Chapter 12
Integrated Care for Pain Management Among Hispanic Populations

Gwen Sherwood and Jeanette A. McNeill

Introduction

The management of pain continues to challenge health care providers and the health care system with high direct expenditures for medical care and medication related to pain and the indirect costs associated with lost productivity in the work force. This has contributed to a “pain crisis in America” (Meghani, Byun, & Gallagher, 2012, p. 150) and resonates globally. Researchers report community populations may have a pain prevalence as high as 40 % noting minority members are overrepresented and more frequently undertreated (Mossey, 2011). Hispanic populations may present unique considerations that derive from the diversity of multinational backgrounds with strongly held values and beliefs and cultural perspectives. The purpose of this chapter is to explore the pain management experience of Hispanic populations, examine a quality improvement approach, and propose evidence-based integrated care solutions for more effective approaches.

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Managing Pain in Hispanic Populations

Pain is one of the primary reasons people seek health care; it can be a symptom of a condition in the body requiring treatment. Treating the accompanying pain may be in addition to treating the condition and may invoke other responses and reactions due to both long held beliefs and attitudes on the part of the patient and family but also for health care providers.

Perspectives on Pain

The varied nature of pain is one factor in the conundrum of managing pain effectively, and particularly for vulnerable populations. Pain is a subjective experience with multiple definitions. A common definition comes from the International Association for the Study of Pain which defines pain in terms of an unpleasant and emotional sensory experience associated with actual or potential tissue damage (2012); pain is therefore both a physical experience but also has a psychological and subjective context. McCaffery is credited with an oft quoted classic definition of pain as whatever the person who has pain says it is (Herr, Coyne, McCaffery, Manworren, & Merkel, 2011). As such, pain can best be explained with a biopsychosocial model that begins with the noxious stimulus, awareness that the stimulus is pain, followed by recognition from the brain of these signals as emotional and cognitive factors that determine perceptions of pain; these responses drive how one responds to pain including facial or verbal expressions and ultimately the decision to seek attention to resolve what is happening.

Pain is primarily classified as acute or chronic (International Association for the Study of Pain (IASP), 2012). Accurate assessment is critical as each classification may require unique approaches and behavioral interventions. Acute pain is of short duration, perhaps lasting less than 30 days, and may resolve as the body heals from another condition (Marchand, 2012). Persistent pain lasting more than 6 months may be classified as chronic pain and may be associated with a chronic illness such as arthritis, or may be a condition itself. Pain may also be further delineated between nociceptive (somatic, visceral), neuropathic (results from a disease or lesion affecting the somatosensory nervous system) or cancer related (IASP, 2012).

Managing pain involves several interacting components: pain assessment, strategies and interventions to manage pain, evaluation of effectiveness of pain management, and continuing reassessment of pain. High-quality pain management is collaborative; planning and decision making with the patient and interdisciplinary team lead to best management outcomes. To effectively manage pain, providers are responsible for appropriate comprehensive assessment and delivering treatment that is "efficacious, cost-conscious, culturally and developmentally appropriate, and safe," (Gordon et al., 2010, p. 1173). Providing education and information on pain management is an essential component of an effective management plan. Finally, evaluation and reassessment of response to treatment completes an effective management plan (Fig. 12.1).

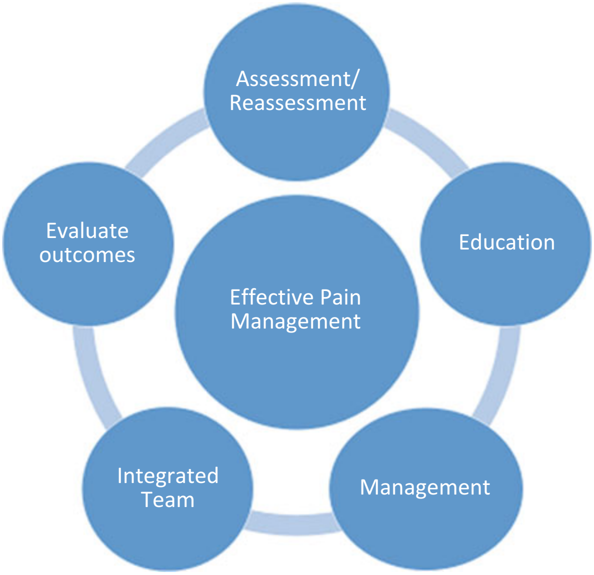

Fig. 12.1 Essentials of effective pain management

Pain and Culture: Biocultural Models of Pain

Few studies have examined the pain experience of Hispanics, yet evidence indicates a multicultural influence on the way people respond and interpret pain. The Biocultural Model of Pain integrates social learning theory into the physiologic explanation of how pain develops and is interpreted (Bates, 1987), therefore, fits with the aims of this book. Bates' biocultural model of pain is an integrated model combining the physiologically based gate-control, social learning, and social comparison theories to more comprehensively describe the pain experience; pain is far more than a strictly physiological experience. The outcome, or pain response, is affected by the physiological processing that occurs as well as the sociocultural influences on the individual. Bates model fits well with McCaffrey's definition of pain based on the subjective experience of the person, meaning pain is influenced by each person's experience, beliefs, and context.

Bates' model questions commonly held assumptions based on research primarily from a Caucasian perspective that the pain experience is the same for all. With worldwide attention on solving the problem of pain and the increasing globalization of health care, issues of disparity in treatment are a significant research topic. Bates' model bridges the narrow medical conception of pain as a symptom of tissue damage with the social and behavioral view of pain as a product of attitude, value, and experience that affects the physiological processes and outcomes involved in pain perception and response (Bates, 1987). Social modeling, group norms, and learned values influence pain perception, the processing of the pain response, and the behavior related to pain. It is assumed that all humans have similar neurophysiological responses to painful stimuli; however, this model exposes factors that influence response, namely social learning processes within ethnocultural groups.

