



Food Security Screening & Intervention in Pediatric Populations

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Division of Community Health

Title of course: Food Security Screening & Intervention in Pediatric Populations

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Date and location: August 18, 2021—Webex—Recorded live and available to view virtually thereafter

Time: Noon –1 p.m. (includes presentation and Q&A session)

Target audience: Doctors (Family practice/pediatricians), nurses, and staff

Course director(s): Johanna Vidal-Phelan, MD, MBA, FAAP; Debra Zeh, RN, BSN; and Andrea Sweeney, RN

Moderator: Andrea Sweeney, RN

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Learning Objectives

- Explain the relationship between food insecurity and children's health.
- Describe current approaches for addressing food insecurity in pediatrics.
- Identify and advise on food insecurity.

What is Food Security?

- **Food security**, as defined by the Food and Agriculture Organization of the United Nations (FAO), occurs when “...all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life” (2012).
- So what is **food INsecurity**?
 - Worry/anxiety about meeting food needs
 - Insufficient quality of food
 - Insufficient quantity of food

Source: Food and Agriculture Organization of the United Nations 2012

Prevalence of Food Insecurity (2019)

10.6%

of Pennsylvanians
are food insecure

14.6%

of children in
Pennsylvania
are food insecure

23.8%

Predicted number of
children in
Pennsylvania to be
insecure due to
COVID-19 pandemic

Source: Feeding America "Mapping the Meal Gap" 2019

The Need for Screening



Food insecurity may present in children in a number of ways

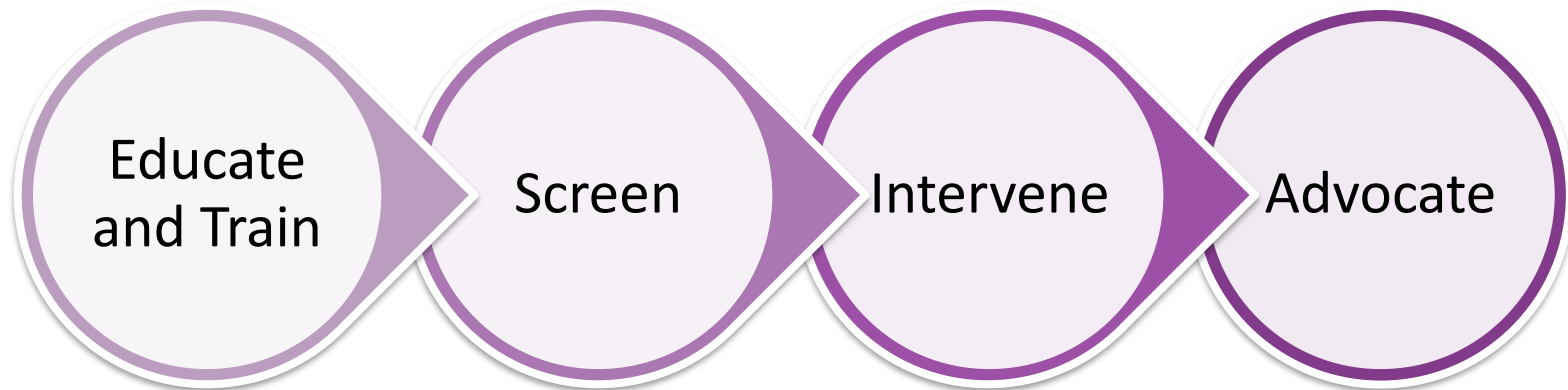
Food insecurity can have a lasting impact on the health and well-being of children, including a number of related short- & long-term health issues.

- | | | |
|--|--|---|
| <ul style="list-style-type: none">• Inappropriate feeding practices• Iron deficiency anemia or other nutrient deficiencies• Stomach aches, headaches, colds, and fatigue | <ul style="list-style-type: none">• Poor growth• Dental caries• Compromised immune function• Obesity• Developmental delays | <ul style="list-style-type: none">• Behavioral problems• Depression, anxiety, stress• Missing school, repeating grades, requiring special education |
|--|--|---|

