Draft CDC Guideline for Prescribing Opioids for Chronic Pain

September 18, 2015

To Whom It May Concern,

The National Hospice and Palliative Care Organization is pleased to submit these comments on the draft CDC Guidelines for Prescribing Opioids for Chronic pain. Our comments are below.

Intended Use of Guidelines

The purpose of the CDC guidance is to provide recommendations for the prescribing of opioid pain medication for patients 18 or older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (i.e. pain lasting longer than 3 months past the time of normal tissue healing outside end-of-life care).

NHPCO is pleased that the guidelines exclude patients who are at the end of life, with language that states “outside end-of-life care.” We have concern however, about special populations, such as the elderly or those with cognitive impairment, since these patient groups cannot participate in goals of care discussions. There is no mention of the role of family caregivers or family members and how they will be involved in the decision making process.

Core Expert Group/Stakeholder Review Group

NHPCO wishes to express concern that the core expert group and the stakeholder review group are not listed on the CDC website, so there is no way to determine whether a particular constituency was represented in the discussions and deliberations. We respectfully request that the participants in each of the groups be made public and that the review process become more transparent.

Timing for Comment Submission

NHPCO wishes to express concern that the time allowed for public comment on the draft guidelines was extremely short and dissemination of the actual guidelines is only available to those who attended the webinars. It is surprising that the draft guidelines, even today, are not available on the CDC website, making public comment difficult.
1. Draft Recommendation 1

Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain. Providers should only consider addition opioid therapies if expected benefits for both pain and function are anticipated to outweigh risks.

NHPCO has no comments.

2. Draft Recommendation 2

Before starting long-term opioid therapy, providers should establish treatment goals with all patients, including realistic goals for pain and function. Providers should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

NHPCO believes that this recommendation will be difficult or impossible for those with impaired cognition and many elderly patients. There is no mention here of the role of family caregivers in the treatment goals discussion, and there should be a note of their importance for these patient populations.

3. Draft Recommendation 3

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

NHPCO again notes that there should be a notation for providers on how to have a patient discussion when patients have impaired cognition or are elderly, including the inclusion of family caregivers or the patient’s representative in the discussion.

4. Draft Recommendation 4

When starting opioid therapy, providers should prescribe short-acting opioids instead of extended-release/long-acting opioids.

NHPCO has no comments.

5. Draft Recommendation 5

When opioids are started, providers should prescribe the lowest possible effective dosage. Providers should implement additional precautions when increasing dosage to 50 or greater milligrams per day in morphine equivalents and should increasing dosages to 90 or greater milligrams per day in morphine equivalents.

NHPCO has no comments.
6. **Draft 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 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 major surgery.

NHPCO questions the limitation of three days, since it seems arbitrary. It is important for the guidelines to share the empirical basis or research that supports the three day limit.

7. **Draft Recommendation 7**

Providers should evaluate patients with 1 to 4 weeks of starting long-term opioid therapy or of dose escalation to assess benefits and harms of continued opioid therapy. Providers should evaluate patients receiving long-term opioid therapy every 3 months or more frequently for benefits and harms of continued opioid therapy. If benefits do not outweigh harms of continued opioid therapy, providers should work with patients to reduce opioid dosage and to discontinue opioids when possible.

NHPCO has no comments.

8. **Draft 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-related harms are present.

NHPCO has no comments.

9. **Draft Recommendation 9**

Providers should review the patient’s history of controlled substance prescriptions using state Prescription Drug Monitoring Program data to determine whether the patient is receiving excessive opioid dosages or dangerous combinations that put him/her at high risk for overdose. Providers should review Prescription Drug Monitoring Program data when starting opioid therapy and periodically during long-term opioid therapy (ranging from every prescription to every 3 months).

Some primary care practitioners may find this recommendation burdensome, although NHPCO supports it.
10. Draft Recommendation 10

Providers should use urine drug testing before starting opioids for chronic pain and consider urine drug testing at least annually for all patients on long-term opioid therapy to assess for prescribed medications as well as other controlled substances and illicit drugs.

As long as patients at the end of life are excluded from this recommendation, this recommendation seems reasonable.

11. Draft Recommendation 11

Providers should avoid prescribing of opioid pain medication and benzodiazepines concurrently whenever possible.

NHPCO agrees with the intent of this recommendation.

12. Draft Recommendation 12

Providers should offer or arrange evidence-based treatment (usually opioid agonist treatment in combination with behavioral therapies) for patients with opioid use disorder.

NHPCO believes that many primary care practitioners would not know what this recommendation is referring to, and encourages the reviewers to clarify and reword the recommendation so its intent is clear.

Thank you so much for the opportunity to comment. We look forward to having a part in the dissemination of the final guidelines.

Sincerely,

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President and CEO