

Food Insecurity Screening Efforts in Los Angeles County



Overview

The Los Angeles County Department of Public Health's Nutrition and Physical Activity Program partnered with community based organizations, hospitals, school districts, universities, and other agencies to improve nutrition and physical activity opportunities among low-income residents who are eligible for the Supplemental Nutrition Assistance Program-Education (SNAP-Ed). This project sought to establish lessons learned from several agencies' efforts to address food insecurity through implementation of a validated food insecurity screening tool in healthcare settings and establishment of a referral pathway to SNAP, SNAP-Ed classes, and local food pantries.

Description of the Project

During a six-week time period in 2018, the Los Angeles County Department of Public Health (DPH) and the RAND Corporation evaluated a food insecurity screening project. There were two parts to the project.

- Key informant interviews with 15 staff at 5 agencies. Three agencies were funded by DPH and two were clinics that had been selected as part of a pilot project by the Los Angeles County Health Agency in response to a Board Motion in 2017 by the County Board of Supervisors to implement food insecurity screening, an effort separate from the DPH funded initiative. The goal of the interviews was to establish lessons learned from agencies that are focused on developing or expanding food insecurity screenings in low-income clinics.
- Intercept surveys with 1,013 patients across four healthcare systems. In total, the survey sampled patients from 11 different clinic waiting rooms including Adult Medicine, Pediatrics, Women's Health, and Family Medicine. The goal of the surveys was to understand patients' perceptions of whether health care providers are sensitive to food insecurity and whether providers are taking appropriate steps to screen and refer clients to food-related services.



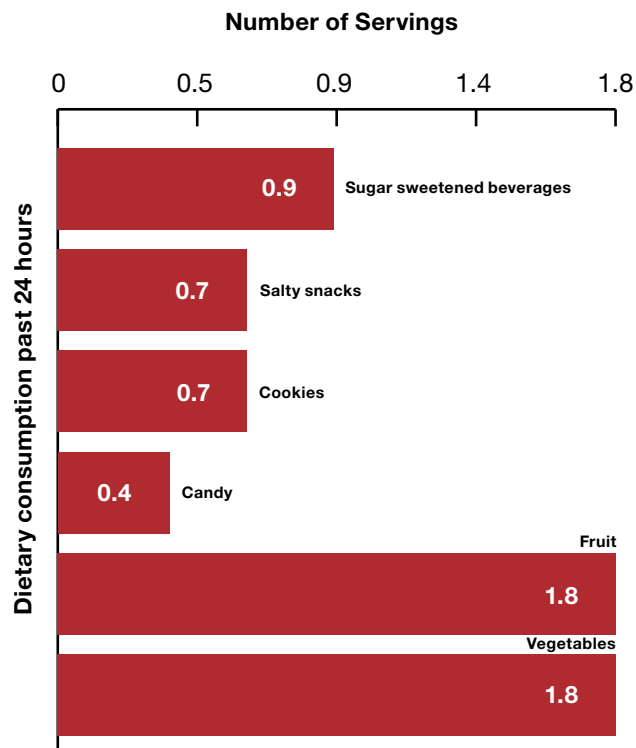
Participants' Characteristics: Intercept Survey

Among the clinic patients interviewed, a majority were female (76%) and the average age was 43. Slightly over half the respondents completed the survey in English. Three out of four sampled patients (75%) were Latino and 15% were African American. Slightly over a third of respondents (35%) reported not completing high school, 30% reported having a high school diploma, and the remaining individuals reported educational attainment that went beyond high school. A little over a quarter of the respondents (26%) were enrolled in CalFresh, California's version of the federal Supplemental Nutrition Assistance Program, 22% in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and 63% in Medi-Cal. Patients' consumption of sugary beverages, candy, cookies, and salty snacks was common in the previous day. Consumption of fruits and vegetables summed to 3.6 servings. Among patients, 32% were overweight, 26% obese, and 19% morbidly obese (BMI ≥ 35).

