



Community Health Pain Management Improvement Project Proposal

Wisconsin Primary Health Care Association (WPHCA)
Pain Peer Learning Network (PPLN)

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Primary Contact: Pamela Crouse, MS, RN
pcrouse@wphca.org

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Overall Goal & Objectives

The overall goal of the Wisconsin Primary Health Care Association's Community Health Pain Management Improvement project is to implement a sustainable and team-based Pain Peer Learning Network (PPLN) that is based on a PCMH framework and guideline-recommended practices for the care of patients with chronic pain. The anticipated project outcomes include improvements in patient and staff satisfaction and patient quality of life. We will accomplish this with the following objectives:

Objective 1: WPHCA and Community Health Centers (CHC) PPLN teams will build upon WPHCA's existing peer learning network structure and the PCMH model of care to implement system changes to improve care for patients with chronic pain.

Wisconsin CHCs have engaged in learning collaboratives since 1998 when the Health Resources and Services Administration (HRSA) launched its National Health Disparities Collaboratives (HDCs). The initial focus of the HDCs was on care management and improvements targeting patients with clinical chronic conditions such as heart disease and diabetes. The goals of the HDCs were to disseminate practice guidelines, establish processes for collecting and using data to drive improvement and establish communities of learners.

When HRSA support for the HDCs ended in 2009, WPHCA and all Health Centers decided to continue a WI specific "quality improvement collaborative" that integrated all departments: medical, behavioral health, fiscal, dental, and operations. Improvement was driven by all CHCs reporting transparently on an integrated list of core metrics and a peer learning network model to facilitate shared learning between CHCs. This current model employs shared learning strategies similar to that of the HDCs and has been well received by the CHCs. WPHCA supports peer learning networks for cohorts of CHC staff ranging from finance, operations, medical, dental, and behavioral health departments. In addition to regular peer learning network conference calls and/or face-to-face meetings, peer learning networks are supported through modalities such as individual coaching and on-site assistance provided by WPHCA staff and consultants, a virtual resource library, a list-serve, and annual conferences. CHC staff are actively engaged in performance improvement through this wide array of learning modalities. Participation in the HDCs and this "new" WI specific integrated quality improvement program has positioned WI CHCs to engage in current significant system redesign and performance improvement initiatives such as Patient Centered Medical Home (PCMH) transformation and the Meaningful Use (MU) goals in response to and preparation for health care reform.

The tenets of PCMH transformation are foundational and congruent with the goals of this project and 7 of 17 CHC organizations in Wisconsin are now recognized as PCMH. The change concepts of PCMH match well with the unique health center model established in 1965 to address the complex needs of their patients: multidisciplinary team-based primary care (including medical, oral, and behavioral health services); responsiveness to the needs of the community; and availability of enabling services to address barriers of care (translation, transportation, health education, and case management). Adoption of PCMH team-based care

standards has prompted teams to consider new team members (such as pharmacists and social workers) and enhanced processes for the specific conditions they addressed in their transformation. This project will allow participating CHCs to consider the optimal team members and communication processes, standardized care processes, optimize communication between patients and providers, and measure results for the population based management of patients with chronic pain. Of the 6 potential participating CHC practice sites, 2 have achieved NCQA recognition as PCMHs, while all others are working towards that goal.

This PPLN will build on the foundation of WPHCA's peer learning network model and the foundation of Health Center's PCMH transformation. WPHCA will host a face-to-face kick-off event designed to establish a common foundational knowledge of screening practices, guidelines, decision support and patient tools, QI processes (such as the PDSA), electronic health record (EHR) optimization, and evaluation methodology. Since participating CHCs have either transformed to a PCMH model within the last year or are in process currently, teams will identify their own primary targets for change and create project plan to accomplish their goals. Through the project period, teams will meet monthly via collaborative learning network calls, and as needed with the WPHCA project manager for individualized coaching calls.

Over the course of the project, training and skill development will focus on the PCMH change concepts in managing chronic pain: enhanced access, coordination and continuity, systematic identification and management of patient with chronic pain, including high risk patients, using evidence based practices, promotion of patient self-management strategies and community resources, and development of processes to measure and improve performance.

