Strategies for Supporting Health Center Patients Experiencing Food Insecurity

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Food insecurity has doubled since the onset of the COVID-19 pandemic, and has tripled among families with children. Not having enough access to food is a key contributor to negative health outcomes for adults and children alike, and it is important now more than ever for health centers to identify and support patients who are experiencing food insecurity.

This resource is designed to support health center efforts to identify and assist patients who are experiencing food insecurity. This resource consolidates research from various partners to outline key considerations around integrating social determinants of health (SDoH)-related screening and intervention into the electronic health record (EHR) workflow, highlights standardized screening tools and data elements to monitor the prevalence of food insecurity among patients, and describes several strategies to meet food-related needs.

SDOH CONCEPTS FOR HEALTH CENTERS

SDoH play an integral role in shaping health outcomes at the individual and population levels. Implementing a social needs screening strategy is an important step in the journey toward improving population health and achieving value-based care. Through the implementation of a social needs screening strategy that is integrated into the EHR, health centers can collect and act on SDoH data in standardized, consistent ways. Collecting standardized SDoH data enables health centers to better assist their patients, shape innovative and promising interventions, and convey the value of their SDoH approaches to key audiences, such as their governing boards, in data-driven ways. This resource refers to three key SDoH concepts:

Social Determinants of Health: The conditions where people are born, live, learn, work, play, worship, and age. These conditions are neither positive nor negative, and they are one group of factors that affect population-level health.

Social Risk Factors: Specific adverse social conditions that are associated with poor health.

Social Needs: A patient's most pressing, immediate needs, which may not always align with the social risk factors that screening tools flag as a patient experiencing.

These are only three of several key concepts that the healthcare field is increasingly using in value-based care conversations. Dive deeper into these and additional key SDoH concepts: Meanings and Understanding: A Social Determinants of Health Lexicon for Health Systems.

INTEGRATE YOUR SCREENING STRATEGY INTO YOUR EHR WORKFLOW

Identify Your Screening Goals and Capacity

A comprehensive screening and intervention strategy requires health centers to set up standardized workflows for collecting, documenting, and acting on SDoH data. Integrating a food insecurity screening strategy into your health center's EHR workflow is an important step toward standardization.

It is important to understand health center goals, current infrastructure capacity, and already-established workflows as a first step in establishing or refining a screening and intervention strategy. Review and answer the following questions to identify your screening needs, capabilities, and opportunities:

1. **What are your team's goals for collecting SDoH data?** Understanding your team's goals for an SDoH screening strategy will help you select the best screening tools and workflow adaptations for your health center.

2. **What screening strategy would be best to integrate into your workflow in a way that meets your goals? If your clinic already has a screening strategy, how can that be adapted to best meet your goals?**

   o For example, if your goal is to screen patients for food insecurity as part of their telehealth visits, you will need to identify tools or approaches that can help your team collect SDoH data outside of clinical settings, such as assessments that can be completed virtually.

   o You may want to review if there are existing strategies to leverage other social or demographic information that your health center collects and could be used to help identify patients at risk for food insecurity.

3. **Can your EHR support food insecurity screening and outcome documentation?**

   o If yes, see the following 'Integration Considerations' section to find out how your clinic might integrate the screening process into the EHR.

   o If you are unsure, your health center may need to engage with your EHR vendor to find out what is available through your platform. Also, review the 'Standardized Food Insecurity Screening Tools' table on page 5 to see if your EHR already supports standardized screening tool(s).

   o If no, there are several third-party tools your team could consider that are designed to support a health center's screening efforts.

> **(!) REMEMBER**
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> • Additional costs may be associated with certain EHR features. Inquire about what is already available in or for your EHR, as many vendors have begun integrating social screening tools into their platforms.
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> • Third-party software integrated into the EHR can be a great way to record screening responses, and even track other SDoH. For example, PRAPARE templates are available at no cost for many common EHRs and Epic has standardized screening built in.

Integration Considerations

Once you have assessed your needs and overall goals for your screening strategy, it is time to think about its implementation. The following considerations build on work that the National Association of Community Health Centers, the Association of Asian Pacific Community Health Organizations, and the Oregon Primary Care Association engaged in to create the PRAPARE protocol (described in more detail within the 'Standardized Food Screening Resource' section below). Specifically, the steps below are rooted in the Five Rights of Clinical Decision Support, which is a framework designed to support the implementation of screening strategies in health care settings, such as the PRAPARE protocol. To learn more about the Five Rights Framework, review the PRAPARE Implementation and Action Toolkit. With your team, review the following key steps and considerations for integrating your food insecurity screening strategy into your EHR workflow.

