Central Oregon Health Council

Pain Standards Task Force
PacificSource Community Solutions – Boardroom
2965 NE Conners Ave, Bend OR 97701

Agenda: April 5, 2017 from 7:00am-8:00am

Call-In Number: 866-740-1260
7-Digit Access Code: 3063523

1. 7:00-7:05 **Introductions—All**

2. 7:05-7:20 **Legislative Session Follow Up—Dr. Swanson**

3. 7:20-7:30 **Potential Grand Rounds Topic—Dr. Swanson**
   - **"The Relief that Binds You: pain induced by opioid use and withdrawal"**

4. 7:30-7:40 **Harm Reduction—Dr. Swanson**
   - **Naloxone Access & Pharmacy Education**

5. 7:40-7:50 **HERC Alternative Therapies Update—Dr. Little**

5. 7:50-8:00 **Monthly Updates—Dr. Swanson**
   - **Performance Improvement Project—Dr. Little**
   - **Pain 101 Workshop—Dr. Raymond**
   - **Community Education—Julie Spackman**
   - **Safer, Informed, & Compassionate Opioid Prescribing—Dr. Safford**
   - **PDMP Grant—Harriet Godoski**
   - **Living Well with Chronic Pain for Central Oregon—MaCayla Arsenault**

Consent Agenda:
- **Approval of the draft minutes dated March 1, 2017 subject to corrections/legal review**

2017 Legislative Session

SB 50	
Status of Bill	**In Senate Committee on Health Care**
Sponsor	**No sponsor listed**
Summary	**Requires certain health care professionals and persons holding certificate of certified alcohol drug counselor to complete pain management education once every four years.**
SB 270	
Status of Bill	**Public Hearing Held, Feb 14th**
Sponsor	**No sponsor listed**
Summary	**Prohibits issuing initial prescription for opiates to adults for outpatient use in quantity exceeding seven-day supply.** **Prohibits issuing initial and refill prescription for opiates to minors for outpatient use in quantity exceeding seven-day supply. Creates exceptions.**
SB 423	
Status of Bill	**In Senate Committee on Health Care**
Sponsor	**Senator Steiner Hayward**
Summary	**Allows physician assistants to dispense controlled substances in schedules III and IV under federal Controlled Substances Act.**
SB 818	
Status of Bill	**In Senate Committee on Health Care**
Sponsor	**No sponsor listed**
Summary	**Requires health benefit plan that covers opioid analgesic drug products to cover abuse-deterrent opioid analgesic drug products, at no greater cost to insured than other preferred drugs under plan, and specifies other requirements regarding coverage.**

HB 2114	
Status of Bill:	In House Committee on Health Care

Sponsor	Representative GREENLICK; Representatives NATHANSON, PILUSO (Presession filed.)
Summary	**Prohibits issuing initial prescription for opioids or opiates to adults for outpatient use in quantity exceeding seven-day supply.** **Prohibits issuing initial and refill prescription for opioids or opiates to minors for outpatient use in quantity exceeding seven-day supply. Creates exceptions.**
HB 2517	
Status of Bill	In House Committee on Health Care
Sponsor	Representative BUEHLER; Representatives KENY-GUYER, NOSSE, Senators MONNES ANDERSON, STEINER HAYWARD (Presession filed.)
Summary	**Provides that Director of the Oregon Health Authority may enter into agreements governing sharing and use of information reported to prescription monitoring program with regulatory authorities of other states that administer prescription monitoring programs.**
HB 2518	
Status of Bill	In House Committee on Health Care
Sponsor	Representative BUEHLER; Representatives KENY-GUYER, NOSSE, Senators MONNES ANDERSON, STEINER HAYWARD (Presession filed.)
Summary	**Requires pharmacy to report de-identified information to prescription monitoring program upon dispensing prescribed naloxone.** **Requires pharmacy to report certain other identifying information to prescription monitoring program upon dispensing prescribed controlled substance classified in schedules II through IV. Requires information to be disclosed from prescription monitoring program to medical director or pharmacy director. Requires information to be disclosed from prescription monitoring program for certain other purposes. Requires licensing information of licensees who are authorized to prescribe or dispense controlled substances to be provided to Oregon Health Authority for purpose of qualifying licensees to report information to, or receive information from, prescription monitoring program. Provides that Director of the Oregon Health Authority may enter into agreements governing sharing and use of information reported to prescription**

