

CHILDHOOD HUNGER: A Public Health Concern

Screening and Intervention in the Clinic

Childhood Hunger



COALITION

www.childhoodhunger.org

OREGON CHILDHOOD HUNGER COALITION STATEWIDE PROVIDER SURVEY REPORT

Spring 2010

The Childhood Hunger Coalition is an interdisciplinary collaborative that educates, conducts research and advocates to link food security and health outcomes. Our network of health care professionals, anti-hunger advocates and other interested Oregonians believes that childhood hunger must be understood as a public health concern. Our mission: to eliminate public health problems arising from childhood hunger.

Hunger remains a significant problem in Oregon. More than 12 percent of Oregon's households are food insecure. That means 180,000 households have limited or uncertain availability of nutritionally adequate food. Of that number, 79,000 households experience hunger: household members go without food for an intermittent or extended period of time.

Hunger is particularly difficult for households with children. Households with children experience food insecurity at about twice the rate of households without children. Children living in food-insecure households are at risk for developmental and academic problems, frequent illness and poor nutrition, resulting in underweight and, paradoxically, overweight. Health providers are well positioned to identify patients at risk and to provide appropriate intervention.

In 2007, the Childhood Hunger Coalition (CHC) surveyed Portland metro-area physicians and nurse practitioners to assess

perceptions about food insecurity and to gauge interest in continuing education on the subject. Ninety-seven percent of respondents (n=174) identified food insecurity as a problem that should be addressed in the clinic setting, with the proper screening and intervention tools. Based on survey results, CHC developed an online course "Childhood Food Insecurity: Health Impacts, Screening and Intervention" (ecampus.oregonstate.edu/hunger). In one year, over 500 health practitioners registered and completed the course.

Since the 2007 survey was conducted, the country has experienced an economic downturn that resulted in soaring unemployment rates. Oregon was particularly hard hit, with unemployment rates as high as 12 percent. Participation in the Supplemental Nutrition Assistance Program (SNAP), formerly known as the Food Stamp Program, has increased by 35 percent, and more than 216,000 Oregonians eat meals from emergency food boxes each month. Statewide demand for emergency food increased an average of 14 percent this past year, and as high as 20 percent or

more in some Oregon counties. The need to monitor the health and development of children in struggling households and to provide appropriate interventions is more urgent than ever.

In response to this critical situation, CHC expanded the 2007 Portland metro survey (conducted in Clackamas, Washington and Multnomah counties) to the 33 non-metro counties in Oregon—

About this report

This report highlights results of the Childhood Hunger Coalition's Needs Assessment Survey of Oregon physicians and health-care providers.

It reports on findings on three key topics:

- Families struggle to meet basic needs
- Households strategize to feed children
- Hunger impacts children's health and development

about 1,800 physicians and nurse practitioners in pediatric, family practice and women's health settings. This report illustrates current findings in the context of the previous survey and of today's economic crisis. While it is useful to compare the Portland metro and non-metro Oregon surveys, the data are not directly comparable due to the two-year time lag between surveys.

This report highlights three key issues,

Issue no. 1: Families struggle to meet basic needs

Issue no. 2: Households strategize to feed children

Issue no. 3: Hunger impacts children’s health and development

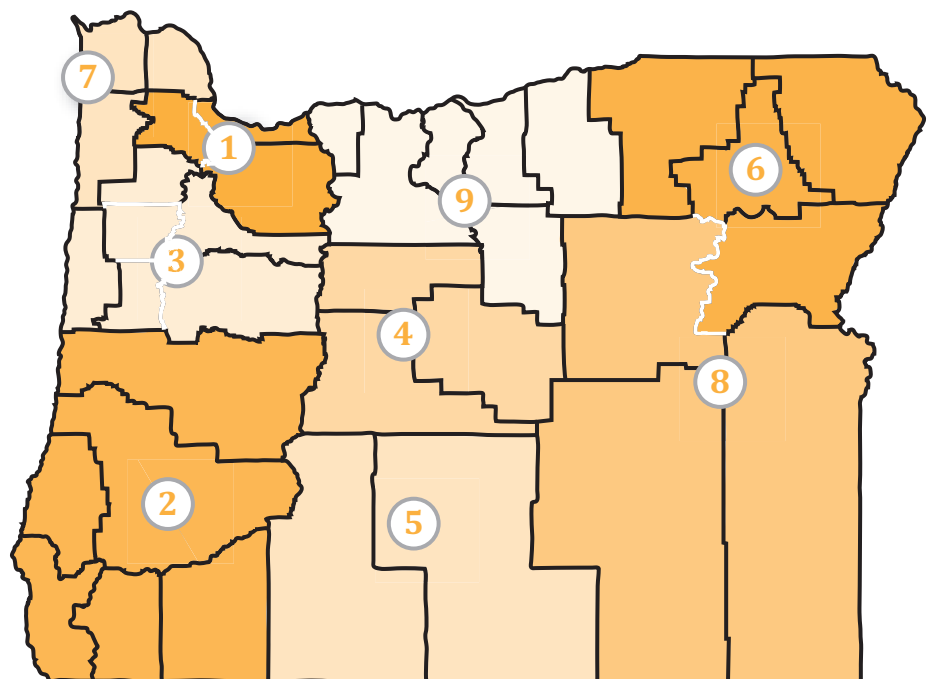
and concludes with recommendations that health care providers learn the risks and predictors of childhood hunger, incorporate the Childhood Hunger Coalition’s screening tool in the clinical setting and refer at-risk patients to additional resources.

