ISSUE BRIEF

A collaboration between AARP Foundation | IMPAQ INTERNATIONAL LLC

Addressing Food Insecurity in Primary Care
Models for Patient Screening and Referral

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In 2014, more than 10 million adults aged 60 and older in the United States were at risk of hunger or were food insecure, meaning that they lacked access to enough nutritious foods to lead a healthy, active lifestyle. Routine food security screening and referral for older adults in primary care practice is one opportunity for identifying and addressing food insecurity, which can be a significant contributor to poor health outcomes.

IMPAQ and AARP Foundation sought to document models for food security screening and referral in primary care practices that could be used to identify food insecurity among older adult patients. This Issue Brief describes ways in which health systems have implemented food security screening and referral processes, including partnering with community organizations for referrals, and key factors in their success.

IMPAQ International evaluates and enhances public programs and policies.

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

OVERVIEW

In 2014, more than 10 million adults aged 60 and older in the United States were at risk of hunger or were food insecure, meaning that they lacked access to enough nutritious foods to lead a healthy, active lifestyle.[i] From 2001 to 2014, food insecurity among older adults increased by 47 percent.[i] The linkages between food insecurity, poor nutrition, and poor health outcomes are well established in the literature.[ii] Food insecurity among older adults is associated with poor nutrition and poor health status,[iii] as well as greater likelihood of activity limitations,[iv] and higher prevalence of chronic conditions, medication non-adherence, and hospital readmissions.[v,vi,vii]

Routine food security screening and referral in primary care practice is one avenue to identify and address food insecurity. In recent years, health systems and hunger advocates have made efforts to integrate food security screening into primary care; however, it appears that many of these efforts have focused on pediatric populations. In collaboration with AARP Foundation, IMPAQ sought to identify models for food security screening and referral that could be implemented with older adult patients in primary care practice.

APPROACH

IMPAQ conducted case study site visits at three medical practices to document a variety of food security screening and referral systems within a primary care setting. The site visits consisted of observational walkthroughs to understand how the screening and referral process worked and one-on-one or group interviews with health professionals and community partners involved in the process. The selected sites included practices that conduct food security screening and referral for patients age 50 and older, pediatric patients only, and patients of all ages. While these models do not all focus exclusively on older patients, the screening and referral processes offer unique attributes and lessons learned that can be adapted and used in primary care settings for patients of all ages.

KEY ELEMENTS FOR SUCCESS

While each case study site offered a slightly different approach to food security screening and referral, the typical process is shown in **Exhibit 1**. Interviews revealed common themes that contribute to the successful development and implementation of a food security screening and referral process:

- **Champions.** An advocate or champion is critical for maintaining the drive and forward momentum for food security screening and referral processes. The champion may be a doctor, clinic director, or other medical professional in the health system, such as a medical assistant. Organizations within the community who are committed to ending hunger and food insecurity can also play a key role by championing the health system's efforts.
- **Organizational commitment.** Health systems' staff must recognize the need for food security screening and the positive impact it can have on patients. Commitment from the health system is also important to effectively integrating a screening and referral process, especially in updating electronic medical records systems to record the results of the screening and automate referrals.
- **Community partnerships.** Each case study site involved a community advocate or partner in the referral process. The community partners create critical links to ensure the continuum of care and can be an anti-hunger organization or a social services provider, such as the nonprofit community organization, Impact NW, which provides food assistance referrals for patients at Providence Medical Group.
- **Funding.** The case study sites noted a number of funding sources that contributed to the successful implementation of the food security screening and referral process. These included hospital foundations, community partners, donations, and grants. Funding supported changes in electronic medical record systems, training staff, and referral staff compensation.

Food Security Screening Tool Validated for Use in Primary Care

Hager et. al (2010) validated a 2-item food security screening tool that can quickly and easily screen patients for risk of food insecurity.[viii] This tool has been implemented in primary care practices as a verbal or written screen.

