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RESEARCH BRIEF

Using a Strengths, Opportunities, Aspirations, and Results Analysis to Explore How Ohio Federally Qualified Health Centers are Addressing Food Insecurity

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ABSTRACT

Introduction: The United States Department of Agriculture (USDA) defines food insecurity as the absence of consistent access to enough food for a healthy and active life. Federally qualified health centers (FQHCs) are community-based health care facilities, often located in underresourced areas where food insecurity is of public health concern. The purpose of this study was to provide an opportunity for FQHC staff and patient board members to discuss how they can positively impact food insecurity.

Methods: An observational study using mixed-methods approaches was conducted from January through September 2023. A presentation of study results involving an online facilitated discussion was open to representatives of all 57 Ohio FQHCs via email recruitment. Participant feedback was collected using appreciative inquiry, specifically a strengths, opportunities, aspirations, and results (SOAR) analysis.

Results: Fourteen FQHCs (approximately 25% of the total number of Ohio FQHCs) were represented, by one person each during the presentation and facilitated discussion. Best practices identified in this research study included having community health workers (CHWs) on staff to connect patients to resources; having dietitians on staff to provide nutrition counseling; operating patient centered medical homes (PCMHs); and using AmeriCorps volunteers to screen patients.

Conclusion: Federally qualified health centers focus on serving underserved and at-risk populations. Increasing services, specifically primary care services, are likely to decrease health care costs. Federally qualified health centers also help to provide patients with better access to health care and promote improved health care outcomes. Facilitated discussion participants were able to network via an online chat, which will allow for future collaboration and sharing of health center practices.

Keywords: Federally qualified health centers; Food insecurity; Social determinants of health; Strengths, opportunities, aspirations and results (SOAR) analysis; Observational study; Mixed-methods approach

INTRODUCTION

The United States Department of Agriculture (USDA) defines food insecurity as the absence of consistent access to enough food for a healthy and active life.[1] Furthermore, very low food security is when the food intake of members in a household is reduced, and normal eating patterns are disrupted because money and resources are inadequate.[1] An active, healthy life referred to in the USDA food insecurity definition

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depends on both adequate amounts of food and the proper mix of nutrient-rich food to meet an individual's health and nutrition needs.[2]

While it is important to understand the adverse health outcomes resulting from food insecurity, examining the socioeconomic factors associated with being food insecure are also critical to developing effective prevention strategies. Limited access to healthy food can be driven by income (people do not have enough money to purchase nutritious foods), accessibility (the money is there, but the person cannot access due to a disability, lack of transportation, or living in a food desert where there is a lack of access to affordable fruits, vegetables, low-fat milk, whole grains, and other foods that make up a healthy diet), and culture (people can afford the food and it is accessible, but they do not know how to identify or prepare the food).[3]

Economic and physical access to healthy food is critical to ensuring food security. Food insecurity and associated undernutrition adversely affect health and socioeconomic development in the short and long term, for individuals and communities.[4]

Federally qualified health center program awardees and FQHC look-alikes are required to report on measures annually as defined by the Uniform Data System (UDS). Like FQHCs, FQHC look-alikes are community-based health centers that meet the Health Resources and Services Administration (HRSA) Health Center Program requirements, but do not receive HRSA funding.[5] For purposes of this study, FQHCs refer to FQHCs and FQHC look-alikes. The HRSA uses UDS data to evaluate the impact and performance of health centers, and to promote quality improvement. The UDS data include information on health center patient characteristics, clinical processes and health outcomes, services provided, staffing, patients' use of services, revenues, and expenses.[6]

Comparing Ohio to the United States

The UDS database is useful for comparing different sets of data. There were 51 reporting awardees in 2020. Nationally, there were 1375 reporting awardees during the same year. In Ohio, 793 469 patients were served; 2.8% of the total number of patients served nationally. Ohio patients received 917 781 services (medical, dental, mental health, and substance abuse). This is 2.8% of services received nationally. The majority of patients in Ohio and the US are either uninsured or are Medicaid recipients. Over one-third of patients served in Ohio and over half of patients nationally belong to a racial and/or ethnic minority.[6]

The majority of HRSA programming and funding in Ohio is devoted to the primary health care area where health conditions (including those associated with nutrition) are treated.

