

Engaging Patients to Address Food Insecurity: Partnerships between Food Banks and Health Clinics

Presenters

Nancy Coffey – University of Wisconsin - Extension

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Illuminating Intersections: Hunger & Health

<https://www.youtube.com/watch?v=QkGdGLNj0HM>

Food as Medicine Partnership



**Prescribing
Healthy Food -
the Medicine
Families Need to
Thrive**

Hunger Prevention Coalition - UWEC Food Security Project Team



- Feed My People Food Bank
 - Emily Moore, Executive Director
- UW Extension FoodWise Nutrition Coordinator
 - Nancy Coffey
- University of Wisconsin-Eau Claire
 - Mary Canales, Nursing Professor
- Community Organizer, JONAH
 - Paul Savides

Food Security/Hunger

- **Food Security**

- Access by all people at all times to enough food for an active, healthy life

- **Food Insecurity**

- **Low food insecurity:** reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake.
- **Very low food insecurity:** multiple indications of disrupted eating patterns and reduced food intake.

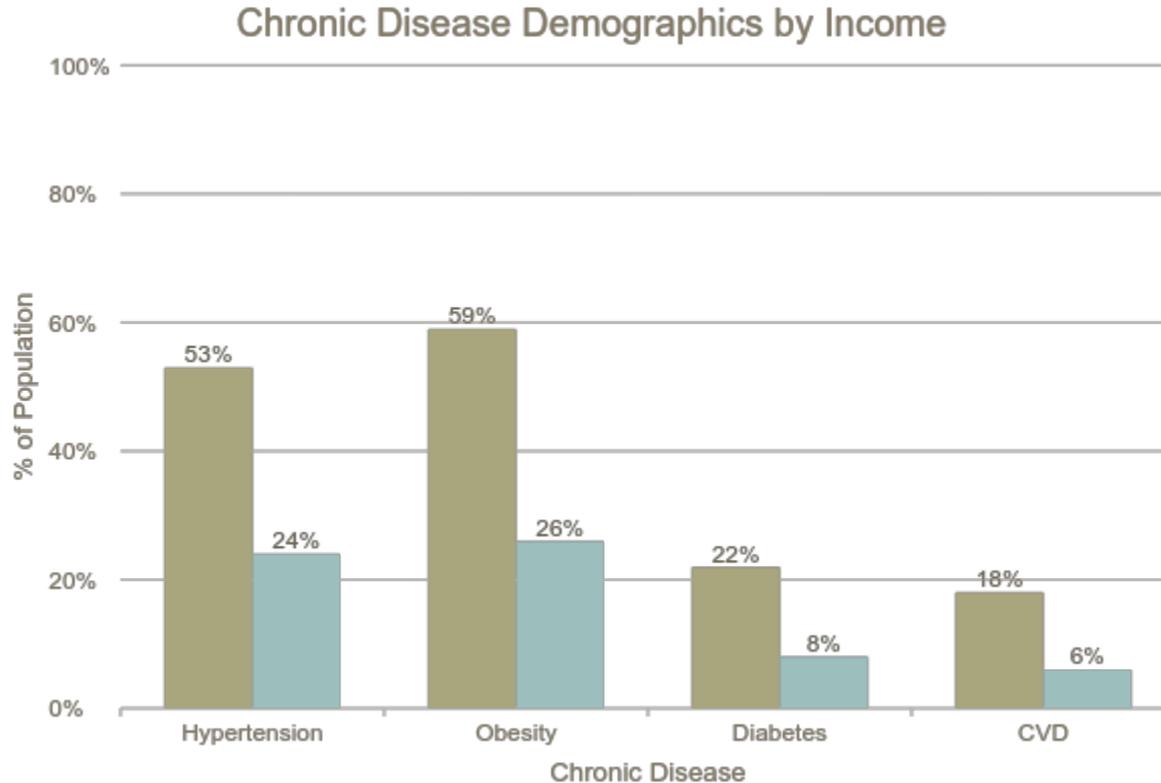
(USDA Definitions)

Eau Claire County Food Insecurity (FI)



- 1 in 5 children in food insecure household
(Feeding America, Map the Meal Gap, 2016)
- 1 in 8 residents food insecure
(Feeding America, Map the Meal Gap, 2016)
- 1 in 6 residents participated in FoodShare (nationally SNAP)
ECC-38% kids (DHS, 2016)
- % children enrolled in free or reduced price lunch; Eau Claire Area School Dist-42%,
Augusta School District -50% (DPI, 2016)

Health Consequences of Low income



Bodenheimer, T., Chen, E. & Bennett, H.D. (2009). Confronting the growing burden of chronic disease: can the U.S. health care workforce do the job? *Health Affairs*, 28(1), 64-74. doi: 10.1377/hlthaff.28.1.64

2Q FI Screening Tool

- For each statement, respondents choose whether the statement was “*often true, sometimes true, never true, or don’t know or refused*” for their household.
 - Within the past 12 months we *worried* whether our food would run out before we got money to buy more.
 - Within the past 12 months the *food we bought just didn’t last* and we didn’t have money to get more.

Voices of Food Insecure:

"[If I were asked about my food insecurity], I'd be happy that someone was keeping track of my nutrition."

"It would be nice to get the food right there [at the clinic]...I can only carry so much on my bike."

"Some mornings I hurt so bad I can't even get out of bed. If my roommate didn't help, I wouldn't eat all day. I wish food could be delivered [to my apartment] like my drugs."

"I'd be glad to talk about [my food insecurity]. I have to feed my kids. My kids come first."

