January 13, 2015

National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
4770 Buford Highway NE., Mailstop F-63
Atlanta, GA 30341

Attn: Docket CDC-2015-0112

On behalf of the osteopathic medical profession, we appreciate the Centers for Disease Control and Prevention (CDC) taking steps to address our nation's rapidly growing prescription drug abuse epidemic. We strongly agree that the problem is of rampant proportions and continues to worsen, and that changes are needed throughout the entire healthcare system in order to address it. The American Osteopathic Association (AOA), American Osteopathic Academy of Addiction Medicine (AOAAM), American College of Osteopathic Family Physicians (ACOFP), American College of Osteopathic Internists (ACOI), and American College of Osteopathic Neurologists and Psychiatrists (ACONP), are all committed partners in the Administration's initiative announced by the President in October to reduce the overprescribing of opioids, and as such have pledged to educate our physician members and provide resources to enable best prescribing practices.

Osteopathic principles can provide an effective foundation to treating chronic pain by driving individualized care plans that can combine nonpharmacologic treatment strategies with pharmacotherapy. The osteopathic approach uses physical examination as well as patient history to identify causes of chronic pain, and can include screening for depression or other significant nonphysical contributors to pain. This offers a framework for patient education to encourage adherence to treatment based on an understanding of the associated inter-related factors.

We appreciate the CDC's statement that the "guideline offers recommendations rather than prescriptive standards." This is in keeping with our position that guidelines must allow for individual patient circumstances. As well, guidelines allow for adjustments as evidence-based best practices evolve with newer research and healthcare advances. We are concerned, though, that they will be used by some health systems to implement blanket practices and rigid care decisions, or by payers and pharmacy benefit managers as justification for coverage decisions that contravene the physician's judgement for an individual patient's circumstances. The recently passed omnibus spending bill (H.R. 2029; S. Rept. 114-57) directs the Department of Veterans Affairs (VA) to adopt the Guidelines, once finalized and released, into its Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain. Given that the VA currently manages the healthcare of over 6 million veterans, this significantly broadens the impact these Guidelines will have.

We are also disappointed that in developing the Guidelines, the CDC did not have an open and transparent process that allowed for broad stakeholder input. We are especially disappointed that the Steering Committee, Core Expert Group, Stakeholder Review Group, nor the Peer Reviewers, included a single osteopathic physician. DOs receive significant additional training in musculoskeletal conditions as compared to their allopathic counterparts, and have particular expertise in pain management. As well, all DOs receive an average of 200 hours of education and hands-on experience in osteopathic manipulative medicine. This training is continued in osteopathic residencies, providing osteopathic physicians with extensive training in the care of patients suffering from musculoskeletal pain, and the ability to provide

an effective, non-pharmacological treatment (osteopathic manipulative treatment, or OMT) for these conditions when warranted.

Additionally, many practicing primary care physicians have participated in considerable continuing medical education to further hone their knowledge and skill in the care of patients suffering all types of pain. Singling out primary care physicians, as these Guidelines do, ignores this extensive additional training. Further, simply because a physician practices in a particular specialty area does not guarantee they have the knowledge or skill to provide high quality pain management.

For these reasons, we urge the CDC to rethink the issuance of this guideline. We instead request that the CDC reconvene a broader panel of experts with equal representation of all relevant specialties and stakeholders. We believe this will lead to guidelines with far broader applicability and much greater acceptance by both the physician community, and the patients they serve.

Despite these concerns, we strongly agree that clinical practices surrounding use of opioids, especially long-term use for chronic pain, need to be re-examined and reconsidered, and therefore support a number of aspects of the CDC's proposed guidelines. We offer the following specific comments on the draft:

