

Addressing Food Insecurity in our Community

Summary

Social Determinants of Health screening cards we utilize in our office identified two major areas of need: food insecurity and transportation. We partnered with our payers and community stakeholders to support both of these needs. This poster focuses on addressing food insecurity.

Strategy for Change

We took the following steps to provide better access to healthy food for our patients:

- We identified the patients most affected by lack of access to healthy food are those with diabetes and/or heart disease.
- We meet quarterly with each of our payers groups to discuss quality performance, set practice goals and identify patient needs.
- We forged partnerships with community organizations, such as the local community college, YMCA and a food distribution organization (Harvesters).
- We developed a plan to hold a monthly food distribution for our patients and the community.

“Care, compassion, and community spirit continue to build stronger, healthier patients. We all win.”
– Deb West, Practice Manager



Results

Our first food distribution was held on 6/28/2021. We served 125 families, including 228 children, 60 seniors and 200 adults. Families received healthy food, which contributes to better management of diabetes and heart disease. Many of the volunteers plan to return to help in the future.

Next Steps/Best Practices

Based on the success of our first food distribution, we will continue to offer this service monthly at the same site.

- The partnership with not only the payers, but other community organizations contributed to the success.
- The local college was a great resource, as the students need community service hours to meet graduation requirements.



Family Medical Group Kansas City, Kansas

Practice type:
Hospital-owned

Track: 1

EHR: eClinicalWorks

CPC Classic participant: No

Number of practitioners: 4

Number of patients: 4,284

Type of patient population:
Urban

Insurance breakdown:

35% Medicare, 14% Medicaid, 48% private insurance, 3% uninsured/self-pay

Population characteristics: Our practice has a high number of patients over 65 years, and an equal population of White, Hispanic and African-Americans. In our county, over 19% of residents live below the poverty level.

Change concept:

1.3.F. Establish effective linkages with neighborhood/community-based resources to support patient health goals and health-related social needs