Source: American Academy of Pediatrics

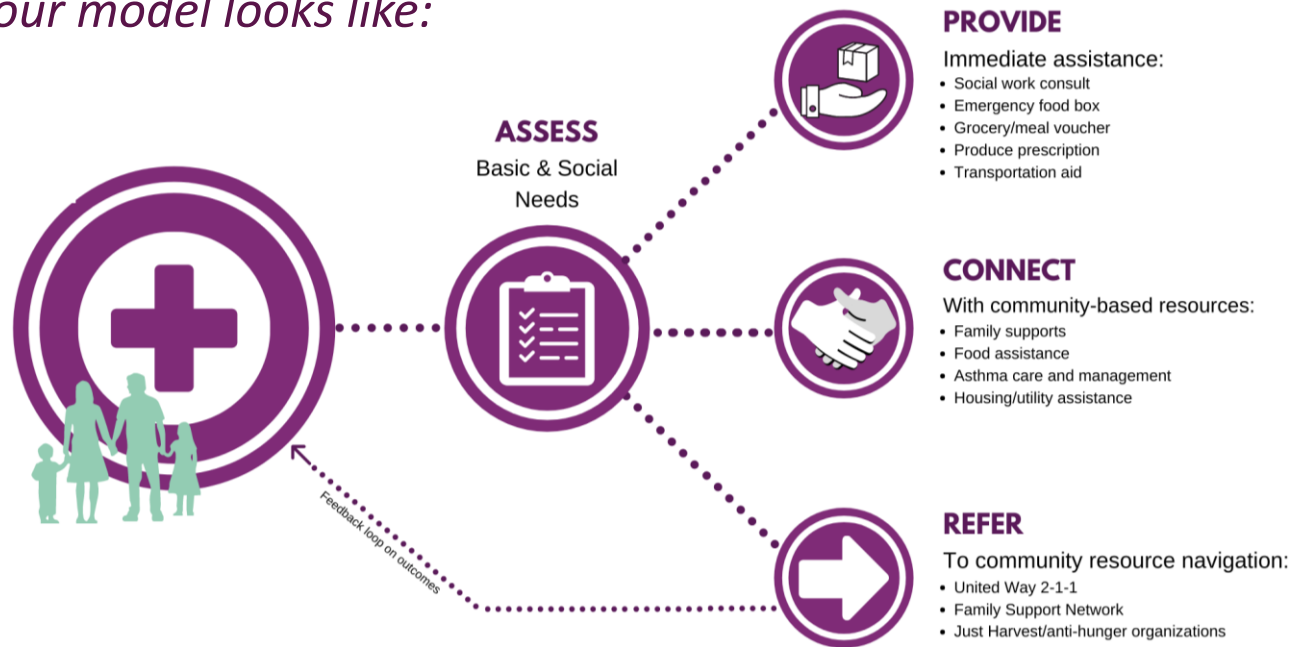
American Academy of Pediatrics Policy Statement

Promoting Food Security for All Children



Children's addresses food insecurity within our patient population through clinical-community connections

Here's what our model looks like:



Screening Guidance

Determine what screener to use

Hunger Vital Sign™

Question	Response Options
1. Within the past 12 months we worried whether our food would run out before we got money to buy more.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Within the past 12 months, the food we bought just didn't last and we didn't have money to buy more.	<input type="checkbox"/> Yes <input type="checkbox"/> No

When a family responds “Yes” to either OR both food security questions, they are POSITIVE for food insecurity (their household is food insecure)

Source: AAP, Children's HealthWatch

What does the Hunger Vital Sign™ tell us?

Children at risk of food insecurity had worse health outcomes compared to those who were food secure

- 17% more likely to have been hospitalized
- 56% more likely to be in fair or poor health
- 60% more likely to be at risk for developmental delays

Source: <http://childrenshealthwatch.org/public-policy/hunger-vital-sign/>

Other Screening Tools

SWYC	In the past month, was there any day when you or anyone in your family went hungry because you did not have enough money for food?
WeCare	Do you always have enough food for your family?
IHELP	Do you ever have a time when you don't have enough food? Do you have WIC? Food stamps?

