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Screening for Basic Social Needs at a Medical Home for Low-Income Children

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The goals of this cross-sectional study were to (*a*) describe the prevalence of 5 basic social needs in a cohort of parents attending an urban teaching hospital–based pediatric clinic, (*b*) assess parental attitudes toward seeking assistance from their child's provider, and (*c*) examine resident providers' attitudes and behaviors toward addressing these needs. Parents (n = 100) reported a median of 2 basic needs at the pediatric visit. The most common was employment (52%), followed by education (34%), child care (19%), food (16%), and housing (10%). Most parents (67%) had positive attitudes toward requesting assistance from their child's pediatrician. The majority of resident providers (91%) believed in the importance of addressing social needs; however, few reported routinely screening for these needs (range, 11% to 18%). There is great potential for assisting low-income parents within the medical home. Further practice-based interventions are needed to enhance providers' self-efficacy to screen and address low-income families' needs at pediatric visits.

Keywords: low income; basic needs; medical home; pediatrician

Introduction

Addressing basic social needs such as employment, parental education, and housing was not traditionally a component of pediatric preventive care. Roghmann and Haggerty,[1] in 1972, first emphasized the "new morbidities" such as social difficulties, which presented new threats to child health. Longitudinal research has demonstrated the direct effects that the social milieu has on a child's health and development.[2] Previous studies have demonstrated the negative impact that low parental education, food insecurity, and housing instability have on child learning and behavior.[2-8] Current pediatric preventive care guidelines emphasize the importance of understanding family and community influences on the child and the need for pediatricians to incorporate this understanding into routine anticipatory guidance.[9-11]

Low-income families often face multiple constraints in the context of poverty, including limited education, food insecurity, unstable housing, lack of quality child care, and limited employment opportunities. This inability to meet such basic needs such as food and shelter is a pediatric issue because it directly affects the health of children[12] and parental well-being.[13]

Pediatric providers have the potential to address low-income families' basic social needs at medical visits. However, no prior studies to our knowledge have examined low-income parents' attitudes toward having their child's pediatrician screen for multiple social needs. Furthermore, providers' attitudes and behaviors toward screening for basic social needs at pediatric visits are unknown. This knowledge is

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important to determine the acceptability and feasibility of screening for basic social needs within the context of pediatric primary care. The objectives of this study were to (*a*) describe the prevalence of basic social needs in a cohort of low-income parents attending an urban pediatric clinic, (*b*) assess parental attitudes toward seeking assistance from their child's provider, and (*c*) examine resident providers' attitudes and behaviors toward addressing basic social needs at visits.

Methods

This cross-sectional descriptive study was conducted using baseline data collected during a randomized controlled trial of a family psychosocial screening intervention at an urban teaching hospital–based pediatric clinic in Baltimore, Maryland.[14] The clinic serves as a medical home for approximately 10 000 children ages from birth to 21 years with Medicaid as the primary source of health care coverage. Data were collected from April to June 2006.

Parents of children aged 2 months to 10 years of age who presented for a well-child care visit with a pediatric resident provider during continuity clinics were eligible. Parents were excluded if they were not the child's legal guardian, non-English speaking, previously enrolled in the study, or lacked access to a working phone. Recruitment was conducted by a research assistant in the waiting room prior to the visit. For this study, we focused on parents assigned to the intervention arm (n = 100) because baseline data on self-reported basic social needs was not ascertained from control parents. Parents completed a self-report written questionnaire that screened for family psychosocial needs. Five basic social needs were included (parental education, employment, housing, food, and child care availability). The questionnaire's format allowed parents to identify problems and to indicate their motivation to address them.[14] Two focus groups of clinic parents were conducted to assess face validity. The questionnaire's readability was at the third-grade level based on the Flesh-Kincaid grade level formula. The 2-week test–retest reliability for the first 20 respondents was high (r = .92). Parents also were asked 2 questions regarding attitudes about their willingness to ask their pediatrician for help with social problems and whether they believed that their pediatrician could assist them with their social issues. Their responses were scored on a 5-point Likert-type scale (1 = strongly disagree, disagree, neutral, agree, or 5 = strongly agree). Based on the data distribution, the responses were categorized into 3 categories (disagree, neutral, agree).

