Central Oregon Health Council

RHIP Substance Use & Chronic Pain Workgroup
Deschutes County Health Services (Stan Owen Room)
2577 NE Courtney Drive, Bend

Agenda: June 19, 2019 from 4-5:00pm

Goals

Clinical Goal(s): Create a bi-directional integration approach for people with severe substance use disorders.

Prevention Goal(s): Implement a community standard for appropriate and responsible prescribing of Opioids and Benzodiazepines.

Health Indicators by 2019

1. Reduce the 3-year rate of overdose hospitalizations due to any drug in Central Oregon to 35 per 100,000 population (2012-2014 rate: 40.27 per 100,000 population)
2. Identify costs saved in Central Oregon due to properly assessing, treating, and referring individuals with moderate-to-severe SUDs.
3. Reduce the percentage of adults who had 4 (women) 5 (men) drinks of alcohol on one occasion in the past 30 days from 15.3% to 13% (non-age adjusted 2012-2015 Central Oregon rate from BRFSS data).
4. Reduce the percentage of 8th and 11th graders who binge drank alcohol one or more time in the past 30 days from 7.9% and 24.6% to 5% and 20% respectively. (2014 Central Oregon rate from Student Wellness Survey)
5. Reduce the percentage of 8th and 11th graders who have used any marijuana in the past 30 days from 10.2% and 25.1% to 7% and 20% respectively. (2014 Central Oregon rate from Student Wellness Survey)
6. Decrease the percent of patients on prescription opioid doses ≥90mg MED/day for more than 30 consecutive days or more from 15.2% to 5%. (Baseline: 2014 data)
7. Increase the number of completed referrals and feedback loop from medical settings to alternative pain management programs from 0 to 100 referrals yearly. (2014: Zero pain management programs in Central Oregon. Zero is baseline.)

1. **4:00** **Introductions - All**
2. **4:00-4:05** **Review Tertiary Pain Model Components - Gwen Jones**
3. **4:05-4:30** **Direction-Setting Discussion and Decision: What now? – All**
   - **Shared learnings from last attempt**
   - **Who else do we need to involve and/or inform**
   - **What questions do we have and how will we answer them?**
   - **A3 process and funding**
4. **4:30-4:45** **Dawn's House 6-Month Report Out - Dawn Holland**
5. **4:45–5:00** **Embedded SUD Report out - Rick Treleaven**

Next Meeting: 7.17.19 from 4-5pm (Deschutes County Health Services)

BH Substance Use & Chronic Pain (20)	Organization
Brian Evans, PsyD	St. Charles Health System
Mike Franz, MD	PacificSource
Erica Fuller, MA, LPC, CADCIII	Rimrock Trails Adolescent Treatment Services
Laurie Hubbard, RN, MSW	Deschutes County Health Services
Larry Kogovsek	CAC Consumer Representative
Matt Owen, JD	Bend Treatment Center
Laura Pennavaria, MD	St. Charles Health System
Sally Pfeifer, BA, CADCII	Pfeifer & Associates
Scott Safford, PhD	St. Charles Family Care
Elizabeth Schmitt, MS	CAC Consumer Representative
Bob Snyder, BA, CADC II, NCAC I	BestCare Treatment Services
Erin Solomon	COHC Pain Standards Task Force: Prescription Drug Overdose
Julie Spackman, CPS	Deschutes County Health Services
Barbara Stoefen	Adaugeo Healthcare
Heather Stuart	Crook County Health Department
Ralph Summers, MSW	PacificSource
Kim Swanson, PhD	Mosaic Medical
Karen Tamminga, LCSW	Deschutes County Behavioral Health
Rick Treleaven, LCSW	BestCare Treatment Services
Bill Ward, CADCI	Serenity Lane

From: Konsella, Laurie (HHS/OASH) <Laurie.Konsella@hhs.gov>
Sent: Thursday, May 30, 2019 6:59 PM
Subject: Pain Management Task Force Final Report released! Please share

News Release

U.S. Department of Health and Human Services

202-205-0143
ashmedia@hhs.gov
www.hhs.gov/news
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FOR IMMEDIATE RELEASE
May 30, 2019

Pain Management Task Force Issues Final Report on Best Practices for Treatment of Pain

The Pain Management Best Practices Inter-Agency Task Force, a federal advisory committee established by the Comprehensive Addiction and Recovery Act of 2016 - PDF, today released its final report on acute and chronic pain management best practices, calling for a balanced, individualized, patient-centered approach.

