



Implementation of a food insecurity screening and referral program in student-run free clinics in San Diego, California

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ABSTRACT

Food insecurity is associated with many poor health outcomes yet is not routinely addressed in clinical settings. The purpose of this study was to implement a food insecurity screening and referral program in Student-run Free Clinics (SRFC) and to document the prevalence of food insecurity screening in this low-income patient population. All patients seen in three SRFC sites affiliated with one institution in San Diego, California were screened for food insecurity using the 6-item United States Department of Agriculture (USDA) Food Security Survey between January and July 2015 and referred to appropriate resources. The percentage of patients who were food insecure was calculated. The screening rate was 92.5% (430/463 patients), 74.0% (318/430) were food insecure, including 30.7% (132/430) with very low food security. A food insecurity registry and referral tracking system revealed that by January 2016, 201 participants were receiving monthly boxes of food onsite, 66 used an off-site food pantry, and 64 were enrolled in the Supplemental Nutrition Assistance Program (SNAP). It is possible to implement a food insecurity screening and referral program into SRFCs. The prevalence of food insecurity in this population was remarkably high yet remained largely unknown until this program was implemented. Other health care settings, particularly those with underserved patient populations, should consider implementing food insecurity screening and referral programs.

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1. Introduction

Food insecurity is an “economic and social condition of limited or uncertain access to adequate food” (United States Department of Agriculture: Economic Research Service, 2016). The United States Department of Agriculture (USDA) further describes food insecurity as “limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways” (Life Sciences Research Office & Anderson, 1990). There are various length survey instruments used by the USDA to measure food insecurity, which include a 10-item tool and an expanded 18-item tool utilized for households with children (United States Department of Agriculture Economic Research Service, 2016; Bickel et al., 2000). A 2014 population study surveying over 43,000

households utilizing the 10- or 18-item screen as indicated based on household members estimated that 14.0% of households, or a projected 48 million people in the United States, were food insecure (United States Department of Agriculture Economic Research Service, 2016). The prevalence of food insecurity is higher in households with children (19.2%) as well as those headed by Hispanics (22.4%), and Blacks (26.1%) (Coleman-Jensen et al., 2015). The highest prevalence of food insecurity is seen in households headed by single mothers (35.3%) (Coleman-Jensen et al., 2015). The American Academy of Pediatrics (AAP) recently released a policy statement “Promoting Food Security for All Children” (Council on Community Pediatrics, 2015). This statement urges clinicians to screen all children for food insecurity, not just those in underserved communities, as many middle class families are also vulnerable to food insecurity with small changes in income (Council on Community Pediatrics, 2015). Appropriate referrals to food resources include local food pantries, Supplemental Nutrition Assistance Program (SNAP, formerly known as food stamps), Women Infants and Children (WIC), and free or reduced-price school lunch programs (Council on Community Pediatrics, 2015).

Adverse health consequences of inadequate access to food are apparent throughout the lifespan. Insufficient resources for food leads to

Abbreviations: AAP, American Academy of Pediatrics; ADA, American Diabetes Association; SNAP, Supplemental Nutrition Assistance Program; SRFC, Student-Run Free Clinic; SRFCP, Student-Run Free Clinic Project; UCSD, University of California San Diego; USDA, United States Department of Agriculture.

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individuals developing poor dietary habits and choosing less expensive, more filling, less healthy food options (Drewnowski, 2010; Rao et al., 2013). Analyses of data from the National Health Examination and Nutrition Examination Survey (NHANES) reveal that food insecurity is associated with hypertension, hyperlipidemia, and diabetes (Seligman et al., 2010; Seligman et al., 2007). Food insecurity is an independent risk factor for poor glycemic control in diabetes and nearly half of diabetics in safety-net clinics were food insecure (Seligman et al., 2012). The American Diabetes Association (ADA) recently added a section on managing food insecure patients to their Standards of Medical Care in Diabetes 2016 (American Diabetes Association Standards of Medical Care in Diabetes, 2016). The ADA described that patients with limited access to food are at risk for hyperglycemia as well as hypoglycemia, and recommended that providers seek local resources to help patients obtain nutritious foods (American Diabetes Association Standards of Medical Care in Diabetes, 2016). Feeding America, the nation's largest hunger relief agency, found that over two-thirds of their clients had to choose between paying for food or medical care within the last year (Weinfield et al., 2014). While health care providers do not routinely screen for food insecurity, most are willing to use a standardized screening instrument (Hoisington et al., 2012). Routine screening is an underutilized tool to address food insecurity, as food insecurity is often not readily apparent during clinical visits (Hoisington et al., 2012). In light of recent national guidelines changes, it is timely and pertinent for health care providers to consider systematically screening for food insecurity and referring to local resources in a broad range of settings, particularly those serving the underserved.

