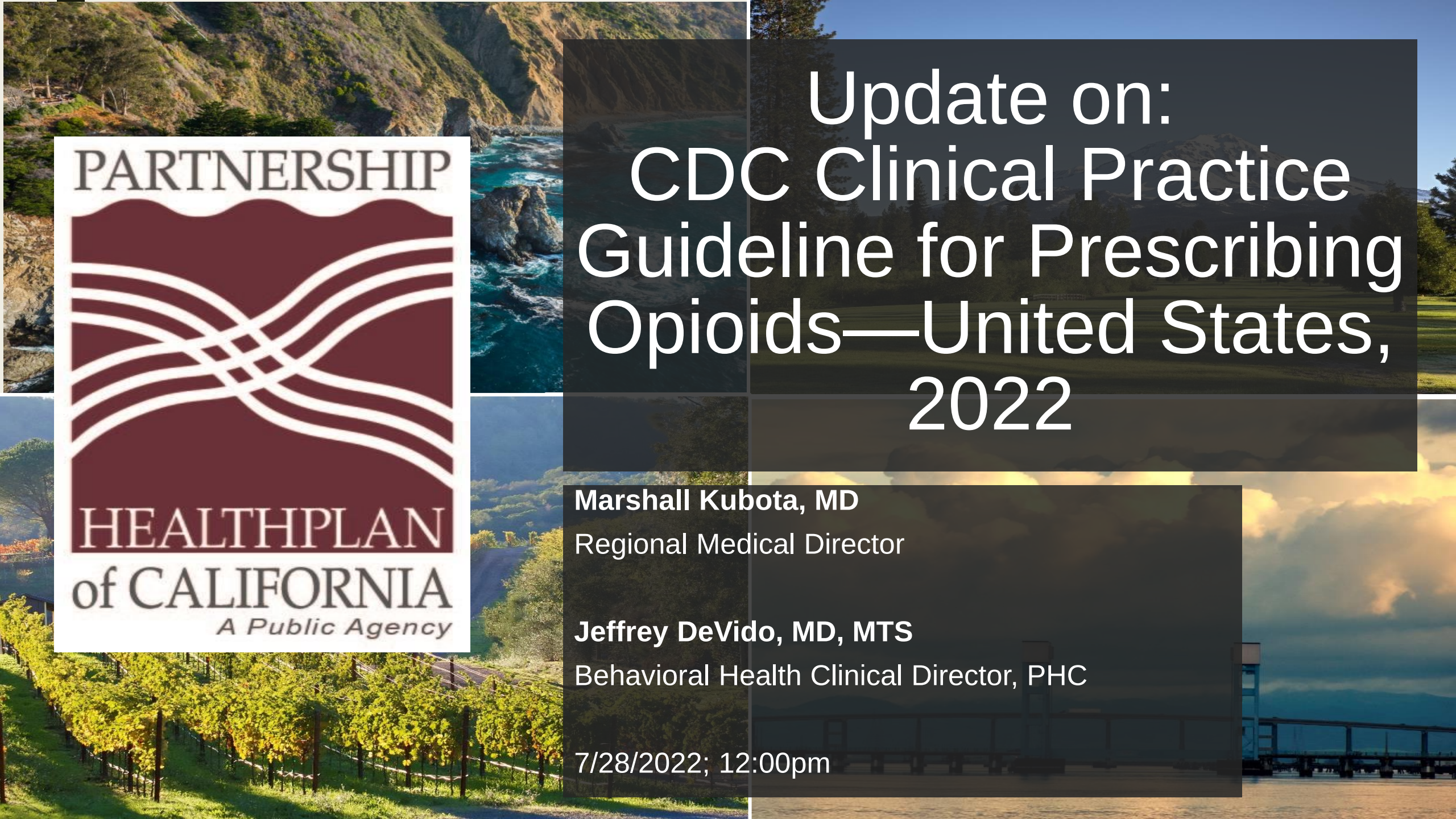


Update on: CDC Clinical Practice Guideline for Prescribing Opioids—United States, 2022

