Chronic Pain and Occupational Therapy: A Proposal to Virginia Garcia Memorial Health Center

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Description
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Disciplines
Occupational Therapy | Rehabilitation and Therapy

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Chronic Pain and Occupational Therapy:
A Proposal to Virginia Garcia
Memorial Health Center

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May 2012
Abstract

This innovative practice project explores the needs of a local community-based healthcare non-profit and the possibility of incorporating occupational therapy within current practice with regard to clients experiencing chronic pain. Methods included learning about the organization, interviews and observations at other local organizations that treat chronic pain, instrumental implementation of stretch breaks during pain courses, and completion of a pilot home assessment. Outcomes thus far have improved setup of pain courses and incorporated facilitated movement for clients with chronic pain who are wary to increase their level of activity. A formal assessment of home setup and activity analysis was completed for a client, which led to recommendations and educational opportunity to improve self-management of pain. Future ideas include development of occupational therapy services in addition to future projects for occupational therapy students.
Table of Contents

Introduction 1

Needs Assessment 3

Models and Theories 5

Evidence of Efficacy: Occupational Therapy and Chronic Pain Management 7

Gathering Info: Current Local Practices Addressing Chronic Pain 12

Pain and Function 17

  Pain Myths and How to Promote Movement 17

  Pain and Cognition: Memory & Attention 18

Pain and Generalization of Information: Home Assessment as Possibility 19

Occupational Therapy as Part of Treatment at Virginia Garcia Memorial Health Center

  Groups

  Home Visits

  Interdisciplinary Team Role

Outcomes & Future Directions of OT @ VGMHC

References
Table of Appendices

Appendix A: Pain Class Client Binder Materials
Appendix B: Instructional Stretch Posters for Pain Class
Appendix C: Additional Class Resources Developed
Appendix D: Presentation
Chronic pain has become an increasingly important issue in health care. For the purpose of this project, “chronic pain” is defined as persistent perception of pain signals by the nervous system for weeks, months, or years (American Academy of Pain Medicine, 2011). According to the Board on Health Sciences Policy’s Committee on Advancing Pain Research, Care, and Education (2011), chronic pain affects an estimated 116 million Americans. The cost for care regarding pain in the United States is estimated to range between $560 and $635 billion dollars (in 2010 dollars) (Ibid).

Along with national trends, providers at Virginia Garcia Memorial Health Center (VGMHC) experienced an increase in the early-to-mid 2000’s regarding narcotic prescription requests while there were limited standards within the organization to address the complex needs of clients with chronic pain (A. Turner, personal communication, December 22, 2011). Upon reviewing the data in the following years, VGMHC noticed an increase in overdose-related deaths. Turning to the literature, their practitioners noted a reflection in increased risk of death that positively correlated to higher doses or prescription narcotics. The literature also demonstrated a higher incidence of addiction and brought forth ethical concerns regarding chronic pain management and narcotic use.

VGMHC brought on a staff of behavioral health providers to be included in the team—they would teach 8-session pain classes that became mandatory for clients who wanted to receive prescriptions for narcotic medications. In 2010 and 2011, the healthcare providers at VGMHC began to review and discuss their policies regarding best-practice care for clients living with chronic pain. These revised policies included:

- No prescription of narcotic medications on a client’s first visit
- Client to complete urine and drug screening
- Receipt and review of outside medical records
- 3 visits with behavioral health providers regarding pain inventory, risk assessments, etc.
- VGMHC staff held to strict policies regarding early refills
- Increased multidisciplinary commitment by developing the Controlled Substances Oversight Committee
  - Reviews cases, recommends course of treatment and dosage of narcotics, if necessary
- Lowered ceiling dose of narcotic prescriptions by two-thirds from equivalent of 180 mg morphine to 60-mg
- Many narcotics removed from list as options

This new system was launched on November 1, 2011. However, recognizing that many of the clients would no longer be eligible for narcotic prescriptions, the providers at VGMHC looked to other options in pain management. One of these potential options is occupational therapy, which will hopefully pilot at the Hillsboro site and easily spread to the other clinic sites.
The following document describes current best-practice in occupational therapy as part of a multidisciplinary approach to chronic pain management. It includes specific ideas/pilots of what can easily and quickly be incorporated within VGMHC’s system, as well as explores an option of home assessment to further promote independence and self-efficacy of clients living with chronic pain.
Needs Assessment

Virginia Garcia Memorial Health Center (VGMHC) was developed in 1975 by local healthcare professionals in Cornelius, Oregon, in response to the preventable death of a six-year-old girl, Virginia Garcia. She was the daughter in a migrant farmworker family and they did not have access to healthcare. Virginia died of a bacterial infection that could have easily been treated with antibiotics. The community deigned that healthcare should be accessible to all persons, and so the clinic was started. It has since grown from a single location in a three-car garage to a multi-site organization.

The VGMHC Mission is to “To provide high-quality, comprehensive, and culturally appropriate primary health care to the communities of Washington and Yamhill Counties with a special emphasis on migrant and seasonal farmworkers and others with barriers to receiving healthcare” (VGMHC, 2012). VGMHC recognizes and supports quality care for all clients, but also recognizes the high cost of clients with chronic pain.

VGMHC’s goal is to provide the highest quality and most comprehensive service possible for its clients, recognizing financial and time constraints, and so desires to explore interdisciplinary models of care.

VGMHC currently has three locations in Washington County, Oregon (Cornelius/Forest Grove, Hillsboro, and Beaverton). The Cornelius clinic is temporarily housed in Forest Grove while a new building is constructed, and is planned to open in the fall of 2012). There is a fourth location in Yamhill County, Oregon (McMinnville). VGMHC also has three dental offices and two school-based health centers (Forest Grove and Tigard). They have a mobile clinic that travels to schools, provides community outreach, and addresses basic needs of local migrant worker campus.

VGMHC serves over 34,000 clients from a variety of ethnic and cultural backgrounds and languages. In relation to this project, VGMHC recognizes the need to provide comprehensive services for clients with chronic pain, but also recognizes that prescription narcotics are not an effective method of treatment alone. Instead, there is increasing evidence of the efficacy of interdisciplinary care with regard to chronic pain (see Evidence of Efficacy).