	monitoring program with regulatory authorities of other states that administer prescription monitoring programs. Becomes operative January 1, 2018. Declares emergency, effective on passage.
HB 2519	
Status of Bill	In House Committee on Health Care
Sponsor	Representative BUEHLER; Representatives KENY-GUYER, NOSSE, Senators MONNES ANDERSON, STEINER HAYWARD (Presession filed.)
Summary	**Requires pharmacy to report de-identified information to prescription monitoring program upon dispensing prescribed naloxone.** **Requires pharmacy to report certain other identifying information to prescription monitoring program upon dispensing prescribed controlled substance classified in schedules II through IV. Requires information to be disclosed from prescription monitoring program to medical director or pharmacy director. Requires information to be disclosed from prescription monitoring program for certain other purposes. Requires licensing information of licensees who are authorized to prescribe or dispense controlled substances to be provided to Oregon Health Authority for purpose of qualifying licensees to report information to, or receive information from, prescription monitoring program. Becomes operative January 1, 2018. Declares emergency, effective on passage.**

PSTF Bills Discussion

HB 2114
Opinion: The PSTF agrees limiting an initial prescription of opioids to a seven-day supply is an over-legislation of medicine. The PSTF agrees the goal of reducing opioids in circulation is good, however the method would bring an undue burden on some patients.
Concerns: Ensuring access to a provider within seven days to get a refill if needed. General concern for the application & practicality of this practice.
Questions: How is "seven-days" defined? How is "initial" defined? What are the loopholes/exceptions to this rule?

HB 2517
Opinion: In granting PDMP access to regulatory authorities, the PSTF sees benefit in extending access across state lines. The PSTF agrees granting law enforcement access to the PDMP can be useful in some situations. However, to protect providers, prescribing guidelines are not law and prescribers should not be held accountable to law enforcement for their prescribing patterns.
Concerns: PSTF is uncomfortable with grating access without subpoenas.
Questions: Where is the accountability? What will law enforcement be looking for? Will they have PDMP access with or without subpoenas?

HB 2518
No clear understanding of the intent of the bill.
Question: Who is the sponsor?

HB 2519
No clear understanding of the intent of the bill.
Question: Who is the sponsor?

SB 50
Opinion: The PSTF is supportive of providers receiving chronic pain management education. Having CADC's completing pain management education every 4 years seems a bit often; significant advancements do not come out on this topic that frequently.
Concerns: Pharmaceutical companies sponsoring CE to meet the demand created by the requirement.
Questions: What is the intent of the bill? How many credits will be required?

SB 270
Opinion: The PSTF agrees limiting an initial prescription of opioids to a seven-day supply is an over-legislation of medicine. The goal of reducing opioids in circulation is good, but the method would bring an undue burden on some patients.
Concerns: Ensuring access to a provider within seven days to get a refill if needed? General concern for the application and practicality of this practice.

Questions: How is "7 days" defined? How is "initial" defined? What are the loopholes/exceptions to this rule?

SB 423
This bill allows Physician's Assistants to dispense controlled substances.
NO DISCUSSION

SB 818
Opinion: The PSTF agrees this bill requires the health plan to cover abuse-deterrent opioid analgesic drug products and has good intentions by introducing consumer price caps. The PSTF is concerned about the redistribution of cost to the consumer and health plan. They would like to see price caps at the health plan level.
Concerns: Not a lot of choices besides Naloxone and seems promotional like the goal is to sell more Oxycodone.
Questions: How many other options are there besides the brands listed in the bill?

OREGON STATE PUBLIC HEALTH DIVISION
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Kate Brown, Governor

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September 22, 2016

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Opiate Overdose Treatment: Naloxone Training Protocol

This training protocol must be presented under the general oversight of a licensed physician or a nurse practitioner with prescriptive authority, or a pharmacist with prescriptive and dispensing authority. The overseeing practitioner does not need to be present during training. As required per rule, a pharmacist provides patient counseling prior to dispensing naloxone. Agencies and organizations using protocols developed prior to this training will not be considered out of compliance with this version.

