INTRODUCTION TO PRESCRIBING GUIDELINES COMPARISON

Attached is a comparison between the Centers for Disease Control and Prevention's *Guidelines for Prescribing Opioids for Chronic Pain* and the Medical Board of California's *Guidelines for Prescribing Controlled Substances for Pain*. While there are a few differences between these two prescriber guidelines, overall there are many more similarities demonstrating how each complements the other and together can be effective educational tools for prescribers. Differences between the two Guidelines are not due to contradicting opinions/recommendations, but rather to the intended use and audience for each.

BACKGROUND

The Medical Board of California (MBC) is a state regulatory agency whose mission is to protect health care consumers through the proper licensing and regulation of physicians and surgeons and certain allied health care professions and through the vigorous, objective enforcement of the Medical Practice Act, and to promote access to quality medical care through the Board's licensing and regulatory functions. The MBC is the only entity who can take disciplinary action against a California physician's license. In prescribing cases, the MBC takes action based upon the standard of care that a physician provides to a specific patient.

The Centers for Disease Control and Prevention (CDC) is a federal agency that conducts and supports health promotion, prevention and preparedness activities in the United States with the goal of improving overall public health. As the nation's health protection agency, CDC's mission is to save lives and protect people from health threats. CDC's primary role is tackling the biggest health problems causing death and disability for Americans, including reducing deaths due to prescription painkiller abuse and overdose.

INTENDED USE

The MBC Guidelines are **intended for all physicians practicing in California**. They provide a broader range of recommendations for explicit patient populations in specific settings. The MBC Guidelines were designed to educate physicians for improved outcomes of patient care and to prevent overdose deaths due to opioid use. Since the MBC Guidelines' primary goal was to educate physicians, and are based upon the enforcement role of the MBC, the MBC Guidelines do not have the specificity that the CDC Guidelines contain.

The CDC Prescribing Guidelines were developed to address the opioid epidemic currently sweeping across the United States. The CDC Guidelines are **intended for primary care physicians** to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than 3 months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care.

PRIMARY DIFFERENCES

1. The MBC Guidelines recommend referral to pain specialists while the CDC Guidelines encourage Primary Care Physicians (PCP) to work with their patients to manage pain.
2. The MBC endorses up to 45 days for initiating opioid trial, with the explanation that after 90 days there is risk. The CDC notes after seven (7) days there is risk with prescribing opioids.
3. The CDC recommends taking precaution when increasing from 50 morphine milligram equivalents (MMEs) per day and to avoid increasing past 90 MMEs per day. The MBC recommends a physician proceed cautiously once 80 MMEs per day is reached.

CDC and MBC PRESCRIBER GUIDELINES OVERALL OBJECTIVES

Improving the way opioids are prescribed through clinical practice guidelines can ensure patients have access to safer, more effective chronic pain treatment while reducing the number of people who misuse, abuse, or overdose from these drugs. Prescribers should be encouraged to use both Guidelines to educate themselves on appropriate prescribing practices.

CDPH
California Department Of PublicHealth

Safe and Active communities

COMPARISON OF PRESCRIBING GUIDELINES FOR CONTROLLED SUBSTANCES (OPIOIDS) FOR CHRONIC PAIN

Centers for Disease Control and Prevention (CDC) Prescriber Guidelines for Chronic Pain	Medical Board of California (MBC) Prescriber Guidelines for Substances for Pain
CDC recommendations are based upon the following assessment: • No evidence of long-term benefit from opioids in pain and function for chronic pain with outcomes examined at least 1 year later; • Extensive evidence shows the possible harms of opioids (including abuse and dependence, overdose, myocardial infarction, motor vehicle crashes); and • Extensive evidence suggests benefits of alternative treatments compared with long-term opioid therapy, including non-pharmacologic therapy and non-opioid pharmacologic therapy, with less harm.	MBC's guidelines are intended to improve outcomes of patient care and to prevent overdose deaths due to opioid use. They particularly address the use of opioids in the long-term treatment of chronic pain. MBC recommendations are based upon: **Special patient populations** including: Emergency Departments, Urgent Care Clinics, Acute Pain, End-of-Life Pain, Cancer Pain, Older Adults, Pediatric Patients, Pregnant Women, Patients Covered by Workers' Compensation, Patients with History of Use Disorder, Psychiatric Patients, Patients Prescribed Benzodiazepines and Patients Prescribed Methadone or Buprenorphine for Treatment of a Substance Use Disorder.
These guidelines are intended for primary care physicians who are treating patients with chronic pain (i.e., pain lasting longer than three months or past the time of normal tissue healing) in outpatient settings. The recommendations are not intended: a) for guidance on use of opioids as part of medication-assisted treatment for opioid use disorder; b) for patients who are in active cancer treatment, palliative care, or end-of-life care.	These guidelines are intended for all physicians practicing in California. These guidelines are not meant for the treatment of patients in hospice or palliative care settings or to limit treatment where improved function is not anticipated and pain relief is the primary goal.

