Implementing Food Security Screening and Referral for Older Patients in Primary Care

A Resource Guide and Toolkit

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A collaboration between

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AARP Foundation serves vulnerable people 50+ by creating and advancing effective solutions that help them secure the essentials.

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TABLE OF CONTENTS

INTRODUCTION

Food security is critical for low-income older adults as poor nutrition can contribute to and exacerbate chronic illness. **Health care providers must be particularly sensitive to the lack of access to food** for low-income older adults, since many have to choose between paying for utilities, food, and medication – each of which is vital to their health and well-being.

Implementation of food security screening and referral in primary care practices in low-income communities is gaining momentum. However health professionals experience significant challenges to implementing these practices, including time constraints and the lack of easily accessible and current resources to address food insecurity.

This resource guide seeks to address some of the challenges of incorporating food security screening and referrals in primary care settings serving older adult patients.

Throughout the guide, the term "older adults" is used to refer to individuals aged 50 and older and the information provided is specific to that population wherever possible; when research is cited that only applies to specific age groups that is noted in the text.

Intended for use by health care systems, clinics, and accountable care organizations, the content of the guide synthesizes findings from case studies conducted with health systems that have incorporated food security screening and referral (see *Addressing Food Insecurity in Primary Care*) and an environment scan identifying implementation strategies and methods for screening and referral.

The guide provides a rationale for the importance of food security screening older adults, offers suggestions on how to implement screening and referrals, and describes community partnerships that can help ensure that patients' needs are addressed. The resource guide concludes with an extensive list of resources and tools developed by primary care practices and community partners across the country.

SECTION 1

Making the Case for Food Security Screening

In 2014, over 10 million adults aged 60 and older faced the threat of hunger in the United States, that is, they were food insecure or on the cusp of being food insecure.[1] Older adults are more likely to experience food insecurity if they:[2]

- Have lower incomes
- Are African-American or Hispanic
- Reside in southern states
- Have been separated, divorced, or are living alone
- Have a disability

Despite increasing rates of food insecurity over the past decade, participation in federal nutrition assistance programs, such as the Supplemental Nutrition Assistance Program (SNAP), has been well below average for older adults. In 2014, only 42 percent of eligible adults aged 60 and older participated in SNAP, compared to 85 percent of eligible adults under age 60.[3]

This section provides a working definition of food insecurity and describes how food insecurity can be particularly harmful for the well-being and health of older adults. The section closes by providing a rationale for health systems to step in and aid older adult patients who are facing the challenges of food insecurity.

1.1 WHAT IS FOOD INSECURITY?

Food security is having access to enough foods at all times to lead an active, healthy lifestyle, and includes being able to acquire nutritionally adequate and safe foods in socially acceptable ways.

Food insecurity occurs when individuals or households are unable to adequately meet basic food and nutritional needs in socially acceptable ways. Food insecure households can be further classified as experiencing "low food security" or "very low food security" depending on the extent to which individuals *reduce their food intake* as a result of the lack of resources to acquire adequate amounts of food.[4] Marginal food security refers to households that meet the standard for food security, but show some indications of food insecurity. These households are "at risk" for food insecurity.

According to the U.S. Department of Agriculture, **food insecurity** is a household-level economic and social condition of limited access to food, while **hunger** is an individual level physiological condition that may result from food insecurity.

While hunger is sometimes used interchangeably with food insecurity, hunger refers to the discomfort, illness, weakness or pain that occurs as a result of an individual's prolonged, involuntary lack of food.[5] An individual can experience food insecurity without experiencing hunger.

The U.S. Department of Agriculture (USDA) created a validated scale for identifying food insecure households. The Household Food Security Survey (HFSS) asks adults about specific conditions in their homes in the previous 12 months. Households that respond positively to 3 or more of the 10 questions are considered food insecure. Shorter screening modules have been developed based on this survey, including a 2-item screening tool validated for use in primary care setting (see Section 2).

The HFSS addresses the following characteristics that may indicate food insecurity:

- Worrying that food would run out, or running out of food before there is money to buy more
- Being able to afford to eat balanced meals
- Cutting the size of meals, skipping meals, or not eating for a whole day because of insufficient money for food
- Eating less than one felt one should, being hungry and not eating, or losing weight because of insufficient money for food

Food insecurity is typically periodic, not chronic, but even periodic disruptions in nutrition can pose challenges for those individuals who are at risk for or managing chronic conditions.

1.2 HOW DOES FOOD INSECURITY IMPACT OLDER ADULTS?

A growing body of research has explored the relationship between health and food insecurity among older adults. Food insecurity among older adults is an independent risk factor for depression and asthma, poor self-reported health status, and activity limitations, even after accounting for other individual characteristics and income levels.[2] Older adults that are food insecure are more likely to suffer from heart conditions, such as heart attacks, chest pain, and coronary heart disease than food secure older adults.[6]

While food insecurity is associated with reduced nutrient and caloric intake,[7] food insecurity has also been associated with obesity[8] and obesity-related conditions, including hypertension and hyperlipidemia.[9]

Food insecure older adults are **60% more likely to experience depression** than food secure older adults.

Food insecurity is a social and economic condition and many older adults must choose between spending their limited resources on utilities, food and medicine. Cost-related medication non-adherence, which includes skipping medications or delaying purchasing medications, are reported by more than 40 percent of food insecure older adults.[10,11] As such, food insecurity can contribute to poor disease management practices among patients.

An older adult experiencing very low food security is **nine times more likely to skip medications** to save money than one who is fully food secure.

While malnutrition and nonadherence to medical treatments are associated with higher rates of hospitalization and hospital readmissions, researchers have also independently associated food insecurity as a factor that contributes to risk of hospitalization.[12]

1.3 WHY SHOULD HEALTH SYSTEMS PLAY A ROLE?

Federally funded programs are available to support the nutrition and food needs of low-income older adults, but often they are underutilized. Meanwhile, older adults use health care at high rates and rely on their health providers to connect help them understand how to maintain a healthy lifestyle. Access to adequate and healthy food can play a large role in adherence to medical treatment plans and can reduce the need for inpatient services or more expensive treatment options. For these key reasons, both older adult patients and their health providers have much to gain by including food security screening and referral in routine visits:

- ***Food assistance programs are available.*** Federal nutrition programs mitigate the effects of poverty by increasing the amount of food available to food insecure households. Participation in SNAP is one of the most direct mechanisms to ensure individuals are able to afford healthy foods. Studies show that adults aged 60 and older enroll at disproportionately lower rates than other SNAP-eligible groups, with 3 out of 5 eligible seniors failing to receive SNAP benefits.[3]
- ***Screening tools are easy to administer.*** Screening consists of asking patients two brief questions that providers can include in routine intake and screening procedures. Once in place, the administration of food security screening adds only a few minutes to patients' routine visits and enables providers to improve patients' health outcomes by making referrals that will help meet their basic needs.[13]

- ***Community organizations need help locating eligible older adults in need.*** Social service agencies and anti-hunger organizations conduct outreach and support enrollment in government-funded and other programs for low-income older adults. They continuously seek ways to connect with older adults who may be eligible for nutrition assistance. Once connected, staff work directly with older adults to help them apply for food assistance, locate nearby resources, learn how to maintain a healthy diet, and answer questions about nutrition and food resources.
- ***The Affordable Care Act (ACA) has shifted toward value-based reimbursement.*** Identifying patients who are food insecure and connecting them with resources can support adherence to treatment plans and better outcomes, by helping ensure that patients don't have to choose between eating a healthy meal and taking their medications. In particular, food insecurity has been associated with increased risk of hospital admissions which can have significant financial consequences under ACA.[12,14]

SECTION 2

Food Security Screening and Referral in Primary Care

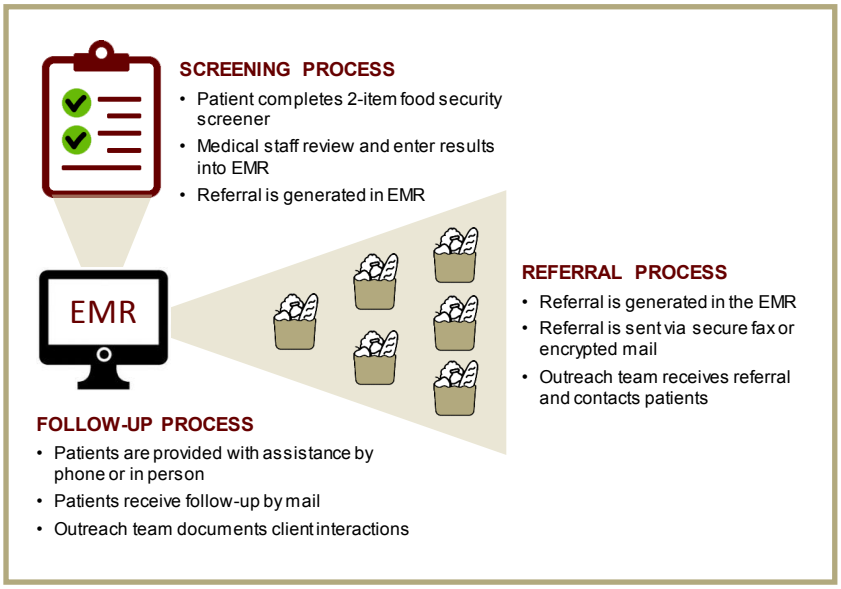
This section provides health systems, medical providers and staff with an overview of how professionals can administer food security screening and referrals in a clinical setting, the resources needed and considerations to set up a screening and referral process, and the features that contribute to successful screening and intervention practices. This information has been gathered through case studies conducted with three health systems in 2016 and an environmental scan of literature and web sites describing food security screening and referrals in practice.

