Pediatric Social Risk Screening: Leveraging Research to Ensure Equity

Danielle Cullen, MD, MPH, MSHP; Leigh Wilson-Hall, MSW, LSW; Katie McPeak, MD; Joel Fein, MD, MPH

From the Department of Pediatrics and Emergency Medicine, Perelman School of Medicine at the University of Pennsylvania, Children's Hospital of Philadelphia (D Cullen and J Fein), Philadelphia, Pa; Department of Population Health, Children's Hospital of Philadelphia (L Wilson-Hall), Philadelphia, Pa; and Department of Clinical Pediatrics, Perelman School of Medicine at the University of Pennsylvania, Children's Hospital of Philadelphia (K McPeak), Philadelphia, Pa
The authors have no conflicts of interest to disclose.
Address correspondence to Danielle Cullen, MD, MPH, MSHP, Department of Pediatrics and Emergency Medicine, Perelman School of Medicine at the University of Pennsylvania, Children's Hospital of Philadelphia, 2716 South St, Office 10-241, Philadelphia, PA 19146 (e-mail: CullenDL@chop.edu).
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WHAT'S NEW

> This progress report explores the potential for social risk screening practices to inequitably distribute social resources to families and suggests steps that can be taken by healthcare systems to consider the most ethical, patientcentered approach.

THE EFFECTS OF poverty on child health have been exacerbated by the coronavirus disease 2019 pandemic and concurrent economic recession, magnifying the urgency for pediatric health care institutions to effectively address patients' unmet social needs. Simultaneously, there is increasing policy and payer pressure to implement screening protocols for social risk factors—such as food and housing insecurity, financial strain, and unsafe environments—within pediatric health care. Although the intent to bring equitable care to families is paramount, it remains unclear what effect standardized social risk screening has on engagement with resources and whether the screening process itself unintentionally introduces disparity.

Over the past decade evidence has built in favor of using self-administered tablet-based screeners to provide anonymity, offering audio-assist and/or pictures to overcome literacy barriers, and applying introductory and sensitive language to decrease concerns about being targeted for screening. Our study, "Food for Thought: A Randomized Trial of Food Insecurity Screening in the Emergency Department," found that tablet-based written screening was both preferred by families and maximized elicitation of food insecurity as compared to verbal face-to-face screening.[1] While we found overall high reported comfort with screening, it is notable that comfort levels were lower among those reporting food insecurity. In our related qualitative work, caregivers expressed fear of stigma or negative repercussions as a consequence of reporting social risk.[2] This and other studies emphasize the potential for unintended consequences and have led to a growing interest in a model of universally offered social assistance, rather than one of screening and intervention.

Screening is generally the first step in social risk interventions and has been shown to lead to increased referrals to assistance agencies and an opportunity for health care providers to adjust care to a patient's needs.[3] However, the path from screening to referral to resource engagement is non-linear (Figure). It remains unclear whether the screening process itself unintentionally leads to inequitable allocation of social resources and disparities in outcomes of child health and health behaviors based on caregiver receipt of and engagement with these resources. This potential for inequity exists through three major mechanisms: 1) discordance between screening results and desire for services (risk vs need); 2) discomfort with screening and fear of negative repercussions; and 3) racial biases in screening practices.