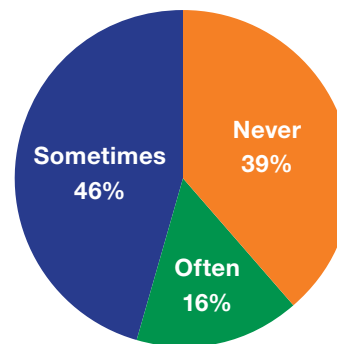
Nearly 30% of patients reported currently participating in CalFresh. When patients were asked why they were not enrolled in CalFresh, the most common response was that they were not eligible (39%), followed by not wanting to be dependent on the government (27%). The majority of respondents had experienced food insecurity in the past year, with 62% often/sometimes worrying about running out of food and 53% reporting often/sometimes that food did not last and they did not have money to get more.

Patient Participation in CalFresh

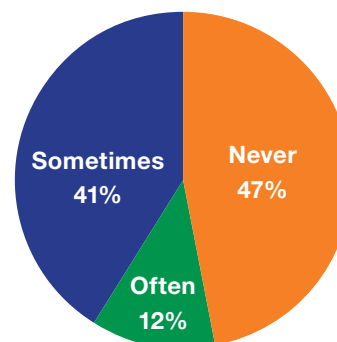
Currently participate in CalFresh	26%
If not currently enrolled, why:	
Don't know how to apply	20%
Am not eligible	39%
Don't want to be dependent on government	27%
Application too difficult	3%
Concerned what others will think	2%
Worried about citizenship	7%
Applied and waiting	2%
Other reason	12%



Frequency of worrying that food would run out in past year



Frequency that food did not last and did not have money for more in past year



Strategies in Food Insecurity Screening and Referral Process

Key informant interviewees described the following aspects of the screening and referral process:

- the screening tool
- data tracking at intake and follow-up
- referral resources and hand-offs
- screening feasibility
- integration of nutrition education for patients who screened positive for food insecurity

For many agencies the screening process was not systematic, and physicians at most agencies inquired about patients' food and other quality-of-life problems on an ad hoc basis. Most participants reported using the Hunger Vital Sign, a two-question screening tool that asks patients if they endorse the following statements:

- 1) "Within the past 12 months, we worried whether our food would run out before we got money to buy more"**
 - (a) often true
 - (b) sometimes true
 - (c) never true
- 2) "Within the past 12 months, the food we bought just didn't last, and we didn't have money to get more"**
 - (a) often true
 - (b) sometimes true
 - (c) never true

Some agencies adapted this two-item tool or merged it into one question for an easier integration with other screening tools they use for other conditions. Interviewees at clinics that integrate the screening tool and other social determinants of health information into their electronic health record (EHR) were most enthusiastic about the process, the progress, and the ability to use the data in a meaningful way.

"The two questions are a great tool to open discussion and demystify or destigmatize the idea of food insecurity. A lot of our parents don't want to admit being food insecure, but when brought up in the form of a question it gives validity to the issue without judgment. It is a perfect way to open up discussion." (Children's Hospital Los Angeles)

A screener can capture many who have hidden food insecurity and who might not otherwise have been connected with resources. Before the most recent screening efforts, the focus of food related discussions was nearly always on food education. As one doctor remarked,

"From a provider perspective, the focus was always on educating on what to eat. But there was an assumption: it always focused on what to eat, not whether you even have food to begin with, or do you even have the ability to choose." (LA County USC)

Implementation of food insecurity screener

Once a patient is identified as food-insecure, key informants stated typically three stages that follow:

- 1. First**, a packet of information is given to the patient about food insecurity and local resources (varies by location, resources are not compiled in a standardized way).
- 2. Second**, the physician refers patients to the clinic's nutritionist or health educator.
- 3. Third**, the nutritionist then refers patients to other resources, such as a DPSS social worker, food banks, community centers, and farmers' markets.

Warm hand-offs to the Los Angeles Department of Public Social Services (DPSS) and post-referral follow-up do not appear to be the norm, although essential to the establishment of a functioning referral pathway. Factors that

can undermine the feasibility of the screening process include insufficient staff to cover all stages of the screening and referral pathways, and to establish the usefulness of the resources to which patients are referred. In some instances, DPSS determined that patients were ineligible to enroll in CalFresh while staff said that patients referred to food banks complained about the quality of the food offered.

