Launching Rx for CalFresh in San Diego:

Integrating Food Security into Healthcare Settings

A special report for healthcare providers,
policy makers, and anti-hunger advocates

SAN DIEGO HUNGER COALITION

October 2016 *(revised)*

ACKNOWLEDGEMENTS

This work, which began in the fall of 2014, would not have been possible without the involvement of numerous stakeholders in the healthcare and food security domains. The University of California, San Diego School of Medicine and the Hospital Association of San Diego and Imperial Counties provided input, guidance and leadership in engaging the healthcare community. Family Health Centers of San Diego, Sharp Grossmont Hospital and San Diego County's Public Health Services stepped forward as leaders, willing to innovate and pilot various models to identify food insecurity and link patients to food resources. Other important partners in this work include the County of San Diego Health and Human Service Agency Eligibility Operations; the CalFresh Task Force, a partner network of more than 50 CalFresh outreach organizations facilitated by San Diego Hunger Coalition; and two key food security partners, Jacobs & Cushman San Diego Food Bank and Feeding America San Diego. These partnerships have been, and continue to be, critical to the development of Rx for CalFresh in San Diego County.

ABOUT THE SAN DIEGO HUNGER COALITION

San Diego Hunger Coalition (SDHC) is a nonprofit (501c3) organization that leads coordinated action to end hunger in San Diego County, supported by research, education and advocacy. Our vision is that everyone in San Diego County has enough food for an active, healthy life.

Funding for this work was generously provided by The California Endowment, Price Philanthropies, and the Moxie Foundation.

To download this report, please visit www.sdhunger.org/research.

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FOREWORD

Food insecurity impacts our society on multiple levels, but perhaps its most direct impact is on our health. Working with numerous partners over the past two years, the San Diego Hunger Coalition has piloted various models of *Rx for CalFresh* to identify and address food insecurity in five distinct healthcare settings throughout San Diego County. A vital part of this work has been the development of a teaching curriculum for healthcare practitioners on the connection between food security and health.

Through these pilots, the Hunger Coalition has identified a number of best practices and lessons learned to inform future efforts to integrate food security into healthcare settings. Of note, this report finds that once aware of the connection between food security and health, many practitioners become and remain interested in screening for and addressing food security with their patients. It also finds that integrating food security screening and providing onsite support for patients to access food resources is both possible and highly effective.

San Diego Hunger Coalition has used a collective impact approach to bring together the healthcare sector, community based organizations, and government agencies with the intention of developing long term sustainable models that are co-created by the organizations implementing the model. In using this approach, the Hunger Coalition operates as a backbone support agency, acting as incubator, convener, facilitator and technical assistance provider.

Our ultimate goal is to develop and implement enduring system-level solutions that enable food insecure individuals to more easily access food assistance during their time of need. The goal of this report is to further engage and inspire organizations considering or interested in learning more about opportunities to integrate food security into healthcare settings.

Anahid Brakke
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I. INTRODUCTION

An estimated 485,521[1] San Diego County residents, or 15.7 percent of the county's population, do not have enough food for an active, healthy life [1]. To put this information into context, the percentage of San Diegans experiencing food insecurity is larger than those populations affected by the region's top three health concerns: cancer, coronary heart disease and diabetes, affecting 10, 6 and 6 percent of the population respectively [2]. While all too prevalent, food insecurity is often hidden from the public eye behind walls of stigma and inaccurate assumptions as to what a food insecure person "looks like." Our region's food insecurity is further compounded by complicated and often inefficient food assistance systems that leave individuals without access to critical support in meeting basic needs. The need for collaborative approaches to addressing food insecurity couldn't be more apparent.

Until recently, most healthcare practitioners have been unaware of the relationship between access to food and health. While the healthcare sector is beginning to recognize the importance that food security plays in the health outcomes of their patients, providers are often limited in their ability to identify and address food security within their healthcare settings.

While all too prevalent, food insecurity is often hidden from the public eye behind walls of stigma and inaccurate assumptions as to what a food insecure person "looks like."

San Diego Hunger Coalition (SDHC or Hunger Coalition) and its partners trained practitioners and piloted various models to identify and address food insecurity in five distinct healthcare settings throughout San Diego County. The Hunger Coalition found that, once aware of the connection between food security and health, many practitioners are interested in screening for and addressing food security with their patients. Furthermore, integrating food security screening and providing onsite support for patients to access food resources is both possible and effective.

This report begins with a brief literature review of the impacts of food insecurity on health, the role of the federal Supplemental Nutrition Assistance Program (SNAP), and the need for integrating food insecurity screening and SNAP application assistance into health care settings. This is followed by a description of the pilot programs and a set of recommended models for healthcare systems to utilize when integrating food security into their settings. Finally, this white paper presents best practices and key considerations, as well as recommendations for expansion.

[1] This number has been updated in the October revision of this report based on the latest research from the San Diego Hunger Coalition. Please see Citation 1 for details.

II. BACKGROUND

Food Insecurity Harms Our Health

Food insecurity impacts our society on multiple levels, but perhaps the most direct impact is on our health. Numerous studies have shown that food insecurity results in poor health outcomes throughout the life cycle.

Children

Beginning in utero, children of food insecure mothers are more likely to be low birthweight, carrying higher likelihood of complications and early hospitalization [3]. During childhood, even marginal food insecurity can have lasting effects on children, including higher likelihood of poor health status, hospitalizations, and delayed physical and cognitive development [4,5,6]. The effects of food insecurity can carry into the classroom, leading to lower math scores and increased likelihood of needing to repeat a grade [7]. Children who are food insecure are also more likely to exhibit behavioral problems or have difficulty getting along with other children, making it hard for children to develop important social skills to support them later in life [4,7]. All too often, the damage resulting from food insecurity is permanent, predisposing children to further negative outcomes later in life.

Food insecurity impacts our society on multiple levels, but perhaps the most direct impact is on our health.

