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Screening Children for Structural Drivers of Health

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From the Editor

How Should SDoH Screening Happen for Children? 631
Brigid Garrity, DO, MS, MPH

Case and Commentary

How Should Clinical Teams Integrate Findings From Social Needs Screenings Into Children's Care Plans? 634
Stephanie G. Menko, MD, Michael J. Luke, MD, and Aditi Vasan, MD, MSHP

How Should Clinicians Follow Up About Nonresponses to Mandatory SDoH Screening Questions? 642
Audriana Mooth, DO

What Should Be the Nature and Scope of Pediatricians' Duties to Keep Their Patients Insured? 649
Sarah D. Ronis, MD, PhD and Genevieve M. Birkby, MPH

Medical Education

Centering Social Pediatrics in Graduate Medical Education 657
Raquel Selcer, MD, Derek Ross Soled, MD, MBA, MSc, and Rohan Khazanchi, MD, MPH

Three Things Students and Trainees Should Learn About Public Health Insurance for Children 668
Aubrey D. Brown, MD, Lauren Ameden, MD, and Brigid Garrity, DO, MS, MPH

State of the Art and Science

Trauma-Informed Screening for Structural Drivers of Health 678
Elizabeth Lanphier, PhD, MS, HEC-C and James Duffee, MD, MPH

Policy Forum

How Should Children's Medicaid Eligibility Be Monitored? 686
Gabriella Aboulafia, MPP and Adrianna McIntyre, PhD, MPH, MPP

What Would Be Required of Structural Determinants of Health Screening and Follow-Up to Improve Children's Health Equity? 695
Brigid Garrity, DO, MS, MPH, Danielle Cullen, MD, MPH, MSHP, and Haeyeon Hong, MD, MPH

Medicine and Society

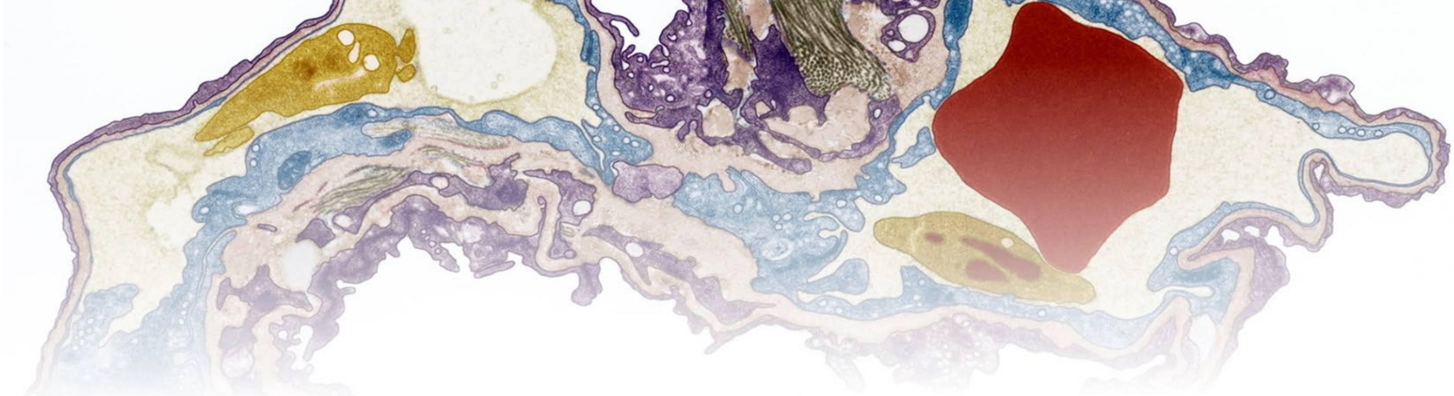
Critical Pedagogical Approaches to Structural Drivers of Health 700
Jake Young, PhD, MFA, MPH

History of Medicine

Advocacy as an Origin of Pediatrics 708
Jorie Braunold, MLIS

Podcast

Ethical and Clinical Complexities of SDoH Screening and Follow-Up: An Interview With Dr Laura Gottlieb and Rachel Landauer



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FROM THE EDITOR

How Should SDoH Screening Happen for Children?

Brigid Garrity, DO, MS, MPH

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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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

How Should Clinical Teams Integrate Findings From Social Needs Screenings Into Children's Care Plans?

Stephanie G. Menko, MD, Michael J. Luke, MD, and Aditi Vasan, MD, MSHP

Abstract

Unmet social and structural needs negatively influence children's health outcomes. Even in pediatric health systems in the United States that have implemented social needs screening programs, little guidance exists about best practices for how clinical teams should respond to children's unmet needs. This commentary on a case discusses ethical principles and caregivers' perspectives that can be used to guide best practices for screening and resource referral.

Case

Dr K is a pediatric hospitalist caring for DD, a child insured by Medicaid who is admitted to an inpatient general pediatrics service with an acute asthma exacerbation. DD's mother completes a validated tablet-based social needs screening questionnaire during her child's admission. Questions on the screening form include "Do you always have enough food for your family?" and "Do you think you are at risk of becoming homeless?" DD's mother expresses concerns about food and housing. Dr K reaches out to a social work colleague, SW, who meets with DD's family to discuss food and housing resources. As part of their follow-up assessment, SW learns that DD's family is concerned that they may need to leave their current home due to environmental triggers contributing to DD's asthma symptoms, including mold exposure. SW and Dr K document key findings in DD's health record, noting that these concerns will require follow-up.[1,2]

SW asks Dr K, "How should our team follow up with DD's family regarding their concerns?" Dr K considers how to respond and how to document progress toward short- and long-term goals of DD's care plan.

Commentary

Health-related social or structural needs (HRSN) are household-level social and economic factors that affect health, such as food insecurity, unsafe or unstable housing conditions, and difficulty paying utility bills. HRSNs can negatively influence children's health and well-being.[1] For this reason, HRSN screening and resource referral programs are used to help identify and address these needs, thereby increasing access to resources and improving health outcomes for children like DD.[3]

Although evidence on the health benefits of social needs screening is still evolving, the Centers for Medicare and Medicaid Services (CMS), the Joint Commission, and several state Medicaid managed care organizations have all recently issued mandates or incentives encouraging screening, resulting in its widespread implementation within health systems across the country.[4,5,6] In particular, CMS has incentivized social needs screening through coverage of some HRSN interventions.[7] However, these organizations have provided limited guidance on how health systems should address families' needs and tailor patient care based on screening results.[6]

In determining whether (if not required), when, and how to ethically screen for and address HRSNs in clinical settings, health systems should consider how to maximize potential benefits and mitigate potential harms to patients, families, and members of health care teams.

Best Practices for Responding to Screening Results

In qualitative studies, caregivers of pediatric patients have expressed concerns about the sensitivity of questions asked during HRSN screening, the potential for bias and discrimination, and the risk of child protective services (CPS) involvement as a result of disclosing needs.[8,9,10] Parents requested that health systems explain that HRSN screening is the standard of care for all families, provide transparency about documentation of social needs in the electronic health record (EHR), and allay their concerns about CPS referrals by emphasizing that the primary purpose of screening is to provide families with resources and tailor their care based on their needs.[8,9,10]

Health systems implementing screening might first consider whether to screen universally (as mandated by CMS for adults in inpatient settings[11]) or target screening to individuals believed to be at highest risk of experiencing HRSN. While the Joint Commission allows hospitals to select a representative sample of patients to screen,[5,12] we believe that universal screening is the most ethical and equitable approach, in line with recommendations from CMS and the American Academy of Pediatrics.[7,13] Targeting HRSN screening based on patients' demographic or clinical characteristics could increase stigma associated with screening and inadvertently exclude some families who could benefit from support.[14]

As they implement screening, health systems should also recognize that not all families that express needs desire assistance. One commonly used screening tool, WE CARE, aims to prioritize autonomy by asking caregivers whether they want help with each of their identified needs, allowing them the agency to opt-in to support.[15,16]

Some parents experiencing social needs have expressed concerns about "double loss," described as disclosing HRSNs and expressing a desire for assistance without receiving meaningful support.[17] Health systems implementing HRSN screening should therefore work to ensure they have the capacity to connect families with resources targeted to their needs.[18] Providing this support requires the knowledge and experience of an interdisciplinary team, including physicians, nurses, social workers, community health workers, and community-based organizations, to develop a strategy for connecting families with resources and tailoring care plans to their needs. For example, if a family has trouble paying utility bills, their community health worker could refer them to the

Low-Income Home Energy Assistance Program, their social worker could write a letter to their utility company advocating for a medical exemption to utility shutoff, and their physician could modify their care plan to minimize reliance on medical equipment, particularly if they are at risk of having their utilities shut off. Importantly, when clinical teams make referrals, they cannot predict the support families will receive. Community-based organizations may determine that a family is not eligible for support, or the support provided may not meet a family's needs. Therefore, health systems implementing HRSN screening should be transparent about the limitations of these resources and avoid over-promising support. For example, instructions for HRSN screening, which are typically either read to patients' guardians or given to them to read, should explicitly state that health systems might not be able to provide support for families' needs.

Regardless of what concrete resources are provided, clinical teams can also work with families to tailor their care plans based on their social needs.[3,19] In DD's case, SW conducted a thorough assessment following their positive HRSN screen and identified mold exposure as a potential contributor to DD's uncontrolled asthma. In response, Dr K could consider the addition of nasal corticosteroids or antihistamines to DD's asthma care plan, which could ameliorate some of the risks associated with this environmental exposure. Dr K and their team could also share information about community-based asthma education and home remediation resources that might benefit DD, some of which have been shown to improve asthma morbidity and reduce rates of rehospitalization.[20,21,22,23]

As another example, if DD's family members shared that they had difficulty paying for transportation to appointments, Dr K's team could arrange to have DD's primary care and pulmonology appointments scheduled on a single afternoon, thereby minimizing the need for repeated travel. Providing care tailored to families' needs could improve patient-clinician relationships, destigmatize conversations about social needs, and ultimately enhance access to care and improve health outcomes.

Providing Short-Term and Long-Term Support

Many social needs, like DD's family's housing concerns, cannot realistically be resolved with a single conversation or referral; these needs are complex and multifaceted and may therefore require longitudinal follow-up.[24] We can consider the response to social needs, particularly those identified in the hospital, in terms of short- and long-term strategies that maximize benefits for patients and families.

In the short-term, hospitalists should use information about patients' HRSNs to partner with families and develop safe discharge plans. Screening tools like WE CARE can be particularly helpful for discharge planning because they include questions about the urgency of families' needs.[15,16] If urgent needs are identified during an inpatient admission, members of the care team should prioritize connecting families to resources while their child is in the hospital to ensure a safe discharge and reduce the risk of readmission related to HRSNs. For non-urgent needs, families could be connected with resources either prior to or soon after patient discharge.

In the longer-term, hospitalists' ongoing partnership with families, community-based organizations, and primary care practitioners (PCPs) may be necessary to address social needs. In our health system, families who indicate social needs during an inpatient admission receive a follow-up phone call from a community health worker 2 to 4 weeks after discharge to provide ongoing support and troubleshoot challenges that families may have experienced with resource connection.

As longer-term follow-up of unmet social needs may not be feasible for inpatient care teams, hospitalists should also talk to families about whether they would like ongoing support for their HRSNs from their outpatient care team. If families request this additional support, inpatient care teams could reach out to the patient's PCP prior to discharge and provide them with information about social needs identified, resources provided, and any potential obstacles families have faced in connecting with resources.

It is important to recognize that primary care clinics can vary significantly in their ability to support families with social needs, as these offices have varying levels of support from social workers, community health workers, and other staff members who might assist in responding to these needs. Inpatient teams should strive for open communication with PCPs about ongoing needs but also be cognizant of these limitations. Inpatient teams should aim to begin addressing any acute needs during hospitalizations and set realistic expectations for families regarding resource availability in the outpatient setting.

An EHR can be a useful tool for transmitting information about families' HRSNs across care settings and thereby facilitating longitudinal support. However, studies have found that families value autonomy and transparency in determining how this sensitive information is shared.[8,9] Health systems engaged in EHR-integrated social needs screening should therefore inform families whether and how information about their social needs will be documented and shared in the EHR. Families should be given the option to opt-out of screening if they would prefer not to have their needs documented or shared with other providers, and families who do opt-out should still have the option of requesting confidential resources and support.

Who Should Be Responsible for Addressing Social Needs?

It is important to note that implementation of HRSN screening has the potential to exacerbate feelings of burnout and moral injury among physicians, social workers, and other members of the care team, particularly if they feel they do not have the time or resources needed to appropriately respond to families' needs while balancing their many other competing priorities. Payers and policymakers incentivizing HRSN screening should ideally also provide sustainable financial support for the interdisciplinary workforce needed to respond to positive screens, including social workers, community health workers, and hospital-community-based organization partnerships.[6] Incentivizing or mandating HRSN screening without providing support for health systems to respond to positive screens may be unethical, as it could lead to more harms than benefits for patients, families, and health care teams.

Health systems should consider investing in tiered models of HRSN support in which social workers are responsible for responding to the highest acuity needs, such as acute homelessness; other staff members, like community health workers, are responsible for responding to lower acuity needs, such as food insecurity; and physicians are responsible for tailoring patients' medical care based on their families' social needs. Working as part of a well-resourced interdisciplinary team to effectively address families' HRSNs could help mitigate burnout and moral injury if physicians and social workers feel they are equipped with the resources needed to ensure their patients' and families' needs are adequately addressed.

