Food Insecurity Screening and Intervening in Healthcare Setting

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Food Insecurity Defined

Limited resources or uncertain access to adequate food to live an active, healthy lifestyle

Unable to acquire food in socially acceptable ways

Different levels: "low food security" and "very low food security"

Can be chronic or sporadic

Effects of Food Insecurity

Children

- Impaired or delayed growth and development
- Asthma
- Poor school performance
- Behavioral problems

Adults

- Hypertension
- Diabetes
- Overweight/obesity

Seligman HK, Laraia BA, Kushel MB. Food Insecurity is Associated with Chronic Disease among Low-Income NHANES Participants. *Journal of Nutrition*. 2010; 140: 304-310.
Feeding America. Child Development. Consequences of Food Insecurity in Children. http://www.feedingamerica.org/hunger-in-america/impact-of-hunger/child-hunger/child-development.html. Accessed August 8th, 2016.

Figure 1: Food Insecurity Trends Among Households <300% FPL, LACHS 2002-2015

Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, Food Insecurity in Los Angeles County, September 2017
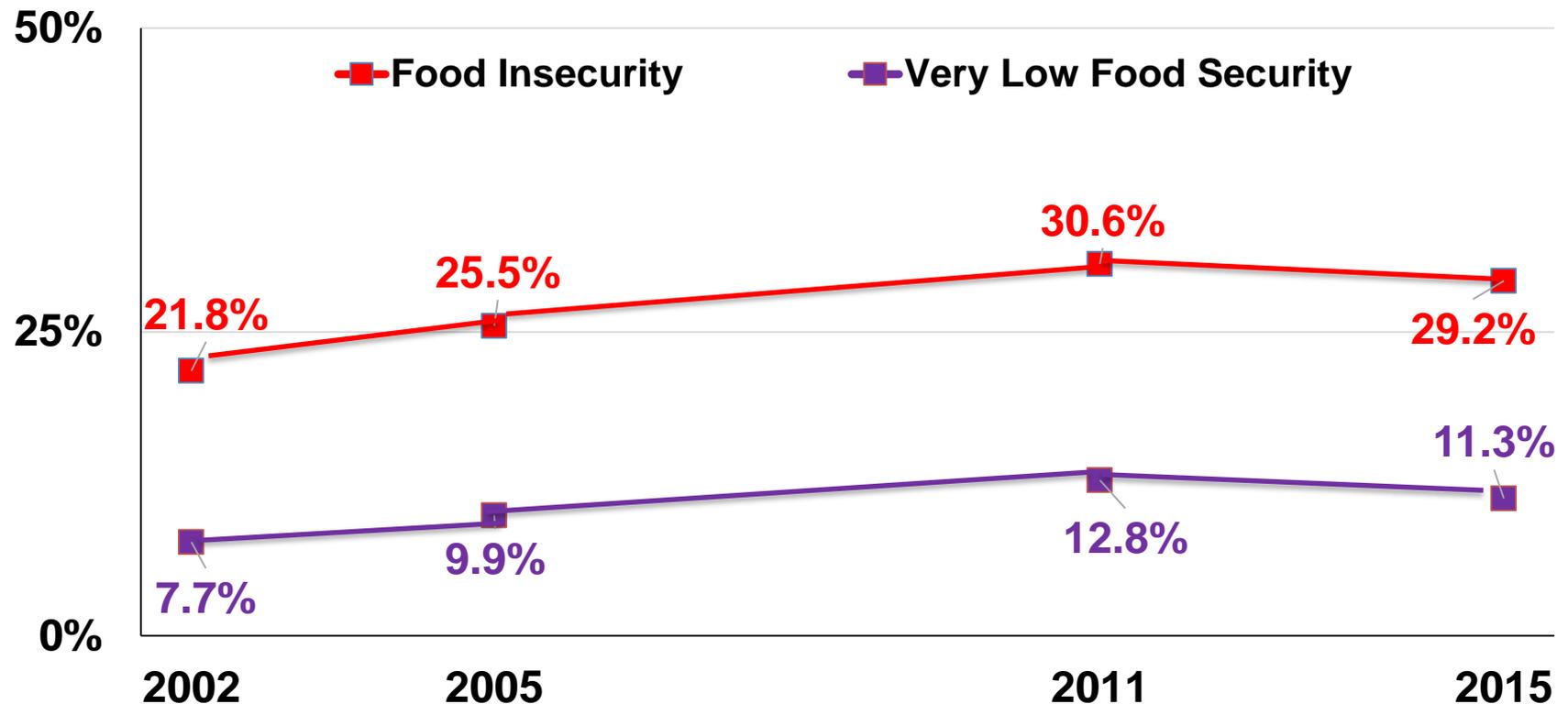
Figure 2: Food Insecurity by Households <300% FPL With and Without Children, LACHS 2002-2015

