

Food Insecurity Screening Survey Summary - October 5, 2021 (see also [executive summary & resources links posted on VTFoodInHealth.net](#))

Summary of Results:

- The majority (80%) of practices surveyed use a formal food insecurity screening tool, and these practices serve a significant percentage of Vermont patients.
 - Because respondents largely did not know what percent of their overall patient panel were screened, it is not possible to say what portion of Vermonters receive food insecurity screening on a regular basis at their health care practice. However, the screens were most frequently tied to new patient intake, annual wellness visits, and well child visits, and so it is likely a non-trivial number.
- Prior to the survey we knew that specific initiatives highlighted the use of Hunger Vital Sign or other screens that incorporate Hunger Vital Sign. The survey responses show that Hunger Vital Sign is broadly used by practices with a food insecurity screening policy, with 100% of practices using these questions. Only one practice indicated that the majority of patients screened use a different screening tool (this practice uses Hunger Vital Sign for a subset of patients and PRAPARE as the standard screen).
 - SBINS (Blueprint) and CMS' Accountable Health Communities screen incorporate Hunger Vital Sign, some respondents indicated they had modified other screening tools to add the Hunger Vital Sign.
- 75% of practices with formal screening processes enter the results into the EHR in a structured way. Changes in standard EHR options to incorporate food insecurity screening will likely help this percent continue to increase.
- Primary care sites use screening generally at new patient intake, annual wellness visits, and well child visits. Hospitals additionally indicated their starting specialty areas for screening and plans to continue to expand specialties included. Multiple respondents use screening and resource referrals as part of care transitions management. One area for future expansion may be food insecurity screening at times / following events that are known to indicate increased risk for food insecurity. The survey did not provide information on how practices use population data from screening (or other sources) to shape outreach around food resources outside of medical visits.

- The survey included an open-ended question regarding what happens following a positive food insecurity screen. Although only exploratory, the responses suggest a strong starting point for food insecurity screening followed by referral to staff who can connect patients to community resources. One caveat is that while practices responding to the survey indicated an internal referral as a follow up step, the responses do not add detail on how many patients complete the follow up appointment / any challenges to that completion, so capacity issues may still be a significant barrier. Responses did not provide information on how a positive screen translates into engagement with patients past the original referral, on either clinical or social needs. For example, the survey offers no insight into how PCPs integrate food insecurity screen information into working with patients on effective treatment plans. Because this individual connection and follow-up is one of the key reasons to implement structured food insecurity screening in health care, it is important to better understand the ‘what next?’ question.

Background to the Project:

In 2021 the Food Access & Health Care Consortium (FAHC), as part of HRSA-funded strategic planning, identified food insecurity screening at health care practices as an area for additional work. The question appeared in several project areas:

- **Outreach Systems:** Establishing systems to connect more Vermonters who need food assistance with community resources. Formalized screening at health care practices supports this goal because of the high percentage of Vermonters interacting with the health care system during a given year, and because screening as a routine part of health care reduces stigma and increases awareness that food access is foundational to good health.
- **Increasing Program Impact:** Researching clinical evidence and cost savings studies related to ‘food in health care’ model programs. Following an “evidence based model” includes the ability to match the patient screening process and, for many clinical interventions, being able to track information relevant for individual patients’ health plans / goals.
- **Sustainable Reimbursement:** Understanding and implementing common elements in health care payer systems that reimburse for food as part of necessary health care services. Reimbursement needs to match medical need and reasonable cost. A validated screen that reflects established economic and clinical measures (such as Hunger Vital Sign) makes this connection and allows

for the necessary data collection to track the impact of a food-based intervention on individual patients' health outcomes.

It is important to note that the FAHC was looking at formalized food insecurity screening as part of specific goals that had been identified related to integrating food access in health care practices. This is *not* the same as screening, or putting up any type of barrier, for community food access programs.

Survey and Responses:

In early fall 2021, the Food Access and Health Care consortium conducted an informal survey of the landscape of food insecurity screening systems in health care practices serving Vermont patients. The original survey received responses from 23 unique practices (see list at end, some answers were combined if received from sites within the same practice system). Outreach targeted hospitals, federally qualified health centers (FQHCs), and independent primary care practices because these were the focus of the grant supporting the work.

