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Healthy Families in Healthy Communities

Implementation of Food Insecurity Screening for Pediatric Patients in a Family Medicine Clinic

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Introduction

The prevalence of food insecurity among children in the United States is high. Per USDA data, 21% of households with children were food insecure at times during the year in 2011.[1] These children are twice as likely as those not in food insecure households to be at a developmental risk.[2] In 2015, the American Academy of Pediatrics Council on Community Pediatrics Policy recommended that providers use a screening tool to assess for food insecurity among their patients and offer community resources for those who screen positive.[3] We wished to address this by determining an effective screening and intervention strategy for the patients at our Family Medicine residency based clinic. Our first goal was to determine the burden of food insecurity on pediatric patients in our clinic. Our second goal was to develop and evaluate a food insecurity screening protocol which involved both providers and support staff.

Methods

We instituted a clinic wide protocol with the goal of screening all children presenting for well child checks using a brief validated two item questionnaire.[4] The questions included:

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 we bought just didn't last and we didn't have money to get more.

A flowchart was created as seen in Figure 1 outlining the process for screening.. This was distributed around the clinic and reviewed with all staff and providers. The completed questionnaires were collected for a total of five months and visit data from the EMR was used to estimate the percentage of well child checks in which the screening was completed and recorded.

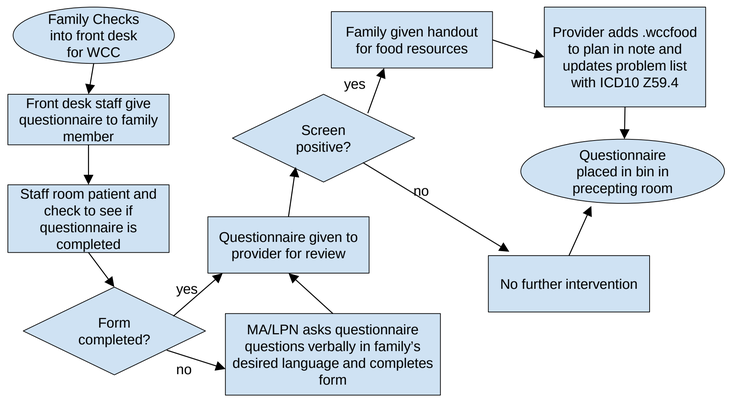
We subsequently conducted an attitudes assessment of providers (physicians and nurse practitioners) and support staff (front desk staff, registered nurses, medical assistants, and licensed practical nurses) by distributing a questionnaire during after the conclusion of the 5 month data collection period.

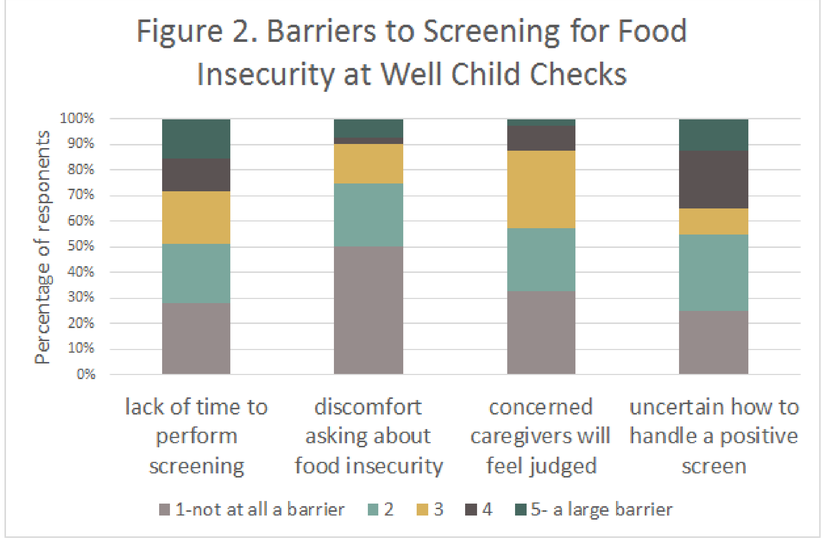
Results

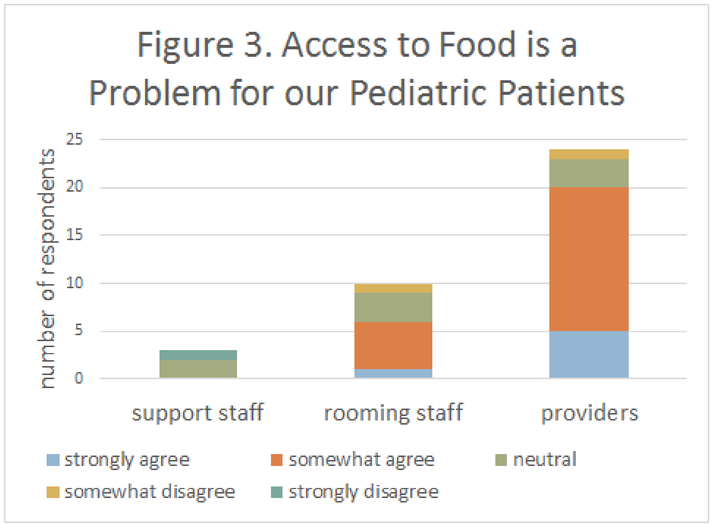
20.8% screens were positive for food insecurity. Only approximately 25% of children over a five month period presenting for well child checks were screened during their visit.

We had 40 responses to our attitudes assessment questionnaire. The most common barriers to screening were lack of time to perform a screening and uncertainty on how to handle a positive screen (Figure 2). Some attitudes varied by the respondent's role in the clinic. For example, all support staff either answered "neutral" or "strongly disagree" to the statement "Access to food is a problem for our pediatric patients", whereas 83% of providers answered "agree/strongly agree" to the same statement (Figure 3).

Figure 1. FLOWCHART FOR FOOD INSECURITY SCREENING







Conclusions

Food insecurity is a major burden on our patient population and it is important to incorporate regular screening into routine well child checks. Despite the implementation of a clinic wide protocol, screening rates were low due to multiple barriers.

Perhaps changes to the flowchart with input from clinic staff would improve screening rates. Further education and training for all staff may help to improve screening rates. Training should also focus on management of positive screens including culturally appropriate community food resources and patient education on nutrition. Further studies should measure the effects of resources provided to families with food insecurity.

References

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4.ER Hager et al, *Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity*, Pediatrics Vol 126, 26-32 (2010).

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