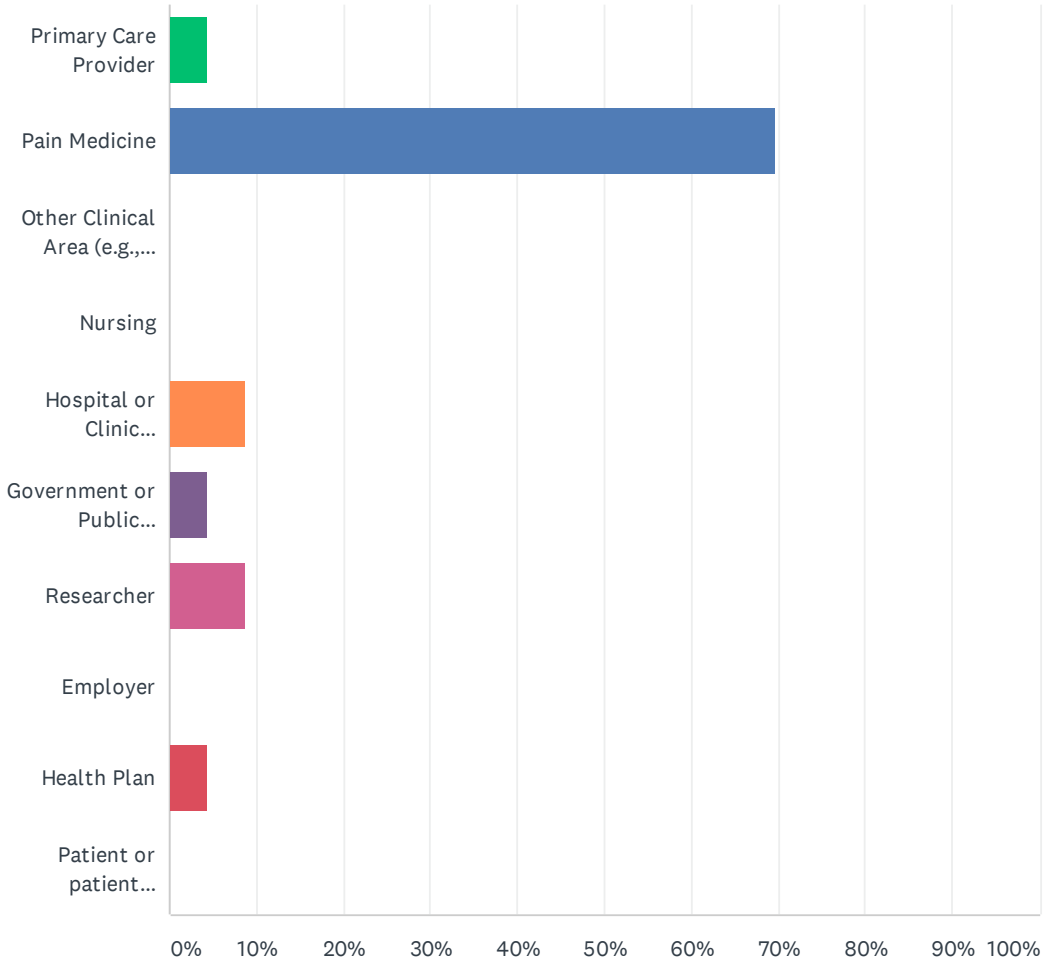
Q1 What sector do you represent? (Choose the option that is the best fit.)

Answered: 23 Skipped: 0



ANSWER CHOICES	RESPONSES	
Primary Care Provider	4.35%	1
Pain Medicine	69.57%	16
Other Clinical Area (e.g., orthopedics)	0.00%	0
Nursing	0.00%	0
Hospital or Clinic Administration	8.70%	2
Government or Public Purchaser	4.35%	1
Researcher	8.70%	2
Employer	0.00%	0
Health Plan	4.35%	1
Patient or patient advocate	0.00%	0
TOTAL		23

#	OTHER (PLEASE SPECIFY)	DATE
1	Six Building Blocks to Improving Opioid Management in Primary Care Team (www.improvingopioidcare.org)	4/16/2020 7:12 PM
2	WSMA	4/16/2020 11:17 AM
3	Hospital association	4/13/2020 12:55 PM
4	State Behavioral Health Program Manager	3/24/2020 8:06 AM

Q2 Do you have any comments on the background (pg 1)

Answered: 17 Skipped: 6

#	RESPONSES	DATE
1	NO	4/17/2020 5:05 PM
2	No	4/17/2020 2:44 PM
3	No comment	4/17/2020 8:15 AM
4	2015 AMDG guidelines seem a bit outdated at this point.	4/16/2020 11:03 PM
5	Appreciate the work of the group. I note "pain experts" listed, but am curious as to how many of those listed practice as pain physicians regularly. I recognize some of the physicians listed, but would find the guidelines much more helpful if 5-10 physicians or more were actually those that prescribed these types of medications. With as many prescriptions that are being prescribed in WA state, is there a way to collaborate more with those that are specialized in this?	4/16/2020 7:21 PM
6	No comments for this section	4/16/2020 7:12 PM
7	n/a	4/14/2020 11:34 PM
8	What background?	4/14/2020 3:09 PM
9	does not address legacy patients versus initiation of opioids	4/14/2020 12:59 PM
10	Look at 2019 HHS Interagency Task force recommendations https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf	4/13/2020 5:29 PM
11	None	4/13/2020 12:55 PM
12	The background utilizes HHS Interagency Task Force 2015 guidelines, but ignores the 2019 HHS Interagency Task force recommendations (https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf). The 2019 guidelines are important as it includes much more up to date information.	4/12/2020 8:35 PM
13	Unfortunate that none of discussion advisors is a pain psychologist who may able to render more insightful on COT patient	4/12/2020 4:49 PM
14	Page 1 mentions HHS Interagency Task Force 2015 guidelines, but ignores the 2019 HHS Interagency Task force recommendations (https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf) which is important as it is inclusive of more recent data.	4/8/2020 2:33 PM
15	No mention of interventional therapies to offer or consider only that care should be individualized.	4/6/2020 10:51 AM
16	none	4/3/2020 11:16 AM
17	No	3/24/2020 8:06 AM

Q3 Do you have comments on patient engagement (pg. 2)?

Answered: 23 Skipped: 0

#	RESPONSES	DATE
1	Goals of care are not always clear in many chronic pain patients. It is helpful in theory, but rather difficult in real life	4/17/2020 5:05 PM
2	Agree, appreciate that this report calls out the social and emotional dynamics of patient engagement. In the Collaborative Care for Chronic Pain Recommendation report from Bree Collaborative, there was mention of trauma-informed care. Recommend including that aspect here as well.	4/17/2020 2:44 PM
3	No comment	4/17/2020 8:15 AM
4	Practical for initiation of opioid management, but in a specialist setting, a large percentage are already on opioid therapy. Hardly more than a sentence was committed to pain treatment options. It's not surprising that even physicians are limited in their knowledge of this with this lack of emphasis.	4/16/2020 11:03 PM
5	There are other areas of pain relief that seem to be ignored in these guidelines. I know it is not all encompassing, but what about interventions/procedures, surgeries, and more emphasis on psychology as well?	4/16/2020 7:21 PM
6	As noted in the general comments, for each section, it is not clear what the gap is that this section is filling. Was this missing from prior recommendations? Is there more evidence related to establishing a relationship? Is there new evidence about gaps in care related to establishing a relationship? This is not clear. This section includes recommendations related to respect, consistency, and cultural competency. It would be helpful to link to training opportunities that providers and their staff can use to augment these skills	4/16/2020 7:12 PM
7	No	4/16/2020 11:17 AM
8	n/a	4/14/2020 11:34 PM
9	I think patient engagement is always encouraged provided it does not interfere with the care.	4/14/2020 3:09 PM
10	these goals, while ideal, are not practical for the primary care provider, if only due to time constraints and enumerating them in this fashion is intended to discourage providers from considering opioids at all	4/14/2020 12:59 PM
11	d	4/14/2020 9:57 AM
12	Would like to see more emphasis on using FUNCTION as a primary outcome measure of therapy.	4/14/2020 8:35 AM
13	no	4/13/2020 5:29 PM
14	- Perhaps mention using motivational interviewing here as well as later in document; goals should be meaningful to the patient - For "setting expectations", it may take more than one visit to establish rapport and develop trust - For "gain understanding of patient's knowledge...", using decision aids would be helpful to mention - For "respect" section - would be nice to also add "dignity" - "Respect and dignity"	4/13/2020 12:55 PM
15	Respectfully, the committee does not include interventional pain physicians. In fact, the committee involves many that do not practice Pain Medicine. Interventional pain procedures decrease the need for opioids. There are NO studies that support the use of opioids for chronic pain long term. Yet, there is a multitude of data supporting interventional pain procedures as effective for chronic pain and decreasing the use and even eliminating opioids. We are in the midst of an opioid crisis. The CDC states opioids should be used as a last resort after all other therapy and interventions have failed.	4/12/2020 8:35 PM
16	NO. Very elaborated. Can be very time consuming to many chronic opioid treatment patients	4/12/2020 4:49 PM
17	I agree	4/10/2020 10:51 AM
18	a	4/9/2020 10:00 AM
19	Data on the effectiveness of Interventional procedures in decreasing opioid burden and pain seems to have been ignored, in part because the members of the committee may not have been informed or may not be in practice. Patients often seek and gain relief of pain with these measures	4/8/2020 2:33 PM

20	Relationship and Expectation does not mention reducing pain with procedures that likely will reduce patient pain. No mention of interventional pain specialists.	4/6/2020 10:51 AM
21	I would like to see more of an integrative approach with the practitioners and the patients. If practitioners of adjunct therapies, such as acupuncture/chiro/ etc would be included in the engagement process then the patient could receive optimal and consistent support through all the avenues of care.	4/3/2020 11:16 AM
22	Should have more on Cultural competency.	3/24/2020 8:06 AM
23	No comment.	3/20/2020 9:30 AM

Q4 Do you have comments on assessment (pg. 3-4)?

