Safe Prescribing Action Group:
The Art and (very little) Science of Tapering Opioid Medications
Agenda

• Housekeeping & Accreditation
• The Art and (very little) Science of Tapering Opioid Medications
• Progress and bright spots
• Planning for March 24, in-person convening
Faculty

Andrea Rubinstein, MD
Kaiser Santa Rosa Medical Center
Chief, Department of Chronic Pain
Department of Anesthesiology
Local Research Chair - Santa Rosa
Assistant Clinical Professor of Family and Community Medicine UCSF
Housekeeping

• This session will be recorded
• Slides and recording will be posted on action group website (Basecamp) within a week
• To ask a question:
  – Logistical questions: Use CHAT to the Host
  – Questions for Speakers: Use CHAT to ALL
• Webinar Evaluation: please take a moment at the end of the webinar to give feedback
Accreditation Information

Physicians

Boston University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Boston University School of Medicine designates this live activity for a maximum of 1.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Target audience: Residency Programs Across California

• Educational Objectives:
  – Identify situations when tapering is appropriate
  – Learn to design most appropriate type of taper for particular patients
  – Gain skills at trouble shooting taper problems to avoid derailing

FOR CME CREDIT: Complete evaluation
Faculty

**CME Course Director:** Daniel Alford, MD, MPH, FACP, FASAM

- Dr. Alford has nothing to disclose with regard to commercial interests.

**Andrea Rubinstein, MD**

- Dr. Rubinstein has nothing to disclose with regard to commercial interests. She does not plan on discussing unlabeled/investigational uses of a commercial product.
The Art and (very Little) Science of Tapering Opioid Medications

Who, Why, When and How

Andrea Rubinstein, MD
Chief, Department of Chronic Pain
Santa Rosa
Objectives

- Identify situations when tapering is appropriate
- Learn to design most appropriate type of taper for particular patients
- Gain skills at trouble shooting taper problems to avoid derailing
Disclosure

All persons involved with the planning and presenting of this activity have not had any financial relationships in the past 12 months with any commercial interest or any proprietary entity producing health care goods or services that is relevant to this CME activity.
Warning
Survey #1
I believe opioids are safe and effective in selected patients when used long-term

A. True
B. False
Survey #2
How confident are you that you could create and execute a taper plan for a patient on opioids?

A. Very confident
B. Somewhat confident
C. Not confident
What is an Opioid Taper?

A opioid taper is a progressive decrease in the amount of opioid taken with a goal of leading to reduced risk and or opportunity for greater overall quality of life for the patient.
The Bottom Line:

Do not start a medication you do not know how to stop.
When to Taper

When what the drug is doing TO the patient is more than what the drug is doing FOR the patient.
Identifying Clinical Risk of Opioid Use

- **Abuse and Diversion**
  - Early refills
  - Lost or stolen medications
  - Escalating dose requests
  - Emergency Room Visits
  - Hx of substance Abuse

- **Medical Risks**
  - Endocrine
  - Sleep apnea
  - EKG changes
  - Polypharmacy

- **Psychological Risks**
  - Depression
  - Relationship Issues
  - Cognitive decline

- **Functional Issues**
  - Disability
  - Inability to manage co-morbidities
  - Falls
  - MVA
Who to Consider for Taper

- Motivated patients
- Young patients
- Patients who say “it’s not working” or “it takes the edge off”
- Patients with diagnosable hyperalgesia
- Patients with declining function despite opioids
- Patients on opioids and complex polypharmacy
- Patients whose underlying pain issue may have resolved
Who not to taper

- Addicted patients
- Palliative care patients
- Psychiatrically fragile or unstable patients
- Pregnant patients
Digression: Dependence vs. Addiction

National Institute of Drug Abuse 2007
Reasons NOT to not taper

- “It takes the edge off….”
- “I have more pain when I skip a dose so I know it is doing something…”
- “I tried to stop before and my pain got out of control”
- “It is the only thing that lets me work 16 hours per day”
- “I can’t figure skate competitively without this”

Opioids are not performance enhancing drugs
And avoidance of withdrawal is not a reason to remain on opioids long-term
Survey #3

- Titrating opioid doses up over time to compensate for tolerance can be a successful long-term strategy for helping chronic pain patients manage their pain
  
  A. Agree
  
  B. Disagree
Types of Tapers

- Physician Directed Taper
- Patient Directed Taper
- Rapid Taper
- Group Taper
- Inpatient Taper
Rules of Thumb for Tapering