Partnership with Pacific University and the College of Health Professions strengthens VGMHC’s ability to carry out its mission by making services more accessible to its clients. The Pacific University School of Physical Therapy Clinic currently sees some of VGMHC’s clients on a sliding fee-for-service scale. Pacific University’s students in the School of Physician Assistant Studies see VGMHC and other clients with barriers to healthcare at Essential Health Clinic. The School of Dental Health Science also provides services to VGMHC clients with sliding scale and monthly payment plans. Students in the School of Pharmacy have intern experience at the VGMHC Pharmacy at the Hillsboro campus.
Despite this vast array of partnerships with Pacific University, the practitioners at VGMHC recognize that there is a gap in service availability for persons with chronic pain who will not receive prescription narcotics. VGMHC currently has a thorough screening process regarding client history, potential for substance abuse, and other concerns. Not all of their clients will meet criteria to receive narcotics, and the clinic is trying to decrease the prescriptions overall. Data from VGMHC regarding clients that have been seen for pain-related issues (2,558 total) show that 1,541 (60.24%) are receiving narcotic pain medications.

The School of Occupational Therapy at Pacific University entered an interdisciplinary discussion with the other schools and VGMHC to discuss potential options, partnerships, and services to address the specific needs of the chronic pain population. The potential partnership was, in turn, included within a list of community-based projects for students to explore during their final semester of studies. This author showed interest and so joined the interdisciplinary team in learning about VGMHC’s perceived needs and exploring the potential role of occupational therapy services for their clients with chronic pain.

VGMHC is a dynamic and visionary program that has strong roots within the Washington County community and is branching into Yamhill County. They, like most other healthcare agencies, are experiencing the increased service utilization of persons with chronic pain and re-assessing their current standards of practice to not only facilitate comprehensive and quality care, but also provide a safe and well community that recognizes prescription narcotics as one of many ways to address pain management. Occupational therapy is one service which may prove efficient in meeting the vast needs of this growing sub-population while decreasing utilization of other services.
Models and Theories

The Model of Human Occupation, the Person-Environment-Occupation model, and Cognitive Behavior Therapy were selected to be utilized as frames of reference for the profession occupation, and for this project in specific.

The Model of Human Occupation

The Model of Human Occupation (MOHO) is a leading framework for occupational therapy practitioners that focuses on the motivation behind engaging in an occupation, as well as how the activity/occupation is carried out. This model has the following assumptions: a) a person’s characteristics and the external environment are linked together into a dynamic whole, b) occupation reflects the influence of both the person’s characteristics and the environment, and c) a person’s inner characteristics (i.e., capacities, motives, and patterns of performance) are maintained and changed through engaging in occupations (Kielhofner, 2009, p. 149).

An individual’s personal characteristics are heavily taken into consideration while using MOHO as a framework. Volition (i.e. motivation and desire to enact), personal causation (thoughts and feelings about personal capacities), values and interests make up the personal characteristics explored in an interview and brought into consideration for client-centered practice.

Habituation—the “process in which people organize their actions into patterns and routines” (Kielhofner, 2009, p. 151)—allows for a holistic look at the individual’s daily activities, the occupational value set forth by the client, and explores the habits, roles, and routines that are fulfilled while engaging in such.

Performance capacity (that ability a task and how it may be affected by client factors) and environment interplay in a client’s ability to perform. In the example of chronic pain, a client may have a strong desire to cook their own dinner, but have limited time standing without an increase in pain, and so may adapt their environment to include a chair close to their cooking location to promote taking breaks and occupational success in the completion of the task.

The utilization of MOHO as a foundational framework in this project enhances the ability to be client-centered (for example, in home assessment or specific intervention). It includes the client as the greatest source of information regarding their performance, their explanation and understanding of their situation, and promotes comprehension of their individual needs.

Therapeutic strategies within the MOHO framework include validation of the client’s experience, giving feedback (which enhances understanding about their situation), negotiating (acknowledging the client as a team member in their own care and engaging in a give-and-take), coaching and encouraging (Kielhofner, 2008a, p. 185-203).
The Person-Environment-Occupation Model

Law et al (1996) proposed a model to describe the interactions between people, their environment, and the occupations in which they are interested and/or engaged. This model looks at how the client, environment, and demands of the occupation interact to affect or promote occupational performance as a whole.

The person is defined as having dynamic “roles that vary across time and context in their importance, duration and significance” (Law et al, 1996, p. 16). The individual qualities will impact a person’s desire and/or abilities to perform occupations throughout their lifespan, and these attributes may change over time. Their roles also change over time.

The environment is context in which the occupation takes place and may be influenced by the person (ibid, p. 17). It can facilitate or limit performance.

The occupation is any activity to meet “the person’s intrinsic needs for self-maintenance, expression and fulfillment within the context of his/her personal roles and environments” (ibid, p. 17). They are carried out with a purpose.

Combined, these three factors affect occupational performance, or rather, the dynamic and complex interaction of person, environment, and occupation. Each are assumed to affect one another, thus promoting or hindering one’s ability to perform as they would like, or as may be expected and allow for a holistic exploration of multiple factors to be addressed as necessary.

Cognitive Behavioral Therapy

Cognitive behavioral therapy (CBT) addresses an individual’s thoughts in relation to their emotions and behaviors (Kiellhofner, 2009). It is used to help clients reframe the way that they think, change the way they perceive their world around them in relation to their abilities and behaviors. It is used by a wide range of professionals within the health fields for a variety of populations.

Occupational therapists utilize CBT in coordination with occupation, enhancing one’s ability to do while participating in dialogue of thoughts, emotions, and actions to promote generalization of the information and/or proposed change in cognition. This model is one of the bases in VGMHC’s current pain curriculum.
Evidence of Efficacy: Occupational Therapy and Chronic Pain Management

Occupational Therapy as Team Member in Chronic Pain Management


The report from this forum addresses the growing need regarding awareness of occupational therapy’s role within the management of chronic pain, as well as the increase of awareness among therapists (within Canada). The need for a clear, concise description of occupational therapy will assist stakeholders and policy makers to understand its unique contribution.


This literature review explores factors influencing the development of occupational therapy services with regard to meeting the needs of clients living with chronic pain. Layered analysis explored litany (public/media descriptions, quantitative trends); social causes (social, economic, political causes); worldview (paradigm/discourse used to understand our world); and myth/metaphor (identifying/deconstructing conventional metaphors). Three significant factors identified: a) influence of biopsychosocial model, b) occupational therapy philosophy, c) social construction of people with chronic pain. Occupational therapy services are currently needing reflection and ways to measure efficacy of client-centered interventions.


