Update: New CDC Guidelines for Prescribing Opioids for Pain

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Learning Objectives

- Outline key updates to the CDC Guideline for Prescribing Opioids for Chronic Pain, 2016
- Incorporate the updated CDC Guideline for Prescribing Opioids to practice for safe and competent prescribing and improved HRQoL for patients with chronic pain
- Apply knowledge of acute and chronic pain pathways and underlying mechanisms to clinical assessment and appropriate management of pain

2019 National Health Interview Survey

- 20.4% (50.2 million) of U.S. adults had chronic pain
  - 7.4% (18.2 million) of adults had high impact chronic pain
- Increased with age, highest among 65+ yrs
- Non-Hispanic white adults (23.6%) were more likely to have chronic pain compared to
  - Non-Hispanic black (19.3%)
  - Hispanic (13.0%)
  - Non-Hispanic Asian (6.8%) adults
- Incidence was higher in rural areas
- The total value of lost productivity due to chronic pain is nearly $300 billion annually

Patient Case

DL is a 68 yo patient with a history of multiple myeloma, PE, anemia, CAD, and COPD on 3L O2 via nasal cannula. DL has chronic low back pain and chemotherapy-induced peripheral neuropathy in their feet and hands.

Pain Medications
- Hydromorphone 4mg PO Q6h ATC
- Pregabalin 300mg PO BID
- Duloxetine 60mg PO BID

Other medications
- Lorazepam 0.5mg PO BID prn anxiety

Failed Medications
- Capsaicin - 0.1% cream 1app TID (added to lidocaine) - discontinued per pt
- Lidocaine 5% ointment 1 app TID – patient no longer taking

PEG: 8, 10, unsure
Quality: burning
Aggravating factors: physical activity
Alleviating factors: meds
Goals: pain relief, able to increase ADLs

Pathophysiology of Acute, Subacute and Chronic Pain

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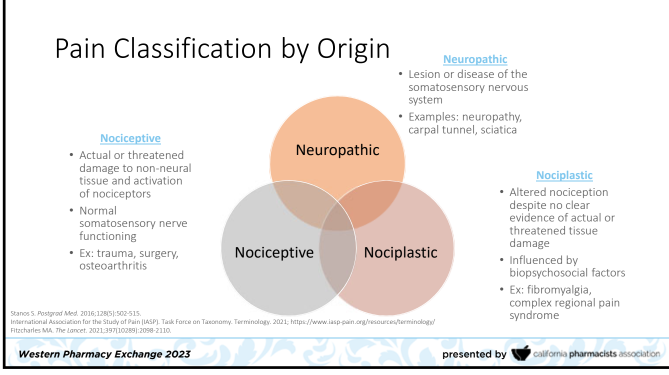

Pain Classification by Duration

Acute
- Duration: < 4 weeks
- Due to acute injury, disease, or abnormal function
- Adaptive response eliciting motivation to minimize harm and allow healing

Subacute
- Duration: 4-12 weeks
- May be due to attempting to resume normal activities following healing or scar tissue development

Chronic
- Duration: > 12 weeks
- Maladaptive disorder of somatosensory pain signaling pathways
- May be due to chronic pathology or may occur after original injury has resolved

Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95.
King W. *Encyclopedia of Pain;* 2013:60-63.
Chanda ML. *J Pain*. 2011;12(7):792-800.

