Pain Management: Real-World Tactics to Address Health Inequities

CMEO Podcast Transcript

Monica Peek, MD, MPH, MS, FACP:

Hello and welcome to a very special Briefcase that is part of a series I'm leading on diversity, equity, and inclusivity with CME Outfitters. Today's CME Briefcase is entitled Pain Management: Real World Tactics to Address Health Inequities. Today's program is supported by an educational grant from Johnson and Johnson. I'm Dr. Monica Peek, and I'm the Ellen H. Block Professor of Health Justice in the section of General Internal Medicine. I'm also the Associate Director of the Chicago Center for Diabetes Translation Research and the Director of Research at the MacLean Center for Clinical Medical Ethics at the University of Chicago here in Chicago, Illinois. I'm very delighted to be joined by my distinguished colleague, Dr. Charles Vega. Charles, can you introduce yourself?

Charles Vega, MD, FAAFP:

Happy to, and thank you very much for having me, Dr. Peek. My name's Charles Vega. I'm a Health Sciences Clinical Professor of Family Medicine at the University of California at Irvine. I also serve as Assistant Dean for Culture and Community Education there and run a special program entitled the Program in Medical Education for the Latino Community. Great to be here.

Monica Peek:

Thank you so much. We're very excited. You have so many different skills and expertise that are so relevant to our conversation today. It's really an honor to have you. Let's start with our first learning objective for today, which is to identify the impact of health inequities on pain management. I want to remind our audience that this CMO Briefcase is a continuation of our initiative to address unconscious bias, health disparities, and racial inequities. We're building a comprehensive library of educational activities addressing these important issues, and today's activity continues the discussion in pain management. On this slide are the titles of the activities in this series with links to each of them. To view any of these programs, simply click on the activity title. If you participate in at least three of the programs in our D&I hub, you'll be eligible to receive a digital badge demonstrating your commitment to education on diversity, equity, and inclusivity.

As we begin to address disparities in pain management, I want to review some foundational points regarding historical racism to remind us all how we got here. We've done previous programs that cover these topics in more detail, and these programs can be found in our DNI hub. We have some groundwater issues and I encourage everyone to participate in our foundational program so that we can learn and do better, but to just provide an overview of context for this program, what I want to make sure that we cover is just the existence of structural racism. That is the framework for what we're going to be talking about today, and how structural racism disproportionately affects the distribution of what we commonly know as a social determinants of health, the negative ones. Food insecurity, housing instability, limited education and work opportunities. In addition, how structural racism impacts healthcare provider bias.

Monica Peek:

It also affects things in the community, the social and built environment, as well as the natural environments. The disproportionate presence of toxins and pollutants that are more likely to be present in marginalized neighborhoods where racial and ethnic minorities are more likely to live. All of these things have impacts on people's health. That means that when we think about food insecurity, we know that there's a large and growing body of evidence that relates that to worst diabetes outcomes. We know that healthcare bias has been translated into unequal treatment and deviations from standards of care. We know that elevated stress from exposure to discrimination triggers a series of pathological responses that has increased cardiovascular disease and increased risk for cancer and other kinds of diseases, as well as increase for mental health disorders like anxiety, depression, PTSD, et cetera.

All of these things ultimately, impact whether or not people are retained in care, whether or not people trust our healthcare system, whether or not they're going to be willing to uptake new things like COVID vaccines or any kind of new technology that comes along that we're wanting to offer marginalized communities. We saw that in the pandemic, and we're going to continue to see that. That is the backdrop quickly, the thumbnail sketch in which we talk about to these, the structural racism and healthcare disparities before we dive very specifically in to what we're talking about today, which are disparities in pain management. Before we do that dive in, we're going to have an audience response question, which you'll now see on your screen. The question is, how familiar are you with health inequities that exist in pain care?

Charles, I provided a brief overview of health disparities just a few moments ago. Can you provide some insight on inequities seen in pain care, especially in relation to race and ethnicity?

Charles Vega:

Yeah, certainly. Thank you, and no matter how familiar our audience is regarding these issues, it's certainly something that's highly relevant and has been so for decades and remains so to this very day. It starts with the fact that Black and Hispanic adults have a higher rate of pain severity. They're more likely to have pain related disability. Why? For my patients, a lot of that has to do with higher rates of chronic illnesses like obesity and diabetes, which predispose them to pain conditions. Then also, working in tough manual labor jobs. I personally worked in landscaping construction and know just how difficult those jobs can be. You're more likely to be injured, you're more likely to suffer some wear and tear, and that can lead to chronic conditions including pain. Now in addition, those same folks are less likely to use prescription analgesics. They're less likely to be referred to a pain specialist.

