Resources and Innovative Interventions in Medicaid for Managing Patient Pain

November 14, 2017

Oregon Health Authority

Webinar overview

- Health Evidence Review Commission low-back pain guidelines for Medicaid members: *Ariel Smits, MD, MPH*
- Oregon Pain Commissions' new resources and trainings for providers: *Denise Taray, RN*
- Clinic-level panel on innovative pain management projects from across the state
  - Persistent pain education program in the Columbia Gorge region: *Andy Roof, MPT*
  - Pain management in the Patient-Centered Primary Care Home: *Kevin Cuccaro, DO*
  - Columbia Pacific CCO pain clinics: *Leslie Ford, LCSW*

The Oregon Health Plan
Coverage of Back and Neck Pain

Ariel Smits, MD, MPH
Medical Director
Health Evidence Review Commission
ariel.smits@state.or.us

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Presentation Outline

- Quick review of the Oregon Health Plan
- Overview of opioid misuse in Oregon
- New back condition care benefit
  - Reduction in opioids
  - Alternative care options
- Anticipated outcomes/implementation challenges

Health Evidence Review Commission

Formerly Health Services Commission (1989-2011)

13 Governor-appointed, Senate-confirmed Members

- 5 Physicians
- Dentist
- Public health nurse
- Behavioral health representative
- 2 consumer representatives
- Complementary or Alternative Medicine provider
- Insurance industry representative
- Retail pharmacist

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The Prioritized List of Health Services

- Ensure coverage for the most important services in maximizing population health while controlling costs
- Ranks all condition/treatment pairs in priority order
- Funding line determined by state Legislature and approved by CMS
  - Only conditions “above the line” receive coverage
- Guidelines help further define coverage
- Mental, physical and dental health merged
- CAM treatments available for a variety of conditions
  - Include acupuncture, chiropractic, osteopathic manipulation, naturopathic care

Prescription Opioids in Oregon: Scope of the Problem

Non-Medical Use of Prescription Opioids

- 6th in the nation in 2012-2014[1]
- 212,000 Oregonians (5% of population); 9% of 18-25 year olds

Hospitalizations

- 330 hospitalizations for overdose; 4300 for opioid use disorder
- $8 million in hospitalization charges in 2014

Death Rate

- 180 deaths (4.5 per 100,000 residents) for pharmaceutical opioid overdose in 2015

Source: National Survey on Drug Use Health (NSDUH)[1], Oregon Health Analytics Hospital Discharge Dataset[2], Oregon Vital Records: Death Certificates[3]

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Opioids & Back Pain: Scope of the Problem in Oregon

Oregon's opioid epidemic

~50,000 Medicaid patients w/ back pain diagnoses

~30,000 of those w/ back pain received an opioid prescription

Average of 148 opioid prescription days for those with back pain

$5 million spent on opioids

Data source: CY2013 Medicaid data

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Historic OHP back pain coverage (simplified)

With radiculopathy

Medication

Surgery

Chiropractic

Acupuncture

PT/OT

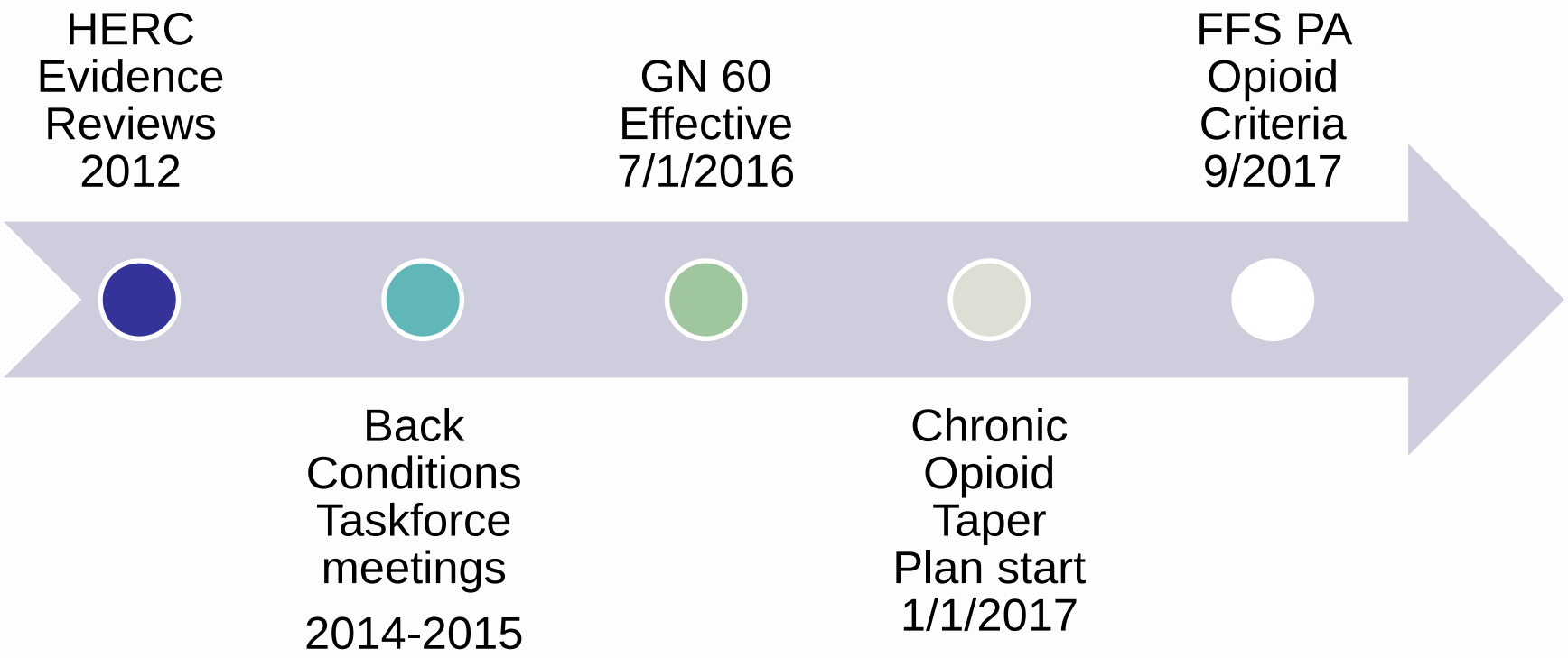
Funding Line

Without radiculopathy

Theoretically no coverage w/o comorbidity rule.