HOW will SDoH data be collected and documented in your EHR?

Determine what method of collection and documentation makes the most sense for your health center and its EHR functionality. Example collection and documentation strategies include:

In-Person Options

Incorporating screeners into kiosk and/or tablet check-in options, which feeds data directly into the EHR, either in structured data fields or as PDF.

Administering a paper screener, such as an intake form, during in-person visits that is later entered into the EHR by staff.

Remote Options

Directing patients to pre-register and complete screeners on patient portals or other electronic means online via their own tablet, laptop, or cell phone, which feed back into the EHR.

Conducting pre-visit phone calls with patients to collect demographic information and conduct assessments and screeners, which is entered in EHR by staff conducting calls.

HIGHLIGHT FROM THE FIELD

Allina Health has integrated its social needs screening tool directly into the patient portal, which is pushed to patients five days before an upcoming visit. Patient responses feed directly into the EHR, which allows staff review and respond to the data.

WHO will be responsible for conducting screenings, documenting outcomes, and acting on data?

It is important to outline staff responsibility and roles in implementing your food insecurity screening strategy. Key questions to consider include:

- Will screenings be administered by clinical staff, non-clinical support staff, or specialized staff, such as a population health manager or patient navigator?

- If patients are screened remotely, such as through the patient portal, who will ensure providers and relevant staff are able to review and respond to collected data?

- Who will oversee the screening strategy and identify areas for improvement?

- What additional training and data permissions will be needed for staff that will hold this responsibility?

WHEN AND WHERE will screenings be implemented, and how often?

Determine what makes most sense for your health center, given current workflows and staff availability. For example, consider:

Time	Place	Frequency
• Before a visit? If screened virtually, how many days in advance will a patient be contacted? • During a visit? • After a visit? Within how many days will a patient be reached?	• In a waiting room, exam room, or virtually (e.g., online or over the phone)? • In virtual visits, how will patients' privacy be assessed prior to administering screening?	• At every new patient visit, either in-person or virtual visits? • At annual physicals? • At any vital signs check if screening has not been previously completed?

EHR TIP

Incorporate a prompt or alert into your EHRs to remind staff to administer your selected screening tool to promote compliance.

WHAT will happen to SDoH data after it is collected?

Acting on SDoH data in a timely manner is essential to supporting patients experiencing food insecurity who need access to food-related resources or other social services. Consider the following questions to help you establish next steps to respond to needs your patients express:

- Where will this data be available in the patient record and/or EHR?

- What intervention model will your health center use to connect patients with available resources? (See examples in the 'Connect Patients to Available Resources' section on page 14.)

- Who will be responsible for implementing your selected intervention model and/or reviewing referral outcomes?

- How will the prevalence of social needs be monitored across your patient population, and how can this data inform current and future health center strategies?

HIGHLIGHT FROM THE FIELD (CONTINUED)

Digitize referrals. In addition to digitizing its social needs screening tool, Allina Health integrated NowPow (a social network described in more detail below) into its EHR and is now able to make referrals to other organizations and track the outcomes of these referrals if partner organizations have also integrated with NowPow.

PARTNER SHOWCASE: INCORPORATING SOCIAL NEEDS SCREENINGS WITHIN THE ONEHEALTH NETWORK

Overview: The oneHealth Network includes five rural health centers across Montana. Leveraging their existing screening tools and PRAPARE, they built a screener for their patient population to identify social needs in the EHR. The summary below outlines oneHealth's experience implementing their screening strategy, which was originally shared with the PRAPARE team as part of the webinar *Adapting SDOH Data Collection Workflows during COVID-19* hosted by NACHC and AAPCHO in October 2020.

