

# Identifying Food Insecurity in Diabetes Population

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**BronxCare Health System**

# BronxCare Health System

The largest voluntary, not-for-profit health and teaching hospital system serving the South and Central Bronx, with **859 beds and more than 4,500 employees.**

Two main hospital divisions, comprehensive psychiatric and chemical dependency programs, a long term care facility and an extensive outpatient network.

BronxCare is among the largest providers of outpatient services in NYC, with **nearly one million visits annually.**

Our emergency department is one of the busiest in New York, with **141,000 visits per year.**



# BronxCare Health System

- BronxCare’s service area, in the south and central Bronx, is among the poorest in the nation.
  - High disease incidence,
  - Large minority and immigrant populations,
  - Low socioeconomic status,
  - High SDOH risks,
  - 80% of the population is non-white (Hispanic and Black), and
  - 32% of the population is not proficient in English.
- BronxCare is a “safety-net” provider. We serve many Bronx residents who are on public insurance programs or are uninsured, and who have high rates of obesity, diabetes, asthma, hypertension, heart disease, mental illness and substance abuse.
- Health metrics in BronxCare’s service area demonstrate **greater mortality and morbidity, and worse health outcomes than most areas in New York city and New York state.**
- BronxCare leadership is committed to addressing the health disparities and social care needs of its service area to improve overall health outcomes. We have a number of initiatives in place to do so.

# Problem statement

## What we wanted to address

There was no standardized practice and workflow to identify food insecure diabetic inpatients and provide needed social services

By utilizing best practices implemented in our outpatient areas, the interdisciplinary team will assess food insecurity needs in admitted patients with a medical history of diabetes.

Patients that are identified thru this assessment will be connected to community food insecurity distributors.

## Gap Assessment Identified the Following:

- No automated process/workflow in the EMR for other disciplines to screen patients and refer to Social Work
- EMR did not have any type of work list or action list for Inpatient Social Work to easily identify those patients requiring intervention

# Where we started (May 2022)

- Since 2021- The Hunger Vital Sign questions developed by Children's' Health Watch organization were included in The Outpatient Social Work Needs Assessment and Outpatient Nutrition Assessment templates to assess patients with diabetes.
- BronxCare team discussed whether we wanted to capture all of the SDOH, or focus on one specific aspect of SDOH.
- We assembled an inpatient team, including:
  - Health Information Management
  - Medicine and Family Medicine
  - Nursing
  - Nutrition
  - Social Work/Care Management
- We were collecting data in our EMR, but it was not standardized.
- Organizational leadership discussed improving data collection through stratifying data by race, ethnicity, gender and language.
- The IT and HIM departments began exploring how to use the EMR problem list to identify patients with diabetes.
- When identifying community partners, organizational leadership considered Harvest Home and God's Love We Deliver.

# What we did this year

## What we have accomplished through AHEI:

### IT improvements

- Included PRAPARE and Hunger Vital Sign questions in multiple locations to effectively share information across disciplines (Social Work/Care Management, History & Physical, Nursing, and Nutrition Assessments).
- IT and SDOH Team improved data collection processes to streamline data.
- Migrated existing outpatient action list to inpatient EMR to show patients' answers to food insecurity questions. This improved care transition communication and allowed Social Work to access this information in both settings (Inpatient and Outpatient).

### Staff education

- Trained Social Work and Care Management staff to use PRAPARE and Hunger Vital Sign questions. Training covered how to ask these questions, types of interventions, and connecting with multiple community agencies.

### Community partnerships

- Formed new partnerships with Harvest Home and God's Love we Deliver.
- Updated food insecurity resource lists, using [Hitesite.org](https://www.hitesite.org).

