Foreword on Moving Forward

Language about **identity**, **diversity**, **equity**, and **inclusion** evolves relatively quickly. The language and terms used throughout this course reflect contemporary best practice and guidance. To ensure continuous alignment with current best practice, terminology will be reviewed and updated as guidelines evolve. For example, when color is used regarding race, capital letters are used (e.g., Black, White, Brown), as recommended by the National Association of Black Journalists.

Patients throughout this course will use varying pronouns, such as she/her, he/him, and they/them, to reflect the range of gender identities that exist within our communities.

CMEO
BriefCase

Pain Management: Real-World Tactics to Address Health Inequities

Supported by an educational grant from Johnson & Johnson

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Learning Objective 1

Identify the impact of health inequities on pain management.

Previous Activities to Check Out:

CME CAST

Equity and Health Care Disparities: The Role of Leaders in Addressing the Crisis

CMEO BriefCase

Addressing Racial Disparities in Orthopedic Care

CME CAST

Parameters of Pain Care: Mitigating Racial Disparities in Patients with Chronic Pain

CMEO BriefCase

Achieving Equity in the Management of Chronic Pain: Treating the Whole Patient

Health Disparities: How We Got Here[1-5]

Elements of ingrained systemic racism

- Unequal access to housing, education
- Higher exposure to poverty, crime
- ↓ access to fresh food supply
- HCP bias
- ↑ exposure to pollutants, toxins

Indirect effects of systemic racism

- Unequal health care access
- Deviation from SOC
- ↑ depression, anxiety, PTSD
- Elevated stress levels

Long-term effects of systemic racism

- ↓ retention in care
- Pro-inflammatory state

HCP = health care professional; PTSD = post-traumatic stress disorder; SOC = standard of care

1. Hasan B, et al. *Clin Rheumatol*. 2022;31:1–13. 2. CME Outfitters, LLC. 2021. Equity and Health Care Disparities: The Role of Leaders in Addressing the Crisis. 3. CME Outfitters, LLC. 2021. Addressing Racial Disparities in Orthopedic Care. 4. CME Outfitters, LLC. 2021. Achieving Equity in the Management of Chronic Pain: Treating the Whole Patient. 5. CME Outfitters, LLC. 2021. Parameters of Pain Care: Mitigating Racial Disparities in Patients with Chronic Pain.

Audience Response

How familiar are you with health inequities that exist in pain care?

A. Not familiar
B. Somewhat familiar
C. Familiar
D. Very familiar

Race/Ethnicity Inequities in Pain Care

Chronic Pain

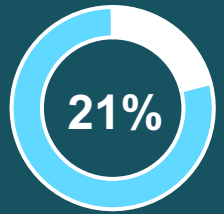
Compared with White patients, Black and Hispanic patients report[1]

- ↑ Increased **pain severity**
- ↑ Increased **pain-related disability**
- ↓ Lower use of **Rx analgesics**
- ↓ Fewer **referrals to specialists**

Pediatrics

% of **children** presenting to ED with **acute appendicitis** who receive **opioid analgesia**[2]

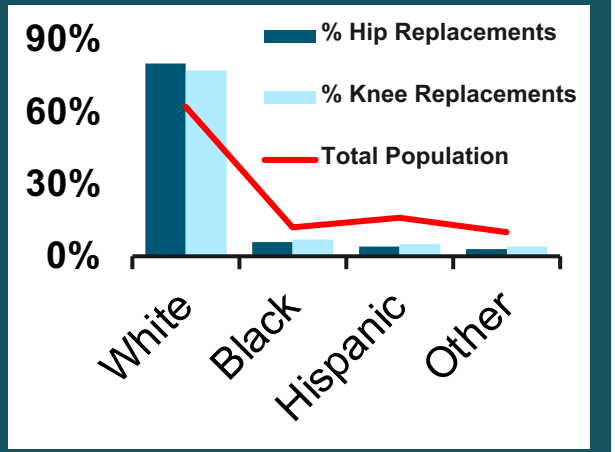
White



Black

Aging and Elderly

Share of Hip and Knee Arthroplasty Procedures by Race/Ethnicity[3]



ED = emergency department

1. Morales ME, et al. *Pain Med*. 2021;22(1):75-90. 2. Goyal MK, et al. *JAMA Pediatr*. 2015;169(11):996-1002. 3. Agency for Healthcare Research and Quality (AHRQ). *Overview of the National (Nationwide) Inpatient Sample (NIS)*. 2013. https://www.hcup-us.ahrq.gov/nisoverview.jsp. Accessed October 7, 2022.