The biocultural model of pain perception proposed by Bates can be applied as a framework for interpreting the influence of cultural context, group characteristics, and language barriers on the pain experience and has been used to better understand pain management among Hispanic populations (McNeill, Sherwood, Starck, & Nieto, 2001). For example, people of Hispanic background may highly value *familismo*, a core value of family attachment such that pain is viewed in terms of family impact. The commitment to family may influence decisions to seek treatment because of not wanting to disrupt family roles and responsibilities. *Personalismo* and *respecto* are other key cultural concepts that focus on mutual respect, empathy, and politeness in interactions, and *simpati*, that values harmonious relationships without interpersonal conflict (Zoucha & Reeves, 1999). Pain is often a symptom of other disease conditions and seeking treatment may focus reluctant attention on the person experiencing pain or lead to a disruption in family life because of care required to address symptoms. Respondents in a qualitative study on the pain experience among Hispanic populations in the southwestern, border area of the US (Sherwood, McNeill, Palos, & Starck, 2003) revealed cultural values and attitudes about pain and its influence within the family unit, and disruption in attending to activities of daily living related to pain, as important influences on decision making regarding obtaining treatment for pain. These findings were consistent with Bates' framework.

Perspectives on Managing Pain in Hispanic Populations

There is wide diversity among Hispanic subgroups and their views regarding healthcare treatment often differ from health care providers. Among Hispanics, three basic sets of factors commonly affect world views: (1) core values, as noted above, including the value of family, respect for the individual and authority, and harmonious relationships; (2) the degree of acculturation and assimilation; and (3) the educational, economic, and social status of the individual. Acculturation contrasts with assimilation; acculturation is the ability to function in the new culture whereas assimilation is the adoption of the new host culture's beliefs, values, and practices (Kawaga-Singer, 2012). The most reliable indicators of acculturation that distinguish among Hispanic subgroups include place of origin, ethnic self-identification, and language reported to be preferred or used during an interview (Marin & Marin, 1991).

Several unique characteristics of Hispanic populations must be considered when developing health care interventions and in particular, managing the subjectivity of pain. The heterogeneity of the Hispanic population in the US compounds treatment approaches as the term Hispanic covers wide geographic diversity for country of origin and length of residency in the US. “Hispanic” is an umbrella term for several groups of Spanish speaking peoples, and includes persons of Mexican, Puerto Rican, Central or South American, or other Spanish culture, regardless of race. This broad classification means there are many background factors such as country of origin, time in the United States for acculturation, how well assimilated one is into the local culture and health care delivery system, one’s support system such as family near-by, and language. Language is another compounding factor; many speak only Spanish. The limited availability of Spanish language measurement instruments and methods designed specifically for this population limit accurate communication to obtain comprehensive health history and assessment. And, there is general reluctance leading to low rates of participation of Hispanics in research to enhance the evidence base and resolve some of these limitations (Vilaro, 1994).

In spite of the challenge of language, the subjective nature of pain means communication, interpersonal communication, and history taking are important components of pain assessment and intervention. Communication is an important factor in establishing the relationship between health care providers and the patient and family, and language is key. Given that Spanish continues to be the primary language, and perhaps the only language spoken by many in Hispanic populations in the US, providing effective care may be problematic if health care providers are not themselves bilingual or translators are not readily available. Furthermore, Spanish language assessment tools, educational materials, and treatment strategies are limited although hospital regulations now mandate professional translation services to assure accurate communication between providers and patients without relying on family members to translate.

Evidence Base: Pain Outcomes among Hispanic Populations

Reports continue to reveal varying degrees of disparity in treating pain among Hispanic populations (Payne, 2009). Ethical principles in terms of beneficence and justice support the critical value of providing equitable and appropriate distribution of resources in a society. The social determinants of health may in some part help explain the continuing disparity in spite of research that has helped identify evidence and solutions. Disparities in pain treatment may derive from lack of access to health care due to living conditions, location and distance from providers, language, economic status, values and beliefs, and education. As such, the Institute of Medicine (2001) established a quality of care model based on the acronym STEEEP: quality care must be Safe, Timely, Equitable, Effective, Efficient, and Patient-Centered which fits the examination of quality of care for this vulnerable population.

Patient-centered care is the core of effective pain management and fits the emphasis noted previously on communication, relationships, and family that are important tenets in caring for patients from Hispanic populations. A first and critical step in providing patient-centered, effective, and equitable care is language;

communication between patient and provider is the cornerstone of effective treatment. Hispanics with limited English skills may be uncomfortable discussing health concerns if they feel unable to express their feelings about illness appropriately (Gordon et al., 2002). Translation is an important aspect of quality pain management in working with Hispanic patients experiencing pain, both for educational information and for service delivery. Because many Hispanic patients experience limitations of health care coverage, geographic factors or even educational level, providers may fail to establish collaborative partnerships with the patient and family. Effective pain treatment is grounded in a collaborative, integrated, interdisciplinary approach in which the patient and provider share decision making (Novy, Ritter, & McNeill, 2009). Language appropriate communication and tools help promote a collaborative partnership between members of the interdisciplinary team and the patient and family.

