MALNUTRITION RESOURCES TOOLKIT

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OUR ED STAFF IS FIGHTING FOOD INSECURITY IN THE COMMUNITY

Thank you for screening senior patients for food insecurity!

Together, we are fighting senior hunger by identifying older adults in need and linking them to community-based services.

Let's keep it up!

Screen

Ask patients 60 and older 2 screening questions to find out if they are **food insecure.**

Refer

When you identify a patient who is **food insecure, contact care management.**

Document

Document the **results** of every screen in **the EMR.** Your ID badge card has smart phrases to help you document.

QUESTIONS? Study Coordinator: _____ Clinical Champion: _____

RESPONDING TO A POSITIVE SCREEN

INFORM THE PATIENT

Patient responds sometimes or often to either food insecurity question.

Thank the patient and offer them the opportunity to speak with a social worker or care manager.

Informing the Patient

For example," Thank you for sharing that with me, Mr. Jones.

I'm going to ask one of my colleagues in care management to come by and speak with you about resources that might be available for you."

PAGE CARE MANAGEMENT

No pager? No worries. Page easily through the online directory.

Page Care Management. Include **patient name**, **bed number**, and **your name.**

Care Manager Pager

ED Care Manager (day):

ED Care Manager (night):

For example, "Theo Jones in Bed 74B screened positive for food insecurity. Needs referral to communitybased resources. Screened by NA Julie Hurtado."

DOCUMENT THE RESULTS

Enter the screening results into the patient's chart.

Documenting in the EHR

Enter screening results in the social determinants of health tab and use the smartphrase ".foodinsecuritypositive" in the notes tab.

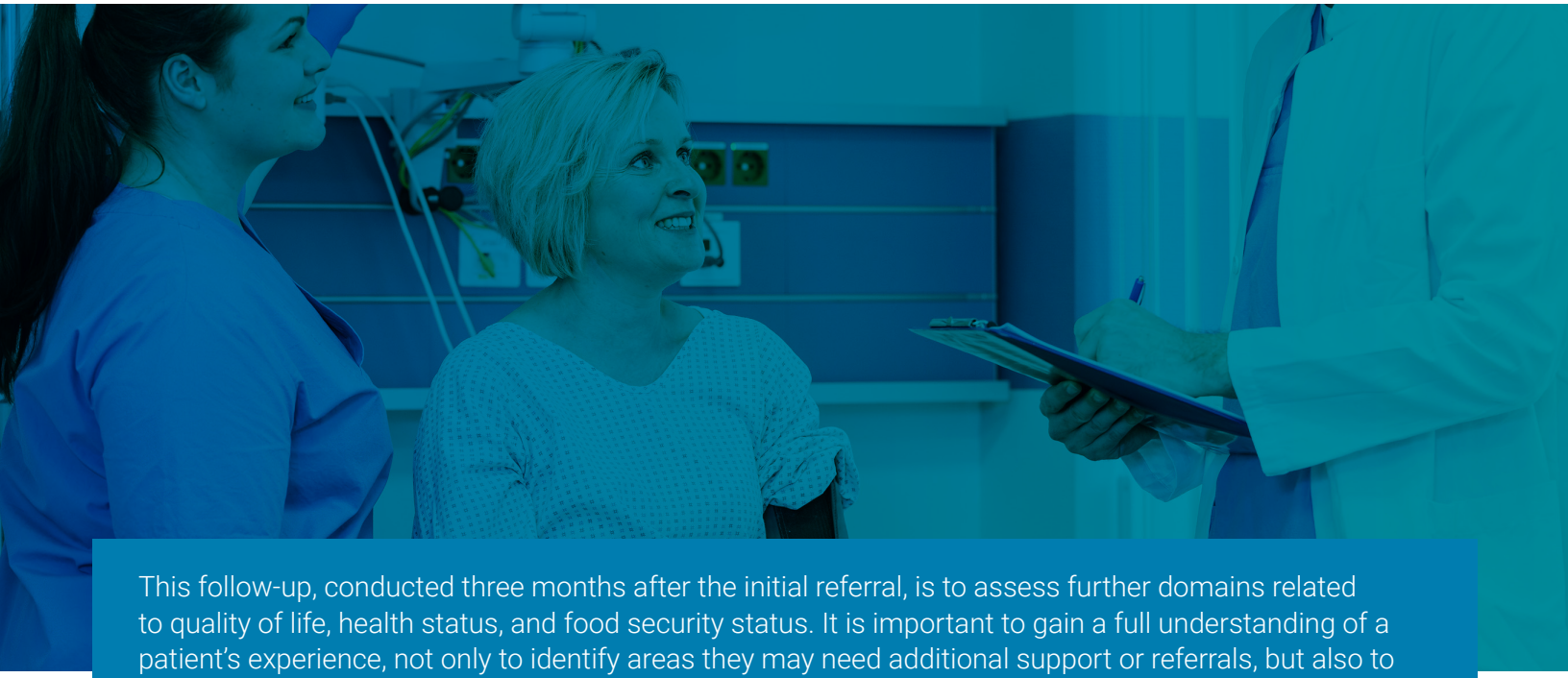
Questions?

