Public Comments to Bree Opioids Prescribing in Older Adults

Guideline Section	Commenter	Comments	Draft Response
General	Shelley Gray	In general, recommend being consistent with how referring to the 2019 AGS Beers Criteria. If want to be more brief, after the first time spelling this out completely, could indicate that these criteria will be referred to as "AGS Beers Criteria" from this point forward. These are referred to differently throughout the document (AGS Beers Criteria, 2019 AGS Beers, etc.)	Replaced references to AGS Beers Criteria with 2019 AGS Beers
General, table 1	Swedish Pain Services	Clinical goals include "Prevent transition to long term opioid use". We suggest modifying this clinical goal to "Prevent unnecessary transition to long term opioid use."	Added suggested language "Prevent unnecessary transition to long term opioid use"
Acute Prescribing – table 2, row 3	Public Commenter – Opioid Prescriber	"Current mixed opioid agonist/antagonist treatment (e.g. buprenorphine, naltrexone)" Where is the data for this comment coming from? Current literature points away from this being the case. I practice acute pain at Harborview Medical Center in Seattle and commonly take care of people on buprenorphine both for chronic pain and OUD. I do not think that buprenorphine should have a separate row in this table, it should be included in the opioid tolerance row (row 2). Keeping it separate continues the misperception that it is somehow different and more risky than other opioids when in fact it is, if anything, safer	No change. The table was adapted from the 2015 AMDG guideline
Acute Prescribing – table 2	Swedish Pain Services	"Risk for Difficult to Control Postoperative Pain" The table is not referenced and if these two categories are actually risks for difficult to control postoperative pain. If these "risks" are not supported by published evidence, we suggest removal from the document.	Added "Adopted from 2015 AMDG Interagency Guideline on Prescribing Opioids for Pain" below table for reference
Acute Prescribing – during discharge and follow-up, bullet 2	Public Commenter – Opioid Prescriber	"Track opioid use and signs of potential misuse and related outcomes (e.g., mood, mobility, activities of daily living, sleep, appetite, cognitive impairment, and weight changes)" Many of the things listed above are not relevant for a short <7 day prescription of opioids. It is confusing that things like weight changes, mood, and appetite are listed when they are irrelevant.	Removed examples
Acute Prescribing – when consider initiating opioids	Swedish Pain Services	Suggest, "When considering imitating opioids, recommend providing a written treatment plan to patients."	Added to first bullet: "See opioid prescribing rules on acute non-operative and perioperative pain." Hyperlink to DOH toolkit: https://doh.wa.gov/public-health-

			healthcare-providers/healthcare-professions-and-facilities/opioid-prescribing/healthcare-providers/toolkits
Co-prescribing with Opioids – sub bullet 3	Public Commenter – Opioid Prescriber	"Avoid combining opioids with gabapentinoids. Exceptions are when transitioning from opioid therapy to gabapentin or pregabalin, or when using gabapentinoids to reduce opioid dose, although caution should be used in all circumstances." I agree that one should reduce the co-prescribing of opioids and CNS depressants, however I also know that benzos are much more risky when co-prescribed than gabapentinoids. If gabapentenoids get such strong language, and a point all to themselves, then benzos certainly deserve a bit more!	Clarified bullet 2, sub 2 (page 6) to add at the beginning "Avoid combining opioids with benzodiazepines. If benzodiazepines are prescribed…."
Co-prescribing with Opioids	Swedish Pain Services	When co-prescribing with opioids access to behavioral health providers continues to be a significant issues. Recommend including links resources for telehealth options.	Clarified bullet 2, sub 2 to add "provider-to-provider consult…"
Co-prescribing with Opioids	Swedish Pain Services	Medication therapy programs are well intended, but continue to create an increased burden on prescribers while offering little guidance with risk assessment and monitoring tools.	No change
Non-Opioid Pharmacologic Pain Management - medication management, bullet 1	Public Commenter – Opioid Prescriber	Acetaminophen is rarely indicated for chronic pain as stated page 8 and is also risky	No change. Current language explained the risk associated with acetaminophen
Non-Opioid Pharmacologic Pain Management - medications to avoid	Swedish Pain Services	Last bullet under "Muscle Relaxants". Consider changing to "In addition, carisoprodol is metabolized to meprobamate, a benzodiazepine metabolite and controlled substance that can contribute to chronic dependency and misuse."	Added suggested language "In addition, carisoprodol is metabolized to meprobamate, a benzodiazepine metabolite and controlled substance that can contribute to chronic dependency and misuse."
Non-Opioid Pharmacologic Pain Management, page 9	Shelley Gray	"Consider SNRI agents, such as venlafaxine and duloxetine, for adjuvant treatment of neuropathic pain, fibromyalgia, and low back pain if other therapies are ineffective, as there is good evidence of effectiveness. Utilize care in patient selection, initiate at a low dose with slow titration, and monitor carefully for side effects such as falls or changes in cognition. The AGS Beers	Replaced with suggested language, "The 2019 AGS Beers Criteria has a moderate recommendation to use this class of drugs with caution in older

