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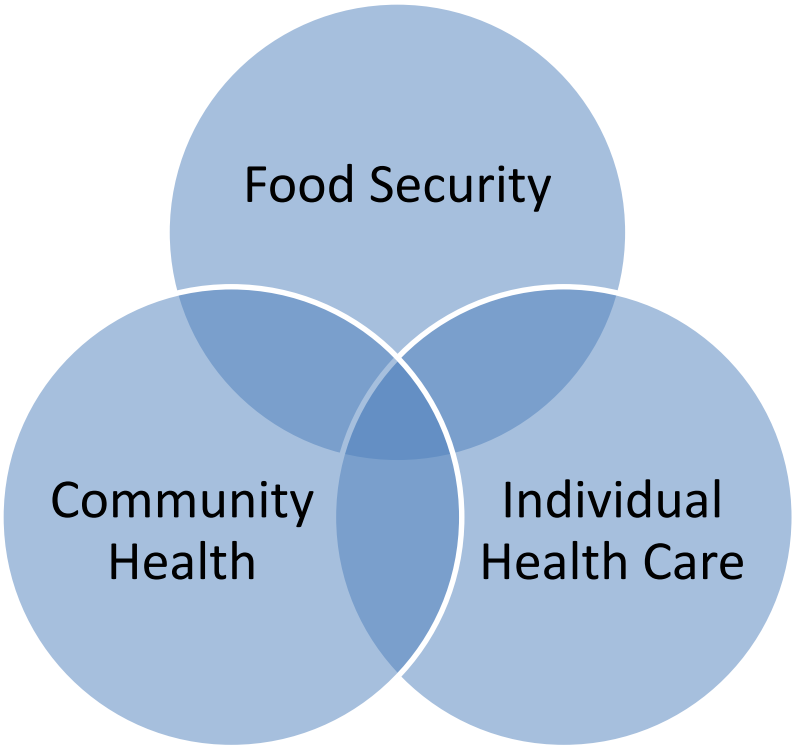
VERMONT FOOD ACCESS & HEALTH CARE CONSORTIUM



Strategic network planning to integrate food access across the continuum of care in rural health care systems

(Federal Grant Funded Project at Bi-State Primary Care Association)

VTFoodInHealth.Net

Outreach Systems connecting:
- Health Care Practices & Community Based Organizations
- Patients with Food Access Programs
- Local Organizations with Statewide Networks
- Community Members with Information on Food Access

Medically Tailored Meals:
- 2021 Capacity Assessment
- Presentations on Meals in Health Care
- October 11th Webinar – Meals as a Covered Health Benefit in Vermont

Increasing Program Impact:
- Connecting with National Research & Evidence-Based Models
- CSA & Health Care Community of Practice
- Addressing Transportation Barriers

Data & Measurement:
- Community Health Reports
- Food Systems Reports
- Tools for Measuring Dietary Change
- Common Program Evaluation Structures

Nutrition Services:
- Landscape of Nutrition Services in VT

2021 Food Insecurity Screening Systems Survey & Link to 2022 Survey

https://www.vtfoodinhealth.net/updates/food-insecurity-screening-1

Examples of How Survey Used:

- 2021 responses used to create 2022 survey to generate common data points across practice types.
- Hunger Vital Sign Explainer Series responding to questions about implementing most common screen.
- Technical assistance building relevant practice dashboards.
- Policy analysis and comments.
- Improving referral systems and closing resource gaps.

HUNGER VITAL SIGN

"Within the past 12 months we worried whether our food would run out before we got money to buy more." Often / Sometimes / Never True.

"Within the past 12 months the food we bought just didn't last and we didn't have money to get more." Often / Sometimes / Never True

Hager, E.R et al (2010) Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity.

HUNGER VITAL SIGN APPEARS IN MANY NATIONAL MODELS OF FOOD & MEDICINE

- Early model for social risk screening; used across practice types.
- Most common HRSN; most widely available resources to help address.
- Validation & common use provide benchmarks.
- Focus on “first step” supports many pathways – from essential food security to medical treatment.
- Regulatory changes have increased focus on screening systems.

