1. 7:00-7:05  Introductions—All

2. 7:05-7:20  Lessons Learned from Southern Oregon Pain Conference—Dr. Swanson, Dr. Safford, Dr. Mann, and Dr. Raymond

3. 7:20-7:25  MED Chart—Dr. Mann

4. 7:25-7:35  PDMP Grant Update—Rebeckah Berry & Harriett Godoski

5. 7:35-7:45  Safer, Informed, & Compassionate Opioid Prescribing—Dr. Swanson

6. 7:45-7:50  Chronic Pain 101 Provider Workshop (September 23, 2016)—Rebeckah Berry

7. 7:50-8:00  Monthly Updates—Dr. Swanson
   • Caveats of the New “Opioids in Central Oregon” Dashboard—Rebeckah Berry
   • Medicaid Rollout of Back Pain Guidelines & Alternative Treatments—Dr. Little
   • High Lakes Healthcare Provider Presentation—Dr. Mann
   • Living Well with Chronic Pain for Central Oregon—Rebeckah Berry
   • Naloxone Statewide Workgroup—Rebeckah Berry

Consent Agenda:
• Approval of the draft minutes dated June 1, 2016 subject to corrections/legal review
Highlights from Southern Oregon Pain Conference: Scott Safford

I presented at my clinic’s physicians meeting and below are the bullet points from what I presented to them:

• S. is 5% of world population, but 80% of opiate prescriptions
• Study of Workman’s comp: Those placed on long-term opiates more disabled and LESS likely to return to work; no indication of improved functioning/improved engagement in activities
• Addressing co-occurring sleep problems reduces reported pain scores more than any other intervention
• Handouts: Opioid and Benzo tapering guidelines; Guidelines for treatment of acute and chronic pain
• Website: oregonpainguidance.org
• Has lots of helpful resources

There was also a good presentation on “brain pain” that talked about different regions of the brain that are often activated with chronic diffuse pain conditions, such as fibromyalgia, as opposed to the brain regions activated by nociceptive pain, and that this can often predict poor response to surgical interventions such as back surgery or knee/hip replacement for co-occurring pain conditions.

I went to a presentation on Acceptance and Commitment Therapy (ACT) that focused on developing a sense of life purpose as a way to address chronic pain. Essentially, helping patients identify what is their reason for living, so they are enduring the pain because they have a reason to. There was also a focus on fostering mindfulness as a way to increase pain tolerance rather than focus on pain avoidance or trying to make it go away.

I went to a presentation on switching the biopsychosocial model of chronic pain to a PsychoSocial-bio model because the psychosocial factors are believed to play a much bigger role in chronic pain than the physiological factors.

I also went to a presentation on the book “Dreamland” that talked about the history of America’s opiate addiction, drawing parallels between the marketing of opiates and the drug cartels selling of heroin.
Target/Goals for MEDs (Morphine Equivalency Dosages)

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* Or a reduction of 30% per year in MED
  (Specifically for legacy non-cancer pain patients)
Safer and Compassionate Chronic Pain Care
Tools & STRATEGIES to support “response-able” action

By Kim Swanson, Ph.D.
Chair Pain Standards Task Force
For
High Lakes Medical Center

Acknowledgements

• Central Oregon Health Council
• Pain Standards Task Force
• PacificSource Community Solutions

Gratitude is not only the greatest of virtues, but the parent of all others.
- Cicero
Acknowledgements

- We would like to especially thank Laura Heesacker, LCSW, Behavioral Health Innovation Specialist from Jackson Care Connect for allowing us to use her insights and presentations on compassionate conversations.

Background

“What’s your drug of choice?” she asked. “Hope” he said. “The most addicting one of all.”
Background

- “The opioid epidemic has been called the worst drug crisis in American history. Death rates now rival those of AIDS during the 1990s, and with overdoses from heroin and other opioids now killing more than 27,000 people a year.”

References: http://www.pbs.org/wgbh/frontline/article/how-bad-is-the-opioid-epidemic/

Background

The epidemic has hit nearly everyone, regardless of race

For every 1 death there are...
- 10 treatment admissions for abuse
- 32 emergency dept visits for misuse or abuse
- 130 people who abuse or are dependent
- 825 nonmedical users

http://www.cdc.gov/
Background

**Patient Histories of Trauma and Chronic Pain**

- Approximately 15% to 35% of patients with chronic pain also have PTSD.
- Only 2% of people who do not have chronic pain have PTSD.
- One study found that 51% of patients with chronic low back pain had PTSD symptoms.
- Survivors of physical, psychological, or sexual abuse tend to be more at risk for developing certain types of chronic pain later in their lives.

**PTSD Impact on Chronic Pain Outcomes**

- For people with chronic pain, the pain may actually serve as a reminder of the traumatic event, which will tend to make the PTSD even worse.
- Pain related hypervigilance
- Pain related catastrophizing
- Fear avoidant coping
- Kinesiophobia


What is the Pain Standards Task Force

- Please visit us at [www.copainguide.com](http://www.copainguide.com)
What is the Pain Standards Task Force

Why was the Pain Standards Task Force formed?

The Pain Standards Task Force (PSTF) is supported through the Central Oregon Health Council (COHC), which is the governing body of Central Oregon’s Coordinated Care Organization (CCO), PacificSource Community Solutions.

