INTRODUCTION & BACKGROUND

Learning Objectives

- Learn about local collaboration through COACH to address food insecurity.
- Understand value of incorporating an understanding of patient social needs into care.
- Gain background on food insecurity and its impact on health.
- Understand how to screen for food insecurity and how your institution is intervening to address positive screens.
- Based on your role, learn specific ways that you and others on your team can help to identify food insecurity and get patients the food they need to lead healthy lives.

COACH & Food Insecurity

Since 2017, 8 health systems in Greater Philadelphia have been working on a shared implementation strategy to address food insecurity through the Collaborative Opportunities to Advance Community Health (COACH) initiative.

These health systems are screening for food insecurity in varied clinical sites and responding to needs with referrals to resources and interventions such as pop up markets and summer meal programs.

Through COACH's Food Insecurity Workgroup, health systems and food access partners:

- Coordinate programming
- Share best and emerging practices
- Carry out data collection and dissemination projects.

Training Approach

This training, a product of the Food Insecurity Workgroup, distills the latest research, toolkits, and best practices into a flexible training framework.

The training is organized around 4 modules:

- Module 1: Social Needs & Their Impact
- Module 2: Background on Food Insecurity
- Module 3: Identifying & Addressing Food Insecurity in Healthcare Systems
- Module 4: Role-Based Guidance for Healthcare Systems

All team members at a site should complete as many module(s) as appropriate, based on their familiarity with the content and their role in the site's food insecurity project.

Summaries of each of the modules follow to be used as quick reference guides for the material covered in the PowerPoint slides.

MODULE 1: SOCIAL NEEDS & THEIR IMPACT

Key Terms

The opportunity for health begins—long before illness—in homes, neighborhoods, communities, schools, jobs.

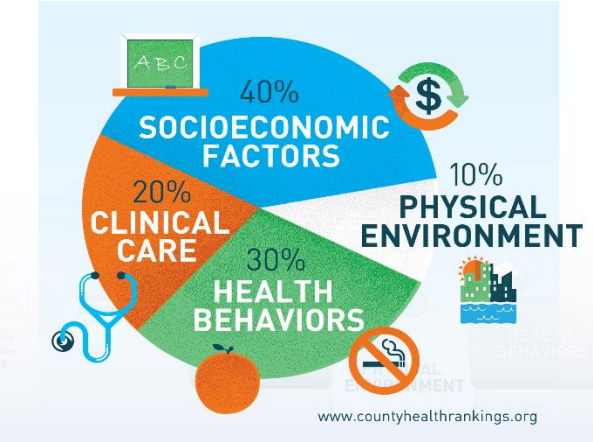
An expansive view of health that takes into account the impact of non-medical factors has given rise to greater awareness of several key terms. These terms are often used interchangeably but are distinct. Precision with these terms helps to hone in on and clarify the target and content of interventions.

Social determinants of health are the conditions in which people are born, grow, live, learn, work, play, or age. They are not something that a person can have or not have, and they are not positive or negative. Acting to address these determinants entails, for example, advocating for policies that improve communities' underlying social and economic conditions.

Social risk factors are negative conditions that contribute to poor health and assessment is done at the individual patient level. Screening for food insecurity or housing instability in clinical settings is an example of assessing for social risk factors.

Social needs are immediate and involve individual patients' preferences and priorities for what they would like to get help with. An example intervention is connecting patients to resources for needs identified as priorities and for which they request help.

Social Needs & Health



Health is complex, influenced by the health care we receive, our own choices, and our communities. These estimates of relative contribution of modifiable factors is based on the County Health Rankings model. As you can see, some modifiable factors impact health more than others. Clinical care alone is not enough to improve health. Although medical care is essential for relieving suffering and curing illness, 80% of the things that can help make us healthy are not part of the health care system. Given this, the proposal that health systems across the country are embracing is that we devote our collective attention and energy to that 80%.

This is critical, as it is truly a matter of life and death.

For babies born within 4 miles of Center City Philadelphia, opportunities to lead a long and healthy life can vary dramatically. Life expectancy in North Philadelphia is 68 years, as compared to 88 years in Old City. Why this striking 20-year gap? Maps of cities across the country show that the same communities with lower life expectancy also have low incomes and low educational attainment, as well as higher rates of obesity, diabetes, tobacco use, preventable hospitalizations, adverse childhood experiences, and frequent mental distress. There is a great deal of research demonstrating the association between social risk factors and these poor outcomes.

