Testimony on SB 607
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May 15, 2023

Thank you Chair Nosse, and Representatives for your time.
I am a pain educator, and physical therapist with 25 years' experience working with persistent and chronic pain. I am a former chair of the pain commission and know well the work of the commission and its scope and reach in the state as a force for improving pain care. I will elaborate in a moment on these strengths to help legislators better understand the value of the commission.

Firstly, though, I am writing in opposition to SB 607, which requires that Oregon Health Authority study the membership of Oregon Pain Commission. My reason for opposition to this bill is that the commission is designed to be multidisciplinary in nature and to represent the breadth of clinicians who treat folks dealing with pain and it in fact continues to have excellent representation across disciplines, as a result of open application and review. Additionally, I will say that, in my 8 years at the commission, I have not seen the commission address addiction but rather addressed pain itself, with significant thought put into revising the focus as new pain science has come to light. What is true is that contemporary pain science tells us that opioids should be only one part of a pain care plan and not the primary focus of treatment. Chronic or persistent pain should never, ever be treated with opioids alone. Multidisciplinary pain care is proper pain care. I will also say that I believe that the commission would welcome a new module on opioid prescribing if funding is available. Ongoing conversation about this is reasonable and not in contradiction to with the OPMC's mission.

The reasons for the composition of the commission have been as follows:

1. The role of many disciplines:
   Pain is multifactorial and its treatment should include a range of clinical members depending on the individual but nearly always including, optimally, physicians and other PCPs, physical therapists and mental health clinicians. Additionally, all clinical disciplines are included in OPMC as well as people with lived experience. This means that pain will be appropriately addressed across the care continuum, thus avoiding chronicity due to poor care early on. As illustration of this, consider a patient seen in the emergency room. If a patient given the impression that their pain can only be treated with opioids, then that patient is put at a disadvantage by establishing the belief that their pain is mysterious, untreatable and outside their own scope of control. This is a disempowering message that has in fact, led to chronicity for many.
   The commission's inclusion of a full range of clinicians historically has meant that, of the practitioners who a patient may encounter, the majority within Oregon should have accurate basic messaging about pain.
   The disciplines represented by the commission are the same group that take the required online and popular module, "Changing the Conversation about Pain." This

representation has helped the commission to ensure that the concerns of different clinical groups are addressed.

2. The role of prescribers:
   While the commission has always included prescribing practitioners as members, OPMC recognizes through contemporary pain science, that pain is a multi-faceted experience that is changed by interventions largely done by the patient themselves, active interventions that remodel the nervous system and gradually quiet pain. This is in opposition to an earlier misunderstanding of pain, that pain existed in the body and that chronic pain was a mystery and impossible to change. This led in large part to the opioid crisis, where greater and greater quantities of narcotics were prescribed to an increasingly immobilized, isolated, and physically addicted person. We now understand that, while medication may be a part of the treatment plan, it should never be either the sole or primary more of care for persistent pain.
   With this awareness in mind, the membership of OPMC, has always been well represented by those key clinical contributors to pain care, such as rehabilitation services (PT/OT) and psychological services, in addition to PCPs, nursing, acupuncturists dentists, and people with lived experience. If we were to skew membership more strongly towards prescribers, the commission would lose some of the most important clinical expertise in treating pain.

3. The role of pain science and evidence-based care
   Lastly, the pain commission was founded during the pro-opioid-prescribing era in the 90s, when it was believed that extensive prescribing was the humane way to treat pain. The tragic folly of this belief is now well understood, and contemporary pain science has replaced a lack of knowledge with a great breadth of understanding about how pain works and how it can change. This very positive message is at the heart of the pain commission's work and of its state training. As an evidence-based health care commission, we must be rooted in the evidence and in contemporary pain science. To that end, members of the commission must share an understanding of the contemporary pain science and appreciate the importance of the biopsychosocial model of pain and the role of neuroplasticity in treatment. This is fundamental to the purpose of the commission, as without a rooting in contemporary pain science, there would be no organizing principle to the commission and no actual use to the state.

4. Geographic diversity and representation of patients from across populations in Oregon
   a. OPMC seeks to include commissioners from all regions of the state, including rural areas
   b. Breadth of representation of patient and community populations has been an important focus recently, involving clinicians who treat underserved and underrepresented groups such as low income urban dwellers such as Latinx community members. While this can always be improved upon, it has been a priority in evaluating applications.

Though I am no longer part of the commission, I am aware that OPMC continues to maintain a balanced membership of both prescribing and non-prescribing practitioners who share a common understanding of pain science and the biopsychosocial nature of pain and pain treatment. To that end, I see no reason for OHA to involve itself further in the composition of OPMC, as the commission members and leaders are a dedicated group of professionals who steward their responsibilities wisely.

Other aspects of the pain commission and the role of OPMC in the state of Oregon:

1. Pain toolkit resource: Serves both clinicians and the public, open access to all. This resource is being used in the clinic, in telehealth, and by the public to better understand pain and understand how changeable it actually is. This content, developed by the commission, is patient centered easily accessible to all in the state, including those in rural regions.
2. Use of pain ed module for widespread training. The OPMC module, "Changing the Conversation about Pain," is a 1 hr. required module that is also being voluntarily disseminated among many large and small health care organizations as they look for ways of changing the culture within their own groups.

Both of these resources together have been used by the following organizations to improve pain care and help those living with pain to reclaim their lives:

- Clackamas County Primary Care and Behavioral Health
- Providence Rehab Services statewide
- Providence Nursing statewide
- Provide Medical Group state wide
- Oregon Health Sciences University
- OUR Tillamook
- Central Oregon Behavioral Health Consortium
- La Clinica Medford.

The positive feedback on both resources is overwhelming and can be found through OHA.

In response to some other questions that have arisen during testimony:

1. I believe that the commission would be open to a new module on prescribing
2. Yes there is a paid staff member
3. We do need a better reporting system to the governor
4. We need better presence from the legislature at commission meetings.

Thank you for your time and for your work for the state of Oregon.

Sincerely

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