Moving Clinics Upstream in Los Angeles

Session #2 - March 11, 2020 Convening
WELCOME

GREETINGS

HI

HELLO

HOWDY

GLAD YOU'RE HERE
Our Objectives for Today

✓ Have renewed clarity on what to expect in this learning community.

✓ Learn from your peers’ efforts to inform your own approach.

✓ Learn low-effort ways to keep doing human-centered research to inspire and inform your project design.

✓ Hear different perspectives, approaches to addressing food/transport needs.

✓ Have a more fleshed out project roadmap.

✓ Leave feeling glad you came!
Agenda

Morning
• MCU program refresh and lessons to date
• Project gallery walk
• Human-centered research excursions (includes lunch)

Afternoon
• Excursion Debrief
• Team time w/ coach support
• Speakers from the field share different perspectives and approaches (live stream!)
Housekeeping

Bathroom

Wi-Fi

Take Breaks!
Refresh: What MCU is About
In partnership with Cedars-Sinai, CCI launched an 18 month learning community to support **10 clinics in Los Angeles** in building capabilities needed to assess for and address **social needs**, with an emphasis on **food insecurity & transportation**.
Our Ask of You:

Come into the program open-minded & willing to modify your proposed solution
Program Support & Delivery

Grants of up to $75,000 from Cedars-Sinai

- Individual Priority Project/Focus
- Toolkits & Resources
- Access to Technical Experts
- In-Person Sessions
- Virtual learning
- Site Visits
- Metrics Support as needed
- Coaching
- Peer Learning Community
Communication Tools

- Newsletter
- Calendar invites for big events
- CCI Program Portal Page
Phase 1: Build a Foundation

Sep. 2019 - Dec. 2019

Build your team & clarify roles. Assess your organizations’ strengths and opportunities, including leadership and staff buy-in.

Gather & synthesize staff, patient & community input to inform strategies.

Inventory current approach – i.e. partnerships and relationships – to addressing food insecurity or transportation.
Develop, refine plan to identify and address transportation access or food security in your clinic population

Start testing approach(es) in at least one clinical site

Measure, learn and modify!

Phase 2: Plan-Do-Study-Act

Jan. 2020 - Aug. 2020
Phase 3: Implement & Document

Sep. 2020 – Feb. 2021

- Address gaps in services/referrals/partnerships
- Document standard internal work and protocols AND impact
- Scale/spread approach and lessons within organization and to inform other social needs initiatives
Moving Clinics Upstream Timeline

**Program Activities**

<table>
<thead>
<tr>
<th>In-Person Sessions</th>
<th>Virtual Learning</th>
<th>Site Visits</th>
<th>Coaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept 26, 2019</td>
<td>Weekly Office Hours with Jill Rees</td>
<td>Monthly</td>
<td>By Oct 15</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>By Nov 1</td>
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<td></td>
<td></td>
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<td>Dec 9 &amp; 16</td>
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</tbody>
</table>

**Phase 1: Getting Started & Building Your Foundation**

- Sept 2019 – Dec 2019
- Project Plan Roadmap
- Baseline Assessment
- December Webinar Presentation

**Phase 2: Testing & Implementing Your Project while Developing Core SDOH Capabilities & Infrastructure**

- Jan 2020 – Aug 2020
- NEVHC & WCIC Jan 2020
- Project Charter Drafted & Updated
- Journalist interviews/Share & learn
- Y1 reflection conversations
- Design Sprints for select sites

**Phase 3: Spreading & Sustaining Your Work**

- Sept 2020 – Feb 2021
- Coaching ends by Oct 2020. Coaches available as needed.
- Session Presentation
- Endline Assessment
- Final Case Study
- Feb 2021
- By Mar 31, 2021
- By Apr 2021

**Goals**

- Clarify program team roles
- Assess your organization's strengths & opportunities
- Gather & synthesize patient & community input to inform strategies
- Develop or refine a plan for how to identify/address food insecurity or transportation
- Start testing approaches to identify & address food insecurity or transportation at least one clinical site
- Address gaps in services, referrals or partnerships
- Document standard internal workflows and protocols
- Document impact of efforts
- Spread lessons within organization and to other work to address social needs
Re(Meet) Your Support Team!
How Clinics Hope to Build Capacity
<table>
<thead>
<tr>
<th>Capacity Building Areas of Focus re: Addressing Social Needs through Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SN-1</strong></td>
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<tr>
<td><strong>SN-2</strong></td>
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<tr>
<td><strong>SN-3</strong></td>
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<tr>
<td><strong>SN-4</strong></td>
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<tr>
<td><strong>SN-5</strong></td>
</tr>
<tr>
<td><strong>SN-6</strong></td>
</tr>
</tbody>
</table>
Self-Reported Organizational Capacity at “Baseline”

