Episode: *Ethics Talk: Ethical and Clinical Complexities of SDoH Screening and Follow-Up*

Guests: Laura Gottlieb, MD, MPH and Rachel Landauer, JD, MPH
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[mellow theme music]

[00:00:02] TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. Nearly half of us children—that's 40 million kids—are insured by Medicaid or children's health insurance programs. In 2024 the Centers for Medicare and Medicaid Services added a requirement that all hospitalized Medicaid patients be screened by a qualified clinician for structural drivers of health—that's SDoH—since 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 influence the health of US children. Despite the value of SDoH screening in improving US children's health outcomes, key questions remain about whether and when the translation from screening to intervention is appropriate or even possible. Structural drivers of a child's health can be identified during screening, but the range of a child's needs identified by screening usually can't be met during clinical encounters. And in fact, research about whether and to what extent identifying structural drivers of children's health is, or even can be, effectively followed by interventions and improved outcomes is ongoing.

[00:01:24] With me now to discuss currently available screening methods and the difficulty in establishing causal links among data about structural determinants of health interventions and outcomes is Dr Laura Gottlieb, professor of family community medicine in the School of Medicine at the University of California, San Francisco, and the founding co-director of the Social Interventions Research and Evaluation Network. Dr Gottlieb, thank you so much for being here.

DR LAURA GOTTLIEB: Oh, it's an absolute pleasure. Thank you for inviting me. [music fades]

[00:01:55] HOFF: Even well-crafted screens can be imperfect. So, what are the merits and drawbacks of currently available screening methods and tools that seek to gather information about how a child's health is influenced by positive or negative structural drivers of health?

GOTTLIEB: Well, first Tim, I think it's important to underscore that there really is no comprehensive, multi-domain screening tool that has technically been validated in the sense of being tested against a gold standard. So we have plenty of tools that have imported some validated questions or have content or face validity even across the entire tool. But even the most widely used tools, like the one recommended by the

Center for Medicare and Medicaid Innovation and the Accountable Health Communities demonstration was never quote-unquote “validated” per se. So, we do have sort of some scientific ambiguity around the tools that are being used across the country. That doesn’t mean that they’re...it’s not reasonable to use them, but I just don’t know that I would say that we’ve had enough validation work in the area of social risk screening.

The second thing that I would say in response to that question is that I don’t really think that the point is that we’re gathering info about how a child’s health is affected by these structural drivers. These tools are actually being designed to just gather info about the drivers. Whether or not they’re affecting health is kind of a different question.

And then at the population level, we know that adversity is associated with poor health. So our assumption when we’re using these tools is that we’re going to find some kind of adversity, and that puts them at higher risk of having poor health. That’s actually the basis for so many of the interventions we’ve seen in the health care sector around social drivers, is our assumption is that if we can decrease adversity, we should improve health. But that hasn’t been the clear causal mechanism in some of the rigorous trials we’ve seen published in this area. And I think hopefully we’ll get to that later in our conversation.

[00:04:07] But then third, I just think it’s clear from the literature that we have a lot more to learn about screening itself, so how to do it in ways that make people feel cared for and empowered and receptive to supports. So the mandates that we’ve seen for universal screening haven’t necessarily led to universal screening in the health care sector, and to be fair, the mandates are actually changing under the new administration. But the reasons that they haven’t led to universal screening are complex. I think, first and foremost, clinical teams are not on board with universal screening absent the sense that they can provide a meaningful intervention in response. The way that clinicians and patients define “meaningful” seems to differ, however. So I think we need to think about what meaningful means and come to a shared understanding of that.

And then I obviously think it’s hard to introduce more work into very busy, already overtaxed clinical settings. So I think, the...you framed it in terms of the merits and drawbacks. I would say opportunities and challenges. Like, there’s a lot that we’re still figuring out about screening methods, whether universal screening is even appropriate, whether potentially it should be universal education about available resources, and then more targeted screening for the purposes of other kinds of interventions as well. So there’s just, there’s a lot more to learn about screening.

[00:05:37] HOFF: You mentioned briefly alternative strategies for screening. We’ll be talking with our next guest on this episode about how screening, especially for so-called negative structural drivers of health, can exacerbate stigma and distress for patients and families. But could you briefly expand now on what those strategies for gathering SDoH data in ways that avoid some of those negative outcomes are?

