



Overcoming Disparities in Pain Management: Beyond the Decade of Pain

September 23, 2010
Minneapolis, Minnesota

Agenda: Pain Treatment Disparities

- A Call to Action
- Framework for Analysis
- Specialized Populations
- Formulating Plans of Care
- Panel Discussion/Questions & Answers
 - From Research to Practice
 - Your Role in Reducing Disparities in Pain Treatment

Learning Objectives

- Identify patient, provider, health care system, and regulatory barriers to effective pain management for all Americans
- Formulate care pathways to identify individual patient pain goals, improve symptom assessment, and document plans of pain care
- Employ evidence-based practice and policy resources to address health care disparities in pain management
- Discuss implementation strategies for overcoming barriers in the care of diverse populations

Transforming Thinking About Health Care Disparities: What We Hope to Accomplish

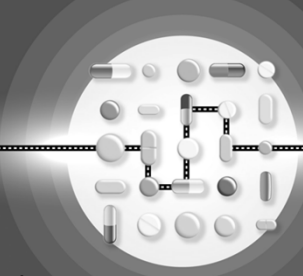
- Define terminology
 - Distinguish race from ethnicity
 - Show that cultural competency is a passé term; rather, diversity awareness and sensitivity is in vogue
 - Draw attention to the lack of clarity of disparity terminology that influences interpretations of the science¹
- Demonstrate that pain disparities are pervasive across all health care settings
- Replace traditional stereotypical ideologies with individualized focused care
- Consider individual differences (eg, cultural, religious, spiritual, values, norms, and health beliefs) as uniting us and not dividing us

We don't have all the answers ...

1. Etenwa MO, et al. J Nurs Scholersh. 2006;38:225-233. 4

Introduction

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Why Be Concerned About Pain Treatment Disparities?

- Equitable treatment is a fundamental human right!
- Health policy makers and professional organizations have promulgated calls for action
- The Joint Commission mandates that organizations respond to the diverse needs of all patients¹
- Addressing the health care needs of diverse patient populations is a core value of Magnet-designated organizations²



1. Wilson-Stronks A, et al. <http://www.jointcommission.org/NR/rdonlyres/88C2C901-6E4E-4570-95D8-8496D77756CF/0/HLCOneSizeFinal.pdf>. Accessed September 8, 2010.
 2. ANCC Magnet Recognition Program. <http://www.nursecredentialing.org/Magnet/ProgramOverview.aspx>. Accessed September 8, 2010. 8

Who Are Our Most Vulnerable Populations?

- Racially, ethnically, and culturally diverse populations
- Socioeconomically disadvantaged
- Older adults
- Infants and children
- Substance abusers
- Prisoners
- Individuals with chronic pain
- Individuals in need of palliative care



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Pain Treatment Disparities: A Call for Action

- Institute of Medicine
 - “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care” <http://www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx>
- American Pain Society
 - “Racial and Ethnic Identifiers in Pain Management: The Importance to Research, Clinical Practice, and Public Health Policy” <http://www.ampainsoc.org/advocacy/ethnoracial.htm>
- American Academy of Pain Medicine
 - “Ethics Charter” <http://www.painmed.org/Workarea/DownloadAsset.aspx?id=3283>
- American Society for Pain Management Nursing
 - Position statements



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Health Care Disparities: A Framework for Analysis¹

- Patient-related variables
 - Biological, psychosocial, and cultural variables contribute to differences in endogenous pain modulation and response to pain and treatments^{1,2}
- Health care provider-related variables
 - Pain is often underestimated with minority populations³
 - Minorities are less likely to receive adequate analgesia⁴
- Health care system-related variables
 - Access to general and specialty care is a problem for minorities⁵⁻⁷
 - Socioeconomic demographics contribute to disparities in access to opioid medications⁸

1. Anderson KO, et al. *J Pain*. 2009;10:1187-1204.
2. Campbell CM, et al. *J Pain*. 2008;9:759-766.
3. Cleveland CS, et al. *Ann Intern Med*. 1997;127:813-816.
4. Chen L, et al. *J Gen Intern Med*. 2005;20:593-598.
5. Freeman HP. *CA Cancer J Clin*. 2004;54:72-77.
6. Green CR. *J Pain*. 2008;9:1071-1073.
7. Fiscella K, et al. *JAMA*. 2000;284:2053.
8. Green CR, et al. *J Pain*. 2005;6:689-699.

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Case Study (cont'd)

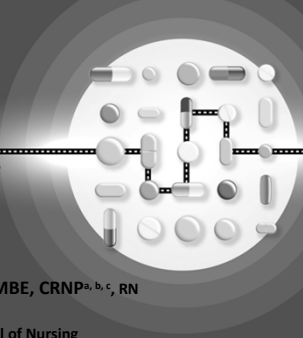

- **Analgesic therapy**
 - NSAIDs are contraindicated due to his renal insufficiency
 - Unable to afford long-term therapy with gabapentin or pregabalin
 - Tricyclic antidepressants have been prescribed but these have been poorly tolerated due to anticholinergic effects; he currently takes 50 mg of desipramine at bedtime with little relief
 - Trials of intermittent, short-acting oxycodone have been prescribed for unbearable episodes of pain
- **Functional status**
 - Can barely walk more than 1 block because of pain from his degenerative arthritis
 - Confined to the home with the use of a wheelchair when he leaves the house
- **Pain history**
 - Experiences average daily pain ranging from 5 to 7 on a scale of 0 to 10
 - Daily worst pain intensities range from 7 to 10
- Mr. C feels that no one is taking his pain seriously

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Questions

- Why hasn't Mr. C. been started on chronic opioid therapy?
- Why hasn't he been referred to a pain specialist?
- Why hasn't the option of joint replacement been pursued?
- Why is the ED staff perceived as making him wait and not sympathetic to his pain issues?

