The OREGON HEALTH AUTHORITY

Health Policy and Analytics
Oregon Pain Management Commission

2026

Representing Concerns of Patients in Oregon

A report from the Oregon Pain Management Commission

Executive Summary: Representing concerns of patients in Oregon

This summary is being presented on behalf of the Oregon Pain Management Commission. The full report is available on the Commission website at the following link:

https://www.oregon.gov/oha/HPA/dsi-pmc/Pages/reports.aspx

Introduction

The Oregon Pain Management Commission (OPMC) was created by the Oregon Legislature in 1999. Its mission is to improve pain management in Oregon through education, development of pain management recommendations, and related research and policy analysis. One of the duties of OPMC, per ORS 413.570(1)(c), is to represent the concerns of patients in Oregon on issues of pain management to the Governor and the Legislative Assembly, which is the purpose of this report. The Commission welcomes feedback from the public, the Legislature and the Governor's office on the format and content of this report. Thank you to those who testified at public meetings and responded to the report surveys for taking time to share their concerns.

Themes expressed by members of the public and Commissioners

This report summarizes information from the public from five sources: public verbal testimony delivered during OPMC meetings (July 1, 2025– April 30, 2026); written testimony received from members of the public during that same timeframe; a 2026 OPMC Commissioner online survey; and an online public survey conducted between January and April 2026.

Themes - Members of the Public:

The 2026 Representing Concerns Survey gathered input from people across Oregon about their experiences seeking pain management care. Optional demographic responses showed broad participation from individuals with varied backgrounds and identities, with most identifying with a single primary racial or ethnic category and reporting high English proficiency.

Respondents consistently reported significant difficulty accessing appropriate treatment, and described barriers such as limited provider availability, insurance restrictions, high costs, and denied

claims. Many participants indicated that stigma—both related to chronic pain and the use of prescribed opioids—further limited their ability to obtain care, with a large proportion of respondents reporting that their pain was not believed or that they were treated as drug seeking. These challenges persisted despite respondents generally reporting strong knowledge of available pain treatment options with the main problems being systemic issues beyond patients' control.

In addition to access concerns, the survey revealed participants' widespread experiences of frustration and discrimination in healthcare settings, as well as inconsistencies in information provided about available providers and treatment pathways. Overall, the findings point to a complex landscape in which structural barriers, insurance limitations, and stigma intersect to create significant obstacles for individuals seeking effective pain management across the state.

Commissioner perspectives

Commissioners reported that access to comprehensive, multimodal pain care in Oregon remains limited, particularly in rural areas and for pediatric, neurodivergent, and gender-diverse populations. They noted ongoing shortages across essential provider types including physical therapy, integrative health, and behavioral health which restrict ability of people in pain to engage in evidence-based treatment. Insurance barriers further exacerbate these challenges, with exclusions, cost-sharing requirements, and limited in-network options delaying or preventing patients from receiving appropriate care. Commissioners also observed that many patients lack access to clear, plain language information about chronic pain, and that opportunities for meaningful education depend heavily on provider capacity and the availability of specialized services.

Commissioners expressed concern about the instability patients experience when prescribers retire, relocate, or discontinue pain management services. These disruptions often leave patients unable to find replacement care or have complex medical conditions. Stigma was also identified as a persistent issue, with patients frequently reporting being disbelieved, labeled, or judged for using prescribed medications. Commissioners emphasized that system-level factors including insurance limitations, administrative pressures, and lack of a trained workforce contribute to these barriers and underscored the need for policies that support individualized, comprehensive, and accessible pain management across the state.

Other formats and languages

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact the Oregon Pain Management Commission at pmc.info@oha.oregon.gov or 971-208-1855 (voice/text). We accept all relay calls.

INTRODUCTION

The Oregon Pain Management Commission (OPMC or Commission) was created by the Oregon Legislature in 1999. Its mission is to improve pain management in Oregon through education, development of pain management recommendations, and related research and policy analysis. One of the duties of OPMC, per ORS 413.570(1)(c), is to represent the concerns of patients in Oregon on issues of pain management to the Governor and the Legislative Assembly. The Commission welcomes feedback from the public, the Legislature and the Governor's office on the format and content of this report. Thank you to those who testified at public meetings, submitted written comments and responded to report surveys for taking time to share their concerns.

Summary and Commission Responses

This report contains the findings of a thematic qualitative content analysis of surveys and testimony delivered to the OPMC between 7/1/2025 and 4/30/2026.

Themes from Online Survey - Members of the Public:

The 2026 Representing Concerns Survey gathered responses from 122 participants across Oregon, with especially strong representation from Multnomah, Washington, Clackamas, and Marion Counties. Respondents reported widespread challenges accessing appropriate pain management care. Most described access as very hard or somewhat hard, citing issues such as long wait times, lack of available providers, and significant barriers within the insurance system. Only a small fraction of respondents indicated that accessing care was easy or straightforward.

There were 96 respondents who answered the optional racial/ethnic questions included in the survey. The largest group identified was White (78.1%), followed by American Indian/Alaska Native (4.2%), Hispanic/Latino/a/x (4.2%), Asian (3.1%), Native Hawaiian/Pacific Islander (3.1%), Other (5.2%), Black/African American (1.0%), and Middle Eastern/Northern African (1.0%); percentages reflect aggregated racial/ethnic categories and may exceed 100% because respondents could select multiple identities. Beyond the racial/ethnic differences no further details could be determined from the survey instrument.

Insurance-related barriers emerged as a major theme. Participants frequently reported limited coverage for needed treatments, restrictions on which providers they could see, and high out-of-pocket costs. Denied claims for recommended care, particularly surgical procedures, were also reported. These findings underscore the degree to which administrative and financial hurdles shape the lived experience of patients seeking pain management services.

Despite these barriers, respondents indicated a high level of knowledge about pain treatment options and the main problems are systemic issues beyond

patients' control. Many reported difficulties finding a provider willing to continue existing medications, experiences of being switched to buprenorphine without clear explanation, or a lack of information about available clinicians. Stigma was a prominent concern, with a majority describing encounters where their pain was not believed or where they felt labeled as drug seeking. Social stigma from healthcare providers, family, or community added further strain to respondents already navigating chronic pain.

Overall, the survey findings highlight substantial gaps in access, equity, and provider responsiveness within pain management systems across Oregon. Respondents' experiences point to systemic challenges, particularly around insurance limitations, provider availability, and stigma that require coordinated policy and practice improvements to ensure equitable, patient centered care.

Themes of Written Testimony - Members of the Public:

Public written testimony submitted for the 2026 report described significant challenges accessing adequate pain care in Oregon, including difficulty finding providers willing to treat chronic or complex pain, experiences of forced or non-individualized treatment changes, and reports of stigma or dismissive treatment within healthcare settings. Individuals highlighted the impacts of undertreated pain on daily function, independence, and family life, and expressed concern that current policies and clinical environments contribute to provider hesitancy, disrupted continuity of care, and reduced access to essential treatments. Several submissions also raised concerns about the structure and accessibility of the OPMC's 2026 patient survey, noting that its limited response options did not capture the complexity of patient experiences. The Commission changed the survey instrument this year to remove open-ended questions to present an efficient way of getting the main points across to readers, and because protected health information had been exposed in past surveys.

Additional themes included financial and insurance barriers, limited access to palliative care, increasing the number of public representatives on the

commission (there are currently three public member seats), and concerns about transparency in policy processes affecting pain management. One advocacy group submitted additional content, including an independently generated survey, but its data cannot be independently verified and reflects the perspectives of that group's participants alone. Collectively, these submissions underscore the urgency expressed by many patients and families for more consistent, individualized, and accessible pain care across Oregon.

Written testimony from individuals is included in the addendum to this report.

Survey Responses to Individual Questions – Members of the Public

The Commission invited members of the public to participate in an online survey tool developed by OPMC. The survey tool included a combination of eight multiple and ranked choice questions. This year's survey was edited at its winter meeting to include plain language and streamline the survey tool to improve data collection and to help identify trends in the coming years. The survey was open from January to April, 2026. The Commission distributed the survey via its listserv and announced it at public meetings. Altogether, 122 respondents completed the short answer, multiple choice and ranked choice questions in the survey. The combined summary results for each question are listed below:

Demographic characteristics of respondents

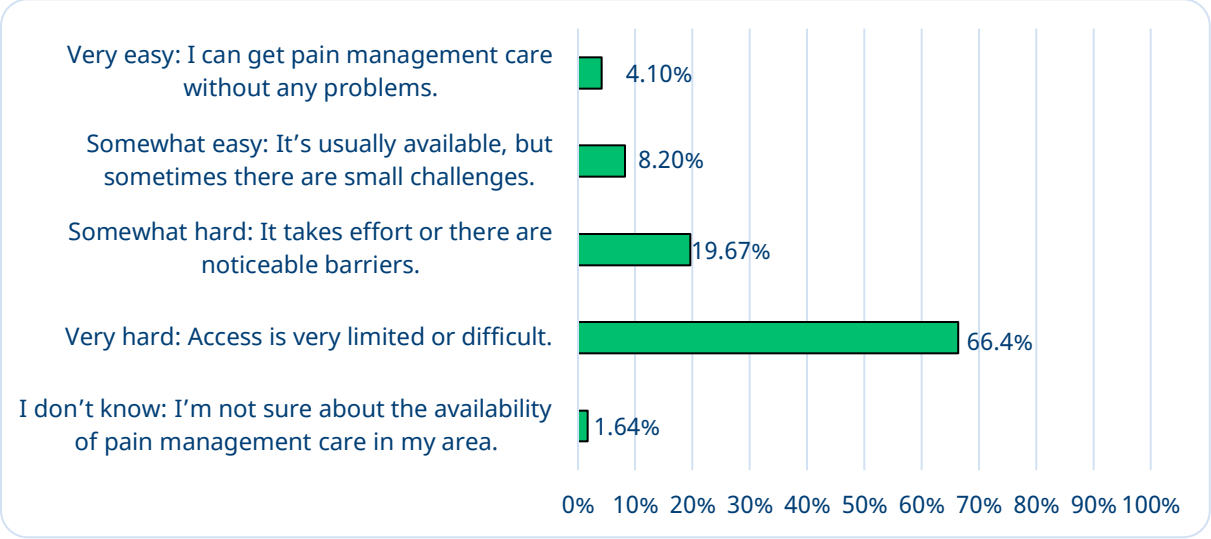
An optional demographic section, completed by 68 respondents, showed that most identified with one primary racial or ethnic identity, though a meaningful minority identified as multiracial or selected "other." Most respondents reported speaking English very well, and the majority indicated that demographic identifiers such as disability status or veteran identity did not apply. Participation across these optional items varied, with some questions receiving high rates of "no," "don't know," or "prefer not to answer," which would indicate a range of comfort levels with identity related disclosures.

OPMC Survey Responses by County

COUNTY	PERCENTAGE	NUMBER OF RESPONSES
Benton	3.28%	4
Clackamas	10.66%	13
Clatsop	0.82%	1
Columbia	2.46%	3
Coos	0.82%	1
Crook	0.00%	0
Curry	0.00%	0
Deschutes	0.82%	1
Douglas	6.56%	8
Gilliam	0.00%	0
Grant	0.00%	0
Harney	0.00%	0
Hood River	1.64%	2
Jackson	1.64%	2
Jefferson	0.00%	0
Josephine	0.82%	1
Klamath	2.46%	3
Lake	0.00%	0
Lane	4.10%	5
Lincoln	0.82%	1
Linn	1.64%	2
Malheur	0.00%	0

COUNTY	PERCENTAGE	NUMBER OF RESPONSES
Marion	10.66%	13
Morrow	0.00%	0
Multnomah	26.23%	32
Polk	0.82%	1
Sherman	0.00%	0
Tillamook	0.00%	0
Umatilla	0.82%	1
Union	0.00%	0
Wallowa	0.00%	0
Wasco	0.82%	1
Washington	21.31%	26
Wheeler	0.00%	0
Yamhill	0.82%	1
TOTAL		**122**

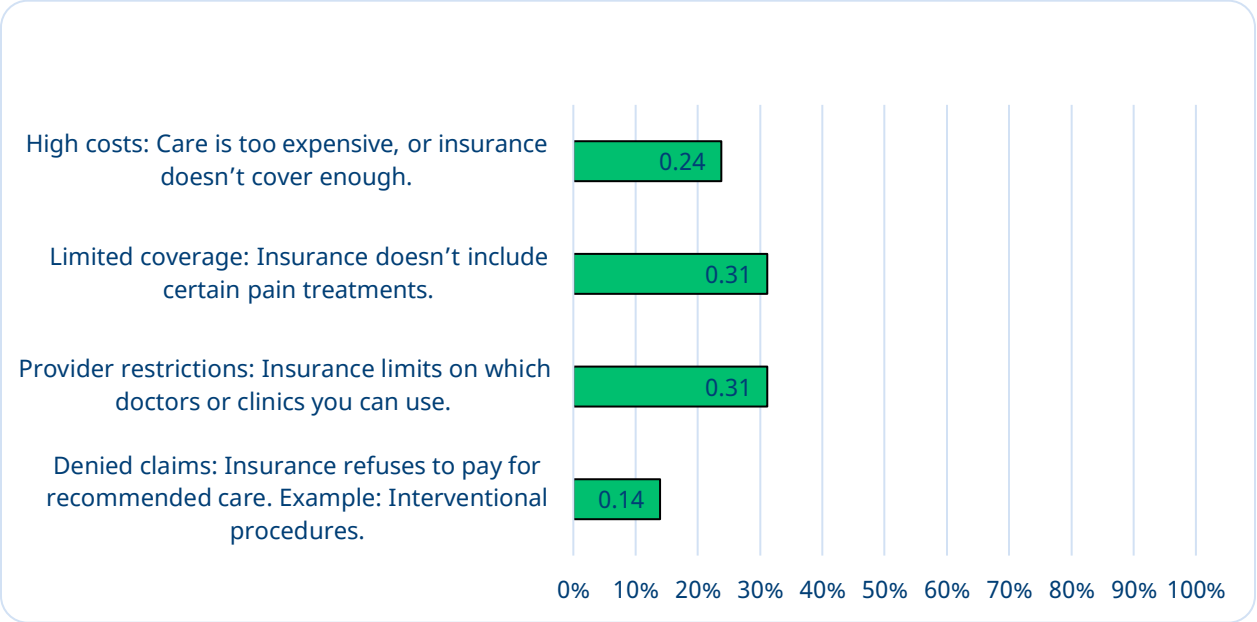
Q1: From what you know or have experienced, how easy is it to get pain management care where you live in Oregon? Please choose the answer that best matches your opinion.