I. Signs and symptoms of opiate overdose

The signs and symptoms of opiate overdose include:

- Unresponsiveness to yelling or stimulation, like rubbing your knuckles up and down the person's sternum, or breast bone (also called a sternum rub) [This symptom effectively draws the line between overdosing and being really high but not overdosing.]
- Slow, shallow, or no breathing
- Pulse (heartbeat) is slow, erratic, or not there at all
- Turning pale, blue or gray (especially lips and fingernails)
- Snoring/gurgling/choking sounds
- Body very limp
- Vomiting

II. Opiate overdose treatment overview

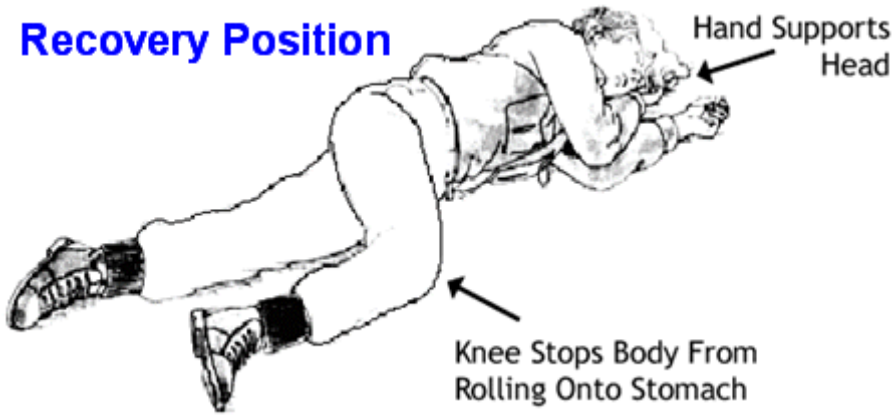
1. Check for a response.
2. Call 911.
3. Start chest compressions.
4. Administer naloxone.
5. Resume chest compressions with rescue breathing if the person has not yet started breathing.
6. Conduct follow-up – administer a second dose of naloxone if no response after 3 minutes and resume chest compressions with rescue breathing.
7. If naloxone is administered, provide details to emergency medical services.

III. Responding to an opiate overdose

1. **Check for responsiveness**.
   a. Yell.
   b. Give a sternum rub. Make a fist and rake your knuckles hard up and down the front of the person's sternum (breast bone). This is sometimes enough to wake the person up.
   c. Check for breathing. See if the person's chest rises and falls and put your ear near the person's face to listen and feel for breaths.
   d. If the person does not respond or is not breathing, proceed with the steps listed below.

2. **Call 911**. If you have to leave the person, put the person in the **recovery position.***
   a. State that someone is unconscious due to suspected overdose and indicate if the person is not breathing. (If you call police or 911 to get help for someone having a drug overdose, Oregon's Good Samaritan Law protects you from being arrested or prosecuted for drug-related charges or probation or parole violations based on information provided to emergency responders.)
   b. Give the address and location.
   c. Be aware that complications may arise in overdose cases. Naloxone only works on opiates, and the person may have overdosed on something else, e.g., alcohol or benzodiazepines. **Emergency medical services are critical.**

   ***Recovery position:**
      a. Roll the person over slightly on the person's side.
      b. Bend the top knee.
      c. Put the person's top hand under the person's head to support it.
      d. This position should keep the person from rolling onto his/her stomach or back, so the person does not choke if he/she vomits.



3. **(A) Start chest compressions with rescue breathing (CPR).**
   a. Place heel of one hand over center of person's chest.
   b. Place other hand on top of first hand, keeping elbows straight with shoulders directly above hands.
   c. Use body weight to push straight down, at least 2 inches, at rate of 100 compressions per minute.
   d. Give 2 breaths for every 30 compressions.
   e. CPR should be performed for 5 rounds (2 breaths for every 30 compressions), or for approximately 2 minutes, before reassessing.

Image courtesy of Nursing411.org

OR

(B) If overdose is witnessed, i.e., you see the person stop breathing, or you are sure it is overdose due to personal knowledge of the person or situation, you have the option to start rescue breathing. Be aware when you call 911 that they may instruct you to perform CPR as well.