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Conceptualization of Disparities in Pain Treatment

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Pain Matters...

- Pain affects more Americans than diabetes, heart disease, and cancer **combined**¹
- More than 75 million people suffer from persistent pain²
- Pain has tremendous personal, relational, and social cost¹...
- Fiscal cost \$100 billion per year¹
 - Just under the amount needed to insure 45 million uninsured people in the U.S., ie, \$122.6 billion³
 - Equals the GDP of 65 lowest income countries combined⁴

1. American Academy of Pain Medicine. <http://www.painmed.org/patient/facts.html>. Accessed September 8, 2010.
 2. Alex YS. *SMA News*. 2007;39:24-26.
 3. Hadley J, et al. *Health Aff*. 2008;27(19):W359-W415.
 4. CIA World Factbook. <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2001rank.html>. Accessed September 8, 2010.

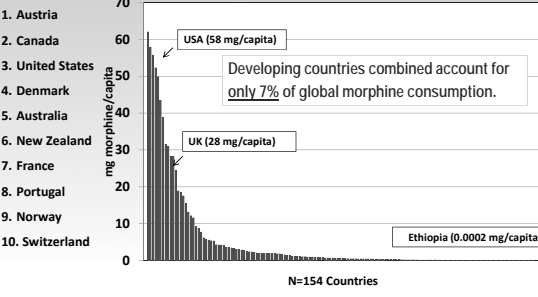
Capacity to Manage Pain

- The International Narcotics Control Board (INCB) uses *"morphine consumption"* in a country as a proxy to gauge "country's access to pain medications"^{1,2}



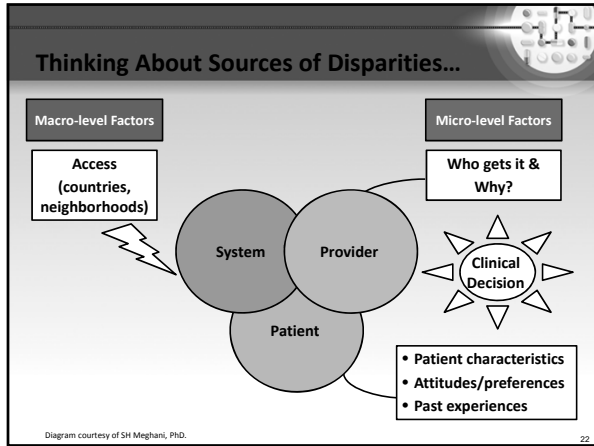
1. INCB. http://www.incb.org/incb/en/annual_report_1995.html. Accessed September 8, 2010.
 2. WHO. *WHO Tech Rep Ser*. 1990;804:1-75.

Consumption of Opioids for Medical Use by Rich and Poor Nations



1. Austria
 2. Canada
 3. United States
 4. Denmark
 5. Australia
 6. New Zealand
 7. France
 8. Portugal
 9. Norway
 10. Switzerland

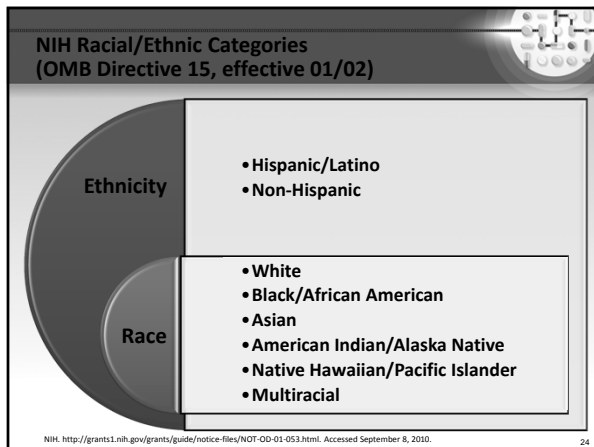
Pain & Policy Studies Group/WHO. <http://www.painpolicy.wisc.edu/interat/global/morphine06.pdf>. Accessed September 8, 2010.



Premise of "Racial/Ethnic" "Disparities" Research?


- That we understand "race/ethnicity..."
- That we understand "disparities..."

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Asians/Pacific Islanders Alone Range....

- Afghanis
- Bangladeshis
- Burmese
- Cambodians
- Chinese
- Filipinos
- Hmong
- Indians
- Indonesians
- Japanese
- Koreans
- Laotians
- Malaysians
- Mien
- Nepalese
- Pakistani
- Sri Lankans
- Thai
- Vietnamese



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That We Understand "Disparities..."

Disparities "in Defining" Disparities...

NIH (2004)

- "...differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States"¹

IOM (2002)

- "...racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences and appropriateness of intervention"²

1. NCMHD. http://ncmhd.nih.gov/our_programs/strategic/pubs/Volume1_031003EDrev.pdf. Accessed September 8, 2010.
2. Egede LL. *J Gen Intern Med*. 2006;21:667-669.

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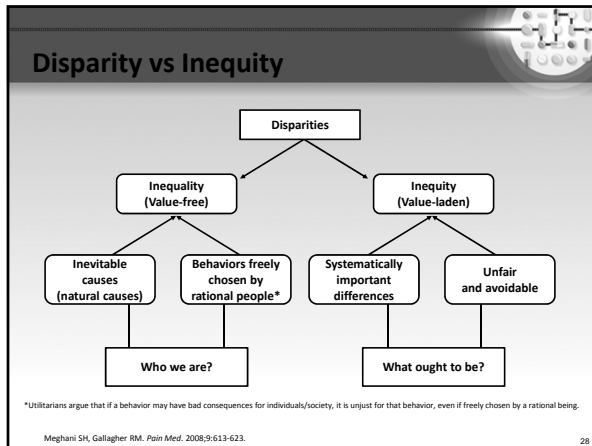
Chomsky...Thinking Beyond the Word...