Evidence on the nature and prevalence of disparity in pain management among Hispanics is unclear. Historically, studies have reported that ethnic minority populations experience poorer pain management than white, non-Hispanics (Bonhan, 2001; Cleland et al., 1994; Ng, Dimsdale, Schragg, & Deutsch, 1996; Payne, 2009; Todd, Samaroo, & Hoffman, 1993). A more recent study by Meghani et al. (2012) reports that while Hispanics were prescribed some type of analgesic for acute pain, they were significantly less likely to be prescribed an opioid than non-Hispanic whites. This may be interpreted as a lack of collaboration with the Hispanic individual experiencing moderate to severe pain in working with providers due to misunderstanding, education, or language. In contrast, Bijur, Berard, Esses, Calderon, and Gallagher (2008) reported no evidence of a relationship between receiving analgesics, specifically opioid analgesics, and race or ethnicity of emergency department patients. A comprehensive analysis is reported in a meta-analysis of analgesic treatment disparities covering a 20 year period based on 34 qualifying studies (Meghani et al., 2012). While there were no overall disparities in use of analgesics for Hispanics, the use of opioid analgesia was significantly lower among Hispanics; they were 22 % less likely than white counterparts to receive treatment with opioids (OR 0.78, $p = 0.006$).

This evidence points to lingering questions about the role providers have in managing pain and the role of the partnership between patient and provider in accurate assessment and consideration of treatment choices. A study of analgesia in childbirth by Atherton, Feeg, and El-Adham (2004) found that Hispanic women were twice as likely *not* to receive an epidural procedure during childbirth, although the authors note that decision making in childbirth is influenced not only by provider choice but also by mothers' decision making in accordance with cultural expectations.

Communication has a pivotal role in establishing a partnership role between patients and their healthcare providers for most effective pain management, and so does education and information about pain management. Katz et al. (2011) interviewed focus groups of Hispanic and Non-Hispanic white patients with knee and back pain regarding management of their pain problem and preferences for decision making in relation to treatment. Hispanic participants reported a general preference for allowing their physicians to take the primary role in decision making, as well as the importance of faith and religion in coping with their pain and disability. This may indicate a need for more current education about pain management to improve care outcomes.

Provider bias may also contribute to ineffective or inadequate management of pain (Payne, 2009). Stepanikova (2012) found that two potential factors affecting the occurrence of disparities involve implicit biases and pressures related to time to treat. Eighty-one family physicians and general internists were provided a case vignette of a patient with chest pain; the clinicians were advised regarding the time they had for decision-making as well as treatment possibilities such as diagnosis and referral. Among the findings, perceived bias regarding race and ethnicity led to increased likelihood that Hispanic and African American patients were not diagnosed with serious pain, and were not referred to specialists. These reports confirm the need to continue to study the complex issues surrounding pain management in ethnic populations and to provide education and information to both providers and patients.

Measuring Pain Management Quality: Key to Improvement

Language may pose a significant barrier for Hispanics seeking health care. Spanish assessment tools and educational materials are limited. Hispanics with limited English skills may be uncomfortable discussing health concerns if they feel unable to express their feelings about illness appropriately (Gordon et al., 2002). Bonhan (2001) noted that because the majority of studies have found a disparity in pain treatment by ethnic group, further study of language in the communication about pain will help to unravel the causes of these disparities. The Joint Commission on the Accreditation of Healthcare Organizations, (2003) recognized the need for linguistically appropriate pain assessment tools to have available Spanish versions of the numeric scale (continuum with 0 no pain graduating up to 10 as worst pain), FACES in both English and Spanish (Wong-Baker FACES Foundation (2015). Wong-Baker FACES® Pain Rating Scale. Retrieved September 19, 2015 with permission from http://www.WongBakerFACES.org) (Fig. 12.2), and pain location diagrams. Another is the Spanish version of the Brief Pain Inventory (Cleland, 2009). However, until recently, there were no tools developed for Hispanics that were both culturally and linguistically appropriate for assessment of the experience of pain for Hispanic individuals of a range of cultural traditions (Mexican American, Puerto Rican, etc.) (Table 12.1).

National regulations (The Joint Commission, 2003, 2012) emphasize the need to assess the effectiveness of pain management and specify components of an acute pain management program for health care (The Joint Commission, 2012). Culturally appropriate approaches are essential to achieve effective pain management for any cultural group. Language is crucial; communication is the cornerstone of accurate pain assessment (Juarez, Ferrell, & Borneman, 1998). Although Bonham

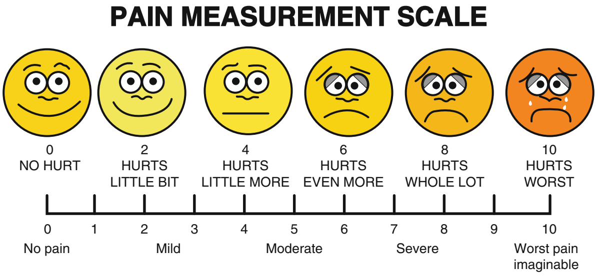

Fig. 12.2 FACES pain measurement scale for adults or children (Wong-Baker FACES Foundation (2015). Wong-Baker FACES® Pain Rating Scale. Retrieved September 19, 2015 with permission from http://www.WongBakerFACES.org) in English and Spanish

Table 12.1 Measuring outcomes of pain management: spanish language tools

Instrument focus	Instrument title	Available in Spanish
Unidimensional measures of pain intensity	Numeric pain intensity scale, verbal intensity scale, FACES scale (Wong-Baker and others)	Yes
Multidimensional measures of pain	Brief Pain Inventory	Yes
	American Pain Society-Patient Outcome Questionnaire-Revised	Yes
Acute pain	Houston Pain Outcome Instrument (HPOI)	Yes
Multidimensional measures of pain	Chronic Pain Acceptance Questionnaire (CPAQ) (Rodero et al., 2010)	Yes
Chronic (Fibromyalgia)	Pain Self Perception Scale for Fibromyalgia (Garcia-Campayo et al., 2010)	Yes

recommended as early as 2001 that further study of language to communicate about pain will help to unravel the causes of continuing reports of disparities, still there are reports of disparity and inadequate treatment. Hispanics experiencing pain are not consistently managed in accordance with the components of quality proposed by Gordon et al. (2005) nor by the IOM STEEEP model for quality care (2001). For example, assessment may lack language interpretation and thus overlook critical information. Pain management disparities, then, can derive from the linguistic challenges in the assessment process as well as the underreporting of pain intensity among minority individuals (Mossey, 2011).