The PSTF was formed in response to the concerning rise of opioid related deaths & health care costs in our community to transform health care delivery for chronic or persistent non-cancer pain in our region.

Kim Swanson, PhD (Chair)
Clinical Psychologist - St. Charles Family Care

Gary Allen, DMD, MS
Dental Director - Advantage Dental

Robert Andrews, MD
Physiatrist - Desert Orthopedics

Wil Berry, MD
Psychologist – Deschutes County Health Services

Rebeckah Berry, MS, CHES
Project Manager – Central Oregon Health Council

Patty Buehler, MD
Ophthalmologist – InFocus EyeCare

Muriel DeLaVergne-Brown, RN, MPH
Director - Crook County Health Dept.

Shana Geigle, FNP
Provider – Veterans Administration

Maria Hatcliffe, RN, MPH
Clinical Quality Improvement Coordinator - PacificSource

Central Oregon Health Council
What is the Pain Standards Task Force

<table>
<thead>
<tr>
<th>Name</th>
<th>Title and Organization</th>
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</thead>
<tbody>
<tr>
<td>David Holloway, MD, CPE, FAAFP</td>
<td>Chief Medical Officer – BMC</td>
</tr>
<tr>
<td>Janet Kadlecik, OTR/L</td>
<td>President – Work Capacities LLC</td>
</tr>
<tr>
<td>Jennifer Laughlin, DO</td>
<td>Medical Director, Hospital Medicine – St. Charles</td>
</tr>
<tr>
<td>Jessica LeBlanc, MD, MPH</td>
<td>Physician – Mosaic Medical &amp; Bend Treatment Center</td>
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<tr>
<td>Alison Little, MD, MPH</td>
<td>Medical Director for Medicaid Programs – PacificSource</td>
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<tr>
<td>Sharity Ludwig, BS, RDH, EPP</td>
<td>Quality Improvement Manager - Advantage Dental</td>
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<tr>
<td>Steve Mann, DO</td>
<td>High Lakes Healthcare and COIPA</td>
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<tr>
<td>Kyle Mills, PharmD</td>
<td>Clinical Pharmacist - Mosaic Medical</td>
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<tr>
<td>Laura Pennavaria, MD</td>
<td>Chief Medical Officer - La Pine Community Healthy Center</td>
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<tr>
<td>Christine Pierson, MD</td>
<td>Chief Medical Officer - Mosaic Medical</td>
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<table>
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<tr>
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<tr>
<td>Kerie Raymond, ND</td>
<td>Practitioner – Hawthorn Healing Arts Centre</td>
</tr>
<tr>
<td>Robert Ross, MD</td>
<td>Medical Director, Community Health Strategy - St. Charles</td>
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<tr>
<td>Marie Rudback, DC</td>
<td>Practitioner – Endeavor Chiropractic</td>
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<tr>
<td>Scott Safford, PhD</td>
<td>Clinical Psychologist - St. Charles Family Care</td>
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<tr>
<td>Divya Sharma, MD, MS</td>
<td>Medical Director - Central Oregon IPA &amp; Mosaic Medical</td>
</tr>
<tr>
<td>Julie Spackman</td>
<td>Community Project Coordinator – Deschutes County Health Services</td>
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<tr>
<td>Pamela Tornay, MD</td>
<td>Attending Physician – ER</td>
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<tr>
<td>Rick Treleaven, LCSW</td>
<td>Executive Director – BestCare</td>
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<tr>
<td>Tom Watson, PT, DPT, DAAPM</td>
<td>Physical Therapist - Rebound</td>
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</tbody>
</table>
Community Wide Endorsement of Safer Prescribing Practices

- Adherence to 120 mg MED limit for opiates
- Avoidance of polypharmacy of controlled substances
- Judicious use of opiates particularly beyond a period of 8 weeks for acute pain
- Referral to appropriate treatment for opioid and other substance use addiction
- Compassionate, supportive and patient centered treatment

Facts are stubborn things; and whatever may be our wishes, our inclinations, or the dictates of our passion, they cannot alter the state of facts and evidence

~ John Adams

WWW.THEFEDERALISTPAPERS.ORG
Community Wide Endorsement of Safer Prescribing Practices

- Incorporation of practice safeguards to minimize potential for misuse, abuse, aberrance, dependence and diversion of controlled substances

- Consistent use of Materials Risk Notice
- Written Controlled Substance Agreement
- Random Urine Toxicology Screening
- Regular consultation of PDMP
- Assessment of risk of abuse prior to initiating or continuing a chronic controlled substance

Target/Goals for MEDs (morphine equivalency dosages)

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*Or a reduction of 30% per year in MED (Specifically for legacy non-cancer pain patients)
Co-Prescription of Naloxone as Universal Precautions

- Early access to the opioid reversal agent Naloxone through community-based models has demonstrated positive outcomes during its use in the last decade.
- Pain patients and their loved ones can be educated on overdose symptoms and administration of intranasal naloxone in the community setting.

