

No Shortcuts to Safer Opioid Prescribing

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Since the Centers for Disease Control and Prevention (CDC) released its Guideline for Prescribing Opioids for Chronic Pain in 2016,¹ the medical and health policy communities have largely embraced

its recommendations. A majority of state Medicaid agencies reported having implemented the guideline in fee-for-service programs by 2018, and several states passed legislation to increase access to nonopioid pain treatments.² Although outpatient opioid prescribing had been declining since 2012, accelerated decreases — including in high-risk prescribing — followed the guideline's release.^{2,3} Indeed, guideline uptake has been rapid. Difficulties faced by clinicians in prescribing opioids safely and effectively, growing awareness of opioid-associated risks, and a public health imperative to address opioid overdose underscored the need for guidance and probably facilitated uptake. Furthermore, the guideline was rated as high quality by the ECRI

Guidelines Trust Scorecard. In addition, the CDC (including the authors of this Perspective, who were also authors of the Guideline) engaged clinicians, health systems leaders, payers, and other decision makers in discussions of the guideline's intent and provided clinical tools, including a mobile application and training, to facilitate appropriate implementation.⁴

Efforts to implement prescribing recommendations to reduce opioid-related harms are laudable. Unfortunately, some policies and practices purportedly derived from the guideline have in fact been inconsistent with, and often go beyond, its recommendations. A consensus panel has highlighted these inconsistencies,⁵ which include inflexible application of rec-

ommended dosage and duration thresholds and policies that encourage hard limits and abrupt tapering of drug dosages, resulting in sudden opioid discontinuation or dismissal of patients from a physician's practice. The panel also noted the potential for misapplication of the recommendations to populations outside the scope of the guideline. Such misapplication has been reported for patients with pain associated with cancer,⁵ surgical procedures,⁵ or acute sickle cell crises. There have also been reports of misapplication of the guideline's dosage thresholds to opioid agonists for treatment of opioid use disorder. Such actions are likely to result in harm to patients.

We need better evidence in order to evaluate the benefits and harms of clinical decisions regarding opioid prescribing, including when and how to reduce high-dose opioids in patients receiving them long term. The CDC developed the guideline on the basis

of the best available evidence, with input from a multidisciplinary group that included experts in pain management as well as representatives of patients and the public. In situations for which the evidence is limited, it is particularly important not to extend implementation beyond the guideline's statements and intent. And yet in some cases, the guideline has been misimplemented in this way.

For example, the guideline states that "Clinicians should . . . avoid increasing dosage to ≥ 90 MME [morphine milligram equivalents]/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day."¹ This statement does not address or suggest discontinuation of opioids already prescribed at higher dosages, yet it has been used to justify abruptly stopping opioid prescriptions or coverage.⁵ This recommendation also does not apply to dosing for medication-assisted treatment for opioid use disorder. The CDC based the recommendation on evidence of dose-dependent harms of opioids and the lack of evidence that higher dosages confer long-term benefits for pain relief. However, we know little about the benefits and harms of reducing high dosages of opioids in patients who are physically dependent on them.

Patients who are able to successfully taper their opioid use are likely to have a lower risk of overdose, and evidence is accumulating that they might experience reduced pain.⁴ Other patients may find tapering challenging; could face risks related to withdrawal symptoms, increased pain, or unrecognized opioid use disorder; and if their dosages are abruptly tapered may seek other sources of opioids or have adverse psychological and physical outcomes. Policies should allow clinicians

to account for each patient's unique circumstances in making clinical decisions.

The guideline offers guidance for caring for patients who are already taking opioid dosages of 90 MME or more per day long term, including guidance on when tapering the dose might be appropriate, the importance of empathetically reviewing risks associated with continuing high-dose opioids, collaborating with patients who agree to taper their dose, maximizing nonopioid treatment, and tapering slowly enough to minimize withdrawal symptoms. Patients exposed to high dosages for years may need slower tapers (e.g., 10% per month, though the pace of tapering may be individualized).¹ Success might require months to years. Though some situations, such as the aftermath of an overdose, may necessitate rapid tapers, the guideline does not support stopping opioid use abruptly.¹

Guidelines can improve patient outcomes when they lead to policies that reduce harm, while offering support and coverage for underused services (e.g., nonpharmacologic strategies, naloxone co-prescribing, and treatment for opioid use disorder). However, policies invoking the opioid-prescribing guideline that do not actually reflect its content and nuances can be used to justify actions contrary to the guideline's intent. The CDC has engaged quality-improvement organizations, payers, federal partners, state health departments, and others in discussions to encourage adherence to recommendations while avoiding actions that might cause harm. For example, the CDC worked with the American Society of Addiction Medicine to clarify that dosage thresholds in


the guideline should not direct dosing of medication-assisted treatment for opioid use disorder.