Classify DL'S Pain

- Nociceptive
- Neuropathic
- Nociplastic
- Nociceptive + Neuropathic
- Neuropathic + Nociplastic
- Nociplastic + Nociceptive

- Acute
- Subacute
- Chronic

Classify DL'S Pain

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- ✓ Nociceptive + Neuropathic
- Neuropathic + Nociplastic
- Nociplastic + Nociceptive

- Acute
- Subacute
- Chronic ✓

Acute vs Chronic Pain

Characteristic	Acute Pain	Chronic Pain
Relief of Pain	Highly Desirable	Highly Desirable
Dependence & Tolerance to Medication	Unusual	Common
Psychological Component	Usually Not Present	Often a Major Problem
Organic Cause	Common	Often Not Present
Environmental Contributions & Family Involvement	Small	Significant
Insomnia	Unusual	Common Component
Treatment Goal	Cure	Functionality

McCaffery M, Herr K, Sparrow C. Assessment. In: Sparrow C, McCaffery M, eds. *Pain Assessment and Pharmacologic Management.* St. Louis, MO: Mosby Elsevier; 2011.
Clayton HA, Reschak GL, Gaynor HE, Creamer JL. *Medsurg Nurs.* 2000;9(6):317–321.

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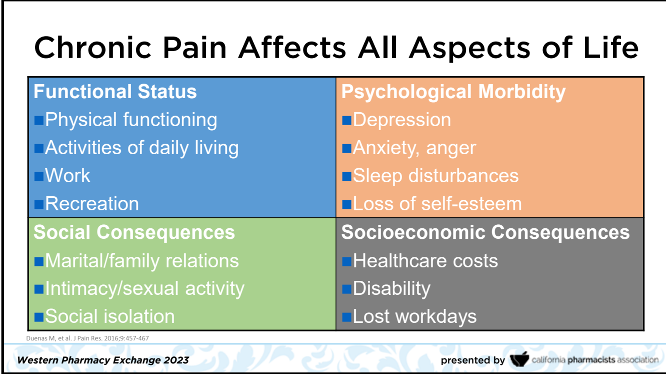

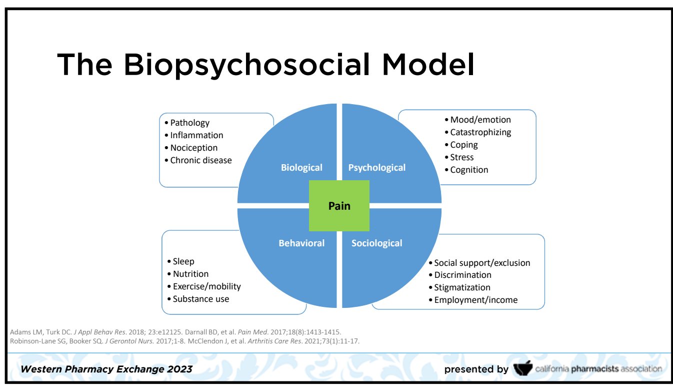

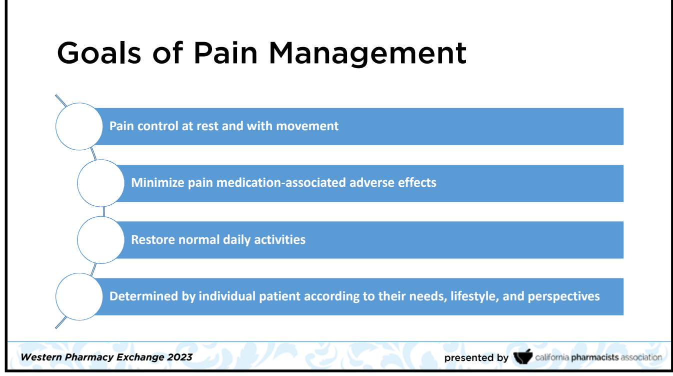

Comprehensive Pain Assessment

Patient History
Functional Pain Assessment
Psychosocial Evaluation
Risk Screening
Diagnostics
Physical Exam
Shared Decision Making

- Populations at risk for inadequate pain assessment
  - People of color
  - Women
  - LGBTQ+
  - Older adults
  - End-of-life
  - Patients with substance use disorders, cognitive impairment, mental illness, cancer, and sickle cell disease

