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

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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.

References

1. Sokol R, Austin A, Chandler C, et al. Screening children for social determinants of health: a systematic review. *Pediatrics*. 2019;144(4):e20191622.
2. Moen M, Storr C, German D, Friedmann E, Johantgen M. A review of tools to screen for social determinants of health in the United States: a practice brief. *Popul Health Manag*. 2020;23(6):422-429.
3. Ganatra S, Khadke S, Kumar A, et al. Standardizing social determinants of health data: a proposal for a comprehensive screening tool to address health equity a systematic review. *Health Aff Sch*. 2024;2(12):qxae151.
4. Henrikson NB, Blasi PR, Dorsey CN, et al. Psychometric and pragmatic properties of social risk screening tools: a systematic review. *Am J Prev Med*. 2019;57(6)(suppl 1):S13-S24.
5. Samuels-Kalow ME, Ciccolo GE, Lin MP, Schoenfeld EM, Camargo CA Jr. The terminology of social emergency medicine: measuring social determinants of health, social risk, and social need. *J Am Coll Emerg Physicians Open*. 2020;1(5):852-856.
6. Molina MF, Li CN, Manchanda EC, et al. Prevalence of emergency department social risk and social needs. *West J Emerg Med*. 2020;21(6):152-161.
7. Food insecurity: screening. US Preventive Services Task Force. March 11, 2025. Accessed April 22, 2025. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/food-insecurity-screening
8. Attridge M, Brown R, Cullen D. Centering caregiver perspectives in social care integration. *Acad Pediatr*. 2023;23(7):1312-1314.
9. Brown R, Barouk N, McPeak K, Fein J, Cullen D. Barriers and facilitators to caregiver comfort with health-related social needs data collection in the pediatric clinical setting. *Health Serv Res*. 2025;60(suppl 3):e14425.
10. US Citizenship and Immigration Services. Public charge fact sheet. US Citizenship and Immigration Services. Accessed March 24, 2025. https://www.dshs.wa.gov/sites/default/files/ESA/eaz-manual/Public%20Charge%20Fact%20Sheet.pdf
11. Brown R, Ortiz P, Berrigan L, Cullen D. Multilingual research strategies to enhance equity. *JAMA Pediatr*. 2025;179(2):214-215.
12. Garg A, Brochier A, Tripodis Y, Messmer E, Drainoni ML. A social care system implemented in pediatric primary care: a cluster RCT. *Pediatrics*. 2023;152(2):e2023061513.
13. Find free or reduced-cost resources like food, housing, financial assistance, health care, and more. Findhelp. Accessed March 21, 2025. https://www.findhelp.org/
14. Unite Us. Accessed April 24, 2025. https://uniteus.com/
15. Boston Medical Center. Appendix 1: social determinants of health screening tool. Boston Medical Center; 2017. Accessed March 24, 2025. https://www.aahd.us/wp-content/uploads/2019/06/THRIVESocialDeterminatsofHealthScreeningToolBostonMedicalCenter.pdf
16. Boston Medical Center—Thrive screening tool. Social Interventions Research and Evaluation Network, University of California San Francisco. Accessed March 24,

2025. https://sirenetwork.ucsf.edu/tools-resources/resources/boston-medical-center-thrive-screening-tool
17. Cartier Y, Fichtenberg C, Gottlieb LM. Implementing community resource referral technology: facilitators and barriers described by early adopters. *Health Aff (Millwood)*. 2020;39(4):662-669.

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