Top Strengths:

• Leadership perspective on social needs (SN-1)
• Strengthening partnerships to address social needs (SN-6)

Greatest Opportunity for Improvement:

• Using data from social needs assessments (SN-3)

Other Areas for Improvement:

• Establishing system for assessing social needs (SN-2)
• Closing loop on referrals for social needs (SN-5)
## Capacity Areas the Teams are Focusing On

<table>
<thead>
<tr>
<th>SN-1</th>
<th>Leadership perspective on social needs</th>
<th>Top strength!</th>
</tr>
</thead>
<tbody>
<tr>
<td>SN-2</td>
<td>Establishing system for assessing social needs</td>
<td>BHS Oscar Romero Eisner St. Johns LA LGBT</td>
</tr>
<tr>
<td>SN-3</td>
<td>Using data from social needs assessments</td>
<td>Kheir THE</td>
</tr>
<tr>
<td>SN-4</td>
<td>Linking patients to social needs resources</td>
<td></td>
</tr>
<tr>
<td>SN-5</td>
<td>Closing the loop on referrals for social needs</td>
<td>AltaMed/CHLA St. Johns</td>
</tr>
<tr>
<td>SN-6</td>
<td>Strengthening partnerships</td>
<td>Top strength!</td>
</tr>
</tbody>
</table>
Reflections from MCU Coaches
Gallery Walk Feedback Requests

On a large sized sticky note (any color), write down:

What aspect of your project would you like feedback on from your peers?

Paste in the center of your board.
Move to the Food or Transportation boards. Using sticky notes, jot down your thoughts about the other teams’ project charters:

- What do you see as a strength?
- What are you curious to know more about?
- What tips or ideas do you have to share in response to the team’s feedback request?
Gallery Walk Debrief
Excursion Activity!
Excursion Activity

What?

• Experience another organization’s services with a fresh perspective and an observant eye!
  • Transportation service
  • Restaurant service

Why?

• Develop empathy for your own patients/clients.
• Be inspired (or turned off) by how other services work.
• Move from what you “believe” is the need to what patients actually experience as a need.
Organizations We Will Be Learning From
Your Human-Centered Design Tools

Observation

On-The-Spot Interviewing (Intercepts)
Observation

Be curious.
Look at the details.
Note what’s missing.
Capture feelings.

**Transportation - Observation Notes**

<table>
<thead>
<tr>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What mode of transportation are you researching?</td>
</tr>
<tr>
<td>2. What happened before, during, and after the service?</td>
</tr>
<tr>
<td>Before</td>
</tr>
<tr>
<td>During</td>
</tr>
<tr>
<td>After</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What does the space look like?</td>
</tr>
<tr>
<td>2. How does it feel?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Interactions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How are people interacting with...?</td>
</tr>
<tr>
<td>The Space</td>
</tr>
<tr>
<td>Other Individuals</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>People</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Who is present? Describe them! What are their emotional states?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objects</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What physical objects are...</td>
</tr>
<tr>
<td>Present?</td>
</tr>
<tr>
<td>Missing?</td>
</tr>
</tbody>
</table>
On-The-Spot Interview (Intercepts)

Be curious.

Listen.

No judgement.

Explore everything.
Think about a person you know who receives services at your clinic. You will keep this person in mind during your excursion.

Gather with your assigned group. Look for the sticker on your name tag!

Before embarking on the excursion, identify your photographers, interviewers and observers.

Depart via your mode of transportation. Observe & interview during your ride!

Order your lunch. Observe & interview at your restaurant.

Have fun & enjoy each other's company! Continue transportation research. Leave restaurant by 12:00 pm.
Excursion Assignments & Leads:
Check the sticker at the bottom left hand corner of your name tag!

Diana
Michael
Laura
Veenu
Jill

Opt-Out: Natasha, Deena & Rachel
In your excursion groups...

• Complete the pre-exursion activity.
  • Jot down notes about the patient/client you will be keeping in mind, as you experience excursions.
  • Quickly share about this person in your group.
  • Identify the photographers, observers & interviewers in your group.

