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INCREASING EQUITY IN PAIN MANAGEMENT, SUBSTANCE USE DISORDER TREATMENT, AND LINKAGES TO CARE

A RESOURCE GUIDE FOR HEALTH CENTERS

WELCOME

Welcome to *Increasing Equity in Pain Management, Substance Use Disorder Treatment, and Linkages to Care: A Resource Guide for Health Centers*

Purpose

The purpose of this Resource Guide is to support health center care teams in providing equitable, compassionate, high-quality care for patients in the contexts of pain management, substance use disorders (SUDs), and meaningful linkages to care. Inside, you will find actionable strategies and resources to help your care team reduce health disparities and advance health equity among minoritized and stigmatized people who, due to historical and structural injustices, are more vulnerable to undertreatment and mistreatment of pain and SUDs.

Background

This Resource Guide is based on the findings from a February 2023 convening of 25 experts in health equity, pain management, and SUD treatment, and who represented communities and organizations from across the United States. During the two-day convening, this group of experts provided diverse and critical perspectives on key topics and resources for providing compassionate and equitable, high-quality care to patients experiencing pain, SUDs, or both. The meeting was a collaboration among the National Association of Community Health Centers, the National Health Care for the Homeless Council, and The Fenway Institute, with funding from the Centers for Disease Control and Prevention.

Learning objectives

After using this Resource Guide, health center care teams will be able to:

- Demonstrate increased awareness and understanding of health equity, implicit bias, intersectionality, cultural humility, and harm reduction
- Apply strategies for providing patient-centered, strengths-based, and trauma-informed care with patients experiencing pain, SUDs, or both
- Access additional evidence-based resources and best practices for providing equitable pain management, SUD treatment, and meaningful linkages to care

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HOW TO USE THE RESOURCE GUIDE

To navigate the Guide, use the Table of Contents to go directly to a section.

This Guide also includes special features that provide additional insight and resources. Each feature is associated with an icon for easier identification and navigation. These features are described below.



PATIENT PERSONAS

Patient personas are stories representing the human experience of being a patient who experiences systemic injustices. These personas offer an opportunity to “walk in the shoes” of a patient with complex life experiences and health needs. Each persona reflects the unique assets of a patient, as well as their challenges and successes.



VIDEOS

Interspersed throughout the Guide are short video clips of interviews with national experts who provide unique and diverse perspectives on improving health equity within health centers. The videos feature the following advisors:

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RESOURCE LISTS

Accompanying each section is a list of resources for further learning, training, and action.



ONE THING YOU CAN DO TODAY

At the end of each strategy, you will find an idea for one thing you can do today to improve health equity at your health center.

DISPARITIES

IN PAIN MANAGEMENT AND SUBSTANCE USE DISORDER TREATMENT

Chronic pain is common among U.S. adults



Nearly **52 million** people in the U.S. are living with chronic pain.¹



Millions of Americans misuse opioids

9.2 million Americans misused prescription opioids or used heroin in the last year; 5.6 million Americans had an opioid use disorder in the last year.⁵

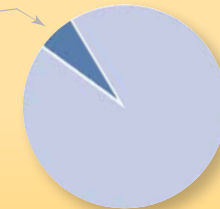


Many Americans receive opioid prescriptions through primary care

Primary care providers prescribe about 37% of all opioid prescriptions.²

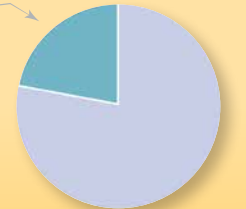
Substance use disorder (SUD) is undertreated in the U.S.

6.3%
Received SUD treatment



Of the 41.1 million people in the U.S. with a SUD in the past year, only 2.7 million (6.3%) received any SUD treatment.⁵

22.3%
Received medication for opioid use disorder



Of the 2.5 million people with an opioid use disorder in the past year, only 22.3% received medication for opioid use disorder.⁶

In the U.S., pain is not equitably assessed

After cesarean birth, Black/African American, Asian, and Hispanic/Latino women have fewer documented pain assessments than non-Hispanic white women.³



Hispanic/Latino people are 30% less likely than non-Hispanic/Latino white people to receive opioids for non-traumatic/non-surgical pain.⁴

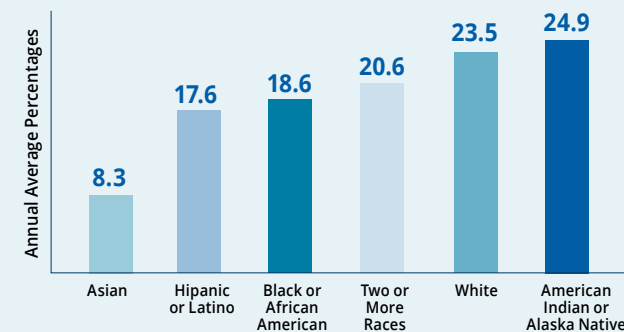


Black/African American people are 22% less likely than white people to receive any type of pain medications for non-traumatic, non-surgical pain.⁴

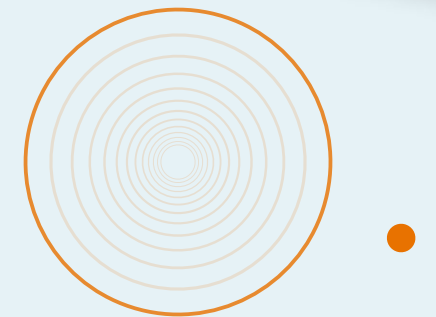


In the U.S., pain treatment is not equitably prescribed

There are racial/ethnic disparities in treatment for substance use disorders



Among all people in the U.S. who needed treatment for a drug use disorder,⁷ people who were Asian, Hispanic/Latino, and Black/African American had lower treatment utilization than white people.⁸



In the U.S., Black/African American people are 14 times less likely to receive medications for opioid use disorder than white people.⁹

1 Rikard SM, Strahan AE, Schmit KM, Guy GP Jr. Chronic pain among adults — United States, 2019–2021. MMWR Morb Mortal Wkly Rep 2023;72:379–85.

2 Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical practice guideline for prescribing opioids for pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95.

3 Johnson JD, Asiodu IV, McKenzie CP, et al. Racial and ethnic inequities in postpartum pain evaluation and management. Obstet Gynecol. 2019;134(6):1155–62.

4 Meghani SH, Byun E, Gallagher RM. Time to take stock: A meta-analysis and systematic review of analgesic treatment disparities for pain in the United States. Pain Med. 2012;13(2):150–74.

5 Center for Behavioral Health Statistics and Quality. Key substance use and mental health indicators in the United States: Results from the 2021 National Survey on Drug Use and Health. Substance Abuse and Mental Health Services Administration; 2022.

6 Jones CM, Han B, Baldwin GT, Einstein EB, Compton WM. Use of medication for opioid use disorder among adults with past-year opioid use disorder in the US, 2021. JAMA Netw Open. 2023;6(8):e2327488.

7 Drug use refers to the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, and methamphetamine, as well as the misuse of prescription pain relievers, tranquilizers, stimulants, and sedatives.

8 Center for Behavioral Health Statistics and Quality. Racial/ethnic differences in substance use, substance use disorders, and substance use treatment utilization among people aged 12 or older (2015–2019). Substance Abuse and Mental Health Services Administration; 2021.

9 Jones CM, Han B, Baldwin GT, Einstein EB, Compton WM. Use of medication for opioid use disorder among adults with past-year opioid use disorder in the US, 2021. JAMA Netw Open. 2023;6(8):e2327488.



PATIENT PERSONA: Diana

Diana is a 57-year-old divorced woman of Mexican descent who works as a floating lab tech for a large healthcare system in the Midwestern U.S. Diana provides financial support to her 80-year-old mother and helps to watch her 3 grandchildren on the weekends. For work, Diana commutes to multiple labs across the city. Diana has long wanted to return to school to become a nurse, but cost and time constraints have prevented her from doing so. In addition, Diana lives with chronic pain from fibromyalgia, degenerative joint disease of the neck and spine, and moderate arthritis in her right hip and bilateral knees. Her arthritis frequently flares up when she works more than 8 hours a day. To reduce her symptoms, Diana eats healthy food and uses integrative health practices, such as group acupuncture and yoga, both of which she accesses at the local community center. Despite these efforts, Diana's pain prevents her from sleeping well at night. She has found that taking high-dose hemp-based cannabidiol with a single tablet of hydrocodone-acetaminophen can minimize her pain enough to improve sleep. Her primary care provider, however, will not prescribe hydrocodone-acetaminophen for long-term use. Because of sleep deprivation due to untreated chronic pain, Diana has been making mistakes at work. She now worries she will lose her job.



