

PainWeek[®]

How Pain Management Coaching Impacts Pain Outcomes

Becky Curtis, NBC-HWC

Disclosure

- None

Learning Objectives

- Identify how the latest research on the brain and pain relate to relearning and pain management
- Discuss the role Pain Management Coaching plays in reshaping the learned phenomenon of chronic pain
- Describe how coached clients acquire knowledge and implement effective pain-management strategies with the guidance of a coach.

“The notion of brain plasticity is fundamental to new developments in pain management. There is recognition that the same neuronal changeability that contributes to the persistence of pain could potentially allow its resolution. Evidence suggests that **‘focused attention’** can increase neuronal plasticity and hence be used to positively reprogram brain pathways.”

Pain-Management Coaching

- Completely telephonic
- TCC is International and utilized throughout North America
- English and Spanish
- Difficult to treat, housebound clients to have a world class **bio/psycho/social** program brought right to their home

EOVAHCS Pain Program

- Started in 2013 with one pain therapist & a part time physiatrist with the focus of
 - Addressing pain from Biopsychosocial Whole Health model
 - Improving quality of life
 - Increasing access to proactive self care, appropriate conventional, complementary & preventative treatment options
 - Supporting Primary Care Providers (PCP's) in their provision of pain care

Our Missing Link

- As the Pain Program grew, we struggled with how to help Veterans utilize services effectively versus giving them individual treatments
- How to help people make the connection to active self care and to reap the benefits
 - Solution: Utilization of the Whole Health Model in combination with Pain Coaching
- So What About Funding?
 - We had a grant from the Office of Rural Health (ORH) for pain self management and relaxation

Meet Mary

- 53 year old female Veteran
- Diagnosis
 - Fibromyalgia/low back pain/shoulder pain
 - Couldn't walk, filled fear
- Angry, depressed
- “Had no life”
- “Didn't do anything”
- She was referred to Take Courage Coaching

Slow Road to Recovery

- Thought she was a positive person, but identified many negative thoughts
- Learned reframing
- Wanted to get well
- Practiced time-based pacing
- Not only helping with chronic pain, but also helping with life stress
- Keep stress level down, nutrition up, visualization
- Helps with anxiety
- Learning new normal/took away fear

"One way to avoid resistance is to encourage people to progress from one stage to the next rather than trying to pressure them to take action for which they are not prepared."

Transtheoretical Model of Change, Stages of Change

What Makes Pain Management Coaching Different?

- The Coach has ample time to spend with client to help facilitate positive change, using a collaborative and empowering approach
- Nonjudgmental partnership focusing on strengths and solutions
- The Client learns and makes positive lifestyle changes at their own pace, not at the pace of their coach or provider.
- Information, modalities and new tools are provided to the client in a way that allows them to be the expert about their life. The coach's role is not to be the expert authority but rather to elicit from the client what they already know and to fill in the gaps of information at the consent of the client.