		CriteriaR has a weak recommendation to avoid this class of drugs in older adults, and thus, they should be used with caution." SNRIs are tricky and appear in several recommendations in the Beers. I just wanted to mention that Beers does not recommend to avoid this drug class in most older adults, just in those who have a history of falls (Table 3 of the document—strong recommendation but this applies to ALL antidepressants) and when a person is taking 3 or more CNS active medications (table 5-strong recommendation). There is a general recommendation to use SNRIs with caution in most older adults (table 4—moderate recommendation). I did not find a mention of a "weak recommendation" as it relates to SNRI. This may seem like it is going in the weeds, but I just didn't want the possibility to exist for someone misunderstanding the recommendation from the Beers Criteria. This might be better phrased as: "The 2019 AGS Beers Criteria has a moderate recommendation to use this class of drugs with caution in older adults. Avoiding SNRIs altogether are recommended in older adults with a history of falls (as with all antidepressants) or those who are taking multiple CNS-active medications.	adults. Avoiding SNRIs altogether are recommended in older adults with a history of falls (as with all antidepressants) or those who are taking multiple CNS-active medications."
Non-Opioid Pharmacologic Pain Management – medication recommendations, bullet 3	Pam Davies	"Combining gabapentinoids with opioids and benzodiazepines should be avoided, especially in frail older adults, as there is "evidence of substantial harm" with this combination" According to the AGS, combining gabapentinoids with opioids and benzodiazepines should be avoided, especially in frail older adults, as there is "evidence of substantial harm" with this combination (2019, p. 688)	Replaced with "According to 2019 AGS Beers, combining gabapentinoids with opioids and benzodiazepines should be avoided, especially in frail order adults, as there is evidence of substantial harm with this combination."
Non-Opioid Pharmacologic Pain Management – general recommendations, bullet 4	Pam Davies	"Since age does not always correlate with physiology, give particular attention to renal function (estimated glomerular filtration rate) when prescribing non-opioid medications for pain." The first use of abbreviation "GFR" needs to be defined. § add "eGFR" after mention of: " (estimated glomerular filtration rate)" on p. 8 § p. 9: abbreviation should be "eGFR" rather than just "GFR" (because a calculation [an estimation] is used for most lab values -- the true GFR is not commonly measured.)	Added "or eGFR" in parenthesis

Tapering or Deprescribing of Long-Term Opioid Therapy	Swedish Pain Services	Again a more robust discussion of the maintain and monitor pathway would be of great assistance to prescribing providers. The focus is on deprescribing and tapering yet in clinical practice many patients cannot be tapered and may need monitoring. This guideline provides little assistance in this regard.	
Tapering or Deprescribing of Long-Term Opioid Therapy	Marian Wilson	I noticed a redundant bullet point # 2 and 7 about motivational interviewing that can be edited next iteration.	Deleted duplicate bullet 7
Tapering or Deprescribing of Long-Term Opioid Therapy	Public Commenter – Opioid Prescriber	"Increase use of motivational interviewing approaches to draw on intrinsic motivations to taper." Mentioned twice in same bullet section. You might also refer to the VA's Opioid Taper Decision Tool as a well written and researched tool : https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.	Deleted duplicate bullet 7 and added suggested link
Tapering or Deprescribing of Long-Term Opioid Therapy	Swedish Pain Services	Consider clarifying definition of “tapering” and “deprescribing” early in the document or deciding to use one, but not both terms.	No change, document defined tapering and deprescribing
Tapering or Deprescribing of Long-Term Opioid Therapy	Swedish Pain Services	“Transition to medications for opioid use disorder (MOUD)” Suggest “Transition to buprenorphine products as an option for opioid tapering and for patients with needing medication to treat opioid use disorder (MOUD)”	No change. Currently there are 3 FDA-approved medications to treat OUD
Recommendations for Healthcare Delivery Sites and Systems	Swedish Pain Services	“Provide adequate access to at least some nonpharmacologic modalities to manage pain, improve patient self-efficacy, and address sleep disturbances for older adults.” “Provide adequate access and reimbursement to nonpharmacologic modalities including restorative therapies (physical and occupational therapy), behavioral health (cognitive behavioral therapy, mindfulness training, and counseling), and interventional therapies (image-guided spine and joint injections) to help patients better manage pain and improve psychosocial functioning	No change. Some proposed treatments were not reviewed
Recommendations for Healthcare Delivery Sites and Systems	Kara Shirley	“Expand coverage for topical medications.” Most medicare advantage members already have coverage for OTC topical analgesic medications through their medical benefit, although be it plan specific. I would recommend modifying the second bullet to state the following: “1. Individual consideration of topical prescription medication coverage.” I	Clarified statement with suggested language “Recommend transparency and ready accessibility of over-the counter- medication benefits for