HUNGER VITAL SIGN EXPLAINER SERIES

VTFoodInHealth.net/hunger-vital-sign-toolkit

- Modules that answer common questions, with links to research for more details.
- Answered by the people who created the models and who lead ongoing research.
- Resources in multiple formats.
- Resources can be combined / recombined / expanded for particular training needs.

HUNGER VITAL SIGN EXPLAINER SERIES

VTFoodInHealth.net/hunger-vital-sign-toolkit

Part 1: Creation of the Hunger Vital Sign Tool - Richard Sheward, Children's HealthWatch

See all featured Hunger Vital Sign resources collected by Children's HealthWatch here.

1: Origin of Hunger Vital Sign

Audio & Transcript | Summary of Key Points

Related Materials:

- Children's HealthWatch
- USDA Household Food Security Survey
- Introduction of the Hunger Vital Sign Tool (2010): Development & Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity

2: Screening Tools

Audio & Transcript | Summary of Key Points

Related Materials:

- Social Determinants of Health Lexicon (Milbank Quarterly, 2019)
- Moving Health Care Upstream
- Integrating Social Care Into the Delivery of Health Care (NASEM, 2019)

3: Creating a Valid Tool

Audio & Transcript | Summary of Key Points

Related Materials:

- USDA Food Security Reports
- Research on Impacts of Changing Food Assistance Policies - Food Research & Action Center, Center on Budget & Policy Priorities
- Health Impacts of Food Insecurity - National Research.

Basic Structure:

10-15 Minute Interview | Transcript | Summary of Key Points | Reference Materials

HUNGER VITAL SIGN EXPLAINER SERIES

VTFoodInHealth.net/hunger-vital-sign-toolkit

Implementing Food Insecurity Screening:

- Screen and Intervene: A Toolkit for Pediatricians to Address Food Insecurity (first published in 2017) - Food Research and Action Center & American Academy of Pediatricians
- Guide to Implementing Social Risk Screening & Referral (2022) - OCHIN & Kaiser Permanente
- Food Insecurity Screening Toolkit (2022) - Feeding America & Humana
- Using Health IT to Identify & Support Patients Experiencing Food Insecurity (2021) - HITEQ Center
- Accountable Health Communities Model - Center for Medicare & Medicaid Innovation

See also the tools at the UCSF Social Interventions Research & Evaluation Network (SIREN) resource library and report State of the Science on Social Screening in Health Care Settings (2022)

Plus:

- Links to frequently cited toolkits (external).
- Links to research library and review of social screening literature (external).
- FAQs on implementation that pull excerpts from resource materials.
- Broader "food is medicine program evaluation" kit showing common metrics for other elements.

DASHBOARDS Care Coordination Example

Knoxville Screening Information	2020 to Present	Aug-22	FY 2020-2021	FY 2021-2022	FY 2022-2023
Total Patients Screened (Positive and Negative Screening)	**2,584**	186	287	1,973	**324**
Patients Having One or More Need(s)	**713**	54	133	480	**100**
Patients Requesting Assistance w/ CHW	**273**	14	85	163	**25**
Needs are *URGENT*	**65**	3	24	33	**8**
Number of Patients Referred to a Resource	**401**	21	103	258	**40**
Number of Resources Contacted by Patients	**293**	-	142	146	**5**
Patients w/ Full or Partial Needs Met	**187**	12	-	151	**36**
Number of Needs Full or Partiall Met	**187**	15	-	-	-
Protocol Closed - Successful	**219**	11	94	97	**26**
Protocol Closed -All other reasons	**101**	9	11	73	**17**
Open Protocols (Patient case load)		**103**	-		-
CHW Initial Patient Interactions	**391**	29	108	235	**48**
CHW Patient Follow-Up Interactions	**736**	47	106	549	**81**
Colleague Consultations	**1**	1	-	-	1
Total Patient Interactions	**1,128**	77	214	784	**130**
Food Insecurity	**187**	13	31	132	**24**
Housing Assistance	**125**	5	23	92	**10**
Utility Assistance	**108**	9	16	80	**12**
Medication Assistance	**113**	8	21	76	**16**
Transportation	**156**	12	26	110	**20**
Social Isolation/Loneliness	**354**	19	41	269	**44**
Health Literacy	**210**	26	28	138	**44**

