

VIEWPOINT

Clinic-to-Community Models to Address Food Insecurity

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Overview

Food insecurity (FI)—unreliable access to a sufficient quantity of affordable, nutritious food—is a social and economic condition with direct and indirect consequences, including poor dietary intake, poor physical and mental health, hospitalizations, stress, reduced academic achievement, and fetal epigenetic changes.¹⁻³ Food insecurity affects 16.6% of US households with children.⁴ Centers for Medicare and Medicaid Services, the American Academy of Pediatrics, and the American Diabetes Association have each recently highlighted the clinical relevance of FI through funding initiatives, screening recommendations for children, or treatment recommendations.

Food insecurity is assessed in clinical settings using a sensitive and specific 2-item screener.⁵ The screener asks an individual whether each of the following statements were often true, sometimes true, or never true for his or her household in the last 12 months: (1) "We worried whether our food would run out before we got money to buy more," and (2) "The food that we bought just didn't last and we didn't have money to get more."

"Often" or "sometimes true" responses to either question indicate a positive screen result. Screening success hinges on linking FI households to community resources tailored to household needs and delivered outside of the practice setting.⁶ Such linkages demand coordination among clinicians, administrators, policy makers, and community providers. Clinic-to-community models for addressing FI are emerging. This Viewpoint reviews 2 initial models, translational challenges, and opportunities for clinical settings to better support patients living in FI households.

Current Clinic-to-Community Treatment Models

A comprehensive clinical model of care requires dedicated expertise and support from clinical team members, such as social workers, with expertise in evaluating social needs, connecting to resources, and following up to ensure successful community connection. (See <http://www.NOPREN.org> for model details.) In the most high-functioning systems, medical records document patient assessments and referral statuses. Model variations include using (1) clinical staff members (eg, social workers and/or registered dietitians) to identify and prioritize social needs and facilitate individuals gaining connections to resources, (2) trained volunteers to access a resource database and provide follow-up until unmet needs are resolved, and (3) community health workers to conduct home social assessments and assist high-risk patients by providing community connections.

An alternative model of care is the health care clinician prescription for food resources. In this model,

health systems or clinics develop direct relationships with community organizations providing food and, sometimes, support for enrollment in federal nutrition assistance programs that are proven to improve children's health, such as SNAP (the Supplemental Nutrition Assistance Program) and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). Compared with comprehensive models, this approach is less expensive and more narrowly focused on unmet food needs. Examples include collaborating with local food banks to develop on-site pantries providing immediate food access, community-based food pharmacies (typically overseen by a dietitian) that fill prescriptions for medically tailored foods for children with nutrition-related chronic diseases living in FI households, and vouchers for reduced- or no-cost produce that are redeemable at local food vendors.

Identifying the appropriate model depends on personnel, leadership support, funding, and the availability of food resources in the local community. Active referrals that assist patients at every stage of the referral process until their food access is improved are more effective than passive models that are limited to providing information about how to access food resources (eg, a hunger hotline number). Food banks and referral organizations (eg, 2-1-1, a free service referring callers to local resources for a range of basic human needs) are integral partners in these efforts.

Translational Challenges

The clinical integration of these models must be achieved against a backdrop of variation in the availability of community resources and the accessibility of federal nutrition assistance programs. For example, state-level differences in SNAP eligibility and enrollment rules influence the demands on the charitable feeding system and its excess capacity. Additionally, clinic-to-community models often depend on identifying resources through 2-1-1 listings, the accuracy of which depends on the local infrastructure and funding.

Systematic clinical screenings for FI will likely increase the demand for access to SNAP, WIC, and charitable feeding programs. These programs must invest in an infrastructure that will allow them to absorb new health care system referrals, coordinate services, and build a nutritionally appropriate food supply. The health care system must contribute financially to these efforts to avoid overburdening an already stretched system for addressing FI in the United States.

Additionally, building the capacity of the health care system to recognize and respond to FI will require additional personnel (eg, social workers and registered dietitians) to oversee clinic-community connections.

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Because the upfront costs of establishing such support can be prohibitive, evidence from process evaluations, quasiexperimental studies, and rigorous randomized clinical trials are necessary. Examining quantitative outcomes such as diabetes control, hospitalizations, and school absenteeism is feasible. However, the positive effect on children and their families of interventions to improve food security is likely to build over longer periods than those that are typically observed in clinical studies. We must also determine whether and how to incentivize systems and clinicians to adopt screening recommendations.

Efforts to initiate universal FI screening programs are hampered by concerns that FI screening (and addressing FI once it is identified) adds to growing clinician time demands. The clear adverse health outcomes associated with FI and the likelihood of positive effects associated with connections to food resources, combined with the strong psychometric properties and brevity of the screening instrument, make the benefits of FI screening very likely to outweigh the costs. Training clinicians in the clinical relevance of screenings, efficient delivery and framing of screening questions, and systematic treatment responses to patients who identify as at risk will be crucial. Independent training resources exist.⁷

Opportunities

Despite challenges in implementing clinic-to-community models, tremendous opportunities exist for enhanced patient outcomes through collaborations between the health care systems and community food assistance providers. Health care clinicians can adapt existing programs to support patients with FI. Clinicians with access to social workers can leverage these workflows to respond to

FI. Clinicians and health systems can be active voices in community FI discussions to underscore its health implications and advocate for community support. Clinicians can collaborate with community food assistance providers to support their efforts to highlight the interconnections between FI and health. Perhaps the greatest opportunity and need is for clinicians to actively support food assistance programs (eg, SNAP and WIC) that are vital to ensuring many households with children remain food secure.

Innovative opportunities also exist. Because of overlapping eligibility criteria, Medicaid expansion through the Affordable Care Act offers a tremendous opportunity to expand SNAP enrollment (dual enrollment). Adapting electronic health records or developing web-based applications allows immediate data sharing between health care clinicians and charitable food providers, which could also provide community-based organizations with the information that is needed to tailor nutrition programs to the health and social needs of individuals. These approaches have an additional advantage of allowing for a more robust public health surveillance of FI and its health implications.

Conclusions

The success of efforts to identify and address FI in clinical settings depends on developing innovative processes and programs to address the gap between the clinic and the community. We challenge communities to invest in stronger community referral support, such as augmented 2-1-1, identify strategies to implement dual enrollment, and support clinicians with training and infrastructures to successfully connect children living in food-insecure households with community-based resources.

ARTICLE INFORMATION

Published Online: April 3, 2017.

doi:10.1001/jamapediatrics.2017.0067

Conflict of Interest Disclosures: None reported.

Disclaimer: The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

Additional Contributions: We acknowledge the following Nutrition and Obesity Policy Research and Evaluation Network members who participated in developing this Viewpoint: Marianna Wetherill, PhD, MPH, RDN-AP/LD, University of Oklahoma, Melissa Cannon, RD, California Food Policy Advocates, Marydale DeBor, JD, Yale University, Skye Cornell, Wholesome Wave, and Angela Liese, PhD, MPH, University of South Carolina. None of these individuals were compensated for their contributions.

Additional Information: This Viewpoint represents the work of the Nutrition and Obesity Policy

Research and Evaluation Network's Hunger Safety Net Clinical Linkages Workgroup funded by the Prevention Research Centers at the Centers for Disease Control and Prevention.

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