Commentary

Poverty, the Elephant in the Room

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As is often referenced, the Institute of Medicine defines quality of care in 6 domains: safety, effectiveness, patient centeredness, timeliness, efficiency, and equity.1 And although we have seen tremendous focus on the first 5 domains in pediatric health care, equity (provision of care that does not vary in quality because of characteristics such as sex, race, ethnicity, or socioeconomic status) is a dimension that we need to continue to address. Efforts to improve population health and promote equity have led to efforts to define and address social determinants of health (SDOH): the conditions in which people are born, grow, live, work, and age.2 SDOH encompass aspects of well-being, like food security and adequate housing, that are linked to health outcomes.3,4 Poverty is a key factor that limits access to food and housing, and poverty is the "elephant in the room" when navigating patient and family factors that affect chronic disease management.5

In this month's Hospital Pediatrics, Foster et al6 evaluated the association between SDOH and emergency department (ED) encounters or hospital admission among children with chronic disease. They demonstrated that participants who reported unaddressed housing and food insecurity at the time of enrollment in a case management program had increased ED use, and those who reported addressed food insecurity (referring to families who had received food-related resources and assistance before enrollment in this case management program) had decreased ED use. Neither food nor housing insecurity, addressed or unaddressed at the time of program enrollment, was associated with hospitalization rates.5 The impact of these SDOH on ED encounter versus hospitalization rates may reflect the impact that SDOH have on caregiver-driven versus provider-driven use. Foster et al6 highlight an important consideration: do SDOH impact use differences in health care access (seeking care in the ED) rather than an increase in severity of a child's chronic illness (needing hospitalization)? These findings align with previously published work highlighting that housing and food insecurity have been associated with missed medical care, medications, and preventive medical care as well as increased ED visits among low-income children, but neither food nor housing insecurity was associated with hospitalization rates.5 Foster et al6 add to the body of literature that SDOH, specifically food and housing insecurity, affect how children and their families interact with the health care system. As pediatricians, we are compelled to address these unmet health needs to optimize families' interactions with the health care system and their children's health. This may be driven by a lack of a comprehensive social safety net in the United States, as compared with other developed peer countries. Despite having one of the highest health care expenditures, the United States falls behind almost all countries of the Organization for Economic Co-operation and Development in terms of health insurance coverage.8 In addition, we have an alarming rate of childhood poverty compared with peer countries.9 The relative child poverty rate tends to be lower in countries that choose to invest more of their national income in programs that alleviate poverty and material hardship. It is disappointing that the
United States has the second highest child poverty rate (20%) among peers in the Organization for Economic Co-operation and Development countries (data from 2014). This linear association between child poverty rates and social expenditure as a percentage of gross domestic product (GDP) is highlighted by looking at the extremes: the United States spends only 12% of their GDP on social support programs and has a childhood poverty rate of 20%, in comparison with Denmark, which spends 20% of their GDP on social support programs and has a childhood poverty rate of <3%.9

As providers, we are acutely aware of the striking lack of a social safety net in the United States, and we seek to support vulnerable communities to minimize SDOH and optimize health outcomes. Although the first step may be implementation of SDOH screening in all pediatric health environments, a myriad of challenges to this concept have been raised. At the forefront is the concern that SDOH will result in unintended consequences to these families. For example, positive screening results may not equate with a family’s desire for assistance, or sufficient resources may not be available to provide families with positive screening results.10–12 However, caregivers have expressed that social risk screening is important and connected to their child’s health, whether completed at their pediatrician’s office or in the ED.13 Interestingly, this feeling for caregivers existed even when acknowledging the limitations of the health system to completely address or resolve these issues.15 Staff working in the ED and the hospital settings also appreciate the importance of SDOH screenings and believe it should occur in these settings.14 In fact, these locations may have an added benefit of an on-site case manager or social worker to help assist families with positive screening results.14 Furthermore, if food- or housing-insecure families preferentially seek care in these acute settings, these interactions may be the only opportunity to identify families who need assistance with SDOH.

Once screening is completed, how can pediatricians act? Start by supporting families with increased SDOH risk by optimizing their access to existing resources. Focusing on food and housing insecurity may be imperative initial steps to help families of all children reframe how they interact with the health system. For food-insecure families and children, it is important to connect them with resources like Women, Infants, and Children and Supplemental Nutrition Assistance Program (SNAP) if they are eligible. Of note, SNAP benefits have been associated with decreased ED visits among children with asthma.15 For housing-insecure families, this may translate into connecting them with emergency housing because having any shelter impacts how frequently a child uses the acute health system. Health care use, including ED visits and hospitalizations, has been shown to accelerate in the 12 months preceding entrance to emergency housing, the time period when families are most housing insecure.16 In this same study, pediatric health care use then slowly declined over the next year after placement in a shelter.16 Beyond having any shelter, connecting families with housing voucher resources and applications matters. In 1 study, receipt of a housing voucher in childhood was associated with a significant decrease in hospitalizations and, subsequently, hospital spending in children <13 years of age.17 If pediatricians screen families for food and housing security in these acute care settings, it is likely these families can be identified and their pediatrician can intervene as their SDOH risk is accelerating.

Pediatricians can also be creative with community partnerships. Local food banks have often provided a foundation for such collaborations. In one example, an ED housed a summer food service program, providing boxed lunches to its pediatric patients along with education on how to access similar programs in the community. Caregivers found this program acceptable, and the program improved their awareness of these community resources without interfering with clinical care.18 Another collaborative effort between a local farmer’s market and primary care center provided families with “produce prescriptions,” and participating families appreciated this support for improving food security.19 Technology can also be leveraged to connect families with local food resources. One ED created an electronic medical record order set that triggered a fax referral to a local food bank for food-insecure families. This program resulted in 75% of referred families being contacted by the food bank and subsequently receiving assistance, including enrollment into SNAP, if eligible.20 These partnerships can be similarly founded on housing resources. In New Zealand, a comprehensive healthy housing program used multiple social agencies to help families with their home environment: this included moving them into larger homes or optimizing the existing home environment. For the youngest children in this study (ages 0–4 years), hospitalizations decreased by 11% after participation in this home-based intervention.21 Identifying these unique collaborative efforts and integrating them into the acute health care settings are necessary steps toward being able to examine if SDOH interventions result in improved child health.

Unmet needs for families and the overwhelming impact on child health have been painfully evident to pediatricians. SDOH, specifically food and housing insecurity, impact children’s health and influence how their families access health care. As pediatricians, we can prioritize and implement SDOH screening in acute care settings using existing screening tools. Simultaneously, we can seek and create unique, creative partnerships between acute care units and local food and housing resources. Until we have a stronger social safety net in the United States, it is our responsibility as pediatricians to identify and intervene at each and every opportunity afforded to us to support these families and optimize the health of their children.

REFERENCES


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