Federally qualified health centers are community-based health and social service providers, often located in underresourced urban and rural areas where food insecurity is of public health concern.[7] These health centers are safety net providers that mainly provide services in an outpatient setting. FQHCs include public housing primary care centers, community health centers, migrant health centers, health care for the homeless health centers, and FQHC look-alikes. They also include outpatient health programs or facilities operated by an urban Indian organization, a tribal organization, or a tribe. The FQHCs are paid based on the FQHC prospective payment system (PPS) for eligible preventive health services furnished by a FQHC practitioner and medically necessary primary health services.[7]

It is critical that health centers have access to and are supported in their efforts to employ appropriate providers, reverse the increasing economic costs of chronic conditions such as obesity and diabetes, prevent the onset of chronic disease, and provide evidence-based interventions to lessen the burden of chronic disease.[8] The extent to which FQHCs address food insecurity is not well understood or documented. This study provided an opportunity for FQHC staff and patient board members across the state of Ohio to discuss how they can positively impact the issue of food insecurity.

METHODS

This observational study using mixed-methods approaches sought to gather responses from FQHC staff and patient board members across the state of Ohio. This included seeking FQHC information on how food insecurity is addressed through community health centers. See Appendix for the Facilitated Discussion Guide.

Research findings from a prior survey, along with semistructured interviews, were presented to Ohio FQHC professionals via an online platform. Specifically, FQHC executives, frontline staff and patient board members were recruited for the study. Executives in FQHCs are responsible for operations and overall performance. Frontline employees are patient-facing and are essential to handling patient concerns. The FQHC boards of directors are required to have actual patients representing 51% of their board memberships. It is important to understand the perspectives of all 3 of these groups in order to understand and possibly influence the direction of the agency. The objective of the survey and interviews was to explore the ways in which FQHCs in Ohio are addressing the public health challenge of food insecurity through their policies, services, and community partnerships using a social determinants of health (SDOH) lens.

The presentation was based on research highlights for which additional reactions and feedback were obtained in an effort to identify best practices. It was an opportunity to better understand FQHC policies, services, and community partnerships for addressing food insecurity. During the presentation the information shared included study objectives, background and context, the problem statement and study questions, and preliminary results. Preliminary results indicated that one way in which FQHCs are addressing food insecurity is through their services. Survey respondents were asked to share services/programs/initiatives offered by their FQHC to address diabetes, hypertension, obesity, cholesterol management, or other chronic diseases. Response options were National Diabetes Prevention Program, National Hypertension Control Initiative, Weight Watchers, Nutrition Counseling, or other. The majority of respondents (54%) stated that nutrition counseling was the most popular service, followed by the National Diabetes Prevention Program, and National Hypertension Control Initiative each at 24% and none selecting Weight Watchers (Figure 1).

In addition, 10 (27%) of survey respondents selected other and these responses included 1 of the following: Diabetes Education (with and without certified diabetes educators), Food is Medicine, Produce Perks, Referrals, and Purple Apron Project (program that provides diabetic management education and addresses food insecurity).

Another survey question asked what resources are provided if a patient is food insecure. Food pantries were listed by 76% of respondents, while only 8% listed after school programs (with meals provided). Food banks (70%), SNAP (65%), and WIC (62%) were listed by respondents. Respondents also mentioned food vouchers (32%), summer school programs with meals provided (11%), meal delivery services (14%), and food boxes (38%) as resources provided to FQHC patients who are food insecure. Some respondents who responded "other" shared resources which are: a food clinic, a food rescue program, and a backpack program.

Expanding on what was reported in the survey regarding FQHC policies and services, the interviews conducted provided greater detail to the survey responses and helped to better understand programs offered by FQHCs to address chronic diseases.

After the presentation, a facilitated discussion took place to determine the next steps. The facilitated discussion was recorded, transcribed, and verified. The strengths, opportunities, aspirations and results (SOAR) framework was used to analyze discussion details, which were incorporated into the final analysis of this research project. The discussion was open to staff and patient board members of all 57 Ohio FQHCs. Participant recruitment was via email. Feedback was provided from representatives of 14 FQHCs across the state of Ohio. This was an opportunity for Ohio FQHC staff and patient board members to collaborate on addressing food insecurity in the same virtual room at the same time. It also allowed the researcher to engage in a member checking activity regarding findings on the identification of best practices for FQHCs interested in this topic.

