Screening and Interventions for Food Insecurity in Health Care Settings

State Strategies to Increase an Underutilized Practice in California

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CALIFORNIA FOOD POLICY ADVOCATES

California Food Policy Advocates

California Food Policy Advocates (CFPA) is a statewide public policy and advocacy organization dedicated to improving the health and well being of low-income Californians by increasing their access to nutritious, affordable food.

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Table of Contents

Introduction

Despite a growing body of evidence suggesting that food insecurity has significant consequences for the health of low-income Californians, very few hospitals and health clinics in our state are routinely screening for food insecurity.[1,2,3] In this paper we examine how food insecurity screening tools can be used to increase the number of referrals to federal nutrition assistance programs such as CalFresh – programs that have the potential to address the scope and scale of challenges associated with poor nutrition across our state. Specifically, we examine how screening for food insecurity is underutilized in California health care settings and discuss how the State can both support expansion of screening for food insecurity and enhance intervention by supporting on-site CalFresh application assistance in health care settings and proactive referrals to the federal nutrition assistance programs.

We aim for this paper to serve as an informative guide for administrators, health care affiliates, and advocates at the city, county, and state level. By understanding the potential of screening to increase enrollment into the federal nutrition assistance programs and the barriers to more widespread and effective use, we can all better collaborate to ensure that vulnerable Californians are not missing out on the important food resources they need to maintain good health.

A Primer on the Federal Nutrition Assistance Programs

CalFresh

CalFresh (known federally as SNAP, Supplemental Nutrition Assistance Program) is the nation's most well funded and wide reaching source of nutrition assistance. CalFresh is administered by the California Department of Social Services and provides benefits to supplement household food budgets when individuals and families cannot afford enough to eat. The average CalFresh participating household receives monthly benefits of $200.[4] By providing access to a nutritious, affordable diet, CalFresh benefits support productivity, promote health, and help prevent hunger. The state of California also extends state-funded nutrition assistance benefits through the California Food Assistance Program (CFAP) to legal permanent non-citizens who are determined ineligible for federal SNAP benefits because of their immigration status.

The Federal Child Nutrition Programs

In California, the National School Lunch Program, the School Breakfast Program, the Child and Adult Care Food Program, and the Summer Food Service Program are administered by the California Department of Education and play a major role in increasing access to healthy food for children by reimbursing organizations such as schools, family child care homes, child care centers, summer feeding sites, and after-school programs for providing healthy meals to children. Meals are available to children from low-income families at no cost or at a reduced price.

WIC

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a federal nutrition program that provides food assistance, health care referrals, nutrition education and breastfeeding support for low-income, nutritionally at-risk pregnant women, postpartum women, and children up to age five. Participants use WIC cash value vouchers to purchase supplemental foods designed to meet the special nutritional needs of participants from certified vendors.

Emergency Food Resources

Although this paper focuses on linking food-insecure Californians with the federal nutrition assistance programs, the role of emergency food resources cannot be ignored. Food banks and charitable agencies operating food pantries and soup kitchens play an important role in fighting hunger for individuals who are not participating in the federal nutrition assistance programs and for families and individuals who may require additional nutrition support.

Food Insecurity is a Health Care Crisis

California is touted for having the sixth largest economy in the world, but one in ten Californians (4.1 million) are food insecure, lacking consistent access to enough food.[5,6] That is more than the entire population of some California cities: imagine every child and adult living in Los Angeles, three times the population of San Diego, almost five times the population of San Francisco, or eight and a half times that of Sacramento. The sheer number of low-income, food-insecure Californians highlights a striking health inequity plaguing our state and demanding the attention of our health care system.

Food Insecurity is a Health Care Issue

Research suggests that food insecurity triggers compensatory behaviors that exacerbate poor health. Individuals who are food insecure are more likely to skip meals and binge eat when food is available, often on low-cost foods that are calorically dense

but poor in nutritional quality.[7,8,9] A growing body of research connects food insecurity with an increased likelihood of chronic disease, hospitalizations, poorer disease management, developmental and mental health problems, as well as increased health care spending.[1,2,3] So unfolds the harmful cycle of food insecurity and chronic disease: without the ability to access sufficient healthy food options, individuals are left with unhealthy food choices that ultimately worsen their health. The competing financial demands of declining health further drain household budgets (e.g., increased hospitalizations, more frequent medical visits, increased prescription drug costs). With little money for nutrition, medications, and proper health care, the likelihood of food insecurity is further increased.