Leave for your excursion by 10:30 am!
Excursion Activity Debrief
Organizations We Will Be Learning From
Research Excursion Debrief
Team Time: Until 1:50 pm

**10 Min Break**

Speakers start @ 2:00 pm sharp!
Different Perspectives + Approaches from the Field
Our Special Guests

Dipa Shah (she/her)
LADPH
Director, Nutrition & Physical Activity Program

Amirah Dales (she/her)
LA Regional Food Bank
Senior Programs Manager

Río Oxas (they/their)
People for Mobility Justice
Building Power Director

Adam Schickedanz (he/him)
LADHS Olive View-UCLA Medical Center
Pediatrician and health services researcher
Dipa Shah - Director, Nutrition & Physical Activity Program
Addressing Food Insecurity in Los Angeles County: Engaging the Health Care Sector

Dipa Shah-Patel, MPH, RD
Director, Nutrition and Physical Activity Program
Los Angeles County Department of Public Health
March 11, 2020
Defining Food Insecurity

• A household-level economic and social condition of limited or uncertain access to adequate food
  • **Low food security**, formerly “food insecurity without hunger”: Reports reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake
  • **Very low food security**, formerly “food insecurity with hunger”: Reports of multiple indications of disrupted eating patterns and reduced food intake
Food Insecurity Increases Health Risks

Children

- Asthma, iron deficiency anemia
- Behavioral problems
- Impaired or delayed growth
- Overweight/obesity
- Poor school performance

Adults

- Diabetes
- Depression
- Hypertension
- Overweight/obesity
- Suicide ideation, poor mental health

DPH Food Insecurity Report

• Released in September 2017
• Assessed trends in the status of food insecurity among LA County households using data from the Los Angeles County Health Survey (2002-2015)
• Provided a set of strategies and recommendations to improve food security
Prevalence of Food Insecurity in LA County

• In 2015, 29.2% of households were food insecure
  – 561,000 Households
  – Income < 300% FPL
Food Insecurity by Service Planning Area

- 29.2% of households experienced food insecurity
- 11.3% experienced very low food security
- 33.9% increase in food insecurity among households from 2002-2015

### Table 1: Percent of Households <300% Federal Poverty Level That Have Food Insecurity and Very Low Food Security, LACHS 2015