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How	The nursing and medical assistant staff performed a verbal screen and entered the results into the EHR in real-time. Staff audited oneHealth's intake process before implementing the PRAPARE tool to ensure no questions were being duplicated, ultimately adopting a tailored PRAPARE screener. Originally, their EHR, Athena, did not have a template for PRAPARE, so oneHealth developed its own template and embedded it within the EHR's social history tab.
Who	All patients interacted with a member of the nursing or medical assistant staff prior to the COVID-19 pandemic. Nursing and medical assistant staff were responsible for screening patients given the consistency of their interaction with patients. Staff used empathic inquiry in conducting in-person screens to build trust with their patients. After screening patients, nursing staff would then inform a patient's provider of the result of the screen.
When and Where	Before COVID-19, patients were screened during triage at every in-person visit because oneHealth wanted to ensure patients knew that their clinic was always thinking about their whole health. The pandemic reduced screening rates across some provider teams, so oneHealth staff is currently assessing how to adapt its workflow to encourage standardized screening rates.
What Comes Next	Members of oneHealth's resource team pull screener data from patient charts daily. Additionally, after assessing a positive screen, a provider or member of the resource team can make a referral through Athena by sending a patient case to the "resource support" bucket that is monitored by Community Health Advocates. Before the COVID-19 pandemic, oneHealth prioritized in-person warm handoffs to Community Health Advocates. Currently, oneHealth uses its telehealth platform, Tytocare, to connect patients to Community Health advocates who can support referrals to programs such as Medicaid and SNAP.
Impact	With the SDoH data collected from this screening effort, oneHealth applied and received a grant to establish an in-clinic food pantry at one of its sites. oneHealth also received grant funding to establish a food voucher program in partnership with No Kid Hungry Montana, a local food bank. Through this partnership, oneHealth will be able to provide supermarket gift cards and access to financial literacy education to families with children in need.

oneHealth's Lessons Learned	**Use a Patient-Centered Approach**: oneHealth selected their strategy based on what made the most sense for its patients. For example, empathic inquiry and direct documentation of screening results within the EHR helped to limit the paperwork patients need to fill out. Nurses and medical assistants were selected to conduct the screenings because they had rapport with the patients, making it easier for patients to provide honest answers to screener questions.
	Ensure Staff Buy-In: Gaining the support of staff involved in the screening process, especially those conducting the screening, is crucial to success. If clinic staff does not see the value of screening, it is challenging to implement screening consistently. oneHealth found that dedicating time to explaining why the screenings are important for patients, working with staff through workflow issues, and providing explicit support that was communicated from clinic leadership helped increase screening compliance. A clear workflow graphic (see below) can also help show the importance of the role that staff play in connecting patients to resources.
	Share Successes: If there are tangible impacts of the screening program, share those outcomes with staff and, when appropriate, patients. oneHealth was able to establish an in-clinic food pantry and establish a food voucher program in partnership with No Kid Hungry Montana through grant funding that was awarded as a result of screening efforts. By communicating that these grants were awarded because of the data clinic staff gathered through screening, staff and patient support for screening increased.

Figure 1: oneHealth Social Determinants Screening Workflow
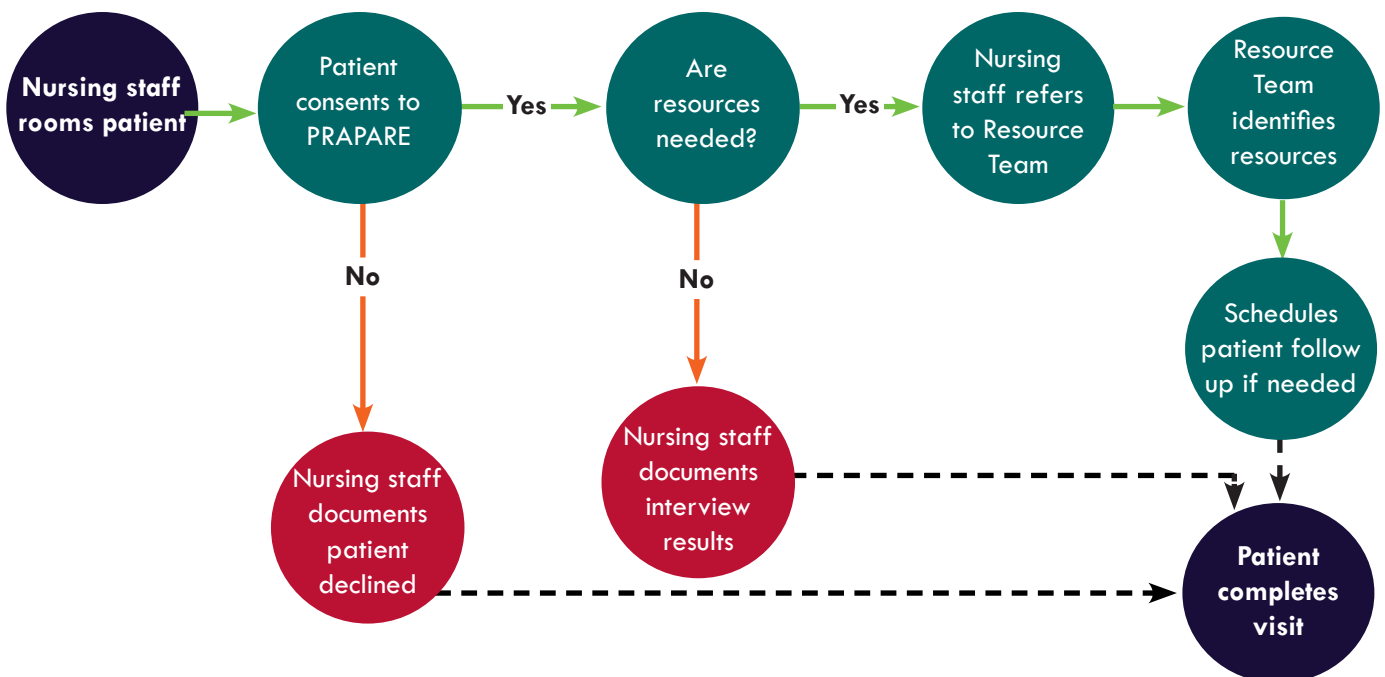
Workflow image originally featured in and adapted from the NACHC and AAPCHO webinar: Adapting SDOH Data Collection Workflows during COVID-19 (October 2020)