Call, text, or email:

Project Coordinator: _____

Clinical Champion: _____

3-MONTH FOLLOW UP – LONG ASSESSMENT *(19 QUESTIONS)*



This follow-up, conducted three months after the initial referral, is to assess further domains related to quality of life, health status, and food security status. It is important to gain a full understanding of a patient's experience, not only to identify areas they may need additional support or referrals, but also to inform your program's ongoing development.

The results of this follow up should be logged and tracked for your quality improvement purposes -- not only for the patients who may present with a "red flag" but for all who your program has served. This contributes to a clearer understanding of your patient's situation and can help gauge how your community is doing overall.

Assessment Response/ Next Steps:

SAY: "Hello! My name is _____. I'm calling from _____. I understand that in the past few months, you've received services from providers in your community [give example]. We'd like to learn about how you like these programs and how they have affected you. Would you be willing to answer a few questions about your experience?"

1. Can you tell me what services you've been connected to in the past 3 months?

a. List all, follow up with specific questions about referrals documented by AAA

2. On a scale of 1-5, (5 being most helpful), how helpful have [name of services] been for you? [repeat as needed for each additional service the patient has received]

a. very helpful.

b. somewhat helpful

c. neither helpful nor unhelpful

d. somewhat unhelpful

e. very unhelpful

Concerns About Current Services

If patients have specific questions or concerns about the services they are receiving, identify a plan for you or a related staff member to follow up --- which may include directly contacting the resource with them, referring to an alternative service, or making sure they feel supported.

3. Can you tell me why you chose that answer?

4. On a scale of 1-5, (5 being most satisfied), how satisfied are you with [name of services]? [Repeat as needed for each additional service the patient has received]

a. very satisfied

b. somewhat satisfied

c. neither satisfied nor unsatisfied

d. somewhat unsatisfied

e. very unsatisfied

5. Can you tell me why you chose that answer?

6. Are there other services you'd like to learn more about? [prompt if necessary]

Reassessing Food Insecurity

SAY: "I'm going to read you two statements people have made about their food at home. Please tell me if each statement is often, sometimes, or never true for you/your household in the *past month.*"

7. "We worried whether our food would run out before we got money to buy more."

a. often true

b. sometimes true

c. never true

8. "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

Food Insecurity

If seniors report additional needs or issues with their services, you may follow a similar protocol used during the initial screening such as contacting your local Area Agency on Aging (or related referral partner, if applicable).

Hager, E. R., Quigg, A. M., Black, M. M., Coleman, S. M., Heeren, T., Rose-Jacobs, R., Cook, J. T., Ettinger de Cuba, S. E., Casey, P. H., Chilton, M., Cutts, D. B., Meyers A. F., Frank, D. A. (2010). *Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity*. Pediatrics, 126(1), 26-32. doi:10.1542/peds.2009-3146.