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Pain Assessment Tools

- Functional assessment more critical than numeric pain score (NPS)
- Functional scoring tools
  - Patient Reported Outcome Measures Information System (PROMIS)
  - Short Form Health Survey (SF-36)
  - Pain intensity, Enjoyment of life, and General Activity (PEG)
- Identify functional goals of the patient

PEG: A Three-Item Scale Assessing Pain Intensity and Interference

1. What number best describes your pain on average in the past week?

   0 1 2 3 4 5 6 7 8 9 10
   No pain … Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

   0 1 2 3 4 5 6 7 8 9 10
   No pain … Pain as bad as you can imagine

3. What number best describes how, during the past week, pain has interfered with your general activity?

   0 1 2 3 4 5 6 7 8 9 10
   No pain … Pain as bad as you can imagine

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Morphine Equivalent Conversion Factors

How this table works:

Multiply the mg of each drug on the left by the factor on the right to get the morphine equivalent dose.

Examples: 1mg hydromorphone = 4mg morphine

1mg oxycodone = 1.5mg morphine

1mg oxymorphone = 3mg morphine

Type of Opioid	MME Conversion Factor
Buprenorphine patch[2]	12.6
Buprenorphine tab or film	10
Butorphanol	7
Codeine	0.15
Dihydrocodeine	0.25
Fentanyl buccal or SL tablets, or lozenge/troche[3]	0.13
Fentanyl film or oral spray[4]	0.18
Fentanyl nasal spray[5]	0.16
Fentanyl patch[6]	7.2
Hydrocodone	1
Hydromorphone	4
Levorphanol tartrate	11
Meperidine hydrochloride	0.1
Methadone	3
Morphine	1
Nalbuphine	1
Opium	1
Oxycodone	1.5
Oxymorphone	3
Pentazocine	0.37
Tapentadol	0.4
Tramadol	0.1

Depression Assessment

Proposed Treatment Action by PHQ 9 Score

PHQ-9 Score	Depression Severity	Proposed Treatment Actions
0-4	Non – Minimal	None
5-9	Mild	Watchful waiting; repeat PHQ 9 at follow-up
10-14	Moderate	Review treatment plan if not improving in past 4 weeks; Consider discussion of additional support such as pharmacotherapy
15-19	Moderately Severe	Consider adjusting treatment plan and/or frequency of sessions; Discuss additional supports such as pharmacotherapy; For SonderMind Anytime Messaging clients, consider converting from asynchronous to synchronous therapy channels
20-27	Severe	Adjust treatment plan; focused assessment of safety plan and pharmacotherapy evaluation/ re-evaluation; If emergent then refer to higher level of care; Likely Not a candidate for asynchronous/text therapy

Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener. Medical Care. 2003;41:1284-92.

Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001;16:606-13.

Kroenke K, Spitzer RL. The PHQ-9: a new depression diagnostic and severity measure. Psychiatr Ann. 2002;32:509-21.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

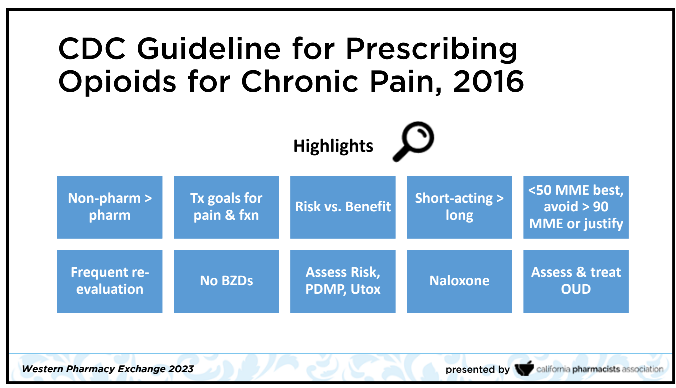
ID #: ______________________ DATE: __________

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	
Not difficult at all	____
Somewhat difficult	____
Very difficult	____
Extremely difficult	____