In addition, the responsibility for addressing HRSNs should not fall on health systems and clinicians alone. While health systems may be able to support individual patients and families experiencing food insecurity or housing instability, communities and local, state, and federal governments should collectively be responsible for addressing these needs at the population level. Health systems could contribute to this work by investing their community benefit spending in local organizations focused on addressing HRSNs and by using their position as anchor institutions to advocate for government programs and policies that mitigate inequities in access to resources and provide economic support for children and families living in poverty.

Conclusion

HRSN screening and resource referral programs have the potential to enhance family-centered care delivery, strengthen relationships, build trust between families and clinicians, and improve health outcomes for pediatric patients. However, these benefits are contingent on performing screenings and providing support via an ethical, team-based approach that maximizes benefits and minimizes harm to families, prioritizes autonomy, and preserves trust in the health care system. Physicians can achieve these goals by partnering with an interdisciplinary team to provide families with support, thoughtfully incorporating information about social needs into medical care plans, and upholding principles of family-centered care throughout the social needs screening and support process.

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Editor's Note
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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

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

Audriana Mooth, DO

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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CASE AND COMMENTARY: PEER-REVIEWED ARTICLE

What Should Be the Nature and Scope of Pediatricians' Duties to Keep Their Patients Insured?

Sarah D. Ronis, MD, PhD and Genevieve M. Birkby, MPH

Abstract

Access to health care is a key structural determinant of health, with lack of health insurance as a main barrier. In the United States, nearly half of children rely on Medicaid or the Children's Health Insurance Program for health insurance. Children's eligibility for coverage under these programs is income dependent and can vary over time, so changes in insurance status signal a need to screen for unmet structural needs. Clinicians, who are obligated to respond to what screening reveals, should be prepared to help deploy practice-based, health system, and community resources to help meet the needs of children and families.

Case

DD lives in a rural state, works 2 jobs, and is a grandparent and legal guardian of 3 children under the age of 12. DD's English language proficiency is limited, so DD brings a letter she received in the mail for review by Dr P, the children's pediatrician. The letter states that, unless several forms are completed, DD's grandchildren will be ineligible for the state's Medicaid insurance coverage. Dr P walks DD and her grandchild to the front desk and says, "Our staff will help you with this paperwork," and then moves on to their next patient.

A member of Dr P's office staff looks briefly at the letter and informs DD, "You need to find these forms on the internet, print them, fill them out, and then send them to the address on the bottom of the letter." Office staff members are overwhelmed with helping patients complete enrollment paperwork and structural determinants of health (SDoH) screening documentation.

Three months later, when DD brings one of the grandchildren to Dr P, Dr P's office staff inform DD that the child is no longer enrolled in Medicaid. DD's grandchild is part of the 72% of individuals disenrolled from Medicaid for procedural reasons.[1]

Commentary

Events experienced by Dr P, Dr P's staff, DD, and her grandchildren are, unfortunately, likely all too familiar to clinicians working in US primary care settings, particularly those serving under-resourced communities. Defined by the National Academies of Science, Engineering, and Medicine (NASEM) as the "timely use of personal health services to achieve the best possible health outcomes,"[2] access to health care is a key SDoH.

Lack of health insurance or inadequate health insurance coverage is among the most common barriers to health care access.[3] Among all children, those who identify as American Indian or Alaska Native or as Hispanic,[4] and those in the South and West,[5] are most likely to lack health insurance. In the absence of health insurance coverage, many choose to delay or forego care, further contributing to health inequity. Uninsured children are less likely than insured children to have a regular source of care and more likely to have unmet dental and preventive care needs, including immunizations.[6,7] Moreover, children with chronic conditions without health insurance are less likely to receive appropriate treatment, increasing their risk for morbidity and mortality across the lifespan.[8,9] In general, pediatric patients are more likely to fragment their care across primary and emergency department care,[10] thereby increasing opportunities for errors and for gaps in services that could be prevented—and duplication of services that could be provided—through a medical home.

Accessing Health Insurance

Today, for nearly 40% of US children, health insurance coverage is synonymous with Medicaid enrollment.[11] Medicaid, jointly financed by states and the federal government, was first expanded to include children in 1984.[12] In 1997, the State Children's Health Insurance Program (now the Children's Health Insurance Program, or CHIP) was established to provide a public option for children left out of employer-based insurance systems who resided in low- and moderate-income households with incomes exceeding Medicaid's upper income limits.[13] Under the Affordable Care Act of 2010, income limits nationwide for Medicaid eligibility for citizen children under 18 years of age were increased to 138% of the federal poverty level,[14] with some states choosing to expand even higher. In addition, Medicaid serves as a key source of supplemental insurance for children with special health care needs for whom employer-based coverage is insufficient to cover their care.[15] Eligibility varies by state: in some states, lawfully residing immigrant children and pregnant women are immediately eligible, while others first require 5 years of residence.[15] However, children's eligibility for these programs, which is tied to household income, can vary substantially over time. Frequent changes in insurance status, referred to as "churn,"[3] can incur substantial administrative burden (time costs, psychological impact, stigma)[16] for families and result in disruptions in care as substantial as those experienced by children who lack insurance altogether.

Despite limitations on eligibility, Medicaid and CHIP coverage helped reduce the percentage of children without health insurance from 12.3% in 1980 to an all-time low of 4.8% in 2015.[15] Among families in one state's CHIP program, unmet needs for dental care, mental health care, and eye care decreased and visits for routine care increased within a year of enrollment without concomitant increases in emergency department care or hospitalizations.[17] Since 2015, however, the percentage of children without insurance has steadily increased to 5.3%,[18] largely due to losses in Medicaid coverage. Reasons for Medicaid losses include policy reversals to streamline enrollment and renewal, temporary expansion of the public charge rule to include Medicaid use,[19] and, most recently, Medicaid unwinding efforts (ie, the end of continuous coverage) following the COVID-19 pandemic,[20] with the result that an estimated 4.7 million fewer children were enrolled in Medicaid and CHIP by January 2025 than at peak enrollment in April 2023 at the start of unwinding.[20]

Responding to Structural Determinants

As "babies don't go to the doctor by themselves,"[21] pediatricians are charged with not only delivering care to the child in their exam room but assessing and diagnosing the child's family context. In the case of DD, her limited English language proficiency, combined with a request for assistance with the Medicaid enrollment forms, should signal to Dr P that this family likely faces other health-related social needs (including, but not limited to, food needs, housing, and legal aid) and would benefit from connection to services that address her household's health-related social risks.

The 2019 NASEM consensus report, *Integrating Social Care Into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health*,[22] provides a useful framework whereby individuals and organizations can tailor their approach to coordinating such care. The framework identifies 5 strategy areas that can be implemented individually or in combination to increase the likelihood that patients can access and make optimal use of health care services in a timely fashion.

Awareness. As a minimum standard, every clinical team should engage in "activities that identify the social risks and assets of defined patients and populations," such as by screening all patients at a regular cadence or leveraging population-level data to inform practice.[22] A growing body of research indicates that universal approaches to such awareness activities mitigate practitioner bias and patient experience of stigma.[23,24,25] Thoughtful planning of SDoH screening and documentation workflows is essential to ensure that such screening is implemented not merely as a "box-checking" activity[26] but in alignment with patient preferences, as well as staff skills and capacities. A practice-level needs assessment can be useful in determining the social needs most likely to impact the population served and thus inform which screening questions should be universally asked and how those questions should be framed.

Notably, many commonly used SDoH screening tools for children do not include specific questions about insurance status,[27] perhaps because most are designed for implementation in the context of a health care visit that presupposes health insurance coverage. It is therefore important for pediatric practices to have a good understanding of the populations they serve and tailor their SDoH screening activities accordingly—for example, by adding a question to their screening protocol to elicit parent concerns regarding insurance. Practices may also leverage extant tools embedded within the electronic medical record to alert team members to patients who are without, or who are at risk of losing, health insurance. Practice workflows and documentation procedures should prioritize upstream opportunities to identify unmet needs and intervene early.[25]

Adjustment. The NASEM report defines adjustment as "activities where social risk information is used to inform clinical care decision making."[22] In DD's case, such adjustment might include providing language- and literacy- concordant information resources (eg, handouts, flyers, videos),[28] integrating interpreter services into the appointment,[29] and extending appointment times,[30] with a scheduling flag applied to all of her grandchildren's charts to signal these needs. When balanced against lost revenue due to Medicaid disenrollment and no-shows, interpreter services have been demonstrated to be nearly cost neutral,[31] while manifesting the ethical commitment to ensure clear communication with families[32] and quality care.[29]

Assistance. The NASEM report defines assistance as "strategies to link patients with social needs to government and community resources."[22] Assistance can take many forms, depending on the resources available to the clinical team and accessible in the broader community. Within a given practice, options for assistance range from provision by the clinician of a language-concordant resource list to active navigation of resources by volunteers[33] or employed community health workers.[34] Where space, funds, or other considerations limit face-to-face intervention, referral to community-based social care resources may be necessary. In DD's case, rather than verbally directing her to search the internet for the correct application, office staff could instead provide a flyer in her preferred language that provides instructions, contact information, and hours for local organizations that focus on Medicaid enrollment. In many communities, local libraries and neighborhood family service centers are staffed to support those who need help applying for public health insurance. 2-1-1 is another widely available service providing free and confidential referral services.[35] For Dr P, an effective strategy could be for Dr P's front desk team to verify DD's current address, telephone number, and other relevant contact information at every visit. Caregivers like DD often miss communications from Medicaid and other social services because of frequent changes in residential address and telephone number.

For practices that function within larger hospital or health systems, it is also important to identify any internal (in-system) financial assistance resources. For example, financial counselors might be available to assist patients with insurance enrollment or, at a minimum, to help patients get on a payment plan until their insurance can be reinstated.

Alignment. Alignment is defined as "[a]ctivities undertaken by health care systems to understand existing social care assets in the community, organize them to facilitate synergy, and invest in and deploy them to positively affect health outcomes."[22] While less often implemented than the other strategies, alignment strategies can help mitigate the "wrong pocket problem" by supporting health systems' and funders' investment in those individuals and organizations best positioned to provide SDoH resources to patients and their families.[36] Alignment activities typically occur at the organizational level, examples of which might include investment in infrastructure to facilitate electronic referrals and closed-loop communication between health care and community organizations or direct funding of community-based personnel. In Dr P's case, alignment might take the form of working with the state's Medicaid program, managed care providers, or local health system to support the presence of an in-practice-facilitated enroller so that caregivers like DD can meet with an expert in a comfortable and familiar location.

Advocacy. Advocacy concerns "activities in which health care organizations work with partner social care organizations to promote policies that facilitate the creation and redeployment of assets."[22] Advocacy can take many forms—from local efforts to inform and educate the public on the impact of a current or proposed policy to formal legislative advocacy. In the case of seismic events, such as Medicaid unwinding, pediatricians and practices can serve as key communicators to impacted families by posting signage in waiting areas, by having staff wear buttons, or by disseminating informational flyers to families to maximize awareness of what may be coming and what steps they may need to take to preserve coverage. For example, in advance of the

Medicaid unwinding, the authors' team sent out a series of letters to all patients in the practice, informing them of the upcoming change and alerting them to the forthcoming communication from state Medicaid, the timeline for response, and resources available to them in the practice and community if they had questions or concerns.

Pediatricians and health care systems also have opportunities to advocate for more far-reaching solutions to barriers to enrollment in state Medicaid programs, such as improving automated renewal procedures, simplifying renewal forms, extending time to respond to renewal notices, increasing income eligibility levels for children, and extending continuous coverage periods for young children. Indeed, between 2020 and 2024, 25 US states reported having made efforts to expand children's Medicaid and CHIP eligibility and reduce churn by increasing income eligibility or eliminating the 5-year enrollment wait for lawfully residing immigrant children and by otherwise reducing administrative barriers to enrollment.[37]

Conclusion

Health insurance is foundational to children's access to health care, and thus even in the face of competing demands, helping families to acquire and sustain health insurance coverage for their children must be a high priority to clinicians, practices, and health systems. Given that access to care is a key SDoH, lapses in health insurance should trigger assessment of and response to related structural needs. Although practices can devise their own response strategies, they should also leverage health system, community-based, and policy approaches to ensure that all children are afforded the opportunity for optimal health.

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The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

Centering Social Pediatrics in Graduate Medical Education

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Abstract

This article problematizes the normalization of social pediatrics as extracurricular or optional rather than necessary for children's health care. Drawing on critical pedagogical frameworks like structural competency and accompaniment, this article illuminates clinical, institutional, and structural obstacles to mainstreaming social pediatrics training. This article also identifies examples of how training programs, health systems, and policymakers can facilitate and sustain care environments that support social pediatrics and advance health equity.

