Good Morning. My name is Kate Nicholson and I am the Executive Director of the National Pain Advocacy Center.

There is much I value in this update -- its emphasis on collaboration, patient-centered decision-making, individualized care, and clinician discretion; its qualification of the use of MMEs; the clarification that deviations from the pain agreement alone may not indicate diversion and that patients should not be dismissed based solely on UDT results or a finding of OUD; the definition of tapering and of when a taper trial is considered successful (i.e., "if treatment decisions are individual and based on the patient's response to the last dose") -- are all excellent.

I have a few minor suggestions.

1. Page 20 says: "All patients, including legacy patients, deserve a slow, balanced, empathic, good faith taper trial." This language could be read as incentivizing tapering across all patients. Starting the sentence with the phrase: "where tapering is indicated" would align this sentence with the rest of the document.

2. Similarly, on page 15, where the guideline discusses failed tapers, OUD, and buprenorphine transition, the following sentence appears:

"There is a fraction of patients who are likely benefitting from opioids and a dosage reduction makes their pain worse, increasing their difficulty in weaning."

The use of the term fraction here is potentially problematic, marginalizing, and even stigmatizing. In common parlance, fraction suggests that the number is tiny – the rare exception, the unicorn – creating a presumption that very few patients benefit from medication or most who fail tapers likely have an OUD. Replacing "a fraction" with "some" would allay these concerns.

3. There is excellent language in the section on legacy patients acknowledging how long it can take for patients to find a provider. These suggestions should be cross-referenced in the general section on Termination of Care.

If a patient is cut off medication in a termination of care situation, simply providing names of clinicians or a single bridge prescription may be insufficient to protect both patient safety and the provider from liability. Patients in an

emergent situation could be considered abandoned even if the name of a new provider is offered and a 30-day time frame limit is met.

4. Given well-acknowledged disparities and inequities in pain treatment, adding a few sentences to the GL encouraging providers to be mindful of not compounding existing disadvantages would be helpful. Paying for frequent drug tests when not covered by insurers, out-of-pocket costs for some alternative treatments, and even paying for both an opioid and naloxone can be hardships for some patients. CA law (and CDC) for this reason counsel "offering" naloxone. Similarly, where inquiry into abuse is addressed, language might be added to say that a history of abuse alone is not a reason to deny a particular treatment.

   Thank you.