“We were identifying all the determinants especially for food, and then we never knew what was happening. That’s when we realized we really needed to connect someone here with us, track it, follow up, see did they get food resources, did they go, was that helpful to them—that’s how we discovered some of the food banks weren’t so helpful, others were too far.” (Los Angeles County USC)

Patient Experience with Food Insecurity Screening

About 85% of all adults, who responded to the participant survey, agreed or strongly agreed with the statement that clinics should help them find food. One-third of respondents reported ever being asked by staff if they have enough to eat. Nearly 29% reported that staff recommended CalFresh, but only 20% of the sample said they enrolled due to a staff referral. Respondents were most comfortable sharing personal information about not having enough to eat with their doctor. The second most common preference was using a written format to share the information, followed by speaking with a nurse.

Participants who were food insecure were more likely to expect clinics to help them find food than those who were not food insecure. They were also less likely to report having been asked by staff if they have enough to eat, but were more



Patient Responses by Food Insecurity Status

	All	Food insecure	Not food insecure	P Value
Clinics should help me find food (strongly agree or agree)	84.6%	87.3%	79.4%	*
Staff at clinic ever asked if client has enough to eat (yes)	33.7%	31%	38.4%	*
Staff at clinic recommended CalFresh	28.9%	28.9%	28.6%	NS
Enrolled due to staff referral	20.1%	23.6%	14%	*
Frequency that staff asks about finances				NS
Never	66.4%	68.2%	62.3%	
Rarely	11.8%	11.6%	12.7%	
Sometimes	12.8%	12.6%	13.2%	
Often	5.3%	4.5%	7.0%	
Always	3.7%	3.2%	4.8%	
With whom most comfortable sharing personal information about not having enough to eat:				
Doctor	44.6%	51%	35.6%	*
Nurse	15.2%	17.9%	11.6%	*
Front desk staff	4.3%	5.6%	2.5%	*
On paper	20.6%	24.6%	15.2%	*
On a computer or tablet	10.1%	11.8%	7.7%	*

p < 0.05, NS = non-significant

likely to enroll in CalFresh due to a staff referral. Participants who were food insecure felt most comfortable sharing information about food issues with their doctor.

Workforce to implement screener

The need to have a sufficiently large workforce to support activities at each point in the screening process and referral pathway was mentioned by many key informants. Clinics need to have enough employees to implement steps related to addressing food insecurity, i.e., conducting case management, providing warm hand-offs, making follow-up calls, and learning whether patients perceive referral resources as helpful.

Empathy training was an important factor. Many participants noted that, initially, staff did not understand the importance and pervasiveness of food insecurity, and many were unable to conduct screenings in an empathetic way. Many sites held internal trainings to address these issues. Some participants noted increased support from the staff after bringing in clients to speak about how they were affected by food insecurity.

“[The staff] tell me they never knew it was a problem, you know, from a [provider] perspective. They never realized it could affect patient health. And admittedly, I have had some of our own staff come back after our training and come talk to me personally about how they themselves and their families have suffered from food insecurity.”
(Children’s Hospital Los Angeles)

Defined roles within the clinic were noted as important to the successful implementation of food insecurity screenings. It was also noted that the siloing of these roles led to communication issues.

“We want to work on making sure we’re communicating with our clinic admin, clinic nutritionist, care navigators because they are the talking to our patients one-on-one. We want to make sure all of the information is up to date and accurate. We want to close those referrals and check in with them to make sure their needs are met.”
(Northeast Valley Health Corporation)



The Results

Barriers

Across the healthcare system, perceived barriers to implementation of a food insecurity screener occur at three levels: population, organization, and system.

- **Population-specific challenges** included stigma of poverty, low literacy, difficulty filling out forms, difficulty navigating systems of care, and multiple ongoing problems, such as housing insecurity, job insecurity, and lack of transportation. For many patients, food issues are not always a priority.

