Food Insecurity and Health
Overcoming Food Insecurity Through Healthcare-Based Interventions
AN IMPLEMENTATION GUIDE IN COLLABORATION WITH HUMANA

qualityforum.org
Prepared exclusively for Richard Sheward.
ABOUT NATIONAL QUALITY FORUM

The National Quality Forum (NQF) sets standards to improve healthcare quality with measures and guidance based on evidence and innovation to make care better for all people. NQF-endorsed measures are used in federal public reporting and pay-for-performance programs as well as in private-sector and state programs. Hundreds of individuals from NQF’s member organizations and beyond devote their time and expertise to address issues of national importance. Together, NQF develops and advances quality improvement strategies through collaboration. NQF collaborates and defines field-tested, evidence-based quality standards on a variety of key topics.

NQF identifies and works to close gaps essential to high-value care. Strategic measure frameworks and quality improvement priorities identify critical gaps and practice innovations to drive measurable health improvements and deliver better person-centered outcomes and value.

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ACKNOWLEDGEMENTS

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The conclusions, findings, and opinions expressed by individuals who contributed to this publication do not necessarily reflect the official position of any contributor’s affiliated organization.
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Reducing Food Insecurity

Food insecurity and health are tightly intertwined, mainly because a poor diet can worsen individuals’ health outcomes. Food insecurity occurs when a household lacks access to enough nutritious food for a healthy, active lifestyle. The condition of food insecurity can include inadequate quantities and inadequate quality of nutrients available. Food insecurity can contribute to chronic diet-related diseases such as diabetes and heart disease, making management of these chronic conditions even harder for individuals and their care providers.

Food insecurity differs from hunger, the physical sensation of discomfort due to lack of food, and malnutrition, where the body does not receive enough nutrients to function properly. Food insecurity means that individuals lack the means to satisfy their hunger and consume the nutrients their bodies need. Food insecurity is a national public health issue. It has adverse consequences for people at all stages in life.

In 2018, an estimated 11.1 percent of households in the United States were food insecure at least some time during the year: One or more household members ate less food and their eating patterns were disrupted because the household lacked money and other resources to obtain enough nutritious food.

Food insecurity can be chronic where the individual experiences it for three months or longer, but it can also be cyclical where households experience food insecurity or more adverse food insecurity during certain times. For example, households living paycheck to paycheck may have enough food at the beginning of the month but then face food scarcity towards the end of the month. Low-income households may also experience food insecurity or higher levels of food insecurity during certain times of the year when expenses are higher—or after a major unexpected expense or loss of income. Changes to the accessibility of or eligibility for food security benefits can also affect a household’s food security.

WHAT IS FOOD INSECURITY?
“the limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways.”

Food insecurity is a complex problem. It likely does not exist in isolation, and an individual or family experiencing food insecurity might be affected by multiple overlapping issues such as housing instability, high utility costs, high medical costs, lack of transportation, unemployment, poverty, and other sociodemographic factors.

For example, rates of food insecurity were higher than the national average for households that include children or the elderly and for individuals and households that have income near or below the federal poverty line, those that are African American or Hispanic, and those in principal cities and nonmetropolitan areas.
Healthcare’s Role in Addressing Food Insecurity

Health is influenced by factors beyond receiving medical care and medicine. Improving health requires addressing the social determinants that shape a person’s ability to engage in healthy behaviors. Food insecurity can result in individuals and families making trade-offs that harm their health and well-being. Families and individuals affected by food insecurity report skipping meals, eating less expensive foods to fill up, rationing Supplemental Nutrition Assistance Program (SNAP) benefits for multiple shopping trips, and delaying payment of bills to manage each month.\(^\text{11}\)

These actions can add to risk of chronic disease and higher medical bills that put pressure on households and amplify their risk of facing further food insecurity. Studies have shown that those with food insecurity have cost-related medication nonadherence, as they ration necessary medications in order to redirect money to the purchase of food.\(^\text{12}\)

When individuals have difficulty accessing food, tailoring their diet to their medical needs becomes far more complicated.\(^\text{13}\)

To improve health, healthcare organizations need to focus on the social and medical needs of individuals and communities. Research has demonstrated that individuals who are food insecure are more likely than those who are food secure to have double the number of unhealthy days in a year, higher rates of obesity, higher levels of chronic disease such as arthritis, chronic obstructive pulmonary disease, diabetes, and stroke. The Centers for Disease Control and Prevention (CDC)’s Healthy Days Measures define unhealthy days as an estimate of the overall number of days during the previous 30 days when the respondent felt that either his or her physical or mental health was not good.\(^\text{14}\)

Commonly cited negative health outcomes related to food insecurity also include high probability of mental health issues, higher rates of iron-deficiency, and development issues in children.\(^\text{15}\)
Food insecurity also contributes to higher costs of care with individuals who are food insecure having higher risks of hospitalization. Poor health outcomes related to food insecurity have a negative financial impact on individuals, families, and the healthcare system through higher overall healthcare expenditures. On average, annual healthcare expenditures for individuals who are food insecure are $1,863 higher than those who are food secure, with the cost difference rising to $4,413 for individuals with diabetes and $5,144 for those with heart disease.

| Average Annual Healthcare Costs Linked to Hunger and Food Insecurity Were |
|-----------------------------|-----------------------------|-------------------------------|
| **$4.4 M**                  | **$687 M**                  | **$130.5 B**                  |
| AT THE COUNTY LEVEL         | AT THE STATE LEVEL          | AT THE NATIONAL LEVEL         |

These negative health outcomes and expenditures not only affect food insecure individuals, but also communities and the health systems that serve them. Food-based interventions have shown improvements in both mental and physical disease and symptoms. Medically tailored meals have shown promise in certain populations, with a 16 percent decrease in healthcare costs and as much as a 49 percent improvement in inpatient admissions. In a dual-eligible population, participants who received medically tailored meals had fewer visits to emergency departments, fewer inpatient admissions, and lower medical expenditures.

