Developing an Intervention to Increase Understanding of Food Insecurity

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Background

Project Beginnings

- Prevalence of food insecurity is high in Mesa County (and now rising due to COVID-19 pre-pandemic, was around 11% of the population)
- Many medical practices now aiming to identify food insecure patients and refer them to resources
    - Initiatives like the Accountable Health Communities Model & Community Resource Network
- 2019: Received funding from the Colorado Evaluation and Action Lab (COLAB) to do research to inform the development of the Community Resource Network (CRN)
    - Interviews and surveys with medical providers and staff, social service agency staff, and food insecure community members
    - Examined understanding of food insecurity and comfort with sharing data related to screening and referral

Year 1 Key Findings

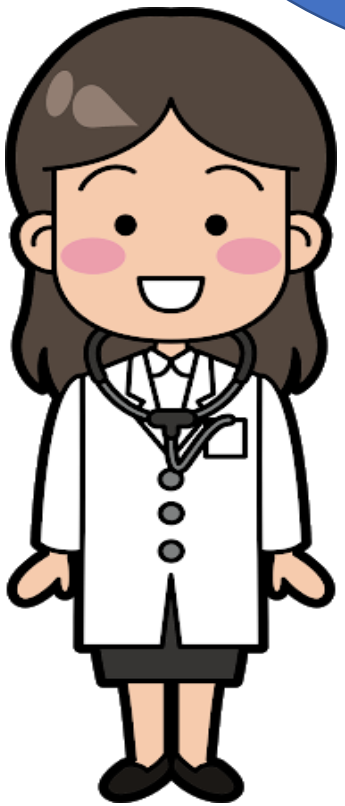
- Variation in experience of food insecurity: medical providers much less likely to have lived experience

Food Insecurity Status	Community Members	Medical Providers	Social Services
Never Food Insecure	1 (2.0%)	28 (71.8%)	14 (37.8%)
Previously Food Insecure	12 (24.0%)	9 (23.1%)	13 (35.1%)
Currently Food Insecure	37 (74.0%)	2 (5.1%)	10 (27.0%)

Year 1 Key Findings

- Medical providers tended to see food insecurity as partly a knowledge problem
  - 72% of providers surveyed thought that people not knowing how to buy and cook nutritious food cheaply “contributes a lot” to food insecurity
  - Around half of the other two groups responded similarly
- Medical providers tended to be less aware of the stigma around food insecurity and use of food access programs that was frequently reported by community members
  - Mostly this was in the qualitative results, but providers also more likely to think patients would be comfortable discussing food insecurity and services than organizational staff

"It's like pulling teeth to get people to talk about this. I don't know if there's so much stigma, they're worried that a doctor's going to judge them cause they're eating too many cookies and chips."



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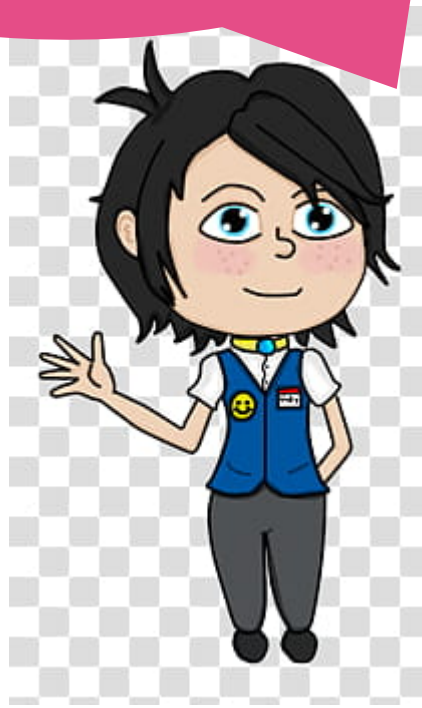
"I have gotten dirty looks, myself, in [the grocery store check-out] line, and it just makes me feel like less of a person… they see that I'm using food stamps, you know, the SNAP card that I have, I sometimes get a little side glance like, 'Really, does she need that?'"



