Comparative Effectiveness Research Review Disposition of Comments Report

Research Review Title: *Multidisciplinary Pain Programs for Chronic Noncancer Pain*

Draft review available for public comment from November 02, 2010 to November 30, 2010

Research Review Citation: Jeffery MM, Butler M, Stark A, Kane RL. Multidisciplinary Pain Programs for Chronic Noncancer Pain. Technical Brief No. 8. (Prepared by Minnesota Evidence-based Practice Center under Contract No. 290-07-10064-I.) AHRQ Publication No. 11-EHC064-EF. Rockville, MD: Agency for Healthcare Research and Quality. September 2011. Available at: www.effectivehealthcare.ahrq.gov/reports/final.cfm.

Comments to Research Review

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Comments on draft reviews and the authors' responses to the comments are posted for public viewing on the EHC Program Web site approximately 3 months after the final research review is published. Comments are not edited for spelling, grammar, or other content errors. Each comment is listed with the name and affiliation of the commentator, if this information is provided. Commentators are not required to provide their names or affiliations in order to submit suggestions or comments.

The tables below include the responses by the authors of the review to each comment that was submitted for this draft review. The responses to comments in this disposition report are those of the authors, who are responsible for its contents, and do not necessarily represent the views of the Agency for Healthcare Research and Quality.

Commentator & Affiliation	Section	Comment	Response
Peer Reviewer #2	Abstract	The purpose of the Technical Brief has been stated in a clear and concise manner. The four components of treatment, as defined by the authors, have been clearly articulated.	Thank you.
Public Reviewer Gunning	Abstract	Interesting in that it deals with all of the methods, drugs and processes that patients can opt for in their search for relief. I am a patient with pain, a licensed clinical social worker, and have experience in many of the areas of treatment. Would like to participate in this work as much as possible from a patient's point of view. Information is below.	Thank you for your interest in the project; this Technical Brief is now complete.
Peer Reviewer #1	Background	One concern that I have is that they compare the US and Europe. We all know that the cultures are very different as is their way of life which would impact the response/therapies/interventions between the two countries. I would have liked this to focus only on the US given our health care system and culture. (page 1, lines23-28; p.9, line 24-26)	One purpose of this project was to present a broad overview of the research available on MPPs, much of which is based in Europe. The section on implications and challenges facing MPPs is largely US focused.
Peer Reviewer #1	Background	The goal of treatment is correct: evolved from eliminating pain to managing pain to an extent that the patient's independence is restores and overall quality of life improved. (P. 2 line 3-4) This is key in treating any person with pain.	Wording has been revised to emphasize physical and emotional functioning rather than the less precise "independence"—but we agree the overall point is key to understanding the purpose of MPP treatment.
Peer Reviewer #2	Background	B.1. Chronic Non-cancer Pain. This first subsection of the Background seems to focus on the epidemiology and economic burden of chronic pain. While this is important, please consider including the internationally recognized definition of pain as developed by the International Association for the Study of Pain (IASP). Clearly stating the definition of pain would then provide the foundation for stating the definition of chronic pain, which would then allow chronic pain to be further differentiated from acute pain. Providing a clear definition of pain, and differentiating chronic from acute pain, could be critical material for the readers of this Technical Brief who may not have a broad knowledge base of this particular topic.	The IASP definition has been added, along with a brief explanation of chronic vs acute pain. Interested readers should consult the references for a much more in-depth treatment.
Peer Reviewer #2	Background	B.2. Current Medical Practice as Related to Management of Chronic Pain. The focus of this section is not entirely clear. This subsection contains a substantial amount of information, but it does not clearly describe the current practice continuum of pain medicine. Pain medicine is a recognized, board certified medical subspecialty. It may be important for the readers of this Technical Brief to have a brief overview of the history of this new medical subspecialty including the	We agree that this is an important topic; limitations of space and scope precluded coverage in this technical brief. However, we did add language to emphasize that MPP is different than regular ambulatory pain clinics.

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		necessary training requirements. This information would then provide the framework for describing the various practice models that exist which would allow the reader to better understand how and where MPPs "fit in" to this continuum of care. This would also provide the opportunity to compare and contrast the different services provided by a MPP and an ambulatory pain clinic. Furthermore, an understanding of how MPPs differ from ambulatory pain clinics will facilitate a more meaningful understanding of why patients are referred to a MPP.	
Peer Reviewer #2	Background	Page 1, line 57. Please consider deleting the term "upper extremity pain disability" in that this is not a recognized pain diagnosis.	Suggestion adopted.
Peer Reviewer #2	Background	Page 2, line 5. Please consider changing the word "independence" to "physical and emotional functioning." Patients can have impairments in functionality but retain various levels of independence.	Suggestion adopted.
Peer Reviewer #2	Background	Page 2, line 7. It is stated that "Through discussions with our Key Informants, we developed a definition of the MPP…" This subsection of the document is part of the Background section. Therefore, discussing the results of the work performed as part of this initiative should not be included in this section.	Suggestion adopted.
Peer Reviewer #2	Background	Page 2, line 13. Please replace the word "deal" with "…treat the many aspects…"	Suggestion adopted.
Peer Reviewer #2	Background	Page 2, line 14. Please consider consolidating the list of medications. It is not the purpose of this brief to provide an exhaustive list of all possible medications used to treat chronic pain. A possible list could include NSAIDs, acetaminophen, topical agents, serotonin-norepinephrine reuptake inhibitors, tricyclic antidepressants, anticonvulsants, and opioids.	Suggestion adopted.
Peer Reviewer #2	Background	Page 2, line 21. Please move the term "transcutaneous electronic nerve stimulation" to the "Adjunctive treatment" bullet item (line 29).	Suggestion adopted.
Peer Reviewer #2	Background	Page 2, line 24. Please consider deleting the phrase "pharmacological treatment for depression and anxiety…" Pharmacological treatment of psychiatric disorders is not within the scope of practice of a psychologist. An alternative statement could read "cognitive behavioral treatment of depression and anxiety."	Revised wording to include psychiatry.
Peer Reviewer #2	Background	Page 2, line 34. Please consider replacing the current material as follows: "…including: implantable intrathecal drug delivery systems, spinal cord and peripheral nerve stimulators, image-guided percutaneous spinal procedures and surgery."	Suggestion adopted.