Prevalence of Unmet Social Needs

Taking into account patients' contexts is particularly important in light of recent data that suggests that many of our patients experience significant unmet social needs. A 2019 survey of over 1,000 U.S. adults found:

- One-third experience stress related to meeting basic needs, such as housing, food, and transportation.
- Among families at the highest income levels ($125k+), 40% reported at least one unmet social need in the past year.
- 97% of respondents said that medical providers should ask about social needs during visits.

Impact of Unmet Social Needs

These unmet needs show up in ways that you might recognize from your own patients. Some red flags include children with failure to thrive and repeated utilization of emergency rooms for chronic uncontrolled conditions. Not addressing these needs may result in limited therapeutic efficacy, as patients may be unable to adhere to treatment and recommendations, and limited impact on the most vulnerable populations, whose social needs worsen clinical needs.

Physicians, health insurance plans, and health systems increasingly recognize the impact of unmet social needs on health. Many health systems are beginning efforts to screen for and address unmet social needs. A growing research base demonstrates that specific interventions such as providing housing, medically tailored meals, fresh produce boxes, Earned Income Tax Credit, and the Low Income Home Energy Assistance Program (LIHEAP) can improve outcomes related to chronic disease and reduce healthcare utilization and cost.

As Sir Michael Marmot, a foundational researcher on social determinants of health, puts it, the "unequal distribution of health-damaging experiences" to certain social groups are a key cause of health disparities. It therefore makes sense that social determinants of health are inextricably tied to health equity. A focus on addressing unmet social needs provides one pathway towards addressing health disparities and ultimately promoting health equity.

MODULE 2: BACKGROUND ON FOOD INSECURITY

What is Food Insecurity?

Food insecurity is the lack of consistent access to enough food for an active, healthy life. Food insecurity is a household-level economic and social condition of limited or uncertain access to adequate nutritious food. Food insecurity is associated with poverty, unemployment, and scarcity of household assets.

Families can be considered food insecure if they experience anxiety about having enough food in the house; have to purchase lower quality, lower variety, or less desirable food; or have to eat less or less often. In households experiencing food insecurity, members unwillingly go without food occasionally or cyclically, such as at the end of a pay period or during peak fuel months. Summer months may be worse for children who are not receiving school meals.

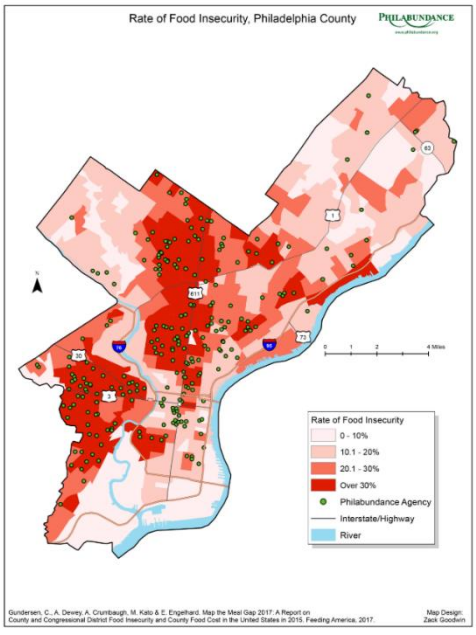
One in 8 U.S. households were food insecure in 2017. Food insecurity affects all communities in the U.S., and there is no single face of food insecurity. Food insecurity is often invisible and hidden.

Health care organizations across the country are increasingly embracing "Food is Medicine," or a spectrum of services and health interventions that are premised on the link between nutrition and chronic diseases or acute illness. According to Food is Medicine Massachusetts, "Food is Medicine interventions consist of healthy foods that are tailored to meet the specific needs of individuals living with or at risk for serious health conditions affected by diet."

Food insecurity interventions are **distinct** from "Food is Medicine" interventions. The target population of "Food is Medicine" efforts is those with acute or chronic illness or disability. Interventions to address food insecurity are broad-based and deployed regardless of severity of illness or symptoms.

Food Insecurity: Local Context

In Pennsylvania, 1 in 8 people struggles with hunger, in line with national estimates of food insecurity. The problem of food insecurity is more acute in Philadelphia: 1 in 5 Philadelphians—over 300,000 residents—are food insecure. Philadelphia County is among the top 10 counties in the U.S. with the highest number of food insecure people. Recent analyses show that hunger, including among children, is worsening in Philadelphia, in the context of declining rates of food insecurity across the U.S.