<table>
<thead>
<tr>
<th></th>
<th>Food Insecurity</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Percent</td>
<td>95% CI</td>
<td>Estimated #</td>
</tr>
<tr>
<td>LA COUNTY HOUSEHOLDS</td>
<td>29.2%</td>
<td>27.1 - 31.3</td>
<td>561,000</td>
</tr>
<tr>
<td>FEDERAL POVERTY LEVEL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-99% FPL</td>
<td>41.1%</td>
<td>37.3 - 44.9</td>
<td>307,000</td>
</tr>
<tr>
<td>100%-199% FPL</td>
<td>25.4%</td>
<td>22.4 - 28.4</td>
<td>203,000</td>
</tr>
<tr>
<td>200%-299% FPL</td>
<td>13.7%</td>
<td>10.2 - 17.2</td>
<td>51,000</td>
</tr>
<tr>
<td>HOUSEHOLDS WITH CHILDREN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>27.7%</td>
<td>24.3 - 31.1</td>
<td>223,000</td>
</tr>
<tr>
<td>No</td>
<td>30.4%</td>
<td>27.7 - 33.1</td>
<td>338,000</td>
</tr>
<tr>
<td>SERVICE PLANNING AREA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antelope Valley</td>
<td>34.4%</td>
<td>27.5 - 41.3</td>
<td>27,000</td>
</tr>
<tr>
<td>San Fernando</td>
<td>27.2%</td>
<td>22.7 - 31.6</td>
<td>96,000</td>
</tr>
<tr>
<td>San Gabriel</td>
<td>21.8%</td>
<td>17.2 - 26.4</td>
<td>72,000</td>
</tr>
<tr>
<td>Metro</td>
<td>32.0%</td>
<td>25.6 - 38.4</td>
<td>93,000</td>
</tr>
<tr>
<td>West</td>
<td>30.5%</td>
<td>18.5 - 42.5</td>
<td>26,000</td>
</tr>
<tr>
<td>South</td>
<td>32.4%</td>
<td>27.3 - 37.6</td>
<td>71,000</td>
</tr>
<tr>
<td>East</td>
<td>32.4%</td>
<td>26.2 - 38.6</td>
<td>79,000</td>
</tr>
<tr>
<td>South Bay</td>
<td>30.3%</td>
<td>24.7 - 36.0</td>
<td>97,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Very Low Food Security</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percent</td>
<td>95% CI</td>
<td>Estimated #</td>
</tr>
<tr>
<td>LA COUNTY HOUSEHOLDS</td>
<td>11.3%</td>
<td>9.8 - 12.8</td>
<td>217,000</td>
</tr>
<tr>
<td>FEDERAL POVERTY LEVEL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-99% FPL</td>
<td>17.5%</td>
<td>14.5 - 20.5</td>
<td>131,000</td>
</tr>
<tr>
<td>100%-199% FPL</td>
<td>9.2%</td>
<td>7.1 - 11.3</td>
<td>73,000</td>
</tr>
<tr>
<td>200%-299% FPL</td>
<td>3.6%</td>
<td>2.0 - 5.2</td>
<td>14,000</td>
</tr>
<tr>
<td>HOUSEHOLDS WITH CHILDREN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9.6%</td>
<td>7.2 - 11.9</td>
<td>77,000</td>
</tr>
<tr>
<td>No</td>
<td>12.6%</td>
<td>10.6 - 14.6</td>
<td>141,000</td>
</tr>
<tr>
<td>SERVICE PLANNING AREA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antelope Valley</td>
<td>16.3%</td>
<td>9.9 - 22.6</td>
<td>13,000</td>
</tr>
<tr>
<td>San Fernando</td>
<td>10.9%</td>
<td>7.7 - 13.2</td>
<td>37,000</td>
</tr>
<tr>
<td>San Gabriel</td>
<td>6.1%</td>
<td>3.4 - 8.8</td>
<td>20,000</td>
</tr>
<tr>
<td>Metro</td>
<td>16.9%</td>
<td>11.4 - 22.4</td>
<td>49,000</td>
</tr>
<tr>
<td>West</td>
<td>6.4%*</td>
<td>1.8 - 11.0</td>
<td>5,000</td>
</tr>
<tr>
<td>South</td>
<td>12.9%</td>
<td>9.2 - 16.6</td>
<td>28,000</td>
</tr>
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<td>12.4%</td>
<td>7.3 - 17.4</td>
<td>30,000</td>
</tr>
<tr>
<td>South Bay</td>
<td>10.7%</td>
<td>6.9 - 14.4</td>
<td>34,000</td>
</tr>
</tbody>
</table>
Racial Distribution in Households <300% FPL by Food Security Status, LACHS 2015

Note: Percentages do not add to 100% as data for Native Hawaiian and Other Pacific Islanders and American Indian/Alaskan Native are not presented due to unstable data or suppressed for purposes of confidentiality.
Chronic Disease and Food Security Status

FIGURE 4: Percent of Adults with Chronic Conditions in Households <300% FPL by Food Security Status, LACHS 2015

- Obesity: 34.4%
- Hypertension: 30.0%
- High Cholesterol: 29.6%
- Current Depression: 15.3%
- Diabetes: 24.3%
- High Cholesterol: 10.1%
- Current Depression: 5.9%
Los Angeles County Board of Supervisors Adopts Board Motions

December 2017: Screening for Food Insecurity in County clinics
February 2019: Reducing Food Waste and Food Insecurity
Food Insecurity Screening in County Clinics

Directed DPH, DHS and DPSS to:

• Describe current efforts to screen for food insecurity in County health clinics
• Determine the feasibility and cost of including a screening questionnaire in the County’s electronic medical record system and training staff on how to use the tool
• Implement a plan for establishing a referral process to onsite CalFresh enrollment, WIC, and other food assistance resources
• Conduct nutrition education classes in clinics focused on healthy eating and food resources management
Barriers to Food Insecurity Screening Implementation

- Current clinic staffing is inadequate to carry out secondary assessments and referrals to CalFresh and emergency food assistance (e.g. food pantries)
- Time required to adequately screen patients and refer to resources
- Resources provided (e.g., food pantry lists) need to be accurate and frequently updated
Partnership with RAND: Food Insecurity Screening