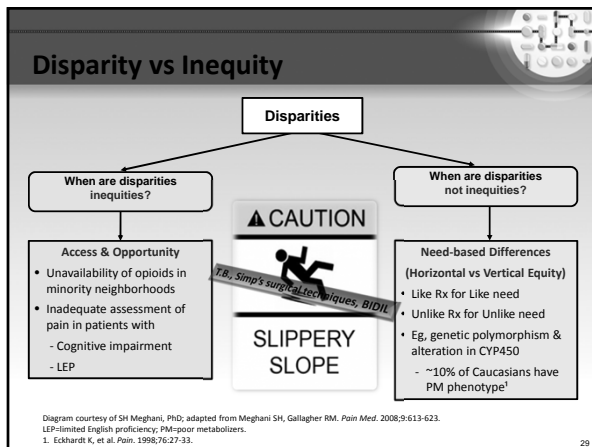
**Confusing use...Confusing meaning...
Confusing application...¹**

- **Disparity = mere differences (value free)²**
- **Inequity = unfair and unjust (value laden)**

1. Chomsky N. *Necessary Illusions: Thought Control in Democratic Societies*. Brooklyn, NY: South End Press, 1999.
2. Meghani SH, Gallagher RM. *Pain Med*. 2008;9:613-623.

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What Are the Gray Areas in the Disparity/Inequity Discourse?

- What is fair and just?
- Can a person's choice, wants, and preferences take priority over justice?
- To answer, examine what makes up preferences?

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JGIM Journal of Pain and Symptom Management Vol. 31 No. 2 August 2007

Original Article
Preference for Analgesic Treatment for Cancer Pain Among African Americans
 Salimah H. Meghani, PhD, MBE, CRNP, and Anne Keane, EdD, CRNP, FAAN

A Typology of Analgesic Preference

Meghani SH, Keane A. *J Pain Symptom Manage*. 2007;34:136-147. 31

Analgesic Preferences

Nonbelievers: "Pain medication hides the signal"
"You need to know where your pain is coming from, if it's the same pain, if it's something different and what happens when you hide the pain, then, the doctors really can't help you [with cancer] cause they don't really know if this is something new that has been laying, I would say dormant, because you have been hiding it with pain medication. I like to know what kind of pain I'm dealing with."

Centralists: "A bittersweet dilemma"
*"Pills, I just don't like them. I just don't want, don't want them. I wish I could stop them but I know I can't so I have to deal with it, you know...although I don't like to."
 "When it hurts, the pain wins and I have to give in."*

Strong believers: "I don't mind taking pain pills"
"I don't mind taking them [pain medicine] because it relaxes me and it keeps the pain down and it gives me a chance to get my rest. I don't have no side effects, no constipation or anything like that."

Meghani SH, Keane A. *J Pain Symptom Manage*. 2007;34:136-147. 32

What May Be Shaping Heterogeneity in Preference Structures?

Key BPI variables (Medians)	Non-believers	Centralists	Strong-believers
Duration of cancer pain (months)	70.5	8.0	24.0
Pain "worst" index week (0-10)	6.5	7.5	6.0
Pain "least" index week (0-10)	2.5	2.0	3.0
Pain interference (cumulative score)	58.5	37.5	50.0
Relief with pain medicine (%)	50%	70%	70%
Problems with side effects (yes)	75%	29.2%	16.6%
Preference for pain medicine on a regular basis (%)	0%	29.2%	71.4%
Need for strong pain medicine (yes)	25%	37.5%	42.9%
Total number of CAM used	3.0	1.0	1.0

CAM=Complementary and alternative medicine methods.
 Meghani SH, Keane A. *J Pain Symptom Manage*. 2007;34:136-147. 33

Preferences Are Social Constructions

- Need to be careful as so-called cultural needs, wants, preferences may be social constructions

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graph LR; A[Past experience with pain treatment] --> B((Preferences)); B --> C[Negotiation of pain treatment with providers]; C -.-> A;
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Diagram courtesy of SH Meghani, PhD. 34

Feeling Believed and Construction of Preference?

- *“The only thing I just want to add is that a lot of black people feel, especially when we’re in pain, that we aren’t believed, and that is the main problem with us. And we accept that, that we’re not gonna be believed. So therefore we don’t make that a major issue. And then when anything is offered to us, the first thing that’s being thrown up in our face is that, well, it’s got a street value, you know. You don’t need to hear that.”*
(African American patient with cancer, age 47)

Meghani SH, Keane A. J Pain Symptom Manage. 2007;34:136-147. 35

On-Average Differences and Mirage of Cultural Competence

People are not measures of central tendency

The diagram shows two normal distribution curves. The left curve is labeled 'Blacks' and the right curve is labeled 'Whites'. Each curve has a vertical line indicating its central tendency (mean) and a horizontal double-headed arrow indicating its width (variance). The 'Blacks' curve is wider and has a lower peak than the 'Whites' curve, which is narrower and has a higher peak.

Diagram courtesy of SH Meghani, PhD. 38

"On-Average" Differences and Clinical Care

"On-Average" differences between groups

- Goals
 - Sensitizing providers to their blind spots
 - Offer a "vantage point" to approach care
 - Policy goals


"Interindividual" differences

- Goals
 - Patient-centered care

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One Size Does Not Fit All

- Different individuals may benefit from *different* types and levels of interventions



Wilson-Stonks A, et al. <http://www.jointcommission.org/NR/rdonlyres/88C2C901-6E4E-4570-95D8-B498D7F756CF/0/HLCOneSizeFinal.pdf>. Accessed September 8, 2010.