USDA 6-Item Food Insecurity Module

SAY: *"These next questions are about the food eaten in your household in the past month and whether you were able to afford the food you need."*

SAY: "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)."

9. The first statement is, "The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more." Was that often, sometimes, or never true for (you/your household) in the last month?

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true
- ☐ DK or Refused

10. "(I/we) couldn't afford to eat balanced meals." Was that often, sometimes, or never true for (you/your household) in the last 12 months?

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true
- ☐ DK or Refused

11. In the last 12 months, since last (name of current month), did (you/you or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?

- ☐ Yes
- ☐ No (Skip AD1a)
- ☐ DK (Skip AD1a)

Source: *US Adult Food Security Survey Module: Three-Stage Design, With Screeners. (2012). https://www.ers.usda.gov/media/8282/short2012.pdf*

11a. [IF YES ABOVE, ASK] How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?

- ☐ Almost every month
- ☐ Some months but not every month
- ☐ Only 1 or 2 months
- ☐ DK

12. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

- ☐ Yes
- ☐ No
- ☐ DK

Food Insecurity Scoring

Responses of "often" or "sometimes" on questions 9 & 10, and "yes" on 11, 12 & 13 are coded as affirmative (yes).

Responses of "almost every month" and "some months but not every month" on 11a are coded as affirmative (yes).

The sum of affirmative responses to the 6 questions is the household's raw score. The raw scores indicate the following:

0-1: very low food insecurity

2-4: moderate food insecurity

5-6: high food insecurity

13. In the last 12 months, were you every hungry but didn't eat because there wasn't enough money for food?

- ☐ Yes
- ☐ No
- ☐ DK

Quality of Life

14. In general, would you say that your quality of life is:

a. Excellent

b. Very good

c. Good

d. Fair

e. Poor

15. Since you first started receiving services, would you say that your quality of life is:

a. Much better

b. Moderately better

c. A little better

d. Unchanged

e. A little worse

f. Moderately worse

g. Much worse

When More Help is Needed

If patients show red flags, like worsening food insecurity or distress, contact your local partnering agency or specific providers to ensure that their needs are met.

16. Would you say in general that your health is:

a. Excellent

b. Very good

c. Good

d. Fair

e. Poor

Health Care Utilization

17. In the past three months, how many times have you visited the Emergency Room ***[not including the visit at which patient was screened]***?

18. In the past three months, how many days have you spent in the hospital?

Other concerns

19. Are there other concerns or questions you'd like to share with me today?

3-MONTH FOLLOW UP – SHORT ASSESSMENT *(14 QUESTIONS)*

This follow-up, conducted three months after the initial referral, is to assess further domains related to quality of life, health status, and food security status. It is important to gain a full understanding of a patient's experience, not only to identify areas they may need additional support or referrals, but also to inform your program's ongoing development.

The results of this follow up should be logged and tracked for your quality improvement purposes -- not only for the patients who may present with a "red flag" but for all who your program has served. This contributes to a clearer understanding of your patient's situation and can help gauge how your community is doing overall.

Assessment Response/ Next Steps:

SAY: "Hello! My name is _____. I'm calling from _____. I understand that in the past few months, you've received services from providers in your community [give example]. We'd like to learn about how you like these programs and how they have affected you. Would you be willing to answer a few questions about your experience?"

1. Can you tell me what services you've been connected to in the past 3 months?

a. List all, follow up with specific questions about referrals documented by AAA

_____

_____

_____

2. On a scale of 1-5, (5 being most helpful), how helpful have *[name of services]* been for you? *[repeat as needed for each additional service the patient has received]*

a. very helpful.

b. somewhat helpful

Concerns About Current Services

If patients have specific questions or concerns about the services they are receiving, identify a plan for you or a related staff member to follow up – which might include directly contacting the referred-to resource, referring to an alternative service, or making sure they feel supported.

c. neither helpful nor unhelpful

d. somewhat unhelpful

e. very unhelpful

3. Can you tell me why you chose that answer?

4. On a scale of 1-5, (5 being most satisfied), how satisfied are you with [name of services]? [Repeat as needed for each additional service the patient has received]

a. very satisfied

b. somewhat satisfied

c. neither satisfied nor unsatisfied

d. somewhat unsatisfied

e. very unsatisfied

5. Can you tell me why you chose that answer?

6. Are there other services you'd like to learn more about? [prompt if necessary]

Reassessing Food Insecurity

SAY: "I'm going to read you two statements people have made about their food at home. Please tell me if each statement is often, sometimes, or never true for you/your household in the *past month.*"

7. "We worried whether our food would run out before we got money to buy more."