Adults

Food insecurity also plays a critical role in the health of adults. Many studies to date have illuminated the link between food security and chronic disease, particularly diabetes. Because access to healthy food plays such a critical role in keeping diabetes symptoms in check, disruptions due to a patient's inability to purchase healthy food create major barriers to keeping chronic disease under control. Recent studies have found that food insecure people with diabetes are more likely to have poor glycemic control, difficulty maintaining a proper diet, lower confidence in their ability to control their disease and higher emotional distress [8]. Potentially as a result, food insecure diabetics have been found to have poorer adherence to blood glucose monitoring, more emergency department visits for hypoglycemia and higher Hb1AC levels [9,10]. A recent study conducted at San Francisco General Hospital found that the risk for hypoglycemia hospital admissions among low-income populations increased by 27 percent in the last week of the month compared to the first week. Meanwhile, higher income populations, who were less likely to run out of food at the end of the month, showed no marked difference in hospital admissions for hypoglycemia [11]. Food insecurity plays a similarly significant role in diabetes management among children, as children in food insecure families are 3.5 times more likely to be hospitalized for their diabetes compared to their food secure counterparts [12].

Seniors

Continuing through the life cycle, seniors are often disproportionately affected by food insecurity. A study found that more than 50 percent of seniors admitted to the hospital are either malnourished or at risk for malnourishment [13]. Not only can malnourishment predispose seniors to a variety of health problems, it can result in serious negative impacts to recovery by slowing wound healing, increasing risk for healthcare related infections, lengthening hospital stays, and increasing likelihood of readmission or death [14].

Obesity

As a nation, we struggle with the idea that an individual who is low-income or food insecure could be overweight. Recognizing the role that food insecurity plays in obesity is critical to addressing this multifaceted epidemic. The presence of family food insufficiency at some point during preschool years more than triples the odds of a child becoming obese and doubles the odds of a child becoming overweight at 4.5 years of age [15]. Studies have also found a relationship between food insecurity and overweight in single mothers, who often act as buffers limiting both the quantity and quality of their food intake to maximize that of their children [16].

Stress

Numerous studies have found that families exposed to food insecurity experience what is known as cyclical food availability. Food is more accessible in the beginning of the month, as paychecks and benefits are received, and regularly runs out near the end of each month [8,17,18]. On a molecular level, episodic eating and high stress levels resulting from cyclical food insecurity [19] can predispose individuals towards overweight or obesity by changing the way that the body utilizes and stores energy [20,21]. Simultaneously, higher stress levels result in increased cortisol and neuropeptides that increase desire for energy dense, satiating foods that are high in sugar and fat [20,21]. These hormones and neuropeptides can also result in the storing of additional visceral body fat, which has been found to play a role in chronic disease [22,23].

At all stages of life, advanced levels of food insufficiency and insecurity have increasingly severe impacts on health. That is to say, the less access to food, the more detrimental the health outcomes [5,6,7].

The Cost of Purchasing Healthy Food

While the overwhelming majority of evidence supports the link between access to healthy food and strong health outcomes, healthy food is often out of reach for low-income families. Recent studies have found that in order to eat the U.S. Department of Agriculture (USDA) recommended meal plan, low-income families would have to spend 43 to 70 percent of their food budget on fruits and vegetables [24]. This does not take into account additional competing priorities like housing, utilities, basic living expenses or medical costs. As a result, many low-income individuals and families find themselves making tough decisions between paying for food and other basic needs [25]. As a result, adults who reported food insecurity were four times more likely to report cost-

related medication underuse [25]. To complicate matters, food purchasing decisions are made in a context of super markets and corner stores filled with a wide variety of low cost, high calorie foods, allowing households to "fill up for less" when budgets are tight [26,27]. Studies find that low-income, food insecure families are especially vulnerable, decreasing fruit and vegetable servings while maintaining consumption of high carbohydrate foods like juices and starches [8,28,29]. These purchases, however, come at a price of short and long term health consequences, often in the form of overweight, obesity and chronic disease [29].

SNAP/CalFresh Reduces Food Insecurity and Improves Health Outcomes

In an effort to expand food budgets and promote healthy purchases, our nation has developed a number of responses to combat food insecurity. To date, the most impactful nutrition intervention has been the Supplemental Nutrition Assistance Program (SNAP) [31]. SNAP (called "CalFresh" in California) functions in two ways. The program provides families with financial resources to purchase healthy food, and it reduces poverty by increasing the household's total budget [30]. In 2014, 4.7 million people across the nation, including 2.1 million children and 320,000 seniors, were lifted above the poverty line when taking into account SNAP benefits as income [31]. Overall, SNAP has been estimated to reduce food insecurity by 8-16 percentage points [32,33,34].

> Contrary to somewhat popular belief, receiving SNAP does not lead to poor food and beverage choices.

In addition, SNAP has been directly linked to improved health outcomes. In a study of children seeking healthcare between 2004 and 2010, it was found that those children receiving SNAP were less likely to be underweight, less likely to experience developmental delays, and less likely to experience food insecurity than their counterparts in families with similar income levels who did not receive SNAP [35]. Families were also less likely to report having to make difficult tradeoffs between paying for healthcare and food for their families [35]. Contrary to somewhat popular belief, receiving SNAP does not lead to poor food and beverage choices [36].

Unfortunately, while a vaccine against food insecurity exists, it has yet to be consistently administered. CalFresh is underutilized in San Diego and throughout the state. According to California Department of Social Services, in 2014 an estimated 52 percent of CalFresh eligible San Diego County residents were utilizing the program [37]. Actual rates may be higher, given the difficulty of estimating ineligible populations in San Diego County such as active duty military and undocumented individuals, but would still be very low compared to metropolitan areas in other states which average between 80 and 90 percent participation [38]. While CalFresh alone will not end food insecurity, it is one of our most powerful and effective tools in the fight against hunger.

