Speaker 1: Welcome to PT Elevated Podcast, a clinically focused podcast for physical therapist and other rehab providers. We may occasionally talk about big ideas and nerd out on research, but our ultimate goal is to provide knowledge and tools that you can apply in the clinic right away. We want you to learn something that helps you elevate your practice and increase your confidence. Let's get started.

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Korey: Well, welcome to this week's episode of the EIM PT Elevated podcast, where we look to gain insights from our expert clinicians and researchers on helping you elevate patient care and improve your outcomes. I'm Kory Zimney and I'm here today with Megan Doyle. Megan, so glad to have you here joining us today. Today we're going to talk obviously as a physical therapist. I think in the past, pretty much all of our guests have been physical therapists, but we're going to look at the other therapy we oftentimes work with a lot is occupational therapy, and that's obviously your kind of expertise being an occupational therapist. But before we get into talking clinical stuff and how OT, and especially in your area of chronic pain that you kind of gained some special knowledge and training and really worked in the last few years, but maybe if you just want to give a little introduction of yourself to our audience.

Megan: Yeah, absolutely, Korey, and I just really appreciate this opportunity to speak about my scope. Love that advocacy piece for occupational therapy. So I've been practicing as an occupational therapist now for 10 years. I've actually worked across a multitude of settings, so I've gotten to see pain and certainly chronic pain in a lot of different types of practice settings. And I currently practice in Boise, Idaho for a large non-profit health system.

Korey: Perfect. And like I said, you and I, we've known each other for a while and obviously in the chronic pain world and stuff and in that area, obviously occupational therapy's role in chronic pain, I think, is maybe unknown or confusing to some people. It's like, well, isn't that just PT stuff? But how does OT work with them if they got low back pain or chronic knee pain? How is an OT involved in some of those things if they're not just working on their dressing and eating skills, which I think sometimes is our limited view of what OT can do. So maybe just, we'll just open it up real broad and just kind of talk a little bit just OT's involvement with patients that have persistent pain and how you guys can be involved so intricate and helpful in so many ways with that clientele.

Megan: Yeah, no, absolutely. It's kind of funny, right? It's like what was old has become new again because one of the things that we forget is that occupational therapy as a profession was at the table for a long time in those older models of restoration programs for chronic pain. I think we all know that there was a time period there where

third party payers, insurances kind of unfortunately started to break up those big programs started to put us unfortunately as practitioners into silos, and I just feel like it's been a lot of trying to get occupational therapy known again as a profession that once was there and definitely can play a role in treating patients with chronic pain. Our scope is so big and broad. I think that's what makes us so great and unique, but also understandably very confusing to other professions. You might see us almost as these chameleons that do different things depending on the practice setting or the populations that we work with.

But a lot of the same things for the whole scope of practice for occupational therapy are always going to be the same. We're so focused, as physical therapists and other providers are, on really being person-centered. That's first and foremost, but looking at the bigger picture when we talk about what is occupation, what the heck is that even? Occupation is what occupies our time. It's the things that we need and want to do in our daily lives. And so what an OT's going to do is they're really going to look at how does that person's persistent pain transcend every single area of that person's life. So even if their persistent pain experience is more centered, let's say, in a particular body region like the back or the knee, we are going to want to know and support them. Well, how does that affect your ability first and foremost, like you said, doing some of those ADLs activities of daily living, but even beyond that, we know as human beings that we all have treasured and valued roles, habits, routines that we want to participate in.

We're mothers, fathers, brothers, sisters, husbands, wives, workers, want to be productive in society. And so recognizing how can we help support that person and first and foremost, I think problem solve. How can they engage in those daily activities? We can really partner with other providers. So one of the things I love to talk about is let's say we're working together with a physical therapist. That physical therapist has a great treatment plan, really great exercises or other strategies that they want that person to engage in in their daily life. That occupational therapist is going to say, "Great, how can we make that work for that person?" We can sit alongside them, collaborate with them, really guide them to make that work in their daily lives.

So it's a lot of that proactive problem solving. Same thing for the mental health and behavioral health piece. We are not going to have somebody be on a couch and performing a psychoanalysis or treatments as such as maybe a pain psychologist or a counselor might, but we absolutely recognize that engaging in those valued activities we know is going to help bring about that confidence for that person. We know that's going to reduce that pain experience and that pain interference for that person. So it really comes back to that daily quality of life, but helping people first and foremost engage in those activities that they need and want to do.