Standardized Food Insecurity Screening Tools

A standardized approach to collecting SDoH data is important for accurately monitoring the prevalence of food insecurity among patient populations and designing data-driven strategies to meet patient needs. Based on your screening goals and capacity, your health center may want to consider one of the following standardized data collection tools that include food insecurity screening questions. Key considerations when selecting a tool include:

- Current screening questions and practices

- Specific characteristics of your health center patient population

- Available EHR integrations

- Mapped diagnostic codes

- Current EHR workflow

Table 1: Standardized Food Insecurity Screening Tools

Screening Tool	Available EHR Integrations	Workflow Recommendations	Food Insecurity Screener Questions	Coding Specification for Positive Screen
Hunger Vital Sign: A 2-question validated screening tool to identify **families at risk for food insecurity.** Recommended by the American Academy of Pediatrics and the Food Research & Action Center.	Screening tool is already built into Epic.	Hunger as a Vital Sign Screening algorithms are available for: • Adult • Children • Patients living with Diabetes	*Hunger Vital Sign includes associated LOINC Codes for each possible response.* **For each statement, please tell me whether the statement was true, sometimes true, or never true for your household:** *Within the past 12 months, we/you worried whether our/your food would run out before we/you got money to buy more.* • Often true — LA28397-0 • Sometimes true — LA6729-3 • Never true — LA28398-8) • Don't know/ refused — LA15775-2	Households or individuals who respond "often true" or "sometimes true" to either or both statements are considered positive for risk of food insecurity. Use: • LOINC code: At risk – LA15992-3 If negative, use: • LOINC code: Not at risk – LA19983-8

Screening Tool	Available EHR Integrations	Workflow Recommendations	Food Insecurity Screener Questions	Coding Specification for Positive Screen
			Within the past 12 months, the food we/ you bought just didn't last and we/you didn't have money to get more. • Often true — LA28397-0 • Sometimes true — LA6729-3 • Never true — LA28398-8 • Don't know/ refused — LA15775-2	
Protocol for Responding to and Assessing Patient's Assets, Risks, and Experiences (PRAPARE) Tool: The PRAPARE protocol was developed by the National Association of Community Health Centers, the Association of Asian Pacific Community Health Organizations, and the Oregon Primary Care Association, who partnered together to create, test, and promote a standardized patient risk assessment protocol that focuses on the social determinants of health. This protocol is tailored for use in community health centers and consists	Free EHR templates exist for athenaOne, athenaPractice (formerly GE Centricity), Cerner, eClinicalWorks, Epic, Greenway Intergy, NextGen.	The PRAPARE toolkit workflow implementation chapter of the PRAPARE toolkit describes protocol workflows for clinical staff, non-clinical staff, self-assessment, and more.	*Question 14. In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? (Check all that apply.)* **Food** • Yes • No	An individual who responds "yes" is considered positive for food insecurity. Use: • PRAPARE code: Food 0 • ICD-10 Z code: Lack of adequate food – Z59.4 • LOINC code: LA30125-1