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Social Pediatrics

Social pediatrics is "an approach to child health that focuses on the child, in illness and in health, within the context of their society, environment, school, and family"—that is to say, within the broader framework of their life circumstances.[1] An aspiring social pediatrician must continually work toward structural competency, armed with the tools necessary to help enhance a child's community context while recognizing its intrinsic strengths.[2,3] These tools cannot be crafted in isolation within clinic and hospital walls.[2,3] To truly engage in social pediatrics is not simply to observe an individual child within their lived context, nor is it to impose solutions to complex social problems from within the "ivory tower"; rather, it is to actively engage with communities in their understanding and shaping of their social and material conditions.[4,5,6,7,8] Part and parcel of this notion is the praxis of *accompaniment*: of clinicians walking closely alongside children and their families through health and social crises alike through provision of relationship-based, team-delivered, community-engaged care that can improve equity, reduce costs of care, and save lives.[9,10]

To date, most social pediatrics training is implemented informally within other core requirements or formally in single seminars, didactics, or one-time advocacy events,[11,12] rather than through shared knowledge building over time in longitudinal relationships with proximate communities.[13] While these efforts provide a necessary starting point, they risk devaluing social pediatrics training as "hidden curricula,"[12] and they frequently presuppose intransigent systems-level barriers to the provision of true social pediatrics education or clinical care.[2,14] While social pediatrics training should ideally be a dialectical, longitudinal, and time-intensive process, it is often relegated to brief "schooling" that reinforces hegemonic, deficit-based views of communities and ignores social complexity.[13,15] It follows, then, that normalizing social pediatrics in medical training and practice will require addressing educational, clinical, institutional, and structural barriers in an integrated fashion.

Obstacles to Training Social Pediatricians

While definitions of social pediatrics and social medicine are expansive and rooted in rich ideological and theoretical frameworks, most pediatric residents struggle to engage in the praxis of social pediatrics within a health care system that actively disincentivizes structurally competent care.

At the interpersonal level, pediatric trainees and clinicians often face significant time and "bandwidth" constraints when discussing complex socio-structural factors with patients and families. Currently, the American Academy of Pediatrics (AAP) Bright Futures initiative identifies 208 individual screening "actions" to be completed at different time points during a child's 21 well-child visits, none of which explicitly include conversations about structural determinants of health (SDoH) or adverse childhood experiences (ACEs).[16] Pediatricians might notice a patient with elevated body mass index at a well-child check, discuss healthy eating, and identify opportunities for exercise. Yet, without interrogating barriers to consistent healthy food access, pediatricians could miss opportunities to work with school districts on offering more well-balanced lunches or to advocate for affordable whole-food stores in their neighborhood.[17] While even AAP guidance indicates that pediatricians should identify, refer, and advocate for families experiencing food insecurity,[18] clinical educators are often constrained in their role as preceptors to demonstrate medical knowledge of disease processes during busy clinic sessions, rather than simultaneously uncovering socio-contextual health-related factors and advocacy opportunities.

Time constraints aside, at the institutional and systems level, it remains clear that SDoH and ACE screenings are far from a stand-alone solution to achieving health equity.[2] Even when care environments do deploy universal social care screenings, their utility remains limited without their linkage to robust interventions or without sufficient time during the clinical encounter to address the traumatic experiences or socio-contextual challenges identified.[19,20,21] Electronic health record-based screens can be experienced as stigmatizing and biased and, even in their best form, might be immediately outsourced to community health workers or ancillary teams,[22,23] leaving little opportunity for accompaniment by pediatric trainees and clinicians. Amid these complicating factors, it is easy to see how even the most concrete and tangible aspects of social pediatrics education—like identifying and intervening upon a specific social need—can quickly become intractable.

Finally, at a policy level, future pediatricians orienting toward social pediatrics often struggle to contend with the perception of clinical pediatrics as aligned with carceral systems and approaches that can harm children.[24] A key example of this disconnect is categorical mandates for child welfare reporting, particularly because marginalized families are disproportionately shunted into punitive systems that often fail to provide support,[25] cause breakdowns of trust,[26] and exacerbate devastating consequences for child and family health.[27] Increased reporting does not lead to better identification of children at risk, as only about one-fourth of maltreatment reports lead to substantiation.[28,29] For example, due to vague language in the federal Child Abuse Prevention and Treatment Act, which fails to explicitly define "reasonable cause" reporting standards related to prenatal substance exposure,[30] most jurisdictions interpret the law by requiring that pediatricians categorically report newborns of parents taking medications for opioid use disorder (MOUD).[31,32] These punitive policies actively dissuade birthing parents with substance use disorders from prenatal and postpartum care engagement,[33] decrease adherence to lifesaving MOUD,[34] and prolong newborn hospitalizations for neonatal opioid withdrawal syndrome,[35,36,37] in addition to potentially limiting the ways in which social pediatricians can build trust with their patients and communities. Punitive policies also exemplify that health care systems are not structured to incentivize future pediatricians to undertake the work of creative, meaningful, longitudinal coalition-building to advocate for community-driven solutions.[38]

Operationalizing Social Pediatrics Training

Although obstacles abound, incorporating and formalizing social pediatrics training in resident education remains essential and can be achieved through a variety of individual, institutional, and structural changes.

First, at the patient-clinician level, clinical training must integrate opportunities for accompaniment. The Accreditation Council for Graduate Medical Education (ACGME) recently enacted new requirements for pediatrics residency programs that explicitly identify community and physician advocacy as a critical tenet for guiding development of the future pediatrics workforce.[39,40] The new ACGME residency program requirements will expand outpatient and behavioral health training, which may present novel opportunities to prioritize interprofessional and community-engaged experiences. For instance, for each half-day of an outpatient clinic, pediatric trainees could be allocated prolonged appointment slots for patients identified as facing socio-structural barriers to health and well-being. These appointment slots could be prioritized for multidisciplinary visits involving interdisciplinary clinical care team members in tandem with community health workers, social workers, or cultural brokers. While program-specific training environments will be heterogenous, embedding SDoH-related services within clinical settings may be another opportunity to reduce administrative burden, motivate conversations about health-related social needs, and facilitate co-enrollment for families seeking access to safety-net resources.[41,42,43] Other possible avenues for accompaniment in pediatrics training might include longitudinal trainee involvement in home visits and hospital-at-home services.[44] Foundational and proximate experiences within and beyond clinical settings—supported by new ACGME competencies and requirements—will enhance how social pediatricians recognize and understand the socio-structural determinants of child and family health.

Second, at the institutional level, social pediatric curricula must equip trainees with structural competency and longitudinal opportunities for direct action.[2,3] For example, at Boston Medical Center, Health Equity Rounds (HER) is a solutions-oriented, department-wide quarterly grand rounds series that aims to confront the effects of intersectional systems of oppression on health and health care.[45,46,47] Similar to a morbidity and mortality conference, HER presentations dissect the "whys" of a clinical narrative in a protected peer environment while striving to identify individual, institutional, and structural opportunities to improve care delivery. Early evaluations of HER from 2016 to 2018 highlighted that at least 88% of attendees felt HER promoted personal reflection on implicit biases, and at least 75% of attendees intended to make one or more tangible changes to their clinical practice.[47] At our institution, carefully refined HER topics have directly led to trainee-driven media advocacy,[31,48] amplified attention to nationwide crises with key pediatric implications,[49,50,51] reformed clinical teaching teams' care and education approaches,[52] and motivated institution-funded research to inform equity-focused interventions.[53] Perhaps most importantly, HER has continued to serve as a venue for facilitating accompaniment through the recognition of lived expertise as a means of training social pediatricians, as panelists are often recruited from other teams in the hospital or local organizations. Institutions should fund protected time for faculty, staff, and community partners committed to developing dialectical, longitudinally supported, social pediatrics-oriented education of this nature.

The impact of HER has been felt on institutional and systems levels alike. For example, a 2018 HER presentation led to the creation of a new institutional guideline advising that child welfare agency reporting for prenatal substance exposure should be limited to cases in which the multidisciplinary team identified specific, tangible child protective concerns.[53] This guideline in turn motivated a research study to evaluate this novel hospital-level guideline,[53] the implementation of similar guidelines at other area hospitals,[54] endorsements by prominent local news outlets,[55,56] and a 2024 legislative bill that will end state-mandated child welfare agency reporting for the use of prescribed MOUD.[57] Across the country, HER has now been implemented at more than 65 institutions and integrated as a regular article series for the journal *Hospital Pediatrics*.[45,58,59] These impacts reflect ideal outcomes for social pediatrics training: expanding the real-world praxis of social pediatricians, within and beyond clinic and hospital walls.

Finally, at a structural level, social pediatrics can be prioritized in resident education when it becomes more robustly integrated into clinical practice for all pediatricians. One starting place may lie in decoupling carceral and punitive systems from systems of medical care and social support, so that at-risk children can be identified and aided outside the specter of family policing[60] and pediatricians can focus on service linkages and co-enrollment for families seeking safety-net resources ("you can support a family without having to report a family"[61]). Building a noncarceral support model, however, would necessitate the development of avenues for patients and families to confidentially disclose intervenable socio-structural barriers to their health and well-being.[62,63] By supporting policy change that explicitly defines reporting obligations,[64] works toward replacing categorical reporting mandates with risk-based permissive reporting,[65,66] and recognizes that child welfare agencies often prioritize investigation over service provision,[27,60,67] social pediatricians—and therefore pediatric trainees—can better provide structurally competent care.

Integrating social pediatrics into the core fabric of resident education will also require shifting care to community-centered models that incentivize sustained accompaniment by restructuring health system incentives. While evidence and experience suggest these models could improve care outcomes, enhance equity, reduce clinician burnout, and lower costs, restructuring health system incentives will require a multipronged approach.[10,68,69,70,71] Necessary interventions might include ensuring universal access to insurance,[72,73,74] financing creative approaches to address health-related social needs,[21,75] establishing rate parity across payers,[76,77] interrupting cycles of hospital price discrimination,[78,79] improving social risk adjustment,[80,81,82] strengthening rather than penalizing the health care safety-net,[80,83,84,85,86] and continuing to iteratively evaluate these interventions at every stage.[87,88] Although these structures may seem far-removed from the training and practice of social pediatricians, the sustainability of social pediatrics—and the pediatric workforce writ large[77,89,90]—may hinge upon these fundamental care delivery reforms.

Conclusion

By drawing upon critical pedagogical frameworks like structural competency and long-standing social medicine paradigms like accompaniment, we argue that social pediatrics training can move toward a future that prioritizes a deeper patient-clinician relationship, necessary professional development for all trainees, and equitable systems reforms that will empower the pediatrics workforce of the future.

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MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

Three Things Students and Trainees Should Learn About Public Health Insurance for Children

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Abstract
Despite the inclusion of health equity and public health in undergraduate and graduate medical curricula, many medical students and trainees have minimal understanding of health insurance coverage for children of families with low incomes. Since children's eligibility for Medicaid and the Children's Health Insurance Program (CHIP) significantly influence their care, this article proposes that students and trainees, especially in pediatrics, should receive formal instruction about Medicaid and CHIP in 3 key areas: program structure; eligibility determinations, redeterminations, and range of covered or partially covered services; and enrollment requirements and processes. This article also suggests the nature and scope of expertise required to responsibly offer such instruction in classroom- and clinic-based settings.

Health Economics in Medical Education

While medical students and residents in the United States are taught much about anatomy, physiology, organ systems, and disease management, education on health insurance and Medicaid is lacking. Of topics learned in medical school, trainees have reported having the lowest confidence in their knowledge of health policy and economics.[1] Nevertheless, exposure to health policy and health equity in medical school is occurring through public health clubs or optional public health and health policy electives in medical schools and residencies.[2] For example, one student-led program sought to raise awareness of racial bias in medicine and demonstrate how racial injustice can be incorporated in preclinical medical student education.[3,4] However, few schools or residencies mandate an *extensive* public health curriculum, and fewer provide comprehensive education on public insurance. The Association of American Medical Colleges reported that 132 of 147 medical schools taught some health care financing in required courses preclinically,[5] but, in our experience as recent medical school graduates, this teaching was limited to superficial topics, such as the broad differences between Medicare, Medicaid, and private insurance—content that covered only what is tested on United States Medical Licensing Examination board exams.[6]

Upon reviewing the board exam content distribution for the specialties of emergency medicine, pediatrics, and family medicine, we found that none require knowledge of health insurance programs, let alone specifics of Medicaid or similar programs.[7,8,9] However, the American Medical Association has adopted a policy encouraging medical schools and residencies to provide more in-depth health care economics education.[10] Thus, the pressure is on medical schools or individual physicians to cover this content more thoroughly.

Given the brief coverage trainees receive, in this article we first discuss the benefits of coverage and then propose several key points about insurance coverage that trainees should understand: (1) the general structure of Medicaid and the Children's Health Insurance Program (CHIP), (2) who qualifies for Medicaid as compared to CHIP and what services each cover, and (3) how patients and families can enroll in Medicaid or CHIP. Additionally, we propose who may be the best qualified to deliver this content to medical students and residents.

Insuring Children

It is estimated that roughly 36% of children in the United States in 2023 had health insurance coverage through a Medicaid program and 10% through CHIP.[11] Additionally, Medicaid and CHIP programs covered two-thirds of children in families with low incomes (below 200% of the federal poverty level, or FPL) in 2015[12] and approximately 44% of children with special health care needs in 2019.[13] Although the rate of uninsured children has dropped to near 5%, it is estimated that approximately 55% of these children qualify for Medicaid or CHIP programs.[14,15] Based on these numbers, one can assume that most medical students and residents will care for patients either eligible for or insured by Medicaid or CHIP.