Patient Case: Lucía

- 43-year-old Hispanic female presenting to the emergency department with right knee pain, rates pain at 7 out of 10
- Height = 5’1”, weight = 159 lbs; BMI = 30 kg/m^2
- Spanish speaking (speaks limited English), struggles during the registration and triage process to communicate with staff
- No primary care physician currently
- Uninsured
- Reports knee pain causing problems at work (cleaning homes)

BMI = body mass index

Patient Case: Lucía (cont.)

- ED visit 7 months prior with same symptoms. Discharged with recommendations for R.I.C.E. strategies and OTC ibuprofen every 4-6 hours as needed
- Previous X-ray showed mild degenerative changes
- Reports stomach discomfort with ibuprofen. Denies trying other OTC medications.
- Unable to rest much with work and family care responsibilities

OTC = over-the-counter; R.I.C.E. = rest, ice, compression, elevation

Audience Response

What should Lucia's next treatment option be?

A. Acetaminophen
B. Orthopedics referral
C. Change ibuprofen to scheduled naproxen
D. Alternate acetaminophen and ibuprofen
E. I don't know

Reviewing Barriers in Chronic Pain Care

- Emergency Department
  - Establishing or losing patient trust starts with very first staff interaction (i.e., microaggressions from registration staff when discussing insurance status, employment, green card status, or not having a primary care physician)[1]
  - Cultural and language barriers to communication
  - Patients may only have access to the ED for care (location, work schedule, insurance status)
  - Limited time, no continuity and focused on acute conditions = poor pain management
- Historical and Systemic Racism
  - Conflicting data on optimal pain management in patients of color
  - Derogatory stereotypes (ex. “Hispanic panic”) devalues patients and biases medical decision making[2]
  - BIPOC groups are particularly vulnerable to care inequities: less likely to have access to mental health services and more likely to receive poor quality care[3]
  - Race based stereotypes, conscious and unconscious, affects the healthcare offered
    - Examples: non-compliant, drug seeking, emotional

1. Tajeu GS, et al. *Am J Public Health*. 2015;105(10):2076-2082.. 2. Aronson J, et al. *Am J Public Health*. 2013.103(1):50-56.
3. Perzichilli T. Counseling Today. 2020. https://ct.counseling.org/2020/05/the-historical-roots-of-racial-disparities-in-the-mental-health-system/.
BIPOC = Black and Indigenous People of Color

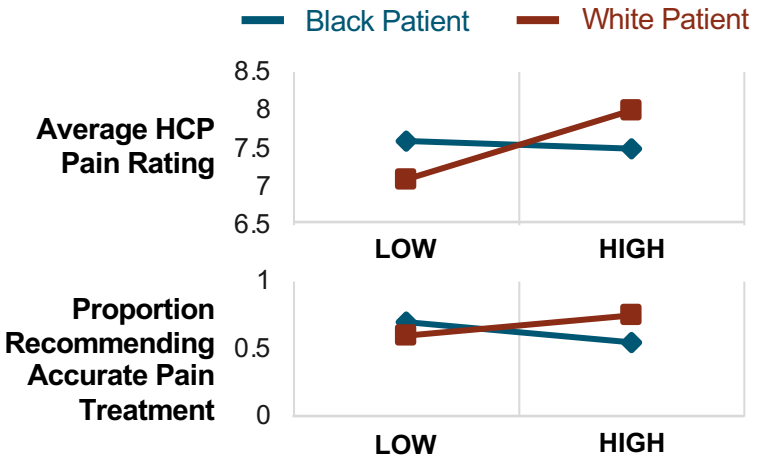
Reviewing Barriers in Chronic Pain Care (cont.)

- Pain Management and Systemic Racism
  - Opioid epidemic has led ED clinicians to be watchful of drug-seeking behavior for non-definitive pain conditions (back pain, abd pain, etc.)
  - Non-Hispanic Black patients prescribed opioids at discharge less often for non-definitive conditions vs. White patients[1]
  - Persistent gap in prescribing seen over a 13-year period: White patients more likely to receive opioids for ED pain-related visits than Black, Hispanic and Asian patients[2]
  - Disparities in prescribing between White and Black patients persist after adjusting for patient preferences to receive/not receive opioid treatment at discharge[3]
  - Hidden curriculum in medical education perpetuates racist ideologies and practices[4]

1. Singhal A, et al. *PLoS One*. 2016;11(8):e0159224.2. Pletcher MJ, et al. *JAMA*. 2008;299(1):70-78. 3. Engel-Rebitzer E, et al. *JAMA Netw Open*. 2021;4(7):e2118801. 4. Rajput V, et al. *MedEdPublish*. 2017; 6:155.