Provider education and group visit curriculum development were identified as needs in the survey of interested participants. Access Community Health Center, a Madison-based CHC with long-standing expertise in the integrated primary care/behavioral health model in community health center setting, identified interest and capability for developing and testing provider/staff pain management training modules along with group visit curriculum, but needed additional resources to advance their goals. This project proposes to support the development of group visit curriculum, to include overall goals, educational curriculum, patient recruitment strategies, and patient resources, so that deliverables can be shared with the participating teams and others more broadly post-grant period. The modules will be available "on-demand" to ensure consistency in care delivery and communication between providers and their patients while contributing to sustained change.

The project funding will support initial efforts to implement system changes to improve care for patients with chronic pain. In Wisconsin there are no current fiscal incentives for implementing or sustaining guideline-based chronic pain management in a PCMH context. To support the sustainability of system changes the PPLN will engage with other WPHCA Peer Learning Networks and projects to explore fiscal implications of evidenced based pain management.

Continuing education credits for primary care providers and nurses has been offered for WPHCA learning events in the past, and the interest in CME and Part 4 American Board of Family Medicine (ABFM) maintenance of certification for this event will be considered and offered through our partnership with the Wisconsin Academy of Family Practice.

Objective 2: CHCs will identify a pain management improvement project and implement rapid improvement cycles to achieve their individualized goals.

Based on the PCMH team-based approach to care, participating CHCs will identify multi-disciplinary teams and appoint a pain management project leader. CHC teams will participate in monthly collaborative learning network calls to identify best practices that can be implemented individually and collectively. Teams will be expected to identify one pain management improvement goal and conduct one or more PDSA rapid improvement cycles (PDSA) within the project period. CHC pain management system improvements will be focused on systematic approaches so that the entire care team – medical provider, behavioral health specialist, nurse, MA, health educator – all have a role in educating and engaging chronic pain management patients in their care. Thus, as one provider shared, “spreading the burden for caring for chronic pain patients beyond the provider.”

As rapid improvement cycles are implemented locally at individual Health Centers, pain management improvement teams will share their early findings on PPLN calls. Ultimately, findings and lessons learned from PPLN will be shared broadly among WPHCA’s peer learning networks including the medical directors, behavioral health cohorts and clinical operations group.

Objective 3: Participating CHC pain management teams will establish standardized evaluation and data methodologies to measure patient outcomes and patient and provider satisfaction.

Health Centers are not currently using standard pain management assessments, treatment guidelines, treatment monitoring tools, and quality improvement measures for their patients with chronic pain. The PPLN will focus its efforts on training teams on implementation of best practices.

WPHCA staff and project participants have researched treatment guidelines and tools in the planning of this proposal, but guidelines and tool selections have not been finalized. In addition to learning from the Physicians’ Institute for Excellence in Medicine, WPHCA staff and collaborative participants are also considering the Institute for Clinical Systems Improvement Health Care Guideline: Assessment and Management of Chronic Pain.

https://www.icsi.org/_asset/bw798b/ChronicPain.pdf

Another tool that is being considered as a tool to measure clinical outcomes is the Patient Activation Measure (PAM) developed by the Health Policy Research Group at the University of Oregon. This tested and validated tool is used to assess level of patient activation and guide providers in strategies to increase patient activation based on these premises: many of the

behaviors we are asking of people are only done by those in highest level of activation; when we focus on the more complex and difficult behaviors, we discourage the least activated; and if we start with behaviors more feasible for patients to accomplish, the individual's opportunity to experience success is increased.

As outlined in the attached logic model, within the first three months of this program, WPHCA's pain management PPLN will establish standardized provider/staff satisfaction measurements and patient satisfaction/engagement/activation measurements. This network will test the evaluation measures by implementing a baseline assessment period with providers and chronic pain patients during the fourth month of the project and the twelfth month of the project. Clinical outcome measures that the group will consider include patient quality of life and/or functional status, patient satisfaction or engagement, and provider and staff satisfaction.

Objective 4: CHCs will develop relationships with external behavioral health specialists and/or increase internal behavioral health capacity to serve patients with chronic pain.

While CHCs are required to provide behavioral health services to their patients directly or through a referral, the degree to which behavioral health services are integrated into primary care services varies considerably. Within the past several years, Wisconsin's CHCs have recognized that their patients' needs for behavioral health services far outweigh the availability of community-based behavioral health services. A long-term outcome of WPHCA's pain management improvement project will be to assist health centers in building internal capacity to provide behavioral health services and/or identify behavioral health referral sources that benefit their chronic pain patients.

