Relating to SB 50 expanding clinical groups required to take the basic 1 hour pain education module through Oregon State Pain Commission (OPMC), and increasing from 1 x only to every 4 year.

This testimony is in support of the bill without amendment.

My name is Nora Stern, MS PT. I am a member of the OPMC and work in the area of pain education and persistent pain rehab therapy as a physical therapist, at Providence Health and Services. I have worked with this population for 21 years and teach clinicians including nursing, MDs, DOs, ED physicians, primary care, pain specialists, orthopedists, occupational medicine physicians and case managers, primary care case managers, PT/OT and speech inpatient and outpatient. My job at Providence is to promote a common understanding of pain, for all clinicians across the care continuum and across disciplines, so that all clinicians are accurately supporting knowledge of pain on the part of the patient. This is consistent with the call from the National Pain Strategy (2016) and the Institute of Medicine (2011).

There is now considerable evidence that pain education improves the patient experience and decreases health care costs. (Louw A, et al Arch Phys Med Rehabil. 2011, Louw, et al SPINE 2014, National Pain Strategy, 2016 and the Institute of Medicine's "Relieving Pain in America 2011.) If the patient fundamentally believes, as most do, that their pain is purely a result of something wrong in their body, reinforced often and inadvertently by clinicians, then efforts to help them often are unsuccessful. A difference in understanding of pain can change this.

Take for example a simple scenario where a patient is worried after a spine surgery that there is still something wrong. Let's call him Mark. Mark has begun to do less and less, as his pain becomes greater with more activities. He is depressed. With the old way of thinking, we are trained to look for the "source of the pain" in the body. So, Mark might very well be sent to get another x-ray or MRI. We know that 68% of people age 40 with disc degeneration, and 50% of people age 60 with facet degeneration will all be asymptomatic, yet these findings may lead to another surgery (Brinkijki et al 2014 Am J Neuroradiol). We also know that, when a patient is sent first to get radiological testing, there is an average cost per episode of care that is $4793 greater than with physical therapy first (Fritz et al Health Services Research 2015). When the next surgery is unsuccessful Mark will likely be put on ever higher doses of pain medication in the absence of a better idea. And down he goes on the slippery slope that we are seeing all around us.

This is a terrifying and completely avoidable scenario.

With a contemporary understanding of pain, that physician might instead reassure the patient that the surgery was successful and that there are many things that could be causing the pain to persist, based on new neuroscience regarding the biopsychosocial nature of pain. With some simple change in language, the primary care physician or nurse can reinforce the notion that pain and harm are not the same thing, and they could identify the clear pattern of fear avoidance in his presentation. This would lead to a new conversation about physical activity and physical therapy, and allow Mark to know that he is "sore but safe" to quote from the words of David Butler, author of the very valuable text, "Explain Pain." Now Mark has now gone down a very different path, because of a common understanding and common language regarding pain. With all clinicians updating their basic pain knowledge through the OPMC updated module, the physician, the nurse, the case manager, the PT, the ED doc, all clinicians

who make contact with Mark can reinforce a sense of safety and hope, and gently encourage him to slowly return to activity.

This is the intent of the OPMC updated pain module. Much has changed in the world of pain since most clinicians first took the pain module required by the state. Much will change again. Since we spend $566- 635 billion on pain care in this country per year (IOM 2011) it is important that we do our best in treating pain. Thus far, as a society, we have not done so. Outdated knowledge has been identified as a key factor. In my experience, teaching pain science and patient pain education to MDs, DOs, nursing, physical therapists, occupational therapists, pharmacologists, behavioral health specialists, speech language pathologists, massage therapists, and case managers, I concur with the assessment of the National Pain Strategy and the Institute of Medicine that all clinical professions need to work further to update our knowledge of pain science and our clinical processes in developing a plan of care with the patient.

I am concerned that the OMA and the nursing board are objecting to a requirement to re-take the module. One of the responses that I heard was concern that it might be "too basic." The intent of this module is in fact that it be basic common pain education that allows us to all give consistent messaging. As smart and specialized as any given clinician may be, I think we all need to get better at changing our language to create a message for the patient from one of *danger and threat* to one of *safety and hope.* None of us have mastered that, as a group, in my experience.
Additionally, the module will include relevant and easily updated links which will allow the module to be a resource for greater learning.

I support SB 50 without amendment.

Sincerely,

Nora Stern, MS, PT

Program Manager
Persistent Pain Project
Providence Health and Services Ambulatory Services Department
545 NE 47th St, Suite 215
Portland OR 97213

503-215-6202
Nora.stern@providence,org

Nora Stern, PT, MS PT
Program Manager, Providence Persistent Pain Project and
Rehabilitation Services Persistent Pain Program

545 NE Glisan St. Suite 215

Phone 503-215-6202
Fax: 503-215-6206

nora.stern@providence.org

Rethinking Pain