Marshall Kubota, MD

Regional Medical Director

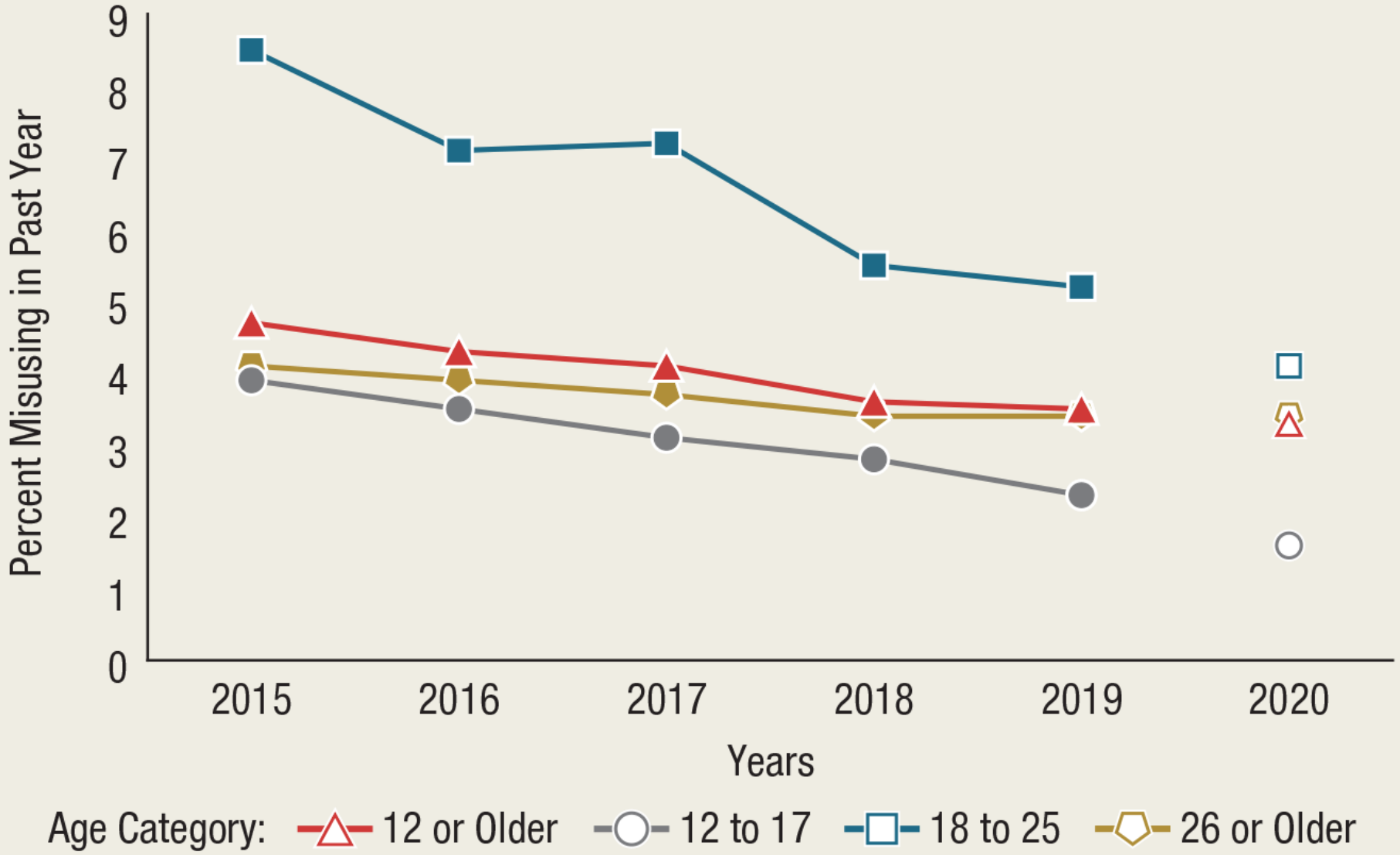
Jeffrey DeVido, MD, MTS

Behavioral Health Clinical Director, PHC

7/28/2022; 12:00pm

Backdrop

Past Year Prescription Pain Reliever Misuse: Among People Aged 12 or Older; 2015-2020