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Peer Reviewer #2	Background	Page 2, paragraph extending from line 38 to line 53. The material in this paragraph seems to be most focused on providing a definition of chronic pain and it is not directly related to the core subject matter of the subsection which is titled “Current Medical Practice….” Although this is important information, it may be more appropriate for the first subsection of the Background section.	We’ve left the material in this section to provide an introduction to the current medical view of chronic pain as a biopsychosocial phenomenon.
Peer Reviewer #2	Background	Page 3, paragraph extending from line 3 to line 9. Similar to that discussed above, this content may be better suited for the first subsection of the Background section.	This material has been left in the medical practice section to introduce the need for MPPs.
Peer Reviewer #2	Background	Page 3, line 11. Please consider re-wording the opening statement of this paragraph as follows: “When chronic pain does not fully respond to treatment….”	Suggestion adopted.
Peer Reviewer #2	Background	Page 3, line 17. “…influenced by psychological and social factors…” By definition, all pain experiences are influenced by psychological (i.e., emotions) factors. Please consider revising the sentence.	Sentenced revised to emphasize that it is the prognoses that are influenced by psychological and social factors rather than the experiences themselves
Peer Reviewer #3	Background	Some of the data on prevalence and cost presented in the background are based on secondary sources and somewhat dated. I think the authors should have gone to the primary sources when possible.	Thank you for your comment; we’ve decided to leave the figures as is.
Peer Reviewer #3	Background	Page 2, lines 11 and 24: Behavior therapy is listed both in the "four components" and in other treatment modalities	Corrected.
Peer Reviewer #4	Background	Important definitions are well presented particularly the definition of chronic pain and the fact that it becomes a disease in of itself.	Thank you for your comment.
Peer Reviewer #4	Background	I would consider passive physical therapy and active physical therapy two different approaches and would consider separating these out in the section that lists "other treatment modalities used to deal with the many aspects of chronic pain". As it is stated (with Tens) it implies passive modalities and this is an important difference to identify in a world where PT is largely viewed as passive primarily. As later mentioned in the brief this difference is briefly mentioned.	Wording has been revised
Peer Reviewer #4	Background	Defining the Key Components of Multidisciplinary Pain treatment is excellent. There is a lot of misrepresentation as to what components define MPP treatment by largely unimodal pain providers.	Thank you for your comment.
Peer Reviewer #4	Background	I believe that a statement should be made in the section that states the multiplicity of pain treatments available for chronic pain as to what the primary treatment approaches are (primarily interventional at this point in time) and the fact that there is a polarization in pain practice supported by the varying professional pain societies. To simply mention this at some point would serve to educate the reader as to the current lay of the land. Although it is implied, some mention as to	Thank you for your insight. This is an important topic in the pain treatment community, but is beyond the scope of this document

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		where the dollars are currently going is important (primarily interventional and invasive care). This is a major obstructive force in getting appropriate pain care in the US.	
Peer Reviewer #5	Background	The review of the prevalence of chronic pain, though concise, well documents the major health burden associated with this group of conditions.	Thank you for the comment.
Peer Reviewer #5	Background	Page 2 (numbering refers to bottom center of page), line 31 would better read: "such as sympathetic block or epidural steroid injections; ".	Suggestion adopted.
Peer Reviewer #5	Background	Page 2 Lines 46-47 (and throughout this manuscript): avoid the word "narcotics" and instead specify which particular drug class is referred to in the specific context. Here, it would be "opioids".	Thank you for pointing that out; wording has been revised
Peer Reviewer #5	Background	Page 2 Lines 47-48: change "that something is wrong" to "of new or impending tissue damage". I make this suggestion because clearly there is something wrong in chronic noncancer pain – many things may in fact be wrong, such as peripheral perineural inflammation, central sensitization, glial activation etc – and in aggregate these mechanisms form the basis for chronic pain being considered as a disease entity per se.	Suggestion adopted.
Peer Reviewer #5	Background	Page 2 Lines 50-51: delete "best described as" and add "in detail" between "knows" and "how".	Suggestion adopted.
Peer Reviewer #5	Background	Page 3, line 13: change "narrative" to either "pattern" or "trajectory".	Suggestion adopted.
Peer Reviewer #5	Background	Page 3 Lines 15-18: this sentence is confusing and should be broken up and placed in active voice. As presently written, it is not clear whether the patients or the conditions are "influenced" and "amenable".	Sentence has been revised
Public Reviewer Smith	Background	Quoting a paper as quoted by another paper may not be as optimal as quoting the original source itself.	Agreed; unfortunately, the original source is out of print and difficult to find.
Public Reviewer Ward, APTA	Background	Page 2. As written, it appears that the technical brief limits physical therapy interventions for pain to strictly TENS. We believe that a disproportionate focus on just the TENS modality would misrepresent the full value of physical therapy as a treatment option for chronic pain. TENS is just one intervention that a physical therapist uses in the treatment of chronic pain. In fact, the reference used for this section of the technical brief (footnote #4) uses the direct quote, "Physical therapy, focusing on active therapy with secondary time-limited, passive physical therapy (e.g., transcutaneous electronic nerve stimulation [TENS], ultrasound, heat/ice, and traction) if needed." The focus is on active therapy, and only passive modalities	Thank you for your input. We have revised the wording.

