April 11, 2022

Rochelle P. Walensky, MD, MPH
Director
Centers for Disease Control and Prevention (CDC)
4770 Buford Highway NE, MS 106-9
Atlanta, GA 30341

Re: CDC-2022-0024

Re: Proposed 2022 CDC Clinical Practice Guideline for Prescribing Opioids

Dear Dr. Walensky:

On behalf of the American College of Emergency Physicians (ACEP) and the Society for Academic Emergency Medicine (SAEM), we appreciate the opportunity to provide comments on the "Proposed 2022 CDC Clinical Practice Guideline for Prescribing Opioids."

ACEP is the national medical society representing emergency medicine. Through continuing education, research, public education, and advocacy, ACEP advances emergency care on behalf of its 40,000 emergency physician members and the more than 150 million Americans they treat on an annual basis. With over 8,200 members, SAEM is dedicated to the improvement of care of the acutely ill and injured patient by improving research and education. To achieve this mission, SAEM influences health policy through forums, publications, interorganizational collaboration, policy development, and consultation services for physicians, teachers, researchers, and students.

Many patients seeking care in the emergency department (ED) present with severe pain, which may be due to an acute illness or an exacerbation of a chronic condition. A primary goal of emergency care is to alleviate pain quickly, safely, effectively, and compassionately. Opioid medications remain the mainstay for treatment of severe pain. However, the tragic results of misuse and abuse of opioids are seen all too frequently in the ED. Emergency physicians see the devastating consequences of the opioid epidemic every day, and ACEP and SAEM are proud leaders in the battle against this epidemic by supporting emergency physicians as active participants in the quest for solutions, strong advocates for their patients, and adapters of their practices to this new societal reality.

In addition, as safety-net physicians, we believe that it is critically important to address health care disparities in pain management, especially with respect to access to follow-up care for low-income people who are suffering from acute pain. The Centers for Disease Control and Prevention (CDC) recommendations therefore should not simply focus on limiting opioid prescribing but should also have an equal emphasis on the follow-up that patients receive after the ED visit. Further, we believe

that the recommendations should acknowledge the unique nature of ED care, including acknowledging that existing Opioid Use Disorder (OUD) risk assessments lack validation in ED settings.

With that context in mind, ACEP and SAEM provide the following responses to the specific recommendations included in the draft guideline.

Determining whether or not to initiate opioids for pain

Recommendation 1: Nonopioid therapies are effective for many common types of acute pain. Clinicians should only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient (recommendation category: B, evidence type: 3).

Comments on Recommendation 1: ACEP and SAEM support the recommendation overall but request that CDC add some additional guidance and specificity—particularly regarding the importance of utilizing multimodal therapy/analgesia and emphasizing opioid use in combination with other therapies. Given the known harm potential of opioid therapy and the existence of effective, evidence-based nonopioid approaches to pain management, ACEP and SAEM believe that it is critical to evaluate benefits and harms of the opioids in consideration, and clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient.

This feedback is further reinforced in the 2020 ACEP Clinical Policy: Critical Issues Related to Opioids in Adult Patients Presenting to the Emergency Department. Opioid prescribing in the ED, even when limited to short-acting, low-potency medications for a few days of therapy, exposes patients to potential risks. Patients may experience immediate adverse effects and are at risk of developing an OUD, complications from chronic opioid use, and death from overdose. Therefore, the clinical policy recommends that clinicians should preferentially prescribe nonopioid analgesic therapies (nonpharmacologic and pharmacologic) rather than opioids as the initial treatment of acute pain in patients discharged from the ED.

Recommendation 2: Nonopioid therapies are preferred for subacute and chronic pain. Clinicians should only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient. Before starting opioid therapy for subacute or chronic pain, clinicians should discuss with patients the known risks and realistic benefits of opioid therapy, should work with patients to establish treatment goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks (recommendation category: A, evidence type: 2).

Comments on Recommendation 2: ACEP and SAEM support the recommendation but believe that the CDC should possibly consider an addition here that would support the utilization of

multidisciplinary pain management specialists or teams. Doing so would maximize the efficacy and utilization of nonopioid therapies resulting in reduced exposure, dependance, and misuse of opioids.

Opioid selection and dosage

Recommendation 3: When starting opioid therapy for acute, subacute, or chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids (recommendation category: A, evidence type: 4).

