Food Insecurity Screening in Pediatric Clinical Practice

Child Health Advances Measured in Practice (CHAMP) Learning Session
The University of Vermont Dudley H. Davis Center

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Disclosures

• I have no relevant financial relationships to disclose or conflicts of interest to resolve
• I will discuss no unapproved or off-label pharmaceuticals
What do we know about Provider Knowledge & Practices

Hoisington, et. al, Prev Med 2012

• In 2007:
  • 8% of providers considered themselves very knowledgeable about food insecurity
  • 13% indicated that they consistently ask about the sufficiency of food in their families homes.

Unpublished Data, Wash, DC

• In 2016:
  • 8% very knowledgeable
• Screening:
  – 85% Verbal by provider
  – 4% Use of other staff
  – 4% Use of Written forms
  – 13% Use of EMR
  – ~90% no standardized screener
  – 45% only when concern noticed
Barriers to Screening

1. **Time** Constraints (80%)

2. Community interventions that address this issue are unknown to me (52.8%)

3. Resources addressing this issue are unavailable to me (50.6%)

4. I don’t know enough about the issue (45.5%)

5. I am worried about the sensitivity of these type of questions (27.0%)

6. Don’t know how to ask this type of question (22.3%)

Hoisington et al, Preventive Medicine, 2012
Physician Lived Experiences with Screening

- Time & Workflow **were not barriers** to screening, but concerns about embarrassing families and being unable to provide adequate resources
- Clinicians reported that parents felt the screening **showed caring**, which reinforced the clinicians continued screening
- Suggested implementing screening **before** visit

Palakshappa, et. al, Pediatrics, 2017
“At first, it was like, ‘oh, my gosh, another question.’ But then truly, once you got into the workflow, it wasn’t that much additional [time]”

“It’s a really personal question. You’re asking somebody about money. I mean, I think that’s probably why it’s just awkward, no matter what”
Family Lived Experiences with Screening

- Parents expressed **initial surprise** at screening **followed by comfort** discussing their unmet food needs.
- Parents experience **shame**, frustration, and helplessness regarding FI, but discussing FI with their clinician **helped alleviate these feelings**.
- Parents suggested **practices could help them more directly access food resources**, which, depending on income may not be available to them through government programs.

Palakshappa, et. al, Pediatrics, 2017
“I was really kind of shocked because when she did ask me, I was struggling at the time. I didn’t want to lie, but I didn’t want to be completely honest because I didn’t want her to think I was neglecting my child.”

“I was a little shocked because usually they don’t ask that. But it gave me an opportunity to say something to somebody who might be able to make a difference.”

“As a parent, it’s horrible. Because you don’t want to see your children in need of anything. Of course, I keep it together for them.”
2015
• Screen & Intervene @ “scheduled health maintenance visits or sooner if indicated”
• Advocate for programs/policies that end childhood food insecurity
• Hunger Vital Sign recommendation
AAP recommends that pediatricians use the Hunger Vital Sign™ to screen for food insecurity in practice. The two questions are:

1. Within the past 12 months, we worried whether our food would run out before we got money to buy more.
   - often true
   - sometimes true
   - never true
   - don’t know/refused

2. Within the past 12 months, the food we bought just didn’t last and we didn’t have money to get more.
   - often true
   - sometimes true
   - never true
   - don’t know/refused
Pediatricians play a critical role in protecting children from food insecurity

**KEY FACTS ABOUT CHILDHOOD FOOD INSECURITY**

**1 in 6** U.S. children lives in a food-insecure household

**Childhood food insecurity can lead to:**
- Poor Health Status
- Developmental Risks
- Mental Health Problems
- Poor Educational Outcomes

**Childhood food insecurity may present:**
- Developmental Delays
- Behavioral Problems
- Obesity
- Poor Growth
- Inappropriate Feeding Practices

**NUTRITION PROGRAMS TO KNOW**

The federal nutrition programs play a critical role in improving food security, health, and well-being

- **SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP)**
- **SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)**
- **CHILD CARE MEALS**
  - SCHOOL BREAKFAST AND LUNCH
  - AFTERSCHOOL MEALS
  - SUMMER MEALS

**Prepare**

- Educate and train staff on food insecurity and the need for universal screening
- Follow AAP's recommendation of screening at scheduled check-ups or sooner, if indicated
- Incorporate food insecurity screening into the institutional workflow
- Show sensitivity when screening for food insecurity

**Screen**

- Use the AAP-recommended Hunger Vital Sign™
  1. “Within the past 12 months, we worried whether our food would run out before we get money to buy more.”
     - Often true
     - Sometimes true
     - Never true
     - Don’t know/refused
  2. “Within the past 12 months, the food we bought just didn’t last and we didn’t have money to get more.”
     - Often true
     - Sometimes true
     - Never true
     - Don’t know/refused

**Intervene**

- Administer appropriate medical interventions per your protocol
- Connect patients and their families to the federal nutrition programs and other food resources
- Document and track interventions in medical records
- Support advocacy and educational efforts toward childhood food insecurity

For more information, visit: [http://www.frac.org/aaptoolkit](http://www.frac.org/aaptoolkit)

http://www.frac.org/aaptoolkit
PREPARE
Prepare

• **Educate & Train** staff on food insecurity and screening

• **Follow** AAP’s recommendation of screening at scheduled well-child visits or sooner, if indicated.