Feedback from facilitated discussion participants was collected using appreciative inquiry. Appreciative inquiry is designed to focus on the positive (strengths and successes), not on what is broken or on challenges. Specifically, the SOAR framework was used. The SOAR framework is a specific application of appreciative inquiry. This strategic planning technique helped illuminate what is working, explore how to increase success, determine what can be enhanced, and identify additional desires/outcomes relating to how Ohio FQHCs are addressing food insecurity.

RESULTS

Fourteen FQHCs were represented during the presentation and facilitated discussion exploring how Ohio FQHCs are addressing food insecurity. This was about 25% of the total number of FQHCs in the state of Ohio. Table 1 shows responses that participants shared in the presentation and facilitated discussion during the associated SOAR activity.

DISCUSSION

FQHCs focus on serving underserved and at-risk populations. Increasing services, specifically primary care services, are likely to decrease health care costs related to hospitalizations and emergency room visits.

Figure 1. Bar Chart Ohio Federally Qualified Health Centers Services/Programs/Initiatives to Address Chronic Diseases (N=37)

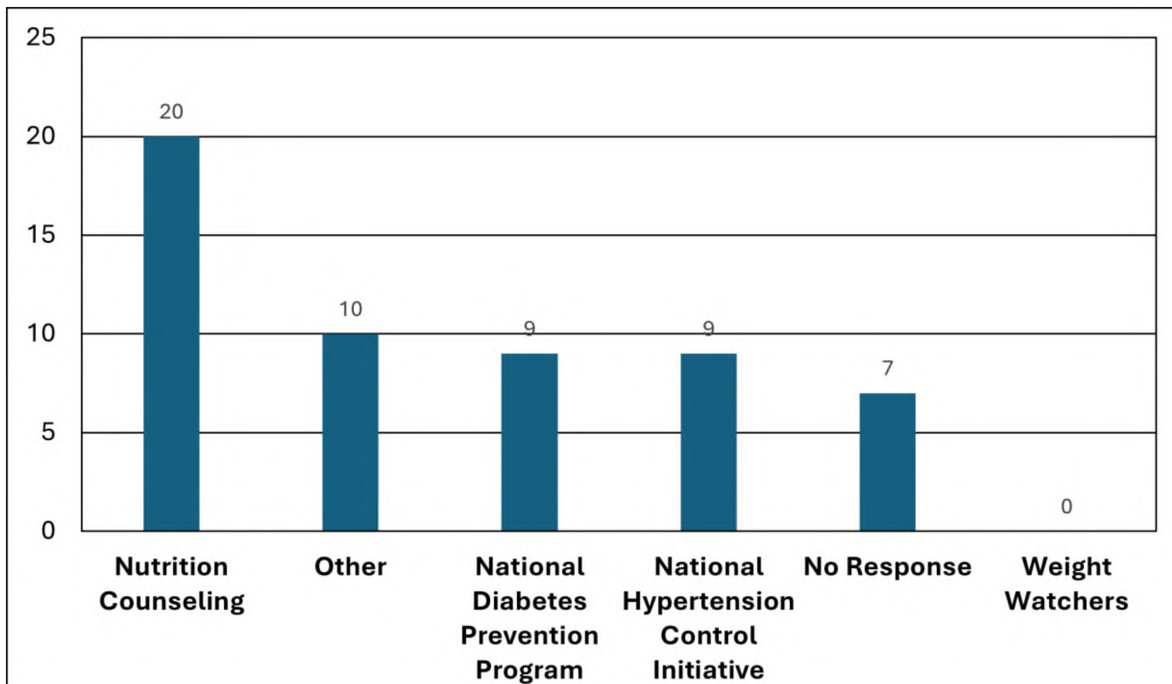

Table 1. Facilitated Discussion Strengths, Opportunities, Aspirations, and Results (SOAR) Responses