Los Angeles County Department of Public Health, Office of Health Assessment and Epidemiology, Food Insecurity in Los Angeles County, September 2017
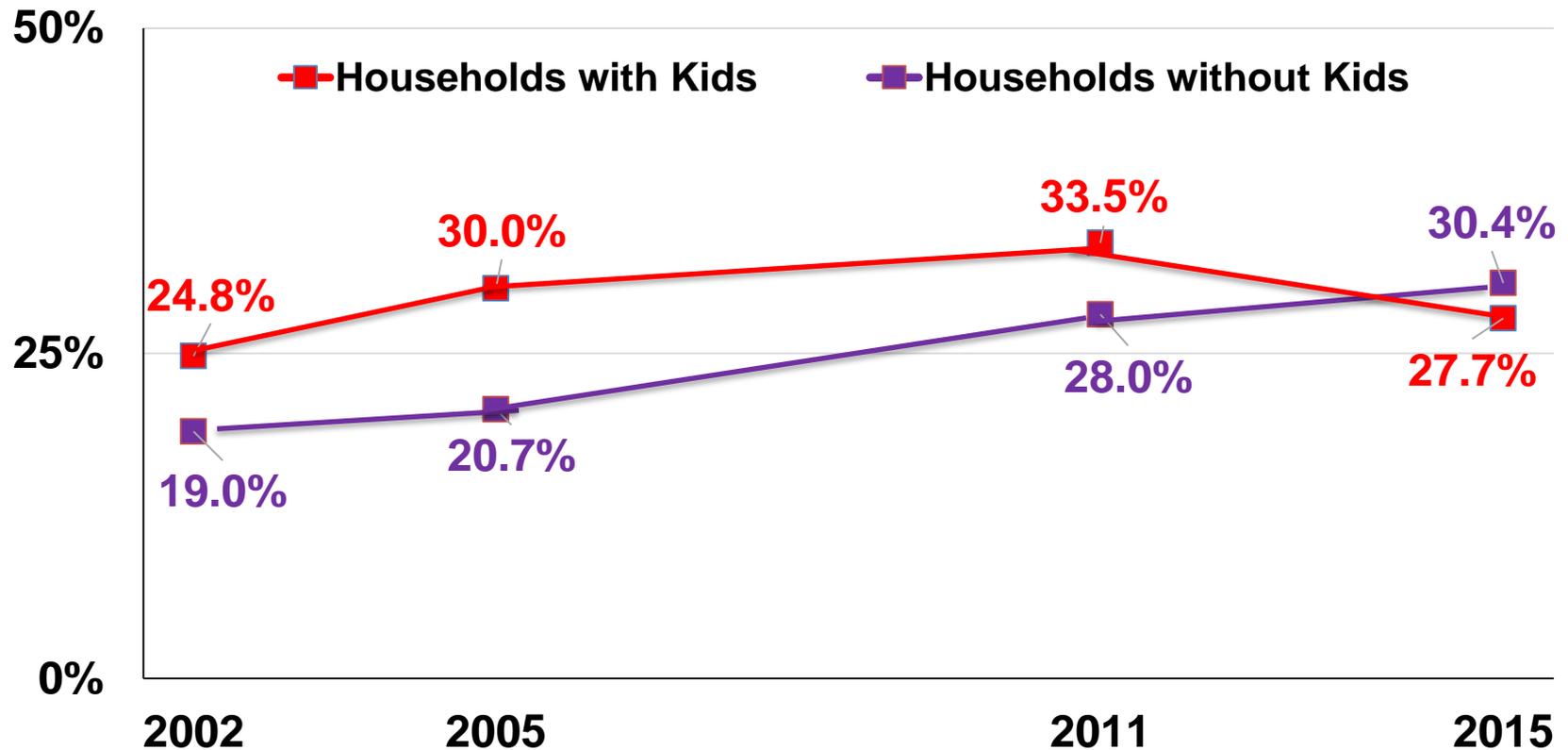
Steps to Implement Food Insecurity Screening & Intervention