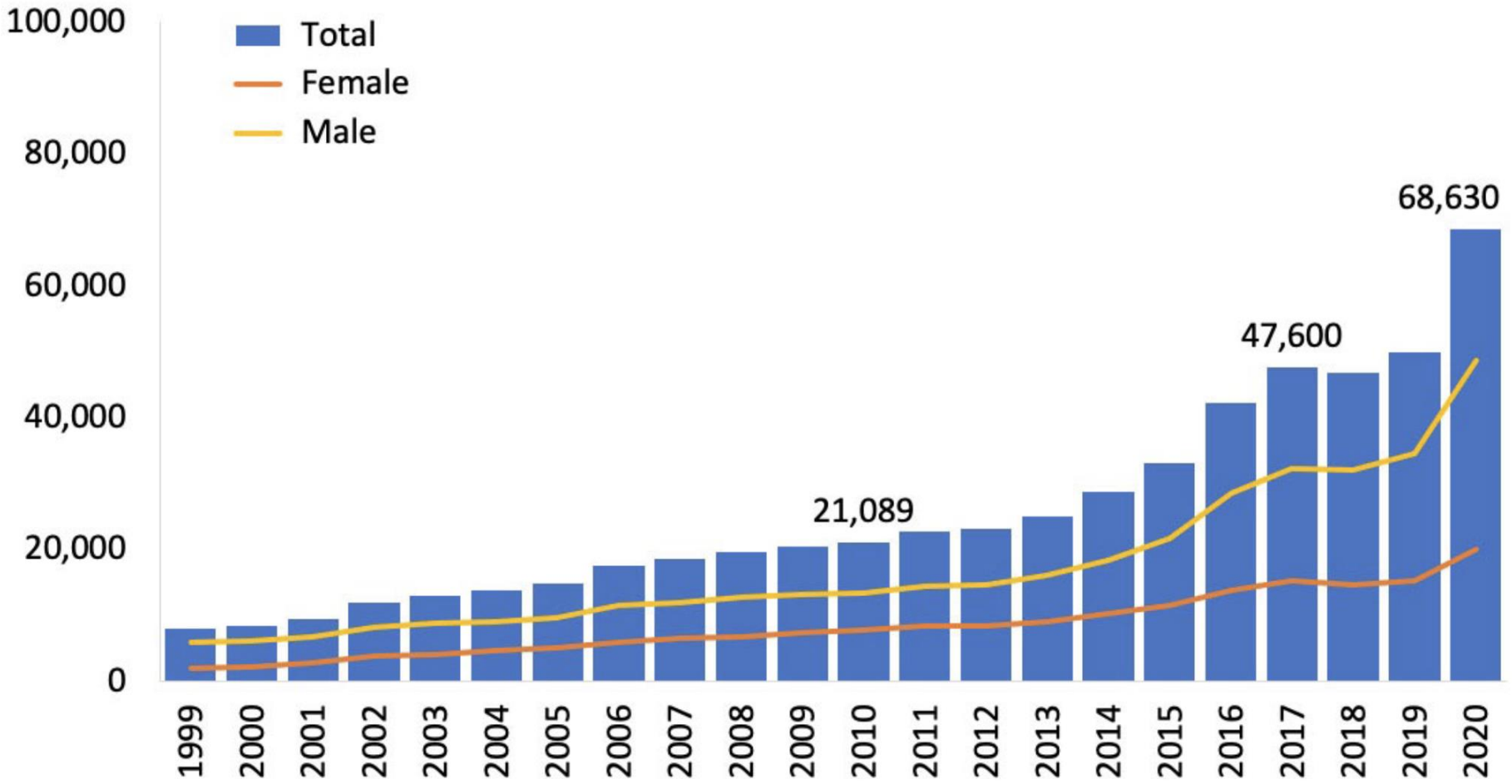


Note: There is no connecting line between 2019 and 2020 to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

Note: The estimate in 2020 is italicized to indicate caution should be used when comparing estimates between 2020 and prior years because of methodological changes for 2020. Due to these changes, significance testing between 2020 and prior years was not performed.

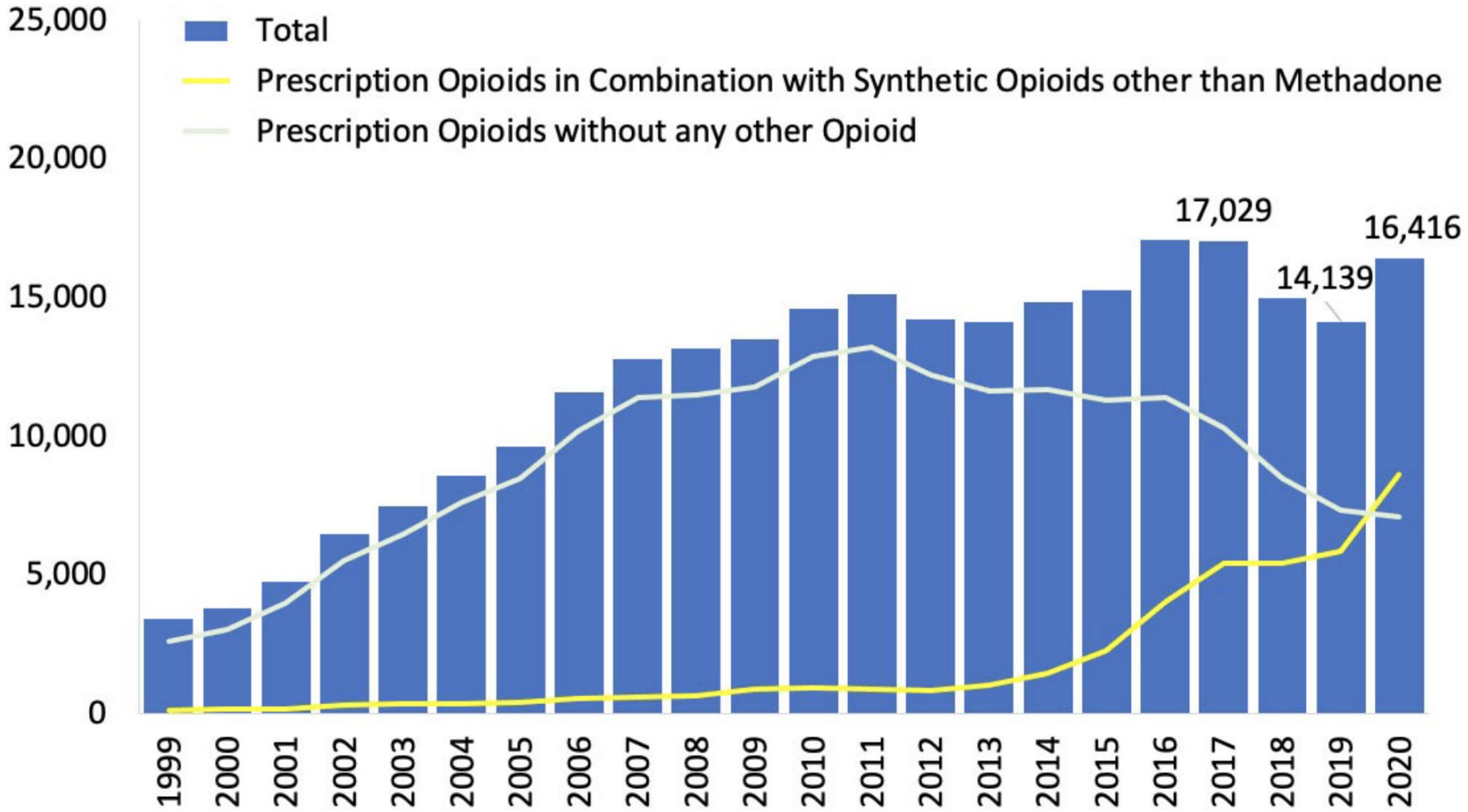
https://www.samhsa.gov/data/release/2020-national-survey-drug-use-and-health-nsduh-releases

Figure 3. National Overdose Deaths Involving Any Opioid, Number Among All Ages, by Gender, 1999-2020



*Among deaths with drug overdose as the underlying cause, the any opioid subcategory was determined by the following ICD-10 multiple cause-of-death codes: natural and semi-synthetic opioids (T40.2), methadone (T40.3), other synthetic opioids (other than methadone) (T40.4), or heroin (T40.1). Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2020 on CDC WONDER Online Database, released 12/2021.