• **Incorporate** food insecurity screening into the institutional workflow

• **Show** sensitivity when screening for food insecurity
Screening Questions

Red Flags

Administer Connect Document/Track Support
SCREEN
Screen

- Goal: Screen at scheduled health maintenance visits or sooner if indicated
- Prioritize Screening:
  - Routine Well Child Checks
  - Visits for nutrition related conditions
  - Emergency Room Visits
  - Hospital Admissions
  - Newborn care before discharge
- Team based approaches
- Multiple food insufficiency screeners available
  - Goal: Identify and use screener best captures our patients in need and fits into our workflow.
Hunger Vital Sign©

1. “Within the past 12 months, we worried whether our food would run out before we got money to buy more. “
2. “Within the past 12 months, the food that we bought just didn’t last and we didn’t have money to get more.”

- Yes or No in the last 12 months.
- Recommend: Often True, Sometimes True, Never True, or Don’t Know/Refused to answer for you in the last 12 mo.
Addressing Food Insecurity

*Tips*

- Sensitivity
  - Verbal vs Written/Electronic

- Provide Safe Setting
- Normalize Questions
- Parent Preferred Language
- Reassure
- Ask
- Acknowledge
- Connect
- Follow up

- Provide Safe Setting
- Normalize Questions
- Parent Preferred Language
- Acknowledge
- Connect
- Follow up
• Developmental Delays
• Behavioral Problems
• Obesity
• Poor Growth
• Inappropriate Feeding Practices
• Anemia
Screening Questions

Prepare
- Educate/Train
- Follow
- Incorporate
- Show

Screen
- Administer
- Connect
- Document/Track
- Support

Intervene
- Red Flags
INTERVENE
Intervene

• **Administer** appropriate medical interventions per your protocols.

**Connect** patients and their families to the federal nutrition programs and other food resources.

• **Document & Track** interventions in medical records.

• **Support** advocacy and educational efforts to end childhood food insecurity
Connect

• Step 1: Educate the medical team on available federal nutrition programs and emergency food resources

• Step 2: Decide who in your practice can help connect patients and their families to nutrition programs and food assistance and where you need to enlist the help of a partner
  – Model 1: Providing referrals to a community partner
  – Model 2: Hosting a community partner to provide on-site assistance
Connect

• Step 3: Post information on federal nutrition programs in your waiting room to encourage program participation.

• Step 4: Assess the capacity of your practice to implement other strategies to address food insecurity.
Washington, District of Columbia
2017 Population Estimates:

- 690,945 Population
- 46.5% Black/African-American
- 40.7% White
- 11.21% Hispanic (Ethnicity)
- 4.1% Asian
- Median Income: $73,518
- 14.71% live below poverty line
• **Food Insecurity in DC:**
  – 13.2% of households
  – Smaller Sample Size: Nationally (~40,000); Locally (2,379)

• **Food Hardship in DC:**
  – “Have there been times in the past 12 months when you did not have enough money to buy food that you or your family needed?” Yes or No
  – Larger Sample Size: Nationally (~176,000)
  – 11.3% Households w/o children
  – 26.6% Households w/children
    • #1 in the country
    • 1 in 4 households with children
The Diana L. and Stephen A. Goldberg Center for Community Pediatric Health (Goldberg Center) includes all hospital and community-based primary care services.

- The Goldberg Center is the largest provider of pediatric primary care services in DC.
- Serving about 35,000 patients ages birth to 21 (over 100,000 annual visits)
  - ~40% of the children in the District of Columbia
- 85% of patients are enrolled in Medicaid
- 91% of patients are members of ethnic/racial minority groups.
- ~60 Pediatric Providers
Completed needs assessment (AUG 2016)

Grand Rounds on Food Insecurity (DEC 2016)

Strengthened community-hospital ties (DEC-MAR 2017)

Instillation in EMR (FEB 2017)

Written & Recorded Training Completed (FEB 2017)

Go Live! (MAR 2017)
Goldberg Center – Food Insecurity Screening

**FOOD INSECURITY SCREENING QUESTIONS**

Q1 – “Within the past 12 months we worried whether our food would run out before we got money to buy more?”