Integrating food insecurity programs into healthcare has the potential to improve health outcomes and lower the total cost of care.

Given the critical role of food in health outcomes and preventing chronic disease, healthcare organizations are increasingly exploring strategies to address food insecurity in their populations. This guide brings together multistakeholder perspectives on the key components necessary to overcome food insecurity through healthcare-based interventions.

We hope that the guide increases attention and investments in partnerships between healthcare organizations and community partners. We encourage healthcare organizations to use the guide to tailor efforts to combat food insecurity in ways that meet the unique needs of their communities.
Using this Guide

This guide will help organizations to implement routine food insecurity (including medical and nonmedical treatment methods) and prepare to measure change in rates of food insecurity in their populations. The guide offers options from which to choose, depending on organizational context, resources, and needs. Rather than prescribing a list of “must-do’s,” the guide details a range of strategies that different healthcare organizations can tailor to different contexts to enhance food insecurity interventions with the goal of improving health.

While intended primarily for healthcare organizations—specifically health plans, healthcare delivery systems, and clinician groups—a broad set of stakeholders, including patient advocates, nutrition programs, community-based organizations (CBOs), and policy and regulatory bodies may find value in the guide. It may help them encourage increased adoption of food insecurity programs and collaboration among entities working to address food insecurity across the nation.

The guide begins with a section on overarching facilitators that provides strategies for success. These strategies apply to a wide range of stakeholder groups as they prepare to create, implement, and sustain a food insecurity program. The guide then addresses three fundamental actions to address food insecurity: screening, appropriate clinical action, and tracking. For each fundamental action area, the guide gives a brief description and then presents strategies for success, potential barriers and suggested solutions, and curated tools and resources that offer more in-depth guidance. Another section identifies strategies and resources on policy, payment, education, research, and data integration as key drivers of change.

The strategies for success require varying levels of resources and organizational effort. The approaches are broad to allow stakeholders to identify what best suits the needs of their community and organization, recognizing that stakeholders may not be able to pursue all implementation examples at once. Supported by evidence, the strategies derive from practical experience of experts in the field.

The guide relied on multistakeholder input from experts including patients, practitioners, healthcare administrators, payers, and community partners to ensure strategies are practical and feasible (see Appendix A). Experts recommended approaches to build, strengthen, and enhance an organization’s ability to address food insecurity through screening, appropriate clinical action, and tracking. Appendix B includes hyperlinks to all tools and resources organized by action area.

This guide does not replace guidance that professional societies, associations, and other agencies have produced. Rather, it builds on current efforts to provide practical and action-oriented strategies. From this guide, diverse stakeholders can gain insights on lessons learned, innovative and promising practices, and solutions to common barriers. These insights will help healthcare stakeholders overcome challenges they face in implementing actions to address food insecurity.
Overarching Facilitators to Reduce Food Insecurity

Many factors affect organizational success when engaging in a new endeavor to address food insecurity. To start, it takes organizational and clinical awareness of food insecurity and its impact on health outcomes. Leading organizations integrate data on food insecurity and interventions to reduce it into healthcare settings. They establish standard processes and engage patients and communities. They train their workforce in screening, appropriate clinical action, and tracking food insecurity to reduce it in their populations.

The overarching facilitators build a strong foundation for organizations looking to address food insecurity. These facilitators help organizations prepare to execute strategies related to screening, clinical action, and tracking. Not all organizations will have the capacity to fully accomplish the strategies listed below. Organizations can think creatively about the resources they have internally and externally and develop partnerships with CBOs where resource gaps are identified.

**FACILITATOR:**
**Awareness of the importance of food insecurity within the healthcare system**
Build awareness to help ensure that all stakeholders—including patients, clinicians, care teams, administrators, and Board members—understand the impact that food insecurity can have on health outcomes and healthcare costs. Gaining that awareness helps make everyone feel invested in addressing food insecurity through training, engaging champions, sharing success stories, and highlighting the role of healthcare in reducing food insecurity.

**STRATEGIES FOR SUCCESS**

- Tie together the mission of the organization, its responsibility to the community, and the role it has in addressing food insecurity
- Demonstrate how engaging individuals in food insecurity interventions allows them to become more active participants in other aspects of their healthcare (e.g., improved medication adherence)
- Promote opportunities for sharing stories and learning throughout the organization (e.g., Town Halls, organizational updates and newsletters)
- Identify champions at all levels of your organization and within each partner organization to support implementation of strategies to address food insecurity
- Incorporate food insecurity into existing training, including what food insecurity is, why it matters, how it impacts health, and what resources are available
- Create training partnerships with community experts to support relationship building and facilitate warm handoffs from healthcare to social services
- Encourage and fund individuals to attend conferences, join associations, and participate in educational opportunities to learn more about food insecurity
- Require training as part of the onboarding process and on an ongoing or annual basis
  - Establish accountability for completing the training program by requiring that individuals pass a comprehension test
FACILITATOR: Organizational Culture

An organizational culture attuned to addressing social determinants of health (SDOH) and reducing health disparities can inspire organizational pride about treating an individual as a whole person and improving health outcomes. While strategies listed below focus on shifting organizational culture to address food insecurity, these strategies can be applied more broadly to include other social needs in patient populations (e.g., transportation, housing, etc.).