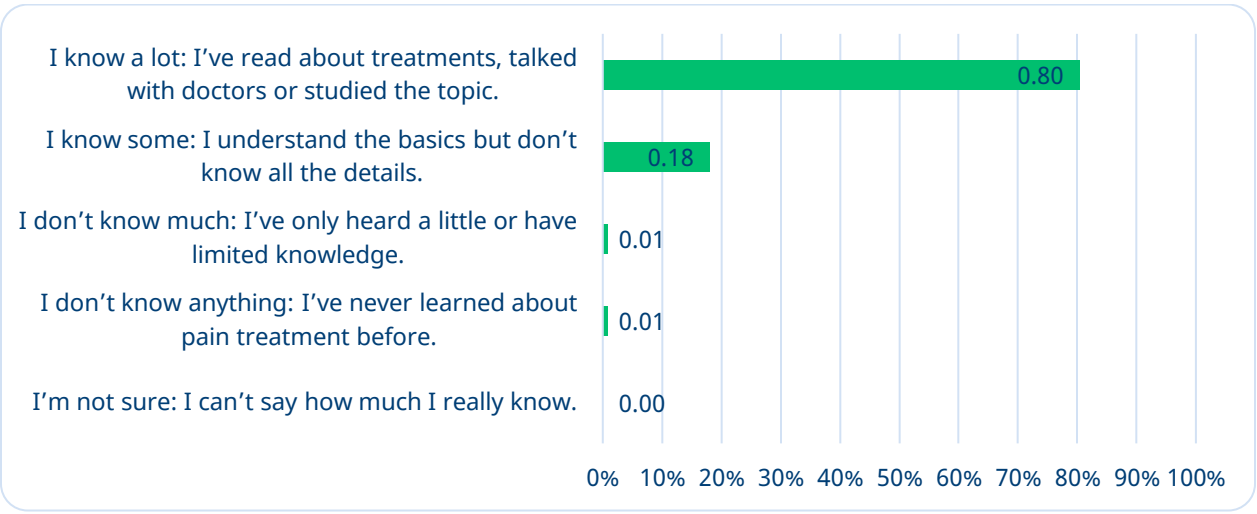
Q2: From what you've seen or experienced, which problem has made it hardest for you or someone you know to get full pain treatment in Oregon? Please choose the one that feels most important. [Ranked Choice]

Option	Weighted Average (Higher numbers represent more significant challenges)
Limited providers (e.g., physical therapy, mental health, specialty care): Not enough doctors or clinics that offer pain treatment.	6.46
Cost of care: Treatment is too expensive or not covered by insurance.	4.22
Travel distance (such as transportation, internet): Services are too far away or hard to reach.	4.2
Lack of information: Not knowing where to go or what options are available.	3.8
Limited pharmacy access: Have trouble filling prescriptions or finding needed medications.	3.32
Challenges faced by gender diverse individuals: Feeling judged or not taken seriously when seeking care.	3.26
Not enough pain treatment services for children: Too few clinics, doctors, or programs that provide pain care for kids.	2.73

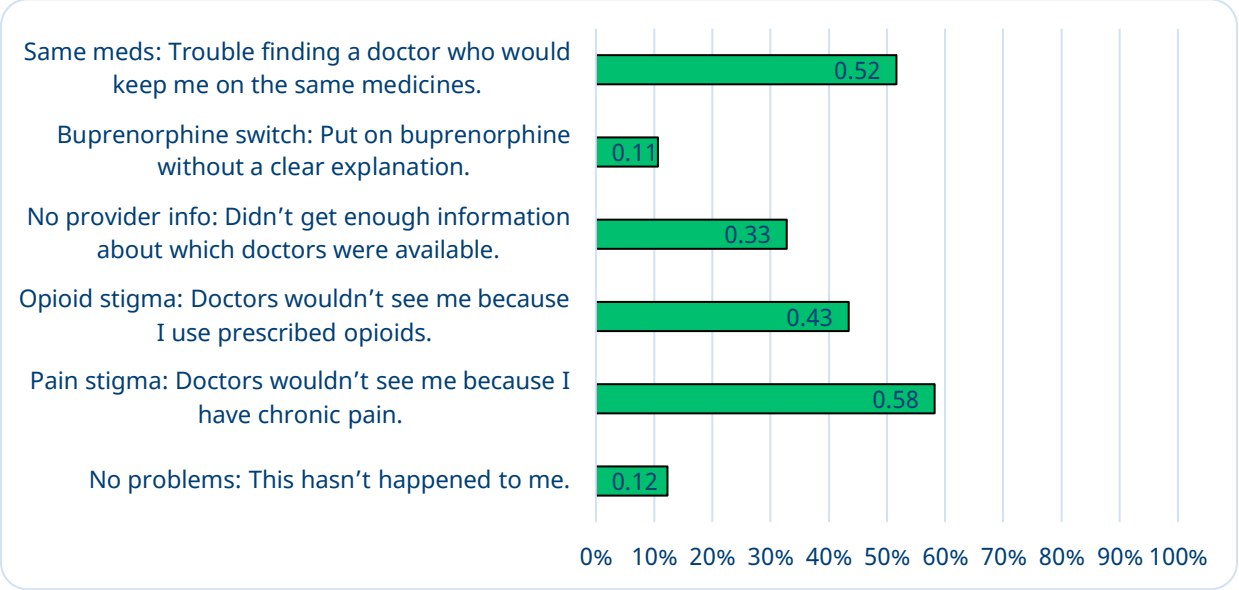
Q3: Thinking about your insurance and pain treatment, which problem has affected you the most? Select all that apply.



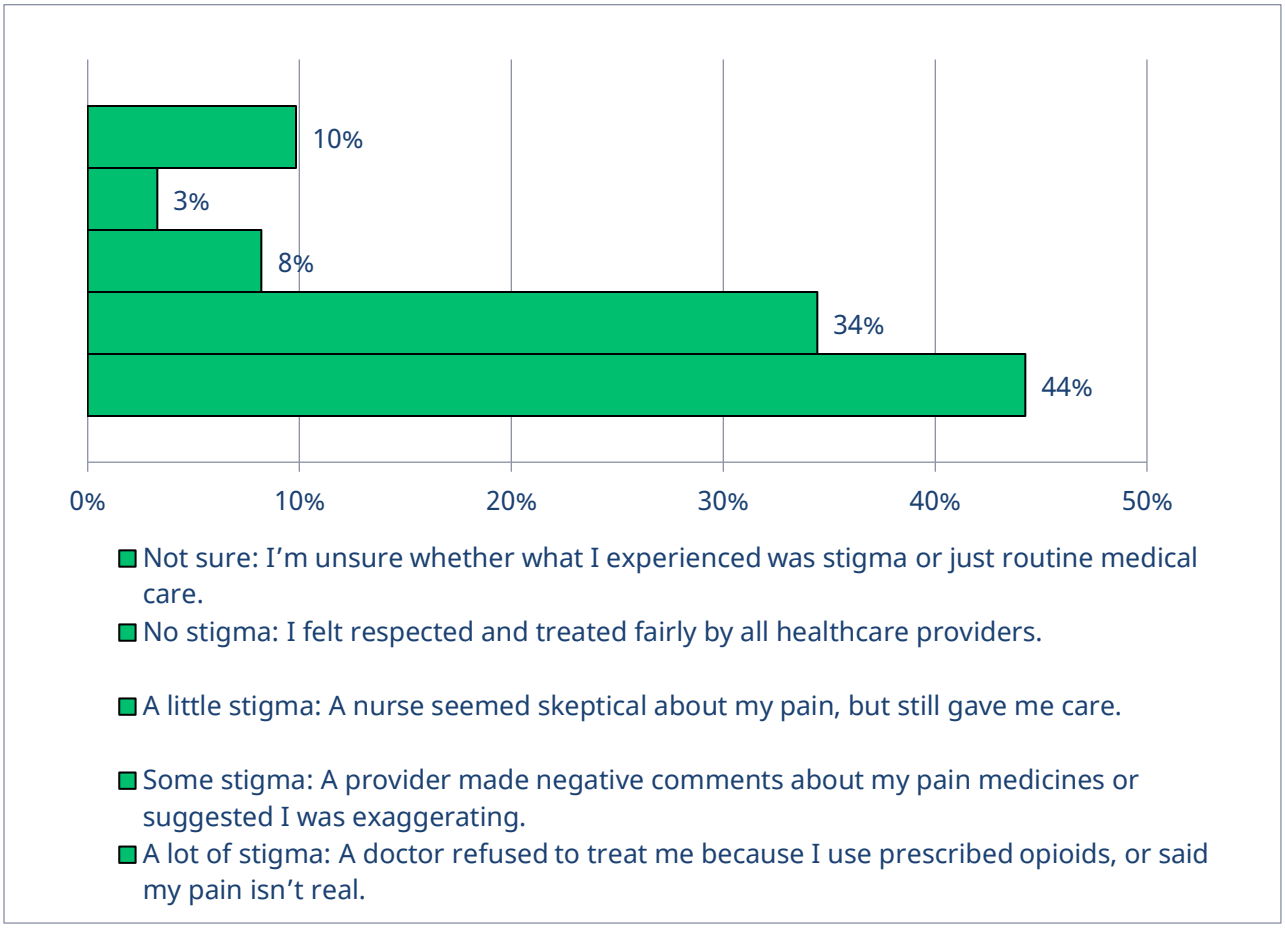
Q4: From your own experience, what do you know about pain and how it's treated? Please select the option that best represents your view.



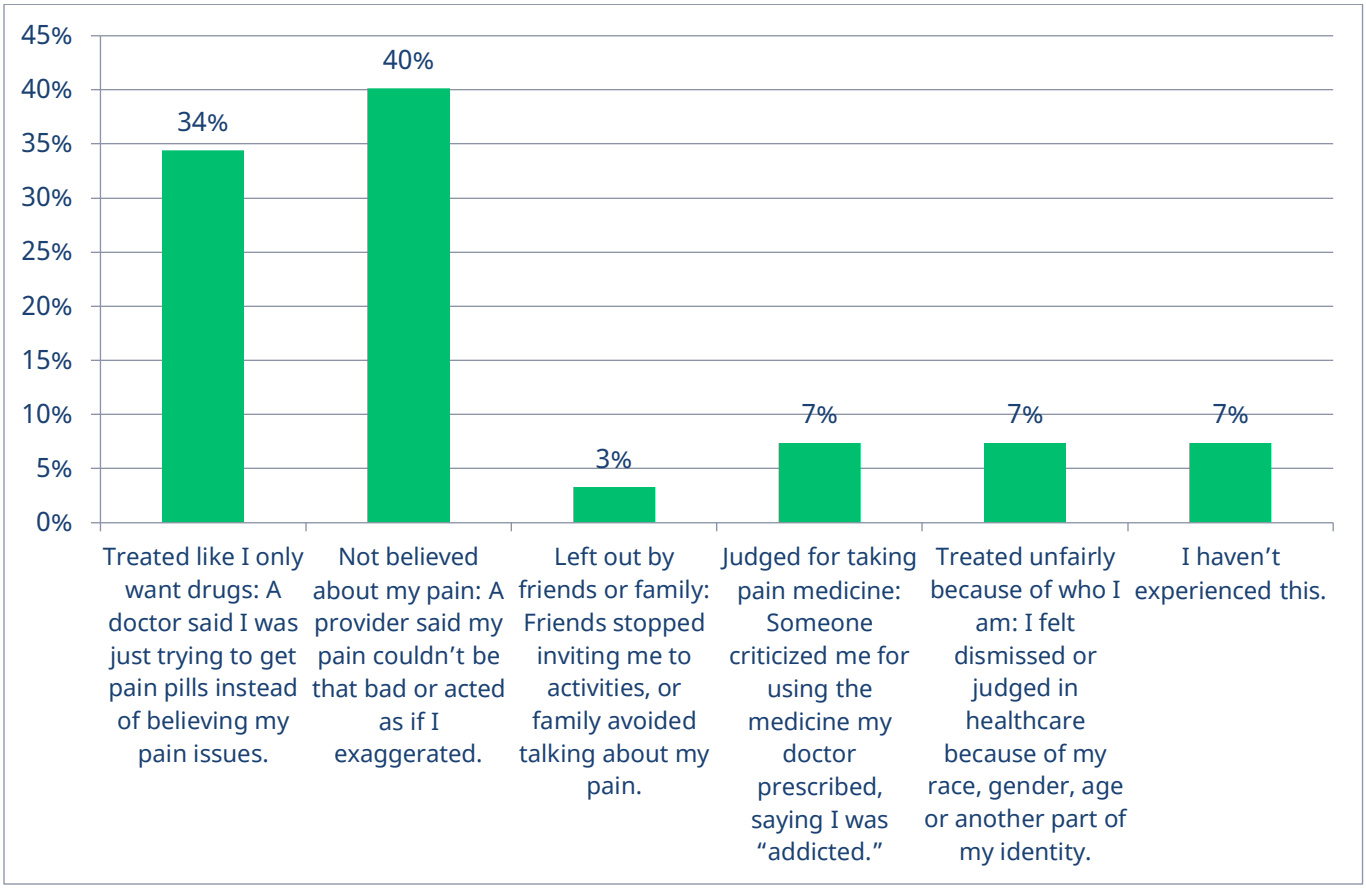
Q5: If you tried to find a new doctor for pain care, and you have experienced unfair treatment or problems, often called stigma, what did you run into? Select all that apply



Q6: If you have experienced unfair treatment or problems (stigma) because of your pain, have you felt: Pick the answer that comes closest to what you've been through.



