CDC Guidelines for Prescribing Opioids for Chronic Pain
July 11, 2016
By Plews Shadley Racher & Braun LLP

On March 15, 2016, the Centers for Disease Control ("CDC") issued an extensive report and accompanying checklist resources entitled "CDC Guidelines for Prescribing Opioids for Chronic Pain – United States, 2016" ("Guidelines") While the title describes a focus on opioids and chronic pain, the Guidelines include important analyses and recommendations relating to acute pain treatment and non-opioid treatment options.

Ultimately, the Guidelines describe a high degree of attentiveness to the risks and benefits of opioid treatment and pharmacological, as well as non-pharmacological, options to opioid treatment. This attention presumes careful, individualized assessments, discussions, monitoring, reassessments and adjustments in treating pain issues. This is a valuable resource. At the same time, it serves as an important contribution to "best practices standards" that will heighten both expectations and risk exposure for all healthcare providers, not just pain management specialists.

It is important to note that the Guidelines are directed at primary care physicians who are prescribing opioids for chronic pain <u>outside of</u> active cancer treatment, palliative care, and end-of-life care. These latter exclusions are noticeable because some providers in those specialty settings have been concerned that increased scrutiny can lead to undue caution about use of opioids in those situations where addiction is a secondary issue. The stated purpose of the Guidelines is to "improve communication between clinicians 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 opioid use disorder, overdose and death."

The Guidelines contain twelve recommendations broken down into three areas for consideration that can be summarized as (i) use non-opioid therapies; (ii) start low and go slow; and (iii) follow up:

A. Determining when to initiate or continue opioids for chronic pain (defined as equal to or greater than three months).

1. The Guidelines start from the perspective that non-pharmacological therapy and non-opioid pharmacologic therapy is preferred for chronic pain. Clinicians are encouraged to balance the benefits versus the risks when considering opioid therapy, and attempt to combine it with non-opioid pharmacologic therapy.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals that are realistic and openly anticipate discontinuation of opioids if benefits do not outweigh the risks.

3. Before starting opioid therapy, and periodically during the therapy, clinicians should discuss with patients known risks and realistic benefits of the opioid therapy.

B. Opioid selection, dosage, duration, follow-up, and discontinuation.

1. When starting opioid therapy for chronic pain, immediate-release rather than extended-release opioids should be prescribed.

2. Clinicians should start with the lowest effective dosage.

3. Prescriptions should be for the expected duration of the pain, which will often be three days or less, and rarely more than seven days.

4. Clinicians should evaluate benefits and harms with patients within one to four weeks, and then at least every three months.

C. Assessing risk and addressing harms of opioid use.

1. Clinicians should incorporate strategies to mitigate risk into the management plan.

2. Clinicians should use state prescription drug monitoring programs to review past controlled substance prescriptions and dangerous combinations for the patients.

3. Clinicians should use urine drug testing before starting opioid therapy.

4. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

5. Clinicians should offer or arrange for evidence-based treatment, including behavioral therapies, for patients with opioid use disorder.

The Guidelines provide an extended discussion of the background and rationale for the development of these recommendations. There is also an attempt to compile and update the current state of research and clinical information regarding pain treatment and risk assessment and mitigation. Part of the urgency is reflected in a variety of statistics, including the fact that the death rate associated with opioid pain medication has “increased markedly,” while the death rate for other leading causes of death such as heart disease and cancer have “decreased substantially.”

Here is a link to the Guidelines, along with very useful resources, including checklists, guidelines and treatment alternatives.

http://www.cdc.gov/drugoverdose/prescribing/guideline.html

The Guidelines provide inpatient guidance for all healthcare providers, especially in light of the publicity surrounding opioid abuse and increased regulatory scrutiny and enforcement activity.

Additional information about Plews Shadley Racher & Braun LLP and its health care practice is available at www.psrb.com.