As you can see on the map, food insecurity rates can exceed 30% in large swaths of the city. Areas of high food insecurity are the same areas with high poverty.

The residents of these communities are at higher risk of trauma, which results when emotionally or physically distressing external events or experiences overwhelm a person's ability to cope and respond.

Food insecurity intersects with trauma in at least two ways:

- Individuals experiencing food insecurity may be more likely to have high exposure to adverse childhood experiences and may therefore be dealing with some form of trauma.
- Experiences of stress, anxiety, fear, and feelings of hunger related to food insecurity cause trauma. Sensitivity in our approach is therefore critical, or we may risk re-traumatizing patients.

Many households that are food insecure can be described as ALICE (Asset Limited, Income Constrained, Employed). These families live above the poverty line but struggle with household expenses like food. In 2017, 27% of Philadelphia households were ALICE (in addition to 28% living in poverty).

The Experience of Food Insecurity

Households experiencing food insecurity face tough choices and trade-offs. A large majority have to choose between food and utilities, medicine, housing, transportation, and education. They use coping strategies such as purchasing inexpensive, unhealthy food and watering down food or drinks.

Add to the other constraints food insecurity imposes, consider the specific challenge of healthy eating on a tight budget. In order to eat the USDA-recommended meal plan, families with low income would have to spend **43 to 70 percent** of their food budget on fruits and vegetables.

Food Insecurity's Impact on Health

Food insecurity is associated with these health issues:

- Higher levels of chronic disease, such as diabetes, hypertension, coronary heart disease, hepatitis, stroke, cancer, asthma, arthritis, chronic obstructive pulmonary disease, and chronic kidney disease
- Medication non-adherence
- Poor diabetes self-management
- Higher probability of mental health issues, like depression.

According to the Center for American Progress, the annual illness costs linked to hunger and food insecurity in America is **$130 billion.**

Impact on Special Populations

Food Insecurity Among Children

1 in 5 children in Philadelphia live in food insecure households. Children experiencing food insecurity have increased rates of:

- Behavioral issues (e.g., being less attentive, more aggressive and at a higher risk of delays in cognitive and social development)
- Low birth weight and high risk of infant mortality
- Anemia, asthma and poor oral health
- Increased school absences, reduced concentration and poor performance on cognitive tests
- Fatigue, headaches, anxiety, and depression.

Food Insecurity Among Seniors

According to the Philadelphia Corporation for Aging, hunger among Philadelphians aged 60+ rose from 11% to 12.25% between 2015 and 2018. Food insecurity in seniors is associated with:

- Increased risk of depression, asthma, poor self-reported health status, and activity limitations.
- Greater likelihood of suffering from heart conditions, such as heart attacks and coronary heart disease.

MODULE 3: IDENTIFYING & ADDRESSING FOOD INSECURITY

"Screen & Intervene" Process
This is the basic process for screening and intervening COACH participants are implementing.

Getting Ready
As you get ready to design your institution-specific processes, a collaborative team-based approach is strongly recommended.

- Consider who has the time, skills, and experience to talk to patients about sensitive topics and navigate patients through resource connection.
- Though physicians may not be involved in screening directly, they can play an important role in supporting the patient with resources and use the information for treatment planning.

These are key principles to keep in mind as you design your process:

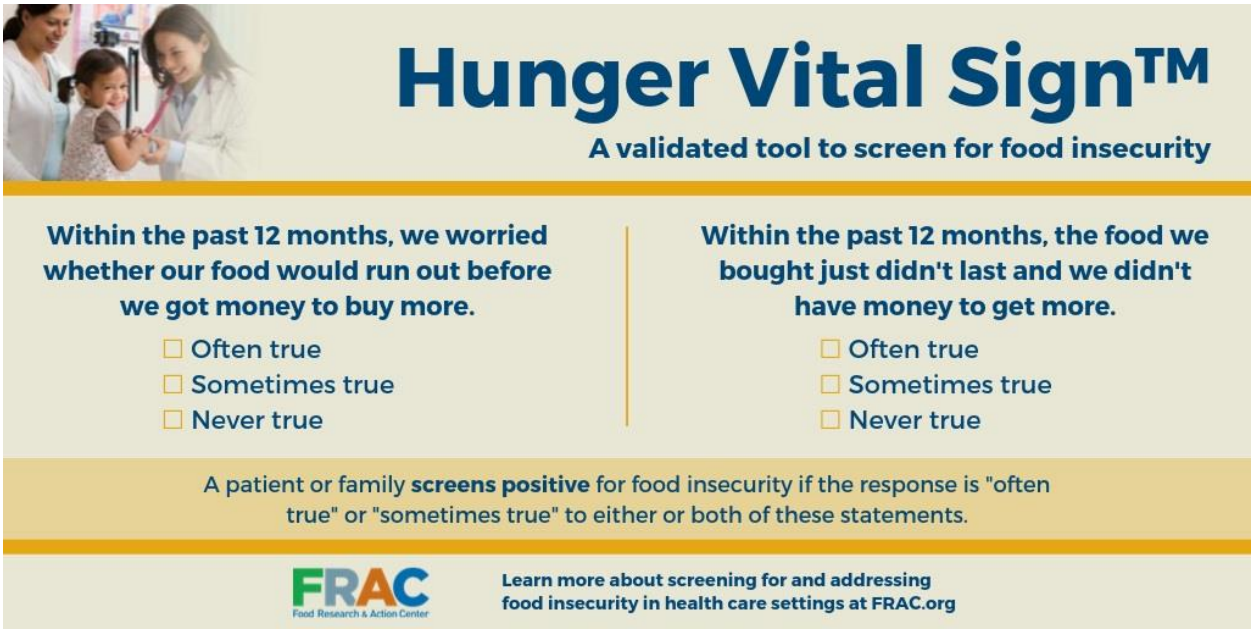
- Avoid targeted screening but instead adopt universal screening. You can't tell by looking!
- Provide context for your patients to understand why the questions are being asked
- Inquire about needs with sensitivity and support.
- Adopt a patient-centered, strength-based approach to engaging patients about their needs.
- Ensure actionability and capacity to refer and link to appropriate resources in response to need.

To prepare for implementation of your process:

- Channel **curiosity** about your patients' situations as you get ready for screening.
- Posters in waiting or exam rooms can help set the stage for questions about food and nutrition.
- Keep in mind that patients may be dealing with trauma arising from a variety of causes, including food insecurity itself. Consider how you could do the following for patients:
    - Convey safety, trustworthiness, and empathy.

- Invite their collaboration.
- Establish choice and sense of control.
- Empower their action.

Screening
Use the Hunger Vital Sign to screen for food insecurity.



Growing evidence suggests that screening methods that preserve anonymity (e.g., written or tablet-based screening, screening in the emergency department) elicits higher rates of disclosure.

If you are screening verbally, it will be critical to approach screening with sensitivity and empathy. Food insecurity is a sensitive subject. Patients may be embarrassed, ashamed, uncomfortable, or even afraid to admit that they struggle to meet the food needs of their families.

To help direct your support of patients who have food needs, you might also consider asking:

- If they would like assistance
- If they are already receiving services or participating in programs
- About potential barriers to accessing resources
- About the kinds of resources they are most interested in.

Intervening
As you devise responses to positive screens, consider the following:

- Providing patients resource lists alone is not sufficient to facilitate resource connection and ultimately meet their needs.
- Local research has demonstrated the complexity of patients' situations that prevented resource connection:
  - Food insecurity was just one of several other significant social needs patients were balancing.
  - Patients encountered significant system barriers.

A more comprehensive, layered approach that offers patients multiple types of resources (immediate vs. longer term, food vs. other resources) presents the possibility of meeting patients where they are and offers them choice with regards to types of resources.

This "menu" was developed through COACH in 2019 to present possible interventions COACH members could consider adopting.

Spotlight on SNAP

The slides provide an overview of the Supplemental Nutrition Assistance Program (SNAP). The key points to keep in mind:

- SNAP is a critical tool for combating food insecurity.
- Getting and keeping SNAP benefits can be difficult due to eligibility and application requirements.
- The amount of SNAP benefit is often not enough for most households, but research shows that it provides a crucial stepping stone to better health.

Local Food Access and Hunger Relief Organizations

These slides provide an overview of important food access partners in the Philadelphia area. Organizations, their primary programming, and points of contact are listed here. For more information, refer to the slides.