Answered: 23 Skipped: 0

#	RESPONSES	DATE
1	. “Document history of long-term opioid use from the first prescription, as accurately as possible. Include dosage and changes in dosage over time”. It is important to know the opioid treatment history however most chronic pain pts do not remember that much of details, especially the first Rx	4/17/2020 5:05 PM
2	Agree with the recommendations here.	4/17/2020 2:44 PM
3	No comment	4/17/2020 8:15 AM
4	It incomprehensible how in most cases anyone other than a fellowship trained pain physician would be able to perform these tasks adequately.	4/16/2020 11:03 PM
5	I believe physicians who have a complement of tools at their use have a much better way of tackling the opioid crisis - meaning a pain specialist who works closely with psychology, surgery, psychiatry, and primary care. AND also does medications (opioid and non-opioid), procedures, interventional techniques. AND is in a multi-disciplinary program including therapy, psych etc, would now employ multiple approaches to pain rather than just focus on one area such as opioids.	4/16/2020 7:21 PM
6	It is not clear what is “new” in this section. It is not clear why different colored font is included in this section.	4/16/2020 7:12 PM
7	No	4/16/2020 11:17 AM
8	n/a	4/14/2020 11:34 PM
9	thorough assessment is essential	4/14/2020 3:09 PM
10	same as the engagement section	4/14/2020 12:59 PM
11	d	4/14/2020 9:57 AM
12	Recommend focus on assessment including how pain scores & function have changed over time with the opioid medication. This would be helpful in identifying if tolerance has occurred.	4/14/2020 8:35 AM
13	Assessment should involve a Fellowship Trained and board certified Pain Medicine subspecialist whenever possible. History should be queried whether prior treatment including interventional procedures were performed by fellowship trained and board certified Pain Medicine subspecialist or by technicians such as radiologists who neither evaluate nor follow patients, or by unqualified professionals such as nurse practitioners or CRNAs or by PAs who have no expertise nor proper training in interventional pain management procedures nor in the management of chronic pain patients. Were patients treated in "pill-mill" clinics previously, where they were never evaluated nor treated by a Pain Medicine subspecialist? Were they delegated to mid-level care? All these things lead to the appearance of prior interventional pain management care but substandard or non qualified delivery of it. Patients with chronic pain deserve the attention of fellowship trained board certified Pain Medicine subspecialist, and this should not be delegated to other medical professionals.	4/13/2020 5:29 PM
14	It would be nice to also mention using a trauma-informed approach/perspective in the assessment.	4/13/2020 12:55 PM
15	Yes, an interventional Pain Medicine physician should be involved in the diagnosis and treatment recommendations for chronic pain patients.	4/12/2020 8:35 PM
16	NO. It looks very detailed	4/12/2020 4:49 PM
17	I agree	4/10/2020 10:51 AM
18	a	4/9/2020 10:00 AM
19	? A Fellowship trained, Board Certified Interventional Pain Specialist who is versed with comprehensive pain management practices would be better able to assess the patient and offer legitimate alternatives to medications, physiotherapy, and opioid replacements (methadone-suboxone)	4/8/2020 2:33 PM
20	Again, why haven't the role of a board certified interventional pain doctor been part of the explanation, expectation or plan with the patient?	4/6/2020 10:51 AM
21	none	4/3/2020 11:16 AM

22	I am under the impression that part of this assessment is done by a doctor? SUDP's are not qualified to do physicals or the pain and functional status that I know of.	3/24/2020 8:06 AM
23	pg. 3 I would propose that providers query EDIE once or twice yearly to assess for ED visits for pain/OD/pulmonary disease, suicidal attempts/ideation. pg.4 a. Psychiatric history is a key component of risk assessment, more important that the physical exam or any of the available risk stratefication instruments. (Adverse risk selection.) pg4 b. Health record review for Hepatitis C (proxy for h/o IVDA)	3/20/2020 9:30 AM

Q5 Do you have comments on develop a treatment plan (pg. 5-6)?

Answered: 23 Skipped: 0

#	RESPONSES	DATE
1	I cannot believe that none of any interventional procedures are proposed in your plan. Washington state Workmen's Comp. denies most of procedures, as much as it can.	4/17/2020 5:05 PM
2	Agree with the recommendations here.	4/17/2020 2:44 PM
3	No comment	4/17/2020 8:15 AM
4	Sections like these have always reminded me how truly tone-deaf these committees are. Most of our patients are on state of federal insurance. Only a fraction of them have access or can afford many of these options out of pocket. Mentioning topical analgesics (lacking evidence) or NSAID's (cardiac/renal/GI) isn't really helpful. It's almost as if someone is just throwing something at the wall hoping something sticks. Was interventional pain intentionally left out for a reason?	4/16/2020 11:03 PM
5	YES! Collaboration with the physicians taking care of the patient. Examples: 1. Formal pain conferences discussing patients in a HIPAA approved setting. 2. Pain medication stratification in high risk patients with formal psychology consultations/pain medicine specialists involvement 3. Interventional pain procedures when indicated - these actually can help decrease the knee jerk reaction to increases in opioids. 4. Appropriate involvement with surgeons who have a better understanding of pain (as one of the more common reasons patient take medication is chronic back pain/failed back/post-laminectomy syndrome etc) 5. Emphasis on allied health providers including the importance of therapy, nutrition, weight loss, sleep apnea management, etc.	4/16/2020 7:21 PM
6	The quote about motivational interviewing on page 5 doesn't seem necessary. Hyperlinking to the motivational interviewing training resources would be helpful. The non-pharmacological pain management section is very non-specific. The CDC has a more specific handout and there are evidence reviews that are more specific and could be linked: o National Center for Complementary and Integrative Health: Complementary Health Approaches for Chronic Pain: What the Science Says, September 2016 https://nccih.nih.gov/health/providers/digest/chronic-pain-science o Agency for Healthcare Research and Quality: Skelly AC, Chou R, Dettori JR, et al. Noninvasive Nonpharmacological Treatment for Chronic Pain: A Systematic Review. Comparative Effectiveness Review No. 209. AHRQ Publication No 18-EHC013-EF. Rockville, MD: Agency for Healthcare Research and Quality; June 2018. https://effectivehealthcare.ahrq.gov/topics/nonpharma-treatment-pain/research-2018	4/16/2020 7:12 PM
7	No	4/16/2020 11:17 AM
8	n/a	4/14/2020 11:34 PM
9	A multi- faceted plan involving different specialists would be ideal	4/14/2020 3:09 PM
10	specific painful conditions have specific evidence-based treatments (knee osteoarthritis, migraine, etc.) It is never clear when reading one of these gauzy review articles or general guidelines about chronic pain NOS what conditions they are talking about. It should be made clear that the Procrustean bed being here prepared refers to patients without obvious or with mild bodily pain generators, and whose symptoms more often than not are due to a sensitized nervous system.	4/14/2020 12:59 PM
11	d	4/14/2020 9:57 AM
12	Need to consider that in some instances, patient is referred to pain provider specifically for purpose of tapering the opioids. If there is not a provider willing to support prescription long term, this assistance in tapering safely is the objective. Need guidelines on this situation.	4/14/2020 8:35 AM
13	Why do you not have any practicing Interventional Pain Management physicians advising on this document? Why are interventional pain management procedures not on this list, while modalities such as qigong and acupunture are? Opioids should be the last resort in a treatment plan algorithm for benign chronic pain, far after Interventional Pain Management procedures have been trialed and failed.	4/13/2020 5:29 PM
14	None, but see notes below regarding naloxone. Each treatment option should also include counseling and prescription (or dispensing) of naloxone.	4/13/2020 12:55 PM
15	Clinically proven interventional procedures, implantable therapies, and adjuvant therapies have been left off the list of appropriate treatment plans. Again, one cannot ignore the fact that the committee is devoid of true interventional pain physicians.	4/12/2020 8:35 PM

16	Who and what plan are going to cover such all the non-pharmacological pain management. Even having a pain psychologist on our staffs creates negative financial flow to clinic. We are currently providing this at loss cost. Yet you are recommending elaborated non-pharm treatment without any substantial support. Not sure how a provider or patient can afford such therapies? What is your plan to cover these treatments?	4/12/2020 4:49 PM
17	I agree	4/10/2020 10:51 AM
18	a	4/9/2020 10:00 AM
19	Why are clinically proven interventional pain procedures left off of this list? Even if the alternatives had demonstrated RCT data of effectiveness, the lack of access and reimbursement to alternative therapies (Yoga, Tai Chi Massage, acupuncture) remains an issue.	4/8/2020 2:33 PM
20	yoga, Tai chi, massage, spinal manipulation, PT activity coaching and acupuncture are all listed. are all of these being paid for by payers? Why is clinically proven interventional pain procedures left off of this list?	4/6/2020 10:51 AM
21	Again here, where the CDC guidelines are given for including alternative treatments for pain, the alternative practitioners could be offered a prominent role in developing a treatment plan with the primary care provider. Integrative medicine is the future- appropriate guidelines to establish this type of care is much needed. It would be great to have us lead the way with this.	4/3/2020 11:16 AM
22	A team based approached is always the best since opioid dependency affects all areas of the patient's life.	3/24/2020 8:06 AM
23	No comment.	3/20/2020 9:30 AM

Q6 Do you have comments on treatment pathway #1 Maintain and Monitor (pg. 6-7)?