Reflections and questions

- How does Diana's persona represent a unique, yet also universal story of the intersection of pain, substance use, and social and health inequities?
- As you navigate through this Resource Guide, think about Diana's story and ask yourself how the information and resources presented here could help address Diana's needs.

STRATEGIES FOR HEALTH CENTER CARE TEAMS

STRATEGY:

Learn about Health Disparities and Health Equity

Why focus on health equity?

Racial, ethnic, and additional identity-based health disparities are rooted in historical, systemic, and structural injustices.¹ Health equity strives to remove economic, social, and other structural barriers while creating and strengthening fair and just practices and structures so that all people can attain optimal health and wellness.

Health center care teams are well positioned to reduce the impact of health inequities on their patients, and to advocate for broader structural and systemic change. This Resource Guide focuses on methods for reducing health inequities among people who experience stigma, discrimination, and marginalization, including but not limited to the communities listed below, and recognizing that people can hold multiple identities:

- People who are Black/African American, Hispanic/ Latino, American Indian/Native American/ Indigenous, and/or Asian American/Pacific Islander
- Lesbian, gay, bisexual, transgender, queer, intersex, asexual, and all sexually and gender diverse (LGBTQIA+) people
- Immigrants and refugees, with and without documentation
- People who have experienced incarceration or are involved with the criminal legal system
- People experiencing housing instability and homelessness
- People with mental illness or cognitive impairment
- People with disabilities

¹ National Academies of Sciences, Engineering, and Medicine. [Communities in action: Pathways to health equity](#). The National Academies Press; 2017.

- People who have experienced violence and other types of trauma
- People who have opioid use disorder (OUD) and/or other substance use disorders (SUDs), or a history of SUDs

Further reading and exploration

To gain a deeper awareness and understanding of health disparities and health equity, care teams can engage in further reading and exploration of these topics. In this section, you will find resources that:

- Define health disparities and health equity
- Explain the root causes of health disparities
- Clarify how addressing health disparities can contribute to the health and wellbeing of all communities
- Review recent governmental goals and policies that have been implemented to decrease health disparities



RESOURCES

Health Disparities and Health Equity

[Addressing Health Equity and Racial Justice within Integrated Care Settings](#).

National Council for Mental Wellbeing and Center of Excellence for Integrated Health Solutions

[Advancing Health Equity](#). The Joint Commission

[Communities in Action: Pathways to Health Equity](#). The National Academies Press

[Disparities in Health and Health Care: 5 Key Questions and Answers](#). Kaiser Family Foundation

[Health Equity and Behavioral Health Integration](#). Agency for Healthcare Research and Quality

[Health Equity Curricular Toolkit](#). American Academy of Family Physicians

[Health Equity Grand Rounds](#). American Medical Association

[Health Equity in Healthy People 2030](#). Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services

[Publications](#) from the National Institute of Minority Health and Health Disparities, National Institutes of Health

[U.S. Health Map](#). Institute for Health Metrics and Evaluation



Eboni Winford lists the reasons why it is important for health centers to be mindful of racial and ethnic disparities.



Visit the [interactive map](#) from the Institute for Health Metrics and Evaluation to see a visualization of disparities in mortality and life expectancy by race/ethnicity, age, and sex in your county.

STRATEGY:

ACCESS Evidence-Based Guidelines and Best Practices for Pain Management and SUD Treatment

Accessing and consistently applying evidence-based guidelines and best practices for pain management and SUD treatment is foundational to providing equitable care. When utilized with a health equity lens, these resources can minimize treatment inequities and disparities.

This section highlights resources and tools developed by the U.S. governmental sources and professional societies for:

- Pharmacologic and non-pharmacologic pain management
- Medication-assisted treatment for opioid use disorder and other SUDs



RESOURCES

Evidence-Based Guidelines and Best Practices

Pain Management Approaches

[Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022](#). Centers for Disease Control and Prevention (CDC)

[Mind and Body Approaches for Chronic Pain](#). National Institutes of Health, National Center for Complementary and Integrative Health

[Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders](#). Substance Abuse and Mental Health Services Administration (SAMHSA)

[Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline](#). American College of Physicians

[Pain Management Best Practices Inter-Agency Task Force Report](#). U.S. Department of Health and Human Services

Treatment for Opioid Use Disorder and Other Substance Use Disorders

[Addiction Medicine Toolkit](#). CDC

[Addiction Medicine Toolkit for Health Care Providers in Training](#). National Institute on Drug Abuse (NIDA)

[Medications for Opioid Use Disorder: Treatment Improvement Protocol \(TIP\) Series 63](#). SAMHSA

[Medications for Substance Use Disorders](#). SAMHSA

[Medications to Treat Opioid Use Disorder Research Report](#). NIDA

[Opioid Overdose Prevention Toolkit](#). SAMHSA

[Opioid Use and Opioid Use Disorder in Pregnancy](#). American College of Obstetricians and Gynecologists

[Providers Clinical Support System: Medications for Opioid Use Disorders](#). SAMHSA and American Academy of Addiction Psychiatry

[Substance Use Resources](#). Agency for Healthcare Research and Quality



On your browser, bookmark the evidence-based guidelines most relevant to your work.

STRATEGY: Recognize Intersectionality and Reduce the Impacts of Implicit Biases

What is intersectionality?

Intersectionality is a concept coined by Kimberlé W. Crenshaw, JD, LL.M., Professor of Law, Columbia University, to describe the overlapping and compounding effects of racial, gender, and class discrimination. Every individual holds interconnected identities (e.g., race, ethnicity, socioeconomic class, gender identity, sexual orientation) that affect their experiences of health and wellness. Rather than being defined by just one identity or social characteristic, each person is the totality of their experiences and identities, as well as all of the associated privileges and oppressions.

Why intersectionality is important for care teams

In healthcare, intersectionality can be used as a framework for providing patient-centered care. Seeing the whole patient, and all of that person's intersecting identities, allows care teams to recognize and reflect on the different advantages and disadvantages that patients bring with them to the care setting. Without considering intersectional identities, care teams run the risk of losing patient trust. Ultimately, an intersectional approach can lead to more holistic, patient-centered, and culturally responsive care.



Kevonya Elzia explains why it is important for providers to see and understand a patient's intersectional identities.

What are implicit biases?

Implicit biases are automatic thoughts about groups of people based on stereotypes. All people have implicit biases, and if left unchecked, these biases can lead to unintended, harmful outcomes. Among healthcare providers, implicit biases can negatively impact decision-making and patient-clinician communication.² Fortunately, there are effective strategies for acknowledging bias, challenging your thinking, and minimizing the harms of implicit bias.

STRATEGIES FOR REDUCING IMPLICIT BIAS^{3,4}

1. Recognize your "blind spots" (identify and acknowledge your implicit biases)
2. Believe that even though implicit biases are automatic and inevitable, you are capable of challenging those thoughts
3. Actively engage in rejecting and countering stereotypes and attitudes by:
 - Creating mental images of counter-stereotypes
 - Intentionally planning to address stereotypical thoughts whenever they appear
4. Engage organizational leadership in:
 - Offering educational training programs to address implicit bias
 - Increasing diversity and inclusion across the organization
5. Use the IMPLICIT mnemonic (see Box: [The IMPLICIT mnemonic](#)) to help remember strategies for overcoming implicit biases
6. Commit to using a [cultural humility lens](#)

2 Edgoose JYC, Quiogue M, Sidhar K. How to identify, understand, and unlearn implicit bias in patient care. *Fam Pract Manag.* 2019;26(4):29-33.