The Decision to Integrate SNAP/CalFresh Application Assistance into Healthcare Settings

Healthcare settings are an ideal place to connect food insecure patients to resources. Studies have shown that the presence of on-site food assistance has been critical to successfully engaging patients in accessing and utilizing resources. Individuals are more likely to sign up for food assistance resources when this is seen as a health goal and a part of the patient care visit. This is particularly true where clinics are able to offer social service resources onsite. As a result, many healthcare practitioners have labeled CalFresh and other food assistance referrals in the healthcare setting as the "missing link" to addressing food insecurity in their patient populations [39,40,41].

Studies have also found that provision of food resources can be a successful way to engage new patient populations in accessing medical services [42], and that partnerships with community based organizations specializing in helping patients access social service resources, like CalFresh, can play an integral role in developing sustainable models for holistic patient care [43]. Recent expansions in Medicare and Medicaid (called "Medi-Cal" in California) as a result of the Affordable Care Act have brought an influx of low-income, previously uninsured, underinsured, and underserved residents into the healthcare system, providing an important new access point for food security intervention.

> Individuals are more likely to sign up for food assistance resources when it is seen as a health goal and a part of the patient care visit.

In San Diego County, there has been a very high level of interest and engagement by the healthcare community in integrating food security into patient care, and there are numerous opportunities to build upon this work. Similarly encouraging is that much of the work that is occurring in San Diego County is happening across the nation. Various iterations of *Rx for SNAP* or *Rx for Nutrition* are being piloted in multiple counties and states. Pilots are taking place on a variety of scales, from individual clinics in Minnesota to entire healthcare systems in Colorado and Oregon [44,45,46]. There are also a number of efforts across the state of California, including *Rx for CalFresh* interventions in Santa Clara and San Mateo counties, as well as the Bay Area [47].

All of these models are rooted in the belief that holistic care incorporating social determinants of health, such as ensuring access to basic needs, are integral to long term health outcomes, particularly among low-income patient populations [48]. Recognizing the limited time that practitioners can spend with their patients, various models have proven that a CalFresh referral or connection to other social services can be just as powerful as a prescription in improving a patient's health [49,50,51].

III. THE APPROACH

In an effort to begin integrating food security into healthcare settings, the Hunger Coalition worked with a variety of partners to develop and pilot *Rx for CalFresh*. Rx for CalFresh aims to identify and address food insecurity by, first, screening patients for food insecurity and, second, connecting food insecure patients to available food assistance resources, starting with CalFresh. This work began in the fall of 2014 and continues to date.

Curriculum Development

Through the development of various pilots, the need for a standardized curriculum for healthcare practitioners implementing Rx for CalFresh became evident.

> Very few, if any, medical school curriculums incorporate nutrition or food insecurity, leaving many practitioners unsure of where to start.

While studies have unequivocally highlighted the effectiveness of social service delivery in healthcare settings, a large number of studies also show that healthcare practitioners not currently connected to a resource referral system feel unprepared and uncomfortable identifying and addressing food insecurity in their patients [41,52,53]. Very few, if any, medical school curriculums incorporate nutrition or food insecurity, leaving many practitioners unsure of where to start. Therefore, curriculum development and testing became an important part of the work.

Two primary concerns raised by healthcare practitioners considering implementing a screening and referral program to identify and treat food insecurity are: 1) ensuring that validated screening tools exist to accurately identify food insecure patients; and 2) confirming strong internal referral systems are in place, so that those patients identified as food insecure are able to be "treated." Over the past five years, validated screening tools have been developed and successfully integrated into clinical settings with high sensitivity and specificity in identifying food insecurity [40,41,54].

Working together with University of California San Diego (UC San Diego) School of Medicine faculty member, Sunny Smith, M.D., and her team, the San Diego Hunger Coalition and UC San Diego jointly developed a 50-minute curriculum designed for medical students, residents and health care practitioners. The goal of the curriculum is to increase: 1) understanding of food security as a health issue; 2) motivation and intent to screen for food security in patient visits; and 3) motivation and intent to refer patients to food resources, including CalFresh. The curriculum has been implemented at community medicine resident rotation sites across San Diego County, as well as in UC San Diego School of Medicine classrooms.

Pilot Development

From fall 2014 to present date, the Hunger Coalition helped develop and implement six distinct pilots in five healthcare settings across San Diego County. These pilots occurred in a free clinic, public health clinic, Federally Qualified Health Center, two County Public Health home visiting nurse programs and a hospital out-patient program. As each healthcare system has its own patient intake and flow process, each Rx for CalFresh pilot was tailored for its unique setting, with different models of connecting with patients through doctors, nurses, discharge case managers, or administrative assistants.

The goal of piloting various models across different healthcare settings was to identify best practices and an array of models to be expanded throughout the larger healthcare system. Information on the specific pilots projects, including settings, populations served, the food security screener used and specific outcomes is detailed in *Appendix A: Overview of Rx for CalFresh Pilots* (page 21).

In all but one pilot, healthcare practitioners administered a two-question food security screening to identify potential cases of food insecurity. This screener was developed by the USDA and has been scientifically validated to accurately identify individuals who are currently experiencing food insecurity. In a study with a sample of more than 30,000 patients, the two-question food insecurity screener identified 97 percent of those cases who were, in fact, food insecure [54]. While numerous organizations have attempted to utilize a single question to ask patients about food security, none of these questions have been scientifically validated to accurately and reliably elicit the information healthcare practitioners need to diagnosis patients as food insecure. The Hunger Coalition highly recommends using the two-question screener in the healthcare setting, because it has been scientifically proven to work nearly as well as extended surveys and is shorter for ease of use.

Two-Question Food Insecurity Screener

Answering often true, sometimes true, or never true, over the last twelve months:

1. We worried whether our food would run out before we got money to buy more.
2. The food we bought just didn't last, and we didn't have money to get more.

Patients who screened positive on at least one of the two questions were referred for assistance. While the first priority of the pilots was to connect patients to healthy food through the CalFresh program, connection to additional food assistance resources was a critical second priority. Additional resources offered to Rx for CalFresh patients included the Senior Commodity Supplemental Food Program, the Emergency Food Assistance Program, information about fresh produce and food distribution sites, and chronic disease-specific food boxes in participating locations. Connection to additional food resources is vital for patients who do not meet CalFresh eligibility guidelines, or for those whose CalFresh benefits run out before month end.