Drivers of Pain Care Inequities

HCP Bias in Pain Recognition



* Healthcare professionals (HCPs) who endorse false beliefs about Black bodies (ex. "*Black people's nerve endings are less sensitive than White people*"") underrecognize and undertreat pain in Black patients.

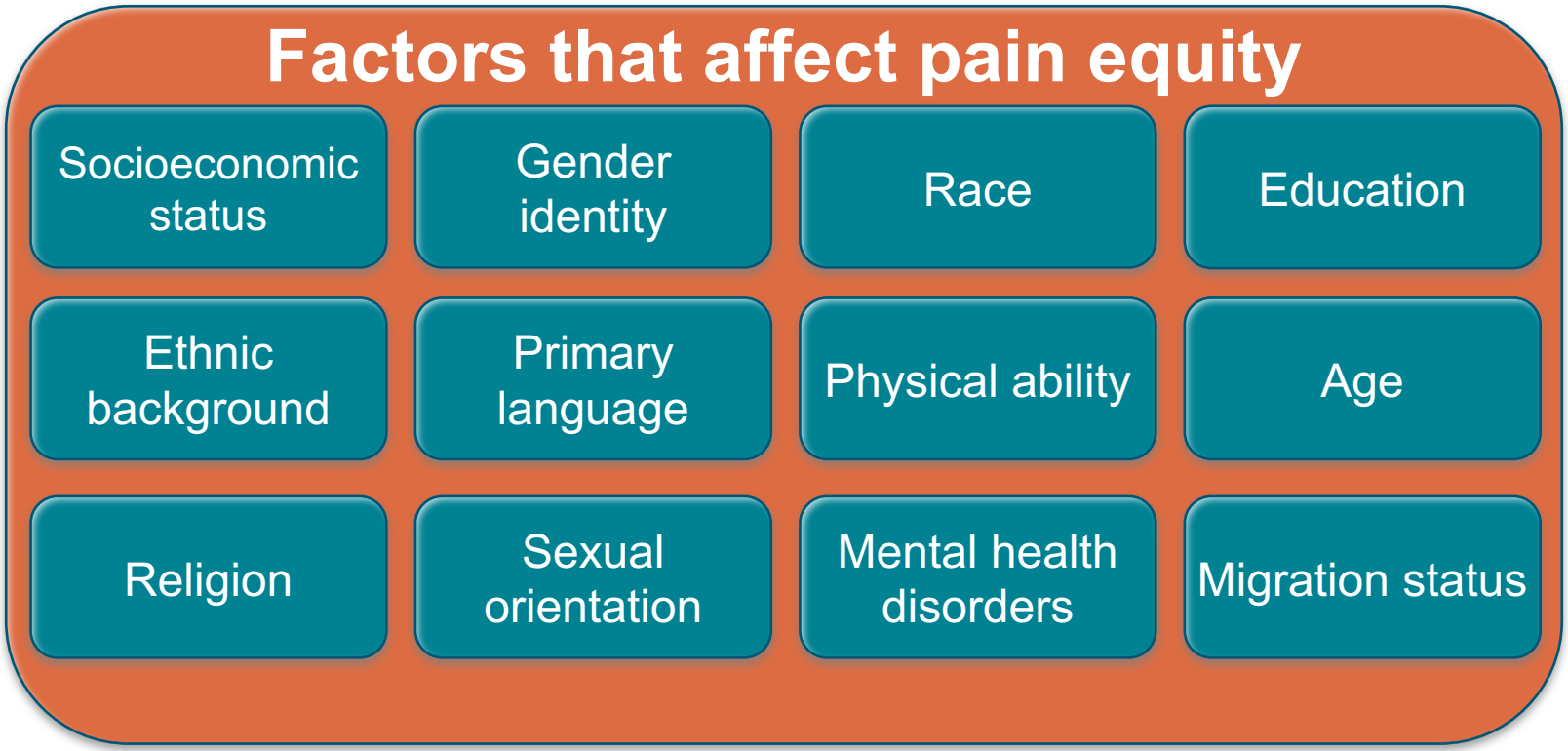
Bias in prescription drug monitoring

- More urine drug screens, fill restrictions, office visits required for POC
- "Red flag" algorithms discriminate based on SDoH (ex. multiple / longer distance providers)
- Pain complaints and subsequent denial of pain assessment / treatment not documented in medical record (esp. affects Black women)
- Assumed criminality → POC more likely to have opioid therapy reduced/stopped and referred for SUD, less likely referred to pain specialist

