April 11, 2022

National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
4770 Buford Highway NE
Mailstop S106-9
Atlanta, GA 30341

ATTN: Docket No. CDC-2022-0024

Submitted electronically via Regulations.gov

To Whom it May Concern:

The American Psychological Association (APA) appreciates the opportunity to provide comments to the Centers for Disease Control and Prevention (CDC) regarding the agency’s proposed CDC Clinical Practice Guideline for Prescribing Opioids—United States, 2022. The clinical practice guideline proposal would update and expand your agency’s previous guideline issued in 2016, and add important clarifications to support more effective, patient-centered pain management.

APA is the largest scientific and professional organization representing psychology in the U.S., numbering over 133,000 researchers, educators, clinicians, consultants, and students. As pain management specialists, psychologists have developed effective evidence-based behavioral health interventions for managing acute and chronic pain, which have been recommended by the Pain Management Best Practices Inter-Agency Task Force as first-line interventions. The Task Force’s final report accurately describes pain as a biopsychosocial phenomenon, with both sensory and emotional components. Psychological pain management and other nonpharmacological pain management services play a vital role in not only reducing the use of prescription opioids and their harmful effects, including potential development of opioid use disorders, but also in improving the recovery, functioning, and quality of life of individuals experiencing pain.

As an organization engaged in advancing behavioral health research, including the development and review of practice guidelines, we would like to share brief comments regarding the 2022 guideline development process. We endorse the agency’s use of widely accepted best practices for guideline development, including the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) framework, and systematic reviews conducted by the Agency for Healthcare Research and Quality (AHRQ). We also applaud the attention to patients’ values and preferences, and the contextual review that was done to help ascertain this information.

We encourage greater clarification of the inclusion of resources allocation (as part of GRADE) in decision-making on guideline recommendations, and stronger attention to and encouragement of
shared decision-making between patient and provider throughout the guideline document. Additionally, we would note that a lead author of the clinical practice guideline was also the lead author of the systematic review on which the guideline was based. Typically, greater separation between the systematic review team and clinical practice guideline authors would be expected, and we recommend that this relationship be clarified.

Following are comments and suggestions regarding the content of the proposed guideline:

- **We encourage including a stronger statement of the importance of addressing coverage and reimbursement barriers to the use of nonpharmacological, integrative, and non-opioid pain management.** Increasing provider awareness of best practices for treating pain, including the prioritization of non-opioid alternatives and the precautions needed if opioids are used, will have minimal effect on the quality of care received by patients if non-opioid alternatives aren’t covered and adequately reimbursed. Pain clinicians and treatment programs should not face financial penalties for providing treatment consistent with CDC guidelines. We urge CDC to establish partnerships with the Centers for Medicare and Medicaid Services (CMS) and other interested federal agencies to identify payment barriers to high-quality pain management care.

- **We applaud the removal of specific morphine milligram equivalent (MME) dosage thresholds in favor of patient-centered care, and the increased clarification that the 2022 guideline should not be interpreted as an inflexible standard of care.** We share the concerns stated in the proposed guideline regarding the unintended effect of the 2016 guideline on public policy and health insurance practices. While pain treatment within the U.S. continues to overemphasize the use of opioids, pain management must be tailored to the needs of the individual patient.

- **We applaud the expansion and clarification of the intended audience for the guidelines.** This is an important step, since as noted beginning on line 369 of the report, nearly two-thirds of opioids are prescribed by providers besides primary care physicians. We also appreciate the clarification on line 380 that “use by pain management specialists is not the focus of this practice guideline.” Pain management, especially for complex cases, are more effective when integrated services are provided by pain psychologists and other pain management specialists working as a team.