Q7: What types of unfair treatment or problems (stigmas) have you experienced? (Pick the answers that come closest to what you've been through).



Q8: Which of these issues should Oregon elected officials address? Rank the issues from 1 (most important) to 8 (least important).

Treated like I only want drugs: A doctor said I was just trying to get pain pills instead of believing my pain issues.	34%
Not believed about my pain: A provider said my pain couldn't be that bad or acted as if I exaggerated.	40%
Left out by friends or family: Friends stopped inviting me to activities, or family avoided talking about my pain.	3%
Judged for taking pain medicine: Someone criticized me for using the medicine my doctor prescribed, saying I was "addicted."	7%
Treated unfairly because of who I am: I felt dismissed or judged in healthcare because of my race, gender, age or another part of my identity.	7%
I haven't experienced this.	7%

Commissioner Perspectives – Thematic Summary

1) Access to providers who offer pain management care, especially multimodal pain management services, is limited in Oregon. It is particularly limited in rural areas, for pediatric patients and for gender-diverse individuals. The shortage exists for a variety of provider types, including primary care, physical therapy, chiropractic, osteopathic manipulation, acupuncture, massage therapy and behavioral health.

2) Insurance limitations pose a barrier to optimal results and limit access to treatment by providers trained in pain management. Cost sharing and insurance exclusions of certain services including complementary and integrative services and interventional procedures can prevent patients from accessing optimal care.

3) Patients most commonly benefit from a multimodal approach to pain management, including pain-focused physical therapy, complimentary and integrative care, and pain psychology. Patients are often not adequately informed by their providers on key concepts related to chronic pain such as neuroplasticity and central sensitization.

4) When a patient's current prescriber has moved, retired or is no longer prescribing, the patient often can't find another prescriber or primary care physician who will continue to prescribe their preferred regimen. For example, some providers may transition patients to buprenorphine rather than other opioid medications that are preferred by the patient. Others refuse to see patients with chronic pain, especially if they use prescribed opioid medications.

5) People in pain are dismissed and stigmatized by the healthcare system and in society. They say some providers and others discriminate against them and don't believe them about their experience of pain. Many patients report a sense of isolation. They feel singled out as "drug seekers" or "addicts" if they use medications as prescribed, or even if they do not use medications with risk of dependence.

6) The relationship between opioid medications and chronic pain and substance use is complex. Some members emphasized the importance

of opioids as a chronic pain treatment for some patients. Others emphasized that use of prescribed pain medications can lead to addiction and said loss of access to prescribed medications can lead some patients to seek medications on the street. Some patients with chronic pain have substance use disorders and others do not.

Commissioner Online Survey

Because OPMC members collectively see a wide variety of patients, we also conducted a separate survey to gauge their perception on the concerns of people experiencing pain and was the basis for the thematic summary above. Nine of 15 seated members submitted responses; these questions and results are below:

Multiple Choice Response Distributions

(Counts reflect the number of commissioners selecting each option.)

Q2. Accessibility of multimodal pain care in Oregon

- A) Very accessible 0
- B) Somewhat accessible 2
- C) Not very accessible 5
- D) Not accessible at all 2

Total responses: 9

Q5. How well patients are informed about chronic pain concepts

- A) Very well informed 1
- B) Somewhat informed 1
- C) Not very informed 5
- D) Not informed at all 1
- E) Unsure 1

Total responses: 9

Ranked Choice- Question Summaries

Q3. Most significant barriers to multimodal pain care

- A) Limited availability of providers 6
- B) Geographic barriers in rural areas 2
- C) Insufficient pediatric services 0
- D) Challenges for neurodivergent/gender-diverse 0
- E) Lack of awareness/education 1

Total responses: 9

Q4. Most significant impact of insurance limitations

- A) Increased out-of-pocket costs 0
- B) Exclusion of complementary/integrative services 4
- C) Limited access to in-network pain specialists 2
- D) Restrictions on procedures 1
- Responses Skipped: 2

Total responses: 7

Q9. Perceived level of stigma against people with chronic pain

- A) Very significant stigma 4
- B) Somewhat significant stigma 3
- C) Minimal stigma 1
- D) No stigma at all 0
- Responses Skipped: 1

Total responses (non-skipped): 8

Q10. Types of stigma (Rank #1 most significant)

- A) Labeled “drug seekers/addicted” 4
- B) Disbelief from providers 3
- C) Social isolation 0
- D) Judgment for using prescribed meds 1
- E) Judgment from healthcare staff 0
- F) Judgment from family 0
- G) Judgment from school systems 0
- H) Judgment in work settings 0
- I) Difficulty obtaining accommodations 0

Total responses: 9

Q11. Policies policymakers should address first

- Improving rural access 4
- Opioid prescribing policies 1
- Insurance coverage 3
- Continuing education 0
- Policies for special populations 1
- Responses Skipped: 1

Total responses: 8

Select All That Apply Questions

Q7. Challenges when finding a new prescriber

- Difficulty finding prescriber to continue regimen 7
- Transition to buprenorphine without explanation 3
- Providers refusing patients using prescribed opioids 7
- Lack of information on available providers 4
- PCPs unable/uncomfortable prescribing pain meds 8
- Providers unwilling to treat patients using cannabis 3

Thematic Summary of Short Answer- Responses

(All themes derived from commissioner answers to Q6, Q8, and Q12.)

1. Need for Accessible, Patient Appropriate Pain Education

Commissioners repeatedly emphasized the need for educational materials that explain neuroplasticity, central sensitization, and chronic pain physiology in language patients can relate to. They stressed that timing, empathy, and cultural relevance impact effectiveness. Many noted that patients often gain understanding without experiencing symptom relief, which can lead to frustration.

2. Barriers Created by Insurance Policies and Systemic Structures

Several commissioners stated that limited insurance coverage for multimodal therapies, high administrative burdens, and inadequate reimbursement prevent patients from accessing evidence-based care. Some noted that systemic barriers, rather than patient misunderstanding, are the main obstacles.

3. Difficulties Finding New Prescribers After Loss of Provider

Commissioners described widespread disruptions when prescribers leave practices. Patients often cannot find anyone to continue existing prescribing regimens. Some must call dozens of clinics without success. Transitions from pediatric to adult care were highlighted as particularly difficult.

4. Stigma and Judgment Within the Healthcare System

Many commissioners reported that patients experience substantial stigma, especially those using prescribed opioids. Stigmatizing behaviors include disbelief of pain reports, labeling, dismissiveness, and avoidance by providers. Stigma was noted as a significant barrier leading to isolation, distrust, and decreased care-seeking.

5. Lack of Provider Willingness or Comfort with Opioid Management

A major recurring theme involved providers' difficulty in managing opioid prescribing, discomfort with comorbid mental health or substance use treatment issues, or reliance on buprenorphine transitions. These issues sometimes lead to unsafe care gaps or destabilization.

6. Shortage of Multimodal Pain Care Options

Commissioners highlighted shortfalls in physical therapy, pain psychology, integrative therapies, pediatric pain services, and rural access. Limited provider availability was a dominant barrier affecting nearly every patient population.

7. Policy Needs and System-Level Improvements

Recommendations included greater oversight of insurance practices, expanded reimbursement for multimodal care, improved provider education in pain science, and policies that promote individualized care. Some noted that current structures incentivize surveillance metrics rather than functional outcomes.

Conclusion

Both commissioners and members of the public shared several common concerns regarding pain management in Oregon. They strongly agreed that access to pain care is limited, particularly for rural, Medicaid-insured, and other underserved populations. Both groups also highlighted systemic stigma, reporting that patients are frequently disbelieved, judged, or labeled unfairly when seeking pain treatment. Additionally, both emphasized the impact of insurance barriers, including limited coverage and low provider

reimbursement, as significant obstacles to effective pain care. Disruptions in care due to provider turnover and the resulting risks were also acknowledged by both parties.

However, there were some differences in emphasis. Members of the public focused more on the misapplication of pain management prescribing guidelines. They particularly identified the negative consequences of rigid enforcement, such as opioid dosing guidelines, forced tapering and patient dismissal. They also prioritized the need for improved education for both patients and providers on current pain science. In contrast, commissioners placed more emphasis on the complexity of balancing pain management with concerns about medication, mental health conditions and substance use, advocating for individualized treatment approaches while following standardized protocols.

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Oregon Pain Management Commission

Written Testimony Received
From
Members of the Public
Addendum 1

These statements represent the authors' perspectives and should not be taken as the official position of the Oregon Health Authority (OHA) or the Commission.

Some submitted citations reference scientific terminology that may be considered outdated, stigmatizing, or harmful to readers. Readers are advised to proceed with awareness.

Commentor: Tim

Dear Oregon Pain Management Commission,

For context, I am not currently taking opioids for pain. However, as the partner of a chronic pain patient who is not receiving the individualized care they need and deserve, I see several critical gaps in the current system. I believe the following issues are not being adequately addressed:

Pain care in Oregon continues to be shaped by rigid MME limits rather than individualized medical judgment. Despite updated guidance advising against fixed thresholds, many providers still operate under outdated interpretations. Evidence shows that reducing or tapering stable patients can lead to increased emergency department visits, hospitalizations, and mental health crises, yet these risks are not adequately reflected in current practice. Care should be based on patient need, not arbitrary limits.

There are also serious concerns about transparency in PDMP subcommittee decisions. When I attended a PDMP subcommittee meeting, I witnessed a vote pushed through to lower the MME threshold that defines “high risk” prescribing without any cited evidence supporting what constitutes a “high dose,” particularly in the context of individual patients. This vote was advanced before multiple patients who were present and waiting to comment were given the opportunity to speak. More broadly, changes that directly affect prescribing practices are being made with minimal notice and without accessible records, leaving patients without a meaningful opportunity to participate.

Finally, pain specialists appear increasingly constrained by policies that limit their ability to provide individualized, patient-centered care. This creates frustration among clinicians and contributes to reduced access for patients. Leading medical organizations emphasize that treatment decisions should be guided by clinical judgment, not blanket restrictions, yet current conditions make that difficult to achieve in practice.

The Commission serves as the primary state body tasked with representing the concerns of this patient population. Because of that role, the accuracy and completeness of what is reported to lawmakers is critical. Patients rely on this process to ensure their experiences are truthfully conveyed.

Thank you for your consideration. I respectfully request that this comment be included in the Patient Concerns Report to ensure these concerns are accurately represented.

Commentor: Leon

Dear Oregon Pain Management Commissioners,

I've recently become aware of your work on this year's report that's meant to represent the concerns of pain management patients in Oregon. As I'm fighting for my life and livelihood right now, I appreciate this opportunity to advocate for myself and others like me. Thank you for providing this platform.

My husband and I landed in Eugene in mid-July, after fleeing escalating threats in Ohio from anti-transgender legislation and discriminatory policies and attitudes toward people with disabilities. In order to move here and enjoy this beautiful state's codified LGBTQ and disability rights protections, I left behind a job that I loved, and I had to withdraw from an MSW program I was excelling in—but worst of all, I had to leave behind a healthcare team that had helped me keep my refractory psoriatic arthritis and resultant severe chronic pain condition under control for four years! I began looking for new providers in Oregon two months before our move, but no one would allow me to join their waitlists, of course, until after we arrived. And then the rejections, which I did not anticipate, would commence...

Since only my partner was able to find employment, as a dual-diagnosis chemical dependency counselor, we had moved up our wedding date before we left Ohio so I could be covered under his health insurance. Plus, his income here is too high for him to qualify for OHP, nor a home care waiver like he had in Ohio (he is quadriplegic and needs physical assistance with most ADLs), so all of his caregiving was going to have to come from me and be unpaid anyway. I also believed I would find sustainable employment here, as I have

demonstrated skills and experience in nonprofit marketing and communications (but I did not understand how rapidly AI and federal policies would devastate that employment sector).

So here we are, wholly dependent on a single income to support our higher rental payments (all wheelchair-accessible housing is either reserved for low incomes or marked up as luxury), higher auto insurance premiums (on an accessible van), health insurance deductibles and copays, rising food costs, and most jarringly, my intravenous ketamine infusions.

Before moving here, I was receiving IV ketamine for my pain disorder for four hours every four weeks, plus either five consecutive infusions (called "loading doses") once annually or three consecutive infusions twice a year. My last set of just three loading doses was in early March 2025, as I have not been able to fit another set into my budget; just getting the infusions ~monthly ($1,300 each is the best price available) has us spending at least $600 more than we receive in income each month. Unlike my insurer in Ohio, my health insurance policy in Oregon, via Moda, does not cover these treatments, and I'm having to appeal the denial with no real guidance on how to do so successfully. My doctors have watched my condition deteriorate, and while they are trying their best to help, I am now having to use my husband's backup/travel powerchair part time to ensure I can maintain my ability to care for him at the end of the day. And all that I need to get better is to have this crucial treatment get covered by my health insurance!

My call to action, then, is that your commission would relay to the Oregon Legislature and Governor the request for (1) a full and proper review of the growing body of literature supporting the safety and efficacy of IV ketamine for chronic pain and (2) enact legislation requiring insurers to cover this treatment for patients with severe intractable chronic pain disorders.

As IV ketamine treatment is provided in a controlled setting, there should be no concern about pain patients abusing this modality. The only reason I can see that the FDA has not approved this well-documented and medically supported use of IV ketamine for pain is that, unlike Spravato (esketamine) for clinical depression, it cannot be patented and used to line the pockets of this country’s pharmaceutical conglomerates. But it is unethical to deny coverage for this treatment based solely on profitability, and this state seems to care

about making ethical choices, so I hope my pleas for my life will be honored. Otherwise, I fear I will not live another five years, as my autoimmune disease will devastate my body, and that outcome is preventable—for me and for others like me who would benefit from this medicine's anti-inflammatory and immunomodulatory effects.

Thank you for your time and advocacy

Commentor: Katie

My name is Katie, I am a disabled single parent to an autistic child. I previously was a PDMP member until a couple months ago. I have had over 40 surgeries at 35 years old, I share this so you may understand that the level of pain I experience is great. I write in support with other patients around the state who are gravely concerned the state is not moving quickly enough to swing the pendulum back into balance.