Categories and Questions	Summary of Findings
Strengths What are Ohio FQHCs doing well when it comes to addressing food insecurity? What are you proud of concerning how food insecurity is addressed in your FQHC?	Prioritizing SDOH screening. Employing staff to focus on SDOH including food insecurity. Providing a Food is Medicine program that provides fresh produce from April- October each year. Establishing a medical food pantry aimed at people experiencing food insecurity and having a chronic disease. Making it a priority that meal bags are always ready. Connecting to multiple resources outside of just food insecurity. Encouraging patients with diabetes to visit with the dietitian. Having a food pantry in the FQHC to give patients food during their visit. Exploring door dash where produce can be sent to the patients' homes. Creating a booklet with all of the food pantries and places for free meals in the county.
Opportunities What opportunities are there for your FQHC to address food insecurity? How can positive findings be scaled across FQHCs in the state?	Expand transportation services. Allow community health workers (CHWs) services to be billable services. Address food deserts through grocery stores and mobile markets. At every provider visit, when Medical Assistants (MAs) are rooming patients, the screening questionnaire should be part of the rooming protocol. Report positive findings through Health Resources and Services Administration (HRSA) and Uniform Data System (UDS) information. Engage the Ohio Association of Community Health Centers (OACHC).
Aspirations Reflecting on the strengths and opportunities what should FQHCs do in the future to best meet the needs of patients and staff assisting patients? What tools, programs, processes, etc, need to be in place to support food security among FQHC patients?	To train and employ staff that can support food insecurity screening and needs. To prioritize funds for staffing and food. To have a statewide referral platform that integrates with electronic health records for shared referrals and loop closure. For the state to work with managed care organizations (MCOs) to reimburse for CHWs. To provide cooking instructions on how to prepare unfamiliar foods. To have more coordination between FQHCs in Ohio to share ideas. To have internal committees in our health systems to make sure we are actually promoting healthy foods in our vending machines and cafeterias too. To partner with stores to get discounted produce at the store while patients are there. To remove language barriers. To help educate patients on what foods are healthy in the store and how to purchase those things while still staying within budget. To have a map where the food banks are so you can tell patients what food bank is closest to them.
Results What measurable results would indicate that FQHCs are succeeding in having food secure patients in the state of Ohio? How will you know that you are making a difference?	Collect responses to pre/post surveys for those utilizing services. Track patients accessing pantries at FQHCs and chronic conditions on a shared statewide platform. Have one release of information form across FQHCs so shared data are possible. Have fewer positive food insecurity screenings. Have better metrics for chronic disease outcomes. Pull reports from Azara database (provider of population health solutions). Pull screening results and see positive on social determinants of health (SDOH) measures.

FQHCs help to provide patients with better access to health care and promote improved health care outcomes.[9] Facilitated discussion participants were able to network via an online chat, which will allow for future collaboration and sharing of health center practices. The research findings will be of particular interest to the Ohio Association of Community Health Centers (OACHC). The OACHC, a practice partner, is the membership organization that represents the 57 Ohio FQHCs and is committed to accessible, high-quality and affordable health care for all Ohioans. The research findings will assist the OACHC with advancing the best practices described in this study. These best practices will also aid Ohio FQHCs in providing effective policies, services and community partnership strategies that are designed to promote food security among

patients thereby contributing to improved and more equitable clinical health outcomes. Best practice policies in the research include a statewide referral system and reimbursement for community health worker services. Best practice services include food prescription programs, resource connections, prioritizing SDOH screening, and coordinating/sharing information across FQHCs. Best practices for community partnerships include establishing a booklet of community resources, identifying transportation partners to get patients to needed services. and engaging OACHC.

Policies, community resources and services present opportunities for partnerships between community-based organizations and health care organizations including FQHCs. Together, a link is formed connecting health to food resources. This link could potentially reduce food insecurity and improve health outcomes.[10] Federally qualified health centers should consider SDOH strategies in their work as these social determinants are responsible for many health disparities and are linked to chronic diseases, lack of health care access, food insecurity, and equity.

This research using the SOAR analysis makes the case for FQHCs to take a more explicit role in addressing food insecurity in their patients. There are key programs and actions to be taken based on health center staff perspectives.

