To: Policy Learning Lab team from Los Angeles County Department of Public Health

From: Richard Sheward, Children's HealthWatch & Heather Hartline-Grafton, FRAC

CC: Kate Burke Blackburn, Nemours Children's Health System & Sara Bartel, ChangeLab Solutions

Subject: Technical assistance re: food insecurity screening and referral workflow design, multi-site expansion, and county-wide examples

Date: September 7, 2018

Workflow design of food insecurity screening and referral with a specific focus on best practices for "warm hand-off" referrals

The following summary was adapted from the recent book: "Identifying and Addressing Childhood Food Insecurity in Healthcare and Community Settings."

Citation: H. B. Kersten et al. (eds.), *Identifying and Addressing Childhood Food Insecurity in Healthcare and Community Settings*, SpringerBriefs in Public Health, 2018. Available at: (https://bit.ly/2MVtDUA)

Deciding how you want to address food insecurity (FI)

After a positive FI screen, interventions could range from giving families paper or electronic resource listings, providing food or a prescription for a box of food, connecting with on-site staff (e.g., social worker, legal advocate, or community health worker [CHW]), and referring families to community-based programs. Some clinics may even have on-site food pantries. Clearly, these interventions will carry different challenges and opportunities since they vary significantly in scope. Not all of these approaches may be needed, but each provider or clinical setting should decide which tools and initiatives are best suited to effectively meet the needs of their patients.

Health care provider-based approaches to addressing FI

There are many types of in-house providers who can help healthcare providers care for families confronting FI. A team approach is becoming the standard way to approach FI and other social determinants of health (SDH). Some clinics may be "resource-rich," with a multi-disciplinary team capable of a range of potential actions. Others may be more "resource-limited," forced to consider those other connectors that may exist outside the clinical walls. Either way, clinics are confronted with the question of "do we buy it" or "do we build it"?

Community-based approaches to addressing FI

Regardless whether or not the FI intervention takes place within the four walls of the clinic or not, healthcare providers should also consider community-engaged approaches that develop and sustain authentic long-term community partnerships with agencies and organizations that are similarly focused on addressing issues of FI. At this level of engagement, collaborative work around shared priority areas should include the presence of shared values, mutually identified strategies, and partnerships that embody shared respect, inclusiveness, equal power sharing, and the possibility of mutual benefit. These partnerships go beyond simple referrals, focusing more on how a multi-disciplinary team can work together to develop and implement innovative collaborative efforts that meet community-identified needs.

Building and Sustaining Community-Based Interventions

Unlike medically-focused interventions that are still within the bailiwick of the healthcare system (e.g., referral from the primary care setting to a cardiologist), linking families to a community-based organization for an intervention focused on the SDH calls for more intentional strategies, processes, and commitment from both sides. Successful clinical-community partnerships require alignment around goals, leadership and resources, effective communication, processes that facilitate meaningful data sharing, and a plan to sustain and grow the collaboration. In essence, this is the "warm hand off".

On the frontier: Current state of warm hand off referrals

Given the hectic clinical environment in today's health care landscape, addressing patients' FI and other SDH must constantly compete with the multitude of responsibilities health care providers face. The overarching goal of a community-based partnership approach to FI interventions is to make the referral to the community agency as easy and seamless as possible for both the provider and partner.

Option #1 -- Build it: Clinics with access to CHWs, those who can bridge the gap between the healthcare provider's office and the families' home to assist with their needs are the most robust provider-based approach. They may meet the family in the office and go into the home to help connect families with services. This more intensive approach has been shown to improve the social needs and the reported health status of families. Some insurance payers have begun to support the utilization of CHWs to address the social needs of the highest healthcare utilizers. In this scenario, the CHW is not only responsible for making the referral, but for ensuring that the necessary follow up is conducted to ensure that the patient was able to access the community partners' resources.

Option #2 -- Buy it: Increasingly, electronic-based referral platforms that act as an intermediary between the clinic and community partner have filled a gap for clinics that are not able to hire the staff or take on the level of staff support needed to implement robust closed loop referrals. In November 2018, the Social Interventions Evaluation Research Network will release a useful guide for clinics to understand the quickly-changing referral platform landscape. This guide will answer the following questions:

- What are referral platforms and why are health care organizations interested in them?