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Bringing It All Together

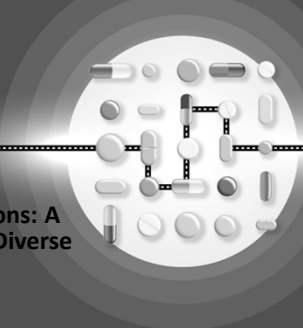
- Race, ethnicity, and disparity are murky concepts
- "Whatever this race construct represents" matters in pain treatment outcomes
- Culture is not a monolith; cultures and subcultures are social constructions
- "On-Average" care may be appropriate for policy development but may not be sufficient for patient-centered clinical care
- Cultural competence sometimes is really about accepting and recognizing our "lack of competence" in navigating through the plethora of cultures and subcultures
- "Simply" make patients in-charge... and *learn about them from them*
- What would "a" patient want...just ask "the" patient!

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One who sets off in the wrong direction is a fool to hurry.....




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Pain Disparities in Specialized Populations: A Focus on Aging and Diverse Race Groups

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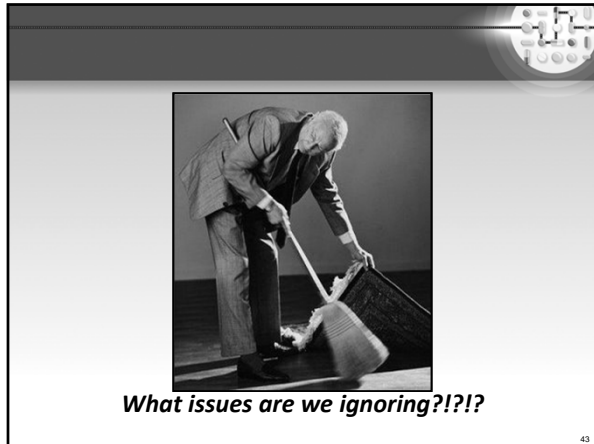
SCHOOL OF AGING STUDIES 

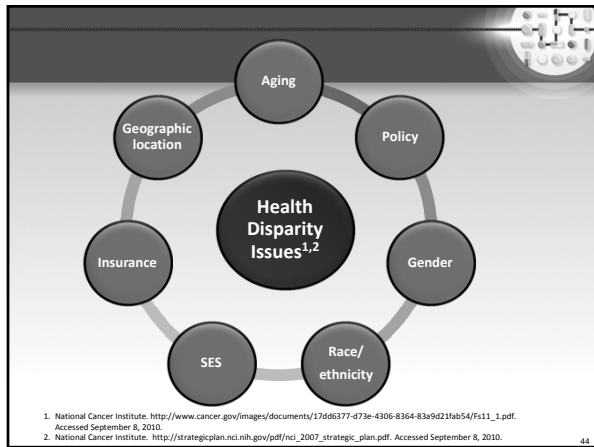
Defining Racial and Ethnic Health Care Disparities

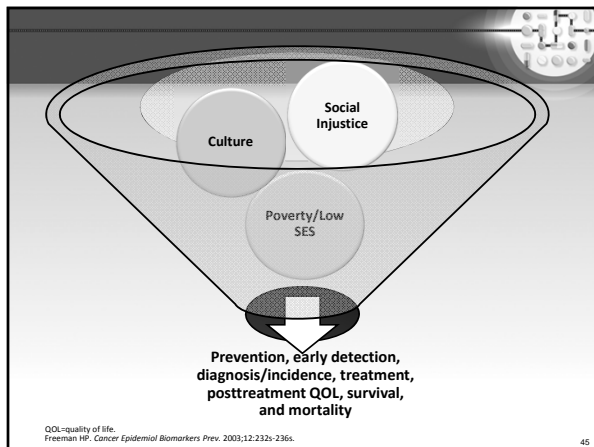
- Differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention
- Studies have shown that racial and ethnic disparities remain even after adjustment for SES differences and other health care access related factors

SES=socioeconomic status.
Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care; Smedley BD, et al, eds. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: National Academies Press; 2003.

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Culture

- **The individual and the role of culture**
 - Lack of accurate information
 - Available information useless because of literacy, language, and cultural aspects
 - Cultural belief about diseases (seeking treatment)
 - Perception of quality of care
 - Lack of community support
 - Perception of illness

Freeman HP, Chu KC. Surg Oncol N Am. 2005;14:655-669. 46

Social Injustice

- **Racial/age profiling**
- **Biases associated with treatment of racial and ethnic groups (and age)**
- **Perceptions toward certain populations**
- **Limited access because of racial and ethnic issues**

Freeman HP, Chu KC. Surg Oncol Clin N Am. 2005;14:655-669. 47

Poverty/SES

- **Education**
- **Income**
- **Insurance status/coverage**
- **Health practices**
- **Dietary behavior**
- **Stress**
- **Residential segregation (impact of segregation)**
- **Age (minority status)...cumulative disadvantage**

Williams DR, Jackson PB. Health Aff. 2005;24:325-334. 48

Link between health disparities and pain...

Does race matter!?

First, let's make sure that we're all on the same page...

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Definitions

- **Race**
 - Category to describe groups based on physical characteristics (eg, skin color, shape of eyes)
- **Ethnicity**
 - Sense of identity based on common ancestry and national, religious, tribal, linguistic, or cultural origins
- **Culture**
 - Systems and value orientations that influence customs, norms, practices, values, and beliefs

APA, <http://www.apa.org/pi/ocma/resources/policy/multicultural-guidelines.aspx#>. Accessed September 8, 2010.

50

Pain

- Certain racial groups have “specific rituals about pain,” and based on these rituals, members of that group learn what to expect and how to tolerate the pain experience

Pfefferbaum B, et al. J Am Acad Child Adolesc Psychiatry. 1990;29:642-647.

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Race, Pain, and Aging

- To understand the relationship between race and pain, one must *FIRST* consider the historical context of race and health
 - Health is embedded in larger historical, geographic, sociocultural, economic, and political contexts
 - Strength and resilience
 - Discrimination
 - Social disadvantage
 - Thus, health should be understood not only based on individual characteristics, but also in light of societal risks and resources

Why is Mr. C still experiencing unrelieved chronic pain?