PDMP = Prescription Drug Monitoring Program; POC = people of color; SDoH = social determinants of health; SUD = substance use disorder

Morales ME, et al. Pain Med. 2021;22(1):75-90. Netherland J, Hansen H. *Biosocieties*. 2017;12(2):217-238. Gillispie-Bell V. *Obstet Gynecol*. 2021;137(2):220-224. Hoffman KM, et al. *Proc Natl Acad Sci U S A*. 2016;113(16):4296-4301.

Who Experiences Inequities in Pain Management?



Baciu A, et al. *Communities in Action: Pathways to Health Equity*. 2017. https://www.ncbi.nlm.nih.gov/books/NBK425845/. Accessed October 7, 2022.
Clarke G, et al. *BMC Palliat Care.* 2022;21(1):46. Onwumere J, et al. *Pain*. 2022;163(9):1653-1660.

Audience Response

Now, how familiar are you with health inequities that exist in pain care?

A. Not familiar
B. Somewhat familiar
C. Familiar
D. Very familiar

Learning Objective 2

Individualize treatment strategies that include assessment of SDoH to improve patient pain management outcomes.

Audience Response

Now, what do you think should be Lucia's next treatment option be?

A. Acetaminophen
B. Orthopedics referral
C. Change ibuprofen to scheduled naproxen
D. Alternate acetaminophen and ibuprofen

Patient Care: Lucia (cont.)

Improving communication

- Get interpretation services for ED visit
- Establish an open dialogue to encourage patient to ask questions
- Printed discharge instructions provided in Spanish
- Ensure electronic health record (EHR) lists patient preferred language as Spanish

Short-term planning: Pain management plan

- Non-opioid options reviewed
- Multimodal pain mgmt. reviewed
- Switch to acetaminophen 650 mg TID
- Review risk-benefit ladder
- Discuss interventions that could be trialed between now and starting an opioid to avoid higher levels of risk

Long-term: Preserving joint function

- Discuss need to prevent knee OA
- Discuss wt loss/exercise to preserve joint function. Small amounts of weight loss make a difference in pain and function.
- Discuss work related contributors to joint stress

Establishing F/U: Optimize long term care

- Refer to a primary care provider (PCP)
- Select a *specific* practice site that meets pt needs for scheduling and insurance status
- Send a referral to PCP: identify that patient needs follow-up from ED visit within specific timeline

Patient Case: Arthur

- 35-year-old Black male; retired army veteran honorable discharge after active-duty injury causing chronic pain to his left lower extremity
- Height = 6’2”, weight = 216 lbs; BMI = 27.7 m/kg^2
- Uses a cane, walks with a slight limp
- Numbness, tingling, burning pain to left calf, shin and top of foot.
- Mild weakness with left ankle dorsiflexion and great toe extension
- Pain is worse with increased amounts of walking
- He used to work out routinely and has tried going back to the gym to rebuild his leg strength, but the pain is worse for several days after