Client Centered Coaching

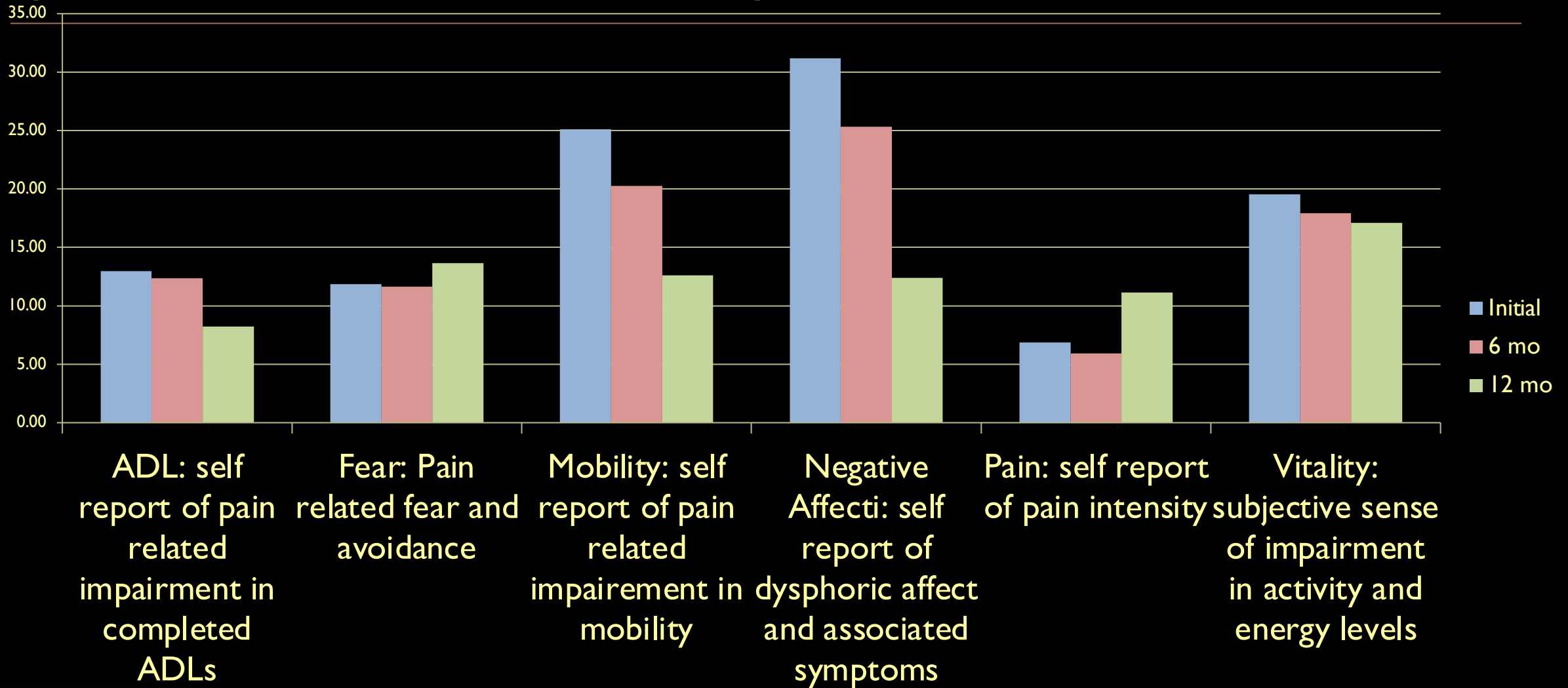
- The Client shifts the mindset from “What is wrong with me?” to “What is right with me?”
- The mindset shift results in the client becoming empowered and motivated to take action steps regarding their own health rather than remaining dependent on passive treatments and medical interventions.
- Coaching eliminates people’s natural tendency to resist uncomfortable changes because the client is put in control of their own outcomes. Actions from either the coach or provider that move more aggressively than the client’s pace or comfort level often produce resistance leading to discord and distrust between the client and coach and the patient and provider.
- Once clients develop the coping skills to deal with their pain independently, they are much more likely to approach their provider about the idea of discontinuing passive treatments and to take a more active role in their pain experience.

Where One Veteran is Now

- “Interacting in life”
- Facilitator for the ACPA support group for the VA hospital
- Post chaplain for the American Legion
- Attended his first American Legion Convention and is planning to go next month to the National convention
- Communications/mechanic for adaptive cycling clinic
- Planning to do the MS bike ride (136miles)
- Rides adaptive bike 100 miles a month
- Cooks/raffles off cheesecake for the bike group

Pain Outcomes Questionnaires (POQ)