One occupational therapist’s perspective about their role within chronic pain management. The author discusses research and clinical guidelines such as self-management, client-centered strategies and modifications, multidisciplinary team, biopsychosocial perspective of addressing pain, and cognitive-behavior therapy. Also addresses when it is appropriate to refer a chronic pain client for occupational therapy services.

Multidisciplinary Team and Chronic Pain Management

This study explored the efficacy of interdisciplinary team, paired with biopsychosocial approach, in care of 108 clients with chronic pain (80 completed 6-month followup, 46 complete 1-year follow-up). Six treatment domains were assessed: pain severity, emotional distress, interference of pain on function, perceived control of pain, treatment helpfulness, and number of hours resting. Within-subject analysis demonstrated statistically significant findings in five of the six domains between pre-treatment, post-treatment and at 6- and 12- month follow-ups. Emotional distress, while demonstrating statistically significant improvement between pre- and post-treatment, did not further improve in such a manner at 6- and 12- month follow-ups. However, there was noted improvement for all clients after receiving 4 weeks of comprehensive interdisciplinary care.


This article explores current occupational therapy practice in relation to persons with chronic pain, emphasizing the uniqueness it can provide in contributing to clients’ quality of life. As chronic pain affects occupational performance in all areas (work, social participants, activities of daily living, etc), as well as a person’s independence, the philosophy of occupational therapy is equipped to meet the vast needs of this population. Acknowledging the need for more evidence of such, it calls practitioners to learn about the evidence and gather data regarding efficacy of occupation-based intervention within the chronic pain population.

**Evidence Regarding Specific Intervention Approaches**


The development of a tool to assess the functional impact of pain was explored in this article. The need for such a tool stemmed from the importance of understanding how pain impacts one’s ability to function and participate in meaningful activities while more clearly understanding pain from the client’s point of view. Having a tool that will promote client-centered care while educating the clinician about how pain affects their lives supports a holistic approach to meeting a client’s needs. The authors recruited clients and therapists to give feedback on a previously used version of the assessment and, after compiling the data and comments, integrated feedback to improve the Pain and Functional Performance Assessment- Final Version (PFPA-FV). It should be noted that this assessment provided some basis for assessment development at Central
City Concern in a previous innovative practice project, which in turn influenced the current assessment of chronic pain clients that takes place at VGMHC.


In a continuing education article that focused on pain management and older adults, the author pointed out that it is estimated that approximately 50% of community-dwelling older adults by 2020 will live with chronic pain. Occupational therapy services provide a unique approach to holistically treat clients in a blend of biopsychosocial methods that are client-centered, including looking at client roles, routines, habits, and sleep. Physical agent modalities (PAMs) have become the primary non-pharmaceutical method to address pain management on a physical level, followed by therapeutic and range of motion exercises, energy conservation, and adapting tasks or teaching use of adaptive equipment. Orthotics may be included as part of the practice in this area. Client education provides an important basis for psychosocial intervention as it empowers the clients in improving their understanding of their body and provides tools for how they can control pain symptoms. Behavioral approaches, relaxation techniques, mindfulness-based practices, and acceptance and commitment therapies all address the psychosocial factors of pain management. Furthermore, spirituality may be included in part of the psychosocial factors as clients find a way to work with their pain, and such physical interventions such as walking a labyrinth help pair all of the realms of a client’s potential needs into one activity. Occupational therapy has several tools to address the dynamic and varied needs of clients with chronic pain and has demonstrated its effective use of such tools over time and through the research.

**Occupational Performance and Chronic Pain**


The complex experience of clients with chronic pain in relation to daily performance was explored by completion of client interviews and data analysis for common themes. These themes were described as a) “performing is an ongoing attraction,” b) “Getting used to taking breaks is not easy,” and c) “The challenge to finish performing” (p. 49). “Performing as an ongoing attraction” speaks to the innate desire to “do,” to use one’s time in a meaningful way and participate. “Getting used to taking breaks is not easy” addresses the varied method in which clients have learned to cope with their pain as they remain active- be it taking a break, scheduling, developing goals, and dealing with the change in ability to complete tasks. “The challenge to finish performing” addresses the frequent inability the clients experienced to fully
perform a task and how they came to terms with such, or have adapted. It is important to remember that clients are truly motivated to participate.


This study investigated how people with chronic pain adjust to doing activity with pain and how they alter their lives to cope with pain. This study randomly selected 70 participants with widespread pain and 71 with localized pain from a previous study participant pool. 12 participants were selected to participate as a representative sample. Narrative interviews were conducted to understand the effects of pain in three themes: a) experience of current normal weekly structure of occupations, b) coping with pain and sense of well-being, and c) hopes for future occupational life (p. 190). “Reappraisal” of daily activities was a consistent theme, further explored by “altering doing” and “altering values” (p. 191). The alteration of doing activities had common themes: a) slowing down pace/performance, b) opening up for improvisation, c) daydreaming, and d) prioritizing pain-defiers. Altering activities was divided into the follow sub-categories: a) adoption of new values, b) accepting social restrictions and upgrading loneliness, c) finding non-material values, and d) appreciating the ordinary. Participants adapted with concrete, symbolic, and self-reward strategies as they changed their daily routines, activities, and/or values. This article promotes the understanding of a client’s story in coping and adaptability so that the client’s own knowledge about their pain and its impact is validated and included as important information. Furthermore, clients further understand the value they place on occupations and may more effectively use such strategies to improve pain management and improve satisfaction in functional capacity.


Six focus groups were completed with 25 occupational therapists regarding their perceived outcome indicators for interventions among chronic pain clients. An overarching theme of “Limitations for occupational performance” was identified, with five subthemes: a) pain behavior, b) lack of knowledge, c) occupational imbalance, d) emotional stress, and e) physical or environmental strain. The research demonstrates the importance of clinicians recognizing
behaviors so that they may address them and their causes during interventions. Also, the role of the occupational therapist as an educator is further stressed by the outcomes of this research.
Gathering Info: Current Local Practices Addressing Chronic Pain

Background at Virginia Garcia Memorial Health Center

Several meetings took place in order to further understand current services within and close to Washington County that address the needs of clients with chronic pain. In an initial meeting took place on December 22, 2011 with Dr. Ann Turner, Co-Medical Director for VGMHC, to share the clinical history and increase of incidence in chronic pain.