3 National Institutes of Health. Chief Officer for Scientific Workforce Diversity. [Implicit bias.](#)

4 Galinsky AD, Moskowitz GB. Perspective-taking: Decreasing stereotype expression, stereotype accessibility, and in-group favoritism. *J Pers Soc Psychol.* 2000;78(4):708-24.



Eboni Winford explains how people use implicit bias as a mental shortcut to make sense of the world.



Eboni Winford describes a technique she uses from Acceptance-Based therapy to challenge her implicit biases.



Kevonya Elzia identifies an implicit bias of her own about patients who use methamphetamine.



Kevonya Elzia discusses the steps she went through to understand the root of her implicit bias, and to adjust her approach to meeting patients where they are.

THE IMPLICIT MNEMONIC⁵

Introspection. Identify and examine your blind spots. Maintain compassion for yourself while confronting your biases.

Mindfulness. Recognize that people are more likely to use stereotypes and other cognitive shortcuts when under pressure. To improve coping skills, attention, and emotional regulation, try mindfulness techniques like breathing techniques, yoga, and meditation. There are several free and low-cost apps for smartphones that can be used at home or work. YouTube also has short videos that demonstrate seated exercises, yoga, and mindfulness techniques that can be completed at work.

Perspective-taking. Take the first-person perspective of a member of a stigmatized group: e.g., what might it be like to know that people doubt your abilities based on your identity?

Learn to slow down. Pause and reflect on any potential implicit biases prior to engaging with people from stigmatized groups.

Individuation. Gather specific information about the person interacting with you to prevent yourself from activating and applying stereotypes.

Check your messaging. Use terms and language known to create a more inclusive environment.

Institutionalize fairness. Organizational leaders can reduce bias by placing all program ideas and interventions through an equity lens, and by displaying images and using messaging that is counter-stereotypic and promotes equity.

Take two. Recognize that addressing implicit biases is hard work and lifelong work.

⁵ Edgoose JYC, Quiogue M, Sidhar K. How to identify, understand, and unlearn implicit bias in patient care. *Fam Pract Manag.* 2019;26(4):29-33.



RESOURCES

Intersectionality and Implicit Bias

[Combating Implicit and Unconscious Bias toward Transgender and Gender Diverse People.](#) National LGBTQIA+ Health Education Center

[Implicit Association Tests.](#) Project Implicit

[Implicit Bias and Power Imbalances.](#) National LGBTQIA+ Health Education Center

[Implicit Bias Training Course.](#) National Institutes of Health, Chief Officer for Scientific Workforce Diversity

[Intersectionality Resource Guide and Toolkit.](#) UN Women and United Nations Partnership on the Rights of Persons with Disabilities

[Learning to Address Implicit Bias towards LGBTQ Patients: Case Scenarios.](#) National LGBTQIA+ Health Education Center



ONE THING YOU CAN DO TODAY

Take a moment to try to identify one of your blind spots. If you need help in thinking about blind spots, take an [Implicit Association Test](#).



PATIENT PERSONA: Destiny

Destiny is a single 42-year-old transgender Latina woman who works at a clothing store. Growing up, Destiny experienced severe bullying related to her gender expression, including physical violence in school. At 16 years old, when she told her parents that she is transgender, they were not supportive of her, and she left home to stay with friends. She was unable to complete high school and has worked ever since in restaurants and stores to support herself. Destiny has been on gender-affirming hormones (estradiol) since she was 18 years old. She underwent facial feminization surgery at 26 years old, breast augmentation surgery at 31 years old, and vaginoplasty at 36 years old. Her surgical care team prescribed oxycodone for pain management after vaginoplasty. Post-operative dilations triggered Destiny's PTSD related to a sexual assault she experienced at 19 years old when she was working at a restaurant. In the context of this distress, she began overusing prescribed oxycodone, then started obtaining this from the street. Her opioid use progressed to intranasal then IV heroin and fentanyl. She has had two opioid overdoses thus far with resulting hospitalizations. Due to behavioral health workforce shortages, she has not yet been connected to stable outpatient psychopharmacology and psychotherapy services. She mistrusts most providers, due to concern that they will not provide gender-affirming and culturally responsive care. She is open to considering medication assisted therapy for opioid use disorder.



Reflections and questions

- What are Destiny's intersecting identities and lived experiences?
- What are the different advantages and disadvantages that Destiny brings to the care setting?
- How might recognizing Destiny's intersecting identities help you to see Destiny as a whole person and thus provide more patient-centered and culturally responsive care?
- What systemic and structural inequities contributed to Destiny's current situation?
- How might these inequities affect Destiny's trust in, and engagement with clinicians and the healthcare system?
- Did you notice any implicit biases arise while reading this persona?
- What strategies can you use to acknowledge and reduce any implicit biases?

STRATEGY:

Practice Patient-Centered Care Using a Strengths-Based Approach

What is a patient-centered, strengths-based approach to care?

Patient-centered care recognizes the patient as a fully participating member of the care team who is actively involved in setting goals and making decisions relevant to their health and well-being. When creating a care plan, care teams can use a strengths-based approach to identify and amplify what is working well for the patient, rather than focusing on deficits and weaknesses. Importantly, a strengths-based approach enables patients to tap into the resilience they have developed in the face of stigma, trauma, discrimination, and marginalization. Overall, the aim is to collaborate with the patient to recognize the internal strengths and community resources that have helped the patient overcome life challenges, and to integrate those strengths and assets into the care plan.

Using a patient-centered, strengths-based approach to build the care plan

- Ask patients about their strengths and sources of resilience
 - What is going right in the patient's life?
 - What are the assets and strengths of the patient's family and communities?
 - What is the patient already doing that is working right now, and what has worked in the past?



Eboni Winford gives pointers on how to use a patient-centered, strengths-based approach with patients.

- Refer to the [Trauma-informed Care in Behavioral Health Services: Treatment Improvement Protocol \(TIP\) Series 57](#) (page 28) for a list of strengths-oriented questions
- Consider how the care team can reinforce patient strengths and resilience
 - How can you help a patient see their own strengths and worth?
 - How can you empower a patient to access their strengths in order to navigate and manage their health concerns?
- Keep in mind the following strategies and principles
 - Remember that patients are more than their circumstances and their medical condition, and that they are complete and complex human beings
 - Realize that it is often necessary to first build the patient-clinician relationship and gain trust before the patient will share their strengths and values
 - Recognize that patients often overcome multiple barriers just to see their provider, and that this shows resilience and determination
 - Recognize that patients may come from communities that face great adversity and marginalization, and that these communities often demonstrate strength and resilience
 - Acknowledge that the health care system needs to become more resilient and flexible to accommodate patients
 - Consider co-facilitating support groups in order to help level the power imbalance between clinicians and patients, and to make time to hear more about patients' lives
- Build the care plan based on patient strengths and goals
 - Ask the patient about their health goals, priorities, and what they most value
 - Learn how each patient defines wellbeing
 - Do not assume that your goals for the patient's wellness are the same as the patient's goals
 - Create the care plan in collaboration with the patient
 - Build the care plan based on the patient's individual strengths, community assets, values, goals, and priorities
 - Avoid letting your own expertise take over the need to keep the patient front and center
 - Partner with the patient to identify potential barriers to achieving their health goals, and help the patient access services to navigate those barriers



Kevonya Elzia describes her process of using a strengths-based approach with patients who are struggling with chronic pain or substance use.



Sharad Kohli describes how clinician participation in support groups can lead to more patient-centered care.

Using person-first language

Using person-first language is an effective communication strategy to help move from a deficits-based to a strengths-based approach. Person-first language leads with the person rather than with the diagnosis, disability, or circumstances. In other words, person-first language humanizes the patient as someone who has an illness/condition, etc., rather than stigmatizing the patient as someone who is the “problem.”

DO Use

Person who uses drugs, injects drugs, has a lived experience of substance use disorder

Person experiencing homelessness

Person diagnosed with diabetes

Patient requesting medical treatment for pain

Person who is incarcerated

Person living below the poverty line, with lower income

DON'T Use

Drug abuser, addict, user

Homeless person

Diabetic

Drug seeker

Inmate, prisoner

Impoverished person, poor person



Kevonya Elzia explains how person-first language humanizes patients.



Eboni Winford describes the benefits of person-first language, and how it centers the care on the patient.



