better and more effectively manage her pain. The patient-centered principles Betts' physician employed are echoed in these guidelines.

The CDC is taking the appropriate steps by examining the existing data and making recommendations on how opioids should be responsibly prescribed. The principles set forth in these guidelines promote better information sharing between patient and provider while providing clear guidance and resources to physicians who want to effectively treat chronic pain. This valuable tool is greatly needed in the United States.

Treatment of illness and injury requires a careful balancing of risks and benefits. However, we know the increased use of opioids has directly led to the thousands of deaths in the last 20 years. Further, epidemiological studies have suggested that when opioids are used for chronic pain, they worsen the quality of life. Opioids should be used with great caution only when all other options have failed, and continued use should be periodically re-evaluated, which is a common practice applied to other classes and types of drugs such as anticoagulants and isotretinoin.

CDC has used scientific rigor and the most current available literature to develop guidelines that represent best practices for the use of opioids in the treatment of pain. These guidelines are not just appropriate, but necessary to save lives.

Jonathan Fielding, UCLA School of Public Health

My name is Jonathan Fielding, M.D., MPH, MBA I am the co-director of the UCLA Center for Healthier Children, Families and Communities. I have previously served as director of Public Health and a health officer for Los Angeles County. I was the founding board member and chairman of the California Wellness Foundation, the largest U.S. foundation devoted to disease prevention and health promotion. I was a founding member of the U.S. Preventive Services Task Force and am a former president of the American College of Preventive Medicine. I am currently the Chair of the Community Preventive Services Task Force, an independent, nonfederal, unpaid panel of public health and prevention experts that provides eviden-based findings and recommendations on policies and programs to improve health. I received my M.D., M.A. and M.P.H. from Harvard University and my MBA from the Wharton School.

Opioids offer pain relief to many suffering patients and are an important treatment option, when medically indicated, for pain management; however, it is clear from prescribing data and related addiction treatment admission and overdose death data that the medical community has over-relied on opioids to treat pain. Prescription opioid sales in the US have increased by over 300% since 1999 while opioid-related overdose deaths nearly quadrupled[1,2]. To reverse this horrific epidemic of opioid drug overdose deaths and prevent opioid-related morbidity, the medical community is urgently in need of guidance from the CDC because aggressive opioid prescribing is harming pain patients and fueling an unprecedented epidemic of addiction and overdose deaths.

I applaud the CDC scientific committee and the rigourous process they undertook to develop these guidelines to improve the dialog between primary care physicians and patients surrounding the benefits and risks associated with these medications for the treatment of chroinic, non-malignant and non-terminal pain. These guidelines will improve the way opioids are prescribed and can ensure that patients have access to safer, more effective chronic pain treatments while reducing the number of people who misuse, abuse, or overdose from these powerful medications.

The CDC Guideline is based upon an unbiased, exhaustive analysis of the best available research. Critics have suggested that there is not definitive evidence to support the guideline related to levels of dosage and duration of use recommendations: however, I believe the CDC guidelines have sufficient evidence to provide clinical guidance to physicians and further delays will cause more American lives to be lost. Not to mention the millions of Americans who will lead subpar lives.

I have read the Proposed 2016 Guideline for Prescribing Opioids for Chronic Pain ("CDC Guideline") and based on my clinical and public health experience, I strongly urge the CDC to release the guidelines without revision as quickly as possible.

Thank you for the opportunity to comment on this important draft guideline and again, I applaud the CDC's leadership in developing these much needed guidelines. I strongly encourage the immediate release of these guidelines without revision.

[1]Paulozzi, Mack, & Hockenberry, 2014. [2]CDC. Vital Signs: Overdoses of Prescription Opioid Pain Relievers – United States, 1999-2008. Morbidity and Mortality Weekly Report 2011: 60(43): 1487-1492. Available at https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm?s_cid=mm60434a4_w#fig2. August 17, 2015.

Laurence Little

Persons giving comments must be in attendance or on the telephone at the start time of the public comment period listed in the Federal Register notice: Federal Register Notice

Written Comments:

I can appreciate where an individual with a family member "in pain" may believe these guidelines are going to somehow strip their loved one from getting their pain remediated. Unfortunately their education on the subject likely comes from the big money drug company lobby groups who have been so successful in the past few decades ensuring the growth of addiction is accelerating unabated. Sadly too few understand that these guidelines could save that same person's life (or of a relative in their family who is addicted to these viscous drugs and has been pilfering them unbeknownst to the family). I would venture most folks are not aware that the fastest growing group for overdose is the age range of 45-85, much faster than young adults. Sadly the statistics likely underestimate the issue with seniors because when a senior fails to wake up in the morning nobody does the autopsy to determine they actually died of an overdose. The assumption is old age or due to other health issues they may have had.