In August 2006, the Primary Care Learning Collaborative (PCLC) (of which VGMHC is one of five participating organizations) traveled to Anchorage, AK to explore how they had redesigned the local health system to address the vast needs of their community in a more efficient manner. All of the PCLC organizations agreed that there need to be specific parameters regarding care for chronic pain, including broader evaluation, contracts, and ceiling doses for narcotic pain medications.

At this point, VGMHC partnered with Lifeworks NW to provide a team of behavioral health providers within their clinics who see clients individually as well as lead mandatory pain classes for clients anticipating receipt of prescription narcotics.

While the investment in behavioral health services and comprehensive assessment improved the situation, VGMHC continued to see an increase in narcotic-related overdoses. They found that the evidence pointed to increased risk of death with higher doses, as well as increased incidence of addiction.

In 2010 and 2011, VGMHC decided to implement new policies that included a) no given narcotic prescription on the first visit; b) mandatory urine and drug screening; c) receipt of outside medical records; d) extensive visits with behavioral health specialists (~3) for comprehensive assessment including pain inventory, functional impact questionnaire, screening for possible addiction concerns, etc. In general, rules tightened regarding early refills. A multidisciplinary committee (Controlled Substance Oversight Committee) was formed to review cases, recommend treatment, and discuss continuation of narcotics and dosage on an individual basis. Ceiling doses were lowered by two-thirds from 180mg morphine equivalence to 60 mg equivalence.

The initial hope of VGMHC at this point is to explore the next steps in providing care, especially for persons who do not meet the criteria to receive prescription narcotics and/or who do not benefit from them. The plan is to implement changes at the Hillsboro site first, and possibly branch to other VGMHC sites. At present, the Controlled Substance Oversight Committee is seeing an increase in younger clients and has an increased concern regarding chronic pain perpetuating decreased function in life overall.
CareOregon and Addressing Chronic Pain

To further understand how VGMHC might address the needs of chronic pain clients, I met with Mr. James Schroeder, CareOregon’s Director of Healthcare Systems, on January 26, 2012. He has been at CareOregon since 2008 and in his tenure has worked on policies, procedures, and methods of improving healthcare delivery systems, including services specifically for chronic pain management.

CareOregon is a non-profit health plan that service Medicaid and Medicare recipients. They have experienced an influx of chronic pain clients to the point where they now provide split services, general primary care and a specialized pain program. They have instituted specific rules and regulations regarding pain management similar to the new rules at VGMHC: drug screening and refusal of narcotic prescriptions at initial visit, behavioral health to address psychosocial needs and applicants for medical marijuana program as well as promote change in client thinking about pain, and physical therapy.

Primary care providers within the CareOregon system are required to refer chronic pain clients to the pain clinic. They are currently working to improve preparation for behavioral health services. Motivational interviewing has become an effective tool in learning about the client and their needs, as well as working with their perception of pain.

Schroeder reports that there are already 300 clients receiving services and oversight by the pain clinic, which is their projected capacity. A few surprises have included negative drug screenings during treatment (and they have found that caregivers are either utilizing the prescriptions and/or selling them) and the need to install panic buttons to can be used to alert office staff and local authorities when a client is aggressive or threatening.

Progressive Rehabilitation Associates and Pain Management

Another service within the Washington County area is Progressive Rehabilitation Associates (PRA). The writer observed and discussed pain management with Jodi Johnson, MOTR/L over three separate days. About half of the services offered at PRA address work hardening and chronic pain management. Their intensive 20-day program for work hardening and chronic pain address physical and/or cognitive abilities, reduction of pain, increased self-management of pain, returning to work, improved functioning, and quality of life (Progressive Rehabilitation Associates, 2012).

The pain management program includes occupational therapy and physical therapy, in addition to psychology, vocational rehabilitation, and occupational medicine as indicated. Participants receive Biofeedback therapy in order to increase their awareness of their body’s functioning and reactions to stimuli. Participants participate in individualized weight training and exercise programs to increase their activity levels in a monitored environment. They attend
a variety of classes, including, but not limited to, sensory processing and strategies, pain cycle and physiological responses to pain, health and nutrition, relaxation, and activity analysis.

Given the need for the majority of VGMHC’s clients to work (L. Eberhardt de Master, personal communication, February 28, 2012; L. Vanorio Kliewer, personal communication, February 29, 2012; B. Tucker, personal communication, March 15, 2012), a twenty-day intensive program would not be appropriate. However, the topics covered in the PRA classes are all appropriate and some of them are currently addressed in the VGMHC pain management class.

Central City Concern and Emerging Practice

The occupational therapy component of pain management at Central City Concern’s Old Towne Clinic developed from a similar innovative practice project to this one. The previous focus included both individual and group therapies and is currently undergoing a re-model of services as a new occupational therapist has recently filled the position.

Geoff Sittler, MOTR/L, with the help of two level-II fieldwork students, is currently remodeling the course of service to include more classes with a monthly structured format. Also, clients attending the classes have binders with class calendars, goal sheets, and space for handouts from classes to help organize the information that they receive while building a personal resource for themselves.

The first two weeks of the month have clients meeting with occupational therapy in group settings while they wait for provider appointments. The second two weeks of the month have three classes/groups per day and focus on exercise, leisure, relaxation, and/or nutrition. Additional services include individual sessions and home assessments as needed.

Virginia Garcia Memorial Health Center Meetings to Follow-Up

The investigator initially met with Lucas Eberhardt de Master (a current student in Pacific University’s School of Professional Psychology) on February 28, 2012 to learn the basics about VGMHC and Lifeworks NW services for chronic pain clients. Lucas was, at the time, completing an internship with Lifeworks NW at the Hillsboro office for VGMHC, as well as PRA. He heard about this project via Jodi Johnson, OTR/L. He facilitated communication with members of the behavioral health team for VGMHC by sharing this project with his supervisors and contact information.

During the discussion, Mr. Eberhardt de Master shared a basic overview of services so that the following meeting with Lexy Vanorio Kliewer, the supervising behavioral health specialist for VGMHC’s team of Lifeworks NW employees, could delve into more specific details and needs. He explained that the behavioral health services were currently facing challenges due to the struggle of who receives narcotic pain prescriptions as VGMHC is decreasing the number of clients managing their pain with this method. He is concerned
regarding the potential lack of continuity of care because people who do not receive narcotics may search elsewhere and receive inadequate care due to incomplete medical records. He has experienced that the clients perceive a dis-connect between the administration, care practitioners, and client expectations in delivery of services that focuses around prescription medication and alternative treatment methods, but that there is a lack of education and information being shared with the clients (from their perception). It has been difficult to engage some clients.