Components of Quality Pain Management

Questions about pain management can be evaluated in terms of quality (Zoega, Gunnarsdottir, Wilson, & Gordon, 2016). The acronym STEEEP proposed by the Institute of Medicine in 2001, cited above, provides a framework for examining quality of care relevant to pain management among Hispanic populations that fits the goals of this chapter. STEEEP examines health care in terms of care that is safe, timely, effective, equitable, efficient, and patient-centered. Increasingly, patient-centered care is recognized as the foundation for delivering quality care because it addresses cultural perspectives. Additionally, safety is a closely linked concept to quality; quality measures safety and safe care is concerned with quality. There are inherent safety issues in managing pain, and in fact, pain mismanagement is described as a medical error (Starck, Sherwood, Adams-McNeill, & Thomas, 2001) when not delivered according to standards of care to meet the unique needs of the patient (McNeill, Sherwood, & Starck, 2004) or address the quality aims described previously in the STEEEP model.

Measurement of Effective Pain Management in Hispanic Populations

Differing results in reporting the effectiveness of pain management among Hispanic populations may be attributed to the lack of effective measures, the variability among Hispanic populations, reluctance to participate in research studies, and assumptions and attitudes of researchers and clinicians about pain management (McNeill et al., 2003). Evidence supports the importance of using language appropriate tools and strategies to achieve best outcomes; see Table 12.2 below. Two comprehensive quality management tools are presented that have been field tested in Spanish language with Hispanic populations to meet the need for linguistically appropriate measurement tools, the American Pain Society—Patient Outcome Questionnaire and the Houston Pain Outcome Instrument.

American Pain Society-Patient Outcome Questionnaire

The most reported measure of pain management is the American Pain Society-Patient Outcome Questionnaire (APS-POQ) (2001). Comprehensive studies using the APS-POQ have consistently revealed patient reports of moderate to severe pain

Table 12.2 A quality pain management approach (Adapted from Porche, 2010)

• Appropriate assessment and management
• Initial assessment upon admission/provider contact and on-going assessment
• Documentation of assessment and reassessment
• Relevant treatment plan consistent with patient pain severity, duration, and level
• Education and information about pain management and resources
• Discharge information, resources, and options
• Knowledgeable, informed providers
• Monitoring health care delivery organization effectiveness of pain management outcomes

intensity and interference ratings, and high satisfaction ratings among general populations (Gordon et al., 2002). The APS-POQ was revised in 2010 as the American Pain Society-Patient Outcome Questionnaire-Revised (APS-POQ-R) (Gordon et al., 2010). However, data was not reported on Hispanic populations in these studies. The APS-POQ-R is available in 11 languages, including Spanish, on the American Pain Society web-site (http://americanpainsociety.org/education/2010-revised-outcomes-questionnaire).

McNeill et al. (2001) reported using the original APS-POQ with a sample from Hispanic populations. They found that 98 % of patients ($n = 104$) in a rural sample of Mexican American postoperative medical/surgical patients in a regional hospital on the U.S.-Mexico border reported pain in the preceding 24 h. Mean current pain and usual pain ratings were in the moderate range, while worst pain ratings and pain-related interference for activities associated with recovery from surgery were in the severe range. Satisfaction ratings were moderately high (4.67) (on a 1–6 scale with 6 being very satisfied) in spite of pain. From these findings and realizing the importance of language, this research team pursued development of a Spanish language instrument to better understand issues in pain management for Hispanic populations, described below.

Houston Pain Outcome Instrument (HPOI)

Modeled on the prototype APS-POQ, the Houston Pain Outcome Instrument (HPOI) derived from a qualitative study on the experience of pain among Hispanics in a sample of 35 Hispanics from urban and rural sites in Texas who were between 18 and 70 years of age (Sherwood et al., 2003). The qualitative interviews were conducted in Spanish and translated as the first phase of the project to develop a linguistically appropriate pain assessment instrument for Spanish speakers. Data from the interviews describe Hispanic individuals' past experiences with pain, attitudes toward pain and attention to pain stimuli. These descriptions are consistent with Bates' biocultural model in which social learning processes regarding pain integrate with cognitive awareness and physiological variables.

Participants' responses were categorized into five themes, which then formed the basis for organization of the new, Spanish language instrument: Characteristics of pain experiences, Managing pain, Information about pain, Interactions with providers, and Cultural considerations.

- Characteristics about pain were described by sharing attitudes, beliefs, and expectations; responses to pain; effects of pain on their lives; and descriptions of the pain itself.
- Managing pain included multiple approaches to pain and descriptions of the effectiveness of formal prescribed interventions and those not prescribes, such as nonpharmacological. While most participants described use of analgesics, many also described nonpharmacological approaches such as meditation and prayer, special teas, and support of family.

- Information about pain included sources and types of information, whether from providers, family, or multimedia; language preferences; and, effectiveness of information received.
- Interactions with providers included both how providers approached and responded to the participants' pain, but also how patients responded to the providers, hence the relationship mattered.
- Cultural considerations included gender-specific considerations, religious beliefs and approaches, specific ethnicity, and other factors such as acculturation and assimilation.

Using these findings, researchers developed the Houston Pain Outcome Instrument (HPOI) as a culturally sensitive assessment tool to measure satisfaction with pain management, or also known as the *Cuestionario de Houston Sobre el Dolor*. The HPOI was systematically developed in Spanish, translated from Spanish into English, and then back translated by a professional translation service. The resulting instrument was pre-tested to assess Spanish and English forms for clarity, content, and linguistic equivalence, and to estimate the time and ease of administration, and adapted to a final version with 27 items that assess pain intensity, pain interference, satisfaction, and barriers to effective management. It differs from the APS-POQ by including items that reflect culturally specific opinions that may pose barriers to pain management due to language or cultural perspectives. Items were expanded to assess pain interference with emotional well-being, expectations about pain, sources of information about pain and ways of managing pain. The HPOI is available from the chapter authors.