# Harvest Home



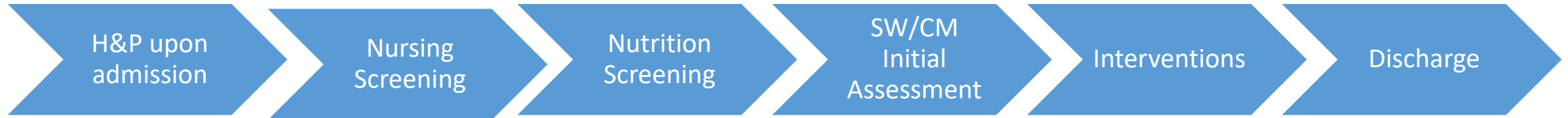
Harvest Home Mt. Eden, Bronx NY  
Fresh Food Stands



Harvest Home Mt. Eden, Bronx NY  
Fresh Produce

# What we did this year

## EMR Food Insecurity Hunger Vital Sign Questions Flow





**PRAPARE TOOL**

**PERSONAL CHARACTERISTICS**

1. Ethnicity  2. Race

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?  
 Yes  No  I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?  
 Yes  No  I choose not to answer this question

5. What language are you most comfortable speaking?  
 English  Spanish  French  Other

**FAMILY AND HOME**

6. How many family members, including you?  
 I choose not to answer this question

7. What is your housing situation today?  
 I have housing  I do not have housing

8. Are you worried about losing your housing?  
 Yes  No  I choose not to answer this

9. What address do you live at?  
 1665 morris ave, , BRONX, USA, 10457

**MONEY AND RESOURC**

10. What is the highest level of school that you completed?  
 Less than high school degree  High school

11. What is your current work situation?  
 Unemployed  Part-time or temporary work  Otherwise unemployed but not seeking work

12. What is your main insurance?  
 None/Uninsured  CHIP Medicaid  Other  
 Medicaid  Medicare  Other

13. During the past year, what was the total amount of income you or your family received from all sources, including any benefits?  
 I choose not to answer this question

14. In the past year, have you or any family member experienced any of the following?  
 Food  Medicare or Any Health Care  Utilities  Phone  Clothing  Other  Child Care  I choose not to answer this question

**SOCIAL AND EMOTIONAL HEALTH**

16. How often do you see or talk to people you care about and feel close to? (ex: talking to friends on the phone, visiting friends or family, going to church or club meetings)  
 Less than once a week  1 or 2 times a week  3 to 5 times a week  5 or more times a week  I choose not to answer this question

17. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?  
 Not at all  A little bit  Somewhat  Quite a bit  Very much  I choose not to answer this question

**OPTIONAL ADDITIONAL QUESTIONS**

18. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?  
 Yes  No  I choose not to answer this question

19. Are you a refugee?  
 Yes  No  I choose not to answer this question

20. Do you feel physically and emotionally safe where you currently live?  
 Yes  No  Unsure  I choose not to answer this question

21. In the past year, have you been afraid of your partner or ex-partner?  
 yes  no  unsure  I have not had a partner in the past year  I choose not to answer this question

# Allscripts- Social Determinants of Health Screening Tools

# Allscripts- Social Determinants of Health Screening Tools

1854 - Production Environment - BL0SCM1APVIS023.BL1ADCV1 (Windows Remote Desktop Protocol)  
 oodtransfusiontest - Social Determinants of Health Screening Tools

30 - Nov - 2022 Time: 04 : 52

Copy Forward Refer to Note Preview Modify Template Acronym Expansion

PRAPARE TOOL **FOOD INSECURITY**

**FOOD INSECURITY SCREENING/HUNGER VITAL SIGN**

Within the past 12 months we worried whether our food would run out before we got money to buy more

Often true 
  Sometimes true 
  Never true 
  I don't know / Refused

Within the past 12 months the food we bought just didn't last and we didn't have money to get more

Often true 
  Sometimes true 
  Never true 
  I don't know / Refused

**FOOD INSECURITY INTERVENTIONS**

Supplemental Food Interventions

Provided food pantry list 
  Informed of local church food pantry 
  Other  
 Contacted NYC.gov Emergency Free Food Delivery 
  Provided Health Bucks (voucher)  
 Provided food assistance truck flier 
  Applied to God's Love We Deliver

**FOOD INSECURITY SCREENING FOLLOW-UP**

Date of Last Supplemental Food Intervention(s) Social Determinants of Health Screening Tools : 11-30-2022

