

## ARTICLE 1

### **Cultural Aspects of Pain and Pain Management**

By Marcia Carteret

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Even though the assessment and treatment of pain is a universally important health care issue, modern medicine still has no accurate way of measuring it. Patients are often asked to rate their pain on a scale from 1- 10: mild (1-4), moderate (5-6), and severe (7-10). Sometimes smiling and frowning faces are used as visual aids to help both doctor and patient convey what the numbers signify. Cultural differences in response to pain compound the inherent challenges of communication. Although nearly all people experience pain sensations similarly, studies show there are important differences in the way people express their pain and expect others to respond to their discomfort. There are also culturally-based attitudes about using pain medication. An understanding of the impact of culture on the pain experience is important in assuring effective and culturally-sensitive patient care.

**Pain Response & Culture:** It is well established that pain is a highly complex phenomenon that involves biological, psychological, and social variables.<sup>1</sup> Patients' culturally-based responses to pain are often divided into two categories: stoic and emotive. Stoic patients are less expressive of their pain and tend to "grin and bear it." They tend to withdraw socially. Emotive patients are more likely to verbalize their expressions of pain, prefer to have people around and expect others to react to their pain so as to validate their discomfort. We can make the broad generalization that expressive patients *often* come from Hispanic, Middle Eastern, and Mediterranean backgrounds, while stoic patients *often* come from Northern European and Asian backgrounds. If we use such broad generalizations to help understand human behavior, however, we must always keep in mind that while culture is a framework that directs human behavior, not everyone in every culture conforms to a set of expected behaviors or beliefs. Rigid use of generalizations leads to cultural stereotyping which in turn can lead to serious inaccuracies. Any individual's experience of pain will manifest itself in emotional and behavioral responses particular to his or her culture, personal history, and unique perceptions.

**American Culture & Pain Response:** For western health care professionals it is important to understand how our own culture affects the attitudes we may hold about pain. Only through this self-awareness can we establish a basis for comparison that allows us to see where our attitudes and beliefs are likely to collide with those of patients who come from very different cultures. We are apt to believe that our reaction to pain is "normal" and anything substantially different is "abnormal". For example, a doctor or nurse raised

in a family that encouraged stoicism may not know how to react to a patient who responds to pain with loud verbal complaints and may even discount such “overly expressive” reactions. There is a long tradition of stoicism in European American culture; generations of children, especially boys, would be admonished for crying like babies but applauded for keeping a stiff upper lip. In general, people made as little fuss as possible over injuries and illness. Naturally, children socialized in this way will grow up to be “easy patients” who behave in ways consistent with the values of the western medical system. On the other hand, there are cultures where a child’s crying immediately elicits the greatest sympathy, concern, and aid. In such cultures, children’s health is fretted over constantly – even a sneeze can be seen as illness. This predisposes children to become more anxious about their health in general, and as adults, they may need greater reassurance from caregivers even in the face of minor symptoms. In general, when people are ill they revert to childhood behavior. If complaining brought them attention as children, they will likely complain out of habit as adults – even if the desired results are not forthcoming from the caregivers around them.

**Asian Culture & Stoicism:** Patients from Asian cultures may often exemplify stoicism in the face of pain, which relates directly to strong cultural values about self-conduct. Behaving in a dignified manner is considered very important, and a person who is assertive or complains openly is considered to have poor social skills. This behavior might be tolerated in very small children, but not in adolescents and adults. In traditional Asian cultures, preserving harmony in interactions with others is very important, so an individual should never draw attention to himself, especially in negative ways. Though an individual may feel sadness or pain, it is not customary to make this obvious. On a related note, some Asian patients will be socialized to observe status differences between people and will avoid making demands of health care professionals for this reason. Asian societies have traditionally emphasized status differences between people based on variables such as age, sex, education, and occupation. A doctor or nurse will most surely be seen as a person of high status, not to be questioned or bothered with complaints about discomfort.