Real world: Office visits, medication, including opioids

Back Line ChangesTimeline



The New Back Care Paradigm: Medical Coverage

Increased Coverage:

Guideline Note 56

- Cognitive Behavior Therapy
- Spinal Manipulation
- Acupuncture
- PT/OT
- Non-opioid medications
- Yoga *
- Interdisciplinary Rehab *
- Supervised exercise *
- Massage Therapy *

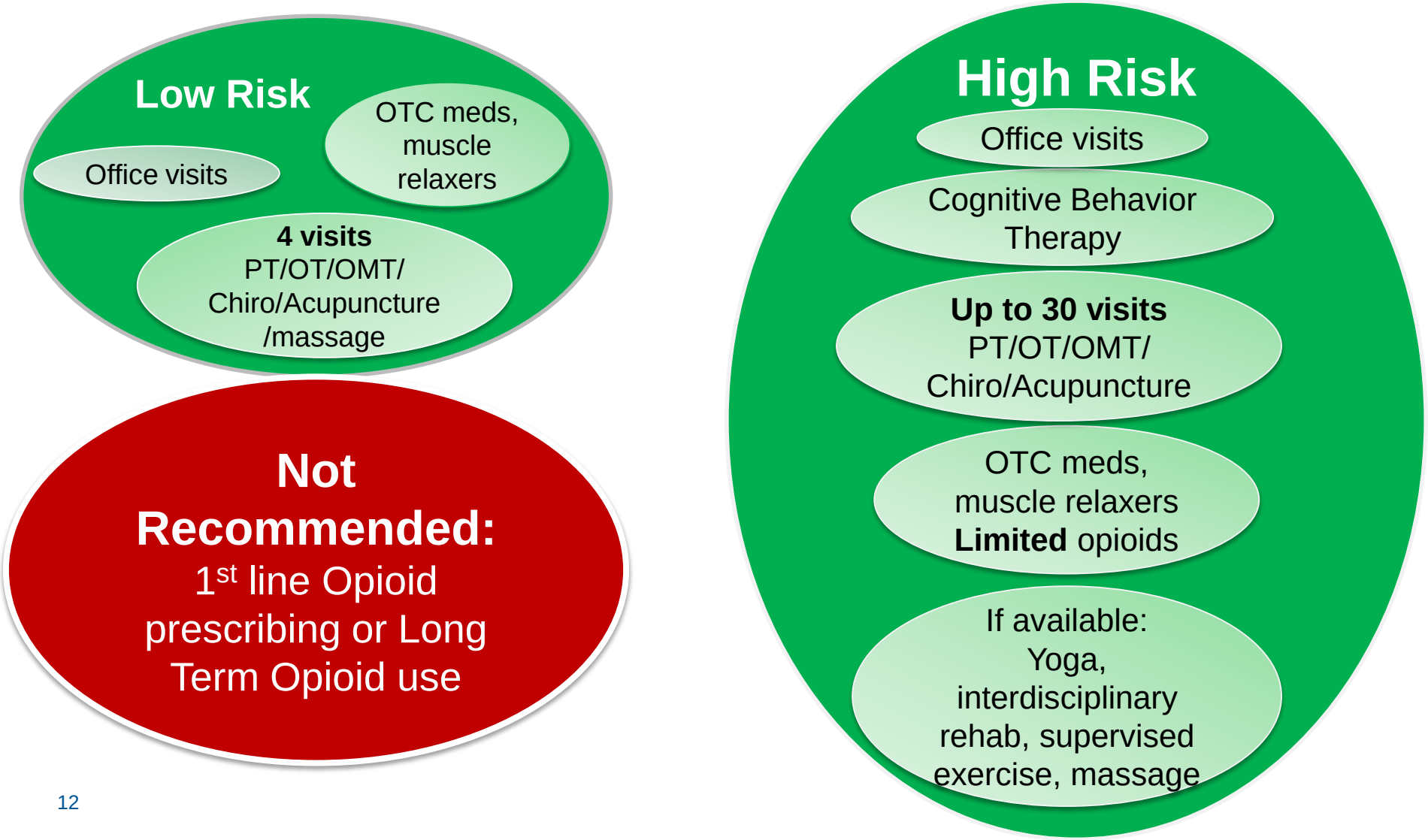
* If available

Decreased Coverage:

- Surgeries
- Opioids
- Epidural Steroid Injections

Guideline Note 56: New Treatment Pathways

(Medical Treatment Line)



Guideline Note 60: Opioid Medications (Coverage Criteria)

During the first 6 weeks after injury, flare, surgery:

- Prescription limited to 7 days, and
- Short acting opioids only, and
- First line pharmacologic therapies are tried and ineffective, and
- Treatment plan includes exercise, and
- Opioid risk assessment

Opioid use after 6 weeks, up to 90 days:

- Functional assessment – 30% improvement
- With spinal manipulation, physical therapy, yoga, or acupuncture
- Opioid risk mitigation:
  - PDMP
  - Screen for opioid use disorder
  - Urine drug test
- Prescriptions limited to 7 days and short acting only

Opioids after 90 days:

- Not Covered without new injury, flare, surgery

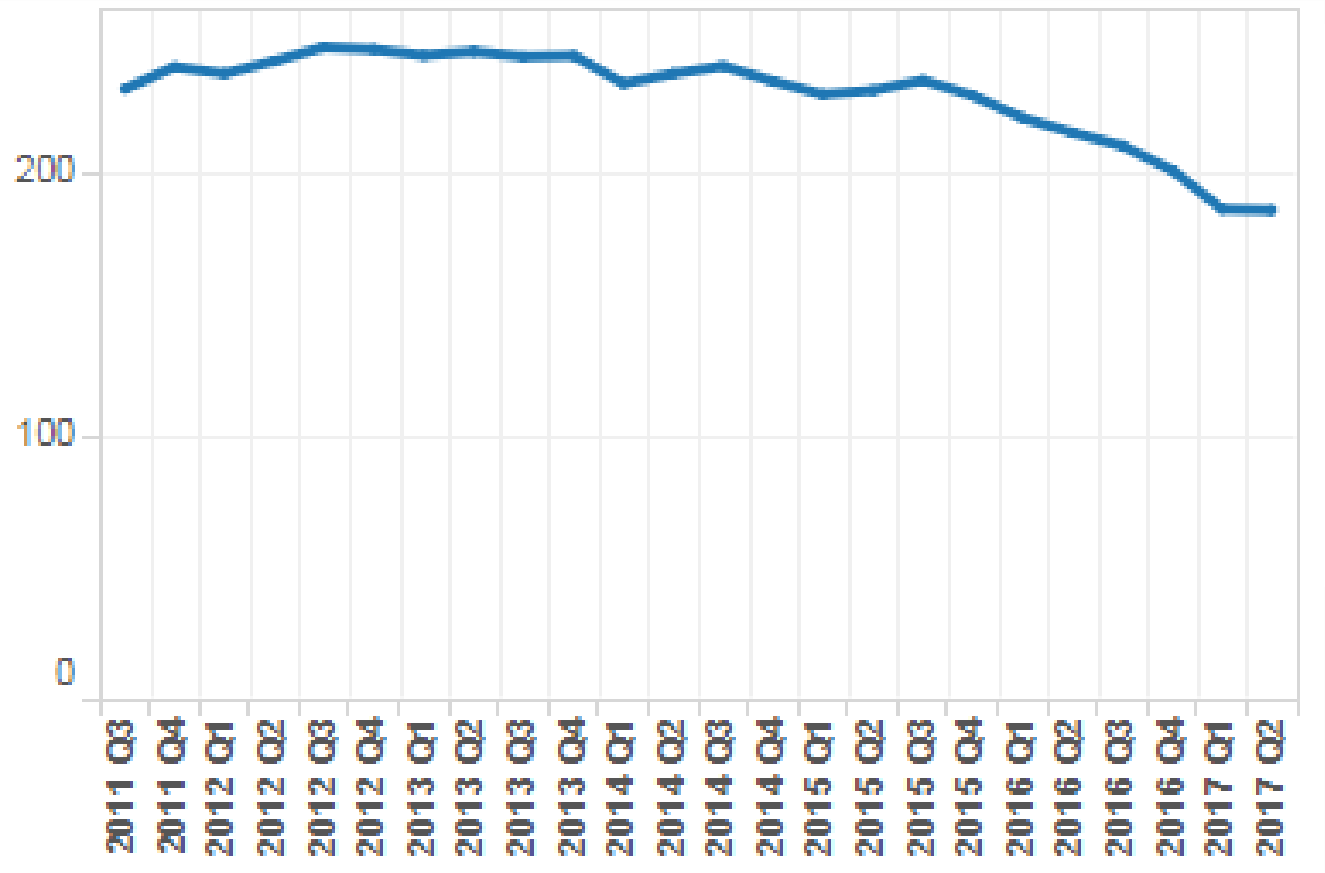
Transitional coverage for those on long-term opioid therapy through 1/2018:

- Taper plan
  - In place by January 2017
  - Include nonpharmacologic treatment strategies

Anticipated Outcomes

- Reduced opioid use for back conditions
  - Improved public health: fewer ER visits, overdoses, deaths
- Improved outcomes for patients
  - Reduced pain and better function
  - Access to evidence-based effective care
  - Reduced harms from opioids and ineffective surgery
- Better educated medical workforce
  - Evidence based assessments and tools
  - Improved knowledge of best practices
- Ultimately, reduced costs through paying only for effective care

2015-2017 Oregon Opioid Prescribing: Decreased by 21%



Q2 2015: 232 opioid prescriptions per 1,000 residents

Q2 2017: 187 opioid prescriptions per 1,000 residents

Source: Oregon Prescription Drug Monitoring Program healthoregon.org/opioids Data dashboard

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Implementation Challenges

- Workforce
- Payment challenges (e.g. yoga)
- Education of providers, patients, public
- Dissemination of evidence based tools
- Controls on narcotic prescriptions (FFS v CCOs)
- Ability to taper chronic opioid patients
- Availability of treatment for patients with opioid use disorder

For more information

www.oregon.gov/OHA/HERC

Health Evidence Review Commission

HERC.Info@state.or.us

Resources and Training for Managing Patient Pain

Oregon Pain Management Commission

Denise Taray, RN

Oregon Health Authority

Oregon Pain Management Commission:

Legislation established a Pain Task Force in 1997; followed by The Pain Management Program and Coordinator position in 1999; And, in 2001 the Pain Management Commission.

- 17 voting members, 2 legislative members

- MDs
- Physician Assistant
- Nurses
- Nurse Practitioner
- Naturopathic Physician
- Chiropractic Physician
- Acupuncturist
- Pharmacist
- Psychologist
- Dentist

- Addiction Counseling
- Physical Therapist
- Occupational Therapist
- Health Care Consumers
- Patient Advocates
- Public Representative
- Legislative Members
  - -Senate
  - -House

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Oregon Pain Management Commission:

The Oregon Pain Management (OPMC) Role:

- Develop a pain management educational program for required completion by health care professionals.
- Recommend curriculum to health care educational institutions.
- Represent patient concerns to the Governor and Legislature.
- Improve pain management in Oregon through research, policy analysis and model projects.