Even guideline-concordant care can be challenging. Implementing recommendations with individual patients takes time and effort. An unintended consequence of expecting clinicians to mitigate risks of high-dose opioids is that rather than caring for patients receiving high dosages or engaging and supporting patients in efforts to taper their dosage, some clinicians may find it easier to refer or dismiss patients from care. Clinicians might universally stop prescribing opioids, even in situations in which the benefits might outweigh their risks. Such actions disregard messages emphasized in the guideline that clinicians should not dismiss patients from care, which can adversely affect patient safety, could represent patient abandonment, and can result in missed opportunities to provide potentially lifesaving information and treatment.¹

Effective implementation of the guideline requires recognition that there are no shortcuts to safer opioid prescribing (which includes assessment of benefits and risks, patient education, and risk mitigation) or to appropriate and safe reduction or discontinuation of opioid use. Starting fewer patients on opioid treatment and not escalating to high dosages in the first place will reduce the numbers of patients prescribed high dosages in the long term. In the meantime, clinicians can maximize use of nonopioid treatments, review with patients the benefits and risks of continuing opioid treatment, provide interested and motivated patients with support to slowly taper opioid dosages, closely monitor and mit-

igate overdose risk for patients who continue to take high-dose opioids, and offer or arrange medication-assisted treatment when opioid use disorder is identified. The CDC offers several tools to assist, including a pocket guide on tapering, a mobile app and online training with motivational interviewing components, and information about nonopioid treatments for pain.⁴ We are also working to identify ways to integrate recommendations into medical education and to support best practices among the next generation of medical professionals.

Appropriate implementation of the guideline includes maximizing use of physical, psychological, and multimodal pain treatments. However, these therapies have not been used, available, or reimbursed sufficiently. The CDC has supported research to better define the evidence and coverage gaps for nonopioid pain treatments and has articulated the need to improve insurance cover-

 An audio interview with Dr. Dowell is available at NEJM.org

define the evidence and coverage gaps for nonopioid pain

age.^{2,4} Efforts to support more judicious opioid use will become more successful as effective nonopioid treatments are increasingly available and used.

The CDC is evaluating the (intended and unintended) impact of the guideline and other health system strategies on clinician and patient outcomes and is committed to updating recommendations when new evidence is available. The CDC is funding the Agency for Healthcare Research and Quality to conduct systematic reviews on the effectiveness of opioid, nonopioid pharmacologic, and nonpharmacologic treatments for acute and chronic pain. Results of these reviews will assist in identifying research priorities and determining when evidence gaps are sufficiently addressed to warrant a guideline update or expansion. Until then, we encourage implementation of recommendations consistent with the guideline's intent.

The views expressed in this article are those of the authors and do not necessarily

represent the official position of the Centers for Disease Control and Prevention.

Disclosure forms provided by the authors are available at NEJM.org.

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This article was published on April 24, 2019, at NEJM.org.

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DOI: 10.1056/NEJMp1904190

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Getting Coverage Right for 500 Million Indians

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India is in the midst of a remarkably ambitious health insurance expansion. In September 2018, Prime Minister Narendra Modi announced a plan that will cover an additional 500 million Indians.¹ The motivation? India grossly underspends on health care, and health outcomes in some regions are among the worst in the world.² For an emerging economic superpower, India's health care spending, accounting for less than 4% of its gross domestic product, is woefully low,

and it has fallen since 2000. The majority of spending is out of pocket, burdening the middle class and the poor. Given the country's epidemiologic profile — India sees nearly a third of the world's tuberculosis cases and faces a growing burden of chronic disease — failures to invest in health have shackled the Indian economy. Government leaders, irrespective of party, now recognize that India's economic progress depends on the health of its people.

India's health reform, *Ayushman Bharat* ("long life for India"), has two pillars: health insurance covering up to \$7,000 (500,000 Indian rupees) of care per family per year for the poorest 500 million people (regardless of preexisting conditions) and reinvestment in primary care by transforming existing facilities into 150,000 new "Health and Wellness Centers" that provide comprehensive primary care. Historically, primary care has been underfunded and disconnected from secondary