Prior Interventions (Read Only)

Provided food pantry list 
  Informed of local church food pantry 
  Other  
 Contacted NYC.gov Emergency Free Food Delivery 
  Provided Health Bucks (voucher)  
 Provided food assistance truck flier 
  Applied to God's Love We Deliver

Other test

<b>Provided food pantry list</b> <input type="radio"/> Received food <input type="radio"/> Did not receive food	<b>Contacted NYC.gov Emergency Free Food Delivery</b> <input type="radio"/> Received food <input type="radio"/> Did not receive food
<b>Provided food assistance truck flier</b> <input type="radio"/> Received food <input type="radio"/> Did not receive food	<b>Informed of local church food pantry</b> <input type="radio"/> Received food <input type="radio"/> Did not receive food
<b>Provided Health Bucks (voucher)</b> <input type="radio"/> Received food <input type="radio"/> Did not receive food	<b>Applied to God's Love We Deliver</b> <input type="radio"/> Received food <input type="radio"/> Did not receive food
<b>Other</b> <input type="radio"/> Received food <input type="radio"/> Did not receive food	

# Allscripts- Social Determinants of Health Screening Tools

Structured Notes Entry - ZZDONOTUSE, Bloodtransfusiontest - Nursing Intake Note

Create Preview Date of Service : 30 - Nov - 2022 Time : 04 : 59

Sections

- NURSING INTAKE NOTE
- SMART SCREENING
  - REASON FOR VISIT
  - VITAL SIGNS
  - SOCIAL HISTORY
  - MENTAL HEALTH
  - FOOD INSECURITY**
  - POINT OF CARE

Copy Forward Refer to Note Preview Modify Template Acronym Expansion Surgical

REASON FOR VISIT VITAL SIGNS SOCIAL HISTORY MENTAL HEALTH **FOOD INSECURITY** POINT OF CARE

**FOOD INSECURITY SCREENING/HUNGER VITAL SIGN**

**Within the past 12 months we worried whether our food would run out before we got money to buy more**

Often true  Sometimes true  Never true  I don't know / Refused

**Within the past 12 months the food we bought just didn't last and we didn't have money to get more**

Often true  Sometimes true  Never true  I don't know / Refused

# Allscripts- Social Determinants of Health Screening Tools

Structured Notes Entry - ZZDONOTUSE, Brian - Admission, History & Physical Note, General

Create Preview Date of Service : 30 - Nov - 2022 Time : 08 : 55

Copy Forward Refer to Note Preview Modify Template Acronym Expansion Health Issue

Depression and Suicide Screening Health Equity Questions

**Health Equity Questions:**

Within the past 12 months we worried whether our food would run out before we got money to buy more  
 Often true  Sometimes true  Never true  I don't know / Refused

Within the past 12 months the food we bought just didn't last and we didn't have money to get more  
 Often true  Sometimes true  Never true  I don't know / Refused

What is your current work situation?  
 Unemployed  I choose not to answer this question  
 Part-time or temporary work  Other  
 Full-time work  
 Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary caregiver)

What is your housing situation today?  
 I have housing  I do not have housing  I choose not to answer this question

Are you worried about losing your housing?  
 Yes  No  I choose not to answer this question

**ATTENTION PHYSICIAN**  IF YES TO ANY OF THE ABOVE QUESTION, PLEASE CONSIDER REQUESTING A SOCIAL WORK CONSULT.

Need Help? Mark Note As:  Results pending  Priority  Incomplete  E&M Calculation  Char

# Allscripts- Nutrition Assessment

Allscripts Gateway | My Applications | Ambulatory Care

My Applications ▶ Ambulatory Care ▶ Flowsheets

File Registration Surgery View GoTo Actions Preferences Tool

Previous Next Refresh Find Find Health Allergies Enter En Patient Patient Screen Patient Visit Issues Summary Order Docu