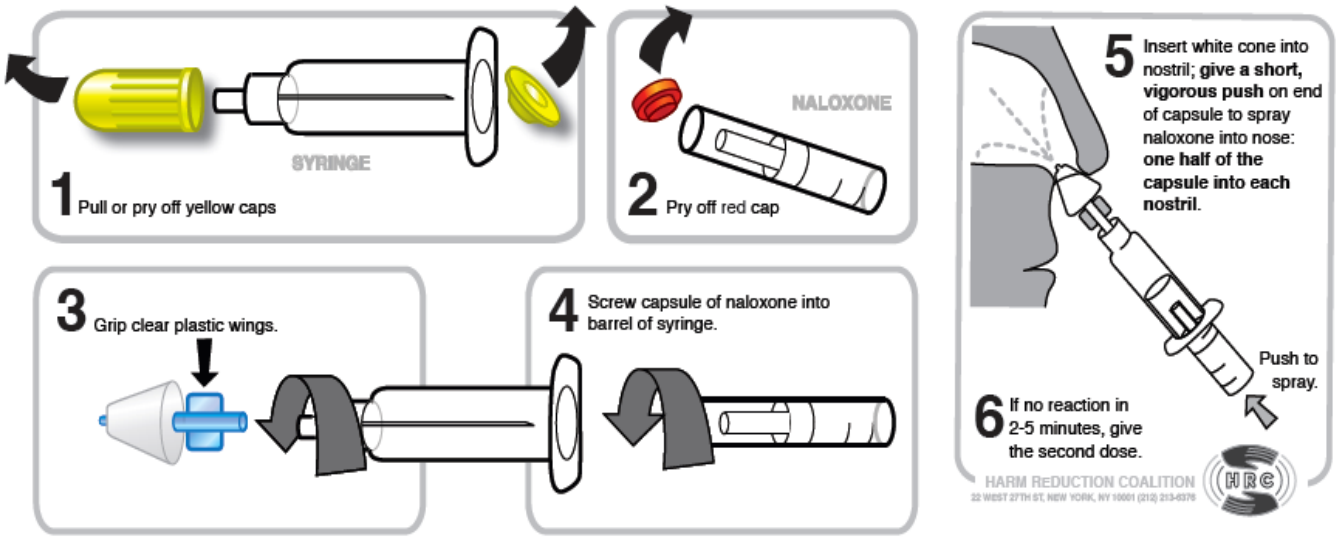
   a. Check the person's airway for obstructions and remove any obstructions that can be seen
   b. Tilt the person's forehead back and lift chin – see diagram below.
   c. Pinch the person's nose and give normal breaths – not quick and not overly powerful breaths.
   d. Give one breath every five seconds.
   e. Continue rescue breathing for approximately 30 seconds.

Image courtesy of Nursing411.org

4. **Administer naloxone**.
   If the patient has been receiving opioids, giving them naloxone may result in temporary withdrawal symptoms. This response can include abrupt waking up, vomiting, diarrhea, sweating, and agitated behavior. While these symptoms can be dramatic and unpleasant, they are not life threatening and will only last until the naloxone has worn off. See details about specific naloxone products below.

   a. **<u>If your naloxone kit is a syringe set up to be given as a nasal (nose) spray</u>**:

      1. Pull or pry off both top and bottom covers on the syringe.
      2. Pry off the cap of the naloxone capsule.
      3. Grip the clear plastic wings.
      4. Screw the naloxone cartridge into the barrel of syringe.
      5. Insert white cone into nostril; give a short vigorous push on the end of the naloxone cartridge to spray naloxone into the nose: one half of the cartridge goes into each nostril.
      6. If minimal or no response in 3 minutes, then give a second dose.



b. <u>If your naloxone kit is NARCAN® Nasal Spray</u>:

1. Peel back the package to remove the device
2. Hold the nozzle between two fingers as shown in image below.
3. Place the tip of the nozzle in either nostril until your fingers touch the bottom of the patient's nose.
4. Press the plunger firmly with thumb to release the dose into the patient's nose.
5. If minimal or no response in 3 minutes, then give a second dose.

NARCAN Nasal Spray: Peel back the package to remove the device

Place the tip of the nozzle in either nostril until your fingers touch the bottom of the patient's nose