Source: AAP

Screening Guidance

Determine how you will screen

- **Written/self-administered**
Patients/caregivers respond to screening questions on their own. Upon a positive screening result, staff converses with patient to offer resources.
- **Verbal method:**
Patients/caregivers are asked to respond to the screening questions verbally within a conversation

Example of Written Screen

We have found that many of our families are running out of food at the end of the month. We are trying better help with this problem. To do this, we have started asking every patient who comes into this clinic about access to food. We appreciate your answering these questions. Even if you receive other benefits, we know this can sometimes not be enough. **No matter your answer, the care you or your child receive will not be affected, but we will give you resources for gaining access to food.**

1. Within the past 12 months we worried whether our food would run out before we got money to buy more:
 - a. Yes
 - b. No
2. Within the past 12 months, the food we bought just didn't last and we didn't have money to buy more:
 - a. Yes
 - b. No

If you circled "Yes" to least one question above, we have resources that can help.

Would you like to hear about the resources available?

- a. Yes
- b. No

Example of Verbal Screen

Conduct Food Insecurity Screening

1. Within the past 12 months we worried whether our food would run out before we got money to buy more:
 - a. Yes
 - b. No
2. Within the past 12 months, the food we bought just didn't last and we didn't have money to buy more:
 - a. Yes
 - b. No

Conduct Follow Up

If patient screens positive:

"As a health provider, we want to make sure our patients have the food they need. We have resources available for patients and families. Would you like to hear more about these resources?"

Screening Guidance

Determine when you will screen

Considerations:

- Whether the child should be present for the encounter, or if providers would prefer to speak with caregiver privately.
- At which point in the workflow will screening be most sustainable? Most universal?

Examples of screening placement:

- Registration/routine paperwork
- Vital signs
- Rooming
- Nutrition assessment
- While waiting for care

Screening Guidance

Determine who will screen

- Verbal screen: Specific staff members must be designated to ask screening questions
- Written screen: Specific staff members must be designated to hand out the form and respond to a positive screening result

Screening Guidance

Key points to remember

- Screening is for **everyone**; you are not singling out specific patients
- If you treat screening as a standard part of a visit, it will become a standard part of a visit
- When you are comfortable asking, a patient is more likely to ask for help
- Consider discussing when the child is not in the room or is distracted
- Work within your clinic and community to identify the available resources so that you feel confident in what you can provide your patients

***So what are some ways to start a conversation
with a patient or caregiver?***

How do we ask?

“We care about how all of our patients and their families are doing at home. We are checking in with everyone to make sure that your household has everything you need.”

How do we ask?

“Pediatric offices across the country are now asking about this so that we can offer the most assistance to each of our families.”

What do we do when patients are at risk for food insecurity?

1. How does this affect the patient's medical condition or treatment plan?
2. What emergency resources are available to meet immediate food needs?
3. What longer-term resources are available to mitigate food insecurity?


Supplemental Nutrition Assistance Program (SNAP, formerly food stamps)

How it Works	Who can apply	Impact
Monthly benefits to purchase food at grocery stores, farmers' markets, and food retail outlet that accept SNAP	Gross income typically at 130% of the federal poverty level	Effective at reducing food insecurity
Benefits loaded on an EBT card	More than 80% of all benefits go to households with a child	Families who participate in SNAP are twice as likely to be healthy than those who do not
Average benefit is ~\$31/week – or about \$1.47 per person, per meal	Expands during economic times or natural disasters	Well-documented benefits to children's health, development and well-being

Special Supplemental Program for Women, Infants, and Children (WIC)

How it Works	Who can apply	Impact
Designed to safeguard health of low-income women and young children who are at nutritional risk	Gross income typically at 185% of the federal poverty level	Higher birth weight and longer gestation
Provides nutritious foods and/or benefits to supplement diets, nutrition counseling, and referrals to healthcare	Pregnant women, new mothers, infants, children up to 5y	Lowers iron-deficiency anemia
	Serves over 50% of all infants in US, but participation drops off	Higher intake iron-rich foods and vegetables in preschoolers

National School Breakfast and Lunch Programs

How it Works	Who can apply	Impact
<p>Free, reduced-priced or paid school meals in participating schools</p> <p>Nutrition standards recently updated to improve quality of food</p> 	<p>Children of families at low or moderate income levels can qualify for free or reduced-priced meals</p> <p>Free to all students at schools adopting community eligibility</p>	<p>Breakfast program participation is associated with reduced hunger, better school attendance, higher math scores and graduation rates</p> <p>Lunch program has favorable impact on food insecurity, dietary intake, obesity, and health status</p>

