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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Clinicians Follow Up About Nonresponses to Mandatory SDoH Screening Questions?

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Abstract

Structural determinants of health (SDoH) screening is key to good pediatric care, but fear of life-altering consequences can prevent adults from disclosing information, while time constraints disincentivize clinicians from addressing some awkward but important SDoH topics relevant to good care planning and management. Transparency, clarity, and a nonjudgmental attitude can help cultivate safe multidisciplinary communication and openness during a clinical encounter. Even more important than screening for SDoH is responding to children's unmet needs that screening reveals, which is the focus of this commentary on a case.

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Case

JJ is a single parent of twins, who is recently unemployed and struggling to cover costs of everyday living. When JJ takes their child to a family medicine physician, Dr P, for the child's annual physical examination, Dr P asks JJ to complete a form. One question, *Do you have trouble paying utility bills*?, makes JJ nervous about answering honestly, due to worry that they will be perceived as incapable of caring well for their child. JJ leaves the response area to this question blank. Dr P notices this omission but must enter information into the child's electronic health record as part of the structural determinants of health (SDoH) screening required by the state's Medicaid managed care plan. Dr P considers how to bring up JJ's lack of response to this screening question.

Commentary

Cases like this one are common in primary care and reflect resource distribution inequity that affects SDoH. Poverty and other SDoH are correlated with increased pediatric morbidity and mortality, including increased rates of hospitalization for acute as well as chronic illnesses.[1,2,3,4] Addressing these SDoH can improve the health and well-being of children and families.[1,2,3,4] Despite the fundamental impact that SDoH have on patients' health, patients' social needs can be a difficult topic to address—from the

perspective of both the patient and the physician. What are the barriers to discussing and addressing SDoH, and how can clinicians in different practice settings circumvent these barriers?

Incentivizing Silence

Physicians are privy to sensitive information that patients are unlikely to share, even with their closest relations. It can be easy to dismiss someone's hesitation to divulge this information—after all, it's just another day at work as a doctor—and yet those moments are some of the most critical in any appointment. All the medical knowledge in the world won't suffice unless clinicians can inspire their patients to participate in their care or inspire the caregivers of pediatric patients to participate in the care of the child.

Despite the importance of SDoH, there are incentives for caregivers to omit or even falsify information. Given the systemic biases in our society—including in health care and government agencies—the perception of personal inadequacy can be terrifying to members of marginalized communities. For example, it has been shown that child protective services disproportionately investigates and removes children from homes of families of color, especially those living in poverty or in rural counties.[5,6,7] Thus families from this demographic might perceive their inability to afford home utilities not just as embarrassing, but as posing a risk of child removal. Some parents might worry that any failing on their part could lead to termination of custody or visitation rights, while others might fear that drawing any attention from government services could jeopardize their immigration status.[8,9,10] They might also be trying to protect their child from the trauma of discovering the struggles the family is facing.[11]

Even before these barriers become an issue, patients must be able to access the health care sites where SDoH screening occurs. Children might not be able to make it to a clinic; they might be living on a friend's couch or be otherwise unhoused, have unreliable adults in their lives, have caregivers that are unfamiliar with the local health care options (especially if they have recently immigrated), or not have any transportation to get to a clinic. This scenario presents a paradox: SDoH in and of themselves can be a barrier to screening for and addressing SDoH.

Physicians also face incentives to avoid discussing SDoH. With limited time to cover as much preventive care as possible, clinicians can find it difficult to address every item on the long checklist of a well-child visit without falling behind for the rest of the day. Physicians experiencing burnout, time crunch, and fatigue might be more prone to simply gloss over any unanswered screening questions or to dismiss potential red flags, investigation of which would require the most precious commodity in medicine: time. In the case, Dr P could see the blank screening question and briefly say, "Oh, you missed this one—no issues with paying utility bills, right?", opening the door for JJ to simply smile and nod and allowing Dr P to fulfill their obligation to complete the mandated screening and move the appointment along. Alternatively, Dr P could investigate further, knowing that to do so would add more time to the appointment. After all, it takes time to understand the complex dynamics of a family, let alone figure out how best to support each family based on those dynamics. How does a clinician fit it all in, knowing the next patient is waiting?

When screening for SDoH, clinicians must also take into account more basic considerations, such as literacy, language barriers, comprehension, and disability. Are the child's caregivers literate in the language of the forms? Are those with visual

impairments given alternative methods of answering questions? Is a parent simply too overwhelmed to read and thoroughly respond to each question? There are many things that an unanswered question on a screen for SDoH could mean, so more information is needed.

Open, Safe Communication

Despite their busy schedule, Dr P decides to further investigate the question JJ left blank. How could Dr P do so without embarrassing JJ? There are surely many physicians who have struggled to find the right words in these situations, and while no one will be able to get each patient conversation exactly right every time, there are things clinicians can do to increase their chances of successfully navigating these topics.

It's easy for clinicians to project their own anxieties onto their patients, which inevitably makes gathering sensitive information that much more awkward for everyone involved. The first step is to never make assumptions. The adult accompanying the child might not be a parent—they could be an adult sibling, grandparent, or some other relation. They might even be a family friend, foster parent, or social worker. If there are multiple adults present, one adult might not be comfortable discussing SDoH in front of whoever else has accompanied them. Clinicians thus should start the visit by establishing the relationship between a child and the accompanying adult.