- How are health care organizations selecting platforms?
- What general functionalities do these platforms offer?
- Comparison of 10+ commonly used referral platforms (Healthify, NowPow, Aunt Bertha, Charity Tracker, Cross TX, Livwell, One Degree, Pieces Iris, Reach, TavHealth, and Unite US)
- How are organizations implementing platforms?
- Recommendations based on experiences of organizations that have implemented referral platforms

For more information, and to request a copy of this resource when it becomes available in November 2018, please contact:

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Option #3 -- Build it/Buy it hybrid: The Cambridge Health Alliance (CHA) has recently built an electronic health record (EHR)-based referral tool that results in an auto fax to their community partner agency, which then contacts the patient to offer services. One important feature of this model is the fact that Project Bread (the community partner) receives funding from the Massachusetts Department of Transitional Assistance to conduct SNAP outreach via their FoodSource hotline. Without this sustainable funding mechanism, the partnership would need to identify a funding source for the community partner to absorb the influx of referrals to their hotline. The workflow* for this partnership is as follows:

1. CHA screens patient, if screen is positive CHA provider receive consent from patient to share name and phone number with Project Bread
2. CHA provider sends referral to Project Bread via EHR
3. Referral is auto faxed to Project Bread and arrives in a shared email inbox
4. Project Bread staff contact the patient to provide services
5. A monthly summary of connections made is sent back to CHA

*For more detail, see the Project Bread algorithm below. Also, please feel free to contact the following project leads for more information

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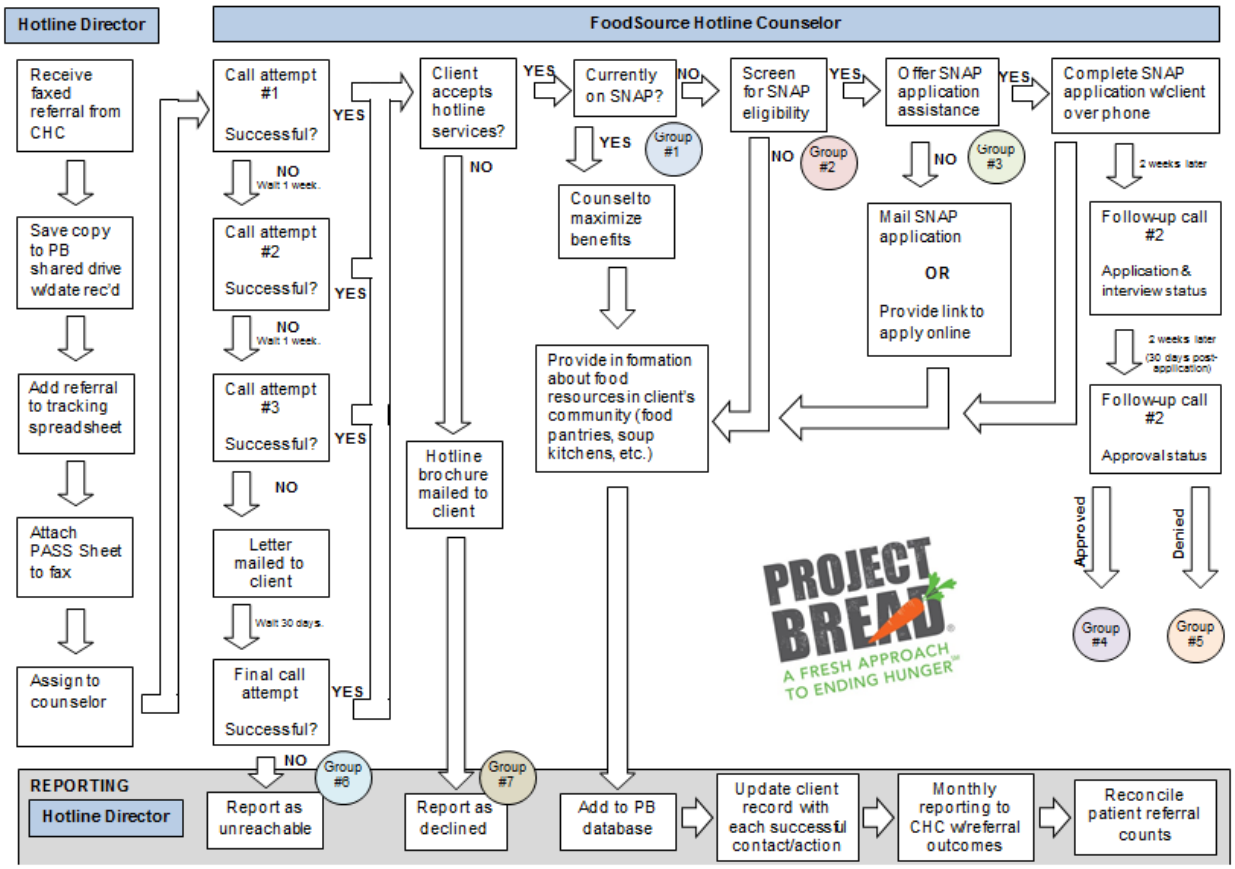