GOTTLIEB: So, I mentioned that I think that there’s a lot more that we have to learn about screening for social risk factors. There is some really interesting qualitative work suggesting that the way that you frame, introduce and frame, screening may impact patients' receptivity to screening. And in some cases where the framing or the introduction to screening is not carefully thought through, I think there is a real danger of alienating patients or further, or of exacerbating well-earned distrust of the health care system rather than the opposite, which, of course, is the aim of trying to provide whole-person care, including care that considers and supports positive social drivers of health. So, I would keep, I'd encourage your listeners to keep an eye out for some of the really interesting work that has begun to emerge about how to decrease stigma, increase trust, improve patient-provider relationships through screening. Because I think that as we learn more, we're also going to be called on to roll out screening in more thoughtful ways rather than just as a knee-jerk response to a national mandate.

[00:07:51] HOFF: I also wanted to pick up on the difficulty in establishing the causal link between structural drivers of health and then pediatric health outcomes. Much of your research examines whether, and to what extent, structural drivers and social needs interventions actually work to mitigate health consequences of negative structural drivers. And there seems to be a fundamentally flawed assumption about how much a single billable clinical intervention could ever be expected to respond to a wide range of socially and environmentally-situated structures that influence how healthy or ill any one person can be. So, what should our audience know about this research?

GOTTLIEB: I love this question, Tim, because I do believe that the shared logic model behind social care policies and many of the programs that have come from them, is that screening for social risk factors like food, housing, or transportation insecurity will then lead us to refer patients who endorse social risks to social services. And that means the patients who are experiencing the social barrier will get the social service, and that the services will help reduce or resolve their social needs. So, the assumption is that that change in social needs will then contribute to improved health. But I really think that as the health care services research on social care matures, we're seeing a much more complex story about why, how, and when different social care initiatives can impact health.

So, we've proposed a revised, more comprehensive logic model that includes multiple pathways through which understanding patients' social conditions might lead to an improvement in health and potentially a change in health care utilization. That logic model is presented in a *Milbank Quarterly* paper that we published a couple of years ago. But the pathways really have to do with okay, sure, the kind of shared assumption, one, around reducing the burden of social risk, but also that there's a pathway that seems to lead through providing emotional support for patients, another pathway that seems to lead or be mediated through health care services connections, and then a final pathway that has to do with it leading to the tailor-, better tailoring of clinical care. And all of those together mediate the health and health care utilization impacts of the social care programs that we're seeing in the field. So, there is something about that you go from understanding of patients' social risk to an improved health outcome, but it's not necessarily through this singular pathway of changing social risk and thereby improving health.

[00:10:53] So, that's not to say that the pathways are not intersecting. I think they actually are often interconnected. So, for instance, feeling emotionally supported might lead patients to seek more connections with health care services. And those connections to health care services can contribute to more tailored care, shared decision making. So there are a lot of intersections between those pathways, and they should be the subject of future research. But I just think we're wrong in assuming that there's only one pathway between a better understanding of the whole person, including their social drivers of health and this health outcome. And I think the way we're seeing that, the research that we're seeing that makes me think that that's a flawed assumption includes the research from the largest demonstration of a social care navigation program that has existed in the United States to date, the Accountable Health Communities Project, which included 28 sites across multiple states funded by the Centers for Medicare and Medicaid Innovation, where they really have shown that the screening that they did and the navigation to services did not actually seem to lead to either an increase in connections to services, nor a change in social risk. And yet, the patients in the intervention arm did significantly better than the patients not in the intervention arm in terms of health care utilization outcomes. And the qualitative work from that and from several other studies seems to suggest that there are these other reasons that patients' health improved.

[00:12:41] HOFF: Can you quickly clarify what doing better in terms of utilization means in this instance? Is it that they're seeking care less or that the care that they're receiving is more efficient?

GOTTLIEB: Yeah. Good question. So in the Centers for Medicare and Medicaid Innovation Accountable Health Communities Demonstration Project, the outcomes that they were looking at were hospitalizations and ED utilization. And they defined improvements as decreased ED use and decreased hospitalizations. And then the other thing that I would say is that there's actually another study that also suggests that there are other pathways that came from the impact team, Shreya Kangovi's team. When they did the study, she was still at University of Pennsylvania. And that study actually looked at the outcome of changed utilization patterns, so less acute care utilization and more outpatient care utilization.

