

Eliminating disparities in pain assessment and treatment: Recommendations from the National Pain Strategy

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Today's Goals

- ▶ **Overview** of the National Pain Strategy, developed by the Interagency Pain Research Coordinating Committee
 - ▶ Focus on **disparities** objectives and strategies
 - ▶ **Interactive discussion**
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Poll Question #1

- ▶ Who is in the audience?
 - A. Researchers
 - B. Clinicians
 - C. Other

Poll Question #2

- ▶ Do you believe that certain patient groups receive poorer pain treatment?
 - Yes
 - No

If yes: What patient groups? [write-in comment]



Examples of patients who receive poorer pain treatment because of the group they belong to:

“Younger women seem to be less likely to be believed that they have pain, more likely to (attribute) it to stress by providers.”

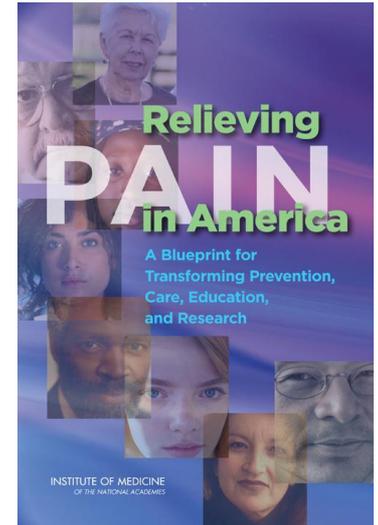
“...minority veterans and older veterans who tend to present differently initially.”

“Patients who have a history of narcotic abuse/misuse..”



Background

- 2010 – Patient Protection and Affordable Care Act (ACA) –> Institute of Medicine (IOM) report on state of pain care in the U.S
- 2011 – IOM report called for a “**cultural transformation**” in pain prevention, care, education and research and development of a “**comprehensive population health–level strategy**”
- 2012 – Creation of federal Interagency Pain Research Coordinating Committee (IPRCC) to create **National Pain Strategy (NPS)**



National Pain Strategy – 6 key areas:

- ▶ Population research
- ▶ Prevention and care
- ▶ **Disparities**
- ▶ Service Delivery and Reimbursement
- ▶ Professional Education and Training
- ▶ Public Education and Communication

<http://iprcc.nih.gov/docs/draftthhsnationalpainstrategy.pdf>



Some IOM conclusions that guided NPS

- ▶ **Improve public understanding of pain and its treatment to improve timely care and medical management and combat stigma**

Communication challenges... speak to importance of improving public understanding

“Getting patient on the same page with treatment goal, not fixated on pills only”

“Patient’s goal of being pain free”

IOM conclusions (cont'd)

- ▶ People with pain are often **stigmatized**
 - Can lead to delayed diagnosis, misdiagnosis, bias in treatment and decreased effectiveness of care

Many stories of stigma

“But mostly I just, you know, do the old soldier thing and suck it up and press on with pride. “

“Or, you know, people looking at you kind of funky because here I am, you know, I'm relatively young and before I was using a cane, at one time. You know, it's stigma that, granted, I know it shouldn't be, but in society, people look at you different. And I don't want to be looked at different. I want to be like a regular person. “

–Male Veteran with chronic knee pain

IOM conclusions (cont'd)

- ▶ **Focus on chronic pain:** disease in itself that requires adequate treatment and a research commitment
 - ▶ **Primary care clinicians** play large role in treating chronic pain, but often lack training in that area
 - ▶ **Greater collaboration** between primary care clinicians and pain specialists
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IOM conclusions (cont'd)

- ▶ Many barriers to pain care need to be overcome
 - especially for **populations disproportionately affected by and undertreated for pain**

Health Disparities: Healthy People 2020 Definition

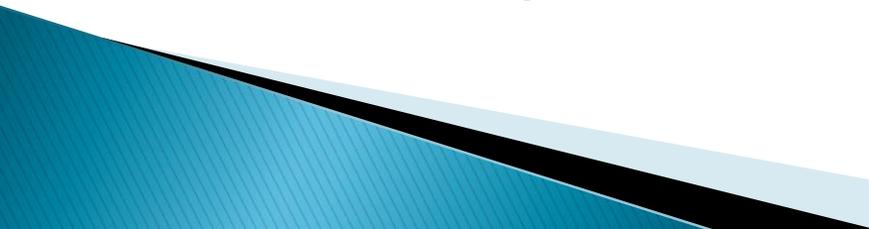
- ▶ Health difference closely linked with social, economic, and/or environmental disadvantage.
- ▶ Affect groups who have systematically experienced greater obstacles to health based on:
 - Racial or ethnic group
 - Geographic location
 - Religion
 - Socioeconomic status
 - Age
 - Gender
 - Sexual orientation or gender identity
 - Mental health, cognitive, sensory, or physical disability
 - Other characteristics historically linked to discrimination or exclusion

