**Introduction**

- Purpose of the webinar: to provide an opportunity for public engagement in the review of draft CDC opioid prescribing recommendations.

- The target audience: primary care providers (e.g. family practitioners, internists) who are treating patients ages 18 and older for chronic pain in outpatient settings.

- The webinar will be audiotaped to provide a complete and accurate record of the comments made. It will not be archived for public viewing.

- CDC staff will prepare a written summary of the comments resulting from the webinar. The written summary will:
  - Not include names or affiliations of persons making comments
  - Be posted on a CDC public website in October 2015
Overview of Webinar Comment Process

- CDC will review the guideline development process and present clinical recommendation statements.

- Participants may offer comments in response to each recommendation statement through the following means:
  - Verbally over the phone during the webinar
  - Electronically via webinar comment box (real time); or
  - Via email sent to opioidcomments@cdc.gov before 5:00 PM EDT on September 18.

- During the webinar, CDC will provide minor clarifications when requested but will not otherwise respond to comments offered.
Disclaimer

- This information is distributed solely for the purpose of pre-dissemination review. It has not been formally disseminated by the Centers for Disease Control and Prevention. It does not represent and should not be construed to represent any agency determination or policy.

- Funding support: CDC provided funding for evidence synthesis and meeting support.
Overview of Guideline Development Process

- Literature Review
  - Draft Recommendations
    - Core Expert Group Meeting*
      - Revise Draft Recommendations
        - Core Expert Group Review
        - Federal Partner Review
        - Stakeholder Review
          - Peer Review and Public Engagement
            - Revise Draft Guidelines
              - HHS Review
                - Publish and Disseminate

* Using GRADE Methodology
Rating of Recommendations

Grading of Recommendations Assessment, Development, and Evaluation (GRADE) method

• Strong
  ▪ Most patients should receive the recommended course of action; recommendation could be adopted as policy in most situations

• Weak
  ▪ Different choices will be appropriate for different patients; clinicians must help patients decide based on clinical situation, and patient values and preferences; policy-making requires much debate and stakeholder involvement

Based on the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) method
(http://www.gradeworkinggroup.org/)
Rating of Recommendations (continued)

- Four factors influence recommendation ratings:
  - Is the recommended course of action effective in improving patient outcomes?
  - Does the recommended course of action do more good than harm?
  - How much do values and preferences vary about the recommended course of action?
  - Are the benefits worth the costs?
- A recommendation is likely to be strong when the anticipated benefits are expected to be great relative to the likely harms

Based on the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) method (http://www.gradeworkinggroup.org/)
Rating of Evidence Quality

- Ratings = high, moderate, low, or very low
- Many factors influence, such as:
  - Study design
  - Number of patients included in studies
  - Variation in findings across studies
- Low quality evidence signals uncertainty, not an absence of evidence
- Recommendations can be confidently made, and are frequently made, with low quality evidence

Based on the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) method (http://www.gradeworkinggroup.org/)
Organization of Recommendations

The 12 recommendations are categorized into three conceptual areas:

- Determining when to initiate or continue opioids for chronic pain outside end-of-life care
- Opioid selection, dosage, duration, follow-up, and discontinuation
- Assessing risk and addressing harms of opioid use
Determining when to initiate or continue opioids for chronic pain outside end-of-life care

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. *(strong recommendation, low quality of evidence)*

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. *(strong recommendation, low quality of evidence)*

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. *(strong recommendation, low quality of evidence)*
4. When starting opioid therapy, providers should prescribe short-acting opioids instead of extended-release/long-acting opioids. (*strong recommendation, very low quality of evidence*)

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 avoid increasing dosages to 90 or greater milligrams per day in morphine equivalents. (*strong recommendation, low quality of evidence*)
Opioid selection, dosage, duration, follow-up, and discontinuation (continued)

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. (strong recommendation, very low quality of evidence)

7. Providers should evaluate patients within 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. (strong recommendation, very low quality of evidence)
Assessing risk and addressing harms of opioid use

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. *(strong recommendation, very low quality of evidence)*

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). *(strong recommendation, very low quality of evidence)*
Assessing risk and addressing harms of opioid use (continued)

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. (*weak recommendation, very low quality of evidence*)

11. Providers should avoid prescribing of opioid pain medication and benzodiazepines concurrently whenever possible. (*strong recommendation, low quality of evidence*)

12. Providers should offer or arrange evidence-based treatment (usually opioid agonist treatment in combination with behavioral therapies) for patients with opioid use disorder. (*strong recommendation, low quality of evidence*)

PRE-DECISIONAL; DRAFT; DOES NOT REPRESENT AGENCY DETERMINATION OR POLICY
Instructions For Comment Period

• CDC will present each recommendation one at a time (5 minutes per recommendation).
• To make a comment on a specific recommendation, participants will:
  – Follow phone operator instructions to make a verbal comment; or
  – Type comment into the webinar comment box on the screen; or
  – Submit comment via email by 5:00 EDT September 18th to opioidcomments@cdc.gov.
• All participants should:
  – Keep comment brief to allow time for others to participate.
  – Address the specific recommendation under discussion.
• During the webinar, CDC will provide minor clarifications when requested but will not otherwise respond to comments offered.
• Again, please note that these slides are for purposes of today’s discussion only and will not be available for public viewing upon conclusion of today’s webinar.