The examples in this section provide practitioners with the information necessary to conduct meaningful discussions surrounding the development and implementation of food security screening and referral processes for older adult patients. The examples do not include every possible approach to screening and referrals, rather, it is our hope that health systems and clinicians can adapt or modify the examples to fit their own objectives and clinic structure.

2.1 HOW FOOD SECURITY SCREENING AND REFERRAL SYSTEMS WORK

The typical food security screening and referral process involves systematic screening of patients at regular intervals using a validated tool, followed by review of the results and a referral generated for patients identified as food insecure in an electronic medical record (EMR). Internal or external staff may then conduct the follow-up from the referral, depending on how the process is designed in the clinic. Figure 1 demonstrates the typical process.

FIGURE 1:
Food Security Screening and Referral Systems



SYSTEMATIC FOOD SECURITY SCREENING

Health professionals who do not regularly screen for food insecurity may still talk to older adult patients about access to food in certain situations. Health professionals discuss availability of food in the home when they prescribe medication in order to ensure that the patient takes the medication appropriately. Health professionals may also discuss food when they notice that a patient is underweight, or in the context of chronic disease self-management, such as regulating diets for patients with diabetes.[15] While these are important for health professionals to discuss with

patients, they may not identify all food insecure patients who are at increased risk for poor health outcomes due to the lack of access to safe and affordable foods.

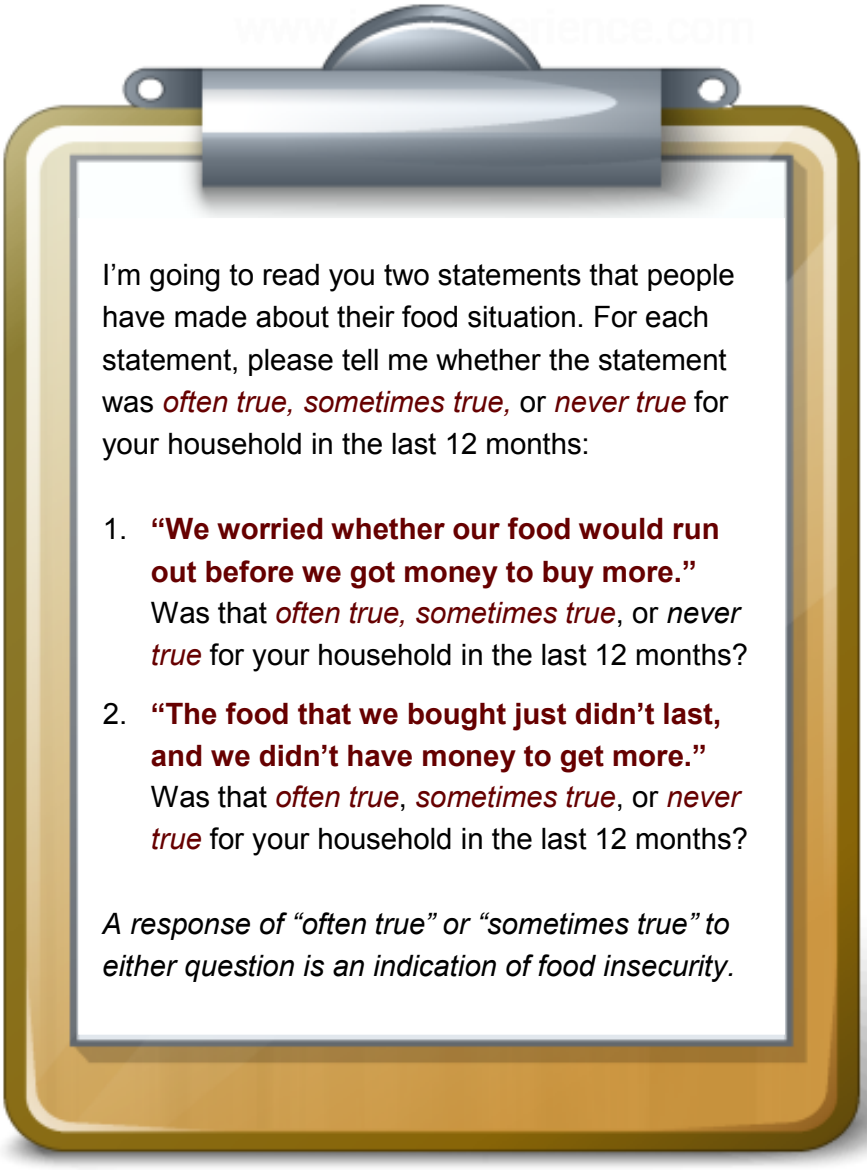
"Systematic" food security screening means that all patients are screened, regardless of health insurance, personal appearance, or health conditions, using a validated screening tool that is implemented by all providers in the health system or clinic. By incorporating the food security screening questions into his or her routine practice, a health care professional achieves the following benefits:

- Screening is not contingent on nutrition being a factor in the diagnosis or outcome of the visit
- Asking the same questions of all patients destigmatizes food insecurity
- Tracking patients' food insecurity in the electronic health record provides information important to the patients' health care in the long-term
- Systematically referring patients to food and nutrition resources in the community can have a positive impact on their health

While underweight patients may appear food insecure, food insecurity is just as likely to occur among normal and overweight patients, as well as those who appear 'put-together.' **Systematic screening** is the only way to **identify everyone at risk**.

Hager et al (2010) validated the use of a two-item food security screening tool with high levels of sensitivity (97%) and specificity (83%) when compared to the longer USDA HFSS.[16] The American Academy of Pediatrics recommends this tool for use at all well-child visits; health systems have implemented these questions for older adult populations as well. Medical staff, such as medical assistants and patient navigators can administer the questions as shown in Figure 2.

FIGURE 2:
Validated 2-Item Food Security Screening Tool
Recommended for Routine Screening in Primary Care



Health systems and individual clinics have demonstrated ample flexibility with respect to how, when, and by whom the food security screening is administered. A typical process is described in more detail on the following page.

FIGURE 3:
Overview of Food Security Screening & Referral Process

CONDUCTING THE SCREEN

When administering the screen, explain that all patients are asked to complete the form. The information that the patient provides will help the clinic connect the patients with resources available to them in the community.

- Food security screening questions can be administered to patients *verbally* or in a *written* format, depending on the preference of the health system, how it fits into the patient intake process, and the literacy and language preferences of patients.
- Typically, a *medical assistant or patient coordinator* administers the screening tool, alone or in conjunction with other screenings, *during the intake or rooming process.* Some clinics have opted to screen at every visit or only annual wellness visits—the frequency of screening should encourage consistent use and fit with the patient flow.
- To reduce stigma or embarrassment, some medical assistants explain to patients that they ask the food security questions of all patients and that there are resources in the community to which the clinic can refer patients based on their needs.

REVIEWING THE RESULTS AND MAKING THE REFERRAL

- The medical assistant reviews the results of the screen and logs the result in the electronic medical record.
- After a patient is identified as food insecure, *health providers may ask more* about his or her current situation, whether the patient's need for food is chronic or periodic, and how it may impact his or her current diagnosis.
- Before generating a referral in the EMR, medical staff describe the referral process and *ask permission to refer the patient for additional food assistance*.
- When a patient accepts the referral, the medical assistant generates the referral in the electronic medical record. Depending on the sophistication of the system, the referral may be sent automatically to the outreach team or faxed by the medical assistant or other staff.
- Medical staff review food security status and referral follow-up at subsequent visits.

REFERRAL OUTREACH AND FOLLOW-UP

The development of the outreach team depends largely on resources available within the health system, as well as the capacity of community partners to engage patients and connect them with available resources.

- The outreach team receives the referral by email or fax and may conduct in-person or telephone follow-up with patients.
- The outreach team may include caseworkers or patient navigators who operate within the health system or work externally for community partners, such as nonprofit social service agencies or anti-hunger organizations.
- The outreach teams track follow-up activities and ensure that patients are able to access the resources available to them.

2.2 GETTING STARTED

Health systems or primary care practices that are beginning to implement systematic food security screening and referrals for older adult patients have many current examples to inform the development and implementation process.

This section describes some of the resources that health systems or primary care practices need to implement a food security screening and referral process successfully. Strategies to use or acquire those resources, and challenges and solutions that systems or practices will encounter in securing those resources are also discussed.