Methodology

As noted, we have strong concerns regarding the closed process the CDC used in developing these draft Guidelines. The outcome of this work will impact thousands of physicians and millions of our patients, yet it was done without transparency and was not at all inclusive. As noted, no osteopathic physicians were included in the Guidelines' development. The CDC stated at the December 16, 2015 Health and Human Services' Provider Roundtable meeting that those involved in the Guidelines' development and review were selected to represent a cross-section of the prescriber community. Yet osteopathic physicians represent almost twenty percent of the physician workforce, and were not in the Steering Committee, Core Expert Group, Stakeholder Review Group, nor the Peer Reviewers. We appreciate the report's inclusion of and emphasis on the importance of non-pharmacological approaches to chronic pain management, and the mention of manipulation as one such effective approach especially. Yet DOs, as the only physicians currently trained in osteopathic principles and practice, including osteopathic manipulative treatment (OMT), played no part in the Guideline development process prior to their draft release. OMT is an effective treatment for chronic pain – a recent meta-analysis found evidence that OMT has a significant effect on pain relief and functional status for chronic lower back pain[1], and more than half of regular opioid users report back pain[2]. In fact, guidelines incorporating the use of OMT for chronic low back pain are in use in many states, including Oregon.

More concerning, there was no representation of other important stakeholders, including the very patients who will be impacted by the Guidelines. Osteopathic medicine is patient-centered, and we therefore believe patients should have been included in the development and review process. Should the CDC follow our request to reconvene a broader group to revisit guideline development, we would

[1] Franke, H., Franke, J.-D., & Fryer, G. (2014). Osteopathic manipulative treatment for nonspecific low back pain: a systematic review and meta-analysis. *BMC Musculoskeletal Disorders*, 15, 286. http://doi.org/10.1186/1471-2474-15-286

[2] Deyo, Richard; Von Korff, Michael; Duhrkoop, David. Opioids for Low Back Pain. *BMJ* 2015; http://dx.doi.org/10.1136/bmj.g6380

recommend representatives of veterans be included, given the previously cited statutory requirement for the VA to adopt these Guidelines.

As well, beyond these concerns regarding those involved in the development and review of the Guidelines, was the lack of a process to ensure sufficient opportunity for public review and comment. The proposed Guidelines were originally not going to be published at all for comment. Instead, they were only previewed in summary form on a webinar in September, which was announced with little advance notice and followed immediately by only a two-day comment period. Such a short comment period left organizations such as our own unable to effectively review and respond. Only after significant outside pressure were the Guidelines then published for this current comment period. Yet this publication too was done with very little warning in mid-December, with only a 30-day comment period. Providing such a short comment period that bridges the holiday season is at best akin to offering only a two-week comment period. This again contributes to both a lack of transparency and of an inclusive approach, and creates further barriers for those with relevant expertise to weigh in and comment.

Lastly, we appreciate the CDC's focus on clinical and contextual evidence in developing the guidelines. The AOA supports the use of evidence-based guidelines as part of physician decision making, while still allowing the physician to determine the best care plan for her patient. Yet we are concerned that the Guidelines are based at least in part on assumptions surrounding the *lack* of evidence surrounding long-term use of opioids. For example, the document states:

> *"In summary, the categorization of recommendations was based on the following assessment: No evidence shows a long-term benefit of opioids in pain and function for chronic pain with outcomes examined at least 1 year later (with most placebo-controlled randomized trials <6 weeks in duration)."*

If most placebo-controlled randomized trials are less than six weeks in duration, then how can we conclude there is no evidence of long-term benefit of opioids for chronic pain, which is defined in the same document as pain longer than 90 days, i.e. twelve weeks? As noted earlier, we are supportive of a number of the recommendations in the Guidelines, but question such blanket assumptions when a call for further research is more warranted. We recommend at minimum that the above quoted assertion be reworded in the document to clarify the CDC's intent.

A further example of this is when the document seems to negate concerns that prescribing changes such as dose reduction for opioids will not have an unintended consequence, such as patients seeking heroin. The document states, "With the exception of a study noting an association between an abuse-deterrent formulation of OxyContin and heroin use, showing that some patients in qualitative interviews reported switching to another opioid, including heroin, for many reasons, including cost and availability as well as ease of use (140), CDC did not identify studies evaluating these potential outcomes." We would offer that law enforcement may be a more accurate predictor of these outcomes than the scientific community. The United States Drug Enforcement Administration (DEA) in its 2015 National Heroin Threat Assessment Summary notes, "In the 2000s, a very large number of people became opioid abusers by using CPDs [controlled prescription drugs] non-medically, many after initially receiving legitimate prescriptions. Some CPD abusers throughout the country continue to use heroin when some CPDs are expensive or unavailable. After the 2010 reformulation of the commonly abused prescription opioid OxyContin®, which made it difficult to inhale or inject, some people who abused OxyContin® migrated to heroin for access to a potent injectable drug. **This phenomenon is contributing to the increase in heroin use in the United States**" (emphasis added).