In my own experience I have been forced to accept scripts for pain killers I have flat out refused to use as they were not necessary. Similarly my wife was recently admonished for not filling her prescribed ***30 day supply*** of pain killers even after assuring the hospital staff she did not need them post surgery. They even called her at home the next day to see if she had filled the prescription!

I'm actively involved in recovery groups to try and counter the tide of direct and collateral damage. I see the ridiculously easy LEGAL access addicts can have 1st hand. We need to be doing more than just creating guidelines. We need to be closing the loopholes that allow for so many unnecessary scripts to be written and better protect people from these incredibly dangerous drugs.

These drugs ruin families and lives. I have seen this first hand in my own family.

Laurence & Tina Little
67 Crestview Drive
Clinton, NJ 08809

G. Caleb Alenxander, Johns Hopkins Bloomberg School of Public Health

JOHNS HOPKINS BLOOMBERG SCHOOL of PUBLIC HEALTH

Center for Drug Safety and Effectiveness *Center for Injury Research and Policy*

January 18, 2016

Dear Board of Scientific Counselors:

As you know, there is an epidemic of injuries and deaths from prescription opioids in the United States. These issues are urgent.

The CDC's Guidelines focus on a critical area where clinicians need more guidance. Contrary to what some have claimed, the recommendations provide sufficient scientific support to justify their strength, and the derivation of "strong" recommendations is consistent with best practices in guideline development. A big part of the problem is that manufacturers have generated much of the "evidence" used to promote opioids, and almost none is relevant to chronic opioid use. Despite how frequently some argue that guidelines like these may hurt patients' access to effective treatments, I am not aware of any evidence to support such assertions.

Much of the opposition to the Guidelines has been based on a faulty premise, namely, that these recommendations will somehow jeopardize the care of those living with pain. This is a false dilemma that presupposes there are only two options – reducing opioid use or maintaining patients' access to beneficial treatments. There are multiple options for doing both. High quality care for those in pain is not jeopardized by guidelines such as these; in fact, it requires them.

We support transparency in the Guideline development as well as efforts to ensure the opportunity for stakeholders to participate. However, it is also important for those opposing the idea that CDC can play a constructive role in this area to disclose whether they have conflicts of interest, such as having received payments from manufacturers of the drugs in question.

Too often those involved in conversations about opioids fall into an unproductive dichotomy. Those suffering from chronic pain who use opioids under medical supervision to achieve some relief from their debilitating conditions are pitted against those seeking to reduce the pain and suffering associated with prescription opioid misuse, abuse, addiction and overdose. The simple fact is both sides should be able to agree that opioids have a place in pain treatment, that the death toll from these drugs is too high, and that interventions to reduce the risks and maintain the benefits are urgently needed.

I fully support the CDC's efforts to establish meaningful Guidelines, and I believe the recently proposed recommendations are consistent with the evidence and do not represent any conflict between the laudable goals of improving the safety of clinicians' opioid prescribing and improving the quality of care for those living with chronic pain.

Thank you for your consideration.

G. Caleb Alexander, MD, FACP

Adrienne Breidenstine, Baltimore City Health Department

Thank you for opportunity to provide comments on the Centers for Disease Control and Prevention's (CDC) Proposed 2016 Guideline for Prescribing Opioids for Chronic Pain (CDC-2015-0112-0001). In Baltimore City, we have declared opioid abuse a public health emergency. This epidemic is claiming the lives of people across our city and county. We applaud the CDC's efforts to encourage best practices for prescribing; in this case, for those suffering from chronic pain and also for bringing greater national attention to this public health crisis.

With approximately 19,000 active heroin users in Baltimore City and far more who misuse and abuse prescription opioid medications, our city cannot be healthy without addressing opioid addiction and overdose. In 2014, 303 people died from drug and alcohol overdose, which is more than the number of people who died from homicide. Drug addiction impacts our entire community and ties into nearly every issue facing our city including crime, unemployment, poverty, and poor health. It claims lives every day and affects those closest to us – our neighbors, our friends, and our family.

We fully support the CDC's proposed Guideline for Prescribing Opioids for Chronic Pain. The guideline includes key recommendations that align with our framework to fight addiction and overdose in Baltimore, which is built on three pillars:

1. Preventing deaths from overdose and save the lives of people suffering from addiction;
2. Increasing access to quality and effective on-demand treatment and provide long-term recovery support; and
3. Increasing addiction education and awareness for the public and for providers, in order to reduce stigma and encourage prevention and treatment.

A key part of our efforts has been to educate primary care providers on the growing opioid addiction and overdose epidemic and the importance of safe opioid prescribing practices as a way to prevent opioid addiction and overdose deaths.