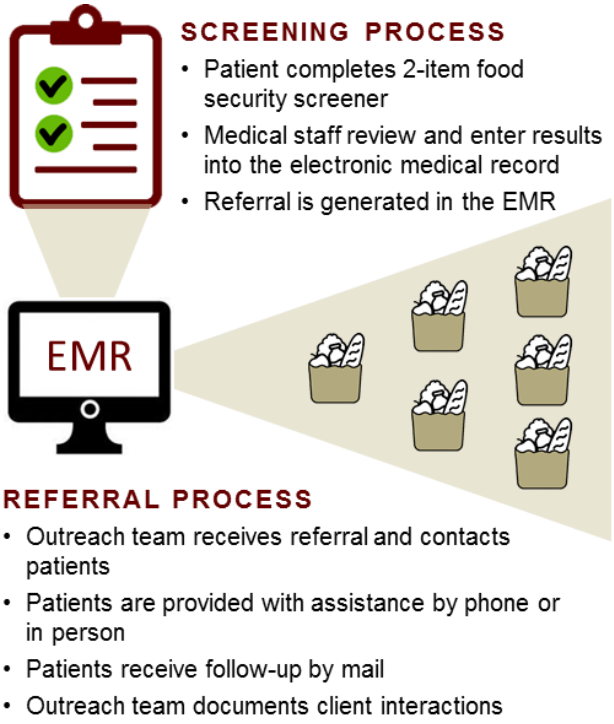
I'm going to read you two statements that people have made about their food situation. For each statement, please tell me whether the statement was **often true**, **sometimes true**, or **never true** for your household in the last 12 months.

1. **"We worried whether our food would run out before we got money to buy more."** Was that often true, sometimes true, or never true for your household in the last 12 months?
2. **"The food that we bought just didn't last and we didn't have money to get more."** Was that often true, sometimes true, or never true for your household in the last 12 months?

A response of "often true" or "sometimes true" to either question is an indication of food insecurity

Source: Feeding America. Clinical Training: Food Insecurity Screening. Available at: http://healthyfoodbankhub.feedingamerica.org/wp-content/uploads/mp/files/tool_and_resources/files/feeding-america-food-insecurity-screening-brief-for-fnce.pdf

Exhibit 1. Screening and Referral Process



CASE STUDY MODELS

Hennepin County Medical Center, Minneapolis, MN

Hennepin County Medical Center (HCMC) is home to multiple clinics with over 6,800 staff members across the hospital system. HCMC's Senior Care Clinics at Parkside and Augustana implemented a pilot food security screening and referral process in spring 2016 as a joint effort between HCMC and Second Harvest Heartland Food Bank, a community-based anti-hunger organization. This initiative is an outgrowth of a partnership that began under the leadership of Dr. Diana Cutts, a pediatrician and researcher at HCMC, and Mr. Kurt Hager, the Supplemental Nutrition Assistance Program (SNAP) Family Resource Coordinator at Second Harvest Heartland Food Bank.

At intake, patient service coordinators administer a paper survey that includes the two-item food security screening tool. The medical assistant collects the screener and offers referrals to patients who screen positive for food insecurity. Once a patient accepts a referral, the medical assistant documents the referral in the electronic medical record, and a fax with patient contact information is automatically sent to the outreach team at Second Harvest Heartland.

The Second Harvest Heartland outreach team calls patients directly and screens their income eligibility for SNAP and the Commodity Supplemental Food Program (CSFP), a food-assistance program designed for people over age 60. Outreach workers complete the SNAP application for older adults over the phone and submit it on their behalf to reduce the burden of applying. Outreach workers also search for food assistance resources in the community – food pantries, dining sites or soup kitchens, summer feeding programs for children in the household, and "Fare for All" sites (mobile markets throughout the city providing discounted nutritious foods). The outreach team follows up each telephone contact with a mailed letter containing referral information.

> ***Successful Approaches:*** *Standardized food security screening in the Senior Care Clinics has resulted in a one thousand percent increase in referrals for food insecure older adults. The program is a result of a strong partnership with Second Harvest Heartland which actively promotes the program throughout the HCMC with presentations on food assistance programs, how to use the food security screener, and patient success stories.*
>
> ***Challenges:*** *The food security screening and referral system started as a hospital-wide effort, but has been challenging to maintain without screening questions being added directly to the electronic medical record as part of the intake process.*

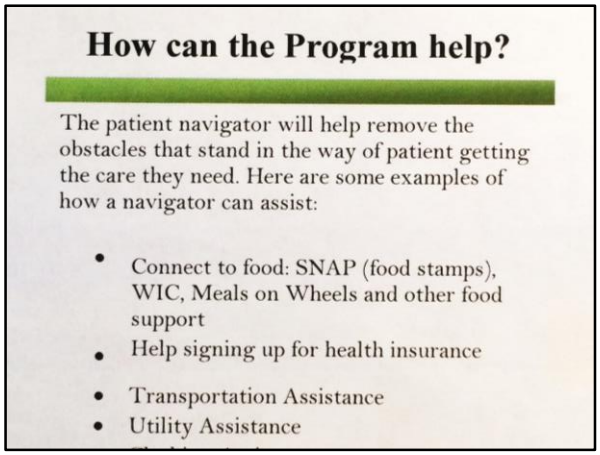
For more information about food security screening and referrals at HCMC, please contact Diana Cutts, MD at diana.cutts@hcmed.org.