		PORTLAND METRO (2007)	NON-METRO (2009)
Who responded?*	GENDER	Female: 137 (69.9%) Male: 47 (30.1%)	Female: 195 (69.9%) Male: 84 (30.1%)
	AVERAGE AGE	48 yo (range 26-78)	51 yo (range 29-75)
	PRACTICE	MD: 80 (43.0%) NP: 106 (57.0%)	MD: 160 (56.1%) NP: 125 (43.9%)
	SPECIALTY	Family Practice: 92 (49.5%) Pediatrics: 61 (32.8%) Other: 33 (17.7%)	Family Practice: 195 (68.2%) Pediatrics: 52 (18.2%) Women’s Health: 39 (13.6%)
	YEARS IN CLINICAL PRACTICE	Resident—11: 90 (48.9%) >11 years: 94 (51.1%)	Resident—11: 96 (33.8%) >11years: 188 (66.2%)

* Missing data on some variables; % reflects proportions of valid responses.

Number of respondents per region

1	Metro	183
2	Southwest	121
3	Midwest	74
4	Central	23
5	South Central	23
6	Northeast	18
7	Northwest	13
8	Southeast	9
9	North Central	6



ISSUE NO. 1:

Families struggle to meet basic needs

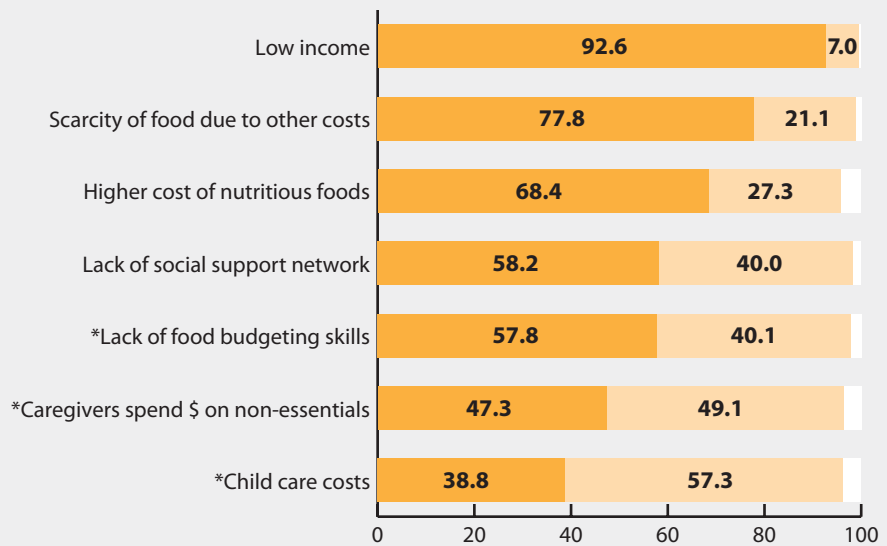
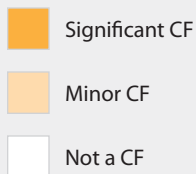
Income is a strong predictor of the severity of food insecurity. Hunger is highest among single-mother households, renters, unemployed workers, and households with adults who are Hispanic and African American.¹ The following characteristics (independent of poverty rates) may also influence prevalence and severity of food insecurity:^{2,3}

- Cost of housing, energy, medical costs and other necessities.
- Increases in unemployment rates.
- Under-utilization of food assistance programs and other safety nets.
- Circumstances creating needs for which households allocate resources – such as the needs of a disabled family member.
- Lack of social support networks.

