GNYHA Comment on National Quality Forum Food Insecurity Measures

GNYHA submitted the below comments in response to a proposed set of food insecurity measures published by the National Quality Forum (NQF). The measures were developed through an NQF project that convened clinicians, payers, researchers, measure developers, and patients to discuss strategies to overcome the impact of food insecurity on health outcomes. Building on the strategy discussions, three electronic clinical quality measures were developed to examine food insecurity screening, appropriate clinical action, and change in food insecurity status.

1. **Having reviewed the three measures, what is your initial reaction? Could each measure be used for accountability and/or performance improvement, why or why not?**

Greater New York Hospital Association (GNYHA) members—which comprise more than 160 hospitals and health systems across New York, New Jersey, Connecticut and Rhode Island—are committed to assessing and addressing health-related social needs whenever practical in order to improve health outcomes for their communities. Currently, there exists a lack of endorsed process and outcome measures around such needs, which include food insecurity. Understanding social needs, including food insecurity, can give important context for providers as they prescribe medication and make clinical decisions. However, GNYHA is concerned that certain measures could place inappropriate accountability and burden on providers to address multi-faceted and complex social needs. As food insecurity and other related measures are developed, we encourage NQF and measure stewards to consider that health care providers cannot directly change, nor are they responsible for changing, environmental and social conditions.

Measures 1 and 2 may be appropriate for accountability and performance improvement. Many health care providers screen for food insecurity, and it is helpful to encourage screening using a validated questionnaire. Health care providers caring for high-risk patients and patients with chronic disease have a particular interest in screening for food-related needs, as the availability of adequate and healthy foods can impact the health outcomes for which providers are already accountable. Providers who currently screen for food insecurity and other social needs have emphasized the importance of referrals and connections with community-based organizations (CBOs) that can directly address those needs and provide support outside of the health care setting. Measuring screening and subsequent referrals for patients screening positive may ensure that providers take food insecurity into account as they create care plans and provide clinical instructions.

GNYHA believes that measure 3 should not be used for accountability and/or performance improvement in a clinical setting. Food insecurity is based on social, economic, and environmental factors which are outside of providers' control, and it is not appropriate for providers to be held accountable. Additionally, GNYHA recommends postponing development of outcomes measures until providers are more accustomed to screening for food insecurity and making appropriate referrals.

2. **Are denominator criteria for each measure appropriate? For measure 1, 2 and 3, is stratification appropriate?**

For measure 1, the measurement period needs to be made clear. It is also unclear as to whether the screening is required at *each* eligible encounter, or whether it is required only once during the measurement period.

For measure 2, the denominator is defined as a *percentage* of patients that screened positive (from measure 1). This does not seem to align with the numerator, which appears to be the *number* of individual patients who had their severity measured and received a referral. GNYHA recommends that the denominator definition be "the number of patients that screened positive" (from measure 1).

GNYHA does not believe that measure 3 is appropriate for health care providers. Health care providers should not be held accountable for factors outside of their control. Further, this measure is not appropriate for screenings that take place in inpatient and emergency department settings where 6-month follow-up is atypical.

With regard to stratification, what would be most useful for health care providers is stratification by chronic disease status. This would be particularly meaningful for patients with diabetes, congestive heart failure, cancer, and other chronic conditions where adequate food and nutrition can directly affect health care outcomes.

3. **Are numerator criteria for each measure appropriate? What changes, if any, would you make to numerator criteria and why?**

Measure 2 requires the use of U.S. Food Security Modules for a patient to be included in the numerator. This may be problematic and burdensome for providers who use the Hunger Vital Sign (HVS) screening tool, and additionally burdensome for providers who have embedded the HVS into a screening tool that asks about other health-related social needs. GNYHA recommends aligning the numerator definition with measure 1. The numerator should include patients screening positive for food insecurity based on the standardized and validated food insecurity screening tools described in measure 1 AND are referred to CBOs or other resources that can address food insecurity.

4. **Would you find implementation of any of these measures in your practice useful? Why or why not? Is there anything that could make each measure more useful?**

Measures 1 and 2 would be useful in ensuring that providers are incorporating social and environmental context into clinical decision-making. Based on feedback from practices that currently screen for food insecurity and other social needs, the screening data also provide insights into "rising-risk" patients who do not currently, but could potentially drive increased costs to the health care delivery system.

Measure 2 could be made more useful if it included stratification on chronic disease diagnosis, such as diabetes, congestive heart failure, cancer, and other diseases where nutrition becomes an important factor. Reporting could include the overall percent as well as the percent for certain chronic diseases. In the pediatric setting this might include patients diagnosed with malnutrition or obesity. This may encourage

providers to focus efforts and resources on assisting the subset patients for whom food insecurity significantly impacts health care outcomes.

5. **Will implementation of any of these performance measures, as specified, lead to any unintended consequences?**

An unintended consequence of Measure 2 (as written) is that, as stated previously, providers would have to spend additional time assessing food insecurity severity. This is the case in particular for providers using the HVS screening tool. This would take time and effort away from the patient encounter and clinical decision making. While some providers could have other care team members complete this portion of the encounter, not all providers have the practice resources necessary to do this. For this reason, GNYHA recommends removing the requirement of assessing food insecurity severity in Measure 2 and focusing specifically on the referral component.

A concerning unintended consequence of Measure 3 (as written) is that, due to the increased accountability for addressing food insecurity severity, hospitals and health systems could attempt to create their own internal systems to address food-related needs. This will do a disservice to CBOs which already address these needs, and which do so in the communities where patients spend most of their time. Providers should be encouraged to connect patients to existing resources and experts.