Specifically, we have identified the five key factors that a health system or primary care practice should consider closely when planning for food security screening and referral: champions and advocates, organizational commitment, community partners, modifications to the EMR, and HIPAA compliance. Figure 4 provides tips for planning a food security screening and referral process.

FIGURE 4:
Tips for Planning a Food Security Screening and Referral Process

1 **Champions and Advocates**	- Create an internal working group that includes staff at all levels in the process - Set timelines for milestones, hold regular meetings, and assign tasks to all members - Generate buzz and keep the energy and enthusiasm building
2 **Organizational Commitment**	- Engage leadership and staff early - Educate colleagues on the importance of food security screening and referrals for older adult patients
3 **Community Partners**	- Work with community partners and anti-hunger advocates to identify community resources and referral solutions - Assess potential partners' abilities to contribute to the planning and referral process
4 **Modifications to the EMR**	- Engage IT to discuss potential EMR solutions - Keep in mind that changes to the EMR will take time to achieve; low-tech screening and referral can still be implemented while EMR changes are under development
5 **HIPAA Compliance**	- Engage your legal department to identify the best way to set up community-based referrals while remaining compliant with HIPAA

1 CHAMPIONS AND ADVOCATES

Champions and advocates are an integral part of the development and implementation of food security screening and referral processes. Building and maintaining support and momentum throughout each step in the process is a key factor in ensuring the success of such an initiative.

STRATEGIES

The process of developing and implementing a food security screening and referral process takes time and patience. Champions can serve many important roles:

- Organize a working group that includes clinic staff and other stakeholders to develop a plan for food security screening and referral.
- Maintain forward momentum by holding regular meetings and keeping all parties engaged in the process.
- Work with medical staff to design and implement a system for food security screening at routine visits.
- Facilitate collaborations between the health system or clinic and community organizations that can provide referrals.
- Engage and educate health system staff to emphasize the importance of food insecurity to the health of older adults.
- Train clinic staff on the food security screening and referral process.

CHALLENGES & SOLUTIONS

Championing an initiative within the health care system can be a formidable task and it is easy to experience burnout when championing a cause on top of your regular job duties. Champions and leaders should keep the following in mind:

- Celebrate small achievements with your team or working group. You may develop a relationship with community partners before you finalize the details of the screening and referral process. Every achievement on the path to full implementation is a success.
- Planning and facilitating a screening and referral system is a large task: seek out help, divvy up tasks, and set reasonable expectations for follow-up.
- Setbacks are normal occurrences: your willingness to adapt and maintain focus can help you achieve your goals.

Champions or advocates of food security screening and referral can be **medical assistants**, **clinic directors**, **physicians**, or **patient navigators**—anyone who has the energy and determination to ensure that all older adults be screened for food security.

2 ORGANIZATIONAL COMMITMENT

Health systems' staff and leadership must recognize the need for food security screening and the positive impact it can have on patients' health. Commitment from the health system is important to effectively integrate a screening and referral process, especially in updating the EMR to record the results of the screening and automate referrals.

STRATEGIES

The organization's leadership should commit to developing, implementing and maintaining the food security screening and referrals to ensure the following:

- Alleviating food insecurity for older adult patients remains a priority in the long-term.
- Resources are dedicated to training staff on food security screening topics, and all staff participate in trainings.
- Changes are made to the EMR to document the results of screening and automating referrals.
- Funding is secured to support changes to the EMR and referrals.

CHALLENGES & SOLUTIONS

Securing the support and commitment of health systems' staff and leadership can be challenging in the face of funding concerns and competing initiatives. Champions and advocates of food security screening and referral may take the following steps to win over key stakeholders:

- Make the business case for why addressing food insecurity among older adult patients should be a key priority.
- Work with community partners to understand and communicate the challenges that older adults face in your area related to food insecurity and utilization rate of food assistance programs, such as SNAP.
- Clearly and concisely communicate your solution to address this critical issue; present examples of similar settings in which screening and referrals have been successfully implemented.

Demonstrating the need for food security screening in your practice is key to eliciting support. Consider administering the two food security screening questions with older adult patients **over several clinic days** using a pen-and-paper questionnaire. Explain that all patients are being asked to respond to these questions and that responses are anonymous. At the end of the test period, tally responses to calculate the proportion of patients reporting food insecurity.

3 COMMUNITY PARTNERS

Community partners can create critical links to ensure the continuum of care for food insecure patients. Primary care practices can develop mutually beneficial relationships with community partners, such as anti-hunger organizations or social services agencies (i.e., Area Agencies on Aging), to provide assistance to food insecure patients.

STRATEGIES

Community partners can be well-positioned to support health systems in addressing food insecurity for older adult patients. For example, health systems have partnered with community agencies in the following ways:

- Maryland Hunger Solutions conducts on-site SNAP application screening and enrollment for food insecure patients at Chase Brexton Health Care in Baltimore.
- Second Harvest Heartland Food Bank conducts referrals for Hennepin County Medical Center. Trained outreach team workers call older adults who have been identified as food insecure and connect them with food assistance programs and other community resources.
- Impact NW, a nonprofit social services agency, supports patient referrals at Providence Medical Group – Milwaukie, Oregon. Impact NW's patient navigators set up in person meetings with food insecure patients to assist them with completing applications for food assistance and address other concerns such as housing or utilities.

CHALLENGES & SOLUTIONS

Organizations within the community committed to ending hunger and food insecurity can play a key role in championing the health system's efforts, but may also face challenges in handling patient referrals.

- Community partners often have limited resources or limited capacity to engage in new work. Work with partners to figure out what resources are available and how a referral process can fit into their existing infrastructure. For instance, community partners may be able to provide trainings or informational materials on food insecurity among older adults at little or no cost.
- Consider seeking funding in collaboration with community partners through foundations, donations, or grants to support referrals to outreach teams.
- Identify resources or activities in collaboration with community partners that are mutually beneficial. For instance, if an organization's goal is to increase access to SNAP, focus efforts on increasing SNAP participation among food insecure older adult patients.

A number of **funding sources** can be accessed to contribute to the successful implementation of the food security screening and referral process. These include **hospital foundations**, **community partners**, **donations,** and **grants**. Funding can support changes in electronic medical record systems, training staff, and referral staff compensation.

4 MODIFICATIONS TO THE ELECTRONIC MEDICAL RECORD

Incorporating food security screening questions and automating referrals in the electronic medical record (EMR) is not a requirement for a screening and referral process, but the benefits of doing so likely outweigh the costs.

STRATEGIES

Documenting food insecurity and automating referrals can be a quick and seamless process when the EMR is designed to efficiently handle these functions. Incorporating screening and referral into the EMR can benefit patients, medical staff, and the health system as a whole:

- Documenting food insecurity in the patient's EMR enables medical staff to incorporate food security status into care plans.
- Conducting the screening, logging the results, and making a referral in an automated system can take as little as a few minutes for well-trained clinic staff.
- Food insecurity among patients can be quantified and reported in community health needs assessments, used to secure funding for new initiatives, and to strategize on how to effectively improve health outcomes for older adults.
- Including the food security screening in the EMR makes screening a standard operating procedure and increases the number of patients who are screened.

CHALLENGES & SOLUTIONS

Modifying the EMR may be one of the more challenging, and potentially costly, aspects of setting up a food security screening and referral process. Individuals championing the implementation of a screening process should prepare to overcome the following potential challenges:

- EMRs are typically designed to record medical diagnoses and referrals with a focus on billing for services rendered. Incorporating food security screening questions and community-based referral into the EMR may not be easy, but workarounds can be developed through collaborations between health professionals and IT professionals.
- Modifying the EMR within a large health system may pose additional challenges, as decisions to change the EMR are made outside of the clinical environment. Planners may need to identify potential food security advocates who are in positions to make these decisions within the organization.

Food security screening and referrals **may become more common in EMR software**. Children's Health Watch has been working closely with Epic software developers to incorporate the screening tool in future versions of the software. As this practice becomes more commonplace, other EMR companies may follow suit.

5 HIPAA COMPLIANT REFERRALS

When sharing patient information with community partners as part of the food assistance referral process, health systems must comply with the Health Insurance Portability and Accountability Act (HIPAA). HIPAA regulates the use and disclosure of health records and limits the use of personally identifiable health information to reduce the chance that a health care provider will disclose a patient's information inappropriately.

STRATEGIES

When a health system develops and implements a food security screening and referral process, it must take special care to ensure patients' privacy, especially when it works with community partners. Health systems have successfully implemented referral processes by taking the following actions:

- Asking patients' permission to send their contact information to a community partner for food assistance.
- Limiting the amount of information sent to community partners, by sending, for instance, only the patient's name, address, phone number, and preferred language.
- Sending referrals via a secure method, such as fax or encrypted email.