Answered: 23 Skipped: 0

#	RESPONSES	DATE
1	NO	4/17/2020 5:05 PM
2	Agree with the recommendations here.	4/17/2020 2:44 PM
3	No comment	4/17/2020 8:15 AM
4	While I agree with it in principle, the wording seems a bit strong for benzodiazepines, barbituates, and hyponotics seem strong. I feel that the prior recommendations to avoid this, but if continued to have adequate educations and documentation serves the patient best.	4/16/2020 11:03 PM
5	some of the pathways seem vague and nonspecific. giving more solid specific answers may be helpful. Example: "no history of non-fatal overdose or other serious adverse events" can mean many different things. For some patients even constipation can be life-threatening resulting in ileus, bowel obstruction, perforation and death. I understand this is not all encompassing, and we need to do better to explain to prescribing physicians, but these categories seem generic, leading to potential inattention to details. What about adding an addendum sheet with a list of potential opioids. "No history of diversion"? Why would I prescribe in the first place if there was a diversion. Maybe shouldn't be in the maintain and monitor section, rather those patient should have been pre-screened. I could go on, but I don't want to sound to nit-picky. I agree with the overall intention and scope of the wording.	4/16/2020 7:21 PM
6	The statement “Opioid prescribing is consistent with the WAC” assumes the provider will be knowledgeable about the WAC. It would be optimal to avoid acronyms (here and in general) and to hyperlink to a resource that outlines opioid prescribing rules that are consistent with this code.	4/16/2020 7:12 PM
7	No	4/16/2020 11:17 AM
8	n/a	4/14/2020 11:34 PM
9	No	4/14/2020 3:09 PM
10	it's a rehash of recommendations made throughout the literature for many years, so no. I would say, just as it clumps all pain patients together as one, it clumps opioids together as all the same. Butrans or Belbuca, for instance, are nothing like oxycodone. No distinctions made anywhere in this document. Which is deliberate.	4/14/2020 12:59 PM
11	d	4/14/2020 9:57 AM
12	Agree with point about abstaining from benzos, barbituates, soma, etc. What about lyrica/gabapentin? Are these included?	4/14/2020 8:35 AM
13	Opioids should be the very last resort treatment option for benign chronic pain patients.	4/13/2020 5:29 PM
14	Each treatment option should also include counseling and prescription (or dispensing) of naloxone.	4/13/2020 12:55 PM
15	Yes, waiting beyond a few weeks to introduce interventions can have devastating effects. It is well documented that the longer patients remain away from work, the less likely they are to go back.	4/12/2020 8:35 PM
16	I defer with recommendation on page 6, "periodically review..." For high risk patients, need to see monthly for monitoring. Moderate bimonthly, and low for quarterly. That is very dangerous recommendation for high risk patients.	4/12/2020 4:49 PM
17	I agree	4/10/2020 10:51 AM
18	a	4/9/2020 10:00 AM
19	There should be a timeline, perhaps maintain and monitor for 6 weeks but beyond that these patients deserve Interventional Options as the consequences of not doing so results in perpetual pain and suffering.	4/8/2020 2:33 PM
20	No	4/6/2020 10:51 AM
21	none	4/3/2020 11:16 AM
22	No	3/24/2020 8:06 AM

23	No comment.	3/20/2020 9:30 AM

Q7 Do you have comments on the treatment pathway #2 Tapering or Discontinuation (pg. 7-9)?

Answered: 23 Skipped: 0

#	RESPONSES	DATE
1	NO	4/17/2020 5:05 PM
2	Agree with the recommendations, appreciate that this report included the 2019 HHS Guide for Clinicians on the Appropriate Dosage Reductions or Discontinuation of Long-term Opioid Analgesics. Echo, that treatment plan needs to be individualized.	4/17/2020 2:44 PM
3	Object to the addiction language in Table 1. OUD is not the same as addiction and to imply that will confuse patients and providers. It will also make appropriate treatments to patients difficult to access. Addiction is no longer a "medical diagnosis" and is not an ICD-10 code. It is a stigmatizing term and part of the difficulty we have is dealing with the stigmatization of this chronic health care diagnosis. I have patients that fit the criteria for "less suggestive for addiction but are increased in depressed patients" and know they are in trouble if they continue opioids. They are unable to taper, admit to craving and even though they have health risks and know opioids are harmful to them they feel they have to stay on opiates if there is no alternative. They fit the OUD diagnosis and it should be available to them without stigmatization. There are also patients that I can recognize are having issues and are OUD when they do not wish to recognize it. Destigmitizing OUD is critical to providing passionate care. I suggest you take any work that is a derivative of addict out of the document.	4/17/2020 8:15 AM
4	The third bullet under when a taper should be considered should be looked at. In the incapacitated patient (e.g. spinal cord injury), often function is difficult to assess. Documenting emotional relief of suffering should suffice.	4/16/2020 11:03 PM
5	I like this section. Helpful. Many of us in pain management practices do this all the time. There are lots of caveats to this, and would encourage updating some of the information on table 2 as there are newer medications. Also I think there are exceptions to some of these guidelines. For example (Not recommended), but once in a while, I will use a stronger sedative, even low dose benzodiazepine for a short course during the worst parts of an opioid taper. In a very controlled, closely monitored situation, that can be helpful but only RARELY done. Having addictionologist/psychiatrist would be great, but unfortunately most of us have very limited access to those specialists. The next best thing, (in my opinion), is a pain medicine physician who is used to tapering opioids. (I'm a pain doctor, and I'm not being self-serving. These are difficult and challenging situations when it comes to tapering and usually consumes more of my time and stress than I care to admit.)	4/16/2020 7:21 PM
6	Tapering is such an important topic that it warrants its own section, again introducing the section with what the gaps have been and what is new. This is especially important because the background section states that this document is a supplement to resources like the HHS Guide, but then quotes the guide extensively here. Clarification of this document’s purpose as noted in the comments for the document overall is important.	4/16/2020 7:12 PM
7	On page 7, under Before initiating a taper…, “avoid dismissing patients from care” may need caveats such as, “unless clinically indicated” or else it may be too black and white. On page 9, under Follow tapering flowchart…, “Once the smallest available dose formulation is reached, the interval doses can be extended,” implies that you cannot do this before you reach the smallest dose, which may not be the most appropriate.	4/16/2020 11:17 AM
8	n/a	4/14/2020 11:34 PM
9	I prefer tapering and discontinue if that is applicable to the patient.	4/14/2020 3:09 PM
10	see above	4/14/2020 12:59 PM
11	d	4/14/2020 9:57 AM
12	I would like to see some language about it being the responsibility of the provider who initiated or escalated prescription to also be the provider responsible for reducing them.	4/14/2020 8:35 AM
13	A trial of interventional pain management should be an adjunct to reduce pain while tapering off opioids to help maintain function and reduce pain and suffering.	4/13/2020 5:29 PM
14	Each treatment option should also include counseling and prescription (or dispensing) of naloxone.	4/13/2020 12:55 PM
15	When patients are being tapered they will require access to interventional procedures, withdrawal medications, and psychological support. This is in-line with the 2019 HHS recommendations.	4/12/2020 8:35 PM

16	The difficulty tapering off is not solely depends on dose, but also depends on duration of COT patients has been on. This is my anecdotal opinion.	4/12/2020 4:49 PM
17	I would like to see a line in there protecting physicians who feel that high doses might be justified for certain conditions/situations (ie: muscular pain) although patients vehemently believe they should continue therapy. A patient's desire to continue opiate therapy should not alone justify continued prescription.	4/10/2020 10:51 AM
18	a	4/9/2020 10:00 AM
19	Tapering or discontinuation requires that while the patient is being tapered, he or she will need psychological support (e.g. CBT), withdrawals medication and also amelioration of pain with Interventional Pain procedures. In tapering 1000s of patients off opiates in my last 20 years of practice, this has been the best approach. This is consistent with the HHS Interagency 2019 recommendations.	4/8/2020 2:33 PM
20	Page 7- "Pain-generating condition resolved" how is this to happen with the suggested therapies on page 5 & 6 have limited clinical evidence and are not commonly covered by payers?	4/6/2020 10:51 AM
21	none	4/3/2020 11:16 AM
22	No	3/24/2020 8:06 AM
23	Prefer tizanidine 2mg TID over clonidine due to hypotention. There are times when quetiapine 50mg TID may be appropriate for severe anxiety during acute withdrawal prior to induction.* *Pain Med. 2020 Mar 12. pii: pnaa029. doi: 10.1093/pm/pnaa029. [Epub ahead of print] Outcomes in Long-term Opioid Tapering and Buprenorphine Transition: A Retrospective Clinical Data Analysis.	3/20/2020 9:30 AM

Q8 Do you have comments on the recommendations for treatment pathway #3 Medications for Opioid Use Disorder (pg. 9 -10)?

Answered: 23 Skipped: 0

#	RESPONSES	DATE
1	NO	4/17/2020 5:05 PM
2	Same comments as #7.	4/17/2020 2:44 PM
3	no comment	4/17/2020 8:15 AM
4	Lifetime use of these medications still seems like a miserable answer; and often the pain is just worse than before.	4/16/2020 11:03 PM
5	Has there been thoughts of adding off label type treatments in here? Maybe not the right area, and probably this guideline is more geared for primary, but ... For example,use of low dose naltrexone for long term maintenance, or Buprenorphine pain patch/oral Belbuca for these situations. Also maybe emphasize the importance of regular f/u, patient support, psychology, therapy, interventions. It may be helpful to say there's a lot more out there rather than just buprenorphine, methadone, ... What bothers me is sometimes feel like "Suboxone shops" is the next big thing and everyone should be prescribing it etc. Shouldn't we emphasize getting off opioids as much as possible, and in those that need some maintenance, or replacement, then this is the alternative, rather than sounding like this is the goal?	4/16/2020 7:21 PM
6	The Medications for Opioid Use Disorder section is very short, given that it is a substantial topic. This is particularly true for the instructions about initiating buprenorphine/naltrexone treatment. We recommend linking to another more detailed guide rather than trying to include these instructions here.	4/16/2020 7:12 PM
7	No	4/16/2020 11:17 AM
8	LUCEMYRA is a safer alternative to Clonidine	4/14/2020 11:34 PM
9	No	4/14/2020 3:09 PM
10	I don't think primary care, or pain doctors, should be managing people with addiction problems.	4/14/2020 12:59 PM
11	d	4/14/2020 9:57 AM
12	Agree.	4/14/2020 8:35 AM
13	These medications are supportive for withdrawal symptoms but should not be viewed as a long term option for any patient. If such options are needed, should be managed by a board certified Addiction Medicine subspecialist.	4/13/2020 5:29 PM
14	Each treatment option should also include counseling and prescription (or dispensing) of naloxone.	4/13/2020 12:55 PM
15	These medications are substitutes for opioids and serve the financial wants and needs of the “addiction centers” and big business pharmacy but do little to address the core pain issue at hand. Furthermore, they keep patients on systemic opioids when other options exist.	4/12/2020 8:35 PM
16	this appears to be an appropriate recommendation and agree	4/12/2020 4:49 PM
17	I agree	4/10/2020 10:51 AM
18	a	4/9/2020 10:00 AM
19	These lifelong medications are substitutes for opioids serve the financial wants and needs of the “addiction centers” and the pharma but do little to address the core pain issue at hand.	4/8/2020 2:33 PM
20	No	4/6/2020 10:51 AM
21	none	4/3/2020 11:16 AM
22	No	3/24/2020 8:06 AM
23	No comment.	3/20/2020 9:30 AM

Q9 Do you have comments on the recommendations for health systems (pg. 11)?

