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Commentary

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12 Recommendations the CDC Should Have Made

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Opioids as a treatment for chronic pain have exposed the holes in our country's health care system in an unparalleled fashion. Now, a new guideline issued by the Centers for Disease Control and Prevention (CDC) discourages the use of opioids in treating chronic pain, excluding cancer and end-of-life care (*MMWR Recomm Rep* 2016;65:1-49). The CDC touts 12 recommendations targeted to primary care providers, including risk assessment, improved monitoring, avoidance of benzodiazepine–opioid combinations and choice of short- over long-acting formulations for acute pain.

Professional pain organizations have advocated for similar recommendations (*Pain Med* 2013;14:959-961), although it has often been like speaking to the deaf in a dark room. One major party that must open its ears is the payor community, which routinely fails to cover many safer and more effective therapies recommended by the CDC, as detailed in a 2014 position paper published by the American Academy of Pain Medicine (AAPM). Instead, the insurance system has forced a simple solution, reinforcing cookie-cutter, minimally monitored, drug-only therapy for complex medical and psychological problems in a highly diverse population.

Unfortunately, the CDC guidelines fail to challenge payors' interests, choosing instead to push for opioid supply reduction measures that include dosing limits without regard for the necessity of individualized therapy and with very little consideration of the needs of people in pain. These needs have been urgently set forth and thoughtfully analyzed in the National Pain Strategy, which proposes a population-based approach to meeting the comprehensive, complicated care needs of people with chronic pain.


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However, public statements that accompanied the release of the CDC guideline instead embraced reductionist—even superficial—views. In an interview with the *Los Angeles Times*, CDC Director Tom Frieden, MD, MPH, said the current opioid crisis is "doctor driven." This partial truth is dangerous when presented so simplistically and without examination and discussion of true root causes. As far back as 2005, when the *Salt Lake Tribune* published a story with the headline "Fatalities Linked to Pain Pills on the Rise," I knew that if indeed the medical profession unknowingly was contributing to the incidence of opioid overdoses, it was incumbent on the medical profession to take the lead to correct the problem. I feared that if the "epidemic" described by the newspaper was not reversed, the public would demand legal and legislative efforts to correct the problem. That fear has been realized.

Now, the CDC and others are using shortcuts and formulaic approaches that will cause people in pain more suffering. To truly reduce abuse, misuse, addiction and overdose risk from prescription opioids, clinical recommendations should

acknowledge the complex challenges presented by current payor coverage, clinical reality and legislative/regulatory policy. Research into root causes of the opioid crisis indicates change can happen without worsening the lives of people with chronic pain, and payors absolutely must be part of the solution.

The following are 12 additional recommendations with a stronger evidence base than most of the CDC guidelines, and that would be far more likely to reverse the harm from opioids while not creating more suffering for people in pain. In Utah, a multipronged, state-funded program that included provider education (*Pain Med* 2011;12:S73-S76) with elements from the eight principles mentioned below was followed by a 28% reduction in the number of unintentional, opioid-related drug overdose deaths from 2007 to 2010, as reported by the Utah Department of Health:

1. Apply the “Eight Principles for Safer Opioid Prescribing” endorsed by the AAPM (Pain Med 2013;14:959-961).
2. Use abuse-deterrent formulations when an extended-release opioid is indicated.
3. Remove the cap on the number of opioid-addicted people who can be treated for addiction with medications such as buprenorphine.
4. Allow nurse practitioners to prescribe medication agonist therapy for opioid addiction.
5. Recommend affordable, perhaps free, access to buprenorphine and methadone therapy in line with public policy that recognizes addiction as a disease.
6. Push U.S. and state legislatures to issue mandates to payors demanding a minimum level of benefits for patients in pain to increase coverage for evidence-based alternatives to opioids.
7. Remove methadone as a preferred opioid for pain from state formularies.
8. Ask that payors require prescribers to demonstrate methadone-specific knowledge before being allowed to prescribe methadone for chronic pain.
9. Encourage the U.S. Congress to increase funding to find safer and more-effective alternatives to opioids for the treatment of acute and chronic pain.
10. Recommend legislation for partial prescription filling for Schedule II controlled substances to reduce the quantity of unused prescription drugs.
11. Implement the National Pain Strategy as a top priority.
12. Consider prescribing naloxone with all extended-release opioid prescriptions.

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