- 2018: DPH collaborated with RAND Corporation to better understand client perceptions around food insecurity at county medical clinics.
- 1013 clinic patients responded to the survey.
## CalFresh Healthy Living

### Access to Healthy Food

<table>
<thead>
<tr>
<th>LEARN</th>
<th>Behavioral Economics</th>
<th>Daily Quality PA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>K-12</strong></td>
<td>Expanded/Mobile Produce Distribution</td>
<td>Smarter Lunchrooms Movement (SLM)</td>
</tr>
<tr>
<td><strong>After School</strong></td>
<td>CalFresh Promotion</td>
<td></td>
</tr>
<tr>
<td><strong>ECE</strong></td>
<td>Expanded/Mobile Produce Distribution</td>
<td>Smarter Mealtimes (SMT) Physical Activity (PA) in ECE</td>
</tr>
</tbody>
</table>

### Comprehensive

<table>
<thead>
<tr>
<th><strong>Access to Healthy Food</strong></th>
<th><strong>Nutrition Standards</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>CalFresh Promotion</td>
<td>Healthy Default- Beverages in Kids Meals</td>
</tr>
</tbody>
</table>

### Access to PA Opportunities

<table>
<thead>
<tr>
<th><strong>Access to Healthy Food</strong></th>
<th><strong>Behavioral Economics</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Expanded/Mobile Produce Distribution</td>
<td>Parks Physical Activity Programming</td>
</tr>
<tr>
<td>CalFresh Enrollment Coordination</td>
<td></td>
</tr>
</tbody>
</table>

### Behavioral Economics

<table>
<thead>
<tr>
<th><strong>Nutrition Standards</strong></th>
<th><strong>Restaurants</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Default- Beverages in Kids Meals</td>
<td>Healthy Stores for a Healthy Community</td>
</tr>
</tbody>
</table>
Look to the Future

- Establish **Food Insecurity Screening** in health clinics and referral to CalFresh and local nutrition assistance
- Partner with food rescue organizations to provide **free produce** to patients and communities
- Capacity building for food distribution
Connect with us!

Join our ListServ!

• Bi-monthly newsletters
• Community Events
• Job Postings
• Funding opportunities

E-mail Tania Marquez @ tmarquez@ph.lacounty.gov
Thank You!
Amirah Dales – Senior Programs Manager
Recommendations

• Feeding America recommends to improve partnerships between health care coverage and food assistance programs; to conduct outreach, screen for food insecurity, and other healthy food resources. Achieved by:
  – Addressing Health at Food Distribution Sites
  OR
  – Addressing Food Insecurity in Health Care Settings
Food Pharmacy Initiative

• The LA Food Bank has launched an initiative to **address food insecurity in the health care setting** by piloting Food Pharmacies.

• Food Pharmacies:
  – An innovative solution to growing food insecurity and rising chronic disease prevalence.
  – Goal: To be an extension of the health care system by putting focus on providing patients with healthy foods to prevent and/or improve malnutrition and chronic disease.
  – Track health outcomes in relation to healthy food provided.
Food Pharmacy

Fresh Food Pharmacy Model

Health Care Team
- Primary care doctor
- Community health assistant
- Case manager
- Registered dietician
- Pharmacist
- Community health educators

Patient/Family

Social Environment & Community Partners
- Food Bank
- Social workers
- Access to resources
- Wellness events
- Physical activity

Reduction in diabetes disparities

Food secure and personal engagement in own well-being

Better health

Model recreated based on Gaiser Health “Fresh Food Pharmacy Model”
Our Strategy

- **HEALTH CARE PARTNER**
  - CONDUCT Food Insecurity Screening
  - HOST New Food Distribution Programs

- On-Site Pantry (Preferred)
- Mobile Food Pantry (Storage/Space Constraints)
- Chronic Disease Prevention Program (Temporary Intervention)
Our Current Food Pharmacy Pilots
1. On-Site Pantry

- This model provides health clinics/hospitals with fresh foods readily available to patients.
- Pantry is managed by clinical staff, who determine what foods a patient should receive based on what was prescribed by the physician.
- Patients are screened and referred to the program.

**Site: LAC+USC Medical Center**
2. Mobile Food Pantry

- This model aims to encourage health care partners to provide additional resources, such as health screenings, cooking demonstrations, nutrition education, and CalFresh enrollment during the distribution.