Ms. Vanorio Kliewer met with the investigator on February 29, 2012 to provide further information regarding evaluation and assessment of chronic pain clients, discuss the partnership with Lifeworks NW, and share insight regarding functional deficits most prominent with this particular client population. She elaborated upon a recap of the discussion with Mr. Eberhardt de Master by discussing the pain curriculum and current experience at the clinic. Most of the clients that she meets with come in with a hope, if not expectation, of a prescription for pain medication. She incorporates some education for clients within the assessment and finds that addressing “learned helplessness” is one of the biggest themes that she works on with clients.

The current pain curriculum is being utilized at the four clinics, but there appear to be fewer participants now that it is no longer a “guarantee” for receipt of a prescription. The behavior specialists are increasing their patient education with regard to the dangers of prescription medications and attempting to increase the understanding that prescription pain medications are not the only way to manage pain.

Without completing a formal client survey, Ms. Vanorio Kliewer was able to provide some insight into the functional deficits of chronic pain clients at VGMHC. Primary activity areas include activities of daily living (ADLs), instrumental activities of daily living (IADLs), and Sleep/Rest. ADLs were most affected in the areas of bathing (getting in and out of the tub/shower safely), toileting (sitting down and standing up as antagonists for pain), and dressing (primarily bending and arm movements). Sleep is often interrupted by pain, or clients report that they cannot fall asleep because of pain.

IADLs were most affected in meal preparation, housework, laundry, exercise, and shopping. Perceived barriers include too much pain to stand long enough to complete the task, movements required for activity provoke pain, bending and lifting are difficult and/or painful, and limited functional mobility. Also, with a decrease in IADLs, most clients talk about decrease in social participation because leaving the house can be difficult/painful and/or they are too tired from their pain to engage in social activity.

A meeting took place with Brian Tucker, Psy. D. on March 15, 2012 regarding the clients he sees at the Hillsboro location and potential to partner on a project. Current needs were discussed (reiterating discussions from previous VGMHC participants), as well as potential for home assessment. He and Mr. Eberhardt de Master both agreed that there are clients who may benefit from more specialized approaches to managing their pain. Collaboration with an
upcoming pain class was also discussed, and ideas regarding materials to enhance cognitive strategies and organization were accepted. At the end of the meeting, the following was determined: the student would develop a resource binder for pain class participants (see Appendix A), develop a stretch protocol to increase movement and provide breaks during the class, and attempt a home assessment with one of the clients at VGMHC. Mr. Tucker would facilitate participation of a client for the home assessment.
Pain and Function

Pain Myths and How to Promote Movement

A quick search on www.google.com for “pain myths” and any person has a wealth of popular science at their beckon call regarding pain, remedies, pain management, and the varied myths. However, a more selective look will bring forth the following myths over and over:

a) Too much pain to exercise (or, “Stop moving and rest”)
b) “No pain, no gain”
c) “It’s all in my head”
d) “It hurts, so I can’t do my favorite activities anymore”

(Harutyunyan, 2008; Nierenberg, 2008; Palma, 2011)

A brief investigation of scientific literature reveals a plethora of studies regarding pain and function, especially with relation to back pain (of which 17.47% of VGMHC’s clients have diagnosis of back pain).

Hagen et al (2000) completed a randomized control trial addressed the effect of basic information regarding the importance of remaining active with back injury. A total of 457 participants completed the study, 237 receiving intervention and 220 receiving “conventional primary health care”. The intervention consisted of an examination at a spine clinic followed by advice to remain active and receipt of information. Upon follow-up at 12 months, 68.4% of the intervention group had return to work, as compared to 56.4% of the control group participants. A three-year follow-up was completed (Hagen et al, 2003), and found that the amount of sick days needed by the intervention group had significantly decreased (125.7 days average) as compared to the control group (169.6 days average). It appears that the primary difference is reflected within the first year of injury and a rapid return to work. The investigators did not find any increased risk of reoccurrence, and the intervention group used stretching and walking more to cope with their pain versus the control group’s primary coping mechanism of bed rest.

One study, Birkholtz et al (2004a), completed a literature review related to pacing as intervention in chronic pain management. They found that pacing is essential in occupational therapy and its contribution to pain management because clients with chronic pain often participate in under- or over-activity and exacerbate their pain. The importance of stressing time or quantity of work versus work dependent on pain was described as one way of teaching pacing activities. A follow-up study (Birkholtz et al, 2004b) included a national survey of occupational therapists concluded that there are several ways to teach clients about pacing, including planning activities, breaking activities into manageable parts, increasing activity amounts gradually and alternating tasks.

Such research led to the recommendation of incorporating movement breaks within the pain courses (currently approximately 90 minutes each session). Stretch breaks would include a
facilitator leading clients slowly and safely through a stretch protocol (see Appendix B) that would promote movement of most major muscle groups, as well as include discussion of safe versus damaging stretch. Clients in the pain course were encouraged to participate as able, and stretch until they felt their muscle tightening but not to force the movement. If they are unable to perform a movement, at the time the behavioral health specialist will advise them to either not perform the stretch (if it causes pain), or to at least try as they are best able without causing pain.

Pain and Cognition: Memory & Attention

Pain has been demonstrated to affect cognition, which in turn can affect quality of life. Dick and Rashiq (2007) explored working memory of clients with chronic pain by completing computerized tests before and after short-term local analgesia was distributed. End results note that two-thirds of chronic pain participants scored “clinically impaired” in relation to attention-demanding tasks. It did not appear that there was improvement in short-term, either, suggesting that long-term pain can significantly affect a person’s cognitive abilities in relation to working memory.

Buhle and Wager (2010) investigated current theories of pain, distraction, and interaction within attention, memory, and cognitive performance. Working memory tasks reportedly decreased participants’ perception of pain as compared to visual control. Increase in heat (and perceived pain) decreased task performance. It appears that cognition-especially with relation to working memory and attention-are related to pain processing and perception in an inverse way.

Taking these studies into account, the development of a client binder for pain class participants focused on tools to enhance participation, memory, and learning. The binder addressed schedule, goals, and safety tips. It also provided a resource to pain clients that they could use to take notes, write down individual ideas with regard to their pain class goals and topic discussions.