CHALLENGES & SOLUTIONS

Numerous health systems have shown that it is possible to successfully protect patients' personal information while referring food insecure patients for assistance. Screening and referral teams can ensure a successful process by taking the following actions:

- Working closely with health systems' legal departments when developing and implementing the referral process.
- Talking with other health systems that have successfully implemented referrals.
- Ensuring that community partners understand HIPAA and how it applies to the referral process.

Everyone has a role to play in protecting patient privacy. Working with a legal department, asking patients' permission for referrals, and sending referrals through secure methods will help ensure HIPAA compliance.

2.3 CHARACTERISTICS OF SUCCESSFUL SYSTEMS

There is no one way to develop and implement a food security screening and referral process in a primary care practice. After reviewing information available on health systems and clinics that have implemented food security screening and referrals, we identified the following characteristics that appear to have contributed to the success of those efforts:

- Clear communication
- Reducing burden on primary care physicians
- Long and short term solutions to alleviate food insecurity
- Planning for sustained implementation

In this section we discuss the ways in which these characteristics play a role in enhancing different aspects of the screening and referral process and provide examples of how health systems have successfully demonstrated these qualities.

CLEAR COMMUNICATION

Clear and consistent communication with staff, partners, and stakeholders both within and outside the health system are key factors that contribute to a program's success. The following examples illustrate how health systems maintain consistent communication for screening programs:

- Ongoing communication between Chase Brexton Health Center staff and Maryland Hunger Solutions outreach staff helped identify and address issues as they occurred. Because food insecure patients initially were not following up on in-person appointments, the case management team began to schedule outreach team visits to coincide with medical appointments and provided transportation vouchers to patients.[13]
- The food security screening implementation team at the Peach Tree Health in Yuba County, California developed a communication matrix to organize sharing information with staff members with dates and times.[17]
- A project team from Hunger Free Colorado and Kaiser Permanente Colorado holds quarterly telephone meetings where primary care providers share best practices and areas for improvement. Additionally, Hunger Free Colorado provides a monthly report to the staff at Kaiser Permanente identifying the number of people enrolled in federal food assistance programs and accessing other resources.[18]

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REDUCING THE BURDEN ON PRIMARY CARE PROVIDERS

Our interviews with primary care providers and lessons learned from previous research indicate that primary care providers are enthusiastic about addressing food insecurity but often are pressed for time and face competing demands that may prevent them from fully engaging patients with regard to food insecurity.[15,19,20] In many cases, primary care providers have contributed to the development and implementation of food security screening and referral programs, but are not heavily involved in the actual practice of screening or referring patients.

- Medical assistants at the Senior Care Clinics at Hennepin County Medical Center conduct the food security screening and initiate referrals for those identified as food insecure. Notes in the EMR inform primary care providers of the issue.[13]
- Kaiser Permanente Colorado and Hunger Free Colorado deliberately integrated food security screening into the existing clinical workflow tailored to each department to reduce burden for primary care providers.[18]
- A report from California Food Policy Advocates recommends embedding screening questions into existing workflows and having members of the health care team such as nurses and medical assistants initiate the screening and referral.[21]

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LONG AND SHORT TERM SOLUTIONS FOR ADDRESSING HUNGER

Food insecurity among older adults can be chronic or cyclical. Patients who respond affirmatively to the food security screening tool may have immediate and/or long-term needs, which can negatively impact patients' adherence to treatment plans, such as when physicians prescribe special diets or medication that must be taken with meals.[22] While not all food assistance referrals are immediate, health systems have demonstrated ways in which they can help address patients' immediate and long-term needs.

- Working with community partners, Chase Brexton Health Center case managers are able to provide a local grocery store gift card to patients who have an immediate need for food. Patients are also scheduled to meet with a Maryland Hunger Solutions outreach worker to enroll patients in SNAP or other food assistance programs.[13]
- At the Boston Medical Center, primary care providers screen patients and provide referrals to the onsite preventative food pantry, which supplies patients with enough food to last three to four days to meet that patient's immediate food needs.[23]
- At Hennepin County Medical Center Parkside Clinic, patients are offered a bag of healthy food to meet their immediate needs and referred to Second Harvest Heartland Food Bank for long-term solutions. Second Harvest Heartland helps eligible patients enroll in food assistance programs and connects patients with other community programs, such as "Fare for All"—mobile markets providing discounted nutritious foods.[13]

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PLAN FOR SUSTAINABILITY

Many of the characteristics described in this section will help to ensure the long-term sustainability of food security screening for older adults in primary care practices. Clinics may take a few additional steps to solidify or prioritize food security screening and referral processes:

- **Participate in anti-hunger partnerships and coalitions**. Participating in local partnerships or coalitions aimed at addressing hunger, especially for older adults, will help the food security screening and referral project team stay up-to-date on existing and new funding opportunities, relevant policy changes, and other opportunities to promote access to food resources for older patients.
- **Explore non-conventional sources of funding**. Existing programs have found a variety of funding sources to promote and implement screening and referral processes. Other opportunities have been used less frequently, such as Section 1115 Medicaid waivers that allow states to test new approaches including experimental, pilot, or demonstration projects.[21]
- **Data collection and evaluation**. Food security screening and referral processes are new to most health care systems. Researchers have not documented or quantified the long-term effects on food insecure older adult patients' health outcomes, nutrition, and chronic disease management. Health systems and partners that implement food security screening and referrals should collect data and evaluate those services to ensure the needs of patients are being met and that their programs have the intended result of improving patients' health and nutrition.

SECTION 3

Community Partners and Food Assistance Resources

Health system staff who seek to implement a food security screening and referral process should take time to understand the measures that their local communities are taking to address hunger.

In this section we describe the different types of community partners and the roles that they play to support a robust referral and follow-up system. We also describe how health care systems can develop partnerships with senior services and anti-hunger organizations, and the types of food and nutrition assistance they provide to older adults.

3.1 THE ROLE OF COMMUNITY PARTNERS

Community partners play important roles in the food security referral and follow up process. They are experts in food assistance resources in the community and have outreach staff who are trained to screen people for federal nutrition programs, such as SNAP, and help them apply to those programs. This is especially important for older adult patients who are unfamiliar with the programs, who might have tried to access them when they were younger (when criteria were more stringent), or who are uncomfortable using technology, to submit application materials.

WHO ARE COMMUNITY PARTNERS?

There is no prescription for a health care system to form a successful partnership with an agency that conducts eligibility screening and referral services for older patients. Each community has unique attributes and a variety of organizations that are concerned with food insecurity, nutrition, and older adult health.

The following types of organizations are often interested in partnering with health systems and clinics to ensure that low-income older adults are connected to nutrition resources:

- ***Social services agencies*** are valuable partners to community based primary care providers, assisting patients with housing needs, social security issues, etc. These organizations also can connect patients to nutrition support programs.
- ***Food banks*** are non-profit organizations that warehouse and distribute large quantities of donated and government-funded commodity foods throughout the community through food pantries, shelters, and other community partners.
- ***Anti-hunger advocacy groups,*** sometimes working within or in collaboration with food banks, promote the effective use of government funded food security programs for eligible individuals.
- ***Area Agencies on Aging*** provide a wide array of services to people 60 or older to help them age in place, including hot or cold home-delivered meals (often called “Meals on Wheels”).
- ***Other organizations,*** including senior centers offering meals, farmer’s markets, nutrition education programs, cooperative extension programs, public health departments and other healthy communities initiatives may also be potential partners in your community.

WHAT COMMUNITY PARTNERS BRING TO THE TABLE

Community partners receive funding from various sources to provide services to low-income adults and households. Funding to support food assistance for older adults is provided by various federal government agencies (e.g., USDA nutrition assistance programs, the Older Americans Act), state governments (e.g., state SNAP Outreach Plan, State Unit on Aging), national or community foundations, and other charitable organizations.

Community partners can play a critical role in the screening and referral process by not only aiding older adults in acquiring food, but also assisting the health system and contributing to the success of a screening and referral program.

Community partners may support ***patients*** in the following ways:

- Screen referred patients for eligibility to receive federal nutrition benefits – SNAP, Community Supplemental Food Program, Senior Farmer's Market Nutrition Program – and assist older adults with the application process.
- Connect referred patients to community food resources, such as food banks, senior feeding programs, and community-based healthy food initiatives.
- Provide access to dietitians, nutritionists, chefs, and other experts who can support patients' unique needs.
- Develop and provide nutrition education that is tailored to older adults, different cultural groups, and in various languages that inform patients about healthy eating and how to best use available food resources.

Community partners may support ***health systems*** in the following ways:

- Provide expertise in food insecurity, its prevalence, and its impact on older adults, as well as extensive knowledge on food assistance resources and barriers that impede patients' participation in federal assistance programs for older adults.
- Conduct training for health system staff on the screening and referral process, community food resources, and federal nutrition programs.
- Contribute to grant writing and fundraising efforts for joint initiatives that help sustain and grow food security screening and referral.
- Assist with tracking referrals and evaluate the overall referral effort to help build the case for further funding and increase support from the medical community.

