NPAC
NATIONAL PAIN ADVOCACY CENTER

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July 31, 2023

Re: Updating Colorado's Prescribing Guidelines

Dear Ms. Werner:

On behalf of the National Pain Advocacy Center (NPAC), I am writing to recommend (1) that Colorado issue its own prescribing guidance in concordance with the updated CDC Guideline and Colorado S.B.144 and (2) that it do so by means of a robust expert and stakeholder-engaged process.

NPAC is a 501(c)(3) national nonprofit of clinicians, scientists, public health experts, and people with lived experience working to advance the health and human rights of people with pain. We envision a world in which pain is treated equitably and effectively so that all people living with pain can lead full and productive lives.

In disclosure, I was also an appointed member of the CDC's Opioid Workgroup, and NPAC was involved in securing the passage of S.B. 144 in Colorado.

The negative impact on people with pain of the 2016 CDC Guideline was, as the agency has acknowledged, primarily a problem of implementation; specifically, one of misapplication by later policy actors and providers.[1]

The CDC's 2022 update has much better framing. It favors individualized care and provider discretion over simplistic, one-size-fits-all thresholds that have, as the agency plainly acknowledges, resulted in patient harm. Moreover, its topline recommendations do not contain concrete thresholds. But the document overall is voluminous and has already been interpreted like a Rorschach test with different actors highlighting different aspects to suit agendas. A top expert witness in the opioid litigation has, for example, argued on Twitter that the new Guideline is stricter than the 2016 Guideline and mandates a 50 MME dose threshold.

Because of past and ongoing implementation issues, more directed guidance to support clinicians in appropriate prescribing practices is needed.

In 2019, when we urged the CDC to come out with a public-facing corrective of how its 2016 Guideline had been misapplied, the agency responded with a press release and an article in the New England Journal of Medicine reminding providers that there are no shortcuts to safer prescribing.[2] But unfortunately,

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[1] *See* Beletsky, Leo and Nicholson, Kate, *CDC's Updated Opioid Guidelines are Necessary but not Sufficient: additional steps are needed to calibrate opioid access and undo harm*, MedPage Today, Second Opinion, November 18, 2022, https://www.medpagetoday.com/opinion/second-opinions/101825.

[2] Dowell, Deborah, Haegerich, Tamara, and Chou, Roger, Perspective: No Shortcuts to Safer Opioid Prescribing, N Engl J Med 2019, https://www.nejm.org/doi/full/10.1056/NEJMp1904190

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that effort did not translate to an improvement in patient experiences. NPAC saw no slowing in the number of unsolicited reports of abandonment and forced tapering. Nor has the pace of such complaints slowed since the CDC's issuance of its 2022. Indeed, the persistence of the problem of patients losing access to medication and care is what motivated NPAC to work alongside like-minded organizations such as the Colorado Cross Disability Coalition in securing the passage of S.B. 144.

During DORA's recent meeting as part of oral testimony, some testifiers suggested that patient stories, while compelling, should not be taken too greatly to heart and that we should instead consider those who couldn't be present to speak for themselves (presumably those who have died from a drug overdose). But framing the issue as a zero-sum game and pitting the needs of patients with pain and patients with addiction against one another is shortsighted. One need not be sacrificed to protect the other: it's possible to develop nuanced and directed guidance that protects both.

Nearly a dozen studies now show that forced and abrupt tapering is on the rise and that it actually increases risks of overdose and suicide, leads to the need for emergency medical care and hospitalization, breaks down healthcare relationships, and destabilizes people's health, mental health, and lives.[3] This evidence suggests that people with pain are likely among those who have lost their lives. Indeed, legal actions[4] and media stories suggest as much.[5]

Studies also show that people who have been placed on opioids experience discrimination in primary care: and that many primary care clinics in America will refuse to care for a new patient who has been prescribed opioids to manage pain.[6]

Colorado should follow the path of California, which recently engaged in a rigorous stakeholder process to update and issue new prescribing guidelines that provide direction to clinicians in implementing both the CDC's recommendations and California law (including a law that requires providers to offer naloxone to patients receiving higher doses).[7] Colorado should similarly engage experts and stakeholders and issue guidance that provides clinicians direction in navigating both federal guidelines and Colorado law.

Thank you for your consideration.

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[3] *See* Appendix A (attached).
[4] Joseph, Andrew, Her Husband Died by Suicide: she sued his pain doctors—a rare challenge over an opioid reduction, STAT, November 22, 2021 https://www.statnews.com/2021/11/22/her-husband-died-by-suicide-she-sued-his-pain-doctors-a-rare-challenge-over-an-opioid-dose-reduction/
[5] Szalavitz, Maia, My Entire Body is Shaking: Why Americans with Chronic Pain are Dying, New York Times, Jan 3, 2023, https://www.nytimes.com/2023/01/03/opinion/chronic-pain-suicides.html.
[6] *See* Appendix A *supra n. 2.*
[7] The updated 2023 California prescribing guideline can be found here, https://www.mbc.ca.gov/Download/Publications/pain-guidelines.pdf.

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Warm regards,

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Appendix A: Studies on barriers to care and opioid disruption

On Barriers to care:

- Two surveys found that half of primary care clinics are unwilling to take on a new patient who uses opioids to manage pain.
- The original study is of clinics in Michigan (Lagisetty, JAMA Netw Open 2019).
- A follow-up study looked at primary care clinics in 9 states (Lagisetty, PAIN 2021).

Tapering poses risks:

- One study found just changing a patient's dose resulted in a three-fold increased risk of overdose death. (Glanz, JAMA Netw. Open 2019).
- One study of Medicaid patients on opioids for more than 90 days found discontinuation often happened abruptly, in 24 hours, with almost half of such cases resulting in hospitalization or an ER visit (Mark, J Subs.t Abuse Treat. 2019).
- Tapering resulted in an increased risk of death in primary care settings (James, J Gen Intern Med 2019).
- Veterans who were tapered experienced a higher risk of death from overdose or suicide (Oliva, BMJ 2020).
- Opioid tapering is associated with later termination of care relationships (Perez, J Gen Intern Med 2020).
- Discontinuation of opioids in patients stable on opioids is on the rise and happens too abruptly (Neprash, J Gen Intern Med 2021).
- Dose tapering is associated with mental health crises and overdose events. (Agnoli, JAMA 2021).
- Higher incidence of overdose and mental health crisis continued two years post-taper. (Fenton, JAMA Open Netw. 2022).
- Heightened risk of overdose and suicide in patients without OUD/misuse risk w/ no difference in outcome btw. abrupt or slow taper. (Larochelle, JAMA Netw. Open 2022).
- Increase in emergency department visits and hospitalizations, fewer primary care visits, and lower medication adherence (diabetes, hypertension). (Magnan, JAMA Netw. Open 2023).

Voluntary tapering poses fewer risks:

- The largest study of voluntary tapering shows that where there is patient buy-in, education, and readiness to taper, and when the taper is not unidirectional, most patients reduced their dose (although not everyone, so individualization continues to matter). (Darnall, JAMA Intern Med. May 2018).

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