Site: Latino Kids Health
3. Chronic Disease Prevention/Management

- This model enrolls patients with a diagnosed chronic disease and facing food insecurity into an education program, which may include support groups, interactive cooking, exercise, and nutrition education.
- This model is a weekly distribution offering a client-choice pantry: geared towards disease prevention.

Site: Bayani Health Center
# Operational Needs

<table>
<thead>
<tr>
<th>Space/Equipment</th>
<th>On-Site Pantry</th>
<th>Mobile Food Pantry</th>
<th>Chronic Disease Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room (can be small)</td>
<td>• Room (for class)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shelves</td>
<td>• Tables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cold Storage</td>
<td>• Cold Storage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carts</td>
<td>• Bags</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bags</td>
<td>• Bags</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Database</td>
<td>• Database</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parking lot (20 spaces)</td>
<td>• Parking lot (20 spaces)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room (for class)</td>
<td>• Room (for class)</td>
<td></td>
<td></td>
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<tr>
<td>Tables</td>
<td>• Tables</td>
<td></td>
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</tr>
<tr>
<td>Cold Storage</td>
<td>• Cold Storage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bags</td>
<td>• Bags</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff/Volunteers</th>
<th>On-Site Pantry</th>
<th>Mobile Food Pantry</th>
<th>Chronic Disease Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician(s), Dietitian(s)</td>
<td>• MFP Coordinator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Manager, Health Educator</td>
<td>• 10-12 volunteers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pantry Workers</td>
<td>• 10-12 volunteers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MFP Coordinator</td>
<td>• Clinical Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-12 volunteers</td>
<td>• Coordinator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-5 volunteers</td>
<td>• 4-5 volunteers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>On-Site Pantry</th>
<th>Mobile Food Pantry</th>
<th>Chronic Disease Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily, weekly, or monthly</td>
<td>• Monthly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly</td>
<td>• Weekly, depends on frequency of class</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>On-Site Pantry</th>
<th>Mobile Food Pantry</th>
<th>Chronic Disease Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client-choice vs. Pre-packaged Recipes, demonstrations, etc.</td>
<td>• Client-choice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recipes, demonstrations, etc.</td>
<td>• Recipes, demonstrations, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screenings, CalFresh enrollment, etc.</td>
<td>• Screenings, CalFresh enrollment, etc.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of Individuals Served</th>
<th>On-Site Pantry</th>
<th>Mobile Food Pantry</th>
<th>Chronic Disease Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent on program/funding</td>
<td>• Approx. 200-300 each distribution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approx. 200-300 each distribution</td>
<td>• Approx. 25-30; depends on program enrollment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target Population</th>
<th>On-Site Pantry</th>
<th>Mobile Food Pantry</th>
<th>Chronic Disease Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>General community, including current patients</td>
<td>• General community, including current patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals with a diagnosed chronic disease</td>
<td>• Individuals with a diagnosed chronic disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Objectives</th>
<th>On-Site Pantry</th>
<th>Mobile Food Pantry</th>
<th>Chronic Disease Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Must track A1c, BP, etc.</td>
<td>• Must track A1c, BP, etc.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No requirements</td>
<td>• No requirements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Must track A1c, BP, etc.</td>
<td>• Must track A1c, BP, etc.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Our Ideal Partner

- Be a non-profit entity
- Serve high food-insecure population
- Designated clinical staff/volunteers
- Desire to address food insecurity in the community
- On-Site Pantry (willing to work towards)
- Shared vision
- Flexible
- Strong communication
- Provide expertise
- Understands the operations of the Food Bank
Future Directions

• Partners in Conversation:
  – Venice Family Clinic
  – White Memorial Hospital
  – Eisner Health
  – Kaiser Permanente
  – CHA Health Systems
  – CHLA
  – Olive View
  – Watts Health Corporation
  – St. John’s Well Child and Family Center
Thank You!

Questions?

Let’s Connect!
Amirah Dales, Senior Programs Manager
323.234.3030 ext. 217
adales@lafoodbank.org
Río Oxas – Building Power Director
Our Special Guests

Dipa Shah (she/her)
LADPH
Director, Nutrition & Physical Activity Program

Amirah Dales (she/her)
LA Regional Food Bank
Senior Programs Manager

Río Oxas (they/their)
People for Mobility Justice
Building Power Director
Adam Schickedanz – Pediatrician, Health Services Researcher
Resourcing & Sustaining Upstream Care

Adam Schickedanz, MD PhD
UCLA Department of Pediatrics
1. Payment
   Funding for sustaining upstream care

2. Partnership
   Collaborating for sustaining upstream care

3. Priorities, Passions, & Principles
   Cultures for sustaining upstream care
Upstream care resourcing is a process of attunement, harmonizing, and orchestration.