STRATEGIES FOR SUCCESS

- Recognize that good nutrition can be effective in improving an individual’s health, and diets customized to medical needs will result in better outcomes
- Employ one or more dedicated full-time staff members to oversee and lead the food insecurity program
  - This will allow the staff member to thoroughly understand the needs of your community and build programming that best meets those needs and the goals of the organization
  - The program will not be as successful if it is just one more role on top of many others
- Dedicate a multidisciplinary team, including a project manager, quality improvement leaders, IT leaders, legal leaders, clinical leads, social workers, dietitians, and an executive sponsor to develop and implement the food insecurity program
  - Small organizations lacking the capacity to field a multidisciplinary team can partner with community groups and other healthcare organizations to fill any resource gaps and assign an organizational representative to coordinate the partnerships
- Consider using students, volunteers, community resource specialists, and other liaisons to support a multidisciplinary team when developing sustainable, community-focused programming
- Create a systemic allowance for increased visit times by focusing on quality instead of quantity
- Expand the definition of return on investment for food insecurity interventions to include improved health outcomes along with other metrics (patient satisfaction, improved food security, improved dietary intake, etc.) and evaluate program success through multiyear versus single-year analyses
- Consider alternative forms of sustainable funding outside current reimbursement mechanisms to fund food insecurity initiatives (e.g., donors, healthcare and nonhealthcare state, federal, and public initiatives, grants, and funding, and local corporate partnerships
- Encourage innovation and testing of unique approaches by reassuring staff that if efforts do not achieve desired outcomes, these attempts still add to lessons learned
FACILITATOR:
Standard processes to screen, intervene, and track food insecure individuals and households

An organization-wide systematic food insecurity strategy, incorporated into regular clinical workflows, supports clinicians and care teams to integrate screening, clinical action, and tracking into their day-to-day encounters with patients. Standard processes should outline how to properly screen patients; determine the needs of individuals that screen positive; identify what resources are available; select the best options based on the individual’s needs; and track the individual’s progress, creating closed-loop interventions where results are shared back with those involved in screening and referrals.

STRATEGIES FOR SUCCESS

- Involve a diverse group of healthcare organization staff and external stakeholders in developing the strategy. Include representatives from leadership, clinicians from different specialties, community partners, patients, and other relevant partners in setting the vision and creating the plan to ensure broad buy-in
- Allow for customizable clinical action pathways within standard processes to meet individual needs of those experiencing food insecurity and maximize the likelihood of achieving the best outcomes
- Standardize the food insecurity screening, clinical action, and tracking process and align the activities of your healthcare organization with those of the community to avoid duplicating efforts
- Coordinate with partners to set uniform screening and documentation standards across settings, sites, and sectors, and ensure partners share a vision for desired outcomes
- Create incentives to use a consistent food insecurity process, including technical, staffing, and financial assistance to partners with limited resources
- Provide the financial and non-monetary resources staff and partners need to succeed in executing food insecurity plans
- Create a continuity plan around the management of food insecurity to enable ongoing program operations regardless of staffing and/or resource changes
- Start small and test for success of food insecurity approaches before scaling up
- Use continuous quality improvement to test food insecurity initiatives and adjust, as appropriate. Some examples include:
  - Encourage all stakeholders, including patients, to identify problems and opportunities for improvement and to offer solutions
  - Create metrics and targets for success, and frequently check your progress on the selected metrics
  - Pilot work using diet-based conditions such as diabetes
FACILITATOR:
Patient and community engagement

Ensure that patient and community voices are heard loud and clear in designing and implementing food insecurity programs. Focusing on the needs of patients and communities and embracing patient-driven approaches help organizations to engage patients and communities in programs. This adds to the long-term sustainability of food insecurity approaches in healthcare organizations.

STRATEGIES FOR SUCCESS

• Include the patient voice in creating workflows and food insecurity procedures (e.g., engaging patient partners through patient and family advisory councils when selecting a screening tool, and develop resources based on their needs)

• Incorporate cultural sensitivity and implicit bias training into food insecurity programs to support open, stigma-free environments and overcome misperceptions of who is at risk of food insecurity

• Reduce stigma around food insecurity through storytelling to highlight patient success stories, without compromising patient privacy, to raise awareness of food insecurity and to change perceptions of the “typical” person experiencing it

• Address barriers to patient and community engagement such as health literacy, language, and cultural differences by using qualified medical interpreters and trained bilingual staff and by providing instructions in both written and spoken formats at multiple touch points

• Employ tools and resources for addressing food insecurity that take ethnicity, religious preferences, language, and other cultural aspects into consideration

• Work with neighborhood associations and CBOs to disseminate information on food insecurity

• Advertise support services and resources in the community and in your healthcare organization
Fundamental Action Areas

SCREENING AND ASSESSMENT

A critical first step in addressing food insecurity is understanding which patients and populations are food insecure. Who is living in a food insecure household? Who requires support accessing healthy foods? Who is at risk of food insecurity? Organizations must answer these questions to act on food insecurity and improve health outcomes. To identify who may need targeted support, healthcare organizations can integrate screening strategies into standard care. Screening for food insecurity as part of broader efforts to integrate SDOH into healthcare conversations will enable healthcare organizations to better meet their patients’ needs and improve population health. Ensure that screening is standardized: This supports data collection, data analysis, data sharing, and measurement. Screening provides the opportunity to direct resources to those who need them the most and tailor clinical actions and approaches to specific individuals and populations.