		would also recommend a second statement to add however you see fit: 2. "Recommend transparency and ready accessibility of over-the counter-medication benefits for individuals with medicare advantage plans, especially those inclusive of over-the-counter topical and or oral analgesics currently covered." o Many individuals already have over-the counter topical analgesic coverage through medicare advantage plan medical benefits yet many individuals lack an understanding of what items are available to them and how those treatments may be obtained. Some MCO's/CCO's have OTC benefits which allow patients to order OTC analgesics online or over the telephone with a specific vendor chosen by the plan. Unfortunately it is not readily apparent to most providers, inclusive of pharmacists/pharmacies which individuals have these benefits and how they are accessed by either insurance card or point of sale billing through the pharmacy. This often results in patient's paying out of pocket and/or simply going without OTC analgesics their providers prescribe and send to the pharmacy due to this lack of transparency for patients and providers alike. o On behalf of CHPW I'll state for the record that due to the lack of evidence provided regarding efficacy, I and the CHPW pharmacy team cannot support a bullet broadly supporting access to all topical medications for all patients; as opposed to the bullets added for the nonpharmacologic modalities given all of the evidence-based work completed by the workgroup. Also, nothing OTC can be billed successfully through medicare as it will automatically reject "OTCS no covered". We can't change CMS and federal regulations regarding OTCS for all medicare recipients. Medicare advantage plans however can offer an expansive OTC benefit which addresses most of the groups concerns regarding topicals, on a state by state, MCP/ACO/CCO basis.	individuals with Medicare advantage plans, especially those inclusive of over-the-counter topical and or oral analgesics currently covered."
Recommendations for Healthcare Delivery Sites and Systems	Swedish Pain Services	Multidisciplinary pain treatment programs, first dark bullet. Suggest, "Consider creating or collaborating with a multidisciplinary or interdisciplinary pain rehabilitation program, such as Structured Intensive Multidisciplinary Programs (SIMPs)currently offered under L&I coverage, or similar interdisciplinary functional restoration programs that include a rehabilitation-based approach with multiple providers (PT, OT, behavioral health, exercise, pain management, and pain education) working in one setting delivering time limited individual and group-based therapies to help patients learn additional skills to decrease pain and improve psychosocial functioning. These structured and more comprehensive programs may be additionally helpful for those	No change. Language came from 2020 Bree Guideline on Long-Term Opioid Therapy

		patients tapering from opioids or presenting with significant functional impairments and pain related psychosocial distress."	
Evidence – Acute Prescribing, page 14	Deb Gordon	"Optimal pain control following surgery is important for functional recovery and for reducing the risk of post-surgical complications, and persistent postsurgical pain and is best managed using a multimodal approach." Suggested edit: Optimal pain control following surgery is important for functional recovery and for reducing the risk of post-surgical complications. Persistent postsurgical pain and is best managed using a multimodal approach.	Clarified statement with suggested language
Evidence – Co-prescribing, page 18	Swedish Pain Services	The co-prescribing of opioids with CNS-activating medicine is significantly stigmatized in this part of the guideline. The collaborative provides no clear guidance as to when this may be a reasonable option including when encountering patients with psychiatric co-morbidities such as bipolar disorder, post-traumatic stress disorder, severe anxiety, that may or may not be also managed by psychiatry or a behavioral health specialist. It comprehensively highlights the risks without any potential options for therapy or example of clinical scenarios. Consider integrating case examples, guidance on tapering of benzodiazepines, and a listing of state or local resources	No change
Evidence – Non-Opioid Pharmacologic Pain Management: Topical Analgesics, page 22	Swedish Pain Services	Correction. Document states "The use of topical salicylate-containing creams and ointments is widespread and can be confusing; for example, topical diclofenac is marketed under the name Aspercrem." Aspercream contains trolamine salicylate, which is a counter-irritant and not diclofenac.	Removed reference to Aspercream
Evidence – Non-Opioid Pharmacologic Pain Management: Topical Analgesics, page 23	Pam Davies	p. 23: please add the underlined section to the first words on p.23: § A high dose capsaicin 8% patch (Qutenza®) is also available <u>by prescription</u>	Clarified statement with suggested language and removed reference to Brand
Page 34		Ensure format is consistent Correct title for Jason Fodeman (Associate Medical Director) and Jaymie Mai (Pharmacy Director) Add Kara Shirley, PharmD, BCACP, BCPS, BCPP (Clinical Pharmacist) to Community Health Plan of Washington	