Again, why? Well, oftentimes because of a lack of a usual source of care like me, I'm in primary care and of course, we want to do our best equitable job in taking care of patients, but there's bias as well that we're going to cover. That bias starts really early. You can see that even among children presenting with appendicitis, Black children are less likely to receive opioid analgesics versus White children. That's something I think we'll come back to several times, but it's not just appendicitis and it's not just kids. When you look at long bone fractures in adults, there's multiple pain states where it's clear that being a person of color relates to less pain management for you.

Charles Vega:

Then this last box describes joint replacement. Really something that's critically important. I care for a primarily older population and they are getting their hips and knees replaced, but at a slower rate being a primary Latino population that I take care of than we see with White patients. That's the interesting thing about these important procedures, whether we're talking about joint replacement or we're talking about coronary vascularization, sure they've gotten more common, become more the standard of care and all boats have lifted. More of these procedures are being done, but it's not being lifted equitably. White adults still have the lion's share of those procedures, whereas persons of color, Black, Latino, Native American and Alaska native, all lag behind in terms of rates of getting those really, I think, life-changing types of procedures for pain.

Monica Peek:

Absolutely. Every time there is innovation that opens the door for increased disparities, because the people who have access, the social capital, the good insurance, the access to tertiary centers that are doing these procedures, they're the ones who will get it first. We almost always see disparities in access and outcomes initially when there's a new technology or new innovation that comes about. Point well-taken. We can actually spend an entire discussion about inequities in pain care loan. Thank you for providing this really great overview. Let's turn to our first patient case. What can you tell us about our patient Lucia?

Charles Vega:

Sure. I like cases, they help provide a nice framework for and make it clinically relevant for some of these concepts we're talking about. Lucia's 43 years old, she's Hispanic, she has right knee pain, rates at seven out of 10% in the emergency department. You can see that she meets the qualifications for obesity with BMI of 30. She speaks limited English, prefers speaking Spanish, she struggles during registration and during the triage process communicating with the staff. She doesn't have a primary care physician. She is uninsured and her knee pains causing problems at work.

Right there, for those of you, I'm sure many of our audience take care of folks like Lucia, you can see there's a bunch of red flags here and predictors of the fact that she'll receive worse care right off the bat. Now, she did present to the ED seven months ago with similar symptoms that was essentially told to rest, take some over the counter Ibuprofen, did get an x-ray. That's good, but it showed some mild degenerative changes. Now, when she took the ibuprofen, she had some stomach discomfort and she hadn't tried anything else. I'm starting to think that probably she's not getting ongoing care for this chronic knee pain, but she probably has a difficult time coming into appointments and getting those set because uninsured also really busy. She has work commitments, she has family commitments. Lucia, I think, encapsulates a lot of the patients I see each and every day.

Monica Peek:

Mm-hmm, and specifically, her work is cleaning homes where she likely does not have health insurance or good health insurance. Her ability to have sick leave, paid time off, all of those things are probably nonexistent or very minimal, and so limit her ability to fully engage in the kinds of multiple visits it sometimes takes to get, like, I come in for this visit, let's see if this works. Maybe that didn't work. Let's try an injection. Okay, let's the x-ray, let's do this. Sometimes it takes multiple visits to resolve a problem and people may really only have time for one visit, maybe two over the course of, like you said, the manual labor that's actually causing the problem in the first place.

Charles Vega:

Well, and that's absolutely right, point well-taken. Then the fact that she's presenting the emergency department for a pain that's been ongoing for a year is also, speaks volumes to me.

Monica Peek:

Yes.

Charles Vega:

She should not be in the emergency department for that problem.

Monica Peek:

Exactly, and so she's probably there because that's the time window in which she is available to then go seek help, but a lot of times we penalize patients and say, "Ugh, why don't you go to the primary care doctor? What's wrong with you? You must not really care that much. It's three in the morning. Why are you here now?" Without stepping back and taking a broader look at the social determinants of health and how and why people are forced to make the choices that they do about their care, and how we can make the system better with extended hours, with weekend hours and other things where people can come when it's more convenient for them. Now that we've heard a bit about Lucia, let's see what our audience thinks about what the next treatment option should be.