IV. RESULTS

The results of both the curriculum development and Rx for CalFresh pilots provide strong best practices to guide future efforts.

Validated Healthcare Curriculum

Between March and August 2015, 85 medical students, residents and faculty member physicians were trained using the curriculum developed by UC San Diego School of Medicine and San Diego Hunger Coalition. Pre- and post-tests were administered. The pre-test revealed that, on an aggregate level, participants reported recognition of food insecurity as potentially relevant to their patient population. However, there was little knowledge of the relationship between food security and health outcomes, and even less knowledge regarding food resources available in the community. Few participants had previously referred patients to local food resources, including CalFresh. In the pre-post survey comparison, participants showed statistically significant increases in knowledge of food security as a health issue, and increased willingness and motivation to both screen for food insecurity and refer patients to local food resources, including CalFresh [55,56]. Most notably, a one year follow-up survey found that increased knowledge and intention had translated to action. One year after the intervention, participants reported increased discussion of food insecurity and referral to food resources during patient visits [56]. These results have significant implications for future work in this area, as will be discussed later in this report.

> One year after receiving standardized training, healthcare practitioners reported increased discussion of food insecurity and referral to food resources during patient visits.

Recommended Rx for CalFresh Models

After analyzing the various food insecurity screening and referral methods developed for each of the six pilots, five Rx for CalFresh models emerged that can be adapted or combined to meet the precise needs of a healthcare setting. For a more comprehensive description of these models, including the strengths and weaknesses of each, populations best served, and healthcare setting requirements, please refer to *Appendix B: Recommended Rx for CalFresh Models* (page 25). *Appendix C* outlines Emerging Add-On Models that can be enhancements to the models outlined.

Table 1. Recommended Rx for CalFresh Models (*Further expanded in Appendix B*)

1. On Demand Onsite Assistance	Patients are referred to a full-time, onsite resource coordinator to assist with applying for CalFresh and accessing additional food resources. Little to no loss to follow-up.
2. Intermittent Onsite Assistance	Patients are referred to an onsite partner organization to assist with applying for CalFresh and accessing additional food resources. Availability of service may vary based upon capacity. Limited loss to follow-up, if assistance is provided regularly.
3. Partner-Initiated Phone-Based Referral	After providing consent, patient receives a follow-up call from a partner organization to provide phone-based application assistance and additional food resource referrals. Loss to follow-up is often high.
4. Patient-Initiated Phone-Based Referral	Patients are provided with a phone number to call for assistance. Loss to follow-up is high.
5. Referral to Local Community Based Organization	Patients are provided with names, addresses and phone numbers of local community based organizations for assistance. Loss to follow-up can be extremely high, unless the community partner is located in close proximity.

Early pilots utilized the Partner-Initiated Phone-Based referral model, also known as "proactive referral." With this model, patients who expressed interest and gave permission were contacted by a community based organization and offered application assistance over the phone. The Partner-Initiated Phone-Based model resulted in 37 percent of applicants being lost at some point during the ensuing application assistance process. Recognizing that patients with acute health issues need a higher level of support, one healthcare setting is adding On Demand Onsite Application assistance, utilizing the Out-Stationed Eligibility Worker Add-On (see Appendix C). This provides patients with bedside application assistance by hospital billing department staff and County eligibility workers who are "out-stationed" at the hospital to enroll people onsite, which is quickly showing promising results.

> Pilots where CalFresh application assistance was provided immediately, or a follow-up appointment was scheduled during the patient visit, had the highest rates of success.

On Demand Onsite Assistance was found to work best. The pilots where CalFresh application assistance was provided immediately, or a follow-up appointment was scheduled during the patient visit, had the highest rates of follow-up and enrollment compared to the pilots utilizing models requiring organizations to follow up with referred patients at a later date over the phone. Removing the most common barriers that applicants confront increases the likelihood that patients receive benefits.

Same Day Service for CalFresh enrollment is another promising model add-on that has already become a best practice for hard to reach populations (see Appendix C). Same Day Service combines Intermittent Onsite Assistance with an onsite County eligibility worker who conducts interviews,

determines eligibility, and issues benefits on the spot. Typically, a Same Day Service enrollment workshop is three to four hours in length and is arranged and facilitated by the site. Same Day Service has been proven to best serve populations with limited CalFresh verification requirements, such as homeless individuals, or applicants who are connected to an organization that has their personal information on file, like a healthcare center. Current Same Day Service workshop efforts consistently average between 75 and 100 percent approval for applicants.

V. RECOMMENDATIONS

The San Diego Hunger Coalition offers the following recommendations for others considering integration of food security screening and referral to food assistance resources into the healthcare setting.

1. Use Different Rx for CalFresh Models for Different Systems and Populations

In early discussions with various healthcare providers, it became clear that each site's unique patient intake and care process required a tailored food security screening and referral process. While the release of policy recommendations for universal screening and referral has placed pressure on many systems to develop a one-size-fits-all strategy, the San Diego Hunger Coalition strongly recommends tailoring Rx for CalFresh for the most impact on patient outcomes.

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Acute care settings are a good example of the need for a tailored Rx for CalFresh model. These settings have historically focused more on immediate medical needs and less on the social determinants of health or preventive care models. SDHC observed this perspective both with the practitioners, who were challenged with the concept of addressing social service needs, and with the patients themselves, who often felt their health condition prevented them from focusing on complex tasks like applying for CalFresh benefits. As a result, these patients benefit from additional one-on-one support in accessing services. Variability between patient populations and their levels of self-agency is an important consideration across all settings.

The Hunger Coalition recommends that clinics and CalFresh partners work together to develop and adapt outreach and application assistance in a way that integrates into existing systems and/or leverages existing services onsite. *Appendix B: Recommended Rx for CalFresh Models* can serve as a menu of options for healthcare providers and CalFresh application assistance agencies to utilize when developing service models and seeking collaboration.