Figure 4. National Overdose Deaths Involving Prescription Opioids*, Number Among All Ages, 1999-2020



*Among deaths with drug overdose as the underlying cause, the prescription opioid subcategory was determined by the following ICD-10 multiple cause-of-death codes: natural and semi-synthetic opioids (T40.2) or methadone (T40.3). Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2020 on CDC WONDER Online Database, released 12/2021.

Society

The Guardian

Number of fentanyl-filled pills seized by US law enforcement up 4,850%

A study found that more than 2m counterfeit pills were confiscated in the last quarter of 2021 alone

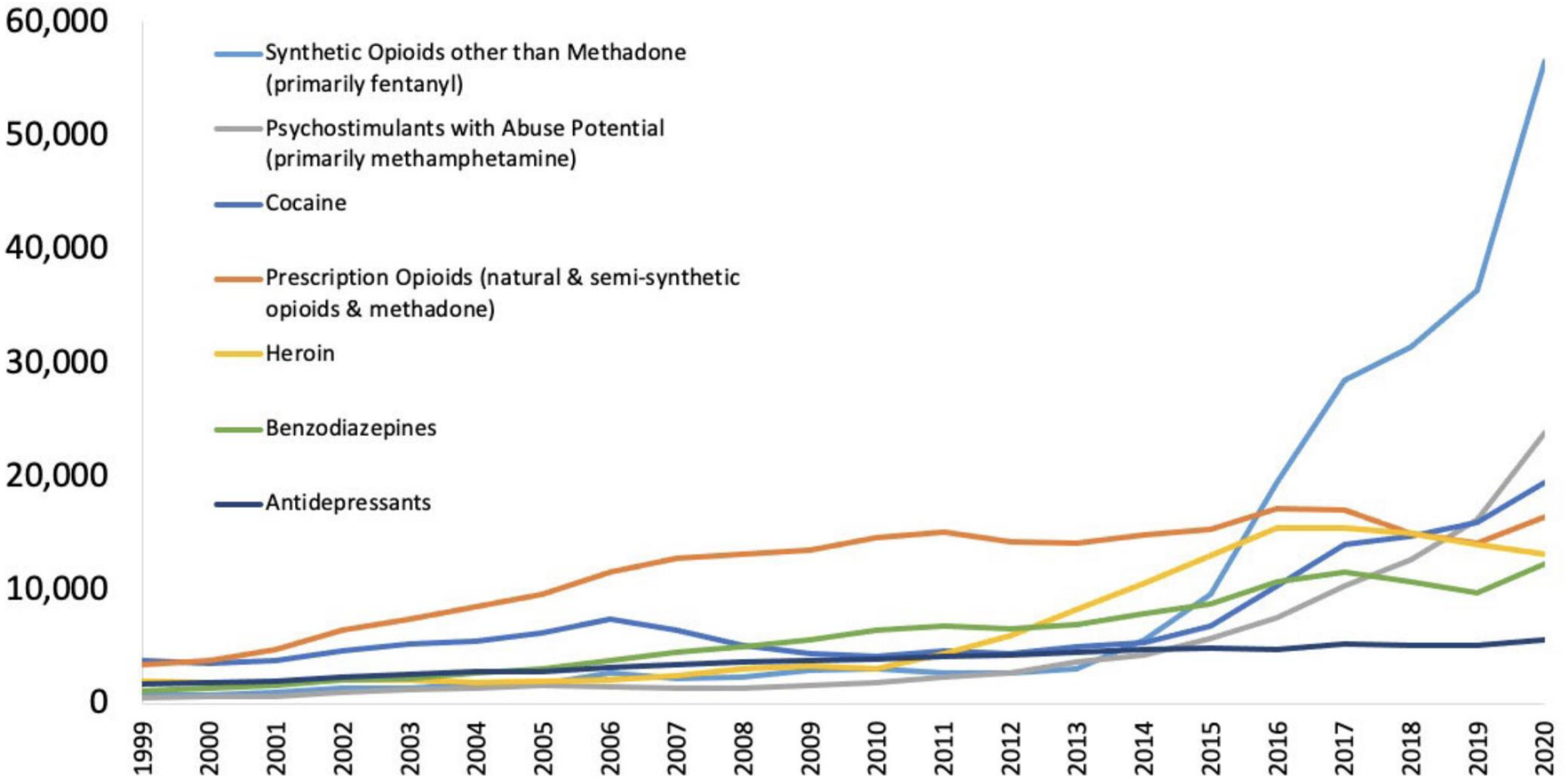
Erin McCormick

12:00 UTC Thursday, 31 March 2022

https://www.theguardian.com/society/2022/mar/31/fentanyl-overdose-us-law-enforcement

https://www.drugabuse.gov/drug-topics/trends-statistics/overdose-death-rates

Figure 2. National Drug-Involved Overdose Deaths*, Number Among All Ages, 1999-2020



*Includes deaths with underlying causes of unintentional drug poisoning (X40–X44), suicide drug poisoning (X60–X64), homicide drug poisoning (X85), or drug poisoning of undetermined intent (Y10–Y14), as coded in the International Classification of Diseases, 10th Revision.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2020 on CDC WONDER Online Database, released 12/2021.