In patients who speak limited or no English, we know that language can act as a barrier to care, unless that it's properly addressed. Charles, what other barriers do patients endure in the face of chronic pain care?

Charles Vega:

That's an excellent point. Lucia's not speaking English well is going to be a risk factor for worse health outcomes, including worse pain management for her. It's also how the system, as you mentioned, Monica, is designed to help patients such as Lucia. You really want from that first interaction, you want to create a warm, welcoming environment that includes language and cultural concordance as certainly as much as possible. What it comes down to is you need translation. We are beholden to provide appropriate translation for patients who need it. Then I think beyond that, I think there's a stronger sense of empathy towards patients that you don't ... That's a universal language. If you see a receptionist or a staff member who's standoffish, who looks irritated and annoyed or angry, that really sets a tone. Unfortunately, that's why Lucia may not be going to a primary care office where I'd love to see her and help take care of this problem.

Maybe she had a bad experience there too. It really comes down from the first moment the patients arrive, you really want to make them feel comfortable, that this is a place where they are there to be cared for. You're going up, though, against a history of systemic racism, including in healthcare, that precludes many people of color where they have had a personal bad experience, where they have known of these historical tragic events that have occurred, whether we're talking about Latino populations, Black populations, Native American, Alaska natives, this is something that those stories are perpetuated. There is this lack of trust, unfortunately, that keeps patients from seeking the care they need. Many of us as providers might minimize symptoms as well. I have heard directly in care settings in my own institution talking about Hispanic panic. That Hispanic patients have all these symptoms that are uncontrolled and that they're catastrophizing everything. When actually, there's research that shows that's not true. They actually have about the same number of acute complaints in primary care offices that white patients do. There's a fact that many black patients may not be heard. Particularly Black women may not be heard.

Monica Peek:

Yes.

Charles Vega:

I think that it's important to empower patients through some of these real challenges when it comes to the systemic racism we face in healthcare. Monica, do you have a comment?

Monica Peek:

Oh, I did. I was just going to say that using the stereotype that Hispanics are so dramatic, but one of the other things that I wanted to align was the fact that a lot of our front office staff, a lot of our medical assistants and LPNs are coming from the same communities that our patients are. They frequently are experiencing the same kind of racism within our healthcare system as our patients are, but just as employees as opposed to patients. When we think about team-based care and letting people operate at the top of their license, letting them be more involved in the decisions that happen at the clinic level, just like we want patients to be more involved in the decisions about their care and we can have happier employees, that then translates the experience to happier patients.

Monica Peek:

All of this is related, so when we take that same mindset of justice and equality to our looking inward as we do to looking outwards, we can improve patient outcomes and improve job satisfaction, because a lot of times the people who are serving our patients first are coming from those very same communities and serve as social bridges, as opposed to people who are burnt out and turning our patients off. It can be a way of a win-win if we do appropriate investment.

Charles Vega:

Yeah, staff is certainly more diverse than our healthcare professional workforce and of course, we want to diversify our entire healthcare system, but staff is a great place to start. You're absolutely right on that. I think I'm just going to mention a couple other things is that, I think that bias that folks of color are more likely to potentially misuse or abuse drugs, means that we're not giving Black and Hispanic patients as many opioids or other controlled substances. That's why we see those disparities. There certainly is, it has to be a rigor to the follow up of prescriptions of drugs like opioids. I believe in applying that standard, but I think you also have to look at that historical context and make sure that you're applying those rules evenly across your populations. Also, allowing for the fact that maybe Lucia, because she has a very difficult time making appointments, she might have a hard time dropping off, say a urine drug screen if that's the way we were going to go.

That's not where I would probably go with this case, but I do see those barriers and I talk to patients and understand them one-on-one. When I think about risk mitigation, I apply it in these equitable ways that therefore, allow for some patients, and I try to create workarounds, for patients who really need those drugs. Not many, it's a small minority in my practice that does, but really need them. I'm working with them to try to make it easier because that's going to improve their function, it's going to improve their quality of life significantly.

Monica Peek:

Absolutely. What are some of the driving forces in pain care inequities?