3.2 REFERRAL MODELS AND COMMUNITY PARTNERS

The assistance provided as follow-up to each food insecurity referral can vary widely, depending on the financial and human resources available to address the need. Figure 5 provides a brief description of the different types of models that are being tested across the country and their respective levels of intensity. Medical staff can refer patients to on-site staff for immediate assistance or to off-site community partner staff who will contact the patient after the visit. The latter has the advantage of higher levels of completion but requires more staff time and effort. Referrals that require the patient to initiate follow up with community partners are less effective, but take less staff time and effort.

FIGURE 5:
Types of Referral Models and Level of Intensity

Model	Description	Level of Intensity
On-demand onsite assistance	Patients are referred to full-time, onsite case managers, patient navigators, or resource coordinators who can assist them in accessing food resources and applying for food assistance programs	
Intermittent onsite assistance	Patients are referred to an onsite partner organization to assist the patient with accessing food resources and applying for food assistance programs	
Partner-initiated, in-person referrals	Patients consent to external referral and receive a follow-up call from a partner organization to schedule an in-person visit. An outreach worker meets with the patient to help him or her access food resources and apply for food assistance.	
Partner-initiated. phone-based referral	Patients consent to external referral and receive a follow-up call from a partner organization, which assists patients to access food resources or apply for food assistance programs over the phone.	
Patient-initiated, phone-based referral	Patients are provided with a phone number to call a community partner for assistance. The community partner organization assists patients to access food resources or apply for food assistance programs over the phone.	
Referral to local community-based organizations	Patients are typically provided with contact information for local community-based organizations for assistance; sometimes these referrals are paired with food prescriptions or coupons for healthy food.	

 Significant intensity

 Moderate intensity

 Minimal intensity

Source: Adapted from San Diego Hunger Coalition Report: Launching Rx for CalFresh in San Diego: Integrating Food Security into Healthcare Settings (2016).[24]

The following examples illustrate the different types of referrals in use by health systems throughout the U.S.:

- Using SNAP outreach funding from the state, Maryland Hunger Solutions is able to provide intermittent on-site, in-person SNAP application assistance to food insecure patients.
- Second Harvest Heartland Food Bank, also a recipient of SNAP outreach funding, provides partner-initiated phone based follow-up to enroll older adults in SNAP and other services for which they qualify, and connects them with resources near their homes, such as "Fare for All" sites (mobile markets throughout the city providing discounted nutritious foods).
- An enhanced referral to local community-based organizations can include screening for food security and provision of a prescription to a farm stand, farmer's market, or retailer. Examples include Fresh Prescription: Recipe for a Healthy Detroit; Wholesome Wave's Fruit and Vegetable Prescription Program (FVRx); Community Harvest Project's Farm to Health Initiative; Food Rx Initiative developed by the University of Chicago Medicine and Walgreens; Veggie Rx through Gorge Grown Food Network; and Waste Not OC Coalition.

As noted previously, champions of food security screening within the health system should identify and talk with local community partners early in the planning process. Health system staff and community partners should have honest discussions regarding ways in which referrals can be conducted given existing resource constraints, whether additional resources are required to support referrals, and, if so, what are the potential ways to acquire those resources.

3.3 MAKING THE CONNECTION WITH COMMUNITY PARTNERS

As health systems and communities work to improve patients' health and health outcomes, partnerships between primary care practices and groups addressing hunger and food insecurity have evolved:

- Maryland Hunger Solutions' efforts to increase SNAP enrollment among vulnerable and hard-to-reach populations led to a partnership with Chase Brexton Health Center, whose patients were largely underserved by SNAP. With the partnership in place, patients' needs are being met without increasing the burden on medical or case management staff.
- The Providence Medical Group – Milwaukie, Oregon has implemented "Screen & Intervene," a food security screening and referral system, which began in partnership with the Oregon Food Bank. As a result, first year residents in the Providence Oregon Family Medicine Residency program are required to complete a Childhood Food Insecurity online course, and staff at the clinic are looking to expand screening to all populations, including older adults.

Developing partnerships with community organization are key to successfully planning a food security screening and referral program in primary care practices. Health systems can successfully develop partnerships by participating in or contacting community food security councils, nutrition researchers on staff within the health system, and community organization board memberships.

If health system staff do not have existing connections with anti-hunger organizations, a good first step is contacting a local food bank. Other local or state organizations focused on improving health and nutrition for older adults can also play a role. For instance, the local AARP chapter can help direct medical providers to possible community partners. The state SNAP Education (SNAP-Ed) provider is also a good resource.

3.4 FEDERAL NUTRITION RESOURCES FOR OLDER ADULTS

Two federal agencies operate nutrition programs for older adults: the U.S. Department of Agriculture and the U.S. Department of Health and Human Services, Administration for Community Living (ACL).

USDA operates six nutrition assistance programs that support food access for food insecure older adults. Two of USDA's nutrition assistance programs are exclusively for older adults: the Commodity Supplemental Food Program (CSFP) and the Senior Farmers Market Nutrition Program (SFMNP). The rest of the programs serve older adults as part of the general population; these programs often have special eligibility rules to facilitate access for this underserved population.

Federal entitlement programs such as SNAP, CSFP and SFMNP, serve all eligible individuals and **are not subject to caps or waiting lists**.

ACL's Office on Aging operates the Elderly Nutrition Program through the Older Americans Act via Title III Grants for State and Community Programs an Aging and the Title VI Grants for Native Americans. The Nutrition Services Incentive Program is a joint effort between USDA and ACL to provide food to older adults in need.

Child and Adult Care Feeding Program (CACFP)

What the Program Does: The CACFP provides funding to adult day care facilities that serve nutritious meals to older adults. CACFP provides reimbursements to centers that provide adult day care services that meet the needs of functionally impaired adults, which lower the centers' costs of serving meals.

Whom the Program Serves: To participate in CACFP, adult day care centers must provide supervised care in a community-based setting, outside of the homes, on a less than 24-hour basis. The Program serves adults who are age 60 or older, or adults of any age who are functionally impaired and whose independence and ability to carry out activities of daily living are limited. Centers must be licensed or approved by a state or local agency, and may be public, private nonprofit, or private for-profit; however, for-profit centers must serve higher numbers of low-income adults or adults who receive Medicaid or Supplemental Security Income in order to be eligible to participate.

To Learn More: http://www.fns.usda.gov/cacfp/adult-day-care-centers

Commodity Supplemental Food Program (CSFP)

What the Program Does: The CSFP supplements the diets of low-income older Americans who are at least 60 years old with a monthly food package. Food packages include a variety of foods, such as shelf-stable milk, juice, farina, oats, ready-to-eat cereal, rice, pasta, peanut butter, dry beans, canned meat, poultry, or fish, and canned fruits and vegetables.

Whom the Program Serves: CSFP operates in 47 States, the District of Columbia, and 2 Indian Tribal Organizations (ITOs). Older persons at least 60 years old can apply. States establish income limits at or below 130 percent of the Federal Poverty Income Guidelines.

To Learn More: http://www.fns.usda.gov/csfp/commodity-supplemental-food-program-csfp

Elderly Nutrition Program

What the Program Does: Authorized by the Older Americans Act (OAA), the Elderly Nutrition Program provides grants to states and tribal organizations to provide congregate and home-delivered meals (commonly referred to as “Meals on Wheels”) to older adults. Meals provided through the Elderly Nutrition Program must adhere to the Dietary Guidelines for Americans and provide at least one-third of older adults’ dietary reference intakes.

Whom the Program Serves: The Elderly Nutrition Program serves adults aged 60 and older. There is no means -based test to participate in the Elderly Nutrition Programs, but services may be targeted to vulnerable populations, including older adults with low incomes, living alone or socially isolated, living in rural areas, or at nutritional risk.

To Learn More: http://www.aoa.acl.gov/AoA_Programs/HPW/Nutrition_Services/index.aspx

Food Distribution Program on Indian Reservations (FDPIR)

What the Program Does: FDPIR provides monthly food packages to low-income members of Indian Tribal Organizations (ITOs). Approximately 276 tribes receive benefits under the FDPIR through 100 ITOs and 5 state agencies. USDA purchases and ships FDPIR foods to the ITOs and state agencies based on their orders from a list of available foods. These administering agencies store and distribute the food, determine applicants' eligibility, and provide nutrition education to recipients.

Whom the Program Serves: Low-income American Indian and non-Indian households that reside on a reservation, and households living in approved areas near a reservation or in Oklahoma that contain at least one person who is a member of a federally-recognized tribe, are eligible to participate in FDPIR. Households are certified based on financial (e.g., income) and non-financial standards set by the federal government. Elderly and disabled households may be certified for up to 24 months. Households may not participate in FDPIR and the Supplemental Nutrition Assistance Program (SNAP) in the same month.

To Learn More: http://www.fns.usda.gov/fdpir/about-fdpir

Nutrition Services Incentive Program (NSIP)

What the Program Does: NSIP is authorized by the OAA and administered by the Administration for Community Living (ACL) within the Department of Health and Human Services. ACL provides funding to state agencies, Territories, and Indian Tribal Organizations exclusively to purchase food. State agencies may choose to receive the funds as cash, USDA Foods, or a combination of cash and USDA Foods. USDA also donates bonus foods to NSIP when feasible.