Examples of other entities/cities/counties that have implemented food insecurity screening and related components across multiple sites, and examples of who has developed County-wide policies on food insecurity screening and referral.

Boston Public Health Commission's Boston REACH: Partners in Health and Housing

Boston REACH: Partners in Health and Housing is a partnership between Boston Public Health Commission (BPHC), Boston Housing Authority (BHA), Boston University School of Public Health (BUSPH) and the Partnership in Health and Housing's Community Committee. Funding from US Center Disease and Control and Prevention (CDC) support the development, enhancement and expansion of partnerships with Boston Housing Authority developments and residents. As part of this initiative, four Community Health Centers (CHCs) collectively serving over 27,000 public housing residents (South End Community Health Center, Southern Jamaica Plain Health Center, Upham's Corner Health Center, and

Whittier Street Health Center) have committed to incorporating or sustaining a food insecurity screening for patients, along with making appropriate referrals. Over 565 patients have been screened for food insecurity at these CHCs with over 7,174 healthy affordable on-site food transactions.

Results

With the commitment of 4 CHCs to integrate food insecurity screening (FIS) questions into the workflow of at least one of their departments and with technical assistance from CHW, over 565 residents have been screened for food insecurity in the first several months, with 3 out of 10 being referred to local food resources. Some CHCs chose to integrate screening questions during their intake process and others during a point of contact with a nutritionist or social service department. Additionally, 7,174 on-site free and low-cost healthy food transactions materialized through our non-profit food partners; that's about 800 transactions per month. Screening was made possible through personalized calls and trainings by Children's Health Watch and the development of an operational online Community of Practice (CoP). FIS is the first of its kind in Boston.

Sustaining Success

Identifying a need and targeting resources can be a challenge. Food insecurity screening questions have been built into daily workflow of trusted clinical institutions in regular contact with our priority population. Not only has this helped many families in a sustainable way, this model is scalable to other departments within these CHCs and across the city and state. MassLeague, which convenes all Boston CHCs, is interested in scaling this to other CHCs, with potential to reach patients and BHA residents served at another 22 Boston CHCs. The online MA Community of Practice and virtual library remain open to those interested, and City of Boston colleagues have committed to strengthening food insecurity screening in Boston after REACH: PHH.

You can learn more about Boston REACH: Partners in Health & Housing at www.bphc.org/reachphh. Contact Aileen Shen Boston Public Health Commission 1010 Massachusetts Ave Boston, MA 02118 617-534-2633.

Vermont Child Health Improvement Program (VCHIP) Child Health Advances Measured in Practice (CHAMP) project

The CHAMP program is a unique statewide initiative for all interested Vermont primary care practices dedicated to improving preventive services and health outcomes for children from birth through adolescence. With providers from forty-nine (49) pediatric and family medicine practices now in CHAMP, VCHIP engages practices of all sizes and from all regions of the state. CHAMP is a voluntary network of practices connected by, and focused on, learning about relevant clinical topics, having access to current evidence-based resources and tools, joining their colleagues in quality improvement initiatives, and participating in an important annual data collection program staffed by VCHIP.

