Disclosure to Participants

Notice of Requirements For Successful Completion
Please refer to learning goals and objectives
Learners must attend the full activity and complete the evaluation in order to claim continuing education credit/hours

Conflict of Interest (COI) and Financial Relationship Disclosures:
Presenter: Kimberly Prendergast, RD, MPP  – No COI/Financial Relationship to disclose
Presenter: Anne Gargano Ahmed, MPH, MPA  – No COI/Financial Relationship to disclose

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Off-Label Use: None

Learning Objectives

1. Define food insecurity and describe the role food insecurity plays in chronic disease development and management
2. Describe Feeding America and member food bank diabetes & health initiatives and the need for food insecurity screening in the clinical setting
3. Describe and encourage use of food insecurity screeners, clinical tools, and resources to mitigate food insecurity in low-income patient populations

Healthy Eating for all:
Use of Food Insecurity Screening Tools to Improve Diabetes Outcomes

Food Insecurity is the lack of access to enough food for a healthy, active life
48 Million
PEOPLE ARE
FOOD INSECURE IN AMERICA

Feeding America Network

200
FOOD BANKS

46.5M
AMERICANS
SERVED ANNUALLY

58K
FOOD PANTRIES
AND MEAL
PROGRAMS

Making Tough Choices

Feeding America's clients report that their household income is inadequate to cover their basic household expenses.

69% HAVE HAD TO CHOOSE BETWEEN PAYING FOR UTILITIES AND FOOD

67% HAVE HAD TO CHOOSE BETWEEN PAYING FOR TRANSPORTATION AND FOOD

66% HAVE HAD TO CHOOSE BETWEEN PAYING FOR MEDICINE AND FOOD

57% HAVE HAD TO CHOOSE BETWEEN PAYING FOR HOUSING AND FOOD

Sources: Map the Meal Gap (2014) and Hunger in America (2014)

Coping Strategies

55% of households reported using 3 or more coping strategies in the past year

79% 
Purchase Inexpensive, Unhealthy Food

53% 
Receive Help From Friends

40% 
Water Down Foods or Drinks

35% 
Sell or Pawn Personal Property

23% 
Grow Food in a Garden

The Real Affordability of Healthy Food

Hunger in America 2014

47% of clients responded they are in fair or poor health
In 29% of households all members have no health insurance*
55% of households report some medical debt
66% of households have to choose medicine and food

Cost of groceries

Storage and Cooking

Prep Time

Food Quality & Variety

Cooking Skills & Knowledge

Fear of Food Waste

Time's to set to store
Why Screen for Food Insecurity in the Health Setting?

Key Points in AAP Statement
- Importance of food insecurity for children’s physical and mental health, behavior, and developmental/academic outcomes
- Recommendations for pediatricians
  - Two-item screening tool “at all scheduled health maintenance visits”
  - Learn how food insecurity impacts health outcomes
  - Familiarize yourself with community resources
  - Be advocates for increasing access to and funding for nutrition programs

ADA Standards of Care
- Providers should carefully evaluate hyperglycemia and hypoglycemia in the context of food insecurity (FI) and propose solutions accordingly.
- Providers should recognize that homelessness, poor literacy, and poor numeracy often occur with food insecurity, and appropriate resources should be made available for patients with diabetes.

Importance of ADA Statement
- Advises providers to consider hyper- and hypoglycemia in the context of food insecurity and propose solutions
- Offers suggestions for medication management
- Linkage to community resources – we can’t do this work alone
How to Screen for Food Insecurity?

I'm going to read you several statements that people have made about their food situation. For these statements, please tell me whether the statement was often true, sometimes true, or never true for (you/your household) in the last 12 months—that is, since last (name of current month).

“We worried whether our food would run out before we got money to buy more.” Was that often, sometimes, or never true for you in the last 12 months?

“The food that we bought just didn’t last and we didn’t have money to get more.” Was that often, sometimes, or never true for you in the last 12 months?

Where Can Screening Happen?

- Clinics & Outpatient Private Practices
- Diabetes Education Programs
- Dialysis Units
- Hospital Inpatients
- Hospital Emergency Rooms
- YOUR SETTING!