Korey: Yeah. You talked about the mental health too, and I mean, I know historically OT was hugely, and obviously with the cuts unfortunately in mental health and schools have actually transitioned and probably don't teach as much of the mental health component as they used to. And we know in definitely people with persistent pain, that is such a key focus. But you guys still, your schooling has a lot of stuff that you guys do in regards to understanding those mental health concerns and issues.

But with that, I think, yeah, even if you can just, because I think the majority of our audience are a physical therapist and just helping them probably decide, geez, do I need to consult with an OT? If I'm seeing a patient, what things should cue you to say, "This is something that an OT could help me with that maybe isn't as much of my skillset."

I think some therapists recognize that, yeah, I got a little bit of diet information, but I don't know a ton about a diet. So we make a referral to a dietician. We see they have some mental health issues. Yeah, I probably should refer them to a psychologist, but I think that transition of when should I maybe consider even referring to an OT is not something that we're probably quite as good at recognizing. So just a few tips, ideas, things that they might see in their patients that a PT working in an outpatient clinic might recognize and go, "It'd probably be a good idea to bring in another person, especially my OT counterpart to help me in this area." So if you could give our audience a few thoughts in that area.

Megan: Yeah, no, absolutely. And it goes back to that problem solving piece. So let's say you're interviewing a patient and they're making it very clear that pain is clearly transcending all areas of their daily life, but they're saying, "I really just having a hard time being able to take care of my house. The pain is to the point where I'm not even able to drive myself. I'm falling behind on being able to manage other areas of my life. What are your ideas on this?" And that's a great starting point for occupational therapy because an occupational therapy practitioner, and when I say occupational therapy practitioner, we have similar to PTs and PTAs, we have occupational therapists who are the evaluators and OTAs are counterparts there, so we lumped them in as OT practitioners.

But that referral when that person is really saying that they're really having a hard time engaging in their daily life that way. And that's not to say that physical therapy is not going to do a bang up job on helping them get strong or make recommendations for pacing. They're going to work with them on graded exposure in the context of different activities, in particular physical activity. They are going to give them different exercises to do, make recommendations, hopefully, fingers crossed on areas like sleep and other things.

But again, take advantage of us because if you have another person coming alongside that person that can devote that energy to how can we make those recommendations in that person's daily life, especially if they are saying as well that they're having difficulty with sleep. Occupational therapies practice takes nine different areas of occupation with rest and sleep being one. That's how important it is. Health management actually is its own area of occupation. That was just added in our new practice framework in 2020. Again, that's how important that is. So recognizing that an OT can work alongside you when that patient of yours is really saying, "Hey, I need some help figuring out how I can engage in these different areas in my daily life." And an occupational therapeutic practitioner can really work on, again, pacing, energy conservation, but making some of those problem solving recommendations, also helping with some of those pain coping skills as well.

Korey: Yeah. And I know you've gone on and done additional training. You've gone through the TPS and went on and did fellowship and kind of the cool thing about that is obviously you were in there with other PTs, but just maybe if you want to just talk a little bit how just your knowledge changed and how you actually maybe helped change some of the PTs' knowledge and understanding just being an OT and them having an opportunity to kind of learn with and from you going through that process of fellowship and really taking a deep dive into that area.

Megan: Yeah, absolutely. I think what fellowship provided me as an occupational therapist more than anything was a new language. Going through TPS and then fellowship was really going into that deep but needed dive of being up-to-date on all the new pain neurophysiology, understanding different pain phenotypes, understanding what is it that I need to be, and not only listening for when I'm working with that patient subjectively, but recognizing needed outcome measures that I need to be using, more rigorously, assessments, things like that. It gave me then that language to support those recommendations for those different interventions and helping empower somebody with that understanding of how persistent pain can come to be and it's really its own diagnosis, deservedly so.

That's been the greatest thing is that foundation. And then laying upon that different occupational therapy interventions, I think what I've been reflecting on is that some of those areas I focused on a little too much, or what I was taught 10 years ago in my schooling was too much of a focus on biomechanics joint protection. It was a little more biomedical than I think even I realized. And then kind of coming back around to, "Hey, wait a minute, biopsychosocial is biopsychosocial." We applied that in our OT practice to so many other areas, individuals that we work with because we really do take that biopsychosocial really spiritual lens for any and all people we're working with.