2. Engagement of Staff at All Levels and Strong Evaluation Early in the Process

Developing individual processes to incorporate food security screening and referral, changing electronic health record systems, and training health care staff requires multiple decision points on how to allocate clinic staff time and resources, as well as operating systems. Across models, identifying internal "champions" at a decision-making level early in the process increased the likelihood of success. Decision-maker buy-in afforded pilots the ability to quickly adapt to evolving needs of the intervention throughout the pilot life cycle. Because of their early involvement, decision-makers were also more willing to invest additional resources like staff time or internal expertise to overcome any initial challenges that emerged in the process.

Another important lesson was the importance of building knowledge among frontline healthcare providers, as well as higher level decision-makers, about the link between food security and health outcomes and the importance of supporting patients in accessing food assistance resources. Pilots that offered limited training on these topics saw lower compliance by frontline staff, while those pilots that provided immediate, comprehensive training to staff at all levels saw higher levels of successful adoption. In addition to increasing understanding, a formal training can also create space for feedback and collective brainstorming on how to best adapt Rx for CalFresh processes based upon the needs of the population served and constraints or opportunities specific to the setting.

Once systems are in place and staff are trained, it is important to monitor progress to ensure that tools are being utilized consistently and with fidelity. Developing strong tracking mechanisms allowed partners to monitor and evaluate the status of their efforts from the individual to the aggregate level, including the number of individuals referred to CalFresh and the outcomes of those referrals. Monitoring results along the way also enables sites and partners to make process adjustments in real-time to maximize efficiency and effectiveness.

3. Integration into Electronic Health Records

One of the most promising outcomes of this work is the successful incorporation of food security screening questions, as well as referral to food assistance programs, into electronic health records (EHR). By tracking food security screening and referrals in the EHR, healthcare organizations and their partners can begin to formally collect data on food security levels of entire patient populations, as well as the effectiveness of food assistance resources in combating food insecurity and improving health outcomes of their patients. Collecting data will improve understanding of the problem, as well as ability to craft the most effective solutions.

One of the largest challenges to date in large-scale cross-application is the lack of standardization across EHRs. Different EHR systems require individualized development, forcing each healthcare system to "re-invent the wheel." A lack of uniformity with how food security and referral information is captured may also make standardized data collection and comparison across healthcare systems challenging. In order to reach a long-term goal of countywide data collection, participating healthcare systems will need to develop and agree upon a standardized coding classification to compare individual and aggregate data points across systems. Conversations with

other states implementing similar models have yielded recommendations to use billing codes as a way to maintain standardization across EHR platforms [45]. Healthcare systems should convene early in the process of development to coordinate efforts.

4. *Beyond CalFresh, the Case for Comprehensive Food Assistance Referrals*

While federal nutrition assistance programs provide the most extensive and dignified access to food resources, additional programs are often critical to fill the gaps for food insecure households [11]. CalFresh alone, for many low-income families, is not enough to eliminate food insecurity because the benefit amount is too low. Numerous studies point to the unsettling truth that SNAP benefits run out before the end of the month [11], and that low-income families receiving SNAP or WIC often still classify as food insecure by USDA standards [49]. Other household circumstances, like immigration status or receipt of Supplemental Security Income (SSI), may also limit the amount of assistance for which a patient's household is eligible. Therefore, it is ideal that Rx for CalFresh programs include referral to emergency food resources, such as nearby food pantries, in addition to CalFresh application assistance. Emergency food distribution can also meet patients' needs while waiting for their CalFresh application to be processed and approved. By working with San Diego County's food banks, healthcare setting pilots were able to provide food assistance resources above and beyond the CalFresh program.

5. *Focusing on Federally Qualified Health Centers*

Until there is enough capacity to support universal food security screening and referral, the Hunger Coalition recommends targeting settings with large patient populations that are most likely to be food insecure based on factors such as household income, age (focusing on children and seniors), and disability status. The most promising pilots to date in reaching large numbers of eligible patients have been at Federally Qualified Health Centers (FQHCs) providing CalFresh application assistance and food resources referral onsite. FQHCs are tasked with providing community resources and have a long history of being trusted sources of information in the communities they serve. FQHCs often have strong infrastructure and stable funding streams, enabling them to integrate complementary, ancillary services. It is particularly appropriate for FQHCs to consider providing CalFresh application assistance, as most clinics already have a strong Medi-Cal application assistance department in place and the majority of Medi-Cal patients will also be eligible for CalFresh.

Healthcare settings with fewer staff may be best suited for Rx for CalFresh models utilizing partnerships with community based organizations that can provide application assistance and food resource referral. Settings that serve a high population of CalFresh ineligible patients, such as low-income seniors receiving SSI, may need to prioritize access to food resources, including direct food assistance in the form of onsite food pantries, *Food Pharmacies*, or coordinated, disease specific food distributions.

6. Policy Considerations

Incorporation of Food Insecurity into Community Health Needs Assessments

Community health needs assessments are critical tools utilized by public and private institutions to determine the health of a community and what, if any, additional resources or services are needed. These assessments often have significant influence on the types of programs that are funded to promote health within communities and can guide long term plans for community and social sector engagement. While the academic community is developing a strong evidence base for the role food security plays in health and wellbeing, food security has not yet become a standardized indicator in local community health needs assessments.

In 2015, the Hunger Coalition worked with Hospital Association of San Diego and Imperial Counties and San Diego State University Institute of Public Health to include food security in the 2016 Community Health Needs Assessment for San Diego County. The assessment utilized existing food security related indicators and gathered qualitative feedback through focus groups and in-depth interviews. Many anti-hunger advocates will not be surprised that the community's top health concerns in the 2016 Community Health Needs Assessment for San Diego County were "food security and access to healthy food" [57]. Emerging resources exist to support healthcare entities to incorporate food security into future assessment efforts [58]. Adding food security to more community health needs assessments can inform both program and policy development.