RESOURCES

Strengths-Based Care and Communication

[Improvement Protocol \(TIP\) Series 57](#). Substance Abuse and Mental Health Services Administration

[Inclusive Communication Principles: Preferred Terms for Select Population Groups and Communities](#). Centers for Diseases Control and Prevention (CDC)

[Person-Centered Language “Style Guide”](#) National Association of Community Health Centers and the Association of Asian Pacific Community Health Organizations

[Remove Stigma: Talk with Your Patients About Substance Use Disorder](#). CDC

Gottlieb LN. [Strengths-based nursing](#). Am J Nurs. 2014;114(8):24-32 (article); Gottlieb LN and Gottlieb B. [Strengths-Based Nursing Care: Health and Healing for Person and Family](#). Springer; 2012 (book)

[Trauma-informed Care in Behavioral Health Services: Treatment](#)

[Words Matter: Preferred Language for Talking About Addiction](#).

National Institute on Drug Abuse

Caveats for person-first language

When people see their disability, diagnosis, or circumstance as a key part of their identity, they may prefer using identity-first language over person-first language. For example, some people refer to themselves as “autistic” or “neurodiverse,” rather than as “a person with autism.” In general, care teams can start with person-first language, while also listening to how patients refer to themselves, and then mirroring the patient’s language. If you are unsure of the appropriateness of mirroring a term, you can ask your patients if they want you to use that term.



ONE THING YOU CAN DO TODAY

Read the patient persona about [Destiny](#) and think about her strengths and assets, and how they can be leveraged for a care plan that meets Destiny’s health goals. Consider how this approach could be used with one of your patients.

STRATEGY:

Practice Trauma-Informed Care

Why is trauma-informed care important?

Many health center patients have experienced trauma in their lives, which can manifest as chronic pain, SUD, or mental illness. If health centers do not recognize and respond to patient trauma, they are unlikely to gain the trust necessary for the patient to engage and remain in care and services. Minoritized and stigmatized patients may already have little trust in the healthcare system, due to personal or historical racism and other forms of discrimination. The experiences of racism, discrimination, and oppression can be traumatic experiences. To achieve health equity, it is therefore critical for organizations to apply a trauma-informed approach with a focus on building relationships and trust with patients.

What is trauma-informed care?

Trauma-informed care is an organizational-level approach to providing care and services that are oriented towards healing and resilience. To become trauma-informed, organizations seek to do the following:⁶

- Realize the widespread impact of trauma and understand paths for recovery
- Recognize the signs and symptoms of trauma in patients, families, and staff

⁶ Trauma-Informed Care Implementation Resources Center. [What is trauma-informed care?](#) Adapted from the Substance Abuse and Mental Health Services Administration's "Trauma-Informed Approach.")



Sharad Kohli discusses the manifestation of trauma as pain and substance use, and the importance of using a trauma-informed and relational approach to rebuild trust for patients so that they will engage in care.

- Integrate knowledge about trauma into policies, procedures, and practices
- Actively avoid re-traumatization

Core principles of trauma-informed care

The process of becoming trauma-informed involves ongoing work towards aligning your organizational mission, culture, policies, and practices with the following core principles:

- "Safety: Throughout the organization, patients and staff feel physically and psychologically safe.
- Trustworthiness and transparency: Decisions are made with transparency, and with the goal of building and maintaining trust.
- Peer support: Individuals with shared lived experiences are integrated into the organization and viewed as integral to service delivery.
- Collaboration: Power differences — between staff and patients and among organizational staff — are leveled to support shared decision-making.
- Empowerment: Patient and staff strengths are recognized, built on, and validated — this includes a belief in resilience and the ability to heal from trauma.
- Humility and responsiveness: Biases and stereotypes (e.g., based on race, ethnicity, sexual orientation, age, geography) and historical trauma are recognized and addressed."⁷

Further reading and exploration

Becoming a trauma-informed clinician and organization takes time, involves many phases of implementation, and requires engagement of organizational leadership. The resources in this section offer information, tools, training, guidelines, and interventions to support implementation of trauma-informed care. These resources can be shared with leadership and champions of trauma-informed care.

⁷ Trauma-Informed Care Implementation Resources Center. [What is trauma-informed care?](#) Adapted from the Substance Abuse and Mental Health Services Administration's "Trauma-Informed Approach.")



Kevonya Elzia explains how, in order to be effective, trauma-informed care principles must inform care engagement at multiple levels: between clinicians and patients, across the organization, and during staff interactions with each other.



Eboni Winford describes the importance of recognizing the history of oppression and medical trauma when caring for minoritized and stigmatized populations.



Naomi Windham explains how power differentials between patient and provider play a role in trauma-informed care.



Eboni Winford, who prefers the term "trauma-responsive care," explains the importance of having representation of the community on staff (e.g., peer specialists) in order to help build trust and create a sense of psychological and physical safety for patients.



RESOURCES

Strengths-Based Care and Communication

[Concept of Trauma and Guidance for a Trauma-Informed Approach.](#) Substance Abuse and Mental Health Services Administration (SAMHSA)

[E2i: Interventions to Identify and Address Trauma.](#) Ryan White HIV/AIDS Program, Health Resources and Services Administration, HIV/AIDS Bureau

[Fostering Resilience and Recovery: A Change Package.](#) Kaiser Permanente and the National Council for Mental Wellbeing

[Healing Centered Restorative Engagement.](#) MENTOR

[Incorporating Peer Support Into Substance Use Disorder Treatment Services.](#) SAMHSA

[Incorporating Racial Equity into Trauma-Informed Care.](#) Center for Healthcare Strategies (CHS)

[National Center on Domestic Violence, Trauma, and Mental Health.](#) National Center on Domestic Violence, Trauma, and Mental Health

[Practical Guide for Implementing a Trauma-Informed Approach.](#) SAMHSA

[Supporting People with Lived Experience.](#) National Health Care for the Homeless Council (NHCHC)

[Trauma-informed Care in Behavioral Health Services: Treatment Improvement Protocol: \(TIP\) Series 57.](#) SAMHSA

[Trauma-Informed Care Webinar Series.](#) NHCHC

[Trauma-informed Care Implementation Resources Center.](#) CHS

[Trauma-informed Care Champions: From Treaters to Healers.](#) CHS

[Trauma Informed Care: Improving Services, Saving Lives.](#) AIDS United and Christie's Place



Naomi Windham describes the resources and modalities used to improve trauma-informed care at her organization.



Kevonya Elzia offers an example of a trauma-informed late policy that gives options to patients who arrive late to appointments. She also stressed the importance of assessing and addressing the structural barriers that cause patients to miss visits or arrive late.

ONE THING YOU CAN DO TODAY

If your organization does not provide trauma-informed care training to all staff members, talk to your supervisor, department head, or other organizational leader about the importance of staff training. Share the videos on this page to gain buy-in: [Trauma-informed Care Champions: From Treaters to Healers.](#)

STRATEGY: Practice cultural Humility

What is cultural humility?

Cultural humility refers to an active and ongoing process of learning from, honoring, and relating respectfully to people from all cultures, as well as reflecting on one's own culture and beliefs and how those may impact care. Culture is inclusive of race, ethnicity, religion, sexual orientation, gender identity, country of origin, as well as many other characteristics. To practice cultural humility is to cultivate openness and self-awareness, and to engage in critical self-reflection while interacting with people from diverse cultures. Applying a cultural humility lens to healthcare also means being mindful of intersecting cultures and identities, and the associated historical oppressions and traumas for people who hold those identities. Ultimately, engaging in the process of cultural humility can reduce the power imbalance between provider and patient, increase patient trust in healthcare, strengthen the partnership with the patient, and even strengthen collaboration within the care team.^{8,9}

How is cultural humility different from cultural competency?

Cultural competency refers to learning about the beliefs and values of different cultures in order to provide care that aligns with those beliefs and values. To become competent, however, this framework makes the

8 Lekas H-M, Pahl K, Fuller Lewis C. Rethinking cultural competence: Shifting to cultural humility. *Health Serv Insights.* 2020;13:1178632920970580.