The federal government plays a critical role in advancing the campaign against addiction and overdose. In addition, to the proposed guideline, three specific areas must also be addressed:

1. Expand funding and availability of on-demand addiction treatment services
2. Monitor and regulate the price and availability of naloxone.
3. Advocate for a national stigma-reduction and opioid-awareness campaign

The Baltimore City Health Department looks forward to the release of the final CDC guideline. We believe the guideline will be a valuable tool to continue our efforts to educate providers about the important role they play in addressing the opioid epidemic and improve accountability as it relates to safe opioid prescribing practices. Thank you again for the opportunity to provide comments and we look forward to working with the CDC to curb the opioid abuse epidemic in Baltimore City and across the country.

Joan Peters-Gilmartin, Nauset Family Practice & The Open Door of Cape Cod

January 8, 2016

Please read my letter to CDC public comment registration supporting their proposed guidelines.

I am not only a Primary Care Provider in Family Medicine but represent a family of loss having lost my son to Heroin overdose in 2014. This opioid abuse disorder began with prescription pills.

Most of the general public have no idea about the history of Pain Management that was promulgated to health care providers over the last twenty years and how we got to where we are today with a widespread, full blown epidemic of opioid overdose deaths across all ages and demographics. Health care providers are just as poorly trained in assessing pain as they are in treating it and there have never been evidence-based guidelines for using long term opioids for chronic pain until recently. New neuro-biological research indicates, in fact, that we have been doing it wrong for decades, unwittingly following the pressures of big Pharma and medical board warnings that pain was being under treated. In fact, we have often made chronic pain worse with long term opioid use, driving the patient request for increased doses by creating the condition of hyperalgesia.

Given that the USA is the largest consumer of opioid prescriptions, it also is time to look at this issue and ask why that is the case. In part, prescribers were driven this way because insurance companies refused to cover other modalities for chronic pain that can be efficacious, and that other countries use first line, such as acupuncture, myotherapy/massage, chiropractic or osteopathic manipulation, biofeedback, yoga, etc.; or they limit access. Additionally, insurance has limited access to mental health to deal with the psychodynamic alterations that accompany chronic pain and are known to exacerbate it or alter the perception of pain. People living with chronic pain need to have a treatment plan that includes teaching them how to live with some level of pain and not to have it define their existence; which I see so often in clinical practice. Primary Care practitioners need to receive better training in the use of opioids and the management of chronic pain syndromes as it often takes weeks or months in regional areas to get a patient referral to a Chronic Pain Management specialist. Practitioners need to be mandated to use a Prescription Monitoring Program, but first that program needs to be uniform, nationalized and simplified for the user. The ability to renew a DEA license to prescribe controlled substances should be tied to demonstrated use of the PMP in the future in addition to proof of continuing education hours devoted to not only Pain Assessment and Management but Addiction Management as well.

No one is saying “never use opioids for Chronic pain” and nowhere is it being suggested to ever not treat post-surgical, malignant or end of life pain and suffering. These very sensible and practical new guidelines proposed by the CDC for opioid use are just a recommended new paradigm for fixing the problem we have created, because now that we recognize the breadth and depth of the wrong that we, as a medical community have been part of; we have a moral and ethical responsibility to fix it. Because we have done something wrong for so long is no reason to continue to do so.

As a medical provider, as a parent of loss, as an addiction recovery advocate, I support these proposed CDC guidelines.

Joan Peters-Gilmartin, PA-C, MHP
24 Mansion Street, West Harwich, MA 02671

David Juurlink, University of Toronto and American College of Medical Toxicology

Overview of proposed comments:

In my view, the CDC's initiative regarding prescription opioids for chronic pain is tremendously important. If offered an opportunity to address the BSC meeting, I would touch briefly on i) the harms of opioids, particularly vis-à-vis dose (for this, I would draw upon our research on the subject), and ii) the importance of being mindful of physical dependence on opioids when interpreting testimonials from patients.

Regarding dose, I believe CDC's proposed 90 mg MME/day threshold would avert a great deal of harm if widely adopted. I recognize this has been a contentious issue, but the available data make very clear that the harms of opioids are dose-related. Our research team has documented this with regard to all-cause mortality, opioid-specific mortality and motor vehicle collisions. In a recent paper (PLOS One 2015), we observed that among men receiving > 200 mg MME/day, 3.8% eventually died of opioid-related causes. The corresponding number in women was 2.2%. These are staggering statistics, and the notion that the benefits of such doses exceed their risks is highly improbable.

Regarding physical dependence, there are few concepts more important than this when interpreting feedback from patients. Many patients with chronic pain who believe they need opioids hold that belief because of physical dependence rather than actual analgesic benefit. When a patient on chronic opioid therapy reduces his or her dose, or misses doses altogether, he or she often feels unwell not because their pain is inadequately treated, but because of the onset of opioid withdrawal. These symptoms abate when the medication is resumed, and patients understandably perceive this as evidence of an ongoing need for opioid therapy to remain well. Physical dependence is a predictable (indeed, uniform) consequence of chronic opioid therapy, and what it actually represents is harm, because it leads to the perpetuation of treatment that for most patients does not afford benefits in excess of risks.

