PAIN MANAGEMENT IN DIVERSE OLDER ADULTS

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About the Presenter

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Pain Management in Diverse Older Adults

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A Community Initiative

“Chronic pain alone affects the lives of approximately 100 million Americans, making its control of enormous value to individuals and society. To reduce the impact of pain and the resultant suffering will require a transformation in how pain is perceived and judged both by people with pain and by the health care providers who help care for them. The overarching goal of this transformation should be gaining a better understanding of pain of all types and improving efforts to prevent, assess, and treat pain.”

(Relieving Pain in America: A Blueprint for Prevention, Care, Education and Research, IOM, 2011)

Learning Objectives

• At the completion of the program the participant will be able to:
  – Articulate the scope of the pain in older adults and disparities in pain management.
  – Describe challenges in the assessment of pain in older adults.
  – Identify unique management considerations managing pain in older adults.
Mrs. Mary Clark, a 62 year old African-American widow, lives alone in subsidized housing. She was diagnosed with hypertension, arthritis and obesity by her primary care provider (PCP) several years ago. Her PCP retired two years ago and she has not received care since.

Mrs. Clark was found down in her hallway. A neighbor called 911 and she was brought to the ER and admitted to acute care with CHF.

The physicians (mostly European-Americans and ~ 30 yrs. younger than the patient) questioned why Mrs. Clark was not receiving care and "taking better care of (her) self so (she) wouldn’t wind up in the hospital."

Mrs. Clark became defensive. She thought no doctor would take care of her without getting paid. She hasn’t had health insurance since her husband died and doesn’t have money to pay for medicines, even if there was a neighborhood pharmacy.

Mrs. Clark denies pain to her medical team. However, the nurses notice she winces with transfers and has been seen rocking herself in the chair.

When the physicians question her again, she continues to deny she is in pain and says, “I leave everything in the Good Lord’s hands.”

Mrs. Clark is very worried about her medical bills and tells the MSW she’s been using some of her deceased husband’s medicines that are more than 5 yrs old.

Mrs. Clark also tells the MSW that she stays in her apartment all the time because where she lives is dangerous and she’s afraid to go out, "There’s a lot of drug dealing... I’ve seen the damage drugs have done to my community..."

Consider the patient, provider and system barriers to the assessment and management of pain for Mrs. Clark.
Scope of Pain Problem

- Chronic pain affects 100 million U.S. adults exceeding the combined impact of heart disease, cancer and diabetes. (IOM, 2011)
- Direct medical costs and lost productivity related to pain costs between $560 - $635 billion annually; Medicare covers 25% of pain related medical costs. (IOM, 2011)
- Gaps in knowledge, practice, and policy prompted a recent IOM report (2011) to call pain a public health challenge.

Pain in Older Adults

- Prevalence of chronic pain among community dwelling older adults ranges from 18 - 57% (noted in IOM 2011 report).
- Excluding older adults in nursing homes, the prevalence of pain in older adults in last 2 years of life averaged 28%; 1 month before death, pain increased to 46% (Smith et al, 2011).
- Persons with arthritis (60%) were at greater risk for pain than those without arthritis (26%), near time of death (Smith et al, 2011).

Pain in Older Adults (cont)

- 62% of U.S. nursing home residents report pain (IOM, 2011):
  — arthritis is the most common painful condition
  — 17% have substantial daily pain (Teno, 2001)
Older adults, the age group with the highest prevalence of pain, are often excluded from randomized clinical trials, considered the gold standard for testing medications. (Zulman, 2011)

Consequently, the research basis for the pharmacological management of pain in older adults is extrapolated from studies with healthy younger adult subjects, who have few co-morbidities and who do not have age-related organ changes that may affect drug metabolism and drug excretion.