Pediatric residents were the primary care providers for the enrolled children. Two weeks prior to the randomized controlled trial, residents were administered a 27-item self-administered written survey during their continuity clinic session. The survey assessed their attitudes and behaviors regarding psychosocial screening. It was piloted to pediatric residents (n = 5) from another residency program who provided feedback on its clarity and ease of use. Five items focused on providers' attitudes toward screening for the 5 basic social needs and were scored on a 5-point Likert-type scale with options ranging from 1 = strongly disagree to 5 = strongly agree. Items focusing on providers' screening behaviors were scored as follows: almost never (<25% of visits), sometimes (25% to 49% of visits), usually (50% to 74% of visits), and almost always (≥75% of visits). Routine screening was defined as occurring at ≥75% of pediatric visits.

Descriptive statistics were used to report baseline characteristics of parents, prevalence of basic social needs, parental attitudes toward the pediatrician's role for addressing social problems, and residents' attitudes and behaviors toward addressing these needs at pediatric visits. The χ^2 test was used to explore associations between categorical variables of parental education, household income, and number of visits with parental attitudes toward their pediatrician's role with addressing social problems. χ^2 and Fisher's exact test were also used to explore associations between gender and level of training (pediatric level [PL]-1 vs PL-3) with residents' attitudes and behaviors toward screening for family basic needs at pediatric visits. SPSS version 13.0 was used for the statistical analyses. Statistical significance was defined as $P < .05$.

The study was approved by the institutional review board at the Johns Hopkins University School of Medicine. Written informed consent was obtained from all participants.

Results

Of the 100 parents, the majority were African American (96%), mothers (86%), reported household incomes <$30 000 (79%), and received Medicaid

Table 1. Baseline Characteristics (n = 100)

Characteristics	Percentage
Relationship to child	
Mother	86
Father	3
Other	11
Age, mean years (SD)	30.4 (9.3)
Race	
African American	96
White	1
Other	3
Ethnicity	
Hispanic/Latino	0
Uninsured	14
Household income	
<$15 000	47
$15 000-29 000	32
>$30 000	21
Medicaid insurance for child	89
Temporary cash assistance	20
Food stamps	59
WIC	43
Supplemental security income	9

Note: SD = standard deviation; WIC = women, infants, children.

insurance for their child (89%) with a mean age of 30.4 years (Table 1).

Basic social needs were prevalent. Parents reported a median of 2 needs at the index visit. The most common needs were employment (52%), followed by obtaining a GED (34%), child care (19%), food insecurity (16%), and housing (10%).

Sixty-seven percent of parents agreed that they could ask their child's doctor for assistance with social issues, and 70% of parents agreed that their child's doctor could assist them with their social issues. Less than 10% of parents disagreed with either statement. There were no significant associations between parental baseline characteristics and their attitudes.

All eligible providers participated in the study. Of the 45 residents, 65% were female and 73% white with a mean age of 29 years. The majority of parents (44%) were at the PL-3 level (PL-2, 23%; PL-1, 33%).

The majority of providers agreed or strongly agreed that screening for family social needs was important (91%) and effective (98%). All residents reported that it was their responsibility to ask parents about their social problems. Yet, overall, few residents routinely screened for basic family needs

Table 2. Comparison of Providers' Attitudes with Screening Behaviors (n = 45)

At Visits, I Believe It Is My Job to Ask Parents About Their:	Percentage Reported Yes	Percentage Routinely Screen	Difference Between Attitude and Screening Rates
Child care needs	80	16	+64%
Educational status	41	11	+30%
Employment status	84	11	+73%
Food insecurity	84	11	+72%
Housing problems	89	18	+71%

(range, 11% to 18%; Table 2). There were no significant associations between gender and training level with residents' attitudes toward screening for family needs. Overall, there was a large discrepancy between residents' attitudes (ie, job responsibility) and screening behaviors for each family need (Table 2).