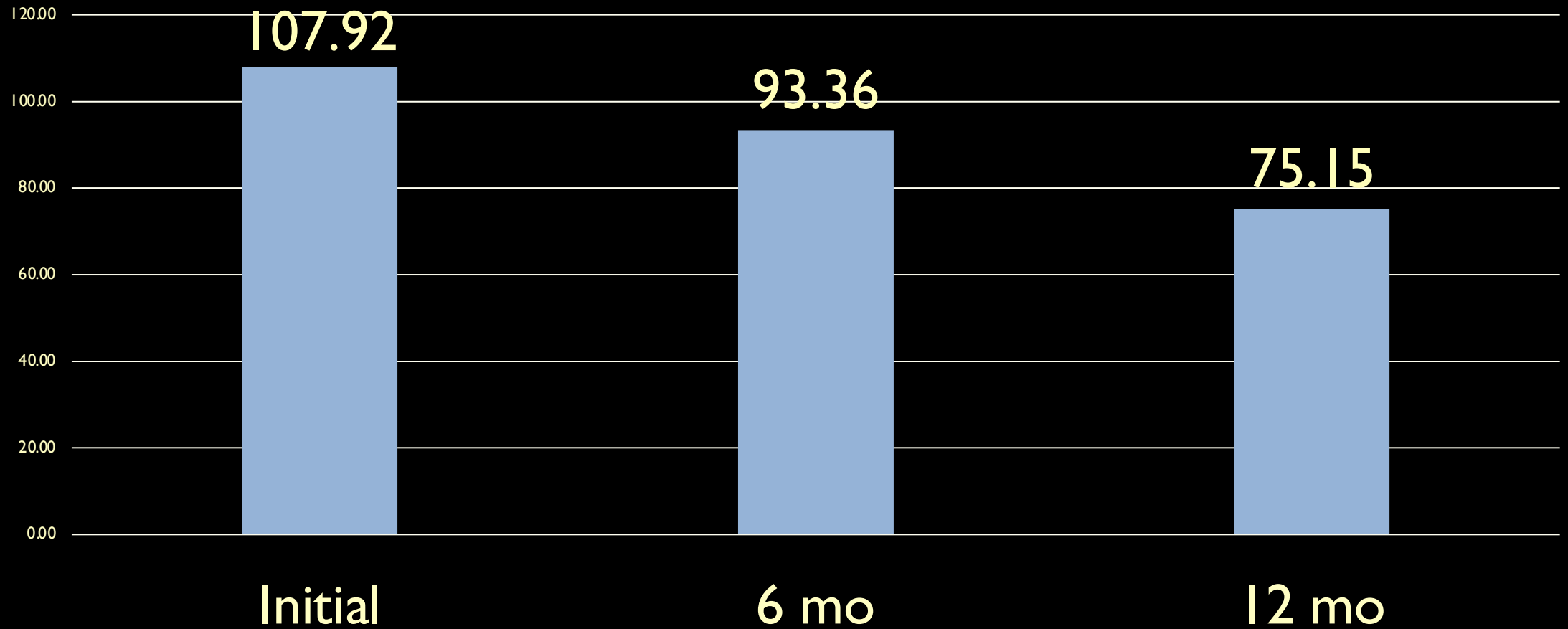
(Initial =74, 6mo =44, 12mo = 33)