Williams DR, Jackson PB. *Health Affairs*. 2005;24:325-334.

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Race, Pain, and Aging (cont'd)

- Race groups are disproportionately exposed to unrelieved pain due to inadequate medical treatment
- Minority patients
 - Have less access to pain management¹
 - Are less likely to have pain recorded²

1. Cleeland CS, et al. *Ann Intern Med*. 1997;127:813-816.
2. Bernabei R, et al. *JAMA*. 1998;279:1877-1882.

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Race, Pain, and Aging (cont'd)



- Minority patients
 - Receive less medication
 - Are at risk for under treatment^{1,2}
- Women, minorities, and elderly are at risk for under treatment of pain³

1. Anderson KO, et al. *Cancer*. 2002;94:2295-2304.
2. Cleeland CS. *JAMA*. 1998;279:1914-1915.
3. Green CR, et al. *Pain Med*. 2003;4:277-294.

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Epidemiology of Pain in the Elderly

- 20%-50% of community elderly suffer from pain
- Up to 80% of institutionalized elderly report at least 1 pain problem
- Experience multiple pain etiologies
 - OA, RA, neuropathic pain, bone/joint disorders, cancer, degenerative joint disease, immobility, post stroke syndromes, headaches, low back disorders, pressure ulcers

OA=osteoarthritis; RA=rheumatoid arthritis.
Barkin RL, et al. Clin Geriatr Med. 2005;21:465-490.

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Epidemiology of Pain in the Elderly, (cont'd)

- Pain is among the most common reasons elderly patients present for medical care¹
- Nursing home residents suffer from poorly controlled pain²
- Presence of pain in the elderly: nonspecific signs, symptoms, and misconceptions¹
 - Frowning, moaning, grimacing
 - Sighing, groaning, withdrawal
 - Striking out, guarding, rubbing
 - Eating or sleeping poorly
 - Decreasing activity levels

1. Barkin RL, et al. Clin Geriatr Med. 2005;21:465-490.
2. AHRQ. <http://www.ahrq.gov/research/dec06/1226RA8.htm>. Accessed September 8, 2010.

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Recognition of Persistent Pain in the Elderly


Patient (elderly)-related barriers	Common misconceptions	Health care professional barriers
<ul style="list-style-type: none"> • Reluctance to report pain or take meds • Coexisting medical conditions • Multiple medications • Multiple pain etiologies • Sensory, emotional, cognitive impairment • Fear of reporting sign of weakness 	<ul style="list-style-type: none"> • Personal weakness • Terminal event • Presence of serious disease • Loss of independence • Pain as attention-getting device • Cannot accurately self-report • More likely to become addicted to pain medications 	<ul style="list-style-type: none"> • Inadequate knowledge of pain treatment management • Lack of documented baseline and ongoing assessments • Reliance solely on pain scales • Concern about side effects (medications) • Ineffective staff education and evaluations

Barkin RL, et al. Clin Geriatr Med. 2005;21:465-490.

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Consequences of Unrelieved Persistent Pain in the Elderly

- Depression
- Anxiety and agitation
- Decreased socialization
- Loss of appetite, weight loss, poor nutrition
- Sleep disturbances
- Increased health care use and cost
- Decreased ambulation



Barkin RL, et al. Clin Geriatr Med. 2005;21:465-490. 58

The Impact of Pain

• “...with pain your independence is stolen from you...realizing you have to depend on others to help you with day to day activities, this is when depression sets in because of the pain—losing the ability to help oneself, wanting to die to stop burdening your family, afraid of dying and leaving loved ones. The thought of being put in a nursing home because you can no longer do for yourself. Not having money to pay bills. Needing medication and not being able to get it...all of which brings on the pain and makes it more severe...and then you become depressed all over again...”

C. Baker (RA patient), 1943-2007. 59

Minorities and elderly (minorities) are at risk for under treatment of pain

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Pain/health disparities alert levels...

What do we know about minority elderly and pain?

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Population Growth

- 20% of current population 65+ are minorities (42% by 2050)¹
- Older Latino populations fastest growing¹
 - 503%; 2.9 million in 2010 to 17.5 million in 2050²
- Older populations of color are increasing at a faster rate than whites¹
 - 434% vs 79%¹

1. Administration on Aging. http://www.aoa.gov/AoaRoot/Aging_Statistics/future_growth/future_growth.aspx. Accessed September 8, 2010.
2. Administration on Aging. http://www.aoa.gov/AoaRoot/Aging_Statistics/Minority_Aging/Facts-on-Hispanic-Elderly.aspx. Accessed September 8, 2010.

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Race Differences in the Health of Elderly Patients Reporting Chronic Pain

- Cross-cultural differential effects of chronic pain in older Americans
- Retrospective, comparative analysis (N=2,040)
 - Pain Disability Index (0-70): $P < .01$
 - Blacks=42.35
 - Whites=38.03
 - Pain Intensity (MPQ): NS
 - Blacks=25.37
 - Whites=23.62

*7-point Likert Scale.
MPQ=McGill Pain Questionnaire; higher score=greater intensity.
Green CR, et al. J Pain. 2003;4:82-90.

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Intra Race Group Differences in Reports of Pain: Young vs Old

- Self-report information on pain and psychosocial variables from those with chronic pain
 - Younger blacks reported more depressed, greater pain intensity, less successful at coping than older blacks
 - Attests to differences in coping skills, social learning, attitudinal differences
 - Implementation of various strategies beneficial in decreasing psychological distress

Baker TA, Green CR. Pain Med. 2005;6:29-38. 64

Where do we go from here... strategies to overcome disparities

How can Mr. C obtain better access to adequate pain care?