Objective 5: CHCs will demonstrate awareness and utilization of non-pharmacological pain management options available to them by establishing new community collaborations, partnerships and referral sources.

Best practice in pain management care involves the integration of mind-body-spirit therapies, that health center patients, who are historically low-income and uninsured, may experience more barriers to access than other populations. CHCs differ in their ability to refer patients to internal and external non-pharmacological treatment options and resources such as community-based behavioral health services, massage, acupuncture, yoga, exercise and meditation and have expressed a need to identify these modalities as referral sources. Effective referrals however, require an understanding of CHC patients and interventions to reduce barriers that patients experience. WPHCA's pain management improvement project aims to address this objective through sharing ideas and resources for these services through the collaborative learning component.

WPHCA has an existing partnership with the Wisconsin Association of Family Physicians (WAFP) from our prior work together on PCMH implementation and workforce development strategies. For this project, WAFP will serve as a critical partner on the project in a number of ways: they will provide the continuing education credits for training events conducted through this project;

they will assist participants in identifying promising community collaborations; and they will help to disseminate lessons learned among other primary care providers within their network.

Objective 6: The pain management collaborative learning network will identify and share key recommendations and lessons learned with statewide, regional and national primary care networks.

Participants will identify best practices and recommendations based on processes, creative solutions, and partnerships that work well for CHCs in Wisconsin. These recommendations will be shared within the PPLN on an ongoing basis, and will be shared with non-participating Wisconsin CHCs through existing peer learning networks.

More broadly, Health Centers identified as “best in class” by the Physicians’ Institute for Excellence in Medicine and Pfizer’s Independent Grants for Learning and Change commit to share their lessons learned in Atlanta, Georgia. In addition, WPHCA and CHCs will pursue opportunities to disseminate lessons learned through other venues including HRSA webinars and National Association of Community Health Center (NACHC) trainings and conferences.

Objective 7: Explore the feasibility of integrating best practice pain management assessment, treatment monitoring, and evidence-based guidelines within Health Center EHRs for each CHC pain management team.

All participating CHCs have implemented EHRs and their providers have attested to stage 1 meaningful use (MU). However the six participating CHCs are on four different EMR platforms: GE Centricity, Success EHS, Vitera, and Epic. Over the past three years, WPHCA has implemented individualized, on-site technical assistance to support each of its CHC members in achieving MU and optimizing their EHRs for patient care, practice management, and quality improvement. Building on WPHCA’s health information technology staff expertise and technical assistance approaches, the PPLN project proposes to support the needs of each CHC team in optimizing the use of their EHR to improve care for chronic pain patients and population-based care management.

Technical Approach and Workplan

The PPLN project will use a collaborative learning approach which will be supplemented by technical assistance from WPHCA staff. Participating CHCs will be guided as they select their own project aims to meet the overall PPLN goals and objectives. See attached logic model and workplan for detailed timeline and deliverables.

Assessment of Need

To explore the need and interest in participation in this program, WPHCA staff initiated a conversation with its Board of Directors in October and facilitated subsequent focus group telephone conference calls for CHC members interested in participation. Interest was robust, with 8 out of 17 CHCs indicating that they saw a need in their organizations for a pain management quality improvement initiative. A baseline survey was conducted via Survey Monkey. Seven respondents completed the survey between 11/2/13-11/6/13. A literature review was conducted and existing measures of quality metrics were reviewed.

A qualitative analysis of survey responses and key informant data revealed several trends and themes. The prevailing theme is that the current state of managing the care of patients with chronic pain is not optimal: a patchwork of approaches is in place with inconsistent utilization of guideline-based practices; monitoring of quality has been largely absent; providers and staff feel ill-equipped to deal with the complexities that patients present as they seek care; and patients express dissatisfaction with their experiences of care.

Use of guideline-based practices: Survey responses indicated that several basic key areas of guideline-based practices are not routinely in place at our participating CHCs. Only 67% of respondents indicated they used a standardized tool to assess or measure pain severity in patients. Only 17% indicated that they used a standardized pain inventory tool or physical functional ability tool. Only one respondent indicated the use of an EHR to assess and track diagnosis and treatment, and assess risk of misuse and abuse of treatment. They noted several areas where EHR capabilities were not being fully used or standardized.