2016 CDC Guidelines

*This guideline provides recommendations for **primary care clinicians** who are prescribing opioids for **chronic pain** outside of active cancer treatment, palliative care, and end-of-life care.*

- Chronic pain is defined within this guideline as pain that typically lasts >3 months or past the time of normal tissue healing

- The recommendations are grouped into three areas for consideration:
  - *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.*

https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

Determining When to Initiate or Continue Opioids for Chronic Pain

- Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain.
- If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

- When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids
- When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, especially ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day
- Acute pain: Three days or less will often be sufficient; more than seven days will rarely be needed
- Re-evaluate: 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Every 3 months or more frequently.

Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

- If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids
- Tapers reducing weekly dosage by 10%–50% of the original dosage have been recommended by other clinical guidelines, and a rapid taper over 2–3 weeks has been recommended in the case of a severe adverse event such as overdose

Assessing Risk and Addressing Harms of Opioid Use

- Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present
- Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data
- Clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually

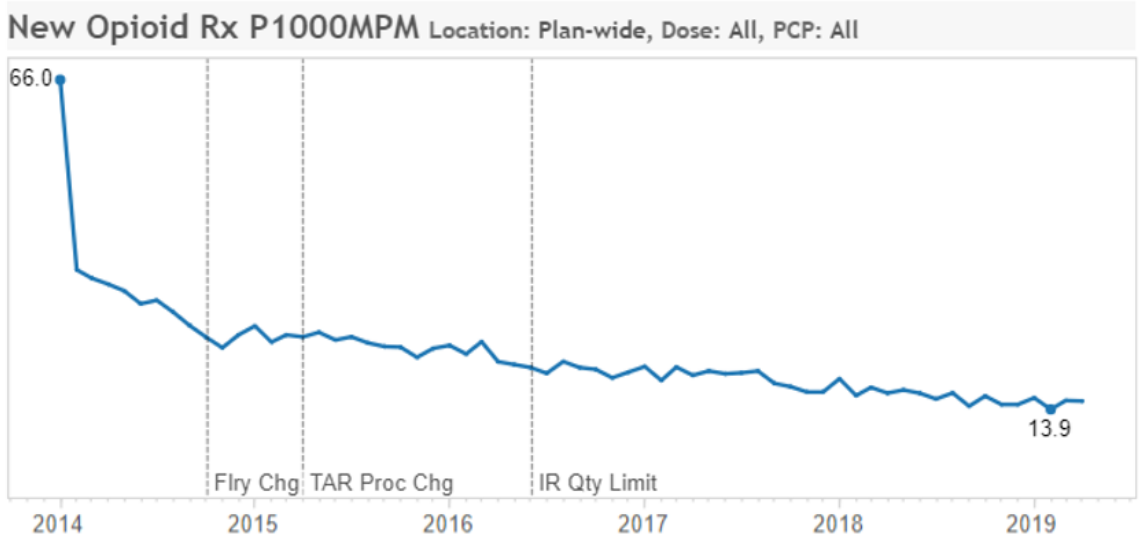
Assessing Risk and Addressing Harms of Opioid Use

- Avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible
- 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

THE PHC MANAGING PAIN SAFELY INITIATIVE (2014)

- Reduce initial opioid prescriptions
- Reduce escalating doses
- Reduce high dose prescriptions

Decrease New Starts

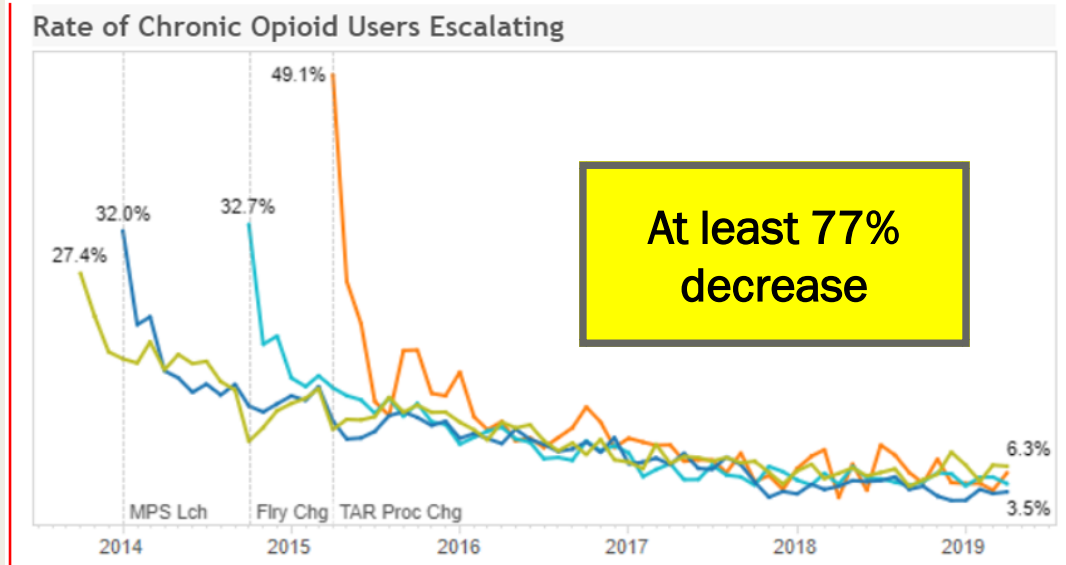


In the graph of new opioid prescriptions (defined as those who have not filled an opioid prescription in the previous 90 days), there has been an 77% decrease from 66.0 New Opioid Prescriptions per 1000 members per month (January 2014) to 15.2 New Opioid Prescriptions per 1000 members per month (April 2019). For the time period of January 1 – December 31, 2018, there was a 25.16% decrease in this measure.