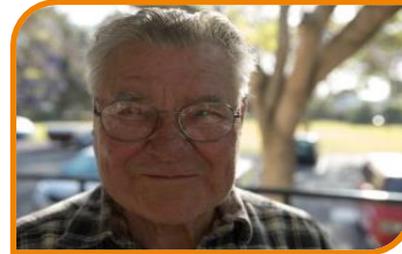
Food as Medicine Partnership



- Program in Infancy
- Rural Community
- No full time Food as Medicine Partnership staff
- Addressing Community Stigma



Improving Food Access for Healthier Outcomes

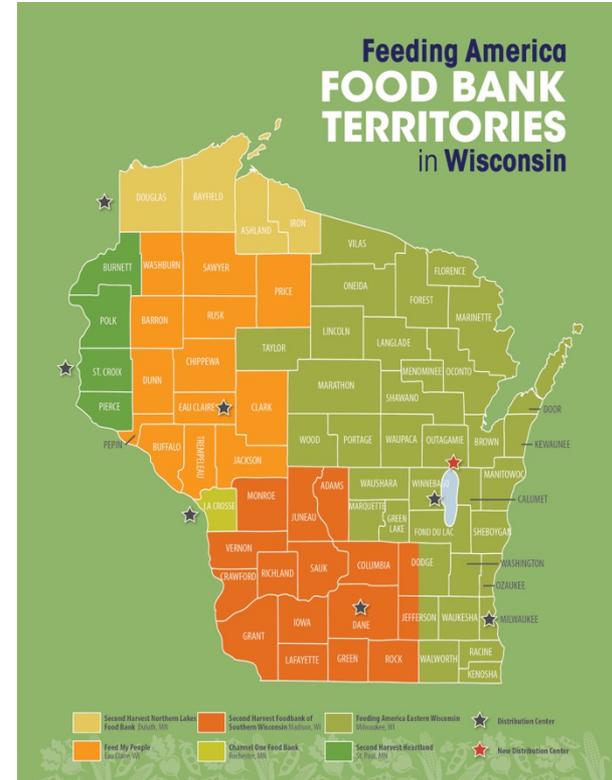


*Anne Gargano Ahmed, MPH, MPA
Second Harvest Foodbank of Southern Wisconsin*

Second Harvest Foodbank of Southern WI



- **Mission:** Ending hunger in SW WI through community partnerships
- More than 225 partner agencies and programs
- Provided over 13.7 million meals to more than 100,000 people facing hunger in FY16



About the HungerCare Coalition

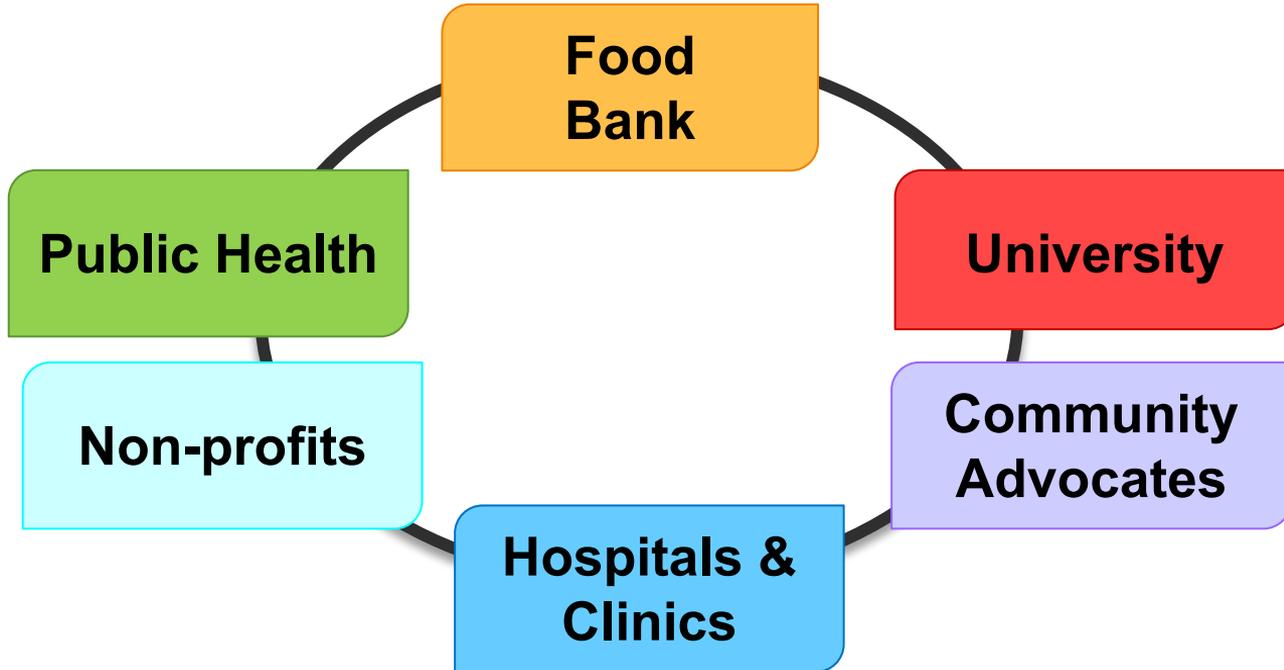


Mission: *To improve physical, mental and emotional health outcomes in southwestern Wisconsin by increasing access to healthy, nutritious food, through strategic partnerships with members of the health care community.*

- Partner with health care providers
- Provide tools to screen
- Connect patients with resources
- Improve health outcomes



Coalition Members



Coalition Design



- **Staff Coordinator** to work one-on-one with clinics and hospitals
- **Coalition Workgroups**
 - Provider Education
 - Intervention Strategies
- **Quarterly Coalition Meetings** to share successes & challenges

Who is screening so far?