Charles Vega:

Yeah, so you think that, well, I've got my attitudes and beliefs, or maybe you're not aware and that's implicit bias, maybe some overt biases, but that doesn't affect the way I take care of patients. We all believe that because we all want to aspire to that. We all want to be equitable and be there for our patients and not let our internal biases affect the way we practice care. The fact is, if you have more biased beliefs such as Blacks have less nerve endings and they're less sensitive to pain, we're less likely to prescribe analgesics for Black patients. Our beliefs and our thoughts certainly correlate with the way we actually practice healthcare. That certainly applies to pain management. I brought up the fact that black patients especially are more likely to be scrutinized for drug misuse and more likely to be referred into substance use disorder programs, as opposed to seeing a pain specialist who might really be able to help them more.

Monica Peek:

Mm-hmm, and so you were just getting to that, but the important question of who experiences these inequities in pain management. You noted race, are there other kinds of social identities that experience disparities in pain management?

Charles Vega:

Yes, absolutely. There is a broad range of biases that affect one's ability to get adequate pain care because just to step back for a second, pain management is something I do every day. It is challenging at times for complicated patients who have had pain for many years who have tried X, Y, and Z. It can be challenging, but I find we often improve outcomes, but it starts with that level of trust. If you don't share an identity with anyone in the clinic, if you don't speak a language that the clinical entity can translate for, if you're an older adult, if you have lack of education, a lower educational attainment or you're someone who lives in poverty, there's so many different forms of bias that work against patients. Unfortunately, the more of these boxes that you check, because there's a lot of intersectionality, of course, the bias and the stigma increase and unfortunately, the less likely you are to get adequate care.

Monica Peek:

Right. The greater that power differential is between providers and patients. Let's go back to a question we asked a bit ago following this great discussion so far. Now that we've had this discussion, how familiar are you with health inequities that exist in pain care?

Hopefully, you've had a chance to increase your familiarity with inequities. This now brings us to our second learning objective for the day, which is to individualize treatment strategies that include assessment of social determinants of health to improve patient pain management outcomes. Before we move on to our second patient case, let's go back to our audience response question. Now, what should Lucia's next treatment option be?

Charles, how did you assess and develop Lucia's treatment plan?

Charles Vega:

Well, as I said, great question and it starts with just building trust. Really sitting down with Lucia, making sure she is heard. A lot of the techniques we use for building trust between patients, they break through different cultures and racial and ethnic groups because it comes down to just being empathic, to listening, to reflecting back on the patient, to validating their concerns and their questions and then of course, offering your own opinion. "Hey, thank you for sharing all that. This is what I think is going on and here's what we might be able to do about it. What do you think about that?"

Charles Vega:

I think that exchange in español por favor would be great for Lucia. Yeah, I'd talked to her about maybe changing her pain management regimen, but I might try acetaminophen because it's going to be safer for her stomach and if she hasn't tried it and especially on a routine basis, taking it might be helpful. Putting her through a routine pain management program and starting to think about multimodal therapy and how that might possibly fit into her busy life. It's a challenge but we have done it. Then I would also work on other issues like her body weight, that can make a difference over time, and try to promote some exercises which might help not just her body weight but also her lower extremity strength and stability, which might help that osteoarthritis over time.

Monica Peek:

Excellent, so I really liked how some of the things that you had mentioned were validating her experience, working on that therapeutic alliance. I totally understand. I hear where you're coming from. I understand that. Let's talk about that more. These are things that we know from studies and science work to, again, sort of established a safe space where people feel that physicians are more empathic, that they feel more heard and they can then be more adherent to the plan of care. They have increased trust in their providers. They then feel more comfortable talking about their problems, et cetera. I appreciate that, the insight from you about just how to connect with patients. Hopefully, Lucia will see some pain relief following her new regimen and next steps, which you've done a wonderful job of describing a multimodal plan. Charles, what can you tell us about our next case, Arthur?

Charles Vega:

Right, so Arthur is a 35-year old Black male and now he's a retired army veteran. Honorably discharged after active duty injury causing chronic pain to his left lower extremity. Now, he meets qualifications for being overweight. He uses a cane, he walks with a slight limp. He also has some numbness, tingling and burning pain and that's over his left caption and the top of his foot and on an exam, he has some weakness with ankle dorsiflexion and great toe extension as well, so there's definitely some neurological qualities to his chronic pain. It gets worse with a lot of walking, and he wanted to workout, return to that, which is great. I'm very excited about that but unfortunately, a bad experience and just the pain took days to recover after his workout. Really, that workout is not working out, as a matter of fact.