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		(such as TENS) if needed. APTA feels that the phrase "including transcutaneous electronic nerve stimulation" is unnecessary to be specifically listed in this technical brief, and should instead read as "Physical therapy" within the bullets under "Other treatment modalities used to deal with the many aspects of chronic pain include:"	
Peer Reviewer #2	Guiding Questions	The four questions have been clearly summarized in the paragraph on page 3, extending from line 29 to 48. However, in the subsequent material contained under the heading of each question (e.g., "Question 1. The Existing Technology"), the use of multiple bullet items diffuses and dilutes the core focus of each question. Please consider using one 2 to 3 explanatory bullet items under the heading of each question, and further discussion of relevant details could occur in the latter sections of the document. Related bullet items should be combined, especially for Question 3. In other words, this section contains too much detail which makes it difficult to quickly identify the core focus of each question.	The guiding questions are presented here as they were originally published, per policy.
Peer Reviewer #5	Guiding Questions	The questions posed appear thorough and appropriate. However, on page 12 bottom there should be added a question addressing gaps in providing MPP access to patients who require or would at least benefit from such therapy, and possible recent widening of such gaps. Much is made of this point later in the text but other than general comments (e.g., about carve-outs) the supporting data is lacking.	The guiding questions are presented here as they were originally published, per policy.
Peer Reviewer #5	Guiding Questions	Further, over the past several years accumulating translational research points to genotypic factors that place patients at increased risk for chronic pain. Given the likelihood that personalized medicine will become more important in the future, the authors should address in one or more questions this exciting opportunity for risk stratification and early, even pre-emptive treatment to avoid chronic pain.	Unfortunately, this is beyond the scope of this Technical Brief.
Peer Reviewer #5	Guiding Questions	Page 4, line 10: shouldn't this read "accreditation of MPPs"? Line 19: make "MPP" plural.	Suggestion adopted.
Peer Reviewer #5	Guiding Questions	Page 4 Lines 20-21 are awkward and should be rephrased as "What clinical conditions were present in the included patients?"	Suggestion adopted.
Peer Reviewer #1	Methods	With the broad range of illness/conditions that can cause chronic pain, it would have been difficult to include them all. Focusing on the most common was best for the inclusion and exclusion criteria.	Thank you for the comment.
Peer Reviewer #2	Methods	Page 6, line 6. Please clearly state the inclusion and exclusion criteria. This material may be contained in Appendix D but, as stated, I was not able to download this section.	This material has been added to the appendixes. Thank you for noting the oversight.

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Peer Reviewer #2	Methods	Page 6, line 12. Regarding the statements: "These data were extracted by one researcher…" and "Other researchers provided advice…" Please put the initials of the different authors who made these contributions to the document.	Suggestion adopted.
Peer Reviewer #2	Methods	Page 6, line 19. This definition was developed through discussions with our Key Informants…." Please revise this statement to reflect that the definition derived from the Key Informants is also consistent with the definition of MPP in the broader literature.	Suggestion adopted.
Peer Reviewer #3	Methods	All methods seem appropriate.	Thank you for the comment.
Peer Reviewer #4	Methods	The methods are utilized are sound and the inclusion and exclusion criteria are clearly stated. Perhaps a comparison as to outcomes regarding specific conditions such as fibromyalgia / mixed pain presentations low back pain and other pain disorder/ versus low back pain could be mentioned. Question would be is ... is multidisciplinary pain management equally effective for all conditions? I believe this to be an important question. Otherwise I believe the methodology was sound.	Technical Briefs do not present information on efficacy or summaries of study results—it's beyond the scope of this project.
Peer Reviewer #4	Methods	Regarding accreditation subject, it is important to at least briefly discuss why many programs are not accredited. My understanding is that economics plays a large role in CARF accreditation but an important topic. Also why are there not any comprehensive resources that would help to direct patients to MPPs. This is a large barrier to their use.	Accreditation specifics were beyond the scope of our research and the short timeframe of Technical Brief projects
Peer Reviewer #5	Methods	The statement that key informants were identified, without presenting a systematic basis for their selection, makes one concerned about ascertainment bias. How the leaders were selected for interviews is not clear to this reviewer.	Key informants were essentially a convenience sample suggested by pain experts at our university and other experts for this project. The purpose of the key informants is to provide a larger perspective than might be available in the literature to inform the authors through the process. While we endeavored to locate key informants that would provide a broad and diverse set of views, the scope and timeframe available for technical briefs does not allow for a systematic sampling frame such as might be found for qualitative research.
Peer Reviewer #5	Methods	"Grey literature" should be defined but if it includes unrefereed internet chat boards, etc then it should be addressed because of the importance of such literature (? Including direct to consumer advertising) for shaping consumers' views about pain. While it is true that much of the literature cited was peer-reviewed, that literature	Wording has been changed to describe the role of grey literature in this project. Unrefereed internet chat boards and other sources of consumer conversations were not addressed as part of grey literature.