Providence Medical Group, Milwaukie, OR

The Providence Medical Group–Milwaukie is part of the Providence Health & Services system in Oregon and Southwest Washington, and one of two clinics implementing the "Screen & Intervene" program – a food security screening and referral process. Led by Charlotte Navarre, a registered nurse and faculty at the Providence Oregon Family Medicine Residency Program, Screen & Intervene was developed in partnership with Oregon Food Bank and the Oregon Childhood Hunger Coalition. Providence Medical Group–Milwaukie began implementing Screen & Intervene in 2014 in collaboration with Impact NW, a local, nonprofit social services organization.

At every well-child visit, medical assistants ask parents to complete a two-item food security screening tool. Parents answer the questions using a laminated questionnaire and a grease pen. The medical assistant enters the responses into the electronic medical record, which is reviewed by the attending physician. The primary care provider will speak with food insecure families during the visit and offer a referral to Impact NW. When a patient accepts the referral, the medical assistant completes the referral in the electronic medical record, then prints and faxes the referral to Impact NW. Information is also provided to patients about Impact NW's services and what to expect from the referral (Exhibit 2).

Exhibit 2. Informational Brochure for Patients



How can the Program help?

The patient navigator will help remove the obstacles that stand in the way of patient getting the care they need. Here are some examples of how a navigator can assist:

- Connect to food: SNAP (food stamps), WIC, Meals on Wheels and other food support
- Help signing up for health insurance
- Transportation Assistance
- Utility Assistance

Patient navigators at Impact NW call each family to schedule an in-person meeting. The navigator conducts an assessment during the family interview to identify other resources needed, such as shelter and employment. Patient navigators provide assistance in completing and submitting applications for food assistance and other programs, and connect families with resources in the community to help meet their food and other resource needs.

The clinical staff at Providence are working toward expanding Screen & Intervene to serve older adult patients and believe that this model is easily transferable, especially since Impact NW already works with older adults through other programs.

> ***Successful Approaches:*** *When Providence first implemented Screen & Intervene, the large number of families identified as food insecure surprised the medical team. By partnering with a social services organization, Providence addresses not only food insecurity among patients, but other needs as well. The team has found that food insecurity is a key indicator of need with regard to other social determinants of health, such as housing and utilities.*
>
> ***Challenges:*** *As part of a large, multi-state health system, Providence found it challenging to incorporate the two-item screening tool and referral in the electronic medical record. Initially, staff used workarounds to record the information, but this resulted in low screening rates. Rates increased significantly after the health system added the screening to the electronic medical record system.*

For more information about food security screening and referrals at Providence Family Medicine Residency Program Clinics, please contact Charlotte Navarre, RNC at charlotte.navarre@providence.org.

Chase Brexton Health Care, Baltimore, MD

The clinical and case management care teams at Chase Brexton Health Care provide patients with access to services that address all of their basic needs, including access to food resources. In 2015, Chase Brexton and Maryland Hunger Solutions (MDHS) collaborated to expand patient services to include on-site SNAP outreach and enrollment for patients identified as food insecure. By taking a lifespan approach, Chase Brexton and MDHS connect all patients, from children to older adults, to the resources they need to lead an active, healthy life.

For all new patients, and at annual wellness visits, a care resource coordinator verbally administers a psychosocial screening, which captures information on basic needs including food security. The results of the screening are recorded in the patient's electronic medical record. The health care provider may also discuss issues related to food insecurity with patients during primary care visits in the context of nutrition, medication, or other health-related concerns. Patients identified as food insecure may be referred to case management services by any member of the care team.

After a referral is made, case managers have a number of resources available to help patients who are food insecure, including grocery store gift cards to meet immediate food needs, referral to the MDHS outreach staff, and food bank and pantry location and information. Case managers are also able to connect food insecure patients with an HIV/AIDS diagnosis to a home meal delivery program that is funded by the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act.