Dual Enrollment Platforms

The most efficient way to significantly increase the number of individuals enrolled in both Medi-Cal and CalFresh is to streamline the current online application systems to allow for application to both programs at once, often referred to as "dual enrollment." Prior to the Affordable Care Act, San Diego County healthcare providers used an online benefits portal called CalWIN to allow residents to apply for assistance. This platform allowed users to apply for CalFresh and Medi-Cal simultaneously. With the passage of the Affordable Care Act, the state of California developed a new online platform (CALHEERS) for enrolling in health insurance, including Medi-Cal. This new platform does not integrate with existing online public benefits application portals like CalWIN, and does not allow for cross-sharing of information with CALWIN. Healthcare providers were incentivized to use the new CALHEERS system, however, because the Affordable Care Act initially offered payment to the provider for each Medi-Cal patient enrolled – but only through CALHEERS. These payments have been phased out, but healthcare providers continue to use CALHEERS for Medi-Cal. Therefore, if a

DUAL ENROLLMENT

San Diego Hunger Coalition urges healthcare providers to offer both CalFresh and Medi-Cal on-site application assistance, as this is most efficient for the patient applying and the organization assisting.

In California, both online and paper dual application opportunities exist based on the county of residence through:

- MyBenefitsCalWIN.org or C4Yourself.com (state websites to apply for public benefits); and
- SAWS2Plus dual Medi-Cal/CalFresh paper application.

patient wants to also apply for CalFresh, they must start the application process over from the beginning, including resubmitting information that is already in a state system. Implementation of CALHEERS had the unintended consequence of significantly increasing the number of applicants who applied for Medi-Cal but chose not to pursue CalFresh, even though they were eligible. Changes must occur at the state level to integrate and streamline these two systems and may be aided by legislation to ensure timely implementation.

Streamlined Verification Processes

It is much easier to apply for Medi-Cal than CalFresh due to differences in how current regulations permit county-level program administrators, such as San Diego County Health and Human Services Agency, to verify applicant information. The Medi-Cal program is effectively utilizing federal data systems to access applicants' information for eligibility verification, such as identification and income. Access to federal data hubs is often credited for the high enrollment rates in Medi-Cal, however, state and federal restrictions prevent the CalFresh (SNAP) program from doing the same. Inability to provide sufficient hard-copy documentation verifying eligibility is one of the top reasons that eligible people are denied CalFresh benefits. The State of California is currently utilizing one federal data source for income verification called the Work Number. Unfortunately, this database only includes information for a small percentage of employers in the state. Progress on these measures is currently dependent upon the federal approval of a USDA waiver application, allowing counties to utilize existing federal data hubs. Administrative advocacy could have significant impact on the likelihood of approval and timeliness of implementation.

V. OPPORTUNITIES FOR EXPANSION OF RX FOR CALFRESH

Many of the lessons learned and best practices outlined in this report are echoed across other counties and states implementing Rx for CalFresh/SNAP. Use of EHR systems, data sharing, tailoring the process along the way, and key stakeholder engagement have all been consistently identified as critical to program success. Another common thread to be further explored is the importance of building capacity for scaling up.

While San Diego County healthcare systems and agencies providing CalFresh application assistance are currently able to manage the number of referrals from the pilots outlined in this report, the opportunity to scale up from pilot to broader program implementation may be limited by the availability of internal and external resources. In some cases, scaling up may necessitate more efficient procedures for processing referrals and connecting patients with food assistance resources. Examples of how organizations have increased efficiency often include increased use of technology, such as information-sharing platforms between healthcare settings and agencies accepting referrals, or enhanced client management systems for application assisters. In other cases, increased demand may require overall program expansion, including increased staffing, either onsite or contracted through a community based partner organization.

One of the greatest challenges for this work is the limited availability of funding sources to support CalFresh application assistance. While new federal and state level funding sources to integrate social service resources into the clinical setting are beginning to emerge, these sources focus more on the development of processes rather than on-the-ground capacity [59,60].

Long term, strategic conversations need to occur with food assistance organizations, healthcare systems and potential funders, both public and private, who are willing to support building local capacity where identified needs exist. The healthcare sector, in particular, stands to gain by investing in strategies that produce long term cost savings through both individual and community health outcome improvements. By investing in a patient's access to food, we are investing in the health of the whole person, family and community.

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APPENDIX A: Overview of Rx for CalFresh Pilots

(*See Appendix B for Recommended Rx for CalFresh Models*)

2014-2016 Rx for CalFresh Pilot Projects in San Diego County

PILOT 1: FREE CLINIC

Healthcare Partner: UCSD School of Medicine Student-Run Free Clinic
Location: Third Avenue Charitable Organization in downtown San Diego
Additional partners: UCSD School of Medicine, Feeding America San Diego, San Diego County Health and Human Services Agency (HHSA)

Population served:
High concentration of homeless and undocumented residents

Screening & Referral:
- Six-question USDA food insecurity screener.
- Screening incorporated into EHR.
- Medical students screen and refer patients as a part of the patient care visit.
- Developed food insecurity registry to target follow up with food insecure patients at subsequent clinic and onsite food pantry visits.

Food Assistance Provided:
- Onsite Intermittent CalFresh Application Assistance provided by Feeding America San Diego.
- Referred to monthly Same Day Service CalFresh enrollment clinics held onsite. If patient cannot wait for monthly enrollment clinics with HHSA, referred to the nearest County office, a few blocks away.
- All patients were enrolled in a monthly food distribution program which provided 50 lb. food boxes that were developed specifically for diabetic patients.

Staff Training:
Residents and medical students were trained using UCSD-SDHC food security and healthcare medical education curriculum.

Outcomes:
While many of the patients are ineligible for CalFresh due to immigration status, future efforts will target eligible family members, with the goal of increasing the overall household food budget. Those patients eligible for CalFresh had successful results with Same Day Service workshops. Approval rates averaged between 75 and 100.