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Distal Social Policies (and Disparities)

- Addressing segregation
- Narrowing the income gap
- Improving medical care
- Rethinking health policy



Williams DR, Jackson PB. Health Affairs. 2005;24:325-334. 66

Public Policy and Advocacy

- Health care is a resource “tied to social justice, opportunity, and QOL for individuals and groups”¹
 - Disparities in health care are problems that have implications for health professionals, administrators, policymakers and health care consumers
- Healthy People 2010 challenges individuals, communities, and professionals—indeed, all of us—to take specific steps to ensure that good health, as well as long life, are enjoyed by all²
 - Increase quality and years of healthy life
 - Eliminate health disparities

1. Siegel ER, et al. J Med Libr Assoc. 2005;93:510-520.
2. Healthy People. <http://www.healthypeople.gov/>. Accessed September 8, 2010.

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Public Policy and Advocacy (cont'd)

- NIH's NCMHD: an America in which all populations will have an equal opportunity to live long, healthy, and productive lives¹
 - To promote minority health and to lead, coordinate, support, and assess the NIH effort to reduce and ultimately eliminate health disparities
 - Research, research capacity, community outreach, information dissemination, and public health education
- Office of Minority Health & Health Disparities²
 - “The future health of the nation will be determined to a large extent by how effectively we work with communities to reduce and eliminate health disparities between non-minority and minority populations experiencing disproportionate burdens of disease, disability, and premature death.” ~ Guiding Principle for Improving Minority Health

NCMHD=National Center on Minority Health and Health Disparities.
1. NCMHD. http://ncmhd.nih.gov/about_ncmhd/mission.asp. Accessed September 8, 2010.
2. CDC. <http://www.cdc.gov/omhd/about/disparities.htm>. Accessed September 8, 2010.

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Ethical and Health Care Policy Considerations in Pain Assessment and Treatment

- Racial and ethnic disparities
 - Advocate for research funding in monitoring disparities
 - Ongoing research to inform public policies
- SES disparities
 - Physicians support efforts to ensure access to quality care for all regardless of financial means
 - Advocating for reform in public policy to remove barriers through provision of health insurance

Green C, et al. Pain Med. 2006;7:530-533.

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Ethical and Health Care Policy Considerations in Pain Assessment and Treatment (cont'd)

- **Geographic disparities**
 - Advocate for and help organize improved pain management education to primary care physicians practicing in areas with limited access to specialized care
 - Work with advocacy groups to eliminate barriers in prescribing and obtaining analgesics
- **Access to pain care**
 - Provide care to reduce miscommunication, stigma, stereotyping
 - Advocate for cultural competence education and training programs
 - Pain medicine physicians become involved in undergraduate and postgraduate education opportunities to encourage minority students to pursue careers in pain medicine

Green C, et al. Pain Med. 2006;7:530-533. 70

Future Goals: Professional, Educational, and Research

- **Increasing the diversity of providers, program administrators**
- **Educating professionals about diversity and pain management**
- **More participation by diverse race groups in research (intervention studies)**
- **Understanding aging and diversity, and increased research and education on minority aging**

Green C, et al. Pain Med. 2003;4:277-294. 71

Future Goals: Professional, Educational, and Research (cont'd)

- **Research on how gender, economic factors, language, acculturation, and family and health support influence health, QOL, and quality of care in racial and ethnic minorities experiencing pain**
- **Pain assessment measures that are culturally and linguistically (*age*) sensitive**
- **Research directed to understanding clinical decision making, stereotyping, bias, variability**
- **Multidisciplinary approaches: integrating basic, clinical, and health service research methodologies**

Green C, et al. Pain Med. 2003;4:277-294. 72

**Continuum of Diversity Awareness/
Cultural Sensitivity/Competence**

Cultural Empowerment +
Cultural Proficiency +
Cultural Competence/Sensitivity/Diversity Awareness +
Cultural Pre-competence +
Cultural Blindness -
Cultural Incapacity -
Cultural Destructiveness -

Adapted with permission from P.C. Coggins & Associates, LLC. Multicultural Education Institute.

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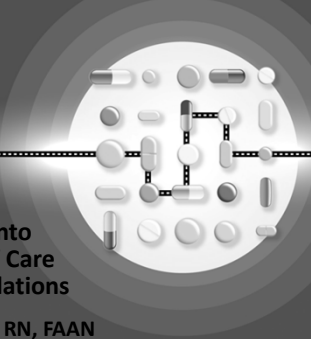
**These Are the Many Faces of Pain, With All Its
Diversity in Ages & Color... Are We Ready?**

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***“We must advocate. We must dare to
step inside circles that are unfamiliar
to us as public health leaders...”***


David Satcher, MD, PhD
Former Surgeon General
JAMA, December 13, 2000

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Translating Science Into Formulating Plans of Care For Vulnerable Populations


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Disparities in Chronic Pain

- Disparities continue to occur in pain and pain management in minorities and underserved populations
- Potential causes
 - Limited access to
 - Health care
 - Medications
 - Pain specialists
 - Miscommunication and misperceptions
 - Patient beliefs and behaviors
 - Provider attitudes, knowledge, and beliefs

Shavers VL, et al. J Health Care Poor Underserved. 2010;21:177-220.



Prevalence of Chronic Nonmalignant Pain in Underserved Populations

- Blacks have been found to experience higher pain severity than whites across the lifespan, regardless of gender^{1,2}
- Blacks report significantly
 - More disability
 - More distress
 - More symptoms consistent with depression and PTSD
 - More suffering
 - Less control over pain
- Blacks are at risk for more negative sequelae
 - Psychological morbidity
 - Impaired social functioning
 - Increased physical disability due to chronic pain¹

PTSD=post-traumatic stress disorder.
1. Green CR, et al. J Pain. 2003;4:176-183.
2. McCracken LM, et al. Clin J Pain. 2001;17:249-255.

