Pennsylvania
Department of Health

MODULE 1:

Pain Management Guidelines Overview

Intended Use of CDC's Clinical Practice Guideline for Prescribing Opioids for Pain

CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022

This clinical practice guideline *is*:

- A clinical tool to improve communication between clinicians and patients and empower them to make informed, person-centered decisions related to pain care.
- 12 recommendations intended for clinicians who are prescribing opioids for outpatients aged ≥18 years with:

acute pain	*(duration of <1 month)*
subacute pain	*(duration of 1–3 months)*
chronic pain	*(duration of >3 months)*

This clinical practice guideline is *not*:

- A replacement for clinical judgment or individualized, person-centered care.
- Intended to be applied as inflexible standards of care across patients by clinicians, health systems, pharmacies, payers, or governmental jurisdictions or to lead to the rapid tapering or abrupt discontinuation of opioids for patients.
- A law, regulation, or policy that dictates clinical practice or as a substitute for FDA–approved labeling.
- Applicable to palliative care, end-of-life care, or the management of pain related to sickle cell disease or cancer.
- Focused on opioids prescribed for people with opioid use disorder (OUD).

Guiding Principles for Implementing the Clinical Practice Guidelines

1. Acute, subacute, and chronic pain must be appropriately assessed and treated independent of whether opioids are part of a treatment regimen.
2. Recommendations are voluntary and are intended to support individualized, person-centered care. Flexibility to meet a specific patient's care needs and clinical circumstances is paramount.
3. A multimodal and multidisciplinary approach to pain management that attends to each person's physical health, behavioral health, long-term services, supports, expected health outcomes, and well-being is critical.
4. Avoid misapplying this clinical practice guideline beyond its intended use or implementing policies derived from it that might lead to unintended and potentially harmful consequences for patients.
5. Clinicians, practices, health systems, and payers should vigilantly attend to health inequities; provide culturally and linguistically appropriate communication, including communication accessible to persons with disabilities; and ensure access to an appropriate, affordable, diversified, coordinated, and effective nonpharmacologic and pharmacologic pain management regimen for all persons.

Centers for Disease Control and Prevention (CDC). (2023, March 23). Highlighted Updates: 2022 Clinical Practice Guideline. Accessed October 8, 2024. https://www.cdc.gov/overdose-prevention/hcp/clinical-guidance/whats-different.html

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12 Recommendations for Prescribing Opioids for Outpatients with Pain

Determining Whether or Not to Initiate Opioids for Pain

1. Non-opioid therapies are at least as effective as opioids for many common types of acute pain.
   - Clinicians should maximize nonpharmacologic and nonopioid pharmacologic therapies and only consider opioid therapy for acute pain if benefits are anticipated to outweigh the risks.
2. Non-opioid therapies are preferred for subacute and chronic pain.
   - Before starting opioid therapy, clinicians should discuss with patients the realistic benefits and known risks, work with patients to establish treatment goals for pain and function, and consider how opioid therapy will be discontinued if the benefits do not outweigh the risks.

Selecting Opioids and Determining Opioid Dosages

3. When starting opioid therapy for acute, subacute, or chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release and long-acting opioids.
4. When opioids are initiated for opioid-naïve patients with acute, subacute, or chronic pain, clinicians should prescribe the lowest effective dosage. If opioids are continued, clinicians should:
   - Use caution when prescribing at any dosage.
   - Carefully evaluate individual benefits and risks.
   - Avoid increasing dosage if risks outweigh benefits.
5. For patients already receiving opioid therapy, clinicians should carefully weigh the benefits and risks and exercise care when changing the dosage.
   - If the benefits outweigh the risks of continued therapy, clinicians should work with patients to optimize nonopioid therapies while continuing opioid therapy.
   - Unless there are indications of a life-threatening issue, such as warning signs of impending overdose (e.g., confusion, sedation, or slurred speech), opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages.

Deciding Duration of Initial Opioid Prescription and Conducting Follow-Up

6. When opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.
7. Clinicians should evaluate benefits and risks with patients within 1–4 weeks of starting opioid therapy for subacute or chronic pain or of dosage escalation.

Assessing Risk and Addressing Potential Harms of Opioid Use

8. Before starting and periodically during the continuation of opioid therapy, clinicians should evaluate the risk for opioid-related harms and discuss risks with patients. Clinicians should work with patients to incorporate strategies to mitigate risk, including offering naloxone.
9. When prescribing initial opioid therapy for acute, subacute, or chronic pain, and periodically during opioid therapy for chronic pain, clinicians should review the patient's history of controlled substance prescription dispensations using the Pennsylvania Prescription Drug Monitoring Program (PDMP) to determine if the patient is receiving opioid dosages or combinations that put them at high risk for overdose.
10. When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for other prescribed and nonprescribed substances.
11. Clinicians should use caution when prescribing opioids and benzodiazepines concurrently and consider whether the benefits outweigh the risks of concurrent prescribing of opioids and other central nervous system depressants.
12. For patients with OUD, clinicians should link patients to treatment including medications for OUD. Detoxification without medications for OUD is not recommended because of increased risks of resuming drug use, overdose, and overdose death.

Dowell, D., Ragan, K. R., Jones, C. M., Baldwin, G. T., & Chou, R. (2022). CDC Clinical Practice Guideline for Prescribing Opioids for Pain - United States, 2022. MMWR. Recommendations and reports: Morbidity and mortality weekly report. Recommendations and reports, 71(3), 1–95. Accessed October 8, 2024. https://doi.org/10.15585/mmwr.rr7103a1