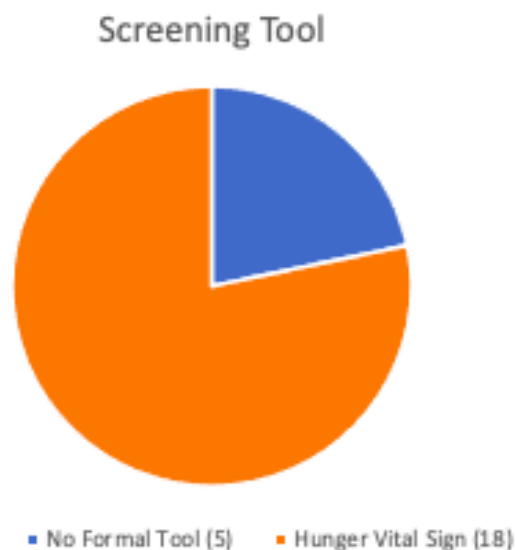
A few notes on the overall respondent pool:

- The information that follows is *not* weighted by the number of patients connected to each responding entity. For example, a network of hospital owned practices that all follow the same policy appear as one response, listed under that network.
- Vermont has targeted programs related to food insecurity screening for particular practice or patient types. For example, VCHIP and UVM Children's Hospital have supported a multi-year quality improvement project for Vermont pediatric practices on integrating food insecurity screening ([see this 2018 presentation for citations / examples](#)). Some programs, like the Women's Health Initiative at the Blueprint and some diabetes management programs, require SDOH screening prior to enrollment. Two practices indicated that they *only* screened for specific programs that required it, but most indicated that the reach was broader.
- FQHCs and hospital networks were very well represented in the survey, independent primary care practices were under-represented.
- Outreach was for health care *practices* not all health professionals who may be performing food insecurity screening - for example the Area Agencies on Aging do food insecurity screening as part of care coordination and were not included.

The goal of this survey was to get a snapshot that suggested trends, ideas, and useful questions for the future - it is not a definitive accounting of the state of food insecurity screening in Vermont.

Use of a Structured Food Insecurity Screening Tool

Hunger Vital Sign (HVS) is the most widely endorsed and implemented food insecurity screening tool. These questions appear on many SDOH screens, including Accountable Health Communities and SBINS. The screen has been validated against both the US Department of Agriculture's household food insecurity survey and against clinical outcomes. Additionally, HVS is a commonly used tool at partner and community organizations. More information on the background of this tool is available from [Children's HealthWatch](#).



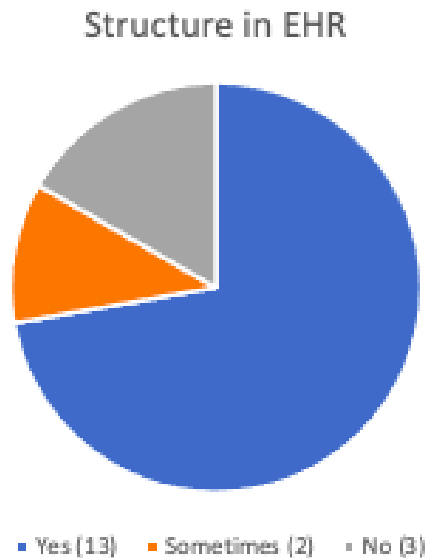
All respondents who incorporate formal screening use the Hunger Vital Sign questions.

The survey was structured to allow respondents to identify HVS in several different ways, it did not require familiarity with the term "Hunger Vital Sign." The most frequently cited comprehensive screen was the Blueprint SBINS tool, which itself incorporates the CMS Accountable Health Communities Health Related Social Needs (HRSN) screen, both of which use HVS. Some respondents indicated adjusting other SDOH screens, such as PRAPARE or a

self-created tool, to use HVS for the food insecurity question. One respondent uses HVS for some patients and unmodified PRAPARE for others.

Respondents who indicated that they do informal referrals or are planning to screen in the future were classified as not having a formal screening process.

Comments suggest that changes to EHR systems, in particular the Epic Foundation



System, to include the HVS food insecurity screening questions facilitated standardization for some practices. Some practices indicated the need to use different SDOH screens for different patients tied to enrollment in certain programs - because HVS is a common set of questions it is often (but not always) the same between screens. For other social risk factors with less standardized approaches this might create greater disconnects. In all cases it may cause confusion and hinder well-structured patient data. Standardized data systems for SDOH are an issue being discussed nationally, for example

in this [Health & Human Services report](#) (2019), [ONC work on SDOH data in Health IT](#), and the [Gravity Project](#).

Responses were not as unanimous for structured EHR input of screening results, with 75% of respondents who screen consistently entering results.

Patients Screened / Screening Process

The survey asked an open-ended question encouraging respondents to describe which patients were screened and in what settings. This question was designed to elicit initial responses to inform possible follow up, not to be the final answer.

Primary care practices indicated that screening takes place primarily at:

- New patient intake
- Adult annual wellness visits
- Well child visits

Several respondents described food insecurity screening as part of programs to manage transition in care as patients leave hospital stays.

Hospital respondents speaking to non-primary care settings described rolling out food insecurity screening by specialty area, with a list of both where screening currently takes place and where it is in the process of being implemented.