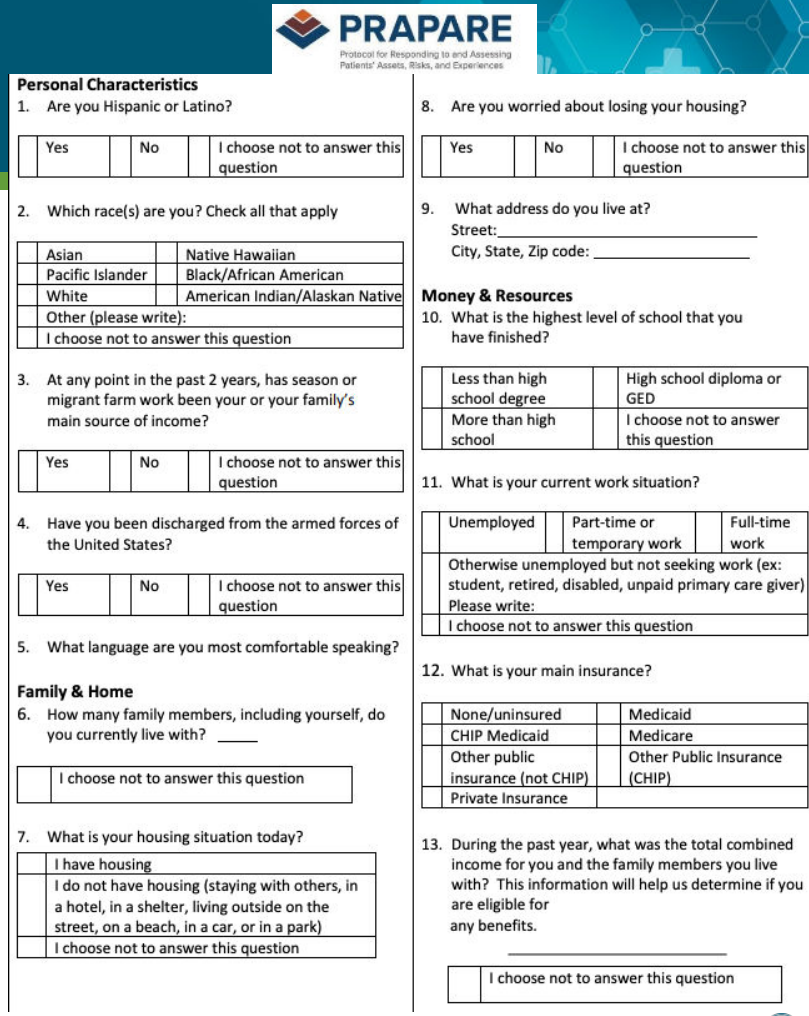
Patient Case: Arthur (cont.)

- Reports use of alcohol 5-7 days/week due to PTSD leg pain (symptoms worse at night)
- Tobacco/nicotine use: chews tobacco daily
- Not interested in discussing alcohol use; “Yea, I have a few drinks but I haven’t had a DUI, it's fine.”
- Orthopedics notes “*non-compliant"* due to missed post-op follow-up appointments. "*Patient lost to follow-up*”
- Treatment concerns: “I don’t want to go back on oxy. It messed with my head. I didn’t like how it made me feel.”

DUI = driving under the influence; EMR = electronic medical record

SDoH and Pain Management

- First need to build patient-clinician trust
- All pts should be screened for SDoH using standardized tools
- Tools used to assess social determinants of health (SDoH)
  - PRAPARE screening tool available in 25+ languages and a version specific to Native Americans[1]
  - The EveryONE Project[2]
  - AHC HRSN Screening Tool by CMMI[3]
- Military service is considered a social determinant of health[4]
- Recognize bias. Patients labeled as “drug seeking” due to race/ethnicity or if they attempts to advocate for effective pain management[5]



PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Personal Characteristics

1. Are you Hispanic or Latino?

☐	Yes	☐	No	☐	I choose not to answer this question

2. Which race(s) are you? Check all that apply

☐	Asian	☐	Native Hawaiian
☐	Pacific Islander	☐	Black/African American
☐	White	☐	American Indian/Alaskan Native
☐	Other (please write):		
☐	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

☐	Yes	☐	No	☐	I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

☐	Yes	☐	No	☐	I choose not to answer this question

5. What language are you most comfortable speaking?

Family & Home

6. How many family members, including yourself, do you currently live with? ____

☐	I choose not to answer this question

7. What is your housing situation today?

☐	I have housing
☐	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
☐	I choose not to answer this question

8. Are you worried about losing your housing?

☐	Yes	☐	No	☐	I choose not to answer this question

9. What address do you live at?
Street:_____
City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

☐	Less than high school degree	☐	High school diploma or GED
☐	More than high school	☐	I choose not to answer this question

11. What is your current work situation?

☐	Unemployed	☐	Part-time or temporary work	☐	Full-time work
☐	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
☐	I choose not to answer this question				

12. What is your main insurance?

☐	None/uninsured	☐	Medicaid
☐	CHIP Medicaid	☐	Medicare
☐	Other public insurance (not CHIP)	☐	Other Public Insurance (CHIP)
☐	Private Insurance		