Answered: 23 Skipped: 0

#	RESPONSES	DATE
1	For patient suffering from chronic pain condition, minimize opioid supply without providing any other ways to substantially reduce the pain is not going to be effective.	4/17/2020 5:05 PM
2	Would like Bree Collaborative to share learnings from health systems (health plans specifically).	4/17/2020 2:44 PM
3	No comment	4/17/2020 8:15 AM
4	Academics have served us well in both clinical and bench research as well as assessment of atypical cases. Their utility is questionable in patient management given the fact that often a fellow is managing their patients, or given the academic model, often they are not able to see the outcomes of their recommendations which I believe would greatly influence decision making in a field with so many "gray" areas.	4/16/2020 11:03 PM
5	Helpful information. However bigger health systems are not always the answer. Having the right providers, group, staff and having an efficient way to have patients enter/go through the program is more important. Agree that motivational interviewing is very important for those interacting with patients on opioids.	4/16/2020 7:21 PM
6	This section emphasizes collaborative care, which is aspirational but not realistic for a large number of clinical organizations at this time. One way to make this section more practical would be to emphasize and/or point to the evidence for which patients might benefit from more intensive services through collaborative care or Structured Intensive Multidisciplinary Programs. This would clarify when it is important to call on these programs in clinical care. We would recommend that this section include more feasible, practical and less intensive approaches for health care organizations to delivery more guideline-concordant care. We would be happy to discuss some of the successes we have had as a Six Building Blocks team helping clinics make systems change even when collaborative care is not possible. Within these building blocks is work on caring for a subset of more complex patients who might indeed benefit from a collaborative care approach. This would be one way to frame how and when the collaborative care model would benefit this subgroup of patients.	4/16/2020 7:12 PM
7	On Health care systems and tapering – Agree there is a significant potential cost and there is likely a disincentive for many regarding the metrics, mandatory training and multimodal training. The warm handoff may also be a problem from a siloed system challenge.	4/16/2020 11:17 AM
8	n/a	4/14/2020 11:34 PM
9	Regulation must be in place to prevent abuse but also flexible to accommodate to different patients needs	4/14/2020 3:09 PM
10	If pain patients with symptoms but mild or no objective findings actually engage with therapists and avoid specialists like ortho and others and stay out of the procedure suites (which they should) then health systems will lose a lot of money. I don't have a problem with that.	4/14/2020 12:59 PM
11	d	4/14/2020 9:57 AM
12	Add communicate to staff that the provider who starts and increases script will be responsible for ultimate outcome of that script - can't simply refer the patient away for that management.	4/14/2020 8:35 AM
13	Interventional Pain Management should be integrated into a comprehensive approach and is opioid-sparing. Mutiple pain syndromes can be succesfully addressed by interventional procedures and spare patient the side effects of opioids, the time of physical thearpy, and the agony of inefficacy.	4/13/2020 5:29 PM
14	It would be nice to briefly define (could also be link or footnote) SIMP in the first reference.	4/13/2020 12:55 PM
15	The Biopsychosocial models are important but the Biological cause of the pain should precede the Psychosocial support system. If anything, they should occur concurrently. For example, 15-30% of lumbar pain is facetogenic and The acrtual biological cause of the pain, in this example. Facet pain is consistently addressable with facet joint injections (not covered in WA, physical therapy (very difficult to get authorized), and radio-frequency ablation of the medial branch nerves (nearly impossible to get authorized). Another example is low back pain and leg pain in the elderly patient with symptomatic lumbar spinal stenosis. This can be addressed with both Epidural steroid injections and Indirect spinal decompression. Both rarely if ever covered by Washington State insurances. Yet, more invasive, riskier open spinal surgeries are often authorized and performed. Indirect spinal decompression has 5 year randomized controlled data showing a decrease in opioid utilization and improved pain and function.	4/12/2020 8:35 PM

16	Yes. Without health plan to implement the coverage of non-pharm therapies and psychological aspect of pain management therapy and counseling, all the above recommendations are very much lip service and becomes mute point. Furthermore, in WA, I have encountered brick wall with UW pain medicine department on patients we sent for comprehensive multidisciplinary management for complex patients. UW pain medicine, the institution supported by tax-dollars, simply kicks back patients to referring providers with elaborated recommendations that private practitioners don't have access to it.Again, it feels like just lip service instead of providing the multidisciplinary treatment. I believe this is due to scarce resource and revenue from insurances and goverment payers?	4/12/2020 4:49 PM
17	I agree	4/10/2020 10:51 AM
18	a	4/9/2020 10:00 AM
19	The Biopsychosocial models are important but the Bio precedes the Psycho-social supports. E.g. 15-30% of pain is facetogenic and biological cause of the pain, in this case Facet pain is consistently addressable with radiofrequency, another example is LBP in the elderly patient with lumbar stenosis can be decreased with both Epidural steroids and Spinal spacer. The latter has 5 year data showing a decrease in opioid utilization.	4/8/2020 2:33 PM
20	Who is to train the staff on motivational interviewing? How is this to be billed, and what type of provider should perform this? Collaborative care program sounds ideal, where do we get the capacity especially in a rural setting? Are payers going to provide for such level of care? Will prior authorization be required for such treatment encounters?	4/6/2020 10:51 AM
21	Again - more discussion about an integrative care approach within the system would be great. Having a road map for all to follow is much needed.	4/3/2020 11:16 AM
22	No	3/24/2020 8:06 AM
23	If possible develop a centralized prescribing/deprescribing clinic, coumadin clinic model. Collect data and publish.	3/20/2020 9:30 AM

Q10 Do you have comments on the evidence section (pg. 12-15)?

Answered: 23 Skipped: 0

#	RESPONSES	DATE
1	no	4/17/2020 5:05 PM
2	No	4/17/2020 2:44 PM
3	No comment	4/17/2020 8:15 AM
4	Seems heavily skewed towards the least expensive route as opposed to the most practical or beneficial.	4/16/2020 11:03 PM
5	I generally agree that opioids have many risks, pitfalls, and emphasis should be on looking at alternatives, and strategies at taper when indicated. However I think the guidelines should also have some positive areas when it comes to appropriate patients for opioids. Otherwise some physicians or providers may be "alienated" by reading this guideline and "chalking" it up as the state trying to stop opioids prescribing. Maybe even going to the point and discussing some positive areas of opioids may be worth adding?	4/16/2020 7:21 PM
6	Consider making the evidence section an appendix. This would improve the flow of the document and focus the reader's attention on the more practical recommendations in the sections above. This section could use additional organization of each of its subsections, with an introductory statement at the beginning of each topic area to introduce what the new evidence is, and how it relates to the new recommendations in the main body of the supplement. That could then be followed by more detail on the studies themselves. The evidence section doesn't seem to support all of the recommendations in the supplement. Is there a reason that the evidence section includes the particular studies that are cited? It would be best to discuss why these studies are included. There is quite a bit of uneven detail in the evidence provided. For example, summarizing details of individual studies on tapering such as number of subjects in each arm of the study, etc. may not be needed. Consider summarizing findings and providing a reference. This would create a more homogeneous Evidence section. Consider creating a Table with sub-headers for each of the four previous sections and list summaries of the new evidence along with the citations to support each. At the bottom of page 14 there is a bullet specific to the Six Building Blocks program that requires revision for accuracy. Here is our recommended language for this bullet: o "The Six Building Blocks for Opioid Medication Management provides an evidence-based guide for primary care clinics to deliver more guideline concordant care to patients on long-term opioid therapy. Developed as a collaboration between the Kaiser Permanente of Washington Health Research Institute and the University of Washington, it has been used to assist a diversity of primary care clinics across the U.S. including safety net clinics such as Federally Qualified Health Centers."	4/16/2020 7:12 PM
7	No	4/16/2020 11:17 AM
8	n/a	4/14/2020 11:34 PM
9	Evidence is the only way to have a more consensus in treatment approach	4/14/2020 3:09 PM
10	why bother	4/14/2020 12:59 PM
11	d	4/14/2020 9:57 AM
12	Any thoughts about gabapentin since it has been recently included in research as medication of concern with regard to OD risk?	4/14/2020 8:35 AM
13	This is biased towards pharmaceutical care and omits our most powerful and fastest acting options for most patients which is Interventional Pain management.	4/13/2020 5:29 PM
14	None	4/13/2020 12:55 PM
15	The data you are using is archaic! It is biased towards payers, and non-interventional practitioners and against Interventional Pain. It ignores a multidisciplinary approach and ignores studies that prove spinal interventions improve function pain and decrease the utilization of opioids.	4/12/2020 8:35 PM
16	It is time and cost. How are we planning to execute the such recommendations with no financial backing to providers?	4/12/2020 4:49 PM
17	I agree	4/10/2020 10:51 AM
18	a	4/9/2020 10:00 AM

19	Woefully dated and biased towards payers, and non-interventional practitioners and against Interventional Pain as part of a comprehensive approach	4/8/2020 2:33 PM
20	Interventional pain doctors routinely treat patients with complex and debilitating pain, yet the collaborative members listed include various providers and administrators, but lack the doctors who administer clinically proven procedures routinely performed for interventional pain treatment.	4/6/2020 10:51 AM
21	I have some research I would like to share, but need to send files.	4/3/2020 11:16 AM
22	No	3/24/2020 8:06 AM
23	Suicidality/Ideation. In our data - 1100 pts refered/3yrs - 15% came with a h/o SI/SA. Also very high rates of undisclosed - but identified through chart reivew - of bipolar disorder, hepatitis C, historical or current methamphetamine use, and PTSD. It's in the chart but most ignore.	3/20/2020 9:30 AM

Q11 Do you have any general comments?