Emily Brunner, Hazelden Betty Ford Foundation

Written testimony of Emily Brunner, MD

Staff physician, Hazelden in St. Paul, part of the Hazelden Betty Ford Foundation
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Re: Docket No. CDC_2015-0112, Guideline for Prescribing Opioids for Chronic Pain

I am in strong support of the proposed draft recommendations in the CDC Guideline for Prescribing Opioids for Chronic Pain.

Here at the Hazelden Betty Ford Foundation, we have seen a pronounced increase in the number of patients with opioid use disorders. Opioid dependence among residential treatment admissions in our youth program, for example, increased from 15 percent in 2001 to 42 percent in 2014. We work with countless families who have been devastated by opioid addiction, and far too many have lost loved ones to the disease.

This is a crisis that demands our attention and commitment, and at the center of this problem is overprescribing. To be sure, we doctors didn't start overprescribing opioids out of malicious intent, but rather out of a desire to relieve pain more compassionately. But years of misinformation and, frankly, a lack of education on addiction led us to underestimate the risks of these medications.

It doesn't help that the No. 1 reason people visit a physician is pain, or that physician visits are increasingly shorter. Pressure to make decisions and provide quick solutions add to the doctor's dilemma. Reimbursement tied to patient satisfaction surveys also intensifies the pressure to prescribe opioid painkillers in hospital emergency departments. Often it is easier for a physician to write a prescription to maintain the 'status quo' than to ask the difficult question, "Should I change how I am treating this patient?"

In our view, physicians need to limit opioid medication to the treatment of moderate to severe acute pain, and rarely use them for chronic pain. Mistakes made with these drugs can be lethal. As a result, we have the responsibility to be as cautious as possible in prescribing them.

The proposed guidelines would encourage more and better physician-patient conversations and help both parties by encouraging alternative interventions and treatment strategies when appropriate.

The national crisis around opioid addiction and overdoses deserves the attention you are providing and requires a substantial response not only from the federal government, but from all of medicine as well. Every day we put off meaningful action, more people's lives and families are endangered.

This is not about taking needed medications away from those who need them; instead, it is about changing the culture around prescribing opioids so the next generation of pain patients receives the best and least risky treatments possible.

Contrary to the claims of opponents, you have put forth what is actually a rather modest proposal. It's not a mandate. It includes no black-and-white requirements, and it does not apply to active cancer treatment, palliative care for other serious illnesses or end-of-life care. The proposal is more likely to bring about a balanced approach than to swing the pendulum too drastically. My organization and I thank you for your leadership on this important topic and wholeheartedly back your efforts.

Rebecca Cunningham, University of Michigan

Specific Comments will be less then 2 minutes and will focus on:

1 The enormous impact of the current epidemic and the need for public health response simply can not be overstated and the CDC is to be commended for taking the large action that can impact the nations public health.

In my 20 years of medical practice I was first trained that opioids were dangerous medications to be used with great care- and then the pendulum swung to widespread opioid prescribing for many of our patients. With that swing I have watched first hand the river of patients brought in to our hospital doors who have overdosed, and the anguishing increasing calls by our 911 providers seeking medical guidance who are unable to revive teens and young adults often who are overdosing in the community and are too late for help. There is a urgent need for public health action.

2 As a clinician- educator there is great need for guidance on best practices given the current vacuum and wide disparity in daily and individual practice. Clinicians are currently working almost blindly on how to care best for their patient's pain. They are confused at the best action, do not want to see their patients in pain but without clear guidance can not make safer prescribing decisions. We need immediate guidance on how to best align our care with safer prescibing. Only then can we begin to have difficult conversations with our patients and to aid the next generation of doctors in safer prescribing. There is widespread lack of understanding of benefits and potential harms of the typical options and tremendous physician variability. Every day that we continue to practice medicine with this much variability and not guided by current science is another day that we teach our next generation of students doctors potentially harmful practices and fail our patients by not providing safer options to ameliorate their pain.

3-The state of the science around opiate use is fairly extensive and very convincing around harms and the need for action relative to other practice guidelines. Although grade one evidence is the gold standard this is not level of evidence that drives most change in practice. Many such practice guidelines are typically based on observational data such as used in these guidelines --as the science of rigorous RCT's is often fundamentally cost prohibitive, not ethical when studying outcomes that include death from overdose. Finally the time lag to obtain the highest ideal of evidence is arguably not ethical given the national epidemic of overdose. There are many times in medicine that doing nothing is not ethical, in this case waiting for the gold standard RCT longitudinal study while there is evidence that current practice is harmful is not ethical.

