Social Determinants of Health and Pain Management

What are Social Determinants of Health?

Social determinants of health (SDH) are the environmental conditions in which people are born, live, learn, work, play, worship, and age that affect health, functioning, and quality-of-life outcomes and risks. SDH examples include wealth, access to healthy foods, education, housing conditions, discrimination (e.g., based on race, gender identity, sexual orientation), and isolation or social supports.

What is the Connection Between SDH and Chronic Pain?

Research demonstrates a linkage between chronic pain and a number of social determinants, including mental and physical stress at work, socioeconomic status (SES), rurality, occupational status, neighborhood, and education. For example,

- Patients with a lower level of education were 2.8 times more likely to develop chronic knee pain after knee arthroscopy compared to those with a higher level of education.
- Individuals living in lower socioeconomic status neighborhoods report significantly higher levels of chronic pain one year after a motor vehicle accident.

How do Social Determinants Impact Opioid Prescribing and Outcomes?

- For acute pain in the emergency department, lower SES patients are 24% less likely to receive an opioid medication.
- Compared to higher SES patients, those in lower SES levels are 63% more likely to receive only opioids for chronic pain instead of opioids plus a non-pharmacologic treatment.
- Buprenorphine prescriptions are given to significantly more white patients than patients of other races/ethnicities.
- Compared to people living in households at least five-times above the poverty line, people who lived in poverty were 36% more likely to die from an opioid overdose.

Implications for Pain Management

- *Screen & Identify*: The presence of social risk factors often goes unrecognized during a medical encounter. There is a growing movement to screen for social risk factors during clinic visits just like we screen for depression or high blood pressure. Examples of screening tools include: The National Association of Community Health Centers (NACHC) social needs evaluation tool and the AMA Screening for Social Needs: Guiding Care Teams to Engage with Patients.

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- *Connect Patients to Local Resources*: Once identified, consider team-based approaches to linking patients to local resources. For example, identify someone on your health care team with that responsibility and build this task into existing clinic visit workflows.
- *Collect Data*: Gather and share data on pain management by patients' social risk factors. Health care systems can review the data and create strategies to address disparities in chronic pain management.
- *Consider Implicit Bias*: We all make automatic associations based on past experiences, cultural messages, education, and other influences without even knowing that we do so. A good first step for clinicians and clinical staff is to explore these associations by taking Implicit Association Tests, such as for weight or race. Another way to address these implicit biases is to remove as much individual discretion as possible when managing patients with pain. Use clinical guidelines, standardized checklists, and system-wide protocols for managing pain. This leaves less room for individual discretion — and therefore bias — to influence patient care. The Six Building Blocks program offers a roadmap on how to build in these systems of care for patient with pain.