Goal: 75% decrease

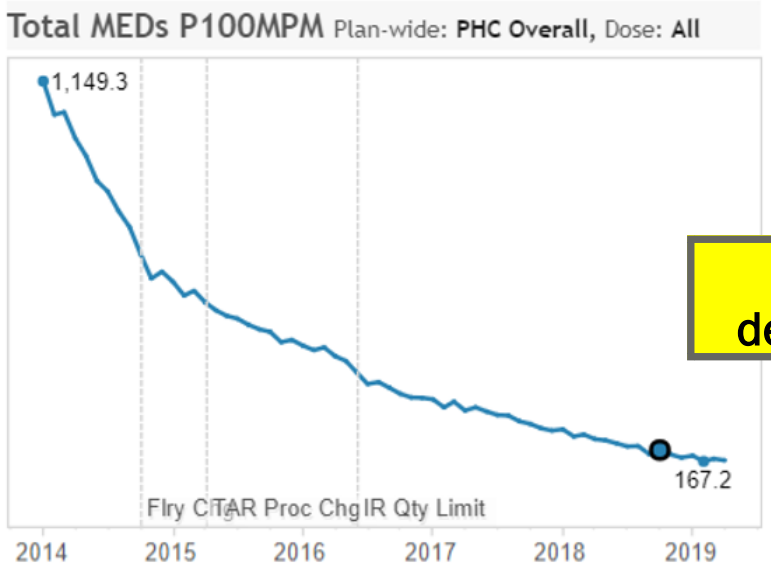
Outcome: 77% decrease

Reduce Dose Escalations



This graph demonstrates the deep decreases in the rate of escalation of four cohorts of chronic opioid users starting on a high dose (>120 MED) identified in October 2013, January 2014, October 2014, and April 2015. In all four cases, the rate of escalating has dropped to single digit percentages, which all represent at least a 77% decrease since the baseline data. For the January 1-December 31, 2018 time frame, there was a .05% decrease in total number of prescription dose escalations PMPM.

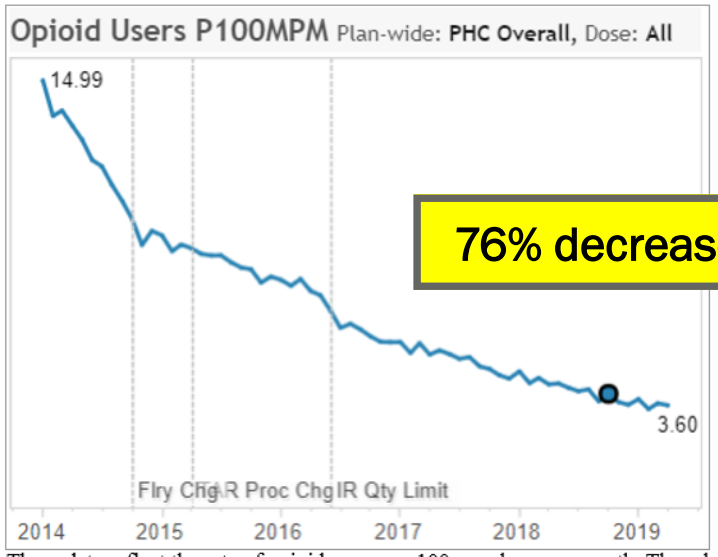
Reduce opioids in the community



85% decrease

These data reflect the sum of daily Morphine Equivalent Doses (MEDs) per 100 members per month. There has been a continual decline on this measure. The larger blue dot indicates the data for October 2018, when the implementation of the 90 mg MED quantity to all formulary opiates occurred. In April 2019 (which is the last data point on the graph above), there were 170 MEDs per 100 members per month, which is an 85% decrease from the rate of 1149.3 Total MEDs per 100 members per month from the January 2014 baseline.