Research suggests that the expansion of Medicaid and CHIP coverage reduces pediatric hospitalizations, care gaps, and mortality and improves health outcomes.[16,17,18,19,20] There's also mounting evidence of the positive impact of insurance coverage beyond children's immediate health, including higher educational attainment,[21] better adult health, and decreased poverty for children and their families on Medicaid,[22] although it is hard to differentiate between the impacts of CHIP and Medicaid because children frequently switch between programs as their family's income fluctuates.

Funding Structures

Medicaid is jointly state and federally funded and designed to help individuals with low incomes, including pregnant individuals, families, the elderly, and individuals with disabilities.[23] Each state must follow minimum federal requirements but otherwise may administer Medicaid as they see fit.[24] There is no cap to the funding match that the federal government provides for qualified services, and states may apply for waivers to administer the program in other ways if it is determined that the proposed changes are in line with Medicaid goals.[24,25] Therefore, there is significant variation from state to state in services covered, payment structures, and qualifying income levels. For example, the default pay structure is fee-for-service; however, most states adopt managed care plans.[26] Additionally, Medicaid benefits that states can opt into include, but are not limited to, dental care, physical therapy, home health care, hospice, prosthetics, and targeted case management programs.[26,27]

Although Medicaid covers both adults and children, CHIP is focused solely on expanding health insurance coverage for children. CHIP was initially created in 1997 to offer coverage to children in families with household incomes too high to qualify for Medicaid but too low for health care to be affordable.[28] CHIP can be operated by states as a separate program from Medicaid or as a Medicaid expansion wherein CHIP is a subprogram of Medicaid. Similarly to Medicaid, CHIP is jointly state and federally funded. While the percentage of CHIP's funding from the federal government is larger than Medicaid's (approximately 15% higher), unlike Medicaid, there is a federal cap to the CHIP funds allocated to each state annually.[29] Thus, if a state has hit its annual cap, applicants are not allowed to enroll or are placed on a waiting list.

Although pediatric Medicaid and CHIP cover many of the same services, such as routine checkups and vaccinations,[27,30] there are some key differences between the two. The federal government mandates that Medicaid programs in every state fully cover all services outlined under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program for any child under the age of 21, which includes comprehensive and preventative care consisting of vision and hearing care, mental health care, developmental services, and dental care.[20,30,31] CHIP programs are not subjected to the same EPSDT coverage minimums, which can lead to gaps in services depending on the state, as states can opt in to offer some services that are optional at the federal level. Moreover, for pediatric Medicaid programs, premiums and cost sharing are federally prohibited in most cases, whereas many CHIP programs have premiums or cost sharing that increase in proportion to family income.[32]

Qualifying for Medicaid and CHIP

Eligibility for pediatric Medicaid and CHIP is primarily based on a child's age, family income, family size, and insurance status. Unlike Medicare for persons at least 65 years of age, eligibility for both pediatric Medicaid and CHIP requires the child to be uninsured; CHIP and Medicaid cannot be used as secondary insurance.[33] Additionally, a child cannot be on *both* Medicaid and CHIP in the traditional sense of primary and secondary insurance.[33] For both programs, modified adjusted gross income (MAGI) is used to determine eligibility expressed as a percentage of the FPL.[34] For a family of 3 in the 48 contiguous states and the District of Columbia, as of 2024, the FPL is $25 820 and has increased annually with inflation.[35] (The FPL is slightly higher in Hawaii and Alaska due to increased cost of living[35]). The percentage of FPL that is used as a cutoff varies by state.[34] Recent state-specific data on pediatric Medicaid and CHIP eligibility from 2024 demonstrate a range of FPL cutoffs stratified by age—from 107% of the FPL ($27 627) in North Carolina (ages 6-18) to 324% of the FPL ($83 657) in Washington, DC (ages 0-19)[36] (see Table). If Medicaid is expanded in a state, there are often higher income limits for both programs, with CHIP most often having the highest family MAGI eligibility cutoff. Finally, it should be noted that children in the foster care system may qualify for extended coverage until age 26, although the availability of this provision varies by state.[23]

Table. 2024 Income Maximums ($ US) for Federally Funded Pediatric Health Insurance Programs by Child Age and State

State	0–1 years[a]	1–5 years[a]	6–18 years[a,b]
Alabama	37 697	37 697	27 627–37 697
Alaska	41 054–53 706	41 054–53 706	32 017–53 706
Arizona[c]	39 246	37 697	26 853–35 632
Arkansas	37 955	37 955	27 627–37 955
California[d]	53 706–67 132	36 664–68 681	27 886–68 681
Colorado	37 955	37 955	27 886–37 955
Connecticut	51 898	51 898	51 898

Delaware	50 091–56 029	37 955	28 402–36 632
District of Columbia	53 189–83 657	37 697–83 657	28 918–83 657
Florida[e,f]	49 574–54 480	37 439	28 918–36 632
Georgia	54 222	39 763	29 177–36 632
Hawaii	49 316–80 817	35890–80 817	34 341–80 817
Idaho	37 955	37 955	27 627–36 632
Illinois	36 664–82 108	36 664–82 108	27 886–82 108
Indiana	40 537–54 997	36 406–42 087	27 369–42 087
Iowa[g]	61 968–98 116	44 410	31 500–44 410
Kansas	44 152	39 763	29 177–35 632
Kentucky	50 349–56 288	36 664–56 288	28 144–56 288
Louisiana	36 664–56 029	36 664–56 029	27 886–56 029
Maine	49 316–78 751	36 148–78 751	34 082–53 706
Maryland	50 091–83 140	35 632–83 140	28 144–83 140
Massachusetts	47 767–52 931	34 361–40 021	29 435–40 021
Michigan[h]	50 349–56 029	36 923–56 029	28 144–56 029
Minnesota[i]	71 005–74 362	72 296	72 296
Mississippi	51 382	38 214	27 627–35 632
Missouri	51 898	38 214–40 021	28 402–40 021
Montana	38 214	38 214	28 144–38 214
Nebraska	41 828–56 288	37 439–56 288	28 244–56 288
Nevada	42 603	42 603	31 500–35 632
New Hampshire	50 607–83 399	50 607–83 399	50 607–83 399
New Jersey	51 382	37 955	27 627–37 955
New Mexico	51 640–78 751	51 640–78 751	35 632–63 259
New York	57 579	39 763	28 402–39 763
North Carolina	50 091–55 771	36 406–55 771	27 627–55 771
North Dakota	37 955–52 931	37 955–52 931	28 660–52 931
Ohio	36 406–54 480	36 406–54 480	27 627–54 480
Oklahoma[j]	43 636–54 222	38 988-54 222	29 693–54 222
Oregon	34 341–49 058	35 632	25 820–35 632
Pennsylvania	56 804	41 828	30 756–35 632
Rhode Island	49 058–68 681	36 664–68 681	28 144–68 681
South Carolina	50 091–54 997	36 923–54 997	27 627–54 997
South Dakota	37 955–48 283	37 955–48 283	28 660–48 283
Tennessee	50 349–55 771	36 664–55 771	28 144–55 771
Texas	52 415	38 472	28 144–35 632
Utah	37 181	37 181	27 111–35 632
Vermont	61 193–81 849	61 193–81 849	61 193–81 849
Virginia	38 214	38 214	28 144–38 214
Washington	55 513	55 513	55 513
West Virginia	42 087	37 697	27 886–35 632
Wisconsin[k]	79 009	49 316	26 078–40 297
Wyoming	39 763–52 931	39 763–52 931	30 726–52 931

Adapted with permission from the Kaiser Family Foundation using data from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families.[36]

Range of income maximum cutoffs for Medicaid and Children's Health Insurance Program (CHIP) federally funded or subsidized pediatric health insurance programs using modified adjusted gross income (in dollars) for a family of 3 calculated from a percentage of the federal poverty level as published by each state. In states where no range exists, this reflects a unified income eligibility maximum across pediatric Medicaid and CHIP programs.

[a] Ranges for a state reflect the variation between pediatric Medicaid and CHIP program income cutoffs within the state. States have the option to run CHIP within their Medicaid program or as a separate program or programs based on child age and Medicaid expansion or waiver status. For example, Florida has three separate CHIP programs for ages 1-4, ages 5-18, and children with special health care needs up to age 21.

[b] For ages 6-18, Medicaid funding through rule XXI funds sets cutoffs that are lower than the standard 138% ($35 632) of federal poverty level (FPL), and states may further modify this cutoff.

[c] Arizona expanded eligibility for its separate CHIP program in March 2024 to 230% of the FPL ($59 386) through a Section 1115 demonstration amendment. Due to a technical change in the Affordable Care Act, states are required to use Section 1115 authority to increase CHIP eligibility up to the greater of 200% of the FPL ($51 640) or more than 50 percentage points above their 1997 Medicaid income levels.

[d] In California, children with higher incomes are eligible for separate CHIP coverage in some counties.

[e] Florida has expanded coverage for children with special health care needs through age 21.

[f] Florida did not respond to the 2024 survey; eligibility levels reported are from 2023.

[g] Iowa passed legislation that will reduce eligibility levels for infants in Medicaid to 215% of the FPL ($55 513), effective January 1, 2025. The upper eligibility limit for infants ages 0-1 is now 307% of the FPL ($79 267), down from 380% of the FPL ($98 116).

[h] Michigan provides CHIP-funded Medicaid expansion coverage to children affected by the Flint water crisis with family incomes between 212% of the FPL and 400% of the FPL ($54 738-$103 280).

[i] Minnesota covers children up to age 2 as infants under Medicaid through a Section 1115 waiver.

[j] Oklahoma offers a premium assistance program through its Insure Oklahoma Program to children aged 0-18 years with family incomes up to 222% of the FPL ($57 320) with access to employer-sponsored insurance.

[k] In Wisconsin, children are not eligible for its separate CHIP program if they have access to job-based health insurance coverage where the employer covers at least 80% of the cost.

Additionally, federal regulations on citizenship and immigration status limit Medicaid or CHIP access for noncitizens. Research shows that states without expanded eligibility for noncitizens have less overall pediatric health care utilization.[37] Noncitizens are subject to a 5-year waiting period before being eligible for these services, with exceptions being made for lawful permanent residents (green card holders), Cuban or Haitian entrants, members of nationally recognized Indian Tribes, and for those who entered the United States under asylum or refugee status or immigrated due to being victims of domestic violence or trafficking.[38,39] Reassurance should be offered to immigrants applying for health insurance that, as long as they are not requiring long-term nursing home care, the US Citizenship and Immigration Services does not take into account Medicaid or CHIP utilization as part of the public charge determination for immigration status.[40] However, requirements can change with different presidential administrations and executive guidance on how to apply the public charge ruling—an example being a recent change in guidance for adult patients only.[41] There is some evidence that changes in executive office guidance on the public charge ruling affect applicants' decisions about enrolling or reenrolling in pediatric Medicaid and CHIP. For example, the American Community survey found a 20% drop in Medicaid and CHIP participation among noncitizens between 2016 and 2019, and another 2019 survey of health centers found that 38% reported being aware of immigrant patients declining to enroll their children in Medicaid and 28% reported being aware of immigrant patients disenrolling or declining to reenroll their children in Medicaid over the previous year.[42,43] Even though a child's use of Medicaid or CHIP does not affect immigration applications, 22% of surveyed health centers in 2019 saw a decrease in immigrant parents seeking care for their children.[42]

Enrolling in Medicaid and CHIP

Clinicians' understanding of the basic, state-specific requirements for Medicaid and CHIP eligibility, which vary based on income and legal situation, as well as of the services each covers, can help guide their recommendations to patients and families. Despite the complexities of eligibility and coverage rules, most states have a simple and unified application process for Medicaid and CHIP. Importantly, a parent being ineligible for Medicaid does not mean their child will be ineligible, because familial income cutoffs for children (see Table) are typically higher than adult cutoffs. Even if the adults in the household are insured through their employer, their children are typically still eligible for Medicaid or CHIP if they meet the income cutoffs.[39] Parents, grandparents, and guardians may complete the applications for Medicaid or CHIP on behalf of their children.[39] Teenagers who are emancipated are also eligible to complete their own application.[39] While social workers can help families navigate the application process, they are often unable to directly file on behalf of someone. Some states have employed health insurance marketplace or Medicaid navigators[44] who are familiar with eligibility rules and can help applicants find the most appropriate plan for a child and their family. Applications can be found on each state's Medicaid or CHIP website, their health insurance marketplace, or the federal government website.[28,45,46]

Curricular Administration and Engagement

All this information is essential to providing improved patient care for children and their families. Medical school and residency curricula tend to have limited room for additional lectures and information sessions, but we feel that more in-depth education about Medicaid and CHIP is warranted. We know that improving access to health care improves health outcomes, and students and residents should have the tools and knowledge to advocate for their patients to obtain appropriate health care coverage. Although education on Medicaid and CHIP may be covered during pediatric and family medicine rotations, we also propose that medical schools incorporate this information in the preclinical years of medical education. Social workers and other financial administrative staff who assist patients and families with Medicaid registration, as well as health insurance navigators, may be best equipped to teach this information, although physicians who care for a significant number of underinsured and uninsured patients may also be able to teach these lessons. Lectures from staff at state Medicaid offices may also be beneficial, as they can offer trainees a better understanding of the enrollment process. Moreover, content on Medicaid and CHIP could be included in lectures on public health or in general medicine courses. Students should not have to "opt in" to a class or program that offers this information. Some suggestions for improving students' knowledge of public insurance include rotations with a social worker and spending a day with staff who assist patients in registering for Medicaid and CHIP. All students should enter clinical rotations and residency with this knowledge, and residencies should integrate training on Medicaid and CHIP into their scheduled didactic sessions. Without knowledge of insurance options and coverage for patients with low incomes, physicians cannot provide adequate care for all patients.