I am writing today because I feel the current survey does not capture the extent of what is happening to patients right now in Oregon and limits the patient voices.

Accessing any type of pain management is rare right now. Doctors are scared to prescribe because of the oversight and letters going out. While they are not intended to be punitive that is exactly as they are being perceived. With the added burdens our medical professionals are facing with current shortages (staff, funding, medications etc) there is a lot of pressure they deal with day to day to handle upwards of 1500 patients a year.

Complex patients requiring more nuanced care and could potentially put their license at risk or even the perception of risk cannot access care. At the peak of my health struggles in 2017-2019 I was actively seeking palliative care options per my medical team's recommendations. I qualified on paper but the actual program didn't exist in Oregon. Insurance companies cover palliative care for certain medical conditions but the facilities that provide that level of care are only able to accept a small subset of conditions. During that time period across several different counties they were only accepting cardiac conditions. I needed access to nursing support, palliative doctors to manage my medications and assist with improving my quality of life.

Today the situation hasn’t changed much, though now I am hearing of patients being either turned away or told they will not help manage pain. Today the situation hasn't changed much, though now I am hearing of patients being turned away outright or told that managing their pain simply isn't something providers will do. That should alarm this commission. Palliative care exists specifically for people like us, patients with complex, layered conditions who need coordinated support, not a revolving door between urgent care and the emergency room. It is designed to treat the whole person, stabilize their care, and reduce the kind of medical chaos that drains patients, families, and the system itself. We already know it works. The gap is not in the concept, it is in the fact that Oregon has not built it out to meet the actual need. That is a choice that has been made, and it is one that can be unmade. We need rapid expansion of these programs now, not as a future goal.

I understand the commission is working on education modules to cover additional conditions and while I appreciate the effort to broaden the education, I urge the commission to understand how quickly we need these changes. This is not just about accessing care but also the ability for us to take care of ourselves, families, work and be functioning members of society. The inability to manage these tasks leads to losing housing, employment, and for some their life. During this current economic crisis where families are already struggling to put food on the table and continue paying rapidly rising costs of housing we need a more urgent approach to our concerns.

Families are also coming to me with concerns about their children, specifically neurodivergent kids who are experiencing pain that isn't being recognized or treated. Autistic children in particular do not always express pain the way a provider expects. They may go silent, they may shut down, they may not have the language to describe what they are feeling or the ability to point to where it hurts. Some will spike in behaviors that look like a mental health crisis when the root cause is actually physical pain that has gone unaddressed. Medical staff are not consistently trained to identify this, and many families are being turned away or told nothing is wrong when something clearly is. As a single parent to an autistic child I know firsthand how much time and capacity it takes to support a child through a health or behavioral crisis. When that crisis is being caused or worsened by untreated pain that no one caught, it can stretch into months of lost work, lost stability, and real harm to both the child and the family holding everything together.

We are asking the commission to create an emergency interim process for complex patients who cannot wait for the full arc of policy change to play out. There are people right now who do not have a provider, cannot get a referral, and are falling through every gap in the system simultaneously. An interim process, something that gives these patients a clear pathway to coordinated care while longer-term solutions are built, would be a meaningful and immediate signal that this commission understands the urgency. We are not asking for perfection. We are asking for something that works well enough to keep people housed, employed, and alive while the rest catches up.

Thank you

Commentor: Dan

To The OPMC Chairman,

Thank You, for preparing the governors report, unfortunately i find it to be incomplete, i hear no patient voices spoken, the survey questions, cover many of the problems that CPPs face on a daily basis, but they only touch on the tip, of the iceberg, had the committee allowed REAL patients (those that have been, dismissed, forced tapered, forced transitioned to MAT) with "lived experience" to be part of the membership, per the statutes, and have them provide input, for the survey, it would of been far better, including a patient comment line, to express their personal concerns, is tantamount, to doing a proper survey, but again, the patients had NO voice, which has required CPPs, to additionally write to the OPMC, to make these concerns visible, via the public record.

Other concerns i have, we need to make it crystal clear, there is no MME limits in Oregon, the CDC states this, and on 1/2024, the OMB published their pain philosophy, and reiterated there is no MME limit in oregon, the OMB emailed this statement to the OPMC board, 2 meetings ago, there was no discussion on it, personally i feel it was sent, as a soft request to the OPMC, to align themselves wholly, with the OMB SOP, why else send it to the commission.

I would like to know where the OPMC was at, when there was a recent meeting with the PDMP, about risky RXing, the OPMC , should of been there to support the patients and

providers, as we all know, there are not many providers willing to RX opioids, due to provider stigma, potential DEA harassment, and red flags, I would suggest in todays RXing climate, patients are only RXed enough to treat their pain, as medically neccessary, no provider today, is going to put themselves at risk, or the patient, and if a patient, requires 200 MME daily, to control their pain, it should not be considered risky, as it's done carefully, and medically appropriate, the OPMC should of spoke out against this, risky outcry.

I strongly feel, changes need to happen at the OPMC, a movement of support, for those requiring opioids, not just the patients, but also encouraging the use of, when a patient could benefit, when i heard that almost 1/3 of those applying for the death with dignity act, cited uncontrolled pain, for their reason to end their lives, i was appalled, in this day and age, nobody should be forced to live in pain, but in reality, that's what's happening, and in the last month, Clackamas County, saw a uptick in suicides, related to un attended pain, none of this should be happening, the OPMC should find this quite concerning, and look for ways to help those same people, by teaching and coaching providers to use all tools at their disposal, to alleviate a patients pain.

Another issue, many face, and many are not CPPs, just patients requiring general surgeries, a Tylenol, after a back surgery, or a like surgery, is not sufficient to adequately control pain, in many cases, the key to healing, is getting up and moving, but we leave post surgicals in so much pain, for many, moving is very difficult, if at all, this delays the healing process, even pain control for as little as 5 days, can make a world of difference, and typically that short of duration, should raise no addiction concerns, this is possibly, an area, the OPMC can help with, letting providers know, its ok, to use opioids to treat post-surgical pain.

Many would like to see more emphasis, given to palliative care, in many cases, we are dealing with lifetime illnesses with no cure, we need to remove the hurdles to access opioid care, those enrolled are exempt from CDC guidance, so there's no MME limit, never was, but yet, we are still denied opioids in many cases, the OPMC could readily clear this up, thru provider teachings, and should work to protect those, with these debilitating illnesses.

In closing, we need to re evolve the OPMC, to help everyone, no matter, what their pain treatment requires, from making sure patients have access, to multimodal providers, to encouraging providers, to use all treatment forms, without fear, they have done something wrong, this is what the OMB, has done, the OPMC needs to mirror the OMB/SOP, protocols,

to create a better climate for Oregon patient and their providers, in a very hostile pain environment.

Thank You

Commentor: Amara (Advocate Volunteer OPAG, National Council on Independent Living)

April 2026

Subject: Public Written Comment for additional input /OPMC Patient Survey, Access to Pain Care, and

Policy Gaps in Oregon (Patient Concerns Report for Legislature)

Dear Members of the Pain Commission,

My name is Amara, and I am submitting this comment as both a chronic pain patient and an advocate for others living with serious life impacting pain causing conditions, in the state of Oregon.

We respectfully disagree with both the method and content of the OPMC's 2026 patient survey. The survey does not meaningfully capture the patient voice. By relying on leading questions and limited, pre-selected responses, it functions as a constrained instrument rather than a genuine opportunity for input (critically important now). Patients are restricted to predefined answers with no opportunity for open-ended feedback.

We are concerned this approach does not fulfill the legislative intent behind the Commission—to ensure that the lived experience of people in pain is meaningfully represented, particularly those at risk of undertreatment or crisis. Patients raised concerns about survey limitations in prior years, yet the current version further reduces meaningful participation by eliminating written response options.

Access to the survey is also limited. It is not readily visible on the Commission's website (we looked and could not find it posted) and appears primarily distributed through email

lists, leaving many patients unaware it exists. Given that many individuals cannot attend meetings due to disability or illness, accessible participation pathways are essential.

For these reasons, I am submitting this independent comment.

Key Patient Concerns

1. MME Thresholds and Restricted Prescribing Practices

Patients continue to experience barriers to opioid pain medication due to the functional use of Morphine Milligram Equivalent (MME) thresholds as prescribing limits.

Oregon practice remains misaligned with current federal guidance, including the CDC's 2022 opioid prescribing guideline, which explicitly discourages rigid dosage thresholds and emphasizes individualized, patient-centered care. Despite this, legacy interpretations of earlier guidance continue to shape clinical and regulatory environments.

While some clinicians maintain individualized practice, the broader system environment continues to discourage opioid prescribing for complex chronic pain patients due to perceived regulatory risk and institutional pressure. This results in a system where access is often determined by provider risk tolerance rather than clinical need.

Opioid analgesics remain FDA-approved as safe and effective when appropriately prescribed for moderate-to-severe pain, underscoring the need for balanced, individualized policy implementation.

2. Forced or Disruptive Transitions in Stable Care

Patients report being transitioned away from stable, effective opioid regimens to alternative treatments, including buprenorphine-based therapies, without adequate individualized assessment.

While these therapies are appropriate in selected clinical contexts, they are not universally effective for pain management. Non-individualized or non-consensual transitions can destabilize patients, reduce function, and increase suffering. Treatment decisions must remain grounded in clinical judgment and shared decision-making.

3. Harms from Rapid Tapering and Discontinuation

Evidence continues to demonstrate that rapid dose reduction or abrupt discontinuation of long-term opioid therapy can result in significant harm, including worsened pain, psychological distress, functional decline, and increased risk of adverse outcomes.

These risks reinforce the need for patient-centered, individualized tapering practices when changes in therapy are clinically indicated, with careful attention to risk-benefit balance.

4. PDMP Subcommittee Oversight and Policy Alignment

Patients have significant concerns regarding the Prescription Drug Monitoring Program (PDMP) subcommittee.

Recent changes lowering "risky prescribing" thresholds from 200 MME to 150 MME represent a substantial policy shift that appears inconsistent with current federal guidance, including the CDC's 2022 recommendations against rigid dose thresholds and in favor of individualized care.

Concerns also exist regarding process transparency, including following public meetings rules, limited public notice, restricted comment opportunities (intentionally placing public comment after the vote regarding the topic they are voting on), and lack of accessible meeting records, including transcriptions of meetings.

It is unclear whether this policy shift was fully aligned with or communicated to the broader Oregon Health Authority (OHA), including the Pain Management Commission, which along with the PDMP subcommittee operates under OHA's shared oversight structure. Given this structure, coordinated communication and alignment across entities would be expected for policy changes of this magnitude.

This is particularly important because PDMP-related actions may have unintended downstream effects. Even nonpunitive tools such as risk notifications or informational letters can contribute to provider hesitancy in treating patients with complex or higher-dose needs, further limiting access to care.

For these reasons, policy development affecting prescribing practices should include clear oversight, cross-entity alignment within OHA, transparency, and meaningful patient and public input prior to implementation. Such alignment is essential to prevent fragmented policy implementation that inadvertently reduces access to appropriate pain care.

5. Inadequate Pain Management in Surgical and Procedural Care

There is growing concern regarding undertreatment of pain in surgical and post-surgical settings, particularly for patients already receiving opioid therapy for chronic pain.

Patients report disruption of established pain management plans during surgical care episodes, including inadequate post-operative pain control. Because surgical pain is predictable, these situations should allow for planned, individualized pain management strategies and continuity of care.

Untreated or undertreated acute pain can impair recovery, increase physiological stress, and negatively affect outcomes. It also contributes to patients delaying or avoiding medically necessary procedures due to fear of unmanaged pain or destabilization of existing treatment.

This pattern suggests a systemic gap in perioperative continuity of care and warrants formal review.

6. Mental Health Impact and Suicide Risk

The psychological burden of untreated or undertreated pain is substantial and requires urgent attention. Patients report increased depression, anxiety, and hopelessness when effective pain treatment is reduced or withdrawn. Of particular concern, the Clackamas County Suicide Prevention Coalition has engaged with the pain community for two consecutive years regarding increased suicide and suicide attempts among individuals with chronic pain. These cases are frequently associated with unmanaged pain, forced tapering, disrupted care, or inability to access treatment.

This trend should be treated as a serious public health warning. Pain management and suicide prevention are closely linked, and policy decisions affecting access to care must reflect this relationship.

7. System Access Barriers and OHA Ombuds Data

System-level indicators further reinforce concerns about access to pain care in Oregon.

The Oregon Health Authority (OHA) Ombuds Office continues to receive a sustained and increasing volume of complaints related to difficulty accessing pain care, including forced tapering, loss of providers, and inability to establish care with pain specialists or primary care providers when chronic pain is present.

According to the Ombuds Office director, this trend has not improved despite increased staffing and continues to rise. This indicates that access barriers reflect systemic structural issues rather than isolated experiences.

These patterns are consistent with broader provider practice environments in which reluctance to initiate or continue opioid therapy for complex chronic pain patients is influenced by regulatory concern, perceived scrutiny, and institutional risk. This contributes to reduced provider willingness to accept or maintain care for medically complex patients, further limiting access.

8. Limited Access to Palliative Care and Misclassification

Access to palliative care remains limited and frequently misunderstood within clinical systems.

Palliative care is often incorrectly conflated with hospice care, even among healthcare professionals. However, palliative care is a broader, interdisciplinary approach focused on symptom management, quality of life, and support for patients with serious illness at any stage—not solely end of life.

This misunderstanding contributes to inappropriate denial of services for patients who would otherwise benefit from palliative care. Clearer definitions, provider education, and policy guidance are needed to ensure appropriate access.

9. Systemic Imbalance in Pain and Substance Use Policy

Current policy frameworks often treat pain management and substance use as competing priorities. In practice, this has resulted in a system where neither population is adequately served.

Patients with legitimate medical need face increasing barriers to evidence-based pain care, while overdose deaths continue to rise due to an increasingly toxic and unpredictable illicit drug supply.