Screening is most effective when:

- Individuals have access to electronic screening in a neutral environment (e.g., in the waiting room or prior to the clinical encounter)\(^ {21,22,23} \)
- An individual with a good relationship with the client conducts the verbal screening (e.g., a community health worker or community member)
- The verbal screener and/or electronic screen reviewer understands the established triage process very well

What is Needed to Support Screening

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<td>• Make regular screening part of routine care to reduce stigma, capture chronic and episodic food insecurity, and assist in tracking if positive changes can be observed</td>
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<td>• Conduct a community health needs assessment that includes assessing food insecurity and/or use a health-mapping tool to identify individuals who may be at a high risk for food insecurity based on their geographic location</td>
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<td>• Use a screening tool that assists in identifying both individuals and families that may be food insecure</td>
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<td>• Use a validated Likert-based screening tool to capture individuals who might be experiencing less intense food insecurity or might not consider themselves food insecure to ensure all those in need receive access to resources</td>
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<td>• Collaborate within the healthcare organization and across health and community partners to create a standardized screening process and share data so individuals do not have to answer sensitive questions repeatedly</td>
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<td>• Leverage the multidisciplinary team to build screening practices that reduce burden on providers</td>
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How to Screen Individuals

**STRATEGIES FOR SUCCESS**

- Allow self-administration or administer verbal or electronic screenings through clinicians (such as physicians, nurses, medical assistants, and/or social workers), and/or voluntary community workers
- Identify patients experiencing food insecurity through screenings within the healthcare organization
- Partner with CBOs to identify individuals who may not be in the health system, yet may be at risk for negative health outcomes due to food insecurity
- Group food insecurity screening with other social need screenings to understand the needs of the individual as a whole
- Ask individuals if they would like assistance with their food-related needs, and enable them to mark needs as urgent or to request additional resources even if screening results are negative
- Educate staff on resources available to patients who screen positive for food insecurity to promote staff confidence in implementing screening (many may be reluctant to screen without knowledge of available resources within their own communities
- Link screenings directly to the organization’s electronic health record (EHR), using an electronic form (through computers, tablets, or kiosks), in order to improve the ability of the organization to document results and reduce administrative burden on staff

**Potential Barriers and Suggested Solutions**

**Limited staff capacity, time, and resources to conduct screenings**

*Suggested Solutions*
- Enable patients to complete pre-visit assessments
- Select the best-equipped staff members (clinical and/or nonclinical) to conduct screenings and/or follow-up
- Centralize screening, follow-up, and outcome management to one role, and standardize across the organization in order to create role clarity and accountability

**Lack of a single standardized tool and lack of clarity on which tool is best**

*Suggested Solutions*
- Identify the end goal for screening and select the tool based on information needed to best meet the goal
- Select a validated tool that is used in multiple settings across the country
- Coordinate with other healthcare and CBOs to agree on a screening tool to support data sharing and tracking

**Clinicians reluctant to screen due to insufficient knowledge of food insecurity and its treatment**

*Suggested Solutions*
- Identify a clear and shared vision for food insecurity that resonates across the organization
- Engage frontline clinicians in policy creation and development of tools and organizational guidelines to generate staff buy-in
- Ask preestablished follow-up questions on urgency, frequency, and potential barriers beyond the initial screening questions to fully understand the needs of the individual
- Develop clear patient education policies to enable clinicians to provide effective and consistent education on the risks and benefits of food insecurity options
- Set performance expectations across the organization for individuals to demonstrate competencies in identifying and addressing food insecurity
Suggested Tools and Resources

Community Health Needs Assessments
- Community Food Security Assessment Toolkit
- PHATE™ The Population Health Assessment Engine
- Making Food Systems Part of Your Community Health Needs Assessment
- Map the Meal Gap: Food Insecurity in The United States
- USDA Economic Research Service (ERS) Food Environment Atlas
- Urban Institute Food Insecurity Dashboard

Staff Training
- Food Insecurity Screening: Health Care’s Role in Identifying Food Insecurity
- Health Care Provider Training: Screening for Addressing Food Insecurity in Clinical Settings
- Screening and Referral for Older Patients in Primary Care

Social Needs Screening
- Screening for Social Needs: Guiding Care Teams to Engage Patients
- Social Needs Screening Toolkit

General Surveillance Instruments and Survey Tools
- Food Insecurity Screening and Referral Algorithms
- Household Food Insecurity Access Scale (HFIAS)
- Hunger Vital Sign™
- PRAPARE Implementation and Action Toolkit
- Third National Health and Nutrition Examination Survey (NHANES III)
- The U.S. National Household Food Security Survey Measure (HFSSM)

Population-Specific Surveillance Instruments and Survey Tools
- Behavioral Risk Factor Surveillance System (BRFSS)
- The Children’s Food Security Scale
- The Community Childhood Identification Project Questionnaire (CCHIP)
- A Tool to Assess Past Food Insecurity of Immigrant Latino Mothers
- The U.S. Adult Food Security Survey Module
CLINICAL ACTION

Once an individual or family is identified as food insecure, the next step is identifying the best resources to meet their needs. The level of effort, investment, and impact of the various food insecurity interventions can vary across organizations and communities. Not every option for clinical action may be available or well-suited to achieve the desired outcome for improving a patient’s or family’s level of food insecurity.

**Organizations can implement one or more interventions that involve:**

- Helping individuals participate in public programs
- Making referrals to food sources
- Providing food directly
- Addressing the root cause of food insecurity by teaching individuals essential skills to become food secure

**What is Needed to Support Appropriate Clinical Action**

**STRATEGIES FOR SUCCESS**

- Define a clear scope and determine the ultimate end goal before starting any initiative and confirm that selected interventions are positioned to achieve the desired end goal
- Take desirability, accessibility, and eligibility into account when designing and recommending interventions
- Use community health needs assessment results to tailor interventions to specific community needs
- Seek out community and healthcare partners who share your goals and can help you achieve synergies through economies of scale
- Prior to community partnerships, consider the organization’s current or prior track record with the partner and account for any relationship and trust building that will be required in planning and implementation
- Be mindful of potential community partners’ capacity for new food insecurity interventions
- Be prepared to build institutional capacity within and outside the organization to launch and sustain food insecurity initiatives (e.g. Health Insurance Portability and Accountability Act (HIPAA) compliance)
- Research relevant federal, state, and local legislation, policies, and regulations to understand which could assist the organization in achieving its goals
HOW TO TAKE CLINICAL ACTION

Clinical Action #1: Public Programs
Public programs at the federal, state, or local level help individuals experiencing food insecurity to gain access to food but do not provide food directly. Assisting individuals to participate in these programs can be a first step toward moving them into food security. Public program strategies should be paired with strategies that supply food to individuals and families in need in order to fully meet the needs of the community.