Answered: 19 Skipped: 4

#	RESPONSES	DATE
1	no	4/17/2020 5:05 PM
2	I thought I saw another reference to addiction in this document but I am not able to find it. It does support compassionate care on the part of the provider which is critical but is seem weak for supporting for a provider to make the medical diagnosis of OUD when necessary. I have had patients not like the diagnosis of DM2 but they do not have the anger that many have around the OUD diagnosis. OUD is a diagnosis that starts to acknowledge side effects from taking opioids. The question is when is the best time to intervene. Flexibility for provider and patient to "dance" with the diagnosis is paramount to continuing our journey with these difficult patients.	4/17/2020 8:15 AM
3	I would like better statements regarding provider protections. We are the ones on the front lines, hearing the patient physical threats, being reported to the board, opioid registries that focus on punitive measures instead of rewarding comprehensive care. It's put the provider in a precarious position.	4/16/2020 11:03 PM
4	I am not trying to sound negative. I appreciate all the hard work and time that the committee has spent on this. I would like to emphasize a balanced approach as to be inclusive of providers rather than exclusive of those that do prescribe. I also feel that adding the other areas of pain management in more detail gives further merit and strength to the guidelines (IE: therapy, psychology, procedures, surgeries, etc)	4/16/2020 7:21 PM
5	The Six Building Blocks team greatly appreciates the Bree Collaborative Committee's hard work to supplement the current recommendations related to care of patients with chronic pain using opioid medications, and to update these recommendations with the latest evidence. Our team would be delighted to speak more with the committee about how to make this supplement most useful to the clinical community. As a supplement with a target audience of providers, we feel that this document would be most helpful if it: 1) starts each section (e.g., establishing a relationship, treatment) with a summary statement that outlines the original document/s it is updating, the gaps in knowledge that the supplement is filling, and a high level statement about what is new in the section. This will provide consistency and coherence throughout the document, and make it more likely that those reading the document will absorb the key messages from the document. 2) hyperlinks resources to recommendations so providers can more easily implement the recommendations 3) formats each section and the document overall in a systematic way that is easy to read (e.g., makes clear why some font is in color, uses bold or italics when indicated) 4) adds tables, charts, diagrams, or graphics to reduce bullet points when appropriate. Given the current COVID-19 environment, we would suggest adding a section on Use of Telehealth for Managing Chronic Pain. Our Six Building Blocks team has created some resources that may be helpful in this regard. For the Appendix: Appendix D on page 20 has the Group Health logo. Since Group Health has been acquired by Kaiser Permanente, an updated version of this document would be optimal, with a current logo. Alternatively, you could consider not using this table and creating one based on the content in the article that you cite. Also, there is a more up-to-date reference on harms from long-term opioid therapy than the one you cite here: Chou R, et al. Ann Intern Med. 2015;162:276-286. doi:10.7326/M14-2559 Appendix F appears to have been copied from another document, and the first statement "These criteria not considered to be met for those individuals taking opioids solely under appropriate medical supervision." requires some context. As noted here, it is not clear.	4/16/2020 7:12 PM
6	We thank you for the opportunity to participate throughout the process. Our brief comments were provided by clinicians who reviewed the final draft. As previously noted, the WSMA continues to be concerned about payment for these services. The feasibility of implementing the recommendations would require a significant time commitment for which reimbursement is not currently available.	4/16/2020 11:17 AM
7	n/a	4/14/2020 11:34 PM
8	None	4/14/2020 3:09 PM
9	This guideline, like its chronic pain companion, is essentially a polemic, and a victory lap for that faction of the pain community who denounced opioids all these years. Well and good. Like the chronic pain guideline it argues for funding for its multidisciplinary model of care for pain in the primary care setting. Prima facie also well and good but there are two problems. One is that people with actual physical problems involving damaged somatic or neural tissue will not get the best treatment. Guidelines like these lump everyone together into a gauzy whole. The second is that 80% of the treatments in a multidisciplinary care model for pain are not specific	4/14/2020 12:59 PM

	to pain. Mindfulness, acupuncture, nutrition, exercise, CBT, etc. are just good preventive health for a lot of conditions, and I don't see a world where lifestyle and alternative medicine is wholly devoted to the pain patient. Primary care should have a paradigm shift toward these lifestyle measures, but calling them multidisciplinary pain management actually stigmatizes and gets in the way of their development. The Potemkin villages that exist in academia, from which this model derives, and which are supported by cheap resident labor, grants, and usually money from the OR Anesthesiologists, will never exist to any extent in the community. The effect of this guideline, given there aren't these programs to send patients to, will be to make primary care decide that pain patients aren't worth dealing with at all. Many already have, and the stigmatization of these patients have only gotten worse.	
10	Why has Interventional Pain Management been excluded from this document? Why are opioids being considered for benign chronic pain far before interventional pain management procedures? Procedures such as medial branch radiofrequency ablation can eliminate or greatly reduce pain for 1-3 years at a time, allowing patients to return to function and eliminate side-effect laden medications such as opioids.	4/13/2020 5:29 PM
11	Please incorporate the importance of prescribing (and/or dispensing) naloxone in relationship/tandem to long-term opioid therapy. Given overdose potential, we believe this is an important best practice to include with these recommendations.	4/13/2020 12:55 PM
12	The HTA has done very little to improve the opioid crisis in the state of WA. If anything HTA rules have worsened the situation in state insured patients. Providers hands are tied. They cannot perform procedures that are proven to be effective and in some cases are cost effective. For example, I have been involved in a claims analysis study that has shown significant cost reduction in patients with Intrathecal Drug Delivery that stopped the use of all systemic opioids. Where is this study cited? Furthermore, you timing is implorable, during the COVID-19 pandemic!	4/12/2020 8:35 PM
13	Hope such elaborated recommendation become realistic. We have plan, but how will you execute the plan?	4/12/2020 4:49 PM
14	a	4/9/2020 10:00 AM
15	Access to all the therapies is warranted as clearly identified by the Interagency Task Force in 2019. There is nothing to suggest that the Washington AMDG 2015 recommendations helped with the opioid burden and this was in large part because those recommendations failed to be all encompassing of he prevailing literature on Interventional Pain Management	4/8/2020 2:33 PM
16	The state of Washington has perhaps the most restrictive view and policies regarding interventional pain procedures and Washington L&I is the only state agency in the USA to prohibit Spinal Cord Stimulation therapy	4/6/2020 10:51 AM
17	Thank you for doing this work and putting everything together. It's great that alternative therapies are being included, not just different ways to manage pharmaceuticals- employing every tool to support people in being healthy and able to get back to their lives for the best care of the patient is the goal.	4/3/2020 11:16 AM
18	There are so many paths to recovery and so many professionals to help the person's decision on how they want to get to their goal of recovery. How wonderful.	3/24/2020 8:06 AM
19	It's good.	3/20/2020 9:30 AM

Q12 Name:

Answered: 14 Skipped: 9

Ginny Weir

From: Charis Wolf <c.wolf@weama.info>
Sent: Friday, April 3, 2020 11:27 AM
To: Ginny Weir
Subject: additional research
Attachments: Acupunctures-Role-in-Solving-the-Opioid-Epidemic -- JIM copy.pdf; EBA_AcupunctureForPain_2018_NewSize_Print.pdf

Hi Ginny,

I just offered some feedback on the Bree Collaborative work around long term opioid therapy recommendations. We are very happy to see the move towards integrative care and are happy to offer our skills to reduce pain and the need for opioids, and very much appreciate the inclusion in the overall solution.

I also wanted to send in some further information on how acupuncture is a valuable tool for treating pain and how we can partner in moving forward together.

All the best,
Charis

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Medtronic

April 16, 2020

Ginny Weir, MPH
Director, The Bree Collaborative
Foundation for Health Care Quality
705 Second Avenue, Suite 410
Seattle, WA 98104

Dear Ms. Weir:

On behalf of Medtronic, I am writing in relation to upcoming consideration of The Bree Collaborative's draft Long-Term Opioid Use Report and Recommendations.

Medtronic is a global medical technology and services company with a variety of therapies to serve patients. This includes U.S. Food and Drug Administration (FDA) approved therapies such as spinal cord stimulation (SCS) and implantable drug delivery systems (IDDS) for the treatment of chronic, intractable pain. While these therapies do not treat opioid addiction, both provide an important chronic pain relief treatment option for patients when conventional therapies and medications, including oral opioids, provide inadequate pain relief or intolerable side effects.

We appreciate The Bree Collaborative's focus on long-term use of systemic (oral and patch) opioid use and the opioid crisis, including patients who "may want to stop chronic opioid therapy due to a variety of reasons, including lack of efficacy, side effects, impact on quality of life, and concerns about addiction."[1] Further, we agree with the Report's mirroring the U.S. Centers for Disease Control guidelines recommending nonpharmacologic therapy and nonopioid pharmacologic therapy as preferred treatments for chronic pain.[2]

Having said that, we suggest that the section on developing a treatment plan in the draft Long-Term Opioid Use Report and Recommendations be expanded to include a complete list of therapy options, including device-based therapies, particularly for cases of patients who do not respond to conservative medical management and who have a history of long-term systemic opioid therapy. As you may know, the FDA's updated opioid education Blueprint includes discussion on the use of approved/cleared medical devices for pain management.[3] In addition, the U.S. Department of Health and Human Services released The Pain Management Best Practices Inter-Agency Task Force Report in May 2019. The Task Force Report noted that a "multidisciplinary approach for chronic pain across various disciplines, using one or more treatment modalities, is encouraged when clinically indicated to improve outcomes" and included five broad treatment categories: Medications, Restorative Therapies, Interventional Approaches, Behavioral Approaches, and Complementary and Integrative Health.[4] Both SCS and IDDS, along with other therapies, are mentioned as treatment options in the Task Force Report's Interventional Approaches section.

As related background on these therapies, a large retrospective study of insurance claims data showed that 82% of chronic non-cancer pain patients reduced their average daily systemic opioid dose in the year following initiation of IDDS therapy for pain relief, while 43% eliminated oral opioids completely (a prior study showed 51% elimination).[5,6] Among patients that eliminated systemic opioids, total per patient payer cost savings (both medical and pharmacy) in the year following start of IDDS therapy were $11,115 relative to patients with IDDS who remained on systemic therapy.[5] Further, multiple studies have provided clinical evidence to suggest some patients treated with SCS may be able to reduce oral opioid consumption.[7-9] A review of cost studies has also shown that SCS therapy is cost effective among patients with chronic low back pain when compared to conventional medical management or re-operation.[10]

Thank you for your consideration of these comments as you continue to evaluate this complex issue, and please do not hesitate to contact me if you have any questions.