Cognitive strategies, such as goal tracking sheets, worksheets that have been individualized by the clients themselves for information to incorporate between classes, and a location for all handouts is hypothesized to promote participation and integration of information from glasses into daily lives.
Pain and Generalization of Information: Home Assessment as Possibility

As research has demonstrated that people with chronic pain experience decreased capacity for attention and working memory, the investigator hypothesizes that there may be a decreased ability to learn information and generalize it to their lives outside of a clinical setting. Occupational therapists look at the whole of the client’s experience to the best of their ability, and so accommodations to facilitate learning and generalization of information seem appropriate as therapeutic interventions are planned.

Gillen (2009) states that “one of the biggest challenges to providing interventions to [cognitively impaired adults] is the issue of generalizing or transfer of what is learned in therapy sessions to other real-world situations” (p. 39). It may be difficult to generalize information from a clinical setting, where the environment can be set up for specific prompts and/or levels of success. Paired with that and the effects of chronic pain on attention and memory, it appears appropriate to recommend home assessment and home-based intervention as a part of the occupational therapy role at VGMHC.

Home assessment would offer three additional supports: intervention in the most consistent environment for clients, ability to adapt the environment with the client in collaboration so that changes are relevant to their needs, goals, and preferences, and improvement of generalization of health interventions.

Environmental impact is the “opportunity, support, demand, and constraint that the environment has on a particular individual” (Kielhofner, 2008b). Understanding how one’s environment effects their ability to participate in particular occupations allows for collaboration in modification or adaptation of the environment to enhance such. Home assessment would promote client-centered care by inclusion of client as team member, validate their experience, facilitate collaboration in adaptive measures taken, and increase team understandings of dynamics that affect their chronic pain. It would also provide the most naturalistic environment in which to carry out therapeutic interventions, and, in combination with cognitive behavior therapy and carry-over of health information from clinicians and pain classes, the clients at VGMHC would receive a dynamic assessment that could enhance their learning, promote generalization of information, and problem-solve barriers in the moment.

For a pilot home assessment, the Residential Environment Impact Survey (REIS) Version 2.0 (Fisher et al., 2008) was used as a guide. Though it was originally designed to provide holistic assessment of residential environments (i.e. residential facilities and other organized living situations), the REIS was designed for various types of settings. The REIS is a MOHO-based assessment tool, which is not standardized, allows for flexibility in implementation, and assesses environmental and social impacts of living environments (primarily residential settings).

In this case, the REIS was utilized as a guide for an individual home assessment in conjunction with basic interview to gather the client’s occupational profile. Sections one (walk-
through observation guide) and two (observations of activities/tasks) were utilized to promote an assessment focused on environmental impact. The home assessment took place in early May 2012 as a pilot example for VGMHC to provide an example of a home assessment and its potential impact on the client’s well-being.

Following introduction and initial information gathering, a walk-through was completed. All rooms were observed for space setup, objects, room use and its potential facilitation or limitation of the client’s occupational performance. Lighting, integrity of sofa cushion support, and location of objects in relation to toileting and showering were basic observations and discussions related to the client’s initial concerns, yet not identified specifically by the client to have an impact. For example, when lighting was commented upon, the client confirmed that it is difficult to see, but had not thought of more lamps to improve this. Discussion regarding types of lamps, with a collaborative decision of floor lamps (to prevent surface clutter and because they may be located behind larger objects and strategically placed) allowed the client to feel empowered and problem solve a solution that they would be comfortable with in their own home.

As the client was in too much pain to perform specific activities, they were asked to described how they complete them with the therapy student and supervising occupational therapist role-played to understand the client’s ergonomic positioning while performing tasks. This allowed for immediate feedback with education and discussion on appropriateness of ideas to ensue, which were then written down for the client to refer to later.

An additional benefit to the home assessment was education and selection of location for materials/resources. The client was walked through a relaxation technique, then asked if it was helpful. Upon an affirmative response, they were asked if they would be willing to do this on their own. Again, the answer was positive. Collaboration ensued in the discussion of placing a paper to remind them of the technique somewhere visible within the house.

Last, but not least, a home assessment improved connection to strengths-based approach with the client. There were several positive factors in their home setup that were already facilitating their occupational performance, which were then pointed out as strengths and used to affirm their sense of understanding of self and life with chronic pain. Open-ended questions supported the client’s ability to share their specific story, with further questions that asked for more information. They were allowed, in a sense, to lead the session by discussion topics (with redirection as needed, but able to share their story). Client empowerment, paired with asking if they are comfortable discussing the next topic or idea, allowed them to affirm that it is their home, their environment, and that they have the ultimate say in what happens—but without their authoritarian dynamic because they are introduced to the concept of home assessment as collaborative from the initial moment.
Occupational Therapy as Team Member at Virginia Garcia Memorial Health Center

The potential for occupational therapy services at VGMHC are vast and varied, but could improve the overall well-being of clients with chronic pain. Recognizing that interdisciplinary care has been demonstrated as an effective and efficient way to treat clients with chronic pain, occupational therapy would further enhance the comprehensive, client-centered care that VGMHC strives to provide.

Brown et al (2011) discussed the need for clear direction, goals, and contribution of occupational therapy within the service context so that all parties—clients, providers, donors, and other stakeholders—will better understand its contribution to pain management. The overarching goal would be to promote and improve occupational performance and participation among clients with chronic pain. This, in turn, would hopefully decrease service utilization as they improve self-management of pain and increased activity levels.

Occupational therapy services would work in collaborating with current providers, learning from them on the current approach to client needs, as well as ask questions about what has previously been done. Client-centered care would become a pillar for discussions and intervention strategies, yet include input from all team members (Robinson et al, 2011a). The therapist could work collaboratively with behavior health specialists to further accommodate stretching exercises as needed, and provide follow-up for pain class clients in their goals by completing home visits to perform the activity and explore and/or problem solve potential barriers in collaboration with the client.

Services developed within and/or in collaboration with current healthcare practitioners could focus on the clients who utilize services more than the majority—especially interventions such as home assessments and home visits to promote well-being within the community and restore activity slowly and safely. Robinson et al (2011b) supports the concept of the “therapeutic power of occupation” and role of occupation and health. When people are occupied in meaningful activity and have an increased self-worth, there is potential to increase motivation and, explored from the MOHO framework, further promote a client’s ability to “do.”