STRATEGIES FOR SUCCESS

- Facilitate enrollment into federal nutrition assistance programs, such as Supplemental Nutrition Assistance Program (SNAP) and Women, Infants, and Children (WIC) Food and Nutrition Service
- Become a SNAP and/or WIC office where candidates can apply and be approved for the programs
- Assign a community health worker, social worker, or other qualified staff member to individuals who screen positive for food insecurity to support education and aid in applying for public benefits
- Provide a warm handoff to a community partner who can educate and assist in the application process
- Participate in child care meals, school meals, afterschool snacks and meals, and summer food programs
- Offer free lunches and dinners to children in clinics and on campus
  - Sites can be “open,” thus allowing children in the community to receive a free meal without enrolling in a program
  - Consider expanding the program to adults as well
- Direct food insecure individuals to organizations that are administering the programs or connect the individuals to partners who help them navigate the programs
- Research additional programs at the state or local level that might benefit individuals experiencing food insecurity and determine methods for participating in programs through referrals or direct support
Clinical Action #2: Access to Food

Not everyone who is food insecure qualifies for the programs listed above. Even those that do qualify might not be able to access the resources—or enough resources—to meet their current food needs or to maintain food security. A lack of access to food, especially healthy food, is one of the biggest contributors to food insecurity. Individuals may not be able to access nutritious food due their location, age, and/or health status. Programs that refer patients to food sources in the community or that provide food directly can be very beneficial to people experiencing food insecurity.

Food access interventions need to be well thought out and cater to community and patient needs. Interventions can focus on a Food is Medicine approach, where distributed food and meals are matched to the recipient’s specific health condition, and/or an approach that dispenses healthy food to individuals regardless of health status.

Organizations in communities with few food sources may need to invest in in-house based interventions. In communities with strong community resources and programs, the healthcare organization may need to develop stronger partnerships with community organizations and focus on providing direct food delivery or funding to those who are not able to access the resources due to barriers such as financial restrictions or mobility challenges. Knowing which interventions would yield the greatest benefit requires a deep understanding of community needs.

STRATEGIES FOR SUCCESS

- Create an onsite food pantry or provide a warm handoff and support volunteer-led offsite food pantries that offer mostly nonperishable food staples
- Form a fresh food program that offers healthy foods such as fresh fruits, vegetables, whole grains, lean protein, and dairy products
- Curate a community garden onsite or in the community through funding, staffing, and/or oversight
- Partner with grocery stores, food banks, farmers, farmer’s markets, restaurants, the organization’s own cafeteria, and other food service organizations to collect and redistribute healthy and safe food that would otherwise be wasted
- Enable clinicians to write “prescriptions” for medically tailored meals or fresh foods that individuals can use at local grocery stores, farmer’s markets, an internal or external food pantry, or a fresh food program
- Test methods for encouraging individuals to make healthier choices such as moving vegetables, fruit, and other healthy options to the front of the food pantry, fresh food pharmacy, or farmer’s market
- Offer patients who screen positive for food insecurity a grocery bag of nutritious food during the initial screening along with the “prescription” or referral if food resources are not available onsite
- Partner with local grocery stores to provide free and discounted food
  - Provide vouchers or healthy savings cards (which can be automatically refilled) that offer heavily discounted healthy foods at grocery stores
  - Distribute gift cards to local supermarkets for those in immediate need (e.g., those who screen at the highest levels of food insecurity)
- Develop programs within the organization or partner with meal delivery organizations (e.g., Meals on Wheels) to deliver food and meals directly to those in need
- Bring farmer’s markets to your site or mobilize farmer’s markets to bring fresh food options to neighborhoods with limited access through community partnerships and extra incentives
- Brainstorm innovative approaches to increase program convenience, desirability and accessibility, such as including pet food in the program
Clinical Action #3: Access to Supporting Resources

Food insecurity does not occur in isolation. Those affected by food insecurity are also likely to experience challenges with additional SDOH such as housing stability, lack of transportation, unemployment, and/or poverty to name a few. Providing access to food alone will not help those who are food insecure overcome the circumstances that led to their food insecurity. Giving individuals access to resources they need will help them overcome barriers and challenges to sustainable food security. This is key to maintaining health and well-being and realizing long-term health benefits.

STRATEGIES FOR SUCCESS

- Incorporate education on nutrition, healthy eating choices, and food preparation into programs and interventions to address food insecurity
- Develop meal plans and coach individuals on how to achieve their goals
- Offer cooking classes or demonstration kitchens so individuals with food insecurity and their families can learn essential food preparation skills
- Provide or connect individuals to resources and support for matters such as finances, job training, and housing in order to assist food insecure individuals in becoming self-sufficient and food secure
- Establish—or further develop—a user-friendly directory of local referral resources that support the food insecure; update frequently; and make it available in multiple forms (e.g., paper, part of EHR, searchable database)
  - Build a communication plan for notifying staff and the community of the directory and other sources of referral information.

