Children's Hospital of Philadelphia PolicyLab

Hungry for Information: Lessons Learned from Food Insecurity Screening in Pediatrics

Family & Community Health

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While many providers, hospital administrators and community agencies know that social factors such as food insecurity, parental smoking habits, and housing are critical to children's health and well-being, there are multi-layered barriers to screening for these caregiver- and family-focused needs in pediatrics. In this series, we address three of those common barriers: feasibility of screening during children's medical visits; reimbursement for caregiver-directed services in pediatrics; and the formation of meaningful clinical-community partnerships.

As pediatricians, we are trained to fix our patients' ailments by providing medicines and counseling for children and their families on lifestyle choices. We can get frustrated when our treatment doesn't work, or when families do not comply with our recommendations, but often families have underlying social stressors that we fail to uncover.

One particularly strong predictor of poor health outcomes for children is food insecurity (FI)—defined by the U.S. Department of Agriculture (USDA) as the limited or uncertain availability of nutritionally adequate and safe foods. FI in childhood is associated with worse overall heath; increased rates of anxiety, aggression, anemia, asthma, and cognitive delay; and increased hospitalizations. More than one in five children in Philadelphia are affected by FI, and it often goes unnoticed.

So while we often counsel families about diet, exercise and stress reduction, what use is that information if they can't afford to consistently eat or don't have a safe place to play outside or a reliable place to sleep? How can we expect to provide effective care if our patients' basic needs are not being met? It is crucial for us to think about these social concerns and ask these difficult questions.

With encouragement from the American Academy of Pediatrics, there has been growing interest in screening for FI in the clinical setting. Many health care systems have been hesitant to implement screening because of concerns about time, limited knowledge of local resources, and the possibility of patient and provider discomfort during screening.

At Children's Hospital of Philadelphia, we set out to test these barriers. We started screening for FI in primary care centers and the emergency department (ED), providing a list of food resources to all participants, and simultaneously employing a qualitative research lens to assess feasibility and acceptability of FI screening. Through the use of a variety of screening methods across our sites, we learned three important lessons:

1. Screening is feasible and appreciated

The validated, two-question FI screen, known as the Hunger Vital Sign, that we used takes under a minute to complete. Families we screened in the ED felt that FI screening was very important and reported feeling very comfortable with the questions.

When we asked parents in suburban primary care practices how it felt to be screened for FI, they reported three major themes:

- Initial surprise by FI screening, but ultimately comfort discussing unmet food needs with their trusted pediatrician.
- Feelings of shame, frustration and helplessness regarding FI, some of which were alleviated by discussing FI with their clinician.
- Suggestions that practices could help families more directly access food resources, which, depending on income, may not be available to them through government programs.

Clinicians at these practices also had positive things to say. They reported that while time and workflow were not barriers to screening, concerns about embarrassing families and not being able to provide adequate resources were. Clinicians said that parents felt the screening showed caring, which reinforced clinicians' motivation to continue screening. Finally, they suggested screening should occur prior to the visit – either electronically or in written form while a family is in the waiting room – because parents would feel more comfortable answering the questions.

2. The way we ask matters

Disclosing that you can't consistently buy enough food to feed your family is demoralizing, and sometimes families even fear involvement of child protective services. We must be aware of these fears, and protect families against perceived repercussions.

Importantly, we found that families in the ED reported a significantly higher level of comfort with a FI screen than in their primary care office despite lacking the benefit of prior relationship with care providers in the ED. We suspect that that the level of anonymity inherent to being a patient in the ED serves a protective factor for families in disclosing social risk. Similarly, when families were asked whether they would feel more comfortable with screening face-to-face or screening via tablet, greater than 90 percent of those with a preference chose the tablet-based screen.

3. Screening is everyone's responsibility

While screening for social determinants of health has been viewed predominantly as a primary care responsibility, we should remember that there are multiple points of entry into care for at-risk families. A family who is struggling to balance child care and multiple jobs in order to make ends meet may use the ED for minor complaints when their primary care physician isn't available.

In fact, in our studies, we found a 32.4 percent rate of FI reported in the ED—a number far greater than the rate of FI in Philadelphia overall and the 2.8 percent of families who screened positive in the suburban primary care practices. This increased rate of detection may similarly be found across other clinical environments. For example, a child with uncontrolled diabetes because of inconsistent food supply, may follow-up more regularly with their endocrinologist.

Moving Forward

Through our work, we have studied FI as a proxy for other social determinants of health, and the lessons we learned are widely applicable. Screening across a variety of clinical settings can uncover social needs among our patients and connect them with needed services, which are essential to protecting our patients who are at

risk for poor outcomes. However, screening is only the first step. Other crucial stages include ensuring reimbursement structures promote social risk screening and creating meaningful community partnerships to connect families with resources. In the next two parts of this series, our PolicyLab colleagues will describe these processes and how their lessons-learned as we all strive to implement intergenerational family services into pediatrics.

Guest blogger Deepak Palakshappa, MD, MSHP, is a former PolicyLab faculty member and current assistant professor at Wake Forest School of Medicine. His research examines how current policies and systems put individuals at risk for poor health, especially for low-income individuals.

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