In summary, medical schools and residencies should incorporate education on Medicaid and CHIP, as insurance has a substantial impact on patient care and outcomes. Understanding what Medicaid and CHIP are, who qualifies for pediatric Medicaid and CHIP, what services each cover, and how patients and families can enroll in Medicaid or CHIP is essential to improving pediatric health outcomes and health equity.

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STATE OF THE ART AND SCIENCE: PEER-REVIEWED ARTICLE

Trauma-Informed Screening for Structural Drivers of Health

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Abstract

Screening for structural drivers or determinants of health (SDoH), as mandated by recent federal regulations, raises ethical questions about screening processes and tools. Early childhood adversity and trauma, which can influence a person's health throughout their lifespan and contribute to chronic disease and early death, can be identified through standardized screening for SDoH. However, screening without awareness of the potential interface between SDoH and trauma can retraumatize those administering or completing the screening process. This article suggests that implementation of a trauma-informed approach to SDoH screening is consistent with biomedical and public health ethics and contributes to efforts to keep clinical environments emotionally safe.

Adverse Childhood Experiences

Structural drivers or determinants of health (SDoH) are upstream contributors to health that have social, cultural, economic, or political origins and that can contribute to premature morbidity and mortality.[1] The US Department of Health and Human Services (HHS) describes SDoH as "conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[2] HHS offers illustrative examples of SDoH, including "safe housing, transportation, and neighborhoods" and "education, job opportunities, and income," in addition to access to healthy food, water, and air. In its SDoH screening requirements for patients 18 years of age or older admitted to hospitals participating in the Hospital Inpatient Quality Reporting Program, the Centers for Medicare and Medicaid Services (CMS) includes "food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety" as relevant screening domains.[3]

Adversity, including early childhood adversity, is its own driver of health. Childhood experiences of poverty, community violence, and loss of a parent are examples of early childhood adversity; adverse childhood experience (ACEs) are associated with negative health outcomes, including lifelong biopsychosocial maladaptation, chronic adult illness, and other risk factors for shortened life.[4] Classic intrafamilial ACEs, such as parental separation,[5] substance use,[6] incarceration,[7] or death,[8] can create economic strain on individuals and families. Adults who report experiencing more ACE types are more likely to face socioeconomic challenges than those who report no ACEs,[9] which might contribute to their reproducing adverse SDoH, such as unemployment, food insecurity, or housing insecurity, for children growing up in their households. Racism, discrimination, and community violence are all significant SDoH that can also contribute to early childhood trauma, community trauma, and retraumatization during health care encounters. Nearly two-thirds of US adults have experienced at least one ACE,[10] and studies in the United States[11] and globally[12] suggest that 70% or more of adults experience at least one traumatic event in their lifetime. Individual trauma "results from an event, series of events, or set of circumstances that is … physically or emotionally harmful or life threatening and that has lasting adverse effects on … mental, physical, social, emotional, or spiritual well-being."[13] Because early trauma impacts adult health[14]—and given the connections between SDoH, adversity, and trauma—ethically acceptable screening strategies require trauma-informed approaches.

Screening Retraumatization Risk

Trauma-informed care (TIC) is a framework that realizes the prevalence and impact of trauma, recognizes its "signs and symptoms," responds with trauma-informed principles, and seeks to resist retraumatization.[13] Trauma-informed principles promote emotional and physical safety, trust and transparency, peer support, inclusion, empowerment, voice, and choice. The TIC framework also includes the influence of history and culture on achieving these aims.[13] Policy statements on adoption of TIC in health care systems, such as that of the American Academy of Pediatrics,[15] require translating TIC frameworks into actionable practice,[16] including screening practices.

In addition to the implicit, often mutually amplifying relationship between SDoH, adversity, and trauma, there is an explicit connection among these factors in many tools currently used for SDoH screening. SDoH screeners often include questions directly related to trauma and adversity. One review of SDoH screeners deployed in pediatrics identified 11 distinct screeners.[17] Each included questions regarding the domains of adversity and potential trauma, such as intimate partner, household, or community violence; substance use and mental health concerns; physical, emotional, and sexual abuse; and parental separation or incarceration.[17]

CMS does not require or recommend a specific screening tool, recognizing that local and population context may influence how best to screen for its identified screening domains (ie, food, housing, transportation, utilities, safety).[3] Screening for interpersonal safety is particularly open to variable implementation and could include safety within living, working, relational, or community environments. Thus, interpersonal safety screening may identify or reflect sources of adversity and trauma. Considering the absence of specific screener guidance, facilities may seek to adopt or adapt existing screeners to meet CMS requirements. As noted, many of these include questions about adversity or trauma.

For example, the Safe Environment for Every Kid Parent Questionnaire (SEEK-PQ) is one tool that inpatient facilities may adopt to meet CMS screening requirements. Questions include experiences with worrying about or running out of food; needing support with transportation, housing, or utilities; and household safety features like gun locks and smoke detectors in the home.[18] In the pediatric context, screening tools are completed by parents or other caregivers in the service of the pediatric patient. The SEEK-PQ screens the patient's parent or caregiver for drug and alcohol use, fighting with their partner, and depression.[18] These behaviors may constitute ACEs for pediatric patients, impacting their health and well-being. But they may also impact the screened parent or caregiver's health and well-being.

Screening a parent or other caregiver to address the patient's SDoH introduces additional considerations about how to best mitigate stress and retraumatization for the parent or other caregiver when completing the screener. It also introduces concerns about how to address identified psychosocial needs of the screened parent or other caregiver when screening is not occurring within a trusted relationship between the caregiver and their own health care clinician. The different, and sometimes competing, obligations pediatricians have to their patients and to their patients' caregivers create challenges for providing adequately informed—and trauma-informed—consent to screening for SDoH and addressing identified needs. For example, screening may introduce different risks and benefits for the screened caregiver than it does for the patient. Moreover, empowering the voice and choice of a parent or other caregiver to opt-out of screening may be a trauma-informed practice that is attentive to their needs, but opting out of screening may not support the health and trauma-informed needs of the pediatric patient.

Screening Ethics

Like screening for SDoH, screening for adversity and trauma on a population-health level can make connections between these experiences and health outcomes. Given that SDoH screening is now a CMS requirement for some hospitalized patients—and considering the interconnection among SDoH, trauma, and adversity—the benefits and risks of screening for trauma and adversity are relevant to SDoH screening. Potential benefits of screening for adversity, like screening for SDoH, include identifying unmet needs and connecting people to resources, although screening individuals for classic ACEs is more ethically controversial.[19] When resources are unavailable, screening may not be ethically justifiable unless understood by the patient or caretaker as a needs assessment.[20] Surveillance regarding patient safety may be a clinically indicated and ethically supportable alternative to screening that may also help identify and address unmet needs. Informal surveillance is typically a conversational approach that elicits patients' questions and concerns on a topic (as distinct from formal screening that poses structured questions via a validated tool to collect data on the topic[21]). Safety surveillance is commonly adopted in adult[22] and pediatric[23,24] practice and can be more relational when done through attentive, face-to-face discussion rather than through a screening tool alone, paired with private opportunities for disclosure.[25]

Even in the absence of resource referrals, there may be other benefits of SDoH and adversity screening, such as enabling clinicians to promote known protective factors. Protective factors can be personal, familial, or communal sources of strength that buffer the impact of trauma and adversity. The most effective protective factor that mitigates lifelong effects of early childhood adversity is a safe, stable relationship with a nurturing adult.[26] Clinicians can recommend interventions to foster relational health, which is the capacity to develop and sustain these safe and stable relationships. Recommendations may include shared book reading between children and caregivers, encouraging developmentally appropriate play, and connecting families to quality early childhood education.[26] The promotion of protective factors and relational health can also be a universal intervention for all patients, regardless of screening, given the overall benefits of relational health, just as implementing universal SDoH screening rather than only screening Medicaid patients could mitigate potential screening bias.[20] Similarly, universally screening for and promoting protective factors would be a trauma-informed approach that recognizes and responds to the known prevalence of trauma.[10,11,12]

Risks of screening for trauma and adversity include lacking appropriate resources to address identified needs, as well as the potential for retraumatization during the screening process. Weighing potential benefits of screening against harms of retraumatization can be especially complex when parents are screened for their own adversity and early childhood trauma in the context of their child's health outside of a patient-clinician relationship that is oriented to address the parent's needs. Screening may also trigger strong emotional reactions in health care workers who recognize in their patients and families their own similar adverse or traumatic experiences.

Given the intersection among SDoH, adversity, and trauma, SDoH screening needs to be trauma informed to reduce harms and maximize benefits. If SDoH screening cannot be trauma informed, then it might not be ethically supportable to proceed. However, not complying with CMS requirements may burden already vulnerable patient populations enrolled in Medicare or Medicaid if hospitals caring for them face penalties for noncompliance that impact their ability to care for their patients. Inpatient facilities unable to provide trauma-informed SDoH screening may consider a minimal approach to screening by asking narrow questions about housing, transportation, food, and utilities, with safety questions limited in scope and content. Even if care facilities do not use one of the validated screening tools that include questions about adversity or trauma, questions pertaining to CMS' 5 domains may trigger a traumatic response from or retraumatize the parent or other caregiver (ie, questions about personal safety or questions whose answers involve upstream or historical adversity). This possibility should be factored into the screening tool a facility adopts or develops.

Trauma-Informed Strategies

Personal or historical trauma impacts patients, families, caregivers, and health care workers. Because many health care experiences, including being screened for SDoH, can reveal unresolved trauma or retraumatize, TIC should be a universal precaution applied to all health care encounters. As a basic intervention, health systems should provide TIC education for all staff, whether patient facing or not. Implementing ethical SDoH screening means promoting trauma-informed principles in the design, implementation, and outcomes of SDoH screening. These trauma-informed principles are compatible with and can support clinical ethics and public health ethics principles, such as solidarity. Trauma-informed SDoH screening practices and the principles they embody include the following:

- Screening for and promoting relational health and protective factors,[20,26,27] consistent with harm avoidance, prevention, and beneficence.

- Screening for needs for which there are available resources, consistent with distributive justice, family empowerment, and the professional duty to care.

- Involving families and community leaders in the development of screening tools and decisions about which SDoH to prioritize and how they can be addressed in the community, supporting the principle of solidarity and meaningful engagement.

- Offering sincere choices about participation in SDoH screening and, if agreed to, when and how SDoH screening will be conducted, such as face-to-face, on paper, or electronically, to maximize personal choice and enhance the principles of autonomy, proportionality, and cultural awareness.

- Sharing information about why SDoH screening is occurring and what the results of the screening may be, including outcomes at the individual and population levels in terms of how data will or will not be used, analyzed, documented, or retained, supporting the principle of transparency and increasing trust.

- Ensuring that all personnel involved in preparing, performing, and reviewing screening tools are trained in trauma-informed principles and have supportive resources available to mitigate secondary trauma, reflecting the principles of beneficence, justice, and prevention.

A trauma-informed approach to SDoH screening will likely expand the resources that could— and should—be offered in response to positive screening and shape how clinicians approach ethically responsible SDoH screening in their practices and health systems. Specifically, such an approach involves adopting the practices described above and providing resources for health care workers experiencing retraumatization or secondary trauma when screening patients for SDoH and caring for patients experiencing adversity. Finally, extending CMS-required screening from inpatient settings to outpatient settings with trusted clinicians may foster trauma-informed environments for patients and staff and promote relational health.

Conclusion

Screening for SDoH is an important strategy to identify economic and social risk factors that interfere with family and child well-being. However, the screening process may surface previous traumatic experiences and can trigger retraumatization. Application of the principles of trauma-informed care to the screening process, including meaningful involvement with families and identification of relational protective factors, can mitigate the risk of retraumatization. This paper suggests that the principles of trauma-informed care are consistent with public health and biomedical ethics and, if applied, can help create an emotionally safe clinical environment.

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POLICY FORUM: PEER-REVIEWED ARTICLE

How Should Children’s Medicaid Eligibility Be Monitored?

Gabriella Aboulafia, MPP and Adrianna McIntyre, PhD, MPH, MPP

Abstract

Medicaid provides health insurance for nearly 4 in 10 children in the United States, but this coverage can be unstable as a result of annual eligibility redetermination requirements. After the continuous Medicaid coverage mandate during the COVID-19 pandemic ended in March 2023, states were required for the first time to publicly report standardized metrics on terminations and renewals resulting from eligibility redeterminations. Our understanding of redeterminations and their contribution to coverage gaps had been constrained by data limitations, but states’ reporting practices offered researchers and policymakers key insights into these processes and associated coverage outcomes. This article canvasses some of those insights and suggests how federal reporting requirements could be amended to offer actionable insights into redetermination processes.