**Challenges in Pain Treatment**

- Self Report is gold standard for assessing pain.
- Self report means a person with pain, when asked or when if volunteers, is capable of reporting/describing symptom.
- Challenges assessing pain in diverse older adults include:
  - How well is a person able to recognize and then communicate his/her pain if severely cognitively impaired, or with aphasia? (cont.)

**Challenges in Pain Treatment (cont)**

- What words does the person use to describe the symptom (hurt, ache, stitch, sore, pain …)?
- Are there language barriers?
- What attitudes or beliefs might the older adult hold that interferes with his/her reporting pain?
- When an older adult denies pain, and there is compelling behavioral information that contradicts this denial, such as with Mrs. Clark, what should the health care worker do?
- Pain intensity or severity is the most commonly reassessed aspect of pain. Many patients have difficulty quantifying this subjective experience on a 0-10 scale.
Methods to Assess Pain

- Pain Intensity Scales:
  - Verbal descriptor (none, mild, moderate, severe, very severe/horrible)
  - Numeric rating scale (e.g., 0-10, 0 = no pain and 10 = worst pain imaginable)

- Behavioral Pain Scales for those unable to report pain
  - Pain Assessment in Advanced Dementia (PAINAD)

PAINAD

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Score</th>
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<tbody>
<tr>
<td>Breathing</td>
<td>0</td>
</tr>
<tr>
<td>Independent of vocalization</td>
<td>Normal</td>
</tr>
<tr>
<td>Vocalization</td>
<td>None</td>
</tr>
<tr>
<td>Face expression</td>
<td>Smiling</td>
</tr>
<tr>
<td>Body language</td>
<td>Relaxed</td>
</tr>
</tbody>
</table>


Common Patient Barriers

- Some persons are hesitant to report pain.
- Many older adults believe pain or suffering is normal part of aging that is to be endured.
- Many older adults do not believe pain can be relieved without troublesome side effects, e.g., constipation, cognitive changes, OR without becoming addicted.

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### Pain Assessment Strategies

- Appreciate that how you, your family, or your profession respond to pain may not be the same as others’ responses.
- Act unhurried in your data collection to establish rapport, convey caring, and ensure more accurate information even when you are feeling rushed.
- Physical examination and other tests may help in determining the etiology of the pain when a person unable to provide detailed pain history.

### Pain Assessment cont.

- Avoid leading questions, “Your pain is controlled right?”
- Listen to the words the person uses to describe the pain symptom (e.g. ache, twinge, sore etc.)
- Use the patient’s word to complete your assessment (e.g. location, quality, severity, impact on ADLs, duration, pharmacological and complementary strategies used, aggravating and alleviating factors) and reassessment.

### Pain Assessment cont.

- Interview persons who can report pain.
- Use a medical interpreter if you do not speak the patient’s language, (not a family member) if at all possible.
- Monolingual Chinese persons may read a pain intensity scale displayed vertically, i.e. reading downward, better, rather than horizontally displayed, i.e., reading from left to right (McCaffery, Pasero, 1999).
- Elicit the person’s interpretation of the meaning of the pain, and their hopes and concerns about pain management.
Disparities in Pain Management

- IOM report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (2003) summarized research findings on disparities of analgesic use:
  - African-Americans and Hispanic patients were less likely to receive analgesia than white patients with the same long bone fracture.
  - African-American nursing home residents with cancer were less likely to receive treatment for pain compared with white NH residents.

Unequal Treatment, IOM, 2003

- Minority outpatients with cancer received less treatment when treated at a setting that cared for mostly persons of color, than those who received care at settings that served mostly white patients.
- Minority outpatients with cancer received less analgesia than white patients and the severity of their pain was underestimated by their MDs.
- For post op patients receiving Patient Controlled Analgesia (PCA), Hispanics and Asians had less medication prescribed than whites and African-Americans.