This reflects a dual-system failure requiring balanced, evidence-based approaches that address both undertreated pain and substance-related harm without forcing a zero-sum framework.

10. Oregon Patient Impact and Access Inequities

Oregon has developed a reputation among patients as a difficult environment in which to access appropriate pain care.

Some individuals seek care out of state when possible, while others remain without viable alternatives. These disparities disproportionately affect patients with limited financial resources or mobility constraints, raising significant equity concerns.

Conclusion

Current policies and practices do not adequately meet the needs of people living with pain in Oregon. While efforts to address substance use and overdose are essential, they must not result in unintended barriers to appropriate pain care or undermine individualized clinical decision-making.

Across prescribing policy, procedural care, and access systems, consistent patterns indicate systemic barriers affecting patients with chronic pain.

We urge the Commission to:

- Improve accessibility, transparency, and inclusiveness of patient engagement tools
- Ensure meaningful inclusion of patient lived experience in policy development

- Align state practices with current federal evidence-based guidance emphasizing individualized care
- Address systemic barriers affecting clinician ability to provide appropriate pain care
- Review continuity-of-care failures in perioperative and procedural settings
- Evaluate statewide access barriers, including primary care exclusion of patients with chronic pain histories
- Consider formal review of perioperative pain management practices in Oregon

Effective policy must balance safety with compassion and uphold the ethical obligation to treat pain appropriately. Failure to address these issues will continue to result in preventable suffering, reduced function, and loss of care access among Oregonians living with pain.

Thank you for your time and consideration.

Sincerely

Commentor: Anonymous

Dear Commission,

I am a 72-year-old woman who has lived with chronic pain for over 20 years following a work-related injury during my service in a federal position. My medical condition has been thoroughly documented through MRIs, scans, and evaluations, and I have been deemed permanently disabled.

For many years, my pain was well managed. I was able to garden, shop for my groceries, and maintain my home. I had a life.

Since 2014, everything has changed.

My doctor retired because he didn't want to deal with all the pain issues that Oregon was using as an obstacle to people getting pain relief. So I had to find other doctors. Most treated me poorly for being on pain medication. They wouldn't treat my pain. I have been

forcibly tapered off medications that had been effective for years. I was then placed on Suboxone, which did not control my pain. After that, I experienced medical abandonment and spent years unable to find a provider willing to take me as a patient.

I do now have a provider, and they are compassionate and great, but they are always concerned about prescribing limits and can't prescribe me what I once had that adequately controlled my pain due to those limits in Oregon. As a result, my pain is not well-controlled, and I am no longer able to care for myself as I once did.

I have tried every alternative treatment offered to me. None have been effective.

In the last eight years, I have undergone multiple surgeries. In six of them, my pain was inadequately treated. Only twice did I receive appropriate care, and that was due to a compassionate surgeon. I now require another surgery but I won't do it because I cannot endure the post-operative pain without proper treatment.

At this stage in my life, I am not asking for extraordinary measures. I am simply asking to live my remaining years with a reasonable level of comfort and dignity.

I must also express concern about the Commission's 2026 patient survey. It does not allow for meaningful input. It presents limits that doesn't reflect my experience.

Patients like myself are living the consequences of these policies every day. I would like my comment included with the yearly report to legislature. I couldn't take your survey, it didn't address my concerns.

Commentor: Shane

Dear Pain Commission,

I am writing as a husband and a father who has watched what chronic pain—and the system in Oregon—has done to my wife.

My wife was the victim of a hit-and-run accident that crushed her spine. At first, she didn't even want to take pain medication. She tried everything she could to avoid it. But the pain made that impossible.

When her pain is treated appropriately, she is present in our lives. She can spend time with our kids. She can participate in our family. When it is not treated properly, she is in constant pain and cannot function.

What I have witnessed over the years is not just lack of care—it is bias.

A pharmacist once threw her medication at her while she sat in her wheelchair. We have encountered dismissive doctors, judgmental staff, and a general attitude that treats her like she has done something wrong simply for needing medication.

She is fully compliant with her care. She did nothing to deserve this. She was injured, and now she is expected to live in pain because of nonsensical policies.

The biggest issue we have faced is not insurance or cost—it is access. Finding a provider willing to prescribe appropriate medication has been nearly impossible. Even now, she is under-treated because providers are afraid or restricted.

Your survey does not reflect this reality at all. It seems focused on topics that do not match what we and many others are experiencing. It feels directed and limited, not an honest attempt to understand patient concerns.

My wife deserves to live her life. Our children deserve to have their mother present. I deserve to see my wife not suffering when there are treatments that could help her.

This system is failing families like mine.

Commentor: The Oregon Pain Action Group

April 25th, 2026

Public Comment Submission – Oregon Pain Management Commission (OPMC) Per the

Patient Concerns Report to the Legislature 2026 Report

We respectfully submit this comment in opposition to the structure, accessibility, and content of the OPMC's 2026 Patient Survey, as well as to raise urgent concerns about the current state of pain care in Oregon.

The survey, as presented, does not capture the pain community's voice. It relies on leading questions and restricted, pre-selected responses which reflects a push-polling format that limits authentic input. Patients are unable to express individual lived experiences unless those experiences align with the narrow choices provided. This approach filters, shapes, and ultimately distorts the concerns of the pain community (community).

This is especially troubling given the Commission's mandate to ensure the voices of people in pain (PIP) are conveyed accurately and directly to the legislature and the Governor. The current survey structure undermines that mission. It creates the appearance of fulfilling this mandate, but without allowing true sharing of the community's experience, which raises concerns of tokenism rather than representation.

Additionally, the survey's lack of accessibility further restricts participation and creates yet another obstacle for the community. We could not find the survey publicly posted on OPMC's website. PIP who are not on the email distribution list are unaware of the survey and that this opportunity to be heard exists. For many individuals living with pain, attending meetings is not feasible due to health, mobility, or logistical barriers. The survey should serve as a bridge to lessen the gap, not another obstacle.

Because this annual reporting process is one of the only formal mechanisms through which the community can communicate concerns to state leadership, it carries significant responsibility. That responsibility is not being met through a survey that excludes open-ended input and limits sharing of experiences. Understanding each person's individual experience should be paramount.

We are submitting our concerns (and the concerns of hundreds of people in pain in Oregon who interact with our pain advocacy group, the Oregon Pain Action Group–OPAG), through this public comment. We also created our own survey trying to stay somewhat close to the questions that you asked, but allowing open-ended input. Still we find this survey approach (even in the survey we created) to be limiting and not promoting the patient voice. (The content from the survey we created is included in Wendy's comment to stay within the word count here.)

1. Access to Opioid Pain Medication and MME Limits

Patients are deeply concerned about continued restrictions tied to Morphine Milligram

Equivalent (MME) thresholds. Despite updated federal guidance, cautioning against rigid limits, many providers in Oregon continue to adhere to strict caps. These limits are often applied instead of individualized care.

Also, outdated misinterpretations of the 2016 CDC guidelines continue to influence policy and practice. Some state-affiliated resources still reference them, which contributes to restrictive prescribing environments. Patients report that providers feel unsafe prescribing above informal thresholds, even when clinically appropriate.

2. Forced or Coerced Transitions to Alternative Treatments

Patients who are stable on opioid therapy report being pressured—or required—to transition to alternative treatments and alternative medications such as buprenorphine (Suboxone) under Medication-Assisted Treatment (MAT) frameworks. While these medications may be appropriate in certain contexts, they are not universally effective for pain management. In addition, other alternative treatments such as physical therapy, chiropractic, and mindfulness aren't effective for everyone. The evidence doesn't universally support clinical improvement for chronic pain conditions using these alternative treatment options. Yet, many patients are required to use alternative treatments instead of opioid medications, even after the patient has tried the treatments and found them ineffective. Many alternative providers insist on injections. Some aren't covered by insurance and sometimes they harm patients instead of helping, but still no attention is given to this common scenario. Forced transitions–which often involve a forced taper from opioid medication–(whether to MAT or alternative treatments) can destabilize patients

and lead to tissue damage, worsening pain and function.

3. PDMP Subcommittee Transparency and Process Concerns

Very recently the Prescription Drug Monitoring Program (PDMP) subcommittee made disturbing changes to prescribing thresholds without public input, including lowering the "high-risk" threshold from 200 to 150 MME. Public comment was intentionally placed after the vote to eliminate input from the people directly affected by this policy change which is in opposition with CDC warnings, updates by the Oregon medical board and the AMA. The reason given for this change lacked merit, attention to the urgent state of emergency, and the current climate facing this population. This policy change risks harming this vulnerable population leading to more abandoned patients as providers fear taking on the patient population with complex and debilitating medical conditions associated with higher medication needs. The PDMP's data from a Comagine report proves the harm. The subcommittee operates under OHA's shared oversight structure. Given this structure, coordinated communication and alignment across entities would be expected for policy changes of this magnitude and not to exclude the patient population directly impacted by this decision. Lack of transparency and representation is the exact actions that should be investigated by the OPMC.

Additionally, concerns include:

- Insufficient meeting notice (less-* than required timelines)
- Lack of publicly available recordings or transcriptions of past meetings
- Limited transparency in decision-making processes
- No cross referencing or communication with the OPMC, OMB, PCAC, OHA's Ombuds data etc.

These practices reduce accountability and limit public participation.

4. Pain Management in Surgical and Post-Surgical Care

Patients report increasing instances of inadequate pain control during and after surgical procedures. This includes both adults, children, and pets. Increasingly patients are denied appropriate post-operative pain management and only given Tylenol and/or NSAID regardless of the patient's pain.

In pediatric populations, reports indicate that some providers refuse to prescribe opioid medications following surgery to any child, resulting in preventable suffering. Inadequate

pain control can impact healing, increase stress responses, and deter future necessary medical procedures.

5. Mental Health Impact and Suicide Risk

The psychological toll of untreated or under-treated pain is severe. Patients and advocacy groups are observing increases in suicide risk within the pain community. An Oregon suicide prevention group recently contacted OPAG with deep concerns about the huge increase in suicide rates reported to be from uncontrolled pain. They want answers and solutions, but all we can give them is the hope that someday someone will listen, someone will care, and hopefully someday we won't disregard pain management because it's inconvenient, but instead recognize it as the World Health Organization does–as a fundamental human right.

6. Access to Palliative Care

There is widespread confusion regarding palliative care, including among healthcare providers. It is often incorrectly equated with hospice care, leading to underutilization and denial of services for patients who qualify.

Palliative care should be more clearly defined and expanded. It serves as a critical support system for patients with complex or high-need conditions and can help prevent gaps in care.

7. Oregon's Reputation and Patient Migration for Care

Oregon is increasingly perceived as a difficult environment for pain patients seeking appropriate treatment. While other states are revisiting and correcting prior overcorrections in pain policy, Oregon appears to be lagging behind.

Some patients are traveling out of state for care when financially possible. Others do not havethat option and remain without adequate treatment. This creates inequity and places vulnerable populations at further risk.

8. A Disturbing Trend

PIP, some with significant medical conditions are reporting that they utilize Medication-Assisted Treatment (MAT) as a last resort to manage their pain. Some report limited improvement, while others find no reduction in pain. This leads them to seek other ways to deal with their pain (see number 5). An anonymous counselor working within a MAT

program in Oregon confirms what patients are reporting. She calls it, “a concerning trend” among her clients. She says, a significant number of her clients aren’t coming to the clinic with substance use disorders, but instead they are seeking treatment for chronic pain and have been unable to access adequate pain care through the medical system. She relays it as her client’s last resort to obtain medications that provide some degree of pain relief. This pattern highlights a critical gap in the healthcare system, where barriers to appropriate pain management are inadvertently redirecting patients into programs not designed to treat their underlying condition.

Conclusion

The pain community includes individuals with serious medical conditions, disabilities, and limited mobility. They rely on the OPMC to fulfill its intended role: to accurately represent their concerns and advocate for balanced, patient-centered care.

We urge the Commission to:

- Revise its survey methodology to include open-ended responses
- Improve accessibility and transparency in public engagement
- Recommit to its original mission of representing patient voices
- Ensure policies and educational materials reflect current, evidence-based guidance
- Prioritize individualized care over rigid, one-size-fits-all approaches

This comment is submitted in the interest of restoring patient representation and addressing the urgent impacts of current pain management practices in Oregon.

Sincerely

Commentor: Wendy

Dear Commission Members,

Thank you for the opportunity to submit my comment.

I don’t want my life to be defined by my injury or my pain. Unfortunately, it is a factor in my life, but it doesn’t define me.

Since I was young, my life has been focused on helping others. I tried to make a difference. Much of my life has been spent with the outcasts because I recognized how unfairly some people are treated just because they are different, financially challenged, or not as popular.

In adulthood that translated to becoming a foster parent for some pretty angry and sad children (often with neonatal drug exposure) and then adopting four of them.

There were many busy days with four of my biological children, four adopted children, and two step children, but I felt it was my purpose. In addition to being a teacher, I loved being a mom and wife.

In 2014, a drunk driver hit my vehicle and left the scene, but I couldn't walk away. My spine was crushed, had a brain bleed, and man broken bones.

Thus began a new form of discrimination. My damage is evident on scans—mutated pieces of vertebra, (thanks EDS). After the accident, my provider said he'd "give up on me" because of taking opioids and sent me to [physician name redacted]. He began forced tapering, though he said nothing else would help—an introduction to the ideology that deprescribing is the priority and people are an unfortunate but necessary casualty.

As medication reduced, my function reduced and pain increased. I transferred providers, but he wouldn't increase to a therapeutic dose, no one will. I live with pain every minute/every day and I'm lucky—I get some medication.

Given this reality, it's concerning the OPMC's 2026 patient survey relies on limited responses that don't reflect the complexity of what patients face. It restricts input rather than inviting it—seeming like an attempt to solicit patient input, but it's a controlled façade.

Also, the survey isn't easily accessible. Many are unaware it exists. For a population that faces significant barriers, this further limits our voices.

This is the only formal yearly opportunities for patients to communicate concerns to the legislature and the Governor. It's important not to filter or minimize patient input. We are asking to receive care that reflects the reality of our conditions.

