Measures for Patient Program Access

HC Practice Food Insecurity Screening Policy

# Patients Eligible for Screening	# Patients Screened	# Positive Screen for Food Insecurity

Quality check for screening implemented, results available in EHR, results reviewed by PCP & care team

Referral Pathway for Patients at Risk of FI

% Positive Screen Accept Care Coordination Referral	% of Referred Offered a Service	% that Complete Enrollment in Referred Service

Example: SDOH Business Model Toolkit. (Depending on practice workflow, some steps may not apply).

Includes quality check for menu of services available meeting patients' needs and evaluation of adding new referrals to close gaps.

For Non-Health Care Food Partners

Direct or indirect connection to clinician / health condition management?	% Complete Enrollment after Referral (see above)	% Participate After Enrolling

Screening Results & Accepting Referral & Program Participation creates baseline patient cohorts.

Baseline Measures at Program Enrollment

6-question USDA Food Security Module	Date of enrollment marked in EHR	Enrollment in federal nutrition programs	Other baselines depend on program

Implementation Measures

Program Measures

Frequency -classes, CSA pick up, voucher redemption, etc

Size - $ in vouchers, food in share. If by household unit, then also average HH size.

Duration - of the intervention or of phase (for example, MTMeals then step down)

Other Services nutrition education (non-clinical), transportation, etc.

Example: GusNIP metrics

Clinical Measures

Medication Management – Access Includes both services & frequency of monitoring clinical indicators

Medication Management – Did medications change? New diagnoses + new medication? Reducing medication as diet change occurs?

Nutrition Services – Access Includes clinical services from licensed provider. See FAHC report.

Nutrition Services – Participation And is there a closed loop with the primary care provider?

Other Services – Tobacco cessation, engagement in preventive care, Chronic Condition Management

Example: Geisinger Case Study

Measures at Program Completion

6-question USDA Food Security Module – 30 day modified. Pre- / Post-indicates level changes.

# of Patients Completing the Program. Date of completion marked in EHR.

Biomarker trend comparison across patient groups (enrolled, eligible but not enrolled, general population, etc.). Trend analysis only, unless program is designed for treatment (e.g. Medically Tailored Meals).

Example: CVD Risk Dashboard developed for HRSA-HRHI Grant.

Dietary change measure – defers to tool in current use by nutrition service / nutrition education provider within program.

Health Care Use Core Metrics – Primary care engagement, nutrition services, ED utilization