- **a.** often true
- **b.** sometimes true
- **c.** never true

8. "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

Food Insecurity

If seniors report additional needs or issues with their services, you may follow a similar protocol used during the initial screening such as contacting your local Area Agency on Aging (or related referral partner, if applicable).

Quality of Life

9. In general, would you say that your quality of life is:

- **a.** Excellent
- **b.** Very good
- **c.** Good
- **d.** Fair
- **e.** Poor

10. Since you first started receiving services, would you say that your quality of life is:

- **a.** Much better

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b. Moderately better

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e. A little worse

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g. Much worse

11. Would you say in general that your health is:

a. Excellent

b. Very good

c. Good

d. Fair

e. Poor

Health Care Utilization

12. In the past three months, how many times have you visited the Emergency Room [not including the visit at which patient was screened]?

13. In the past three months, how many days have you spent in the hospital?

Other concerns

14. Are there other concerns or questions you'd like to share with me today?

When More Help is Needed

If patients show red flags, like worsening food insecurity, increased visits to the ED/hospital or distress, contact your local partnering agency or specific providers to ensure that their needs are met.

If seniors report additional needs or issues with their services, you may follow a similar protocol used during the initial screening such as contacting your local Area Agency on Aging (or related referral partner, if applicable).

2-4 WEEK FOLLOW UP

This questionnaire was designed to help you assess the effect of your food insecurity screening and referral program. This follow-up, conducted 2-4 weeks after initial screening, is meant to ensure that services are being delivered and meeting patient needs. Responses from this questionnaire can be used for quality improvement by helping inform how well your screening process works and where there may be opportunity for improvement.

SAY: "This is _____ from [organization]. We spoke a few weeks ago about getting you linked to nutrition programs in your community. I wanted to check in and see how those services have been for you."

1. *Review the referrals sent to community organizations. Ask seniors to confirm services they have received.*

_____

_____

_____

2. ***[If receiving services]*** are you still enrolled in _____ _____ [service name]?

a. If no, why not?

_____

_____

_____

3. ***[If receiving services]*** On a scale of 1-5, how satisfied are you with the services you are receiving?

a. very satisfied

b. somewhat satisfied

c. neither satisfied nor unsatisfied

d. somewhat unsatisfied

e. very unsatisfied

4. Can you tell me why you chose that answer?

5. Are there other services that you are interested in? *[prompt if necessary: transportation, home health, etc.]*

6. Is there anything else that we can assist you with today?

7. Do you have any feedback for the community service provider?

WORKSHEET: PLANNING FOR EVALUATION

A strong evaluation rests on clearly defined outcomes.

What do you expect will happen as a result of your efforts to screen and intervene in food insecurity? Common answers might include improved health for older adults, reducing repeat ED visits, decreased levels of food insecurity and hunger among older adults. In evaluation, these big picture goals are known as impacts. To achieve big goals, however, you need reach short and medium-term outcomes first. To plan an evaluation, consider all the steps you'd need to make and milestones you need to reach in order to make your impact a reality.

What is the expected impact of your food insecurity screening and referral program?

An evaluation is an opportunity to tell the story of your food insecurity screening and referral program. How is it working? How can it be improved? Who has benefited from it, and how? Consider the stakeholders involved in launching the programs and the outcomes they prioritize. This will help you conduct an evaluation that will be relevant to the different groups involved in launching your program.

Step 1: Identifying Stakeholders

Who is affected by the program?	
Which groups or individuals are involved in the operation of the program?	
Who needs to see evaluation results and how will they use them?	