**Putting Pain Into Words:** The limitations of language to convey experience – even between people who speak the same language – are extremely obvious when we can’t explain something as important as the intensity of pain we feel or the unrelenting worry and frustration pain sometimes causes. To further complicate communications, not all cultures describe pain in the same way. Words such as “sharp,” “throbbing,” “stabbing,” or “aching” make sense to most people in the U.S., but in many tribal cultures stories or symbols are essential in relating one’s worldview, so very different words are used to describe pain. Clinicians might be baffled by patients explaining their pain in terms of natural symbols like lightning, trees with deep spreading roots, spider webs, or the tones of drums and flutes.<sup>2</sup> In cultures where evil spirits are believed to cause illness and pain, patients may talk about their suffering as punishment. Indeed, some patients will need

help in understanding how to talk about pain in ways western doctors and nurses can interpret. Through careful listening and probing health care professionals will uncover what is really happening with each patient's pain. Keep in mind that referencing pain measurement tools that rely on numbers or any kind of linear format, such as a row of faces, won't work equally well across cultures. People in some cultures attach great superstition to particular numbers, and smiling does not suggest feeling good in *all* cultures. In fact, in some Asian cultures, people tend to smile when they are embarrassed or angry.

**Religious and Spiritual Aspects of Pain:** In many cultures around the world where belief in fate and karma are strong, people often believe illness and injury are caused by a higher power. In many cases, the acceptance of pain is important in demonstrating a person's religious faith. In one case, a Nigerian refugee to the U. S. suffered a severe knee injury and underwent arthro-miscroscopic surgery. His American nurse waited for him to request pain medication, but he never did. Being Muslim, he offered his pain to Allah in thanks for the good fortune of being allowed the special surgery.<sup>3</sup> In a similar case, a Filipino patient hospitalized for shoulder surgery admitted to his nurse that he was in severe pain. However, he wasn't taking his pain medication because he believed it was God's will that he had such pain, and God would give him the strength to bear it.<sup>4</sup> A similar stoicism in the face of pain may be common among Buddhists who believe acceptance of suffering leads to spiritual growth. Among some Native Americans, the blessing of medications by a tribal medicine man puts a patient more at peace with the creator which in turn makes the medicine "stronger".

### **Cultural Perceptions of Pain Treatments:**

A tendency to discount immediately the sort of cultural practices and beliefs mentioned above can be countered by invoking the placebo effect, which is well-documented. There is also its opposite – the "nocebo effect" where a person who *dis*believes in a treatment experiences a worsening of symptoms due to pessimism about getting well. What motivates people's reactions to placebos is interesting in how it parallels different cultural perceptions and expectations around medicines in general. Are shots more effective than pills? Does a bigger pill work better than a smaller one? Is bitter medicine stronger and more effective than medicine that tastes good? Answers to questions like these are indeed often dependent upon cultural background. In some cultures, people believe that the more intrusive a procedure is, the better it is for them. So, an intravenous pain medication would be preferred to narcotic analgesic tablets even if the tablets were highly effective. In some countries, injections are very common; so a Cambodian patient, for example, might believe that without an injection, treatment is inadequate. A Filipino or East Indian patient might reject pain medications altogether out of fear of harmful effects, including addiction. Clearly, it is important to explain the rationale behind use of pain medication to all patients, and to ask patients from different cultural backgrounds which type of medication is preferred in their culture. Also, how do they feel about taking pain

medications *personally*? Since cultural and/or religious reasons may inhibit someone from asking for pain medication, it is often necessary for doctors and nurses to anticipate a patient's pain needs and to initiate important discussions.

**Conclusion:** Part of understanding our own culturally-based attitudes about pain includes gaining awareness of the things we take for granted. We have come to expect pain management as part of proper treatment in the U.S., but in many countries pain medications aren't readily available or affordable. Or, their use may be stigmatized - as being self-indulgent, addictive, etc. An appreciation of the influence of culture on affective responses to pain and expectations for pain treatment is critical to culturally responsive management of people in pain. The role of the health care provider is to help patients advocate for what feels appropriate for them within their cultural context. □

**For more information on this and related topics visit [www.dimensionsofculture.com](http://www.dimensionsofculture.com)**