“I remember one patient told me that, right now they’re going to start getting housing, and once they get housing, they’ll be able to focus more on the food.” (Northeast Valley Health Corporation)

Frequently mentioned barriers include resistance to answering the screening questions, and to taking the follow-up calls from the clinic. In addition, many patients experience competing family or work responsibilities that prevent them from following through with the referrals. To

address this, one agency is monitoring no-show rates and increasing how many reminder calls their patients get.

“We’ll give patients the resources, connect them with the right people and families will return saying: they were not able to access the services, they forgot to call, or that they lost the paper.” (Children’s Hospital Los Angeles)

- **Organizational barriers** included staff turnover, challenges with staff role definition, challenges establishing the screening and referral workflows (e.g., screening tool is not integrated into electronic health records, team communication is inconsistent), competing programs (e.g., PCMH accreditation, PRIME Waiver), and insufficient training.

“In a perfect warm hand-off scenario, we would personally walk the patient over to the DPSS representative and introduce them to their new point of contact. Unfortunately, our clinic does not have the staff capacity to leave and see the other awaiting patients.” (Hubert Humphrey)



Facilitators

All key informant participants discussed factors that contribute to the success of their efforts. They include empathy training and training that draws on patient-reported feedback, a motivated workforce, team-based workflows and communication, co-location of other agencies' social workers, leadership support, and on-site resources such as wellness centers and farmers' markets. The latter factor emerged as a distinctly strong facilitator, with participants noting that farmers' markets allow clinic staff to offer food-insecure patients something tangible on the day of the visit, such as farmers' market tokens.

Other workflow challenges include communication lapses between medical assistants and providers, and between medical staff and social workers, forgetting to ask the food insecurity questions, inability to hand-off a patient, and the follow-up with the patients. These challenges are explained to a certain extent by competing demands on a clinic's limited resources: high patient volume, inadequate staffing, medical urgency, or limited appointment time for follow-up visits.

- **At the system level**, some participants reported some challenges coordinating with DPSS and delays in getting DPSS to co-locate social workers at clinics and confusing information on eligibility for CalFresh enrollment. A good working relationship with DPSS social workers is central to a successful referral pathway. Some patients have very complex social problems (such as domestic violence), and some participants felt that the clinic is not always best equipped to address them.

“The addition of a medical case worker to our workflow has been challenging for us, but having a case worker has allowed us to offer more services. Most importantly, it has provided opportunities for our patients to talk about their issues and for us to connect them with the appropriate resources.”
(Los Angeles County USC)

“Our clinic is primarily Spanish speaking; probably ninety-five (95) percent of our Medical Assistants are bilingual.” (Children's Hospital Los Angeles)

A key facilitator for some agencies has been a workflow designed around team work, where everyone from the Medical Assistants to the social workers know what they are supposed to be

doing and are communicating well with each other.

Leadership support is important. One key informant described how leadership buy-in manifests itself in practice. At one site, the Pediatric Medical Director is part of the core planning team and is very supportive of the work, as is the Director of Quality and Health Education. The CEO and Chief Medical Officer are also very supportive in providing needed resources.

Co-location of other agencies' representatives/social workers at clinic sites is perceived as a facilitator in the referral pathway, especially in terms of conducting warm hand-offs.

“When beginning this work, we worked with the Department of Public Social Services to co-locate a staff member when we hosted food insecurity related events as a way for families to enroll into SNAP immediately and bridge the gap of access.” (Los Angeles Trust for

Children's Health)

On-site resources such as wellness centers and farmers' markets are another facilitator, helping clinics link patients with the most need to a direct food supply. One agency provides patients with reduced-cost tokens so that for \$5 they can buy \$10-worth of food.

Impact

Some key informants discussed how introducing food insecurity screening has had an impact on staff awareness about the issue, as well as on the way they provide care to their patients. In particular, they commented on a shift to a holistic approach to care, whereby providers try to understand the content and context of life for their patients. A majority of informants see the value of intake data tracking and outcome measurement to understand population needs, screening rates, the percentage of patients for whom the provider has documented an intervention, and the percentage of patients who have been reached by the nutritionist, patient



satisfaction, successful linkage to food services, utilization rates, and other clinical outcomes (BMI and labs).