The HPOI was administered to a sample of postoperative, self-identified adult Hispanics drawn from three hospitals in the Rio Grande Valley and Houston ($N = 95$) (Sherwood, McNeill, Hernandez, Penarrieta, & Peterson, 2005). Mean age was 41 years, 74 % were female, over 50 % had less than a high school education, and 33 % were first generation Hispanics in the US. With 0 meaning no pain and 10 worst pain, results indicated that post-surgical patients expected pain (mean rating 7.8), and expected relief from pain (mean rating of 7.5). The pain intensity level for worst pain matched this expectation, 7.9, although reported current and usual pain intensity ratings were somewhat lower. Generally, pain was reported as moderately interfering with mood and physical function. Opinions about pain and pain management ranged from a low of 1.7 for "Showing pain makes me lose the respect of family/friends," to greatest agreement for "Pain medicine is the only way to relieve pain," 7.0. Satisfaction with pain management was high, ranging from 9.2 for comfort in talking to doctor or nurse about pain and pain management to 8.2 for the inclusion of family and friends in the care given for pain and also for education about pain management with means >8. The results of this study are unique in assessing pain with an instrument developed specifically for use in Spanish language and tested with this population.

Content validity was assessed by 14 cultural and pain experts, who served as advisors to the project. The reliability of the HPOI was assessed using Chronbach's alpha to determine its internal consistency. Internal consistency for the entire instrument was estimated at 0.87 using Chronbach's Alpha. Specific items, particularly those related to Opinions about pain and pain management, tended to negatively influence overall reliability. Using this procedure, all subscales achieved an internal consistency reliability of >0.75 (Unpublished data available from authors).

Integrated Approaches to Effective Pain Management in Hispanic Populations

A multilevel approach is necessary to achieve an integrated quality approach to pain management (Fig. 12.3). First, there must be a system commitment to effectively manage pain for all patients, in-patient and out-patient. This includes an educational approach for providers and for patients and families. To initiate effective management, culturally appropriate approaches must be available and used. Communication is the cornerstone of pain assessment, and assessing and documenting language preference is crucial. Management strategies are many and varied so much fit the patient and family expectations and goals.

Systems Approach to Quality Pain Management

To address the complexities of pain management requires a multimodel systems approach to include the institution, providers, and the patient and family. Tables 12.3 (Institution), 4 (Providers), and 5 (Patient and Family) present strategies for implementing a systems approach. A basic tenet of a systems approach to pain management is based on quality (Beck et al., 2010; Gordon et al., 2010; Starck et al., 2001). Gordon et al. (2002) defined quality pain management as the appropriate assessment of pain parameters coordinated by an interprofessional team that encourages shared decision making with the patient. Assessment is both broad and detailed

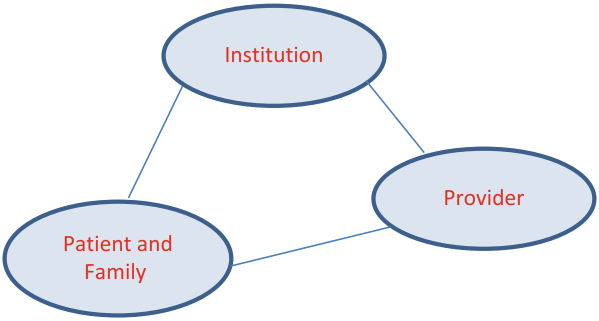

Fig. 12.3 Comprehensive systems approach to pain management involves the institution, providers, and patient/family

Table 12.3 Stage 1: Institutional approach to quality culturally appropriate pain management

First stage: Institutional approach to quality culturally appropriate pain management
1. Determine benchmarks for pain management
2. Approve best practice standards and protocols based on professional and regulatory standards
3. Determine management strategies
4. Measure status of pain management based on STEEEP (IOM, 2001)
(a) Safe: Are pain management strategies delivered without harm to the patient? Are errors disclosed, analyzed, and the system corrected?
(b) Timely: Are pain management interventions, including assessment/reassessment, completed according to the treatment plan?
(c) Effective: What measures are in place to determine effectiveness of pain management interventions both at the individual patient level and at the system level?
(d) Efficient: What is the cost benefit ratio of care delivery to achieve pain management goals?
(e) Equitable: Are there population disparities in pain management strategies and outcomes?
(f) Patient-centered: What is the assurance that pain management assessment, management, education, and outcome measures respect culturally appropriate patient goals, expectations, beliefs, and values about pain?

such as presence of pain; the presence of pain requires comprehensive assessment to examine history, type, level and type of pain followed by periodic reassessment to monitor patient responses. To achieve quality outcomes, treatment should follow the STEEEP guidelines for safe, timely, effective, efficient, equitable, and patient-centered care as an effective model to assure quality pain management. The Joint Commission which accredits hospitals and other clinical settings outlined a systems approach for pain management strategies (Porche, 2010) (Table 12.2) to assure quality care.

One hospital system used a report card or dashboard for baseline expectations (Starck, Adams-McNeill, Sherwood, & Thompson, 2000). The report card helped system administrators consider the prevalence, intensity, and duration of pain experienced by patients in their hospital and discuss with front-line providers the issues confronted in alleviating patient pain. Using a dashboard to report standard outcomes across units can be help raise awareness, improve commitment to education about pain, and foster patient and family engagement in pain management and indicate gaps that may be at the institutional level, in the provider approach, or implementation with patients and family.