9 Foronda CL, Baptiste D, Reinholdt MM, Ousman K. Cultural humility. *J Transcul Nurs.* 2016;27:210-17.



Kevonya Elzia explains how being mindful of intersectionality is a form of practicing cultural humility and is necessary for a trusting relationship between patient and provider.

unrealistic assumption that providers have the resources and time to gain deep knowledge of a range of backgrounds and cultures. In reality, most providers only have time to develop a surface understanding of a culture, which can then lead to more stereotyping and disregard for intersectionality. In contrast, cultural humility encourages providers to acknowledge their own gaps in knowledge about the patient's experiences and culture, reflect on and evaluate their own biases, and be willing and open to learning from the patient.^{10,11}

TIPS FOR PRACTICING CULTURAL HUMILITY^{12,13}

- ✓ **Reckon** with your implicit biases
- ✓ **Actively engage** in countering stereotypes
- ✓ **Recognize** that the person in front of you is an expert on their own life
- ✓ **Take the time to learn** about each patient's experiences and identities
- ✓ **Create space** for patients to be themselves and share openly
- ✓ **Acknowledge** systemic injustices and their impact on the health of minoritized populations
- ✓ **Ask** about the patient's experiences of the healthcare system
- ✓ **Name the challenges** you have seen in the healthcare system, and explain how your practice is working to address these challenges
- ✓ **Use a patient-centered, strengths-based approach to care:**
 - **Reinforce** the message that the patient is an important part of the care team
 - **Leverage** the patient's strengths: What's going well with the patient? What are their assets and strengths? How can these strengths and assets empower the patient to navigate and manage their health concerns?



Eboni Winford gives a personal example of receiving care from a surgeon who practiced cultural humility.



Sharad Kohli describes how patients who experience pain can be stigmatized within the healthcare systems and therefore require a cultural humility approach.



RESOURCES

Cultural Humility

Yeager KA, Bauer-Wu S. [Cultural Humility: Essential Foundation for Clinical Researchers](#). Appl Nurs Res. 2013;26(4):251-6

[Cultural Humility: People, Principles and Practices: Online Course](#). National Health Care for the Homeless Council (NHCHC)

[Effective and Affirming Communication with Sexual and Gender Minority Patients](#). National LGBTQIA+ Health Education Center

[Effective Communication and Its Role in Building Trust: Online Course](#). NHCHC

[Health Equity Guiding Principles for Inclusive Communication](#). Centers for Disease Control and Prevention (CDC)

[Remove Stigma: Talk with Your Patients About Substance Use Disorder](#). CDC

10 Lekas H-M, Pahl K, Fuller Lewis C. Rethinking cultural competence: Shifting to cultural humility. Health Serv Insights. 2020;13:1178632920970580.

11 Stubbe DE. Practicing cultural competence and cultural humility in the care of diverse patients. Focus (Am Psychiatr Publ). 2020;18(1):49-51.

12 Tervalon M, Murray-García J. Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. JHCPU. 1998 9(2), 117-25.

13 Lekas H-M, Pahl K, Fuller Lewis C. Rethinking cultural competence: Shifting to cultural humility. Health Serv Insights. 2020;13:1178632920970580.



Take the 30-minute online course, [Cultural Humility: People, Principles and Practices](#), a documentary style video that mixes poetry, music, interviews, images, and archival footage to explain what Cultural Humility is and why we need it.



PATIENT PERSONA: Idir

Idir is an undocumented refugee who fled his country of origin due to persecution related to his bisexual sexual orientation. Idir is currently unhoused, typically sleeping in shelters or on the street. He has a severe history of trauma and has internalized stigma and shame related to his housing status, opioid use disorder, and sexual orientation. Despite his housing status, Idir takes extra care and effort to maintain his hygiene and appearance. When he uses heroin, he places the IV in the femoral vein to prevent visible track marks.

Idir receives buprenorphine and counseling for OUD at the health center, and presents to the clinic regularly. Recently, however, Idir experienced a relapse in his heroin use. Last week, Idir developed a large, painful groin abscess. Idir has delayed going to the hospital for treatment because he is worried about receiving poor treatment due to his undocumented status, drug use, and homelessness. The last time he was hospitalized, security searched his belongings, and his pain was poorly managed during his treatment and hospital stay. When he complained of pain to the nurse, he was told, “maybe you should have thought about that before you started shooting up.”



Reflections and questions

- How might Idir’s trauma history be affecting his current health status? His care engagement?
- What trauma-informed principles can you apply in order to build a trusting relationship with Idir?
- What cultural humility principles can you apply in order to build a trusting relationship with Idir?
- What are Idir’s strengths and assets?
- What are Idir’s immediate health goals?
- How can Idir’s strengths and assets be applied to his care plan to meet his health goals?

STRATEGY:

Apply Harm Reduction Principles

What is harm reduction?

Harm reduction is an approach to providing compassionate and patient-centered care for people who use substances and who are not ready to reduce or stop their use. Care and services are provided without judgment or coerciveness, and with the goal of reducing the negative consequences (i.e., “harms”) associated with substance use. When practicing harm reduction, the care team collaborates with the patient to center the care plan on the patient’s goals in order to respect the patient’s autonomy. In a nutshell, harm reduction meets people “where they are—on their own terms, and may serve as a pathway to additional health and social services.”¹⁴

Practical harm reduction supplies and services

There is a spectrum of harm reduction supplies and services that health centers and their partners can offer to people who inject drugs. Examples include:¹⁵

- Syringe service programs that safely collect used needles and provide sterile needles for people who inject drugs
- Naloxone to reverse opioid overdose
- Fentanyl or Xylazine strips to decrease the risk of opioid overdose
- Alcohol pads to reduce risk of infection

¹⁴ Substance Abuse and Mental Health Services Administration. [Harm Reduction](#).

¹⁵ Substance Abuse and Mental Health Services Administration. [Harm Reduction](#).



Eboni Winford discusses the process of harm reduction, and provides examples of harm reduction practices with people who inject drugs.



Eboni Winford describes practicing harm reduction with a patient who used opioids and alcohol.



Kevonya Elzia discusses how she applied harm reduction principles with a patient preparing for knee surgery who used methamphetamines.

- Vaccination for hepatitis A and B
- Educational materials on safer injection methods
- HIV and viral hepatitis testing
- Home test kits for HIV

Low-barrier entry to SUD treatment

Low-barrier entry to SUD treatment is a patient-centered form of harm reduction that focuses on addressing structural and programmatic barriers that prevent people from engaging in treatment. Low-threshold services typically involve same-day access to individually-tailored SUD treatment in the clinic, by telehealth, or on a mobile unit that visits areas in the community with a high prevalence of opioid use disorder and other SUDs. Health centers can think creatively about the best ways to streamline systems for their patients. As an example, [The Engagement Center](#), in Boston, MA, is a low-threshold model for people navigating homelessness and SUDs. To help further engage and retain people in SUD treatment, health centers may offer additional onsite services that meet basic needs, such as a pharmacy, food pantry, and employment and housing assistance.



RESOURCES

Harm Reduction

[Delivering Effective, Low Barrier Treatment](#). Agency for Healthcare Research and Quality (AHRQ)

[Harm Reduction](#). Substance Abuse and Mental Health Services Administration

[Harm Reduction and HCH: Supporting People Who Use Drugs Across the Spectrum of Care](#). National Harm Reduction Coalition and NHCHC

[Harm Reduction: Online course](#). NHCHC

[Harm Reduction Resources and Toolkits](#). National Clinician Consultation Center

[Health Centers and Syringe Services](#). National Health Care for the Homeless Council (NHCHC)

[National Harm Reduction Coalition Website](#). National Harm Reduction Coalition

[Safer Injection Practices for People Who Inject Drugs](#). U.S. Department of Veteran Affairs

[The Engagement Center](#). City of Boston

[The Role of Low-Threshold Treatment for Patients with OUD in Primary Care](#). AHRQ



Naomi Windham describes how her organization offers low-barrier, same-day access to mental health and SUD care by having psychiatric nurse practitioners available for same-day appointments.



Naomi Windham elaborates on the systems her organization uses to provide same-day telehealth behavioral health visits.