Thank You!



To learn more please contact:

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www.hungercare.org



Food Insecurity Screening at GHC-SCW

Hunger and Health Summit, May 9, 2017

Alison Craig, MD, FAAP

Chief of Staff, Pediatrician

acraig@ghcscw.com



Agenda

- Intro to Food Insecurity Screening at GHC-SCW
- Lessons learned from our implementation
- Summary



Group Health Cooperative of South Central WI

- Locally managed Health Care cooperative since 1976.
- Providing care to 70,000+ members in Dane and Sauk Counties.
- Six staff model clinics in Dane County.
- 56 primary care providers.
- In-house specialists include Dermatology, PT/OT, Clinical Education, Optometry, Chiropractic care, Behavioral Health and Complementary Medicine.
- Community Care Department
- We partner in specialty care with UW Health

Food Insecurity Screening Project History

- 2011 - The original Nutrition Activity Screening.
- 2015 – GHC Health Equity Committee re-chartered.
- Spring 2015 – Food Insecurity Project team developed. Partnered with the HungerCare Coalition of Second Harvest Foodbank.
- June 2015 – Universal food insecurity screening during pediatric preventative health visits.
- Fall 2015 – Health Equity analytics revealed disparities in utilization and outcomes. Data combined with training to resolve disparities. New languages added.
- 2016 – Utilization improved, disparities reduced. Patient feedback survey.

2016 Overall Data



- 7832 pediatric physicals 18 months to 18 years.
- 85% screened for food insecurity (up from 80% in 2015).
- One in 25 patients screened positive, equaling 243 patients.
- All patients offered written resources. Available in multiple languages.
- 125 families received individualized phone consults with a GHC Community Service Coordinator.

Lesson 1 – A Diverse Project Team Helps

- Health Equity Committee
- Community partners – HungerCare Coalition, Second Harvest Foodbank
- EHR application team
- Care Team Specialist (LPNs/CMAs)
- Primary Care Provider
- Community Service Coordinators
- Business Intelligence (reporting)
- Learning and Development
- Senior Leadership sponsorship
- Patient voice



Lesson 2 – Community Partnerships add to the Innovation and Momentum.



Lesson 3 – Build On What You Already Have

Group Health Cooperative
of South Central Wisconsin

GHC-SCW Nutrition and Activity Screening

Pediatric Patient at
18 Months – 18 Years

Patient Sticker

Please circle the best answer for each question below:

1. **Food Choices** - how many times per day does the patient:

- a. Eat vegetables (excluding French fries)? 0 times/day 1-2 times/day 3+ times/day
- b. Eat fruit? 0 times/day 1-2 times/day 3+ times/day
- c. Eat fried food? 0 times/day 1-2 times/day 3+ times/day
- d. Eat sweets and/or salty snacks? 0 times/day 1-2 times/day 3+ times/day
- e. Drink soda, fruit drink or juice? 0 times/day 1-2 times/day 3+ times/day
- f. Drink milk or eat yogurt 0 times/day 1-2 times/day 3+ times/day

What type of milk does the patient drink: Whole 2% 1% Skim Other: _____

g. Is patient vegetarian? Yes No

h. Does patient take a vitamin/mineral supplement? Yes No

2. **Meal Patterns** – how many days per week does the patient:

- a. Eat breakfast? 0 days/wk 1-4 days/wk 5+ days/wk
- b. Eat dinner with the family? 0 days/wk 1-2 days/wk 3+ days/wk
- c. Eat "fast food" meals? 0 days/wk 1-2 days/wk 3+ days/wk
- d. Eat meals or snacks in front of the TV? 0 days/wk 1-2 days/wk 3+ days/wk

3. **Physical Activity**

How many hours per day of screen time (TV, phone, laptop) does the patient have:

Less than 1 hour/day 1-2 hours 3-4 hours 5 or more hours

How many days per week does the patient (for ages 3 and above):

Participate in physical activity (walk, ride bike, play sports, etc.) for an unburdened total of 60 minutes or more?

0 days/wk 1-2 days/wk 3-4 days/wk 5-6 days/wk 6-7 days/wk

4. **Questions for Parent/Guardian:**

- a. Are you concerned about your child's weight? Yes No
- b. Do you think your child is concerned about his/her own weight? Yes No
- c. Within the past 12 months, did the food that you bought ever run out before you had money to buy more? Yes No
- d. Within the past 12 months, did the food that you bought ever run out before you had money to buy more? Yes No

Fruits
Veggies
Calcium
Sweetened drinks
Protein
Vitamins
Exercise
Screen time

For parents/guardians:
Weight concerns
Food Insecurity

GHC adapted questions:

1. Within the past 12 months, have you ever worried that your food would run out before you got money to buy more?

2. Within the past 12 months, did the food that you bought ever run out before you had money to buy more?

Lesson 4 – Little Kids are Listening

GHC Workflow for FOOD INSECURITY screening

GHC NAS (Nutrition and Activity Screening tool) including the two Food Insecurity questions administered to parent/guardians of children 18 months to 18 years during all well-child exams.

“Thank you for filling out our Nutrition and Activity Screening today. At GHC, I work with a team of people, called Community Service Coordinators, who are often able to connect families with a variety of resource in the community. Would it be okay with you if I ask one of them to give you a call to talk about local food and nutrition resources?” If yes, tell the parent/guardian that the CSC will be in touch within 1-2 weeks. If you sense the urgency is greater, please alert the CSC ASAP.