But then coming to understand the new pain neurophysiology and pain neuroscience education, it was, whoa, whoa, wait a minute. I might be doing more harm than good here. I might be offering some of these pain cognitions that maybe are making people think if it hurts, don't do it, or thinking too much from a biomedical place. So that was a real eye-opener for me. And the answer that second part, really working with the physical therapist in especially my fellowship cohort, talking about how we know, again, I just already mentioned something like graded exposure, so just talking about how from that occupational therapy perspective, we're really going to do it within the context if at all possible of that actual occupation, activity.

So I always love talking about the kitchen and cooking. It's such a relatable example. And how many times maybe have physical therapists heard when they're asking, "Oh, how long can you stand, move?" And somebody might say, "Oh, I can only stand for 10 minutes at the sink while I'm cooking or at the counter and then I have to sit down. My back hurts too much." So an occupational therapist would want to actually do that as closely as possible. Best practice would actually be to actually be in a kitchen and actually cooking. And I've gotten to do that before because then you get this component that we call activity analysis.

So you're getting that real world exposure and then experience. And again, this is not right or wrong. Graded exposure in the context of physical activity is so valid. We know that enjoyable physical activity makes such a big difference, but it's just offering that occupation based perspective that an OT is going to be able to compliment any of the graded exposure, for instance, of physical activity that's helping somebody with chronic persistent low back pain, we're going to work within it in those actual contexts of those activities.

Korey: So you alluded to obviously gaining a new language and with the pain neuroscience and the physiology and understanding those components and stuff. But maybe just other things within your practice, even maybe from a treatment standpoint that you talked about doing that activity analysis. Do you become a little more in tune differently? Have you noticed in some of those areas or has it been more the language or have you even noticed just watching other behaviors with a patient? Maybe if you can just give a window into some of those other things that in your practice you've known that have kind of developed through the years.

Megan: No, absolutely. And I think the behaviors part is key. I'm so glad that you used that word. Something I try so hard to do during that patient interview and something that my cohort mates in my fellowship cohort noted when I had to do, for instance, my grant rounds, which is where we present on cases, they're like, "Wow, OTs do a lot of subjective." It's like we do. It's a lot of subjective and there's ways we objectify the subjective. But what I've really tried to do is use that good motivational interviewing, those good open-ended questions, and when I'm working with somebody and getting them to share with me, first and foremost, creating that safe space, and of course I'm speaking with somebody who knows therapeutic alliance and trust better than anyone. Creating that space where they really feel safe to share their narrative. And then what I'm doing is I'm very skillfully listening and I'm just listening for these little words and little patterns, filing that away.

And that's changed tremendously in my clinical practice over the years. So I'm listening for what is it that they think about their pain? What do they think their contributors are? I'm listening for tone of voice. I'm listening for how is their mental health. How is their mood? How is this affecting all these different areas? And then also I'm listening for, is this someone who feels as though they can help themselves. Is there a window here to facilitate that self-management? So I'm listening for those things. And then, only then, and certainly asking permission first. That's the other thing. Would you mind if I provided you with some education and our new understanding of pain? And once I have that, yes, then I try so hard to take what they've just shared with me and to tie it into whether it's the appropriate metaphors or just giving those explanations to really validate that person and get them to understand, "Wow, you're talking about me and now this is making sense."

And I think when I first was practicing, I was, again, I mentioned about being a little bit more myself in that biomedical model. It was too focused on, okay, I'm going to make recommendations to help take this person's pain away. And that's really hard now to think the best practice of no, no, no, this is always supposed to be that facilitator

relationship. I'm meeting them where they are and assessing their openness for recognizing it needs to be about that independence with self-management first, guiding that participation first and foremost, and some valued activities that would give them confidence and success.

Korey: I appreciate, you talked about your subjective interview and stuff, but that's one thing even I've noticed just since I came on faculty and getting to work with some of the OTs in our OT department, just the qualitative aspect of research and just their ability to... And again, like you said, it's still objective. I think a lot of times we look at qualitative as the subjective, but there's still an objective component to it. And I've really appreciated just the lens that you are training through the OT profession, the lens that you guys look through things from that subjective qualitative information that you still can make some objective criteria and things like that.