Institution

The institution or system sets expectations for its commitment to quality and outcome goals (Blizzard, 2013). Table 12.3 illustrates the important of organizational commitment to resolving pain by providing the resources for providers to have the latest knowledge and best practices for assessing and treating pain from a multicultural perspective. Organizations must also demonstrate commitment to continuous

Table 12.4 Stage 2 of a comprehensive organizational approach to effective pain management: Provider education and implementation

Second stage: Provider education and engagement
1. Update education about pain models and theories, their own beliefs and values about pain, and cultural perspectives about pain reporting and management
2. Set expectations about pain management goals
3. Determine pain management protocols and standards
(a) Discipline-specific roles and responsibilities
(b) Pharmacologic measures
(c) Nonpharmacologic strategies
4. Plan patient education approach
5. Agree on measurements for benchmarks
6. Re-assessment and continuous evaluation
7. Determine out-patient plans
(a) Interdisciplinary team planning
(b) Discharge education
Out-patient pain management

quality improvement by measuring the outcomes of pain management and examine gaps that emerge to resolve care issues. Table 12.4 presents a comprehensive educational approach to assure that all providers have the training and education needed to accurately assess pain as a subjective person based experience while recognizing the impact of culture and the social determinants of health. Table 12.5 completes this three prong approach for addressing pain management with an evidence-based, patient-centered approach and specifically addressing language-specific needs.

Providers

Providers often lack education about comprehensive, patient-centered, quality approaches to pain management. Education to reduce myths about pain helps to reduce the stigma often attached to patients who report continuing issues with pain to better assess, intervene medically and nonmedically, and recognize cultural beliefs and values that impact pain reporting and management. Pain management requires an interdisciplinary team approach that includes primary and behavioral health collaboration such as counselors and behavioral health specialists (Main, Keefe, Jensen, Vlaeyen, & Vowles, 2014).

Patients and Families

The third stage of a comprehensive approach to effective patient-centered pain management is a patient- and family-centered approach that considers patient perspectives and engagement. To achieve quality goals outlined in a systems approach, a

Table 12.5 Stage 3 of a comprehensive organizational approach to effective pain management: A stepped approach for culturally appropriate care for patient and family

Third Stage: Patient and family approaches
Level 1: Assessment and Education
1. Determine language and health literacy for individualized approach
2. Cultural background related to health beliefs and values
3. Translation service as appropriate
4. Language appropriate tools
5. Overall goals for health
(a) Complete accurate medical history for intervening factors
• Family history for genetic/familial traits
• Social support system
• Potential sources of stress
• Health history
(b) Assess pain history and current status
• Characteristics of pain: onset, duration, quality, triggers/stimuli, intensity
• Interference with daily activities
• Management strategies
(c) Operationalize pain management
• Assess expectations for pain management and relief
• Goals for pain intensity, duration, and interference with quality of life
• Preferences for pharmacologic and nonpharmacologic management
Level 3

stepped approach enables providers to work with each patient based on their individual needs and preferences. Table 12.5 offers a culturally sensitive quality approach to pain management that defines each step of the care process. A stepped approach is not necessarily linear, but provides a checklist in working with each patient and family and may include multiple sessions, repeated education to assure understanding, and repeated assessments. Education, assessment, and care management are discussed in greater detail to guide implementation of a stepped approach.

Pain is a broad area of symptom management, and patients present from multiple experiences, pain severity, longevity of symptoms, and accompanying diagnoses that range from the need for surgical intervention to chronic pain, or long term cancer pain, any of which can escalate to the need for integrated behavioral interventions. A four level plan to pain management can accommodate the variety of patient experiences and needs (Table 12.6). Level 1 is primarily bibliotherapy, an approach of providing education and information according to the patient's background, language, and health literacy. The majority of patients who present with acute pain will be effectively managed with Level 1 and Level 2 which is primarily assessment and intervention managed by a primary health care team. Level 3 provides access to

Table 12.6 Integrated Behavioral Health care applied to pain management intervention

Assessment	Assessment
1. Determine language, health literacy, beliefs and values	Level 1 patient education
	Level 2 (group counseling)
2. Gather medical and family history, pain history, previous pain management approaches, and effectiveness	Level 1
	Level 2
	Level 3 (individual counseling, psychiatric services)
3. Management	Level 1 and Level 2 approaches for patient/family members
Operationalize plan	Level 3 and Level 4 (team approach) for patient/family
Set pain relief goals	
Pharmacologic	
Nonpharmacologic/behavioral	
4. Evaluation and Re-assessment	Evaluation
Note outcomes—patient satisfaction, achievement of pain and pain relief goals, physiologic and Activities of Daily Living (ADL)	Continue stepped approach to maintain desired pain relief, support patient/family
	Level 1—continued patient/family education
	Level 2—group counseling as needed
	Level 3—individual counseling
	Level 4—Team approach with consultation as needed

group intervention with a behavioral health care specialist. Level 4 includes a team-based approach with a psychiatrist and behavioral healthcare specialist. A case study illustrates the overlay of a comprehensive approach to pain management as described in Table 12.5, with an overlay of a four level approach to integrate behavioral health care to the complexity of pain management.

Education. Patients and families often lack education about current standards and treatment options to replace myths or misunderstandings. Research among Hispanic populations reveals many individual members have beliefs and values about pain that affect pain management and family participation and engagement (McNeill et al., 2003). Patients who lack education about pain management may not realize most acute pain can be managed with careful attention to symptoms, a combination of pharmacologic and nonpharmacologic approaches, and partnerships with providers. Patients who have language or communication issues or are not provided effective translation services are at higher risk for ineffective pain management. There may be limited Spanish language education materials and assessment tools available for patients from Hispanic populations with limited communication skills in English.