In addition the grade of evidence provided here is well in keeping with other evidence based changes suggested across medical care. Specifically the grade of evidence provided in these guidelines is more then sufficient to support change in practice.

There are several examples of national clinical guidelines for preventive care that have been released in the past year that moved ahead with less rigorous graded evidence then is described here.

Faye Roscoe

Opioids Guidelines

It's imperative that the CDC enforce stricter guidelines for primary care providers in prescribing opioids medication to patients. While pain medications is necessary for many, opioids medication, by default is not. The lack of concern to best prescribe the CORRECT pain medication has fueled a drug addiction epidemic, sky-rocketed overdoses and deaths.

Several years ago my son, then 23, had knee surgery and at the time of release from the hospital the physician prescribed Vicodin, against the request to prescribe a non-narcotic drug due to his existing drug issues. Had stricter guidelines been in place, discussing other alternatives for mediation, I believe Vicodin would not have been prescribed.

Thank you,

Faye Roscoe
1160 San Miguel St.
Gilroy, CA 95202

Ada Guidice-Tompson

In 2002, my son Michael was treated at a hospital emergency department for renal colic and given a prescription for Percocet when discharged. Neither the doctor nor pharmacist provided any information to us about Percocet's potential risks. My son died within two years of his medical exposure to Percocet. On June 9th, 2004 under the care of one doctor for 14 ½ months, Michael was given a prescription for a new opioid, Dilaudid, as well as the usual Percocet. The next morning Michael never woke up. He died at home in bed. The investigating coroner ruled the death as 'accidental' and the toxicology report indicated 'hydromorphone intoxication' as the cause.

If the Draft CDC Opioid Prescribing Guideline was in effect in 2002, I am certain my son would still be alive today. Michael's acute pain would be cautiously treated and he would not have been sent home with a prescription for a month's supply of Percocet.

Since my son's death, I have encountered many individuals, friends and relatives who have been prescribed opioids for pain. Many of them tell me they are doing fine, but when I speak to their family members they provide insight and a different perspective – they do not function like they once did and fear their loved one is addicted to opioids. Many prescribers and patients truly believe opioids are helping relieve pain. However, the impact on pain and its relationship to tolerance, dependence, opioid induced hyperalgesia, withdrawal and substance use disorder must also be carefully considered. With long-term use of opioids, pain is often a surrogate for addiction.

Opioids must be used with care and selectivity, and only when all other options, as well as the known risks of opioids, have been fully considered. Patients deserve pain relief that is safe and does not cut their life short or reduce their quality of life. Opioids do not have to be misused or abused to cause harm. Every patient should be told that opioids are pharmaceutical grade heroin. Looking at the increase in babies born with neonatal abstinence syndrome (NAS) to mothers taking opioids as directed for pain should have made us stop and take notice. Prescribers cannot change the inherent properties of opioids and using opioids "as prescribed" for pain does not prevent harm. Pain and addiction are not mutually exclusive. Relying on REMS and other external measures to mitigate harm is important, however, the natural physiological reaction within a human body cannot be stopped or prevented when an individual ingests an opioid, even an abuse deterrent one.

Patients who are already on opioids should not be abandoned. I support CDC's efforts in updating the opioid prescribing guideline to reflect current evidence to improve medical care for patients in pain. For far too long Pharma marketing, misinformation, conflict of interest and weak regulatory controls have manipulated science, downplayed the inherent risks of opioids within a legally sanctioned system. Both patients and clinicians have been operating under 'impaired choices'. New prescribing guidelines are urgently needed to end the epidemic caused by inappropriate and overprescribing of opioids. Thank you CDC.

Daniel Carr, American Academy of Pain Medicine

The American Academy of Pain Medicine (AAPM) is committed to ensuring the safety, efficacy, and cost-effectiveness of patient care through evidence-based care, patient-centered research, public and professional education, and science-based policy. AAPM appreciates this opportunity to provide further input to the revised CDC draft guidelines on opioids for chronic noncancer pain. It is imperative that the guidelines be rigorous and credible, given their possible use to inform policy by federal and other health care systems and stakeholders such as insurers, legislators and law enforcement. Yet increasingly, patient and provider organizations are voicing concern that the guidelines fail to adhere to standards now expected of such an influential document and are in fact regressive in at least three fundamental respects.

First, evidence assessment and clinical practice now routinely welcome patients in the development of clinical practice guidelines and their application to clinical care, e.g., through shared decision-making. However, no patients or patient representatives appear to have been involved drafting the guidelines (and only one chronic pain expert appears to have been). Patients with chronic pain, particularly the large majority without substance use disorder, are dismayed that their exclusion, together with the guidelines' emphasis on opioid abuse, perpetuate their longstanding marginalization and stigmatization.