To ensure best practices for the treatment of pain, the Task Force final report underscores the need to address stigma, risk assessment, access to care and education. It also highlights five broad categories for pain treatment: medications, interventional procedures, restorative therapies, behavioral health, and complementary and integrative health approaches.

"There is a no one-size-fits-all approach when treating and managing patients with painful conditions," said Vanila M. Singh, M.D., MACM, Task Force chair, and chief medical officer of the HHS Office of the Assistant Secretary for Health. "Individuals who live with pain are suffering and need compassionate, individualized and effective approaches to improving pain and clinical outcomes. This report is a roadmap that is desperately needed to treat our nation's pain crisis."

The Task Force was created in the midst of a national opioid epidemic, but also at a time when an estimated 50 million adults in the United States experience chronic daily pain. As such, the report emphasizes safe opioid stewardship by recommending more time for history-taking, screening tools, lab tests, and clinician time with patients to establish a therapeutic alliance and to set clear goals for improved functionality, quality of life, and activities of daily living. Medication disposal and safe medication storage are also emphasized for patient safety.

The report includes a section highlighting disparities and unique challenges faced by special populations, including veterans, active military, women, youth, older adults, American Indians and Alaska Natives, cancer patients and those in palliative care, and patients with sickle cell disease and other chronic, relapsing painful conditions.
The Task Force has 29 members, representing federal and non-federal entities with diverse disciplines and views. It is overseen by the U.S. Department of Health and Human Services, in cooperation with the U.S. Department of Veterans Affairs and the U.S. Department of Defense. The Task Force members have significant public- and private-sector experience across disciplines, including pain management, patient advocacy, substance use disorders, mental health, veteran health, and minority health.

For your convenience, below are some social media messages and hashtags you can use for sharing the Final Report immediately.

Social Media Messages

- The #PainTaskForce Final Report is now officially available for dissemination of best practices for acute and chronic pain! View the #PainTaskForce Final Report here-> https://bit.ly/2C8ydGF
- The Task Force report is an overview of the complex multidimensional topics of acute and chronic #pain management. The report includes over 150 gaps and recommendations. Learn more about each of the gaps & recommendations here-> https://bit.ly/2C8ydGF #PMTF @cmoHHS
- #PainTaskForce Final Report emphasizes the importance of individualized patient-centered care. #FinalReport, #PainTaskForce, #PMTF bit.ly/2C8ydGF
- The Pain Management Best Practices Inter-Agency Task Force Final Report emphasizes multidisciplinary & multimodal treatment for acute and chronic #pain in various settings. Learn more about specific #PainTaskForce recommendations here: https://bit.ly/2C8ydGF

Again, thank you all for your contributions as we move forward with this important work to improve compassion and science-based pain care for patients, with the goal of improving health outcomes!

Summary of Tertiary Pain Care Model Components

1. Rural Access-
    a. Need to be available in multiple locations

2. Whole-person, Individualized approach

3. Physicaian/PA/MA -

4. Ancillary Therapies provided by local experts-
    a. Sleep
    b. Nutrition
    c. Movement/yoga
    d. Pharmacology
    e. Care Management
    f. Physical therapy

5. Behavioral Health-
    a. ACT/CBT with peer support/mentors
    b. SUD screening-
    c. Trauma assessment- *have a trauma informed approach, training, and ability to explain/demonstrate approach*

6. Plan to address OPIOD dependence *and general addiction*

7. Pain Neuroscience/psychology education

8. Strong Data set, especially around compliance/completion

9. Community, Family and Provider Training to promote de-stigmatization and seeking services

10. Provider and Patient friendly process-
    a. Continued, referral and monitoring with PCP
    b. Specially-trained front office staff for optimal patient engagement

Next Steps:

If agree to move forward, then:

1. Identify What we want
    a. “full” or “partial” Pain Clinic, specify components and parameters of desired outcome

2. Identify additional funding to for sustainable success (BH: SU&CP = $353K)
    a. Additional workgroup
    b. Funding match from partner organization
    c. Other

3. Choose method
    a. RFP
    b. Invite specific entity
    c. Clinics partner with shared ‘ownership’
    d. Other

4. Progress with A3

5. Present A3 proposal to Ops Council for vetting and approval to progress with funding

6. Continue with desired method
    a. Draft and release RFP
    b. Invite specific entity
    c. Develop clinic partnership
    d. Etc. other.