### References

1. Michelle A. Fortier, M., Cynthia T. Anderson, C. and Kain, Z. *Ethnicity Matters in the Assessment and Treatment of Children's Pain* PEDIATRICS Vol. 124 No. 1 July 2009, p. 378
2. Burhansstipanov L. Lessons Learned from Native American Cancer Prevention, Control and Supportive Care Projects. *Asian American and Pacific Islander Journal of Health*. Summer- Autumn 1998: vol. 6. No. 2. pp. 91-99.3,4 *Geri-Ann* 3,4. Galanti, *Caring for Patients from Different Cultures* (Philadelphia: University of Philadelphia Press, 1997 p. 35

## **ARTICLE 2**

### **All CCHAP-affiliated Practices Now Can Receive TELEPHONE CONSULTATION ON MENTAL HEALTH ISSUES FOR CHILDREN ON MEDICAID**

Rick March is a child psychiatrist who has received grant monies to provide phone consultation regarding children and adolescents with mental health problems throughout Colorado. He has over twenty years experience in child psychiatry and is available weekdays during regular business hours. If you do not reach him directly, he would be able to speak with you, at the outside, by the next business day. Dr. March is at the Mental Health Center of Denver which provides services for children who live in Denver County. However, he may be able to arrange to see other patients outside this catchment area, possibly in your practice in very difficult cases. He is also available to provide educational presentation for your providers on a wide variety of mental health topics.

His direct line is 303-504-1500

**So, telephone consultation from a child psychiatrist for Medicaid children cared for in a CCHAP-affiliated practice is now available in all counties in Colorado.**

For Boulder and Jefferson Counties – Don Bechtold, MD – 303-432-5172

For Adams, Arapahoe and Douglas Counties – Joe Pastor, MD – 303-853-3888

For all other counties (including Denver) – Rick March, MD – 303-504-1500

## **ARTICLE 3**

### **INTRODUCING THE CCHAP QUICK REFERENCE LINK!**

Do you need to know the one telephone number to call for a Medicaid mental health referral? Want to reach the CCHAP social worker? Need help in finding resources for a special needs child? Having trouble remembering all of the 14 support services CCHAP provides for your practice? We have a quick reference link for your desk top! For these things and many more...

Recently, our advisory group of physicians and practice administrators suggested an idea for a quick and easy way to access CCHAP affiliated resources for frequently used contacts and services. We liked the idea and have developed a web link that will quickly access a single page that contains contact information as well as additional links to documents and web pages. The goal is to have a computer desktop shortcut that, with just a click or two, will provide CCHAP affiliated providers and staff with the information you need, when you need it.

Because this new tool is for you, we want it to be pertinent and efficient. So please, if you have ideas as to how to improve on this, contact Kevin Heckman [heckman.kevin@tchden.org](mailto:heckman.kevin@tchden.org) or 720.777.6309, our Program Administrator, with your feedback and suggestions. Thanks!

#### **INSTRUCTIONS:**

1. Click on this link <http://www.cchap.org/qr/> to open the Quick Reference Link web page (Note: you can also type this address into a web browser manually).
2. In your browser window menu (upper left corner) click File>Send>Shortcut to Desktop.
3. The Quick Reference Link is available from any computer with internet access.

Kevin C. Heckman  
Program Administrator  
CCHAP  
720.777.6309

## ARTICLE 4

### Quality Improvement Made Easier

If the phrase “Quality Improvement” (QI) causes you a bit of distress, you are not alone. The reality is that effective QI doesn’t have to be implemented on a grand scale, nor does it have to be difficult. Plus, CCHAP is here to help!

No doubt, your practice has already implemented QI projects. Perhaps you didn’t even think of them as “Quality Improvement” because the new or “tweaked” process seems logical, necessary, and efficient.

When we talk about QI, the discussion is really about enhancing the value or excellence of something (for example, a process or a procedure) through a systematic approach.

Making QI easy:

- Medicaid asks that your practice do a quick practice self-assessment, The Medical Home Index (MHI). As you do the MHI you will naturally think of things you would like change or adjust. QI simply involves working together as a team to discover logical and efficient ways to improve effectiveness, efficiency, ROI, communication, performance, etc. in your topic area.
- Be SMART about it! Make sure that your goals are SMART Goals. A SMART Goal is Specific, Measurable, Achievable, Realistic and Timely.
- Plan-Do-Study-Act (PDSA) is a widely accepted model for the implementation of a QI project. It is a relatively simple and effective way to evaluate and improve current or future processes by planning what you want to do, implementing the plan, studying the results, and then acting on your findings in order to produce better outcomes.