1. The longer on opioids the slower you go
2. Medications not used daily can be stopped without a taper
3. Use only one “small currency “ opioid
4. Down is easier than off
5. Rule of thirds
6. Most patients tolerate 10% reductions
7. Virtually no one tolerates 25% reductions well
8. Going slowly is always better than stopping or giving up
9. The best taper is the one that works
10. Once off, many patients return to opioid use within a few years
Case #1: Complex Comorbidities vs. Iatrogenesis Multiforme

- 55 year old man new to KPNC with axial low back pain since 1980’s.
- New chest wall pain since falling off the toilet. Difficulty urinating, permanently disabled.
Past Medical History:

- 9 knee surgeries
- History of melanoma 1991
- History of interstitial nephritis requiring dialysis
- History of alcohol abuse, in AA since 1983
- History of abusing: carbisoprodol, diazepam, codeine, oxycodone
Medications

Medication Detail

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Quantity</th>
<th>Refills</th>
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<tbody>
<tr>
<td>METHADONE 10 MG ORAL TAB (Discontinued)</td>
<td>1800</td>
<td>0/0</td>
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</table>

Sig: Take 15 tablets orally 4 times a day
Route: Oral
Reason for Discontinue: Continue Therapy
Class: Fill Now
Order #: 135085156

2 Years Ago: methadone 40 mg QID
400% increase in 2 years
Digression #1: Opioids and Low Back Pain

No evidence of efficacy for opioid medication for axial low back pain past 16 weeks

Axial low back pain is one of the most difficult to treat pain conditions and *rarely if ever* responds to pharmacotherapy.
Comorbidities:

- Hypertension – hydrocholothiazide, metoprolol
- Hyperlipidemia – on simvistatin
- Depression – on citalopram 60 mg PHQ9=19
- No libido and poor sexual function
- Sleep apnea (refusing CPAP)
- Bladder outlet problem – on tamsulosin
- Chronic nausea – on promethazine
- History of melanoma and interstitial nephritis
Case 1: The Physical Exam

- Alert, oriented and appropriate
- Pale, puffy, slightly feminized features
- Overweight
- Walks with a cane
- Some allodynia generally to light touch
- Examination maneuvers painful
- Exquisitely tender along mid axillary line
- Extreme de-conditioning
The “B.E.S.T” Workup

- Bone Density
- EKG
- Sleep study
- Testosterone, total AM
The Workup:

469  Qtc
41   Total Testosterone
75   SpO2
-2.4 T score
Digression: QT prolongation

Center for Substance Abuse Treatment Consensus Panel Recommendations:

- Inform patient of risk
- Clinical history
  - structural heart disease, arrhythmia, and syncope
- Obtain EKG
  - Pretreatment
  - After 30 days
  - Annually
- More frequent EKG
  - Dose > 100 mg daily
  - unexplained syncope or seizure

- \( QTc > 450 \) and < 500
  - More frequent EKG
  - Risks vs. benefits
- \( QTc > 500 \)
  - Discontinuation?
  - Contributing factors?
  - Alternative?

- Be aware of interactions
  - SSRI
  - antibiotics
  - Psychotropics
  - antiemetics
Sudden Cardiac Death and Methadone

An Analysis of the Root Causes for Opioid-Related Deaths in the United States
Androgen Deficiency

- Common
- Quick
- Profound
- Reversible (usually)
# Elucidating Risk Factors for Androgen Deficiency Associated with Daily Opioid Use

Andrea Rubinstein, MD, Diane M. Carpenter, MPH

*Kaiser Permanente Medical Group, Santa Rosa, Calif; Kaiser Permanente Division of Research, Oakland, Calif.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Odds Ratio</th>
<th>Confidence Interval</th>
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<tr>
<td><strong>Duration of Action</strong></td>
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<tr>
<td>long vs. short</td>
<td>5.78</td>
<td>2.44 -13.67</td>
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<tr>
<td><strong>Dose</strong></td>
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<td></td>
</tr>
<tr>
<td>10 mg short</td>
<td>1.24</td>
<td>1.07 -1.44</td>
</tr>
<tr>
<td>10 mg long</td>
<td>1.02</td>
<td>1.00 -1.03</td>
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<tr>
<td><strong>Age</strong></td>
<td>1.01</td>
<td>0.99 – 1.04</td>
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</tbody>
</table>

Adjusted Odds Ratios for Androgen Deficiency in Patients with BMI <30, No Diabetes, No Hypertension, and No Hyperlipidemia.
Does Opioid Use for Pain management Warrant Routine Bone Density Screening in Men?