1. Benefits Data Trust
   a. BenePhilly: a free program that helps low-income Philadelphians enroll in critical benefits and services over the phone
   b. Contact: Benephilly@bdtrust.org

2. The Food Trust
   a. Healthy Food Incentives/Produce Prescription Programs
   b. Farmers Markets
   c. Financing and Technical Assistance for Healthy Food Retail
   d. Nutrition and Education Screenings in food retail sites, schools, and community settings
   e. Contact: Julia Koprak (jkoprak@thefoodtrust.org)

3. Greater Philadelphia Coalition Against Hunger
   a. Immediate relief: connections to direct relief food pantries and kitchens
   b. Short-term relief: SNAP application hotline
   c. Long-term relief: local, state, and federal policy advocacy
   d. Contact: Tanya Sen (tsen@hungercoalition.org)

4. Greener Partners
   a. Food access: including farm sites, community and school education, and produce distributions
   b. Food education: the Farm Explorer mobile field trip farm
   c. Food sovereignty: through school and community gardens
   d. Contact: Helen Nadel (helen.nadel@greenerpartners.org)

5. Philabundance
   a. Relieve Hunger Now: 350+ member direct service network
   b. Ending Hunger for Good: healthy food and services paired with long-term solutions to food insecurity
   c. Contact: Emily Glick (eglick@philabundace.org)

6. Share Food Program
   a. Commodity Food Supplemental Program hunger relief
   b. Emergency Food Relief Program and The Emergency Food Assistance Program
   c. Contact: Danny Griffith (dgriffith@sharefoodprogram.org)

MODULE 4: ROLE-BASED GUIDANCE

The following provides guidance on what different members of the team can do to support your screen and intervene efforts.

If you're at the front desk…

- People may approach you with questions about the screening tool.
- Be prepared to share the purpose of the screening:
  - "We are asking all of our patients these questions."
  - "We want to be sure that all of our patients are connecting to resources for which they might be eligible."

If you're conducting the screening…

If screening is happening verbally, here are possible scripts for introducing the questions:

- "Our goal is to provide the best possible care for your child and family. That's why we ask all patients about their access to food. We would like to make sure that you know all the resources that are available to you for your problems. Many of these resources are free of charge."
- "I'm seeing so many patients that have a hard time affording food, so I'm asking all my patients some questions about this. Please let me know if these statements are true for you and your family…"

If you're connecting patients to resources

After a positive screen, affirm their experience:
"That must be very difficult. I'm glad you shared this with me because the kinds of foods you eat are really important for your health. I'd like to connect you to a local organization that can help you access available food assistance programs, such as food pantries near your home and the Supplemental Nutrition Assistance Program, which is often called SNAP. I can help you connect to them now, if you're interested."

To help target resources and interventions, ask:
"Can you tell me what resources you are already using? What types of programs would be helpful to you? What barriers to getting to these resources can I help you with?"

Consider using physical environment cues (e.g., posters, brochures) that help to normalize program participation. Share personal stories about food assistance (e.g., "when I was a child, my family used SNAP" or "I have other patients that use SNAP and it is really helpful"), as appropriate.

Normalize the need:
"Help is available, and I'm happy to work with you to make sure that you get access to what you and your family need. Most people across the country need assistance at some point in their lives."

Encourage use of the resources by connecting to how they will benefit family members (e.g., health and well-being of children):
"SNAP will help you buy the fruits and vegetables your child needs to grow and stay healthy. I'm recommending SNAP just like a doctor would prescribe a medication."

Consider patients' immigration status:

- Immigrant families may be "mixed status," with children who are citizens and therefore may be eligible for food assistance. These families may still have concerns about accessing these resources.
- Before referring immigrant families to nutrition programs, consider partnerships with organizations who serve immigrants and refugees. These groups may be able to help teams navigate eligibility:
    - Benefits Data Trust
    - Community Legal Services
    - Greater Philadelphia Coalition Against Hunger
    - Legal Clinic for the Disabled
    - Nationalities Service Center

If you're following up with patients

Potential questions:

- **If they did connect:** "Can you walk me through your experience with this particular food resource?," "What has been most helpful about this resource?," and "Can you tell me about any problems you faced contacting or using this resource?"
- **If they did not connect:** "Can you tell me why you have not connected with the resource?" "Would you consider using any of the food resources we talked about in the future? Why or why not?"

If you're a clinician on the care team

Consider food insecurity status when making diagnoses and creating care plans. Could lack of access to nutritious food be the cause of or exacerbating a patient's symptoms? Could financial stress cause the patient to fail to take their prescribed medication?