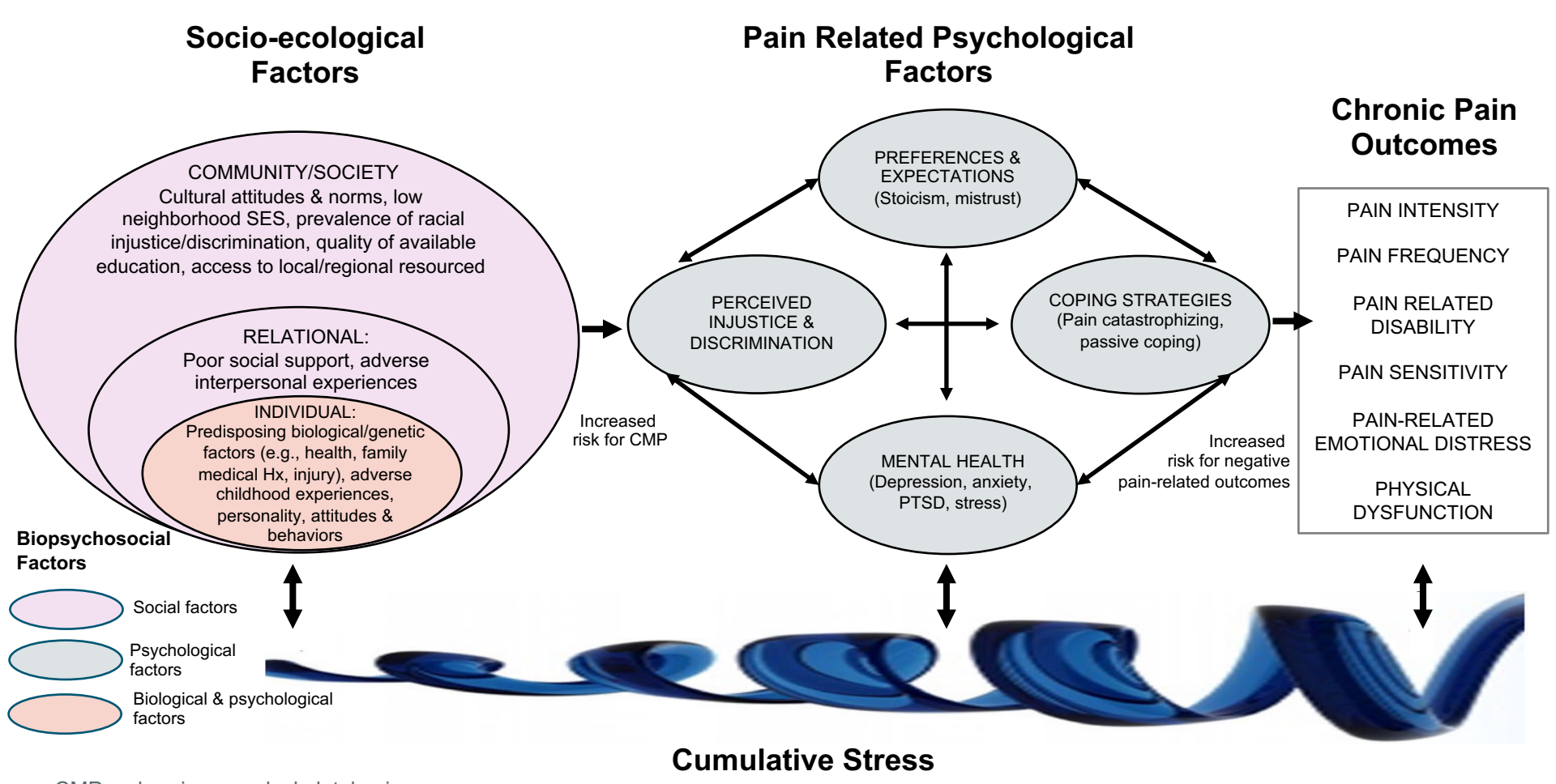
13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

_____

☐	I choose not to answer this question

AHC = Accountable Health Communities; CMMI = Centers for Medicare and Medicaid Innovation; HRSN = Health-Related Social Needs; PRAPARE = Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

1. National Association of Community Health Centers, Inc (NACHC), et al. PRAPARE Website. 2022. https://prapare.org/the-prapare-screening-tool/. Accessed Sept. 2, 2022.
2. American Academy of Family Physicians. AAFP Website. 2019. https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/hops19-physician-guide-sdoh.pdf. Accessed Sept. 2, 2022. 3. CMMI. Centers for Medicare & Medicaid Services (CMS) Website. 2018. https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf. Accessed Sept. 2, 2022.
4. Betancourt JA, et al. *Healthcare (Basel).* 2021;9(5):604. 5. Sun M, et al. *Health Aff (Millwood).* 2022;41(2):203-211.