References:
https://www.ihs.gov/odm/overdose-prevention-treatment/naloxone-prescribing/

Co-Prescription of Naloxone as Universal Precautions

- Consider co-prescribing naloxone in these situations:
  - Recently rotated to a new opioid
  - Prescribed morphine equivalent daily (MED) dose of 50mg or more
  - On long-acting opioids particularly if in conjunction with short-acting opioids
  - Poly-opioid use
  - Prescribed opioids greater than 30 days
  - Over the age of 65 years
  - Households with people at risk of overdose such as children or someone with a substance abuse disorder
  - Patients who have difficulty accessing emergency medical services (distance, remoteness, lack of transportation, homelessness, and/or without phone services)
Co-Prescription of Naloxone as Universal Precautions

- Consider co-prescribing naloxone in these situations
  - Concurrent prescription or over-the-counter medications
    - Benzodiazepines
    - Antipsychotics
    - Antiepileptics
    - Muscle relaxers
    - Hypnotics
    - Antihistamines

The Art and Science of Compassion

- Redirecting conversations away from eliminating pain and moving toward managing pain to live a meaningful life.

References: Courtesy of Laura Heesacker, LCSW, Jackson Care Connect
The Art and Science of Compassion

It will take a **team** effort…

- Consistently apply established policies and procedures
  - Treatment agreement; medical history review; risk assessments; screenings; etc.

- Equip all team members with tools and training

- Be familiar with all aspects associated with the change
  - Physical exam; Opioid Risk Tool (ORT); STOP BANG assessment; multiple visits; reassessments; etc.
  - Prescription Drug Monitoring Program (PDMP); Urine Drug Screen (UDS); pill counts; etc.

---

The Art and Science of Compassion

Start the conversation the right way. Your **1 minute** elevator speech:

- "Recent research has demonstrated that the use of opioids is proving to be less effective and less safe than we were once led to believe. In fact, there are some potentially dangerous side effects. We are learning that when we follow certain guidelines when treating people living with chronic pain, we can increase both the safety and effectiveness of treatment. I would like to take a few minutes to share how these new safety guidelines relate specifically to your medical treatment."

---

References: Courtesy of Laura Heesacker, LCSW, Jackson Care Connect
The Art and Science of Compassion

- Thoughts and emotions play a significant role in LIVING with complex chronic pain and TREATING it.

The CHALLENGE is...

to get your patients working with you not against you!

References: Courtesy of Laura Heesacker, LCSW, Jackson Care Connect
"This isn’t fair. You promised you wouldn’t reduce my medications, and you are going back on your word."

"You have no idea how much pain I am in. You are not in my body."

"Are you saying you are just going to let me suffer?"
"This isn’t fair. You promised you wouldn’t reduce my medications, and you are going back on your word."

"You have no idea how much pain I am in. You are not in my body."

"Are you saying you are just going to let me suffer?"

"Well, I’m just going to go to the ER."

Do you want me to go get drugs from the street?

"I’ll be finding another provider, who believes me and cares!"

References: Courtesy of Laura Heesacker, LCSW, Jackson Care Connect
The Art and Science of Compassion

- The parallel process of the patients and providers is... both brains take the “low road”

**The limbic system – the emotional brain**

---

The Art and Science of Compassion

Tools and strategies to help you remain “response-able” and successfully navigate difficult conversations with challenging and desperate patients:

- Slow down, breath connects mind and body, be conscience of your physiology
- Practice and rehearse what you will say to counter your patients’ emotional pleas and “negotiations” (your pre-prepared responses)
- Start the conversation right by using YOUR rehearsed elevator speech
- Use permission phrases to give the patient some control and input
- Actively listen to the patient's concerns, emotions, opinions, etc.
- Repeatedly state how much you care about them and emphasize your confidence in their ability to make the proposed changes!
- Network – share “best practice” and support with like-minded peers

References: Courtesy of Laura Heesacker, LCSW, Jackson Care Connect
Helpful Resources

- UW Telepain
  - Telepain is a way to receive multi-disciplinary consultation for chronic pain mgmt. regarding patients. Registration is required, but it is free, and it occurs every Wednesday from 12-1pm.
- Federally funded Continuing Medical Education courses are available to providers at no charge on chronic pain management
  - [http://www.opioidprescribing.com/overview](http://www.opioidprescribing.com/overview)

Free Webinar on Motivational Interviewing

- [http://integratedcare-nw.org/webinarsmotivinterview_050610.html](http://integratedcare-nw.org/webinarsmotivinterview_050610.html)
Next Steps?

- Q&A

Internet Sources:

- www.oregon.gov/oha/pharmacy/Pages/prescription-drug-abuse-task-force.aspx
- www.cdc.gov/drugoverdose/
- www.public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Pages/index.aspx
- www.cdc.gov/primarycare/materials/opoidabuse/index.html
- www.supportprop.org/
- http://www.npsf.org/?page=askme3
- Doc.com
This event is FREE for any Central Oregon healthcare provider. 4 CME and Pharmacy CEs have been approved for this event. Breakfast and lunch will be provided.