Whom the Program Serves: The Nutrition Programs are targeted to adults age 60 and older who are in greatest social and economic need with particular attention to low income and minority older individuals, those in rural communities, those who have limited English proficiency, and older individuals at risk of institutional care.

To Learn More: http://www.fns.usda.gov/nsip/nutrition-services-incentive-program-nsip

Senior Farmers' Market Nutrition Program (SFMNP)

What the Program Does: The SFMNP awards grants to states, U.S. Territories and federally recognized Indian tribal governments to provide low-income older adults with coupons that they can exchange for eligible foods at farmers' markets, roadside stands, and community supported agriculture (CSA) programs.

Whom the Program Serves: Low-income older adults, generally defined as individuals who are at least 60 years old and who have household incomes of not more than 185 percent of the Federal Poverty Income Guidelines.

To Learn More: http://www.fns.usda.gov/sites/default/files/sfmnp/SFMNPFactSheet.pdf

Supplemental Nutrition Assistance Program (SNAP)

What the Program Does: SNAP provides an Electronic Benefit Transfer (EBT) card that works like a debit card to buy food at the grocery store. SNAP benefits are loaded on this card once a month. The amount of benefits a household receives depends on income, expenses, and family size. SNAP also has programs to help recipients learn to eat in a healthy manner and be active.

Whom the Program Serves: SNAP is for people and families who fall below a specified income threshold. Households have to meet these thresholds unless all members are receiving TANF, SSI, or in some cases general assistance. Households with older adults or a person who is receiving certain types of disability payments have to meet a net income test, which allows certain deductions to be made from a household's gross income, including medical expenses and housing and utility allowances.

To Learn More: http://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap

The Emergency Food Assistance Program (TEFAP)

What the Program Does: TEFAP supplements the diets of low-income Americans, including older adults, by providing them with emergency food assistance at no cost. Food banks in every state receive TEFAP food shipments. These local organizations distribute food to eligible recipients for household consumption or use them to prepare and serve meals in a congregate setting. Eligible older adults may be able to eat at local soup kitchens, take food home from local pantries, or have food delivered to their homes. Foods available include canned and fresh fruits and vegetables, eggs, meat, poultry, fish, milk and cheese, pasta products, and cereal.

Whom the Program Serves: Households that meet state eligibility criteria may receive food for home use. States set income standards, which may, at the state's discretion, be met through participation in other existing federal, state, or local food, health, or welfare programs for which eligibility is based on income. States can adjust eligibility criteria to ensure that assistance is provided only to those households most in need.

To Learn More: http://www.fns.usda.gov/fdd/programs/tefap

SECTION 4:

Resources Available to Support Food Security Screening and Referrals

This section offers resources for medical professionals, clinics, and health systems to facilitate food security screening and referrals. Section 4.1 provides links to food security screening tools and information for clinicians. Section 4.2 includes resources that describe implementation of screening and referrals, the connection between health systems and food security, and online courses, presentations and webinars. Section 4.3 provides links to more information about food assistance resources and descriptions of community partnerships and sample programs.

The following organizations' websites also have information on food insecurity, older adults, food assistance resources, and food security screening:

AARP Foundation
http://www.aarp.org/aarp-foundation/our-work/hunger.html

Feeding America
http://www.feedingamerica.org

Food Research and Action Center (FRAC)
http://frac.org/

Meals on Wheels of America (MOWA)
http://www.mealsonwheelsamerica.org/

National Association of Nutrition and Aging Services Programs (NANASP)
http://www.nanasp.org/

National Council on Aging (NCOA)
https://www.ncoa.org/

National Foundation to End Senior Hunger (NFESH)
http://www.nfesh.org/

4.1 FOOD SECURITY SCREENING TOOLS

Screening Tool Validation

Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity

Source: Hager ER, Quigg AM, Black MM, et al. Development and validity of a 2-item screen to identify families at risk for food insecurity. Pediatrics. 2010;126(1):e26-e32.

Description: Children's HealthWatch developed the Hunger Vital Sign, a two-question tool, to screen for food insecurity based on the U.S. Household Food Security Scale. The tool identifies individuals and households as being at risk for food insecurity if they respond positively to either or both of the two questions.

Screening Algorithm

HungerCare Food and Nutrition Screening Algorithm and Provider Resources

Source: HungerCare Coalition, a program of Second Harvest Foodbank of Southern Wisconsin

Description: Steps and tools for providers to start screening for food insecurity and referring patients to food resources. The Food and Nutrition Screening Algorithm provides steps for providers to take, referral resources, and information about the health impact for food insecure seniors. The website also provides a link to a Referral Resource Sheet handout for patients listing the top resources in their area for food and other basic needs.

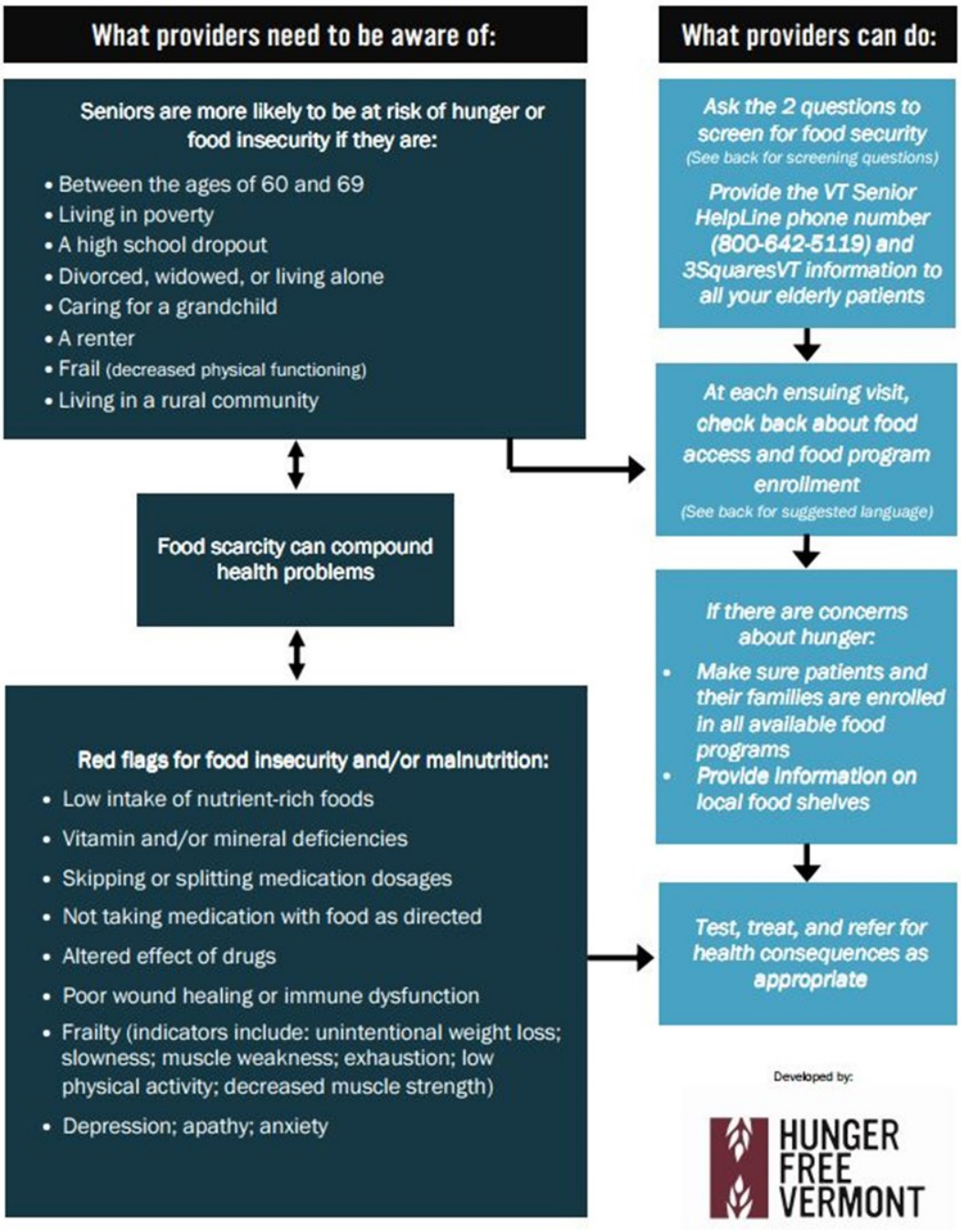
Senior Food & Nutrition Screening Algorithm

Source: Hunger Free Vermont

Description: Hunger Free Vermont designed an algorithm for primary care providers to use with seniors including information on food insecurity among seniors, how providers can screen for food insecurity, and food resources available to seniors.