Pain Clinic Populations

- Compared with whites, black/minority patients have
 - Increased disease burden¹
 - Increased pain severity or unpleasantness²⁻⁴
- Compared with white or older patients, black and younger patients were more likely to demonstrate higher
 - Pain severity²
 - Depression^{1,5}
 - Disability¹

1. Green CL, et al. J Pain. 2004;5:171-182.
 2. McCracken LM, et al. Clin J Pain. 2001;17:249-255.
 3. Sheffield D, et al. Psychosom Med. 2000;62:517-523.
 4. Edwards RR, Fillingim RB. Psychosom Med. 1999;61:346-354.
 5. Riley JL III, et al. Pain. 2002;100:291-298.

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Chronic Low Back Pain

- Racial and gender inequities in assessment and treatment
 - Prospective NC study (N=1600) of black vs white patients¹
 - Reported more pain and disability than whites
 - Rated as having less severe pain
 - Less likely to have comprehensive diagnostic/treatment approaches
 - Retrospective national study (N=5000) of DJD patients²
 - Minority women 52% less likely than nonminority men to have surgery offered as a treatment option

DJD=degenerative joint disease.
 1. Carey TS, et al. Spine. 1995;20:312-317.
 2. Taylor BA, et al. Spine. 2005;30:359-364.

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Increased Risk for Arthritis Pain and Disability in Underserved Populations

>20% of US adults experience arthritis pain

Study	Populations	Results
2002 National Health Interview Survey (31,000 adults) ¹	Blacks vs whites	• Similar arthritis prevalence • ↑ severe joint pain
2002 National Health Interview Survey (31,000 adults) ¹	Hispanics vs whites	• ↓ prevalence arthritis • ↑ severe joint pain
Dominick, 2004 review (OA patients) ²	Hispanics/AAs vs whites	• ↑ risk for higher levels of pain and disability (OA)
Bruce, 2007 (4,730 RA patients) ³	Hispanics/AAs vs whites	• ↑ severe pain
Wolfe, 2007 (12,090 RA patients) ⁴	Minority vs whites	• ↑ pain

AA=African American
 1. CDC. MMWR. 2005;54:119-123.
 2. Dominick KL, Baker TA. Ehin Dis. 2004;14:558-566.
 3. Bruce B, et al. J Rheumatol. 2007;34:1475-1479.
 4. Wolfe F, Michaud K. J Rheumatol. 2007;34:1674-1683.

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Community-Based Chronic Pain

- National telephone sample of 2407 (214 African Americans, 214 randomly selected Caucasians)
 - No significant differences in pain severity, emotional burden, or treatment status
 - Differences found in psychosocial functioning; compared with Caucasians, African Americans reported
 - Greater pain-related interference with daily living
 - Deficiencies in coping
 - Counterproductive attitudes and beliefs
 - Greater impatience and insensitivity from the most important person in their lives

Ruehlman LS, et al. Pain Med. 2005;6:49-60. 82

Race, Income, and Access

- National telephone survey:
 - 454 whites, 447 African Americans, 434 Hispanics
- Blacks >whites: feelings of discrimination when attempting to get pain care
- Factors significantly associated with low access to pain care:
 - 18-34 years old – Single – Male
 - Annual family income <\$25,000
 - Not finishing high school
 - Unemployed

Nguyen M, et al. J Pain. 2005;6:301-314. 83

Perception of Discrimination: *African American Perspectives*

- *"I think it is really bad that they think you get high on this medicine...well, they want to give you [only a] certain amount of pain medicine...but they don't know...this is for real you know and I think nobody should be denied pain medicine if you need it."*
- *"Then whose, whose, whose statistics are they?...You know that's theirs, that's their statistics, but the black man, he got totally different statistics...And they always say that we are the ones that have the most problems. That can't be my facts."*

Meghani SH, Keane A. J Pain Symptom Manage. 2007;34:136-147. 84

Concerns of a Low-Income Primary Care Population

- **Primary care clinic study**
 - Serve only uninsured, low-income patients
 - 500 consecutive patients (18-64 years)
- **Illness content dominated by emotional distress and physical pain**
 - Most common chronic medical problems
 - Headaches
 - Chronic back problems
 - Arthritis
 - Most common concern
 - Problems with mood

Mauksch LB, et al. J Am Board Fam Pract. 2003;16:278-289. 85

Pain in a Primary Care Clinic for Indigent Patients

- **Primary care clinic study**
 - 301 patients, 92% were African American
- **Common observations: lack of control over pain, poor coping, and catastrophizing**
 - Mean worst pain score – 8.2 - 8.5 (0-10)
 - Majority of patients showed signs of depression

Pieper B, et al. J Wound Ostomy Continence Nurs. 2009;36:493-502. 86

Disparities in Pharmacologic Access

- **Racial/ethnic minority patients are**
 - Less likely than white patients to receive any pain medication¹⁻³
 - More likely to receive lower doses of pain medications⁴
 - More likely to have longer wait times to receipt of analgesics in the Emergency Department⁵
 - Less likely to receive opiates as treatment for pain⁶⁻⁸
 - Less likely to be treated in a manner consistent with the WHO recommendations⁴

1. Bernabei R, et al. JAMA. 1998;279:1877-1882. 2. Kposowa AJ, Tsunokai GT. Race & Society. 2002;15:193-223. 3. Won A, et al. J Am Geriatr Soc. 1999;47:936-942. 4. Cleveland CC, et al. Ann Intern Med. 1997;127:813-816. 5. Egge CD, et al. Pain Manag Nurs. 2008;9:26-32. 6. Pletcher ML, et al. JAMA. 2008;299:70-78. 7. Chen L, et al. J Gen Intern Med. 2005;20:589-598. 8. Harris A, et al. J Gen Intern Med. 2006;21:335-340. 87