This is not a theoretical issue—it's affecting real people, families, and lives. Policies and practices that limit appropriate pain care are not neutral; they have consequences—lost function, lost independence, increased pain, and diminished quality of life. Please take these concerns seriously, to ensure that patients are fully and accurately represented, and

to make changes that prioritize care over fear. The current approach is not working. Patients are paying the price.

Sincerely,

OPAG Survey Results:

1. When asked respondent their experience obtaining pain management care and how well it helps with pain and function:

16% were able to access pain care that significantly manages their pain. 12% their pain treatment somewhat manages their pain. 48% receive pain care, but it isn't adequate to manage their pain. 24% can't obtain pain treatment.

2. For those who answered question one saying their pain was less than significantly controlled, we asked why:

42.86% can't find a provider who will prescribe adequate pain medication for unknown reasons. 38% have a provider who won't prescribe more medication because of the fear of retaliation. 9.5% can't get a provider because they are a chronic pain patient. 4.8% can't access their medication because of pharmacy access. Either the pharmacy has a shortage or other filling issues or the pharmacist refuses to fill a prescription. 4.8% live in a rural setting and there aren't enough providers in their area.

3. When asked if their medical insurance limited their access to care:

44% said no. 28% said yes and 28% said somewhat.

4. When asked if they felt state agencies have done enough to support them:

96% said no. 4% said somewhat, 0% said yes..

5. When asked if they experienced stigma for taking pain medication:

52% say yes from the medical community (providers, pharmacists, staff, etc) and friends and family and community. 20% said yes from medical personnel like office managers and staff. 12% have not experienced stigma. 12% said yes from providers, office staff, and medical pharmacists. 4% said yes from providers.

6. If they answered yes above to experiencing stigma, we asked how much did that affect you:

55% were greatly impacted them and severely affected their health care. 27% were impacted them somewhat. 18% were moderately impacted while 0% weren't impacted.

7. We asked what kind of biased treatment they experienced:

56% experienced bias from all of the following sources–being treated like a drug seeker even though they were a compliant patient, their pain was minimized, they were excluded by friends and family, judged by the general population. 24% were treated like a drug seeker even though they were compliant. 12% say their pain was minimized. 8% have not experienced stigma.

8. We asked what they experienced when trying to find a new pain provider, here are the responses:

64% eventually found a provider but their quality of care has decreased and is not adequate. 16% were unable to find a provider and they are in crisis. 16% found a new provider right away and received continuity of care. 4% were completely unable to find a pain provider, but they are managing their pain independently, though they aren't satisfied with their pain levels.

9. We asked what concerned them most about pain care in Oregon and we allowed open-ended responses, here are the answers:

People will go to the streets for pain care and will unalive themselves. Lack of adequate pain medication even after other treatments have failed. The stigma and fear providers face when prescribing opioids. The callous disregard for pain. No post-surgical treatment other than Tylenol, even for children. You name it. Oregon is horrible for pain care if you are a patient that needs opioid treatment. It's so hard to find a provider who will prescribe and if you do, they won't prescribe an adequate dose because of fear. I moved from another state where I received adequate medication and was well taken care of and my pain was taken seriously. I have MRIs x-rays showing my shattered spine but Oregon doesn't care. Oregon's concern about pain care is abysmal. Oregon disregards pain and contributes to the stigma and bias for those who use opioid pain management. No state group advocates or supports or protects this population. No adequate post-surgical pain care even for children. The constant concern I will be forced off my minimal opioid prescription with no safe pain management alternative. Providers are unwilling to prescribe any narcotic pain-relieving medications (opioids, barbiturates, etc.) to patients who have never been on them. My pain has been severe for over two decades but I have been unable to find a provider willing to

prescribe narcotics, even after exhausting all non-narcotic options (incl. non-medication treatments such as physical therapy, massage, acupuncture, etc). That eventually my pain is going to kill me because it's deeply impacted my health and continues to. Lack of individualized care and doctors afraid to treat patient needs. Loss of freedom to fully live a quality life. Not treated as an individual patient and treated as "cookie cutter," human. Under treated pain, lack of providers, doctors uneducated, doctors taught to avoid treating pain, unable to find a doctor willing to treat appropriately without bias and propaganda, pharmacist kicked me out for needing pain meds, shortages of medicine, unable to have a cushion of medicine if there is an outage on weekend, fear and poor medical management of pain. That others can't get proper care and are being RX'd inappropriate meds. A lack of providers, doctors willing to actually treat the pain through modalities covered by insurance, that insurance refuses to treat other modalities or denies treatment.

10. When asked what issues elected officials should address:

88% answered: Enact patient protection bill that includes provider and patient protections for opioid medications, Oversight and accountability (needs to include those with lived experience), Patient input needs to be respected and have a seat at the table in all groups that impact patients, Oregon needs to correct its missteps based on reduced prescribing measures that have harmed patients and a bill to require compliance, Suicide rates due to untreated pain have increased significantly- this needs immediate attention and action. Palliative care should have a clear definition differentiated from hospice care and needs to be accessible to all that qualify. Alignment within state agencies needs to be paramount. 8% said Oregon needs to correct its missteps based on reduced prescribing measures (updated CDC) that have harmed patients and a bill to require compliance. 4% said to enact patient protection bill that includes provider and patient protections for opioid medications.

Oregon Pain Management Commission (OPMC)

Written Testimony Received
From OPMC Members
Addendum 2

These statements represent the author's perspective and should not be taken as the official position of the Oregon Health Authority (OHA) or the Commission.

Some submitted citations reference scientific terminology that may be considered outdated, stigmatizing, or harmful to readers. Readers are advised to proceed with awareness.

Q1: Please enter your full name. Commissioner 1

Q2: How would you rate the accessibility of multimodal pain care in Oregon, particularly in rural areas and for specific populations? Select the option that best reflects your opinion.

A) Very accessible
B) Somewhat accessible
C) Not very accessible
D) Not accessible at all
E) Unsure

Q3: Which of the following issues do you believe most significantly affects access to multimodal pain management services for vulnerable populations in Oregon? Rank the options from most significant to least.

A)	Limited availability of providers (e.g., physical therapy, acupuncture)	1
B)	Geographic barriers in rural areas	3
C)	Insufficient services for pediatric patients	4
D)	Challenges faced by neurodivergent and gender diverse individuals	5
E)	Lack of awareness or education about available services	2

Q4: What do you believe is the most significant impact of insurance limitations on access to pain management treatments? Rank the options from most significant to least.

A)	Increased out-of-pocket costs for patients	3
B)	Exclusion of complementary and integrative services	1
C)	Limited access to in-network trained pain management providers	2
D)	Restrictions on interventional procedures	4

Q5: How well do you think patients are informed about key concepts related to chronic pain management, such as neuroplasticity and central sensitization? Select the option that best represents your perspective.

A) Very well informed
B) Somewhat informed
C) Not very informed
D) Not informed at all
E) Unsure

Q6: In your opinion, what specific information or resources would help improve patient understanding of key concepts related to chronic pain management? Limit your response to 100 words or fewer. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Cultural expectations about medications effectiveness for chronic pain. movement is medicine, period.

Q7: What challenges have you or someone you know faced when trying to find a new prescriber for chronic pain management after a previous provider has moved or retired? Select all that apply.

A) Difficulty finding a new prescriber willing to continue the same medication regimen
B) Transition to buprenorphine without adequate explanation
C) Providers refusing to see patients using prescribed opioids
D) Lack of information on available providers
E) Primary care physicians who cannot or do not feel comfortable prescribing pain medications
F) Providers unwilling to prescribe or manage pain care when patients use cannabis

Q8: Can you describe any specific experiences or challenges your patients have faced while finding a new prescriber for chronic pain management? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. The answers to #7 are my reply here.

Q9: How would you describe your perception of stigma faced by individuals experiencing chronic pain in the healthcare system? Rank the options from most important to least important that best reflects your experience or perception.

A)	Very significant stigma	2
B)	Somewhat significant stigma	1
C)	Minimal stigma	3
D)	No stigma at all	4

Q10: What types of stigma do you believe individuals with chronic pain commonly face? Rank options from most to least important as they apply based on your experience.

A)	Being labeled as "drug seekers" or as addicted	1
B)	Disbelief in their pain experience by providers	2
C)	Social isolation from friends and family	5
D)	Judgment for using prescribed pain medications	3
E)	Judgement from healthcare staff	4
F)	Judgement from Family	7
G)	Judgment from school/educational systems	6
H)	Judgement in occupational or work settings	8
I)	Difficulty obtaining needed accommodations in public spaces	9

Q11: Of the issues listed below, which you would like policy makers to address? Rank from most important to least important. Respondent skipped this question.

Improving access to comprehensive pain treatment in rural access
Policies on prescribing opioids for pain management
Insurance coverage
Continuing education for licensed healthcare providers
Policies that are specific to special populations

Q12: Are there other policies, not listed in Question 11, that you think important for policy makers to consider? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Respondent skipped this question.

Q1: Please enter your full name Commissioner 2

Q2: How would you rate the accessibility of multimodal pain care in Oregon, particularly in rural areas and for specific populations? Select the option that best reflects your opinion.

A) Very accessible
B) Somewhat accessible
C) Not very accessible
D) Not accessible at all
E) Unsure

Q3: Which of the following issues do you believe most significantly affects access to multimodal pain management services for vulnerable populations in Oregon? Rank the options from most significant to least.

A) Limited availability of providers (e.g., physical therapy, acupuncture) 1
B) Geographic barriers in rural areas 2
C) Insufficient services for pediatric patients 4
D) Challenges faced by neurodivergent and gender diverse individuals 5
E) Lack of awareness or education about available services 3

Q4: What do you believe is the most significant impact of insurance limitations on access to pain management treatments? Rank the options from most significant to least.

A) Increased out-of-pocket costs for patients 3
B) Exclusion of complementary and integrative services 1
C) Limited access to in-network trained pain management providers 4
D) Restrictions on interventional procedures 2

Q5: How well do you think patients are informed about key concepts related to chronic pain management, such as neuroplasticity and central sensitization? Select the option that best represents your perspective.

A) Very well informed
B) Somewhat informed
C) Not very informed
D) Not informed at all
E) Unsure

Q6: In your opinion, what specific information or resources would help improve patient understanding of key concepts related to chronic pain management? Limit your response to 100 words or fewer. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. I'm not sure this is an issues related to a patient lack of understanding as much as a systemic issue where insurance denials, lack of coverage and multiple systemic barriers limit access to other types of chronic pain management. Systemic barriers need to be addressed at the government level.

Q7: What challenges have you or someone you know faced when trying to find a new prescriber for chronic pain management after a previous provider has moved or retired? Select all that apply.

A) Difficulty finding a new prescriber willing to continue the same medication regimen
B) Transition to buprenorphine without adequate explanation
C) Providers refusing to see patients using prescribed opioids
D) Lack of information on available providers
E) Primary care physicians who cannot or do not feel comfortable prescribing pain medications
F) Providers unwilling to prescribe or manage pain care when patients use cannabis

Q8: Can you describe any specific experiences or challenges your patients have faced while finding a new prescriber for chronic pain management? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Patients are not provided the opportunity to utilize other modalities to manage pain, leaving prescribing as the most cost effective and also the most judged by a patient care team. Providers need to view the person in environment and understand the conflict in managing pain.

Q9: How would you describe your perception of stigma faced by individuals experiencing chronic pain in the healthcare system? Rank the options from most important to least important that best reflects your experience or perception.

A) Very significant stigma	1
B) Somewhat significant stigma	2
C) Minimal stigma	3
D) No stigma at all	4

Q10: What types of stigma do you believe individuals with chronic pain commonly face? Rank options from most to least important as they apply based on your experience.

A) Being labeled as "drug seekers" or as addicted	2
B) Disbelief in their pain experience by providers	3
C) Social isolation from friends and family	7
D) Judgment for using prescribed pain medications	1
E) Judgement from healthcare staff	4
F) Judgement from Family	8
G) Judgment from school/educational systems	9
H) Judgement in occupational or work settings	6
I) Difficulty obtaining needed accommodations in public spaces	5

Q11: Of the issues listed below, which you would like policy makers to address? Rank from most important to least important.

Improving access to comprehensive pain treatment in rural access	3
Policies on prescribing opioids for pain management	2
Insurance coverage	1
Continuing education for licensed healthcare providers	5
Policies that are specific to special populations	4

Q12: Are there other policies, not listed in Question 11, that you think important for policy makers to consider? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Insurance coverage requirements for alternative modalities and pain management for people with chronic pain. Providing pain patients more time to relay concerns during state and commission meetings.

Q1: Please enter your full name Commissioner 3

Q2: How would you rate the accessibility of multimodal pain care in Oregon, particularly in rural areas and for specific populations? Select the option that best reflects your opinion.

A) Very accessible
B) Somewhat accessible
C) Not very accessible
D) Not accessible at all
E) Unsure

Q3: Which of the following issues do you believe most significantly affects access to multimodal pain management services for vulnerable populations in Oregon? Rank the options from most significant to least.

A)	Limited availability of providers (e.g., physical therapy, acupuncture)	5
B)	Geographic barriers in rural areas	1
C)	Insufficient services for pediatric patients	3
D)	Challenges faced by neurodivergent and gender diverse individuals	4
E)	Lack of awareness or education about available services	2

Q4: What do you believe is the most significant impact of insurance limitations on access to pain management treatments? Rank the options from most significant to least.
Respondent skipped this question.

A) Increased out-of-pocket costs for patients
B) Exclusion of complementary and integrative services
C) Limited access to in-network trained pain management providers
D) Restrictions on interventional procedures

Q5: How well do you think patients are informed about key concepts related to chronic pain management, such as neuroplasticity and central sensitization? Select the option that best represents your perspective.

A) Very well informed
B) Somewhat informed
C) Not very informed
D) Not informed at all
E) Unsure

Q6: In your opinion, what specific information or resources would help improve patient understanding of key concepts related to chronic pain management? Limit your response to 100 words or fewer. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Patients with chronic pain don't always benefit from learning these concepts, and at times the strategies seem more appealing to clinicians than to patients. The impact of pain science education is modest, and education alone rarely changes outcomes. Many patients say, "I understand it better, but I still hurt."