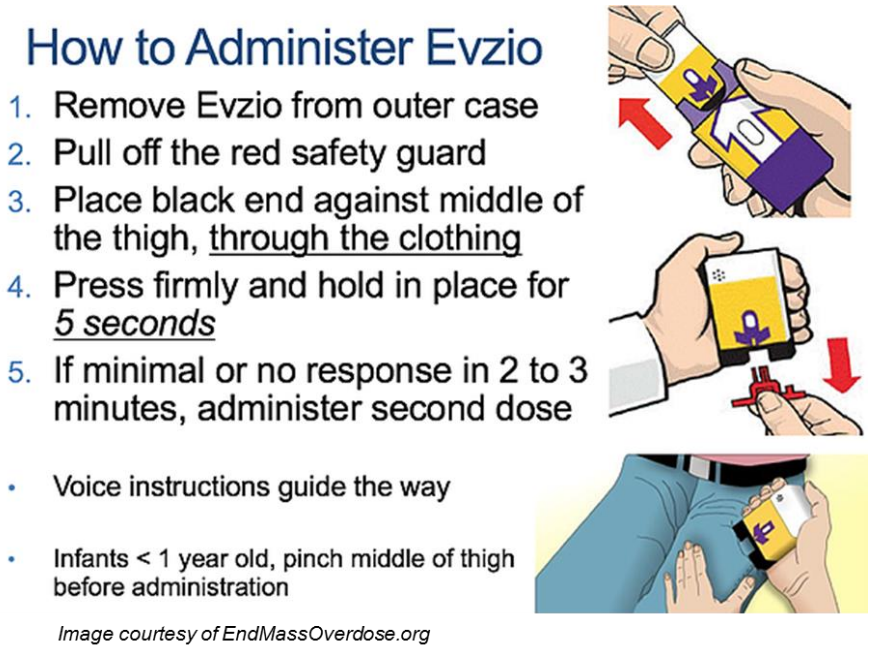
Press the plunger firmly to release the dose into the patient's nose

c. <u>If your naloxone kit is a syringe set up to be given as an injection into a muscle (intramuscular):</u>

1. Remove cap of the naloxone vial.
2. Draw up 1mL of naloxone into a syringe. (Ideally, the needle size for an injection into the muscle is 1 to 1.5-inches long and 25-gauge width)
3. If available, clean the area with an alcohol wipe before you inject.
4. Inject into muscle in the upper arm, thigh, or buttocks.
5. Insert the needle at a 90-degree angle to the skin and push in plunger.
6. If minimal or no response in 3 minutes, then give a second dose.

Image courtesy of the Chicago Recovery Alliance

d. <u>If your Naloxone kit is an Evzio® Injectable Device:</u>



5. **Resume chest compressions with rescue breathing (or chest compressions only) if the person has not yet started breathing.**
   Brain damage can occur after 3-5 minutes without oxygen. The naloxone may not kick in that quickly. You may have to perform CPR for the person until the naloxone takes effect or until emergency medical services arrive.

6. **Conduct follow-up**.
   a. Naloxone takes several minutes to kick in and wears off in 30-45 minutes. The person may go back into overdose after the naloxone wears off.
   b. It is recommended that you watch the person for at least an hour or until emergency medical services arrive, in case the person goes back into overdose.
   c. You may need to give the person more naloxone. Give a second dose if the person does not respond after 3 minutes.
   d. If an overdose victim revives, keep the person calm. Tell the person that drugs are still in his/her system and that the naloxone wears off in 30-45 minutes. Recommend that the person seek medical attention and assist him/her if necessary.
   e. Do not let the person use more opiates. The naloxone will block them and the person could overdose again after the naloxone wears off.

By signing this form, I acknowledge that I have read and understand the naloxone training protocol.

_____	_____	_____
Printed Name	Signature	Date

Name _____ Date _____
Address _____

℞

Refills _____ Pharmacist _____
Pharmacy Name / Address_____
_____

Opiate Overdose Response Training – Statement of Completion

This certifies that:

_____

Address:

_____

has completed an approved training program covering recognition of opiate overdose and its treatment, including proper administration of naloxone. This training and treatment is authorized by Oregon Laws 2013, chapter 340 and OAR 333-055-0100 to 333-055-0115 of the Oregon Health Authority, Public Health Division. Under these laws and rules the above-named trained individual is authorized to administer naloxone in an opiate overdose emergency.

_____ _____

Signature of Authorized Trainer Date Trained

Authorization to Obtain Naloxone

To Pharmacist:
The individual listed on this completed form is authorized to obtain an emergency supply of naloxone. This authorization is good for three (3) years from the date on front of form.

_____ _____

Signature of overseeing nurse practitioner/physician Date

_____ _____

Printed name of nurse practitioner/physician License #

In accordance with OAR 855-041-2330, the pharmacist who dispenses naloxone doses under this rule shall also generate a written prescription for his or her files, as in the case of an oral prescription for non-controlled substances, and file the same in the pharmacy. The generated prescription is based on the prescriptive authority of the overseeing nurse practitioner or physician. The pharmacist may dispense two (2) unit-of-use doses of naloxone per filling. The pharmacist will generate a new prescription for each filling and document the dispensing on this card up to six (6) times until the card expires (3 years from the date on the front of this form). Return certificate to the trained individual.