HOFF: Ah, right. Okay. Yeah, I see. It sounds like that aligns well with something you mentioned earlier about one of the pathways relying on clinical support. And if patients feel supported during their clinical encounters, they might seek out health care more proactively, which sounds like an increase in utilization.

GOTTLIEB: Exactly, exactly.

HOFF: But like you say, it sounds like that increase is more in outpatient settings.

GOTTLIEB: That's exactly right. And actually, we, yeah, there are some, yeah. Both Kangovi's, and then this California Medicaid study have shown exactly that.

HOFF: Right, right. Great. Thank you. Thank you for that clarification.

[00:14:23] Let's wrap up by talking a bit about how these data are being collected in the first place. Are health care organizations required to self-study their own pediatric patients' health outcomes? And if so, what kind of data about structural determinants are used?

GOTTLIEB: So this is an interesting question. I think the answer to that really depends on the funders or who the health system is accountable to. So, for instance, in the uniform data systems that community health centers report, they're required to report on some social drivers. And then these measures from the Joint Commission and the National Committee on Quality Assurance also are requiring that either insurers or hospitals are asking patients about specific social risk data, and then they need to report on their outcomes to the appropriate funder or accountability agency. CMS was starting to require that people, that health systems, at least in hospitals, also ask about some social drivers, but those are changing now under the new administration.

I do think that understanding whether we're delivering the right intervention at the right time to the right patient really does require understanding more about social drivers data. Whether or not that's reported, I think it is an important—you used the term "self-study"—I think it's an important part of the health system's own accountability. So yes, to self-study, I guess. I think that involves understanding the patients' social drivers or experiences of social adversity. And the categories that we're seeing most frequently come up in the literature, which I think these have risen up to the top because they feel like the most actionable, but the ones that we've seen are food, housing, and transportation related.

[00:16:57] I also think that for this work that I've done with Dr Sahil Sandhu, we've been arguing that you have to not only understand the health-related social needs, but in order, again, to target the right interventions at the right time to the right patient, you also have to understand other sociodemographics—so age, race, language, preferred language—in order to make sure that the intervention is targeted appropriately to the needs of the patient. You also need to really deeply consider the diseases. So asthma interventions might differ from interventions to improve someone's self-care of diabetes as an example. So, housing interventions tend to help more for patients with asthma, and food interventions might help more for patients with diabetes. Consider insurance coverage and what the insurance companies are going to cover, or whichever funder is involved in coverage for that patient. And then for sure, thinking about what's the health care setting? So it's not an easy question of like, what social risk factors should be considered? It's more okay, what's the whole picture here? What's the setting that we're in? What's the insurance coverage that this person has? What are the diseases that we're treating? What are the sociodemographics of the patient? And then what are the health-related social needs that I think influence this person's outcomes? [theme music returns]

[00:18:25] HOFF: Dr Gottlieb, thank you so much for your time on the podcast today and for sharing your expertise with us.

GOTTLIEB: It is a pleasure.

[00:18:33] HOFF: Negative structural drivers of health include poverty and a range of potentially stigmatizing environmental and social conditions. So we do well to wonder whether asking patients and their families about structural drivers of health is justifiable if doing so exacerbates stigma and distress for patients and families. Recent changes to the way that Medicaid enrollee data is shared between states and the federal government for the supposed purposes of immigration enforcement, or the increasing surveillance and legal risk associated with pregnancy following the Dobbs decision, for example, underscores the need to think carefully about whether collecting social risk information is clinically and ethically appropriate. Joining me now to discuss is Rachel Landauer, a clinical instructor at the Health Law and Policy Clinic at Harvard Law School and coauthor of *Social Risk Information is Sensitive Information: Privacy Policy and Practice Considerations for Social Risk Factor Screening in Healthcare Settings*. Rachel, thank you so much for being here.

RACHEL LANDAUER: Thanks for having me. [music fades]

[00:19:38] HOFF: The Journal has explored how expanded access to screening for health risks is sometimes neither practically helpful nor ethically justifiable. Screening to identify risk for structural drivers of poor health, such as food insecurity, citizenship status, or environmental toxin exposure could, for example, exacerbate patients' and families' fear, anxiety, or shame. So, to begin with, which criteria should we use to consider whether and when structural drivers of health screens should be used?