From Soloists to Orchestras

Starting an upstream care project is often the work of an individual or a handful of staff, but sustaining a project often takes teams and systems working in concert.
“It’s the group sound that’s important, even when you’re playing a solo. You not only have to know your own instrument, you must know the others and how to back them up at all times. That’s jazz.”

– Oscar Peterson
Payment

Funding Upstream Care
Three Funding Types

- **Organization Funded**: Costs are covered by funding generated elsewhere in the organization.
- **Directly Funded**: Revenues from the program directly cover its costs.
- **Grant Funded**: Federal, State, Local, Foundation, Philanthropic, etc.

### Organization & Direct Funding Structures

<table>
<thead>
<tr>
<th>Organization Funded</th>
<th>Directly Funded</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Federal</strong></td>
<td><strong>State</strong></td>
</tr>
<tr>
<td>Clinic–Wide Payment Change (e.g. FQHC Prospective Payment System Rate Request, PCMH Status)</td>
<td>State Medicaid Waivers (e.g. CalAIM)</td>
</tr>
<tr>
<td>Medicare Advantage &amp; 2018 CHRONIC ACT</td>
<td>ACEs Screening Reimbursement</td>
</tr>
<tr>
<td>Bill for Targeted Care Management Services under Medicaid</td>
<td></td>
</tr>
</tbody>
</table>
Grants

Federal
HRSA, CMMI AHCs

State
ACEs Aware

Local/County/City
First Five, LA DPH

Foundations
Many, including of banks and health plans

Private Donors
Work your network

Resource: https://fconline.foundationcenter.org/
But Does the Funding Harmonize?

- Consider cost/effort of obtaining/maintaining a grant or funding steam in context of other priorities
- Don’t chase short-term funding without investing in attunement & harmonization
- First, tune your piano (i.e. your organizational mission and strategy, grounded in patient input) so other instruments can tune and stay in key
Partnerships

Collaborating for Upstream Care
Finding (& Keeping) Good Partners

Consider: culture, incentives, & willingness to learn

Invest in the relationship(s) over the long haul: Vision, Valley, & Victory
Partner to Solve the Problems You Can’t Fix Alone

Source: Galewitz, P. Uber And Lyft Ride-Sharing Services Hitch Onto Medicaid
By Phil Galewitz
SEPTEMBER 26, 2019
Kaiser Health News.
Partner to Solve the Right Problems You Can’t Fix Alone

Source: Chaiyachati, et al. 2018. Association of Rideshare-Based Transportation Services and Missed Primary Care Appointments: A Clinical Trial. JAMA Internal Medicine

**Figure 1. Rate of Missed Appointments**

<table>
<thead>
<tr>
<th></th>
<th>Intervention Group (n=394)</th>
<th>Control (n=392)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No show</td>
<td>10.7%</td>
<td>12.0%</td>
</tr>
<tr>
<td>Day of cancellation</td>
<td>25.9%</td>
<td>24.7%</td>
</tr>
</tbody>
</table>
Cultures for Sustaining
Priorities, Passion, & Principles
Cultures for Sustaining Upstream Care
Harmonizing & Orchestrating Upstream Care with Organizational Mission

Moving to the Beat of the Same Drummer
Update the Mission Statement to Address SDoH, Refer to Findings of the Community Needs Assessment, Organize Colleagues, etc.

Over Time, These Steps Make Resourcing & Sustaining Much Easier
Your Sustainable Upstream Care Program

Payment

Partnerships

Priorities, Passion, Principles
Finding the Right Mix Takes Time, Trial, & Orchestration

Organization
Grants
Partnerships
Funding
Staff
Passion
Finding the Right Mix Takes Time, Trial, & Orchestration

Organization  Grants  Partnerships  Staff  Passion  Funding
Finding the Right Mix Takes Time, Trial, & Orchestration

Organization Grants Partnerships Staff
Funding Passion
Your Sustainable Upstream Care Program

Payment
Partnerships
Priorities, Passion, Principles

PEOPLE
Thanks!