You also take a little bit more history. Great idea, look at his habits. He's drinking alcohol five to seven days per week, and that's due to a history of post-traumatic stress disorder as well as his leg pain. Also, chews tobacco daily. You talk about his alcohol use, how's he feel about that? He tells you, "I haven't had a DUI, so it's fine," so he may be in a little bit of denial about how much he might be drinking now. Orthopedics note that he is non-compliant due to missed postop appointments and he is lost a follow up. I wonder were they really trying to get him in back and maybe there was a disconnect there between the clinical team and our patient, Arthur.

Charles Vega:

Interestingly, he tells you directly, "I don't want to go back on oxy. I didn't like how it made me feel and messed with my head." That's the funny thing about opioids is they have such strong adverse event profiles. If you take a look between the CNS and the GI side effects, they're actually really difficult drugs to tolerate. I'm on Arthur's side there. I'm not going to be thinking about opioids right off the bat, but I do think he doesn't have good control of his pain. He's trying to do stuff on his own, which may not be the best for him. I really want to partner with him because I think we can help him quite a bit.

Monica Peek:

I have heard that so much from my patients, particularly elderly patient. I'll walk in the room because we use them a lot in inpatient settings and they were like, "Doc, let me tell you what happened overnight. They gave me something," and they start describing all these hallucinations and things and they're like, "I don't care what you do, never give me that again." I think there's just a lot of misinformation about how much people want these drugs, whereas, people are having bad experiences a lot of the times and they're like, "No, no, no, no, no. Can you give me anything but that?"

Charles Vega:

Yeah, they are. In one trial looking at opioids for low back pain. I think the dropout rate due to adverse events in the opioid arm was 70 to 80%. I mean, it really is tough to take those drugs. You habituate to them obviously to a certain degree or to a large degree and so therefore, the side effects get better. Yeah, they are difficult to take, especially if you're older and have other medications on board for sure.

Monica Peek:

Absolutely. Okay. With the note of non-compliant in Arthur's file, I think it's the job with healthcare provider to build trust and foster a relationship with him. How do we address social determinants of health with regard to pain management? Especially when we start seeing red flags in the chart. How do we overcome some of those and address them directly?

Charles Vega:

Right. Well, I think it's just the way you think about it. It's a great question. Is this a red flag or does it signify that there was a lack of connection somehow or another, or does Arthur and what he has to do and his responsibilities keeping him from getting clinic appointments or following up with his medications or whatever other orders? I think it's better to start with understanding and trying to explore the issues around non-compliance, which I never use as a term. I usually will stick with adherence and then frequently, you find out something else that's going on. There are these forms that will screen folks for particular social determinants of health, which could be barriers to good care. I think that is important. I have a problem in my practice with instituting these kinds of screening instruments, especially right away. Now, of course, you want to know right away where the potential barriers to care are because they'll make everything more efficient and patient-centered.

Charles Vega:

My patients, if they saw something like a prepared form, would be very suspicious that why we are gathering this data, you know what this is about. This is not something they're used to. I think it has to be introduced carefully. Especially in marginalized and at-risk communities because it can actually do the opposite. Instead of building trust, you could actually take away trust. I do think that I do get to know patients and by working through the plan of care together and then seeing this, I can sense even sometimes with body language, many times patients won't verbalize, "I can't do that, I can't make it to a specialist office, I can't go to lab fasting," but I'll ask them, "Did you think that's okay with you?"

Then if I see them kind of shrink away, it's like, "Well, let's think about what we could do. Maybe we don't have to do fasting labs. Maybe we can think about referral to a different provider," and just trying to make things as easy as possible for them and getting their buy-in on the plan. When they realize that I'm interested in that and reaching out to them to try to find a bridge and a way we can get these things done, I think things go a lot better in terms of getting that next visit and these social determinants come out in a natural way.

Monica Peek:

Excellent. Really great comments. Two things I would say is one, if you see non-compliant, that as an opportunity to dig deeper and to figure out what are the barriers to that person getting to the visit? Is it transportation? Is it cost? Is it they have physical limitations? They have childcare responsibilities as far as like multi-generational or just whatever. We can have a better understanding of that. The other is how we are implementing these social determinants of health screening. We've just started doing it and the idea of having trusted people, places and spaces, that was sort of my mantra during the pandemic. It's the same thing with anything having to do with things that are very sensitive.