Your QI Coach is here to help take the hassle out of QI by offering **FREE technical assistance**. Practices will be assisted in developing continuous quality improvement programming and making any changes they feel they want to make to improve efficiency or to improve their “medical home-ness.”

Want to get started? Contact Angie Goodger at [angela@cchap.org](mailto:angela@cchap.org)

## **ARTICLE 5**

### **Practice Manager's Corner**

**Kevin Heckman**

#### **SYNAGIS UPDATE AND GOOD NEWS!**

Effective December 1, 2009, the Medicaid reimbursement for Synagis has been increased to \$954.56!

Medicaid protocols for Synagis have been updated as of November 1st. The new policy is based on the American Academy of Pediatrics (AAP) 2009 and the Colorado Chapter of the AAP recommendations for Respiratory Syncytial Virus (RSV) prophylactic therapy. Synagis® is used to prevent serious lower respiratory tract disease caused by RSV in pediatric patients at high risk for RSV disease. Synagis® is administered by intramuscular injections, at 15 mg per kg of body weight, once a month during expected periods of RSV frequency in the community. Please refer to the November 2009 Medicaid Provider Bulletin for complete details. The bulletin is available on line at:

<http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1246972411343>

#### **Add-A-Baby Requests**

(Reprinted from Medicaid Provider Bulletin November 2009)

On October 1, 2009, the Department began accepting all Add-A-Baby requests for processing. Although the eligibility sites will continue to be able to add babies to Medicaid upon request, the Department is giving providers an alternative means to making babies eligible within five business days of the form request being received.

Providers can submit the Add-A-Baby form to the Department in three different ways:

1) An email submission can be sent by completing the [Add-A-Baby Form](#) (Fill-in) located under "Other Forms" in the Provider Services [Forms](#) section and emailing it as an attachment to [add-a-baby@hcpf.state.co.us](mailto:add-a-baby@hcpf.state.co.us). The email must be encrypted for security purposes, please follow the instructions below:

##### **How to encrypt the Add-A-Baby form:**

- a. In Microsoft Word, select the **Tools** option from the menu bar
- b. Select **Options...** from the drop down menu
- c. Click on the Security tab and enter "hcpf" in the **Password to open:** field located in the **File encryption options for this document** section
- d. Click OK

2) Submit the completed form by fax to the Department at 303-866-4517, Attention: Shawna Moreno or mail the completed form to Health Care Policy and Financing, 1570 Grant Street, Denver CO, 80203, Attn: Shawna Moreno. The standardized [Add-A-Baby Form](#) (Print and Fax/Mail) is available under "Other Forms" in the Provider Services [Forms](#) section and as Attachment A of this bulletin.

3) An online form is available through the [Clients & Applicants](#) section of the Department's Web site. Click on [Report the birth of a Medicaid or CHP+ baby online](#)

under the “**I am a Medicaid/CHP+ client, how can I report the birth of my newborn?**” question.

Please note that the Department will only accept the official form for Add-A-Baby requests. We ask that providers do not alter the form in any way, since all of the information on the form is needed to process the requests.

Please contact Shawna Moreno at [shawna.moreno@state.co.us](mailto:shawna.moreno@state.co.us) or 303-866-4456 if you have any questions.

## ARTICLE 6



Cavity Free at Three is a statewide effort aimed at improving oral health in children and pregnant women. We are working with CCHAP to offer our program model to interested participants. Recent Medicaid guidelines allow primary caregivers to provide oral health counseling along with fluoride varnish application and receive reimbursement for these services. In order to participate, the medical provider as well as staff members involved in this provision of care should complete online training through the Smiles for Life Curriculum.

Simply visit <http://www.smilesforlife2.org>, and complete Module 2:Child Oral Health and Module 6: Fluoride Varnish. After the online process is completed, we plan a coordinated effort for site visit based training opportunities offering hands on demonstrations as well as follow up and support of our program.