TOPICS & SPEAKERS INCLUDE

Compassionate Conversations & The Chronic Non-Cancer Pain Patient
- Jessica LeBlanc, MD, MPH (Mosaic Medical & Medical Director at the Bend Treatment Center)
- Laura Heesacker, MSW, LCSW (Behavioral Health Innovations Specialist, Care Oregon and Jackson Care Connect)

Rethinking the Opioid Risk Assessment
- Paul Coelho, MD (Oregon Pain Management Commission)

Marijuana and the Chronic Non-Cancer Pain Patient
- Kevin Hill, MD, MHS (Assistant Professor of Psychiatry, Harvard Medical School and Director, Substance Abuse Consultation Service, Division of Alcohol and Drug Abuse, McLean Hospital)

If Not Opioids, Then What? The Effectiveness of Alternative Therapies
- Dennis Turk, PhD (John and Emma Bonica Endowed Chair in Anesthesiology and Pain Research and Professor, Department of Anesthesiology & Pain Medicine, University of Washington)

This event is for healthcare providers only.
Registration is required and limited to the first 100 registrants.
Please register at: http://pain101providerworkshop.eventbrite.com

Please contact the COHC with any questions at:
(541) 306-3523 or info@cohealthcouncil.org
Pain Standards Task Force Vision: Working collaboratively to improve the health and well being of chronic or persistent non-cancer patients in Central Oregon.

Pain Standards Task Force Mission: Create a health care system that embodies compassionate, patient-centered, holistic, and evidence-based chronic or persistent non-cancer pain care.

7:30 – 8:00 a.m. Registration, Breakfast, & Networking

8:00 – 8:15 a.m. Welcome & Introductory Remarks
• Kimberly Swanson, PhD (Chair, Pain Standards Task Force and Clinical Psychologist, St. Charles Family Care)

8:15 – 9:15 a.m. Compassionate Conversations & The Chronic Non-Cancer Pain Patient
• Jessica LeBlanc, MD, MPH (Practitioner, Mosaic Medical and Medical Director, Bend Treatment Center)
• Laura Heesacker, MSW, LCSW, (Behavioral Health Innovations Specialist, Jackson Care Connect and Care Oregon)

9:15 – 10:15 a.m. Re-thinking the Opioid Risk Assessment
• Paul Coelho, MD (Oregon Pain Management Commission)

10:15 – 10:30 a.m. Break

10:30 – 11:30 a.m. Marijuana and the Chronic Non-Cancer Pain Patient
• Kevin Hill, MD, MHS (Assistant Professor of Psychiatry, Harvard Medical School and Director, Substance Abuse Consultation Service, Division of Alcohol and Drug Abuse, McLean Hospital)

11:30 – 12:00 p.m. Lunch Break

12:00 – 1:00 p.m. If Not Opioids, Then What? The Effectiveness of Alternative Therapies
• Dennis Turk, PhD (John and Emma Bonica Endowed Chair in Anesthesiology and Pain Research and Professor, Department of Anesthesiology & Pain Medicine, University of Washington)

1:00 – 1:15 p.m. Closing Remarks & Adjourn
• Kimberly Swanson, PhD (Chair, Pain Standards Task Force and Clinical Psychologist, St. Charles Family Care)
Pain 101: Provider Workshop
Speaker Biographies

Paul C. Coelho, MD (Oregon Pain Management Commission)

Dr. Coelho is board certified in Physical Medicine & Rehabilitation and subspecialty certified in Pain Medicine. His undergraduate training was performed at the University of California at Davis where he graduated with Honors in Biochemistry. He completed medical school at the University of Chicago, and Internship at Northwestern University where he was awarded Intern of the Year. His residency training was at the University of Washington in Seattle where he was honored with the Harborview House Staff Award. His fellowship training in spine and pain management was at Kaiser Permanente Oakland and he was awarded the Fisher-Peabody award for excellence in 2002. Dr. Coelho’s medical interests include evidence-based pain and spine care, opioid risk abatement, and physical medicine & rehabilitation.

Laura Heesacker, MSW, LCSW (Behavioral Health Innovations Specialist, Jackson Care Connect and Care Oregon)

Laura Heesacker, MSW, LCSW, started her career over 25 years ago working in a Pain Rehabilitation Program in Portland Oregon. She has over 20 years experience working as a Behavioral Health Consultant in primary care. She graduated from Portland State University in 1993 with a Masters Degree in Social Work. Current professional passions include supporting healthcare entities develop integrated behavioral healthcare as well as safe and effective care for people living with chronic pain. Laura enjoys spending time with her family and hiking the trails in Southern Oregon.
Kevin Hill, MD, MHS  (Assistant Professor of Psychiatry, Harvard Medical School and Director, Substance Abuse Consultation Service, Division of Alcohol and Drug Abuse, McLean Hospital)

Kevin P. Hill, MD, MHS, is an addiction psychiatrist conducting clinical research aimed at developing medications and behavioral interventions that might help those who want to stop smoking marijuana or cigarettes. Dr. Hill received a prestigious federal K99/R00 grant award from the National Institute on Drug Abuse: his project is to test the efficacy of a synthetic marijuana-like compound, nabilone, as a medication for patients with marijuana dependence.

Dr. Hill earned a Masters in Health Science from the Robert Wood Johnson Clinical Scholars Program at Yale and has published on numerous topics in addiction. Recently, he has spoken nationally and appeared on television on the topics of marijuana policy and treatment, offering a balanced, evidence-based stance on these issues. Dr. Hill’s book, Marijuana: The Unbiased Truth About the World’s Most Popular Weed, was released by Hazelden Publishing in March 2015. Dr. Hill also maintains a small private practice.

