Food Access in Health Care Consortium

Grant-funded project to build strategies for integrating food access in health care in Vermont. Located at Bi-State Primary Care Association.

Complementary Groups:

- Health Care Without Harm / Healthy Food in Health Care – Hospital food service directors are the primary focus.
- Farm to Plate Network – Had a food & health care group (they are changing their structure this year).
- Community Health / Population Health Programs – Part of the advisory group for this consortium.

Food Access in Health Care Consortium

Network Partners:

- Bi-State Primary Care Association (Project Director)
- Vermont Foodbank
- Hunger Free Vermont
- NOFA-VT
- VAHHS (joining fall 2021)

Advisory Group: Vermont Farm to Plate, Vermont Department of Health, Agency of Agriculture, Blueprint, OneCare, and VPQHC.

Plus anyone interested in participating in FAHC programs & projects.

- Program goal this year is to improve communication systems.

Vermont Food in Health Care Project

About

Outreach Systems

Increasing Program Impact

www.vtfoodinhealth.net

2020 – 2021 Focus Areas

Outreach Systems connecting:

- Health Care Practices & Community Based Organizations
- Patients with Food Access Programs
- Local Organizations with Statewide Networks
- Community Members with Information on Food Access

Medically Tailored Meals:

- A very specific type of food intervention focused on treating medical conditions that respond to dietary change

Increasing Program Impact:

- Connecting with National Research & Evidence-Based Models
- Peer-to-Peer Learning

Data & Measurement:

- 2020 focus largely on MTM systems and Program Impact connections

Sustainable Funding:

- Sustainable Funding for food programs in health care

2021 – 2022 Focus Areas Added:

Transportation Barriers:

- Project led by Farm to Plate as part of statewide food access planning.

Three Pilots Linking Food Interventions to Individual Patients' Heart Disease Risk:

- A separately funded project at FQHCs.
- Broader work on the basic components of establishing 4 links – food insecurity screening, closed loop community referral, diet change measurement, clinical measures.

Plus Ongoing Work In:

- Outreach Systems
- Increasing Program Impact
- Data & Measurement
- Sustainable Funding
- Medically Tailored Meals (and variations)

Food Insecurity Screening:

Looking for validated tool in common use – among SDOH screening options, food is the closest to having a standardized screen.

"Validation" here is against two measures:

- USDA Household Food Security Survey – which has been the national definition of food security for twenty years. (Not the same as nutrition security but does include basic quality considerations).
- Clinical Data / Health Outcomes

"Common Use" has three components:

- Screening at health care practices.
- Can be used by community partners – for example, childcare does screening.
- Meets common use standard for inducements rules (showing financial and medical need before paying for food).

Food Insecurity Screening

Hunger Vital Sign

"Within the past 12 months we worried whether our food would run out before we got money to buy more. Often / Sometimes / Never True."

" Within the past 12 months the food we bought just didn't last and we didn't have money to get more. Often / Sometimes / Never True."

Not Hunger Vital Sign (but something we see used)

"Within the past 12 months we worried whether our food would run out before we got money to buy more. Yes / No."
"Within the past 12 months the food we bought just didn't last and we didn't have money to get more. Yes / No."

One Question Only: "Within the past 12 months the food we bought just didn't last and we didn't have money to get more. Yes / No."

These variations produce a big margin of error (25% and more)

Why Care About Screening?

Assuming that we're talking specifically about health care programs, not general community programs, some reasons why it matters:

- Establishing that food access is a part of health, like all other risks that we screen for.
- Understanding full health picture for new patients and tracking patients' changing food security status.
- Because treatment options for many common conditions may include dietary change, it's important to know a patient's ability to follow those treatment plans.
- Following "evidence based" models for food & diet interventions (either clinical or cost related) – these usually assume screening as a first step. Similarly for comparing models peer-to-peer.
- When health care payers cover food as a medical expense, they almost always require food insecurity screening.

Early Results from FI Screening Survey:

With 20 respondents from health care practices – Note: this round doesn't include other health care professionals.

- 4 do not screen at all
  - These were mostly smaller practices
  - 3 indicated they are interested in starting
- The remainder use a form of Hunger Vital Sign (either alone or in a composite SDOH screen) at least some of the time.
- Not all practices use the same screen for every patient – for example, many use SBINS (which incorporates HVS) for Women's Health Initiative referrals, then a different screen for other patient groups.

Early Results from FI Screening Survey:

- Screening takes place most commonly at:
  - New patient intake
  - Annual Wellness Visits
  - Hospital discharge (either pre- or immediately post-)

- Interest expressed in expanding screening at times when we know there's a risk for changing food security status:
  - Oncology
  - OB /new mothers
  - Older patients

Early Results from FI Screening Survey:

- Screening is not consistently entered into the EHR in a structured way, about half of respondents say yes.
  - This might be influenced by EHR vendor. Epic includes HVS as standard.

- Very few respondents had an estimate for how many patients overall are screened.
  - The estimates provided ranged from 10% to 85%.

- All respondents indicated follow up provided after a positive screen.

There's still time to answer the survey . . .

It's quite brief and we're collecting answers until the end of September.

October 12th there's a webinar on HIPAA & inducements considerations for food programs at health care practices, that will include the role of food insecurity screening.

Survey link & webinar registration link are both online:

https://www.vtfoodinhealth.net/updates/webinar-oct-12th