Comments on Recommendation 3: ACEP and SAEM suggest that clinicians should consider the addiction potential of commonly prescribed opioids and choose those with less risk for abuse. An additional concern with the recommendation is that "long-acting" would include buprenorphine and buprenorphine products, and therefore the recommendation text should include in the main body "with exception of buprenorphine/buprenorphine products" for pain**.** The recommendation would be further strengthened by the inclusion of language clarifying the role of buprenorphine. Grouping acute, subacute, or chronic pain all together into one recommendation on the issue of immediate- vs. extended-release opioids can potentially be problematic as pain management strategies would be different. Further, we believe there are a variety of opioid choice recommendations that should be considered for inclusion that are less strongly evidenced-based, but widely agreed to be best practice:

- Avoidance of codeine and tramadol
- Avoidance of combination opioids (APAP/codone)
- Avoidance of more abuse-prone opioids (hydromorphone, oxycodone, hydrocodone)

Recommendation 4: When opioids are initiated for opioid-naïve patients with acute, subacute, or chronic pain, clinicians should prescribe the lowest dosage to achieve expected effects. If opioids are continued for subacute or chronic pain, clinicians should use caution when prescribing opioids at any dosage, should carefully evaluate individual benefits and risks when considering increasing dosage, and should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients (recommendation category: A, evidence type: 3).

Comments on Recommendation 4: ACEP and SAEM support the recommendation, as we believe that clinicians should initiate the lowest dose, concentration, and duration possible to meet the indication. It is also critical that patients also receive additional medication if needed. There may be variability in the dose, concentration, and duration that should be used to manage pain, and the goal of the recommendation should be to ensure access to appropriate pain management needed for the individual patient.

Recommendation 5: For patients already receiving higher opioid dosages, clinicians should carefully weigh benefits and risks and exercise care when reducing or continuing opioid dosage. If risks

outweigh benefits of continued opioid therapy, clinicians should optimize other therapies and work closely with patients (suggest adding "and experts") to gradually taper to lower dosages or, if warranted based on the individual clinical circumstances of the patient, to appropriately taper and discontinue opioids. 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 abruptly or rapidly reduce opioid dosages from higher dosages (recommendation category: B, evidence type: 4).

Comments on Recommendation 5: While ACEP and SAEM recognize that this recommendation is not directly applicable to emergency medicine, it does address the implications of inappropriate tapering. Inappropriate tapering can be dangerous and significantly detrimental to the patient, and we strongly advocate for tapering being performed under the guidance/coordination and consultation of specialists/experts. Additionally, there is ambiguity regarding a qualifier for "higher opioid dosages." We also suggest potentially adding language around cross-titration/tapering to buprenorphine as an option. Finally, as shown in blue above, we believe that physicians should consult with experts in addition to patients about appropriately tapering opioids.

Opioid duration and follow-up

Recommendation 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 (recommendation category: A, evidence type: 4).

Comments on Recommendation 6: ACEP and SAEM support this recommendation. We acknowledge and appreciate that the CDC has removed language from the recommendation related to day limits as suggested by the Opioid Workgroup. However, ACEP and SAEM do recommend adding language that addresses disparities in access to follow-up care. We believe that the recommendation should do more than just focus on reducing the frequency and quantity of narcotics prescribed. Such a recommendation in isolation erroneously assumes that everyone, especially the uninsured and under-insured, has access to appropriate follow-up care. Limiting opioid prescribing without also focusing on the next step of who will follow up with the patient after the ED visit within a reasonable amount of time (before the limited number of opioids are used up) will lead to a "bridge to nowhere" that fuels preventable ED return visits and clinician and patient frustrations.[1]

Recommendation 7: Clinicians should evaluate benefits and risks with patients within 1 to 4 weeks of starting opioid therapy for subacute or chronic pain or of dose escalation. Clinicians should evaluate benefits and risks of continued therapy with patients every 3 months or more frequently (recommendation category: A, evidence type: 4).

[1] Carpenter, et al. "A Bridge to Nowhere? Challenging Outpatient Transitions of Care for Acute Pain Patients in the Opioid Epidemic Era." 115:3 | May/June 2018 | Missouri Medicine.

Comments on Recommendation 7: ACEP and SAEM support the recommendation. However, with respect to evaluating the benefits and risks of opioid therapy, we believe that if the benefits do not outweigh the harms of continued opioid therapy, clinicians should optimize other therapies and work with patients and specialists/experts to safely taper opioids to lower dosages or to taper and discontinue opioids.

