Food Insecurity Learning Collaborative
Summary Report

July 2017

SUMMARY

In 2016, the Oregon Primary Care Association (OPCA) identified food insecurity as an area to further address with Federally Qualified Health Centers (FQHCs) across Oregon. Clinics were subsequently invited to participate in the Food Insecurity Learning Collaborative (FILC) to pilot food insecurity screening in a variety of Community Health Center (CHC) settings and to better understand the operational nuances of screening for and addressing food insecurity. Six clinics convened to participate in the FILC; ultimately, three piloted an intervention and completed a Plan-Do-Study-Act (PDSA) improvement cycle. Interventions varied from implementing a workflow for screening for food insecurity to following up with patients who received referrals for the food pantry to learn more about their experiences.

There were a few key findings about how food insecurity screening was most successful. Lessons learned include: the importance of thoughtfully determining the target population for the food insecurity screening; resources dedicated to developing and training staff on screening process; the importance of collaborating with external stakeholders on interventions addressing food insecurity; and having a sustainable funding source to support this work.

Several challenges emerged while doing this work. Most noted was the lack in Health Information Technology (HIT) infrastructure to collect and track information regarding food insecurity. Other challenges included accurately assessing the acuity of a positive screen and communicating with external community partners.

PURPOSE

In 2016, OPCA identified food insecurity as an area that clinic leaders hoped to further address in their clinics. As a result, clinics were invited to participate in the FILC facilitated and ran by OPCA Social Determinants of Health and Quality Improvement staff. Clinics opted in to the FILC and played a central role in defining how PDSAs would be developed.

BACKGROUND

Food insecurity is defined as a household-level economic and social condition of limited or uncertain access to adequate food[i]. Hunger is an individual-level physiological condition that may result from food insecurity[1]. Oregon has the ninth highest rate of hunger in the United States and it was one of the few states where the rate of food insecurity *increased* between 2014 and 2015[ii]. Individuals on Medicaid are twice as likely to be food insecure than the general population (Figure 1); nearly 50% of adults on the Oregon Health Plan (OHP) are food insecure. Therefore, the coordinated care organizations (CCOs) in Oregon, which serve a large percentage of Medicaid and food insecure populations, are uniquely situated to address this issue. Many rural areas and urban areas are considered food deserts, making it even more challenging for many patients to access healthy food.[iii]

Food Insecurity Rates by Oregon Counties

Max = 18%
Mean = 14%
Min = 10%

▼ = Rinehart Clinic
▼ = OHSU Richmond
▼ = Rogue
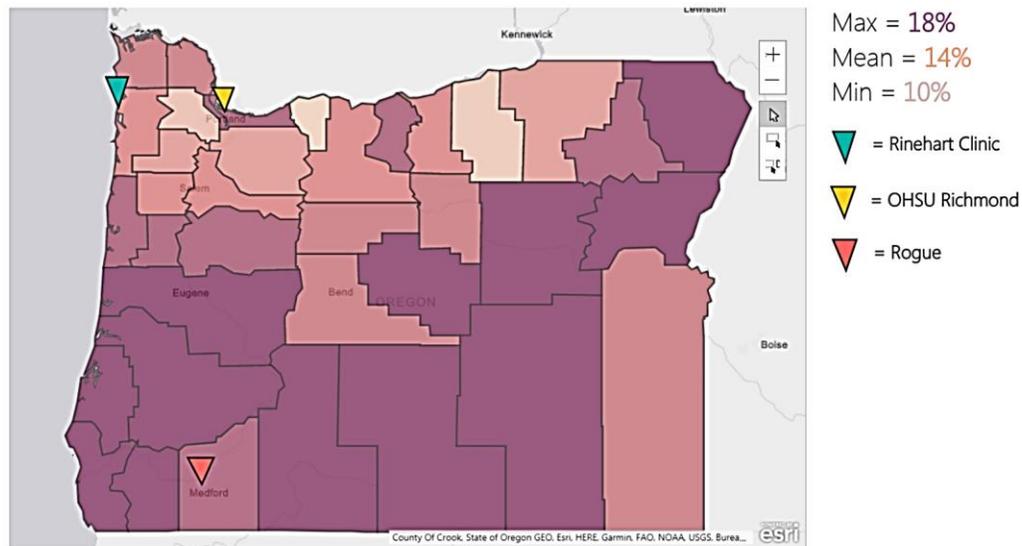
Source: Community Commons and County Health Rankings 2017 data: https://www.communitycommons.org/