CMP = chronic musculoskeletal pain

Bakhshale J, et al. *J Pain.* 2022;23(10:1697-1711.

Audience Response

What comorbid condition is Arthur MOST LIKELY to have?

A. Hepatitis
B. Dermatomyositis
C. Nonalcoholic fatty liver disease
D. Wernicke-Korsakoff syndrome
E. I don’t know

Patient Case: Arthur (cont.)

- Lab results: ALT= 400, AST = 250
- Medication re-review:
  - 10-12 acetaminophen 500 mg tabs/day (missed in initial intake since it is OTC and pt considered it “not real medicine”)
  - Denies any recent opioid use
- Plan
  - Discuss hepatic injury demonstrated by elevated LFTs due to alcohol + acetaminophen use
  - Discuss risk of future opioid use disorder with current alcohol use
  - Discuss cycling acetaminophen 500mg and ibuprofen 200mg.
  - Review future treatment options for neuropathic pain

ALT = alanine transaminase; AST = aspartate aminotransferase, LFTs = liver function tests

Patient Case: Arthur (cont.)

- Plan continued:
  - Refer to a pain psychologist or psychiatrist for talk therapy
  - Patient reports concern about finding a specialist in the VA and about traveling 2 hours round-trip for visits.
  - Refer to social work to assist him with mental health services
- Follow-up
  - Telemedicine appointment for follow-up after confirming he has a device with internet and is comfortable connecting to the patient portal
  - Discuss physical therapy options (home or virtual PT) that fit goal of getting back to strength training

VA = veterans affairs

Personalizing Treatment Options

Patient goal: avoid opioids due to previous side effects

- Build trust by validating the patient's past experiences and current symptoms[1]
- Review all the pharmacologic and non-pharmacologic treatment options that can be used before opioids are considered
- Discuss the therapeutic treatment ladder

Patient goal: resume exercise and strength building

- Focus on meeting function-based treatment goals vs just improving pain scores[2]
- Recognizing patient goals in care planning builds trust[3]
- Provide resources (physical therapy) to help patient work toward this goal

Patient goal: avoid excessive travel time for appointments

- Excessive distance to care, difficulty finding transportation, reliance on others for travel are significant barriers to care[4]
- Utilize virtual appointments for follow-up care, therapy, and PT
- Explore care options closer to the patient's home

1. Edmond SN, et al. *Pain*. 2015;156(2):215-219. 2. Mills S, et al. *Curr Psychiatry Rep*. 2016;18(2):22.
3. Légaré F, Witteman HO. *Health Aff (Millwood)*. 2013;32(2):276-284. 4. Syed ST, et al. *J Community Health*. 2013;38(5):976-993.

Audience Response

Now, what comorbid condition do you think Arthur is MOST LIKELY to have?

A. Hepatitis
B. Dermatomyositis
C. Nonalcoholic fatty liver disease
D. Wernicke-Korsakoff syndrome

SDoH: Individualized Treatment – Intersecting Mental Health and Chronic Pain

- Mental Health Care Options
  - Talk therapy[1], Psychiatrist[2]
  - Considerations for specialized care: addiction medicine, PTSD, pain psychologist
- Screen all patients for mental health disorders
  - Special considerations for BIPOC
    - Community stigma: prioritization of resilience and perseverance
    - Anxiety, depression, and mental health downplayed in the face of greater struggles
  - PTSD screening tools:ptsd.va.gov/professional/assessment/screens/index.asp
  - Mental health screening tools: GAD-7 (anxiety), PHQ-9 (depression)

GAD-7 = General Anxiety Disorder-7; PHQ-9 = Patient Health Questionnaire-9; PTSD = post-traumatic stress disorder

1. World Health Organization (WHO). AUDIT. National Institutes of Health (NIH). https://nida.nih.gov/sites/default/files/audit.pdf. Accessed October 4, 2022. 2. NIH. Screening and Assessment Tools Chart. 2022. https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools. Accessed October 4, 2022.

SDoH: Individualized Treatment – Intersecting Mental Health and Chronic Pain (cont.)