Its usefulness depends on how and when its delivered and should be directly connected to what patients are experiencing. It must be offered with empathy and genuine respect for their pain. As providers, we cant treat pain without understanding the person living with it. Instead of asking patients to understand the concepts, we should focus on understanding them.

Q7: What challenges have you or someone you know faced when trying to find a new prescriber for chronic pain management after a previous provider has moved or retired? Select all that apply.

A) Difficulty finding a new prescriber willing to continue the same medication regimen
B) Transition to buprenorphine without adequate explanation
C) Providers refusing to see patients using prescribed opioids
D) Lack of information on available providers
E) Primary care physicians who cannot or do not feel comfortable prescribing pain medications
F) Providers unwilling to prescribe or manage pain care when patients use cannabis

Q8: Can you describe any specific experiences or challenges your patients have faced while finding a new prescriber for chronic pain management? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. They contacted multiple providers within their communities and in surrounding areas. None were able to accept them or continue their existing treatment plan. Insurance-listed providers were also contacted, but those providers declined as well.

Q9: How would you describe your perception of stigma faced by individuals experiencing chronic pain in the healthcare system? Rank the options from most important to least important that best reflects your experience or perception. Respondent skipped this question.

A) Very significant stigma
B) Somewhat significant stigma
C) Minimal stigma
D) No stigma at all

Q10: What types of stigma do you believe individuals with chronic pain commonly face? Rank options from most to least important as they apply based on your experience.

A)	Being labeled as "drug seekers" or as addicted	1
B)	Disbelief in their pain experience by providers	2
C)	Social isolation from friends and family	5
D)	Judgment for using prescribed pain medications	3
E)	Judgement from healthcare staff	4
F)	Judgement from Family	6
G)	Judgment from school/educational systems	7
H)	Judgement in occupational or work settings	8
I)	Difficulty obtaining needed accommodations in public spaces	9

Q11: Of the issues listed below, which you would like policy makers to address? Rank from most important to least important.

Improving access to comprehensive pain treatment in rural access	3
Policies on prescribing opioids for pain management	1
Insurance coverage	2
Continuing education for licensed healthcare providers	5
Policies that are specific to special populations	4

Q12: Are there other policies, not listed in Question 11, that you think important for policy makers to consider? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. I am concerned about regulatory overreach from state medical boards, the Controlled Substance Monitoring Program (CSMP), and PDMP-driven enforcement. These mechanisms created an effect where fear of sanction overrides individualized clinical judgment, destabilizing legacy pain patients. Current policy forces clinicians to prioritize surveillance metrics over functional outcomes. We must recalibrate so that therapeutic need, not MME thresholds, PDMP alerts, or administrative scrutiny, guides care. Shifting focus from tracking metrics to preserving patient function is the only way to ensure that "safety" initiatives do not systematically harm the very patients they were intended to protect.

Q1: Please enter your full name Commissioner 4

Q2: How would you rate the accessibility of multimodal pain care in Oregon, particularly in rural areas and for specific populations? Select the option that best reflects your opinion.

A) Very accessible
B) Somewhat accessible
C) Not very accessible
D) Not accessible at all
E) Unsure

Q3: Which of the following issues do you believe most significantly affects access to multimodal pain management services for vulnerable populations in Oregon? Rank the options from most significant to least.

A) Limited availability of providers (e.g., physical therapy, acupuncture) 1
B) Geographic barriers in rural areas 2
C) Insufficient services for pediatric patients 5
D) Challenges faced by neurodivergent and gender diverse individuals 3
E) Lack of awareness or education about available services 4

Q4: What do you believe is the most significant impact of insurance limitations on access to pain management treatments? Rank the options from most significant to least.

A) Increased out-of-pocket costs for patients 1
B) Exclusion of complementary and integrative services 3
C) Limited access to in-network trained pain management providers 2
D) Restrictions on interventional procedures 4

Q5: How well do you think patients are informed about key concepts related to chronic pain management, such as neuroplasticity and central sensitization? Select the option that best represents your perspective.

A) Very well informed
B) Somewhat informed
C) Not very informed
D) Not informed at all
E) Unsure

Q6: In your opinion, what specific information or resources would help improve patient understanding of key concepts related to chronic pain management? Limit your response to 100 words or fewer. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Information on social media about on-line resources for chronic pain management.

Q7: What challenges have you or someone you know faced when trying to find a new prescriber for chronic pain management after a previous provider has moved or retired? Select all that apply.

A) Difficulty finding a new prescriber willing to continue the same medication regimen
B) Transition to buprenorphine without adequate explanation
C) Providers refusing to see patients using prescribed opioids
D) Lack of information on available providers
E) Primary care physicians who cannot or do not feel comfortable prescribing pain medications
F) Providers unwilling to prescribe or manage pain care when patients use cannabis

Q8: Can you describe any specific experiences or challenges your patients have faced while finding a new prescriber for chronic pain management? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Primary care physicians who will not prescribe pain medications. And, lack of information on available providers.

Q9: How would you describe your perception of stigma faced by individuals experiencing chronic pain in the healthcare system? Rank the options from most important to least important that best reflects your experience or perception.

A)	Very significant stigma	1
B)	Somewhat significant stigma	4
C)	Minimal stigma	2
D)	No stigma at all	3

Q10: What types of stigma do you believe individuals with chronic pain commonly face? Rank options from most to least important as they apply based on your experience.

A)	Being labeled as "drug seekers" or as addicted	2
B)	Disbelief in their pain experience by providers	9
C)	Social isolation from friends and family	1
D)	Judgment for using prescribed pain medications	3
E)	Judgement from healthcare staff	4
F)	Judgement from Family	5
G)	Judgment from school/educational systems	6
H)	Judgement in occupational or work settings	7
I)	Difficulty obtaining needed accommodations in public spaces	8

Q11: Of the issues listed below, which you would like policy makers to address? Rank from most important to least important.

Improving access to comprehensive pain treatment in rural access	1
Policies on prescribing opioids for pain management	2
Insurance coverage	5
Continuing education for licensed healthcare providers	4
Policies that are specific to special populations	3

Q12: Are there other policies, not listed in Question 11, that you think important for policy makers to consider? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Respondent skipped this question.

Q1: Please enter your full name Commissioner 5

Q2: How would you rate the accessibility of multimodal pain care in Oregon, particularly in rural areas and for specific populations? Select the option that best reflects your opinion.

A) Very accessible
B) Somewhat accessible
C) Not very accessible
D) Not accessible at all
E) Unsure

Q3: Which of the following issues do you believe most significantly affects access to multimodal pain management services for vulnerable populations in Oregon? Rank the options from most significant to least.

A)	Limited availability of providers (e.g., physical therapy, acupuncture)	2
B)	Geographic barriers in rural areas	3
C)	Insufficient services for pediatric patients	1
D)	Challenges faced by neurodivergent and gender diverse individuals	5
E)	Lack of awareness or education about available services	4

Q4: What do you believe is the most significant impact of insurance limitations on access to pain management treatments? Rank the options from most significant to least.

A) Increased out-of-pocket costs for patients 2
B) Exclusion of complementary and integrative services 3
C) Limited access to in-network trained pain management providers 1
D) Restrictions on interventional procedures 4

Q5: How well do you think patients are informed about key concepts related to chronic pain management, such as neuroplasticity and central sensitization? Select the option that best represents your perspective.

A) Very well informed
B) Somewhat informed
C) Not very informed
D) Not informed at all
E) Unsure

Q6: In your opinion, what specific information or resources would help improve patient understanding of key concepts related to chronic pain management? Limit your response to 100 words or fewer. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Integration of pain education earlier, even as part of school programs. Provider familiarity with pain science AND ways to "translate" it to patient appropriate languages, including tools already available (ex: Meg Foundation, @chronic_pain_project)

Q7: What challenges have you or someone you know faced when trying to find a new prescriber for chronic pain management after a previous provider has moved or retired? Select all that apply.

A) Difficulty finding a new prescriber willing to continue the same medication regimen
B) Transition to buprenorphine without adequate explanation
C) Providers refusing to see patients using prescribed opioids
D) Lack of information on available providers
E) Primary care physicians who cannot or do not feel comfortable prescribing pain medications
F) Providers unwilling to prescribe or manage pain care when patients use cannabis

Q8: Can you describe any specific experiences or challenges your patients have faced while finding a new prescriber for chronic pain management? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Working with teenagers, when they switch from pediatric to adult care, that transition can be difficult, especially in consistency of prescriptions.

Q9: How would you describe your perception of stigma faced by individuals experiencing chronic pain in the healthcare system? Rank the options from most important to least important that best reflects your experience or perception.

A) Very significant stigma 2
B) Somewhat significant stigma 1
C) Minimal stigma 3
D) No stigma at all 4

Q10: What types of stigma do you believe individuals with chronic pain commonly face? Rank options from most to least important as they apply based on your experience.

A)	Being labeled as "drug seekers" or as addicted	9
B)	Disbelief in their pain experience by providers	1
C)	Social isolation from friends and family	6
D)	Judgment for using prescribed pain medications	8
E)	Judgement from healthcare staff	2
F)	Judgement from Family	5
G)	Judgment from school/educational systems	3
H)	Judgement in occupational or work settings	4
I)	Difficulty obtaining needed accommodations in public spaces	7

Q11: Of the issues listed below, which you would like policy makers to address? Rank from most important to least important.

Improving access to comprehensive pain treatment in rural access	2
Policies on prescribing opioids for pain management	5
Insurance coverage	1
Continuing education for licensed healthcare providers	3
Policies that are specific to special populations	4

Q12: Are there other policies, not listed in Question 11, that you think important for policy makers to consider? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Respondent skipped this question.

Q1: Please enter your full name Commissioner 6

Q2: How would you rate the accessibility of multimodal pain care in Oregon, particularly in rural areas and for specific populations? Select the option that best reflects your opinion.

A) Very accessible
B) Somewhat accessible
C) Not very accessible
D) Not accessible at all
E) Unsure

Q3: Which of the following issues do you believe most significantly affects access to multimodal pain management services for vulnerable populations in Oregon? Rank the options from most significant to least.

A)	Limited availability of providers (e.g., physical therapy, acupuncture)	1
B)	Geographic barriers in rural areas	2
C)	Insufficient services for pediatric patients	5
D)	Challenges faced by neurodivergent and gender diverse individuals	3
E)	Lack of awareness or education about available services	4

Q4: What do you believe is the most significant impact of insurance limitations on access to pain management treatments? Rank the options from most significant to least.

A)	Increased out-of-pocket costs for patients	2
B)	Exclusion of complementary and integrative services	3
C)	Limited access to in-network trained pain management providers	1
D)	Restrictions on interventional procedures	4

Q5: How well do you think patients are informed about key concepts related to chronic pain management, such as neuroplasticity and central sensitization? Select the option that best represents your perspective.

A) Very well informed
B) Somewhat informed
C) Not very informed
D) Not informed at all
E) Unsure

Q6: In your opinion, what specific information or resources would help improve patient understanding of key concepts related to chronic pain management? Limit your response to 100 words or fewer. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Comprehensive pain treatment programs with multiple modalities. Educating patients on realistic expectations related to drug treatment.

Q7: What challenges have you or someone you know faced when trying to find a new prescriber for chronic pain management after a previous provider has moved or retired? Select all that apply.

A) Difficulty finding a new prescriber willing to continue the same medication regimen
B) Transition to buprenorphine without adequate explanation
C) Providers refusing to see patients using prescribed opioids
D) Lack of information on available providers
E) Primary care physicians who cannot or do not feel comfortable prescribing pain medications
F) Providers unwilling to prescribe or manage pain care when patients use cannabis

Q8: Can you describe any specific experiences or challenges your patients have faced while finding a new prescriber for chronic pain management? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Many prescribers are not comfortable prescribing opioids. Additionally, many prescribers are not willing to coordinate care when another prescriber (such as psych NP or psychiatrist) is prescribing comorbid benzodiazepines or high-CNS burden regimen. Difficulty finding prescribers that take the time to appropriately document evaluation, pain treatment and monitoring, leading to prior authorization delays as insurance tries to get information.

Q9: How would you describe your perception of stigma faced by individuals experiencing chronic pain in the healthcare system? Rank the options from most important to least important that best reflects your experience or perception. Respondent skipped this question.

A) Very significant stigma
B) Somewhat significant stigma
C) Minimal stigma
D) No stigma at all

Q10: What types of stigma do you believe individuals with chronic pain commonly face? Rank options from most to least important as they apply based on your experience.

A) Being labeled as "drug seekers" or as addicted	5
B) Disbelief in their pain experience by providers	1
C) Social isolation from friends and family	6
D) Judgment for using prescribed pain medications	7
E) Judgement from healthcare staff	2
F) Judgement from Family	8
G) Judgment from school/educational systems	9
H) Judgement in occupational or work settings	3

I) Difficulty obtaining needed accommodations in public spaces 4

Q11: Of the issues listed below, which you would like policy makers to address? Rank from most important to least important.

Improving access to comprehensive pain treatment in rural access	1
Policies on prescribing opioids for pain management	5
Insurance coverage	4
Continuing education for licensed healthcare providers	2
Policies that are specific to special populations	3

Q12: Are there other policies, not listed in Question 11, that you think important for policy makers to consider? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Respondent skipped this question.

Q1: Please enter your full name Commissioner 7

Q2: How would you rate the accessibility of multimodal pain care in Oregon, particularly in rural areas and for specific populations? Select the option that best reflects your opinion.

A) Very accessible
B) Somewhat accessible
C) Not very accessible
D) Not accessible at all
E) Unsure

Q3: Which of the following issues do you believe most significantly affects access to multimodal pain management services for vulnerable populations in Oregon? Rank the options from most significant to least.