PILOT 2: FEDERALLY QUALIFIED HEALTH CENTER

Healthcare Partner: Family Health Centers of San Diego
Location: Central Region of San Diego (City Heights)
Additional partners: UCSD School of Medicine, Feeding America San Diego, San Diego Food Bank

Population served:
Low-income, often food insecure patient populations

Screening & Referral:
- Two-question USDA food insecurity screener, followed by a question whether currently receiving CalFresh and/or WIC.
- Medical assistant screens while taking patient vitals. Physician follows up on positive screens by talking to patients and creating a referral to the clinic's case management program.

- Screener and referral integrated into the EHR.

Food Assistance Provided:

- On Demand Onsite Application Assistance
- After receiving the referral, onsite patient navigators spend time with the patient, asking about specific resource needs, whether or not the patient has CalFresh or WIC, and if they are interested in applying. If interested, case managers will help client apply for CalFresh.
- Case managers also provide information about other food resources, including WIC and local food pantries.
- SDHC worked with local partners to upload information about local food pantries and CalFresh information specific to immigrant populations into the EHR for immediate download by case managers.

Staff Training:

- Residents were trained using the curriculum developed by UCSD and SDHC.
- Residents then trained Medical Assistants to interview patients.
- SDHC trained patient navigators providing on Medi-Cal application assistance to also become CalFresh application assisters.

Outcomes:

The clinic has found that incorporating CalFresh application assistance onsite has resulted in increased CalFresh applications, not only for patients screening positive for food insecurity, but for the general patient population. Six months of implementation resulted in ~250 food assistance referrals; however, there have been over 1,200 new CalFresh applications submitted onsite during the same period.

PILOT 3: HOME VISITING NURSE PROGRAM

Healthcare Partner:	San Diego County Public Health Services (Nurse Family Partnership and Maternal and Child Health)
Location:	Central Region of San Diego County
Additional partners:	San Diego County Health and Human Services Agency (HHSA), San Diego Food Bank

Population served:

High-risk pregnant and new mothers, many of whom are teens or young adult single moms

Screening & Referral:

- Both programs utilized an “Rx for Nutrition” prescription pad, including the two-question food security screener followed by a question whether receiving CalFresh.
- Neither program utilizes EHR; however, a copy of the prescription remained in the patient file.
- Nurses screened families for food insecurity using the prescription pad and asked interested families for consent to share their information with San Diego Food Bank.

Food Assistance Provided:

- The food bank then followed up with and helped families apply for CalFresh over the phone. If requested, families were also connected with available food distribution sites based on location.

Staff Training:

- Nurses were trained by HHSA staff on how to integrate the two-question screener into their routine intake process with support from SDHC.

Outcomes:

Loss to follow-up was a major limitation. Of those families successfully contacted, the majority were already enrolled or ineligible. (Many single teen moms living with their parents are ineligible for CalFresh because their parents’ income puts them over the household income limit.) Resources have not been further allocated to this model.

PILOT 4: PUBLIC HEALTH CLINIC

Healthcare Partner: San Diego County Public Health Centers
Locations: Central Region, with recent expansion to North and East Regions of San Diego County
Additional partners: San Diego County Health and Human Services Agency (HHSA), San Diego Food Bank

Population served:
Public Health Centers provide County administered TB, HIV and STD testing as well as immunizations for a low fee or no fee, and are most often utilized by residents without comprehensive health insurance.

Screening & Referral:
- Two-question food security screener followed by whether currently receiving CalFresh.
- Patients were asked to fill out food security questions as part of the clinic paperwork required to register.
- Clinic does not utilize EHRs and does not keep patient files.
- Administrative staff review completed form with patients, ensuring understanding and interest.
- Patients asked for consent to share information with San Diego Food Bank.

Food Assistance Provided:
- The Food Bank followed up with and helped individuals apply for CalFresh over the phone.
- If requested, families were also connected with available food distribution sites based on location.

Staff Training:
- Public Health Clinic administrative staff were trained by HHSA staff on how to integrate the two-question screener into their routine intake process with support from SDHC.

Outcomes:
Loss to follow-up was a major limitation. Of those families successfully contacted, many were already enrolled in CalFresh. The model is being expanded to other regions where social service provision is more limited.

PILOT 5: HOSPITAL

Healthcare Partner: Sharp Grossmont Hospital
Location: East Region of San Diego County
Additional partner: San Diego Food Bank

Population served:
Sharp Grossmont Hospital's Care Transitions Intervention is designed to reduce readmission rates of vulnerable, high-risk Medi-Cal or self-pay patients.

Screening & Referral:
- Due to initial discomfort with the screening tool language, the food security screener was not used. Patients were asked if "they have enough food in their house." As noted below, Sharp staff have since requested training to improve their screening process.
- Patients at high risk for readmission are offered a health coach (nurse) who conducts a home visit and 30-day follow-up services.
- Patients answering "no," to having enough food in the house were asked for consent to share information with San Diego Food Bank.

Food Assistance Provided:
- Patients provided a local food distribution resource list created by the Food Bank.
- The Food Bank followed up with and helped patients apply for CalFresh over the phone.

Staff Training:

- Health coaches were initially trained by Sharp staff.
- Additional training of health coaches has been requested by Sharp to address discomfort with food security conversations and to ensure consistent implementation. Training will be provided by UCSD and SDHC on how to integrate the two-question screener into their routine intake process.

Outcomes:
Loss to follow-up was a major limitation. Of those families successfully contacted, the majority declined or did not send back their application. Other patients were already enrolled in CalFresh or were ineligible due to receiving Supplemental Social Security Income (SSI). There were also concerns that the screener did not fully capture the food insecure population.

Lessons learned from this pilot have informed current efforts underway, including On Demand Onsite Assistance with Out-Stationed Eligibility Workers and Sharp's billing department, as well as a renewed focus on Partner-Initiated Phone-Based Referral with Feeding America San Diego and 2-1-1 San Diego.