**ZZDONOTUSE, Brian**  
ZZR-06  
Allergies: **Aspirin, Iodine., avocado** Intolerance:  
HT: 167.6 cm WT: 30 kg(20-Nov-2022) BSA: 1.18

Patient List Orders Documents Results Pati

Options Panel

Flowsheet Criteria

Chart Selection

This chart  All available charts

Date Range

From: 30-Nov-2022 Today

To: 30-Nov-2022 Today

Filter

Default to summary  
 Show abnormal only  
 Suppress blank rows and cols  
 Show ml/Kg  
 Show cancelled columns

Retain selections for next patient

Flowsheet Selection

- ZZ DO NOT USE
  - Flowsheet
  - CCC Vital Signs Flowsheet
  - Child Outpatient Psych Flowsheet
  - I & O Summary Adult Intensive Care Unit
  - KBC Adult Nutrition Assessment**
  - KBC Adult Rehab Record
  - KBC CPAP BiPAP Record
  - KBC Respiratory Assessment/Ventilator Flowsheet
  - Oncology Clinic Flowsheet

**KBC Adult Nutrition Assessment, From 30-Nov-2022 to 30-Nov-2022**

30-Nov-2022 9:09

Interdisciplinary Care Team

General Information

Nutrition History

Nutrient/Fluid Consumption	Diet Prior to Admission/Restrictions/Preferences Typical Food/Fluid Intake Food Preferences Meal/Snack Patterns Supplemental Drinks/Food Habits Use of Vitamin/Mineral/Herbal Supplements Typical Activity Patterns Food Allergies
Factors Affecting Nutritional Intake	Factors Affecting Nutritional Intake
Nutrition/Health Awareness/Self-Manage	Impact of Ethnicity/Culture/Religion on Intake Knowledge About Health/Nutrition Attitude/Readiness to Change Diet/Health/Behavior
Functional Status	Limitations to Mobility/Ability to Ambulate Typical Activity Patterns Sedentary Time (hrs/day) Planned Participation in Physical Activity
Food Availability	Financial Concerns Ability to Perform Food Planning Ability to Perform Food Purchasing Food Preparation Abilities/Limitations Food Storage Limitations Access to Purchase Food



Within the past 12 months we worried whether our food would run out before we got more food to eat

Within the past 12 months the food we bought just didn't last and we didn't have money to buy more






















Anthropometrics

# Social Determinant of Health Inpatient Tracker

Action List Acute ▾

SDOH Screening Tool ▾ Refresh  [Select Bookmark](#) [Contact Us](#) Export 

Rows: 29

Options ▾	Patient Name	DOB	IP Location	Measure	Status	SW Assessment Started	Diabetes Dx	Last Screen	Last Screen Resu
		1969-Aug-20	15M-1504-A	Food Insecurity Screening	Compliant			Within the past 12 months we worried whether our food would	Often true
		1969-Aug-20	15M-1504-A	Food Insecurity Followup	Intervention Due				Intervention Req
		1957-Dec-07	15M-1518-B	Food Insecurity Screening	Due Now				
		1982-Aug-04	15M-1508-A	Food Insecurity Screening	Compliant			Within the past 12 months we worried whether our food would	Often true
		1982-Aug-04	15M-1508-A	Food Insecurity Followup	Intervention Due				Intervention Req
		1951-Oct-28	15M-1516-A	Food Insecurity Screening	Due Now				
		1956-Nov-29	15M-1515-A	Food Insecurity Screening	Due Now				
		1954-Aug-26	15M-1517-A	Food Insecurity Screening	Due Now				
		1954-Aug-14	15M-1502-A	Food Insecurity Screening	Due Now				
		1960-Mar-28	15M-1512-A	Food Insecurity Screening	Due Now				
		1960-Jan-30	15M-1507-B	Food Insecurity Screening	Due Now				
		1959-Jul-04	15M-1507-A	Food Insecurity Screening	Due Now				
		1951-Jan-01	15M-1506-A	Food Insecurity Screening	Due Now				
		1960-Jul-06	15M-1510-A	Food Insecurity Screening	Due Now				
		1968-Jul-30	15M-1510-B	Food Insecurity Screening	Due Now				
		1965-Dec-27	15M-1503-A	Food Insecurity Screening	Due Now				
		1958-Oct-01	15M-1506-B	Food Insecurity Screening	Due Now				
		1963-Dec-29	15M-1509-B	Food Insecurity Screening	Due Now				