Food Insecurity Screening and Intervention in Health Care

A growing number of health care experts recognize the potential of food insecurity screening to mitigate the harmful effects of the cycle of food insecurity and chronic disease. In 2013, the California Medical Association adopted a resolution promoting the use of food insecurity screening among medical providers to identify children and adults who are food insecure.[10] The American Academy of Pediatrics released a policy statement in 2015 encouraging the integration of food insecurity screening as part of regularly scheduled health maintenance visits for children.[11] In 2016, the American Diabetes Association also encouraged food insecurity screening in their annual Standards of Medical Care in Diabetes.[12]

Health clinics, hospitals, and medical providers across the country are already using validated one- or two-item screening tools to identify patients who would benefit from a food resource referral. These screening tools, shortened for clinical use, have provided a means to integrate food insecurity screening into medical practice. Although multiple validated screening tools are available as in-office tools, food insecurity and health care experts generally agree that the two-item Hunger Vital Sign™ is the most relevant screening tool for medical practice.[13] The Hunger Vital Sign™ identifies individuals and families as being at risk for food insecurity if they answer that either or both of the following two statements is ‘often true’ or ‘sometimes true’ (vs. ‘never true’):

• “ 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.”

When effectively implemented in health care, screening for food insecurity can connect food-insecure individuals with federal nutrition assistance programs such as CalFresh and WIC. Participation in the federal nutrition assistance programs has been shown to improve food security and nutrition.[14] These programs also serve as important income supports, enabling households to redistribute dollars that would otherwise be used for purchasing food. As research supporting the link between food insecurity, health outcomes, and health care costs continues to build, we anticipate that other health care organizations will call for increased food insecurity screening in health care settings. For more information on models to effectively integrate food insecurity screenings into health care settings refer to the San Diego Hunger Coalition's report: *Launching Rx for CalFresh in San Diego County.*[15]

Impact of Screening for Food Insecurity in California

In California, the federal nutrition assistance programs are underutilized, falling short of enrolling all eligible participants. According to the most recently available data from the United States Department of Agriculture, CalFresh, the state's largest and most important nutrition assistance program, missed 34% of eligible Californians in 2013, ranking California as the third to last state in the nation at enrolling eligible individuals.[16] Participation in CalFresh is low for several reasons, including misinformation about eligibility criteria, stigma sometimes associated with public benefit programs, and a complicated and often burdensome application process that can keep CalFresh-eligible households from applying for and receiving benefits in a timely, consistent, and equitable manner.[17] By initiating referrals and reframing participation as an important health support, the health care team can serve as a key connection point to nutrition assistance and reduce the stigma sometimes associated with participation in CalFresh or other programs, particularly among the following populations:

Young Children

In California – where one in four children lives in poverty – the benefits of regularly screening children for food insecurity are heightened.[18] According to the American Academy of Pediatrics, children who live in households that are food insecure, even at low levels, are likely to be sick more often, recover from illness more slowly, and be hospitalized more frequently.[11] The American Academy of Pediatrics encourages integration of food insecurity screening as part of regularly scheduled health maintenance visits for children.[11] Through regularly scheduled health maintenance visits, medical providers and health care staff can help parents learn about and enroll in

the federal nutrition programs including CalFresh, WIC, the school nutrition programs, and summer meal sites. Each of these programs is currently underutilized in California. For example, 85% of students who participated in the national school lunch program during the school year missed out on similar lunches during the summer and 27% of eligible children ages 1-4 years missed out on the nutritional benefits of WIC during 2013.[18,19]

Pregnant and Breastfeeding Women

To fully protect a child from the harmful effects of food insecurity, intervention must start at the earliest of ages. Increasingly, research links nutrition during pregnancy and through the first few years of life to healthy development. It is during these years that the foundation is laid for lifelong healthy habits, including nutritional habits and preferences.[20] Expectant and breastfeeding mothers have increased nutritional and caloric needs.[21] Breastfeeding is widely recognized as a low-cost intervention that protects the health of mothers and babies.[22] Food-insecure mothers can access the critical nutrition resources they need during pregnancy and lactation by participating in programs like CalFresh and WIC. Unfortunately, not all women access these benefits and not all medical providers consistently refer to one or both of these programs. Integration of food insecurity screening into prenatal, perinatal, and postnatal visits can increase the likelihood that pregnant and breastfeeding women are referred to the food assistance they need.