ONE THING YOU CAN DO TODAY

Talk to your colleagues about ways to expand harm reduction in your practice. For example, the care team could strengthen a partnership with the local syringe service program, or could order safer use kits (e.g., kits with naloxone, fentanyl or Xylazine strips, alcohol pads, safer injection brochures) to distribute to patients who inject drugs.

STRATEGY: Provide Leadership to Support Equity Work

Leadership support strategies

In order to achieve health equity goals, health center leaders must create an organizational culture and climate that supports and empowers care teams to provide equitable pain management and SUD treatment. Below are recommended strategies and principles for leaders to support these goals:

- **Maintain open communication.** Leaders need to hear and learn from care teams on a regular basis so they can understand what is happening on the front lines. Regular meetings and other forms of communication can keep leadership aware of program successes, concerns, and resource needs.
- **Provide needed resources.** Leaders can follow-through on care team requests for resources by asking the development team to apply for grants and reaching out to leaders of community organizations to form partnerships.
- **Appoint a leader of health equity.** Health centers can designate an executive to lead organization-wide improvement activities in health equity. This may be a primary role or an addition to a staff member's current role.
- **Engage champions of health equity.** The health equity leader can engage with self-identified champions of equity



Naomi Windham discusses ways in which leadership can equip healthcare staff to provide equitable care through education, making space for asking questions, and interpreting data accurately and with sensitivity.

within the health center. Ideally, champions represent as many departments of the organization as possible.

- **Change internal policies as needed.** Health center leadership along with equity champions can review organizational policies and protocols to ensure they align with equity goals. If policies need updates, leadership can assign a team or task force to suggest revisions.
- **Advocate for external policy change.** If regional or national policies perpetuate health inequities, leadership can determine who to partner with outside the organization to advocate for policy change.
- **Remain patient.** Complex issues require long-term solutions. Leaders can expect care teams and equity champions to report on progress towards measurable outcomes, but they should not expect quick fixes.
- **Acknowledge good work.** It is important to validate and acknowledge the hard work accomplished by the health equity champions and care teams who are implementing changes to promote equity.
- **Provide educational opportunities for all staff.** All health center staff need time and opportunities to learn about health equity and to become skilled and knowledgeable about new methods of care, such as harm reduction approaches and trauma-informed care. Leadership can provide a variety of educational options and can encourage staff to continue asking questions as they implement new tools and skills. For resources on training, see [Strategy: Expand and Train the Care Team](#).
- **Gather feedback from patients.** As practices and policies evolve to support equity, leaders can oversee the collection and analysis of patient feedback on these changes.
- **Promote a culturally responsive environment.** Leadership can set the tone of inclusiveness and health equity by communicating to all staff and patients the goals and rationale for focusing on health equity.
- **Prevent burnout and support staff wellness:** Health center staff are at high risk for work-related burnout and secondary traumatic stress. Caring for patients with complex needs such as SUDs and chronic pain can exacerbate this risk. Health center leaders can proactively offer social support, benefits, and services to promote healing and wellness and prevent burnout.



Sharad Kohli discusses what leadership can do to support the creation of an integrative pain management clinic.



Naomi Windham discusses strategies for integrating health equity work with programs for substance use.

PROMOTING A CULTURALLY RESPONSIVE ENVIRONMENT

Assess current policies and protocols to determine if existing workflows allow care teams the time and space to do the equity work

Review all health center forms, policies, and protocols for language inclusive of the full range of races, ethnicities, sexual orientation, gender identities, and ages of your patients and people in the local community

Do a visual scan of the health center's physical and online environment to see if the images, and signage are inclusive of the full range of races, ethnicities, sexual orientations, gender identities, and ages of your patients and people in the local community

Reflect on whether the organization has equity strategies implemented in all relevant programs and systems

TIPS FOR SUPPORTING THE WELLNESS OF THE CARE TEAM

- ✓ **Provide** access to free and low-cost self-care resources
- ✓ **Host** regular listening and hearing sessions with leadership
- ✓ **Conduct** annual trauma-informed supervision leadership training
- ✓ **Build** wellness supports and check-ins into supervision
- ✓ **Offer** staff support services (e.g., social support groups, SUD treatment)
- ✓ **Host** team-building retreats and exercises
- ✓ **Create** space to share ideas and feedback
- ✓ **Offer** inclusive paid time off (e.g., for mental wellness, SUD recovery, caretaking of family members of origin and choice, and other forms of family and medical leave)
- ✓ **Allow** time and space to debrief after traumatic events
- ✓ **Create** a culture where it is okay to ask, "Are you okay?"
- ✓ **Offer** peer support services
- ✓ **Foster** coaching and mentorship opportunities
- ✓ **Routinely assess** staff on what types of leadership support is needed AND implement practices based on this feedback



RESOURCES

Leadership to Support Equity Work

Corbie G, Brandert K, Fernandez CSP, Noble CC. [Leadership Development to Advance Health Equity: An Equity-Centered Leadership Framework](#). Acad Med. 2022;97(12):1746-1752

[Institute for Healthcare Improvement Leadership for Health Equity Program](#). Institute for Healthcare Improvement

[Organizational change publications](#). National LGBTQIA+ Health Education Center

[Racial and Health Equity: Concrete STEPS for Health Systems](#). American Medical Association

[Resiliency Toolkit: A Comprehensive Guide for Health Centers and their Staff](#). National Health Care for the Homeless Council and STAR² Center



ONE THING YOU CAN DO TODAY

If you are a health center leader, choose a time and place to host a listening session with health equity champions in your organization.

STRATEGY:

Expand and Train the Care Team

Why an expanded care team?

Health center patients experiencing pain, SUDs, or both, often have complex medical and behavioral health needs. The patient personas in this Guide demonstrate the challenges facing care teams in providing compassionate, evidence-based care for people with complex needs.

Coordination of care across multiple disciplines is critical for meeting patient-centered goals. When caring for a patient with complex needs, the primary care team can ask: Who can join our expanded care team in order to best support this patient? Expanded care team members may work within the health center, or may be partners in the community.

Given the multitude of social determinants that influence the health of patients, it is important for teams to include specialists in supportive services, such as housing navigators and case managers, in addition to medical and behavioral health specialists. Hiring a diverse workforce that includes peer specialists (i.e., people with lived experience who represent the identities, backgrounds, and cultures of the communities served by the health center) is another effective way to engage patients.

Training the expanded care team

All health center staff—not just clinical staff—can benefit from receiving training on a range of topics that help to advance health equity and promote patient-centered care. Potential training topics include:

- Cultural humility
- Reducing implicit bias
- Racial and social justice



Sharad Kohli explains how interprofessional teams help to energize staff and prevent burnout.

POTENTIAL MEMBERS OF THE EXPANDED CARE TEAM

- Primary care team: primary care clinicians, nurses, medical assistants
- Behavioral health providers: mental health counselors (licensed clinical social workers, psychologists); psychiatrists
- Peer support specialists and community health workers (peers can be those who are in recovery from an SUD, and/or share one or more identities with the patient)
- Addiction medicine and other SUD treatment specialists
- Chronic care managers
- Case managers
- Mobile/street outreach teams
- Medical specialists (e.g., nephrology, rheumatology, surgery)
- Physical therapists
- Traditional healers
- Integrative medicine practitioners (e.g., acupuncture, chiropractic medicine, massage)
- Wound care nurses
- Housing navigators
- Interpreters
- Legal aid specialists
- Front desk and administrative staff
- Financial navigator/counselors
- Pharmacy and mobile prescribing teams
- Data analysts/information technology specialists

- De-stigmatizing language
- Medications for opioid use disorder and overdose
- Harm reduction approaches
- Safe injection techniques
- SUD treatment competency, inclusive of how drug use and trauma change the brain
- Trauma-informed care
- Customer service, inclusive of de-escalation techniques and understanding how trauma influences behavior
- Creating welcoming, affirming, and safe clinical environments
- Motivational interviewing & empathetic inquiry
- Cultural and linguistic responsiveness
- Healing centered restorative engagement
- Asset mapping & understanding community resources
- Building workforce and organizational resiliency



Eboni Winford discusses the key role of peer recovery support specialists.

The Resource List in this section provides links to organizations with free and low-cost online and in-person training and technical assistance on these topics.