2009 Survey results

We found that Oregon practitioners are knowledgeable about the complex factors contributing to food insecurity:

Perceived contributing factors (CF) to food insecurity, according to non-Portland metro health providers



* Respondents to both the Portland metro-area and non-metro surveys have similar perceptions about why households might experience food insecurity, and accurately identified low income as a strong predictor of this problem. However, a comparison of means indicated a trend for non-metro respondents to believe that lack of food budgeting skills ($p < .012$), dollars spent on non-essentials ($p < .001$), and child care costs ($p < .001$) contribute more significantly to food insecurity than metro respondents.

Clinic resource:

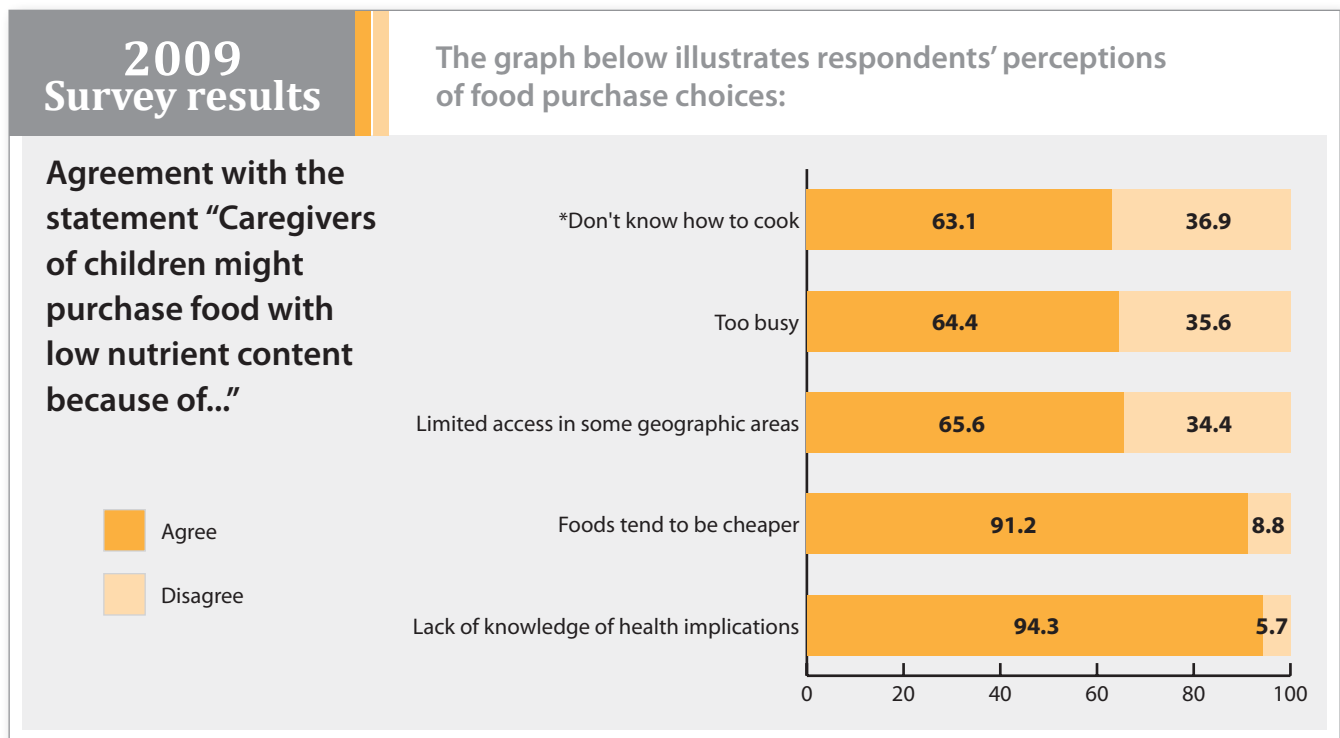
Many food assistance programs have a nutrition education component, including skill-building activities around cooking from scratch, shopping and stretching food dollars: <http://www.oregon.gov/DHS/assistance/foodstamps/nutrition/>.