Year 1 Key Findings

Within group stigma:

- Many community members (and social service agency staff) thought that personal responsibility factors (i.e. budgeting poorly, not wanting to work, being irresponsible) “contributes a lot” to food insecurity
- Many community members (and social service agency staff) also thought that there were often people who exploited food access programs, or who used them when they didn’t really need them
- Overlap in the two groups (community members and social service agency staff) regarding personal experience of food insecurity, meaning that people who are helping others address food insecurity might also be food insecure themselves

Year 1 Key Findings

In summary:

- There was a disconnect between medical providers' and community members' understandings of food insecurity
- This disconnect often prevented effective communication between medical providers and patients about food insecurity and resources

Additionally, many people do not see a doctor regularly, and so will not benefit from medical practice-based screening and referral

Our conclusion: Electronic referral networks (like the CRN) are valuable tools for facilitating connections to resources, but they can't address these "upstream" challenges to effective communication and referral. Therefore, we decided to shift our focus.

Shift in Focus

- Need to improve understanding of food insecurity among medical providers and medical practice staff
- Need to expand the focus beyond just medical practices:

"[Healthcare providers] see people for a microcosm of a person's life. You know, a person comes in every 3 or 4 months, and you might ask them about food, and then you don't see them for another 4 months. Teachers see that little first grader every Monday… and so the point of contact is much more regular and consistent in other sectors in the community 'cause people see 'em every day. In healthcare it's much more sporadic, and our ability to really have our finger on that pulse I think is more difficult."

- Interview with a medical provider

Year 2 Goal and Strategy

Goal for Year 2

Given that:

Medical office and school staff can play a valuable role in linking people with food access resources and are increasingly being asked to do so (i.e. AHCM, CRN initiatives)

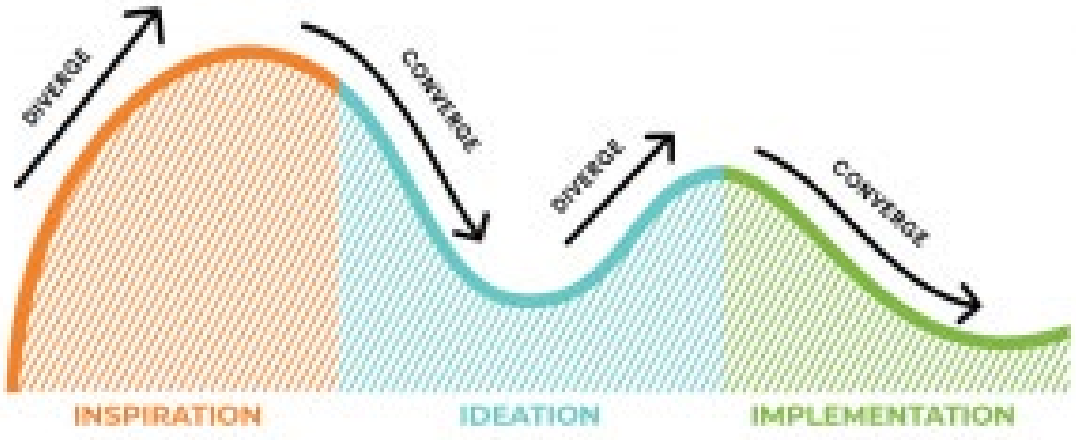
Our goal is therefore to:

Develop an intervention to improve medical office and school staff's ability to effectively and sensitively communicate about food insecurity and provide information about food access resources

What do we mean by “intervention”?

- Definition: action taken to improve a situation, especially a medical disorder
- What we will do is not yet defined but instead will be developed by a group of stakeholders via “User Centered Design”
- Could be educational sessions, messaging campaign, training “trainers”, poverty simulators, empathy building, etc. etc.

Strategy: User-Centered Design (UCD)



- Originated in software development, but increasingly used to design health-related interventions and messaging campaigns
- Initial focus: inspiration (sharing of findings); Subsequent focus: Ideation
- UCD group participants selected from key stakeholder groups (2 medical practice care managers, 2 school staff, 3 social service agency staff)

Year 2 Data Collection

Methods & Participants

- 6 Focus Group Discussions
  - 10 School staff (teachers, counselors, cafeteria workers)
  - 7 Medical practice staff
  - 9 School administrators (including nutrition program directors)
  - 6 Social service agency staff
  - 6 Colorado SDOH experts
  - 9 National SDOH experts
- In-depth interviews with 20 community members
  - Recruited by care managers at two safety net clinics
  - All identified by care managers as having social needs (often, but not necessarily food insecurity)

Results Overview

Key Audiences

What makes it difficult to talk about and provide resources for food insecurity?

What can make it easier?

Key Audiences

Who should we seek to reach with this intervention?