RESOURCES

Organizations that Provide Staff Training and Technical Assistance

Population-Specific Equity Training

[African American Behavioral Health Center of Excellence](#)

[Association of Asian Pacific Community Health Organizations](#)

[Corporation for Supportive Housing](#)

[Farmworker Justice](#)

[Futures without Violence](#)

[Health Outreach Partners](#)

[National Center for Health in Public Housing](#)

[National Health Care for the Homeless Council](#)

[National LGBTQIA+ Health Education Center](#)

[The Tribal Training and Technical Assistance \(TTA\) Center](#)

Workforce Development Training

[Association of Clinicians for the Underserved Star Center](#)

[Bureau of Primary Health Care Behavioral Health Technical Assistance](#)

[Community Health Center, Inc.](#)

[National Center for Medical-Legal Partnership](#)

Harm Reduction Training

[Motivational interviewing Network of Trainers](#)

[National Harm Reduction Coalition](#)

[National Harm Reduction Technical Assistance Center](#)

Substance Use Disorder and Addiction Treatment Training

[Addiction Technology Transfer Center Network](#)

[Centers for Disease Control and Prevention Opioids Training for Healthcare Professionals](#)

[National Clinician Consultation Center: Substance Use Management](#)

[Providers Clinical Support System: Medications for Opioid Use Disorders](#)



Visit [Building Health Equity and Inclusion from the Addiction Technology Transfer \(ATTC\) Network](#), and download a resource on implicit bias, cultural humility, or health equity that can be used to train the whole care team.



PATIENT PERSONA: Tasha

Tasha is a 62-year-old Black woman with chronic back pain who presents to your care team. She previously received care at a health center that had a strict “no opioid prescribing” policy. Patients were provided referral information for local pain management specialists, all of whom were cash-in-advance clinics. Although she felt that her primary care provider and therapist were very responsive, she routinely expressed concern that she couldn’t manage her pain “because I don’t have health insurance.” She believed that her lack of health insurance and inability to afford the pain clinic fees meant she did not deserve to have her pain treated. Tasha began purchasing oxycodone from family members and friends who were prescribed opiates by their medical providers, and she increased her utilization of marijuana for pain relief. She shared this with her primary care team and always answered truthfully when asked about frequency, amount, and duration of use.

Approximately three years ago, Tasha was awarded a disability settlement and enrolled in Medicare. This enrollment allowed her to enter a pain management program that accepted Medicare. To enter the program, she needed to abstain from using marijuana and opioids for 30 days in order to “pass” the urine drug screen. Her pain returned to its baseline, and her functioning was significantly impaired. She enrolled in the pain management program and received treatment for one year until she was dismissed for having a “dirty” urine drug screen--the clinic stated they found cocaine metabolites, which Tasha denied. Because she had been previously “dismissed” from a pain management program, other programs in the community declined to enroll her in their programs. She went six months without prescribed pain management and returned to using marijuana and family members’ prescriptions to manage her pain. When she was offered a referral to another pain management program, she stated she was labeled an “addict” and a “high-risk patient” because of her previous “dismissal.” Now Tasha questions whether returning to this pain management program is worth it if it means she must feel demeaned to receive treatment.



Reflections and questions

- What harm reduction principles might be applied to Tasha’s care?
- Who at the health center should become involved in Tasha’s care? How might you need to expand the care team?
- What kinds of training might care team members and other staff at your health center need to a) best meet Tasha’s health care goals?; b) provide the most culturally responsive care for Tasha?

STRATEGY:

Engage in Meaningful Linkages to Care and Capacity Building

What are meaningful linkages to care?

Meaningful linkage to care refers to increasing and improving patient access to a full array of treatment, care, and supportive services through robust and sustainable partnerships among the health center and partners in the community, including the medical community, local community organizations, and public health agencies. Together, the partners agree on shared goals and values to support all patients and clients, and to advance health equity.

Essential aspects of meaningful linkage to care

Patients who need external referrals are more likely to follow through when they experience meaningful linkage to care. To achieve meaningful linkage to care, health centers can aim to do the following:

- Establish collaborative and robust relationships with all referral partners
- Conduct asset mapping to identify additional partners to fill gaps in services
- Know first-hand that the referral partners provide a safe, welcoming, and trauma-informed space that is culturally responsive to the identities of the people being referred
- Do not assume that patients will follow through on their own, without support from the health center



Naomi Windham expands on three essential aspects of meaningful linkage to care: building partnerships in the community, collaborating with peers, and lowering barriers to navigating the healthcare system.

- Provide a warm handoff of the patient to the referral partner
- Engage peers (people in the community with similar lived experiences) to support and mentor patients in visiting the referring agency and otherwise navigating the health system
- Anticipate and address structural barriers to engagement in care by providing transportation, health navigation, etc.
- Provide intensive case management for patients with complex needs who need additional support in accessing services
- Develop a system to follow-up with patients about the referral (e.g., How was the experience? Are your needs being met?)
- Work directly with the referral partner to make improvements, if needed
- Advocate for patients when they encounter barriers
- Collaborate with the patient to figure out an alternative referral, if needed

Motivational interviewing: improving patient readiness to engage in referrals and treatment

Even when a health center has the systems in place to achieve meaningful linkage to care, patients are unlikely to follow through on referrals unless they are ready to make a change. Motivational interviewing is an evidence-based approach to help patients get to a point of readiness and feel motivated to change their behavior.¹⁶ At its core, Motivational interviewing is: “A collaborative, goal-oriented style of communication ... designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion.”¹⁷

16 Bischof G, Bischof A, Rumpf HJ. Motivational interviewing: An evidence-based approach for use in medical practice. *Dtsch Arztebl Int.* 2021;118(7):109-15.

17 Miller WR, Rollnick S. *Motivational interviewing: Helping People Change* (3rd Edition), p.29. New York: Guilford Press; 2012.



Kevonya Elzia describes what meaningful linkage to care looks like, and the importance of supporting patients in overcoming barriers.



Naomi Windham explains the process of Motivational interviewing.

Building internal capacity to provide SUD treatment and pain management

Meaningful linkage to care may not be an option for health centers located in areas with limited resources and referral agencies. Furthermore, patients may not have insurance coverage for the recommended referrals. To meet patient needs and achieve health equity, health centers may need to focus instead on building internal capacity to provide services to their patients. Capacity-building goals for SUD treatment and pain management could include:

- [Training the primary care team](#) to prescribe medication for opioid use and alcohol use disorders (e.g., buprenorphine and naltrexone), in combination with counseling and behavioral therapies
- [Building an integrative pain management program](#)
- Integrating behavioral health services with primary care



RESOURCES

Meaningful Linkage to Care and Capacity Building

Meaningful Linkage to Care

[Linking People with Opioid Use Disorder to Medication Treatment: A Technical Package of Policy, Programs, and Practices.](#)

National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC)

[Motivational interviewing to Help Your Patients Seek Treatment.](#) CDC

[Motivational interviewing Training Module.](#) CDC

[Motivational interviewing Network of Trainers.](#) Motivational interviewing Network of Trainers (MINT)

[Warm Handoff: Intervention.](#) Agency for Healthcare Research and Quality (AHRQ)

Capacity Building

[Behavioral Health Integration.](#) JBS International

[Center of Excellence for Integrated Health Solutions.](#) National Council for Mental Wellbeing

[Integrating Behavioral Health and Primary Care Playbook.](#) AHRQ



Reflect on the last referral you made for a patient. Would you characterize the referral as meaningful linkage to care? If not, what else could be done to improve linkage for this patient or future patients?

STRATEGY:

Use an Integrative Approach to Pain Management

High-quality, equitable, patient-centered pain management that mitigates risk for opioid use disorder is a priority for the U.S.; however, patients often encounter fragmented systems of care and limited non-opioid options to treat their pain. Fortunately, there is a growing evidence base for non-opioid pharmacological and non-pharmacological treatments for pain management.¹⁸ Health centers can build capacity to offer an array of pain management options for patients, and create partnerships in the community to fill gaps in services.