Potential Barriers and Suggested Solutions

Community partners have limited capacity for new partnerships and referrals

Suggested Solutions
- Connect with potential community partners to understand their capacity and limitations before sending referrals or creating partnerships
- Coordinate within your organization and other local organizations that rely on a community partner to centralize referrals and avoid overwhelming the organizations with referrals
- Directly support the community partner by supplying food, providing funding, and/or offering volunteers or staff members, as necessary
- Share resources and provide technical assistance

Perceived competition limits desire for community partnerships

Suggested Solutions
- Conduct a market assessment to understand what services are already provided in the community
- Explore strategic partnerships and similar approaches to jointly address food insecurity instead of starting an independent program
- Formalize partnerships with a memorandum of understanding that outlines shared goals
- Share success stories around the impact of coalitions of healthcare organizations and community partners

Lack of patient follow-up in accessing food resources and/or benefits

Suggested Solutions
- Customize recommendations to the needs of the patient based on screening results, follow-up questions, and food source proximity
- Have multiple touch points (within and outside the healthcare organization) to reach the individual
- Group food insecurity resources with other social needs resources whenever possible to increase convenience
- Assign a health navigator or community health worker to help patients navigate options
- Seek out organizations with shorter waitlists for warm handoffs, if possible

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Suggested Tools and Resources

Access to Food: Food Insecurity Guidance
• Disrupting Food Insecurity: Steps Communities Can Take
• Food Insecurity and the Role of Hospitals
• Humana’s Tool Kit for Physicians and Health Care Organizations
• Prioritizing Food Security Solutions

Access to Food: Population-Specific Guidance
• Addressing Food Insecurity: A Toolkit for Pediatricians
• Implementing Food Security Screening and Referral for Older Patients in Primary Care: A Resource Guide and Toolkit
• Rural Food Access Toolkit

Access to Food: Program-Specific Guidance
• Food is Medicine Plan
• The Fruit and Vegetable Prescription Program Toolkit
• Healthy Food Pantry Toolkit

• Starting a Community Garden
• Tackling Food Waste In Cities: A Policy and Program Toolkit (specifically the Rescue and Recycle Sections)

Access to Supporting Resources: Community Resource Referral Platforms
• 211 line
• Abundance
• Community Resource Referral Platforms: A Guide for Health Care Organizations (including Aunt Bertha, Healthify, NowPow, and others)
• Zoom In™

Public Programs
• Making WIC Better: Strategies to Reach More Women and Children and Strengthen Benefits Use
• Seniors & SNAP Best Practices Handbook
• Serving Summer Meals in Health Care Institutions: An Implementation Guide
TRACKING AND EVALUATION

Measurement supports food insecurity efforts by showing which interventions are having a positive impact on overall health and quality of life of individuals. Measuring results may also yield information on negative unintended consequences, if any, and identify areas for improvement in existing programs. Organizations can use data show return on investment through improved health outcomes, lowered costs, reduced care utilization, and positive changes in other metrics of interest, such as patient satisfaction and number of healthy days reported.

Tracking progress and changes in rates of food insecurity can also support ongoing regional, state, and national efforts to address food insecurity by providing more evidence of the positive impact of food insecurity interventions. Technology is a major aspect of a healthcare organization’s ability to track, follow-up, and evaluate interventions. When considering which strategies to implement, healthcare organizations should conduct an analysis of both their own technological infrastructure and the patient’s ability to access various types of technology and the internet.

What is Needed to Support Tracking

### STRATEGIES FOR SUCCESS

- Obtain buy-in from senior leadership and community partners by tracking and reporting on the food insecurity related data they think are most important
- Understand what data sources are available and think proactively about what data you can and should collect to understand the impact of food insecurity interventions
- Incorporate food insecurity workflows into EHRs to support data collection, increase productivity, and reduce burden by avoiding manual data collection and transfer
- Break down organizational silos to enable data sharing across practitioners and departments (e.g., behavioral healthcare departments, emergency departments, and others) about food insecurity interventions
- Collaborate with support departments such as legal, IT and communications to develop creative solutions for tracking data and communicating resources available and success stories
- Partner with CBOs to gain a greater understanding of their capacities, capabilities, and needs in order to provide the necessary support for data collection and evaluation
- Create data sharing relationships with healthcare and community partners by:
  - Forming data governance agreements
  - Sharing data consistently
  - Establishing protocols for effective data sharing
  - Joining or launching data sharing collaboratives
- Assist community partners in understanding and meeting patient consent and privacy regulations (e.g., HIPAA)
- Find out what is most important to patients and create tracking and reporting processes that do not alienate, stigmatize, or burden patients who have food insecurity or complete food insecurity screening and follow-up
- Use the data to tell compelling stories to inspire clinicians to follow established workflows
How to Track Food Insecure Individuals and Evaluate Results

**STRATEGIES FOR SUCCESS**

- Define precisely what is being tracked in order to inform care delivery and demonstrate workflow effectiveness
- Use standardized coding and data fields to collect and share data
- Schedule follow-up appointments at initial screening
- Set up touch bases that can be completed electronically (e.g., by phone, patient portal, email) or in person depending on the needs of the individual
- Engage multidisciplinary team members, such as dietitians, social workers, community health workers, students, and/or volunteers, to perform touch bases to help reduce burden on one single team member
- Leverage the EHR to identify individuals as food insecure and monitor related health outcomes from initial screening onward
  - Account for other factors that might affect these health outcomes
- Set up automatic alerts—similar to wellness and vaccine reminders—in EHRs and patient portals for follow-up on food insecurity needs, and coordinate with community partners to send automatic alerts when a referral or warm handoff method is used
- Obtain consents for data sharing to promote continuity of care between different healthcare practitioners, settings, and services
- Enable timely reporting to frontline clinicians and leadership on number of individuals screened, referrals issued, and improved health outcomes to support decision making and understanding of progress
- Trend data over time to demonstrate improvements and identify strategies to address any metrics that are below target
- Create food insecurity patient, caregiver, and provider experience surveys, and use the data to improve the process and consider alternative programs and resources

**Potential Barriers and Suggested Solutions**

**Lack of time and resources for data collection and analysis**

*Suggested Solutions*

- Leverage technology and existing IT infrastructure (e.g., EHR, patient portals, and mobile applications) to assist with or automate data collection, analysis, and transfer
- Build in structured and unstructured fields (such as clinical notes) food insecurity and other SDOH into the EHR
- Train staff on how to gather, interpret, and use data
- Engage healthcare informatics and IT teams at the onset to tailor data collection and build reporting systems and processes that are most relevant to the healthcare organization and its patient population