Medical Office Staff

- **Care managers** play the primary role in talking with patients about social needs and connecting them with resources
- **Nurses** and **Medical Assistants** also often have interactions with patients that allow them to identify food insecurity
- **Front desk staff** are often the ones giving screening questionnaires to patients
- **Providers** (i.e. doctors, nurse practitioners, physician's assistants) generally have little time to discuss and address food insecurity, but have substantial power and authority and are often regarded by patients as a trusted source of information

Importance of Relationships for Medical Office Staff

"But just, you know, asking people to come into their doctor's office and divulge things that are very personal in nature. Like, do you have food? Are you safe at home? Those are, like, intimate questions, you know…I find that when I screen people that I've met before, and they smile, and they're much more likely to be honest with me, and give me an honest screening. Whereas when I'm screening people who I've never met, no's all the way down. Never, never, never, fine, fine, fine; everything's good. When, you know, in your heart of hearts that, like, everything most likely is not fine, you know, and you're probably not getting an honest screening, you know. It's like, 'You want me to divulge what to you? And who are you giving this information to? Is this going into my medical record? Why do you need this? What are you doing with it?' I think there's a lot of distrust in certain populations, and so I think that's why it's like incredibly important to build the rapport and trust."

- *Care manager in primary care practice*

School Staff

- **Classroom teachers** have the most time and opportunities to get to know students and families and identify those that may be food insecure
- **Counselors** are often the ones that other school staff will involve if they are concerned about a student or family
- **School nutrition program staff (cafeteria staff)** and **lunch room instructional aids** have the most direct opportunity to see what students are eating each day, and which are in need of additional food
- **Coaches or other activity leaders** get to know kids outside of the classroom, travel with them, know their families, etc.

Role of School Staff

“We have a very high Hispanic population, so what we have found is that getting them to apply on a free and reduced form doesn’t happen because they’re afraid to be tracked. So, what we do is help them through a lot a community outreach, and through a lot of my kitchen lady staff, frankly, that have [laughing] a relationship with families, reach out to them. And what we do as kitchen managers, when we see a kid that has a high balance, and we can tell that they’re hungry, we encourage the parents to fill out a free and reduced application, and we encourage them to try to get on SNAP because that usually leads to other things. And sometimes [we can address] other needs for that family… sometimes it’s just a phone call home to say, hey, how can we help?

- *Kitchen manager at elementary school*

Importance of Relationships for School Staff

[When we think a student may be facing food insecurity] we talk to their homeroom teacher—their advisory teacher—and see if the teacher has a relationship with the household. We find somebody in that student's life, in the school setting, that has a positive established relationship, and it might be a coach… and we talk to them first and say, 'How do we approach this? What do we need to do?' And we just tread lightly.

- *School administrator*

What makes it difficult to talk about food insecurity?

Barriers the intervention should address

Overview: What makes it difficult?

Medical Office & School Staff

- No lived experience of food insecurity and poverty (not always, but often), so may have difficulty empathizing
- Lack of knowledge about food access resources (particularly details like who qualifies and how to access)

Those Facing Food Insecurity

- Getting by
- Stigma
- Fear of consequences
- Overwhelm

Getting By

- Individual or family may technically meet the definition of being food insecure, but may not identify themselves that way
- May not identify food insecurity as a problem that they could be eligible for support with, because they view themselves as “getting by”
- May hesitate to use resources out of concern that there are others who “need it more”

Getting By

"I think there's a lot of pride in the people here. I was trying to think of a proper way to put it, but I think a lot of the people here are—they're old cowboys [laughing]—if you understand what I'm saying—a really rural western, like, ranching community. We have the resources. I think a lot of times the people don't wanna use 'em, and I'm finding a lot of times, you know, sometimes when I do a screening or I give a resource to somebody they're like, 'Well, I don't have it, but I don't need it.' And so it's really hard to give the help to somebody. It's hard to get the resources here because the people that need it are like, 'Oh, I don't need it,' and so it's hard to bring the resources in when the people that really need it won't take it.

- Care manager in primary care practice

Stigma

- Pervasive social narratives asserting that:
  - Challenges like food insecurity are due to “not working hard enough” or “irresponsible choices”
  - There are “people out there” who take advantage of and abuse support programs
- Contributes to:
  - Concerns about being judged as lazy, irresponsible, and/or as someone who is taking advantage of the system
  - Negative in-person or online experiences with people who reinforce these stigmatizing narratives (i.e. nasty comments in the check-out line, etc.)
  - A sense that those who use food access resources need to “prove that they’re worthy”
- Results in:
  - Feelings of shame and desire for secrecy around challenges like food security
  - Not wanting to be seen accepting help/using programs

Stigma

“I think it’s something that people just don’t really talk about. I mean the kids don’t wanna talk about it. Parents really don’t wanna talk about it. And my doctor’s never once asked me if I was food insecure - that’d be a weird conversation. But I think that just in general it’s not something many people really talk about. You don’t wanna tell your friends you don’t have enough food. You don’t, you know.”