Jessica LeBlanc, MD, MPH  (Practitioner, Mosaic Medical and Medical Director, Bend Treatment Center)

Jessica LeBlanc, MD, is a board certified Family Practice physician who cares for adults and children at Mosaic Medical (one of Central Oregon’s Federally Qualified Healthcare Centers). Dr. LeBlanc is also the Medical Director at Bend Treatment Center, Central Oregon’s only Medication Assisted Treatment (MAT) clinic in the region. Her philosophy incorporates holistic care for the entire family. She has significant experience in addiction medicine, chronic disease management, nutrition, and maternal-child medicine, including breastfeeding education and postpartum health. Dr. LeBlanc completed undergraduate studies at Northern Arizona University with a degree in Anthropology followed by a Masters in Public Health from University of Arizona. She went on to complete medical school at University of Arizona College of Medicine and residency at Swedish Medical Center in Seattle, Washington.
Dennis C. Turk, PhD (John and Emma Bonica Endowed Chair in Anesthesiology and Pain Research and Professor, Department of Anesthesiology & Pain Medicine, University of Washington)

Dennis Turk, PhD, is the director of the Center for Pain Research on Impact, Measurement, & Effectiveness (C-PRIME) at UW Medicine. He was previously an associate professor of psychology at Yale University and a professor of psychiatry and anesthesiology at the University of Pittsburgh School of Medicine, where he also served as the director of the Pain Evaluation and Treatment Institute.

A charter member of the International Association for the Study of Pain and a founding member of the American Pain Society, Dr. Turk is a fellow of the Academy of Behavioral Medicine Research, the Society of Behavioral Medicine and the American Psychological Association.

Dr. Turk has been active for many years in national and international organizations and is past president of the American Pain Society. He was a member of the Council of the International Association for the Study of Pain for six years, and he is a special government employee (advisor) to the U.S. Food & Drug Administration (the Center for Drug Evaluation and Research and the Center for Devices and Radiological Health).

Dr. Turk has received a number of awards, including the Award for Outstanding Scientific Contributions to Health Psychology from the American Psychological Association, the John C. Liebeskind Award for Career Contribution to Pain Research from the American Academy of Pain Management, and the Wilbert E. Fordyce Clinical Investigator Award from the American Pain Society. The latter recognizes “individual excellence and achievements in clinical pain scholarship and is given to a pain professional whose total career research achievements have contributed significantly to clinical practice.”

Dr. Turk is currently editor-in-chief of The Clinical Journal of Pain, co-chair of the Initiative on Methods, Measurement, & Pain Assessment in Clinical Trials (IMMPACT), and co-director of the Executive Committee for the Analgesic Clinical Trials Innovations, Opportunities, & Networks (ACTION) initiative — a public-private
partnered with the U.S. Food & Drug Administration. He is a member of the Institute of Medicine’s Committee on Advancing Pain Research, Care, and Education.

Dr. Turk has contributed over 500 publications to the healthcare literature, and he has authored or edited 20 volumes on pain, chronic illness and clinical decision-making, including Chronic Pain: An Integrated Biobehavioral Approach (with H. Flor), The Pain Survival Guide: How to Reclaim Your Life (with F. Winter), the 4th edition of Raj’s Practical Management of Pain (with H. Benzon, J. Rathmell, C. Wu, and C. Argoft), and the 3rd edition of the Handbook of Pain Assessment (with R. Melzack).

Dr. Turk’s research has focused on the assessment and treatment of a range of chronic pain conditions (e.g., fibromyalgia, whiplash-associated disorders, headache, temporomandibular disorders), clinical trial design, comparative effectiveness research, subgroup identification and treatment matching, and coping and adaptation. Based on an international survey, published in The Pain Clinic in 2001, Dr. Turk was designated one of the 10 leading contributors to the field of pain.
PDMP provided by Oregon Health Authority for Prescriptions in the Central Oregon CCO zip code region. All data is de-identified. Therefore, individual people, providers, payers, and pharmacies are not identifiable.

Rx = Prescription

**OVERDOSE HOSPITALIZATIONS**
Rate per 100,000 residents

**MORPHINE EQUIVALENT DOSING >120mg**
Rate per 1,000 residents

**OVERDOSE DEATHS BY DRUG TYPE**
Rate per 100,000 residents

**CO-PRESCRIBING**
# Individuals prescribed opiates and at least one other drug type in the same month one or more times. (Includes: Opioids, Hypnotics, Suboxone, and Benzodiazepine)
Meeting purpose: The aim of the Naloxone Workgroup is to align and coordinate efforts to increase access to naloxone in Oregon, specifically providing rulemaking support for the recently passed naloxone legislation and public education.