Lesson 5: Without A Screening Tool, Food Insecurity Might Not Come Up

Qualitative interviews with primary care team at one site during implementations. Kate Ridgeway, NP student

Do you ever discuss food access with patients outside of the NAS screen?

- No
- No
- No
- No
- No
- Every once in a while
- No
- Not frequently

Lesson 6: Look To The Data To Identify and Lessen Disparities

Screened	Total	Caucasian/ White	Asian	Latino/ Hispanic	African American/Bl ack
2015 Q3/4	80%	81%	83%	79%	76%
2016	85%	87%	80%	88%	82%
2017 Q1	86%	88%	82%	86%	84%



Food Insecure	Total	Caucasian/ White	Asian	Latino/ Hispanic	African American/Bl ack
2015 Q3/4	5%	2%	5%	7%	15%
2016	4%	2%	4%	6%	17%
2017 Q1	3%	2%	2%	7%	13%



Lesson 7: It takes a Care Team

“It would be nice to have **more information** about the entire process, from screening to what happens after a referral is entered.”

“A lunch and learn would be a good way to provide this information. **It would also help if providers would emphasize its use.**”

“There is some confusion as to who should enter the referral. This task needs to be clearly assigned.”

Lesson 8: Community Service Coordinators are the Secret Sauce

- In-person visits
- Telephone encounters
- Written materials provided
- Interpreter involved
- Personalized needs assessment of household
- Additional screening for other social determinants of health
- Connection to resources
- Son Nguyen, snguyen@ghcscw.com



Lesson 9: Understanding Patient Experience means asking patients for their feedback.

- Thirty-seven (37) families agreed to receive GHC Community Services Coordinator consult to address food insecurity after screening positive for food insecurity at their child's wellness visit during 7/1/16-9/30/16.
- Food resources were mailed to the families either after speaking to them directly or sent to them after 2 unsuccessful attempts via phone.
- A survey was sent to the families in the beginning of December 2016 to evaluate their food insecurity after receiving food resources from GHC staff.
- Sixteen families responded to the survey which comes to be 43% response rate.
- Families who completed survey by 12/30/16 received \$20 gift card at a local grocery store.



GHC-SCW Member Number: _____

1. Did you use the food resources you were offered by the staff at Group Health Cooperative of South Central Wisconsin?

If no, continue to question #3.

- Yes No

If yes, what food resources did you use? Check all that apply.

- Food pantry or Mobile Pantry
- Community Meal/Free Meal Sites
- Foodshare (Quest Card)
- Women, Infants, & Children (WIC)
- Farmers' Market Double Dollars Program
- Summer Food Service Program through school
- Other_____

If you used these food resources above, how true are the following statements?

1. We don't worry as much about running out of food before we have money to buy more

- Often true
- Sometimes true
- Never true

2. After being given food resources, please check the box that is most true for you.

- We rarely run out of money to buy food
- Sometimes we run out of money to buy food
- We often don't have enough money to buy the food we need each month

3. I had trouble getting the help I needed for food because: Check all that apply.

- Transportation
- Child Care
- I didn't qualify for food programs
- I felt ashamed or guilty asking for help
- Other_____

Results of the Patient Survey



- **Did you use the food resources you were offered by the staff at Group Health Cooperative of South Central Wisconsin?**
 - Yes= 13 (81%) No=3 (19%)
- **If yes, what food resources did you use? Check all that apply.**
 - Food pantry or Mobile Pantry = 12 (92%)
 - Community Meal/Free Meal Sites = 5 (38%)
 - Foodshare (Quest Card) = 9 (69%)
 - Women, Infants, & Children (WIC) = 4 (31%)
 - Farmers' Market Double Dollars Program = 5 (38%)
 - Summer Food Service Program through school = 3 (23%)

If You Used These Food Resources, How True Are The Following Statements?

- **We don't worry as much about running out of food before we have money to buy more.**
 - Often true = 2 (17%)
 - Sometimes true = 9 (75%)
 - Never true = 1 (8%)
- **After being given food resources, please check the box that is most true for you.**
 - We rarely run out of money to buy food = 5 (38%)
 - Sometimes we run out of money to buy food = 6 (46%)
 - We often don't have enough money to buy the food we need each month = 2 (15%)

Results Of The Survey

- **I had trouble getting the help I needed for food because: Check all that apply.**
 - Transportation = 5 (31%)
 - Child Care = 2 (13%)
 - I didn't qualify for food programs = 4 (25%)
 - I felt ashamed or guilty asking for help = 2 (13%)
 - Other = 3 (19%)
 - “Only qualified for small amount, plus all income was going to bills. We are doing a little better than before.”
 - “Pain.”
 - “My technical income is above the level that should qualify for assistance. My ability to buy food was a direct result of my husband not providing enough support.”

Lesson 10: Universal and Focused Quality Improvements Are Not Mutually Exclusive

- The Universal interventions – the tide raises all boats.
 - Workflow Training
 - Streamline workflows
 - EHR tools
- Focused interventions – reducing disparities for specific groups.
 - Adding translated versions of screening tool and materials.
 - Diverse representation in education and marketing materials.
 - Identifying disparities in trainings and incentivize reductions.
 - Expanding screening to high risk groups, like patients with ADHD (2 fold greater food insecurity) or adults with diabetes.

Summary of the Lessons Learned at GHC

- The project works better with a multidisciplinary team.
- Community partnerships adds to innovation.
- Build on processes already in place, if possible.
- Remember, little kids are listening. Show respect. Preserve dignity.
- Without a screening tool, food insecurity might not come up.
- It takes a care team. Engagement is key.
- Community Service Coordinators are the secret sauce.
- The Health Equity data lens can motivate engagement to reduce disparities.
- Patient Experience means asking patients for their feedback.
- Universal and Focused Quality Improvements are not mutually exclusive.