A) Limited availability of providers (e.g., physical therapy, acupuncture) 2
B) Geographic barriers in rural areas 1
C) Insufficient services for pediatric patients 3
D) Challenges faced by neurodivergent and gender diverse individuals 4
E) Lack of awareness or education about available services 5

Q4: What do you believe is the most significant impact of insurance limitations on access to pain management treatments? Rank the options from most significant to least.

A) Increased out-of-pocket costs for patients 3
B) Exclusion of complementary and integrative services 2
C) Limited access to in-network trained pain management providers 4
D) Restrictions on interventional procedures 1

Q5: How well do you think patients are informed about key concepts related to chronic pain management, such as neuroplasticity and central sensitization? Select the option that best represents your perspective.

A) Very well informed
B) Somewhat informed
C) Not very informed
D) Not informed at all
E) Unsure

Q6: In your opinion, what specific information or resources would help improve patient understanding of key concepts related to chronic pain management? Limit your response to 100 words or fewer. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Videos they can watch at their own pace that can take the time to explain the concepts and how they impact the patient's experience of pain in simple language.

Q7: What challenges have you or someone you know faced when trying to find a new prescriber for chronic pain management after a previous provider has moved or retired? Select all that apply.

A) Difficulty finding a new prescriber willing to continue the same medication regimen
B) Transition to buprenorphine without adequate explanation
C) Providers refusing to see patients using prescribed opioids
D) Lack of information on available providers
E) Primary care physicians who cannot or do not feel comfortable prescribing pain medications
F) Providers unwilling to prescribe or manage pain care when patients use cannabis

Q8: Can you describe any specific experiences or challenges your patients have faced while finding a new prescriber for chronic pain management? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. If a patient breaks a pain contract, then what?

Q9: How would you describe your perception of stigma faced by individuals experiencing chronic pain in the healthcare system? Rank the options from most important to least important that best reflects your experience or perception.

A) Very significant stigma	1
B) Somewhat significant stigma	2
C) Minimal stigma	3
D) No stigma at all	4

Q10: What types of stigma do you believe individuals with chronic pain commonly face? Rank options from most to least important as they apply based on your experience.

A) Being labeled as "drug seekers" or as addicted	2
B) Disbelief in their pain experience by providers	1
C) Social isolation from friends and family	6
D) Judgment for using prescribed pain medications	3
E) Judgement from healthcare staff	4
F) Judgement from Family	8
G) Judgment from school/educational systems	9
H) Judgement in occupational or work settings	7
I) Difficulty obtaining needed accommodations in public spaces	5

Q11: Of the issues listed below, which you would like policy makers to address? Rank from most important to least important.

Improving access to comprehensive pain treatment in rural access	1
Policies on prescribing opioids for pain management	3
Insurance coverage	2
Continuing education for licensed healthcare providers	4
Policies that are specific to special populations	5

Q12: Are there other policies, not listed in Question 11, that you think important for policy makers to consider? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Respondent skipped this question.

Q1: Please enter your full name Commissioner 8

Q2: How would you rate the accessibility of multimodal pain care in Oregon, particularly in rural areas and for specific populations? Select the option that best reflects your opinion.

A) Very accessible
B) Somewhat accessible
C) Not very accessible
D) Not accessible at all
E) Unsure

Q3: Which of the following issues do you believe most significantly affects access to multimodal pain management services for vulnerable populations in Oregon? Rank the options from most significant to least.

A)	Limited availability of providers (e.g., physical therapy, acupuncture)	1
B)	Geographic barriers in rural areas	5
C)	Insufficient services for pediatric patients	3
D)	Challenges faced by neurodivergent and gender diverse individuals	4
E)	Lack of awareness or education about available services	2

Q4: What do you believe is the most significant impact of insurance limitations on access to pain management treatments? Rank the options from most significant to least.

A) Increased out-of-pocket costs for patients 3
B) Exclusion of complementary and integrative services 2
C) Limited access to in-network trained pain management providers 1
D) Restrictions on interventional procedures 4

Q5: How well do you think patients are informed about key concepts related to chronic pain management, such as neuroplasticity and central sensitization? Select the option that best represents your perspective.

A) Very well informed
B) Somewhat informed
C) Not very informed
D) Not informed at all
E) Unsure

Q6: In your opinion, what specific information or resources would help improve patient understanding of key concepts related to chronic pain management? Limit your response to 100 words or fewer. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Chronic pain is one of the few diagnoses whose pathophysiology is not properly explained to patients, or the chronic pain is often described as being more of a purely psychological issue. This leaves patients exposed to significant level of stigma. I feel that there are patient appropriate approaches to explain pathophysiological changes that are associated with chronic pain, and how in some cases the pathophysiology can be moderated to attenuate or eliminate chronic pain. As in many other medical conditions, proper patient education can increase the chances for more successful outcomes with the care plan.

Q7: What challenges have you or someone you know faced when trying to find a new prescriber for chronic pain management after a previous provider has moved or retired? Select all that apply.

A) Difficulty finding a new prescriber willing to continue the same medication regimen
B) Transition to buprenorphine without adequate explanation
C) Providers refusing to see patients using prescribed opioids
D) Lack of information on available providers
E) Primary care physicians who cannot or do not feel comfortable prescribing pain medications
F) Providers unwilling to prescribe or manage pain care when patients use cannabis

Q8: Can you describe any specific experiences or challenges your patients have faced while finding a new prescriber for chronic pain management? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. 1./ Extremely limited pediatric pain management options 2./ When Rx providers leave practices

Q9: How would you describe your perception of stigma faced by individuals experiencing chronic pain in the healthcare system? Rank the options from most important to least important that best reflects your experience or perception. Respondent skipped this question.

A) Very significant stigma
B) Somewhat significant stigma
C) Minimal stigma
D) No stigma at all

Q10: What types of stigma do you believe individuals with chronic pain commonly face? Rank options from most to least important as they apply based on your experience.

A)	Being labeled as "drug seekers" or as addicted	1
B)	Disbelief in their pain experience by providers	2
C)	Social isolation from friends and family	3
D)	Judgment for using prescribed pain medications	9
E)	Judgement from healthcare staff	8
F)	Judgement from Family	4
G)	Judgment from school/educational systems	6
H)	Judgement in occupational or work settings	5
I)	Difficulty obtaining needed accommodations in public spaces	7

Q11: Of the issues listed below, which you would like policy makers to address? Rank from most important to least important.

Improving access to comprehensive pain treatment in rural access	1
Policies on prescribing opioids for pain management	4
Insurance coverage	2
Continuing education for licensed healthcare providers	5
Policies that are specific to special populations	3

Q12: Are there other policies, not listed in Question 11, that you think important for policy makers to consider? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. The state needs proper oversight of the health insurance industry. There are too many problems to list fully but the problems include poor credentialed panel management; burdensome PA processes; declining reimbursement to providers; insufficient coverage for multimodal pain care.

Q1: Please enter your full name Commissioner 9

Q2: How would you rate the accessibility of multimodal pain care in Oregon, particularly in rural areas and for specific populations? Select the option that best reflects your opinion.

A) Very accessible
B) Somewhat accessible
C) Not very accessible
D) Not accessible at all
E) Unsure

Q3: Which of the following issues do you believe most significantly affects access to multimodal pain management services for vulnerable populations in Oregon? Rank the options from most significant to least.

A)	Limited availability of providers (e.g., physical therapy, acupuncture)	1
B)	Geographic barriers in rural areas	3
C)	Insufficient services for pediatric patients	4
D)	Challenges faced by neurodivergent and gender diverse individuals	5
E)	Lack of awareness or education about available services	2

Q4: What do you believe is the most significant impact of insurance limitations on access to pain management treatments? Rank the options from most significant to least.

A)	Increased out-of-pocket costs for patients	3
B)	Exclusion of complementary and integrative services	2
C)	Limited access to in-network trained pain management providers	1
D)	Restrictions on interventional procedures	4

Q5: How well do you think patients are informed about key concepts related to chronic pain management, such as neuroplasticity and central sensitization? Select the option that best represents your perspective.

A) Very well informed
B) Somewhat informed
C) Not very informed
D) Not informed at all
E) Unsure

Q6: In your opinion, what specific information or resources would help improve patient understanding of key concepts related to chronic pain management? Limit your response to 100 words or fewer. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Videos, websites, support groups. I don't think changing a patient's perspective on pain can be accomplished in one office visit, and the patient needs to be curious about it. All patients are in different stages of change (precontemplation, contemplation, etc.) and have different learning styles. Therefore, a variety of resources need to be offered.

Q7: What challenges have you or someone you know faced when trying to find a new prescriber for chronic pain management after a previous provider has moved or retired? Select all that apply.

A) Difficulty finding a new prescriber willing to continue the same medication regimen
B) Transition to buprenorphine without adequate explanation
C) Providers refusing to see patients using prescribed opioids
D) Lack of information on available providers
E) Primary care physicians who cannot or do not feel comfortable prescribing pain medications
F) Providers unwilling to prescribe or manage pain care when patients use cannabis

Q8: Can you describe any specific experiences or challenges your patients have faced while finding a new prescriber for chronic pain management? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. The above topics pretty much cover it.

Q9: How would you describe your perception of stigma faced by individuals experiencing chronic pain in the healthcare system? Rank the options from most important to least important that best reflects your experience or perception. Respondent skipped this question.

A) Very significant stigma
B) Somewhat significant stigma
C) Minimal stigma
D) No stigma at all

Q10: What types of stigma do you believe individuals with chronic pain commonly face? Rank options from most to least important as they apply based on your experience.

A)	Being labeled as "drug seekers" or as addicted	2
B)	Disbelief in their pain experience by providers	1
C)	Social isolation from friends and family	7
D)	Judgment for using prescribed pain medications	3
E)	Judgement from healthcare staff	4
F)	Judgement from Family	5
G)	Judgment from school/educational systems	8
H)	Judgement in occupational or work settings	6
I)	Difficulty obtaining needed accommodations in public spaces	9

Q11: Of the issues listed below, which you would like policy makers to address? Rank from most important to least important.

Improving access to comprehensive pain treatment in rural access	4
Policies on prescribing opioids for pain management	5
Insurance coverage	1
Continuing education for licensed healthcare providers	2
Policies that are specific to special populations	3

Q12: Are there other policies, not listed in Question 11, that you think important for policy makers to consider? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim.

Enforcing/facilitating existing government and societal recommendations of non-pharmacological treatments first. National Pain Strategy; Expanding Access To Non-Opioid Management Of Chronic Pain by the National Governors Association; American Academy of Family Physician's pain guidelines. MDs are not familiar with what it would be like to try something before a Rx... Let's remove those barriers and add incentives.

Q1: Please enter your full name Commissioner 10

Q2: How would you rate the accessibility of multimodal pain care in Oregon, particularly in rural areas and for specific populations? Select the option that best reflects your opinion.

A) Very accessible
B) Somewhat accessible
C) Not very accessible
D) Not accessible at all
E) Unsure

Q3: Which of the following issues do you believe most significantly affects access to multimodal pain management services for vulnerable populations in Oregon? Rank the options from most significant to least.

A)	Limited availability of providers (e.g., physical therapy, acupuncture)	1
B)	Geographic barriers in rural areas	3
C)	Insufficient services for pediatric patients	4
D)	Challenges faced by neurodivergent and gender diverse individuals	5
E)	Lack of awareness or education about available services	2

Q4: What do you believe is the most significant impact of insurance limitations on access to pain management treatments? Rank the options from most significant to least.

A) Increased out-of-pocket costs for patients 2
B) Exclusion of complementary and integrative services 3
C) Limited access to in-network trained pain management providers 1
D) Restrictions on interventional procedures 4

Q5: How well do you think patients are informed about key concepts related to chronic pain management, such as neuroplasticity and central sensitization? Select the option that best represents your perspective.

A) Very well informed
B) Somewhat informed
C) Not very informed
D) Not informed at all
E) Unsure

Q6: In your opinion, what specific information or resources would help improve patient understanding of key concepts related to chronic pain management? Limit your response to 100 words or fewer. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Both medical providers and patients struggle with understanding the role of pain meds including opioid meds in the management of chronic pain.

Q7: What challenges have you or someone you know faced when trying to find a new prescriber for chronic pain management after a previous provider has moved or retired? Select all that apply.

A) Difficulty finding a new prescriber willing to continue the same medication regimen
B) Transition to buprenorphine without adequate explanation

C) Providers refusing to see patients using prescribed opioids
D) Lack of information on available providers
E) Primary care physicians who cannot or do not feel comfortable prescribing pain medications
F) Providers unwilling to prescribe or manage pain care when patients use cannabis

Q8: Can you describe any specific experiences or challenges your patients have faced while finding a new prescriber for chronic pain management? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Patients feel a stigma related to opioid use from pharmacists, to physicians, to allied health providers.

Q9: How would you describe your perception of stigma faced by individuals experiencing chronic pain in the healthcare system? Rank the options from most important to least important that best reflects your experience or perception. Respondent skipped this question.

A) Very significant stigma
B) Somewhat significant stigma
C) Minimal stigma
D) No stigma at all

Q10: What types of stigma do you believe individuals with chronic pain commonly face? Rank options from most to least important as they apply based on your experience.

A)	Being labeled as "drug seekers" or as addicted	1
B)	Disbelief in their pain experience by providers	3
C)	Social isolation from friends and family	4
D)	Judgment for using prescribed pain medications	2
E)	Judgement from healthcare staff	5
F)	Judgement from Family	6
G)	Judgment from school/educational systems	7
H)	Judgement in occupational or work settings	8
I)	Difficulty obtaining needed accommodations in public spaces	9

Q11: Of the issues listed below, which you would like policy makers to address? Rank from most important to least important.

Improving access to comprehensive pain treatment in rural access	4
Policies on prescribing opioids for pain management	1
Insurance coverage	2
Continuing education for licensed healthcare providers	5
Policies that are specific to special populations	3

Q12: Are there other policies, not listed in Question 11, that you think important for policy makers to consider? Limit your response to 100 words or less. Note: Responses will be summarized and synthesized in the final report; not reproduced verbatim. Policy makers need to kept abreast of the changing arena of pain management, for example policy makers should be educated about the evolving danger associated with kratom.