Step 1: Educate and train staff on food insecurity, importance of universal screening and local food resources.

Step 2: Screen at scheduled health maintenance visits or sooner, if indicated.

Step 3: Incorporate food insecurity screening into the workflow.

Step 4: Show sensitivity when screening for food insecurity – normalize the screening tool

Step 5: Connect pts who screen positive to appropriate local food resources.

Addressing Food Insecurity: A Toolkit for Pediatricians. American Academy of Pediatrics and Food Research Action Center. February 2017. http://www.frac.org/wp-content/uploads/frac-aap-toolkit.pdf/ Accessed on October 1, 2017.

Step 1: Educate and train staff on food insecurity, importance of universal screening and local food resources.

Train staff and leadership (MDs, administrators, RDs) on food insecurity

Collaborate with practice team and support staff on how to screen

Train practice team on how to administer the screening and document results

Identify a "Hunger Champion"

Educate medical team on available food resources

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Step 2: Screen at scheduled health maintenance visits or sooner, if indicated.

If cannot screen at all visits, prioritize screening:

- Routine well-checks
- Visits for nutrition-related conditions
- Emergency room visits
- Hospital admissions
- Newborn care before discharge

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Step 3: Incorporate food insecurity screening into the workflow.

Incorporate screening tool into existing registration, intake procedure or electronic medical records

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Step 4: Show sensitivity when screening for food insecurity – normalize the screening tool.

Food insecurity is a sensitive subject

Hunger is invisible

Families may feel shame or embarrassed

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Step 4: Show sensitivity when screening for food insecurity – normalize the screening tool.

Decide if the screener should be verbal or written.

Administer the tool in the pt's preferred language.

Normalize the tool, "*I'm seeing so many pts that have a hard time affording food, so **I'm asking all my pts** some questions about this. Please let me know if these statements are true for you and your family…*"

Consider asking when the child is not in the room or distracted. Be respectful of the family's privacy.

Step 4: Show sensitivity when screening for food insecurity – normalize the screening tool.

Inform parent/caregiver that assistance is available, and most people need help at some point in their lives.

Use physical environment cues (e.g. poster, brochure) that address food insecurity or nutrition programs.

Encourage parent/caregiver to seek assistance for the benefit of all family members. Be clear that you are recommending food assistance as you would prescribe medication. *"CalFresh will help you buy the fruits and vegetables your family needs to grow and stay healthy."*

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Step 5: Connect pts who screen positive to appropriate food resources.

Decide who in the organization can connect pts to resources

Develop community partnerships

Provide referrals to community partners

Host a community partner to provide on-site assistance

Connect pts to SNAP-Ed nutrition classes

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Intervention Models

Model #1 – Onsite Assistance

Description	• **Pts referred to an onsite care coordinator.** • **Full-time assistance may be provided by onsite partner organization**
Populations Best Served	All populations
Population NOT Well-Suited	N/A
Healthcare Setting Requirements	• Staff trained in food security screening & referral • Staff trained in application assistance or partner organization is identified to provide full-time assistance onsite. • Space that ensures pt privacy • Work station w/phone and computer

Launching Rx for CalFresh in San Diego: Integrating Food Security into Healthcare Setting. San Diego Hunger Coalition. September 2016.
https://static1.squarespace.com/static/55130907e4b018f9300f3e63/t/57dc2edf579fb3ea4671e08c/1474047712306/Rx+for+CalFresh_SDHC.PDF. Accessed October 2, 2017.