Assessment. Pain is subjective, therefore patients are the only reliable source about their pain. All patients should be assessed for pain. Observable behavioral and physiological indicators are not reliable measures of pain, although they may be useful when assessing patients unable to communicate. Assessing language preference is the first step in working with Hispanic populations to assure selection of appropriate assessment tools for the patient, whether for language, cognitive impairment, or age. Many health care systems have found that holding scheduled clinic hours for Spanish speakers contributes to integrated care by staffing with bilingual providers.

Establishing rapport with the patient is important for accurate assessment, so that patients are willing to share their histories, signs, and symptoms. With Hispanic populations that includes family constellation and involvement in care, country of origin, assimilation and/or time in the US, and treatment goals. Pain is most often associated with other conditions or illnesses; accurately diagnosing and managing underlying condition is dependent on a true and revealing history and assessment. Information should include past medical and psychosocial history, pain history and characteristics, and patient expectations and goals for seeking treatment.

Because pain is an unpleasant sensory experience that may also have an emotional response, assessment must be more than the widely practiced pain as a fifth vital sign in which patients may only be asked to rate pain on a numeric scale. Questions must probe deeper to learn the true nature and experience of pain, thus integrating care from behavioral health specialists can help assure effective approaches, and in particular for those with chronic pain (Main et al., 2014). Questions include the onset of pain, the duration, location, type of pain such as sharp or dull, pain triggers, and intensity. Appropriate language is critical; for Hispanic patients, using words other than pain may reveal more information, such as hurt or ache. Providers should ask the patient and family members about management strategies, any relevant medical or family history that helps understand the patient's pain, the impact of pain on the patient's activities of daily living, and expectations for managing the pain.

Re-assessment of pain and evaluation of pain management includes both the assessment of the patient's response to the treatment approach and patient satisfaction with care related to pain, as well as the overall evaluation of a pain management program in an institution or population setting. While there has been purposeful inclusion of both types of evaluation approaches in pain management guidelines (APS, 2001) there has been little research on this aspect of pain management, or its differential application for Hispanic populations, except in the area of development of Spanish language instruments used for evaluation.

Management. Patients may require varied approaches for pain that is acute (AHRQ, 2015) such as post-operative (ASA, 2012), or chronic pain associated with long term illness or behavioral issues (Main et al., 2014), or for pain that is cancer related (WHO, 2012) (materials also in Spanish). Numerous standards of care are available from the American Pain American Pain Society (2001), The Joint Commission (2003, 2012), the Institute of Medicine (2011), the International Association for the Study of Pain (2012), and others. A comprehensive list of available guidelines for various types of pain is available from the Agency for Healthcare Research and Quality (AHRQ, 2015).

Analgesic treatment is complex and is prescribed according to the reason the patient has pain, whether in-patient or out-patient, pain severity, expectations for pain relief, tolerance/side effects. Interference with activities and mood, preference for pharmacologic and/or nonpharmacologic interventions, and other contextual factors (AHRQ, 2015). Prescription is based on holistic assessment that includes patient attitudes and beliefs about pain and desires to include nonpharmacologic adjuvant therapy. Patients and providers must work together to determine pharmacologic and nonpharmacologic treatment regimens that enable patients to attain their pain relief goals and expectations, manage side effects, and anticipate future management for chronic or unrelieved disease manifestations.

To determine an effective management plan requires providers to take into account the patient's sociocultural framework, prior pain experiences, cognitive understanding, and physiological components are important components of an effective approach with the Hispanic patient, and family to effectively manage the pain experience. High-quality pain management is collaborative and based on careful planning and decision making with the patient and interdisciplinary team. To effectively manage pain, culturally sensitive care includes appropriate comprehensive assessment and treatment that is "efficacious, cost-conscious, culturally and developmentally appropriate, and safe," (Gordon et al., 2010, p. 1173). Evaluation. Evaluation and reassessment of response to treatment completes an effective management plan. Reliable and valid measures which are culturally and linguistically appropriate will assure that the strategies are effective and acceptable to the patient and family. The evaluation step is critical in an effective plan leading to improved approaches for individuals and quality improvement in pain management for Hispanic populations. Providing education and tailored information on pain management is an essential component of an effective management plan.

The Case of Ms. Santos Illustrates the Stepped Care Approach for Pain Management

Ms. Santos is a 68 year old woman with a 15 year history of osteoarthritis, and a recent back injury resulting from a fall. She is otherwise healthy with no other chronic illnesses. She is a recent widow, and has three grown children and seven grandchildren. She lives with one of her daughters and family and helps take care of three small grandchildren. Her pain has been managed in the past with over the counter (OTC) medications for her osteoarthritis and some natural remedies, according to her daughter who visits daily while her mother has been in the hospital. She is being treated in the hospital for the fall injury, but is refusing additional pain medicine for her back despite the doctors and nurses urging her to take something. The possible need for back surgery has been explained to her and her daughter. When asked about her pain she rates it as a 3 on a 10 point numeric scale (1 being no pain and 10 the worst pain imagineable), but is moaning softly, restless, and has not been able to sleep. While she speaks English, the nurses overhear her speaking Spanish to her daughter. She is anxious to go home and is concerned about the care of her grandchildren. In order to provide comprehensive, and culturally appropriate care for Ms. Santos, her primary provider would employ a systematic, stepped care, pain management approach. A stepped care approach would begin with Level 1, patient education, and progress if needed to Level 2, group counseling approaches. Depending on the patient response and pain management outcomes, Level 3, provision of behavioral health services on an individual basis, would be employed; finally Level 4 might be used, consisting of a team-based approach with a psychiatrist and behavioral healthcare specialist working with the patient and family.

Stepped care, **Level 1 and 2**. Assessment—this would be a first step toward pain management and also for meeting patient and family educational needs. AT this step the priority is conducting a comprehensive pain assessment in order to plan care, and beginning patient and family education.