So I definitely when you say that head to chuckle thinking, I've definitely noticed that in myself as a PT, recognizing that that is something that OT has a unique ability to bring to the table and a lot of stuff that that's helpful. Well, you kind of mentioned some of just the changes and stuff, and maybe if you want to just share just a few of the mistakes you maybe see some of non-OT type professionals kind of make, and maybe even what some OT professionals maybe are making vice versa too. Just some of those misconceptions, kind of some of those things, if you want to just talk a little bit to those.

Megan: Yeah, no, definitely. And I appreciate that. I would like to just be fully transparent. It's on both sides. So something that keeps coming up is, and that's where you brought it up a little bit at the beginning, but the why should an OT get a referral? There's still that misconception that we need to divide the body. I still see this notion that, "Oh, well, why an occupational therapist is only going to treat the upper extremity, a shoulder, a hand, an elbow with chronic pain? Why are they going to see somebody with persistent low back pain or another body regent?" And just that misconception that then we're really still too much following that biomedical model, right, because what we just talked about is that lifestyle piece, that occupational therapist, again, alongside the PT, other providers, we all need to be speaking the same language, but we can all address, there's so many components for that person with persistent pain to address all those different lifestyle factors, which we know is best practice in order to really treat that from a holistic place.

And then again, the mistake unfortunately I see my fellow OT practitioners make is kind of trying to make themselves out to be other professions. I'll see them default to modalities first or still some of these biomechanical things. And again, there's definitely a place we know, pacing, energy conservation, but they're doing it from a lens that unfortunately is still too rooted in that biomedical explanation of pain versus seeing it for what it is and seeing it in the new context of pain neurophysiology in the biopsychosocial model. So it's my call to my fellow OT practitioners to stay true to your mental and behavioral health roots. Stay true to who we are, that holistic profession. I see that getting applied to other patient populations and then for some reason it doesn't get applied as well to chronic pain.

Now I'm happy to share that the American Occupational Therapy Association, it's almost a year ago now because it was December 2021, put out our new position statement on OT's role in pain management. And it is just chockfull of all of this support and everything. There's been some other documents. I'm super familiar with the International Association for the Study of Pain. Their occupational therapy curriculum really makes it big and bold and clear both for acute and chronic pain that we should be looking at all these different areas. So it's like we know it's out there. It's just making sure that that is finding its way into programs, especially here stateside and making sure that that's getting taught in the correct way.

Korey: No, it's such an interesting point when it seems like nobody knows us, so then we start acting in a way that's different to try to match the like, oh, look at us. And it's like, well, we just didn't know what you were doing and how bad we need it in the first place. And so don't change, like you said, stay true to what you know, because yeah, just the behavioral mental health aspects that OT brings, and again, like you said, just that really looking at that holistic function and yeah, that's something I've learned too, occupation from me, especially coming from my clinical traditional oc med background. It was your job, what did you do from eight to five type of thing, but really seeing occupation is, yeah, what do you do with your time in life? And that really opened up my eyes as I understood that more how you guys as a profession look at things.

I would agree, yes, stay true to yourself because it's those things, the way that you guys and the lens that you look through things is different from my training. Again, like you said, not either is right or wrong, but they're both partial and we can combine them together. We get a little closer to having a more full picture and we kind of cover up each other's blind spots a little bit. So I would echo that. Yeah, we need you guys to stay true to who you are because those are the blind spots that we're currently missing when we're not doing that. And if you start acting more like us, it doesn't do us any good.

Well, the training and your specialty and your passion for working with persistent pain, I know sounds like you have a new opportunity potentially at your employment exploring into a more comprehensive program and stuff, which is really kind of neat to hear that we're kind of hopefully moving back towards some of these more comprehensive type of approaches. And I know the VA's been able to do some of these things, but in the public sector we don't see them quite as much. But if you want to maybe just talk a little bit, I know you guys are still working on the development stages and it's not fully all there yet, but it looks like you're definitely have done a lot of the back work. Maybe just talk a little, yeah, what your guys' program and your role and some of that that you want to share.