The clinicians and administration at VGMHC recognize that current services are not enough to meet the complex and diverse needs of the chronic pain population as they decrease access to prescription pain medication. An occupational therapist would work collaboratively with clinicians across the board, collaborate and empower clients, and evaluate their program for potential discussion with donors and other funding stakeholders.
Outcomes & Future Directions of OT @ VGMHC

Proposed overall goals for implementation of occupational therapy services include a) decreased service utilization by clients with chronic pain, b) improvement in client self-management of pain, c) increased activity tolerance and occupational performance of clients with chronic pain, d) decrease in overall need for prescription pain medications, and e) improved well-being of community members. These goals are in line with concepts brought forth in discussions with staff members at VGMHC, as well as in line with the Centennial Vision of the American Occupational Therapy Association:

“We envision that occupational therapy is a powerful, widely recognized, science-driven, and evidence-based profession with a globally connected and diverse workforce meeting society’s occupational needs” (2006).

Occupational therapy services at VGMHC would be evidence-based, and could include in-services to current practitioners about the role of occupational therapy, the effect of environment upon occupational performance, sensory-based strategies, as well as promotion of client-centered care in a team approach.

Future ideas for occupational therapy at VGMHC include more home assessments with follow-up to provide further support for such programming, as well as collaborative, community-based interventions with clients taking pain classes so that they may more completely generalize the information learned. Individual sessions that take place in the community could focus on IADLs and promote independence and sense of ability within clients. The behavior health team has expressed a desire for an updated curriculum. All of these possibilities could be carried out by occupational therapy students at Pacific University’s School of Occupational Therapy during innovative practice projects, but implementation may be limited due to necessity of a supervisor in presence of clients and time constraints (the projects currently take place January-April).

Occupational therapy could provide a unique, holistic view to further strengthen the current model at VGMHC. Collaboration with professionals and clients could lead to a dynamic environment that promotes positive change, identifies and acknowledges client strengths, and promotes well-being with the client as a team member.
References


Appendix A:

Pain Class Client Binder Materials
Pain Management Class

Virginia Garcia Memorial Health Center
&
Lifeworks Northwest
Virginia Garcia Memorial Health Center
Pain Class

Classes @ Hillsboro 1:30-3:00 PM
Friday, April 20, 2012    Friday, May 18, 2012
Friday, April 27, 2012    Friday, May 25, 2012
Friday, May 4, 2012    Friday, June 1, 2012
Friday, May 11, 2012    Friday, June 15, 2012

Class Topics
Introduction    Medications
Pacing    Diet & Exercise
Mood Management    Communication
Sleep    Relaxation

My goals:

In this folder:

- Pain Class Movement Contract (handed in to class facilitator)
- Group Confidentiality Form (handed in to class facilitator)
- Pain Myths, Why Movement is Good, & Tips for Avoiding Injury
- Handouts (you will receive in each class)
- Goals & Tracking Form
- Resources Page
- Notes Pages

Remember—Movement Guidelines are:

1) If it hurts, STOP the movement and notify your class leader immediately.
2) Follow the motions SLOWLY to allow yourself to gauge how much stretch you feel.
3) Keep hydrated. Drink lots of water.
4) Start small—go easy on yourself
The Pain Management Class at Virginia Garcia Memorial Health Clinic (Hillsboro office) is increasing services to meet the varying needs of clients with chronic pain and/or difficulties with pain management. One of these new services is the inclusion of light movement during class.

Movement will be guided slowly and focus on stretching. Class will also include discussion about pain myths, and how to slowly incorporate movement your daily routine. Don’t fret! We have some simple rules to keep you from getting hurt.

1) If it hurts, STOP the movement and notify your class leader immediately.
2) Follow the motions SLOWLY to allow yourself to gauge how much stretch you feel.
3) Keep hydrated. Drink lots of water before, during, and after.
4) Start small—go easy on yourself.

By signing below, I, ______________________________________________, agree that

- I have read the information above
- I agree to adhere to the movement rules
- I agree to the following:

I release and hold harmless Virginia Garcia Memorial Health Center and Lifeworks Northwest, and its employees, from any injuries that I may incur. I understand that movement is to happen slowly and at my own pace. I am not to force my body into a movement that proves painful.

______________________________________________    _____________________ 
         Class Facilitator           Date
**Pain Myths**

- I’m in too much pain to exercise
  - Actually, your pain cycle can get worse by not moving because muscles, ligaments, and other supporting structures stiffen

- No pain, No gain
  - There’s a line between stretch, feeling like a muscle is being worked, and pain
  - Stretch feels tight, but with therapeutic value
  - NEVER force a stretch!
  - Exercise should not cause pain

- It’s all in my head
  - Pain is a very real sensation
  - Pain is to help us relate to our world, but sometimes the cycle doesn’t get broken

- I can’t do my favorite activities any more
  - You are encouraged to stay active, especially in things you enjoy
  - Maybe the activity can be adapted?
  - What does a specific activity do for you, and what might be other activities that can provide that?

**Why Movement is Good**

- Exercise improves mood and energy levels  (Thank you, Endorphins!)
- Exercise promotes sleep
- Exercise can help to manage/relieve stress

**Tips for Avoiding Injury**

- Drink lots of water—especially before, during, and after exercise
- Listen to your body
- Go slow
- Take time to warm up
- Stretch after exercise
- Stop if something hurts
Resources

Books:


Websites:


Live Well Age Well. Chair exercises for older adults.

http://www.livewellagewell.info/study/2007/12-ChairExercisesUGA113006.pdf
Goals and Tracking: Pain Management

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Appendix B:
Instructional Stretch Posters
For Pain Class
Chair Stretches

Movement Tips
- STOP if the movement hurts
- Move SLOWLY
- Drink lots of water
- Start small—go easy on yourself
Standing Stretches

Movement Tips
STOP if the movement hurts
Move SLOWLY
Drink lots of water
Start small—go easy on yourself
Appendix C:
Additional Class Resources Developed
Estimating Portion Size With Everyday Objects

Breads and Pastas

- 1 cup of potatoes, rice, pasta = tennis ball, ice cream scoop
- 1 pancake = compact disc (CD)
- 1/2 cup cooked rice = full cupcake wrapper
- 1 piece of cornbread = bar of soap
- 1 slice of bread = audiocassette tape
- 1 cup of pasta or cereal = fist
- 2 cups of cooked pasta = full outstretched hand

Dairy

- 1 1/2 oz of cheese = 9-volt battery or 3 dominoes
- 1 ounce of cheese = pair of dice, your thumb
- 1 cup of ice cream = large scoop the size of a baseball