Connecting Families with Resources and Services

AWARENESS

Family made aware of available community services through information dissemination and referrals (e.g., handouts, 211)

ASSISTANCE

Provider offers navigation services to assist family with accessing community services (e.g., electronic referral, case management)

ALIGNMENT

Total partner alignment to ensure clinical and community services are available and responsive to the needs of the family (e.g., 2-way communication on referral outcomes and follow up)

PASSIVE

ACTIVE

Source: Children's HealthWatch, adapted from CMS Accountable Health Communities Model

After Visit Patient Education as a First Step

"Food Assistance Resources"

Basic Needs Support

2-1-1 can help anyone in the United States connect to resources in their area (not just food). Call **2-1-1** for free, private help. You can visit **211.org** or text your zip code to **898-211** to find help close by.

Allegheny County Family Centers are community hubs where families can access resources, participate in educational programs, and connect with other children and caregivers. Call **412-350-3577** to learn more and find a family center near you in Allegheny County.

To find info online, place your smart phone camera over this QR code and click the link provided →



Emergency Food Resources

Emergency Food Assistance (EFA) is for families who need food. Contact the Urban League of Greater Pittsburgh to get food by the next day. A family can get this service once a year. They will help you find a local food pantry: **1-866-395-3663**.

Pittsburgh Community Services, Inc. has emergency food for Pittsburgh residents. Call **412-904-4718**.

National Programs

SNAP (was called Food Stamps) is a government program for individuals and families who need help buying food. You may qualify based on your household size and income level. To find out more, **Just Harvest** can help you for free. Call at **412-431-8960 x 602** or visit them at 16 Terminal Way, Pittsburgh PA 15219. To apply online, go to the COMPASS website:
<https://www.compass.state.pa.us/compass.web/Public/CMPHome>

Women, Infants, and Children (WIC) is a government program. You may qualify based on income. The

2-1-1 CAN HELP.



Looking for resources in your community?
Our friendly staff can help.
Dial 2-1-1 and get connected.
24 hours a day, every day.

Contact us in one of the following ways:

- Dial 2-1-1
- Text your zip code to 898-211
- Visit pa211sw.org

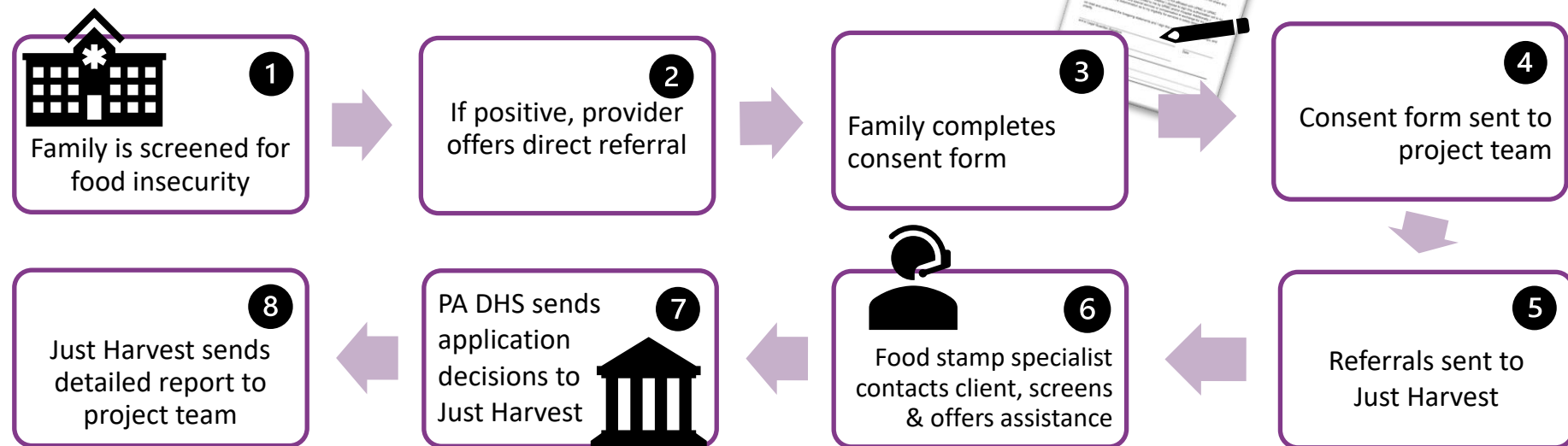


Direct Referral with Feedback Loop

Just Harvest: Action Against Hunger

- Anti-hunger organization that helps families with SNAP (food stamps) enrollment
- Food Stamp Specialists trained to:
 - Screen clients for benefit eligibility utilizing data-integrated screening tool
 - If eligible, assist with SNAP applications
 - Provide additional support, such as advocating for a client who has been denied or lost benefits.
- Professional relationship with Pennsylvania Department of Human Services (DHS), which allows them to track the status of applications

Direct Referral with Feedback Loop



Clinic-based Interventions

- Food security navigators/care coordinators
- Co-locating with food assistance and anti-hunger programs
- Nutrition education, cooking skills and food resource management
- Grocery store gift cards and food vouchers
- Produce Rx programs
- Food pharmacies and pantries
- Medically tailored food boxes (onsite or home delivery)

Intervention Guidance

- Work with local anti-hunger agencies, community partners and other service providers to identify local services and resources.
- Develop partnerships with local organizations that assist low-income families.
- Determine approaches that work best for your practice and patients. When possible, seek opportunities for direct assistance or referrals.
- Encourage caregivers to seek assistance for the benefit of all family members, but especially for the health and well-being of their children.
- Tailor recommendations based on family input and characteristics and residence.
- Be mindful of immigrant and refugee families.

Recommended Resource

Screen and Intervene: A Toolkit for Pediatricians to Address Food Insecurity

- AAP and Food Research and Action Center
- Updated January 2021
- Available at: frac.org/aaptoolkit

Feel free to contact me for more information

Children's Division of Community Health is
available to assist your practice

Jodi Krall, PhD
jodi.krall@chp.edu

THANK YOU!



**Food security screening and intervention
in pediatric populations**

UPMC HEALTH PLAN



PRESENTER

Sarah Elizabeth Morrow, MA
Program Manager, Collaborative Health
UPMC Health Plan



AGENDA

- UPMC Health Plan and Food Security
- Pediatric Care Management
- SDOH Billing
- SDOH Website
- Resources

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Screening is the first step to addressing the issue.

Our teams screen members for social determinants of health needs, including food security.



We use the resources in our communities.

We work directly with agencies that address food insecurity, including The Food Trust, Greater Pittsburgh Community Food Bank, 412 Food Rescue, and Mom's Meals.



We are here to support you and your clinic.

Our clinical and network teams are here to help you navigate SDOH screening and intervention.

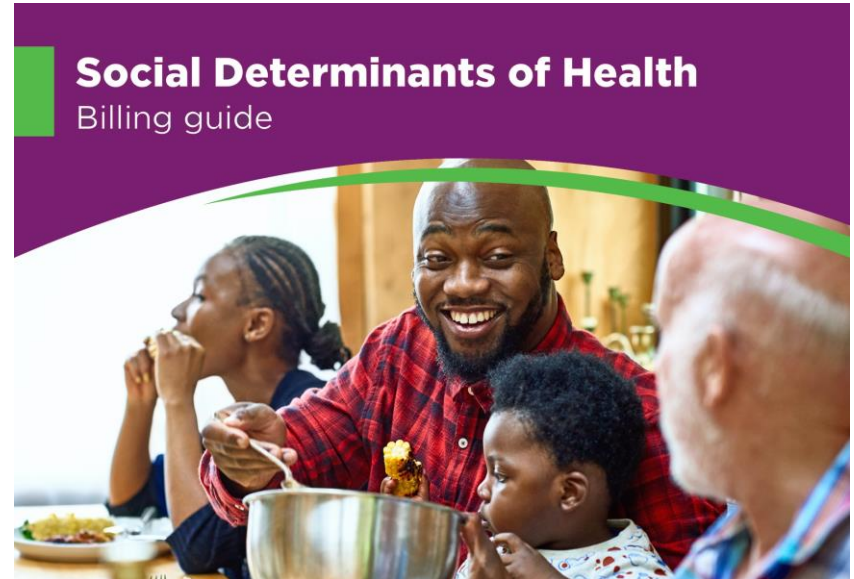
Pediatric care management



- Pediatric care management is available to all UPMC pediatric members.
- Care managers are registered nurses and licensed clinical social workers who can help identify resource needs and navigate members toward food assistance.
- Care managers can also connect families to other resources that can address social determinants of health and clinical care.