Screening Tool	Available EHR Integrations	Workflow Recommendations	Food Insecurity Screener Questions	Coding Specification for Positive Screen
of a set of national core measures and optional measures for community priorities. The PRAPARE protocol aligns with Healthy People 2020, clinical coding under ICD-10, and UDS data.				
Well Child Care, Evaluation, Community Resources, Advocacy, Referral Education Survey instrument (WE-CARE): A 12-question clinic-based survey and referral tool that assesses needs in six domains (parental educational attainment, employment, child care, risk of homelessness, food security, and household heat and electricity). Developed for pediatric settings, but can be adapted to adult primary care.	Screening tool can be custom built into the EHR with smart phrases and responses auto generated with ICD-10 codes.	Several studies are available that discuss the implementation of WE-CARE into the pediatric setting and adult primary care setting.	*Do you always have enough food for your family?* • Yes • No *If no: Would you like help with this?* • Yes • No • Maybe later	Households or individuals who respond "No" are considered positive for risk of food insecurity. This tool does not specify recommended diagnostic codes. Health centers could use: • ICD-10-CM codes for food insecurity (see the following table for example codes).
The Accountable Health Communities Health-Related Social Needs Screening Tool (ACH HRSN): A 10-item screening tool that can help providers find out	Screening tool can be custom built into the EHR.	Rocky Mountain Health Plan (RMHP) implementation toolkit describes tool use for primary care practices. Other available resources from RMHP include:	*Question 3. Within the past 12 months, you worried that your food would run out before you got money to buy more.* • Often true — LA28397-0	Households or individuals who respond "often true" or "sometimes true" to either or both statements are considered positive for risk of food insecurity.

Screening Tool	Available EHR Integrations	Workflow Recommendations	Food Insecurity Screener Questions	Coding Specification for Positive Screen
patients' needs in five core domains (housing instability, food insecurity, transportation problems, interpersonal safety, and utility help needs).This tool **incorporates the Hunger Vital Sign Tool**, and was created by the Centers for Medicare & Medicaid Services Center for Medicare and Medicaid Innovation.	Screening tool can be custom built into the EHR.	- Standard Operating Procedure for Screening and Referral - Accountable Communities Health Model Provider FAQs More clinical resources are available on RMHP's site. These resources are specific to Colorado but may serve as models for other health centers.	• Sometimes true — LA6729-3 • Never true — LA28398-8) • Don't know/refused — LA15775-2 *Question 4: Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.* • Often true — LA28397-0 • Sometimes true — LA6729-3 • Never true — LA28398-8) • Don't know/refused — LA15775-2	Households or individuals who respond "often true" or "sometimes true" to either or both statements are considered positive for risk of food insecurity. Use: • LOINC code: At risk – LA15992-3 If negative, use: • LOINC code: Not at risk – LA19983-8
Health Leads Screening Toolkit: A full social needs screening toolkit in English and Spanish that provides best practices and recommended questions to screen for core social needs, including food insecurity.	Screening tool can be custom built into the EHR as a template or questionnaire, or self-reported data can be captured through EHR integration with third party platform Carescribir.	Health Lead's updated social needs screening toolkit outlines best practices and recommendations for health care providers.	*In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?* • Yes • No	Households or individuals who **respond "yes"** are considered positive for risk of food insecurity. This tool does not specify recommended diagnostic codes. Health centers could use: • ICD-10-CM codes for food insecurity (see the following table for example codes).

Screening Tool	Available EHR Integrations	Workflow Recommendations	Food Insecurity Screener Questions	Coding Specification for Positive Screen
Safe Environment for Every Kid (SEEK) Parent Questionnaire: A 15-item validated questionnaire **intended for parents/caregivers of children ages 0–5 to complete in pediatric primary care settings.** Incorporates the Hunger Vital Sign Tool, but yes/no responses are not coded.	Self-reported data can be captured through software developed to implement SEEK Parent Questionnaire - R, which can operate independently or integrated with the EHR using third party platforms Carescribir and Chadis.	A SEEK screening algorithm is available for Food Insecurity. Algorithms for additional topics and other materials are also available on the SEEK website.	*In the past 12 months, did you worry that your food would run out before you could buy more?* • Yes • No *In the past 12 months, did the food you bought just not last and you didn't have money to get more?* • Yes • No	Households or individuals who **respond "yes" to either question** are considered positive for risk of food insecurity This tool does not specify recommended diagnostic codes. Health centers could use: • ICD-10-CM codes for food insecurity (see the following table for example codes).

Other Data to Document or Monitor Food Insecurity Among Patients

Your health center may be collecting data through other methods that can inform your team about the prevalence of food insecurity within your patient population. The table below outlines some common code sets and data sources that could be used to document or monitor food insecurity among the patient population.

Table 2: Food Insecurity Documentation Codes

Data Source	Brief Description	Data to Support Identification of Food Insecurity Risk	Considerations
International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Code Set	ICD codes are readily used across health care organizations to indicate diagnoses and support billing. This dataset is maintained in the US by the National Center for Health Care Statistics (NCHS).	Z59.4 – Lack of adequate food and safe drinking water. **Other Codes to Consider (presence may indicate patients who have experienced food-related or other social needs in the past):** Z71.89 – Other specified counseling	• Codes are not very specific and do not distinguish between very low and low food insecurity or between food versus safe drinking water availability. • Health centers may need to review additional information to determine what type of support patients may need.