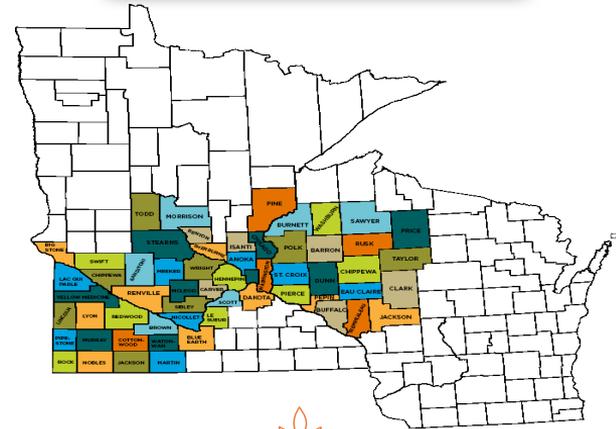
FOODRx-A Patient Centered Approach to Address Food Insecurity

Kristen Williamson, RD, LDN, MBA and Manuel Ravelo Jr., MPH



Who is Second Harvest Heartland?

- Second Harvest Heartland is one of the largest, most innovative and efficient hunger relief organizations in the United States.
- Our mission is to end hunger through community partnerships.
- We achieve our mission by finding creative solutions to connect the full resources of our community with our hungry neighbors.
- We provide, on average, 75% of the food that is distributed through nearly 1,000 partners and programs in 41 counties in Minnesota and 18 counties in western Wisconsin.



2016 Impact



Distributed more than 80 million meals!



55% of the food we distributed was fresh!

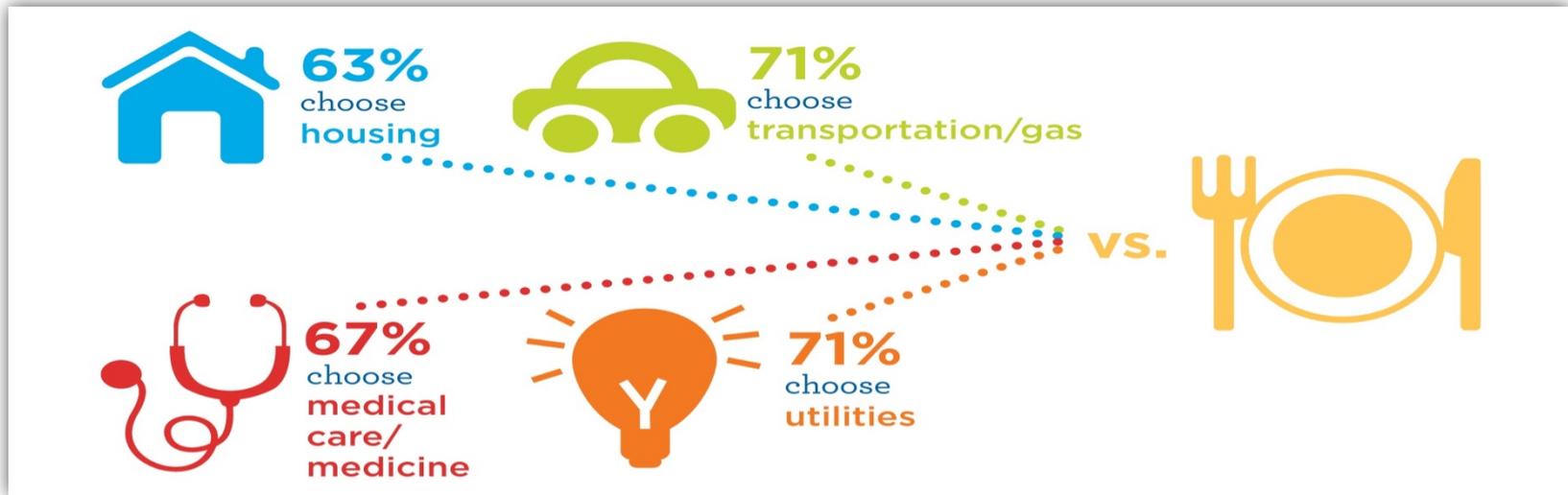


Recruited 28,832 volunteers who donated over 132,333 volunteer hours!



Hunger in the Heartland

Many of our hungry neighbors make tough decisions between food and other necessities.



Our Clients

Intersection of Hunger and Health

- For our clients, lack of food means a higher likelihood of chronic disease and poor health
 - 32% of our clients households have a member with diabetes
 - 45% have a member with high blood pressure
 - 67% choose between paying for food and paying for medicine or medical care in the last 12 months
- Healthier eating is aspirational, and budget usually trumps health
 - Priority is full bellies, and not running out of food
- Everyone accesses the health care system
 - We can connect with clients who aren't accessing the hunger-relief system

FOOD IS MEDICINE

Sources: Urban Institute/Feeding America "Hunger in America" study (2014); SHH qualitative consumer insight research into SNAP consumers (2016)



A Gap To Be Filled

Robert Wood Johnson Foundation Survey of 1,000 primary care physicians (2011)

80% of respondents said that patients' social needs are as important to address as their medical conditions