Q2 – “Within the past 12 months the food we bought just didn't last and we didn’t have money to get more.”

**IF THE SCREEN IS POSITIVE**

Q3 – What services are needed?

**EMERGENT RESOURCES**
- Families that are currently without food or will run out of food within soon

**LONG-TERM FOOD RESOURCES**
- Families that need ongoing assistance securing food
  - Connect families to:
    - WIC
    - SNAP
    - School Meals/ Summer Meals

**JUST IN CASE RESOURCES**
- Families that may not have an emergent need, but may have general food insecurity concerns
  - Education on how to manage and optimize resources (i.e. All services provided by WIC)
  - Connection to community resources

**Referral/Resource**
- Social Work*
- Number to Hunger Lifeline 202-644-9807
- DC/MD Hunger Solutions
- Social Work *

* If social work is available

**SCREEN**

**INTERVENE**
Federal Nutrition Programs

- Supplemental Nutrition Assistance Program (SNAP)
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Child Care Meals
- School Breakfast & Lunch
- Afterschool Meals
- Summer Meals
Figure 6: Food Insecurity by Household Type

Percent Food Insecure

- Among All Households
- Among Households with Children

Overall
Low-Income
SNAP Recipients

Household Characteristic

Note: Low-income identifies households under 130 percent of the poverty line. Source: Current Population Survey, December Supplement 2014, CEA Calculations.
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

- Pregnant women (through pregnancy and up to 6 weeks after birth or after pregnancy ends).
- Breastfeeding women (up to infant’s 1st birthday)
- Nonbreastfeeding postpartum women (up to 6 months after the birth of an infant or after pregnancy ends)
- Infants (up to 1st birthday). **WIC serves 53 percent of all infants born in the United States.**
- Children up to their 5th birthday.
Figure ES.2.
Distribution of Individuals Who Participated in WIC

Women (23.6%)
- Breastfeeding Women: 7.4%
- Postpartum Women: 6.6%
- Pregnant Women: 9.6%

Infants (23.0%)
- 1 Year Old: 19.6%
- 2 Years Old: 13.8%
- 3 Years Old: 12.3%
- 4 Years Old: 7.6%

Children (53.3%)
Figure ES.1.
Number of WIC Participants by Category and Age of Children: April 2014

<table>
<thead>
<tr>
<th>Category</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant</td>
<td>896,551</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>687,351</td>
</tr>
<tr>
<td>Postpartum</td>
<td>615,559</td>
</tr>
<tr>
<td>Infant</td>
<td>2,141,988</td>
</tr>
<tr>
<td>1 Year Old</td>
<td>1,819,921</td>
</tr>
<tr>
<td>2 Years Old</td>
<td>1,286,485</td>
</tr>
<tr>
<td>3 Years Old</td>
<td>1,147,273</td>
</tr>
<tr>
<td>4 Years Old</td>
<td>704,497</td>
</tr>
<tr>
<td>Age Not Reported</td>
<td>3,628</td>
</tr>
</tbody>
</table>

Total WIC Enrollment: 9,303,253

Notes
Data presented in this chart for pregnant, breastfeeding, and postpartum women and infants is shown in table II.1. Total number of children by age group is shown in table IV.8.
What can I buy each month?

- 100% whole wheat bread, buns, and rolls
- 100% whole wheat macaroni products
- Name brand and store brand whole grain cereal
- Brown rice, barley and oats
- Whole wheat or corn tortillas
- Low-fat or skim milk
- Soy milk
- Tofu
- Low fat or non-fat plain yogurt
- Cheese
- Fresh fruit and vegetables
- Frozen fruit and vegetables
- Canned low sodium or no-salt added vegetables
- Canned fruit
- Dried fruit
- Juice and Juice Blends
- Eggs
- Plain peanut Butter
- Beans

WIC PARTICIPANTS WITH CHILDREN AGES 2-5 CAN RECEIVE UP TO $90 WORTH OF FOOD ITEMS PER CHILD EVERY MONTH.
Take Home Point

• Screening is realistic and manageable using a collaborative approach in the clinical setting
Thank You!

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2. Within the past 12 months, the food we bought just didn’t last and we didn’t have money to get more.
   - [ ] often true
   - [ ] sometimes true
   - [ ] never true
   - [ ] don’t know/refused
WIC after age 1yo

- At least a 22% drop off at age 1yo

- Why?
  - 32.3%: Believe they were ineligible
  - 27.8%: No longer needed the food benefits
  - 26.2%: Program is too much effort; benefits are not worth the time
  - 9.3%: Lack of transportation and/or scheduling problems