Best practices for integrative chronic pain management

To ease the opioid crisis and bring about optimal and equitable health for patients, a task force convened by the U.S. Department of Health and Human Services (HHS) recommends that healthcare organizations use a biopsychosocial, multidisciplinary, multimodal approach to chronic pain within 5 treatment categories:¹⁹

- **Medications:** Opioids and non-opioids, such as acetaminophen, NSAIDs, anticonvulsants, musculoskeletal agents, antidepressants, and anti-anxiety medications
- **Restorative therapies:** Treatments by physical and occupational therapists, such as therapeutic exercise, cold and heat, therapeutic ultrasound

¹⁸ U.S. Department of Health and Human Services. [Pain Management Best Practices Inter-Agency Task Force Report: Updates, gaps, inconsistencies, and recommendations](#); 2019.

¹⁹ U.S. Department of Health and Human Services. [Pain Management Best Practices Inter-Agency Task Force Report: Updates, gaps, inconsistencies, and recommendations](#); 2019.



Sharad Kohli describes the start-up of the Integrative Pain Management Program (IPMP).



Sharad Kohli gives advice to other health centers that are interested in building an integrative model of care for pain management.

- **Interventional approaches:** Image-guided and minimally invasive procedures, such as trigger point injections, neuromodulation, and sympathetic nerve blocks
- **Behavioral approaches:** Counseling to address the psychological, behavioral, and social aspects of pain, such as cognitive behavioral therapy, and acceptance and commitment therapy
- **Complementary and integrative health:** Mind-body behavioral interventions, osteopathic and chiropractic manipulation, acupuncture, massage, movement (e.g., yoga, tai chi), and spirituality

Support groups and shared medical appointments

Support groups and shared medical appointments are another important component of integrative pain management that may work well for health centers.²⁰ These facilitated groups meet weekly or biweekly, in person or online, to deliver education and teach skills on a variety of pain self-management methods, such as mindfulness and acupressure, and they also provide a space for patients to feel heard and not alone.

Integrative pain management program

The [Integrative Pain Management Program \(IPMP\)](#) at the People's Community Clinic, a health center in Austin, Texas, is a model program adapted from evidence-based best practices. IPMP offers an array of non-pharmacological strategies to help patients reduce chronic pain and improve quality of life (e.g., nutrition, yoga, acupuncture, therapy, and support groups), as well as onsite access to SUD treatment and a medical-legal partnership. When working with each individual patient, IPMP providers: consider all possible biopsychosocial causes of the patient's pain; talk with the patient about what tools can address those root causes; and ask the patient to choose which tools to try first. If a patient is not ready to engage in pain treatment due to other unmet needs, such as housing, immigration status, or an SUD, the IPMP team supports the patient in accessing those services.

²⁰ California Health Care Foundation. [Pain management on a new track: Complementary therapies in the safety net](#); 2016.



Sharad Kohli explains the biopsychosocial model of care at IPMP.

KEY ACTIVITIES FOR CREATING AND SUSTAINING AN INTEGRATIVE PAIN MANAGEMENT PROGRAM

- ✓ **Review the best practices** in: [Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations](#). U.S. Department of Health and Human Services
- ✓ **Conduct internal and community strengths and needs assessments** (e.g., asset mapping) to identify existing resources and assets as well as gaps in resources
- ✓ Based on the needs assessment, **establish partnerships** with organizations in the community that provide needed services that your health center cannot provide on its own
- ✓ **Hire a coordinator** to oversee operations of the program
- ✓ **Slowly build the program;** do not try to do everything at once
- ✓ **Meet on a regular basis** to discuss complex cases
- ✓ **Hold support groups** for patients to build trust and create community

Principles of pain care

The American Medical Association Pain Care Task Force (PCTF) developed principles of pain care to advance the widespread implementation of safe and effective care for patients with undertreated and mistreated pain. These principles can help with building capacity and guiding care teams in providing integrated approaches to equitable pain care:²¹

- Provide individualized, patient-centered care
- Acknowledge the stigma associated with chronic pain
- Use standardized and validated pain assessment tools
- Find agreement in areas of clinical practice across specialties and guidelines
- Support multidisciplinary, multimodal, and integrated approaches to pain care
- Understand the relationship between acute pain and chronic pain
- Identify and treat disorders coexisting with pain
- Improve physician education and training
- Utilize all available pain medications responsibly and safely
- Keep chronic pain patients engaged in care

²¹ American Medical Association. [Evidence-informed pain management: Principles of pain care from the AMA Pain Care Task Force](#); 2019.



RESOURCES

Integrative Approaches to Pain Management

[Centering Relational Health: The Integrative Pain Management Program at People's Community Clinic](#). [Integrative Practice Webinar Series](#). Academy of Integrative Health and Medicine

[Centers of Excellence in Pain Education: Interactive Modules](#). NIH Pain Consortium

[Chronic Pain: What You Need to Know About the Effectiveness of Complementary Health Approaches](#). National Institutes of Health, National Center for Complementary and Integrative Health

[Community Asset Mapping Guide](#) and [Webinar](#). National Center for Farmworker Health

[Evidence-Informed Pain Management: Principles of Pain Care from the AMA Pain Care Task Force](#). American Medical Association

[Integrative Medicine for the Underserved](#). Integrative Medicine for the Underserved (IM4US)

[Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline](#). American College of Physicians

[Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations](#). U.S. Department of Health and Human Services

[Pain Management on a New Track: Complementary Therapies in the Safety Net](#). California Health Care Foundation

✓ ONE THING YOU CAN DO TODAY

For your next care team meeting, share the [Clinical Best Practices](#) section on [Restorative Therapies and Interventional Procedures](#) from the [Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations](#), discuss which new therapies and procedures you can offer to patients experiencing pain, and make an action plan.

STRATEGY:

Develop and Learn from Patient Personas

As part of life-long learning, health center care teams can write and discuss their own patient personas and can share these with health center leadership. Developing patient personas can help with practicing the principles discussed in this Resource Guide, such as: identifying patient assets, acknowledging intersectional identities, and understanding the impact of implicit bias, assumptions, and structural inequities. Moreover, developing patient personas based on clinical experience can serve as a first step in using human centered design to solve problems and build tailored, patient-centered programs.

On the following page is a patient persona with accompanying questions that care teams can start with to bring about important discussions and problem-solving. Feel free to use any of the patient personas provided in this Resource Guide.



RESOURCES

Personas and Human-Centered Design

[The Field Guide to Human-Centered Design](#). IDEO



ONE THING YOU CAN DO TODAY

Write your own patient persona based on a patient or combination of patients.



PATIENT PERSONA: Darren

Darren is a married 49-year-old Black man, and a former athlete. Nine years ago, Darren felt a sharp pain in his back while showering. He fell and could not get up. At the emergency room, Darren was told that he had strained his back and would be discharged. But Darren and his family members convinced the hospital to admit him. An orthopedist determined that Darren had a severe disc herniation with spinal cord compression and needed immediate surgery.

After multiple lumbar surgeries and 6 months of hospitalization, Darren lost his job as a security guard and thus his health insurance. He began to receive his medical care at a local health center. With assistance from the health center's Medical-Legal Partnership, Darren applied for and received disability insurance. He was referred to a pain management specialist and was put on multiple opioids in addition to muscle relaxers and gabapentin, due to his high level of pain. Family members began to worry that Darren was becoming addicted to pain medications. In addition, Darren was becoming depressed because he could no longer be as active as he was in the past. At the suggestion of his primary care provider, Darren began receiving counseling from a clinical social worker at the health center.

Darren's counselor referred him to the health center's new Integrative Pain Management Program. He began attending their peer support groups, where he has learned about nutrition, mind-body strategies, and gentle yoga. Darren also started regular acupuncture at the clinic. Darren now reports his pain is much better and he no longer uses opioids. Darren also joined the health center's governing board, and uses board membership to maintain support for the Integrative Pain Management Program.



Reflections and questions

- What are Darren's intersecting identities and lived experiences?
- How can Darren's intersecting identities help the care team see him as a whole person?
- What systemic and structural inequities did Darren encounter when seeking treatment for his pain?
- How might these inequities have affected Darren's trust in, and engagement with, the healthcare system?
- Who at the health center became involved in Darren's care, and how did this involvement contribute to improving Darren's health?
- What attributes health center contributed to Darren's improved mental and physical health?