Updates in the 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain



CDC Guideline for Prescribing Opioids for Chronic Pain, 2016
Highlights
Non-pharm > pharm
Tx goals for pain & fxn
Risk vs. Benefit
Short-acting > long
<50 MME best, avoid > 90 MME or justify
Frequent re-evaluation
No BZDs
Assess Risk, PDMP, Utox
Naloxone
Assess & treat OUD
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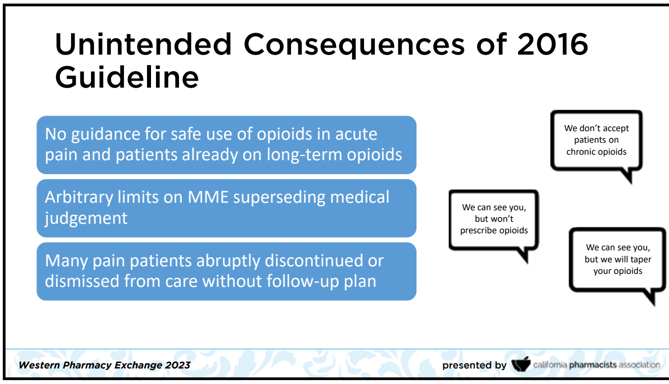

Unintended Consequences of 2016 Guideline
No guidance for safe use of opioids in acute pain and patients already on long-term opioids
Arbitrary limits on MME superseding medical judgement
Many pain patients abruptly discontinued or dismissed from care without follow-up plan
We don't accept patients on chronic opioids
We can see you, but won't prescribe opioids
We can see you, but we will taper your opioids
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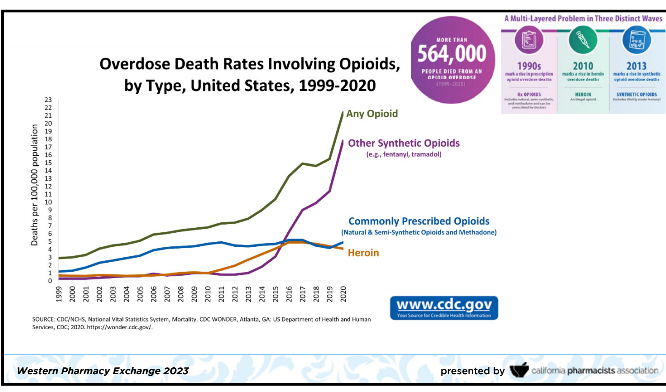

Overdose Death Rates Involving Opioids, by Type, United States, 1999-2020
MORE THAN 564,000 PEOPLE DIED FROM AN OPIOID OVERDOSE (1999-2020)
A Multi-Layered Problem in Three Distinct Waves
1990s marks a rise in prescription opioid overdose deaths
RX OPIOIDS
2010 marks a rise in heroin overdose deaths
HEROIN
2013 marks a rise in synthetic opioid overdose deaths
SYNTHETIC OPIOIDS
Deaths per 100,000 population
Any Opioid
Other Synthetic Opioids (e.g., fentanyl, tramadol)
Commonly Prescribed Opioids (Natural & Semi-Synthetic Opioids and Methadone)
Heroin
www.cdc.gov
Your Source for Credible Health Information
SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC; 2020. https://wonder.cdc.gov/.
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CDC Clinical Practice Guideline for Prescribing Opioids for Pain, 2022

Key Changes

- Emphasis on evaluating pain origin(s) using a biopsychosocial model
- Use of medical judgment to weigh risks and benefits of opioid use
- Encourage opioid safety with patient education and harm-reduction tools
- Screening and treatment recommended for opioid use disorder (OUD)
- Safe management of patients on long-term opioids

Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95.