Sincerely,

Nate Myszka
Senior Manager, State Government Affairs
Medtronic
7000 Central Avenue NE, RCE385
Minneapolis, MN, 55432
Phone: 763-514-0145
Email: nate.myszka@medtronic.com

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[1] The Bree Collaborative. Long-Term Opioid Use Report and Recommendations (February 27, 2020 draft). http://www.breecollaborative.org/wp-content/uploads/Bree-Long-Term-Opioid-Use-Recommendations-20-0227.pdf. Accessed April 2020.
[2] Centers for Disease Control and Prevention. Guideline for prescribing opioids for chronic pain: improving practice through recommendations. https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf, Accessed April 2020.
[3] US Food and Drug Administration. FDA's opioid analgesic REMS education blueprint for health care providers involved in the treatment and monitoring of patients with pain, September 2018. https://www.accessdata.fda.gov/drugsatfda_docs/rems/Opioid_analgesic_2018_09_18_FDA_Blueprint.pdf, Accessed April 2020.
[4] US Department of Health and Human Services. Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies, and Recommendations. 2019; https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf. Accessed April 2020.
[5] Hatheway JA, Bansal M, Nichols-Ricker CI. Systemic Opioid Reduction and Discontinuation Following Implantation of Intrathecal Drug-Delivery Systems for Chronic Pain: A Retrospective Cohort Analysis. Neuromodulation. 2019.
[6] Hatheway JA, Caraway D, David G, et al. Systemic opioid elimination after implantation of an intrathecal drug delivery system significantly reduced health-care expenditures. Neuromodulation. 2015;18(3):207-213.
[7] Sharan AD, Riley J, Falowski S, et al. Association of opioid usage with spinal cord stimulation outcomes. Pain Med. 2018;19(4):699-707. A non-randomized analysis of Truven Health Marketscan databases from January 2010 to December 2014 based on the first occurrence of an SCS implant (N= 5,476).
[8] Gee L, Smith HC, Ghulam-Jelani Z, et al. Spinal Cord Stimulation for the Treatment of Chronic Pain Reduces Opioid Use and Results in Superior Clinical Outcomes When Used Without Opioids. Neurosurgery. 2019;84(1):217-226. A non-randomized prospective cohort study of SCS patients between September 2012 and August 2015 (N=86 [n=53 on opioids]).
[9] Pollard EM, Lamer TJ, Moeschler SM, et al. The effect of spinal cord stimulation on pain medication reduction in intractable spine and limb pain: a systematic review of randomized controlled trials and meta-analysis. J Pain Res. 2019;12:1311-1324. A research review summarising SCS studies with respect to opioid use and a further meta-analysis of comparative SCS RCTs of 1 year or greater duration (N=489).
[10] Hoelscher C, Riley J, Wu C, Sharan A. Cost-Effectiveness Data Regarding Spinal Cord Stimulation for Low Back Pain. Spine (Phila Pa 1976). 2017;42 Suppl 14:S72–S79.

Bree April 2020 Draft Comments
Greg Rudolf MD, Swedish Pain Services

1)From page 9: **“If patients on high opioid dosages are unable to taper despite worsening pain and/or function with opioids, whether or not opioid use disorder criteria are met, consider transitioning to buprenorphine.”**

Consider adding another sentence here directly following which says:
“If the managing provider can consult with a colleague or local specialist with skill and experience in transitioning patients successfully from high dose opioids to buprenorphine as an alternative opioid for pain, the provider should consider offering the patient referral to this consultant to discuss the buprenorphine option early in the process of opioid tapering, even perhaps at the initial discussion phase, rather than waiting for the patient to “fail” an opioid taper. Even if the patient does not elect to pursue the buprenorphine option at first, it may help the patient’s tapering process if it is known that there is another pathway available for pursuit of the goal of a safer and potentially more effective opioid regimen.”

2) From page 10: **Buprenorphine**. “Once a patient is having mild-to-moderate withdrawal, administer 2 to 4 mg of sublingual buprenorphine or buprenorphine plus naloxone. If patient has no unacceptable side effects, administer an additional 4–8 mg sublingually at 1–2 hours, followed by adjustment according to response up to 32 mg daily in divided doses”

The buprenorphine dosing protocol outlined here is consistent with dosing typically used to treat withdrawal in the setting of OUD in young healthy patients, such as those aged 18-35 without any significant medical comorbidities who are dependent on heroin or illicit short-acting opioids such as oxycodone.
This dosing regimen, if applied to older patients maintained on prescription opioids being transitioned to buprenorphine as an alternative opioid for pain management[1], may be too prescriptive and/or the dosing may be too aggressive. It is important to take into account the variables that would affect optimal buprenorphine dosing at the time of initial induction, such as the patient’s age and medical/psychiatric comorbidities, concurrent medications (including not only routine medications but also other medications being given for withdrawal[2]), opioid use history and dose/formulation of opioid(s) being discontinued,

patient's psychosocial milieu, and other factors. It is not uncommon for a provider experienced in using sublingual buprenorphine for pain to successfully stabilize a patient on a dose such as 2mg three times daily, even when the patient was on a regimen of high-dose opioids (>90 MED) prior to the transition. The common factor of opioid-induced hyperalgesia (OIH) as a clinical component contributing to opioid-related dysfunction typically responds to buprenorphine's well-known anti-hyperalgesic effects[1] following the transition, therefore higher doses are frequently not needed; moreover, there may be problems with tolerability of sublingual buprenorphine for a significant percentage of patients if given 8mg within the first several hours. To be sure, some patients transitioning to buprenorphine for pain do benefit from being dosed higher, such as 16-32mg daily, in order to stabilize withdrawal and pain control. It is helpful nonetheless for patients to be dosed lower at first, i.e. no more than 12mg daily, to avoid adverse effects, and trial lower doses of buprenorphine for effectiveness.

A suggestion for the Bree guidelines would be to add a line to the buprenorphine dosing protocol that is given: "If buprenorphine is to be used not only for withdrawal management but also as a sustainable alternative opioid

for treatment of chronic pain, the dosing of buprenorphine might differ, and consultation with an experienced buprenorphine provider is advised."

3) **Payor coverage for buprenorphine.** At present, the formulations of buprenorphine which are FDA-approved for pain, transdermal and buccal buprenorphine (Belbuca^{tm}), are often not covered by either commercial or government-sponsored plans in WA state. Further, sublingual buprenorphine, which is known to be safe and effective treatment for pain[3], is covered only for the diagnoses of "opioid use disorder" and "opioid dependence". Many providers feel uncomfortable using the latter term to describe patients for whom they would like to consider using sublingual buprenorphine due to lack of access to the other formulations via insurance, when the patient has been adherent to opioid dosing guidelines and monitoring expectations and engaged in no aberrant drug-taking behaviors, and therefore does not meet criteria for opioid use disorder. In other cases the choice to prescribe sublingual buprenorphine is made due to its increased potency[1] in comparison to the other buprenorphine formulations. Some providers are using the "opioid dependence" terminology as per the recent Health and Human Services opioid tapering guidelines[4], with the explicit recommendation in that guideline to

consider use of buprenorphine in these cases. Other providers are unaware of this clinical option and are under the impression that sublingual buprenorphine can and should only be utilized for patients who meet criteria for opioid use disorder. It would be appropriate for the Bree recommendations to include advocacy for easing restrictions in coverage for all buprenorphine products used in the treatment of chronic pain, including not only the buccal (Belbuca^{tm}) and transdermal formulations, but also sublingual buprenorphine as an "off-label" but evidence-based choice[3] that has clear advantages pharmacologically over other long-acting opioids for pain. Providers should be able to facilitate use of buprenorphine as a first-line option for patients who require a long-acting opioid, as non-scientific barriers to this care pathway are contributing significantly to opioid-related harm and dysfunction.

An example of the kind of language typically seen with payors' coverage policies on sublingual buprenorphine is the following from Molina:

"Diagnosis clinically based on history and physical exam findings that support Diagnostic and Statistical Manual of Mental Disorders, 5th ed. DSM-V-TR criteria for Opiate Abuse and Dependence and/or DSM-IV-TR criteria for

opioid dependence. [DOCUMENTATION REQUIRED] ‹ Refer to 'Appendix 2' for additional information on DSM-5 or ICD-10 diagnostic criteria6 ‹ Buprenorphine is not FDA-approved for the treatment of chronic pain. **Buprenorphine/naloxone is not appropriate for pain management**"

This language clearly flies in the face of scientific investigation showing that sublingual buprenorphine (with or without naloxone) is not only appropriate but also typically safer and often more sustainably clinically effective than other opioids[3].

References:

1) Rudolf, G et al. **A novel non-opioid protocol for medically supervised opioid withdrawal and transition to antagonist treatment.** Am J Drug Alcohol Abuse. 2018;44(3):302-309.
Note: This reference is included as an evidence-based opioid withdrawal protocol used widely regionally and beyond for transitioning patients from conventional opioids to buprenorphine for pain management, OUD treatment, or both, or for transition to naltrexone for OUD.

2) Rudolf, G. **Buprenorphine in the Treatment of Chronic Pain.** Phys Med Rehabil Clin N Am 31 (2020) 195–204

3) Cote J, Montgomery L**. Sublingual Buprenorphine as an Analgesic in Chronic Pain: A Systematic Review.** *Pain Medicine*, Volume 15, Issue 7, July 2014, Pages 1171–1178

4) D. Dowell, C. Jones, W. Compton, *et al.* **HHS guide for clinicians on the appropriate dosage reduction or discontinuation of long-term opioid analgesics** (2019) Available at: HHS.gov. Accessed October, 2019

April 24, 2020

Bree Collaborative
Foundation for Health Care Quality
705 Second Avenue, Suite 410
Seattle, WA 98104

Re: Opioid Prescribing: Long-Term Opioid Therapy Report and Recommendations

Dear Members of the Bree Collaborative,

Thank you for the opportunity to provide feedback and comments on the Bree Collaborative's Long-Term Opioid Therapy Report and Recommendations.