Case managers schedule patients not already receiving SNAP benefits to meet with the MDHS outreach worker. Outreach workers hold office hours at Chase Brexton and conduct SNAP pre-screening and application assistance on-site. Outreach workers are knowledgeable about SNAP eligibility and application processing. As a result, they can greatly simplify the application process for food insecure patients, which is particularly important for overcoming barriers to SNAP participation among older adults and patients with disabilities.

> ***Successful Approaches:*** *The partnership between Chase Brexton and MDHS allows the clinic to further meet the needs of their clients without increasing the burden on existing staff. At the same time, MDHS advances its goal of increasing SNAP enrollment among vulnerable and hard-to-reach populations.*
>
> ***Challenges:*** *Case managers noted that it was sometimes difficult to ensure that patients followed through on appointments with the MDHS outreach worker. As a result, they have employed techniques to support follow-up, including scheduling appointments with outreach workers to coincide with medical appointments and providing transportation vouchers to patients.*

LESSONS LEARNED

Each of the food security screening and referral models described have unique components that have contributed to their success in connecting patients with food resources. Across sites, there are key lessons learned that health systems and community partners should take into consideration when developing their own system for screening and referral, particularly for older adults.

- **Referrals may take different forms.** The case study sites have taken different approaches to referrals for food insecure patients. Some rely primarily on internal case management support, with additional support coming from community partners, while other sites rely primarily on external referrals to

community partners, who connect the patient with food resources. In all cases, referrals are handled separately from the primary care visit to reduce the potential burden to the provider and care team.

- **Complying with the Health Insurance Portability and Accountability Act (HIPAA) is doable.** Patients' privacy must be maintained for any referral process. For the sites that refer patients to external sources of support, such as community partners, health providers ask permission from patients to create the referral, and share only a limited amount of information, such as the person's name, phone number, and preferred language.
- **Planning takes time; screening doesn't.** In some of our case study sites, the process of implementing a food security screening and referral system has taken years of careful planning and roll-out to ensure that patients' needs could be met efficiently. At the same time, sites reported that once systems are put in place, they don't add more than a couple of minutes to clinical visits, and staff members are proud to be helping their patients and community.
- **Sustainability requires resources.** Screening and referral systems that use internal health system resources and/or reliable and consistent government or community funding sources are likely to be sustained in the long term with continued organizational commitment. Models that provide multiple services to large numbers of food insecure patients, such as the Screen & Intervene model, will require ongoing funding to expand and sustain over the long term. While health systems addressing hunger and food insecurity among older adults could see financial returns downstream as increased food security supports improve patient outcomes, Medicaid or Medicare reimbursement for food security screening could provide motivation and resources to health systems that do not currently have screening and referral systems in place.

As health systems and communities continue to collaborate to end hunger and other issues affecting patient health and health outcomes, it is important to consider the wide variety of ways in which these partnerships evolve, as well as how these efforts can be sustained in the long-term.

CONCLUSION

While the three case studies are not an exhaustive review of the many ways in which a food security screening and referral process can be implemented, the examples shared and lessons learned across the sites provide a wealth of information that can inform the successful development of food security screening and referral processes for older adults in health systems.

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We would also like to thank the staff of the community partners supporting food insecure families, including Maryland Hunger Solutions, Impact NW, Oregon Food Bank, and Second Harvest Heartland Food Bank, who helped to build our understanding of the resources available to patients and how referrals from health systems are handled.

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ABOUT THE AUTHORS

IMPAQ INTERNATIONAL

IMPAQ helps governments, businesses, foundations, nonprofits, and universities evaluate and enhance their programs and policies. Our staff of world class researchers, survey professionals, technical innovators, and subject matter experts combine innovative thinking and rigorous approaches to make a real world impact. We are known for our flexibility, responsiveness, and willingness to adapt to our clients' challenges in order to solve real-world problems.

AARP FOUNDATION

AARP Foundation works to ensure that low-income older adults have nutritious food, safe and affordable housing, a steady income, and strong and sustaining social bonds. We collaborate with individuals and organizations who share our commitment to innovation and our passion for problem-solving. Supported by vigorous legal advocacy, we create and advance effective solutions that help struggling older adults transform their lives. AARP Foundation is the charitable affilitate of AARP. Learn more at aarpfoundation.org.

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