Removal of MME Limits

- No longer recommend specific MME limits
- Emphasis on prescribers exercising caution with any dosage levels and evaluate risks and benefits with any increasing dosage
- Avoid increasing doses above levels likely to yield diminishing returns in terms of risks vs benefits

Management of Acute Pain

- Opioids may be indicated for:
  - Severe traumatic injuries (including crush injuries and burns)
  - Invasive surgeries associated with moderate to severe postoperative pain
  - Severe, acute pain when NSAIDs and other therapies are contraindicated or likely to be ineffective
- If using opioids for acute pain
  - Use short-acting agents
  - Use as needed vs scheduled dosing
  - Prescribe the lowest effective dose for the shortest duration
  - Maximize non-opioid pharmacologic and nonpharmacologic treatments
  - Include a taper if opioids are used around-the-clock (ATC) for more than a few days

U.S. Department of Health and Human Services. *Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations.* 2019. https://www.hhs.gov/ash/advisory-committees/pain/reports/index.html.

When to Avoid Opioids in Acute Pain

- Risks vs. benefits must be weighed
- Even with acute low dose opioids (1 – 36 mg/day MED), patients are at increased risk for developing OUD
- Opioids NOT recommended 1st line:

Low Back & Neck Pain	Headache or Migraine	Other Musculoskeletal Injuries
Minor Surgery, Mild post-op pain	Dental Pain	Kidney Stone Pain

Non-Opioid Pharmacotherapy

Medication or Drug Class	Condition for Use
Acetaminophen	Osteoarthritis (not recommended first line)
NSAIDs	Chronic low back pain, osteoarthritis
SNRI antidepressants (duloxetine and milnacipran)	Chronic low back pain, neuropathic pain, osteoarthritis, fibromyalgia
Tricyclic antidepressants	Neuropathic pain
Gabapentinoids	Post-herpetic neuralgia, neuropathic pain, fibromyalgia
Anticonvulsants	Neuropathic pain
Topical lidocaine or capsaicin	Neuropathic pain
Antispasmodics/muscle relaxers	Spasticity

Cheng J, et al . *Pain Medicine*. 2019;21(1):1-3.
Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95.

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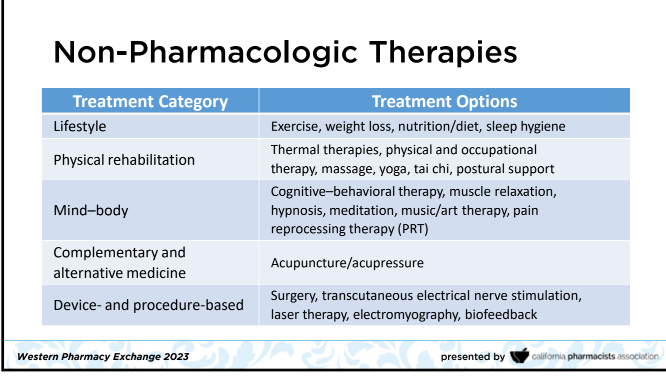

Non-Pharmacologic Therapies

Treatment Category	Treatment Options
Lifestyle	Exercise, weight loss, nutrition/diet, sleep hygiene
Physical rehabilitation	Thermal therapies, physical and occupational therapy, massage, yoga, tai chi, postural support
Mind–body	Cognitive–behavioral therapy, muscle relaxation, hypnosis, meditation, music/art therapy, pain reprocessing therapy (PRT)
Complementary and alternative medicine	Acupuncture/acupressure
Device- and procedure-based	Surgery, transcutaneous electrical nerve stimulation, laser therapy, electromyography, biofeedback

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Patient Case

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<u>Failed Medications</u>
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PEG: 8, 10, unsure
Quality: burning
Aggravating factors: physical activity
Alleviating factors: meds
Goals: pain relief, able to increase ADLs

- **Any concerns regarding opioid therapy for this patient?**
- **Drug-drug/drug-disease interactions?**
- **What would you do to address these concerns?**

Patient Case DL

- Concerns regarding opioid therapy
  - Opioids not first-line, other therapies need to be optimized
  - Short-acting preferred over long-acting
  - MME of 64 mid range
- Drug-drug/drug-disease interactions?
  - High risk combination of lorazepam + hydromorphone
  - Respiratory disease – tolerance builds to central respiratory effects, but caution is still warranted
- What would you do to address these concerns?