The three sections/categories below are based upon CDC recommendations.

• Non-pharmacologic therapy and non-opioid pharmacologic therapy preferred for chronic pain • Before starting opioid therapy for pain, providers should establish treatment goals with all patients, including realistic goals for pain and function • Providers should not initiate opioid therapy without consideration of how therapy will be discontinued if unsuccessful • Providers should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety	Emergency Departments (ED) or Urgent Care Clinics • Physicians should avoid the routine prescribing of outpatient opioids for a patient with an acute exacerbation of chronic non-cancer pain seen in the ED • If opioids are prescribed on discharge, the prescription should be for the lowest practical dose for a limited duration (e.g., < 1 week). • The prescriber should consider the patient's risk for opioid misuse, abuse, or diversion • The physician should, if practicable, honor existing patient-physician pain contracts/treatment agreements and consider past prescription patterns from information sources such as prescription drug monitoring programs

COMPARISON OF PRESCRIBING GUIDELINES FOR CONTROLLED SUBSTANCES (OPIOIDS) FOR CHRONIC PAIN

Centers for Disease Control and Prevention (CDC) Prescriber Guidelines for Chronic Pain	Medical Board of California (MBC) Prescriber Guidelines for Substances for Pain

DETERMINING WHEN TO INITIATE or CONTINUE OPIOIDS for CHRONIC PAIN Continued…

CDC:

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

MBC:

Acute Pain

- Opioid medications should only be used for treatment of acute pain when the severity of the pain warrants it
- Opioid medications should only be used after determining that other non-opioid pain medications or therapies likely will not prove adequate pain relief

Long Term

- When considering long-term use of opioids for chronic, non-cancer pain, the physician and the patient should develop treatment goals together

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, and DISCONTINUATION

CDC:

- When starting opioid therapy for chronic pain, providers should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids
- When opioids are started, providers should prescribe the lowest effective dosage
- Providers should use caution when prescribing opioids at any dosage, should implement additional precautions when increasing dosage to ≥50 morphine milligram equivalents (MMEs)/day, and should generally avoid increasing dosage to ≥90 MME/day
- When opioids are used for acute pain, providers should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids
- Three of fewer days usually will be sufficient for most non-traumatic pain not related to major surgery
- Providers should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation
- Providers should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently

MBC:

- When prescribed, the number dispensed should be for a short duration and no more than the number of doses needed based on the usual duration of pain
- Long (and intermediate) duration-of-action opioids or extended-release/long acting opioids should not be used for treatment of acute pain, including post-operative pain, except in situations where monitoring and assessment for adverse effects can be conducted
- Methadone is rarely, if ever, indicated for treatment of acute pain
- The use of opioids should be re-evaluated carefully if persistence of pain suggests the need to continue opioids beyond the anticipated time period of acute pain treatment for that condition
- The American College of Emergency Physicians (ACEP) recommends that the use of a state prescription monitoring program may help identify patients who are at high risk for prescription opioid diversion or doctor shopping
- Treatment plan and goals should be established as early as possible in the process and revisited regularly

Comparison of Prescribing Guidelines for Controlled Substances (Opioids) for Chronic Pain

Centers for Disease Control and Prevention (CDC) Prescriber Guidelines for Chronic Pain	Medical Board of California (MBC) Prescriber Guidelines for Substances for Pain
• 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 overdose, such as history of overdose, history of substance use disorder, or higher opioid dosages (≥50 MME) are present • Providers should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving high opioid dosages or dangerous combinations that put him or her at high risk for overdose • Providers should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months • When prescribing opioids for chronic pain, providers should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs • Providers should avoid prescribing opioid pain medication for patients receiving benzodiazepines whenever possible • Providers should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder	• When considering long-term use of opioids for chronic, non-cancer pain, given the potential risks of opioids, careful and thorough patient assessment is critical • The nature and extent of the clinical assessment depends on pain and the context in which it occurs – this includes: o Completing a medical history & physical exam o Performing a psychological evaluation o Establishing a diagnosis and medical necessity including Pain Intensity and Interference (pain scale) and Sheehan Disability Scale o Exploring non-opioid therapeutic options o Evaluating both potential benefits and potential risks of opioid therapy o Being aware of aberrant or drug seeking behaviors o Undertaking urine drug testing (as a precaution) o Reviewing the CURES/PDMP report to see if patient is receiving controlled substances from other prescribers in California • The treating physician should seek a consultation, or refer patient to, a pain, psychiatry, or addiction or mental health specialist as needed • Physicians who prescribe long-term opioid therapy should be familiar with treatment options for opioid addition to be make appropriate referrals as needed • When considering use of opioids, physicians should discuss risks/benefits of treatment plan with the patient • If prescribed, the patient and family should be counseled on safe ways to store and dispose of medications • MBC recommends that a patient consent form and pain management agreement be signed • It is important to educate patients and family/caregivers of the danger signs of respiratory depression • Compliance monitoring through CURES/PDMP and drug testing and periodic pill counting is recommended