- **We urge reconfiguration of Recommendations 1 and 2 to provide greater clarity to clinicians on the importance of nonopioid alternatives in pain management and the precautions needed in providing opioid treatment—for both acute and chronic pain.** We suggest that Recommendation 1 describe the nonpharmacological and nonopioid therapies clinicians should typically adopt as first line approaches for managing either acute or chronic pain, in keeping with both these therapies’ effectiveness and the frequent lack of evidence that opioid treatment would be more effective and as safe. Recommendation 2 can then describe the considerations and steps clinicians should take in deciding whether the benefits of prescribing opioids outweigh the risks, and in initiating opioid use. Because of the broad similarity in the proposed guidelines’ recommendations regarding both acute and chronic pain, we believe clinician awareness of and adherence to the new practice guideline for prescribing opioids could be aided by presenting them in this two-step “fail first, then check this” manner.
We strongly support the proposed guideline’s fifth principle regarding attending to health inequities in pain treatment, and the importance of culturally and linguistically appropriate care. However, this principle and the stark differences in treatment noted in the proposed guideline starting on line 135, the recommendations in the following pages rarely mention this critical issue. We urge the inclusion of stronger language within the recommendations to ensure that clinicians bring an awareness of how continuing racial, ethnic, and gender disparities in pain identification and treatment may affect their patient into their initial conversations with the patient. We also recommend the addition of an invitation for the patient to share potential concerns regarding cultural or linguistic competency in pain care as an element of patient discussions.

- **We encourage additional clarity regarding the assessment of risk for initiating opioid treatment within Recommendation 8.** We are deeply concerned that within the implementation considerations for initiating opioid use listed beginning on line 3022, the suggestion that “clinicians should ask patients about their drug and alcohol use” is the 11th bullet point. The preceding implementation consideration is for clinicians to “ensure that treatment for depression and other mental health conditions is optimized, consulting with behavioral health specialists when needed.”

Current substance use and the existence of a mental health diagnosis have both been identified as significant risk factors for developing opioid misuse, and for complicating the effectiveness of pain treatment. The implementation considerations for Recommendation 8 should thus be strengthened to reflect the importance of accurately identifying substance use and mental health disorders prior to initiating opioid treatment, and continuing to screen for their occurrence over the course of treatment, as this concern is repeatedly mentioned in the draft.

Due to the importance of establishing a medical and psychological diagnosis, the guideline should recommend that patients being considered for long term opioid treatment be referred for psychological assessments and mental health evaluations. This would be consistent with recommendations included in the American College of Occupational and Environmental Medicine’s MDGuidelines for treating work-related injuries, and the Chronic Pain Disorder Medical Treatment Guideline promulgated by the Colorado Division of Worker’s Compensation. Psychological assessments are comparable in validity to physical health assessments routinely used in medical care. If such a referral is unavailable, clinicians should screen for the existence of mental health or substance use disorders using validated tools as part of their risk assessment in initiating opioid use. Clinicians who are unable or uncomfortable conducting such screenings should obtain the assistance of a qualified behavioral health specialist.

We also recommend that clinicians providing opioid treatment for pain establish linkages with local opioid and substance use disorder treatment programs, to enable rapid collaboration and referral when needed. Establishing such connections will increase the chance that patients receive needed of substance use treatment, and if substance use treatment options are found to be lacking, this presents an added risk factor clinicians should take into consideration. Continued use of opioids should include consistent evaluations of changes in patient functioning, and pre-post psychometric measures such as PROMIS. Additionally, clinicians
should establish a sense of emotional safety for patients to discuss issues and difficulties related to prescription opioid use.

- **With respect to Recommendation 12, we urge the inclusion of stronger language regarding barriers to effective opioid use disorder treatment.** For example, the first implementation consideration listed within this recommendation, starting on line 3683, states that “[a]lthough stigma can reduce the willingness of individuals with opioid use disorder to seek treatment, opioid use disorder is a chronic, treatable disease from which people can recover and continue to lead healthy lives.” It should be noted that individuals with opioid use disorders face stigma on the part of clinicians, pharmacists, other health care providers, and community members that adversely affects their ability to receive adequate treatment. We encourage clinicians to both be aware of their own attitudes and beliefs regarding individuals with opioid use disorders, and to advocate for the removal of inappropriate barriers to their treatment. We urge CDC to establish partnerships with the Drug Enforcement Agency (DEA), the Department of Health and Human Services, the Department of Justice, and other interested federal agencies to address stigma, payment, and enforcement-related barriers to evidence-based opioid use disorder treatments.

We appreciate the opportunity to comment on this important guideline, and would be happy to provide additional information or research related to our recommendations. For further assistance, please contact Scott Barstow, MSc, Senior Director of Congressional and Federal Relations, at SBarstow@APA.org.

Sincerely,

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Chief Advocacy Officer