Older Adults

The number of food-insecure, low-income seniors in California nearly doubled from 2001 to 2014. In 2014, nearly 31 percent, or 644,000 low-income seniors in California were food insecure.[23] But according to the most recently available data, only 18 percent of our state's eligible seniors participate in CalFresh, the state's largest and most impactful nutrition assistance program.[24] CalFresh enrollment is likely low among seniors for many reasons, including barriers to mobility, barriers to utilizing technology, and the stigma sometimes associated with public assistance programs. Seniors are also more reluctant to participate in CalFresh based on misinformation about how the program works and who can qualify.[25] Medical providers and health care facility staff can play an important role as trusted messengers for low-income seniors by dispelling myths about who qualifies for the program, encouraging enrollment, and providing referrals to CalFresh application assisters who can guide seniors through the process.

It is important to note that some low-income seniors may be receiving Supplemental Security Income (SSI). Under a policy known as "Cashout", California provides a cash benefit to SSI recipients as part of their SSI benefits in lieu of CalFresh. By combining

the food assistance benefits into the SSI payment, California SSI recipients are made ineligible for CalFresh. However, there are other programs like the Nutrition Services Incentive Program (NSIP) and the Senior Farmers' Market Nutrition Program (SFMNP) which also provide food assistance. SFMNP provides coupons that can be exchanged for eligible foods at farmers' markets and the NSIP distributes food purchased by USDA's Food and Nutrition Services such as beef, pork, fish, poultry, dairy, fruits, vegetables, oil and grains to the elderly. Many California communities have additional non-federal programs for seniors, including Congregate Meal Sites or home-delivered meals/groceries for homebound seniors.

Individuals with Diet-Related Chronic Disease

Individuals living with diet-related chronic diseases such as diabetes and heart disease may be more severely affected by the negative health consequences of food insecurity. The American Diabetes Association encourages food insecurity screening for individuals living with diabetes.[12] Research suggests that food insecurity may increase a patient's risk of hypoglycemia.[2] For patients requiring insulin or other blood glucose lowering medications like sulfonylureas, a regular diet without skipped meals is critical for reducing hypoglycemia risk. Food insecurity is also associated with binge eating. As a result, food insecurity may increase the risk of poor glucose control for patients with diabetes. Participation in nutrition programs like CalFresh can reduce food insecurity and may help stabilize the supply of food resources; participation has been associated with improved blood glucose control.[26]

The Growing Medi-Cal Population

Passage of the Affordable Care Act allowed California to expand Medi-Cal (known federally as Medicaid) coverage for low-income households. In December 2015, approximately 13.3 million Californians were enrolled into Medi-Cal, representing an increase of almost fifty percent in just two years.[27] Now one in every three Californians and 57 percent of all 0-5 year olds receive their health coverage through Medi-Cal.[28] That number is likely to grow in coming years as more individuals learn they are eligible and as a result of recent legislation which enables undocumented children to receive full scope Medi-Cal coverage.[29]

According to data from the California Department of Health Care Services (CDHCS), adults in Medi-Cal were almost twice as likely to experience food insecurity in 2011 compared to the privately insured.[30] Due to changes in Medi-Cal eligibility criteria, the Medi-Cal population has likely changed since implementation of the Affordable Care Act. However, we suspect the percentage of food-insecure Medi-Cal beneficiaries remains high. Therefore Medi-Cal beneficiaries may be more likely to experience the

negative health consequences of food insecurity including increased likelihood of chronic disease, hospitalizations, poorer disease management, and developmental and mental health problems.[1,2]

It makes financial sense for the state to support strategies that monitor food insecurity among the Medi-Cal population in addition to strategies that connect food-insecure Medi-Cal beneficiaries with nutrition programs like CalFresh and WIC. There is tremendous overlap in eligibility requirements between these programs. For example the gross income threshold for Medi-Cal eligibility is less than 138% of the Federal Poverty Level (FPL); for CalFresh it is less than 200% FPL, and for WIC it is less than 185% FPL. A recent breakthrough study conducted in Canada found that increased severity of household food insecurity was associated with systematically rising total health care costs and mean costs for inpatient hospital care, emergency department visits, physician services, same-day surgeries, home care services, and prescription drugs.[3] Given the high proportion of Californians participating in Medi-Cal, the state likely bears the brunt of any increased health care costs associated with food insecurity.

California's Landscape: Who is Currently Screening?

