

Title:

Food Insecurity Screening in a Pediatric Clinic

Laurie Sparr, DNP

Deborah Loman, PhD

School of Nursing, Saint Louis University, St. Louis, MO, USA

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Pediatric food insecurity, Plan-Do-Study-Act quality improvement and Two-item food insecurity screen

References:

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Abstract Summary:

The PDSA model was used to implement screening for food insecurity (FI) in a FQHC pediatric clinic. The objective was to increase the percentage of families screened for FI during the routine screening. This project analyzed the proportion and characteristics of families who were screened for FI.

Learning Activity:

LEARNING OBJECTIVES	EXPANDED CONTENT OUTLINE
The learner will be able to discuss the recommendations of screening for Food Insecurity in a primary pediatric clinic.	I. Food Insecurity screening recommendations a) Definition of FI-- the food intake of at least one household member is reduced or the eating pattern is altered at any point during a year due to lack of money and other resources to obtain food b) Food insecurity negatively affects the health of families, both children and adults. c) Negative health outcomes affecting children i) Emotional ii) Cognitive iii) Physical d) Best practices recommended by

	professional organizations i) American Academy of Pediatrics ii) United States Department of Agriculture iii) Academy of Nutrition and Dietetics e) Use of Hager’s two item validated questionnaire to screen for food insecurity i) Sensitivity of 97% ii) Specificity of 83% f) Implement routine screening in primary care practices
The learner will be able to analyze the characteristics of families who were screened for FI and identify trends.	b) Do i) Implement FI screening in clinic with focus on families who present to clinic for well child visits ii) Assess needs of families who screen positive for FI iii) Provide community resources for families who screen positive for FI iv) Support staff and monitor progress c) Study i) Retrieve demographic data from electronic health record (EHR) ii) Determine status of food insecurity iii) Analyze characteristics of families screened for FI iv) Review screening process v) Modify screening process

Abstract Text:

Background

As of 2014, 17.4 million children (14% of U. S. households) were affected by food insecurity (Coleman-Jensen et al., 2014). Food insecurity is the reduction of food intake or altered eating patterns of at least one household member at any point during a year due to lack of money and other resources used to obtain food (Coleman-Jensen et al.) Food insecurity negatively affects the health of families, both parents and children. Food insecurity is associated with negative consequences that affect children’s emotional, cognitive, and physical health outcomes. Despite these known negative health outcomes, routine screening for food insecurity does not regularly occur as part of the well child visit. Due to the known negative health outcomes of FI, the American Academy of Pediatrics (AAP), United States Department of Agriculture (USDA), and Academy of Nutrition and Dietetics recommend routine screening for food insecurity in primary care offices to improve the quality of care and health outcomes (Coleman-Jensen, et al; Council On Community & Committee On, 2015; Ogata & Hayes, 2014). Specifically, the AAP recommends the use of a two-item validated food insecurity screening questionnaire developed by Hager et al., (2010) to determine the need for intervention and referral to community resources to increase access to sufficient food (Council On Community & Committee On).

Methods

A Midwest clinic designated as a Federally Qualified Health Center (FQHC) approved and collaborated in the implementation of food insecurity screening using a Plan-Do-Study-Act quality improvement process. During the 15-week pilot implementation project approximately 300 families were screened for food insecurity using the two-item screening questionnaire with a focus on the routine well child screening visits. Families that screened positive for food insecurity were evaluated by the clinic social worker to determine additional needs and help connect families with community resources to increase access to food. A list of current local food pantries, locations and requirements was offered to families for future use.

Demographic data will be collected from the electronic health records. The data include: child's height, weight, BMI, gender, age in month and year, parent marital status, number of adults in household, number of children in household, race/ethnicity, insurance, type of insurance, referral to case manager and referral to social worker. In addition the response to the FI questionnaire and FI status will be analyzed. Descriptive statistics will be used to report the demographic characteristics of the sample and the proportion of screened families who are food insecure.

Results

The 15 week pilot project has been completed and retrospective data analysis will commence after IRB approval is received. The proportion of those who screened positive for food insecurity, their demographic characteristics will be reported, and the trend in screening by the staff will be reported.

Conclusions

The 15 week pilot project has been completed and retrospective data analysis will commence after IRB approval is received.