Second, multiple sources of the best available evidence, ranging from randomized controlled trials (including those conducted for new drug approval) to unpublished data from clinical trials and registries, are now routinely sought out and considered when preparing practice guidelines. However, the evidence review of opioid efficacy and effectiveness employed by the CDC guideline failed to include these and omitted all literature retrieved by the same methodological consultant in a prior systematic review addressing the same questions. Setting the guidelines' criteria for inclusion of efficacy and effectiveness studies insurmountably high (i.e., >1 year observation) left no clinical evidence remaining to address this important topic.

Third, a burgeoning scientific literature aligns patients' desire and need for individualized care with researchers' ability to inform "precision medicine" amidst substantial individual variability in response to drug and nondrug therapies. However, in framing its recommendations the guideline panel ignored literature on patient variability and the need to manage it by opioid selection and dosing according to patient genetics, gender, age, race, ethnicity, concurrent medical conditions and medications, prior exposure (dose and duration) to analgesics, and duration, severity and etiology of pain.

Given these and other shortcomings in the CDC guidelines, AAPM calls for revisiting the process by which they were prepared. If it does not appear feasible after the fact to remedy it, then a coalition of government agencies should be convened along with patients, pain clinicians and nongovernmental stakeholders to revisit the key questions and produce a product that will meet expectations for such an important document.

Mark Roberts, American College of Occupational and Environmental Medicine

Comment script

The American College of Occupational and Environmental Medicine (ACOEM) supports the CDC's proposed recommendations for the safer and more effective use of opioids for chronic non-cancer pain (CNCP). These practices should protect patients and the American public from the adverse effects of these prescription medications if used as guidance in clinical practice. The rationales supporting the recommendations are well reasoned and supported by the best available evidence and expert consensus. Guidance from an unbiased, authoritative source such as the CDC is especially important in light of the continued absence of quality evidence of effectiveness of opioids for CNCP, and the rapid increase in adverse effects among patients and the public.

The proposed CDC recommendations are consistent with ACOEM's 2014 update of its guidelines for the use of opioids based on an extensive systematic review meeting Institute of Medicine (IOM) and Cochrane Collaboration criteria. A trained multi-disciplinary expert panel developed recommendations as specified by the IOM and the Guidelines International Network. Key conclusions include:

- An absence of quality evidence of effectiveness of opioids for CNCP.
- Large observational studies show harms are dose related, with sharp increases in overdoses, deaths and other adverse effects starting at 20 to 50 mg per day.
- Additional adverse effects including changes in the CNS affecting judgment and social function, reduced REM sleep, hyperalgesia leading to dose escalation, osteoporosis, suppression of adrenal hormones, feminization, birth defects, and effects on balance.
- Functional improvement as the most important outcome of any treatment for CNCP. Studies demonstrate worse functional outcomes with early or chronic opioid use.
- Additional higher risk groups including motor vehicle drivers, all women due to differing metabolism than men, younger patients, and patients with prior suicide attempts by whatever means, patients using sleep medication and those using H1 antihistamines concurrently with opioids.
- Need for a careful review of systems to identify adverse effects at every visit and informed consent and opioid agreements for all patients taking opioids chronically.

The rising rate of prescription drug overdoses, other adverse effects, injuries and deaths is a classic public health problem – increasing levels of potential hazards in a community are associated with increases in adverse effects among both patients for whom opioids are prescribed, and those using others' opioids and suffering "collateral damage." The "opioid epidemic" is the result of the unprecedented widespread use of medications without evidence of effectiveness or careful consideration of hazards, leading to a public health disaster. At the least it is an uncontrolled experiment on the American public and, with wide variation in practice, poor quality care. Clinical judgment must be guided by the best available evidence to achieve such improvements.

Clearly, better, unbiased guidance is needed to support physician and patient decision making. More than 40 surveys of US, UK and Canadian physicians' about opioids and CNCP, show that respondents received minimal education in pain management and felt uncomfortable prescribing opioids for CNCP because there generally are no objective findings or tests for this diagnosis and felt many patients' perceptions of pain were confounded by untreated or inadequately treated psychiatric disorders or emotional distress.

We appreciate the CDC's leadership in this area to protect patients and the public.

David Laws, Georgia Overdose Prevention

Opioid Specific Addiction -Yes-Daughter- Heroin, Oxy, Roxy Morphine

Personal Story- Our daughter Laura Hope Laws was prescribed Opioid based medication after a broken jaw during a soccer game at age 14. That started a journey that ended with the accidental death from overdose on Nov 27, 2013 at age 17.