Another statewide survey conducted by the University of Wisconsin School of Medicine and Public Health of all Wisconsin physicians revealed that only 38% of respondents were aware of at least one clinical practice guideline for treating chronic pain (Wolfert et al, 2010) and concluded that this lack of knowledge “may result in inadequate prescribing of opioids with resultant inadequate management of pain.” This data is consistent with the information shared by CHC focus group participants, who generally indicated that they were aware that there were guidelines, but were not familiar with the recommendations of those guidelines, nor were there systems in place to support the consistent adherence of those guideline-based practices.

Monitoring of quality: Collecting and monitoring quality of the management of chronic pain has been largely absent. There is no CHC-specific or Wisconsin-based quality data available to inform our needs assessment. Among survey respondents, 100% report that they do not regularly monitor quality data for patients with chronic pain.

Opiate abuse: In addition to sub-optimal practices in place for the management of chronic pain, non-medical use of opiates continues to be a significant problem in Wisconsin. During 2008-2009, 5% of WI residents ages 12 and older reported using pain relievers for non-medical purposes in the past year, matching national prevalence (Wisconsin Department of Health Services, 2012). Health care policies and practices have an important role to play in the amelioration of this problem. The Wisconsin State Council of Alcohol and Other Drug Abuse issued a Call to Action in 2012 that included 32 recommendations in eight priority areas. Health care policy and practice was one of the priority areas identified, and several of the recommendations addressed issues of education, training, and safe and consistent access to care. The authors further note that “the medical professional and the regulatory community continue to struggle to identify a true balance between the needs of patients for appropriate pain control and the needs of public health and public safety with respect to controlled substance diversion and overdose deaths. “Practice guidelines... can assist clinicians in making the most appropriate clinical decisions when prescribing controlled substances.” (p 15) This sentiment was shared by a CHC provider in a WPHCA focus group who expressed a strong interest in additional training in treatment best practices and standardization of pain management procedures within their clinic: “[I want to know whether I am] helping the patient with their pain or creating an addict.”

Wisconsin’s Prescription Drug Monitoring Program (PDMP): Wisconsin’s PDMP did not begin collecting data until January 1, 2013. As such, it is a relatively new tool for CHCs to utilize. There are varying levels of awareness of the tool and a significant statewide need for systematic integration of the tool into CHC workflows, policies, and procedures. In May 2012, the National Association of State Controlled Substances Authorities awarded a grant to the Wisconsin Department of Safety and Professional Services to create interactive e-learning tutorials about the PDMP, but they are not yet available. Through the collaborative learning process, our CHCs could share information about use of this tool, integrate the tool into their clinic workflows, and increase the ability of all our learning network participants to integrate this important process into their systems of caring for patients with chronic pain.

Access to behavioral health services and alternative therapies: CHCs operate in a wide variety of locations, ranging from densely populated urban settings to rural communities. The patient population served is racially diverse and low-income. CHCs have varying degrees of integration of and access to behavioral health services for indicated patients. Some CHCs have integrated systems of care, while others have a single behavioral health care provider and are exploring new integration processes through their PCMH team based care model. And still, many CHCs continue to struggle to identify local resources for comprehensive services for specialty assessment and management of patients with complex mental health and substance abuse treatment needs. Additionally, access to alternative therapies such as physical rehabilitation and mind and body approaches is limited, either by geography or by patient ability to afford such therapies.

PCMH transformation: The PCMH recognition process has shown dramatic transformation in the team-based approaches to the diagnosis, treatment, and population management of many chronic conditions. Wisconsin CHCs have undergone this transformation despite an environment that offers no ongoing financial incentives. Additionally, there are no current fiscal incentives for implementing or sustaining guideline-based chronic pain management in the PCMH context. Despite that, our survey of likely project participants found that all but one CHC has already undergone changes to their pain management approach in light of their PCMH transformation. This is a sturdy foundation on which to situate this quality improvement initiative.

Primary audience: The primary audience of this peer learning collaborative will be the 5-6 CHC improvement teams. Each participating CHC will convene a multi-disciplinary team to complete this project, and will incorporate this project in their quality improvement structure of their organization to support systemization of the project. Each team in turn will define the patient population they will be effecting change upon who will benefit from the project outcomes. Following completion of the project, dissemination of lessons learned will be completed as described in the evaluation design.