Some of the standards that are coming out around who should be doing this are people that are already trusted. If you already have community health workers who are already working or social workers with these very sensitive issues who've been talking to patients about this, they may be their better person who already is spending a lot of time talking to patients about these issues to fold that in. There are ways that we're starting to learn about how, when and where to begin asking some of these questions, but it's still kind of like the wild west and trying to figure out how and when to do that. Certainly, maybe not the first form on the first day that they get, we want to know this information, but figuring out how to best introduce it is exactly a very good point. Why don't you introduce the next slide to us?

Charles Vega:

Sure, so this is a diagram, which I'm not going to cover in detail, but it just goes to show that while we certainly want to take care of the patient in front of us and that person is a culture of one, they bring in their own background and experiences and they bring their community with them into the clinical setting. They bring their built environment, they bring their culture and values with them, and those are ingrained at a much larger level, at more the community level and the societal level as well. It's important to think about those things when we're thinking about individualizing treatment plans and the way we communicate with patients in the first place. I think the other thing I would point out is that adverse childhood experiences, current psychological symptoms and diagnoses make a huge impact on pain management. If you have very significant depression and anxiety, yeah, I guarantee your pain management strategy will not be highly successful until you initiate concomitant treatment for the psychological illness. Do think of them together because unfortunately, they're cyclical, one feeds into the other.

Monica Peek:

Right. Given Arthur's medical history, we should consider additional factors that may impact his treatment options. Here's another audience response question. What comorbid condition is Arthur most likely to have?

Some labs have come back for Arthur, what do these labs indicate and what plan did you develop for Arthur?

Charles Vega:

I see transaminitis all the time in my clinic and usually, that non-alcoholic fatty liver disease estimated effect about a third of adults if you actually did ultrasounds on everybody in the United States is the most common cause. Here, we see a significant elevation of his ALT and AST levels. Then we get a little bit more history. One of the risk factors could be acetaminophen toxicity, and he's using 10 to 12 per day. That was not on his medication reconciliations sheet because Arthur, as many patients do who take OTC medications, doesn't consider them any real medicine, but of course, they can have ... There's a negative interaction between the alcohol he is taking, his body weight with it being overweight and high doses of acetaminophen makes for a very dangerous combination for the liver. That's something we're going to have an honest conversation about and then try to work through strategies.

The good news is he got his labs and I had a chance to talk to him about that. We've already started a more therapeutic relationship, so that's great. Now, I think it is time to really start working on Arthur's alcohol use because I think it will be potentially a complication with certainly his liver seeing effects. You can show that, "Hey, your liver's inflamed right now," and I don't know based on that if he has cirrhosis as well but of course, that's something we're going to investigate now. We need to have him initiate treatment for managing his alcohol and reducing his alcohol in a safe way, reducing his acetaminophen use overall. I think that one thing that we use now that has been effective and has been demonstrated to be effective is using telehealth, especially for some of his follow up visits and for his mental health visits, maybe for some substance use counseling.

Charles Vega:

Telehealth can really help save him time, make things a lot more efficient for him. If you have those barriers to time and transportation, it can really cut through those barriers. That's been something of a revelation during the miserable last two and a half years that we've lived through with COVID-19, is the broader use of telehealth has helped many people is what I can say, because I do see a lot of folks who are working and if the day you miss work is the day you might not have a job.

Monica Peek:

Right.

Charles Vega:

Yeah, so I think that there are ... I want to be respectful of Arthur, I don't want to multiply a bunch of visits if he's not ready for that. Especially, if he had a bad experience in healthcare before, but trying to do so in a way that doses it just up to where he can tolerate it and he feels like confident that he can actually accomplish it is critically important.

Monica Peek:

Yes, so it sounds like there's a promising game plan for Arthur, all because you personalized his treatment options, given his social determinants of health, his medical factors and everything else. How should we all go about personalizing treatment options and pain management?