**Noncompatible data systems limit data collection and sharing**

*Suggested Solutions*

- Share data and information on patient outcomes—while adhering to privacy laws—with other partners who have interacted with the patient so the partners can recognize their own impact on patient outcomes
- Develop a data collection, tracking, and data interpretation program that is incorporated into existing technology across different sectors (community partners, healthcare organizations)
- Offer to share resources with partners who may not have the capability to collect and share data on their own
Patients may lack access or knowledge of technology needed to support tracking and follow-up

**Suggested Solutions**
- Incorporate questions about internet access into screening or follow-up discussion to determine individuals who may not have access
- Refer individuals to internal or external resources on free or low-fee internet and phone programs sponsored by the government and private organizations for low income households, the elderly and other individuals in need
- Offer courses or partner with organizations that offer courses on the use of the internet, smartphones, and other related technology
- Have nonclinical staff and volunteers demonstrate use of any relevant websites or apps during initial screening and follow-up appointments, as needed

**Suggested Tools and Resources**

**Data Sources**
- Online Resources for Assessing And Measuring Social Determinants of Health
- An Overview of Food Insecurity Coding in Health Care Settings: Existing and Emerging Opportunities
- Sources for Data on Social Determinants of Health

**HIPAA**
- Food Banks as Partners in Health Promotion: How HIPAA and Concerns about Protecting Patient Information Affect Your Partnership
- HIPAA Compliance in Community Partnerships
Drivers of Change

Addressing food insecurity and improving health outcomes will require hospitals, health systems, payers, professional societies, community organizations, advocacy groups, and state and federal agencies to work together. They will need to develop, strengthen, and sustain effective programs that serve those in need, accurately track food insecurity activities, and educate healthcare professionals about the impact of socioeconomic and environmental factors on health.

FEDERAL AND STATE POLICIES

Programs such as SNAP, WIC and the National School Lunch Program and School Breakfast Program serve as nutrition safety nets that aim to reduce food insecurity. Federal nutrition programs have been shown to reduce the likelihood of being food insecure in several studies. For example, SNAP participants are less likely to be food insecure than eligible nonparticipants.

The process of applying for these benefits may confuse and burden potential beneficiaries. Stigma surrounding these programs can deter those in need from applying. Although there has been progress at the referral level to create consistency in administering these benefits, many states and organizations have expressed concerns that new regulations might cause millions of Americans to lose benefits, and sustainable long-term funding is needed more than additional federal oversight.

Stronger support for the programs and a change in the image of the “typical” person experiencing food insecurity may reduce stigma around these programs. Removing the barriers to federal program assistance, establishing sustainable funding for the programs, and connecting people to benefits is critical to lessening the consequences of food insecurity.

PAYMENT MODELS AND REIMBURSEMENT MECHANISMS

Healthcare organizations are increasingly recognizing the role of SDOH in contributing to health outcomes. Payers are moving towards including SDOH factors into alternative payment models that hold providers accountable for patient health and costs of treatment (e.g., shared savings, global budgets, and capitated payments). However, there are still many inconsistencies in reimbursement procedures among payers, and more work can be done to address food insecurity and other SDOH and social needs through reimbursement and payment.

Recent recommendations in NQF’s National Call to Action: Quality and Payment Innovation in Social Determinants of Health highlight opportunities to align policy, funding, and reimbursement across sectors, systems, and settings. Specifically, opportunities exist to develop key measure sets for SDOH in order to align SDOH measurement and

<table>
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<th>Structural Determinants:</th>
<th>Social Determinants of Health (SDOH):</th>
<th>Health-related Social Needs (HRSNs):</th>
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<tbody>
<tr>
<td>Environmental factors that create or reinforce the stratification in society, and that shape an individual’s socioeconomic position through uneven distribution of power, money and resources.</td>
<td>The community-level conditions in which we are born, grow, live, work, and age.</td>
<td>Non-health factors such as homelessness, inconsistent access to food, and exposure to violence that can have a negative impact on an individual’s health and increase health care utilization.</td>
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activity across the health ecosystem. Incorporating these measure sets into value-based payment models and quality programs will incentivize healthcare organizations to address health gaps related to SDOH, reduce disparities, improve health, and achieve equity.

Several public and private payers have taken the initiative to connect health and CBOs to address food insecurity by collaborating to support a more effective and holistic health ecosystem. The Accountable Health Communities model is one example. It tests “whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries’ through screening, referral, and community navigation services will impact health care costs and reduce health care utilization.”

Additionally, various states allow coordinated care organizations access to Medicaid funds for providing health-related services and allowing Medicaid funds to pay for nonmedical interventions that target the social determinants of health. Other states have received grants from health- and agriculture-based federal agencies to increase SNAP retention. The success of efforts around grant funding, Medicaid waivers, regulatory guidance, and policy change demonstrate that various methods can drive progress toward reducing food insecurity.