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<tr>
<th>Agenda Item</th>
<th>Detail</th>
<th>Action Item</th>
<th>Responsible Party</th>
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<tbody>
<tr>
<td>Welcome &amp; Introductions (10 min)</td>
<td>Group members will share their work and interests related to opioids and Naloxone in Oregon.</td>
<td></td>
<td>Lisa Shields</td>
</tr>
<tr>
<td>Update on OR Prescription Drug Overdose Prevention Program and Partner Grant Activities (15 min)</td>
<td><strong>Background:</strong> Oregon is one of 16 states to receive CDC funding for Prescription Drug Overdose Prevention. <strong>Objective:</strong> Overview of the updated PDO grant objectives including increasing naloxone access (Driver Diagram), updates on activities at the local level in multiple counties and discussion of opportunities to coordinate and align work efforts.</td>
<td></td>
<td>Lisa Shields, Lisa Millet and attending community partners</td>
</tr>
<tr>
<td>Update on recently submitted proposals for funding (10 min)</td>
<td><strong>Background:</strong> Since the April meeting, several grant proposals have been submitted or are in process. <strong>Objective:</strong> Provide an overview and update on proposals submitted or in development.</td>
<td></td>
<td>Lisa Millet, John McIlveen and attending community partners</td>
</tr>
<tr>
<td>Naloxone HB 4124 Overview &amp; Discussion (20 min)</td>
<td><strong>Background:</strong> The Board of Pharmacy is the lead agency for the rule development related to recently passed HB4124. <strong>Objective:</strong> Marcus Watt will provide an update on the rule development process. With regard to naloxone, <strong>HB 4124</strong> permits • In accordance with rules adopted by the State Board of Pharmacy under ORS 689.205, a pharmacist may prescribe and dispense the drug naloxone, and the medical supplies necessary to administer the naloxone, to a person who has completed the existing training on safe and effective administration in</td>
<td></td>
<td>Marcus Watt and Lisa Millet</td>
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accordance with rules adopted by the State Board of Pharmacy under ORS 689.205.

- An employee of a social services agency may administer to an individual a unit-of-use package of naloxone that was not distributed to the employee if:
  (a) The employee conducts or has successfully completed opiate overdose training under ORS 689.681;
  (b) The unit-of-use package of naloxone was distributed to another employee of the social services agency who conducts or has completed the opiate overdose training under ORS 689.681; and
  (c) The individual appears to be experiencing an opiate overdose as defined in ORS 689.681.

| Adjourn (5 min) | **Objective:** Wrap up the meeting and plan next steps | Lisa Shields |
Naloxone Workgroup

Purpose: The aim of the Naloxone Workgroup is to align and coordinate efforts to increase access to naloxone in Oregon, specifically providing rulemaking support and public education for the recently passed naloxone legislation.

Meeting Call in (877) 402-9753 Code# 1439464
Date Time Location
June 22nd 11-12 noon 800 NE Oregon Street, Portland Room 1C
September TBD 800 NE Oregon Street, Portland Room TBD

April 2016 Meeting Follow-up Items
Re-send PDO Driver Diagram with June agenda
Request that Marcus Watt present to OHA Internal Opioid group about Board of Pharmacy role in rulemaking
John McIlveen will provide an update on the SAMHSA applications submitted end of May
 Invite David Hart from DOJ to attend next meeting. (completed)
June Agenda item - Development of a communications plan for naloxone access following rule development.

April 2016 Meeting - Key Points
Rulemaking timeline: Aug (propose) October (review) Nov (rulemaking) Dec (adoption)
Discussion of several ideas - pharmacist using counseling procedure with handout to meet legal training requirement.
Under new law, pharmacist will be able to support agencies to access naloxone for trained staff members.
Suggestion that the Board of Pharmacy send letter to police and other agencies explaining access opportunities.
There is a need for a common communication plan about naloxone access for community members and agencies.

Resource Links
Naloxone Access Training on lifesaving treatment protocols - including naloxone for overdose
SB 384 SB 839 HB 4124
PDMP and PDO Oregon Data Dashboard Oregon PDMP Fact Sheet
Reducing Opioid Overdose and Misuse Oregon Prescription Drug Overdose, Misuse and Dependency Prevention Plan
State Health Improvement Plan Priority: Reduce harms associated with Substance use Naloxone Rescue for Opioid Overdose

Current Participants
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Reduce deaths, hospitalizations, and emergency department visits related to drug overdose

**Aim**

**Primary Drivers**

- Reduce problematic prescribing practices
- Increase access to and reimbursement for non-opioid treatments for chronic non-cancer pain
- Provide Medication Assisted Treatment (MAT) for opioid use disorder
- Increase and improve the infrastructure of naloxone rescue
- Use data to target and evaluate interventions to populations at highest risk

**Secondary Drivers**

1. Implement opioid prescribing guidelines for pain management
   - Engage CCOs, Emergency Departments, health systems, pharmacies, and insurers to expand uptake and use of evidence-based opioid prescribing and management guidelines
   - Fund five high-burden county regions to form and convene regional pain guidance groups (PGGs) and interdisciplinary action teams (IATs) to expand uptake of model opioid prescribing guidelines

2. Enhance and maximize the Oregon Prescription Drug Monitoring Program (PDMP)
   - Reduce barriers and increase PDMP registration and use
   - Reduce data reporting interval
   - Increase PDMP reporting, surveillance, and data sharing
   - Establish messaging to PDMP users
   - Authorize PDMP to share identified data with researchers, public health, and health systems

3. Provide reimbursement for non-opioid pain treatment therapies
   - Require insurers to pay for non-opioid care for chronic non-cancer pain treatment
   - Encourage CCOs and other prescribers to increase the use of non-opioid pain management

4. Increase the number and geographic distribution of primary care physicians certified to provide MAT for chronic opioid dependency