Our caregivers in all settings see patients that have been impacted by the opioid epidemic and the high prevalence of high impact chronic pain. Our leaders and physicians are committed to implementing best practices that support the health and safety of our patients. We are pleased to provide comments on behalf of Providence and its partners in Washington state – including Swedish, Pacific Medical Centers and Kadlec. As the largest health care provider in the state, our not-for-profit network includes 14 hospitals, hundreds of clinics, including the Swedish Pain Services clinics, care centers, hospice and home health programs, supportive housing, and diverse senior and community services. Together, our dedicated caregivers are working to create health for a better world.

Our comments below follow the format of the survey questions posed by the Collaborative.

1. What sector do you represent?

Providence St. Joseph Health represents the hospital system sector, including primary care, addiction medicine, specialty care, and comprehensive pain management services.

2. Do you have any comments on the background (pg. 1)?

Providence St. Joseph Health applauds the Bree Collaborative supporting the National Pain Strategy's (NPS) guiding principles for a patient-centered approach to assessing the use of long-term opioid therapy. As a follow up to NPS, the HHS Pain Management Best Practices Inter-Agency Task Force Report was released in May 2019. The multidisciplinary task force was established to address gaps and inconsistencies for managing chronic and acute pain. The report clearly cautions against misuse of the CDC guidelines and unintended consequences of misapplication by stakeholders leading to forced tapers and patient abandonment. Importantly, the report highlighted five broad treatment categories and a biopsychosocial multidisciplinary approach which includes various classes of medications (non-opioids and opioids), restorative therapies, interventional procedures, behavioral health approaches, and complementary/integrative health. These report's five treatment categories should be integrated as a foundation for the Bree's opioids management recommendations. Supporting and integrating the HHS reports' recommendations in this documents will help to encourage and support the broader implementation of comprehensive multidisciplinary care to all stakeholders, including payers, pharmacy

benefit plans, insurers, government entities, and advocacy groups. (ref. *Pain Management Best Practices Inter-Agency Task Force Report*. Updates, Gaps, Inconsistencies, and Recommendations. May 16, 2019. HHS Pain Task Force. V Singh, Chair)

3. Do you have comments on patient engagement (pg. 2)?

Providence St. Joseph Health supports the focus on goal setting and functional improvement. As a part of patient engagement, consider adding importance of careful review of history, records, and physical examination that establishes a more complete diagnosis. The importance of correct pathoanatomic diagnosis and/or identification of physical and psychological impairments underlying the painful condition should not be underestimated in increasing patient trust, confidence and engagement in care. Recommend additional laboratory testing and imaging studies if needed to establish a definitive diagnosis. We suggest expanding discussion related to "talk about chronic pain treatment approaches outside of COT". A more specific mention of the five HHS treatment categories and consider including "introduce the idea that restorative therapies, interventional procedures, behavioral health and complementary/integrative health may be significantly beneficial in improving pain". A patient-provider interaction should also include a discussion of a patient's understanding of basic nervous system changes with chronic pain and the importance of patient education to help patients better understanding pain but how the various treatment categories can help change pain processing. Evidence-based patient education can help patients to better understand the influence of psychological factors and the pain experience (pain related anxiety, depression, catastrophizing) and adverse effects of opioid therapy. Improved patient education and knowledge will also help to reduce unnecessary utilization of medical services, excessive testing (diagnostic imaging, drug monitoring) and help to limit the development pain chronicity and patient adverse events.

The patient engagement discussion is an important section to helps shift providers away from a narrow focus of opioids as a unimodal treatment approach versus engaging patients to a multidisciplinary approach.

4. Do you have comments on assessment (pp. 3-4)?

a. "Patient History": The document did not include an assessment of sleep related impairment. Disturbed and non-restored sleep is strongly associated with increased pain and psychosocial distress. A history of sleep disorders (sleep apnea) and other respiratory conditions may place a patient at greater risk for respiratory failure and overdose. We recommend including assessment of current sleep quality and history of any sleep related disorders.

b. "Pain and Functional Status": We support the use of PEG as a validated screening tool for patient assessment. In refocusing the assessment on functional outcome rather than pain, one might consider other more robust validated tools for functional assessment (i.e. PROMIS pain interference assessment, Oswestry Disability Index, Neck disability index).

c. "Physical exam" needs clarification. A focused physical exam should not be limited to a neurological exam when neuropathic pain is suspected. Given the complex nature of a presenting pain complaint, a comprehensive physical exam should include a neurologic exam (sensory testing, muscle stretch reflexes, motor strength), targeted joint exam, and soft tissue assessment (myofascial pain, soft tissue restrictions, and tenderness).

d. "Urine drug test UDT": Consider use of less pejorative term such as "urine drug monitoring" (UDM). Assessment should include urine drug monitoring (immunoassays for point of care testing) and more sensitive confirmation measures including gas chromatography/ mass spectrometry (GC/MS) testing. The high rate of false positive and false negatives seen with the use of screening immunoassays (for opioids and other substances) may not only put the patient and prescriber at risk, but adversely affect the provider patient relationship. A more thorough analysis with more sensitive testing, when clinically necessary, can help reduce this pitfall. Confirmation testing will also help to clarify type of opioid/opiate and metabolites but also clarify use of other substances (i.e. benzodiazepines, stimulants, and other drugs of abuse). (Argoff CE, Alford D, Fudin J, et al. Rational urine drug monitoring in patients receiving opioids for chronic pain: consensus recommendations. *Pain Medicine* 2017;0:1-21)

e. "Health record: Any use of sedatives/benzodiazepines": It is useful to highlight risks of concomitant use of opioids and benzodiazepines. It would be useful to explain when a provider may consider their concomitant use permissible even if in the rarest of circumstances. For example, when a patient uses benzodiazepines under the direction of a psychiatrist or on a rare or intermittent basis for management of severe panic or anxiety disorders. In special cases, justification for use can be made based on the risk benefit profile of the specific patient and consideration of related psychiatric disorders. This is consistent with Washington State opioid prescribing rules initiated in 2020 explaining "the physician shall not knowingly prescribe opioids in combination with the following medications (i.e. benzodiazepines, barbiturates, sedatives, carisoprodol, nonbenzodiazepine hypnotics) without documentation of the medical decision making" noted in WAC 246-919-970.

5. <u>Do you have comments on develop a treatment plan (pp. 5-6)?</u>

a. Interventional pain treatments has been excluded in this section of the draft. Interventional pain treatment modalities may be an adjunct in the treatment of chronic pain. This section should include the use of interventional pain procedures and surgical treatments, including neuromodulation, as clinically indicated. Again, integrating recommendations of HHS Interagency Task Force Report can better highlight the need for a comprehensive multidisciplinary approach which may include the careful use of diagnostic and therapeutic injections and/or procedures. *The Collaborative Care for Chronic Pain* Bree document referenced provides valuable guidance on improved chronic pain assessment and management, but is based on a primary care team-based approach to pain management emphasizing self-management. The document does not include interventional or other specialty care approaches that can also be beneficial for patients, and many times offered by pain specialists or other non-primary care providers (physical medicine and rehabilitation specialists, rheumatologists, sports medicine specialists).

b. Problems with the use of term "multidisciplinary" in isolation in this draft. See "Use non-pharmacological pain management".

We suggest using more descriptive terms and clarify difference of "multidisciplinary" vs "interdisciplinary". "Multidisciplinary" may include different interventions being used at one time (physical therapy and spinal injections for acute lumbar radiculopathy) and is usually directed by one provider (physician or nurse) and many times at different facilities. A multidisciplinary approach is a common model of care for many patients with chronic pain. For a smaller percentage of patient, many not benefiting from general multidisciplinary approaches, may need a more biopsychosocially-based interdisciplinary model. An "Interdisciplinary" approaches is more collaborative and includes the use of

multiple disciplines (physical therapy [PT], occupational therapy [OT], vocational rehabilitation, behavioral health, and pain education) provided at one facility usually provided in group and individual one-on-one sessions . Interdisciplinary treatment or "functional restoration" models usually include team meetings and direct communication between providers to better adjust treatment plans and facilitate greater patient outcomes. The draft document may be unintentionally confusing these terms and models of care. Clarification of the terms going forward will only help to improve discussions within health systems regarding models of care and communication with other stakeholders (i.e. payers, legislators). The National Pain Strategy (NPS) specifically recommends "a population-based, biopsychosocial approach to pain care that is grounded in scientific evidence, integrated, multimodal, and interdisciplinary, while tailored to an individual patient's needs."

A similar confusion of terms is noted later in the draft document under "Health Plans" (page 11 of 32). In this section, SHS/PSJH supports recommendations for health plans to "expand reimbursement for Structured Intensive Multidisciplinary Program (SIMP) to increase access and availability when medically necessary." SIMP programs have been the cornerstone of interdisciplinary care for the state of WA, but are limited primarily to patients with work related injuries and active cases under Labor and Industries (L&I). SHS/PSJH provides interdisciplinary treatment programs for Medicare, Medicaid, self-insured, and commercial covered patients without being considered a SIMP. We recommend addition of "interdisciplinary treatment programs" in addition to SIMP programs throughout the document for greater clarity and consistency. "Interdisciplinary programs" is specifically used later in the document (page 12, "treatment Pathways") when quoting Frank et al systematic review on tapering finding "the strongest evidence with fair-good studies included interdisciplinary programs with mean opioid discontinuation rates of 87% . . ."

Page 11. "Health Care Systems". We recommend the Bree supporting "interdisciplinary" models of care by including this model and modify the sentence:

> "Consider creating a SIMP at the health care system or collaborating with one to ensure access to intensive, multimodal treatment options when indicated. This can be helpful venue for patients being tapered off opioids."

Modify to:

> "Consider creating interdisciplinary pain treatment programs (including SIMPs) at the health care system level or collaborating with one to ensure access to intensive, multimodal interdisciplinary treatment options when indicated. These models of care have been shown to improve quality of life and psychosocial function as well as a venue to taper and/or reduce opioids (Mayo Clinic: Gilliam W, et al. *J Pain* 2018;19(6):678-689. Cleveland Clinic program. Huffman K, et al. *Pain* 2017:158:1380-1394.)"