SENIOR FOOD & NUTRITION SCREENING ALGORITHM

For Use by Primary Care Providers



Information for Clinicians

Clinical Training Food Insecurity Screening

Source: Feeding America

Description: Feeding America created a handout for medical professionals implementing food insecurity screening in a clinical setting, which describes background information, rationale, recommendations, and resources. The handout can be tailored for resources in other areas. For example, the Redwood Empire Food Bank tailored the resources to Sonoma County, California: http://healthyfoodbankhub.feedingamerica.org/wp-content/uploads/2014/05/FI-Clinical-Training-Brief.pdf

Food Insecurity Assessment Tool and Resource List

Source: U.S. Department of Health and Human Services, Indian Health Service, Division of Diabetes Treatment and Prevention

Description: The Indian Health Service provides a screening tool (Hager et al. 2010), and action steps for medical providers, as well as a referral form with programs listed and contact information to be completed.

Food Insecurity Screening Information

Source: Oregon Food Bank

Description: Oregon Food Bank developed a brief 3-page handout to explain the purpose of food security screening and referrals in primary care, how to conduct the screening and the types of resources available to patients. The handout can be used in orienting new health system staff to the process or as a refresher for health professionals already engaged in food security screening and referral.

Spotlight on Senior Health: Adverse Health Outcomes of Food Insecure Older Americans

Source: Feeding America, National Foundation to End Senior Hunger

Description: In 2013, Feeding America and the National Foundation to End Senior Hunger created this research brief to describe the impact of food insecurity among seniors and health outcomes using data from the National Health and Nutrition Examination Survey (NHANES) on food insecurity and health implications among seniors from 1999-2010. Among seniors, food insecurity is associated with increased risk of diabetes, high blood pressure, and asthma, and food insecure seniors are 53 percent more likely to report a heart attack.

3 Steps to Promote Food Security

Source: Second Harvest Heartland

Description: Second Harvest Heartland created a one-page handout to serve as a resource for medical professionals at Hennepin County Medical Center. This could serve as a useful tool for other clinics using food security screening.

4.2 HEALTH SYSTEM / CLINIC RESOURCES

Implementation Resources

Launching Rx for CalFresh in San Diego: Integrating Food Security into Healthcare Settings

Source: San Diego Hunger Coalition

Description: The San Diego Hunger Coalition (SDHC) created a report for healthcare providers, policy makers, and anti-hunger advocates on experiences developing and implementing six food security screening pilots in five types of healthcare settings. There were five methods of food insecurity referrals used including: on demand onsite assistance, intermittent onsite assistance, partner-initiated phone-based referral, patient-initiated phone-based referral, and referral to local community based organization.

Linking the Clinical Experience to Community Resources to Address Hunger in Colorado

Authors: Sandra Stenmark, Loel Solomon, Jandel Allen-Davis, and Catherine Brozena. Health Affairs Blog

Description: This blog describes implementation of a two-question food security screening in the Kaiser Permanente Colorado health system. Patients with a positive screen are referred to call the Hunger Free Colorado Hotline. The patient then speaks with a representative at Hunger Free Colorado to receive information about food assistance resources. Demonstrating an alternative referral process, providers can electronically refer the patient to a community specialist within the health system to complete a food security referral form which is submitted to Hunger Free Colorado.

Example referral form: http://www.childrenshealthwatch.org/wp-content/uploads/Hunger-Free-Colorado-Referral-Form-7-2014.pdf

Flyer: http://www.childrenshealthwatch.org/wp-content/uploads/13-HFC-FAB-Medical-Partner-Hotline-Flyer-Kaiser-12202013-Final.pdf

Prescription for Health

Source: Washtenaw County Public Health

Description: In Washtenaw County, Michigan, health care providers review patients' charts for chronic disease risk and food access difficulty; at-risk patients are referred to the Prescription for Health program. At group enrollment visits, the patient receives information about the program, learns about the link between health, chronic disease and food choices, sets goals for healthy eating, and receives a "prescription" for fresh fruits and vegetables that may be filled at a local farmer's market. The program implementation guide can help public health departments, health systems, farmer's markets, funders, and community partners replicate or modify this model.

Screening and Interventions for Food Insecurity in Health Care Settings: State Strategies to Increase an Underutilized Practice in California

Source: California Food Policy Advocates

Description: California Food Policy Advocates created a report as a guide for health care administrators and affiliates, and advocates focusing on the impact of food insecurity screening, how food insecurity screening is being used in California, and recommended state-level strategies to increase use of screening and referrals.

Health System Resources

Advancing Health through Food Security

Source: Aspen Institute

Description: The Aspen Institute convened a Dialogue on U.S. Food Insecurity and Healthcare costs and created a report summarizing the findings of three roundtable dialogues that examine the relationship between food insecurity, healthcare costs, poverty, relevant health outcomes and opportunities for action. The report provides examples of health care systems that have started implementing food security screening.

Cook County Food Access Plan

Source: Cook County Government and Greater Chicago Food Depository

Description: The Cook County Food Access Steering Committee created the Cook County Food Access Plan to identify steps to address the challenge of food insecurity in suburban Cook County. The plan is to be implemented by the Cook County Food Access Task Force and includes three areas of focus, one of which is to expand food insecurity screening and referral to all Cook County Health and Hospital System locations. This focus area provides a rationale for connecting patients with access to food and a "blueprint" of ideas for next steps with partners, outreach, best practices documentation, and indicators of success (see image below). The plan provides an example of county government engagement of food security screening.

BLUEPRINT FOR HEALTH INTERSECTION	
Expand customizable food insecurity screening and referral system to all Cook County Health and Hospitals System locations.	
Possible partners (not exhaustive, in alphabetic order)	• ACCESS Community Health Network • Chicago Community Trust • Community Members • Cook County Board of Commissioners • Cook County Health & Hospital System • Cook County Department of Public Health • Cook County Public Affairs & Communications • Greater Chicago Food Depository
Advocacy & outreach opportunities	• Commissioner visits to screening at health care center • Press releases for new screening locations
Alignment with key Cook County plans	• WePlan 2015 • Illinois State Health Improvement Plan • CCHHS & CCDPH Food Access in Suburban Cook County • A Recipe for Healthy Places
Best practices documentation	• Opportunity to provide guides on expanding this activity through townships and municipalities that want to institute these practices at their local hospitals or FQHCs
Short-term sample indicators of success	• Locations with screening implemented • Clients screened and referred • SNAP applications completed • Patients participating in nutrition education programming • Specialty boxes for chronic disease management and prevention distributed • Patients supplied with specialty distributions for chronic disease management and prevention • Practitioners reporting increased awareness of food insecurity of patients
Promising Cook County examples	• Onsite GCFD member pantries at Hines and Jesse Brown VA hospitals

Hunger in the Community: Ways Hospitals Can Help

Author: Project Bread

Description: Project Bread's hospital handbook provides information on why hospitals should be involved in addressing food insecurity and hunger as well as food access resources specific to Massachusetts.

Making Food Systems Part of Your Community Health Needs Assessment: Practical Guidance for the TACKLING HUNGER Project

Source: Public Health Institute (PHI), Nutrition and Obesity Policy Research Evaluation Network (NOPREN), CDC Foundation

Description: The Tackling Hunger Community Health Needs Assessment (CHNA) Guidance provides health systems with tools and strategies to build organizational support and integrate food security screening through the CHNA process. Investment in food security corresponds to value-based reimbursement by helping to reduce the demand for treatment of preventable conditions.

Online Courses / Training

Childhood Food Insecurity

Source: Oregon State University

Description: Oregon State University offers a free online self-paced course with continuing medical education credits available. The one-hour course is designed for medical professionals and covers how to identify food insecurity, how food insecurity is connected to health and development of children, and food insecurity issues and intervention strategies.

Food Insecurity and Diabetes: What's the Connection?

Source: U.S. Department of Health and Human Services, Indian Health Service, Division of Diabetes Treatment and Prevention

Description: The Indian Health Service website offers an online education course, with continuing medical education (CME) credit available. The course is designed for medical professionals and provides information about the effects of food insecurity on diabetes prevention and management, screening for clinicians to assess food insecurity in patients with diabetes, and community resources.

Presentations and Webinars on Food Security Topics

Food Insecurity Screening: Next Steps

Source: American Academy of Pediatrics Minnesota Chapter, Hot Topics, May 20, 2016

Description: This presentation from the American Academy of Pediatrics Minnesota Chapter features speakers from Hennepin County Medical Center, SNAP-Ed, and Second Harvest Heartland, describing how clinics are starting to provide screening and referrals for food insecurity, as well as how SNAP-Ed and Second Harvest Heartland serve as resources for patient referrals.

Food is Medicine: Promoting Food Security in Health Care and Community Settings

Source: Children's HealthWatch, conference presentation at Hunger Action Conference, May 6, 2016

Description: This Children's HealthWatch presentation by Dr. Richard Sheward covers the Hunger Vital Sign, a two-question food security screening tool's development, validation, and use. He also describes the opportunity for non-profit hospitals to address food insecurity through Affordable Care Act requirements to conduct a Community Health Needs Assessment (CHNA), and Community Health Improvement Plan (CHIP).