Step 2: Stakeholder Roles and Value-Add

Which of our stakeholders are needed to:

Increase the credibility of our evaluation?	
Continue implementing our program?	
Advocate for changes in our healthcare setting that will sustain our program?	
Fund or authorize the continuation or expansion of our program?	

Step 3: Selecting program outcomes based on stakeholder input

Stakeholder	What activities and/or outcomes of the food insecurity screening and referral matter most to them?

The short and medium-term outcomes for our food insecurity screening and referral program are:

Step 5: Crafting an Outcome Measurement Plan

Make sure your team understands how you will measure the selected outcomes. Use this worksheet to develop a plan for evaluation. An example is provided.

- ✓ Agree on the key question the outcome addresses
- ✓ Clarify the data source
- ✓ Make a plan to gather and record needed data. Consider who will be responsible, what additional materials or resources are needed, and the timeline for collecting data

Outcome	Key question	Data Source	Data Collection plan
Reach	What proportion of eligible patients are being screened?	Administrative Data: review of screenings in HER	*We will obtain a monthly report that includes all eligible patients seen in ED, patient screened, results, and name of screener; program coordinator will review data and keep a continuously updated table of screening rates, screen positive rates, and participating screeners.*

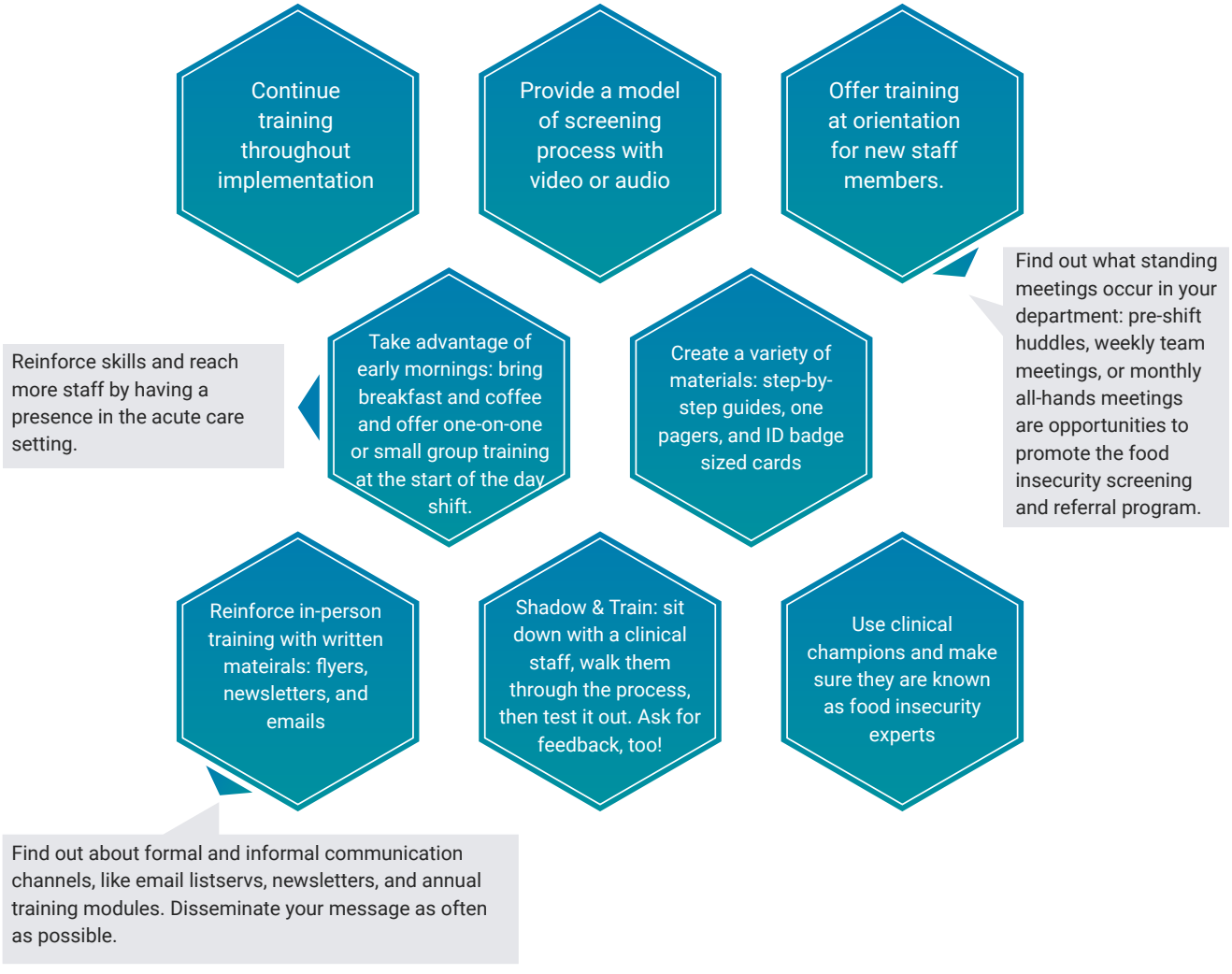
References

1. *Introduction to Program Evaluation for Public Health Programs: A Self-Study Guide.* (2011). *https://www.cdc.gov/eval/guide/CDCEvalManual.pdf*

TOOLKIT
TRAINING IDEAS

Thinking Outside the Box (and outside the conference room): Training and Education in an Acute Care Setting

In a busy acute care setting, it can be hard to gather a group for a 45-minute training session. Seek out creative ways to reach staff, train, and reinforce your program's processes over the implementation period. Below are some ideas to get you started.