SDOH billing guide

- Following screening for food security and any other SDOH needs, providers can include Z codes to track results.
- Z codes help track your patients over time and assist UPMC Health Plan in doing the same!
- The food insecurity Z code is Z59.4: Lack of adequate food and safe drinking water.
- SDOH Z codes will be updated in October, with an additional code for food insecurity: Z59.41: Food insecurity.
- An updated billing guide will be released before the Z code changes take effect!



Social Determinants of Health

Billing guide

View the billing guide at
[upmc.widen.net/view/pdf/jwtq5noufw/
20PV1609551---SDOH-Billing-
Guide WEB.pdf?t.download=true&u=oid6pr.](https://upmc.widen.net/view/pdf/jwtq5noufw/20PV1609551---SDOH-Billing-Guide_WEB.pdf?t.download=true&u=oid6pr)

UPMC Health Plan's SDOH website: Phase 1

UPMC HEALTH PLAN

Find Care Login/Register ▼ For Providers About Contact

FOR INDIVIDUALS & FAMILIES

FOR EMPLOYERS & PRODUCERS

FOR MEMBERS



MEDICAL PROVIDERS

Announcements & Updates

Medical Provider Portal

Medical Provider Resources

Email Share Print

Addressing Social Determinants of Health in Your Clinic

As a provider-led health plan, we know that trusted providers are uniquely positioned to identify and influence social determinants of health (SDOH). We know that health and well-being needs remain when a patient leaves the clinic. We want to work with you to ensure that your patients have access to the resources they need to live their healthiest lives, including through clinical screening and intervention for SDOH.

This approach is also being adopted across Pennsylvania. The Pennsylvania Department of Health aims to "leverage our authority and ability to convene partners to improve Pennsylvanians' access to affordable housing, food, and transportation. Because once we have assessed a person's needs, we must have partners to which we can refer that person to help get those needs met."

UPMC Health Plan's SDOH website: Phase 1

To assist our providers in screening for SDOH, we've outlined some considerations:

What are social determinants of health?

Why do you want to implement SDOH screening in your clinic?

Who are your clinic champions for developing your approach to SDOH screening and intervention?

What community resources do you already have in place? What community resources are you missing?

How will you choose the appropriate SDOH screening tool for your clinic?

Where, how, and when should you screen for SDOH in your clinical workflow?

What technical considerations does your clinic have?

- **Social Determinants of Health Billing Guide**

How can you limit stigma for patients while asking SDOH screening questions?

What training does your team need for success?

How do you evaluate your success?

UPMC Health Plan resources



UPMC Health Plan SDOH website

- <https://www.upmchealthplan.com/providers/medical/resources/other/social-determinants-of-health.aspx>

Pediatric care management

- Call 1-866-778-6073, select option 3 for our pediatric team

Pathways to Work

- Available to all UPMC members and supports non-UPMC members as needed:
pathwaystowork@upmc.edu

Network teams

- Your physician account executive or clinical improvement specialist is available to provide clinical support.

Reach out with questions

- Sarah Elizabeth Morrow, Program Manager for Collaborative Health: **morrowse2@upmc.edu**

Food Security Screening & Intervention in Pediatric Populations

August 18, 2021 (Live-Virtual)

UPMC University of Pittsburgh School of Medicine Center for Continuing Education in the Health Sciences

This is not your official certificate.

How to receive your continuing education credit:

<https://cce.upmc.com/food-security-screening-intervention>

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Records are matched to users by email address.

To receive credit, log in and complete the course evaluation and/or claim credit on the CCEHS Learning Portal, <http://cce.upmc.com>. The activity is accessible in your **Pending Activities**. If you are a new user, click **Register** to create a new account.

For answers to common questions or step-by-step instructions please visit the FAQ available on the **CCEHS Learning Portal**.