Although the question did not ask for planned expansion, many respondents offered comments in the response, including:

- Better coordination of screening and follow up tied to patient intake in emergency departments.
- More regular screening in certain specialty areas, particularly OB and cancer.
- More consistent screening and recording of results for patient intake.
- Screening at points where food insecurity status may change, including with major diagnoses or new mothers. One respondent indicated increased screening frequency for Medicare patients.

One respondent indicated using food insecurity screening data in the EHR to guide outreach for a farm share program. Otherwise, the survey did not provide much insight into using population health data to support proactive outreach to patients at risk for food insecurity. Very few respondents knew how many patients, overall, were screened in a given year, suggesting a possible gap in the use of data, even when entered into the EHR in a structured format. More detailed survey questions might have led to answers that included more insight on this outreach element.

Use of the Screen Results & Next Steps for Patients

A second open ended question asked: “Please briefly describe any additional steps if a patient screens positive for food insecurity.”

In the literature on food insecurity screening, there are many applications of a positive food insecurity screen result, including:

- Referral to an individual who can connect patients to additional resources - Community Health Worker, Care Coordinator, Social Worker, etc.
- Direct provision of services / food by the health care practice - for example a food box for people who need food immediately.

- Modification of treatment plans to reflect food insecurity status - for example, through a broader care team approach to patients managing chronic conditions.
- Integration of patient data into population health and community health initiatives, including outreach plans to engage patients at risk for food insecurity.

Respondents were not provided a check list of possible answers or prompted with these categories, the goal was to capture first responses. The open-ended responses fell almost entirely into the first category of referral to an individual for coordination, often with preliminary community resource information provided to the patient in the visit where screening took place.

One respondent highlighted a food bag program in which patients with a positive food insecurity screen are both referred to a care coordinator and written an immediate prescription to collect food before they leave. Many health care practices have food available for those who need it in the form of a food pantry on-site, pre-packed boxes, prepared meals, and gardens / garden baskets, that are not tied to food insecurity screening. A question for the future may be whether *both* offering open access food resources *and* “prescribing” them after a positive screen increases program impact. Program work in Vermont and elsewhere has suggested a benefit to employing both tactics. A direct prescription can overcome hesitancy in accepting food assistance and reinforce the food-health connection, while an open access option can be geared to patients who want anonymity and/or be designed as a celebration of local food abundance, for example with gardens and garden baskets. (Note: Food access programs without screening have legal constraints in a health care context related to inducements and anti-kickback rules, please implement them legally).

No practices indicated how they use food insecurity screening results for population health work, program design, or outreach to patients. However, we know that structures exist for regional and community collaboration around these topics, in addition to statewide programs and regular Community Health Needs Assessments for non-profit hospitals and FQHCs. Even if the surveys didn’t describe this work at the practice level, we can reasonably assume it does take place in some form.

Only one respondent indicated the capacity to refer patients with a positive food insecurity screen to a dietitian. No respondents indicated how a provider would use food insecurity results as part of working with patients in designing treatment plans for diet-affected health conditions. It is difficult to discern from this survey whether the screening occurred in such a way that the information was available to the clinician when discussing treatment - especially for those practices that indicated the information was not structured in the EHR. Some screenings take place as part of enrollment in a

specific program or within a context where we can assume clinical engagement, for example in arranging transition from hospital stays or as part of pediatric quality improvement projects. It is also likely that some practices are investing in food insecurity work primarily with a public health perspective and not as part of treatment for specific conditions. This survey offered little real insight into how food security status is integrated into individual patients' treatment plans.

Related to the clinical integration questions above, this survey only addressed food insecurity screening, it did not ask about other work done to assess diet quality. Through the HVS validation process, we know that this screening tool gives a rough estimate of reduced diet quality. However, it does not provide details, only that there is reason to believe the overall household diet does not support long term good health due to food affordability concerns. Patients with reduced diet quality for *other* reasons would not be flagged with this screen. This limitation includes patients who receive basic food access assistance after an initial positive screen but require more support for designing a diet to match their particular health needs.

Survey Participants

Caledonia Home Health
Community Health Centers of Burlington
Community Health Centers of the Rutland Region
Copley Hospital
Dartmouth-Hitchcock Medical Center
Gifford Health Care
Grace Cottage Hospital
Lamoille Health Partners
Little Rivers Health Care
Mountain Health Center
Northern Counties Health Care
Northwestern Medical Center
NOTCH
NVRH - Primary Care Practices and Community Connections
Porter Medical Center
Rutland Regional Medical Center - Transitional Care Program
Southwestern Vermont Medical Center
Springfield Hospital
Springfield Medical Care Systems
Stowe Natural Family Wellness

Thomas Chittenden
UVM Children's Hospital
UVM Health Network