<table>
<thead>
<tr>
<th>Testosterone Range</th>
<th>Normal</th>
<th>Osteopenic</th>
<th>Osteoporotic</th>
<th>Total</th>
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<tr>
<td>hypogonadal</td>
<td>11 (50%)</td>
<td>9 (41%)</td>
<td>2 (9%)</td>
<td>22 (27%)</td>
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<tr>
<td>Non-hypogonadal</td>
<td>34 (58%)</td>
<td>20 (34%)</td>
<td>5 (8%)</td>
<td>59 (73%)</td>
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<tr>
<td>total</td>
<td>45 (56%)</td>
<td>29 (36%)</td>
<td>7 (8%)</td>
<td>81 (100%)</td>
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</table>

Fortin JD et. al. Pain Physician 2008; 11:4: 539-541
Risk Benefit Analysis

Abuse and Diversion
- Early refills
- Lost or stolen medications
- Escalating dose requests
- Emergency Room Visits
- Hx of substance Abuse

Medical Risks
- Endocrine
- Sleep apnea
- EKG changes
- Polypharmacy
- Bone Density
- GI / GU

Psychological Risks
- Depression
- Relationship Issues
- Cognitive decline

Functional Issues
- Disability
- Inability to manage co-morbidities
- Falls
- MVA
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- Disability
- Inability to manage co-morbidities
- Falls
- MVA
And of Course...
Patient Expectations of Pain Relief with Opioids (20 women and 27 men)

<table>
<thead>
<tr>
<th>Domain (PCOQ)</th>
<th>Patients Criteria (mean)</th>
<th>Reduction obtained</th>
<th>T</th>
<th>Cohen’s d</th>
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<tr>
<td>Interference</td>
<td>49.34</td>
<td>10.04</td>
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<td>2.63</td>
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</table>

Taper?
Don’t Taper?
STEP 1: The Buy in

- Forwarn
- Option to return
- Reassure
- Educate and Encourage
- Support
- Treatment Plan in Writing
## Physician Directed Taper

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<td>% drop</td>
<td>Daily mg #/DAY</td>
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<td>75</td>
<td>2.5</td>
<td>18</td>
<td>15.00</td>
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Withdrawal
Troubleshooting the Taper

- Reassure Reassure Reassure
- Adjuvant medications
  - Clonidine
    - 0.1-0.2 mg BID or TID
  - Immodium
  - Benzodiazepines only at the last 7 days
- Hold or slow the taper at 1/3s
- Watch the clock
- The lower the dose the slower you go
- PAWS
Buprenorphine

- If a physician prescribes, dispenses or administers buprenorphine (Suboxone®/Subutex®) for the treatment of pain or for any other reason, a DEA registration is required because both products are Schedule III controlled substances. The DATA waiver specifically authorizes qualified practitioners to treat narcotic dependent patients, using FDA approved Schedule III-V narcotic controlled substances for maintenance and detoxification. The DATA waives the requirement for obtaining a separate DEA registration as a narcotic treatment program for physicians using the approved drugs for maintenance and detoxification; however, it does not apply to physicians using Suboxone® or Subutex® for the treatment of pain. A physician using Suboxone® or Subutex® for the treatment of pain would be required to register with DEA as practitioner with Schedule III privileges.

Sincerely, Patricia M. Good, Chief, Liaison and Policy Section, Office of Diversion Control, Drug Enforcement Administration, U.S. Department of Justice

Case 2

- 58 y.o. woman with chronic pain on opioids. First evaluated in Pain clinic in 2011. She says she has had chronic pain since the age of 2 and estimates she has been on opioids for more than half her life. She states she has had 13 concussions, the first at age 2 and the most recent 3 months ago.

- She is the caregiver for her grown daughter who was sexually assaulted and now requires round the clock care.

- Pain is 10/10 now, though she looks comfortable and goes as high as 15-20/10
Her sleep is described as good, sleeping from 11 p.m. to 9 or 10 a.m. with a 2-hour nap during the day. No history of sleep apnea. Bowel function described as normal. Mood is described as good. Memory is described as very good though she admits it used to be better.