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Oregon Pain Management Commission

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"Healthcare providers, insurers, and the public need to understand that although pain is universal, it is experienced uniquely by each person, and care—which often requires a combination of therapies and coping techniques—must be tailored. Pain is more than a physical symptom and is not always resolved by curing the underlying condition. Persistent pain can cause changes in the nervous system and become a distinct chronic disease."

—Relieving Pain in American: A Blueprint for Transforming, Prevention, Care, Education, and Research, 2011: Institute of Medicine (IOM)

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OPMC Pain Management Module – Required Pain Education

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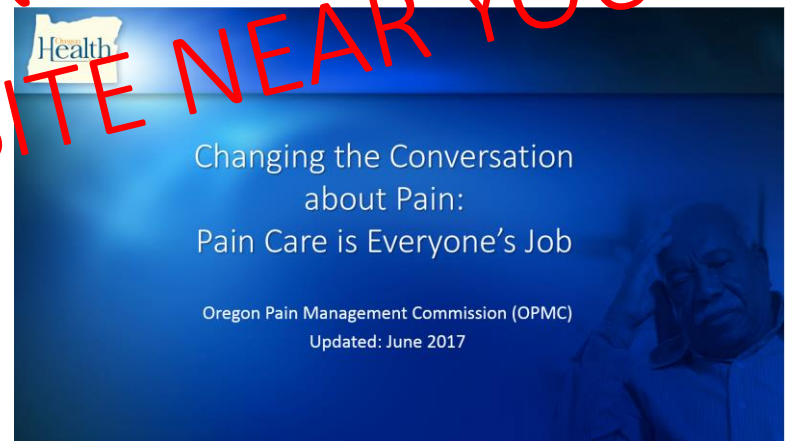


Insert New Module: Landing Page with accreditation for CME/ CNE

Pain Education Program Requirement

Pain Education Program Requirement

Pain Care Toolbox

Key Domains

Assessment Tools

Prioritizing Care: Key Domains

- Key Concepts
- Strategies
- Resources
- Connecting with your patient

Knowledge of Pain: Resources

Pain education video


Rethinking Pain

PROVIDENCE Health & Services

Understanding pain
With knowledge comes power

Did you know?

- **There's a lot you can do to ease your pain.**
- **When people understand their pain, it decreases.**
- **All pain comes from your brain.** That doesn't mean it's "all in your head." It means the brain puts together information and creates a pain response.
- **Pain doesn't always equal harm.** Your brain may have become so good at producing pain that it doesn't stop — even when you've recovered from an injury or illness. In a situation like this, don't avoid movement. Inactivity can make your pain worse.
- **Stress and pain are closely related.** Focus on reducing stress, and change the way you respond to stress.

Your relationship with pain

No one wants to feel pain. Whether you stub your toe or bang your finger with a hammer, that short burst of red-hot sensation isn't pleasant. Even more troubling, though, is long-term, chronic pain – also known as persistent pain. This is pain that won't go away, no matter what you try.

Persistent pain can have a profound affect on daily life. It can disrupt your ability to work, exercise, sleep, and enjoy activities and hobbies.

Acute pain versus persistent pain

Acute pain occurs as a direct result of an injury. The brain sends a signal that something is wrong and produces pain so we know to be careful. This is a very useful response.

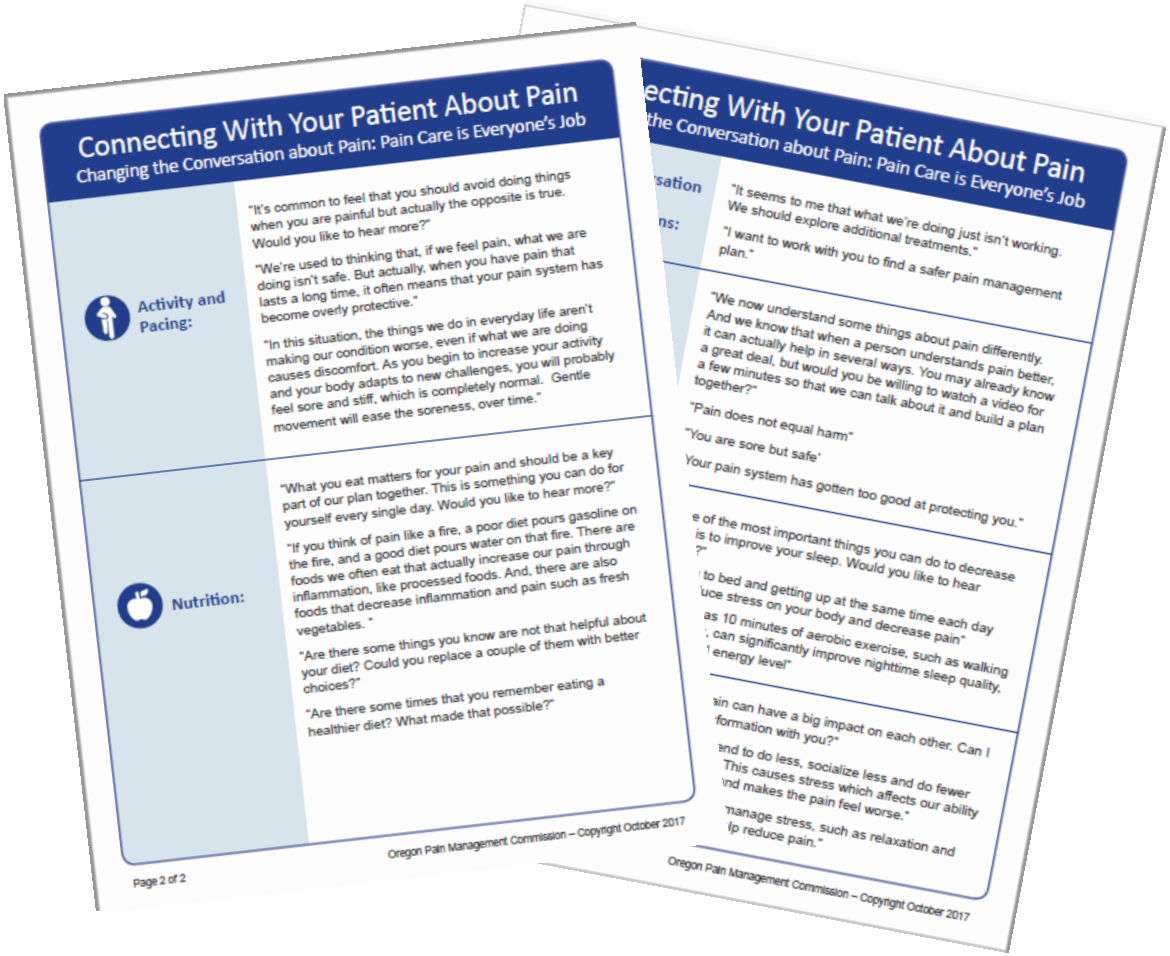
Persistent pain exists after the danger has past. The danger signal gets "stuck" in the brain and it's no longer useful.