Data Source	Brief Description	Data to Support Identification of Food Insecurity Risk	Considerations
Systemized Nomenclature of Medicine - Clinical Terms (SNOMED CT) Code Set	SNOMED CT codes are predominately used by providers to describe clinical observations and findings. They can be used to document almost all aspects of care, in addition to medical problems.	706875005 – "Insufficient Food Supply" 733423003 – "Food Insecurity" **Other Codes to Consider (presence may indicate patients who have experienced food-related or other social needs in the past):** 410292002 – Finances education, guidance, and counseling 410293007 – Food education, guidance, and counseling 41920009 – Patient referral for socioeconomic factors (can be used to document referrals related to food insecurity) 710925007 — Food provision (currently no unique code for food prescriptions, but this code could signal on-site food assistance)	• Providers will document SNOMED CT codes within a patient's EHR Problem List. • The food insecurity code is the first discrete SNOMED CT code for documenting food insecurity assessments. • Other listed codes can also be used to document follow-up steps taken after a positive screen.

⭐ **Learn more about food insecurity coding:** [An Overview of Food Insecurity Coding in Health Care Settings](#)

Table 3: Additional Data Sources for Monitoring Food Insecurity Prevalence

Data Source	Brief Description	Data to Support Identification of Food Insecurity Risk	Considerations
Uniform Data System (UDS) Appendix D: Health Center Health Information Technology (HIT) Capabilities: Social Risk Questions	Question 12a of the HIT Capabilities form captures information on health center patients who screened positive for select social risk factors, including food insecurity.	*Question 12a: Please provide the total number of patients that screened positive for the following:* • Food insecurity: Total patient count	• This data does not capture information on patients' current needs or the severity of food insecurity.

Data Source	Brief Description	Data to Support Identification of Food Insecurity Risk	Considerations
Uniform Data System (UDS) Household Income Data	Federally-qualified health centers are required to collect household income information from all patients annually. About 67% of food-insecure households have reported incomes below 200% FPL.	**UDS Report Table 4: Selected Patient Characteristics, Lines 1–4 (Income as Percent of Poverty Guideline):** • Line 1: 100% and below • Line 2: 101–150% • Line 3: 151% –200% • Line 4: Over 200% Could consider patients with incomes below 200% FPL as potentially at risk for food insecurity.	• Not all families who report incomes below 200% FPL are food insecure or require food-related resources. Similarly, some households may report incomes above 200% FPL and be food insecure. • Federal and state food programs, such as SNAP, often exclude households with incomes above 200% FPL. Health centers may need to take extra care to meet the food-related needs of patients who are not eligible for these programs.

DATA DASHBOARDS AND OTHER TOOLS TO MONITOR FOOD INSECURITY AND OTHER SDOH DATA

Monitoring food insecurity within a patient population requires that health centers have actionable information that is easy to review and access. A well-designed data dashboard makes this possible. Data dashboards can look differently and be created using a variety of tools and platforms, and some advanced planning can help make sure that a new data dashboard is best suited to harness data and guide decision making. The HITEQ Center's Developing Effective Data Dashboards outlines the process for developing a data dashboard, as well as some tips for health centers to consider. If your health center has implemented (or is considering) the PRAPARE tool, this HITEQ Highlights on Developing a Data Dashboard for PRAPARE Data can help.

Many third-party analytical tools also exist to support health care staff in the management of population health and SDoH data.

CONNECT PATIENTS TO AVAILABLE RESOURCES

As community leaders, health centers have a responsibility to act on data demonstrating food-related and other social needs to the best of their abilities in order to support patient well-being. There are many different models for meeting patients' food-related needs that health centers can pursue. Below, we outline three strategies that involve different levels of effort and could be implemented individually or simultaneously.

Develop an Accessible Resource Guide

Health centers can provide all patients or those with identified food-related needs with a one-page resource guide that lists the contact information of available local supports, such as food banks, community organizations, and financial assistance programs. This patient-centered and straightforward action can also aid health center staff in directly referring patients to the supports identified on the resource guide. Storing resource guides within the EHR or through web-based resource libraries makes it easier to access these guides, keep them up-to-date, and integrate workflows for warm-handoffs to staff that can help patients navigate available resources or direct referrals to community resources, such as a local food assistance program.

