Addressing Food Insecurity in Our Communities
Improving Food Insecurity Screening in the Emergency Department
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Background
In 2019, more than 1.35 million Pennsylvanians had barriers to accessing food. In 2020, due to the COVID-19 pandemic, these numbers grew to 1.77 million. Prior to institutionalizing our food insecurity goals, screening patients for social needs was occurring, but at a low rate. ED staff screened approximately 43% of emergency department patients for food insecurity prior to January 2022. Even from these early numbers, the organization approximated that by improving screening rates, most campus EDs would encounter approximately 1–2 food insecure patients per day, plus one campus with as much as five (5) food insecure patients per day. The emergency departments made it a goal to improve screening rates to 85% of all ED patients, acknowledging that it may not be appropriate to screen every patient, depending on their emergency situation.

Goals
Leveraging the reach of the Emergency Departments, MLH aimed to systematically identify and address food insecurity needs in our communities by:
1. Improving systematic screening of patients for risk of food insecurity using a validated tool (the 2-question Hunger Vital Signs).
2. Offering resources to address immediate and longer-term food insecurity needs.

Methods
The following interventions helped achieve improvement:
1. Scripting was developed to help make nursing staff more comfortable having conversations regarding food insecurity risks with patients.
2. The screening questions were made required documentation in the EMR for the ED encounter. While required documentation did not make the screening questions a “hard stop,” it did create a visual cue to the nursing staff to help them remember to ask the screening questions. It also streamlined the EPIC workflow to document the screening question responses in EPIC reducing a workflow that used to take several clicks to navigate the EMR pages, to a single click.
3. Food insecurity resources were made available to ED staff so they could provide patients with support if they screened at-risk for food insecurity. These resources were two options. The emergency departments were stocked with shelf stable food bags to address patients’ immediate food access needs. The EMR was also loaded with food insecurity resources, like local food pantries, that staff can add to the patients discharge paperwork.
4. A Best Practice Advisory (BPA) was implemented. Once a patient screens at-risk for food insecurity, a reminder pop-up window will continuously nudge the nurse to offer a food insecurity resource (food bag and/or community organization) to the patient.
5. A team of social care providers (social work, Community Health Worker, and others) conduct post-discharge telephone outreach to patients to follow up on whether resources offered during their visit were helpful and assess for additional SDOH needs.

Outcomes
Screening rates across the health system were improved from 43% to approximately 85%. Figure 1 includes run charts that show the daily screening rates for each campus both before and after the implementation of required documentation, denoted by the red dotted line. Visually, it appears that every campus experienced a notable increase. Hypothesis testing also confirmed that the increases were statistically significant. Appendix E shows that the increases were statistically significant. Four months post implementation, 530 patients were identified as at-risk for food insecurity (simple annualization equals 1,612 patients this year).

Lessons Learned
• Our process can apply to any program that aims to address any social determinants of health, not just food insecurity.
• Obtain senior leadership buy in, up front
• Assemble an interdisciplinary team that includes all of the stakeholders in the process.
• Subordinate new processes to uncontrollable constraints (embed new tasks into existing nursing workflow)
• Leverage process improvement tools and resources (DMAV/DMAIC, A3, Gemba walks, process maps, data driven control plan)
• Ensure warm handoff to localized process owners