5. Increase access to naloxone
   - Increase access to naloxone through pharmacies
   - Increase access to naloxone through community-based programs
   - Include co-prescribing of naloxone in model guidelines for at-risk patients

6. Evaluations of policy and programs
   - Evaluate the public health impact of removing methadone as a preferred pain treatment drug from the state Medicaid drug formulary
   - Evaluate the impact of 72-hour or "real time" PDMP reporting
Task Force Members Present
Kim Swanson, Chair (St. Charles Family Care)
Gary Allen (Advantage Dental)
Rebeckah Berry (Central Oregon Health Council)
Muriel DeLaVergne-Brown (Crook County Health Department)
Shanna Geigle (Veterans Affairs)
Maria Hatcliffe (PacificSource)
Steve Mann (COIPA and High Lakes Healthcare)
Laura Pennavaria (La Pine Community Health Center)
Christine Pierson (Mosaic Medical)
Rob Ross (St. Charles Medical Group)
Marie Rudback (Endeavor Chiropractic, LLC)
Scott Safford (St. Charles Family Care)
Julie Spackman (Deschutes County Health Services)
Pamela Tornay (Central Oregon Emergency Physicians)
Rick Treleaven (BestCare Treatment Services)
Tom Watson (Rebound Physical Therapy)

Task Force Members Present (Call-in):
Alison Little (PacificSource)

Guests Present:
Misoo Abele, MD (Veterans Administration)
Kat Mastrangelo (Volunteers in Medicine)
Donna Mills (Central Oregon Health Council)

Guests Present (Call-in):
Kristen Dillon (Columbia Gorge Health Council)

Absent
Robert Andrews (Desert Orthopedics)
Wil Berry (Deschutes County Behavioral Health)
Patty Buehler (InFocus Eyecare)
Janet Kadlecik (Work Capacities)
Jennifer Laughlin (St. Charles Health Systems)
Jessica LeBlanc (Mosaic Medical & Bend Treatment Center)
Charity Ludwig (Advantage Dental)
Kerie Raymond (Hawthorn Healing Arts Center)
Divya Sharma (Mosaic Medical and COIPA)
1. Introduction & Opening Remarks
   - Members introduced themselves and their respective organizations and guests were welcomed to the meeting.

2. Pain Resiliency Program Brainstorm—Dr. Swanson
   - Chronic Non-Cancer Pain Tiered Model
     - Dr. Kim Swanson reviewed the Stepped Care model and shared a visual from Bob Kearns of the VA's national pain program. It is a tiered program beginning with primary care on up. Primary care is the gatekeeper for referral into the other two tiers based on individual need and risk. Tier 1 would include pain management classes directed at self-management, as with the Living Well with Chronic Pain (LWWCP) classes. Tier 2 includes specialty programs, such as the model produced by Mark Altenhofen. Tier 3 would include more advanced pain management programs as well as worker’s comp type programs.

   - Pain Program Overview (Mark Altenhofen’s program – Oregon Pain Advisors)
     - Dr. Christine Pierson gave an overview of the pain program that Mark Altenhofen helped to develop at sites across Oregon. The programs entail a marrying of behavioral health, passive, and active modalities housed as CCO, BH, and primary care. Self-management and movement specialists are key. Services are modified and based on a patient’s needs.
     - Ms. Maria Hatcliffe asked what kinds of movement specialists are utilized, and the response was primarily yoga instructors.
     - Dr. Laura Pennavaria requested how the LWWCP group would compare. Christine explained that it differed completely. It includes a cohort that receives peer support, a standardized class and includes a more intensive mental health approach. It also helps link patients to other resources.
     - Mr. Rick Treleaven said that speaking from pain program experience; high end or top tier folks have an increased trauma-base. This group requires an integrated approach with BH, trauma, and addictions. He asked what would happen to Tier 3 patients. The community needs to decide.
     - Dr. Steve Mann stated that we needed to ensure we select candidates correctly for a pain program.
     - Mr. Treleaven expressed that it could not be a dumping ground for patients with difficult situations.
     - Dr. Swanson stated that a selection criterion for Tier 1 and other tiers are needed.
     - Dr. Pennavaria said we need something tangible within our community to offer people.
     - Mr. Treleaven said the majority of people do not need to go to specialty clinic when they can utilize pain school within primary care.
     - Dr. Swanson shared that 85% would have no problem and respond well to Tier 1 approach and self-management. For the other 15%, it gets trickier.
     - Mr. Treleaven asked does research look at the length of time that someone has been taking opioids.
     - Dr. Mann shared that after 90 days of taking opioids results for success decrease.
     - Dr. Rob Ross said that half of the patients had not been to pain school within SCHS.
     - Mr. Treleaven stated that good follow up care (with behavioral health) is needed after program completion.
Dr. Swanson revealed that six months after self-management programs, behaviors go back to baseline so individuals need ongoing (peer) support.

Mr. Treleaven offered that the addictions contract model with PacificSource is outcome driven and there are performance bonus results based at six months and maintaining outcomes.

Dr. Swanson felt a tiered approach seems agreeable and where it is housed makes the difference. In Jackson County, it was in mental health and subsequently closed due to lack of use from stigma.

Mr. Treleaven shared that previous pain program had to been at The Center and not in BH. Many patients state, “Mental Health? Don’t you know this is real pain?”