Student-run Free Clinics (SRFCs) are now present at over 75% of medical schools in the United States (Smith et al., 2014a). Like most SRFCs, the University of California San Diego (UCSD) Student-run Free Clinic Project (SRFCP) serves patients who are uninsured and unable to access care through the traditional health care safety-net. The UCSD SRFCP has previously been described in detail (Beck, 2005; Smith et al., 2014b). All patients are screened for eligibility, do not qualify for other health care programs including Medicaid, and are unable to afford even the low sliding-scale fees of community health centers. Our patient population is largely Latino and monolingual Spanish speaking. The UCSD SRFCP includes an interdisciplinary team that routinely involves social workers and social work interns. However, we had not systematically assessed food security in our patients, nor made routine food resource referrals until this program began.

This study was conducted to implement a food insecurity screening and referral program within the UCSD SRFCP and document the prevalence of food insecurity in this patient population.

2. Methods

This cross-sectional food insecurity screening study was conducted from January through July 2015. Outcomes of referrals to appropriate resources were documented through January 2016.

2.1. Study population

We screened all patients over 18 years of age seen for a medical visit at the Downtown San Diego, Pacific Beach, and South East San Diego sites of the UCSD SRFCP. There were further no exclusion criteria.

2.2. Survey instrument and survey administration

We assessed food insecurity with the 6-item USDA US Household Food Security Survey, 30-day version (See Fig. 1) (United States Department of Agriculture Economic Research Service, 2016; Bickel et al., 2000). This tool is commonly used in research conducted on food insecurity in clinical settings (Seligman et al., 2012, 2015; Moreno et al., 2015; Burkhardt et al., 2012). The 6-item survey has been found to be an acceptable alternative to the longer surveys as

it correctly categorizes 97.7% of households when compared to the longer 10-item and 18-item formats (United States Department of Agriculture Economic Research Service, 2016; Bickel et al., 2000; Blumberg et al., 1999). The 6-item survey is intended to be filled out by an individual who represents the household, as the first four questions are constructed to ask about the household while the last two questions are targeted toward the individual (United States Department of Agriculture Economic Research Service, 2016; Bickel et al., 2000). Pre-health professional volunteer study coordinators handed surveys to patients immediately after check-in. The USDA provides this form in both English and Spanish and we offered surveys to patients in their preferred language. If patients expressed the need for assistance in filling out the form for any reason, including difficulty with literacy or vision, trained bilingual study volunteers offered assistance. Completed surveys were returned to study coordinators.

2.3. Scoring surveys

The USDA Food Security survey is scored on a scale of 0 to 6, with a score of 0–1 indicating high or marginal food security, 2–4 indicating low food security, and a score of 5–6 indicating very low food security (United States Department of Agriculture Economic Research Service, 2016; Bickel et al., 2000). High food security refers to individuals who have no food-access limitations. Marginal food security refers to those who often have anxiety over food shortages but do not tend to experience altered eating habits or diminished intake (United States Department of Agriculture Economic Research Service, 2016; Bickel et al., 2000). In contrast, low food security typically describes individuals who have reduced variety or quality of diet without reduced food intake, while very low food security typically describes both reductions in variety or quality as well as food intake (United States Department of Agriculture Economic Research Service, 2016; Bickel et al., 2000). Individuals with a score of 2–6 are considered to be food insecure according to USDA definitions (United States Department of Agriculture Economic Research Service, 2016; Bickel et al., 2000).

2.4. Referrals

After study coordinators received completed food security surveys, they provided all patients with information regarding local food pantries based on their home addresses. Resources were provided even if participants were not currently food insecure, as food insecurity is often episodic. Study coordinators asked patients if they had any concerns, tried to decrease stigma associated with not having enough food, explored common barriers to utilizing food resources, including food pantries, and answered questions. Study volunteers then verbally assessed patients to determine if they met eligibility criteria for SNAP based on immigration status, family income, household size, and current government assistance. They provided information on applying for SNAP benefits, if eligible. To decrease barriers to SNAP application, the UCSD SRFCP partnered with the County of San Diego, Feeding San Diego, San Diego Hunger Coalition, and Third Avenue Charitable Organization to initiate a pilot program to allow for same-day SNAP enrollment onsite monthly, in addition to providing the traditional two-step application process onsite regularly. If patients had diabetes, they were also offered the opportunity to receive monthly food distributions onsite as part of a new program to provide diabetes-appropriate nutritious foods. A predetermined study outcome included assessing if any differences existed in the prevalence of food insecurity in patients with and without diabetes in this population. Diabetes status was confirmed by checking the Problem List of the Electronic Health Record.

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