DASHBOARDS Internal SDOH Programs Example

Patient Participation Tracker:

Active Medical Patients	**Active Patients with Med Visit in Program Year**	**Active Patients with CVD Risk** (Qlik filter, not FQHC attestation)	**Patients Screen Positive for FI in Program Year**	**Eligible Patients** (Med Visit in PY + FI Positive in PY + Cardio Risk)	**Offered Food Intervention** (Accepted + Declined + Consultation w/o Outcome Marked)	**% of Offered Who Enroll in Food Intervention** (# Accepted / Total # Offered)	**Currently Participating** Enrolled Any Year; Active at Present Time
Total Active	Subset of Total Active	Subset of Total Active	Subset of Total Active	Absolute # Meeting Three Criteria	# Offered (PY)	Percent (PY)	Total # Participating

FI Screening Tracker:

Active Patients with Med Visit in PY	**Patients w/ Med Visit Screened for HVS**
# - Subset of Total	Percent (PY)
# Patients Screened Positive in PY	**% Positive Rate**
# - Subset of Total Active	Percent (PY)

Summary Across Grant Years:

Patients Assisted with Food Access ("complete" marked Y) Any Year	**Days from HVS Screen to Food Program Enrollment**	**% Patients Engaged** [(# Participating + # Complete / Total # Offered)]
Total # Complete	Average Days	Percent

DASHBOARDS Clinical Connection Example

FI Screening Tracker:

Active Medical Patients	Active Patients with Med Visit in Program Year	Patients w/ Med Visit Screened for HVS	Patients Screened with HVS in Program Year	% Positive Rate	% with Current FI Screen Available at Office Visit? Current defined as w/in 90 Days	% of Patients w/ Medical Visit + Positive CVD Risk	% w/ Med Visit + Negative HVS + Positive CVD Risk	% w/ Med Visit + Positive HVS + Positive CVD Risk
Total Active	Subset of Total Active	Percent (PY)	% of Patients With Med Visit	% of Patients Screened	Was current FI risk in chart for clinician	Percent (PY)	Percent (PY)	Percent (PY)

Biomarkers: % of Patients with Test in Past 12 Months

	BMI	A1c	Blood Pressure	Cholesterol
Active Patients				
Active Patients with CVD Risk				
Patients Enrolled in Food Intervention (ever)				

	CVD Risk + Med Visit	CVD Risk + Med Visit + Food Program
Statin Rx (newly active in PY)		
Metformin Rx (newly active in PY)		
Aspirin for CVD (newly active in PY)		
MNT Individual Assessment (PY)		
Self-Management Program Completion (Any)		

POLICY ANALYSIS

Recent CMS Rulemaking Around SDOH Screening

For example: Requiring screening across 5 social risk domains, reporting on screening & percent positive rates. Data generation for future payment structures.

- Framework for choosing domains
- Measures for maturity of screening & referral systems
- Accurate time & cost estimates for screening & referral systems
- Appropriate funders for referral platforms
- Data quality for future resource decisions
- Definition of “patient needs met”
- Open question of SDOH ‘Z-code’ implementation