1. Gathering a medical and social history including Ms. Santos's language preferences, and her understanding of her past pain problems and the impact of the new injury.
2. Obtain translation services if needed. Note: her daughter may be present at the interview but should not be the main translator for her mother.
3. Have an appropriate pain assessment tool on hand such as the numeric scale with Spanish anchors, the faces or verbal rating scale, in Spanish.
4. Inquiring as to her expressed cultural background and health beliefs/values—specifically ask about natural remedies for pain that Ms. Santos feels may be helpful—for example, heat application, prayer, or relaxation.
5. Asking about goals for health—ask what Ms. Santos's goals are for recovery from the back injury, ask how she feels she can manage the new pain related to the injury
6. Complete the history for intervening factors—such as any genetic/familial traits (may influence response to analgesics), Social support system, Potential sources of stress, and verifying health history
7. Specifically assess pain history and current status
    (a) Characteristics of pain: onset, duration, quality, triggers/stimuli, intensity
    (b) Interference with daily activities

    Management strategies she has already tried; again give the opportunity and permission to talk about traditional remedies, indicating acceptance of these as important and valuable to her. Based on the assessment, provide patient education materials (**Level 1**) on nonpharmacologic and pharmacologic therapy and possible side effects. Refer Ms. Santos and her daughter to web based materials, such as the American Pain Society website, the Agency for Healthcare Research and Quality site related to pain management; assure that all information is available in both English and Spanish.
8. Inquire of Ms. Santos and/or her daughter's interest in participating in a group therapy (**Level 2**) situation for chronic pain patients. Working with social services and the psychologist for the pain service, assure that a group is available in Spanish for Ms. Santos.

Stepped care, **Level 2**, **3, and 4**. Plan and Operationalize pain management interventions

1. Reinforce the fact that a group approach to chronic pain care will be a valuable addition to any pain management plan. Follow-up with Ms. Santos regarding participation in a Spanish speaking group.

2. Gather information about expectations and goals for pain relief
   (a) Inquire as to Ms. Santos's expectations for pain management and relief—her goals for pain relief; for instance, does she feel she can go about her daily activities with a low level of pain (up to a 3 on a 0–10 scale)?
   (b) Ask about her tolerance for pain—what pain intensity, duration, she feels would interfere with her quality of life
3. Working in partnership with Ms. Santos and her daughter, discuss their preferences regarding pharmacologic and nonpharmacologic management
4. Reinforce the **Level 1** stepped approach regarding education about pain management—provide information, printed and web-based according to their preference and in English and/or Spanish for Ms. Santos and her daughter about both pharmacologic and nonpharmacologic approaches that could be tried, and the advantages/disadvantages of each approach being suggested for her—(for example. a certain type of medication, scheduled vs. as needed dosing, possibility of using the medication at home, expected side effects and how these would be managed.) If nonpharmacological approaches are her preference, discuss various ones and try to agree on a trial of these to see if effective for her.
5. Reinforce the use of a **Level 2** intervention by referral to an appropriate group.
6. Put the plan into effect in the hospital setting and have providers monitor closely, using language appropriate pain assessment scales.
7. Consider social and spiritual needs and refer to these providers as needed.
8. Refer to a behavioral health specialist (**Level 3**) for assistance with monitoring pain management, effective use of nonpharmacologic approaches, and enhanced understanding of her beliefs about pain.

Reassess and evaluate effectiveness of approaches

1. After each dose of pain medication, reassess for level and quality of pain from her perspective.
2. Note presence of side effects; specifically note gastrointestinal disturbance such as nausea or vomiting, check on occurrence of constipation and be sure to institute a bowel management program for any prolonged use of opiates (longer than 3 days or so)
3. If nonpharmacological approaches are being used, note frequency of use, combination or instead of pharmacological approaches, effectiveness and Ms. Santos's satisfaction with the approach.
4. Plan together with Ms. Santos and her daughter regarding continuation of the pain management program throughout the acute injury period, and when at home.
5. If evaluation of the overall management approach indicates ineffective management of her recurring pain from the osteoarthritis, and the acute pain related to the fall and imminent surgical intervention, Ms. Santos and her daughter may be referred to the interdisciplinary team for **Level 4** care to further explore the use of nonpharmacological approaches, assure that the pain management plan is acceptable to Ms. Santos and culturally appropriate, and prepare her for the

possibility of surgical treatment. It may be that she could benefit from more intensive attention to her beliefs about pain, use of analgesic therapy, and exploration of her concerns about surgery and further pain treatment.

Conclusions and Summary

Education for both providers and patients can help to eliminate perceived and actual disparities, and lead to more effective assessment and management (IOM, 2011). Understanding the role of culture in managing pain is the foundation for patient-centered, quality safe care. Cultural values related to family as well as family support in managing pain are important considerations for Hispanics experiencing pain. Hispanics' disagreement with the statement, "Pain makes me want to be left alone," has not been explored but is congruent with the emphasis on family support in this cultural group, and impacts intervention protocols and planning for the overall hospital experience.

Nonpharmacologic methods require continued investigation. For example, prayer was a pain management strategy reported in two samples including Hispanics (Anderson et al., 2000; McNeill et al., 2001). To improve care, providers must tailor pain management approaches to each person's experience to promote self-management. Collaboration among all team members, then, can coordinate this complex aspect of patient care.

An integrated team approach to improving the pain management of Hispanics in the health care system is imperative. A system approach that establishes pain management as an ethical principle will follow with educational resources to assure the integrated team as well as patients and their families have the information and tools needed to achieve quality outcomes. While reports do not agree whether outcomes of pain management across ethnic groups is equitable and effective, continued research on specific assessment and treatment among Hispanics populations is essential. Establishing consistent goals and assessment strategies can standardize treatment and measurement so that the goals of the STEEEP model are applied throughout the health care delivery system.

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