Ms. Rebeakah Berry said there had been some discussions about locating it at VIM.

Dr. Swanson said that space is an issue because movement is a big part of this approach.

An individual asked Dr. Pamela Tornay about at the hospital.

Dr. Swanson shared that space is not consistently available.

Ms. Muriel DeLaVergne-Brown wondered about transportation issues and asked if we should consider Redmond for accessibility.

Ms. Julie Spackman asked if the Community College had space.

Dr. Mann suggested Juniper Fitness. Patients could see physically challenged people using the setting and have models to observe.

Dr. Swanson asked about the Redmond recreation center.

Dr. Tom Watson offered that the Oncology Rehab Specialist. The owner used her yoga-type facility for ten people with chronic cancer pain.

Dr. Pennavaria asked if there could be more than one venue.

Mr. Treleaven stated that it is expensive to have a tiered model in multiple settings.

Dr. Pennavaria wondered if a traveling group that offered the classes in different locations would be an option.

3. Central Oregon’s Timeline to Align with CDC Guidelines

- Dr. Swanson shared that the State will be adopting the CDC guidelines and will develop Oregon statewide opioid guidelines based on CDC’s example.
- Dr. Pennavaria inquired that with the PacificSource mailing going out around patients at 120 MED or higher, what is the timeline for expecting patients to completely taper off all opioids.
- Dr. Alison Little stated that this is not something that PacificSource can expect or do from an administrative/resource perspective. They would continue to request that members are < 120 MED.
- Dr. Steve Mann asked if it was MED versus managing pain. We need to stay with the community standard we have communicated. We can then ease into the CDC guideline. It is still controversial.
- Dr. Ross stated that re-messaging now is not going to work.
- Dr. Swanson asked about presenting at High Lakes as the pilot for the “dog and pony show,” what they already know about the CDC guidelines. She said that she agreed with Dr. Mann and Dr. Ross.
- Ms. Muriel DeLaVergne-Brown said that many things coming from CDC change and she agrees we should wait and stick with where we are for now.
- Mr. Treleaven wondered if there was any problem with the State with a gradualist approach.
- Dr. Swanson expressed that there was no push back from OHA. Tri-city area in PDX is at 120 MED. She said they would move toward CDC by 1/1/17.
- Mr. Treleaven felt that high doses are more problematic so getting patients to lower, < 120 MED is good.
- Dr. Mann inquired about calendaring our goals: 2017 90 MED is threshold, but 60 is ideal, etc.
- Dr. Ross requested that we revisit it in the fall.
• Dr. Swanson shared that the survey showed that 85% of physicians are supportive of the CDC guideline and lower threshold.

4. Monthly Updates

• PDMP Statewide PIP Update
  o Ms. Hatcliffe provided an update and explained that PacificSource will be mailing letters to members and prescribers and PCPs of members who are on 120 MED or greater. The plan is to initiate the mailing the week of June 27, 2016.
  o Dr. Pierson inquired if Medical Directors could also receive a list of the members/prescribers at their clinics. Ms. Hatcliffe agreed to work on that.
  o Medicaid Rollout of Back Pain Guidelines & Alternative Treatments—Dr. Little will do a presentation on 6/22/16 at PacificSource. Please broadcast widely and an RSVP is required.

• PDMP Registration, Safer Prescribing, & Difficult Conversations—
  o Dr. Swanson noted that the PDMP training was helpful and several attended. June 21, 2016 is the pilot test date for Dr. Swanson, Ms. Berry, Dr. Safford and the new PDMP grant coordinator from Deschutes to do a “Dog and Pony show” at High Lakes with staff. This group name is the “Safer Prescribing Team” and developed as part of a PDMP grant.
  o Ms. Hatcliffe said it would be helpful to offer the services of this team to identified prescribers from the PS mailing who may have higher #’s of patients on > 120 MED or need help with difficult conversations. She requested a write-up of the services this team can offer to share with prescribers.
    • FOLLOW UP: Ms. Berry agreed to provide this information.
  o Ms. Berry stated that as part of the PDMP grant, the coordinator will be present at the dentist conference in July, our September 23 Pain 101 event, our October 7 Grand Rounds, as well as other events and presentations.
    • FOLLOW UP: Please send Rebeckah ideas for other places the coordinator could do PDMP registration or training throughout the region.

• Pain 101 Provider Workshop (9.23.16)
  o Dr. Swanson and Ms. Berry shared that the Planning Committee has identified topics and speakers, which include Marijuana use; Effectiveness of alternative therapies; Compassionate approaches to care; Acute, Chronic, and Legacy pts. Booths will include PDMP and Living Well With Chronic Pain. There will NOT be any pharmaceutical company presence.
    • FOLLOW UP: Please send ideas for other tables to include to Rebeckah.

• Living Well with Chronic Pain for Central Oregon—
  o Ms. Berry noted that registration is open, and first class is in La Pine with next to follow in Redmond.
  o Ms. Hatcliffe said she was planning to include info about the class and fax for referrals in the mailings.

Consent Agenda: A motion to approve the draft minutes dated May 4, 2016, was made by Dr. Mann. Dr. Ross seconded. The Minutes are subject to corrections/legal review. Minutes were accepted in full.