Background on Medicaid Continuous Coverage

Medicaid is a critical source of health insurance for children in the United States, covering nearly 4 in 10 (38.8%) in 2023, second only to employer-based insurance (48.7%).[1] However, coverage through Medicaid and the Children’s Health Insurance Program (CHIP) can be disrupted from year to year by annual requirements to ascertain, or to “redetermine,” ongoing eligibility for the program. Where enrollees can’t have their eligibility automatically renewed based on data states can access (eg, state wage databases), they need to provide information to the state substantiating their eligibility. During the COVID-19 pandemic, as part of a federal law intended to strengthen the safety net, states suspended these redeterminations pursuant to a requirement to keep Medicaid enrollees—children and adults alike—continuously covered until the end of the public health emergency, and they received additional federal funds to do so.[2] With the termination of the continuous enrollment provision effective March 31, 2023, as part of the Consolidated Appropriations Act (CAA) of 2023,[3] early that year states began to roll back Medicaid and CHIP continuous coverage. During the “unwinding” of continuous coverage and resumption of eligibility redeterminations (which typically occur on an annual basis), states were obligated under the act to report metrics on terminations and renewals resulting from Medicaid eligibility redeterminations—the first time that reporting and publishing of such outcomes in any standardized way has been required.[3]

Unwinding jeopardized health insurance for millions of Americans, attracting significant attention from policymakers and researchers alike. Research suggests that gaps in health insurance coverage—and even transitions to other kinds of coverage without a gap—can leave people exposed to financial risk and affect access to care. In particular, people who experience gaps in coverage are more likely to delay needed and preventive care, skip prescription refills, and use the emergency department more often.[4] During unwinding, experts voiced concerns about avoidable "administrative churn" (disenrollment among people who remained Medicaid-eligible but failed to navigate the renewal process); early projections suggested that nearly half of those disenrolled would be people who remained eligible.[5] Other experts highlighted evidence that people who lose eligibility for Medicaid due to increased income—but become eligible for subsidized HealthCare.gov Marketplace coverage—often fail to successfully transition, resulting in avoidable coverage gaps.[6,7]

Following this experience, there has been considerable interest in strategies and best practices to improve Medicaid—and CHIP—redetermination processes. But researchers only recently started measuring redetermination outcomes to rigorously identify and evaluate such strategies. Failure to continue monitoring redetermination outcomes—which varied demographically and geographically—would stymie progress to improve redetermination processes and inhibit policymakers' ability to identify and implement policies that could reduce unnecessary lapses in coverage.[8]

Fallout of Medicaid Unwinding

As of September 2024, 31% of individuals (representing about 25 million people) who had undergone eligibility redeterminations had been disenrolled from Medicaid and CHIP during the unwinding process, which began in April 2023.[9] As of September 2024, most terminations (over two-thirds) were "procedural," meaning the state could not definitively ascertain eligibility.[9,10] Some people whose terminations fell into this group might have acquired other health insurance but not withdrawn from Medicaid.[11,12] Some might have believed they no longer qualified for Medicaid due to changes in income or circumstances and so did not respond to renewal paperwork. Others—the group that concerned policymakers, advocates, and researchers most—might have lost Medicaid because they never received or could not complete renewal paperwork, despite their eligibility. Overall, enrollment in Medicaid among adults declined by 19% between March 2023 and December 2024.[13] The drop in Medicaid and CHIP enrollment among children during this period was about 11%.[13]

Redetermination outcomes varied considerably across states during this process.[9] These uneven results reflected a combination of implementation choices during unwinding, extant differences in state programs and policies, and variation in the capabilities of state eligibility and enrollment systems that process redeterminations.[14,15] They also reflected noncompliance issues, which particularly impacted child enrollees. First, a number of states initially undertook eligibility redeterminations at the *household*, rather than the *individual*, level. This matters because children may remain eligible for Medicaid (or CHIP) even if their parents do not, given more generous income eligibility thresholds for children. Second, at redetermination, some states failed to consider eligibility for *both* Medicaid and CHIP; children may lose eligibility for one program while becoming eligible for the other, depending on family income (CHIP has more generous income thresholds).

The heterogenous redetermination outcomes represent an opportunity to learn about what helps—and what does not help—to keep eligible individuals continuously enrolled in Medicaid and CHIP.[16] However, the lessons from this experience are also limited in a number of ways. Few states separately evaluated outcomes for adult and child enrollees or considered CHIP redeterminations separately from Medicaid redeterminations. Moreover, interviews with state officials suggest that the unwinding strategies implemented with children in mind were limited due to the overwhelming workload Medicaid agencies faced during the unwinding process.[16]

A Nascent Data Ecosystem

While Medicaid disenrollments and churn were common before unwinding, our understanding of these outcomes and their drivers were severely constrained by data limitations. Federal Medicaid enrollment and claims data available to researchers do not contain information on reasons for plan exit. One study attempted to obtain pre-2020 performance indicator data on procedural terminations in Medicaid and CHIP from the Centers for Medicare and Medicaid Services (CMS) with a Freedom of Information Act request, but only 13 states had data of sufficient quality to support analysis.[17]

As mentioned, the federal mandate for states to report redetermination metrics as part of the CAA of 2023—the legislation that also ended the continuous enrollment provision—marked the first time these outcomes were collected and published in any standardized fashion.[3] Starting in April 2023, the law required states to provide CMS with the number of Medicaid and CHIP enrollees who were procedurally terminated, the number found to be truly ineligible for coverage, the number who completed renewals through the *ex parte* process versus using a form, and the number whose coverage was terminated and applied at, or had their information transferred to, the HealthCare.gov Marketplace.[18] States also reported the number of redeterminations that had been initiated but not completed by the time of the report ("pending" cases).[18] These data enabled researchers, policymakers, and the general public to access information in a relatively straightforward way about the total number of people redetermined in a given month and the share of people who were disenrolled in each state.

Many states publicly posted their reports contemporaneously with their submission to CMS, allowing for near-real-time evaluation of unwinding outcomes. CMS harmonized the data across states, publishing complete records with a lag of about 3 months, consistent with other enrollment data the agency has historically published.[19] In early 2024, the number of renewals reported began to reflect a combination of those attributable to unwinding and those for enrollees who entered the program after the continuous coverage provision had sunset.

The CAA specified that states would need to continue reporting redetermination metrics through June 2024.[3] However, in May 2024, CMS announced that it was exercising its regulatory authority to continue collecting and publishing these metrics to "maintain transparency into Medicaid and CHIP renewal outcomes at the national and state level."[20] Because doing so constituted a discretionary regulatory action, current and future administrations could quietly rescind the requirements. Enrollment snapshots reflecting redetermination outcomes, which had been released on a roughly monthly cadence, were temporarily suspended from mid-January 2025 until the end of March 2025.[21] In addition to hindering insights into the consequences of eligibility redeterminations for coverage and access, suspending publication of data on redetermination outcomes makes it more difficult to understand the extent to which states are spending taxpayer dollars on avoidable administrative costs of disenrolling and reenrolling people—and on the costly, but perhaps inefficient, systems that drive those outcomes.[22]

Expanding Data Collection

Ongoing reporting of Medicaid renewal metrics is a critical development that allows researchers and policymakers to assess not only how but why renewal outcomes vary—analyses that could inform strategies to improve redetermination processes and minimize unnecessary coverage gaps and administrative costs. However, there are several ways that CMS could amend the reporting obligations to offer more detailed and actionable insights.

At present, CMS only requires that states report aggregate metrics that combine Medicaid and CHIP program outcomes, irrespective of demographic or eligibility group (eg, children, persons with disabilities). However, some demographic groups—such as Hispanic children and children with parents who do not speak English—are more likely to lose coverage due to administrative burdens.[23] Moreover, different Medicaid and CHIP eligibility groups may be disproportionately affected by renewal processes. CMS should require key metrics reporting, especially for specific groups subject to different eligibility rules. At a minimum, policymakers would benefit from results stratifying enrollees into the following groups: children (in Medicaid or CHIP), non-elderly adults who qualify for Medicaid on the basis of income, and adults who qualify for the program on the basis of age or disability. Doing so would offer more useful insights into enrollment dynamics following eligibility redeterminations.

Children are a particularly salient eligibility group of interest, as they historically have had some of the worst rates of administrative churn—that is, disenrollment while remaining eligible—but, under the CAA, receive 12 months of continuous eligibility.[3] Currently, 16 states conduct interim data checks (in addition to annual redeterminations) by accessing available databases to evaluate whether enrollees' eligibility status may have changed before their renewal date; children, under the new continuous eligibility rules, are exempt from such checks.[24] Unlike annual eligibility redeterminations, wherein enrollees typically have at least 60 days to submit required paperwork, states can give enrollees as few as 10 days to respond to requests for information substantiating their eligibility if the data check suggests their status may have changed.[24] Under regulations finalized in 2024, states will be required to offer at least 30 days for responses starting in June 2027,[25] although rescission of these regulations is under consideration by Congress; the new presidential administration could also undo these regulations in the absence of legislative action. In addition, observing continuous 12-month eligibility for children in Medicaid and CHIP, but not for adults in the same household who might simultaneously qualify for Medicaid benefits, could generate confusion about enrollment requirements and coverage status, as evidenced by the so-called "undercount." Specifically, the gap between the number of people reporting Medicaid coverage in federal surveys and the greater number enrolled per administrative data worsened during unwinding, particularly for children,[26,27] suggesting that parents may be unaware of children's continuous eligibility. Additional research is needed on the best strategies to publicly communicate ongoing Medicaid enrollment for child enrollees.

Enrollees who qualify for Medicaid on the basis of old age or disability status are another eligibility group of interest, as they must meet asset limit requirements in addition to having income below a specified threshold. The resulting administrative burdens—verifying that these enrollees continue to meet the asset limit at each annual renewal—can be a particularly onerous process. Given the nature of their eligibility, these enrollees are likely to have intensive health care needs and to be particularly at risk for disruption to care in the event of lapsed coverage.

Existing measures of redetermination outcomes are also coarser than they could be. The "procedural terminations" metric, for example, captures a wide variety of potential reasons for termination; as an aggregate measure, it offers little information about which policy interventions could best improve outcomes. It would be helpful to know, for example, the number of enrollees who experience a procedural termination after failing to be renewed *ex parte* due to an "over income" determination vs the number for whom the system was unable to determine income (or some other key eligibility criteria). States should also track and report the number of procedurally terminated enrollees for whom they received returned mail.

Lastly, CMS could consider requiring that states report data on Medicaid reentry within 6 or 12 months—which previous research has shown is common, especially for children[28,29]—similar to how HealthCare.gov enrollments are currently reported.[30] Such a policy would be particularly relevant for child enrollees, who are likely to remain eligible for Medicaid or CHIP even if their parent earns above the adult income threshold.

Conclusion

The Medicaid unwinding from April 1, 2023, through May 2024[31] was singular in some ways. National Medicaid enrollment swelled by over 30% from February 2020 to January 2023 while continuous coverage was enforced, meaning states were undertaking their largest eligibility redetermination efforts in history.[32] Larger caseloads created capacity challenges, which some states may have exacerbated with policy choices unique to unwinding (eg, front-loading "likely ineligible" cases or condensing the process over 6 months).[33,34,35] There were also concerns that, after 3 years without redeterminations, enrollees would be more likely to have outdated contact information on file with the state, in consequence of which they might never receive notices and required paperwork.[36]

Yet, in other ways, the Medicaid unwinding was utterly ordinary. States have always been required to conduct Medicaid eligibility redeterminations on an annual basis (and, in some cases, opted to do so more frequently). Researchers have long suspected that these processes, which can be onerous, impose administrative burdens that screen eligible individuals out of coverage. However, data limitations have made these dynamics—and their consequences—difficult to study. The new reporting requirements, intended to provide transparency and support federal oversight during unwinding, offered unprecedented visibility into Medicaid renewal outcomes.

These reporting practices may change with shifting political tides. Some members of Congress have stipulated that they might increase eligibility redetermination cadence as part of a suite of policies to fund an extension of expiring tax cuts; revenue would come from reduced program enrollment.[37] It seems plausible that any single administration would not want to publicize the volume of enrollees—especially children—losing Medicaid eligibility on a monthly basis under these circumstances. The unwinding of the Medicaid continuous enrollment provision has led to a number of policy lessons—and the importance of publicly available redetermination data is a key one. Suppression of these new data would be a loss for policymakers and the Medicaid enrollees they serve.

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POLICY FORUM: PEER-REVIEWED ARTICLE

What Would Be Required of Structural Determinants of Health Screening and Follow-Up to Improve Children's Health Equity?

Brigid Garrity, DO, MS, MPH, Danielle Cullen, MD, MPH, MSHP, and Haeyeon Hong, MD, MPH

Abstract
A growing body of evidence considers how addressing adverse structural drivers of health (aSDoH) can improve children's overall health, thereby reinforcing pediatricians' role in advancing health equity early in life. Yet the optimal strategy for aSDoH screening and intervention remains unclear. This article examines barriers to equitable aSDoH screening, referral, and intervention, questioning the necessity of screening tool validation when the primary goal is to connect families with necessary resources. It also explores caregiver engagement, key considerations behind documentation of results, and the need for multilingual screening.