Megan: Yeah, absolutely. It's been an incredible opportunity, and I do want to say that none of it would not have been possible if it hadn't gone through the full fellowship of pain sciences for EIM. It really did give me that platform, but really also wearing that occupational therapy hat as well. So stepping into a role of manager of the program and having a seat at the table for all these decisions, which is just so fulfilling and really looking at every single piece because every single piece matters. So how do we want to make our referral process? One of the things that I've really had to think about is, again,

making sure that this is about giving an opportunity for individuals that are really hungry and are ready to take that step into a rehabilitation space to address their persistent pain that they have, that mindset.

We are trying to develop a process. There's actually some great outcome measures out there that can look at individuals for their motivation for a self-management program. So making sure that we're, not that we want to turn people away, but it's definitely a program that is, "Hey, your physician referred you because you've made it very clear, you know what? I'm ready. I want to look at all my lifestyle behaviors. I want to participate in a rehab program that's going to have multiple sessions," things like that. So trying to have those individuals. And the other thing, we're trying to make it very clear to we're really going to do a very soft launch because we want to do things right. The last thing we wanted is for this to turn into something where it's kind of a physician referral, easy button. My patient has chronic pains. They should go to this program.

And then also it not being about my patient is taking more opioids than recommended, so they need to go to this program in order to get off opioids. Do I feel that if we do our due diligence and we were to track those types of things, that it's going to be an outcome that may occur? Just we know that may happen, absolutely. But are we doing our due diligence and really supporting these individuals if our focus is on function, if we were to make the focus be that. So those are some of the things that I'm trying to advocate for and make very clear that this is a program that is going to be multidisciplinary and comprehensive, very holistic. It's really starting with both occupational and physical therapy. We really would like to have an in-house behavioral provider piece. We're still trying to work on that, but we know that it's very needed.

And really looking at the literature, it's been really exciting to see successes of programs. You mentioned the VA, but there's some other private sector programs out there as well where they have models where you have more traditional one-on-one sessions, whether that's six to eight weeks, a couple times a week, OTs and PTs working together on all these different areas, making sure we're covering all the bases for that person. But we are very interested in having a transitional model to a group model. So essentially having one-on-one for so many weeks, but then transitioning maybe once a week for maybe four weeks, it's kind of fluid doing, "Hey, you've kind of leveled up. Let's kind of do this group format." And really kind of graduation then from this program would be if you feel successful and that independence with those self-management behaviors.

There's really great literature out there, I'm pleased to share, from the OT space. There is an intervention that's trademarked called Lifestyle Redesign. It's not trademarked to the extent that OTs can't, they don't have to be specially trained to use it, but it's been around for a really long time. Actually the well elderly studies started out in 1999 focused on different lifestyle behavior programming, both individually and for groups for well elderly. So kind of keeping well people well. It's based out of USC's occupational therapy program. But in 2017, they put out a really nice study showing the efficacy of lifestyle redesign for chronic pain. So specifically the individual model, but also that group model.

So having some groups and the efficacy of including some of those different behaviors and really that focus on function and that independence with self-management piece. So it's going to be super fluid trying to problem solve that. But I did a deep dive into the literature building this up. I've got this huge document that has 24 references for stakeholders. It's like, if you think that we haven't done our due diligence showing that this is evidence-based, you're wrong, so that's kind of where we're at. We're just going to get to that stage of starting to get in front of physicians and just educating them on who would be appropriate for this program and what the outcomes we hope to see are.

Korey: Yeah. It's just very exciting. And I think too, it's got to be, I mean, and just historically, most hospital programs either, it's usually driven by a physician, maybe an administrator because they found somewhere where you could make money and stuff. And this sounds like it's unique role because it seems a little more grassrootish that it's coming out of, especially you leading it with OT and stuff. Then what are some of the challenges? Because it is going maybe "the opposite" direction of how it's usually done. To push things through, usually an administrator, a doctor wants it, so they just get it where this is, you've had to kind of flip that a little bit and trying to, like you said, show its worth, show its value and to get other people to buy in. Maybe if you just some of the struggles that you've had with that, because the push may be a little bit different. You've had to pull people along a little differently. So if you want to just anything you could share in that area.