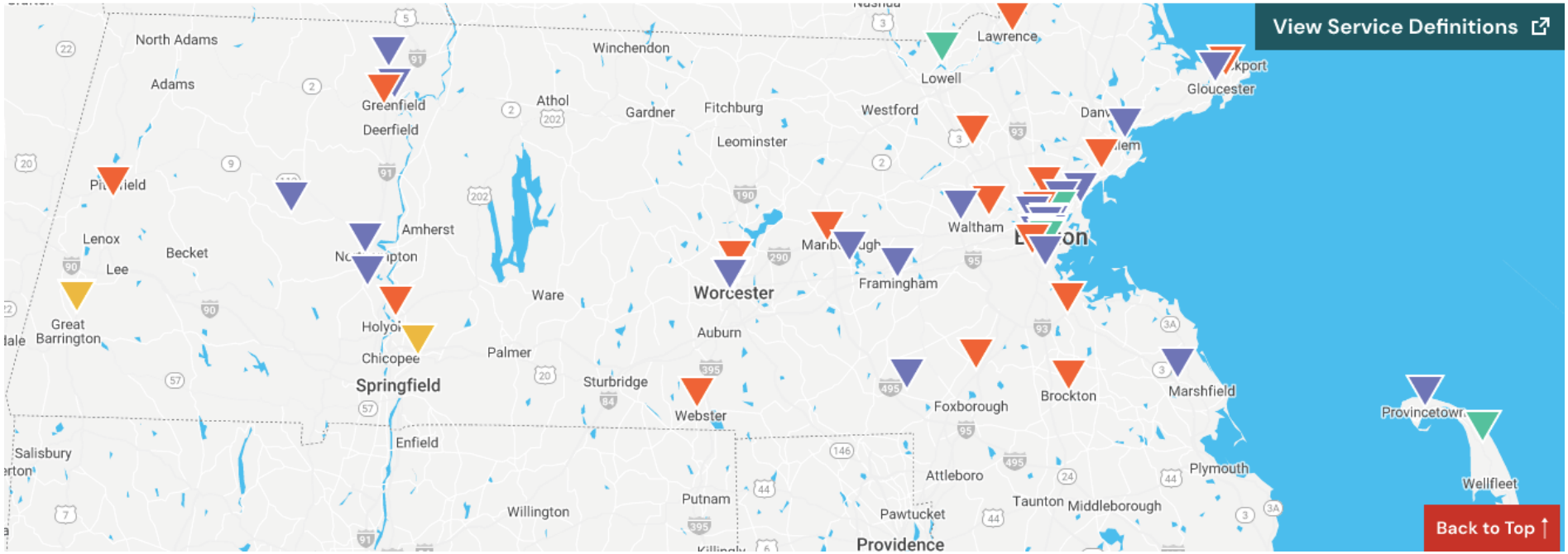
REFERRAL SYSTEMS Community Resources

Food insecurity screening is only a first step.

Food is Medicine Massachusetts SERVICE INVENTORY

Food is Medicine programs represent a spectrum of nutrition services that recognize and respond to the critical link between nutrition and chronic disease. This map presents the results of a 2021 survey to catalogue 4 types of Food is Medicine programs in Massachusetts: medically tailored meals, medically tailored food packages, nutritious food referrals, and community level healthy food programs.

BROUGHT TO YOU BY FIMMA FOOD IS MEDICINE MASSACHUSETTS



Example of food access directory designed to match community services to different clinical use cases – began with service definitions and category creation.

REFERRAL SYSTEMS Health Services

Food insecurity screening is only a first step.

Claims for MNT Initial Assessments

	2017	2018	2019	2020
Burlington	3,275	6,256	9,159	11,355
NH	1,034	1,026	1,155	1,211
Morrisville	811	735	542	670
Rutland	653	541	576	474
Barre	248	697	659	513
St. Albans	405	432	354	527
OOS/Unknown	222	304	415	399
Brattleboro	370	319	259	98
Randolph	95	71	350	293
St. Johnsbury	129	185	233	179
White River Jct	323	220	125	122
Middlebury	74	128	89	87
Bennington		112	176	118
MA	114	105	73	61
NY	31	35	32	33
Newport	15			
Grand Total	**7,799**	**11,166**	**14,197**	**16,140**

Are Utilization Variations Due To:

- Reimbursement systems?
- Reimbursement confusion?
- Primary Care Practice systems for integrating nutrition services?
- Patient / provider perception of efficacy?
- SDOH barriers shaping patient choice to participate?

Integration of Other Nutrition Services?

- DMPP, DSMES
- Self-Management Programs
- 1815 Grant Funded Activities
- Non-Clinical Services

2022 FOOD INSECURITY SCREENING SYSTEMS SURVEY Respond by Oct 14th

https://forms.office.com/r/5hk367cdDY