Assessing risk and addressing harms of opioid use

Recommendation 8: Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss with patients. Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering (recommending changing the word "offering" to "prescribing") naloxone when factors that increase risk for opioid overdose are present (recommendation category: A, evidence type: 4).

Comments on Recommendation 8: ACEP and SAEM suggest potential re-wording, as shown in blue above. This change would strengthen this recommendation to *prescribe* naloxone (rather than only offering) and list some specific examples of factors that would increase risk (such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use). Additionally, we would also suggest the addition of summarized supplemental information around what qualifies patients for/at increased risk and opioid and consider highlighting most frequent/important harms within the text of the recommendation.

Recommendation 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 prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or combinations that put the patient at high risk for overdose (recommendation category: B, evidence type: 4).

Comments on Recommendation 9: ACEP and SAEM support the use of PDMPs but believe that it is important to recognize that PDMPs do not report all opioid use. Further, patients for whom PDMP queries do show history of opioid prescriptions should not be excluded from ongoing opioid therapy (and in fact these patients may be at higher risk to be harmed from opioid discontinuation vs. opioid naïve patients). The CDC should consider including language within the recommendation that addresses the implications and shortcomings, gaps, and pitfalls of using PDMPs, especially highlighting what is and is not captured within the PDMP. We also recommend including in the recommendation support for the integration of PDMPs into electronic health records (EHRs) to reduce physician burden. Finally, the CDC should also potentially consider adding or highlighting specific combinations that would put the patient at high risk for overdose (e.g., sedatives).

Recommendation 10: When prescribing opioids for subacute or chronic pain, clinicians should consider toxicology testing where available to assess for prescribed medications as well as other prescribed and non-prescribed controlled substances (recommendation category: B, evidence type: 4).

Comments on Recommendation 10: ACEP and SAEM support testing and recommending testing as a best practice while acknowledging access and equity realities. We recommend adding the following language: "Testing is not intended to be punitive but to advise appropriate patient management and care." Additionally, we also recommend including guidance on how best to utilize and integrate testing into clinical practice and potentially curating guidance/education to address a variation of clinical practice settings, such as EDs. Lastly, ACEP and SAEM also recommend modifying the recommendation by adding in the phrase "where available" after "toxicology testing," since toxicology testing may not always be available.

Recommendation 11: Clinicians should use extreme caution when concurrently prescribing opioid pain medication and benzodiazepines ~~concurrently and consider whether benefits of concurrent prescribing of opioids outweigh risks of concurrent prescribing of opioids~~ and other central nervous system depressants, and consider whether the benefits of such prescribing outweigh the risks. (recommendation category: B, evidence type: 3).

Comments on Recommendation 11: ACEP and SAEM strongly recommend excluding the clause "concurrently and consider whether benefits of concurrent prescribing of opioids outweigh risks of concurrent prescribing of opioids" from the recommendation. We believe that extreme caution should be exercised when co-prescribing opioid pain medications with either benzodiazepines or other CNS depressants. Separating these out in the recommendation seems to indicate that one co-prescribing carries higher risk than the other. Therefore, we would prefer if the CDC would more generally recommend that clinicians consider whether the benefits of prescribing opioid pain medication and benzodiazepines and other central nervous system depressants outweigh the risks.

Recommendation 12: Clinicians should offer or arrange treatment with medication for patients with opioid use disorder (recommendation category: A, evidence type: 1).

Comments on Recommendation 12: ACEP and SAEM believe that the CDC should consider rephrasing the recommendation to clarify expansion and normalization of treatment to further promote it. During the course of chronic opioid therapy (COT), a significant cohort of patients may develop an OUD. OUD is a life-threatening and treatable disease. Patients who are identified as having developed an OUD as a result of COT should not be abruptly dismissed or fired from practice. Instead, patients who develop OUD should be offered treatment for OUD with medications for opioid use disorder (MOUD), either by the treating clinician or a specialist.

Thank you for the opportunity to provide comments. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory and External Affairs, at jdavis@acep.org, or Melissa McMillian, SAEM's Senior Director of Foundation and Business Development, at mmcmillian@saem.org.

Sincerely,

Gillian R. Schmitz, MD, FACEP
ACEP President

Amy H. Kaji, MD, PhD
SAEM President