Screening Tools
Structural drivers of health (SDoH)—previously referred to as social determinants of health—are defined as community-level factors that influence health. Numerous pediatric screening tools help clinicians identify and assess adverse SDoH (aSDoH) in a wide range of domains.[1,2] Most hospitals adapt existing screening tools but some develop their own, which introduces screening variability across health care settings. This variability is a barrier to children's health equity and to aSDoH research, and it complicates data collection, resource allocation decisions, and intervention targeting.[3]

Notably, while many pediatric aSDoH screening tools are relevant to their target populations, most have not undergone psychometric testing.[1,4] Currently, only 2 pediatric aSDoH screening tools have undergone such testing: Well Childcare Visit, Evaluation, Community Resources, Advocacy, Referral, Education (WE CARE) and the Safe Environment for Every Kid Parent Screening Questionnaire (SEEK-PSQ), each of which was validated in outpatient settings.[1] While these screening tools demonstrate reliability and validity, their implementation and effectiveness remain mixed, particularly in driving interventions that lead to improved health outcomes. Additionally, since SEEK and WE CARE have primarily been used in the outpatient and primary care settings, their validity and applicability in inpatient settings remain uncertain. While pediatric aSDoH screening in the inpatient setting may resemble that of the outpatient setting, important nuances specific to the inpatient population may be overlooked.

While ensuring data consistency and test accuracy through reliability and validity testing may be important, a growing body of recent literature suggests that screening for aSDoH should prioritize guiding clinical decision-making rather than serving as a tool to assess the problem and collect data.[5] The validity of a screening tool depends on its sensitivity and specificity; however, even a validated SDoH screening tool could still yield high false positive or false negative rates. For example, a screening tool might conflate social risks—"adverse social conditions associated with poor health"—with social needs, or an individual's self-identified priorities for assistance.[6] Failing to distinguish between the two in screening data and validation protocols might obscure whether interventions should address broader systemic risks or individual-level needs, ultimately muddying understanding of what patients truly need. This potential confounding is compounded by the fact that aSDoH are deeply intertwined with complex societal structures, cultural influences, and familial histories. Unlike traditional medical conditions with clear diagnostic markers, social needs exist on a spectrum and are influenced by dynamic, often subjective, factors.

This challenge can lead to misallocation of resources: potentially building support infrastructure in areas where it might not be most needed while under-supporting families who require urgent intervention. Given limited resources, screening tools should be used with consideration of social needs' complexities in order to avoid inadvertently creating or exacerbating gaps in care. The US Preventive Services Task Force recently issued a statement concluding that there is not enough evidence to assess benefits and harms of screening for food insecurity and that a family-centered approach without a screening tool might be beneficial.[7]

Family-Centered Screening

Shifting the focus from collecting validated screening data to a family-centered approach to addressing aSDoH, with a strong emphasis on desired supports, is an evolving concept. Building rapport and focusing on what patients and families need can facilitate meaningful connections to essential services without the need for formal screening while also reducing caregiver anxieties about the screening process. Several common pitfalls of aSDoH screening pose barriers to adequately addressing aSDoH.

The majority of pediatric aSDoH screening tools are given to parents and other caregivers to answer on behalf of children; caregivers have the autonomy to decide how to respond to screening questions and determine which supports they believe would be most beneficial. Therefore, facilitating caregivers' engagement with aSDoH screening tools and addressing their concerns is essential. Such screenings are only relevant if caregivers feel they can answer questions truthfully without fear of retaliation. Recent studies suggest that, while caregivers desire support for their social needs, they have concerns about the consequences of disclosing social risk, including fear of judgment and being reported to child protective agencies.[8,9] Furthermore, in today's political climate, immigrant families face additional fears, including "being found to be a public charge"—that is, deemed reliant on government assistance programs—which can render individuals ineligible for permanent residency.[10] These fears can affect caregivers' willingness to participate in aSDoH screening and their comfort in answering questions truthfully.

There is also emerging evidence that parents and caregivers are concerned about the implications of documenting screening results, including loss of insurance and potential access to these records by the government, former partners, or spouses.[8,9] Ensuring transparency about how aSDoH data will be used and who will have access to it, as well as obtaining informed consent, are critical to the screening process. Caregivers should be explicitly informed that their responses will not trigger reporting to any government agencies. More research should focus on whether aSDoH screenings and subsequent referrals effectively reach families who both want and need resources and whether screenings are missing families with needs that do not screen positive.

The lack of availability of multilingual screening forms is another common pitfall in aSDoH screening. Most pediatric aSDoH screening tools are limited to English and Spanish, and many are not readily accessible for low-literacy populations.[1] Health care facilities should have aSDoH screening forms for the most prevalent languages, and these forms should be in plain language with low literacy to allow for easy and reliable translation. If screening tools are not available in a specific language, simply asking caregivers about their support needs may be effective in identifying their needs. While word-for-word translation of screening tools is important, cultural translation is essential to connect families with the resources they need.[11] In addition to the creation of inclusive screening tools, multilingual data collection software is also essential for storing data and tracking social resource referrals.

Responding to Identified aSDoH

More important than how clinicians screen is how aSDoH needs are being met. If patients and families screen positive for aSDoH but there is no sustainable, meaningful resource allocation, the value of screening should be called into question. To be beneficial, screening only for social domains for which resources are available is key. Furthermore, even if resources are available, some social needs are unlikely to be met with a simple referral. For example, if a family is struggling with housing insecurity, addressing that need requires multiple points of contact. Some pediatric hospitals have social workers who make the referrals for social needs based on aSDoH screening, but that option is not feasible for many hospitals.[12]

To increase feasibility of follow-up in addressing identified aSDoH needs, several organizations have adopted digital innovations to establish a closed-loop referral system. Third-party vendor-run services such as Findhelp, Unite Us, and ThriveLink provide online and telehealth platforms designed to streamline this process.[13,14,15,16] Some hospital systems have made organized efforts to customize the national-level referral platforms to better match their patients' needs with local resources for addressing those needs.[17] Ultimately, the goal is for a member of the health system to close the loop by verifying whether the patient received the referral and if their needs were met and to provide any additional navigational support needed. However, further research is needed to determine whether these referrals effectively address the aSDoH needs identified during screening.

Conclusion

Addressing aSDoH and implementing meaningful resource referrals are critical steps toward pediatric health equity. While aSDoH screening has become more common, future research should assess the real-world impact of validated screening tools and explore a patient-centered approach that focuses on meeting families' needs rather than on assessment. Ensuring that families feel comfortable sharing their social needs and providing informed consent before screening is essential. Regardless of the screening methods used, future efforts should prioritize development of robust, closed-loop resource referral systems and interventions to ensure that those who screen positive receive meaningful support.

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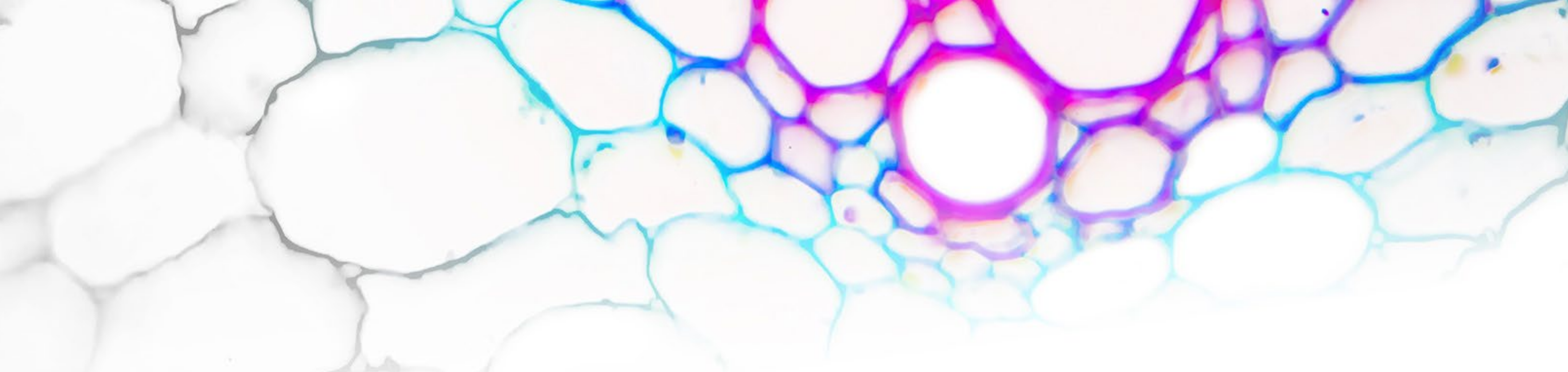

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MEDICINE AND SOCIETY: PEER-REVIEWED ARTICLE

Critical Pedagogical Approaches to Structural Drivers of Health

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Abstract
Social accountability in health professions education prominently has to do with preparing students and trainees in pediatrics to do 3 key things: prioritize social and structural drivers as preconditions of children's health, work to mitigate health inequity among children by partnering with community members and families, and integrate advocacy for health system improvement for children into practice. This article suggests strategies for health justice advocacy and for strengthening cross-disciplinary teaching about how to screen children for structural drivers of health.

Critical Pedagogy and Preconditions of Children's Health

Screening children for root causes of health inequity—sometimes referred to as social, economic, political, and historical influences on health and health outcomes[1]—illuminates key questions about the scope of clinicians' roles in public health, particularly with regard to mitigating health inequity among children. This article investigates how a critical pedagogical focus on screening can reveal possible responses to such questions. Critical pedagogy, founded by the Brazilian philosopher and educator Paulo Freire, is an educational philosophy and social movement that sees education as profoundly moral and political and is designed to provide students with the tools to critically critique the status quo, hold authority politically and morally accountable, and act on their sense of social responsibility to address social problems.[2] A health professions education informed by critical pedagogy would help students learn about the structural drivers of health and could increase not only pediatric screening for such drivers of health but also advocacy by medical professionals to address them and promote public health.

Why Critical Pedagogy?

An argument in favor of bringing critical pedagogy into health professions education rests on the premise that the current educational model teaches students to conform to a status quo that supports social inequities in health and health care and that clinicians have responsibilities to acknowledge and to try to transform the social, cultural, economic, political, and environmental determinants of health.[3,4] At the core of critical pedagogy is a belief that it can, and should, help clinicians "to develop critical health literacy by promoting social justice and the taking of individual or collective action."[4] To center critical pedagogy within health professions education would be to declare the promotion of equity and social justice as core values of health professions education and practice.[5]

One goal of critical pedagogy is to turn students into critically informed social activists. Cavanagh et al suggest that, by asking medical students to think critically about social and structural causes of ill health, they will become well-equipped to screen for and identify drivers of health in their communities and advocate for policy change, actively reconfigure the patient-clinician relationship to better promote collaborative engagement with patients, and actively work to probe and undo structural causes of ill health embedded in their clinics.[6] Similarly, Ross proposes 4 ways that critical pedagogy could improve health education: (1) by embedding the wider social contexts of health in the curriculum, (2) by preparing students for the complexities of the populations they will serve, (3) by ensuring that the effects of place are considered, and (4) by enabling students to enact changes to help achieve equity.[3] A key element in the desire to bring critical pedagogy into medical education is the belief that social accountability should be at the heart of medical school.

The idea that power structures and social inequity influence health is not new and is the basis of what is sometimes referred to as social medicine. Social medicine is interdisciplinary; it examines how social, economic, and environmental factors influence health, disease, and the delivery of care and aims to address health inequities, often through social and political action.[7] A key social medicine framework to help clinicians recognize and understand how socioeconomic, political, and environmental factors affect health is structural competency. Structural competency is the trained ability to discern influences of structural drivers of health in clinical settings.[8] However, while social medicine and structural competency are increasingly being incorporated in health professions education, it is only in the academic year 2023-2024 that the Liaison Committee on Medical Education made coverage of structural competency a requirement, although there is no agreed-upon approach to curriculum development.[9]

An important parallel between social medicine and critical pedagogy is the goal of educating students about the structural underpinnings of inequity and emboldening them to work against oppression. Matthews proposes that Freire's 3-phase model of critical pedagogy be implemented in health education to encourage students to discover their own concerns and develop their own solutions to problems.[4] This model consists of "listening and naming" real-world issues and experiences, facilitating problem-solving through "dialogue and reflection," and promoting "transformative social action" to challenge the ideas and practices that give rise to and support inequality. A crucial part of the process, Matthews notes, is that students "come up with their own ideas about what action to take rather than having other people's ideas imposed on them."[4]

Focusing on the importance of Freire's problem-posing approach to education, Cavanagh et al argue that reconceptualizing problems, knowledge, and patients in health professions education would help students to challenge deterministic concepts of health.[6] Contrary to traditional problem-based education, or "banking" education, wherein questions have a right answer and knowledge is "deposited" into students, problem-posing education encourages students to actively engage with real-world issues by identifying problems within their own context, critically analyzing them, and collaboratively seeking solutions, thereby fostering a sense of critical consciousness and empowering them to take action. Cavanagh et al see this form of health professions education as fostering reflexive commitment to professional advocacy and social justice.[6]

Onuoha et al propose a more theory-oriented approach to bringing critical pedagogy into health professions education by adopting structural competency, critical race theory (which examines the structures of systemic racism and their impacts), and participatory action research (which emphasizes participation in research by members of communities affected by it with the primary goal of bringing about social change within communities) as frameworks to advance health justice.[10] To implement these frameworks in health professions education, Onuoha et al call for 3 fundamental pedagogical shifts.[10] First, redefine who is considered a teacher via self-directed, learner-community action that recenters notions of health equity expertise in health professions education. Second, implement novel educational tools, such as podcasts, neighborhood walking tours, and street art tours, to help facilitate learners' understanding of neighborhood-level social and structural determinants of health. Third, institutionally embed and incentivize antiracism. These pedagogical shifts highlight the importance of taking theory-driven, pragmatic, actionable steps to change institutional culture.