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		was of a rather low quality in general, shifting more weight to the grey literature.	
Peer Reviewer #5	Methods	The definition of medical therapy overlooks that it requires diagnosis, judgment as to possible mechanisms underlying the symptoms, and suitable selection, initiation and titration of therapy with an awareness of potential drug interactions.	The MPPs we included had a range of levels of medical involvement; in some cases, patients remained under the medical supervision of their own doctors, while the MPP physicians and nurses played more of an educational role. The responsibilities you highlight were thus not part of all MPP treatments.
Peer Reviewer #5	Methods	Page 5, lines 41-46: if "grey literature" includes internet sources, this is actually very important.	Grey literature is incorporated to the extent that it informs and supplements the peer-reviewed literature. The general goal of Technical Briefs is to frame the issues to facilitate possible future comparative effectiveness research. As such, a comprehensive review of grey literature, including websites, from internet sources is outside the scope of this review.
Peer Reviewer #5	Methods	Page 5 Line 51: starting in 1985 is probably OK yet it would be helpful if some rationale for selecting this start date were provided.	Justification and citation provided for the search start date.
Peer Reviewer #5	Methods	Page 6, line 28: shouldn't the parenthesis belong at the end of the line?	Suggestion adopted.
Public Reviewer Ward, APTA	Methods	Page 6, under the "Physical reconditioning," APTA recommends that the first bullet be changed to read "Physical Therapy (PT) and/or Occupational Therapy (OT)." As the bullet is currently written, with just an "or," the list implies that physical therapy and occupational therapy are substitutes for one another. This is a misrepresentation of the unique services offered by both professions, while also limiting the collaborative roles that the two separate professions can have within a truly multidisciplinary pain management care team.	Suggestion adopted.
Public Reviewer Ward, APTA	Methods	APTA is also concerned that none of the key informants used for this technical brief were physical therapists. In fact, only one key informant appeared to represent all rehabilitation professionals – Nina McIlree, a physiatrist. APTA believes that rehabilitation professionals, especially physical therapists, should have been included as key informants to ensure a comprehensive process with multiple perspectives from key providers within the health care team.	Thank you for your input. Dr. Stanos, one key informant, is the medical director of the Rehabilitation Institute of Chicago and a strong advocate for the role of physical therapists in rehabilitation programs.

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Peer Reviewer #1	Findings	The detail and characteristic of the studies are clear. The information provided by the IMMPACT paper supported the need for multiple outcomes. (p12). Excellent to include this.	Thank you for the comment.
Peer Reviewer #1	Findings	On page 13 the discussion of pain measures I don't believe are as important as the measure of function and suffering. Page 13 line 41-42 points out that it can be used for other things such as pain interference. I would like to see more studies/reference to the importance of this measure. Perhaps the IMMPACT study does that.	This section presents the measures as they were reported in the publications; the IMMPACT publications are an excellent resource for further information on outcome measurement validity
Peer Reviewer #1	Findings	I would agree (p. 14, line 42-43) the overall literature on MPPs suggest design is a key weakness for evidence base—something that is being used more and more to determine reimbursement.	Thank you for the comment.
Peer Reviewer #2	Findings	It is difficult to identify which material is related to Questions 1-3. For example, the first subsection is titled "Description of Technology and Context for Use." Within this subsection, the headings in bold print pertain to both Questions 1 and 2. This organizational approach is confusing, and it dilutes the focus of the Guiding Questions.	The current structure of the document attempts to strike a balance between the structure of the guiding questions and the unified presentation of key concepts that addressed more than one of the guiding questions.
Peer Reviewer #2	Findings	Page 8, line 17. Please see the following statement: "Though the MPP is seen as the last resort for intractable pain…." Many experts in the field believe that MPP should not be considered a treatment of "last resort." In fact, some will argue that referral to a MPP earlier in the course of chronic pain could mitigate the decline in functionality.	Our research suggests that patients presenting to MPPs have tried many other treatments, suggesting that it is seen by many as a last resort. You are right that many pain experts believe that is not optimal. The sentence has been revised to soften the comment.
Peer Reviewer #2	Findings	Page 9, line 46. Please see the statement: "…treating… patients with the most intractable chronic pain." There are many patients with severe intractable pain that do not experience significant declines in functionality. The primary aim of MPP treatment is to restore function. Therefore, please consider revising the statement to reflect that patients receiving treatment in a MPP have severe pain-related impairments in physical and emotional functioning.	Suggestion adopted.
Peer Reviewer #2	Findings	Page 9, line 49. Please replace the word "things" with the term "clinical factors."	Suggestion adopted.
Peer Reviewer #2	Findings	Page 12 through page 13. Reporting the number of studies that included various components of the IMMPACT criteria is interesting and relevant. However, this material should have been described in the Methods section. In addition, the list of IMMPACT criteria and supplemental IMMPACT recommendations should also be moved to the Methods section. This is a critical point in that it is not appropriate to introduce a method of data analysis in the results section without first describing it in the methods section.	The identification and discussion of IMMPACT was a direct result of answering Guiding Question #3 regarding how MPP outcomes were reported. Thus to move the material to the methods section would divert the reader's attention from the general approach to MPP outcomes in the literature. The results in the report should be seen as an indicator of major trends in the data regarding