(continued)

What about Medications?

Address key domains before reducing medications to

- Improve understanding of pain
- Alleviate fear
- Instill hope



Connecting With Your Patient About Pain

Changing the Conversation about Pain: Pain Care is Everyone's Job

Activity and Pacing:

"It's common to feel that you should avoid doing things when you are painful but actually the opposite is true. Would you like to hear more?"

"We're used to thinking that, if we feel pain, what we are doing isn't safe. But actually, when you have pain that lasts a long time, it often means that your pain system has become overly protective."

"In this situation, the things we do in everyday life aren't making our condition worse, even if what we are doing causes discomfort. As you begin to increase your activity and your body adapts to new challenges, you will probably feel sore and stiff, which is completely normal. Gentle movement will ease the soreness, over time."

Nutrition:

"What you eat matters for your pain and should be a key part of our plan together. This is something you can do for yourself every single day. Would you like to hear more?"

"If you think of pain like a fire, a poor diet pours gasoline on the fire, and a good diet pours water on that fire. There are foods we often eat that actually increase our pain through inflammation, like processed foods. And, there are also foods that decrease inflammation and pain such as fresh vegetables. "

"Are there some things you know are not that helpful about your diet? Could you replace a couple of them with better choices?"

"Are there some times that you remember eating a healthier diet? What made that possible?"

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ecting With Your Patient About Pain

the Conversation about Pain: Pain Care is Everyone's Job

sation

ns:

"It seems to me that what we're doing just isn't working. We should explore additional treatments."

"I want to work with you to find a safer pain management plan."

"We now understand some things about pain differently. And we know that when a person understands pain better, it can actually help in several ways. You may already know a great deal, but would you be willing to watch a video for a few minutes so that we can talk about it and build a plan together?"

"Pain does not equal harm"

"You are sore but safe'

Your pain system has gotten too good at protecting you."

e of the most important things you can do to decrease is to improve your sleep. Would you like to hear ?"

to bed and getting up at the same time each day uce stress on your body and decrease pain"

as 10 minutes of aerobic exercise, such as walking can significantly improve nighttime sleep quality, energy level"

ain can have a big impact on each other. Can I formation with you?"

nd to do less, socialize less and do fewer This causes stress which affects our ability nd makes the pain feel worse."

manage stress, such as relaxation and lp reduce pain."

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Medications & Prescribing

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Prescribing Guidelines

Name	Description
Oregon Opioid Prescribing Guidelines	Recommendations for the Safe Use of Opioid Medications. The Oregon Opioid Prescribing Guidelines Task Force adopted the CDC Guideline as the foundation for opioid prescribing for Oregon and developd a brief addendum to address Oregon-specific concerns.
Oregon Opioid Prescribing for Dentists	Guidelines from Oregon's Public Health Division on Opioid Prescribing for Dentists
Guidelines for Prescribing Opioids for Chronic Pain	CDC Opioid Prescribing Guideline Resources for Providers
Guideline for Prescribing Opioids for Chronic Pain FactSheet	CDC Factsheet for Guidance in prescribing opioids for chronic pain
Oregons-Medical-Use-Cannabis-Clinical-Guideline	Guidelines for Attending Physicians when Recommending the Medical Use of Marijuana

MED Calculators

Name	Description
Oregon Opioid Overdose and Misuse	OHA Public Health Division site for Reducing Opioid Overdose & Misuse
CDC MED Calculator	CDC MED Calculator for Calculatnigi Total Dailly Dose of Opioids for Safer Dosage
Oregon Pain Guidance Conversion Calculator	An Oregon MED Opioid Conversion Calculator for patients taking one or more opioid medications

Opioid Prescribing Continuing Education

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Key Domains

Knowledge of Pain

Understanding Pain: Providence video
5 minute video
Tame the Beast: video

Sleep

Sleep Hygiene: Patient Handout
Health & Unhealthy Balance: Teaching Tool
Sleep Diary: Patient Handout

Mood

Stress & Pain: Teaching Aid

Activity

Pacing: Teaching Aid

Nutrition

Food Diary: Patient Handout
Nutritional Guidelines for Pain: Patient Handout
Healthy Eating on a Budget: Patient Handout
U R What U Eat: Patient Handout

Pain Care Assessment Tools

Assessment Tools

Other Tools

Providence Toolkit
Silver Sneakers
Silver and Fit
Living Well with Chronic Conditions
UW Pain Tracker

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Additional Resources for Healthcare Professionals

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As you use the resources available through this website, remember that people experience pain in many ways. Those with chronic pain should work with their health care providers to develop strategies that work best for them.