Optimizing Therapy

Ongoing Assessment

- See patients at regular intervals
- Track pain and function scoring at each visit
- Evaluate for risk of harm or opioid misuse
- Review non-opioid therapies for optimization
- Discuss plan to continue, adjust, taper or stop opioids
- Review the need for specialist referral

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Patient-Centered Care

- Mutual agreement on goals and expectations (Opioid Agreement)
  - Including monitoring of prescription drug monitoring programs (PDMP) and urine drug screening (UDS)
- Provider to understand context of pain interference with daily activities
  - Empathy, validation
- Provider awareness of treatment barriers & health disparities
- Shared decision making
  - Tailored treatment planning
  - Modification of plan based on reassessment

Zacharoff KL. *PainEDU*. 2011. https://www.painedu.org/patient-provider-relationship/. Accessed October 18, 2022. Matthias MS, et al. *Eur J Pain*. 2014;18(6):835-843. Henry SG, et al. *Pain*. 2018;159(2):371-379. Hood-Medland EA, et al. *BMC Fam Pract*. 2021;22(1):4.

Multimodal Therapies and Multidisciplinary Care

- Use of different classes of analgesics with differing MOA to provide pain relief
  - Synergy
  - Lower doses of individual drugs
  - Lower treatment-related side effects
  - Earlier mobilization and shortened length of stay
- Multidisciplinary approach
  - PT, OT, CBT, etc.

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Monitoring

- PDMP upon initiation of therapy and every 3 months
  - Document
    - That it has been checked
    - Relevant findings
    - Plans for follow up regarding any concerns
    - If you are not able to access
- Urine drug screening (UDS)
- Check your bias
  - More fill restrictions, office visits, and urine drug tests for BIPOC*, less likely to be referred to a pain specialist
  - "Red flags" may not take into account social determinants of health

Patients should be counseled on the monitoring plan with emphasis that it is for patient safety.

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Patient Education - Safety

- Naloxone
  - History of overdose or behavior concerning for OUD
  - Recent detox/rehabilitation or release from prison with OUD history
  - Doses of chronic opioids (> 50 mme/day) or concurrent benzos
  - History of obstructive sleep apnea
  - Educate both patients and their family members/caregivers on overdose recognition and naloxone use
- Store opioids in a secure location
- Dispose of unneeded medications via DEA take back programs

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Treatment Education and Monitoring – Plan for DL

- Clinic appointments every 1-3 months or sooner if needed
- Comprehensive assessment & monitoring
  - MME (every visit)
  - PEG (every visit)
  - PHQ-9 (initial and prn)
  - ORT (initial)
  - UDS (initial, periodic, and prn)
  - Opioid agreement (initial, annual and prn)
  - PDMP (every visit)
  - Naloxone (provide at initial and PRN, counsel at every visit)
  - Need for multidisciplinary care (PT, OT, pain psych, other specialists)
  - Need to taper opioids

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Tapering Opioids

- If no pain reduction or functional improvement
- Medication combinations that increase risk (e.g. starting a BZD)
- Nonadherence
- Unsafe use of meds
- Overdose
- Change in medical or mental health status
- If requested

- No set rules
- Optimize or add adjuvant agents to assist with taper
- 10% reduction (or less!) every 1-4 weeks as tolerated
- Most successful when it is part of shared decision making
- Can decrease long-acting or short-acting
- Ensure adequate support for the patient (psychosocial support, naloxone availability, coordination with other care providers

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Centers for Disease Control and Prevention (CDC). Pocket Guide: Tapering Opioids for Chronic Pain. 2016. https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf.