

Health Policy and Analytics Division

Membership of the Oregon Pain Management Commission

September 15, 2024



Oregon
Health
Authority

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MEMBERSHIP OF THE OREGON PAIN MANAGEMENT COMMISSION

The primary responsibilities of the Oregon Pain Commission (Commission) are to:

- Develop pain management recommendations, ways to improve pain management services and represent the concerns of patients in Oregon to the Governor and Legislative Assembly (ORS 413.570)
- Develop a one-hour training in pain management (ORS 413.572), which must be updated biennially and be completed by a variety of Oregon licensed healthcare professionals to obtain or renew their licenses.

Per Senate Bill 607 (2023), “The Oregon Health Authority shall study the membership of the Pain Management Commission. The authority shall submit a report in the manner provided by ORS 192.245, and may include recommendations for legislative changes to the membership of the Pain Management Commission to the interim committees of the Legislative Assembly related to health no later than September 15, 2024.” This report fulfills this requirement.

This report was developed by Jason Gingerich, HERC director and Mark Altenhofen, Coordinator for the Oregon Pain Management Commission. Mr. Gingerich is Mr. Altenhofen’s supervisor and participates in the member recruitment process. The report was not reviewed by members of the Commission but was reviewed by other OHA staff and leadership.

Membership requirements

ORS 413.574 specifies that there are 19 members of the Oregon Pain Management Commission (Commission). Seventeen are appointed by the director of the Oregon Health Authority (OHA), who is required to “request and consider recommendations from individuals and public and private agencies and organizations with experience or a demonstrated interest in pain management issues.” The statute does not require any qualification for membership, but lists potential qualifications as follows:

- Physicians licensed under ORS chapter 677 or organizations representing physicians;
- Nurses licensed under ORS chapter 678 or organizations representing nurses;
- Psychologists licensed under ORS 675.010 to 675.150 or organizations representing psychologists;
- Physician assistants licensed under ORS chapter 677 or organizations representing physician assistants;

- Chiropractic physicians licensed under ORS chapter 684 or organizations representing chiropractic physicians;
- Naturopaths licensed under ORS chapter 685 or organizations representing naturopaths;
- Clinical social workers licensed under ORS 675.530 or organizations representing clinical social workers;
- Acupuncturists licensed under ORS 677.759;
- Pharmacists licensed under ORS chapter 689;
- Palliative care professionals or organizations representing palliative care professionals;
- Mental health professionals or organizations representing mental health professionals;
- Health care consumers or organizations representing health care consumers;
- Hospitals and health plans or organizations representing hospitals and health plans;
- Patients or advocacy groups representing patients;
- Dentists licensed under ORS chapter 679;
- Occupational therapists licensed under ORS 675.210 to 675.340;
- Physical therapists licensed under ORS 688.010 to 688.201; and
- Members of the public.

Note that there is no requirement for any specific number of members to be selected from any of these categories, and the “member of the public” category does not specify any specific qualifications for members.

The remaining two seats are reserved for Legislative Committee Members appointed by the President of the Senate and Speaker of the House of Representatives, respectively.

Members serve four-year terms and are eligible for re-appointment according to statute. Commission bylaws limit members to two four-year terms.

Current membership

As of August 2024, the Commission has 15 members who were appointed based on recommendations from staff and Commission leadership. Members are recruited through an open public application process. The remaining two seats will undergo additional recruiting this fall. Thirteen of these members have one of the professional licenses specified in statute; the other two members were appointed for their lived experience with chronic pain as well as non-licensed work supporting and representing others who experience pain. A full listing of current members, with brief biographical descriptions is available on the Commission in [Appendix A: Members](#) and on the Commission [website](#).

Recruiting practices

When a vacancy occurs, OHA advertises the vacancy using the Commission's Listserv, which has over 8,000 members. Vacancies are also announced to Commission members and in the Commission's public meetings and are open for at least four weeks. Information from an application survey <https://www.surveymonkey.com/r/OPMC-Application>, which collects information from each applicant about their qualifications, motivation and the perspective they bring to pain management, is used by Committee staff and the Chair and Vice-Chair to evaluate candidates. The application also collects select REALD and SOGI¹ data. Members are also required to submit a letter of recommendation from a third party.

Members are scored on a spreadsheet by the Commission's chair and vice chair as well as the Commission staff. The spreadsheet captures the applicant's name, professional licensure (if any) and offers a scoring rubric on four factors:

- Geographic diversity (1 for Portland-Metro, 3 for Valley or Central Oregon, 4 for Coast/Eastern Oregon. One additional point for small town/rural)
- Clinical experience (for licensed professionals) or non-profit or government representation experience (for applicants who are not licensed) (1 for no experience, 2 for one-four years, 3 for five years, 4 for six-nine years, 5 for more than 10 years)
- Adds diversity of perspective to current Commission membership, including lived experience (1 for no additional perspective, 3 for 'adds to the mix', 5 for 'fills important gap')
- Commitment to improving pain management in Oregon, consistent with research and evidence base (1 for 'not evident', 2 for 'interest', 3 for 'training or strong focus', 4 for 'strong professional/advocacy focus', 5 for 'primary professional/advocacy focus')

There are two additional columns: "Notes on scored columns" (e.g., unique perspectives, groups or perspectives represented) from application materials and "Other factors for consideration" (collaboration, ethics, notable accomplishments, professionalism, approach to conflict, etc.) from application materials and other available information to inform this column.

High-level race and ethnicity categories are included on the spreadsheet for applicants who provide this information but are not formally scored or weighted.

Candidates are recommended considering the scoring, qualitative factors, and to seek Commission member balance in areas such as license types, geographic regions, identities and experiences.

¹ REALD is Race Ethnicity, Language and Disability; SOGI is Sexual Orientation and Gender Identity

Candidates recommended by Commission leadership and the Pain Management Coordinator are then reviewed by at least three layers of OHA management prior to appointment by the OHA Director.

Statute changes for consideration

There is no urgent need to change ORS 413.574, which lists membership requirements. However, following are two changes for the legislature to consider:

- 1) The statute could specify that a certain number of members meet selected membership criteria. This change would provide OHA with more direction on the Commission's composition.
- 2) The membership category "member of the public" is vague and could be made more specific. Staff and OPMC leadership have always sought to include two members who are not licensed providers, but who have lived experience with pain. One option for consideration is that the legislature could require that at least three members of the Commission have lived experience with significant pain. Another option would be to add traditional health worker (such as a community health worker) to the list of possible membership qualifications.

Membership-related process changes underway in response to public comments

- 1) Public comment highlighted statute (ORS 413.574) requiring the OHA Director to request and consider recommendations in making appointments. In the past, this has been done through the letter of reference required as part of the application process. For future recruitments, staff will also request recommendations from non-applicants for members they would like to see appointed.
- 2) Staff will provide Commissioners with training (developed by the Oregon Ethics Commission) related to conflicts of interest and begin the practice of providing members with an opportunity to declare potential or actual conflicts of interest at the beginning of each public meeting.
- 3) The Commission will review its bylaws in 2025 and update them as needed. The public will have opportunities to provide input on changes to the bylaws or adjustments to Commission activities.
- 4) Begin recruitment for a third member with lived experience of pain or who is a caregiver of a person experiencing pain, and who is not a licensed healthcare provider. Refer to these as "members with pain-related lived experience" rather than "public members" in the future.

Appendix A: Members

Zachary Corbett, LAc, Chair

Zachary has been in practice as a licensed acupuncturist since 2001. He originally practiced in California as an acupuncturist, herbalist and massage therapist. His previous career was in molecular biology at a drug research facility at the Veteran's Administration / UCLA. He was a lecturer and faculty member at the Santa Barbara College of Oriental Medicine. He gave his first acupuncture treatments in 1999 and has practiced in Oregon since 2005.

Russell Wimmer, PA-C, Vice Chair

Russell is a physician assistant in Lebanon, OR and currently practices at Samaritan Family Medicine Resident Clinic. He comes to the commission with a variety of experiences across multiple disciplines including management, academic research, emergency services, primary and specialty medical care. His current focus is on improving pain management in the primary care setting and serving as an active member of the Oregon Pain Alliance. He received his Masters of Physician Assistant Studies from Heritage University.

Carolyn Concia, NP

Carolyn brings 32 years of nursing practice to the work of the commission. Her background includes providing in-home medical care to seniors and disabled individuals who are homebound. She has served as a U.S.A.F. Reserve Flight Nurse in the 446th Aero-medical Evacuation Squadron at Joint Base Lewis McChord in Tacoma, WA. Ms. Concia received her MS in Nursing from St. Louis University and is board certified as an ANCC Gerontological Nurse Practitioner.

Lina Dorfmeister, CRNA NSPM-c

Lina is an Oregon Association of Nurse Anesthetist board member practicing in North Bend, Oregon. She provides pain management services for Coquille Valley Hospital and is the Chief Lead Nurse Anesthetist at North Bend Medical Center. Lina completed an advanced fellowship training in acute and chronic pain management at the University of South Florida and received a Masters degree in Nursing from the University of Buffalo, New York. She is committed to providing specialized healthcare services to rural communities facing a shortage of healthcare providers.

Shinta Imnasjah, Pharm D

Dr. Imnasjah serves as a Chief Pharmacist at NARA Northwest. The Native American Rehabilitation Association of the Northwest, Inc. (NARA) provides education, physical and mental health services and substance abuse treatment that is culturally appropriate to Native Americans, Alaska Natives and other vulnerable people in the greater Portland, Oregon area. She has a longstanding interest in pain management and worked with the Navajo and White Earth Reservations. Controlled substance diversion and addiction have been a specialized area of practice and one of her passions after witnessing first-

hand how these issues were affecting the families within Native American communities.

Terrance Manning II, ND, RMSK, MA

Dr. Manning is a naturopathic physician who received multi-year post residency training with an interventional radiologist. He currently practices in an integrative setting (i.e. Interventional radiology, primary care sports medicine, and physiatry) providing interventional pain management. Terrance is familiar with naturopathic approaches, conventional and interventional approaches, as well as emerging treatments to address persistent pain. He hopes to use his clinical experience, unconventional approach and empathy for those suffering with persistent pain syndromes to serve the state as a member of OPMC.

Michelle Marikos, Public Member

Michelle serves as a public member of the commission and has experience working as a Peer Support Specialist living with chronic pain. She also works as a consultant for OHSU Project ECHO, Center for Disease Control Steering Committee, and Oregon Pain Guidance Group Trainings.

Christine Martin, MD

Dr. Martin serves as a physician faculty member at Oregon Health & Science University (OHSU). She has been involved in providing clinical pain management care of patients throughout Oregon for many years and holds a leadership role as the director of Acute Pain Management at OHSU Doernbecher Children's Hospital. Christine is part of a team that provides care for pediatric patients through OHSU's Comprehensive Pediatric Pain Clinic and strives to develop guidance for safe opioid prescribing for younger patients. As part of OPMC, she is interested in working to expand clinical knowledge and advocacy to improve pain management for children throughout Oregon.

Scott Pengelly, Ph.D.

Scott is a licensed Clinical Psychologist and received his doctoral degree from the University of Oregon. He has advanced clinical training in biofeedback, behavioral medicine and EMDR. Dr. Pengelly is dedicated to helping relieve suffering due to chronic pain and implements strategies to help improve quality of life & mood, reduce pain frequency, and lower the intensity and duration of pain flares. Dr. Pengelly wishes to continue working towards these efforts combined with educating patients and colleagues about behavioral pain care. He is a veteran of the US Navy, having served two tours in the Middle East, and regularly volunteers his time to treat vets with chronic pain and PTSD.

Stuart Rosenblum, MD, Ph.D.

Dr. Rosenblum has worked as an interventional pain specialist for over 30 years and brings a diverse clinical background in the management of pain to the work of the commission. He earned his M.S. in Neurophysiology, Ph.D. in Medical Psychology and MD through OHSU. Stuart has experience in teaching, research and direct clinical care in pediatrics, adults, & geriatrics. Dr. Rosenblum believes in a multidisciplinary and team

based approach to care. His philosophy is to partner with the patient and is interested in advancing education in the field of pain management.

Andrew Suchocki MD, MPH

Dr. Suchocki is a Family Physician with a focus on preventative medicine and currently serves as the Medical Director for Clackamas Community Health Centers, Oregon. He specializes and consults on system change in primary care around opiate prescribing, MAT system design and capacity growth in primary care. Dr. Suchocki received his Doctorate degree in Medicine from Ohio State University and a Masters in Public Health from Johns Hopkins University.

Cody Traweck, Pharm D

Dr. Traweck practices as a Clinical Pharmacist for Providence Health Plan of Oregon. She has worked in a variety of clinical settings seeing patients by appointment managing pharmacy related services including pain, diabetes, anticoagulation, and general chronic conditions. She earned her Doctor of Pharmacy from Pacific University and additionally received a Masters degree of Healthcare Administration degree. Her professional interests include ambulatory care, infectious disease, women's health, substance abuse, global health, healthcare management, pharmacy law and policy. She is a member of the American Society of Health-System Pharmacists, American Pharmacist Association, Oregon Society of Health system Pharmacists, Oregon State Pharmacy Association and the Phi Lambda Sigma Leadership Society.

Chavala Bates, FMCHWC

Chavala is a certified Functional Medicine health and wellness coach and an MSW intern, living with chronic pain. With an extensive experience in integrative community health, she has served as an educator, researcher, and clinician. Chavala's work prioritizes the needs of underserved populations, emphasizing the intersection of wellness and social determinants of health. She is an active member of Integrative Medicine for the Underserved (IM4US) and the Oregon Coalition Against Domestic and Sexual Violence (OCADSVA).

Eve Klein, MD

Dr. Klein is CODA's Senior Medical Director. She is board certified in neurology and addiction medicine, and completed fellowships in both pain medicine and addiction medicine at OHSU. She has worked at CODA since 2016 and also currently serves as the Associate Medical Director for the Oregon Medical Board. Dr. Klein is an assistant professor at OHSU, where she teaches medical students on the topics of opioids, pain, substance use disorders, and medical regulation. Prior to her work in addiction medicine, Dr. Klein practiced interventional pain medicine.

Britta Gurgel, PT, DPT PCS

Britta is an Assistant Professor and Physical Therapist at Oregon Health and Science University, working with pediatric populations through the Child Development and Rehabilitation Center. Britta has worked within OHSU's Comprehensive Pediatric Pain Clinic since 2018 and is the Associate Director of Pediatric Pain Physical Therapy. She is delighted to join the Oregon Pain Management Commission to continue their work of expanding access to pain education and improving quality of life for people who live with persistent pain, especially kids and youth in Oregon. .

Appendix B: Application questions

Question 1: The information you submit in this survey will be used by OHA staff and OPMC leadership to evaluate candidates' applications for membership and submittal to the OHA Director for review and appointment. This information will also be used to promote diverse representation on OPMC. In addition, aggregate summary data for all those who respond may be reported publicly. Because of the small size of the OPMC applicant pool, it may be possible to identify how individual applicants have answered the survey from this aggregate information. While you are not required to answer any questions about personal identities or health conditions, we encourage you to include information you are comfortable sharing to aid in our efforts to improve representation, with the understanding that this information may be disclosed (with personal information redacted according to the law) in the event of a public records request. If you require additional information about the confidentiality of this information, please email us at pmc.info@odhsoha.oregon.gov so we can address any questions before you fill out the survey.

Question 2: Please upload your resume or curriculum vitae. Acceptable formats include PDF, DOC, and DOCX. If you are having trouble, please email pmc.info@odhsoha.oregon.gov for help.

Question 3: Please upload a letter of recommendation. Acceptable formats include PDF, DOC, and DOCX. If you are having trouble, please email pmc.info@odhsoha.oregon.gov for help.

Question 4: Full Name

Question 5: Pronouns (optional)

Question 6: Email Address

Question 7: Phone Number

Question 8: Principal occupation or advocacy role (if any)

Question 9: Professional license type (enter NA if you are not a licensed healthcare provider)

Question 10: Other relevant memberships/affiliations (for example, board memberships, professional or service organizations)

Question 11: Please briefly explain why you are interested in serving on OPMC, and why you would be a good candidate for membership

Question 12: What region of Oregon do you reside in?

- Central (Crook, Deschutes, Hood River, Jefferson, Sherman, Wasco)
- Coast (Clatsop, Columbia, Coos, Lincoln, Tillamook)

- Eastern (Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Umatilla, Union, Wallowa, Wheeler)
- Portland Metro (Clackamas, Multnomah, Washington)
- Southern (Curry, Douglas, Jackson, Josephine, Klamath)
- Willamette Valley (Benton, Lane, Linn, Marion, Polk, Yamhill)
- I do not reside in Oregon (to be appointed to OPMC, you must be an Oregon resident and taxpayer)
- Additional information (if you lived for a significant time in another region please describe)

Question 13: If you have a professional role in healthcare (including but not limited to patient care), in what parts of Oregon do those you serve live? (Check all that apply)

- Central (Crook, Deschutes, Hood River, Jefferson, Sherman, Wasco)
- Coast (Clatsop, Columbia, Coos, Lincoln, Tillamook)
- Eastern (Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Umatilla, Union, Wallowa, Wheeler)
- Portland Metro (Clackamas, Multnomah, Washington)
- Southern (Curry, Douglas, Jackson, Josephine, Klamath)
- Willamette Valley (Benton, Lane, Linn, Marion, Polk, Yamhill)
- I do not reside in Oregon (to be appointed to OPMC, you must be an Oregon resident and taxpayer)
- Additional information (if you lived for a significant time in another region please describe)

Question 14: If you have a professional role in healthcare (including but not limited to patient care), in what parts of Oregon do those you serve live? (Check all that apply)

- Suburban/exurban
- Small town/rural
- Remote or sparsely populated areas
- Other (please specify)

Question 15: Please identify any relevant sector that you work in. Check any which apply:

- Consumer/community member
- Advocate/consumer or community representative
- Tribal Nations or other Tribal representative
- Community-based organization (such as a social service provider)
- Provider, hospital or clinic
- Public health agency
- Payer--Commercial health insurer, coordinated care organization (CCO), dental care organization (DCO), other

- Health insurance broker
- Health care association
- Employers/businesses not in the health care or social services sectors (private, nonprofit, etc.)
- Labor union
- State or local governmental agency (county or city) -- not including public health
- Research/academic (including students)
- Medical device/technology sector
- Other (please describe below)

Please describe how experience in the sector(s) above will inform your work with OPMC.

Question 16: Please describe any experience, knowledge, awareness, and/or skills you have with health equity, specifically with racial equity, and how it might help OPMC and OHA staff better understand and advance health equity.

Question 17: Do you identify as a person "with lived experience" with health inequity (meaning someone who has personal knowledge about the world gained through direct, first-hand involvement in everyday events such as racism, homelessness, mental illness, etc.)?

- YES
- NO

Question 18: What is your current age? (Leave blank if you prefer not to answer)

Question 19: How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?

Question 20: Which of the following describes your racial or ethnic identity? Please check ALL that apply.

- Hispanic and Latino/a/x - Central American
- Hispanic and Latino/a/x - Mexican
- Hispanic and Latino/a/x - South American
- Hispanic and Latino/a/x - Other
- Native Hawaiian and Pacific Islander - Chamoru (Chamorro)
- Native Hawaiian and Pacific Islander - Marshallese
- Native Hawaiian and Pacific Islander - Communities of the Micronesian Region
- Native Hawaiian and Pacific Islander - Native Hawaiian
- Native Hawaiian and Pacific Islander - Samoan
- Native Hawaiian and Pacific Islander - Other
- White - Eastern European
- White - Slavic
- White - Western European

- White - Other
- American Indian and Alaska Native - American Indian
- American Indian and Alaska Native - Alaska Native
- American Indian and Alaska Native - Canadian Inuit, Metis, or First Nation
- American Indian and Alaska Native - Indigenous Mexican, Central American, or South American
- Black and African American - African American
- Black and African American - Afro-Caribbean
- Black and African American - Ethiopian
- Black and African American - Somali
- Black and African American - Other African (Black)
- Middle Eastern/Northern African - Middle Eastern
- Middle Eastern/Northern African - Northern African
- Asian - Asian Indian
- Asian - Cambodian
- Asian - Chinese
- Asian - Communities of Myanmar
- Asian - Filipino/a
- Asian - Hmong
- Asian - Japanese
- Asian - Korean
- Asian - Laotian
- Asian - South Asian
- Asian - Vietnamese
- Asian - Other
- Other - Don't know/Unknown
- Other - Don't want to answer
- Other (please specify)

Question 21: If you checked more than one category above, is there one you think of as your primary racial or ethnic identity?

- No. I identify as Biracial or Multiracial
- N/A. I only checked one category above
- Don't know/unknown
- Don't want to answer/Decline
- Yes, it is: _____

Question 22: What language or languages do you use at home? (Answer this question, then skip to question 28 if you use only English)

Question 23: What language would you prefer to use when communicating (in person, phone, virtually) with someone outside the home about important matters such as medical, legal or health information?

Question 24: What language would you prefer to use to read important written information such as medical, legal or health information?

Question 25: (Please skip this question if you do not use a language other than English or sign language) How well do you speak English?

- Very well
- Well
- Not well
- Not at all
- Don't know
- Don't want to answer

Question 26: Are you deaf or do you have serious difficulty hearing?

- Yes
- No
- Don't know
- Don't want to answer
- Don't know what this question is asking
- If yes, at what age did this condition begin?

Question 27: Are you blind or do you have serious difficulty seeing, even when wearing glasses?

- Yes
- No
- Don't know
- Don't want to answer
- Don't know what this question is asking
- If yes, at what age did this condition begin?

Question 28: Do you have serious difficulty walking or climbing stairs?

- Yes
- No
- Don't know
- Don't want to answer
- Don't know what this question is asking
- If yes, at what age did this condition begin?

Question 29: Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering or making decisions?

- Yes
- No
- Don't know
- Don't want to answer
- Don't know what this question is asking
- If yes, at what age did this condition begin?

Question 30: Do you have difficulty dressing or bathing?

- Yes
- No
- Don't know
- Don't want to answer
- Don't know what this question is asking
- If yes, at what age did this condition begin?

Question 31: Do you have serious difficulty learning how to do things most people your age can learn?

- Yes
- No
- Don't know
- Don't want to answer
- Don't know what this question is asking
- If yes, at what age did this condition begin?

Question 32: Using your usual (customary) language, do you have serious difficulty communicating (for example, understanding or being understood by others)?

- Yes
- No
- Don't know
- Don't want to answer
- Don't know what this question is asking
- If yes, at what age did this condition begin?

Question 33: Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

- Yes
- No
- Don't know

- Don't want to answer
- Don't know what this question is asking
- If yes, at what age did this condition begin?

Question 34: Do you have serious difficulty with the following: mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations?

- Yes
- No
- Don't know
- Don't want to answer
- Don't know what this question is asking
- If yes, at what age did this condition begin?

Question 35: Please describe your gender in any way you prefer (You may leave this question blank if you prefer not to answer.)

Question 36: Please describe your sexual orientation/identity in any way you prefer. (You may leave this question blank if you'd prefer not to answer.)

Public Comment Summary and Responses Oregon Pain Management Commission Membership Report

Disposition of Public Comments

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Discussion Table

IDs/#s	Summary of Issue	OHA Response
1	<p>The pain commission lacks members who are experiencing chronic pain and who represent others who experience chronic pain. Current members are selected in an unfair process. The Commission is not fulfilling the statutory duty for the director to request and consider recommendations from others in determining membership. There are unfilled vacancies on the Commission, and statute requires that the OHA director request and review recommendations from various groups in making appointments.</p>	<p>Two members of the Commission have lived experience with chronic pain but no professional healthcare licensure. Generally, there have been two seats on the Commission for members (generally referred to as “public members”) who are not licensed healthcare professionals but who have lived experience with significant pain, though there was a vacancy from July 2023 to June 2024. For the other seats, staff work to ensure representation from a variety of healthcare professions and areas of the state as well as a demonstrated commitment to evidence-informed pain care. As described in the report, statute gives broad discretion to the OHA director in appointing Commission members.</p> <p>In addition to the public members, some members with professional licensure have said they have lived experience with significant pain. They are selected largely on their professional expertise and experience caring for patients with pain. As specified in statute, all members are</p>

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Disposition of Public Comments

IDs/#s	Summary of Issue	OHA Response
		<p>responsible to represent the concerns of patients with pain.</p> <p>Staff will again begin recruiting to fill vacant positions this Fall. While staff believe its current method of requesting comments (asking applicants to include a letter of recommendation) is compliant with the law, we will include in future recruitments a method by which people other than applicants can independently recommend a person for membership. Such recommendations will be treated as additional letters of reference for applicants.</p> <p>In 2025, the Commission will review its bylaws and consider changes to bylaws at a public meeting where public comment is heard.</p>
2	<p>Commenters believe the Commission does not hear their voices or incorporate their feedback. There are discrepancies between how it operates and what is in the law and Commission bylaws. The Commission has a statutory role to represent the concerns of patients to the governor and legislature and has not been doing that. The last report produced by the Commission was published in 2019. Instead, it has focused more on developing the Pain Module.</p>	<p>In addition to the “public” members noted above, the Commission hears testimony at every meeting from members with concerns about pain care and the Commission’s work. During public meetings of the Commission, members frequently respond to commenters and incorporate their concerns into the Commission’s work product.</p> <p>For example:</p> <ul style="list-style-type: none"> • In February, 2024 after public comments recommending this, the Commission endorsed the Centers for Disease Control (CDC) Clinical Practice Guideline for Prescribing Opioids for Pain • The current draft 2025 pain module contains content from the CDC guidelines as well as from the Oregon Medical Board. Commissioners requested inclusion of this content partly in

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Disposition of Public Comments

IDs/#s	Summary of Issue	OHA Response
		<p>response to public comments.</p> <ul style="list-style-type: none"> Commission staff is currently completing a qualitative report to the governor and Legislature summarizing public comments at Commission meetings. Initial posting for public comment is planned for September 2024, with final submission in November. The Commission will produce similar reports annually in June, so that the governor and Legislature are informed about the concerns of patients, family members and caregivers. <p>The Commission has focused primarily on the Pain Module in recent years. This module is used by licensed healthcare professionals in Oregon in order to meet continuing education requirements established by the Oregon Legislature.</p> <p>The report referred to in public comments was on the pain curricula of higher educational institutions and is no longer required by current statute.</p>
3	Some patients experiencing chronic pain need to use opioid medications long-term. Patients are having difficulty accessing these medications due to inappropriate restrictions and because providers don't want to treat them, or don't want to prescribe opioid medications. Some providers have expressed that they fear professional discipline if they continue to prescribe opioids.	The Commission supports individualized risk assessment in conjunction with opioid prescribing that is in alignment with the updated 2022 CDC Guidelines for Prescribing Opioids for Pain. The evidence base that long-term use of opioid is effective for chronic pain is limited. The Commission also promotes pain management strategies that focus on multidisciplinary treatment modalities that support the subjective and

Public Comment Summary and Responses

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Disposition of Public Comments

IDs/#s	Summary of Issue	OHA Response
	<p>In addition, the Commission is overly focused on addiction. It should focus less on the risks of opioid medications and non-opioid treatments. By promoting non-opioid treatments, the Commission is promoting fringe science. It should focus more on the needs of patients facing challenges accessing opioid medications.</p>	<p>complex nature of pain.</p> <p>The Commission believes that patients experiencing substance use disorders should receive appropriate treatment. The Commission does not, however, have a statutory role in providing guidance on addiction treatment but on treatments for the management of pain, including chronic pain. For patients with both substance use disorders and pain, both conditions should be appropriately managed. Commission discussion does include assessment of risk of addiction in association with certain pain treatments, especially opioid medication.</p> <p>The 2022 CDC guideline endorsed by the Commission addresses various aspects of opioid prescribing, including the importance of assessing risks and benefits before prescribing and when increasing doses as well as the risks of abrupt dose reductions or tapers.</p> <p>While no single treatment is effective, available or appropriate for every person experiencing pain, the Commission advocates for an individualized, multidisciplinary approach based on the biopsychosocial model. This aligns with the CDC guideline recommendations to maximize use of nonpharmacologic and nonopioid pharmacologic therapies for acute, subacute and chronic pain.</p> <p>Further, the Commission agrees with the CDC and commenters that guidance on dosage and tapering should not be used as an inflexible, rigid standard of care. Rather they should be guideposts to help inform</p>

Public Comment Summary and Responses

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Disposition of Public Comments

IDs/#s	Summary of Issue	OHA Response
		<p>individualized clinician-patient decision-making.</p> <p>Finally, the Commission recognizes that patients have experienced—and are experiencing—disruptions in care, including disruptions to opioid prescribing. While some of this is due to shortages of providers in particular areas of the state, some disruptions are related to efforts to decrease inappropriate prescribing. While the Commission recognizes the challenges faced by patients experiencing interruptions in care, the regulating the activities of insurance plans, licensing boards and law enforcement agencies are out of scope for the Commission. The Commission can consider collaborative efforts with other groups to improve pain care in Oregon and make related recommendations or statements.</p>
4	<p>The SB607 report should have been conducted by someone other than Commission staff or the Commission itself, and comments should have been sent to that party instead of Commission staff.</p> <p>The SB607 report was only posted for a 24-day public comment period. It should have been posted longer to allow more comments. The report should have been disseminated more widely and there were no instructions posted on how to comment on the report.</p>	<p>Because SB 607 required OHA to “study the membership” of the Commission, but did not provide specificity around the scope of the report or how it should be produced, OHA staff for the Commission (not the Commission itself) developed the report based on the statute, focusing on the Commission’s membership and related process. Because staff value public comment and were aware of some concerns underlying the bill, staff decided to post the report for public comment and to respond to each comment in this document. The 24-day comment period was selected to allow time for staff to address public comments prior to the deadline for finalizing the report. Staff have revised the report based on public comment.</p>

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		<p>An independent review requires funding from the Legislature. SB607 did not include such funding.</p> <p>The public comment period was advertised using an email list of over 8,000 email addresses of people who registered for updates about the Commission’s work. We are grateful to have received 13 responses representing over 140 people.</p> <p>We recognize that we can do better to ensure Oregonians know about opportunities for public comment. When posting future reports for comment, we will make them more prominent on our web site and consider other methods for dissemination as well as longer comment periods.</p>
5	Commission members and staff have conflicts of interest with regards to Commission work and other work they do. They should be required to disclose these and someone should look into these conflicts.	Like other public officials in Oregon, Commission members and staff are required by law to disclose conflicts of interest and potential conflicts of interest. In addition, Commission members fill out an annual conflict of interest survey and their professional roles are listed on the Commission web site.

Commenters

Identification	Stakeholder
A	Oregon Pain Action Group (Signed by 135 individuals)

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B	Amara M.
C	Bradley Spain
D	Emily Wise
E	Jenifer Van Riper, Jenny Rasmussen, Claire Ruth Van Riper
F	John Whitehead
G	Katie Zinno
H	K Judson
L	Melanie Beasley
M	Sarah Terzo
N	Wendy Sinclair
O	Westly Hardt
P	Katie Marie Barr

Public Comments

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A1	<p>SB607 is a small but an important bill, with thousands of Oregonian voices behind it. SB607 was created because the pain community is lacking representation within the Oregon Pain Management Commission (Commission) membership which shows cracks within the foundation of the Commission. Especially within the past seven years, the pain community is witnessing and experiencing discrepancies within the current membership and the intended purpose, bylaws, and required/intended membership. We need better oversight and accountability, including an impartial, third-party study of the membership that examines whether the Commission has (and had in recent years) adequate membership to represent patients. The report from SB607 needs to include member balance, integrity, possible conflicts of interest, and inclusion of the pain patient/advocate population. This bill took three years for patient/advocates working with a representative and then a senator to get the bill passed. We are hopeful that these efforts will better align the Commission membership with the needs</p>	<p>The Pain Management Commission has had, and continues to have, representation from individuals that have lived experience with chronic pain. One of the signers of this letter, Chavala Bates, was recently appointed to fill a vacancy on the Commission.</p> <p>SB607 required OHA (not an independent party) to develop a report on the membership of the Commission, without further specifics. Staff knowledgeable about the appointment process created the report and it was reviewed by several levels of management.</p> <p>OHA staff, Commission leadership and the director carefully consider the balance of perspectives on the</p>

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	<p>of the people living with pain in Oregon.</p>	<p>Commission in making appointments and believe the Commission’s activities are conducted according to relevant laws and bylaws. All OHA staff are subject to relevant laws and regulations regarding integrity and conflicts of interest.</p> <p>The draft report included two recommendations for improving the statutory membership specifications. In response to public comment as well as membership-related operational changes that will be implemented based on public comment.</p>
A2	<p>The Commission was legislatively created in 1999 to bring awareness to the Governor, legislature, general population, and medical community about issues facing the pain community.</p> <p>It was meant to give the pain community representation and a voice. When the Commission first started it fulfilled its intended purpose and their efforts were beneficial to people who live with life-impacting pain. Unfortunately, this has changed. We believe, in large part, due to some critical issues within the membership of the Commission and efforts to focus attention away from the bylaws and missions and the primary duties in exchange for focusing on additional duties that would rather be performed.</p> <p>Here are some concerns we have about the recently released SB607 draft report:</p>	<p>Thank you for your comment acknowledging the long history and original purpose of the Commission.</p> <p>You are correct that one of the roles of the Commission is to “Represent the concerns of patients in Oregon on issues of pain management to the Governor and the Legislative Assembly.” Despite that mandate, there is no legislative requirement to develop a report, and OHA staff had prioritized other deliverables specified in the law, especially the curriculum for the Pain Module provided to help licensed providers meet Legislative requirements for pain education during license renewal.</p> <p>In 2024, based on public comment and requests from Commission leadership, OHA staff is developing a report which will include qualitative analysis (to be published in October of 2024) of verbal comment offered at Commission meetings from 2022-2024. The Commission will continue to produce similar reports annually. In addition, in early 2024, the Commission endorsed the</p>

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		2022 CDC Guidelines for Opioid Prescribing, partly to address the concerns of people who have testified to the Commission.
A3	<p>In SB607, it states that the Oregon Health Authority shall study the membership of the Commission, but what has happened is the Commission staff (who is highly involved with appointing new Commission members) and his Manager are studying the Commission membership and authoring the report. The Commission is essentially studying itself. One might say there's no one who knows the Commission better than the Commission staff who has been very involved with many aspects of the Commission and selecting applicants for membership, but therein lies the problem, with that much involvement comes an absence of objectivity. If the membership required changes or adjustments or if there was anything lacking in the membership, then the staff would have to criticize themselves. This seems like it could be a conflict of interest, which is one of our concerns within the Commission membership already. We question whether this was the intent of the legislation when it passed the bill, because we were under the impression it was not. Nowhere in the bill does it say the Commission shall study and report on the Commission.</p>	<p>You are correct about the developers of the report. SB607 did not provide a requirement for an external report or a requirement for an independent review." Because SB 607 required OHA to "study the membership" of the Commission, but did not provide specificity around the scope of the report, OHA staff for the Commission (not the Commission itself) developed a report to describe the Commission's membership and recruitment practices and posted it for public comment, and will make revisions based on these comments. We have added the authors' names to the report. If the Legislature desires an independent review, funding would be required.</p> <p>Within the broad parameters of the statutory requirements for membership, staff have long recruited for openings based on the current mix of members. This includes acknowledging the needs for diverse representation throughout the state, clinical license types and representation of people with lived experience. Staff consider a variety of factors for submitting candidates to the Director of OHA for appointment and disagree that there is the lack of ability to be critical or objective in decision making. In fact, staff have recommended changes to the statutory membership criteria to codify the practice of ensuring three seats are reserved for people without healthcare licenses with significant lived experience with pain. Whether or not the Legislature acts,</p>

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		going forward, Commission staff will recruit three members meeting these criteria, including people who are caregivers of people with lived experience of significant pain.
A4	Also, the Commission staff is allowing 24 ½ days to comment, instead of the normal 30-day commenting period. We hope this doesn't limit the responses but are even more concerned that people will not comment because they don't believe they will be heard.	Senate Bill 607 contains no requirement to post the report for public comment. For transparency, and to improve its report, staff believed it was appropriate and necessary to post the report for public comment and selected a 24-day comment period to allow time to address comments prior to delivering the report to the Legislature by the prescribed deadline. We are grateful to the community for providing these comments.
A5	Since the Commission staff is studying the Commission, we must give feedback on the draft report to the same recipient at the same email address where we have commented many times before. The lack of Commission member response and interest in our comments is a reason we requested this bill. If an independent third party conducted the study and report, the public will feel more comfortable commenting if they disagree with the study and feel they need to contradict something in the draft report. It is uncomfortable, especially for people who frequent the Commission meetings and try to be as agreeable as possible to promote goodwill.	<p>Thank you for your comments. OHA staff appreciate the frank comments and efforts towards goodwill. Valuing the voice of community members is an important goal at OHA. It is for this reason we are preparing the separate report summarizing member comments from 2022-2024.</p> <p>Commission members are appointed by the Director and each makes their own decisions about how to respond to public comments expressed in public meetings. Staff have observed that members do often interact with commenters or incorporate patient concerns into their direction to staff. This has recently been the case with the feedback on the pain module as well as the direction to generate a report summarizing patient concerns. As staff we seek to treat all who testify with respect and dignity, even though we are unable to fully address all concerns.</p>

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A6	<p>Another concern is that the Commission was supposed to be submitting regular reports to the legislature and the Governor. The reports were to focus on patient concerns and the issues they face, to ensure our vulnerable population of disabled and pain patients never went without representation. The last report the Commission submitted to the legislature was in 2019 and we are not aware that they have ever submitted to the Governor. We were told they'd be submitting a legislative report as part of SB607, but we haven't seen it yet.</p>	<p>Current statute contains no requirement for the Commission to submit regular reports to the legislature and Governor. That said, such a report will be published in October for public comment and submitted to the Governor and Legislative Assembly later in 2024 once comments have been addressed.</p> <p>Previous statute (ORS 413.572) did require a report on pain management curricula of certain Oregon educational institutions of higher education. The last such report was created in 2019. The Commission was not able to create such a report in 2021 due to resource constraints; the requirement was removed from statute in HB 2078 (2021). The Commission is producing a report summarizing public comments over a three-year period, and will continue to develop that report each biennium.</p>
A7	<p>The title of the draft report gives the impression the Health Policy and Analytics Department (HPAD) has some involvement in writing this report or studying the Commission. This seems misleading. While technically the Commission is "under" this department, we confirmed the HPAD is only reviewing the report at some point in the future after the draft report's completion, not authoring it or conducting the study. We believe it is important that the actual authors of the report are properly listed on the document to provide transparency.</p>	<p>Commission staff work under the auspices of the Health Policy and Analytics Division. You are correct that Division leadership will review the report, including these comments, prior to it being delivered to the Legislative Assembly as required by the bill.</p> <p>We will add the authors' names to the report for transparency.</p>
A8	<p>On page 3 of the draft report, the Commission states that the pain module is their primary responsibility, but in ORS 413.570 and 413.572, the Commission's primary and additional responsibility are listed. The pain module is listed under additional duties, not under primary responsibility. This is important because it is a pivotal point that shows the membership has strayed from their responsibilities and are actively trying to eliminate them in favor of secondary responsibilities that they are most interested</p>	<p>Thank you for identifying the Commission's governing statutes. While the Pain Module (referred to in statute as a pain curriculum) is listed under "Additional Duties," it is a specific deliverable that must be produced every two years. Given the Commission's limited staff, that has been a primary focus.</p>

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	<p>in performing. Even before the Commission showed their focus by stating the module as their primary responsibility in the draft report, they have voiced this opinion during meetings. We are deeply disappointed by this, because the patient and disability community deeply needs representation and the benefits the Commission used to embrace responsibilities and bylaws. In addition, the current (soon to be past) pain module is severely lacking in patient voices and input. The primary duties of the Commission are listed in the above ORS: to develop pain management recommendations; Develop ways to improve pain management services through research, policy analysis and model projects; and to represent the concerns of patients in Oregon on issues of pain management to the Governor and the Legislative Assembly.</p> <p>To notify them of patient concerns they must first solicit what those concerns are and interact with patients or include members on the Commission who represent those patient voices. Also, it appears the Commission could be conducting private meetings to go over the final pain module draft, without inviting or informing the public and without any patient/advocate voices.</p>	<p>As described above, OHA staff are developing a separate report to describe the concerns of patients to the governor and legislature. In the past, Commission members did prepare analysis and participate in a task force recommending additional services for chronic pain be covered under the Oregon Health Plan, though HERC decided not to make changes based on the task force’s recommendations.</p> <p>The Commission receives written and verbal comments from the public at each meeting. The Commission also complies with public meeting law, which allows staff to meet with Commissioners to collaborate on Commission work as long as a quorum is not created and all decisions are made in an open meeting.</p>
A9	<p>The Commission draft report states that they now have no term limits, but they previously did. At their November 2023 meeting it was stated that one of their members had exceeded their two terms, but between now and then they have eliminated the limit on terms. We’d like to object to no term limits. Without opening seats to new members, new voices bringing new ideas, and fresh thought, a group like this, especially when it seems to limit the applicants based on their alignment with existing ideologies, is in danger of a version of regulatory capture.</p>	<p>You are correct that members have been limited to two terms, though none are specified in statute. The term limits are referenced in statute and the bylaws and we have corrected the report accordingly.</p>
A10	<p>Legislation requires 19 members for the Commission. The draft says there are 13 members, but Appendix A, which they include in the draft only lists 12 members. There are no members who are pain patients or advocates representing other pain patients. According to the missions and bylaws and the intent of the bill that created the Commission, patients and advocates would be critical seats to fill, there hasn’t been</p>	<p>As stated in the draft report, there are 19 members, though two are to be appointed by the Legislature. Of the remaining 17 seats, four were vacant at the time the draft was published. Since the draft report was published, three new members were appointed and one members’ term</p>

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	<p>one patient or advocate seat filled in over a year.</p> <p>Also, there are supposed to be two seats filled by Legislative members, we are not aware that both seats have been filled. One seat was filled several years ago, but we don't think that member attended any meetings.</p>	<p>expired, bringing total membership to 15 members. Staff will conduct additional recruitment in the fall of 2024.</p> <p>We disagree that patients with chronic pain are not represented on the Commission. The Commission has long had two "public members," who are not licensed providers but who do have lived experience with chronic pain (among other qualifications). Currently, Michelle Marikos and Chavala Bates (one of the signers of your letter) serve as "public members." Before Bates' appointment in July 2024, there was a vacancy for one of these seats since a previous member's term ended July 31, 2023.</p> <p>All the licensed members of the Commission have direct clinical working relationships with people in pain and consistently advocate on behalf of their patients. Some of these members also have personal significant experiences with chronic pain.</p> <p>You are correct that the seats reserved for legislators have been vacant since February of 2021 when former Representative Sheri Schouten served on the Commission and attended several Commission meetings. Staff are working with the Legislature to fill these seats.</p>
A11	<p>Also, in the draft report the Commission shared their application questions which shows some possible scoring inequities for patients, advocates, and the public member since they usually lack a professional role in healthcare which is required to answer question 13 and 14 and receive points for those questions. Also, during the Commission meeting in November of 2023, the Commission says that with their scoring they can capture the professional experience they are looking for. Is that why</p>	<p>Questions 13 and 14 are included to provide applicants with professional healthcare roles an opportunity to describe their credentials and the geographical areas where they serve. As specified on the survey, other applicants are not required to answer these questions. Members do not receive specific "points" for specific</p>

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	<p>there are so many more professional seats filled and zero patient/advocate seats and only one public member seat filled? Where is the balance?</p> <p>Pain patients/advocates who represent other patients, and with lived experience, have an important role within the Commission, it is essential they have a seat at the table.</p> <p>This cannot be stressed enough. Patient voices are necessary to adequately complete the Commission’s purpose and provide balance, perspective, and information. During the last call for applicants in November of 2023, the Commission did not open applications for patient/advocates members, even though there is not even one member filling this required role. Terms for new Commissioners begin on July 1st and without any call for patients or advocates, we will be without representation for at least another year.</p> <p>Given the purpose of the Commission and the bylaws, it seems that patient/advocate seats should be required to be filled. We are aware of applicants within this category who have applied, so this lack of representation isn’t because no one is applying but because applicants aren’t even allowed to apply for these seats. This conveys devaluing of patients’ voices and denies inclusion of patients’ voices which is directly contrary to the Commission bylaws.</p>	<p>application questions but are scored according to the Evaluation form in Appendix C. At the request of OPMC leadership, this form was revised in 2024 in order to include “clinical group, non-profit or government representation experience” in addition to clinical experience so that applicants can be given credit for relevant experience outside of clinical care.</p> <p>We agree that having the voices of people who live with chronic pain on the Commission is crucial. See the response to A10 above.</p> <p>Due to the requirement to develop professional education materials and the large number of different licensed health care license types listed in the membership statute, Commission staff has recommended that a majority of seats be dedicated to licensed professionals for whom a significant portion of their practice is dedicated to pain care. As noted above, the two remaining seats have been long been reserved for “public members” who have been people without health care licenses who are selected largely for lived experience with chronic pain. Staff will begin recruitment for a third member with lived experience of pain or who is a caregiver of a person experiencing pain, and who is not a licensed healthcare provider. Refer to these as “members with pain-related lived experience” rather than “public members” in the future</p>
A12	<p>Because of a huge slant toward substance use disorder and opioid use disorder, which doesn’t serve the nonaddicted pain patient population, we ask that pain patient/advocate/public members not be associated with addiction groups or have an</p>	<p>The Commission endorses a multifaceted approach to pain treatment.</p>

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	<p>addiction focus within the Commission. In recent years, the Commission has been heavily weighted toward nonpharmacological pain care which doesn't work for everyone.</p> <p>Information, especially in the pain module, has been scant and not supported despite patients who benefit from medications. For most chronic pain patients, a combination of treatments is necessary to give the best quality of life, however, to ignore tools (medications) that are available and beneficial to patients can cause harm.</p>	<p>In line with the 2022 CDC Guideline on Opioid Prescribing, the Commission advocates for maximizing non-opioid treatments (including medications) and for individualized consideration of the benefits and harms of any treatment, including non-opioid and opioid medications.</p> <p>Different medications indicated in the treatment of chronic pain are associated with different levels of risk.</p> <p>While all medications have risks, patients taking opioid medications for pain face a dose-dependent risk for addiction, overdose and death. Addressing this risk is an appropriate part of the Commission's role when considering the broad range of clinical interventions available for the treatment of pain. Patient safety is a critically important factor in evaluating any treatment option. While substance use and associate disorders are discussed by the commission, this is not their primary focus. The membership understands the clinical differences between the substance use disorder and pain treatment.</p>
A13	<p>We are a little confused because on page 6 of the draft report, it says there are three changes the Commission staff recommends but then they go on to list only two. We would like to see the third suggestion.</p>	<p>We apologize for the error. There are only two recommendations included in the report. A third recommendation regarding the seats reserved for Legislators had been considered but was removed in editing after review of existing statute.</p>
A14	<p>Also, in their second suggestion, we would like to stress that public members are not the same population as the pain patient/advocate members who represent pain patients. The public member doesn't have the added responsibility of representing</p>	<p>We agree that the requirements of ORS 413.574 are not clear regarding the "member of the public" membership qualification, or about the composition of the</p>

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	<p>other patients in pain, but according to ORS 413.574 the patient/advocacy members must not only represent themselves, but they must be a voice for other people in pain. The statute makes it clear these are two separate groups not only by giving additional responsibilities, but the statute lists them separately for membership consideration. In addition, the documents and discussions surrounding the Commission and its creation, and its purpose and bylaws make clear the distinctions between the two groups as special emphasis is given to the patient/advocate population. These two groups (public member and pain patient/advocate) must not be merged, to do so would not only violate ORS 413.574, but the purpose and spirit of the Commission membership. The groups remain separate with an emphasis on including pain patients/advocates who represent other pain patients as a welcomed and sought after member of the Commission. We are concerned because the patients/advocates seats have been vacant for a year and in the Commission’s last call for applicants, (at the November 2023 meeting) a notice for a public member was requested, as well as two professional members, but no pain patient/advocate members requested. Applicants who requested to fill patient/advocate seats were considered only for the public member seat, not pain/advocate seat. Also, according to ORS 413.574, the public members on the Commission aren’t required to represent other patients, but the pain patient/advocate members have that additional responsibility which is a necessary component to present a full accounting of voices of people with lived experience. This is a huge oversight and should be reported in the draft report for SB607, since this strays from the membership ORS, and from the bylaws and purpose which is for Commission members to be highly informed of patient concerns and input. The patient and advocate group should be the priority with many members, not forgotten as it is now on the Commission.</p>	<p>Commission. In the absence of clear guidelines, the director has appointed representatives of a variety of clinical licensures as well as—for two seats— people with lived experience with chronic pain but no professional licensure. Staff will recruit for an additional seat for a member with lived experience of pain or who is a caregiver of a person experiencing pain. As stated above, we disagree that the Commission’s membership does not include people with lived experience with chronic pain or does not represent pain patients.</p> <p>The Legislative authority in ORS 413.570 is for the Commission to represent the concerns of patients with chronic pain applies to all members of the Commission, not just the public members.</p>

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A15	<p>The request for public comment on the draft report by the Commission only went out by LISTSERV (those subscribed to the OPMC emails) which is roughly 4,000 people. It is not getting dispersed statewide nor have we seen the request for public comment posted on the commission website. As far as we could find, all that is posted is the draft report under Reports & Publications. There are no instructions for the public to comment on the website.</p>	<p>Thank you for describing the distribution method for the survey. We understand that the web site could have been clearer and will make it clearer when posting future reports for public comment. Still, we are encouraged that we received 13 public comments representing over 140 people. There are currently over 8,000 members on the OPMC listserv. For future reports, we will circulate with partners who are likely to be interested, and we are open to suggestions for how to disseminate reports like this more widely in the future.</p>
A16	<p>ORS 409-050-0120 states, "Prior to making appointments, the Director of the Oregon Health Authority shall request and consider recommendations from individuals, public and private agencies and organizations, but not limited to individuals with a healthcare background or individuals representing the healthcare industry or members of the public." This statement sets forth a process for appointing new members to the Commission. This is not the current process that is used. Currently the Commission staff and possibly the chair and vice chair decide which seats need to be filled and they open applications. Once an applicant applies, the Commission staff (and possible the chair and vice chair) then vets the applications and forwards a select number presumably to the Director for appointment (it is possible other departments give their approval for preferred applicants, but we have not confirmed that). However, at no point have we (as founders of a pain advocacy group/ pain patients/members of the disability community and members of the public) been aware of a request from the Director of the OHA for recommendations for new members. We have not been allowed to give recommendations to the Director of the Oregon Health Authority. If we were able to give recommendations directly to the Director, the membership may better represent the people in pain that it serves. The current system doesn't seem to be in alignment with ORS 409-050-0120, or at the least the current process lacks any direct access to the Director of the OHA and by the time the applications reach the director, many have been eliminated. We ask that this ORS be reinstated as the</p>	<p>Thank you for this recommendation. In the future we will include in our recruitment announcement a way for members of the public who are not applying to recommend others who apply for membership.</p>

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	process to appoint new members.	
A17	<p>Conflicts of interest for Commission members need to include individuals who create or benefit from their own pain-related business because of their position on the Commission.</p> <p>We need balanced ideologies about pain among Commission members without potential members being screened for alignment with any predetermined preferred ideology.</p>	<p>Conflicts of interest are defined in statute. Excluding members who own businesses or otherwise work with pain patients would leave the Commission without important expertise needed to fulfill Commission duties. Members fill out a conflict of interest survey and are subject to conflict of interest law, the same as other public officials. The Oregon Ethics Commission has recently created training materials on ethics law and we will provide these to members.</p> <p>Although there is no “predetermined ideology” that is a requirement for membership, applicants’ commitment to evidence-based pain care is considered. A variety of views about pain management are held and expressed by Commission members.</p>
A18	Members in the pain/advocacy community who represent other patients should be required on the Commission. We ask that there be at least three seats filled by people in this category so they can provide a voice in the Commission to adequately fulfill their purpose. We ask that these seats are not ignored, as they are now, with a complete lack of interest and efforts to include patients and advocates on the Commission, which is the opposite of the bylaws of the Commission and run contrary to the intent behind the creation of the Commission.	We are unsure why you are saying that the public member seats are ‘ignored’ and disagree that there is a ‘complete lack of interest and efforts to include patients and advocates on the Commission.’ All members of the Commission share a responsibility to advocate for patients experiencing pain.
A19	We ask that Commission members’ focus return to their primary responsibilities, bylaws, and missions, and for the pain module to be revised to include a section on medication management for patients who benefit from long term opioid medication treatment. We also ask the patient perspective and lived experiences influence the	The Commission’s primary focus has been on producing and updating the legislatively mandated Pain Curriculum (often referred to as the Pain Module). In addition, the Commission will begin creating a report representing the

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	creation and content of the module.	<p>concerns of patients as expressed at public meetings.</p> <p>The new (2025) draft pain module contains a section on opioid medications, drawing from the 2022 CDC opioid guideline and recent publications by the Oregon Medical Board. This reflects requests made in public comment and by Commission members.</p>
A20	We ask the Commission to eliminate misleading terms and fringe science that can give incorrect impressions such as the term pain science, which is not based in science, even though the term suggests it is, and is not Nationally accepted.	<p>We disagree that the Commission uses “misleading terms and fringe science.” Pain science is based on scientific research about the experience of pain and about the effectiveness of different treatments of pain. The Commission references and bases its work on nationally accepted standards of care that are in alignment with federal agencies, educational institutions focused on pain research, peer reviewed professional journals and respected professional associations focused on pain research. This includes the CDC, U.S. Department of Human Services, and the International Association for the Study of Pain (IASP) as several examples among a wider range of resources.</p> <p>The Commission references and bases its work on nationally accepted standards of care that are in alignment with federal agencies, educational institutions focused on pain research, peer reviewed professional journals and respected professional associations focused on pain research. This includes the CDC, U.S. Department of Human Services, and the International Association for the Study of Pain (IASP) as several examples among a wider range of resources.</p>

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A21	<p>We recommend more transparency with the process for appointing new members and ask that applicants who are not accepted be informed of why they were not accepted on the Commission since so many pain patients and advocates have not been chosen as members without understanding why.</p>	<p>Members not selected are informed if not appointed after each round of appointments.</p>
A22	<p>We ask the Commission to submit regular reports to the Legislative Assembly which highlights all patient concerns and solutions with current emphasis on abandoned patients.</p> <p>We ask the Commission to begin to submit reports to the Governor highlighting all patient concerns.</p>	<p>A report reflecting the concerns of patients as expressed in OPMC meetings during a three-year period is currently in development. We plan to post it in September, 2024 for public comment and reviewed it with the OPMC prior to submission to the Governor and Legislative Assembly. Based on feedback from the public and legislative leadership, we will explore a regular process for providing the Legislature and Governor with this information in a way that helps guide their work.</p>
B1	<p>I am writing regarding the draft report on SB607, it states that the Oregon Health Authority shall study the membership of the Commission, but the Commission is writing the draft report. While technically the Oregon Pain Management Commission is part of the Oregon Health Authority, I do not believe this was the intent of SB607 to have the commission itself report on itself.</p> <p>If one goes back to the public comments from the past six years, there is a common theme that emerges regarding membership concerns. Did the commission encapsulate this in the draft report? No. A missed opportunity.</p> <p>There has not been a report to the legislature and Governor regarding the concerns of patients in Oregon since 2019. There has been a palpable downplaying of the patient's voice in the past six-plus years. Many in the community no longer feel like showing up to give testimony anymore. There is not a patient member or patient advocate representing the Pain Commission, another missed opportunity.</p> <p>Going by the by-laws and original mission statement, the patient voice was supposed to be a central component of what the commission stood for and worked with. I also</p>	<p>Thank you for your comments. Many of the concerns you raised were addressed in the responses to the Oregon Pain Action Group letter you referenced.</p> <p>See row 1 of the Summary Table above, and the following rows above related to specific concerns:</p> <p>A1 (concerns about who wrote the report),</p> <p>A2, A22 (regarding representing patient concerns to the legislature and governor's office)</p> <p>A12 regarding concern about a focus on addiction</p> <p>A10, A11, A14, A19 related to patient voice and selection of members.</p> <p>A10 regarding Legislative members</p>

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	<p>feel it is important to have members from the legislature fill the member seats it is intended to fill in this regard. Having a connection with the legislature on the commission as intended keeps the state close to the pulse of pain issues in Oregon, with one less layer to break through. It also helps keep things accountable, in my opinion.</p> <p>Like with any group, the commission is only as good as its parts, why membership is so important. Oregon is in a state of emergency with pain care. The aggressive push to de-prescribe, force taper, and vilify a valuable medication for many with specific and serious medical conditions, caused unmeasurable harm. We are swimming in the aftermath of that shipwreck and the patients are paying the price, right now, and seething more needs to be done.</p> <p>When patients gather the strength to show up and share very personal stories and struggles in public testimonies and there is no follow-up no discussion just silence, this is not going to encourage more to share and engage.</p> <p>We have mentioned in past testimonies written and verbal that we had many concerns about membership being cherry-picked to reflect a specific narrative. While we are seeing a shift for the better, the report failed to cover any past memberships or common themes of concern by the public in past testimony. If we can not reflect we can not learn. There is still work to do in my opinion.</p> <p>This draft report to me felt like a technicality that was just being dealt with.</p> <p>Given this is primarily a community of people with disabilities, complex health needs, and or real physical challenges, I was surprised to see the comment window being less than 30 days, which seems to be what other OHA reports are given.</p> <p>Pain care has many moving parts, right now, access to care is a crisis. Finding providers to take patients who have been abandoned or neglected, underserved, find care and continuity of care. As it is now, if a provider moves away or retires, it is practically impossible for this person to find continuity of care. We know, we are on the front</p>	<p>A4 regarding 30-day comment period.</p> <p>With regard to opioid medications, the Commission has acknowledged the difficulties patients experience in obtaining medications.</p> <p>The Commission does provide a forum for receiving written and verbal public testimony but cannot address all situations or challenges presented.</p>

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	<p>lines hearing this. We do not need the pain commission to be an extension of denial of care or being dismissed.</p> <p>SB607 was an opportunity to address membership issues and the concerns of patients about the membership. I suggest part of this report is collecting current and past themes about membership concerns from the public comments verbal and written, and add these to the draft report.</p> <p>Please refer to the signed letter from Oregon Pain Action Group to see the full list of my concerns and my recommendations for improvement. I agree with the group letter.</p>	
C1	<p>I am writing this letter concerning SB607. The bill was put forth to express concerns in how the OPM is doing that which they are supposed to be doing. They first and foremost were supposed to be protecting pain patients, not addressing addiction which is not what this commission's focus was supposed to be about.</p> <p>I have a question in mind that should probably be asked by anyone in the legislator reading this email. Stating the question simply, would the OPM be policing themselves? Should there not be a third party organization doing this? (Seems like a huge conflict of interest.) Also why has there been no reports to the Governor since 2019? Is it not stated that the OPM would submit these reports yearly? (At least there are no reports on public record.) The OPM on the surface does not seem to care about transparency both to the people they are supposed to be serving and to the Oregon Government that they are supposed to be answering too. I would think that the Governor's office and legislative branch of the government would be highly concerned about this oversight. It seems to me that transparency is of the utmost importance, otherwise many could be harmed by a group that may not be following their stated goals that were originally laid out at their inception .</p> <p>I think too that it would be wise for the governor and legislative branch to look into possible conflicts of interest of those sitting on the board of the OPM. I wonder if there are quite a few of them that set on the board that are monetarily benefiting from their</p>	<p>The Commission's role and responsibilities are defined in Oregon statute (ORS 413.570-572). They include developing and updating a pain curriculum, developing pain management recommendations, developing ways to improve pain management and representing the concerns of patients on issues of pain management to the governor and Legislative Assembly.</p> <p>For your comments regarding the need for an independently developed report and the lack of reports since 2019, see response to comments A3 and A6 above.</p> <p>Regarding conflicts of interest, see responses to comments A1, A3 and A17 above.</p> <p>Regarding seats for "patient advocates" see response to comment A12.</p>

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	<p>positions.</p> <p>I would like to see the seats filled that were supposed to be filled by patient advocates. This would be a step in the right direction towards transparency and policing .Also it would be nice if there was a return to the primary focus to the commission's core values.</p> <p>Thank you,</p> <p>A pain patients concerned husband</p>	
D1	<p>To whom it may concern,</p> <p>This correspondence serves as my commentary on the Draft Report for SB607, a bill intended to address systemic issues within the Oregon Pain Management Commission (OPMC). I am a disabled member of Oregon’s pain community, a group comprised of those living with painful medical conditions/disabilities as well as our caregivers, loved ones, and advocates.</p> <p>The OPMC was created to bring attention to issues facing Oregonians living with high-impact pain, to raise awareness, and to present our concerns to the Governor, the Legislature, medical professionals, and the general public. It was meant to give pain patients/advocates a voice and much-needed representation. At its inception, the OPMC fulfilled its intended purpose. Unfortunately, the Commission has veered off course, gradually moving further away from its bylaws, primary duties, and mission, towards less important ancillary duties. Oregon’s pain community now lacks representation within the OPMC’s membership, partly due to this shift in focus.</p> <p>Myriad discrepancies and Conflicts of Interest (COIs) exist within OPMC’s current membership, which is clearly lacking oversight, accountability, and transparency. SB607 was intended to provide an impartial, unbiased, third-party assessment of the OPMC in order to address systemic issues with its current members, including COIs and lack of balance/integrity in its members, as well as the exclusion of pain</p>	<p>Thank you for sharing your concerns and recommendations. For most of the comments in this letter, see responses to commenter A.</p> <p>The history of the opioid crisis in the United States is described at https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html and https://crsreports.congress.gov/product/pdf/IF/IF12260.</p> <p>Though you are correct that the majority of opioid deaths are now from illegal opioids (often in conjunction with other substances), deaths from commonly prescribed opioids (including commonly prescribed medications) continue at high levels. In addition, patients who develop a dependence on prescribed medications may transition to illicit substances, creating additional risks if the illicit substances are not what the person expects.</p> <p>See the Oregon Overdose prevention dashboard for more details about overdoses and related hospital/ER visits for various substances over time.</p>

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	<p>patient/advocate input.</p> <p>The following is a list of concerns that I and many others share about the SB607 Draft Report:</p> <p>1) The OPMC is assessing and reporting on itself: SB607 states, “The Oregon Health Authority (OHA) shall study the OPMC’s membership,” but this did not occur. Instead, OPMC staff have assumed this role and have also authored the Draft Report. So OPMC staff responsible for appointing members and involved in many other aspects of the OPMC’s operations have also been tasked with assessing their own job performance despite the fact that these individuals undeniably lack objectivity. If discrepancies, red flags, or other issues with OPMC membership conduct were found, those who conducted the study and authored the Report would, of course, be criticizing themselves.</p> <p>In passing SB607, the Legislature couldn’t possibly have intended for the OPMC to study itself. OPMC staff members tasked with scrutinizing their own roles and conduct within the OPMC as well as authoring the Report would clearly have COIs; there is no doubt that they would be inherently biased in favor of protecting their own jobs and positions of authority. Ergo, the only possible conclusion the Draft authors could reach would be favorable. In what world is this a fair, objective, unbiased assessment and reporting process? This is highly unethical, reinforcing and strengthening our concerns that leadership within the OPMC is no longer fit for purpose.</p> <p>2) Time limitations for comment submission: Typically, the public is allowed 30 days to submit comments. However, we’ve only been allowed 24 days to comment on SB607. This reduced timeframe will limit the quantity of responses received and may cause people to avoid commenting due to concerns of not being heard. People living with disabling, high-impact pain conditions have little time and energy to accomplish what may seem like simple tasks to able-bodied people. We need as much time as possible to read the Report and draft comments. Is this time limit intentional, so as to suppress dissenting voices that do not align with the ideologies of those in power</p>	

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	<p>within the OPMC?</p> <p>3) Report feedback is reviewed by the same staff members conducting the assessment and authoring the Draft: Feedback on the Draft Report is directed to the same staff members conducting the study and authoring the Report. This should absolutely not be allowed and is an example of the lack of oversight and accountability rife within the OPMC. Any dissenting voices are suppressed at the whims of those in power, who apparently answer to no one.</p> <p>Historically, OPMC members have not shown interest in feedback from pain patients/advocates. Will our feedback be treated any differently in this case? In point of fact, the OPMC's total disregard for patient/advocate concerns was a primary driver of drafting SB607. An impartial third party didn't conduct the study or author the Report, so at the very least, our feedback should be reviewed by such a person. As it is, comments which contradict or disagree with the Report's findings will fall on deaf ears, rendering them essentially pointless. This needs to be remedied immediately.</p> <p>4) The OPMC should submit reports to the Legislature and Governor: An original goal of the OPMC was to submit reports to the Legislature and Governor to bring attention to concerns within the pain community. It was intended to ensure that pain patients were heard. We're a marginalized community of people with disabilities. Our voices need to be heard by policymakers, medical professionals, and health-related governmental organizations, but the last OPMC Report was submitted to the Legislature in 2019, and a report has never been submitted to the Governor.</p> <p>5) The Draft Report title is misleading and its authors are not divulged: The Report gives the false impression that the Health Policy & Analytics Department (HPAD) was involved in the assessment and/or authoring of the Draft. Technically, the OPMC operates under the HPAD, but the HPAD hasn't reviewed the Draft and will only do so after the Report's completion/release. Furthermore, the names of the Draft's authors aren't disclosed, yet another example of the alarming lack of transparency within the OPMC. Why are the author's names kept secret?</p>	

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	<p>6) The OPMC has shifted focus from primary to secondary responsibilities: The Draft states that a Pain Education Module is the OPMC’s primary responsibility. But according to ORS 413.570 and ORS 413.572, this is not a primary OPMC responsibility and is merely an additional duty. The OPMC is attempting to eliminate its primary responsibilities in favor of ancillary tasks they’d prefer to focus on, a sentiment that its members have made abundantly clear during meetings also. The OPMC’s current Module lacks input from the pain community and could be greatly improved upon, but it is not and should not be a primary duty of the OPMC.</p> <p>The OPMC’s primary responsibilities are to develop pain management recommendations; to develop ways to improve pain management services via research, policy analysis, and model projects; to represent pain patients on issues related to pain management access; and to submit regular reports to the Governor and Legislative Assembly to raise awareness of patient concerns. How can the Governor and Legislature address our concerns if they aren’t aware of them? Obviously, they cannot. The OPMC must shift focus back to amplifying patient/advocate voices, addressing barriers and lack of access to pain care, and acting as a bridge between pain patients/advocates and policymakers.</p> <p>7) OPMC term limits: The OPMC had term limits for its members, but these limits no longer exist. I believe term limits should be restored. If seats are never opened up to new members, things become stagnant and the OPMC devolves further into regulatory capture. The OPMC is known to reject applicants based on their alignment with the ideologies of its leadership. New members with differing perspectives and fresh ideas would restore some semblance of balance to the Commission’s membership, and restoring term limits would help us to achieve this.</p> <p>8) Empty OPMC seats should be filled: Legislation requires 19 OPMC members, but there are currently only 12, none of whom are pain patients/advocates. According to OPMC’s mission and bylaws, pain patients/advocates with lived experience are critical seats to fill. Not a single patient or advocate seat has been filled in over a year. Additionally, two seats should be filled by Legislative members, but neither of these</p>	

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	<p>seats are filled. It's crucial to fill these seats in order to achieve nuanced, balanced representation within the OPMC.</p> <p>9) OPMC application questions create barriers to filling seats: Questions posed to OPMC applicants create scoring inequities for non-professional candidates. Questions 13 and 14 require that the applicant have professional medical education, training, and experience in order to receive points. Most OPMC seats are held by professionals while zero patient/advocate seats and only one public seat are filled. This creates a significant membership imbalance, which contradicts the OPMC's core values.</p> <p>People with lived experience deserve a seat at the table in the OPMC, but the Commission didn't even consider them during their last call for applicants, even though the seats remain empty. Terms for new members begin in July, yet no patient/advocate seats were filled, leaving us without representation for another year. Applicants of this category have applied but were not appointed, showing disregard for the inclusion of patient voices and contradicting OPMC bylaws.</p> <p>10) OPMC is hyperfocused on Substance Use Disorder (SUD): The OPMC's hyperfocus on addiction medicine isn't serving the pain patient population. OPMC members would do well to learn the difference between drug addiction and dependence and should stop pathologizing benign medication dependence in pain patients. Abundant data exists to demonstrate that the overdose crisis isn't driven by prescribed opioids but by the use of unregulated, toxic, illicit substances, as well as polydrug use. Prescribing levels are lower than they were in the 90s while overdose rates soar.</p> <p>While the drug poisoning crisis is tragic and harm reduction efforts are vital for people who use drugs struggling with detrimental patterns of chaotic substance use, this should not be a focus of the OPMC. The Commission wasn't created to serve those with SUD. We already have a lot of groups focusing on substance use and addiction, groups that have a great deal of support, funding, and influence on public policy. The pain community doesn't have a fraction of these resources. We receive virtually no</p>	

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	<p>support from policymakers, politicians, advocates, medical professionals, special interest groups, health-related governmental agencies, the media, or the general public. The opposite is true, in fact. We're often demonized by individuals and groups in addiction medicine circles, accused of being “shills for big pharma” or “drug-seekers,” and we’re rarely shown any empathy or concern, which is why we need representation.</p> <p>Sadly, pain patients lack the representation, funding, and support that people with SUD benefit from. We’re habitually expected to suffer for a mythical “greater good” and are treated as addicts or parolees, made to sign restrictive pain contracts, subjected to frequent urinalyses, and non-consensually monitored via the PDMP, although we’ve broken no laws. We’re routinely denied pain relief to atone for the perceived “sins” of others. The OPMC shouldn’t be associated or affiliated with the addiction treatment industry. OPMC members in this category would surely bring preconceived biases, ideologies, and assumptions about opioid utilization in pain management. Those focused on addiction tend to see everything through the lens of problematic substance use and treatment. As the saying goes, when your only tool is a hammer, it’s tempting to treat everything as if it were a nail, and this is what these individuals are likely to do.</p> <p>11) The OPMC is hyperfocused on nonpharmacological (NP) pain management: OPMC’s Pain Education Module is heavily weighted towards NP pain management and alternative/complementary interventions, despite the majority of these treatment methods lacking robust clinical data to support any evidence of efficacy. This has caused tremendous harm to pain patients for whom those methods are ineffective. Some NP methods are effective for some patients, but certainly not for many others. And there are exceptions, such as physical /occupational therapy, nutrition, surgical interventions, etc., which are evidence-based treatment options. However, many NP treatments are, at best, useless pseudoscience and, at worst, actively harmful.</p> <p>Many NP treatment providers (akin to snake oil salesmen) stand to profit considerably from promoting alternative treatment while disparaging opioids . Robust clinical data</p>	

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	<p>simply doesn't exist to support the use of treatments such as chiropractics, acupuncture, homeopathy, etc. Evidence-based NP treatments should be available to those who desire and benefit from them, but these treatments are ineffective for many patients or are only helpful as adjunct therapies used in combination with opioids to achieve optimal quality of life and functionality outcomes.</p> <p>For years, medical professionals, government agencies, politicians, policymakers, journalists, and the general public have hyperfocused on non-opioid treatments. Many anti-opioid organizations and alternative medicine practitioners push non-opioid therapies already. We don't need more of these groups. The OPMC shouldn't strive to fill this role. Another group of NP/alternative pain treatment providers isn't necessary, nor is another group focused on addiction. What is urgently needed is a group representing pain patients for whom opioids do work, patients who've been abandoned by physicians, patients at risk of suicide due to untreated pain. This was OPMC's true purpose and intention when it was created, and it should still be this way today.</p> <p>12) Lack of reach in request for public comment on the Draft Report: The OPMC's request for public feedback on the Report only went to OPMC email subscribers and wasn't dispersed statewide. A request for public comment hasn't been posted on the Commission's website either. This lack of outreach appears intentional and is another example of the OPMC's lack of transparency, oversight, and accountability. OPMC leadership made no effort to raise awareness of the Draft's release and may be actively working to limit public knowledge of its existence so as to limit and suppress dissenting voices. I hope this isn't true, but I can't help but apply Occam's razor to this situation.</p> <p>The following is a list of recommendations that I would like to submit regarding the SB607 Draft Report:</p> <p>1) An objective third-party assessment and report should be conducted on the OPMC: The OPMC should not be studying or reporting on itself. There needs to be</p>	

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	<p>some oversight and accountability here. A fair and balanced study of the OPMC’s membership and conduct is impossible if the members in question are given the authority and freedom to assess their own job performance. It is unfathomable that this situation would be a simple oversight; it was intentional. I strongly urge the OHA to appoint a third-party assessor to conduct a thorough review of the OPMC and to figure out how this was allowed to happen in the first place.</p> <p>2) Changes to the OPMC’s process for appointing new members: The OPMC’s membership appointment process should align with ORS 409-050-0120. Prior to making appointments, the OHA Director should request and consider recommendations from individuals, public/private agencies, and organizations. Applicants also shouldn’t be limited to individuals with a healthcare background, individuals representing the healthcare industry, or members of the public.</p> <p>Currently, OPMC staff decides which seats to fill, opens applications, vets applicants, and forwards their selections to the OHA Director for appointment. The OHA Director doesn’t request or accept recommendations for new members from anyone else and is not acting in accordance with ORS 409-050-0120. The OHA Director doesn’t review potential applicants until after the OPMC has gone through their own elimination process. ORS 409-050-0120 should be reinstated, and the membership appointment process should be conducted in accordance with this statute.</p> <p>3) Disclosure of Conflicts of Interest (COIs): In the spirit of ethics and transparency, every OPMC member should be required to disclose relevant COIs they may have. This would effectively weed out individuals with inherent biases that could affect their judgment and interfere with their ability to perform their duty to serve the pain community. It would eliminate members who financially/professionally benefit from the promotion of NP pain treatment and/or those who stand to profit from pain management-related businesses due to their position on the OPMC as well.</p> <p>4) The OPMC should strive for balance: The OPMC is extremely unbalanced in its current form. Its members currently maintain unfavorable beliefs and ideologies about</p>	

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	<p>pain patients, pain management, and opioid medications. Potential members shouldn't be screened for alignment with predetermined or preferred ideologies, whether that preference is based on religious/spiritual beliefs, personal history/experience, or moralistic/puritanical views. The OPMC needs balanced membership so a wide range of voices and perspectives are heard and given legitimate consideration .</p> <p>5) Members of the pain patient/advocate community should be required on the OPMC: At least three seats should be filled by members of the pain community, advocates, and people with lived experience acting as representatives of those living with high-impact pain. This is crucial. These members would provide a much-needed voice for members of Oregon's pain community within the OPMC, and it would also help the Committee calibrate so as to realign with its original intended purpose. Currently, there appears to be zero interest in or effort to include pain patients/advocates, contradicting the OPMC's intended purpose, bylaws, and mission statement.</p> <p>6) The OPMC should shift its focus away from the Pain Module, but also needs to update its Education Module: The OPMC urgently needs to shift its focus back toward its primary responsibilities, bylaws, and mission statement, and away from the Pain Education Module, which is a secondary/ancillary duty. While the Module shouldn't be the main focus, as it is an ancillary responsibility, it should be revised to include the following:</p> <ul style="list-style-type: none"> ● Review of the updated 2022 CDC Guidelines and the Oregon Medical Board Guidelines on pain management. In both the CDC and OMB's updated guidelines, patient-physician autonomy has been restored, MME limits have been eliminated, and there is no longer a ban on the co-prescription of opioids and benzodiazepines. Healthcare providers who are still hesitant to prescribe these medications should be made aware of the updated guidelines so that they can practice compassionate, individualized medicine when treating pain patients. 	

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	<ul style="list-style-type: none"> <li data-bbox="226 334 1262 610">● Education on adequate and compassionate medication management for pain patients who benefit from long-term opioid therapy. Physicians are afraid to prescribe now, and for good reason. They’ve been harassed by the DEA, CDC, DOJ, and FDA, have seen their colleagues harassed and even imprisoned simply for treating pain, and are afraid of losing their medical licenses or being unfairly arrested simply for treating patients. Now that draconian prescribing limits and laws have been relaxed and autonomy has been restored, they need to be made aware of this fact and know that it is, in fact, all right for them to care for their patients once more. <li data-bbox="226 634 1262 943">● Relevant data showing that prescribed opioids are not a meaningful driver of the current drug poisoning/overdose crisis should be shared. Ample evidence/data exists to support this statement. Even the CDC’s own data proves this is the case. It should be shared far and wide that prescriptions are not meaningful contributors to overdose deaths, and that those deaths are occurring due to prohibition, not prescriptions, the unregulated and toxic drug supply, and polysubstance use. The OPMC’s Module should make healthcare providers aware of these facts and present any relevant supporting data and statistics to those participating in the Education Module. <li data-bbox="226 967 1262 1211">● Patient/advocate perspectives, the input of those with lived experiences, should be considered and should carry considerable weight in the creation of the Module’s content. Pain patients have been abandoned and treated like parolees for many years now, simply because they’re in pain/disabled and require opioids to function. We have lost thousands of pain patients to suicide due to untreated pain. Some patients have been forced to seek relief on the streets and have died in the process. <p data-bbox="226 1235 1262 1365">Our voices need to be heard and healthcare providers need to be made aware of the risks of denying pain relief, especially the risk of suicide. Dr. Stefan Kertesz is researching this very thing right now with a group of colleagues, so his website would be a great resource to provide within the Module. Dr. Kertesz’s work can be found on</p>	

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	<p>his website: https://www.csiopioids.org/</p> <ul style="list-style-type: none"> • Pseudoscientific alternative/NP treatment methods and language should be eliminated from the Module: Methods of treatment that lack evidence of efficacy and fall into the category of pseudoscience shouldn't be included in the module, nor should misleading terms such as "pain science" which is not based in science or nationally accepted. <p>7) Transparency, accountability, and oversight should be a top priority: Lack of transparency, accountability, and oversight is a huge problem within the OPMC as it is now. It should be a requirement for all OPMC members, new and existing, to disclose relevant COIs. Changes to the membership appointment process should also be made, such as creating equal opportunities for non-professionals to earn points on application questions. The names of all individuals tasked with studying or reporting on OPMC operations and member conduct should be disclosed and made publicly available. Additionally, a concerted effort should be made to fill OPMC seats with pain patients/advocates, those with lived experience, members of the Legislative Assembly, and members of the general public. Basically, we need to fill seats with people who will fulfill their duty to act as a voice of reason and to advocate for Oregon's pain patients.</p> <p>8) Reports to the Legislative Assembly and Governor: The OPMC should be submitting reports to the Legislative Assembly and Governor regularly. This is crucial for highlighting patient concerns and developing workable solutions, especially for patients who have been abandoned by healthcare providers. These reports should be pro-patient, and those making the reports should be working to remove the barriers that pain patients face in accessing adequate pain management and finding new physicians to manage their pain if they've been abandoned.</p> <p>Thank you for your consideration in this matter.</p>	
E	<p>I am a chronic pain patient in Oregon who is currently on palliative care. It has been increasingly hard to access pain control in this state and it is a very huge concern for me and my family. Although opiates should never be the first or second line of</p>	<p>Thank you for sharing your experiences and comments. Your comments are similar to those expressed by commenters A and B; see the responses to those</p>

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	<p>treatment, they should continue to be offered to patients who need them without fear mongering. As they are the gold standard for intractable pain patients like myself. Oregon has pushed too hard to reduce opiate prescriptions and it has made doctors too afraid to prescribe to the patients in need that have been on long term opiate therapy. This in turned harmed patients with intractable pain like myself. Making it impossible to find anyone to continue their care. This caused harm to patients and it's still causing harm today.</p> <p>I feel that pain patients and advocates deserve to be part of this discussion. It seems a little fishy that you don't have anyone on the boards to give a balanced view. As there will ALWAYS be circumstances in medical care where Oppiates are necessary for treatment of intractable pain. I urge you to correct this mishap and place pain patients, advocates in a place to offer balance to this conversation. Many of us are too sick to do much fighting for ourself, but there are people who are trying to advocate for our rights. We deserve ethical care regardless of the medication. This has always been what has been done in palliative care. The staff seems to be gatekeeping and making sure there aren't advocates on the boards. So far you have been unwilling to adjust this despite us making requests. Shame on you. You should be focusing on what is truly important to paitents in our state and access to ethical care is a VERY big concern that I don't think you are taking into consideration.</p> <p>I am a pallative care patient with EDS, Chiari, Syringomyelia, Spina Bifida, POTS, Degenerative Disk Disease and so much more. My pain doctor just lost his state license due to DEA investivations and I have been left with no one to continue my care. I have been turned down by practically every doctor in the state. This is deplorable considering I have safely taken opiates for almost ten years and did so at a moderately high dose. I never once had any issue with abuse. I passed every drug screen and followed all the rules. Do better! Make some changes please and make sure there is someone to advocate for me. I deserve quality of life since.</p> <p>I am writing you today so that you can take into consideration my standpoint and my mom, and my daughter both are standing with me to sign this letter because all three</p>	<p>comments, especially rows A1, A2, A14 and B1.</p>