At the core of this discussion is trust. It is unlikely that someone will disclose sensitive information to a clinician if they do not trust them. Developing this kind of rapport starts with creating a clinic culture of safety and acceptance. Clinicians' use of person-first language whenever appropriate—particularly when discussing disability, substance use, or poverty—establishes that they see their patients as people and not as labels.[12] For example, there is a perceptible difference in respect signaled by referring to someone as an addict rather than a person with a substance use disorder, or as a homeless person rather than a person experiencing housing insecurity. Emphasizing each individual's humanity regardless of their current circumstances keeps the focus on the person rather than their circumstances. Doing so can help patients feel that they are seen as persons with worth rather than being solely defined by whatever issues they might be struggling with. Recognizing that every person's life is unique but that we all have struggles and failings and need support of some kind can help to normalize discussing what might otherwise be taboo subjects.

Equally vital to discussing SDoH is transparency. Clinicians should elicit parents' perspectives on SDoH screening[1,2] and make it known that all patients are screened for these and that they aren't being singled out. Clinicians should explain why screening for SDoH is part of the visit—that it's not to punish or shame anyone but to direct the provision of resources to make sure that every child is receiving the care they need, both at the doctor's office and at home.[1,13,14] Misperceptions can arise in seemingly innocuous parts of the well-child visit, such as screening for lead exposure. Parents might feel that asking about the age of their home is some sort of metric of their success, so prefacing those inquiries with an explanation of the risks of lead exposure would preclude such misunderstandings.

Another key component to discussing SDOH is using open-ended questions.[2] Examples include "What concerns do you have?" and "How can I help you?" Such open-ended questions may seem simple, but in the rush of a full workday, it can be easy to revert to yes-no questions to save time and simplify clicking through a note template. It can be

more difficult to decide what should be the focus of the appointment in order to provide the care the patient most needs than to rigidly follow a checklist with no allowance for idiosyncrasies. Perhaps figuring out how to help JJ pay for utilities is more important in this visit than talking about how many servings of fruits and veggies their child is getting per day, and discussing nutrition can be done during a future appointment. Clinicians can't do it all in every appointment, but they can do enough, and figuring out how to do enough is the art of medicine.

From Communication to Action

Once a clinician has established rapport, utilized appropriate screening methods, asked open-ended questions, and elicited information about SDoH.... Then what? Asking about SDoH means nothing unless there is action that can be taken to address them. Unfortunately, there is no single approach to addressing SDoH as populations and resources vary widely across different locations.

Ideally, addressing patients' SDoH will be interdisciplinary, involving social work, front office staff, and nursing, in addition to the physician.[15,16] There is evidence that having an interdisciplinary team, especially one with members dedicated to providing assistance in accessing community resources, is more effective in addressing SDoH than simply relying on the physician to cover all this information during an appointment.[3,15,16] However, in some practice settings, physicians might need to take on more responsibility to address SDoH if they do not have adequate support staff, as some clinics face staffing shortages or might not have social workers or other support staff available in their clinic. While the absence of such staffing can make addressing SDoH more difficult, it can also present an opportunity to collaborate with local service providers on how to best connect them with those in need, thereby enabling practice facilities to gradually build their own interdisciplinary team outside the clinic walls. This team can be created by developing connections with local food banks, governmental organizations (eg, state Medicaid programs), charitable organizations, and so on. Another possible avenue for addressing SDoH outside of the traditional clinical setting is by utilizing local schools. Schools have more contact with children and their families than the health care system could ever have, and they might have additional resources they can offer families for support. Whether it's connecting local schools to an outside clinic or establishing a school-based health clinic where children can receive care, schools have significant potential for collaboratively addressing SDoH in conjunction with health care facilities.[17] Regardless of the specifics of the process, addressing SDoH requires creativity, problem-solving skills, and a willingness to adapt to the circumstances of the practice environment. But is there more that clinicians can do to tackle SDoH outside of their own medical practices?

While screening for and acting upon SDoH is incredibly important, it brings to mind the famous words of Benjamin Franklin: "an ounce of prevention is worth a pound of cure." Is it possible to address SDoH from a preventative angle and not just a reactionary standpoint? If we can prevent poverty, housing instability, food insecurity, and so on, then it stands to reason that we can prevent the negative health effects associated with these SDoH. The American Academy of Pediatrics position statement, "Poverty and Child Health in the United States," discusses the benefits of programs such as the Children's Health Insurance Program; the Special Supplemental Nutrition Program for Women, Infants, and Children and other nutrition support programs; early education programs (eg, Head Start), and many more.[3] Clinicians can make a difference by leveraging their

medical expertise to advocate for such programs and policies at the local, state, and national level.[3]

It would be myopic for clinicians to see the walls of their clinic as bounding the area in which they can help improve the lives of their patients. Clinicians attain a significant degree of privilege granted few in society—the privilege of advanced education, financial security, and relational power—and they have a responsibility to use that privilege to speak up for their patients. While not everyone can write legislation, lobby on Capitol Hill, or wade in the trenches of frontline community medicine, all clinicians can raise their voices within their own spheres of influence to advocate for the protection of children and public health. Perhaps if we could build a society that values equity and cares for its marginalized members, screening for SDoH would be moot. While that might not be a realistic goal, it is an aspiration worth striving for.

Conclusion

Clinicians should create a safe and welcoming space to discuss SDoH, navigate appointments in a way that allows for addressing SDoH, collaborate with staff and other local stakeholders to connect patients with the resources they need, and advocate for policies and programs that prevent and treat the effects of SDoH. How to achieve these goals in their own practice is up to the individual clinician, but I encourage all clinicians to reflect on how they can address SDoH at the individual and the societal level.

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Contributor disclosed no conflicts of interest relevant to the content.

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