Training Ideas for My Acute Care Setting

- Regular meetings and trainings in my acute care setting:

- Formal communication channels in my acute care setting:

- Informal communication channels in my acute care setting:

- Ideas to motivate staff and show appreciation:

- When should incentives or staff appreciation be offered?

- Formal leaders who can help:

- Informal leaders who can help:

- Locations in our acute care setting can be used for training or to share information (e.g. staff break rooms):

PERIODIC REFLECTION INTERVIEW GUIDE

Periodic reflections are a tool to help you understand how your food insecurity screening and referral program is working by completing repeated measures over time (e.g. monthly or quarterly) with individuals who are implementing the screening. Periodic reflections can be completed individually or in a group. They can be completed as a scheduled or ad-hoc interview. It is fine if you are not able to cover all the questions but try to obtain and transcribe as much detail as possible during the interview.

1. On a scale of 1-5, how confident do you feel with the food insecurity screening?

2. Have there been changes to the screening process during the past month? If yes, can you describe those changes?

a. What's been the impact of those changes?

3. Are you hearing concerns or suggestions from other staff about food insecurity screening? If yes, what are they?

4. Are there other projects, issues, or changes going on in the Emergency Department that you think impact your team's ability to screen patients for food insecurity?

a. If yes, please describe.

5. What can make it hard to screen patients for food insecurity? What barriers to screening and referring patients are you seeing or experiencing?

a. What solutions have been tried to overcome barriers to screening? How is that going?

6. Who would you say has been most involved in food insecurity screening? Who do you consider to be a leader on this project?