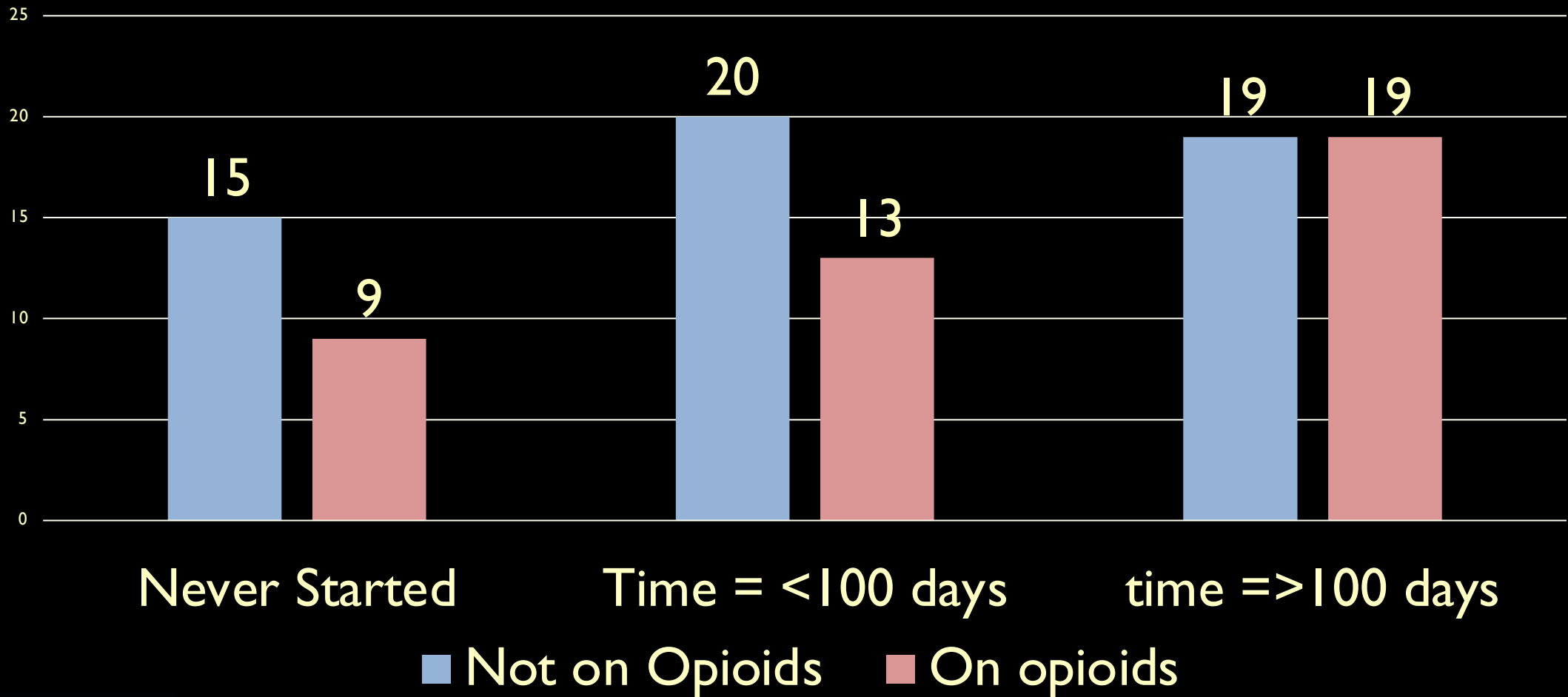
Average Decreases in (POQ)

- Self report of pain related to impairment in completed ADLs
 - (max 40 pts): Avg decrease of 4.74 points
- Self report of pain related impairment in mobility
 - (max 40 pts) Avg decrease of 12.52 points
- Self report of dysphoric affect and associated symptoms
 - (max 50 pts): Avg decrease of 18.80
- Subjective sense of impairment in activity and energy levels
 - (max 30 pt) : Avg decrease of 2.46
- Total Overall Score
 - (max 190): Avg decrease of 32.77