Pain management works best as a collaborative effort, involving professionals, informed patients, who actively participate in self-management of pain, and their families, who can provide additional support.

Resources

Oregon Pain Guidance

Trauma Informed Oregon

Health Care Provider Resources

Videos

David Butler - The Drug Cabinet in the Brain

TED Talk: Dr. Lorimer Mosley - Why Things Hurt

Kelly McGonigal - How to make stress your friend

Daniel J. Clauw MD - Chronic Pain: Is it all in their head?

Sean Mackey - Update on Fibromyalgia

Gordon Irving - What is fibromyalgia and how is it treated?

Gordon Irving - Complimentary Therapy: What can you do to reduce your pain?

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Conference 2018: The Challenge of Pain

1/18/2018 - 1/18/2018

8:00 am - 4:50 pm

University of Washington: School of Nursing, Shoreline Conference Center, 18560 1st Ave. NE, Shoreline WA

Target Audience: Nurses, clinical nurse specialists, nurse practitioners, physician assistants, physicians, respiratory therapists, psychologists, pharmacists, social workers, physical therapists and other interested healthcare professionals in all settings.

Description: Pain causes extensive suffering, disability and expenditure of scarce healthcare resources. This conference focuses on the challenge of pain management for healthcare professionals across the healthcare continuum. Regional and national pain specialists present evidence-based strategies for assessing and managing pain in acute, ambulatory and palliative care settings. Teaching methods include lecture, discussion, case studies, and inter-professional dialogue.

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Medication Safety

- Best Advice for People Taking Opioid Medication (Video)
- Using Medications Appropriately to Manage Chronic Pain (Excerpted)
- Get Relief Responsibly (Website on how to safely choose, use, and store Over The Counter (OTC) pain relievers)

Medication Disposal

Is your medicine cabinet full of expired drugs or medications you no longer use? How should you dispose of them?

- How to Dispose of Unused Medicines (Consumer Health Information)
- Unwanted Drug Drop Off Sites

Prescription Drug Monitoring Program

Patients are encouraged to talk with their healthcare providers regarding their prescription medications.

- Frequently Asked Questions
- Patient Rights

For more information:

Oregon Pain Management Commission (OPMC)

http://www.oregon.gov/oha/hpa/csi-pmc/pages/index.aspx

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Oregon Health Authority

Persistent Pain Education Program

Mid-Columbia Medical Center

Resources and Innovative Interventions in Medicaid for Managing Patient Pain
OHA Transformation Center Webinar 11/14/17
Andy Roof, MPT, OCS

Neuroscience Education:

- Defined as an educational session outlining the neurobiology and neurophysiology of pain
- DOES NOT focus on tissue injury and nociception
- DOES focus on how the nervous system modulates the pain experience

Differs from the “old” model

- Previous educational models focused on anatomic and biomechanical explanations of the tissue “responsible” for pain

- Now, we discuss how the nervous system processes many inputs including emotions, memories and cognitive information in its construction of the “pain experience.”

Research

- Studies have shown that neuroscience education (NE) can decrease fear and positively affect patient's perceptions of their pain[1]; make improvements in pain, cognition and physical performance[2]; and increase pain thresholds during physical tasks[3]. NE can also improve outcomes of therapeutic exercises[4].

PPEP

- The Persistent Pain Education Program (PPEP) is a series of eight presentations that aims to educate people in a comprehensive, pain management approach. Each 90-minute talk is led by a different healthcare professional including Physical Therapist, Clinical Psychologist, Clinical Pharmacist, Sleep Specialist, Dietician and Therapeutic Yoga Instructor. The classes help people dealing with chronic pain to address multiple areas of self-management that can ultimately lead to decreased pain and improved quality of life.

Explain Pain Class

- This class is taught by Andy Roof, Physical Therapist, and covers the basic physiology of pain, what is happening in our brains and nerves when we feel pain, and how a "chronic" pain state develops in our nervous system. Research suggests that people who are able to change their pain cognitions following an educational intervention demonstrate an improvement in physical performance. (Moseley, 2004)

Living a Fulfilling Life with Pain

- This class is taught by Sandy Bushberg, PhD, Psychologist, and builds on the Explain Pain class by covering the neurophysiological and psychobiological effects of the pain experience. Dr. Bushberg instructs participants in Acceptance and Commitment Therapy which involves living a values-driven and purposeful life despite experiencing pain.

Nutrition and Pain Management

- This class is taught by Tracy Dugick, Registered Dietician, and covers the Anti-Inflammatory Diet. Chronic inflammation has been shown to be involved in multiple disease processes that are involved in creating a persistent pain condition. This chronic inflammation is influenced by diet and this class aims to educate people in eating properly to reduce inflammation in the body. This class offers specific recipes that are affordable and healthy.

Mindfulness Meditation Class I & II

- These classes are taught by Jill Kieffer, RN, Therapeutic Yoga Instructor. Certain parts of the nervous system become “wound up” and dysfunctional in a persistent pain state. Yoga, meditation, deep breathing and relaxation can help to calm the nervous system and return it to a healthy state. These classes cover simple breathing and relaxation techniques that can be performed daily as part of a self-treatment program.

Pharmacology Class I & II

- These classes are taught by Eric Holeman, Clinical Pharmacist, and cover proper pain management with prescription drugs. Topics covered also include opioid tolerance, dependence, addiction and safe tapering or weaning techniques.

The Interaction Between Pain and Sleep

- This class is taught by Paul Cardosi, MD, a sleep specialist. Good sleep is beneficial for mind and body, but pain can get in the way and poor sleep may make coping with pain more difficult. This class will explore this relationship and discuss options for treatment.