PHYSICAL EXAMINATION:
She is well groomed but with somewhat pressured speech rambling and unfocused when answering questions. She arrived 40 minutes late for our appointment because she got lost. Cranial nerves II-X appear intact but she's extraordinarily sensitive to even light pressure on her scalp. Sensory and motor appear to be intact.
Current Medications:
- Lorazepam 8 mg daily
- Oxycodone-IR 30 mg 8 tablets 5 times daily
- Fentanyl Patch 250 mcg/hr
- Pseudoephedrine 30 mg tablets, two tablets three times a day.
- Bupropion 300 mg XL
Opioid Escalation

- **2005**
  - Oxycodone IR 80 mg /day
- **2008**
  - Oxycodone 960 mg per day
  - Fentanyl 250 mcg/hr
  - Lorazepam 1 mg per day
- **2009**
  - Lorazepam 2 mg per day
- **2010**
  - Lorazepam 4 mg per day
- **2011**
  - Lorazepam 8 mg per day
  - Oxycodone 1200 mg per day
  - Fentanyl 250 mcg
Total morphine equivalent: 2300 mg/day
Total diazepam equivalent: 40 mg/day
Taper recommended
2014

- Pharmacy calls that patient is claiming pharmacists are writing secret messages on her pill bottle and calling her an addict and laughing at her behind her back
- Patient re-evaluated
  - Lorazepam now 20 mg per day
  - Oxycodone now 1560 mg per day
  - Fentanyl 250 mcg/hr
Identifying Clinical Risk of Opioid Use

**Abuse and Diversion**
- Early refills
- Lost or stolen medications
- Escalating dose requests
- Emergency Room Visits
- Hx of substance Abuse

**Medical Risks**
- Endocrine
- sleep apnea
- EKG changes
- Polypharmacy

**Psychological Risks**
- Depression
- Relationship Issues

**Functional Issues**
- Disability
- Inability to manage co-morbidities
- Falls
- MVA
Patient does not want to taper
# Taper schedule

<table>
<thead>
<tr>
<th>DRUG TO TAPER</th>
<th>PILLS SIZE</th>
<th>dosage</th>
<th># TIMES DAILY</th>
<th>TOTAL DAILY DOSE</th>
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<td>OXYCODONE</td>
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<th>start date</th>
<th>% reduction min</th>
<th>% reduction max</th>
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<th>Daily mg #/DAY</th>
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<th>mg change</th>
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December 2015

- Pain is the same 10/10 though patient claims she is completely non-functional but still cares for her daughter appears well groomed and dressed. Arrives on time to pick up medications monthly.

  Lorazepam 6 mg per day
  Oxycodone 270 mg per day
  Fentanyl 250 mcg/hr
Case 3

- BL is 64 y.o. morbidly obese woman with axial low back pain. Pain is worse with exercise, walking, standing and lying down. Alleviating Factors: “Pain is better with meds.”
- Uses Norco 10/325 4 tablets daily
- Also uses alprazolam daily 0.5 mg
- Dose is stable and modestly effective
- Depressed with daily crying
- Very limited function even before opioid usage due to weight. Requires a walker to walk.
- DOES NOT WANT TO TAPER
Identifying Clinical Risk of Opioid Use

- **Abuse and Diversion**
  - Early refills
  - Lost or stolen medications
  - Escalating dose requests
  - Emergency Room Visits
  - Hx of substance Abuse

- **Medical Risks**
  - Endocrine
  - sleep apnea
  - EKG changes
  - Polypharmacy

- **Psychological Risks**
  - Depression
  - Relationship Issues

- **Functional Issues**
  - Disability
  - Inability to manage co-morbidities
  - Falls
  - MVA
Taper?

Don’t Taper?
Our Plan:

- Sleep Apnea: CPAP titration to good effect
- Weight loss plan to reduce risk
  - Weighs in before picking up her prescription
  - Weight must be less than preceding month
Case 2

Monthly weigh ins:

Weight

1st visit

Date

Lbs

02/12/2011 03/22/2011 08/29/2011 12/06/2011 03/14/2012 06/21/2012 09/23/2012 01/05/2013 04/14/2013 07/22/2013 10/25/2013
Opioid dose the same, Patient is Better

- >10% of her body weight (38 lbs.) lost in 9 months.
  - Reducing diabetes risk > 58%
  - Reduced risk of hypertension
  - Reduced load on knees may be 4 x weight loss
  - Mood is 100% better

- Can walk better

- Offered her the option to return to her PCP for ongoing opioid but she chooses to stay with me even though she must continue to weigh in.
Summary:

- Received bilateral hip replacements at 250#
- Self discontinued all opioids

“I have a whole new life. I am not going to stop losing weight until I weigh less than 200 lbs.”
Summary

- The goal is to make the patient better
- Risk benefit assessment
- Design appropriate taper type
- Modify the taper as appropriate
- Goal is not always off
- Sometimes opioids are not the biggest problem
How confident are you that you could create and execute a taper plan for a patient on opioids?

