

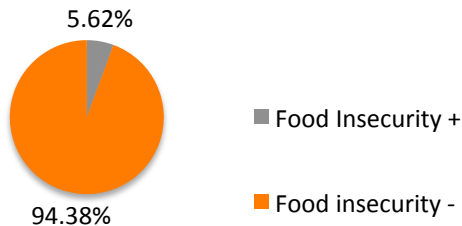
## Background

According to the U.S. Department of Agriculture, food insecurity is defined as the lack of adequate food, which is limited, by a lack of money or other resources. Rates of food insecurity in our clinic, as assessed by anonymous patient survey, which included the Six-Item Short Form of the Household Food Security Scale, were 34.6% in 2015<sup>1</sup>. As a result, the AAP recommended 2-question validated food security screening tool<sup>2</sup> was employed at each visit clinic wide. Patients determined to be food insecure were offered resources and assistance.

## Objectives

The purpose of this study is to evaluate assessment of and responsiveness to food insecurity by providers in an urban pediatric clinic. Secondary endpoints assess age, race/ethnicity and insurance source of patients identifying as food insecure.

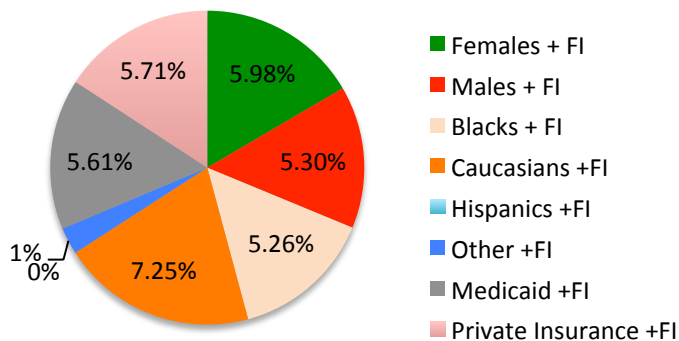
### Positive vs Negative Food Insecurity Screen in the OSU Pediatric Population



## Design

A retrospective chart review of all patient visits from September 1, 2016-August 31, 2017 was completed. 249 charts were chosen at random for review. Data collected included number of patients positive and negative for food insecurity; number of patients positive for food insecurity who were provided resources and clinical guidance; and age, race/ethnicity, and insurance source of children identified as food insecure. Data analysis was performed by Dr. Mark Payton, Department of Statistics, Oklahoma State University.

### Percent Food Insecurity by Sex, Race, & Insurance Source



## Results

Food insecurity was assessed using the 2-question screening in 100% of the patient visits reviewed. Of 249 charts, data showed 5.62% of patients were positive for food insecurity and all providers documented giving community resource handouts to patients. Age had no statistical difference on food insecurity (p-value 0.8948). Female patients were from food insecure families 5.98% of the time and 5.3% of males were from food insecure families (p-value 0.8162). Black patients were food insecure 5.26% of the time, 7.25% of Caucasian patients were food insecure, 0% of Hispanics and 1% of patients identifying as "other" were food insecure (p-value 0.4926). Patients with Medicaid were food insecure 5.61% of the time and patients with private insurance were food insecure 5.71% (p-value 0.9797).

## Conclusion

Findings show that assessment of and responsiveness to food insecurity was high. There were no significant differences in rates of food insecurity across all demographic groups measured. Notably, rates of food insecurity measured via anonymous patient survey vs. 2-question screening tool differed. This could be due to several factors including reporting bias, language barriers, and caregiver discomfort in affirming food insecurity, and differing sensitivities among assessment tools. Additional study is necessary to determine how to best assess and address food insecurity in our clinic.

### References:

1. Carly Sorenson. An Evaluation of Household Food Insecurity and Chaos in An Urban Pediatric Patient Population Poster presented at: ACOP. 2015; Orlando, FL.
2. Council on Community Pediatrics, Committee on Nutrition. Promoting Food Security for All Children, Pediatrics Nov 2015, 136 (5) el 431- el 438; DOI: 10.1542/peds.2015-3301