Outcome Measures

- Program participants will complete outcome measures reflective of their pain levels, physical function, pain acceptance and perception of self efficacy before and after completion of the program.
  - -Brief Pain Inventory: reflects pain intensity and physical functioning
  - -Pain Self Efficacy Questionnaire
  - -Chronic Pain Acceptance Questionnaire (CPAQ-8): reflects acceptance of pain

Preliminary Outcomes

- • 27% (n=30) show clinically significant improvement in measures of physical functioning
- • 31% (n=16) show clinically significant improvements in measures of depression
- • Referring providers reporting improved satisfaction with management of patients sent to program
- •Multiple patients are returning to take individual classes a second time
- •Anecdotally, some patients are reporting decreased dosage or complete weaning of pain medications

Funding

- Initial class series was funded by a Transformation Grant from the Columbia Gorge Health Council and OHA
- Currently funded by MCMC for <$10K/year for 3 class series of 8 weeks each

References

- 1.Moseley GL. Joining forces---combining cognition-targeted motor control training with group or individual pain physiology education: a successful treatment for low back pain. J Man Manip Therapy 2003;11:88-94.
- 2.Moseley GL. Evidence for a direct relationship between cognitive and physical change during an education intervention in people with chronic low back pain. Eur J Pain 2004;8:39-45.
- 3.Moseley GL, Hodges PW, Nicholas MK. A randomized controlled trial of intensive neurophysiology education in chronic low back pain. Clin J Pain 2004;20:324-30.
- 4.Moseley L. Combined physiotherapy and education is efficacious for chronic low back pain. Aust J Physiother 2002;48:297-302.

Resources

- Butler, D., Moseley, L. Explain Pain. Noigroup Publications, Adelaide, Australia, 2003.
- Ratey, J. Spark: The Revolutionary New Science of Exercise and the Brain. Little, Brown and Co., 2008.
- https://www.mcmc.net/for-patients-guests/persistent-pain-education-program/

- andrewro@mcmc.net

Pain ~~Management~~ In The Patient-Centered Primary Care Home

Kevin Cuccaro, D.O.

Understanding Pain For The Patient-Centered Primary Care Home

(Better Title)

Do We Understand Pain?

What We've Done…

- Increased MRI's 300%
- Increased Procedures 130-700+%
- Increased Surgeries 300+%
- Increased Opioids 690+%*

Sehgal N, Colson J, Smith HS. Chronic pain treatment with opioid analgesics: benefits versus harms of long-term therapy. Expert Rev Neurother. 2013;13(11):1201-20.

Deyo RA, Mirza SK, Turner JA, Martin BI. Overtreating chronic back pain: time to back off?. J Am Board Fam Med. 2009;22(1):62-8.

Atluri S, Sudarshan G, Manchikanti L. Assessment of the trends in medical use and misuse of opioid analgesics from 2004 to 2011. Pain Physician. 2014;17(2):E119-28.

What We Got…

- Disability Rates Increased
- Complication Rates Increased
- No Improvement in Self Reports
- Costs Continue to ↑

Overall Outcomes…

2000	2010
US Pop. 282 Million	US Pop. 309 Million
	↑9.6%
45 Million Chronic Pain	100 Million Chronic Pain
	↑122%

Olsen Y, Daumit GL. Chronic pain and narcotics: a dilemma for primary care. J Gen Intern Med. 2002;17(3):238-40. 50 MILLION with chronic pain (2002).

Fishman S, Berger L. The War on Pain. Harper Collins; 2001. (45 million)

Brennan F. The US Congressional "Decade on Pain Control and Research" 2001-2011: A Review. J Pain Palliat Care Pharmacother. 2015;29(3):212-27.

↑122%!?!

After "**The Decade of Pain Control & Research**"? (2001-2011)

The questions to ask:

1. "Why do we have more of a problem now after more 'treatment' than we had before?"
2. "Do we actually understand what we're treating?"
3. "Are our treatments effective? Why or Why not?"

Pilot(s) Goals & Expectations

Goals

- ↑ understanding of pain & mechanisms of treatment
- Improve pain messaging & referral pathways
- ↑ clinician comfort & confidence
- **Improve pain outcomes**

Expectations

Voluntary Participation

Engagement & Feedback

"*Questioning Mind*"

Pilot Structure & Purpose

Structure

- Sequence
  1. Pain Science & Conceptual Model
  2. Risk Factors & Beliefs,
  3. Coping, Control, & Opioids
  4. Back Pain
  5. Fibromyalgia
  6. Summary Session
- Strategic Focus

Purpose

1. Understand Pain,

   Pain Risk Factors/Amplifiers &

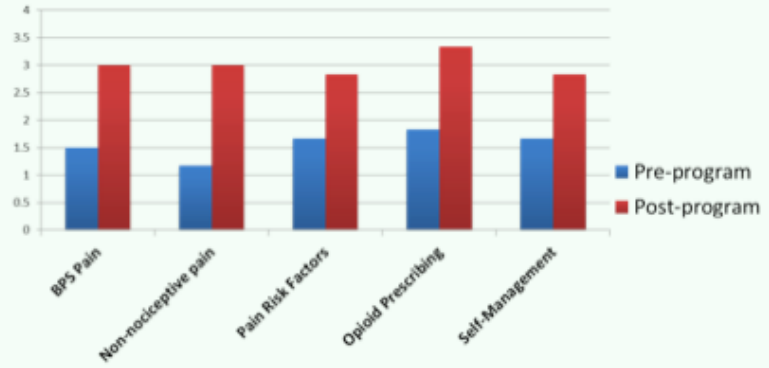
   Targeted Treatment
2. Consistent Message
3. Unified Approach