DAWNS House 2018-19 6-month COHC Report Summary:

Brief Summary to be expanded upon during live presentation June. 19th 4pm

I will be covering four areas of reporting but starting with a short power point about our mission.

1. What the funds are for/how much/how it is being used
2. Programs/Effect of the COHC Grant
3. Suitability of our nonprofit and community partners/Growth
4. Statistics of service/Health & Wellness impact

1. The funds were used for hiring our first ever staff member (Program/Executive Director), our mentor program and our resident assistance program (See Matrix) $50,000 split between two work groups
2. Detail about our funded work will be provided during presentation.
3. DAWNS House has secured matching funds and new partners for the longevity of our mission
4. Effect/Statistics from Dec 2019-June 2019, 32 high risk, homeless addicts/alcoholics were given safety, compassion, guidance and a place to call home.

Please note: On June 19th I will spend 10 minutes covering the above points and answer any questions.

	2018 Sub-Total				
	Consult/ Yes Tx	%	Consult/ No Tx	%	Refused
Number of Patients	35	39.3%	42	47.2%	9
1 yr Pre-Consult Utilization		**Admits/Pt**		**Admits/Pt**	
# ED Admits	59	1.69	84	2.00	12
# Hosp Admits	73	2.09	72	1.71	15
Post-Consult Utilization					
# ED Admits	56	1.60	60	1.43	7
# Hosp Admits	22	0.63	24	0.57	0
SUD Treatment					
90 day SUD Tx Retention	21	60.0%	N/A		N/A
Detox					
Residential					
SUD Diagnosis					
Alcohol	28	80.0%	21	50.0%	N/A
Opioids	3	8.6%	6	14.3%	N/A
Amphetamine	4	11.4%	13	31.0%	N/A
Cannabis	0	0.0%	3	7.1%	N/A

	Cumulative Sept 2018 thru Feb					
	Consult/ Yes Tx	%	**Change in Admits/Pt**	Consult/ No Tx	%	**Change in Admits/Pt**	Refused
Number of Patients	49	36.6%		63	47.0%		18
1 yr Pre-Consult Utilization		**Admits/Pt**			**Admits/Pt**		
# ED Admits	100	2.04		159	2.52		34
# Hosp Admits	97	1.98		105	1.67		32
Post-Consult Utilization							
# ED Admits	66	1.35	**(0.69)**	70	1.11	**(1.41)**	11
# Hosp Admits	23	0.47	**(1.51)**	28	0.44	**(1.22)**	2
SUD Treatment							
90 day SUD Tx Retention	N/A			N/A			N/A
Detox							
Residential							
SUD Diagnosis							
Alcohol	38	77.6%		30	47.6%		N/A
Opioids	4	8.2%		11	17.5%		N/A
Amphetamine	7	14.3%		18	28.6%		N/A
Cannabis	0	0.0%		5	7.9%		N/A

%		Died	%	Totals
10.1%		3	3.4%	89
Admits/Pt			**Admits/Pt**	
1.33		13	4.33	168
1.67		7	2.33	167
0.78		1	0.33	124
-		2	0.67	48
		N/A		
		3	100.0%	52
		0	0.0%	9
		0	0.0%	17
		0	0.0%	3

2019

%	Change in Admits/Pt	Died	%	Totals	
13.4%		4	3.0%	134	
Admits/Pt			**Admits/Pt**		**Admits/Pt**
1.89		13	3.25	306	2.28
1.78		8	2.00	242	1.81
0.61	**(1.28)**	1	0.25	148	1.10
0.11	**(1.67)**	2	0.50	55	0.41
		N/A			
		4	100.0%	72	
		0	0.0%	15	
		0	0.0%	25	
		0	0.0%	5	