Increased vulnerability to pain associated with:

- ▶ Having English as a second language,
- ▶ Race and ethnicity
- ▶ Income and education
- ▶ Sex and gender (women)
- ▶ Age group (children and the elderly)
- ▶ Military veterans
- ▶ Cognitive impairments

But no systematic national studies exist

From IOM Report, *Relieving Pain In America*



Consistent evidence of racial/ethnic disparities in pain and pain treatment

- Greater prevalence of pain and greater impairment/severity of symptoms among nonwhites
- Non-whites receive poorer pain assessment and treatment than whites, across a wide variety of settings and all types of pain (acute, cancer, post-operative, chronic nonmalignant, end of life).
- These racial/ethnic disparities exist outside of and within the VA Healthcare System



See reviews: Anderson et al., 2009; Green et al., 2003; Meghani et al., 2012

Disparities working group

Goal: “To improve quality of pain care and reduce barriers for all minority, vulnerable, stigmatized, and underserved populations at risk of pain and pain care disparities.”

Co-Chairs: J. Nadine Gracia, Deputy Assistant Secretary for Minority Health, HHS and Carmen R. Green

Members: Diana Burgess (VA), Vjieyanthi Periyakoli, Beverly Thorn, Elizabeth Unger (CDC), Salina Waddy (NIH), Diana Wilkie

Objectives:

1. Reduce bias and its impact on pain treatment
 2. Improve access to high-quality pain services for vulnerable groups
 3. Facilitate communication among patients and health professionals
 4. Improve data for assessing impact of pain on higher risk population groups
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1. Reduce bias & its impact on pain treatment:

- A. **Increase the evidence base on adverse effect of clinician bias on pain experience of vulnerable groups, and on potential remedies**
 - Baseline provider survey, expert panels

 - B. **Formulate a research strategy to improve clinician education, pain care and management, direct pain policy**
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1. Reduce bias and its impact on pain treatment:

- c. Conduct **pilot and demonstration projects** to test bias reduction strategies
 - d. Develop, implement, and evaluate **policy recommendations and guidelines** on bias reduction for clinicians
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2. Improve access to high-quality pain services for vulnerable groups

- A. Promote awareness of current patient and provider resources that link people with chronic pain to care
 - B. Develop demonstration projects of ways to improve access to current resources (e.g., web-based gateway)
 - C. Promote and disseminate use of high-quality telemedicine consultations and training programs
 - D. Promote and disseminate effective models from the demonstration projects
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2. Improve access to high-quality pain services for vulnerable groups

- E. Promote and disseminate use of high-quality telemedicine consultations and training programs
 - F. Promote and disseminate effective models from the demonstration projects
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3. Facilitate communication among patients and health professionals

- A. Convene expert panel to review and make recommendations on effects of disparities in pain care
 - Disseminate findings to the general public, researchers, health care providers, and professional organizations in order to **heighten awareness, reduce the stigma of pain and support a national research agenda**

3. Facilitate communication among patients and health professionals

Develop communication guidelines specific to pain care, for patients with low English proficiency or who have low literacy, health literacy, or communications disabilities consistent with culturally and linguistically appropriate (CLAS) standards



What communication challenges have experienced when treating a patient with chronic pain?

“Overuse of medications and dishonesty about med use when addressing; not able to focus on other health problems”

“I have assisted patients with communication difficulties which are often the result of their misunderstanding of medication”

“Not able to provide alternative treatment for pain other than medication”

“Communicating with PCP for recommendations and interventions to better manage pain and avoiding medication errors”

“It is difficult to get a consistent pain assessment”

“Frequently it goes from one end of the spectrum to the other, under reports or over reports.”



4. Improve data for assessing impact of pain on higher risk population groups

- A. Develop data standards that enable tracking of pain prevalence and treatment in the full range of vulnerable populations.
 - B. Create an expert group to assess the current costs of pain care disparities,
 - C. Use current and new data standards as developed above to enable national studies of pain under-treatment among vulnerable populations and to assess progress toward eliminating it.
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Poll: Question #3

Which objective would be most important for VA to pursue?

1. Reduce bias & its impact on pain treatment
 2. Improve access to high-quality pain services for vulnerable groups
 3. Facilitate communication among patients and health professionals
 4. Improve data for assessing impact of pain on higher risk population groups
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What's missing from our discussion of disparities in pain

- ▶ Write in your comments and we will discuss

Status: Where are we now?

- ▶ The IPRCC was tasked to develop the strategy but it is up to DHHS to implement and disseminate the strategy.
 - ▶ VA pain researchers and others in VA have the opportunity to move elements of this strategy forward.
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Questions / Final Thoughts

- ▶ Write in your comments and we will discuss
- ▶ Thanks! Feel free to contact me at Diana.burgess@va.gov