LANDAUER: I find myself asking what's really driving those negative or concerning outcomes, right? So, what's exacerbating patients' and families' fears? What's causing that anxiety or concerns about shame and stigma, right? Is it that there isn't a requisite level of trust in providers? Is it that we aren't asking and/or responding to what we learn in the right way? And so, once we understand that for our patient population, how do we adapt the intervention, our structural drivers of health screening, appropriately?

And so, in our report, we highlight a range of strategies across the intervention spectrum from kind of the pre-implementation phase, the implementation phase, both pre- and post-screening, and then kind of the continuous quality improvement and evaluation phase. And the idea there is that we're really able to identify how our screening intervention is working for patients and not working for them, how we're getting ahead of what those concerns are, and responding to what those concerns are.

[00:21:31] HOFF: Privacy and confidentiality of patients' health information is a cornerstone of how willing patients and families are to disclose their exposure to a range of negative influences on their health. But assurances of privacy and confidentiality don't keep some patients and family members from not responding to screening questions. So which screening tools and communication methods are most helpful for making respondents feel that responding to SDoH screening questions honestly and completely is worthwhile for them?

LANDAUER: In the work that I do, both as an attorney who is really trying to drive a lot of health-related social needs services and supports into health care delivery and financing, into our policies and our practice, and then what I've also learned from our conversations with a range of experts in this field is that I don't actually know that I would put that pressure on screening tools and communication methods themselves. I think a big piece of this is about whether and how we actually use the information that we learn. And that's whether we're adapting a patient's care plan in productive ways because we've identified certain structural drivers of health that impact, for example, medication management; whether we're connecting patients to community resources that are responsive to their needs; or even more directly offering patients responsive services and supports at our site.

[00:23:06] HOFF: How have recent changes to the legal landscape of abortion care changed pediatric SDoH screening?

LANDAUER: I think that Dobbs and the changing legal landscape around abortion really call on us to be intersectional and take an approach grounded in reproductive justice. So Dorothy Roberts and other movement leaders talk a lot about how restrictive abortion laws, pregnancy criminalization, child protection services, or family policing systems are all really kind of interlocking systems of oppression. And this leads me to four things that I would hope for in terms of the pediatric structural determinants of health screening landscape. The first is, I think I would hope to see increased attention to pediatric structural drivers of health because of reproductive justice, where we're really including the right to parent the children that we have in safe and healthy ways. Second, I think that that emphasis on implicit bias training, on intervening in when and how and why we elevate cases of concern to child protection services, that we're really continuing to break down that conflation that can happen of poverty with neglect, right? And this is something that we heard a lot about and really tried to highlight in our issue brief. Third, I think that when we're thinking about the potential for social or structural determinants of health screening, we can also think about that potential to positively impact reproductive health outcomes for adolescents. That's another place where it comes into play in pediatrics. And then what's the role of pediatrics in that kind of advocacy for policies and other kinds of investments in those responsive services and supports?

[00:25:07] HOFF: And finally, what should clinicians know about how recent changes to deportation practices have changed pediatric SDoH screening?

LANDAUER: I think that there are absolutely ways in which immigration-related concerns impact health. I think that that information may be really timely and relevant. And that doesn't mean that immigration is something that we should be asking about in our social assessments in all communities. Is there that requisite level of trust in providers? Is there a legal requirement that we're adhering to? Are we really conducting that risk assessment and building in strategies for risk management and minimization? And so, I think if we don't have to, we may not want to be asking about immigration status, and we may not want to be recording it if we are asking it. If we do have to ask those questions, I think some of the advice that I've heard from immigration law experts really emphasizes clear communication about what are the patients' rights in terms of responding to those questions? And so, again, it might still be really important and meaningful information in caring for our pediatric patients, but that doesn’t mean that it’s going to be the right conversation to be having in all settings. [theme music returns]

[00:26:44] HOFF: Rachel, thank you so much for your time on the podcast. I appreciate you sharing your expertise with us.

LANDAUER: Thank you again for having me. This was great.

HOFF: That’s all for this episode of *Ethics Talk*. Thanks to Dr Gottlieb and Rachel Landauer for joining us. Music was by the Blue Dot Sessions. To read the full September 2025 issue on Screening Children for Structural Drivers of Health, visit our site, journalofethics.org. Follow us on Bluesky @amajournalofethics, and we’ll be back next month with an episode on the History and Future of Diagnostic Research. Talk to you then.