APPENDIX B: Recommended Rx for CalFresh Models

Rx for CalFresh Models Recommended by San Diego Hunger Coalition	
Model #1: On Demand Onsite Assistance	
Model Description	Patient referred to an onsite care coordinator, application assister or similar position for CalFresh application assistance and access to other food resources during patient visit. Full-time assistance may be provided by an onsite partner organization.
Populations Best Served	• All populations • Vulnerable populations • Patients in poor health • Older adults • People who prefer face-to-face assistance • People who have applied for Medi-Cal onsite (since verification information is already in system) • Individuals with limited access to transportation • Rural patients with poor phone reception
Populations Not Well-Suited	N/A
Healthcare Setting Requirements	• Staff trained in food security screening and referrals • Staff trained in application assistance and allocated to providing this service, or a partner organization is identified to provide full-time application assistance onsite • A space that can ensure patient privacy • A work station with phone and computer to provide assistance onsite *Many successful models cross train Medi-Cal application assisters to provide dual CalFresh and Medi-Cal application assistance.*
Loss to Follow-Up	Little to none *Patients may still choose to opt-out; however, healthcare staff should be trained to identify and address patient concerns that may otherwise keep them from applying.*
Model #2: Intermittent Onsite Application Assistance	
Model Description	Patient referred to onsite application assister provided by a partner organization. Partner organization comes onsite on a regular basis (e.g., 1 day per week), but is not available at all times so assistance may require separate visit by patient.
Populations Best Served	• All populations • People who prefer face-to-face assistance
Populations Not Well-Suited	If onsite assistance is infrequent, this model less-suited for: • Older adults • Patients in poor health • Individuals with limited access to transportation

Healthcare Setting Requirements	• Staff trained in food security screening and referrals • Application assistance partner onsite regularly • A space that can ensure patient privacy • Healthcare staff should also be familiar with CalFresh and the partnering agency in order to effectively refer and answer questions when the CalFresh partner is not present *Partner may or may not refer to additional food resources beyond their area of expertise or staff capacity, so healthcare provider may need to compensate for that.*
Loss to Follow-Up	Limited, if assistance is provided regularly. *Possible need for a second visit increases loss to follow-up due to cost and inconvenience for patient, as a second visit may require more time off work or additional cost for childcare or transportation.*
Model #3: Partner-Initiated Phone-Based Referral	
Model Description	Patient asked if they want a follow-up call from a partner organization for assistance. Consent may be given by signature or verbally, in compliance with healthcare setting regulations.
Populations Best Served	Technologically savvy patients with access to smart phones and consistent phone reception. *Patients can use smart phone to take photos of documents for eligibility verification (e.g., pay stubs) and submit via email.*
Populations Not Well-Suited	• Older adults • Patients in poor health • Patients with inflexible schedules • Individuals requiring more hands-on support • Rural patients with poor phone reception
Healthcare Setting Requirements	• Staff trained in food security screening and referrals • Protocols established between healthcare systems and phone-based CalFresh application partners to share patient information
Loss to Follow-Up	Often high

Model #4: Patient-Initiated Phone-Based Referral	
Model Description	Patient provided with a phone number to call for assistance. Consent may be given by signature or verbally, in compliance with healthcare setting regulations.
Populations Best Served	Proactive, technologically savvy patients with access to smart phones and consistent phone reception. *Patients can use smart phone to take photos of documents for eligibility verification (e.g., pay stubs) and submit via email.*
Populations Not Well-Suited	• Older adults • Patients in poor health • Individuals requiring more hands-on support • Rural patients with poor phone reception
Healthcare Setting Requirements	Staff trained in food security screening and referrals
Loss to Follow-Up	High
Model #5: Referral to Local Community Based Organization	
Model Description	Patient provided with names, addresses and phone numbers of local community based organizations for assistance.
Populations Best Served	Best when healthcare setting is located near a community based organization (less than .25 mi) offering application assistance.
Populations Not Well-Suited	• Patients in poor health • Patients with inflexible schedules • Individuals with limited access to transportation
Healthcare Setting Requirements	Staff trained in food security screening and referrals
Loss to Follow-Up	Often extremely high, unless the community partner is located in close proximity

APPENDIX C: Emerging Add-On Options to Supplement Rx for CalFresh Models

Format	Populations Best Served	Healthcare Setting Requirements	Other Considerations
Add-On #1: Same Day Service			
Patient is screened for CalFresh eligibility and assisted with application. County HHSA Eligibility Operations staff are scheduled to be onsite to conduct interview, determine eligibility and issue benefits on the spot. General format is a half-day CalFresh enrollment workshop coordinated by the site.	• Homeless • People with little to no income or expenses • People served by a facility that has access to their income and expenses information (e.g., clinics, universities, senior living facilities, etc.).	• Patients available for 2-4 hours • Onsite coordinator the day of the event • Wi-Fi to allow document sharing between the organization providing application assistance and HHSA staff • A space that can ensure patient privacy	• Same Day Service can be added to any of the Rx for CalFresh models, but dovetails most closely with onsite application assistance, models #1 and #2. • Same Day Service is particularly helpful for agencies with a large number of eligible patients with barriers preventing them from successfully navigating the traditional enrollment process, like those serving the homeless, older adults, or rural communities.
Add-On #2: Out-Stationed Eligibility Workers			
Organizations providing significant levels of application assistance may request to have a County HHSA out-stationed eligibility worker placed at their site. The eligibility worker collaborates with the organization to do outreach and process applications. The level of interaction and collaboration between the host organization and HHSA staff should be mutually determined.	• This option serves all populations and offers the most support to CalFresh application assistance staff at the organization hosting the eligibility worker.	• A space that can accommodate HHSA staff and ensure patient privacy • Ability to meet regularly with HHSA to establish joint protocols, fine tune business processes and maintain strong feedback loops	This option only works in healthcare settings offering onsite application assistance. Well-suited for healthcare sites or organizations with a high volume of eligible applicants and strong case tracking/client management systems in place to support this direct working relationship with HHSA.

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