RISK VERSUS NEED

There is surprisingly low concordance between those who report social risk on screeners and those who desire resources, leading to a subset of participants who screen positive but don't report a specific "need" for services, and missing those who have social need but screen negative. Bottino and colleagues offered a screening tool along with a question assessing interest in a referral and found that only half of those who screened as food insecure desired referrals to food resources, and conversely, half of those interested in food-related referrals reported food
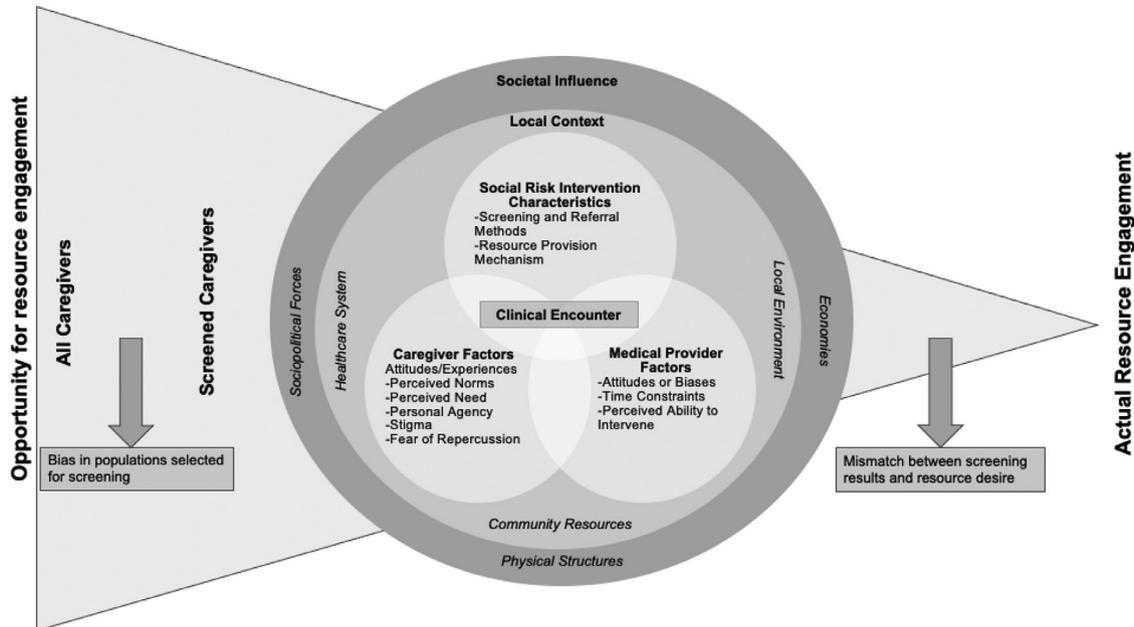
Figure. *Pathway from screening to resource engagement and potential moderators. Adapted from the Health Equity Implementation Framework: Woodward EN, Matthieu MM, Uchendu US, Rogal SS, Kirchner JE. The Health Equity Implementation Framework: proposal and preliminary study of hepatitis C virus treatment. Implement Sci. 2019;14:26.* https://doi.org/10.1186/s13012-019-0861-y.

insecurity.[4] Ray and colleagues provided a list of community resources to all regardless of screening results and found that only 44% of those who reported use of resources would have been identified as having a health-related social need via screening.[5] DeMarchis and colleagues found that interest in receiving social assistance was higher among participants who were asked about their desire for assistance before being screened for social risk.[6]

DISCOMFORT WITH SCREENING

Discomfort with screening and fear of negative repercussions for relaying social risk may lead to decreased resource distribution for families with the highest level of need. Studies have identified that while there is a relatively high level of participant-reported comfort with screening, comfort is lowest among those who report social risk due largely to fear of judgement and involvement of child protective services.[2,7] In the pediatric population, documentation of family-level social risk in the child's medical record can further increase the perceived vulnerability for associated unintended consequences such as child protective service involvement for issues related to poverty.[8]

HEALTH CARE DISCRIMINATION

Although recent innovations have tried to mitigate biases in screening, social risk screening practices are more commonly implemented in clinical settings with majority non-white clientele.[9] Furthermore, families that have experienced prior health care discrimination find social risk screening less acceptable.[7] Black and Brown children are more likely to be referred to child protective services, and have reduced chances of either staying with

their parents or being reunified with them after foster care.[10] This has reverberating implications for the family and child, compromising their trust in the health care system, and criminalizing poverty and race. This also serves to intensify rather than improve socioeconomic and health disparities, and justifies families' fears regarding negative repercussions of social risk screening.

Using the current standard of screening before resource referral, we risk placing our own benchmarks of social need on caregivers, using screening cut-offs to determine eligibility for resources. Furthermore, we require families —particularly those of minority groups who face increased rates of social risk and have increased exposure to health care discrimination—to make themselves vulnerable by reporting social risk to receive resources.

FUTURE WORK

While future work is needed to understand if screening practices help or hinder family-level engagement with social resources, and whether concerns regarding the unintended consequences of social risk screening are warranted, we recommend that health care systems looking to implement social needs interventions consider the most ethical, patient-centered approach. Initial steps may involve: 1) use of Community Health Needs Assessments and other population-level data (ie, Centers for Disease Control and Prevention's Social Vulnerability Index) to identify domains of pressing community need, 2) investments of time and funding in community partnerships to ensure that resources and capacity exist to address the types of social need uncovered, 3) studies to elucidate if a model of universal resource offering, rather than screening and referral, results in more successful connection to resources, 4) providing tiered levels of supports, ranging

from written resources to navigation support, honoring the family's decision of when and how to receive resources, and 5) incorporating patient and family feedback in any strategies employed to identify and address social need. Despite policy and payer pressure, we must remain focused on our main objective: ensuring the well-being of the patients and families that we serve.

ACKNOWLEDGMENTS

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