CDC Recommendations

1. **Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Providers should only consider adding opioid therapy if expected benefits for both pain and function are anticipated to outweigh risks to the patient (recommendation category: A, evidence type 3).**

   We support this recommendation. We note that there is insufficient evidence to inform a more robust recommendation, and hope that this area of investigation will be the focus for future research.

2. **Before starting opioid therapy for chronic pain, providers should establish treatment goals with all patients, including realistic goals for pain and function. Providers should not initiate opioid therapy without consideration of how therapy will be discontinued if unsuccessful. Providers should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety (recommendation category: A, evidence type: 4).**

   We agree with this recommendation. We also suggest the CDC consider adding information on optimal methods for assessing functional and pain improvement.

3. **Before starting and periodically during opioid therapy, providers should discuss with patients known risks and realistic benefits of opioid therapy and patient and provider responsibilities for managing therapy (recommendation category: A, evidence type: 3).**

   Osteopathic physicians work in partnership with their patients and believe shared decision-making in a patient's care plan requires patients to be well-educated about their conditions and treatment options. The more patients understand these options and how to maintain good health, the more likely it is they will comply with treatment and achieve better outcomes.

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

   The potential for purposeful misuse and corruption of the long-acting delivery systems of ER/LA opioids can pose significant risk of potential harm, and therefore providers should consider prescribing them only after immediate-release opioids. As well, because it is not always predictable how a patient will respond to a particular opioid, first trying an immediate-release opioid will more likely ensure any negative response will at least be of a shorter duration.

5. **When opioids are started, providers should prescribe the lowest effective dosage. Providers should use caution when prescribing opioids at any dosage, should implement additional precautions when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should generally avoid increasing dosage to ≥90 MME/ day (recommendation category: A, evidence type: 3).**

   While we agree that all medications and especially opioids should be prescribed at the lowest effective dose, the dosage limitations/cautions appear arbitrary and unsupported by the evidence cited. For example, depending on a number of factors (genetics, past history of recreational drug use, overall tolerance, etc), some patients may require over 90 MME/day. We are concerned that the Guidelines calling for prescribers to avoid this dosage could result in blanket policies being adopted by some health care settings that would leave such patients with inadequate pain management. We therefore recommend revising this guideline to:

"When opioids are started, providers should prescribe the lowest effective dosage. Providers should use caution when prescribing opioids at any dosage, and should implement additional precautions when increasing dosage. If there are additional risks that occur above a certain dosage, those should be expressly discussed with the patient as part of a risk/benefit analysis."

6. **Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, providers should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three or fewer days usually will be sufficient for most nontraumatic pain not related to major surgery (recommendation category: A, evidence type: 4).**

   We agree with the recommendation to treat acute pain with the lowest effective dose of immediate-release opioids and for no greater than the expected duration of pain severe enough to warrant the use of an opioid. We also agree with the additional discussion under this recommendation that providers should not prescribe additional opioids to patients "just in case" pain continues longer than expected, and should instead re-evaluate the subset of patients who experience severe acute pain that continues longer than expected to confirm or revise the initial diagnosis, and to adjust treatment accordingly.

   We are however concerned the recommendation will be interpreted as a blanket limit of opioid use for acute pain to three days. As the CDC notes in the discussion of this recommendation, studies disagree on a specific duration of use. We would instead support rewording this portion of the recommendation to:

   "Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, providers should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Providers should consider when prescribing an initial quantity of opioids for acute pain that three or fewer days can usually be sufficient for most nontraumatic pain not related to major surgery."

   As well, we would suggest adding in to the discussion of this recommendation that payers and pharmacy benefit managers can play a role in quantities of opioids for acute pain exceeding the needed amount. We have received reports of physicians writing for a 3- or 7-day period, but then being contacted by the patient's benefit manager (either directly or through the pharmacy) to change to a 30-day quantity or longer because it will be of lower cost to the patient. Such misaligned incentives that actually make it cheaper for a patient to receive larger quantities of opioid medication than smaller, when not warranted, must be addressed given the high risk for diversion or for future misuse by the patient.