Model #1 – Onsite Assistance

Description	• Pts referred to an onsite care coordinator. • Full-time assistance may be provided by onsite partner organization.
Loss to Follow-Up	Little to none (pts may opt out, however healthcare staff should be trained to address pt concerns that may keep them from applying)

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Model #2 – Intermittent Onsite Assistance

Description	• **Pts referred to onsite application assistance by a partner organization.** • **Partner organization comes onsite on a regular basis but not available at all times.**
Populations Best Served	• All populations • People who prefer face-to-face assistance
Population NOT Well-Suited	<u>If onsite is infrequent</u>, this model is less-suited for: • Older adults • Patients in poor health • Individuals with limited access to transportation

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Model #2 – Intermittent Onsite Assistance

Description	• **Pts referred to onsite application assistance by a partner organization.** • **Partner organization comes onsite on a regular basis but not available at all times.**
Healthcare Setting Requirements	• Staff trained in food security screening & referral • Partner organization is onsite regularly • Space that ensures pt privacy • Healthcare staff should be familiar with CalFresh so they can answer questions when partner organization is not present
Loss to Follow-Up	Limited, if assistance is provided regularly.

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Model #3 – Partner-Initiated Phone Based Referral

Description	• **Pts asked if they want a follow-up call from partners organization for assistance** • **Consent is given by signature or verbally, in compliance with healthcare setting.**
Populations Best Served	Technologically savvy pts with access to smart phones and consistent phone reception.
Population NOT Well-suited	• Older adults • Pts in poor health • Pts with inflexible schedules • Individuals requiring more hands-on support • Rural pts with poor phone reception

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Model #3 – Partner-Initiated Phone Based Referral

Description	• **Pts asked if they want a follow-up call from partners organization for assistance** • **Consent is given by signature or verbally, in compliance with healthcare setting.**
Healthcare Setting Requirements	• Staff trained in food security screening & referral • Protocols established between healthcare systems and phone-based CalFresh application partners to share pt information.
Loss to Follow-Up	Often high

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Model #4 – Patient-Initiated Phone Based Referral

Description	• **Pts provided with a phone number to call for assistance** • **Consent is given by signature or verbally, in compliance with healthcare setting.**
Populations Best Served	Proactive, technologically savvy pts with access to smart phones and consistent phone reception.
Population NOT Well-suited	• Older adults • Pts in poor health • Pts with inflexible schedules • Individuals requiring more hands-on support • Rural pts with poor phone reception

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Accessed October 2, 2017.

Model #4 – Patient-Initiated Phone Based Referral

Description	• **Pts asked if they want a follow-up call from partners organization for assistance** • **Consent is given by signature or verbally, in compliance with healthcare setting.**
Healthcare Setting Requirements	Staff trained in food security screening & referral
Loss to Follow-Up	High

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Model #5 – Referral to Local Community Organization

Description	Pts provided with names, addresses and phone number of local community-based organizations (CBO) for assistance
Populations Best Served	When healthcare setting is located near a CBO (less than .25 miles) offering application assistance
Population NOT Well-suited	• Pts in poor health • Pts with inflexible schedules • Individuals with limited access to transportation

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Model #5 – Referral to Local Community Organization

Description	**Pts asked if they want a follow-up call from partners organization for assistance** **Consent is given by signature or verbally, in compliance with healthcare setting.**
Healthcare Setting Requirements	Staff trained in food security screening & referral
Loss to Follow-Up	Often extremely high, unless the community partner is located in close proximity.

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Discussion

- Out of the 5 models which is the most feasible for your clinic?

- How can DPH support screening and referral process?

- What type of training or technical assistance will your staff need?

Contact Information

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