Vegetables

- 1 cup of green salad = baseball, fist
- 1 baked potato = fist
- 3/4 cup tomato juice = small Styrofoam cup
- 1/2 cup cooked broccoli = one light bulb
- 1/2 cup serving = 6 asparagus spears, 7 or 8 baby carrots, 1 ear of corn on the cob

Fruits

- 1/2 cup grapes = light bulb
- 1/2 cup of fresh fruit = 7 cotton balls
- 1 medium size fruit = tennis ball
- 1 cup of cut-up fruit = fist
- 1/4 cup raisins = large egg

Meats and Proteins

- 2 Tbsp of peanut butter = ping-pong ball
- 1 tsp of peanut butter = fingertip
- 1 Tbsp of peanut butter = thumb tip
- 3 oz cooked meat, fish, poultry = deck of cards
- 3 oz grilled/baked fish = checkbook
- 3 oz cooked chicken = chicken leg and thigh or breast
### Fats and Snacks
- 1 tsp butter, margarine = size of a thumb tip
- 2 Tbsp salad dressing = ping-pong ball
- 1 oz of nuts or small candies = one handful
- 1 oz of chips or pretzels = two handfuls
- 1/2 cup of potato chips, crackers or popcorn = one man's handful
- 1/3 cup of potato chips, crackers or popcorn = one woman's handful

### More Information
- 1/2 cup = small fruit bowl, custard cup, mashed potato scoop
- 1 1/2 cups = large cereal / soup bowl
- 1 1/2 cups of pasta, noodles = dinner plate, not heaped
- 1 cupped hand holds 2 Tbsp of liquid
- 1 slice of bread is one ounce or 1 serving


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<th>Hand Symbol</th>
<th>Equivalent</th>
<th>Foods</th>
<th>Calories</th>
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<tr>
<td>Fist</td>
<td>1 cup</td>
<td>Rice, pasta, fruit, veggies</td>
<td>200</td>
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<td>Palm</td>
<td>3 ounces</td>
<td>Meat, fish, poultry</td>
<td>160</td>
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<tr>
<td>Handful</td>
<td>1 ounce</td>
<td>Nuts, raisins</td>
<td>170</td>
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<td>2 Handfuls</td>
<td>1 ounce</td>
<td>Chips, popcorn, pretzels</td>
<td>150</td>
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<tr>
<td>Thumb</td>
<td>1 ounce</td>
<td>Peanut butter, hard cheese</td>
<td>170</td>
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<tr>
<td>Thumb tip</td>
<td>1 teaspoon</td>
<td>Cooking oil, mayonnaise, butter, sugar</td>
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Appendix D:
Presentation
CHRONIC PAIN AND OCCUPATIONAL THERAPY

A Proposal to Virginia Garcia Memorial Health Center

Victoria Eaton, OTS
Pacific University
School of Occupational Therapy

Virginia Garcia Memorial Health Clinic

- Started in 1975 after death of Virginia Garcia
- Meets the healthcare needs to uninsured, underinsured persons
- Culturally-appropriate care
- 34,000 patients
- 132,000+ office visits
- Increase in chronic pain
VGMHC Mission

- To provide high-quality, comprehensive, and culturally appropriate primary health care to the communities of Washington and Yamhill Counties with a special emphasis on migrant and seasonal farmworkers and others with barriers to receiving healthcare

Why O.T.?

- Occupational therapy’s unique ability to break down tasks
- Energy conservation
- Ergonomics
- Adaptation and Modification
- Contexts
- Roles, Habits, Routines
- Person in Environment Performing Occupation
- Cognitive Strategies
Needs of Clients with Chronic Pain

- Functional impact of pain
- Mobility, movement, exercise
- Pain myths
- Understanding pain cycle
- Role in care
- Hope

How would Occupational Therapy support VGMHC?

- Interdisciplinary Treatment
- Pain Courses (Enhance)
- Client-centered Programming
- Home Visits/Assessments
  - Residential Environment Impact Survey
- Evidence-Based Practice
- Wellness & Health Promotion
The Process...

- Interviews
- Current Programs
- Research & Evidence
- Meetings
- Incorporating Movement
- Participation
- Planning
- Future Ideas

Interviews & Programs

- CareOregon
  - 300+ clients

- Progressive Rehabilitation Associates
  - 20-day program

- Central City Concern
  - Similar clientele
Best Practice in Chronic Pain Management

- Interdisciplinary team efficacy (Oslund et al, 2009)
  - pain severity, emotional distress, interference of pain on function, perceived control of pain, treatment helpfulness, and number of hours resting.

- (Persson, 2011)
  - Adjustment to occupation with chronic pain

- (Robinson et al, 2011b)
  - The uniqueness O.T. can provide in contributing to clients' quality of life.
  - occupational performance in all areas
  - Independence

Meetings @ VGMHC

- Dr. Turner, Medical Director
  - History @ VGMHC
  - New policies
  - Need for interdisciplinary care

- Behavioral Health Team
  - Current role
  - Perceived needs
  - Pain classes
Pain Classes @ VGMHC

- 8 week program
- 1 day/week
- Discuss Pain Cycle

O.T. Contributions
- Autonomic System
- Sensory Impact
- Movement
- Cognitive Strategies

Home Assessment

- REIS
  - MOHO-based
  - Not standardized
  - Used as guide
    - Walk-through observation
    - Observation of tasks/activities

- May 1, 2012
- Single-wide trailer
- Primary concerns
- O.T. in home
Occupational Therapy @ VGMHC

- Team Member
- Client-centered Care
- Pain Courses
- Home Assessments
- Community-Based Practice
- Enhance Wellness & Health Promotion
- Individual & Group

Anticipated Outcomes

- Decrease need for prescription narcotics
- Decrease in number of office visits
- Increase in client health literacy
- Improved self-management of pain
- Improved quality of life
- Increase in occupational performance
Opportunities for O.T. @ VGMHC

- Education
- Updated Pain Curriculum
  - Volition
  - Occupation-Based
- Home Assessment with REIS
- Individual Sessions
- Community-Oriented Sessions

Funding Options

- Current Budget
- Potential Partnerships
- Grant Options
Living & Doing with Pain @ VGMHC

- O.T. & Interdisciplinary Team
- Current Impact
- Future Ideas
  - Updated Curriculum
  - More Home Assessments
  - Individual Sessions
  - Evaluation of OT Services
- Overall Goal
  - Being, Becoming, Doing with Chronic Pain

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