- School administrator

Fear of consequences

- Involvement of Child Protective Services (parents)
- Being removed from their home (seniors)
- Public charge or involvement of Immigration and Customs Enforcement (non-citizens and their family members)

Fear of consequences

"I also think part of the hesitation to talk about it, and again it goes to those old rancher—that generation—is they don't wanna be taken from their homes, and they don't wanna be put in a nursing home. And I think that that hesitation is they think that if they say something, that we will think that they can't take care of themselves, and they will be taken from their home. And I think that that's a real fear."

- Care manager in primary care practice

Overwhelm

- When people are facing multiple big challenges, they may not have the bandwidth to tackle everything at once
- Accessing food resources may not be the priority compared to other immediate issues
- Can be frustrating and insulting to have a well-intentioned outsider suggesting resources

What makes it easier to talk about food insecurity?

Strategies the intervention might leverage

Overview: What makes it easier?

- Resources first
- Normalizing use of resources
- Building a trusting relationship
- Training and increased knowledge and awareness

Resources First

- Suggestions to offer resources initially, rather than making resource information contingent on screening
- Makes it clear initially that the intent is to provide supportive resources, rather than starting off with questions that could potentially be seen as overly intrusive

Normalizing Use of Resources

- Communicating the message that everyone falls on hard times and needs help sometimes
- Being non-judgmental

"We usually hear kids when they go through the [lunch] line saying, 'Don't call my parents. They'll be mad that I'm eating,' so then we kinda figure out a way to have that conversation in an uncomfortable situation, but most of the time [their parents] understand. They just don't want to be judged for not being able to make it."

- Discussion with school staff

Normalizing Use of Resources

- To the extent possible, framing services as available to everyone and “marketing them broadly” rather than just for those who are “in need”

Example of how some schools approached the KidsAid Backpack program: *“So, the way we presented it was, ‘Hey, kids, we want you all to know that these KidsAid [bags] are for everybody across the board. So, everybody will go home with one of these [bags] to take home.’ And for some reason their mentality then changed. It wasn’t, like, ‘Oh, I’m gonna be noticed or labeled because I’m less fortunate.’”*

- Discussion with school staff

Normalizing Use of Resources

COVID-19 may offer an opportunity to change perceptions around use of resources

“I think that stigma’s super heavy right now, but I think that these two months of what we’re going through as a country will hopefully help change that paradigm [and help people realize] that it’s not just this person that’s on SNAP that has hunger needs… everybody needs to understand that if you really look at the economic data and we mainstream that and repetitively communicate that to our communities, I think only then are you gonna change perceptions.”

- Discussion with school administrators

Building a Trusting Relationship

- Taking the time to get to know and empathize with individuals and their situations
    - Importance of seeing the “whole person” and understanding their story
- Being able to provide immediate support for the needs that people would like support with and reliably connect people to resources that are truly helpful helps to build trust
    - Example of clinics with food pantries
    - Importance of familiarity with resources and qualification requirements so that people *“aren’t investing this time to get nothing, because then the very first time they do that, they’ve shut down.”*
        - Discussion with school staff

Building a Trusting Relationship

Ensuring that people have ownership over the process is also important for building trust

“There have also been moments when people are more reluctant because they think I am gonna come in and do a quick swoop and be somewhat of a Mary Poppins type person in their life. And that is really frustrating, and I think insulting… the most success I’ve found is from building relationships, and then asking people to think and work and to do things either alongside me in an equity position or to actually let me step back and have them step forward and to have more ownership.”

- Discussion with school staff

Training and increased knowledge and awareness

- Training on racism, cultural sensitivity, and implicit bias
  - Encouraging people to examine their own biases
- Strategies to raise awareness about the lived experience of poverty, food insecurity, and stigma
  - Poverty simulator
  - Empathy through storytelling
  - Program for medical residents where they gain experience at a food pantry and with the SNAP/WIC application process
- Other suggestions/resources
  - Training one or two individuals within larger organizations to be “champions” within their organization
  - Blueprint to End Hunger is also working on strategies to address stigma

Next Steps

- Use these findings to inform a stakeholder-led intervention design process
- Pilot the intervention in Mesa County schools and primary care practices