Several online social network platforms provide access to free public-facing search engines health centers can use to understand the landscape of available community resources, keep resource lists up to date, and even facilitate direct patient referrals to other organizations.

- NowPow builds hyperlocal resource directories (CommRx) to provide comprehensive and credible information to people. To participate in a resource directory, organizations can Request to Join a Network. In addition to the ability to print referral information, NowPow also includes a 'nudge' feature, which allows staff to directly send text or email messages populated with tailored service information to patients. In response to the COVID-19 pandemic, NowPow has incorporated this texting and email functionality at no cost into its CommRx tool.

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- This HITEQ Center case study describes other resources that can support health centers in creating and updating resource guides.
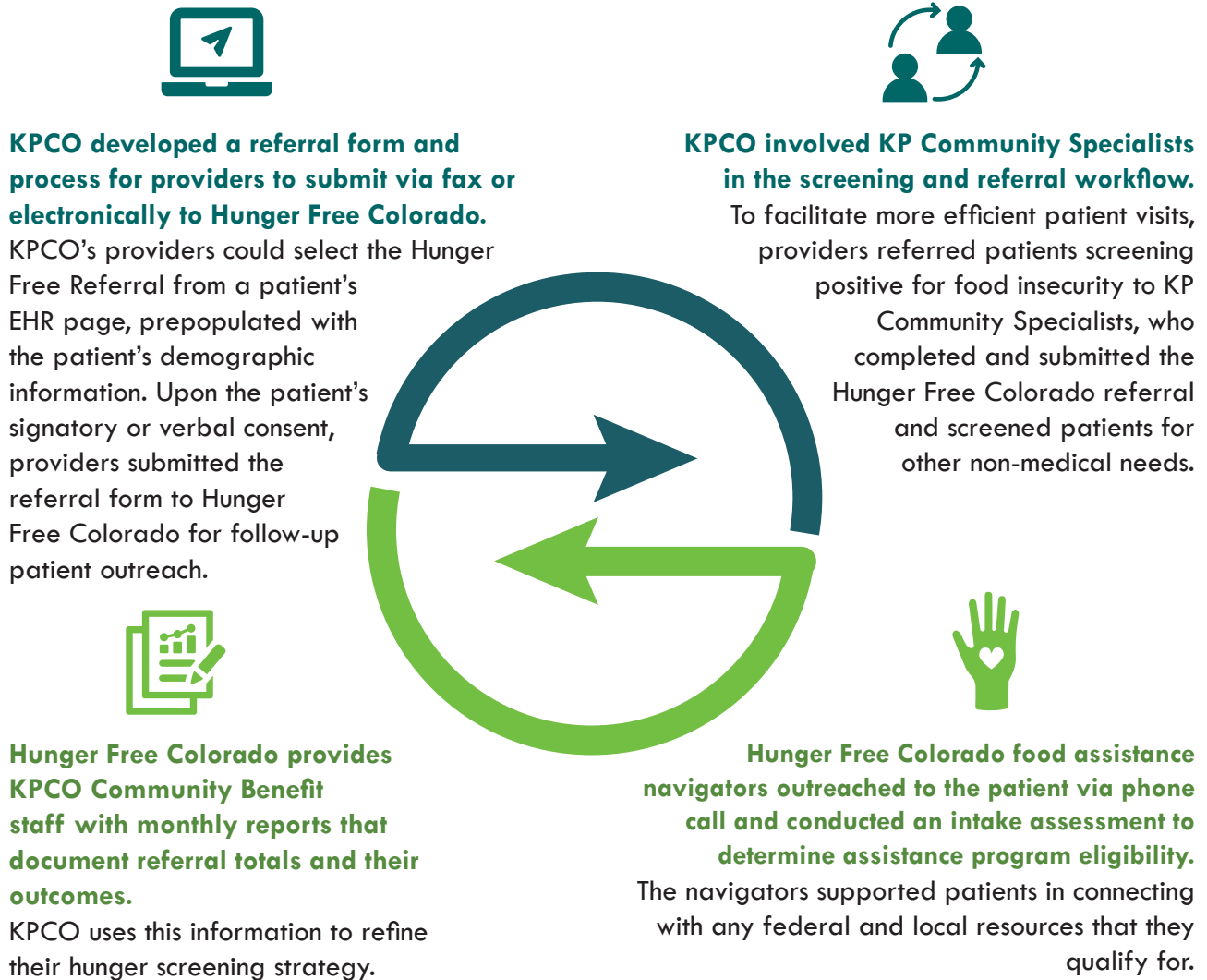
Establish Referral Mechanisms to Connect Patients to Community-Based Organizations

Health centers can aim for a more effective and comprehensive screening strategy across different sectors by establishing bi-directional community-clinic partnerships with local organizations. While providing patients with information about available community resources is a straightforward way to spread information, this model helps patients who may otherwise not act on the information they are provided.