Megan: Yeah, I mean, one of the things that's a big win is any type of program takes that champion. I feel so blessed that our director of all adult rehab is a physical therapist, and he actually has a real deep connection to this. So this has been his side kind of passion thing. So that helps. I mean, when you have that champion at that level, he's really been instrumental and vocal and trying to help this get pushed through. But you're right, eventually we do need to have that physician champion. But you're right, we're going about it kind of backwards. It is going to be interesting that way, and we really want to have that champion that gets it and gets that rehabilitative mindset and gets that really the big picture. First steps are targeting those physician referral groups where a lot of those individuals with chronic pain would be seen.

We certainly do have our own in-house more interventionalist, obviously chronic pain clinic, but we also have our neurosurgery group. So as you can imagine, addressing persistent low back pain more for that spinal group. Rheumatology's another area, kind of looking at that, but really it's getting a chance to get a seat in front of these physicians and just give them the high level of these are the individuals that would really benefit. This is our program's vision, and then, oh, by the way, it's really highly recommended that they have both physical therapy and occupational therapy and here's why. So being able to give them that evidence-based, give them an idea of why they would want to refer their patients and what those quality outcomes are going to be.

Korey: Yeah, cool stuff. Well, I want to be obviously respectful of your time and everything, but anything that we've missed, obviously I've really enjoyed the conversation. I think it's just important to where and learning more how OT fits into a lot of just patients that we

see on a regular basis, especially in that persistent pain. Obviously other areas too, but we kind of focused into that one little area that's your specialty area and stuff like that. But anything else that maybe we've missed or anything else you wanted to share with our listeners in those?

Megan: Yeah, I mean, I appreciate having this platform to, first and foremost, knowing the audience might be majority PT, just educating on our scope and appreciating that it's not about we keep saying right or wrong or territory or things like that. It's just recognizing that that person with persistent pain has so many areas that need to be addressed, working as a team for that person, and again, all the literature out there supports that. So it's more about speaking that same common language.

And then on top of that, I would just be an advocate to my fellow OT practitioners, like you were saying, to stay true to our roots. My concern is that we're still trying to practice in a certain way. We need to educate ourselves on our latest pain neurophysiology, pain phenotypes. We really need to be able to speak to that, understand how to educate our patients in pain and make sure that we're not honestly doing more harm than good. That's probably my biggest concern. So the education piece comes in recognizing, hey, we've made some of these recommendations in the past, but are they really best practice at this point? Are they really evidence-based? So staying true to our roots, but making sure that we are staying up to date with all the latest evidence and being able to speak to that is incredibly important.

Korey: Yeah, it reminds me, the old saying that it takes a village to raise a child, and I think sometimes it takes a village to rehabilitate somebody that's had persistent pain. I think it kind of fits into that same ballpark. Well, Megan, like I said, it's been fun chatting with you. We always kind of finish up, one of the last questions that we always ask people is just any clinical pearl that you kind of wish you knew when you were kind of first starting clinical practice? Anything that you can leave some of our newer clinicians just to help them a long way. Hopefully they can learn from some things that we've learned from or learn from our mistakes. Either way, anything you'd want to share to the audience?

Megan: Yeah, definitely. Really, especially what I shouldn't say, especially when you're working with somebody with persistent or chronic pain, any type of pain, you are not failing if you don't manage to help take that person's pain away. That was like a real big... I just felt so early in my practice, oh my gosh, I'm just failing this person and they still have this pain and I'm not... It's way more about starting that relationship with them and keeping to that facilitator, collaborator, guide, coach mindset, really focusing on that therapeutic alliance and really being that guide for them. Recognizing that in all honesty, it's about guiding them again to those independence with self-management behaviors, helping them help themselves, helping them with those coping skills, helping them be able to participate in those valued activities that they want. So really having that mindset that you are not a failure if that keeps going on. That's not what your role needs to be. You really need to be that coach and that guide for that person. That's really that best practice, and I wish I had known that a lot earlier. I had empowered myself with that.

Korey: Yeah, that is definitely, I think a very good clinical pearl to leave our listeners. So thanks again, Megan, it's been fun chatting with you. Thank you again to our audience for joining us today on the EIM PT Elevated podcast where we hope you continue to elevate your practice along with elevating your patients.

Speaker 1: Thanks for joining us today. A big shout-out to Andy Frazier, a fellow physical therapist at Canyon City, Colorado, and his band mates, Alex Albertson and James Harris for writing and recording our incredible intro and outro music. If you enjoy the conversations we're having, rate the podcast, leave us review and share your favorite episodes with other clinicians. Until next time.