Intervention design & methods

Utilization of guideline-based practices: As a major emphasis of this effort, the implementation of guideline-based practices will be the focus for each team as they identify pain management improvement goals and initiate rapid improvement cycles. In utilizing a project model where we allow CHCs to exercise autonomy in selecting their initial target for improvement, we are “meeting them where they are at” and allowing them to leverage local intelligence about their individual systems and the changes that would be most relevant, have the greatest impact, and be the most reasonably achieved. Such self-directed changes will create a sustainable infrastructure with a high-degree of CHC buy-in for sustaining the changes beyond the program funding end.

- Short-term goals:
 - 100% of CHC pain management improvement teams will have identified at least one pain management improvement goal
 - 100% will have initiated at least one PDSA rapid improvement cycle
 - At least 2 CHC pain management improvement teams will have shared early findings on learning collaborative calls.
 - Baseline data for patient engagement/satisfaction/activation and provider/staff satisfaction.
- Mid-term goals:
 - 100% of CHC pain management improvement teams will have completed 1 or more PDSA rapid improvement cycles
- Long-term goals:
 - 100% Health Centers will have implemented system changes to improve care for patients with chronic pain based on the PCMH model

- 100% CHCs will have increased utilization of guideline-recommended treatment options
- 80% CHCs will have integrated best practices and guidelines in EMR decision support tools
- 50% CHCs will have reported increased internal/external referral sources to behavioral health services for patients
- 50% CHCs will have reported increased internal services/referral sources to alternative therapies

WPHCA staff will maintain documentation of quality improvement targets and PDSA cycles and will assist CHC teams in sharing their findings with the learning network on monthly calls.

Monitoring of quality:

An initial task of the project will be to seek agreement among the teams and establish baseline measures for patient satisfaction/engagement/activation. This will be achieved by month 4 of the project. In month 12 this measure will be repeated. WPHCA staff will analyze results and convey them to participating CHC teams. **We are projecting a 10% increase.** We do not anticipate dramatic improvements in the measure of patient satisfaction in such a short duration, and anticipate that gains may be mitigated by patient reaction to changes as policies are established or more systematically enforced.

We will also measure staff and provider satisfaction by surveying participating CHC staff by month 4 and again at month 12. **We are projecting a 10% increase** in this measure. We anticipate that primary care providers will show improved satisfaction as procedures become more standardized and consistent, knowledge increases, peer support is gained through learning collaborative, and the burden of care for these patients is shifted from the individual provider to the care team. Likewise, we anticipate that gains in care team satisfaction may be mitigated by change fatigue and increased involvement in the care for patients with chronic pain.

In our initial planning process, CHCs will identify metric(s) for measuring patient outcomes utilizing guideline-recommended functional status and/or quality of life assessment tools. Throughout the program period CHC teams will work to integrate these tools. At the end of the project period WPHCA staff will survey teams to determine how many CHCs have systems in place for measuring functional status and/or quality of life.

All of these measurement activities will address the NCQA PCMH Standard 6: Measure and Improve. These measures will serve as an important marker of gains in quality as a result of the changes being made by the CHCs and will also serve to introduce sustainable processes of monitoring quality for patients with chronic pain at the CHCs beyond the project duration and will leave an important legacy of quality monitoring both at the participating CHCs and within the overall learning community of Wisconsin CHCs and PCMH sites across Wisconsin.

Other measures of quality will be based on the system changes selected by each CHC team. Using their PDSA design, the CHC project leader will compile and report data for each team.

Integration of Wisconsin's Prescription Drug Monitoring Program into workflow: WPHCA staff will explore opportunities to partner with the Wisconsin Department of Safety and Professional Services to assist CHCs in capitalizing on learning opportunities. Strategies for the implementation of the PDMP will remain an agenda item on learning collaborative calls until CHCs indicate that they have secure systems in place for the full integration of PDMP into their chronic pain workflow. **Our goal is to document integration strategies and barriers and assist CHCs in sharing experiences throughout the learning collaborative and beyond.**

Access to behavioral health services and alternative therapies:

CHCs will be supported as they identify and engage local and regional expertise for patients with complex mental health and substance abuse needs as well as resources for alternative pain management therapies. **Our target is a minimum of 50% of CHCs reporting increased resources** (see logic model). WPHCA will facilitate the sharing of experiences and will also coordinate state-wide resource exploration and identification. WPHCA staff will record progress on connections and a project-end survey will be administered to collect data on new relationships and referral pathways established as part of this work.