Charles Vega:

Well, I think that it's about meeting the patient where they live is to summarize. I do think that getting a team involved so that multimodal therapy will be important. For Arthur, physical therapy will be really important. Especially, if he can get that in his home or someplace that's very convenient for him. Patients tend to like that a lot and they're more likely to do their PT homework and actually accomplish goals. Then I would also, strongly consider that his behavioral health and trying to get him with the right person, including myself as caring for his psychological disorders as well, but we should think about using he could be a good candidate for an SNRI for example, for the neuropathic pain he's been having. Plus, it may have an effect on the PTSD, but we have to think about those things and try to treat Arthur as a whole patient. Otherwise, I'm not sure he is going to improve.

Monica Peek:

Absolutely. Such a wonderfully complicated medical and social case. Thank you for walking us through it. We're going to go back to the audience response question. Keeping these labs and treatment options in mind. Now for the audience, what comorbid condition do you think Arthur is most likely to have?

Charles Vega:

May editorialize that absolutely anyone with transaminitis needs to be checked for hepatitis B and C, so we really want to follow that up.

Monica Peek:

Yes, and even if they're negative, I would vaccinate because we already see that he has these issues and so the last we want is a viral infection that's going to exacerbate the problems.

Charles Vega:

Absolutely.

Monica Peek:

Another reason to check. While chronic pain management is the ideal goal, it shouldn't be our only goal when treating patients. As with any chronic illness though, there'll be highs and lows with patients medical journeys as well as mental health. Charles, let's meet at the intersection of mental health and chronic pain. How do we address mental health while remaining cognizant of a patient's social determinants of health?

Charles Vega:

This is one thing I like to use and I've come to use them more often, validated tools. They're relatively fast, they provide information that's very helpful in the clinic visit itself, but it's also something that can be tracked over time and they've been validated. I know what I'm dealing with is working. They tend, when you use a validated instrument, not always, but they tend to have less bias than what we might do just based on our gut instinct as clinicians. The patient health questionnaire nine, general anxiety disorders, questionnaire seven, there are PTSD screening tools using audit tool for problem drinking. All of these are good tools to use and really only take a few minutes in your clinic time and can provide information for the busy clinician, that becomes part of your HPI, that becomes part of your history of present illness. Therefore, it doesn't necessarily take a lot more time, but it does provide really important information for finding out where your patients are in terms of those important mental health symptoms.

In terms of follow up, I think that this is one time where having the support and overcoming stigma in our community is a big deal. Having support of family and friends is important. For those who follow a certain faith, leaning on folks within that faith, within their church, whatever it may be, can be very important as well. These are relatively easy things to access because they're often free or low cost and available. I also tend to like the newer applications on your phone or whatever because most of my patients do have smartphones that focus on mindfulness and reducing stress. There is some evidence that they work and again, low cost or free and available anytime. Those are just some of the things I think that can be particularly valuable.

Charles Vega:

When it comes to communities of color, there are some specific opportunities and resources to use that are listed on this slide. It is great to have concordance between say a therapist and a patient. For a boy, for my male patients, getting them in to talk therapy can be a real challenge. That might be something that we have to talk about three times before the patient actually accepts it, and that's okay. We are going to go where the patients like Arthur may live. Maybe he'd be more interested in pharmacotherapy, but at the end of the day, we have to keep bringing it forward, making sure that Arthur and patients like Arthur are comfortable about it and then offering support. A lot of times we might, I'd say don't give up. If you have trouble in that first two visits because patient's just not accepting that's severely depressed or severely anxious. It's on that third visit you may have success, and then that opens the doors to so many better outcomes.

Monica Peek:

Yes, and as you know, primary care providers do so much of the heavy lifting for mental health disorders. While I'm continuing to have the conversation of let's find you a therapist, I'm actively being that stop yet, especially for Black men. Sometimes it has taken me three years for some of my patients to agree to go and they're basically like, "I'm doing this for you Dr. Peek," and I'm like, "Go with my blessing," finally handing them off, but it's me sort of stepping in and finally being able to do that gentle handoff. You're right, persistence can pay off and there are those resources. You have just been so wonderful in all the information that you've given us. In addition to these clinical pearls you've presented, another one to touch on is the notion of cultural competency and cultural humility. Can you elaborate on what each of these practices entails and why they're crucial when identifying individualized treatment plans and strategies for patients with chronic pain?

Charles Vega:

Yeah, certainly. I definitely like one of these terms better than the other.

Monica Peek:

Yes.