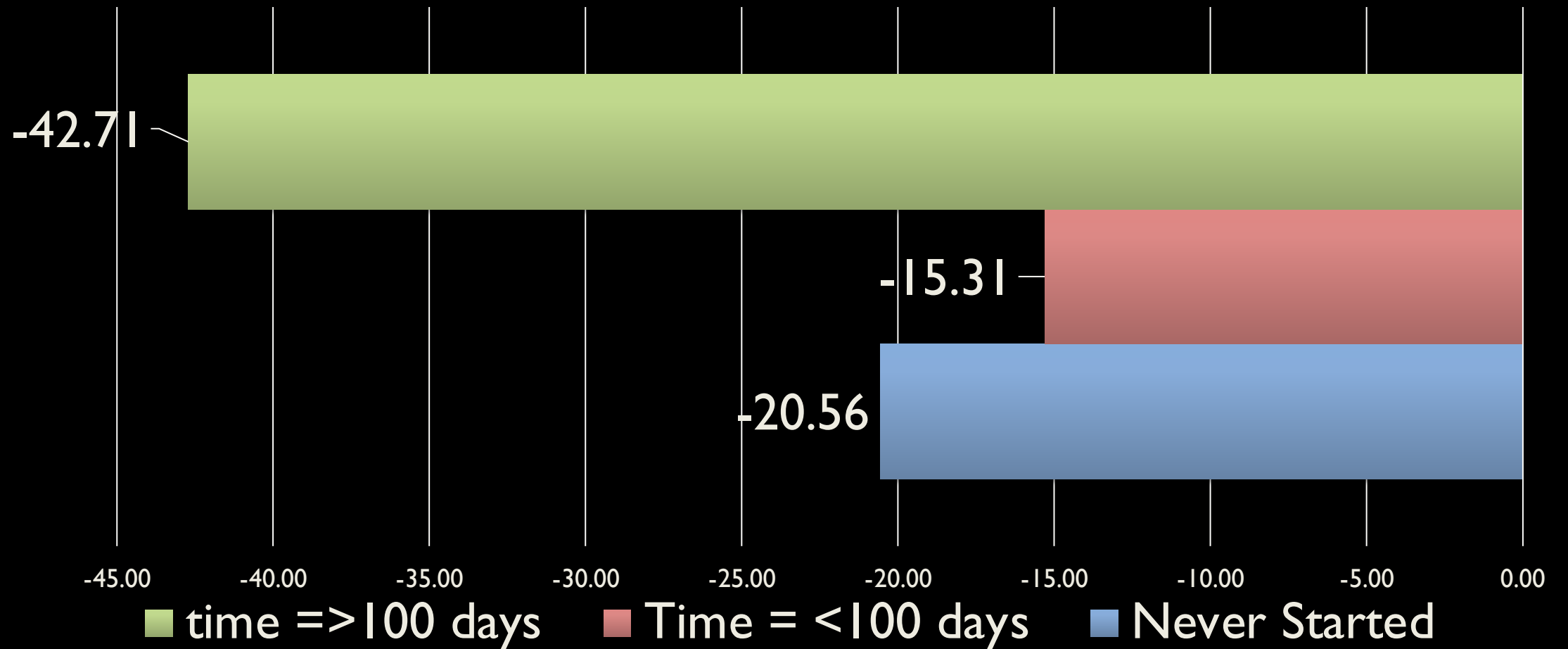
POQ Total Score changes



Opioid Status of Veterans Referred to TCC (active not included)