Research Findings re. Pain Management

- 25% of NYC pharmacies in nonwhite neighborhoods vs. 72% of pharmacies in white neighborhoods carried sufficient opioids to treat pain (Morrison et al. NEJM, 2000).
- African-American veterans with arthritis were more likely than whites to report prayer as helpful in managing their pain; their perception of the helpfulness of prayer influenced their decision not to have surgery (Ang et al., 2002).
African-Americans reported higher levels of clinical pain, greater pain-related disability, and demonstrated less tolerance for experimentally-induced ischemic pain than whites treated at a multidisciplinary pain center (Edwards et al., 2001).

African-Americans reported significantly more pain, greater degree of suffering, and less control of pain. In addition, African Americans exhibited greater disability and susceptibility to PTSD, compared to whites treated at a multidisciplinary pain center (Green et al., 2003).

Older Korean female immigrants living in the U.S. with osteoarthritis constructed a meaning of pain that included (Dickson, Kim, 2003) – recognizing western medicine had no magic cure for the pain, – appreciating the comfort of ethnic/folk remedies and – seeing pain as an aspect of aging rather than a symptom of disease.

Puerto Rican (PR) patients with pain treated in a U.S. pain center compared with those treated on the island (Bates et al., 1997) observed: – Anglo-providers’ own cultural assumptions about individualism and self-responsibility contrasted with PR values of collectivism, family, and a holistic view of illness. – Anglo-providers’ practice was based on mind-body dualism (despite giving lip service to integrated approach) and their focus was on treating the pain and not the associated disability. – Judgmental attitudes of staff were evident when patients were expressive in describing pain. These patients were characterized as being “overly emotional.”
**Pain treatment: self management**

- Self management
  - Expectations about pain relief
  - Medication knowledge, informed consent about risks/benefits of opioids for nonmalignant pain, and monitoring for adherence/misuse
  - Exercise and physical modalities, heat/cold, tub bath, swimming.
  - Use of complementary approaches: meditation, massage, yoga, tai chi, music etc.
  - Cultural/family comfort measures

**Pain treatment: Medications**

- Classes of analgesics
  - Non-opioids, e.g. acetaminophen, ASA, NSAIDs, OTC
  - Opioids –
    - In combination with non-opioids, e.g. Vicodin, Percocet
    - Plain (codeine, oxycodone, morphine, hydromorphone, fentanyl, methadone)
  - Co-analgesics/adjuvants, e.g. antidepressants, anti-seizure
- Scheduling of medications
  - Around the clock for persistent pain
  - PRN, as needed for breakthrough pain or incident pain
  - Long acting vs short acting
- Route of administration, oral (by mouth), transdermal (skin patch), suppository (by rectum), or topical (on skin).
- Side effect monitoring

**Pain treatment: Nonpharmacological**

- Non-pharmacological (complementary) interventions include:
  - Rehabilitation Therapies (PT/OT) for exercises, adaptive devices, strengthening, etc.
  - Cognitive/Behavioral Therapy
  - Massage, Feldenkrais
  - Energy work: Reiki, Therapeutic Touch
  - Yoga, Tai Chi
  - Music Therapy
  - Aromatherapy
  - Meditation practices
  - Swimming
  - Walking program
## Summary

- Older adults from diverse communities are at high risk for under recognition and under treatment of pain.
- Untreated pain has significant consequences to physical and psychosocial wellbeing.
- Pain management requires non-pharmacological and pharmacological interventions.

## Web Resources

- **Joint Commission Facts about Pain**
  [http://www.jointcommission.org/assets/1/18/Pain_Management.pdf](http://www.jointcommission.org/assets/1/18/Pain_Management.pdf)
- **National Comprehensive Cancer Network: adult cancer pain guidelines for professionals and consumers**

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References


References


References

References


References


• Smith AK, Cenzer IR, Knight SJ et. al (2010). The Epidemiology of Pain During the Last Two Years of Life. *Annals of Internal Medicine*, 153: 563-569.

References


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We appreciate your feedback.

NOTE: Continuing Education Participants must complete a final survey in order to receive CEU/CME credit.