Reduce prescription opioid members

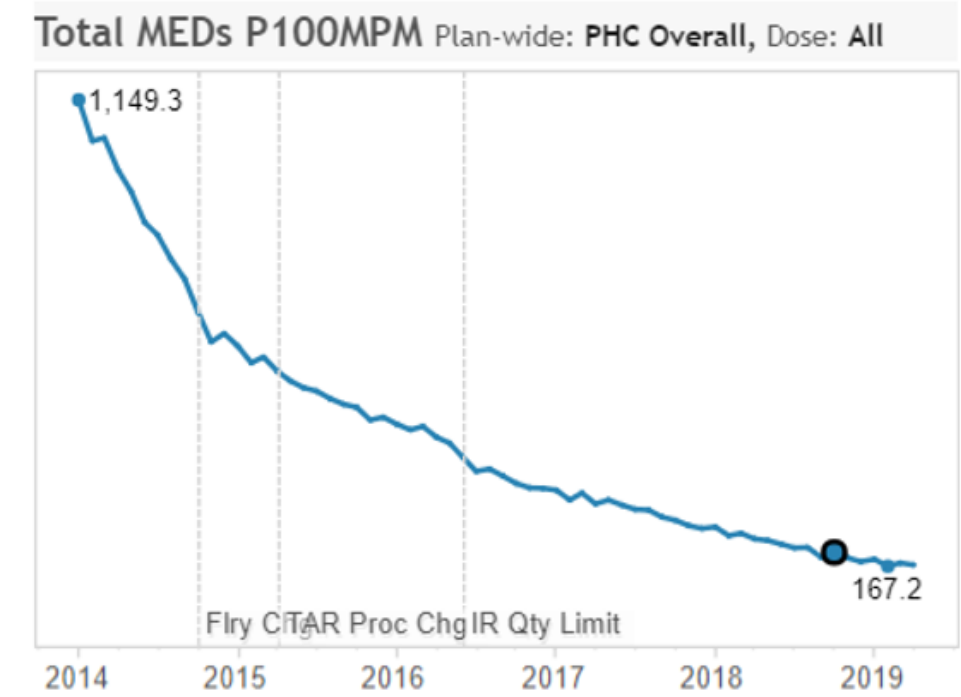


76% decrease

These data reflect the rate of opioid users per 100 members per month. There has been a continual decline on this measure. The blue dot indicates the data for October 2018, when the implementation of the 90 mg MED quantity to all formulary opiates occurred. In April 2019 (which is the last data point on the graph above), there were 3.6 Total opioid users per 100 members per month, which is a 76% decrease from the rate of 14.99 per 100 members per month from the January 2014 baseline.

Move Individuals to Safe Dose (less than 90 mg MED)

- Reduce risk of accidental overdose
- Reduce side-effects of opioids
- Reduce risk of dependence
- Improve quality of life



85% decrease

These data reflect the sum of daily Morphine Equivalent Doses (MEDs) per 100 members per month. There has been a continual decline on this measure. The larger blue dot indicates the data for October 2018, when the implementation of the 90 mg MED quantity to all formulary opiates occurred. In April 2019 (which is the last data point on the graph above), there were 170 MEDs per 100 members per month, which is an 85% decrease from the rate of 1149.3 Total MEDs per 100 members per month from the January 2014 baseline.

Perspective

No Shortcuts to Safer Opioid Prescribing

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

Since the Centers for Disease Control and Prevention (CDC) released its Guideline for Prescribing Opioids for Chronic Pain in 2016,[1] the medical and health policy communities have largely embraced its recommendations. A majority of state

Audio Interview

Interview with Dr. Deborah Dowell on concerns about misimplementation and misapplication of the CDC's opioid-prescribing guideline. (08:46)

Download

June 13, 2019
N Engl J Med 2019; 380:2285-2287
DOI: 10.1056/NEJMp1904190

2022: DRAFT Guidelines

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

Intended for primary care clinicians **and other clinicians** providing pain care for outpatients aged ≥18 years old with:

- acute pain (duration <1 month);
- Subacute pain (duration of 1-3 months); or
- chronic pain (duration of >3 months)

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

2022: DRAFT Guidelines

NOT Applicable to the following types of pain treatment:

- Sickle cell disease-related pain;
- Cancer pain;
- Palliative care; or
- End-of-life care

- Inpatient medical or emergency settings, but DO apply at discharge

2022: DRAFT Guidelines

This clinical practice guideline addresses:

- 1) Determining whether or not to initiate opioids for pain;
- 2) Opioid selection and dosage;
- 3) Opioid duration and follow-up; and
- 4) Assessing risk and addressing potential harms of opioid use

2022: DRAFT Guidelines

Highlights

- 200+ pages
- Emphasizes VOLUNTARY nature of guidelines—flexible, to support clinical judgment
- Intends to improve COMMUNICATION between patients and clinicians (e.g., risks/benefits)
- Patients on chronic opioids should not be abruptly discontinued, or driven from care, and referrals for complications (SUD) should be provided
- Start with lowest dose, immediate release
- Offer naloxone

2022: DRAFT Guidelines

Highlights—12 recommendations:

1. Non-opioid therapies are effective for acute pain. Opioids should only be considered if benefits clearly outweigh risks
2. Non-opioid therapies are preferred for sub-acute and chronic pain
3. If prescribing opioids for acute, sub-acute, chronic pain, use immediate release for opioid naïve patients
4. Prescribe lowest possible dose to achieve effect
5. If already on “higher dose” opioids, consider slow taper, IF WARRANTED based on clinical circumstance. Abrupt discontinuation ONLY if life threatening need (OD, intoxication).
6. If opioid warranted, prescribe no longer than would be expected to need

2022: DRAFT Guidelines

Highlights—12 recommendations:

7. For subacute, chronic pain, using opioids→re-assess every 1-4 weeks; every 3 months (or more frequent) if chronic
8. Before starting, and periodically thereafter, assess risk of opioid-related harms; plan to mitigate risk (e.g. naloxone)
9. Review PDMP, at start and periodically thereafter
10. Consider toxicology screening
11. Risk/Benefit analysis and caution if co-prescribed benzodiazepines
12. Arrange for or offer treatment with medications (e.g., buprenorphine) if opioid use disorder identified

A note about MME thresholds

- “Additional dosage increases beyond 50 MME/day are progressively more likely to yield diminishing returns in benefits relative to risks to patients, and clinicians should carefully evaluate a decision to increase dosage based on individualized assessment of benefits and risks and weighing factors such as diagnosis, incremental benefits for pain and function relative to risks with previous dosage increases, other treatments and effectiveness, and patient values and preferences.”
  - *Page 100 DRAFT Guidelines*

2022: DRAFT Guidelines

Highlights—5 Guiding Principles:

- Acute, subacute, and chronic pain need to be appropriately and effectively treated independent of whether opioids are part of a treatment regimen.
- Recommendations are voluntary and are intended to support, not supplant, individualized, person-centered care. Flexibility to meet the care needs and the clinical circumstances of a specific patient are paramount.
- A multimodal and multidisciplinary approach to pain management attending to the physical health, behavioral health, long-term services and supports, and expected health outcomes and well-being needs of each person is critical.
- Special attention should be given to avoid misapplying this updated clinical practice guideline beyond its intended use or implementing policies purportedly derived from it that might lead to unintended consequences for patients.
- Clinicians, practices, health systems, and payers should vigilantly attend to health inequities, provide culturally and linguistically appropriate communication, and ensure access to an appropriate, affordable, diversified, coordinated, and effective nonpharmacologic and pharmacologic pain management regimen for all persons.