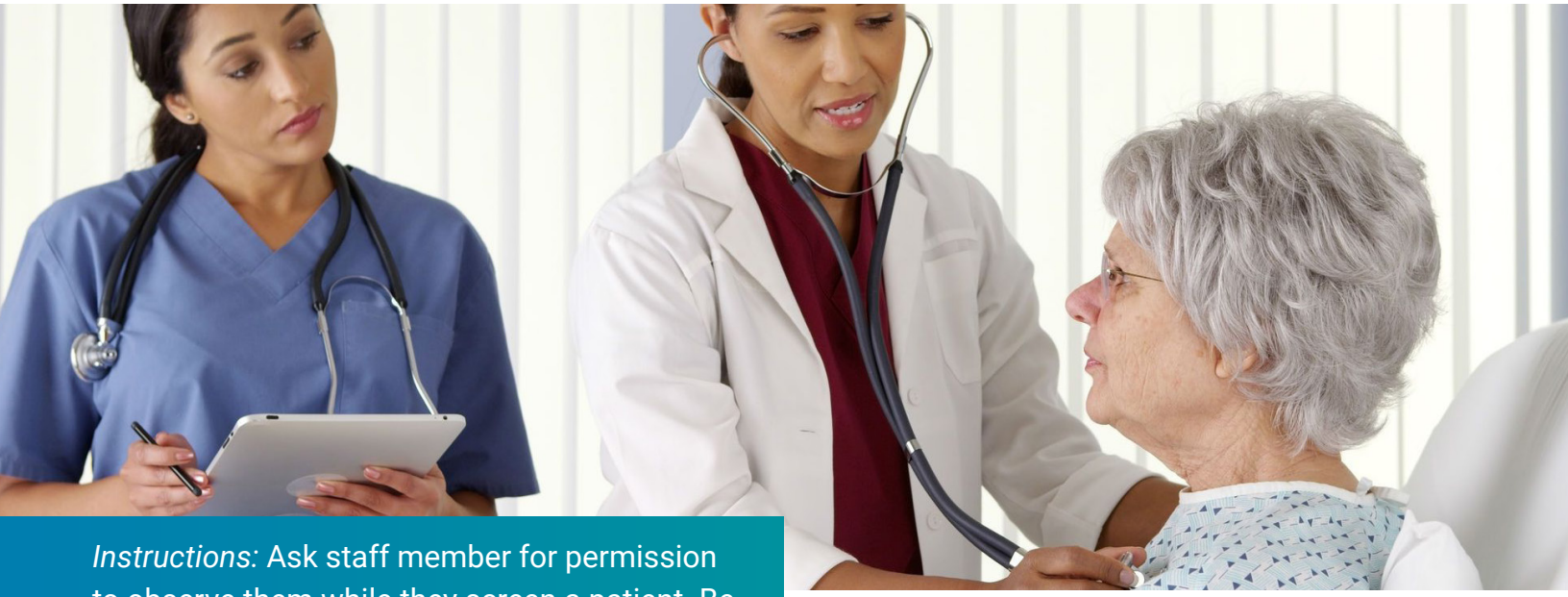
7. Thinking about the screenings you have completed in the last month, have there been any surprises lately, or unexpected events?

8. What new lessons about food insecurity have you learned in the past month?

9. Based on the past month, what changes would you propose to the study?

Elicit feedback on any changes to the program that are under consideration, if applicable

OBSERVING A SCREENING



Instructions: Ask staff member for permission to observe them while they screen a patient. Be sure to time the length of interaction.

1. How does the screener frame the questions? Does he or she introduce themselves?

2. How does the screener ask the food insecurity screening questions? Try to note as close to verbatim as possible. To what extent does the screener deviate from the published wording of the tool?

3. What do you notice about how the patient responds?

4. Characterize the patient's situation: do they have family in the room? Are they in a private room or a hallway bed? Are there significant communication barriers? If so, please describe.

5. In general, how comfortable does the screener appear to be when introducing and delivering the screening?

6. What else does the screener do while in the room with the patient (e.g. measure vital signs, share information, other tasks)

HUNGER VITAL SIGN: 2-ITEM FOOD INSECURITY SCREENER

"Within the past 12 months we worried whether our food would run out before we got money to buy more."

- often true
- sometimes true
- never true

"Within the past 12 months the food we bought just didn't last and we didn't have money to get more."

- often true
- sometimes true
- never true

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COMMON QUESTIONS ABOUT FOOD INSECURITY SCREENING

01 *Why are we screening for food insecurity?*

Seniors struggle with nutrition. Food insecurity is a key risk factor for malnutrition, a serious concern for older adults.