Decrease in MEDD In Veteran's referred to TCC

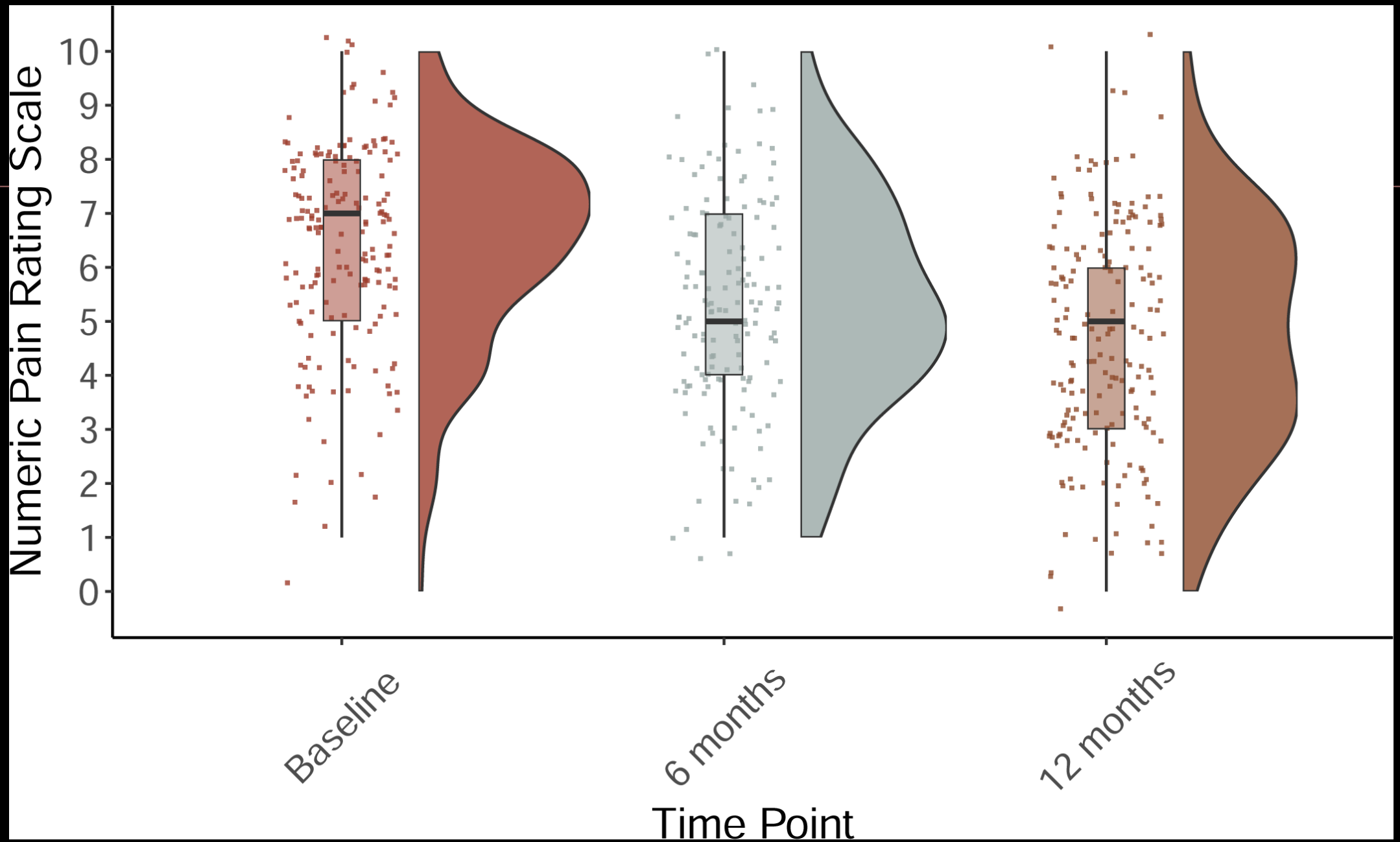


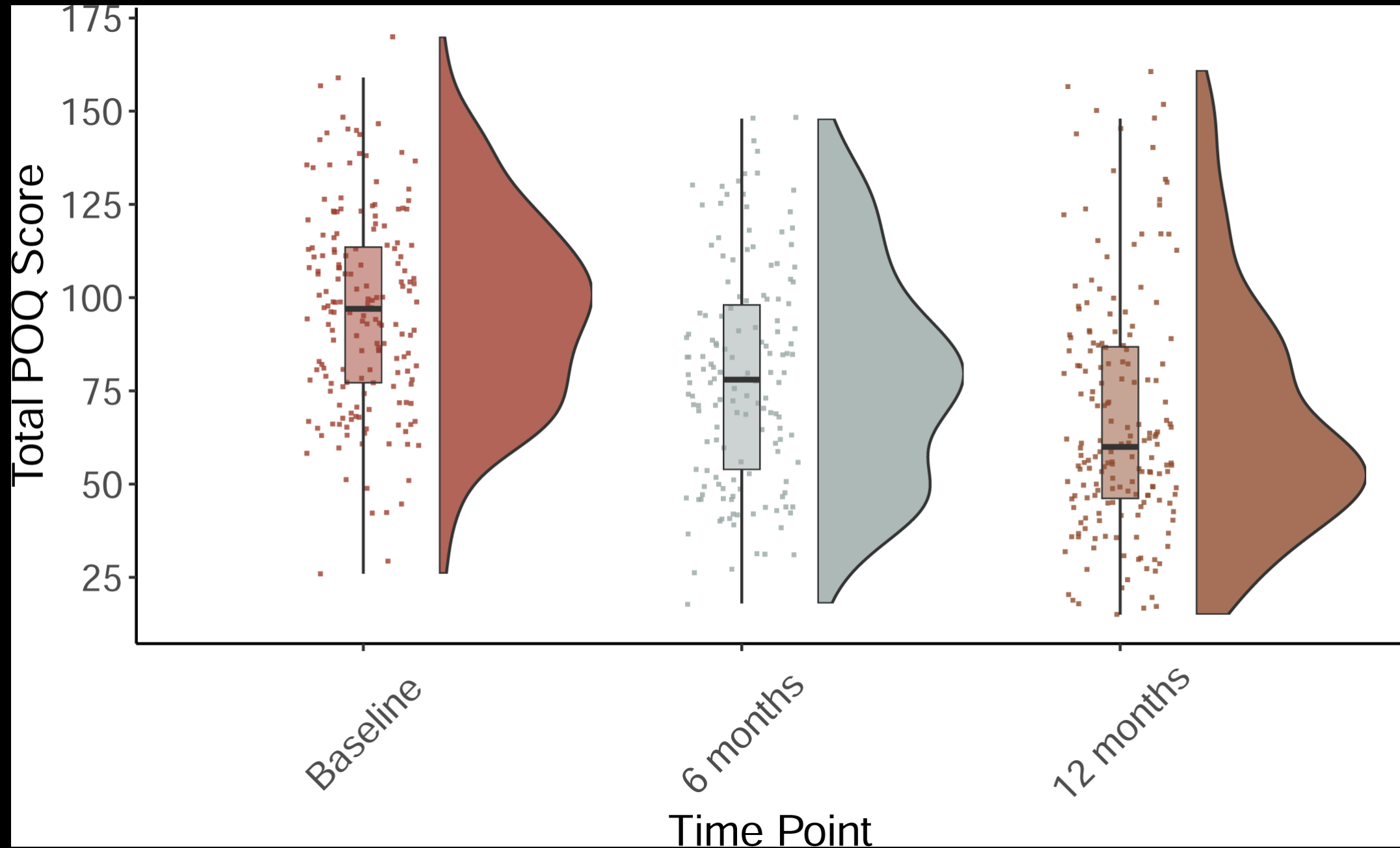
Total TCC Numbers

	2014	2015	2018	2019	Totals
Total Referred	22	22	30	17	91
Total Never Started	4	6	9	2	21 (23.08%)
Total Participating	18	16	21	15	70 (76.92%)

TCC Benefits/Lessons and Future

- All who completed program show significant increases in functionality
- Referrals should be for pain clients who are ready to become actively involved in their self-care
- The VA has looked at options to bring this in-house however we could not do it cheaper unless it was done across multiple VAs
- The VA is currently in a 5- year contract with TCC to provide pain coaching to their Veterans





POQ Scale	Baseline		6 month		12 month		<i>p</i>	Effect size (g) [†]
	Mean*	SD	Mean*	SD	Mean*	SD		
Pain intensity	6.68	1.77	5.41	2.03	4.71	2.12	< 0.001	1.00
Mobility	22.45	10.72	17.52	12.03	13.64	11.29	< 0.001	0.81
ADL	11.10	10.48	8.79	9.75	6.59	9.27	< 0.001	0.44
Vitality	19.78	5.18	16.08	5.54	13.85	5.87	< 0.001	1.10
Negative affect	28.41	11.03	21.61	11.49	17.93	11.26	< 0.001	0.94
Fear	11.23	3.81	11.61	3.52	11.00	2.25	0.236	0.07
Total POQ score	101.50	28.88	82.08	32.61	67.74	31.89	< 0.001	1.13

* Positive values indicate reductions in POQ scale scores.

[†] Effect sizes are reported using Hedges' *g*.