PUBLIC HEALTH IMPLICATIONS

From a practice perspective, FQHCs can adapt the methods and findings in this research study to better address food insecurity as well as other social determinants of health. Some best practices gleaned from the responses shown in Table 1 are to have staff focus on screening for SDOH, provide a list of resources including locations, look for funding for FQHC staff and food for patients, work to eliminate language barriers, and educate patients on how to afford healthy foods on a budget. There is also an opportunity to adapt equity initiatives that benefit patients. Having a better understanding of the perspectives of staff and patient board members will allow for improved knowledge, awareness of services, policy development/implementation, and resource connection. Engaging with community partners lends itself to better understanding available services/resources and allows for broader systems thinking when addressing the public health challenge of food insecurity. The insights from the study will allow FQHCs to work more efficiently toward systemic change and promote more consistent, integrated use of known resources.

AUTHOR CONTRIBUTIONS

Kimberley Freeman conceptualized the research, conducted the data collection and analysis, and prepared the research brief. Karen Peters provided intellectual content and contributed to the review and revision of the article. Dana Vallangeon provided connection and communication with FQHC presentation and facilitated discussion participants and contributed to article review.

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This research used deidentified data and met the criteria for exemption from the institutional review board.

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APPENDIX – FACILITATED DISCUSSION GUIDE

Title: Exploring How Federally Qualified Health Centers (FQHCs) in Ohio are Addressing Food Insecurity
Duration: 90-minute session

Researcher Introduction:
My name is KF. This research study is exploring the ways in which FQHCs in Ohio are addressing the public health challenge of food insecurity through their policies, services, and community partnerships using a social determinants of health (SDOH) lens.
Verbal Consent for Research:
The information we discuss today will be used to compile a report that, together with the survey and interviews that some of you participated in, will yield information about how Ohio FQHCs are addressing food insecurity.
I will first provide preliminary results from this study. Afterwards, there will be a discussion that is intended to collect organizational information only. There will be no personally identifiable information without your permission.
Are there any questions or comments before we begin? [wait for questions]
Perfect. So, let's get started. I will be recording the discussion so that I have accurate information and remember what we discussed. Is that OK? [wait for responses] I'm going to start recording now. I'll let you know when I turn it off at the end of our discussion as well.
Turn on recording device(s).

Session Begins:
I will be using an appreciative inquiry approach with the questions that I will be asking you. Appreciative inquiry or AI is designed to focus on the positive - strengths and successes, not on what is broken or on challenges. Often, we focus on what's not working or on what issues need to be resolved. Today, we will focus on what works, why and how we can build on those things to make Ohio FQHCs the best possible as it relates to addressing food insecurity. Specifically, we will be using SOAR framework. The SOAR framework is a specific application AI. SOAR stands for strengths, opportunities, aspirations, and results.
The goal today is to use SOAR to obtain additional feedback and validate my research study findings that I will be sharing with you shortly. This strategic planning technique will help to better understand what is working, explore how to increase success, determine what can be enhanced and identify additional desires/outcomes.

At this time, I will present my study findings (20-30 minute presentation).
Now, that you have had an opportunity to listen to the presentation I am going to ask you questions based on the SOAR headings, and I want you to provide feedback.

Strengths:
1. In terms of addressing food insecurity, what are the greatest strengths of Ohio FQHCs?
2. In other words, what are Ohio FQHCs doing well when it comes to addressing food insecurity?
3. What are you proud of concerning how food insecurity is addressed in your FQHC?
4. Please share any additional FQHC strengths in addressing food insecurity that may not have been shared.

Opportunities:
You heard me mention several key elements in the presentation. These included policies, services, community partnerships, chronic diseases, equity, health disparities, and social determinants of health. I shared many great things that Ohio FQHCs are doing to address food insecurity in these areas.
1. What opportunities are there to sustain/maintain this status?
2. How can the positive findings be scaled across FQHCs in the state?
3. Where should efforts be focused (top 3 opportunities)?
4. Please share any additional opportunities to address food insecurity that may not have been addressed.

Aspirations:
1. Reflecting on the strengths and opportunities that we discussed earlier what should FQHCs do in the future (short term and long term) to best meet the needs of not only FQHC patients but also FQHC staff to assist in helping the patients?
2. What tools, programs, processes, etc need to be in place to support food security among FQHC patients?

Results:
1. What measurable results would indicate that FQHCs are succeeding at having food secure patients in the state of Ohio?
2. How will you know that you are making a difference?

Closing
1. Is there anything else you'd like to add or that you think is relevant?

Thank you for your time. I will stop recording now.