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			outcome reporting, rather than as a specific application of IMMPACT criteria in analysis. The method used to assign IMMPACT categories to the outcome measures was essentially the judgment of one of the researchers (MMJ).
Peer Reviewer #3	Findings	The amount of material presented is appropriate. The interested reader has sufficient information to review the studies included and to understand the basis for the conclusions. The inclusion and exclusion criteria are clearly presented.	Thank you for your comment.
Peer Reviewer #4	Findings	The amount of detail presented is appropriate and I again will state that the fact that this brief is so easy to read and addresses so many vital issues will make it an important resource. It is one of the major strengths of this brief. The key messages are explicit and very applicable. Figures tables and indices are adequate and descriptive.	Thank you for your comment.
Peer Reviewer #5	Findings	This reviewer finds it odd that the description of the technology and context for use commences with accreditation issues, but does not describe what services are required to achieve accreditation from either source. A clear stratification of various forms of pain treatment facilities was disseminated by IASP about 15 or more years ago, and could well be cited herein. In the description of availability, a discussion of temporal trends could strengthen the point made elsewhere that access to MPPs is decreasing.	We could not do justice in this format to the taxonomies of pain treatment facilities and nuances of interdisciplinary vs. multidisciplinary vs. multimodal, etc. There are some excellent resources for readers of this Technical Brief who want more detailed information; a good place to start is Stanos and Houle 2006 (PubMed ID 16616276)
Peer Reviewer #5	Findings	There is surprisingly little said about the evidence to support the existence of MPPs. Even though the range of studies is quite heterogeneous, it should be possible to do some descriptive statistics, e.g., worsened post-MPP, the same, better, much better and provide this data for pooled studies. Regarding outcomes assessment, please see comments in the appended file.	Presenting the study results is beyond the scope of the Technical Brief
Peer Reviewer #5	Findings	Page 7, line 45: the parenthetical reference to CARF is redundant in view of the preceding text in the immediate prior section.	Suggestion adopted.
Peer Reviewer #5	Findings	Page 8, lines 38-39: I am aware of instances in which patients were injured during exercise or aggressive stretching as part on an MPP, so I think the statement about MPPs being devoid of risks might be dropped or narrowed.	The comment on MPP risks is intended to specifically apply to risks due to the combination of treatments—that is, beyond the risks from each of the individual treatment components. We hope this is clear in context
Peer Reviewer #5	Findings	Page 10, lines 14-15: there is good evidence that certain of the factors listed (litigation status, psychological factors) do influence treatment outcome and so this sentence doesn't add much.	The information was provided precisely because the inclusion or exclusion of patients with such factors in study populations is important to understanding study outcomes and would be germane to future systematic review research.

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Peer Reviewer #5	Findings	Pages 12-13: under "measurements and outcomes" the narrative is misleading as it appears to indicate that the IMMPACT meetings were the first to identify the importance each of the listed outcomes. In actuality, each of the many listed outcomes was already recognized as potentially important and many were components of one or more existing outcome instruments. The purpose of the IMMPACT meetings was to achieve consensus through open discussion as to the relative importance of each of these measures. Since IMMPACT did not (to this reviewer's knowledge) develop a new outcomes instrument, it would be very useful to know which outcomes instruments were most commonly employed in the reviewed literature. This information should also be supplemented by a few sentences to clarify that function is most often assessed in outcomes instruments not in terms of a VAS but instead in terms of the subject's ability to complete certain tasks, generally associated with common daily activities such as walking upstairs. I am not suggesting that Figure 3 be deleted, however – it is a useful way to present the results.	Wording has been revised; IMMPACT certainly does not claim to have invented these concepts! We used their categories as a convenient way to structure this analysis and make it easier to follow.
Peer Reviewer #5	Findings	Page 14, lines 44-45: delete "making causal assessment more difficult" because that phrase adds nothing.	Suggestion adopted.
Public Reviewer Ward, APTA	Findings	Page 7, under "Staffing," the technical brief says "each would have at least one physician or nurse, a psychologist or other behavioral therapist, and a physical or occupational therapist". The "or" between physical and occupational therapist is problematic for the reasons listed in the paragraph above, but also because the interventions listed under "Physical reconditioning" include "Graded therapeutic exercises to safely increase functioning (e.g., flexibility, range of motion, posture, body mechanics, ambulation, gait training, core strength/stability, cardiovascular fitness)". The majority of the interventions included in this list are more within the scope of physical therapist practice. This particularly becomes an issue when it is taken into consideration that the most frequent diagnosis reported in the studies was back pain (90% of the studies), and this is a diagnosis most commonly treated by physical therapists, not occupational therapists. APTA reiterates that physical therapy and occupational therapy are not substitutes for one another.	Thank you for your insight.
Peer Reviewer #1	Summary and Implications	It clearly points out that while there is good substantial literature to support the effectiveness of MPP, they are still declining. On page 15, lines 3-25, they did a great job of explaining why the decline in MPP. The information about "diluting the proven successful outcomes . . . in a effort to cut costs. (p.15, l 49-50.) is very helpful in pointing out a significant problem with third party payers and MPP.	Thank you for your comments.