In order to determine how food insecurity screening tools are being utilized in California, CFPA reached out to leading experts in the anti-hunger field and health care industry to identify the hospitals and health clinics that are routinely screening for food insecurity. We expected that uptake would be widespread with a significant number of health clinics and hospitals integrating food insecurity screening into medical visits. Surprisingly, we found fewer than 10 health clinics/hospitals that have integrated food insecurity screening as a system- or program-wide practice.

However, many individual medical providers may be screening their patients for food insecurity. Melissa Ruiz, a Kaiser Permanente Community Medicine Fellow, conducted a study among pediatricians at thirteen of California's leading pediatric residency hospitals and found that 57% of medical providers reported they were independently screening for food insecurity, but that screening was not systematically implemented hospital- or clinic-wide.[31]

After hearing many success stories from advocates in Oregon, Colorado, and Wisconsin about their efforts to increase food insecurity screening, we were surprised to find so few health clinics or hospitals supporting screening here in California – especially given the high rate of food insecurity in our state. We conducted interviews

with leading health care organizations, medical providers, and anti-hunger advocates working to increase food insecurity screening to better understand the reasons behind California's low uptake. We learned that multiple obstacles have impeded adoption of food insecurity screening and referrals, including:

- Difficulty integrating screening questions into the Electronic Health Record;
- Competing priorities for medical providers and a lack of time to address food insecurity during the medical visit;
- Inadequate on-site support for medical providers to address positive food insecurity screens;
- A lack of knowledge of where and how to refer positively screened patients.

State Strategies to Increase Screening and Intervention

Ensuring food-insecure Californians are being screened and referred effectively to the federal nutrition programs will require the state to adopt multiple strategies. Without effective referral systems that link food-insecure patients with nutrition assistance programs, screening alone will likely not help reduce food insecurity. We encourage state and local health care administrators, health advocates, and health care affiliates to work with California's network of anti-hunger and nutrition advocates to identify promising opportunities to increase the number of health clinics and hospitals that are monitoring and addressing food insecurity effectively within their patient populations. We encourage the state to consider the following goals and strategies as a framework for embedding food insecurity screening and referral into practice.

GOAL #1: Increase the number of health care settings who are screening for food insecurity as a system- or program-wide practice.

The Context

Due to time pressures that result from fiscal realities, medical providers in California's safety net health clinics and hospitals often have fewer than 15-20 minutes to visit with each of their patients. During that short period of time, medical providers juggle multiple competing priorities that make it difficult to integrate new and promising practices like screening for food insecurity. Given this landscape, it is critical that food insecurity screening is integrated in a way that is not overly burdensome and complements care delivery (e.g., embedding screening questions into existing workflows and having members of the health care team such as nurses and medical assistants initiate the screening and referral). Food insecurity screening and intervention is more likely to increase in health care settings if it is easily incorporated into practice and members of

the health care team are aware of how and where to refer positively screened patients. With appropriate support, medical providers can better meet their patient's food security needs.

Strategy #1: Integrate the Hunger Vital Sign™ into the California Department of Health Care Service's Staying Healthy Assessment

The state can support medical providers by integrating food insecurity screening questions and appropriate interventions into existing health assessment forms. Providers serving Medi-Cal patients are already required to administer and report on state-developed health assessment forms. For example, CDHCS requires Medi-Cal managed care plans to administer Staying Healthy Assessments (SHAs) to all Medi-Cal beneficiaries as part of an initial health assessment and periodically depending upon contractual requirements. The SHA comprises multiple, age-appropriate screening questions that assess health care knowledge and behavior. Although SHAs include screening questions about nutrition and healthy eating, they miss an important opportunity to screen for food insecurity by not incorporating the Hunger Vital Sign™. The same may be true of other health assessment forms that are already utilized in health care such as those used by the Comprehensive Perinatal Services Program, the California Diabetes and Prevention Program Sweet Success, and other state and/or federally supported health care programs for low-income Californians. CDHCS, CDPH, health care advocates, and anti-hunger advocates should work together to integrate the Hunger Vital Sign™ into existing health assessment forms and include appropriate prompts for the health care team to refer positively screened patients to CalFresh, WIC, the federal child nutrition programs and/or emergency food services.

Strategy #2: Support efforts to incorporate food insecurity screening questions into the base model of Electronic Health Records in California

Electronic Health Records (EHRs) can be leveraged to prompt medical providers to ask about food insecurity and to make referrals to nutrition assistance programs easier. The capability to submit electronic referrals to social service programs via EHRs can save valuable time for medical providers and fits well into most clinical workflows. EHRs also enhance health care data tracking and allow for more robust population health management. Unfortunately, most EHRs do not incorporate food insecurity screening questions into their base models. Epic has embedded the Hunger Vital Sign™ into its foundation framework, but most other EHRs have not yet done so. As a result, health clinics and hospitals not utilizing Epic's foundation framework must hire consultants or redirect in-house funds to incorporate food insecurity screening questions into the EHR.