ISSUE NO. 2: Households strategize to feed children

Limited-income households use diverse, but often integrated coping strategies to maintain food sufficiency during gaps in food assistance or during times of increased demands on the budget:⁴

- **Reducing unaffordable ingredients such as meat or fresh vegetables, and “stretching meals” by adding inexpensive fillers such as noodles or potatoes.**
- **Stocking up on inexpensive, highly processed meals such as instant noodles and macaroni and cheese. Ease of preparation and taste appeal might be additional perceived benefits for working families with limited time for food preparation.**
- **Stretching food dollars by shopping for sales, cutting coupons, using discount stores, and purchasing food marked down for quick sale.**

Limited-income families use short-term tactics to manage gaps in food assistance or during times of special demands on the budget.



* Respondents to both the Portland metro and non-metro surveys agree (vs. disagree) similarly about why caregivers of children might purchase food with low nutrient value. However, a comparison of means indicated a trend for non-metro respondents to agree (vs. disagree) that caregivers do so because 'they don't know how to cook' more often ($p < .001$) than Portland metro respondents.

Household food insecurity problems may be lessened or resolved, maintained, or worsened, depending on food acquisition tactics, access to and availability of nutritious and affordable foods and use and adequacy of food assistance programs. Food-insecure household members may experience feelings of alienation, frustration, and lack of control due to the food situation.⁵

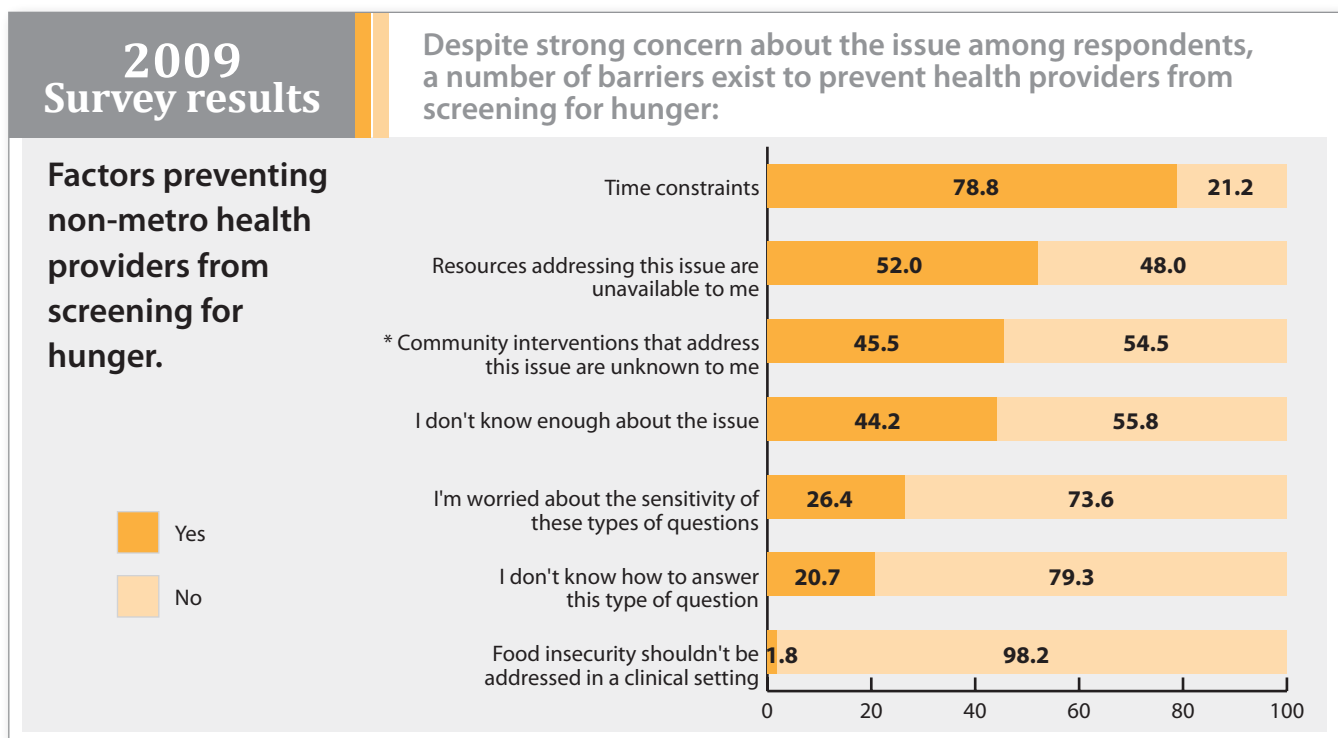
ISSUE NO. 3:

Hunger impacts children's health and development

Children living in food insecure households are at higher risk for problems with both short- and long-term health implications:

- Household food insecurity impacts development milestones, starting in the womb and continuing throughout childhood.⁶
- For infants and toddlers, food insecurity is positively associated with 'fair/poor' health and having been hospitalized since birth.⁷
- Food insecurity may lead to behavioral problems, poor academic achievement and depression among school-aged children.^{8,9}
- Periodic disruptions in food supply may lead to a feast-or-famine food environment; limited exposure to certain foods may lead to lifelong health problems.¹⁰

In fact, evidence of the health impacts of food insecurity is strong enough that the American Academy of Pediatrics has identified food security as one of five health-related social domains that should be addressed in a pediatric visit.¹¹



*Respondents to both the Portland metro and non-metro surveys expressed similar barriers to addressing food insecurity in the clinic. However, a comparison of means indicated a trend for Portland metro respondents to experience barriers due to lack of knowledge about community resources more often ($p < .08$) than non-metro respondents.

Despite the challenges presented to providers, a majority of non-metro respondents (79%, $n=224$) are comfortable addressing household food status in a clinical setting, and an even greater majority (91%, $n=245$) are willing to use a standardized screening question. In 2007, a similar percent of Portland metro-area respondents were comfortable (78%) and willing (89%) to address childhood hunger.

Clinic resource:

CHC has developed a short screening algorithm for use in the clinic setting, available at www.childhoodhunger.org.



RECOMMENDATION TO HEALTH CARE PROVIDERS:

Refer at-risk individuals and families to nutrition programs to improve household food security.

Individuals referred to programs such as the Special Supplemental Program for Women, Infants, and Children (WIC), the national school breakfast and lunch programs, and the Supplemental Nutrition Assistance Program (SNAP, formerly food stamps) will receive help accessing the foods they need. Enrollment in public health and safety-net programs can make a crucial difference in determining a child's health status, development and school readiness:

- By reducing food insecurity, SNAP decreases a child's risk of hospitalization, poor health, iron deficiency anemia, deficits in cognitive development, and behavioral and emotional problems.¹²
- Young children who receive SNAP benefits are 26 percent less likely to be food insecure than eligible children not receiving these benefits, yet 15 percent of Oregon's eligible households do not participate.
- WIC is a cost-effective way to improve lifelong health by supporting healthy pregnancies, decreasing the number of low birth weight infants and helping to prevent chronic conditions such as obesity, diabetes and heart disease.
- Child Nutrition Programs (such as school breakfast and school lunch) improve nutritional intake and can boost math and reading scores.

Oregon health providers have overwhelmingly shown a willingness to incorporate this topic into practice:

- Almost all (99.6 percent) of respondents were willing to refer families at risk to food assistance and public health programs.
- Fewer than 2 percent of survey respondents felt that food insecurity should NOT be addressed in a clinical setting.

Clinic resource:

For free copies of safety-net program outreach materials, email: info@childhoodhunger.org.

TAKE ACTION

Children living in food insecure households are at higher risk for developmental and academic problems, frequent illness, and poor nutrition. In 2007, 97 percent (n=174) of Portland metro health providers identified food insecurity as a problem that should be addressed in the clinical setting, with the proper screening and intervention tools. Our 2009, 33-county non-metro survey indicates a similar willingness to act, (98 percent, n=286).

Oregon health providers can receive a free clinic toolkit from the Childhood Hunger Coalition, containing a research synopsis on childhood hunger, an easy-to-use screening algorithm, and education and outreach materials. Please contact info@childhoodhunger.org.

2009 Survey respondent comments:

I've had a 10-year practice in an elementary school based health center at Title 1 schools. Many kids don't eat when school is closed. Food insecurity is a new term but hunger is very familiar.

(Family Nurse Practitioner, Lincoln Co.)

I would welcome materials (posters, pamphlets, wallet sized cards, etc) which would help clients learn about programs or resources they can access to receive help if they are facing food insecurity.

(Women's Health MD, Yamhill Co.)

Thanks for bringing it up. Look forward to your help in addressing this.

(Family Practice MD, Jackson Co.)

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