**Limited Access to Pain Medications:
African American Perspectives**

- *“Well, most of them, my prescriptions, I have to ask the doctor in Pennsylvania because, most of this, the drug stores in [place] where I live, they don’t deal with Percocet and OxyContin. I don’t know why, but they don’t deal with it, so I have to [go to the town] I used to live in so I still go out there to get my pain medicine.”¹*
- *“Well sometimes I don’t have the money to get the prescription filled so I’ve just got to do without.”²*
- *Another participant said that she did not have “the dollar to pay the co-pay for my medicines.”²*

1. Meghan SH, Keane A. J Pain Symptom Manage. 2007;34:136-147.
2. Crawley J. The Experience of Chronic Pain as Described by African American Indigent Adults Attending an Urban Primary Care Clinic [dissertation]. Detroit, MI: Wayne State University; 2010.

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Pharmacologic Access

- **Cross-sectional study¹**
 - 313 adults reporting chronic headaches
 - African Americans <whites: headache diagnosis or prescription for acute migraine medications
- **African Americans/women with chest pain <whites/men²**
 - Medications for reducing pain and CV risk factors
- **Minority status/low income = risk factors for^{3,4}**
 - Severe orofacial pain³
 - Pain-related impairment in daily activities^{4,5}

CV=cardiovascular.
1. Nicholson RA, et al. Headache. 2006;46:754-765. 4. Riley JL III, et al. J Public Health Dent. 2002;62:132-139
2. Pezzin LE, et al. Acad Emerg Med. 2007;14:149-156. 5. Cohen LA, et al. J Public Health Dent. 2007;67:28-35.
3. Riley JL III, et al. Public Health Dent. 2002;3:166-173.

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Access to Opioids

- **The most consistently observed racial/ethnic disparity in pain management is in the prescription of opioid analgesics**
- **In one study of the emergency department, white patients were**
 - 86% more likely to receive opioids
 - 82% more likely to be discharged with a prescription for pain medication
 - 98% more likely to receive discharge prescriptions for opioids than African Americans
- **This may be improving in African American patients, but no improvement has been seen in Hispanic populations**

Heins A, et al. J Opioid Manag. 2006;2:335-340.

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**Lack of Social Acceptance (Opioid Therapy):
African American Perspectives**

- *"Sometimes they kind of make you feel really bad. I go to the pharmacy and I get my medicine, they preach [to] me. They question and I don't like it because they think I am a problem—you know about my pain medicine, they would go over it, 'you know this is addictive' and 'you know it is narcotic.' So they make you feel bad."*
- *"Oh, it's the same thing whenever I got refills for my Percocet and OxyContin, I always had to get a lecture on how these things are addictive."*

Meghani SH, Keane A. J Pain Symptom Manage. 2007;34:136-147. 91

**Evidence-Based Guidelines and Resources
for the Management of Pain**

Clinical Guidelines for the Use of Opioids in Chronic Noncancer Pain
American Pain Society 2009

Diagnosis and Treatment of Low Back Pain
A Joint Clinical Practice Guideline from the American College of Physicians and
the American Pain Society
Annals of Internal Medicine. 2007;147:478-491.

**Guideline for the Management of Cancer Pain
in Adults and Children**
American Pain Society 2005

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**Evidence-Based Guidelines and Resources
for the Management of Pain (cont'd)**

**Guideline for the Management of Fibromyalgia Syndrome Pain in
Adults and Children**
American Pain Society 2005

The Management of Persistent Pain in Older Persons
Journal of the American Geriatrics Society. 2009

Guideline for the Management of Pain in OA, RA, and JCA
American Pain Society 2002

**Guideline for the Management of Acute and Chronic Pain in
Sickle-Cell Disease**
American Pain Society 1999

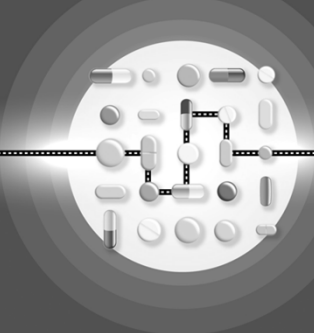
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Reflection on Health Care Disparities

- How important are interindividual differences in pain assessment and management?
- Do we need to adjust standards of pain care for different populations?
- How do we ensure appropriate health care and pharmacologic access for all pain patients?

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Conclusions



From Research to Practice: Your Role in Reducing or Eliminating Pain Treatment Disparities

- Conduct thorough evaluations of health care systems and practice sites to identify vulnerable patient populations most affected by inequitable pain treatment and opportunities to reduce or eliminate disparities through sensitivity training, implementation of practice guidelines, and patient advocacy programs
- Establish mechanisms and procedures to ensure that patients with chronic pain have immediate access to prescribed opioid analgesics
 - Form effective working relationships with community-based pharmacists to recognize the analgesic needs of patients served
 - Assist socioeconomically disadvantaged patients to take advantage of pharma-sponsored indigent or patient assistance programs to procure analgesics

Meghani SH, et al. Pain Med. In preparation. 98

From Research to Practice: Your Role in Reducing or Eliminating Pain Treatment Disparities (cont'd)

- **Seize opportunities to partner with pain advocacy groups/organizations and professional organizations and agencies to promote awareness of pain treatment disparities through education, media communication, and service on advisory boards and special interest groups**
- **Raise awareness about the problem of pain treatment disparities among government officials, legislators, policy makers, and influential health care community leaders**
 - Act as spokespersons at open hearings on health care
 - Participate in state pain initiatives/coalitions
 - Disseminate information to medical, nursing, and other health professional state boards to model state programs, and facilitate the adoption of statutes or guidelines advancing the cause of reducing/eliminating pain disparities

Meghani SH, et al. Pain Med. In preparation.

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