Discussion

This is the first study to our knowledge to examine urban low-income parents' attitudes toward having multiple basic social needs screened by pediatric providers. Our data indicate that 52% of families attending an urban pediatric clinic reported at least 1 basic need; most parents had positive attitudes toward receiving assistance for these needs from their child's pediatrician. Although the vast majority of providers reported positive attitudes toward the importance of screening for basic social needs, few reported routinely screening for these topics. These findings have important implications for the delivery of pediatric primary care to urban, low-income children.

Professional guidelines recommend that pediatricians address family and social factors, the "new morbidities," within the context of primary care.[9] Preventive care guidelines from *Bright Futures* stress the importance of viewing the child in the context of the family.[10] The American Academy of Pediatrics Task Force on the Family in 2003 recommended extending the responsibilities of the pediatric provider to include screening, assessment, and referral of parents for social problems that "can adversely affect the health and emotional or social well-being of their child."[11] Our study indicates that most residents perceive a professional responsibility to screen for family social needs.

Although previous studies have focused on screening for other parental psychosocial problems,

such as smoking,[15,16] depression,[17] and intimate partner violence,[18,19] by pediatric providers, our data suggest that few residents in training routinely address low-income families' basic needs that may underlie the psychosocial problem. Potential barriers to screening include lack of time, professional training, and knowledge of community resources.[20] Our data suggest that the development of pediatric training curriculum focused on training residents to address their patients' families' basic needs is critical, particularly because physicians often incorporate what they learn and practice during residency into their future practice behavior.[21]

We found that low-income parents view their pediatrician as having an important role in addressing their family basic needs. Many low-income parents' only point of access to the health care system is via their child's medical home because many either do not have their own primary care provider or seek health care services for themselves. Implementation of a screening process for social needs during pediatric visits provides an opportunity to evaluate and immediately link low-income families to appropriate resources. Zuckerman and Parker[22] suggested that a new model of pediatric primary care is needed in which services are linked within the pediatric practice or to other community-based programs. Wood[23] recommended that pediatric medical homes in underserved communities offer office-based family advocacy services and connect low-income families with services for which they qualify and/or need in the community. To successfully expand the role of the medical home, pediatricians must also become aware of available community resources (eg, employment centers, food banks, Head Start sites) to refer to for families' social needs. Time-efficient practice-based models need to be developed to incorporate routine screening of basic family needs at medical homes for low-income children. Addressing and ameliorating basic family need by pediatricians may enhance the parent–provider relationship and lead to improved outcomes for low-income children's health and development.

The following study limitations need to be mentioned. Parents and providers were surveyed from 1 urban hospital–based pediatric clinic thereby limiting the generalizability of our findings. We believe that our findings are noteworthy however, because little is known regarding both low-income parents' attitudes toward receiving assistance for basic family needs and providers' attitudes and behaviors for screening for these needs. Our methodology relied on self-reporting, which may have introduced social desirability and recall biases. This would have led to an underestimation of families' needs and potential overestimation of residents' screening behaviors. However, families reported a high prevalence of basic social needs and few resident providers reported routinely screening for these needs at pediatric visits.

Conclusions

Many low-income families have basic social needs such as employment, education, child care, housing, and food. Parents have favorable attitudes toward asking for and receiving assistance for these needs from their child's provider. Providers feel a responsibility to assist their patients' families, but few routinely screen for critical social needs. This discrepancy needs to be addressed to develop new practice-based models for vulnerable children that emphasize routine screening of basic social needs and referral to community resources. Doing so may lead to pediatricians' better understanding of their patients' social milieu, improved partnerships between providers and families, and enhanced child health and developmental outcomes.

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