Specific Discussion Topics- Over Prescription Prevention/Overdose Prevention-/Education, Resources and Implementation of Current Laws and Practices

Pete William Jackson, Advocates for Reform of Prescription Opioids

On behalf of Advocates for the Reform of Prescription Opioids, Inc. (ARPO), I am submitting these comments in strong support of the CDC Opioid Prescribing Guidelines. ARPO represents many people in the United States and Canada who have been harmed by opioid medications, a majority of whom are, or were, pain patients who became involved with opioids through a legitimate prescription for pain, only to become addicted after prolonged use. My daughter's storyline was a bit different: she was a cancer patient who succumbed to a teenage curiosity and died from consuming one OxyContin pill from her uncle's prescription. She was only eighteen, three days from her first day in college. Her tragedy underscores how terribly potent these opioid medications are. How can somebody die from consuming one pill?

With the recent news from CDC that deaths from opioid overdoses were up significantly in 2014, when opioids were involved in 28,647 deaths, the proposed guidelines on opioid prescribing could not come at a more critical time. And yet, there are forces within the opioid industry and their paid lobbyists and pain organizations pushing back mightily, for a variety of reasons which collectively threaten to undermine the public health benefits of these reasonable, long overdue guidelines. We urge the CDC to not allow the profit-driven pressure from the opioid industry to delay further the adoption of these important guidelines.

The opioid industry is clearly very well-organized, and they appear to be very aggressively instilling fear among pain patients who have become convinced that the federal government (and even ARPO) is trying to take their medications away from them. No one is trying to take their meds away from them! We are ALL pain patients at one time or another. No one, especially pain patients, is well-served by the overly aggressive prescribing practices as has been well-documented by the CDC. The CDC guidelines will save many lives and will also result in better health care for people who suffer from pain. We need doctors to prescribe fewer opioids, with more moderate doses and smaller prescriptions. Where I live in Illinois, the standard practice is a month's supply for any pain, no matter how minor: whether for a sprained wrist (such as the one I have now), or two stitches in the palm of my hand, or the two stitches in my mouth. In all of these cases, a few days' worth of medication would have been more than enough (if needed at all).

The bottom line is this: everyone benefits from sound, evidence-based prescribing guidelines, including pain patients. Please adopt these guidelines as soon as possible so more people can live and enjoy better health care. Thank you for protecting American lives!

Tanja Michelle Cupples Meece

18 January 2016

Tanja Michelle Cupples Meece
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702-403-8299

Re: Proposed Guidelines for Prescribing Opiates for Chronic Pain

There are far too many opioid-related overdoses and deaths in the United States. I believe that many of these could have been avoided if there were tighter guidelines for the prescribing and dispensing of opioids, and a better monitoring system, that would track opioid prescriptions, from physician to pharmacy to client/recipient. The manufacture of opioids and all aspects of the supply chain, pre-dispensary, needs to be more closely monitored and policed, as well.

I have personally experienced the overly-cautious physician's approach, which was to suggest back surgery, rather than write another opioid prescription.

I opted to pass on the surgery at that time and get a second opinion. I have sciatica, compressed and fractured and herniated discs in my upper and lower back, osteoarthritis, osteoporosis, scoliosis and other joint-related health issues, that have caused intermittent episodes of pain, lasting for days or weeks, for the past forty years. Over the past six years ,that pain has become chronic and, at times, so extreme as to leave me unable to do much more than lay in bed. My current physician treats these pain issues with a steroid shot, in the hip-area, about every six months and prescribes lidoderm patches on a regular monthly basis.

I know there are other non-opioid medications and other treatments for chronic pain. Primary care physicians need to be made more aware, as should their clients, of the many less-addictive alternatives to opioids currently and these options should be offered to clients first, not last, as they were in my particular case.

I would also like to offer another personal experience, related to my former physician's refusal to write another opioid script, as a further reason for tightening the monitoring of opioids. When my son realized that I was in pain, he decided to get pain pills for me, by purchasing them by other less than legal methods. He came back in less than an hour, about $30.00 poorer, and he had 45 opioid tablets he'd purchased from someone who had a legitimate prescription, from a licensed physician for relief of chronic pain symptoms, but who used marijuana instead of the prescribed medication. Opioids are available and easily obtainable through black markets and other illegitimate and illegal means. In fact, based solely on this experience, I'd say they are far easier to obtain without a prescription than with, and not that much more expensive.

Tanja Michelle Cupples Meece

Carolyn Noel, PAINS (Pain Action Alliance to Implement a National Strategy)

PAINS is a program of the Center for Practical Bioethics in Kansas City Missouri, a 501(c)3 incorporated in 1984. Two of the Center's staff served on the IOM committee that published *Relieving Pain in America*. PAINS was organized for the purpose of advancing the sixteen recommendations in the report, and is focused on improving chronic pain care and reducing the burden on those 100 million Americans who struggle with this disease. In particular, PAINS: (1) advocates for a comprehensive national population pain strategy, (2) promotes biopsychosocial or integrative care for chronic pain, (3) educates policy makers and the public about pain as a chronic disease, and (4) destigmatizes those who live with chronic pain and those who care for them.