When will 2022 Draft Guidelines be finalized?

- Per CDC: By End of 2022

How will Magellan and DHCS manage opioid prescriptions?

In anticipation of these draft guidelines being finalized, PHC has already incorporated these into our policies

Advantages and Disadvantages

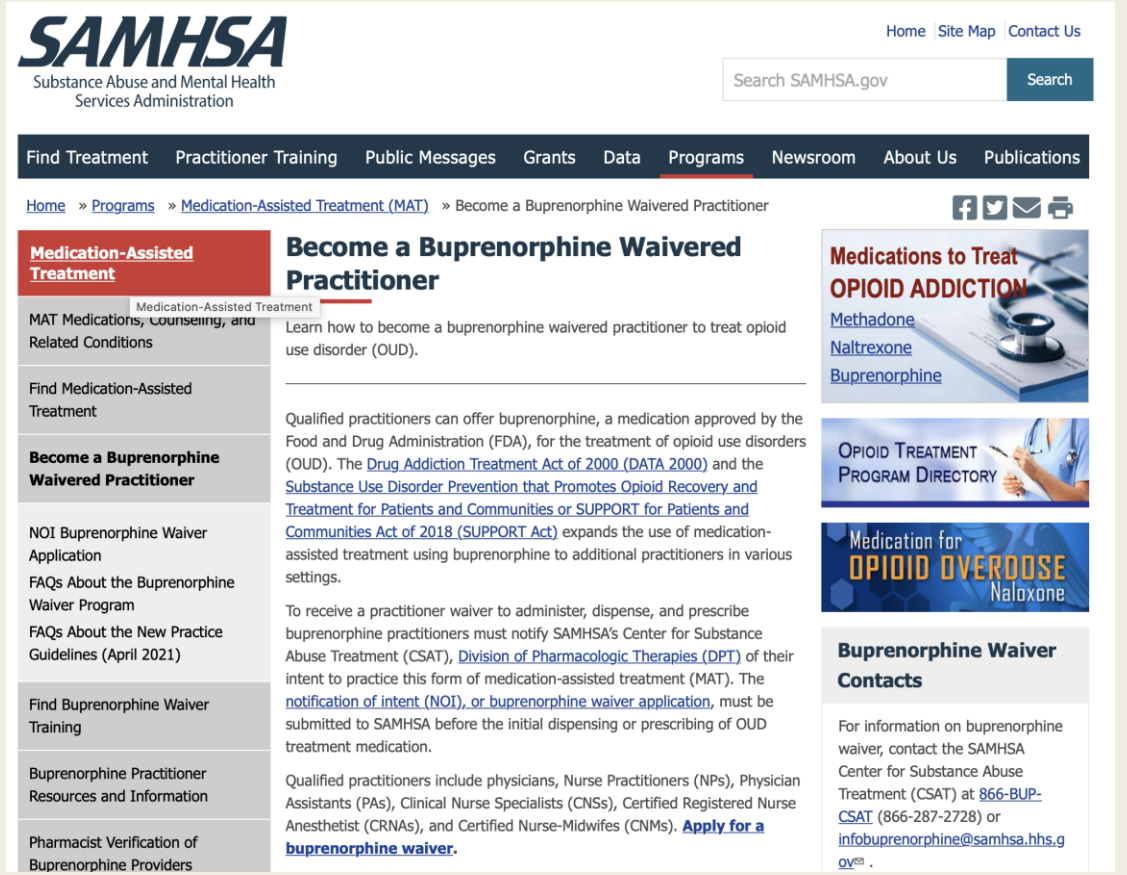
- Advantages
  - *Allows prescribers to make individualized decisions based on clinical context*
  - *Expands guidelines beyond just "chronic pain"*
  - *Extensive document provides additional research data to improve clinician knowledge and communication options*
  - *May lighten some of the regulatory / MBC punitive actions against prescribers*

- Disadvantages
  - *Without clear thresholds/limits, provides less institutional and system-backed support for decreases in opioids for problematic patients*
  - *Multimodal and multidimensional approach advocated for may be difficult to implement*
  - *Tapers can be challenging, but sometimes necessary*
  - *Places responsibility back on the prescriber – historically this has resulted in escalation of opioid prescribing, continuation, and escalation – a cautionary tale*
    - *Desire to "Do Something" about chronic pain*
    - *Demanding, pleading patients*
    - *Easier to just prescribe than argue or do in depth evaluation*
    - *Member satisfaction surveys*

A separate, but related, issue…

- Buprenorphine for the treatment of opioid use disorder
  - *Partial agonist with high affinity at mu-opioid receptor = activates AND blocks*
  - *X-Waiver is still required*
  - *Training requirement is waived if prescribing for 30 or less patients*
    - Prescribing = in active treatment with that provider

https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner

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HEALTHPLAN
of CALIFORNIA
A Public Agency
Questions?