Hunger & Health: Connecting Patients to Nutrition Assistance

Source: Food Research and Action Center

Presenters: Dr. Deborah Frank (Children's HealthWatch), Lynn Knox (Oregon Food Bank), John Randolph (Hunger Solutions Minnesota), Dr. Sandra Stenmark (Kaiser Permanente Colorado)

Description: This webinar provides examples and lessons learned about food security screening processes from health system and community partner perspectives. For example, Hunger Solutions Minnesota is using SNAP Rx in partnership with DaVita Dialysis clinic to support patients screening positive for food insecurity.

Special Populations: Food Insecurity

Source: Oregon Primary Care Association, August 4, 2015

Description: The Oregon Primary Care Association (OPCA) provided a webinar on food security including screening in Oregon Community Health Centers, the role of the Oregon Food Bank, and lessons learned from the Multnomah County Health Department. This presentation provides information for other states and counties interested in implementing food security screening and working with community health centers, food banks, and county health departments.

4.3 FOOD ASSISTANCE RESOURCES AND COMMUNITY PARTNERSHIPS

Information on Food Assistance Resources

Combating Food Insecurity: Tools for Helping Older Adults Access SNAP

Source: AARP Foundation and Food Research and Action Center (FRAC)

Description: AARP Foundation and FRAC provide tools for increasing participation in SNAP among seniors that could be helpful in providing referrals and food access assistance.

Good and Cheap: Eat Well on $4/Day

Author: Leanne Brown

Description: *Good and Cheap* is a cookbook available to download as a free PDF, targeted to people with limited income, including those receiving SNAP benefits.

Community Partnerships

Exploring New Partnerships: Working Together for a Healthy and Well Nourished New Mexico

Source: Roadrunner Food Bank of New Mexico

Description: Roadrunner Food Bank of New Mexico created a guide to promote partnerships between the food bank and healthcare providers to address food insecurity. This report provides examples of successful partnerships including food security screening in healthcare facilities and food prescriptions.

Farm to Families Initiative & FreshRx

Source: St. Christopher's Foundation for Children

Description: Health care providers write "prescriptions" to the Farm to Families program for patients. This started at St. Christopher's Hospital for Children and has expanded to other health centers in North Philadelphia. Families receive a box of fresh produce at a reduced cost.

Food Banks as Partners in Health Promotion: Creating Connections for Client & Community Health

Source: Harvard Law School Center for Health Law & Policy Innovation and Feeding America

Description: Harvard Law School and Feeding America developed a guide for food banks to serve as community-based partners with health care providers to promote health. This can include providing food assistance services on-site at hospitals and clinics such as food pantries and encouraging health care providers to screen patients for food insecurity.

Food Rx Initiative

Source: University of Chicago and Walgreens

Description: As part of the Improving Diabetes Care and Outcomes on the South Side of Chicago project based at the University of Chicago Medicine, primary care providers at six clinics in Chicago can provide a prescription to patients with diabetes for recommended foods and a coupon for $5 off $20 at Walgreens or a $10 voucher for a local farmer's market.

Fresh Prescription: Recipe for a Healthy Detroit

Source: Ecology Center

Description: Primary care physicians can refer low-income patients with chronic disease, caregivers of young children, and pregnant women to the Fresh Prescription program. The clinician gives the patient a prescription which can be filled at a partnering farm stand or market. Implementing partners include: Community Health and Social Services Center (CHASS), American Indian Health and Family Services, Joy Southfield Community Development Center, Mercy Primary Care Center, Henry Ford Health System, Eastern Market Farm Stand – part of Detroit Community Markets, Gleaners' Fresh Food Share, Peaches and Greens, Henry Ford Health System Generation With Promise. This program provides an example of health system and community partnership for food access referrals.

Fruit and Vegetable Prescription Program (FVRx)

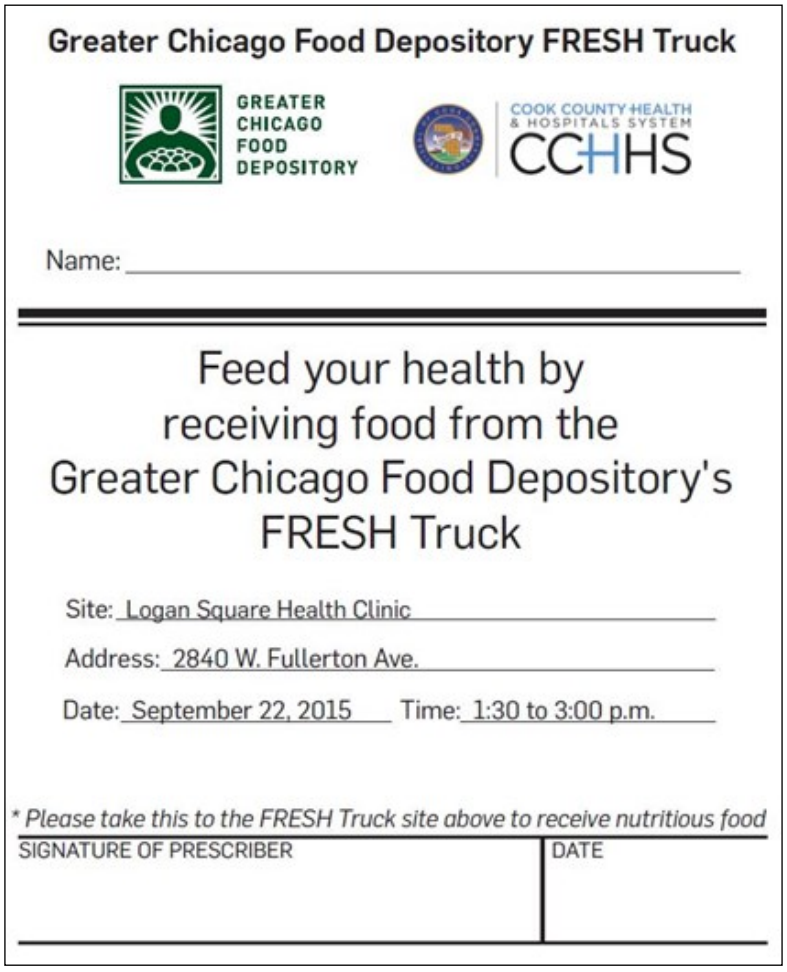
Source: Wholesome Wave

Description: Patients are enrolled by a health provider as an FVRx participant, attend an FVRx clinical visit to set goals and discuss nutrition, receive an FVRx prescription which can be redeemed for fresh fruits and vegetables at participating retailers. The program is being used in 10 states.

Greater Chicago Food Depository FRESH Truck

Source: Greater Chicago Food Depository and Cook County Health and Hospitals System

Description: At Logan Square Health Center, part of the Cook County Health & Hospitals System patients are screened for food insecurity and in addition to being referred to a social worker, receive a prescription for a fresh food truck that comes to the center monthly.



Greater Chicago Food Depository FRESH Truck

GREATER CHICAGO FOOD DEPOSITORY

COOK COUNTY HEALTH & HOSPITALS SYSTEM CCHHS

Name: _____

Feed your health by receiving food from the Greater Chicago Food Depository's FRESH Truck

Site: Logan Square Health Clinic

Address: 2840 W. Fullerton Ave.

Date: September 22, 2015 Time: 1:30 to 3:00 p.m.

* *Please take this to the FRESH Truck site above to receive nutritious food*

SIGNATURE OF PRESCRIBER	DATE

Sample Programs

Preventive Food Pantry

Source: Boston Medical Center

Description: At Boston Medical Center, primary care providers write prescriptions for low-income patients with special nutrition needs, under-nutrition, or nutrition-related illness. Primary care providers screen and refer patients using EPIC electronic medical record (EMR) software, and print out the completed referral form to give to the patient to bring to the Food Pantry located onsite. Families can visit the pantry twice each month to receive enough food to last 3-4 days in their household. Patients do not need a referral to participate in a class at the Demonstration Kitchen.

Therapeutic Food Pantry

Source: San Francisco General Hospital Foundation

Description: As part of a pilot program funded with a $15,000 grant, patients will receive “prescriptions” for healthy food as part of their clinical care plan, which can be filled at the Therapeutic Food Pantry. The pantry is staffed by a nutritionist who provides nutrition education, resources, and referrals to other Wellness Center programs. Patients can receive over 25 pounds of groceries per visit and can return every two weeks. This is one example of how a health system can provide resources for food insecure patients.

Veggie RX Program

Source: Gorge Grown Food Network

Description: Gorge Grown started the Veggie Rx fruit and vegetable prescription program to address food insecurity. Participating primary care and social service providers screen patients for food insecurity using a two-item screener. If there is a positive response, the provider gives the patient a packet of vouchers worth $30 for one month to redeem at one of 30 local grocery stores, farm stands, or farmers markets.

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