Please record dates and number of unit-of-use doses of naloxone prescribed and dispensed below

1._____ 2._____ 3._____ 4._____ 5._____ 6._____

NALOXONE FAQs (OAR 855-019-0450 to 0460 & OAR 855-041-2330 to 2340)

Q: *How does the 2016 law differ from the 2013 law?*
A: The 2013 law allows a pharmacy to distribute naloxone to a trained person, pursuant to a certificate of training completion. Typically, these training programs are offered 'in-person' by an Oregon Health Authority (OHA) authorized person or organization. These trainings are still being offered and a pharmacy may encounter the naloxone certificates (see OAR 855-041-2330).

The new law, 2016 HB 4124 gives the pharmacist authority to prescribe naloxone and supplies to a person who conducts training and to a person who has successfully completed training. In conjunction with the rules adopted for this process (OAR 855-019-0460 and OAR 855-041-2340), the OHA developed a **written training**. That means when a person seeking naloxone comes to a pharmacy that provides this service, but does not have a certificate, or if a pharmacist identifies a patient who would benefit from having naloxone co-prescribed with opiate therapy, the pharmacist can provide the written training for the person to review. The pharmacist can prescribe naloxone to the individual upon his or her determination that the individual seeking naloxone demonstrates understanding of the educational materials.

Q: *Who is considered an OHA authorized person or organization? And what proof is needed to validate the person/organization?*
A: An OHA authorized person or organization is one that serves people in high-risk populations, such as law enforcement, social services agency, needle exchange program, etc. A pharmacist shall use professional judgment to determine that they are prescribing and dispensing naloxone to an appropriate person. When issuing the prescription, utilize the instructor's name or the name of the organization (i.e. Corvallis Police Department).

Q: *What qualifications do I need in order to prescribe naloxone?*
A: A pharmacist educated in opiate overdose and naloxone rescue can prescribe unit-of-use naloxone and the necessary medical supplies to administer the naloxone. There is not a Board required training.

Q: *What does the Board expect for documentation when prescribing naloxone?*
A: The pharmacist must document the encounter and the prescription, and maintain record for three years.

Q: *What are counseling expectations related to prescribing naloxone?*
A: The pharmacist shall determine that the individual seeking naloxone demonstrate understanding of educational materials. The pharmacist must provide oral counseling to the authorized recipient, to include dose, effectiveness, adverse effects, storage conditions and safety. This consultation cannot be waived.

Q: *What naloxone can the pharmacist prescribe?*
A: An FDA approved formulation included in the OHA training (injectable, nasal spray, or nasal kit).

Q: *How many naloxone units can I prescribe per rx?*
A: The number varies. You can prescribe enough units for a person or organization to provide training, and use professional judgment when prescribing to a single individual. It is important to note that these prescriptions are considered the 'final dispensing' to the authorized recipient. When dispensing a number of units to a person or organization conducting training, they should be made aware that the units are only intended to be distributed to and utilized by the persons attending the training.

Q: *Can I bill insurance for naloxone?*
A: The Oregon Board of Pharmacy does not regulate billing. Please check with your outlet and contracts.

Pain Standards Task Force
PacificSource Boardroom
Bend, Oregon
March 1, 2017

Present:
Kim Swanson, St. Charles Family Care, Chair
Gary Allen, Advantage Dental (call-in)
Wil Berry, Deschutes County Behavioral Health
Matthew Cook, St. Charles Health System
Alison Little, PacificSource
Laura Pennavaria, La Pine Community Health Center
Christine Pierson, Mosaic Medical
Michael Powell, St. Charles Health System
Kerie Raymond, Hawthorne Healing Arts Center
Marie Rudback, Endeavor Chiropractic
Scott Safford, St. Charles Family Care
Julie Spackman, Deschutes County Health Services
Rick Treleaven, BestCare Treatment Services
Tom Watson, Rebound Physical Therapy

Absent:
Misoo Abele, Veterans Administration
Robert Andrews, Desert Orthopedics
Muriel DeLaVergne-Brown, Crook County Health Department
Shanna Geigle, Veterans Administration
Jennifer Laughlin, St. Charles Medical Group
Jessica LeBlanc, Bend Treatment Center
Sharity Ludwig, Advantage Dental
Divya Sharma, Mosaic Medical
Robert Ross, St. Charles Medical Group
Pamela Tornay, Central Oregon Emergency Physicians

Others Present:
MaCayla Arsenault, Central Oregon Health Council
Harriett Godoski, PDMP Coordinator
Donna Mills, Central Oregon Health Council

Kelsey Seymour, Central Oregon Health Council

Introductions

- Members introduced themselves and their respective organizations and guests were welcomed to the meeting.