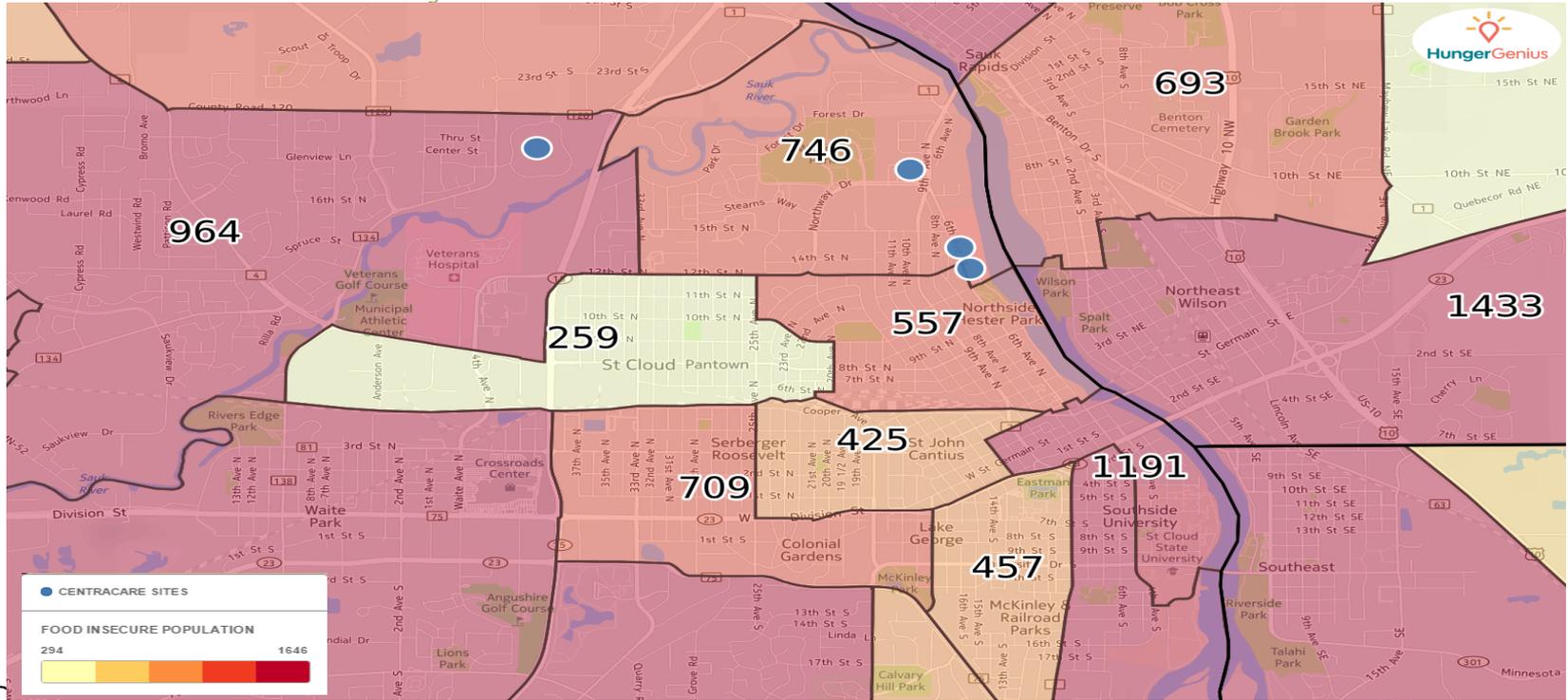
80% also reported that they did not feel confident in their capacity to meet these needs.

When doctors have limited options for helping patients with social needs, they tend not to ask about them.

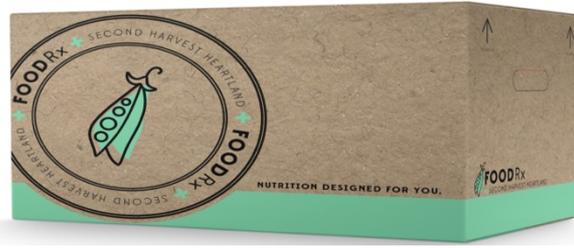


Map of Hunger in St. Cloud

7,434 Food Insecure Individuals in 10 St. Cloud Area Neighborhoods are Missing 1.3 Million Meals Annually



Helping Patients Meet Their Needs



CHRONIC NEEDS

- 7-10 days of meals provided for adult disease states
- Custom disease-specific diets include diabetes & heart disease
- Culturally specific versions
- Custom education and recipe materials



SOCIAL DETERMINANT NEEDS

- Center operates in a clinic waiting room
- Connect patients to food and other community resources they need to be healthy
- Patients given a paper ‘prescription’ that will further facilitate conversation with their provider



Nutrition Education & Recipes

Spanish

English

Meal Frequency and Low Blood Sugar

How often should I eat?

Eating every 3-4 hours will help to keep blood sugar levels from dropping. Plan out 3 meals and use snacks to fill in gaps where you may be unable to eat a balanced meal. Snacks should contain 2-2 servings of carbohydrate and a protein source from the lean protein and dairy group.

What should I do if I have low blood sugar?
Follow the 15/15 rule (outlined below)

Step 1 • Take in 15 g of carbohydrate (or 1 carbohydrate serving)

Step 2 • Wait 15-20 minutes

Step 3 • Check blood sugar

Step 4 • If blood sugar is still low, repeat steps 1-3

Step 5 • Continue to eat meals regularly to prevent a drop in blood sugar

For more information on diet related questions, visit the American Diabetes Association website (diabetes.org)

Frecuencia de las comidas y bajo nivel de azúcar en sangre

¿Con qué frecuencia debo comer?