“For us, success is looking at our data to see the linkages occurring, families having access to food, and a drop in food insecure families coming into our urgent care.”
(Children’s Hospital Los Angeles)

One participant emphasized that screening for food insecurity in isolation is not sufficient. What accounts for their success is screening for a number of wellbeing and quality of life dimensions, including food insecurity.

“It’s an entirely different way of approaching primary care by forming relationships, getting to know the lives of your patients to understand the true barriers to their

health and form a pyramid of needs to address them in the order of highest priority.” (LA County USC)

Many participants provided anecdotal information about the impact they are making among their patients, such as patients expressing gratitude during follow-up visits and explaining that their families now have sufficient food.

“We have families thank us for caring to ask these questions. Many families may feel embarrassment, have pride, and may not think to come to a healthcare institution to report issues of hunger. As providers of health, we are in the best position to give our patients resources they need that people may not ordinarily categorize as healthcare.” (Children’s Hospital Los Angeles)



Looking Forward

The patient surveys revealed several missed opportunities in the clinic setting to help patients enroll in food assistance services. First, many patients would like to get help in the clinic setting, but most have never been prompted to discuss their concerns about food insecurity. The screening tool, Hunger Vital Signs, does not appear to be administered in a standard way across clinics. Another key informant explained that many of the patients they see at their clinic have highly complex needs, with multiple social problems (e.g., unstable housing). In such cases, food may not necessarily constitute a priority, and providers may focus on the more pressing matter for the visit.

While patients mostly said they would prefer to discuss food issues with their physician, in the busy clinic setting, when patients have multiple medical problems, the issue of routine food consumption may not be a priority during a doctor-patient encounter. Conveying concerns about insufficient food in a written format was the second most preferred method. This option would make the screening more efficient.

Given the high rates of food insecurity, screening for food insecurity needs to be universal. Since a relatively high percentage of clients reported not knowing how to apply for CalFresh, patients need more information about and assistance with enrollment in this program. Other informants mentioned that information on CalFresh eligibility is confusing, and one clinic even involved a legal team to clarify CalFresh criteria for patients.

All key informants discussed the resources they need and the strategies they employ to ensure that their current screening and referral pathways can be expanded in the long term. Participants at all five agencies raised the issue of insufficient institutional capacity to follow-up

with all patients identified as food insecure by conducting case management, warm hand-off, post-referral follow-up, and by establishing the usefulness of the referral resources. Proposed strategies to accomplish this include hiring additional staff, enhancing DPSS linkages, securing resources that can be accessed on site (farmers' markets and food pantries), and providing additional nutrition education.

Overall, several key recommendations emerged from the key informant interviews:

- **Facilitate communication and collaboration with DPSS.** This would address the delays in coordinating with DPSS to co-locate social workers at clinic sites.
- **Provide more guidelines on how to implement the screening tool,** to ensure that 100% of patients are screened, implementation is standardized, and clinics all use validated tools.
- **Encourage clinics to advertise food resources in waiting room areas** to increase awareness among patients (print and video).
- **Equip agencies with educational materials** containing legal advice on patients' rights and eligibility for federal programs in relation to immigration status.
- **Provide support with set-up of food pantries at clinic sites.**

Funding

This project is supported by USDA SNAP-Ed, an equal opportunity provider and employer.

DPH would like to thank RAND Corporation, Julia Caldwell, PhD, MPH, Lana Sklyar, MPH, Lynnley Huey, DrPH, RD, Dipa Shah-Patel, MPH, RD, and Tony Kuo, MD, MSHS for their contributions to this report.

CalFreshHealthyLiving.org
publichealth.lacounty.gov/nut

This material was produced by the Los Angeles County Department of Public Health, Nutrition and Physical Activity Program with funding from the U.S. Department of Agriculture's (USDA) Supplemental Nutrition Assistance Program-Education, known in California as CalFresh. CalFresh provides assistance to low-income households and can help buy nutritious food for better health. For CalFresh information, call 1-877-847-3663. For important nutrition information, visit CalFreshHealthyLiving.org.

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