- Screening for Alcohol Use Disorder (AUD)
  - Special considerations for BIPOC
  - Screening tools AUD and SUDs
    - AUDIT, S2BI, DAST, NIAAA, CRAFFT, TAPS Tool, BSTAD
- Including diet and exercise interventions as part of holistic care
- Identify patient support network: family, friends, faith organization, and community

AUDIT = Alcohol Use Disorders Identification Kit; BSTAD = Brief Screener for Tobacco, Alcohol, and other Drugs; CRAFFT = Car, Relax, Alone, Forget, Friends, Trouble; DAST = Drug Abuse Screening Test; NIAA = National Institute on Alcohol Abuse and Alcoholism; S2BI = Screening to Brief Intervention; TAPS = Tobacco, Alcohol, Prescription Medication, and other Substances

1. World Health Organization (WHO). AUDIT. National Institutes of Health (NIH). https://nida.nih.gov/sites/default/files/audit.pdf. Accessed October 4, 2022. 2. NIH. Screening and Assessment Tools Chart. 2022. https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools. Accessed October 4, 2022.

Organizations and Resources for Supporting Patients

- Alcoholics Anonymous
- Examples of treatment resources with specific considerations for BIPOC patients
  - List of resources: https://thesummitwellnessgroup.com/resources/bipoc-resources/ list of 61 mental health resources specific to BIPOC patients
  - REACH from the VA: option for veterans of color, LGBTQ, etc.
  - BlackMenHeal.org: access to mental health treatment, psycho-education, and community resources to men of color in order to remove the stigma.
  - TherapyForBlackMen.org : directory of 135 therapists and 27 coaches throughout the fifty states provides judgment-free, multiculturally competent care to Black men with the purpose of breaking the stigma
- Mindfulness smartphone and tablet apps- may be appropriate for specific patients

1. World Health Organization (WHO). AUDIT. National Institutes of Health (NIH). https://nida.nih.gov/sites/default/files/audit.pdf. Accessed October 4, 2022. 2. NIH. Screening and Assessment Tools Chart. 2022. https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools. Accessed October 4, 2022.

Cultural Competency and Cultural Humility

Cultural competency: remembering traits or health considerations for a specific group or set of people

Cultural humility: recognizing complex, dynamic, and evolving nature of patient experiences

Cultural competency and humility skills must be leveraged in the same way as any other clinical skills to reduce healthcare disparities and improve outcomes.

Learning a new skill	Using a new skill in clinical practice	Improving patient care	Continuous learning to improve skills	Teaching a new skill to others
Training in reducing bias and in cultural humility	Awareness of assumptions and reflective listening	Improve patient safety, outcomes and communication	Seek additional training and education opportunities	Effective role modeling of cultural humility

Agency for Healthcare Research and Quality (AHRQ). Improving Cultural Competence to Reduce Health Disparities for Priority Populations. 2014. https://effectivehealthcare.ahrq.gov/products/cultural-competence/research-protocol. Accessed October 7, 2022. Smith CB et al. *Curr Surg Rep*. 2022;10(1):1-7. Salmond S, Dorsen C. *Orthop Nurs*. 2022:41(2):64-85. Dykes DC, White AA 3rd. *Clin Orthop Relat Res*. 2011;469(7):1813-1816.

SDoH: Health Literacy and Patient Education

Strategies to address health literacy level:

- Recognize literacy level early in the relationship to avoid communication challenges and unintentional poor adherence
- Incorporate literacy evaluation in initial assessment questionnaires; e.g., “What is your highest level of education” or simply, “Do you feel you can read and understand this?”
- Care team can discreetly ask, “Do you need me to read through this form with you?”
- Use the teach-back method to confirm understanding of information
- Patient education materials should reflect the patients and community you serve

Hasnain-Wynia R, Wolf MS. *Health Serv Res*. 2010;45(4):897-903.

SMART Goals

- Establishing trust starts with first patient interaction
- Recognize barriers and SDoH that may require patients to use ED as their provider of care
- Integrate screening tools for SDoH in assessment of all patients
- Recognize the impact of SDoH on underserved patients with pain
  - Manual labor, environment, poverty, lack of access to care
- Partner with patient to individualize their care
- Ensure patient education tools consider health literacy and reflect the community you serve

SMART = Specific, Measurable, Attainable, Relevant, Timely

Check out the entire series for additional activities, resources, and more.

Cardiology

Gastroenterology

Joint Health

Maternal Health

Mental Health

Obesity

Pain Management

Vaccination

Vision Care

www.CMEOutfitters.com/diversity-and-inclusion-hub/

Diversity and Inclusion Hub

Free resources and education for
health care professionals and patients.

https://www.cmeoutfitters.com/diversity-and-inclusion-hub

To Receive Credit

To receive CME/CE credit for this activity, participants must complete the post-test and evaluation online.

Participants will be able to download and print their certificate immediately upon completion.