Policies aimed at increasing the number of EHRs that incorporate food insecurity screening questions without requiring costly EHR build outs could increase the number of screenings across the state while improving health care data tracking. EHRs in California are supported in multiple other states. If California can ensure that EHRs include the Hunger Vital Sign™ then all other states will benefit.

Strategy #3: Support the provision of financial incentives to medical providers to encourage screening for food insecurity

Monetary provider incentives can be an effective tool for improving health care quality and delivery. Medical providers or health care settings who would otherwise not prioritize food insecurity screening may be more likely to do so if proper incentives existed. Incentives for screening can occur in a variety of ways, for example providing quality bonuses for screening a set percentage of patients or providing financial grant support and releasing a request for quality improvement proposals. Such funds can be used by health clinics or medical providers to cover any costs associated with initiating screening including training time for staff and/or costs associated with integrating screening questions into the EHR.

Section 1115 Medicaid waivers are one option that should be considered when exploring potential funding sources for incentives. Section 1115 Medicaid waivers provide states with an avenue to test new approaches to Medicaid that differ from federal program rules. These waivers are intended to allow for experimental, pilot, or demonstration projects that improve care provided to Medicaid recipients while cutting costs. In addition to the Section 1115 Medicaid waivers, there will likely be future funding opportunities through the Centers for Medicare and Medicaid aimed at spurring innovation within health care (e.g., Accountable Health Communities, a pilot project which funds screening and intervention for social needs). Health care and anti-hunger advocates should regularly monitor available funding opportunities and work with CDHCS to pursue funding when it becomes available.

Strategy #4: Adopt food insecurity screening as a performance improvement strategy within the California Department of Health Care Service's quality strategy

Although medical providers are ultimately responsible for addressing their patients' health care needs, the Managed Care Organization (MCOs) under which they operate also play a role in enhancing the care provided to patients. CDHCS contracts with full-scope MCOs and specialty health plans to deliver health care to the Medi-Cal population. Federal law requires CDHCS to conduct a quality review of MCOs and

specialty health plans with which it contracts in order to assess the quality of care Medi-Cal beneficiaries receive.[32] Food insecurity screening could be included as a performance improvement strategy for MCOs and specialty health plans. Inserting food insecurity screening and intervention into quality improvement strategies for health care will raise awareness of the need to address food insecurity as a health care issue while opening the door to embedding food insecurity screening and intervention into more health care settings. Oregon recently approved food insecurity screening and intervention as a performance improvement strategy to impact population health and lower chronic disease. California should follow suit.

GOAL #2: Increase the number of health care settings who provide same day on-site referrals to nutrition programs and food resources.

The Context

In CFPA's conversations with medical providers, lack of adequate on-site support was identified as a potential barrier for some health care settings in incorporating food insecurity screening into practice. Some hospitals and health centers have been able to adopt screening without increased costs by incorporating screening into existing workflows and utilizing members of the health care team for screening and intervening. However, some medical providers expressed concern during our interviews about being able to effectively coordinate referrals to nutrition assistance programs within their existing practice settings. Citing a lack of time and a lack of knowledge about where to refer patients, medical providers felt that on-site support would facilitate the referral process and help ensure patients actually enroll in the federal nutrition programs. Capitalizing on existing supports to address insufficient on-site assistance experienced in some health care settings, particularly in health clinics and hospitals serving a high number of food-insecure patients, may be critical to implementing effective food insecurity referrals.

Strategy #1: Utilize health insurance application assisters in health care settings to also serve as application assisters for CalFresh

Although some health care settings may lack adequate on-site support to address food insecurity, many of these same facilities provide on-site assistance to enroll patients into health insurance. Enrolling individuals into CalFresh requires the same skills and collection of similar information used by enrollment counselors to enroll individuals into Covered California (e.g., information about income level and household size). There may be an opportunity for California to utilize these health insurance application assisters to also serve as application assisters for CalFresh when operating in Federally

Qualified Health Centers or medical practices that serve a high number of low-income individuals. Some health clinics and hospitals may already be utilizing application assisters in this way.