- **8-15% of older adults are food insecure**
  - Food insecurity is "the lack of enough affordable, nutritious food to live a healthy, active lifestyle"
  - Food insecurity contributes to exacerbation of chronic disease symptoms, medication non-adherence, and limits ADL. It adds to stress and is often co-morbid with depression.
  - Food insecurity is associated with increased health expenditures

- **Food Insecurity is a significant risk factor for malnutrition.**
  - Nearly 6% of older adults are clinically malnourished, and as many as 1 in 3 are at risk for malnutrition.
  - Malnutrition leads to falls, poor wound healing, and exacerbates chronic disease symptoms, all of which cause patients to return to the ED time and time again.
  - Malnutrition has clinical causes (like oral health and disease processes) and social causes (like food insecurity)
  - It is highly prevalent in health care settings: one in three hospital patients are malnourished when admitted; pre-existing malnutrition can lengthen hospital stays.
  - Malnutrition extracts a major burden on older adults' health and has a high economic cost: nearly $51 billion in health costs are associated with disease-associated malnutrition.

02 *Why it is important to screen in acute care settings like ours?*

The ED provides a unique opportunity to intervene with an extremely vulnerable segment of our older adult population. For some patients, this might be the only or best opportunity to be connected with life-changing resources. If we are missing screens, then we are missing a chance to effect ***real change*** in the lives of our patients…sometimes in small ways, but sometimes in very large and profound ways.

03 *So what is the staff doing about it?*

Members of our clinical team are asking older adults (60+) just two questions about food insecurity:

> ***Intro:*** *I'm going to read you two statements that people have made about their food at home. Please tell me if each statement is often, sometimes, or never true for your household in the last 12 months.*

a. We worried whether our food would run out before we got money to buy more.

b. The food we bought just didn't last and we didn't have money to get more.

If the patient answers often or sometimes to either of the questions, the screen is positive.

If the patient screens positive for food insecurity, they are connected (via case management system) to a community partner, who can quickly arrange nutrition services for them upon discharge.

04 *Isn't it a lot of work to screen ALL older adults?*

Clinical staff are only screening those with medical complaints, not psychiatric patients, and patients who are critically ill, like trauma patients or patients with MI or stroke, are not screened. Once the screening becomes more familiar, it takes less than 2 minutes to ask the screening questions and document the results. Clinical staff might ask these questions when checking vitals or doing rounds.

05 *Someone told me that a patient screened positive for food insecurity. Or that a patient needs food. Or that a patient is hungry…what do I do now?*

Short and sweet: If food insecurity is present, a case manager should be paged. Confirm that a page to the case manager has been sent. To make it easy for the case manager, make sure the page includes patient name, their bed number, and the name of the person who completed the screening.

06 *What happens when case managers get involved?*

Case managers will help patients get connected to a community partner. The community partner can link patients to the full range of services that are available to them; there is a dedicated staff person who will conduct an assessment, make a warm hand-off to programs (e.g. senior nutrition, transportation, homemaker services) in the patient's community, and follow-up to ensure services have been received.

07 *What can I do to support the food insecurity screening program?*

1. Encourage your clinical team members and thank them for participating! This is a new process for all of us, and the support of colleagues including nurses, residents, and attendings is very motivating and helps boost confidence.

2. Reinforce the workflows: all non-critically ill older adults are screened, results documented, and all food insecurity is reported to care managers.

3. Practice makes perfect: Our food insecurity program includes some new processes—screening patients and paging care management, especially. There may be some bumps in the road as we get used to screening, but as it becomes a habit, it takes MUCH less time. We appreciate your patience!

References

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2. Berkowitz SA, Basu S, Meigs JB, Seligman HK. Food Insecurity and Health Care Expenditures in the United States, 2011–2013. Health Services Research 2017;0.

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4. Kaiser MJ, Bauer JM, Rämsch C, et al. Frequency of Malnutrition in Older Adults: A Multinational Perspective Using the Mini Nutritional Assessment. Journal of the American Geriatrics Society 2010;58:1734-8.

5. Snider JT, Linthicum MT, Wu Y, et al. Economic burden of community-based disease-associated malnutrition in the United States. JPEN J Parenter Enteral Nutr 2014;38:77s-85s.

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