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	of us feel that this is important. Please consider our wishes. I will follow this letter up with letters to all my state representatives that will listen, and even the one's who might not. As patients like myself deserve a voice.	
F	<p>I am writing to the Oregon Pain Management Commission regarding my concerns about the OPMC and its recent draft report on OPMC membership. I am writing as someone who knows people who live with chronic pain and cares deeply about their ability to receive adequate pain management.</p> <p>I have three central concerns:</p> <ol style="list-style-type: none"> 1. In keeping with the OPMC goal, as stated in its bylaws, to “Value the pain patient as an integral part of the pain management team,” the commission should make an effort to expand the number of chronic pain patients who are commission members. 2. The OPMC and its activities should be assessed by an independent third-party group, rather than by the OPMC. Such an outside assessment would have far greater credibility than a purely internal evaluation. 3. The OPMC must release a report to the governor and legislature on pain patients’ concerns (such a report has not been released since 2019). <p>I strongly urge the OPMC to include more people with chronic pain on the commission, accept assessment by an outside group, and release an updated report.</p> <p>Thank you,</p>	<p>Thank you for sharing your experiences and comments. Your comments are similar to those expressed by commenter A; see the responses to those comments, especially rows A2, A3, A6, A10, A11, A18 and A22.</p>
G	<p>I am a chronic pain patient reaching out and requesting that we have a patient advocate and/or member of the public be added to the pain commission to create a more balanced group.</p> <p>The commissions primary focus has been education modules despite the initial creation was to create a rounded approach for treating pain in the state, however it has swung so far in the other direction that patients are being left without any type of</p>	<p>Thank you for sharing your experiences and comments. Your comments are similar to those expressed by commenters A and B; see the responses to those comments, especially rows A8, A12, A17 and B1.</p>

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	<p>care and continuously facing neglect in their care.</p> <p>The recent report highlighted that the commission is focused on addiction prevention as opposed to care for pain patients. The fear mongering created from the letters sent out to physicians and increased monitoring has made it more difficult for patients to get proper care or even be able to fill prescriptions (coming from personal experience as well).</p> <p>There is almost no care in the Portland metro area for chronic pain patients, its become such a problem that patients are unable to function and support themselves.</p> <p>I am a single parent who has endured over 30 surgeries due to a genetic condition that has caused my body to fall apart at a much faster rate. My son has special needs and requires a higher level of care. I recently had a 4 level lower spinal fusion and struggled to find a pharmacy to even fill my prescriptions. My doctors are afraid to properly treat me because of the fear mongering sent out from the state. I have a much higher tolerance due to having so many surgeries and rapidly processing medications, despite having 0 issues with medications and tapering off after every surgery I still require a much higher dose.</p> <p>I am requesting more transparency from the commission as to conflicts of interest including personal vested interests in modalities surrounding pain care, implicit bias towards pain patients, more space at the table for the patients to have our voices heard.</p>	
H	<p>Greetings,</p> <p>I am a retired hospital administrator from Minnesota. I have been out of it for some 30 years and now on the receiving end of the CDC Guidelines, Joint Commission Standards etc. There have several events in my life requiring ER visits in two different hospital systems. The guidelines still need to be "soften" I share the frustration and anger that many 65+ patients feel when one is treated as an abuser of opioids. These medications can provide substantial benefits to older adults with chronic pain and multimorbidity,</p>	<p>Thank you for sharing your experiences and comments. Your comments are similar to those expressed by commenter A; see the responses to those comments, especially row A12.</p>

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	<p>particularly promoting physical functioning which can be vital to achieving other chronic disease goals and emotional well-being.</p> <p>What has happened to the "Patient Centered" concept..Believe me I do understand the need for safe opioid prescribing managing the patient pain and minimizing the risks associated with treatment. I am fortunate to enjoy a Primary Physician relationship that has been built on TRUST for over 15 years. When there is a need/concern for opioid prescribing a thorough screening, options, discussion and a plan is put in place. it's something like a negotiation in good faith, respectfully...that is "Patient Centered". Unfortunately, for many this is not the case. The pendulum of caution needs to find it's way somewhere in the middle. Yes, many have died as a result of addiction, however, how many are not receiving the benefit????</p>	
I	<p>Dear Sirs and Madams,</p> <p>As a US citizen with several family and friends who rely on pain medicine to manage chronic pain, I am writing to express my concern about the Oregon Pain Management Commission and the draft report.</p> <p>It's important that the commission is evaluated by a third party that is free of bias. That should be a given. Also, it seems that people who are directly affected by chronic pain, and people with disabilities are not being heard in this discussion. This is important to make sure that perspective is included.</p> <p>Guidelines for pain management need to be set in order to protect those who cannot live comfortable or productive lives without it. This could affect any one of us in our lives and we need to make sure it is done with compassion.</p> <p>Thank you for considering my comments on this crucial matter. Yours truly,</p>	<p>Thank you for sharing your experiences and comments. Your comments are similar to those expressed by commenter A; see the responses to those comments, especially rows A3 and A12.</p>
J	<p>As a disability rights activist and chronic pain patient, I am writing to express my concern about the Oregon Pain Management Commission and the draft report.</p> <p>First of all, the commission needs to be evaluated by a neutral third party. An</p>	<p>Thank you for sharing your experiences and comments. Your comments are similar to those expressed by commenter A; see the responses to those comments,</p>

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	<p>organization being investigated should not investigate itself. That is a huge conflict of interest.</p> <p>Second, the commission was intended to include the perspectives of disabled and chronic pain patients and it has not done so. The membership of the committee excludes the very people it is meant to give voice to, and the interests of disabled people with chronic pain aren't being taken into account. Chronic pain patients and their advocates need to be part of the membership and have a seat at the table.</p> <p>The commission was supposed to release reports to the governor and legislature on pain patients' concerns, and it has not done so since 2019. A report hasn't been released in five years.</p> <p>Under ORS 413.570, the primary job of the commission was to set guidelines for pain management, and those guidelines were supposed to be written with the interests and feedback of chronic patients and the disability community in mind. THIS HAS NOT BEEN DONE.</p> <p>The commission was not given the task of releasing an hour-long training on pain management, yet the draft lists that as a goal. The goals set out in SB607 have NOT been met, and a new goal, never approved by the legislature and not in the original bill, has been set instead. The commission should fulfill its mission and mandate, not create new projects unrelated to its mandate while ignoring that mandate.</p> <p>In the organization's bylaws, it says that the group wanted to "value the pain patient as an integral part of the pain management team." The actions of the committee (and lack thereof), and the lack of pain patients on the committee, do not in any way reflect this statement.</p> <p>Please end obvious conflicts of interest, give pain patients a voice, and do the work the commission was set up to do.</p>	<p>especially rows A3, A6, A8, A10, A11 and A14.</p>

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K	<p>Dear Oregon Pain Management Commission,</p> <p>I am writing regarding the draft report in SB607, it states that the Oregon Health Authority shall study the membership of the Commission, but it seems the Commission is actually studying itself. I don't see anywhere in SB607 where it authorizes this. Not to mention the Commission studying themselves causes a huge conflict of interest which is exactly what we'd like to see investigated within the Commission membership. I feel this point alone invalidates the draft report.</p> <p>I am concerned that there are no pain patients/advocates who represent other patients, and with lived experience, on the Commission and the position has been ignored and no efforts have been made to include this group on the Commission. The legislation/bylaws/mission of the Commission makes it clear that these voices are the priority and there are none on the Commission and the Commission hasn't opened seats for this essential group that should be required on the Commission</p> <p>Also, public members are not the same as patient/advocate Commissioners. We need non addicted pain patient/advocate seats filled with people who represent those in pain without addiction and not affiliated with addiction groups. This is the missing piece on the Commission and without filling those seats, the entire intent/mission/bylaws of the Commission are null and void.</p> <p>We did not get a 30-day commenting period, which is customary with all initial reports. This is important when working with people with chronic illnesses. It is sometimes necessary for disabled and chronically ill people to need more time, not less time, for things like this.</p> <p>There are many areas lacking in Oregon health care from addiction care, Medicaid dental care, and pain care. They are all essential and need our focus, however merging any of the groups together does a disservice to everyone. I feel the pain Commission has lost its patient focus as evidenced by the lack of representation and interest in the pain community.</p>	<p>Thank you for sharing your experiences and comments. We are sorry for your loss. As you note, your comments are similar to those expressed by commenter A; see the responses to those comments, especially rows A1, A3, A4, A10, A11, A12 and A18.</p>

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	<p>The fact that there are basically no criticisms of the Commission membership and there are a couple of slight suggestions that are listed as nothing urgent, shows this report was done without any real study or investigation. It was nothing more than an unimportant technicality that was not taken seriously.</p> <p>I hope that somehow the Commission can return to the patient focus it once held. It was my hope SB607 could do that, but it is clear by the response from the Commission that it has been dealt with very poorly and is likely to do nothing.</p> <p>Please refer to the signed letter from Oregon Pain Action Group to see the full list of my concerns and my recommendations for improvement. I agree 100% with that letter and I would go into more details in this letter except my son died a week ago today and I don't have the bandwidth to do more.</p>	
L	<p>To Whom It Concerns,</p> <p>I am a pain patient here in Oregon. I have been forced to stop working because my pain medication dose is too tiny to allow me to stand or sit for more than 10 mins. My doctor is terrified of getting in trouble, my last 6 doctors have retired before age 50. Each of them mentioned they felt too much pressure about rxing pain medication. I can tell she is confused about how to rx pain meds work, she has to ask someone's advice each time. She should understand the basics of a medication. She has forced me onto medications that have caused me problems in the past due to necessary policies that target all schedule meds.</p> <p>I am writing to ask that the humanitarian crisis that pain patients are facing is put to an end.</p> <p>I am in danger . It is extremely difficult to find a doctor who will take a chronic pain patient. I will go into medical collapse. I have before. I am suffering every day and can't do things with my family.</p>	<p>Thank you for sharing your experiences and comments. Your comments are similar to those expressed by commenters A and B; see the responses to those comments, especially rows B1, A3, A6,A10, A11, A12 and A22.</p>

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	<p>I ask that the core work of the Oregon Medical Board return to balance. Addiction work is import of course but it is not all of us. Pain patients should not be martyrs for those who suffer addiction.</p> <p>The OMB and SB607 should return Oregon to protecting patients in pain. This should be the obligation of OMB.</p> <p>I ask that a objective 3rd party govern and make sure there is balance , objectivity, removal of junk science, report patients concerns to Governor Kotek, and that doctors who truly care & have dedicated their lives to treating pain with compassion be included.</p> <p>OMB has been failing to be fair and balanced and therefore should not be policing self. There is a focus only from the addiction standpoint.</p> <p>There needs to be voices from pain patients. We are suffering and our concerns need to be addressed.</p>	
M	<p>Loss,grief and pain management.</p> <p>Facing the loss of something cherished ,</p> <p>losing everything will bring a strong person sick to their knees. grief, sorrow, unanswered questions leave a shadow for the mind to dwell with. Guilt, grief, anger, and the misinformation pursudes the actions from family members, neighbors and colleagues.</p> <p>domestic violence has a huge roll to contribute ,gender biases, and instinct .</p> <p>Just as a lion is a killer, so are we in a moment of threat to life or threat to ones offspring. Noticing my own symptoms I started asking homeless persons about their stories.. ...</p> <ol style="list-style-type: none"> 1. Psychosis 2. PTSD 	<p>Thank you for sharing your experiences related to the complex roots of pain and other forms of suffering.</p>

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	<p>3. Obesity</p> <p>4. Hives, rash, lesions</p> <p>5. sadness ,depression, anxiety,paranoia,</p> <p>6. Substance abuse, domestic violence And suicide .</p> <p>In the moment I found only me.</p> <p>influence ,compassion,empathy,trust,faith all uncontrollable conditions that are present values hold strong.</p> <p>Having a safe place to be safe from all outside interference and influences I would recommend it and facilitate it to the full extent of the individuals abilities to want to move forward.</p> <p>Peace of mind prevails all other stimulants. Housing as medicine.</p> <p>best practice to enhance quality of life.</p>	

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