Strategy #2: Provide support to expand on-site 'help desks' to connect more patients to CalFresh, WIC, and nutrition assistance

Many hospitals and health clinics are adopting 'help desks' to meet patient's social assistance needs. Hospitals or health clinics utilizing a help desk model refer patients to a central location where they are then assisted by trained volunteers who connect patients with appropriate referrals to meet their social needs - needs like housing instability, food insecurity, and financial instability. Help desks are typically staffed by trained volunteers or medical staff that use computer programs and algorithms to identify, prioritize, and address patient's health needs. Health Leads provides similar on-site support to health care organizations for a fee. In Colorado, Kaiser Permanente uses Health Leads to enroll patients into the federal nutrition programs. In both Southern and Northern California, Kaiser Permanente is piloting Health Leads.

The effectiveness of these programs at enrolling patients into CalFresh should be explored along with opportunities to expand these programs to additional health care settings. Health care advocates should work with CDHCS to identify strategies that could increase on-site support for patients with nutrition assistance needs.

GOAL #3: Increase the number of health care settings utilizing proactive referral models when on-site assistance is not available.

The Context

Medical providers are often fearful that if they screen for food insecurity, they will not be able to connect their patients with adequate nutrition assistance. Some medical providers are not aware of the multiple federal nutrition programs available, eligibility criteria, and/or how to refer patients to programs. In other cases, medical providers are aware of how to refer to these programs, but lack sufficient time to initiate referrals on their own. Ensuring that referring to nutrition assistance programs is easy, straightforward, and will result in patients receiving benefits is critical to meeting patients' food security needs through health care.

2-1-1 is a free and confidential telephone service that helps individuals identify a variety of local resources ranging from food to disaster assistance. In theory, medical providers who do not have adequate on-site support to offer their patients can refer to 2-1-1 by

instructing their patients to dial 2-1-1. We have learned, however, that simply providing a food-insecure patient with a phone number does not successfully connect patients to nutrition assistance programs. For example, as part of a pilot project by Kaiser Permanente of Colorado, positively screened patients were given a card with Hunger Free Colorado's hotline number and were then expected to contact the organization themselves. Evaluation efforts showed that fewer than five percent of patients actually called the hotline. After switching to a proactive referral model where positively screened patients were instead contacted by Hunger Free Colorado, the process increased the proportion of referred patients receiving resources from 5 to 78 percent.

Strategy #1: Increase the number of health care settings partnering with 2-1-1 agencies, community based organizations, or other resource and referral agencies to offer proactive referrals

In situations where adequate on-site support is not available**,** proactive referrals to over-the-phone CalFresh application assisters can address positive food insecurity screens. With the proactive referral model, upon receiving a patient's consent, medical providers submit a referral to a CalFresh application assister. The application assister then contacts the patient directly to provide CalFresh application assistance over the phone and assesses the patient for additional referrals to other nutrition assistance programs for which the patient qualifies such as WIC or summer feeding sites for children and to emergency food resources. In order to submit the referral, the referring entity needs to set up a contractual agreement with the receiving entity to ensure HIPAA compliance. Establishing appropriate agreements that enable resource and referral agencies, food banks, and anti-hunger agencies (nonprofits) to accept referrals from medical providers can increase nutrition assistance referrals from health care.

Currently, health clinics and hospitals can pay on a fee-for-service basis for some local 2-1-1 agencies to conduct proactive referrals for patients. Sharp HealthCare in San Diego has taken advantage of proactive referrals by partnering with San Diego as part of a comprehensive approach to assessing and meeting their patient's health care needs. Some food banks may be able to offer a similar proactive referral model. For example, Feeding America San Diego has had success at utilizing a proactive referral model for patients of Sharp Grossmont Hospital.[15] Utilizing anti-hunger partners may be particularly important in counties that do not have effective 2-1-1 systems.

Potential obstacles to more widespread use of this model may include: medical practices may be unaware of the services offered by referral networks; health settings may be concerned of violating HIPAA laws; the cost may be prohibitive; and referral

networks providing over the phone CalFresh application assistance may face barriers when working across counties due to the need to set up contracts with multiple CalFresh eligibility databases. California food banks and anti-hunger advocates should work with the state to address these barriers and establish systems that would expand capacity to provide proactive referral follow up.

In conclusion, there are multiple strategies worth pursuing that utilize health care to screen for food insecurity and to refer to the federal nutrition assistance programs. Implementing these strategies incrementally over time can yield significant progress towards increasing low-income Californians access to the federal nutrition programs.

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