PAINS is also concerned about the abuse of prescription drugs and those who also struggle to live with substance abuse disorders. Although no causal connection has been established between opioids prescribed for those with chronic pain and opioid abuse, we are concerned about prescribing practices broadly and believe that clinical guidelines can be helpful to all those in the healing professions.

PAINS has commented on the proposed CDC Opioid Prescribing Guidelines both times there were opportunities to do so, and an ad hoc group of our Steering Committee had the privilege of meeting with Dr. Houry and her team in mid-December to offer our assistance in revising the guidelines and to express our concerns about the guidelines. We appreciate the things that have happened since our meeting, including the announcement of a second public commentary period and this meeting. The inclusion of a chronic pain patient advocate, primary care physician and pain specialists gives us much more confidence in the process.

The concerns we expressed in both of our responses, however, in a large part remain. Broadly, we resist the notion of "strong recommendations" and "low to very low evidence" or evidence rated as 3 or 4 in the newest version of the guidelines. It has been repeatedly said that this should not be of a great concern because the guidelines are not regulatory they are "only" recommendations. It is our view that since CDC has a strong "brand" and has historically been a reliable authority, guidelines will become de facto standard of care that physicians will be held accountable to by state medical boards, health systems, insurance providers, and attorneys. We, therefore, believe that serious consideration should be given to revising the proposed guidelines to include only those recommendations for which a strong consensus emerged via the public commentary periods.

Rather than reiterating specific objections and concerns as we expressed in our submission to CDC, we asked for time to speak today to articulate seven principles that we offer as threshold criteria to make final judgments about the proposed opioid prescribing guidelines.

1) All those in the healing professions have ethical duties and obligations to treat pain to the fullest extent of their capacity.
2) Complex chronic diseases, including chronic pain, require comprehensive, individualized bio-psychosocial approaches.
3) Treatments that are "meaningful and appropriate" can only be discerned via shared decision making that includes patient's goals and values along with clinical knowledge and judgment.
4) A risk and benefit analysis must occur for all treatments included in plan of care.
5) In most instances, treatment with the least potential for harm should precede those with greater risks; however, there are exceptions to this rule.
6) The inherent ambiguity of human medicine calls for the exercise of caution and ongoing monitoring.
7) Although never intended, when iatrogenic harm/injuries do occur, patients are owed an explanation, apology, assistance in remedying or ameliorating the problem and a new plan of care developed. Ambiguity is inherent to the practice of medicine and does not necessarily imply negligence or maleficence.

It is our view that any recommendation that does not affirm these principles should not be included in prescribing guidelines. Thank you.

Carol Thornton, Safe States Alliance

Written Comments from the Safe States Alliance regarding the Centers for Disease Control and Prevention's Draft Guidelines for Prescribing Opioids for Chronic Pain

The Safe States Alliance wishes to offer its support to the Centers for Disease Control and Prevention (CDC) for its leadership in the development of *Guidelines for Prescribing Opioids for Chronic Pain*. Every day, 44 people die in the United States from opioid prescription drug overdoses, costing the country $55.7 billion in healthcare, criminal justice, and work loss expenses. The amount of opioids prescribed and sold in the United States has quadrupled since 1999, and by 2013 nearly two million Americans aged 12 or older either abused or were dependent on opioid painkillers. With no data to indicate an overall change in pain reported by Americans that would justify this significant increase or explain the considerable differences in opioid prescription practices between states, there is a clear need for strong guidance for the medical community to ensure that these potentially dangerous medications are prescribed responsibly.

The Safe States Alliance is a national non-profit 501(c)(3) organization and professional association whose mission is to strengthen the practice of injury and violence prevention. The Safe States Alliance represents a diverse membership, a large part of which is comprised of state health department injury and violence prevention programs. These programs are vital partners in the Centers for Disease Control and Prevention's Prescription Drug Overdose Boost for State Prevention, which provides financial resources and scientific technical assistance to support state prevention efforts. Specific activities include maximizing prescription drug monitoring programs (PDMPs), improving public insurance mechanisms to protect patients, and evaluating policies to identify prevention that works. Many of these state programs are actively engaged with the medical community and other partners to develop, disseminate, and evaluate state level prescribing guidelines.

Safe States Alliance is strongly supportive of providing physicians with tools that can be used, along with their personal clinical judgment, to assess and develop a plan to appropriately address acute and chronic pain for patients in the most appropriate - and safe - way possible. The scientific review conducted by the expert panel provides the best available evidence on which to base responsible guidelines to serve as one of these necessary tools. The *Guidelines for Prescribing Opioids for Chronic Pain* will be a very useful resource for states in the development, review and updating of state-specific guidelines tailored to each state's unique needs.

We thank CDC for its leadership in providing strong scientific analyses and guides to support states and communities in addressing this public health crisis.