Charles Vega:

I've always felt that that cultural competency is arrogant and presumptuous because it implies ... Hey, I wish I could understand every single culture around the planet and speak 300 languages. That would be amazing. I don't think it's in me nor anybody that I've ever met, but humility, it speaks to the fact that you are putting the patient first you. It also speaks to the fact that culture is a constantly evolving process. You may know something about the culture now and that's great, well done, but it's going to shift. It shifts so fast, especially look what's happened in the past several years in this country. I think it's about knowing some perspective about where patients might be coming from, where they live, what their values might be, but then confirming it with the individual patient because yeah, you don't want to be surprised and you don't want to practice based on stereotypes. That is not practicing cultural humility or culturally responsive care, certainly.

Monica Peek:

Mm-hmm. Absolutely, and I think you hit it right on the head about arrogance versus humility and sort of approaching this like this is your world. I'm trying to step into it with humility because I want to learn how to better take care of you. I think when patients see that, their door, they open the door for us to come in and make more space for us than us coming in saying, "Oh, I speak 300 languages." A lot of the attitude with which we approach the multiplicity of ways in which our social identities are different from our patients I think is really important, so thank you for that. On top of these things, the promotion of health literacy, and I say that thinking about health literacy, health numeracy, digital literacy, all of that stuff, and patient education is also critical. What strategies can we implement and address to increase health literacy in our patients and communities?

Charles Vega:

Broadly, I would just not take a very direct approach to health literacy, because I think it can be demeaning or insulting to patients and it hurts the relationship. It has to be handled carefully. That said, about 30% of my patients are functionally illiterate in both English and in Spanish. It can be a real challenge. It's something that I work with every single day, but asking patients if, "Would you like me to help you read that? Oh, is it that too small a font? Can he not see that? Well, let me just walk you through this." Then I really like the idea, teach back at the end of the visit. What are those top three things that we wanted to accomplish today, Ms. Gonzalez?" so continue that conversation. I think those are ways that you can address health literacy in a respectful way that actually builds on your clinician patient relationship.

Monica Peek:

Absolutely. One of the things I say is when I'm writing notes and it's like, and I try and write as neatly as possible for patients, but I say, "I'm a doctor and my handwriting is sometimes horrible, so I'm just going to read to you what I've written and make sure that this makes sense and then let's go over it together." Like you said, trying to find ways that we can explain things to our patients without having to, sort of like universal precautions when HIV came out. Treating all our patients with dignity, but assuming that their literacy may or may not be at a certain level, and just trying to meet them where they may or may not be at, so thank you for that. I just want to really thank you for our conversation today. Oh, I'm going to start crying, and for you just being a wonderful clinician. I can tell how much you care about your patients. All of the work that you do to provide them with cultural humility.

Thank you. Thank you for all the work that you do for your patients, and thank you for all that you've taught us today. This was a fantastic conversation. I feel like we've obtained some great clinical pearls that we can use to provide better pain management to all of our patients. I'm going to try and summarize our discussion with smart goals, which are specific, measurable, attainable, relevant, and timely goals. That is what I hope that you will take from this presentation, our audience, and apply to your practice.

Monica Peek:

Then Charles, you let me know what I may have missed. Establishing trust starts with first, the very first patient interaction. Recognize the barriers in social determinants of health that may require patients to use the ED as their provider of care. Integrate screening tools for social determinants of health and assessments for patients, and think about the ways that you can use trusted people, spaces and places in order to do that, and thinking about the timing of that. Recognize the impact of social determinants of health on underserved patients with pain, and thinking about things like manual labor, the environment, poverty, lack of access to care, et cetera. Partner with patients to individualize their care. Then last, ensure patient education tools, consider health literacy, and reflect the community that you serve, and sort of approach this with empathy in your heart. Anything that you would add to that? Charles?

Charles Vega:

No, I couldn't add anything. That was perfect.

Monica Peek:

Great.

Charles Vega:

Great job.

Monica Peek:

Here are just some of the topics we've covered so far. We'll be adding new content every month. CME Outfitters also has a diversity and inclusion hub with a number of excellent resources to share with your peers and your patients. To receive credit for today's activity, please complete the post-test and evaluation online. You can then download your certificate immediately. Thank you again, Charles, for joining me today, and thank you to our audience for joining us. Please be safe and take care of yourselves so you can provide the best care possible for your patients and especially your underserved patients.

Charles Vega:

Thank you. Be well.