POQ = Pain Outcomes Questionnaire; ADL = Activities of Daily Living; SD = standard deviation.

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	Pain			
<i>Predictors</i>	<i>Estimates</i>	<i>CI</i>	<i>p</i>	<i>df</i>
(Intercept)	5.16	4.34 – 5.98	< 0.001	789.00
6 month timepoint	-1.45	-2.66 – -0.25	0.018	789.00
12 month timepoint	-3.30	-4.56 – -2.05	< 0.001	789.00
Baseline timepoint: vitality	0.06	0.02 – 0.09	0.001	789.00
6 month timepoint: vitality	0.04	0.00 – 0.09	0.045	789.00
12 month timepoint: vitality	0.07	0.03 – 0.11	0.002	789.00
Baseline timepoint: negative affect	0.03	0.02 – 0.05	< 0.001	789.00
6 month timepoint: negative affect	0.07	0.05 – 0.09	< 0.001	789.00
12 month timepoint: negative affect	0.06	0.04 – 0.08	< 0.001	789.00
Baseline timepoint: fear	-0.05	-0.09 – -0.01	0.018	789.00
6 month timepoint: fear	-0.04	-0.10 – 0.02	0.204	789.00
12 month timepoint: fear	0.08	0.01 – 0.15	0.020	789.00
ICC	0.46			
N _{participant}	416			
Observations	803			
Marginal R ² / Conditional R ²	0.297 / 0.618			

CI = confidence interval, df = degrees of freedom, ICC = intraclass correlation coefficient, N = number.

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Questions and Answers

- Becky Curtis, NBC-HWC
- Take Courage Coaching, CEO
- Becky@TakeCourageCoaching.com 406-381-2726