6. Do you have comments on treatment pathway #1 Maintain and Monitor (pp. 6-7)?

There may be scenarios where it is permissible to use combination of opioids and intermittent benzodiazepines in patients when there is a consensus with a psychiatrist that there is no other alternative to manage severe anxiety and/or panic disorder. Consider use of buprenorphine for the treatment of pain. It has properties that do ameliorate pain while carrying less risk of opioid induced hyperalgesia as well as overdose risk. Communication between prescribing physician and behavioral health specialist is critical to ensuring patient safety. This communication and medical decision making

should be documented in the medical record consistent with current WA State pain rules noted in WAC 246-919-970.

7. Do you have comments on the treatment pathway #2 Tapering or Discontinuation (pp. 7-9)?

See below for our comments on question #8.

8. Do you have comments on the recommendations for treatment pathway #3 Medications for Opioid Use Disorder (pp. 9-10)?

a. From page 9, bullet 7: "If patients on high opioid dosages are unable to taper despite worsening pain and/or function with opioids, whether or not opioid use disorder criteria are met, consider transitioning to buprenorphine."

Consider adding:

> "If the managing provider can consult with a colleague or local specialist with skill and experience in transitioning patients successfully from high dose opioids to buprenorphine as an alternative opioid for pain, the provider should consider offering the patient referral to this consultant to discuss the buprenorphine option early in the process of opioid tapering, even perhaps at the initial discussion phase, rather than waiting for the patient to "fail" an opioid taper. Even if the patient does not elect to pursue the buprenorphine option at first, it may help the patient's tapering process if it is known that there is another pathway available for pursuit of the goal of a safer and potentially more effective opioid regimen."

b. From page 10: "Buprenorphine". "Once a patient is having mild-to-moderate withdrawal, administer 2 to 4 mg of sublingual buprenorphine or buprenorphine plus naloxone. If patient has no unacceptable side effects, administer an additional 4–8 mg sublingually at 1–2 hours, followed by adjustment according to response up to 32 mg daily in divided doses"

The buprenorphine dosing protocol outlined here is consistent with dosing typically used to treat withdrawal in the setting of OUD in young healthy patients, such as those aged 18-35 without any significant medical comorbidities who are dependent on heroin or illicit short-acting opioids such as oxycodone.

This dosing regimen, if applied to older patients maintained on prescription opioids being transitioned to buprenorphine as an alternative opioid for pain management may be too prescriptive and/or the dosing may be too aggressive. It is important to take into account the variables that would affect optimal buprenorphine dosing at the time of initial induction, such as the patient's age and medical/psychiatric comorbidities, concurrent medications (including not only routine medications but also other medications being given for withdrawal), opioid use history and dose/formulation of opioid(s) being discontinued, patient's psychosocial milieu, and other factors (Rudolf, G et al. A novel non-opioid protocol for medically supervised opioid withdrawal and transition to antagonist treatment. *Am J Drug Alcohol Abuse*. 2018;44(3):302-309). This reference is included as an evidence-based opioid withdrawal protocol used widely regionally and beyond for transitioning patients from conventional opioids to buprenorphine for pain management, OUD treatment, or both, or for transition to naltrexone for OUD. (Additional reference. Rudolf, G. Buprenorphine in the Treatment of Chronic Pain. *Phys Med Rehabil Clin N Am* 31 (2020) 195–204.)

It is not uncommon for a provider experienced in using sublingual buprenorphine for pain to successfully stabilize a patient on a dose such as 2mg three times daily, even when the patient was on a regimen of high-dose opioids (>90 MED) prior to the transition. The common factor of opioid-induced hyperalgesia (OIH) as a clinical component contributing to opioid-related dysfunction typically responds to buprenorphine's well-known anti-hyperalgesic effects1 following the transition, therefore higher doses are frequently not needed; moreover, there may be problems with tolerability of sublingual buprenorphine for a significant percentage of patients if given 8mg within the first several hours. To be sure, some patients transitioning to buprenorphine for pain do benefit from being dosed higher, such as 16-32mg daily, in order to stabilize withdrawal and pain control. It is helpful nonetheless for patients to be dosed lower at first, i.e. no more than 12mg daily, to avoid adverse effects, and trial lower doses of buprenorphine for effectiveness.

Providence St. Joseph Health suggests adding clarification for the buprenorphine dosing protocol that is given to include:

> "If buprenorphine is to be used not only for withdrawal management but also as a sustainable alternative opioid for treatment of chronic pain, the dosing of buprenorphine might differ, and consultation with an experienced buprenorphine provider is advised."

9. <u>Do you have comments on the recommendations for health systems (pg. 11)?</u>

Providence St. Joseph Health supports recommendations for health plans to "expand reimbursement for Structured Intensive Multidisciplinary Program (SIMP) to increase access and availability when medically necessary." SIMP programs have been the cornerstone of interdisciplinary care for the state of Washington, but is limited to patients with work related injuries and active cases under Labor and Industries (L&I). Using only SIMP in this section without including more inclusive "interdisciplinary program" is problematic and may inadvertently limit access to care for patients. We provide numerous interdisciplinary treatment programs for Medicare, Medicaid, self-insured, and commercial covered patients. We recommend addition of "interdisciplinary treatment programs" in addition to SIMP programs throughout the document for greater clarity and consistency.

Page 11. "Health Care Systems". We recommend the Bree supporting "interdisciplinary" models of care by including this model and modify sentence: "Consider creating a SIMP at the health care system or collaborating with one to ensure access to intensive, multimodal treatment options when indicated. This can be helpful venue for patients being tapered off opioids." Modify to "Consider creating interdisciplinary pain treatment programs (including SIMPs) at the health care system level or collaborating with one to ensure access to intensive, multimodal interdisciplinary treatment options when indicated. These models of care have been shown to improve quality of life and psychosocial function as well as a venue to taper and/or reduce opioids (Mayo Clinic: Gilliam W, et al. *J Pain* 2018;19(6):678-689. Cleveland Clinic program. Huffman K, et al. *Pain* 2017:158:1380-1394.)

10. <u>Do you have comments on the evidence section (pg. 12-15)?</u>

Providence St. Joseph Health encourages broad use of the PEG but we recommend considering the additional use of a potentially more sensitive patient reported outcome measures (PROM) for function such at PROMIS PI (Askew RL et al. Clinical Validity of PROMIS Pain Interference and Pain Behavior in Diverse Clinical Populations. J Clin Epidemiol 2016. May; 73: 103-111.) Refocusing away from pain intensity onto more sensitive functional measures may help track progress and be more meaningful to

patients. The PEG score over time tends to be static and clinically patients may be challenged by accurately reporting the General Activity and Enjoyment of Life on a 0-10 scale.

Urine drug monitoring (UDM) remains part of best practices for opioid therapy and can be helpful to rule out diversion and screen for abuse and addiction to opioids and other substances. There are significant ethical implications and both beneficial and detrimental effects on the doctor patient relationship. The appropriate interpretation and use of "urine drug screens" in monitoring and guiding therapy is essential. Providing additional guidance and resources for prescribers performing these tests may be beneficial if added to the document. (Argoff CE, Alford D, Fudin J, et al. Rational urine drug monitoring in patients receiving opioids for chronic pain: consensus recommendations. *Pain Medicine* 2017;0:1-21; Kaye AD, et al . Ethical perspective on urine drug screening for pain physicians. *Pain Physici*an 2014; 17:E559-E564. Reisfield GM, et al Rational Use and Interpretation of Urine Drug Testing in Chronic Opioid therapy. *Annal of Clinical and Laboratory Science*, 2007; 34(7): 301-314, Vadivelu N et al. The Implications of Urine Drug Testing in Pain Management; *Current Drug Safety,* Volume 5, Number 3, 2010, pp. 267-270(4)).

Injection procedures are a useful adjunct for the treatment of chronic pain. Given the breadth of painful conditions that may be treated with interventional procedures it is difficult to concisely summarize the data in particular as it relates to opioid reduction. In one retrospective study of 4,465 patients undergoing lumbar radio-frequency ablation 1007 had been taking opioids at the time of the procedure. Following the procedure there was a 19.66% reduction in the number of patients needing opioid therapy (Loh, E, et al. Retrospective cohort study of healthcare utilization and opioid use following radio frequency ablation for chronic axial spine pain in Ontario Canada. Reg Anesth Pain Med 2019; 44:398-405).

Do you have any general comments?

Overall this report's analysis adds structure to assessment and strategies for managing patients with persistent pain with long term opioid therapy.

Providence St. Joseph Health urges that integration of the HHS Interagency Pain Task Force recommendations and structure into the document be considered including the five treatment categories including; 1. medications (non-opioids and opioids), 2. restorative therapies, 3. interventional procedures, 4. behavioral health approaches, and 5. complementary/integrative health. It is important that evidence based guidelines, like the Bree Collaborative document also use updated terminology related to models of comprehensive care including "multi;" and "inter-disciplinary". Appropriate and updated terminology will only help to clarify communication between stakeholders and help systems to integrate better models of care.

The addition of more robust and facile patient related outcome measure such as PROMIS, in addition to the PEG, may help to strengthen a provider's ability to assess function and response to treatment. Expansion of use of buprenorphine for opioid tapering, as an analgesic, and the use for opioid use disorder will provide patients and caregivers with safer options for care. Furthermore, clarification as to when it is permissible to co-prescribe sedatives and opioids would be beneficial and consistent with current WA State pain rules and supports patient-centered care while limiting adverse effects of opioids and other centrally acting agents. Finally, recommend inclusion of interventional pain techniques as an adjunctive strategy that may mitigate the opioid burden in this population.

Thank you for the opportunity to share comments with the Bree Collaborative members on this important topic. My Swedish Pain Services pain management and addiction medicine colleagues, Drs. James Babington, Wilson Chang, Chris Merifield, Greg Rudolf, FangFang Xing, and Cong Yu, are grateful for the work already completed by the Bree and your consideration of our comments. If you have any questions about the information shared above, please contact Sarabeth Zemel, Government and Public Affairs, at Sarabeth.Zemel@providence.org or by phone at (425) 525-3228.

Sincerely,

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