Results So Far

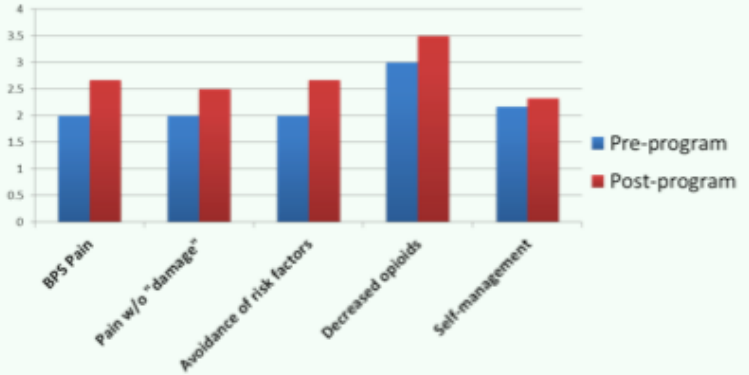
- Direct:
  - 35% of all PCPCHs in Linn, Benton, & Lincoln Counties
  - 60+ primary care clinicians
  - (60+ PTs/Ots)
  - Highly rated
  - Pending: Rx & Imaging Rates pre-/post-
- Indirect:
  - Changed Conversation
  - Community Engagement (MVPA)

One clinic's experience:

Clinician confidence in ability to effectively counsel chronic pain patients about…



Clinician belief that their counseling of chronic pain patients will result in actual change regarding…

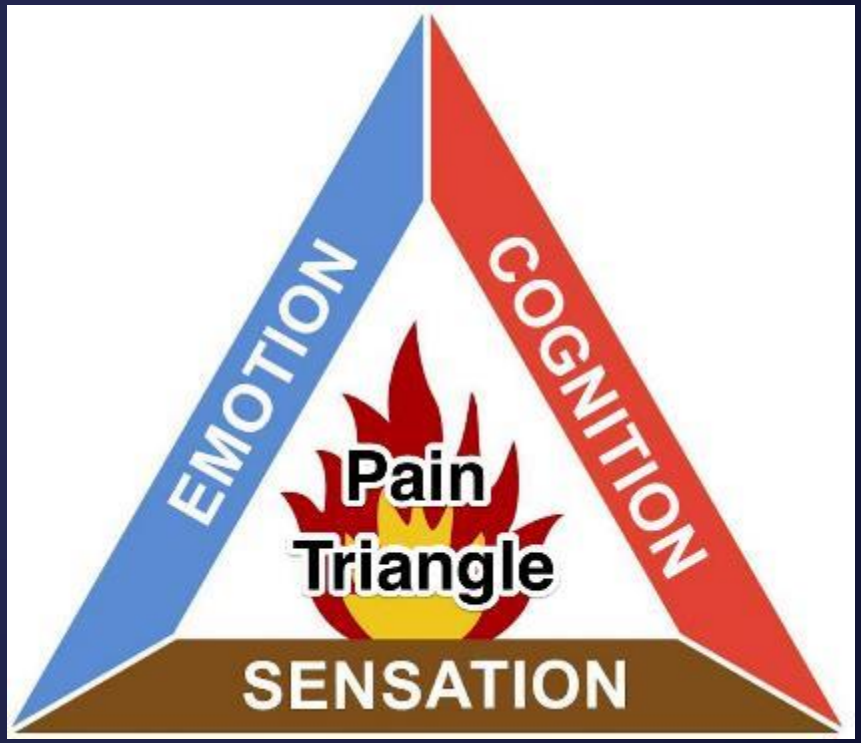


Questions or Contact

- Email:

  Kevin@StraightShotHealth.com

- Phone: 541-224-7508



Columbia Pacific CCO Pain Clinics

Leslie Ford, LCSW
Director of Clinical Innovation
Greater Oregon Behavioral Health, Inc.

Brief Program Overview:
Three components

1. Medical component:
   - Case review
   - Primary care consultation and support
   - HSWC does not prescribe
   - Ongoing support as needed or requested

Brief Program Overview:
Three components

2. Physical component: Movement strategies
   - Activity program
     - Movement is customized based on patient capabilities
     - Stretching and breath; listening to your body
     - Our gentle movement therapy is Yoga-based
   - Patient education on self-management

Brief Program Overview:
Three components

3. Mental component: Living with chronic pain
   - Cognitive Behavioral Therapy
     - Acceptance and Commitment Therapy (ACT)
       - Teach new thought processes – psychological flexibility
       - Giving mindfulness a try
       - Living a life toward values
       - Assist with goal setting
       - Address perceived disability

More on the program…

- ✓ Patient PCP referral required
- ✓ Consultation model
- ✓ Open to EOCCO members only
- ✓ Ten-week program
- ✓ Individual and group involvement
- ✓ On-going support after program completion

Why this approach?

- ✓ Based on research: It works as well or better than other interventions
- ✓ Cost effective
- ✓ The opiate pendulum is swinging:
  - New prescribing guidelines as of 01/01/2017
  - Other changes on the horizon for diagnostic and interventional guidelines

Challenges

- ✓ Perceived disability is high in this population
- ✓ Limited incentive for improvement
- ✓ High no-show/dropout rate
- ✓ Secondary gain factors in chronic pain patients
- ✓ Overcoming perception that only opiates will alleviate “my pain”

Addressing Our Challenges

- ✓ We focus on their abilities rather than disabilities. They focus on possibilities rather than “pain stories.”
- ✓ We give them a variety of incentives, especially empowerment.
- ✓ We will contact them many times to invite them to be involved with our program.
- ✓ We focus a primary gain of living a life in service of their values.
- ✓ We provide them choices through our education, therapy, and movement components.

Contact Information

Health Solutions Wellness Center

906 Sixth Street

La Grande, OR 97850

(541) 962-8886 Phone

(541) 624-5030 Fax

- Andi Walsh, Referral Coordinator/Office Manager
- Dawna Flanagan, Therapist
- Barbara Tyler, Therapist
- Caitlin Ecklund, Movement Specialist
- Adrienne Tyler, Movement Specialist

Health Solutions Wellness Center