With many CHCs piloting and implementing PRAPARE,[iv] a screening tool designed to learn more about the social determinants of health (SDH) that patients face, there has been increased effort to develop and pilot interventions to address SDH. In a survey of Oregon CHCs conducted by OPCA, clinic leadership identified food insecurity and housing as the two most important domains for CHCs to address.

In light of increasing momentum to understand patients' lived realities and social factors that impact their health[v], the Oregon Health Authority (OHA) Metrics and Scoring Committee has been considering implementing "food insecurity screening" as a metric for CCOs.
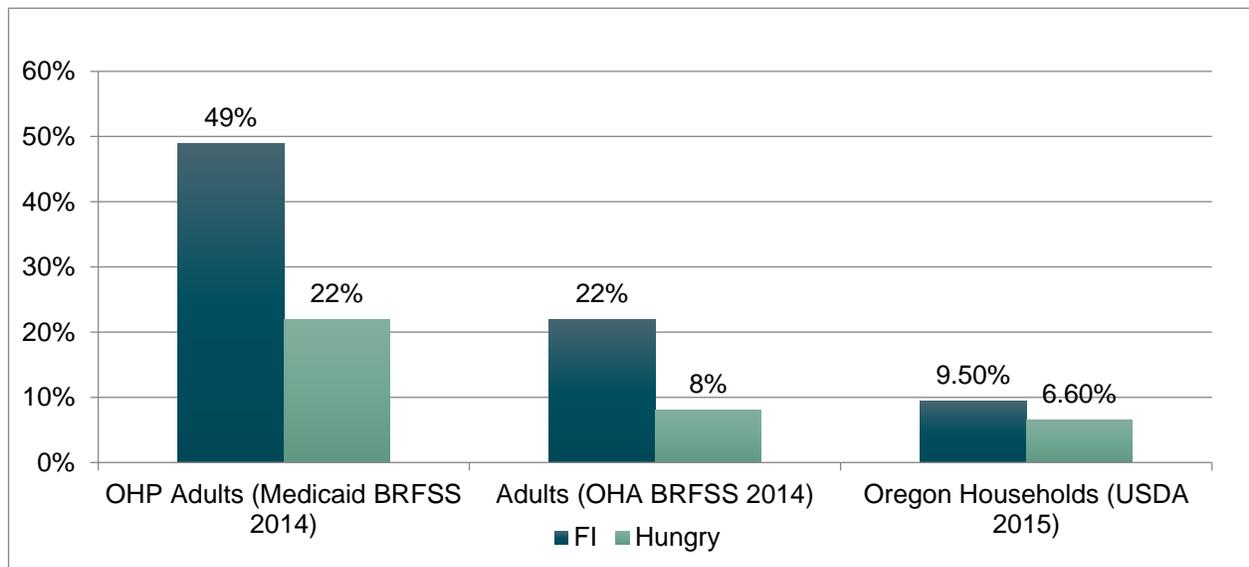
GOALS

A combination of beneficial policy factors in Oregon provided a rich opportunity to pilot food insecurity screening in a variety of CHC settings in an effort to better understand the operational nuances of screening for and addressing food insecurity.