Central Oregon Buprenorphine Waiver Training

- Dr. Kim Swanson shared that OHSU received a grant for Medication Assisted Treatment (MAT) training, and that she is trying to get one of these trainings scheduled in Central Oregon in December. She shared that the region currently has 9 primary care providers (PCPs) with x waivers. Dr. Laura Pennavaria asked if the training is for mid-level providers or physicians.
    - ACTION: Dr. Swanson will find out if the x waiver training is for mid-level providers or physicians.

Legislative Session Update

- Dr. Swanson asked the PSTF to work with her on developing some talking points on legislative movements for possible media use. The group determined it was appropriate and valuable for them, as the experts in Central Oregon, to discuss pending legislation and define their perspective on each proposed law. They agreed that consensus of the group was not required, but rather that "a consensus could not be reached" is a valuable answer in itself.
- The PSTF discussed Senate Bill 270, which prohibits issuing initial prescriptions for opiates to adults for outpatient use in quantity exceeding a seven-day supply. The group asked what defines a "seven-day supply" and "initial" in this case. The group agreed that while they understood the intent of the bill, they expressed concern for the implementation of the new law, the undue burdens it could place on the special cases, and if seven-day access to providers can be ensured. The group identified the pending nature of this bill as an opportunity to inspire providers to alter their prescribing practices in an effort to avoid legislation altogether. Dr. Swanson noted that if this bill does not pass initially, it is likely to return during the short session with tweaks, because of the prevalence of the opioid epidemic.
    - ACTION: Dr. Swanson will get clarification on the exact definitions of "seven-day supply" and "initial" in Senate Bill 270.
- Dr. Watson shared that this bill includes a section on granting law enforcement access to the PDMP. He noted that currently the PDMP can only be accessed by law enforcement with a subpoena, and he is uncertain how this bill affects that rule.
    - ACTION: Dr. Swanson will get clarification on the circumstances required to give PDMP access to law enforcement.
- Dr. Swanson shared that she is in favor of Senate Bill 818, which will implement price caps on opioid analgesics. The group agreed that a price cap would directly benefit the consumer, but could incur some unintended consequences and ultimately raise the cost

of healthcare because the price caps do not extend to the health plan or providers. Dr. Alison Little asked if this bill has any direct affect on Medicaid.
    - ACTION: Dr. Little will find out if this bill has any affect on Medicaid.
- Dr. Swanson noted that she is unclear of the intent of House Bills 2518 and 2519 and wants to read further into them. The group asked who the sponsor of those bills is.
    - ACTION: Dr. Swanson will find out who is sponsoring House Bills 2518 and 2519.
- Dr. Little asked the group for their opinion on Senate Bill 50, which requires certain health care professional and persons holding certification of certified alcohol drug counselor (CADC) to complete pain management education once every four years. Dr. Raymond noted that a requirement to complete pain management Continued Medical Education (CME) was implemented before, but not on a recurring basis. The group noted that in the description provided, it was unclear how many hours of CME would be required, and that the intent of the bill was uncertain. Dr. Pennavaria expressed concern for the CME that may be offered and that pharmaceutical companies may take the opportunity to provide CME to a captive audience.
    - ACTION: Dr. Swanson will find out how many hours of CME would be required by Senate Bill 50, and clarify the intent of the bill.
- Dr. Swanson proposed that she send the full bills to the members of the PSTF and once the group has determined their collective stance on each, a draft of talking points can be shared for use in media interactions. The group agreed this was a suitable course of action.
    - ACTION: Dr. Swanson will send the full senate bills to the PSTF and will draft talking points reflecting the collective opinion of the group.
    - ACTION: Dr. Swanson and MaCayla Arsenault will find out and share with the group when all the referenced bills are scheduled to reach the Senate and House floors.