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		Pointing out the positive impact MPP have overall on society is important as well. (p.16, L 2-3)	
Peer Reviewer #1	Summary and Implications	In addition, the role that opioids have played in pain management was important to address. Perhaps something about REMS might be useful to help the reader understand the issues HCP, people with pain and the FDA are facing.	The section on opioids has been significantly revised and now includes a mention of the REMS initiative of the FDA; thank you for the suggestion
Peer Reviewer #1	Summary and Implications	Issues that the person with pain faces while in the care of the health care community should be addressed in more detail. It is important to address the expectations of the person with pain who looks to medicine to "cure" them and thus the system has also failed the person.	This is an important topic, but largely beyond the scope of this document
Peer Reviewer #2	Summary and Implications	The title of this section suggests that it is related to Question 4. However, several of the subheadings in bold print seem to refer back to Questions 1-3. For example, the term used in the subheading titled "Carve-outs and third-party issues" was the same term used under Question 2 (page 4, line 11, bullet item 'd'). Additionally, the subheading "Role of opioids" could easily fall under Question 3, the subheading "Patient-related issues" could fall under Question 1, and the subheading "Study design" could fall under Question 3. This is very confusing, and the focus of the document is difficult to follow. Again, if the Guiding Questions are to be used as an organizational tool then please ensure that the organization of the document reflects this stated objective.	Thank you for noting this. The current structure of the document attempts to strike a balance between the structure of the guiding questions and the unified presentation of key concepts that addressed more than one of the guiding questions
Peer Reviewer #2	Summary and Implications	Page 14, line 55. Please change the term "…that the treatment works…" to "…the efficacy of MPP…"	Suggestion adopted.
Peer Reviewer #2	Summary and Implications	Page 15, line 17. Please delete use of the personal pronoun "Her". Please change it to "The second dichotomy…."	Suggestion adopted.
Peer Reviewer #2	Summary and Implications	Page 15, line 20. Please change the terms "…procedures like nerve blocks and discectomies…" to "…percutaneous spinal procedures and spine surgery…	Suggestion adopted.
Peer Reviewer #3	Summary and Implications	The review is comprehensive and clearly presents the state of current knowledge. The suggestions for research are appropriate and represent what has frequently been noted. The difficulty in conducting truly randomized controlled trials is acknowledged and double-blinding is virtually impossible. Having said this, and the problems with funding sources for studies of MPCs, it is disappointing as there will probably never be such studies conducted. The data amassed does seem to support MPCs compare to alternatives. However, third-party payers may use the criticisms and the report status as only a	Thank you for your comments and insight.

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		technical brief a justification for lack of payment for treatments at MPCs	
Peer Reviewer #3	Summary and Implications	Note that on page 15, line 37: Jeff Livovich is listed as "medical director" I am not sure that is his correct title.	Dr. Livovich has not provided a correction. We apologize if one was necessary.
Peer Reviewer #4	Summary and Implications	Implications of the major findings are clearly stated. This brief does a good job of fairly assessing the current state of MPPs and the literature that supports them, including weaknesses in the evidence basis.	Thank you for your comment.
Peer Reviewer #4	Summary and Implications	Regarding the decline in access section, One issue not pointed out is that MPPs have done a poor job of education the public and third party payors about their presence, evidence basis and their advantages. For lack of better words they need to evangelize their cause. The current state of pain management is such that the public and third party payors think of interventional pain procedures as current treatment of pain and are uneducated as to the presence of these programs and their advantages. I believe that they attribute insurance tactics to their failure too frequently. The fact is that they don't sell their product. As more third party payors offer disability/ mental health/ and medical coverage in one package to employers there is a great opportunity to make people aware. Employers are interested in return to work and better functioning of their employees but they are largely unaware of this type of treatment. Everyone owns a piece of this mess and everyone will have to be a part of the solution for MPPs to continue.	Please see page 16 for Gatchel et al. on this topic.
Peer Reviewer #5	Summary and Implications	Each of the first three sentences under "Summary and Implications" is flawed. The immediate prior paragraph indicates that the quality of evidence in the field is gravely deficient for several reasons, chiefly the general absence of control groups. It is unclear from the second sentence whether the authors of this report agree or disagree with the researchers in the field -- I can't find evidence in this report that would support such agreement, nor to support the third sentence describing a rapid decrease in MPPs.	This section has been revised.
Peer Reviewer #5	Summary and Implications	The discussion of why there should be a decline in access is intriguing, but would be much more compelling if more text were devoted to providing evidence that this is happening, and linking this evidence to the factors noted. In fact one may argue that the patient-centered, interdisciplinary nature of MPPs is exactly aligned with the model of care proposed under health care reform in the US -- and that is occurring now in the increasing number of accountable care organizations, regardless of the fate of specific legislation. Under such a model, the medical home integrates multiple sources of data	We agree the discussion would have been improved had been successful in locating good data on the reasons for decline; some indicators are provided in the Findings section, under Description of technology and context for use: Availability of programs (pp. 7-8 of revised document)

