IMPLEMENTING FOOD INSECURITY SCREENING

Implementing food insecurity and other social determinants of health (SDOH) screening tools will look different at each health care practice or organization. There are a variety of ways to screen patients, as well as a variety of tools providers can choose from that best meet the needs of their practice. Providers and their teams should review the available options and determine what works best for their practice.

Things to Consider in Selecting a Screening Tool

Different screening tools are available to measure a variety of social determinants of health. Each screening tool has a different number of questions and range of topics covered. When selecting a tool for your practice, consider:

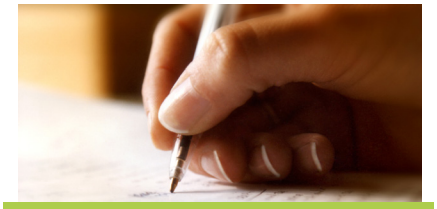
- **Time:** How much time do you have available for screening? Do you have time to complete 21 questions, or do you need to stick with something shorter?
- **Topic Areas:** What are the common needs of the patients you currently serve? Are you prepared to connect patients with resources for all of the needs outlined in the screening tool?

SCREENING TOOLS

SDOH Category	Accountable Health Communities Health-Related Social Needs Screening Tool	American Academy of Family Physicians Social Needs Screening Tool	Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
	26 questions; Developed by Centers for Medicare and Medicaid Services	15 questions; Developed by American Academy of Family Physicians	21 questions; Developed by National Association of Community Health Centers
Food Insecurity	X	X	X
Housing	X	X	X
Transportation	X	X	X
Utilities	X	X	X
Personal Safety	X	X	X
Education	X	X	X
Finances	X	X	X
Employment	X	X	X
Mental/Social/ Emotional Health	X		X
Family and Community Support	X		
Physical Activity	X		
Substance Use	X		
Disabilities	X		
Health Care			X
Child Care		X	X
Clothing			X
Demographics/ Personal Characteristics			X
Prison/Jail Time			X
Refugee Status			X

MODALITIES OF SCREENING

Face-to-Face Screening



Paper Surveys

Electronic Surveys

Three main screening mechanisms are routinely used for assessing various social determinants of health.

When thinking about which modality to select at your practice, consider things like:

- **Staff Capacity**: Is a member of the staff available to take the time to complete a face-to-face screening?
- **Technological Savvy of Patients**: Are the patients you serve familiar enough with technology to complete an electronic form?
- **Data Entry Capacity**: When choosing paper surveys, will you need to enter the data into an electronic health record to include with a patient record?

You may consider implementing one or more of the approaches above, depending on your site and patient population.

SDOH SCREENING: ROLES AND RESPONSIBILITIES

Key personnel: physicians, medical assistants, nurses, social workers, nutritionists, receptionists

Responsibilities of staff are based on capacity and needs of the practice. They can include:

- Distributing the SDOH screening to patients
- Making educational material and resources available to patients
- Counseling and referring patients based on identified needs
- Continued education on available resources and programs in the community
- Entering SDOH assessment into electronic health record
- Reviewing SDOH data at your practice regularly
- Ensuring processes and procedures are being followed

PROCESS OF SDOH SCREENING: WHEN AND HOW OFTEN?

When to distribute the SDOH screen and how often are other decision points to consider. Again, keep the patient at the center of the decisions you make. You will need to consider your staff capacity and the general workflow of your practice, as well.

Below are a few options for when to distribute the SDOH screener. Whatever option you choose, make sure your patients have privacy and feel comfortable completing the screening.

You have lots of options available to you in terms of how often to screen for SDOH. Whichever option works best for your practice, the key is to keep the screening consistent and systematic.

- Prior to appointment
- In waiting room
- In patient room, waiting for provider
- In patient room, with provider

- Once per calendar year
- At every annual visit
- At every visit
- For specific patient popul1ations

CONNECTING YOUR PATIENTS TO RESOURCES

If a patient in your practice screens positive for an SDOH need, you want to make sure you speak to them and see if they would like assistance in finding resources to fill their need.

If they want resources, there are a number of ways to think about connecting your patients with resources. Remember to think through this process prior to implementing SDOH screening.

- Community health worker: A community health worker (CHW) or other patient navigator is an ideal choice for supporting patients. The benefits of a CHW are that they are a trained professional, knowledgeable about available community resources, and able to work with patients in a way that meets their cultural needs. For practices that have chosen to participate in the Screen and Intervene program, funded by Florida Blue, a designated CHW is assigned to work with your patients on all their SDOH needs.
- Other options:
  - Physical resource list
  - Online referral platform
  - Dial 2-1-1

The Screen and Intervene Program, funded by Florida Blue, is brought to you by the following partners:

Alliance for Community Health

Georgia Health Policy Center

primary partners

Second Harvest Food Bank of Central Florida

UCF University of Central Florida