7. **Providers should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Providers should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, providers should work with patients to reduce opioid dosage and to discontinue opioids (recommendation category: A, evidence type: 4)**

   We agree with this recommendation.

8. **Before starting and periodically during continuation of opioid therapy, providers should evaluate risk factors for opioid-related harms. Providers should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, or higher opioid dosages (≥50 MME), are present (recommendation category: A, evidence type: 4).**

   We agree with this recommendation. We would note, though, that even when prescribed by a provider, many patients may still have limited access to naloxone due to insufficient insurance coverage.

   Pregnant Women

   We are concerned by this section's discussion characterizing opioid use during pregnancy as being associated with birth defects. Additionally, while the section simply notes that "Opioid therapy during pregnancy has been associated with…birth defects (contextual evidence review)," the Contextual Evidence Review (Appendix 2) includes this same sentence but first notes "Opioids used in pregnancy **might** [emphasis added] be associated with additional risks to both mother and fetus." The omission of this introductory statement in the Guidelines document itself is misleading. We therefore recommend this section be revised to more accurately reflect the current evidence, or be deleted entirely.

9. **Providers 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 high opioid dosages or dangerous combinations that put him or her at high risk for overdose. Providers should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months (recommendation category: A, evidence type: 4).**

   While we agree with the intent of the recommendation and have worked to educate our members on the benefits of regular use of PDMPs, we are concerned with the specific recommendation on the frequency of PDMP review. As the CDC points out, there is wide variation in state laws on this subject, and there are different levels of usability of PDMP systems across the states. It should also be noted that this tool does not exist in all states, as Missouri lacks a PDMP. This variation highlights the lack of data supporting the recommendation. We would recommend that the recommendation be modified as follows:

   > "When available, providers 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 high opioid dosages or dangerous combinations that put him or her at high risk for overdose. Providers should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy, and any time there is aberrant behavior, or abnormal urine toxicology results."

10. **When prescribing opioids for chronic pain, providers should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs (recommendation category: B, evidence type: 4).**

    We support this recommendation. While the discussion in the Guidelines does note that urine drug testing can assist providers in identifying when the patient is *not* taking a prescribed opioid, we recommend emphasizing this point more. Diversion of prescribed opioids is a serious issue, and

urine drug testing can be an effective means of identifying when it occurs. We agree with the document's further recommendation that providers not terminate patients from care based on a urine drug test result since this could have adverse consequences for patient safety, potentially including the patient obtaining opioids from other sources, and the provider missing opportunities to facilitate treatment for substance use disorder. We appreciate the Guidelines noting the direct costs of urine drug testing, and that it can be a burden on the patient when not fully covered by insurance.

11. **Providers should avoid prescribing opioid pain medication for patients receiving benzodiazepines whenever possible (recommendation category: A, evidence type: 3).**

    This recommendation does not fully appreciate that patients experiencing severe chronic pain often also suffer from chronic anxiety and depression. Osteopathic medicine stresses treating the whole patient, which means treating all aspects of the patient's illness and injury. It is not possible to treat a patient's chronic pain and ignore their concurrent diseases which contribute to their pain.

    We do acknowledge the very real concern present when opioids and benzodiazepines are co-administered, and therefore suggest this recommendation be modified to read as follows: "Providers should be aware of the risks involved and use caution when prescribing opioid pain medication for patients already receiving benzodiazepines. For patients under existing, documented long-term opioid therapy, care should be taken to avoid prescribing benzodiazepines." We support the Guidelines' recommendation that providers should communicate with mental health professionals managing the patient to coordinate care in cases where co-administration of benzodiazepines and opioids are determined appropriate.

12. **Providers should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder (recommendation category: A, evidence type: 3).**

    We agree with this recommendation, and would recommend further strengthening the Guidelines' position that providers should not dismiss patients from their practice because of a substance use disorder. We would also encourage the Administration to inform state licensure boards of the new CDC Guidelines as a tool to support physicians in their treatment decisions of patients determined to need medication-assisted therapy (MAT).