There were three primary goals of the FILC:
- I.   To begin formalizing an approach to screen and intervene on food insecurity for CHC patients
- II.   To identify resources necessary for implementation of food insecurity screening and intervention
- III.   To identify and share initial best practices and lessons learned to inform future efforts around food insecurity screening and intervention

FRAMEWORK

The FILC, comprised of six Oregon FQHCs, was developed based on clinics' ability and interest in furthering efforts to screen for and address food insecurity in their communities. During Phase 1 of the learning collaborative, OPCA hosted four webinars through which clinics were able to learn about and explore potential workflows for food insecurity screening, develop technical capacity, and hear presentations from clinics doing this work. Phase 2 consisted of clinics identifying a pilot intervention to take on and test in their own setting for 8 weeks. Clinics were encouraged to select a population of focus for the pilot, at which point they identified an aim and undertook a PDSA cycle related to this aim. Some of these clinics were already engaged in work around food insecurity, and so chose to further refine their intervention approaches during the pilot. Other participating clinics chose not to participate in the PDSA process due to limiting factors in their own settings (i.e. staff turnover). There was a midpoint check-in to discuss early learnings and refine this work, and at the completion of the PDSA cycle, the clinics reconvened for Phase 3 to discuss their work, lessons learned, and future plans.

Given the screening involves asking personal questions about patients clinic participants were reminded to utilize an empathic inquiry approach during the food insecurity screening process. The goal of empathic inquiry is for the screening to feel less like data collection, but rather an opportunity to connect with patients. It draws on elements of motivational interviewing and trauma-informed care.

OVERVIEW OF CLINIC PDSAS

Rogue Community Health
Patients served: 8,408 in 2016 (small urban)
EHR: OCHIN EPIC

Prior to starting this process, Rogue was already partnered with a local community organization to host a mobile food pantry at one of their clinic sites on a monthly basis and was screening a segment of their population for food insecurity. The clinic's aim for the FILC was to understand the prevalence of food insecurity, particularly at their clinic in White City, and expand the mobile food pantry to that clinic once a month. The clinic utilized PRAPARE to screen for food insecurity and noted success in implementing this tool, as they were able to screen 169 patients in White City. Based on this screening, 30-39% of patients in White City were food insecure, depending on which aspect of food insecurity was being considered. During this process, clinic staff determined that PRAPARE did not always provide information about *current* needs, since the questionnaire asks about a patient's experiences over the past year. In attempts to explicitly assess current socioeconomic needs, the clinic drafted their own questionnaire, which they are working to integrate into the enrollment process for new patients at the clinic. The

clinic is also working with HIT staff to make this information extractable from the Electronic Health Record (EHR) to generate reports. The clinic has partnered with another community health center network in the region, the regional CCO, and a local community organization, ACCESS, to expand the mobile food pantry to other clinic sites utilizing a Community Health Improvement Project grant.

Rinehart Clinic
Patients served: 1,153 in 2016 (small rural)
EHR: OCHIN EPIC

Rinehart's aim focused on following up within one week with patients who screened positive for food insecurity and, as a result, received a referral to the food bank. They hoped to learn how many people had sought out these services and to understand the facilitators and barriers to doing so. Through telephone calls and in-person follow ups, the clinic was able to reach out to 70% of patients identified as food insecure at the initial screening time. Through this process, the clinic found that many of these patients had utilized the food bank at some point, and that having more than one resource for access to food was a key component of success for their intervention. Many people screened positive yet were not eligible or ready to engage in services at the food bank but felt differently when the setting was a local church. Next steps include screening a wider sample of the clinic's patient population and spreading the screening process to other clinic staff.

OHSU Family Medicine at Richmond
Patients served: 13,934 (large urban)
EHR: OCHIN EPIC

OHSU Family Medicine at Richmond aimed to establish a workflow for food insecurity screening for all patient visits. Recognizing this was a sizable scope, the clinic tested food insecurity screening for one clinician's panel and then expanded the pilot to a pod (3-5 clinicians working on a team) to determine if it was feasible clinic-wide. They were able to screen nearly 90% of patients in the clinician and pod pilots, and staff were able to follow up with patients who screened positive for food insecurity. Staff and patients agreed that it was well received and did not seem to add additional time burdens. The clinic decided that the workflow that was developed is implementable clinic-wide, and also improved the follow up and intervention process. To this end, the clinic is aiming to garner patient input through focus groups to ensure that food insecurity screening and interventions are patient-centered and responsive to patients' expectations.