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		through the primary care provider, to individualize care and and enhance patient satisfaction.	
Peer Reviewer #5	Summary and Implications	The reliance upon quotes from a few select sources, chosen through potentially biased processes, makes much of this section very different from typical work products produced by AHRQ -- as the first decision letter alludes to.	Thank you for your comment. The Technical Brief is a very different format from the CERs you may be referring to.
Peer Reviewer #5	Summary and Implications	The section on opioids does not transition smoothly from the prior or subsequent sections. Simply to quote three individuals does not suficiently cite recent evidence-based guidelines (e.g., from the AMerican Geriatrics Soceity) or evidence syntheses (e.g., from the Canadian Pain Society) on the use of opioids for chronic noncancer pain. The first sentence under "patient-related issues" requires further justification. Recognition that pain has biological, psychological and social dimensions does not inherently imply to this reviewer that persistence of pain is the patient's fault. The idea that the psyche can control pain-associated distress is at least as old as the Buddha, and in a possibly separate cultural lineage was advanced by various Greek and Roman philosophers such as the stoics.	This section has been revised.
Peer Reviewer #5	Summary and Implications	Page 14 Lines 53-55: the statement that “researchers in the field seem to have largely accepted that the treatment works” comes out of the blue with no clear supporting evidence such as survey data in the antecedent text. Also, there is obvious possible bias in that the researchers were often if not usually based within or at least associated with MPPs. Please present relevant evidence for this important statement or delete it.	These statements have been deleted.
Peer Reviewer #5	Summary and Implications	Pages 15-16 (top) seem to be a discussion of results from an editorial/ interpretive perspective rather than a summary of data. Does this section belong here? Likewise, the immediately following sections on “role of opioids” and “patient-related issues” appear interpretive and anecdotal, and therefore out of place in this section, especially when the next section is “study design”.	We have made some revisions to make more clear the purpose of these “implications’ sections
Peer Reviewer #5	Summary and Implications	On page 15, line 24 it should read “surgery or a pill”.	Suggestion adopted.
Public Reviewer Cacic	Summary and Implications	Given the fact that in many cases this paper addresses chronic non-cancer pain there needs to be special concern and advisement made with respect to older persons (age 65+). This is a vulnerable population that is frequently adversely affected by inappropriate prescribing of analgesia of particular concern is the potential to increase risk for falls, change in cognition, and altered mental status secondary to alterations in pharmokinetics and pharmacodynamics	Thank you very much for your comment. This document specifically addresses one form of treatment for chronic noncancer pain that has not been used in older populations.

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		coupled with declining health make older persons particularly vulnerable. With the recent report of hospitalizations for medications on the rise per recent AHRQ press release dated 25 Oct 2010 this becomes even more concerning. Among this age group there was a 96% increase in admission rate for all medication and drug related conditions. The Medicare Health Outcome survey (2009) indicated that falls are responsible for two-thirds of the deaths in this population. This is significant and points to the need that while pain MUST be addressed for every individual as a sixth vital sign caution must be used in older persons to avoid potential harm by inappropriate prescribing.	
Peer Reviewer #1	Next Steps	Next steps were well identified, however, I think that early intervention of certain health care issues that could benefit from MPP should be addressed.	This is incorporated in the first bullet point on the last page highlighting future research on when patients should be referred to MPPs
Peer Reviewer #2	Next Steps	Again, the material in this section seems to be related to Questions 3 and 4. The previous stated concerns regarding use of the Guiding Questions applies here. The content of this section is relevant and informative.	Thank you for the comment.
Peer Reviewer #5	Next Steps	The discussion of study designs, while concise, is helpful. On the other hand, it is puzzling to see the body of literature on effectiveness and efficacy of MPPs referred to in passing under "next steps" but without any of it presented. One would think that to aid in decision making, the available evidence on outcomes should be highlighted in this Brief. Similarly, the concern about declining access to MPPs would be much more compelling if data were presented in this regard.	See above.
Peer Reviewer #5	Next Steps	Other next steps that should be commented upon include risk stratification through genetic testing such as preoperatively, and also with respect to substance abuse issues. Given the wide prevalence of the latter in society at large, one would have wished to see some comment about the treatment of patients who have issues both with chronic pain and substance abuse.	Suggestion adopted.
Peer Reviewer #5	Next Steps	Another important opportunity exists for the authors of the briefing to consider how the integrated, outcomes-driven multidisciplinary model of care centered in a medical home and provided through an accountable care organization may enhance the future prospects of MPPs.	This would be an interesting topic for future research; most of these developments happened after this Brief was submitted.
Peer Reviewer #5	Next Steps	Page 17, bottom: the summary of findings from interviews is presented without any description of the methodology used to gather such unstructured or semi-structured qualitative data. A description of the qualitative research methodology employed, including how the interviewees were selected and their contributions synthesized,	Thank you for your comment. The selection of interviewees is described in Appendix B. The Technical Brief format does not include interview summaries

