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FROM THE EDITOR

How Should SDoH Screening Happen for Children?

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Despite spending far more on health care than other high-income countries, the United States (US) has overall worse health outcomes.[1] The US has high rates of child and adult poverty, which leads to unmet social needs and subsequently poorer health outcomes later in life.[2,3] One reason for these high poverty rates is that the US spends less on programs that benefit children, such as parental leave and child allowances, compared to other countries.[2,3,4]

In 2023, more than half of children in the US were insured by Medicaid or the Children's Health Insurance Program.[5,6] Beginning in 2025, the Centers for Medicare and Medicaid Services (CMS) began requiring all health care organizations participating in these programs to screen patients ages 18 years and older admitted to a hospital for structural drivers of health (SDoH).[7] The required SDoH domains are food insecurity, housing insecurity, transportation insecurity, interpersonal safety, and utilities.[7]

SDoH screening and follow-up is essential because health outcomes, particularly for children of color, are widely documented as compromised by social, historical, and fiscal neglect of parental leave and other policies that support children.[8] Screening for SDoH not only allows clinicians to identify patients' unmet needs, but more importantly, to connect patients with resources. As part of a larger initiative, SDoH screening aims to improve access to and quality of care for patients in underserved communities.[7] CMS does not mandate a specific screening tool but does require completion of some inpatient SDoH screening.[7] If screening for any structural driver is positive, the patient or family should be given resources to address identified unmet needs.[9]

Despite the value of SDoH screening in improving US children's health outcomes,[10,11] many clinicians—39.9% in one survey—think SDoH screening is not feasible.[12] Lack of resources to address unmet needs identified in SDoH screening and lack of capacity for follow-up can make some pediatricians hesitant to screen for SDoH.[12] Even if SDOH screening is performed, in order for it to be beneficial to children, the screening methods must be valid. Yet most pediatric SDoH screening tools have not undergone reliability and validity testing.[10] A 2024 study found that, among the 76.7% of pediatricians who screened for SDoH, only 12.6% of them use standardized tools.[13]

This issue of the *AMA Journal of Ethics* investigates clinical, ethical, and policy-level questions about how SDoH screening for children should be implemented and administered and how clinicians who care for children should integrate results of screening into their short-term and long-term care plans.

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