An example of a successful collaboration can be seen through the partnership between Kaiser Permanente Colorado (KPCO) and Hunger Free Colorado, a community-based organization that connects people to food resources. Initially, providers at KPCO would refer patients to the Hunger Free Colorado hotline, which only 5% of KPCO's referrals contacted. To refine their partnership and improve referral outcomes, the two entities worked through several iterations to create an efficient, electronic referral process for KPCO patients experiencing food insecurity. Their improved referral strategy is depicted in Figure 2.

Between 2012 and 2015, about 1,839 members had been referred to Hunger Free Colorado, of which 78% had been successfully outreached to by the community-based organization. Learn more about KPCO's hunger screening efforts.

Figure 2: The bidirectional relationship between Kaiser Permanente Colorado and Hunger Free Colorado

KPCO developed a referral form and process for providers to submit via fax or electronically to Hunger Free Colorado. KPCO's providers could select the Hunger Free Referral from a patient's EHR page, prepopulated with the patient's demographic information. Upon the patient's signatory or verbal consent, providers submitted the referral form to Hunger Free Colorado for follow-up patient outreach.

KPCO involved KP Community Specialists in the screening and referral workflow. To facilitate more efficient patient visits, providers referred patients screening positive for food insecurity to KP Community Specialists, who completed and submitted the Hunger Free Colorado referral and screened patients for other non-medical needs.

Hunger Free Colorado provides KPCO Community Benefit staff with monthly reports that document referral totals and their outcomes. KPCO uses this information to refine their hunger screening strategy.

Hunger Free Colorado food assistance navigators outreached to the patient via phone call and conducted an intake assessment to determine assistance program eligibility. The navigators supported patients in connecting with any federal and local resources that they qualify for.

Establish a Food Prescription (Food Rx) Program

Health care systems across the country have turned to food prescription programs, such as the Food Rx program, to meet patients' food-related needs. The Food Rx program relies on community partnerships to bring free, nutrient-rich foods to health care patients experiencing food insecurity. Health care providers can "prescribe" a specified dollar amount for patients to purchase nutritious foods. Patients can redeem their Food Rx at the end of a visit or after their discharge and make healthy purchases at farmers' markets (on site at a health care organization or throughout the community) or at other participating community businesses. The FoodRx program has been established in communities throughout the country, such as Houston, Portland, Tampa, and Chicago.

In Cuyahoga County, Ohio, the PRxHTN program, a food prescription program for hypertensive patients, was piloted across three health centers and twenty farmers' markets. The PRxHTN program is a 3-month patient-based intervention that was designed to align with hypertension management efforts implemented at each health center. To support integration of the program into the clinic infrastructure, health centers

were encouraged to create a unique PRxHTN patient ID recording system. Health care providers implemented Hunger Vital Signs to identify and refer patients with hypertension and food insecurity to the program. Patients took part in three total health center visits where they received blood pressure checks, targeted nutrition counseling, and four $10 vouchers to purchase produce at participating farmers' markets. Providers also reviewed educational materials with participants, such as a location card listing the participating farmers' markets and a Community Food Guide that described low-cost healthy meal plans, shopping lists, and seasonal Ohio produce. Food insecurity screening, enrollment in the PRxHTN program, and program visits could occur before and/or after the provider visit, and at each visit, care team staff recorded in the EHR the patients' blood pressure and unique identifier, which was connected to their produce vouchers. In total, participating patients visited 12 of the 20 farmers' markets and redeemed $14,590 in vouchers between July 2015 to April 2016.

Centering Patient Wishes in Screening and Intervention Strategies

Community health centers have long been trusted and reliable sources of health care and community leadership for a variety of patients and their families. As such, health centers can play a significant role in ensuring all their patients are able to eat well and stay healthy as our communities rebuild together.

Regardless of what screening and intervention strategy your health center implements, an effective strategy requires that health centers empower all their patients in any effort to meet their social needs. Not all patients who are experiencing food insecurity may feel comfortable taking up referrals to local resources. For example, patients who are undocumented or live in a mixed-status household (where one or more family members may be undocumented) face many barriers to accessing public programs they may be eligible for. The Center for Child Health Policy and Advocacy at Texas Children's Hospital recommends that health care providers always engage in shared decision-making around social needs with families and avoid automatic referrals to available resources without patient consent and understanding.