Pain 101 Steering Committee Update

- Dr. Kerie Raymond shared that the Pain 101 steering committee reviewed the feedback from last year's conference and concluded that the following seven topics would be of interest to providers:
    - Physiology of Addiction
    - Diversion
    - Risk Mitigation
    - Use of Marijuana for Pain
    - Panel of local alternative therapy providers
    - Comparing medication; efficacy, topicals, compounding
    - Nutrition and Naturopathic Pain Alternatives
    - Motivational Interviewing
- Dr. Raymond offered to share this list with MaCayla so it can be disseminated throughout the group.
    - ACTION: Dr. Raymond will share the list of speaker topics with MaCayla, who will share them with the PSTF.

- Dr. Raymond noted that the event is scheduled for Friday, October 20th at the Riverhouse Convention Center. She shared that the committee has been researching and contacting potential speakers and creating learning objectives for the conference. Dr. Swanson noted they are seeking Continued Education (CE) credits for the conference as well. She noted that she and MaCayla will attend the session where CE gets approved and invited any interested members of the steering committee to attend as well.

- Harriett Godoski noted that feedback she heard from last year's conference included a deeper look into difficult conversations with patients and Motivational Interviewing (MI). Dr. Swanson noted while she agrees a more comprehensive look at MI is important, the allotted time in Pain 101 is only one hour, which is not enough for much more than a surface-level discussion on the subject. Rick Treleaven noted that the difficulty he hears from providers in this area focuses on having difficult conversations in a short amount of time without losing the patient. Dr. Swanson suggested that a separate ongoing MI training be made available, and the Pain 101 segment serve as a teaser to engage providers into MI training. Dr. Pierson noted that MI is a broad subject and suggested that the Pain 101 angle should be specific to pain. Dr. Scott Safford explained that he has identified a speaker who discusses MI in the context of chronic pain, and that the steering committee is trying to book him for the event.

Shared Future Coalition Update

- Julie Spackman shared that the Shared Future Coalition (SFC) has identified and secured the rights to reproduce two public awareness campaigns: "Take Meds Seriously," an all-encompassing campaign regarding medicines, and "Stop Abuse" targeted specifically toward opioids. She noted that the SFC would be tailoring the campaigns to Central Oregon and possibly all of Oregon as they have interested partners outside the region.
- Dr. Swanson shared that the "Take Meds Seriously" campaign will be launched on our community partners' social media. She noted that the campaign materials would be shared with the PSTF for review when they are ready.

BHC Learning Collaborative

- Dr. Swanson noted that the Behavioral Health Consultants (BHC) Learning Collaborative has its first meeting scheduled on April 7th and asked the group to invite BHCs. Dr. Pennavaria noted that no RSVP mechanism is in place for this event.
    - ACTION: MaCayla will create an EventBrite for this event and include it on the flyer.

Safer, Informed, & Compassionate Opioid Prescribing

- Dr. Swanson shared that Dr. Safford is scheduled to give this CE presentation at Bend Memorial Clinic (BMC) on March 16th, and Harriett will be present to facilitate PDMP enrollment.

Living Well With Chronic Pain

- MaCayla shared that the LaPine LWWCP course is on its 3rd week, and classes are scheduled for Madras, Redmond, Prineville and Bend in 2017. Dr. Raymond noted that "Complex Care" is what is written on the schedule, not "Bend", and that it should be changed. The group requested that a flyer be made that providers can use to refer patients to the program.
    - ACTION: MaCayla will change "Complex Care" to "Bend" on the schedule, and develop a flyer for classes that can be shared with providers.
- Dr. Swanson invited the group to refer volunteers, patients, and providers to undergo training and lead classes. Dr. Rudback shared that she is currently teaching a class with ten participants in Redmond. Dr. Pennavaria asked if illiterate patients can participate. Dr. Rudback explained that all materials are available in an auditory form and illiteracy is accommodated.
- Dr. Raymond shared that she read the dropout rate for LWWCP was above 50%. Dr. Swanson noted that she believed it to only be 50%, but agreed to look into it.
    - ACTION: Dr. Swanson will confirm if any LWCCP class has/had an abnormally high dropout rate.

Statewide Naloxone Workgroup Update

- MaCayla shared that the Statewide Naloxone workgroup is ready to publish training materials. She noted that the workgroup has discussed the possibility of disbanding to avoid duplication of efforts.
- Dr. Swanson noted that all sheriff and police departments in the region except Jefferson County have completed Naloxone training.

Approval of the Minutes

- Dr. Swanson asked for a motion to approve the minutes. Dr. Raymond moved and Dr. Berry seconded. The minutes were accepted in full.