A. Very confident
B. Somewhat confident
C. Not confident
Andrea Rubinstein
3559 Roundbarn Blvd
Santa Rosa, CA 95403

andrea.L.rubinstein@kp.org
707-571-3931
# Bright Spots – Opioid Review Committees

## Chronic Opiate Review and Evaluation Committee (CORE) Referral Form

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<td>Date of Referral</td>
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What is your reason for referral?

---

### Aberrant medication related behaviors

Please list any aberrant medication related behaviors.

---

- Latest urine drug screening: Yes/No
- Were results consistent with prescribed medication? Yes/No
- Latest Patient Drug Monitoring Program report: Yes/No
- Were results consistent with prescribed medication? Yes/No
- History of positive/negative urine drug screens or abnormal PAMP activity? Yes/No
- Notable prescription written for? Yes/No
- ICU/XX assigned to chart for CORE registry? Yes/No

### Risk Factors for Opioid Abuse/Diversion/Overuse

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<th>Yes</th>
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<td>Family history of substance abuse/addiction</td>
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<tr>
<td>ADHD, ADD, PTSD, Schizophrenia, Bipolar Disorder, OCD</td>
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<tr>
<td>Depression</td>
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<tr>
<td>History of opioid use with medication</td>
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<td>History of overdose</td>
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<tr>
<td>History of physical or sexual abuse</td>
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## Chronic Opiate Review and Evaluation Committee (CORE) Recommendations Form

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<td>Committee Review Date</td>
<td>Date Sent to PCP</td>
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### Completed

#### Medications

- Opioids:
  - Muscle relaxants:
  - SSRIs:
  - SNRIs:
  - TCA:
  - NMDA/Aglycines:
  - Topicals
  - Immuno-modulators

#### Procedures

- Joint injection
- Trigger point injection
- I/F and/or local
- Neuroma referral for epidural injection
- Referral to Pain Management for local block or pump
- TENs/PENS

#### Complementary and Alternative Medicine

- Massage
- Countertreat
- Chiropractic
- CMF
- Yoga
- Tai Chi
- Acupuncture
- Acupuncture
- Anti-inflammatory eating pattern
- Herbs or supplements
- Meditation
- Gratitude journals

#### Referrals

- Rheumatology
- Pain Medicine (Required if on >100 mg morphine equivalent for non-cancer pain)
- Physical Therapy
- Orthopedics
- Neurosurgery
- Psychiatry
- Imaging

#### Safe Prescribing

- Taper medications
- Methadone non-refusal
- Suboxone referral
- Withdrawal symptoms pack: Clonidine 0.1 mg B/D PRN
- Mirtazapine 15 mg PRN evening; Oxycodone 4 mg q6
- PRN nausea: Trazodone 50 mg qHS PRN insomnia
Gearing up for March 24 Convening

• Help shape the agenda http://goo.gl/forms/g38uYcPHXs
  – Non-opioid pain management strategies
  – PT/OT approaches
  – How to avoid new starts
  – Other topics…

• Each residency program will have an opportunity to share (5m)
  – Pecha Kucha - show 15 images, each for 20 seconds. The images advance automatically and you talk along to the images.
  – Share your successes (5 images), challenges (5 images), and lessons learned (5 images), with colleagues.
  – http://www.pechakucha.org/
# Residency Action Group 2015-16 Calendar

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<td>QI and Change Mgmt</td>
<td>Behavioral Health</td>
<td>SCOPE, Team planning</td>
<td>Patient engagement, self-care, integrative medicine</td>
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**California Improvement Network**

Better Ideas for Care Delivery
Please Fill Out the Evaluation (CME Credit)

http://goo.gl/forms/uL2Vbjt7Ig
Questions?

- Kristene Cristobal, coach and project manager
cristobalconsulting@gmail.com

- Kelly Pfeifer, MD, Project Lead
kpfeifer@chcf.org