RESEARCH AND DATA INTEGRATION

Despite a growing literature base, more research is required on why some populations are more likely to be food insecure than others, the health effects of various coping mechanisms used to deal with food insecurity, and the impact of public and private food assistance programs on food insecurity and related health conditions.5 Stronger data collection and analysis of the short-term and long-term effects of food insecurity and associated interventions would also assist healthcare organizations in preparing to aid those in need and in taking an upstream approach to tackle the root causes of food insecurity instead of just treating the symptoms.2 Data would improve understanding the impact of food insecurity interventions on adverse health outcomes and associated healthcare costs—especially in the healthcare field.35

As described in the National Quality Partners™ (NQP™) Social Determinants of Health Data Integration Action Brief, diverse stakeholders must collaborate across sectors to standardize, share, and integrate data, enabling clinicians and CBOs to address a person’s unique needs and evaluate overall effectiveness of interventions. Several barriers impede the capture and investigation of the necessary data. A barrier to data integration is the limited number of billing codes directly related to food insecurity. Healthcare providers often must code for services provided to general food codes for screening and interventions making it difficult to track the diagnosis of food insecurity and the recommended clinical action plan.34 Additionally there is a lack of SDOH-related coded data elements and associated value sets. The Gravity Project is one initiative that seeks to fill this gap for three SDOH factors: food insecurity, housing instability and quality, and transportation access. The work focuses on four clinical activities: screening, diagnosis, planning, and interventions.35 Standardizing data elements and associated value sets would improve an organization’s ability to track food insecure individuals in their EHRs, collect relevant data points, and more efficiently demonstrate the impact of food insecurity and associated interventions on health outcomes and healthcare costs.
Moving Forward

Research confirms that food security significantly contributes to good health in individuals and communities. Food insecurity can increase the risk of developing chronic conditions, reduce an individual’s ability to manage these conditions, increase healthcare costs, and lead to avoidable healthcare utilization. Food-based interventions have shown both clinical and nonclinical improvement for individuals, healthcare organizations, and the broader healthcare ecosystem through more coordinated care and lower healthcare expenditures.

Partnerships and collaboration are critical to addressing food insecurity. It is a complex problem that cannot be solved with siloed or blanket approaches. Healthcare and relevant nonhealthcare organizations must partner together to implement, strengthen, and expand their ability to provide services to individuals affected by food insecurity through routine screening, appropriate clinical action, and tracking health outcomes in their populations.

Broad recognition that managing health goes beyond traditional medical care is essential to support the adoption of various food insecurity interventions. Through these coordinated efforts, healthcare stakeholders can support individuals and families in becoming food secure, enabling them to achieve improved outcomes and overall better health and well-being.
REFERENCES


Appendix A:
KEY CONTRIBUTORS

Casey Health Institute
Kisha Davis

Children's HealthWatch, Boston Medical Center
Richard Sheward

Community Servings
Jean Terranova

DC Greens
Andrea Talhami

Feeding America
Morgan Smith

Geisinger
Maria Welch

Johns Hopkins University
Kristin Topel

Kelly Memorial Food Pantry
Perla Chaparro

Optima Health
Traci Massie

Patient & Family Centered Care Partners, Inc.
Janice Tufte

ProMedica
Kate Sommerfeld

Rush University Medical Center
Jennifer Grenier

University of Arkansas for Medical Sciences and
Arkansas Children's Hospital
Eduardo Ochoa, Jr.

University of Houston College of Medicine
Winston Liaw

Virginia Commonwealth University
Pamela Parsons
Appendix B: URL LINKS TO RESOURCES

### SCREENING AND ASSESSMENT

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<tr>
<th>Resource</th>
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<tr>
<td>The Community Childhood Identification Project Questionnaire (CHIP)</td>
<td><a href="https://eric.ed.gov/?id=ED391603">https://eric.ed.gov/?id=ED391603</a></td>
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<tr>
<td>Food Insecurity Screening: Health Care's Role in Identifying Food Insecurity</td>
<td><a href="https://foodcommunitybenefit.noaharm.org/resources/implementation-strategy/food-insecurity-screening">https://foodcommunitybenefit.noaharm.org/resources/implementation-strategy/food-insecurity-screening</a></td>
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<tr>
<td>Map the Meal Gap: Food Insecurity in The United States</td>
<td><a href="https://map.feedingamerica.org/">https://map.feedingamerica.org/</a></td>
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<td>PHATE™ The Population Health Assessment Engine</td>
<td><a href="https://primeregistry.org/phate/">https://primeregistry.org/phate/</a></td>
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<td>Screening and Referral for Older Patients in Primary Care</td>
<td><a href="https://www.aarp.org/content/dam/aarp/aarp_foundation/2016-pdfs/FoodSecurityScreening.pdf">https://www.aarp.org/content/dam/aarp/aarp_foundation/2016-pdfs/FoodSecurityScreening.pdf</a></td>
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<td>Third National Health and Nutrition Examination Survey (NHANES III)</td>
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<td>A Tool to Assess Past Food Insecurity of Immigrant Latino Mothers</td>
<td><a href="https://www.ncbi.nlm.nih.gov/pubmed/17142195">https://www.ncbi.nlm.nih.gov/pubmed/17142195</a></td>
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**CLINICAL ACTION**

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<td>Abundance</td>
<td><a href="https://www.abundanceboston.com/">https://www.abundanceboston.com/</a></td>
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<tr>
<td>Afterschool snacks and meals</td>
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<td>Food is Medicine Plan</td>
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<td>HIPAA</td>
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<td>How to Start a Food Pantry on Campus</td>
<td><a href="https://www.affordablecollegesonline.org/college-resource-center/setting-up-college-food-pantry/">https://www.affordablecollegesonline.org/college-resource-center/setting-up-college-food-pantry/</a></td>
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<tr>
<td>Implementing Food Security Screening and Referral for Older Patients in Primary Care: A Resource Guide and Toolkit</td>
<td><a href="https://www.aarp.org/content/dam/aarp/aarp.foundation/2016-pdfs/FoodSecurityScreening.pdf">https://www.aarp.org/content/dam/aarp/aarp.foundation/2016-pdfs/FoodSecurityScreening.pdf</a></td>
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<td>Rural Food Access Toolkit</td>
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<td>School meals</td>
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<td>SNAP-Ed</td>
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<td>Supplemental Nutrition Assistance Program (SNAP)</td>
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**TRACKING AND EVALUATION**

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**DRIVERS OF CHANGE**

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<td>Accountable Health Communities</td>
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<td>National Call to Action</td>
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