LESSONS LEARNED

Successful workflows and interventions depend on sufficient staff training
A clinics' ability to successfully implement a food insecurity screening and intervention process relies on having adequate staff training at all levels. Clarifying workflows for staff was important as implementing a new process amidst the many existing responsibilities of staff can be challenging.

Importance of community collaboration and partnerships
All of the clinics emphasized the importance of having at least one resource that they can refer patients to when a patient screens positive for food insecurity. For many clinics, this was a food bank. Clinic partnerships fostered with external community organizations resulted in more robust interventions by harnessing expertise and building upon existing infrastructure without "reinventing the wheel."

Sustainable funding mechanisms

Interventions targeting food insecurity are difficult to implement in a traditional fee-for-service model. CCO's global budgets have facilitated these interventions for many clinics in Oregon. In order for these interventions to continue, sustainable funding streams must be identified.

Scalability is variable
Some clinics are able to screen all patients for food insecurity. Other clinics, whose resources are more limited, find food insecurity screening is more feasible as an intervention targeted towards a segment of patients. This approach requires understanding a clinic's food insecurity needs in order to ensure that the appropriate target population is selected and is being reached. This issue highlights the tension between screening everybody, even if they will not be eligible for an intervention, and narrowing an intervention to those who are highest risk for being food insecure.

CHALLENGES

Need for HIT infrastructure that collects and tracks data surrounding food insecurity interventions
Collecting and tracking data about patients' food insecurity was a substantial challenge for the clinics involved in the learning collaborative. Many of these issues stemmed from the EHRs' inability to accurately track the numerator (number of patients who screened positive) and denominator (total number of patients screened) for food insecurity screenings. As a result, clinics were unable to generate reports with accurate data about food insecurity needs. Instead, many of them performed manual data tracking utilizing Excel spreadsheets to generate reports and metrics for the food insecurity screening.

Assessing the acuity of an identified need
PRAPARE's food insecurity question, which was the standard for many clinics, asks about food insecurity "in the last year," meaning answers did not always reflect a person's current situation. It was not always clear who was *currently* experiencing food insecurity and would benefit from a referral.

Communication with external stakeholders
Interventions addressing food insecurity often involve other social services organizations in the community. Clinics found it challenging to close the loop on referrals placed to these social services organizations because there was no formalized or automated tracking system and they were unable to communicate with external stakeholders via the EHR.

NEXT STEPS

This work has provided valuable lessons about embedding social interventions into FQHCs. To further these efforts, considerations include:
- Discussing EHR and technology challenges with EHR vendors to improve data tracking
- Identify community partnerships and novel ways of accessing food
- Explore the potential stigma and preferred referral pathways from patients, including assessing barriers for people who are unable to successfully complete a referral to a community agency

For clinics who are hoping to implement similar interventions into a clinical setting, demonstrating the effectiveness will be very important, especially given that these types of interventions are relatively new. Choosing a specific population and a health outcome to track will be useful to best understand the impacts of a chosen intervention. Additionally, demonstrating benefit will be increasingly important to sustain ongoing funding for these interventions.

[i] "Definitions of Food Security." *USDA ERS - Definitions of Food Security* https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security/22 June 2017.

[ii] *Oregon's Spike in Food Security Worst Among All States*. (2016, November 21). Retrieved from Oregon Center for Public Policy website: https://www.ocpp.org/2016/11/21/fs20161121-oregon-food-insecurity-spike-worst/

[iii] Walker, Renee E., Christopher R. Keane, and Jessica G. Burke. "Disparities and access to healthy food in the United States: A review of food deserts literature." *Health & place* 16.5 (2010): 876-884.

[iv] Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE). NACHC, OPCA, and AAPCHA partnership. Retrieved from website: http://www.nachc.org/research-and-data/prapare/

[v] Berkowitz, Seth A., and Gabriel E. Fabreau. "Food insecurity: What is the clinician's role?" Canadian Medical Association Journal 187.14 (2015): 1031-1032.

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