Comer cada 3 a 4 horas le ayudará a que los niveles de azúcar en sangre no bajen. Planee 3 comidas y coma meriendas para llenar los espacios donde no pueda comer una comida balanceada. Las meriendas deben contener entre 1 a 2 porciones de carbohidratos y una fuente de proteína del grupo de proteínas magras y productos lácteos.

¿Qué debo hacer si tengo bajo el nivel de azúcar en sangre?
Siga la regla 15/15 (descrita a continuación)

Paso 1 • Coma 15 g de carbohidratos (o 1 porción de carbohidratos)

Paso 2 • Espere entre 15 y 20 minutos

Paso 3 • Compruebe el nivel de azúcar en sangre

Paso 4 • Si el azúcar en sangre sigue estando bajo, repita los pasos 1-3

Paso 5 • Continúe consumiendo alimentos regularmente para evitar una baja del nivel de azúcar en sangre

Para obtener más información sobre preguntas relacionadas con la dieta, visite el sitio web de la Asociación Americana de la Diabetes (diabetes.org)

Somali

Cuntada Sida Joogtada loo Qaato iyo Sokorowga Hooseeya

Imisa jeer ayaan cunaa?

In wax la cuno 3-4 jeer marka waaxay kaa caawiyadaas in sanay dhiciin heerarka dhigga sokorta. Corshayso in 3 jeer cunto la cuno iyo qaadato harruun-trayaal si aad u busaxo faraqa marka aadan awoodin dheellitirka xilliyada cunta cusnata. Hamuurtirayaasha wax in ay ku jiraan 1-2 cunto qaadaasho ee karbohydretka iyo ilo brotiin ee ka yimid brotiinka aan barsurta lahayn iyo kooxda caanaha.

Maxa ila gudboon haddii dhigga sokortayda uu hooseeyo?
Raac xeerka 15/15 (see hoose laga calaamayey)

Step 1 • Qaado 15 g (garam) karbohydretka (ama 1 xilli cunis ee karbohydretka)

Step 2 • Sug 15-20 daqiiqo

Step 3 • Cabbiir sokorta dhigga

Step 4 • Haddii dhigga sokortu uu weli hooseeyo, ku cell tallaabada 1-3

Step 5 • Si wad in aad si joogto ah xilliyadaadi wax u cunto si looga hortago in dhigga sokortu uu hoos udhaco

Wixii macluumaad dheeraada oo la xariira su'aalaha noocyada cuntada (diet) booqo internetka American Diabetes Association (diabetes.org)

Recipe

HEARTY OATMEAL BREAKFAST

Cook Time: 2 minutes

Included in Box:

- 1/2 c. dry oatmeal
- 2 T. peanut butter

Directions:

1. Combine 1/2 c. dry oatmeal with 1 c. cold water
2. Microwave on high for 2 minutes.
3. Add 2 T. of peanut butter and stir until well mixed.

Tips: Sprinkle cinnamon, nutmeg or add a drop of vanilla extract for added flavor without the extra calories!

Nutrition Facts

Serving Size: 1 c.
Calories: 380
Fat: 17.5 g
Sodium: 125 mg
Carbohydrates: 35 g
Fiber: 6 g
Protein: 12 g
Carbohydrate Servings: 2

NUTRITION DESIGNED FOR YOU.



Chronic Disease Research Studies

Studies Overview: The research will measure whether a food box prescription can create positive health impacts on low-income patients with diabetes and heart disease.

Intervention:

- Regular food box prescriptions that are custom designed by a Licensed Dietitian
- Diabetes and heart disease management education

Study Participant Population (CentraCare): approximately 40 diabetic and/or heart disease patients recruited in St. Cloud.

Study Evaluation: An independent, third-party evaluation will analyze the impacts on patient health outcomes and healthcare utilization, pre-and-post the study.

Our goal is that through providing nutritious food, we can help diabetic patients better manage their condition, in turn improving their health status and lowering their health care costs.



Patient Feedback

Information from monthly box surveys

87% found the recipes and education in the boxes helpful

Through the FoodRX program many of the participants are exploring new types of fruits and vegetables, as well as a variety of whole grain products. Exposure to new foods without the risk of wasting participant's own money on new foods is a wonderful part of this program that I have seen from participants. Many are surprised to realize how flexible healthy eating can be. Participants are also excited to find that they enjoy the healthy recipes included.

“Very helpful having healthy food. Feeling better since starting on the program”



Health Resource Center

Overview:

- The Health Resource Center (HRC) expands the capacity of health care clinics by connecting patients to local resources in order to meet any social needs.
- Lower-income patients receive “prescriptions” for resources such as food, housing, and employment assistance.
- Second Harvest Heartland Community Health Ambassadors “fill” the prescriptions by connecting the patient to these resources.

Screening

- Patient completes screening questionnaire via iPad/tablet for unmet basic needs in
 - Housing/shelter
 - Food
 - Child care, and more

Prescription Order

- Paper prescription identifying positive indicators of unmet needs is handed to patient for follow-up with health care provider

Prescription Fulfillment

- HRC staff onsite provides an action plan that lists contact information for community resources specific to patient needs

Coordination & Follow-Up

- HRC staff follows up with patient 3 business days after being seen, and afterward as determined by action plan



How Does the HRC Bring Value in a Health Care Setting?

“Research suggests that more than 70% of health outcomes are attributable to the social and environmental factors that patients face outside of the clinic or hospital”.

- Health Leads, 2016

The goal is to improve the overall health of patients by addressing the social needs that are screened for by the Health Resource Center.