We are in the process of coordinating training opportunities throughout the state of Colorado beginning early 2010. This will allow for representatives from your group to attend trainings in your area. If you are interested in hosting a training, or learning more about Cavity Free at Three opportunities, please contact Anita Rich at [rich.anita@tchdenver.org](mailto:rich.anita@tchdenver.org). If you have questions specific to our program, please contact [karen.savoie@ucdenver.edu](mailto:karen.savoie@ucdenver.edu) or visit <http://cavityfreeatthree.org>. Thank you.

## **ARTICLE 7**

### **Medical Home Certification**

Around 50 of the 150 pediatric and family practices that CCHAP currently works with are in the process of obtaining “medical home certification.” The Colorado Department of Health Care Policy and Financing (HCPF), which administers Medicaid in Colorado, is directed by Senate Bills 07-130 and 07-211 to document that children on Medicaid receive care in a quality medical home. So, HCPF is asking practices that are receiving the enhanced reimbursement (as a CCHAP – affiliated practice) to obtain Medical Home Certification to document the quality of the medical home they provide to children on Medicaid. Practices that have affiliated with CCHAP in the past 8 months have already begun the certification process. The remaining CCHAP-affiliated practices will be asked to begin the certification process very soon.

Medical home certification is a three step process. The CCHAP orientation is step one. The following **two steps** also need to be for practices that were oriented in the past and are already receiving the enhanced reimbursement. Each CCHAP-affiliated practice will be asked to:

- Conduct a self-assessment survey of practice staff and providers called the Medical Home Index. This brief survey seeks to determine your perception of how well you are doing in providing a medical home. The survey also will be given to some parents in your practice.
- After reviewing your survey results, you will be asked to select some aspect of “medical home-ness” to improve using a quality improvement process. CCHAP staff is available to coach you through the quality improvement process if you wish and we have QI projects already prepared for you to implement easily in your practice if you wish. You may already have QI projects going, which will likely meet this objective.

### **Medical Home**

The American Academy of Pediatrics and the American Academy of Family Practice have promoted the concept of a medical home for many years now. A recent combined statement by the two academies reaffirmed their support of the concept. The Academies believe that all children should have a medical home where care is accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. For a reminder of the American Academy of Pediatrics and the American Academy of Family Medicine description of a medical home for children, visit [www.cchap.org/nl33/#7](http://www.cchap.org/nl33/#7)

And if you want someone to come to your office to present a more description of what a medical home is and does, please contact: Anita Rich ([Rich.Anita@tchden.org](mailto:Rich.Anita@tchden.org)) or Angie Goodger ([angela@cchap.org](mailto:angela@cchap.org)) for more information.

### **Medical Home Index**

Starting in April 2009, recently oriented CCHAP practices began the process of Medical Home Certification. The Medical Home Index is completed at a group meeting of your

practice with as many of the practice staff and providers as possible. During this meeting the group will complete a Medical Home Index self-assessment, discuss how each indicator rated relates to a quality Medical Home. The facilitator will conduct informal interviews of families coming to your practice that day asking them to assess the practice's medical "homeness." For a look at the medical home index visit [www.cchap.org/nl33/#7](http://www.cchap.org/nl33/#7)

### **Quality Improvement Projects**

Within a few weeks after the practice takes the MHI, you will be contacted by a Quality Improvement Coach with CCHAP. At that time, you will receive your Medical Home Index results, as well as guidance as to how to interpret the results. HCPF asks that you select an element of being a medical home that your practice wishes to work on. The Quality Improvement Coach from CCHAP – at no cost to your practice – is available to help you decide what your practice would like to work on, develop strategies for making the changes you want to make, and measure the effectiveness of the resultant changes.

The higher reimbursement practices receive for preventive care is the reward for your practice's commitment to providing a quality Medical Home for children on Medicaid.

### **AAP and AAFP Board Certification for pediatricians and family physicians**

Both the AAP and the AAFP require that all physicians, when they recertify, develop a quality improvement project in their practice as part of their recertification. So, CCHAP is helping you obtain both professional board certification and Colorado Medicaid medical home certification.

### **For more information**

Shortly, we will be expanding the Medical Home Certification process to all CCHAP practices. More information will follow. You may also contact Anita Rich ([Rich.Anita@tchden.org](mailto:Rich.Anita@tchden.org)) or Angie Goodger ([angela@cchap.org](mailto:angela@cchap.org)) for more information.