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		would be important.	
Peer Reviewer #5	Next Steps	Page 18: the last paragraph, while plausible, seems to outstrip the data presented. The key informants appear to have presented plausible anecdotal impressions but these are not accompanied by data demonstrating a decline in the numbers of MPPs or their patient capacity over time, nor a decline in the proportion of the estimated number of patients who would benefit from an MPP compared with those who actually receive such therapy. Insurance payments to MPPs over time are not presented but would prove helpful in supporting this final conclusion of the entire report. Estimates of the costs, benefits and risks of medications (both opioid and nonopioid) might be mentioned, along with the predicament of how difficult it has proven to successfully advance drugs for chronic pain through the clinical development process, with so many failures of late-stage trials. Another "next step", given the cost of "interventional" pain therapies, would be to address the costs, risks and benefits of offering such procedures to patients seen in MPPs.	Thank you for these suggestions. The focus of this Technical Brief is largely to describe the existing research on MPPs.
Public Reviewer Smith	Next Steps	A more direct recommendation to use the money appropriated to CMI in HR 3590 §3021 to pilot MPP's using alternative reimbursement schemes is needed. You hint at, but never posit, that a bundled payment with shared savings from avoidance of potentially avoidable complications lends itself perfectly to this model. Let's face it, it is the pending reality of these improved payment systems that is driving this report; that is why AHRQ is doing this now, not 5 years ago.	Thank you for your insight.
Public Reviewer Ward, APTA	Next Steps	APTA respectfully notes that many potential biases exist in study designs, including who enters the study, outcome measures used, high-rates of drop outs, lack of comparison groups, lack of blinded examiners, lack of data on costs (both direct and indirect), etc. These biases will need to be addressed in future studies.	Thank you for your comment. These are definitely important considerations for future research.
Peer Reviewer #2	Appendix A	Page A-1, line 16. Please change the phrase "…restore the patient's independence…" to "…to restore physical and emotional functioning…"	Suggestion adopted.
Peer Reviewer #2	Appendix A	Page A-1, line 24. Again, please change the phrase "…restore the patient's independence…" to "…restore physical and emotional functioning…"	Suggestion adopted.
Peer Reviewer #2	Appendix C	The vast majority of systematic reviews search multiple databases (e.g., EMBASE, PsycINFO, Cochrane Central Register of Controlled Trials). Searching only one database could have affected the findings, and this should be included as an important limitation of this document.	Thank you for the suggestion. Cochrane reports are indexed in MEDLINE. This document should not be considered a definitive list of all studies published on MPPs

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Peer Reviewer #1	General	change the term "chronic pain patients" int he text to "patients with pain." (p.8, line 6;p.18, line35)	Suggestion adopted.
Peer Reviewer #1	General	The report is organized and points out a number of important facts and issues surrounding MPP. I'm not sure if this would influence policy makers or practice decisions without providing some strong examples of the positive impact it has on individuals. While this is a technical brief, bringing it to life with several positive clinical outcome, might do a lot to demonstrate the end "product" of MPP. There are many positive stories out there.	Thank you for the recommendation; we spoke to some very eloquent advocates for MPP treatment whose stories are an important adjunct to the clinical literature
Peer Reviewer #3	General	The report is clear and the clinical implications are appropriately presented. The populations are well-defined and the key questions addressed are laid out in advance.	Thank you for your comment.
Peer Reviewer #4	General	Did not see that this specifically addressed the target audience but indirectly implied in the brief is the target audience, those participating in providing this care, third party payors, legislators, pain practitioners. Perhaps a brief early paragraph defining the target audience would be helpful. The key questions are clearly stated and the important key issues are addressed. Remarkably this brief outlines the important issues surrounding multidisciplinary pain programs for non-cancer pain in an accurate and succinct fashion. This is a difficult complex topic and the ability to convey the "total picture" as well as providing insight into this topic efficiently is impressive. This document, from my perspective, would serve well to educate third party payors for these services. This brief is extremely well organized and structured. The points are clearly presented and the conclusions are valid and will be an excellent resource to inform policy and or practice decisions. It addresses a very complex issue in an in depth and efficient manner.	Thank you for your comments.
Peer Reviewer #4	General	To some degree the brief implies that MPP's are something that are used after all other treatments have been exhausted. I see them as an appropriate treatment for some chronic pain patients as an alternative to many current treatments particularly interventional/ unimodal approaches.	Our research suggests that patients presenting to MPPs have tried many other treatments; many experts do, however, state that MPPs should be used earlier in the disease process.
Peer Reviewer #4	General	This brief does a great job of defining the major issues related to why patient's don't get this care. Societal, medical systems, fee for service, problems with workman's comp systems.	Thank you for the comment.
Peer Reviewer #5	General	The Preface describes the purpose of Technical Briefs as providing an overview of key interventions for which there are limited published data. This document does so, but because of the limits of the literature and perhaps also the approach taken in this specific report,	Thank you for your comment. We hope this document will serve as an introduction to the vast literature available on MPPs and provide interested readers some sources for further

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		seems to fall short of another broad goal, to organize knowledge and make it available to inform decisions about health care. Some data to help patients and their care providers decide whether to participate in a MPP must be present in the analyzed papers but one comes away without a clear sense of what that data is, or how to apply that data to inform health decisions. Specifics as to the range of costs, interventions, insurance coverage, and patient outcomes are referred to in the report, but only anecdotally. The leaders quoted are vocal in their distress that decreased access to MPPs is a major problem but there is no data presented to help one estimate the gap between patients for whom an MPP would be helpful, and those who actually enter one. Nor is data provided as to the absolute numbers of MPPs in the US, the numbers of staff they employ, and temporal trends in these, nor evidence that the outcomes justify the intervention. Despite the quoted invitation of a health care insurance executive to those who run MPPs to persuade him and his colleagues that such programs are worth paying for, this Technical Brief is not suited to accomplish that.	information.

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