Lessons learned in Madison, WI

Anne Gargano Ahmed
MPH, MPA
HungerCare Coalition Coordinator
Second Harvest Foodbank of Southern Wisconsin
Madison, WI

Early Data on Clinical Screening Programs

- Kaiser Permanente of Colorado experience (Dr. Sandra Stenmark)
- Passive referrals are much less efficient than active referrals

http://healthaffairs.org/blog/2015/07/13/linking-the-clinical-experience-to-community-resources-to-address-hunger-in-colorado/

Timely Outreach by Skilled Professionals Increased Connection to Resources
The Role of HungerCare
» Partner with health care providers
» Provide tools to screen for FI
» Connect patients with resources
» Improve health outcomes

Dane County Provider Survey
» 459 surveys completed

Education is Needed
Top 3 Preferred Topics for Provider Training
- Health and nutrition implications of food insecurity
- Resources available for households experiencing food insecurity
- How to incorporate food insecurity topics into your clinical setting

Are providers willing to screen for food insecurity?
84% said Yes!
Survey conducted at 23 mobile pantry sites
» 1,426 responses received
» 85% of respondents screened positive for food insecurity
» 81% of respondents had been to the doctor in the past year

Patient Survey

If you were concerned about your food running out and someone at the clinic asked you about having enough food, would you share your concerns with them?

- Yes, 40%
- No, 22%
- Net Sure, 26%
- Do not know, 4%

(N=1,426)

How can you screen your patients?

Implement the Screen

» Who is food insecure? You never know unless you ask!

» Build the 2-questions into the intake process
  • Ask on paper, record in EMR

If needed, what would be the best way(s) for the doctor’s office to help you with food resources?

Please check all that apply.

By willingness to share concerns about food with doctor:

- Yes
- Net Sure
- Paper hand out
- No

Talking with a staff person (doctor, nurse, clinic social worker) at my appointment:

- Yes
- No
- Net Sure

37% 33% 9%
**Offer Resources**

» Handout or After Visit Summary

» Talk through resources
  - What are they already using?
  - What else could help?
  - What barriers are they facing?

**Incorporate in care plan**

» Keep in mind when discussing treatment
  - How can they access affordable diabetes-appropriate food?
  - Will they be able to afford their medications, testing supplies?
  - What other stressors may they be dealing with?

**Recommended Resources**

- 211 Get Connected Get Answers
- SNAP Supplemental Nutrition Assistance Program
- WIC
- ADRG Aging & Disability Resource Center
- What's Cooking

**Ways to Collaborate with Community Food Organizations**

- Food distribution onsite at your hospital/clinic
- Hospital or clinic pantry (permanent)
- Mobile food distributions
- Food Rx and referrals to local agencies
- SNAP application assistance at a hospital/clinic
- Summer Food Service Program at the hospital

**Case Study: Meet Jim**

Jim is a 34 year old male
- HTN & Type 2 Diabetes
- 5'10", 215 lbs
- BP 146/92; HbA1c 8.6 (higher than previous result, 8 months ago)
- On medication for HTN & Diabetes – MD increased both and asked him to see CDE. Last time you met with him, you discussed Physical Activity

**Social Situation:** Lives with his wife & 20 month old daughter. Employed at a local restaurant.

**The Rest of Jim’s Story**

- Hours reduced to part time and evening shift
- Worried about paying the rent & buying groceries but hesitant to share that information with anyone.
- Never had to get help before. Have not applied for SNAP or WIC. Going to a monthly food pantry and a weekly evening meal program at a local church.
- Wife does the grocery shopping and cooking. She works hard to make sure their daughter has enough to eat.
- Fewer vegetables, more bread & pasta. Gets meals at the restaurant when his shift ends (11pm); generally a burger & fries but it’s free.
- Doesn’t belong to a gym. Not a lot of time to work out between working at night and taking care of his daughter.
- Plays pickup basketball with friends at the local school when his work schedule allows.
Meet Rosemary: 74 year old woman
- Type 2 Diabetes x 6 years
- 5’2” 143lbs (recent weight gain but claims “I’m not a big eater”)
- Daughter her brought her to MD s/p fall
- Recently moved
- Reports some hypoglycemia; HbA1c 6.9

The Rest of Rosemary’s Story
- Lost her job a few years ago; lost her housing and moved into HUD apartment building. Has moved twice since.
- Used to be able to walk in the trailer park but can’t in the apartment building
- Depressed – no longer working; isolation, can’t buy foods she likes
- Eats just one meal a day but still taking medication multiple times per day.
- BS range from 35 – 280’s
- Doesn’t want to tell anyone about her symptoms, but she can’t feel her feet

Food Resources
- 211 or referrals to local food bank, pantries, meal programs
- SNAP (Supplemental Nutrition Assistance Program)
- WIC (Women, Infants, and Children)
- Healthy Food Bank Hub http://healthyfoodbankhub.feedingamerica.org

Discussion & Next Steps:
1) Do you know what resources are available in your community?
2) How can you incorporate food insecurity screening in your clinic/hospital?

Connect with us!
www.feedingamerica.org/find-your-local-foodbank/
healthyfoodbankhub.feedingamerica.org
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