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# Comment from the Academic Consortium for Integrative Medicine & Health on the CDC Clinical Practice Guideline for Prescribing Opioids–United States, 2022

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The Academic Consortium for Integrative Medicine & Health is a recognized leader in evidence-based integrative medicine (www.imconsortium.org). It is a member-supported organization with over 76 highly esteemed academic medical centers and health systems members; our vision is to transform the healthcare system by promoting access to evidence-based healthcare options for all.

We whole heartily welcome the CDC's support for evidence-based nonpharmacologic strategies as first line options for acute and chronic pain care, in alignment with the 2010 Army Surgeon General's Pain Management Task Force Report,[1] the American College of Physician's Guidelines,[2] and the Veterans Health Administration[3] that encourage evidence-based nonpharmacologic options early in patient treatment protocols.

## The 2016 CDC Guideline

The 2016 CDC Guideline for safe opioid use suggested limitations for opioid dosing, discouraged dose escalation to deal with tolerance, discouraged the initiation of opioids for chronic pain conditions, and recommended brief courses of opioids for acute pain.[4] These Guidelines were important in the re-evaluation of opioid policies in many jurisdictions: raising awareness of the failure of opioids to address chronic pain and the dangers of continuing on the path laid out by opioid producers.[5] However, the 2016 Guideline had an unintended consequence: some opioid prescribers were overly enthusiastic in reducing opioid prescribing thereby forcing patients into rapid tapers or even 'abandoning' patients on long-term opioids. The 2022 Draft Guideline appropriately clarifies the CDC's position to avoid unnecessary suffering for people in pain and to avoid the liability of tolerance, addiction, and the increasing number of deaths associated with opioids.[6]

## The 2022 CDC Draft Guideline

The 2022 CDC Draft Guideline (https://www.cdc.gov/opioids/guideline-update/index.html) has detailed the past

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and ongoing tragedy in pain care associated with the over-reliance on opioids and other pharmacologic options. At the center of the opioid/pain crisis is the need to care for persons in pain with evidence-based, effective, low risk options that also maximize patient function and quality of life (QOL).

The 2022 CDC Draft Guideline favors an individualized approach to opioid prescribing that encourages collaborative decisions between patients and prescribers. The collaborative approach may reduce rapid or forced opioid tapers and be more effective at sustained dose reduction. However, collaborative decisions regarding pain care, including opioid use, can only work when providers and patients are informed about the risks of opioids as well as the advantages of other effective and safer strategies.

The over-reliance on opioids grew out of the promotion of opioid disinformation that coincided with an 'opioid knowledge deficit' among providers that continues in medical education today.[7] There is also a 'knowledge deficit' in the appropriate use of effective nonpharmacologic care. It would be appropriate for the CDC Guideline to address this deficit. Ensuring that prescribers have sufficient knowledge of 'opioid risks and best practices' and are allowed adequate compensated time with patients to support complex pain care conversations are essential for success in collaborative opioid management within the framework of comprehensive pain care. Safe and effective options are well studied and within reach.[8] Among our member institutions, we have exemplary pilot models of comprehensive pain care approaches and innovative payment models that are advancing access and demonstrating efficacy, safety and cost-effectiveness.

The rate of inadvertent and/or intentional opioid overdoses continues to rise.[6] In light of the record number of deaths associated with opioids (including fentanyl),[6] promoting the perception that any opioid use is safe should be avoided at all costs. A more relaxed attitude by the CDC regarding opioid tapering and more permissive dose limits may inadvertently be interpreted as a decreased level of concern from the CDC regarding the risk of opioid related deaths as well as the liability of other opioid adverse effects including poor function, QOL and the financial burden of opioid-related abuse.[9]

The 2022 Draft Guideline for acute and postoperative pain care is suggesting more flexibility by allowing providers to increase the number of days for prescribed opioids. We are very concerned since extending the number of days of opioid supply for acute pain has been shown to increase the risk of chronic opioid use.[10] Additionally, if those doses go unused, there will be increased opioid supply in the community leading to increased risk for non-prescribed use by the patient or others. We recognize that the rationale for extending the number of day's supply of opioids may be driven in part by the convenience of patients and their surgical teams. The Centers for Medicare and Medicaid Services (CMS) rules of global payments for surgeries disallow billing for patient visits during the post-op period.[11] As such, patients or their proxy, may need to attend the doctor's office to assess pain management in a non-compensated visit. Extending opioid number of days' supply in general and as a remedy for payment limitations may increase the risk of chronic opioid use or misuse and is especially ill-advised when the best interests of the patient and the community are not well served.

In this reconsideration, the CDC appears to accept a continued reliance on opioids for acute pain without advancing a clear strategy to increase access to evidence-based nonpharmacologic therapies that are effective and opioid sparing.[12] Opioids are familiar to prescribers, are covered by insurance and simple to prescribe.[13] Concurrently, most insurers do not sufficiently cover safe and effective nonpharmacologic therapies. Even with calls from the National Academies of Sciences, Engineering and Medicine for insurers to facilitate reimbursement for comprehensive pain care including proven nonpharmacologic strategies,[14] insurance coverage lags. These updated guidelines can continue the CDC's important work recommending safe and optimal comprehensive approaches to pain that includes appropriate opioid prescribing. However, currently there is not a level playing field of access to opioids and other safer, effective strategies that can be used alone or in conjunction with medications.

In our perspective, the impact of the Draft Guideline's altruistic intent will be blunted by the barriers that continue to deny clinicians and their patients access to comprehensive treatments. We advocate that the CDC use their significant authority to reinforce the selective use of opioids for as few days as possible after an acute event and promote the use of evidence-based nonpharmacologic approaches to provide optimal safe and effective pain care.

## *Summary*

We commend the CDC's support for evidence-based nonpharmacologic strategies as first line options for acute and chronic pain care. A model is needed for widespread dissemination of and insurance coverage for safer, effective pain care options. Prioritizing effective nonpharmacologic strategies would advance the goals of improved outcomes while simultaneously reducing harms associated with opioid use and abuse. The Draft Guidelines must address the larger issue of what can be done to improve the safety and effectiveness of care for pain. Safe and effective options are well studied and within reach.[8] Continued overdependence on opioids for acute and chronic pain care sustains the risk that opioid use, leading to tolerance and addiction, will not abate.

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