Dissemination Plan:

As discussed above in Objective 6, there are dissemination strategies built into the design of the project. Primary dissemination will occur through the PPLN, but will be extended to other WPHCA peer learning networks and activities, such as the medical directors, behavioral health, and clinical operations group networks and the Fall Learning Session. Progress and updates of the project will also be reported to the WPHCA Performance Excellence Committee which reports to the WPHCA Board of Directors.

HRSA supports learning teams among Primary Care Associations nationwide that are analogous to WPHCA's peer learning networks. WPHCA staff will pursue dissemination of lessons learned through the PCA Quality Learning Team, or others as appropriate, as well as NACHC meetings.

Organizational Detail

The Wisconsin Primary Health Care Association (WPHCA) is a 501(c)(3) organization that was founded in 1982 to provide technical assistance to Wisconsin's community, homeless, and migrant health centers. The mission of WPHCA is to advance the efforts of Wisconsin community health centers (CHCs) in providing access to comprehensive, community-oriented, primary health care services. WPHCA accomplishes its mission through a wide range of activities and services, including developing partnerships, gathering and disseminating information, educating the public, and providing training and technical assistance to our CHC members. WPHCA actively works with its health center membership and partners to educate decision-makers about health care access issues facing vulnerable populations, to leverage resources among local, state, and national stakeholders, and to develop collaborative programs to improve the quality and viability of Wisconsin's health centers so they are able to increase access to primary care.

In addition to primary project staff, participating organizations will include 5-6 Health Center teams:

- **Access Community Health Centers – Madison:** Access has significant expertise in integrated behavioral health care. The clinic site involved, William Evjue Clinic, is NCQA Level 3 PCMH recognized.
- **Family Health/La Clinica – Wautoma:** Based in rural central Wisconsin, Family Health/La Clinica's mission is to continually improve the health of all people in the communities they serve. La Clinica currently has two sites, its primary site is in Wautoma and a second dental site is located in Mauston. They have an active PCMH transformation team that intends to submit their survey to NCQA by Fall 2014. They are currently remodeling their Wautoma facility to support the PCMH model of team based, patient focused care.
- **NorthLakes Community Health Center – Hayward:** NorthLakes CHC serves a sparsely populated, rural region in 4 clinic locations. They have recently expanded to provide integrated health care services for members of the communities they serve. In addition to providing medical, dental, and behavioral health care, NorthLakes provides

chiropractic, pharmacy, physical therapy and patient support services. One of the 3 medical sites has achieved PCMH recognition.

- **Northern Health Centers (NHC) – Lakewood:** Northern works to improve the health of their community by providing all persons with quality, family oriented primary health care services. Northern provides medical, dental, and behavioral health services in Lakewood and Oconto. Northern has been actively engaged in PCMH transformation and is preparing their survey for submission to NCQA.
- **Sixteenth Street Community Health Centers (SSCHC) – Milwaukee:** Since 1969, Sixteenth Street has provided high quality health care, health education and social services to low-income residents of Milwaukee’s culturally diverse south side. In 2012, SSCHC opened a fifth clinic location in Waukesha, a suburb of Milwaukee. Sixteenth Street has achieved both Level 3 NCQA PCMH recognition and Joint Commission Accreditation in the last 1 ½ years.
- **Progressive Community Health Centers – Milwaukee:** Progressive exists to improve the health and quality of life of the community by providing culturally competent services that address identified needs. Just 1 week ago, Progressive broke ground to build a new clinic at their Lisbon clinic site, allowing them to expand services to the predominately African-American population that they serve. Progressive currently has a survey submitted to NCQA for PCMH recognition.

WPHCA believes that this cohort of practices is exceptionally strong due to their engagement and interest in the project, the significant leadership buy-in already demonstrated, and the sophistication of their quality improvement systems as organizations.

In conclusion, the PPLN project will assist these CHCs in developing their own capacity and expertise to address the needs of their patients with chronic pain more effectively, while capturing the key program features and lessons learned to share with other CHCs and primary care practices. We appreciate your thoughtful consideration of this proposal.

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