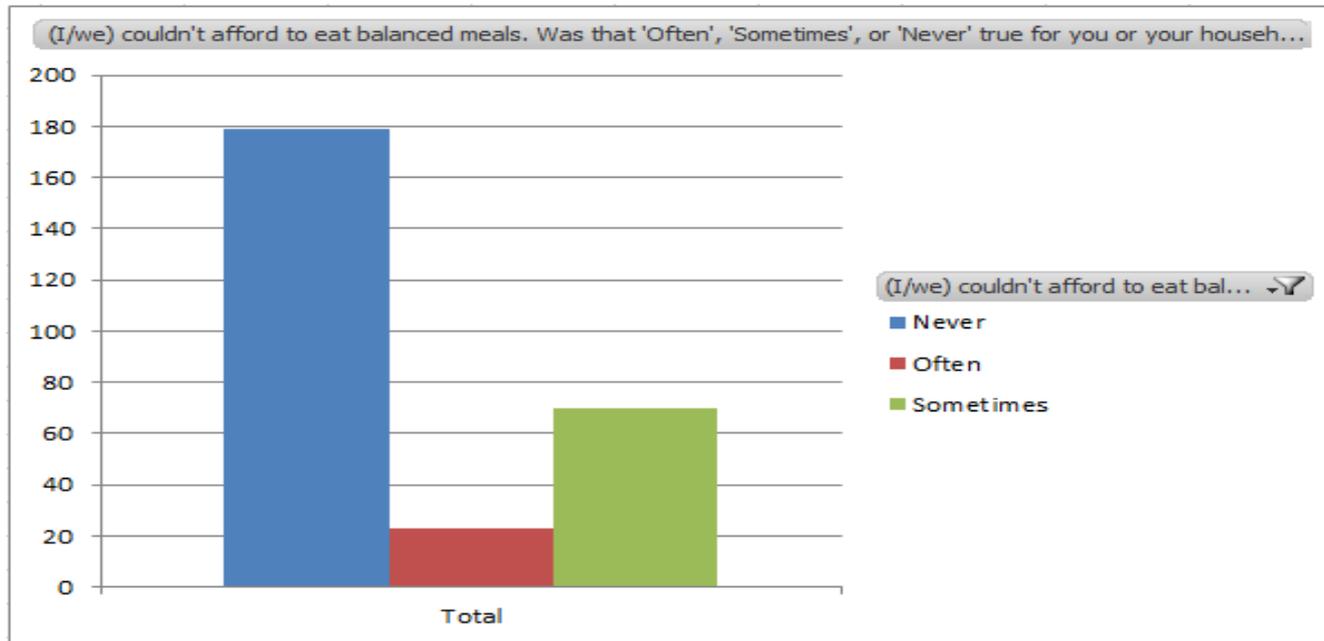
Top Needs Within Target Population: Food Insecurities

37 percent of patients who took the survey screened positive for the food in their household not lasting, and not having money to get more.



Top Needs Within Target Population: Food Insecurities (continued...)

36 percent of patients who took the survey screened positive for not being able to afford to eat balanced meals.



Health Resource Center Feedback-Clinic

A staff member from CentraCare told me that the program (referring to the Health Resource Desk) seems to really be helping people. She said that when she started asking all of the patients that were checking in if they were interested in taking the survey, she was surprised at the people who were screening positive for needs. Because of her experience, on several occasions she mentioned the importance of not assuming people do not need any assistance based on their appearance (apparel, etc.).



Health Resource Center Feedback-Patient

“An elderly patient came in and agreed to take the survey. He screened positive for food insecurities. Anyone’s initial assumption of the patient was that he was well off—he was well dressed and carried himself very well. To my surprise, he screened positive for food not lasting in his household. After conversing with the patient, I discovered that he and his wife are both retired/disabled, and his fixed income often didn’t suffice for the cost of food. He said that he had SNAP, but received a very minimal monthly amount.

After listening to his needs, I discussed the NAPS (Nutrition Assistance Program for Seniors) program. The patient was not aware of this program’s existence—and when he found out that he and his wife would receive a box each per month, he seemed relieved. The NAPS Program Outreach Coordinator gave me some brochures to have at my desk, which allowed me to demonstrate to the patient the type of items that are typical in the food box. After receiving his consent to send his information to the Program Outreach Coordinator, he was able to get the process of enrolling in NAPS started.”



Key Learnings

Make Services Available to All Clients

- Screen all clients for community resources
 - *Client needs may not be apparent*

Be Flexible

- Adapt to changes in work flow
 - *Change in screening procedures*

Adapting Resources to Meet Client Need

- Utilize data to make informed changes
 - *Food insecurity resource referrals*

Utilize Strengths of Partner Organizations

- Create true partnership through communication and shared responsibility
 - *Food safety and food distribution for food banks*

Not All Health Systems are the Same

- Adjust expectations and focus
 - *Rural vs urban health systems*



Engaging Health Systems as Partners in Addressing Food Insecurity

- 1. Create Awareness Around Food Insecurity and Other Social Needs**
 - Prevalence of food insecurity
 - Impact on health outcomes
- 2. Demonstrate Value for Healthcare Systems**
 - Creating ROI
 - Health care staff engagement
- 3. Connect with Local Resources/Community Programs**
 - Partner with community resources to provide wrap around services
- 4. Protect Patient Information**
 - [Feeding America resource for HIPAA compliance](#)



Protecting Patient Information

Examples of HIPAA Compliance Steps Taken by SHH

- Encryption and password protection on all patient data
- HIPAA compliant database and secured server to store patient information
- Physical paperwork is:
 - stored in locked filing cabinets
 - stored in a locked case when transferring to another physical location
 - properly disposed in a secure shred box
- Hardware is locked in a secure room overnight



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Questions?