# Social Determinant of Health Inpatient Tracker

Patient Name	DOB	IP Location	Measure	Status	SW Assessment Started	Diabetes Dx
[REDACTED]	1957-Dec-07	15M-1518-B	Food Insecurity Screening	Due Now		
[REDACTED]	1951-Oct-28	15M-1516-A	Food Insecurity Screening	Due Now		
[REDACTED]	1959-Jul-04	15M-1507-A	Food Insecurity Screening	Due Now		
[REDACTED]	1955-May-30	15M-1509-A	Food Insecurity Screening	Due Now		
[REDACTED]	1956-Nov-29	15M-1514-A	Food Insecurity Screening	Due Now		
[REDACTED]	1936-May-02	15M-1508-B	Food Insecurity Screening	Due Now		

SW Assessment Started	Diabetes Dx	Last Screen	Last Screen Result	Last Screen Date	Social Work Assessments
		Within the past 12 months we worried whether our food would	Often true	01/2022 09:30	
			Intervention Required		
			Often true	May 05 2021 09:1	
			Intervention Required		

View Documents

Click Preview/Modify the document

Document Name	Created	Author	Preview	Modify
Social Work/Case Management In...	12/1/2022 01:38:39 PM	MCMANUS, ERIKA		
Social Work/Case Management In...	None	Start New Note		

Close

# What we did this year

- Provided education on all social determinant codes for inpatient coders, outpatient coders, physician coders, and physician education.
- Developed quarterly reports (one inpatient, one for ED) to teach and track coding data across 2022. Added name, DOB, medical record number, and both diagnosis code and social determinant code.
- Used the data for trending and analytics. Good news: we did coding training in the second quarter, and the number of patients in the reports increased in the third quarter.
- We can now identify groups of patients we want to follow, such as diabetic patients, food insecure patients and others as we expand our program.
- We will continue to provide education on coding these conditions. Sometimes we lack sufficient documentation to code.
- Physician education classes will be scheduled quarterly as needed, and physician documentation templates are being developed for inpatient and outpatient events.
- The hospital department Chairperson will receive education in the next Chairperson meeting in December, and this training will be repeated as necessary.



## What went well?

- Quickly formed a core social determinants team and included disciplines such as food and nutrition when the agenda involved their skills.
- Worked with IT to add PRAPARE and Hunger Vital Sign questions to inpatient documentation templates. Added questions to inpatient Social Work/Care Management templates, trained staff the week before it went into production (week of 9/18/2022).

## What did not go so well?

- The Action List is intensive and has a ripple effect in the EMR – still in the building phase.
- Standardizing PRAPARE questions across settings in Allscripts - still in the building phase.

## Advice for others who are doing similar work:

1. Start ASAP
2. Have support from all levels of the organization
3. Monitor through chart reviews
4. Meet frequently, you may need additional resources, i.e. IT staff

# What's next?

## Plans for the coming year:

- Enhance inpatient templates, action lists and education.
- Enhance outpatient documentation. Work with IT so shared documentation can flow between inpatient and outpatient settings to ease the burden on the clinical team.
- Ensure accurate reporting in inpatient and outpatient settings. Use data to identify trends, set goals, and respond to community needs.
- Train clinical and support staff on all aspects of SDOH.
- Continue collaboration with HANY.
- Share data to evaluate the needs of our greater community in NYC and across the continuum of care. Summarize findings and disseminate reports to the proper parties, empower them to react, and implement solutions to meet the community's needs
- Create progress reports to track and trend BronxCare's success in our diabetes and food insecurity, react to our success and create next steps.
- Race and Ethnicity table through the registration process.



**ADVANCING HEALTHCARE**  
**EXCELLENCE AND INCLUSION**

# Questions?

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