    As well, we agree with the document's note that there may be communities with insufficient capacity for providing buprenorphine treatment for opioid use disorder, the encouragement for physicians to consider obtaining a waiver themselves, and the included suggested resources from the Substance Abuse and Mental Health Services Administration (SAMHSA). The American Academy of Osteopathic Addiction Medicine is a collaborator in SAMHSA's Provider's Clinical Support System for Medication Assisted Treatment (PCSS-MAT), whose overarching goal is to make available the most effective medication-assisted treatments to serve patients in a variety of settings, including primary care, psychiatric care, and pain management settings. In addition to mentoring programs, educational modules and webinars, AOAAM offers training for those osteopathic physicians interested in seeking their waiver to prescribe buprenorphine in the treatment of opioid addiction.

We appreciate the CDC's efforts to address our nation's growing prescription drug abuse epidemic, and thank you for considering our comments. We encourage you to reconsider issuance of these Guidelines as currently developed. Instead, we recommend partnering with a broader community of stakeholders, including the osteopathic profession, as was recently announced with the formation of the CDC Board of Scientific Counselors' Opioid Guideline Workgroup, in seeking ways in which to ensure appropriate prescribing of opioids for long-term management of chronic pain.

Sincerely,

John D. Becher, DO
President
American Osteopathic Association

John B. Bulger, DO, MBA, FACOI
President
American College of Osteopathic Internists

William R. Morrone, DO, DABAM, DAAPM, ACOFP
President
American Osteopathic Academy of Addiction Medicine

Stephen M. Scheinthal, DO, DFACN, DFAPA
President
American College of Osteopathic Neurologists and Psychiatrists

Kevin V. de Regnier, DO, FACOFP dist.
President
American College of Osteopathic Family Physicians

About the American Osteopathic Association
The American Osteopathic Association (AOA) represents more than 122,000 osteopathic physicians (DOs) and osteopathic medical students; promotes public health; encourages scientific research; serves as the primary certifying body for DOs; is the accrediting agency for osteopathic medical schools; and has federal authority to accredit hospitals and other health care facilities. More information on DOs/osteopathic medicine can be found at www.osteopathic.org.

* *

About the American Osteopathic Academy of Addiction Medicine
The American Osteopathic Academy of Addiction Medicine (AOAAM)'s mission is dedicated to improving the understanding of addiction as a disease. The AOAAM is committed to attaining science-based core competencies in the prevention, assessment, and treatment by Osteopathic Physicians; with a leadership voice in the Osteopathic Profession for sound public policy associated with substance use disorders. The AOAAM has a strong grassroots network of providers, serving in both underserved urban and rural areas. The conjoint board of AOAAM includes the American College of Osteopathic Family Physicians (ACOFP). The AOAAM works with the AOA, ACOFP and other organizations to promote PCSSMAT CME courses.

* *

About the American College of Osteopathic Family Physicians
The American College of Osteopathic Family Physicians (ACOFP) was founded in 1950 and today represents more than 20,000 practicing osteopathic family physicians, residents and students throughout the United States. Osteopathic Family Physicians are Doctors of Osteopathy (DOs) who choose to specialize in family practice and Osteopathic Manipulative Treatment (OMT), a method in which they use their hands to diagnose and treat the patient by paying particular attention to joints, bones, muscles and nerves. They provide disease prevention, diagnosis, and treatment strategies for families through all of life's stages, from infancy to end-of-life. More information can be found at www.acofp.org.

* *

About the American College of Osteopathic Internists
The mission of the ACOI is to advance the practice of osteopathic internal medicine. Through excellence in education, advocacy, research and the opportunity for service, the ACOI strives to enhance the professional and personal development of the family of osteopathic internists. More information can be found at www.acoi.org.

* *

About the American College of Osteopathic Neurologists and Psychiatrists
The objectives of this organization shall be to promote the Art and Science of Osteopathic Medicine in the fields of Neurology and Psychiatry; to provide an association of Osteopathic Neurologists and Psychiatrists; to maintain and further elevate the highest standards of proficiency and training among Osteopathic Neurologists and Psychiatrists; to stimulate research and investigation in Neurology and Psychiatry and to collect and disseminate the results of such work for the benefit of the members of the College, the public, the profession at large, and the ultimate benefit of all humanity. More information may be found at www.aconp-acn.org.