VCHIP launched CHAMP in 2012 by building on its long-term partnerships with the University of Vermont College of Medicine, the Vermont Department of Health, the Vermont Chapter of the American Academy of Pediatrics (AAP), and the Vermont Academy of Family Physicians. CHAMP's long-term goal is to increase the efficiency, economy, and quality of care provided to Medicaid-eligible children and families. Building on the momentum of Bright Futures and Vermont's health care reform activities, this initiative has created a multi-year network of practices that engage in collaborative improvement activities to meet the evolving needs of health care professionals, children and families.

The 2017-18 VCHIP CHAMP project focused on food insecurity screening and interventions. Across the state (see map below) pediatric and family medicine practices began screening patients for food insecurity and offering ways to address their patients' food security needs. With technical assistance and support from VCHIP, the practices participated in PDSA (Plan Act Study Do) cycles to give practices a way to quickly test changes on a small scale in real work settings, observe what happens, tweak changes as necessary, and then test again - before implementing anything on a broad scale. Instead of spending weeks or months planning out a comprehensive change, then putting it into practice only to find it is fundamentally flawed, the PSDA cycle enables rapid testing and learning.

Subsequently, Vermont's statewide ACO, OneCare began developing partnerships to investigate social determinants of health screenings in primary care settings (e.g., ACES, food insecurity, and maternal depression). The overarching goal is to enable the OneCare ACO to provide incentives for preventing and addressing impacts of trauma and for investments in social determinants of health (e.g., developing support capacities that prevent hospital admissions and readmissions, reduce length of hospital stays, improve population health outcomes, reward healthy lifestyle choices, and improve the solvency of and address the financial risk to community-based providers).

To learn more about VCHIP and CHAMP please contact:
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Quality Improvement Associate, CHAMP Project Director

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NATIONAL COMMUNITY OF PRACTICE

CHAMP Practices 2018

Northwestern Vermont

Community Health Centers of Burlington, Riverside Health Center
Essex Pediatrics, Essex
Hagan, Rinehart & Connolly Pediatricians, Burlington
Northwestern Pediatrics, Enosburg Falls
Northwestern Pediatrics / Georgia Health Center, Georgia
Northwestern Pediatrics, St. Albans
Rebecca Collman, MD, Colchester
Richmond Pediatric & Adolescent Medicine, Richmond
Shelburne Pediatrics, Shelburne
Timber Lane Pediatrics, Burlington
Timber Lane Pediatrics, Milton
Timber Lane Pediatrics, South Burlington
Thomas Chittenden Health Center, Williston
UVM Children's Hospital Pediatric Primary Care, Burlington
UVM Children's Hospital Pediatric Primary Care, Williston
UVMMC Family Medicine – Colchester
UVMMC Family Medicine – Hinesburg
UVMMC Family Medicine – Milton
UVMMC Family Medicine – South Burlington

Northeastern Vermont

Border Pediatrics, Derby Line
Concord Health Center, Concord
Danville Health Center, Danville
Hardwick Area Health Center, Hardwick
North Country Pediatrics, Newport
North Country Primary Care Barton Orleans
North Country Primary Care Newport, Newport
St. Johnsbury Community Health Center
St. Johnsbury Pediatrics, St. Johnsbury

Central Vermont

Appleseed Pediatrics, Morrisville
CVMC Pediatric Primary Care – Barre
CVMC Pediatric Primary Care – Berlin
Little Rivers Health Clinic, Bradford
Little Rivers Health Care, Wells River
Newbury Health Clinic, Newbury
Porter Pediatric Primary Care, Middlebury
Mt. Ascutney Hospital & Health Center, Windsor
Rainbow Pediatrics, Middlebury
South Royalton Health Center, South Royalton
The Health Center, Plainfield
UVMMC Family Medicine – Berlin
White River Family Practice, White River Junction

Southern Vermont

Community Health Centers of the Rutland Region Pediatrics, Rutland
Green Mountain Pediatrics, Bennington
Hogenkamp & Hogenkamp, Rutland
Just So Pediatrics, Brattleboro
Mountain Valley Medical Clinic, Londonderry
Southwestern VT Medical Center, Northshire Campus
Southwestern VT Medical Center-Pediatrics, Bennington Campus
Springfield Health Center-Pediatrics, Springfield

VERMONT DEPARTMENT OF HEALTH

VCHIP Vermont Child Health Improvement Program
UNIVERSITY OF VERMONT COLLEGE OF MEDICINE