Another source of inspiration for how to bring critical pedagogy into health professions education is Brazil, which has developed a pedagogy of connection that is deeply rooted in the concepts of critical pedagogy.[11] De Carvalho Filho and Hafferty stress that Brazilian medical education is aligned with Freire's concept of "unfinishedness," suggesting that clinical knowledge is not fixed but continually changing and thus open to improvement.[11] To prevent students from feeling powerless in a health care system perceived as unchangeable, students are exposed to and discuss the health care system as a social mechanism susceptible to influence, including by themselves. By demonstrating how education, health care delivery, and social values evolve together, the Brazilian model aims to foster a sense of hope in students that systems can improve, as well as a commitment to future service and social justice.[11]

One of the great benefits of critical pedagogy is that it helps to instill in students a sense of purpose and hope for the future. Embedded within health professions education, it can help students cultivate the knowledge, skills, and attitudes needed to prevent their "becoming part of a static and inequitable system of healthcare."[3] By centering critical social medicine, critical pedagogy also provides students with tools to help them conceptually convert the private sufferings of patients into public issues that demand action.[12] Ultimately, critical pedagogy questions the standard assumption that social activism is a choice for those with the privilege to engage in it and instead suggests that it is, in fact, an ethical responsibility. Adopting critical pedagogy within health professions education would be a call to health professionals to seek richer understanding of the lived experiences of their patients and to stand in solidarity with the most vulnerable, especially the sickest and those who lack full decision-making capacity and authority, such as children.

Structural Drivers in Health Professions Education

In recent years, due in large part to social movements such as Black Lives Matter as well as the disproportionate impact of the COVID-19 pandemic on minority and at-risk communities,[13] there has been heightened attention on systemic and social inequity in health, with some health professions educators pushing for greater advocacy for social change within health care.[14] Curricula about structural drivers of health are often limited and elective,[15,16] however, despite the fact that many students are likely to practice in underserved communities and need the confidence and knowledge to do so well.[15] Noting that social and structural forces have more influence on well-being than all health care services combined, Castillo et al advocate that the Accreditation Council for Graduate Medical Education adopt a new core competency to "better train physicians to be enlightened actors to improve health equity."[17] The proposed competency entails training physicians to (1) understand and recognize the social and structural drivers of health, (2) work with communities and non-health care sectors toward eradicating health inequities, (3) advocate for health care system improvements, and (4) adopt a socially responsible attitude toward patient interactions.[17] One goal of this proposal, like that of critical pedagogy, is to challenge the next generation of medical practitioners not to just treat the symptoms but to address the root causes of the structural drivers of health that impact patients, work that has traditionally fallen under the purview of public health.

Concurring on the importance of training health professionals to address structural drivers of health, Andermann and CLEAR Collaboration outline concrete actions that clinicians and administrators can adopt to do so.[18] These include asking patients about their social history, referring them to local support services, and facilitating access to such services. At the patient level, it is important that physicians ask patients about potential, often hidden, social issues in a sensitive and culturally appropriate manner. At the organizational level, senior management can help reduce barriers to care by providing reimbursement or support for transportation and childcare, extending clinic hours, and creating community outreach opportunities and partnerships. At the local level, physicians can serve as advocates by supporting social and political movements that aim to reduce social barriers to achieving health.[18] The American Academy of Pediatrics suggested that screening for and addressing structural drivers of health should be mandatory, not just recommended, in pediatric clinical encounters.[19]

Public Health Obligations

The notion that clinicians have responsibilities not only to individual patients but also to public health is not new. Despite its controversial and untoward impact on health equity, the 1910 Flexner Report recommended that foundational elements of public health be included within medical education.[20] And, today, the American Medical Association's mission statement is "to promote the art and science of medicine and the betterment of public health."[21] Similar to the teaching of structural drivers of health, many health professions schools have adopted an expanded scope of practice that includes issues related to public and population health, but no standard set of outcomes or practices exists for such training.[22]

Maeshiro and Carney note that the COVID-19 pandemic has revealed many ways in which a physician workforce knowledgeable about public health is better equipped to anticipate and contribute during crises.[20] But how might meaningful partnerships be cultivated between clinical and public health communities? According to Maeshiro and Carney, "To achieve more effective medicine-public health relationships in practice, health professions education across the continuum must include explanations of public health systems, the responsibilities of physicians to their local and state governmental public health agencies, and opportunities for collaboration."[20] They add: "Medical education should also prepare physicians to advocate for public health policies, programs, and infrastructure that will improve and protect the health of their patients and communities."[20] Finkel stresses that, for public health education to be successful, it should be integrated into all 4 years of the medical school curriculum.[23]

Rao et al argue that the COVID-19 pandemic has underscored the need to think about health equity and ways to address the social and structural drivers of health.[24] They suggest that integrating public health into health professions education will better prepare physicians to deal with noncommunicable diseases and to recognize the influence of social determinants of health. It will also enhance data sharing and collaboration. They write: "It is important to note that a public health education also involves training in community organizing, stakeholder communications, working across disciplines and with government agencies toward strategic planning and logistics and innovation, all of which are relevant to clinical practice and have been integral, most recently, in the COVID-19 response."[24] However, they also acknowledge that such a transformation of health professions education will require shifts in clinical mindsets. Maeshiro and Carney likewise emphasize that the challenge is to use recent public health lessons to improve medical education.[20] Johnson et al stress that, while challenging, strengthening curricula and community-academic partnerships is achievable.[22]

Pediatric Practice

While the debate regarding how much public health education should be incorporated in health professions education and how responsible physicians should be for addressing public health issues is perhaps best left to those in the field to resolve, what has become clear is that greater understanding, communication, and cooperation across clinical medicine and public health is needed. Building bridges between medicine and public health is possible. Although health care professionals should not be entirely responsible for addressing the structural drivers of health and ending health inequities, neither should they be permitted to ignore them. The current dilemma is how to change the scope of clinical medicine to incorporate a public health perspective. The first step is to revise health professions education curricula. Adopting critical pedagogy is commensurate with incorporating aspects of public health to address structural drivers of health. If physicians are to be able to effectively screen for structural drivers of health, they need to be better educated about them. As concerns over the feasibility of screening for structural drivers of health highlight,[25] the biggest challenge will be to change the current mindset within medicine about its own responsibility to public health and health equity.[26] Adopting a critical pedagogical lens is a reminder that physicians have a responsibility to use their standing within society to advocate for greater health equity and improve public and population health. It is time that health professions education gives clinicians the tools to do so.

Regardless of whether health care professionals wish to engage in social reform and social justice actions, they should be equipped with the means to advocate for and pursue such changes. At a bare minimum, health professions students should be taught about the structural drivers of health and the important role they play in patient populations. This knowledge will at least allow them to better recognize the impacts of the structural drivers of health when they encounter them in a clinical setting and to be better prepared to talk to patients about them. In pediatrics, structural drivers of health screening is crucial to help improve health outcomes by identifying children who are experiencing challenges like poverty, food insecurity, or housing instability. Screening can facilitate early intervention and access to needed support services, ultimately mitigating negative health impacts, improving child well-being, and saving lives. Unfortunately, despite the importance of such screening, few physicians report regularly screening pediatric patents.[27] Providing proper training is a crucial step in helping physicians overcome barriers to reducing structural drivers of health, and early education about the structural drivers of health should be considered an important part of such training. Incorporating critical pedagogy and a focus on critical social medicine, including public health obligations, in health care professionals' education is an important step in improving structural drivers of health screening and pediatric health outcomes, as "related residency curricula have been shown to increase detection of social issues, the frequency of screening, provider's comfort in addressing sensitive topics, and their competence in linking patients to resources."[27] Incorporating critical pedagogy into health professions education will also offer health professions students a sense of hope for the future and help them to recognize themselves as empowered agents for social change and health justice.

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HISTORY OF MEDICINE

Advocacy as an Origin of Pediatrics

Jorie Braunold, MLIS

Abstract
The work of physician Abraham Jacobi was prominent in development of the field of pediatrics. He envisioned clinicians acting as caretakers and advocates for children and families, especially those who were poor. This article summarizes his work as presaging today's appreciation of many structural drivers of children's health.

Dr Jacobi's Vision

The phrase *structural drivers of health* (SDoH) is new, and strategies for integrating SDoH screening into clinical practice are still being investigated.[1] However, the idea that social, historical, and cultural forces and structures are as relevant to one's health as one's (or one's parents') individual choices and genes is not new. Indeed, structural determinants formed the basis of Dr Abraham Jacobi's approach to practicing medicine and promoting the development of the field of pediatrics. Jacobi believed a physician's role did not begin and end in an examination room. Seeing children living and toiling in substandard and unsafe conditions, Jacobi came to realize that a few clinical encounters were insufficient to address the material health needs of many of the nation's youth. In his 1912 farewell address as president of the American Medical Association (AMA), he exhorted his fellow members to get involved in policy making and public affairs: "[O]ur main position in life should be to wake up our neighbors, particularly the general practitioners, that vast number of men all over the country, and see to it that they participate in public affairs. Nobody's influence is universal, but every man can influence more or less state officials."[2]

This was not a one-off statement, as Jacobi devoted much of his career to public health and to improving the living and working conditions of those living in poverty. In 1904, he wrote: "It is not enough to work at the individual bedside in the hospital. In the near or dim future, the pediatrician is to sit in and control school boards, health departments, and legislatures. He is the legitimate advisor to the judge and the jury, and a seat for the physician in the councils of the republic is what people have a right to demand."[3] Those who would criticize his activism as promoting "socialism" were told: "Where mothers and babies are concerned, the term charity should be supplemented with responsibility. It is useless to call that socialism or communism."[4] For Jacobi, the assumption of civic activism roles was as much a part of medical professionalism as diagnosing and treating disease. He wrote or co-wrote hundreds of scientific papers that were compiled after his death into 8 volumes totaling more than 4000 pages.[5] Beginning in the second half of the 19th century, Jacobi's work served as a focus of pediatric thought and teaching, with his methods and ideas still cited today.[6,7]

Origins of Pediatrics

Born in Prussia (now Germany) in 1831, Jacobi fled to America from his home country in 1853, after being imprisoned for his participation in the revolutions of 1848.[5] Once established in America, he quickly became a leader in developing the field of pediatrics. He was the first to create a free pediatric clinic in the United States,[8] the first professor of pediatrics (at New York Medical College), the founder and chair of the AMA's Section on Pediatrics, the founder and president of the American Pediatric Society, and the founder of New York City's first pediatric department in a general hospital.[9] He also established a method of bedside teaching in which medical school faculty conduct teaching rounds in hospitals with actual patients.[9,10]

In his many academic and professional posts—including serving as president of the AMA in 1912 at the age of 82[8]—Jacobi advanced a vision of a healthier, more just American childhood by reaching out to fellow physician legislators and the public. A colleague wrote of him:

> It is not alone as a medical man that Dr. Jacobi is worthy of honor. He has also sought to promote the welfare of his fellow-men, as a man and a citizen. He has taught the propriety of physicians taking an interest in public affairs, and has exemplified his teaching by taking an active part in many matters of civic and political importance, serving on public committees, addressing legislative bodies, and urging questions of public policy.[8]

The breadth of issues Jacobi took to be determinative of a child's health was wide, ranging from pollution[11] to labor conditions[10] and extending to the care of women who were mothers, whom he described as deserving recognition and "reward" for their service "to mankind in the shape of a healthy child."[12] Jacobi promoted women's needs for sanitary living conditions to care well for children *in utero*, after birth, and throughout their growth and development.[12]

Criticism of Industry, Government, and Physicians

Jacobi believed that modern industry posed important harms to American citizens and he frequently criticized corporate and government policies and practices that would, for example, allow "a boy of 12 [to work] in a coal mine at 4 cents an hour" or withhold that "4 cents . . . from him and his starving family on account of a debt incurred by his father who was killed in the same coal mine."[4] When leaders in the canning industry argued that they simply had to work their child labor force until midnight, lest the food spoil, he sardonically remarked: "The freshness of the strawberry must be preserved even if the children perish."[4]

To Jacobi, government not only failed to protect children and their parents, but insufficiently protected air quality and food safety. Jacobi stated: "If you build houses unfit to breathe in, you steal air which is common property."[12] And he worked to provide pasteurized milk to babies who could not breastfeed; the availability of milk was a structural determinant in early childhood development because industrialization's effect on family structures lead to a decline in breastfeeding during the mid-to-late 1800s.[13] As Jacobi noted in 1912, "starving women make no milk."[12]

Jacobi did not, however, lay all blame for children's and women's ill health at the feet of government and industry. He felt his fellow physicians could do more to promote public health. About physicians, Jacobi said: "Indeed there is no class of citizens that takes less interest in municipal, and political, other than sanitary, affairs, than doctors. It is true their vocation takes all their time and is exhausting; but the examples of European parliaments in which good medical men are representing the people, should not be lost on us."[14] In Jacobi's inaugural address as president of the American Pediatric Society, he encouraged physicians to take active roles in improving hygiene and sanitation to promote disease prevention.[8] Jacobi's legacy of emphasizing structural determinants' importance to children's and everyone's health is still a model of public health professionalism today.

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