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Wrap Up + Next Steps
Please complete your evaluation forms!
✓ Have renewed clarity on what to expect in this learning community.
✓ Learn from your peers’ efforts to inform your own approach.
✓ Learn low-effort ways to keep doing human-centered research to inspire and inform your project design.
✓ Hear different perspectives, approaches to addressing food/transport needs.
✓ Have a more fleshed out project roadmap.
✓ Leave feeling glad you came!
Looking Ahead

### Moving Clinics Upstream Timeline

#### Phase 1: Getting Started & Building Your Foundation
- **Sept 2019 – Dec 2019**
- **In-Person Sessions:**
  - Sept 26, 2019
- **Virtual Learning:**
  - Weekly Office Hours with Jill
- **Site Visits:**
  - Monthly
- **Coaching:**
  - By Oct 15
- **Project Plan Roadmap**
  - By Oct 15
- **Baseline Assessment**
  - By Nov 1
- **December Webinar Presentation**
  - Dec 9 & 16
- **Goals:**
  - Clarify program team roles
  - Assess your organization's strengths & opportunities
  - Gather & synthesize patient & community input to inform strategies

#### Phase 2: Testing & Implementing Your Project while Developing Core SDOH Capabilities & Infrastructure
- **Jan 2020 – Aug 2020**
- **In-Person Sessions:**
  - Mar 11
  - Aug TBD
- **Virtual Learning:**
  - Except Mar & Aug
- **Site Visits:**
  - NEVHC & WCHC Jan 2020
  - Other Site Visits TBD
- **Coaching:**
  - Feb – Aug
- **Project Charter Drafted & Updated**
  - Feb – Aug
- **-Journalist interviews -Share & learns**
  - Feb – Aug
- **Yi reflection conversations**
  - Aug TBD
- **Design Sprints for select sites**
- **Goals:**
  - Develop or refine a plan for how to identify/address food insecurity or transportation
  - Start testing approaches to identify & address food insecurity or transportation at least one clinical site

#### Phase 3: Spreading & Sustaining Your Work
- **Sept 2020 – Feb 2021**
- **In-Person Sessions:**
  - Feb 2021
  - As needed
- **Virtual Learning:**
  - Coaching ends by Oct 2020 Coaches available as needed.
- **Site Visits:**
  - Feb 2021
- **Coaching:**
  - By Apr 2021
- **Project Plan Roadmap**
  - By Apr 2021
- **Baseline Assessment**
  - By Mar 31 2021
- **December Webinar Presentation**
  - By Apr 2021
- **Goals:**
  - Address gaps in services, referrals or partnerships
  - Document standard internal workflows and protocols
  - Document impact of efforts
  - Spread lessons within organization and to other work to address social needs
Phase 2: Plan-Do-Study-Act

Jan. 2020 - Aug. 2020

- Develop, refine plan to identify and address transportation access or food security in your clinic population
- Start testing approach(es) in at least one clinical site
- Measure, learn and modify!
Phase 3: Implement & Document

Sep. 2020 – Feb. 2021

- Address gaps in services/referrals/partnerships
- Document standard internal work and protocols AND impact
- Scale/spread approach and lessons within organization and to inform other social needs initiatives
Next Steps & Updates

Next Steps

• By March 20: Submit interest for hosting a Design Sprint.

• By May 1, 2020: Finalize your initial measurement plan. We will be asking you to share yours by May 1\textsuperscript{st}.

• Until August 2020:
  • Iterate on your project charters at least every two months. You will share new versions with your coach.
  • Develop a process map/workflow for your project by Aug 1.
  • We’ll have our next meeting together in August (to be coordinated)

• Ongoing: Continue meeting with your coaches!

Updates

• ASAP:
  • CCI will be sharing slides & recording from this session.
  • CCI will be sharing details for future virtual learning opportunities.

• Next coming weeks: MCU team stories will be published.
Design Sprint Interest

What?
An accelerated, collaborative problem-solving method from design thinking. Over a few intense days, stakeholders co-create ideas and build and test solutions with stakeholders. The design sprint is facilitated by expert consultants.

Why?
Help your team use design tools to brainstorm food security/transportation approaches and quickly test those approaches with the stakeholders in the room. Build design capabilities at your organization.

Who?
Teams that are open and enthusiastic about applying design to their social needs issues. You may already be testing solutions but hope to unearth more ideas with community members.

Submit your interest by March 20th!

• Receive an honorarium of $5,000 to offset staff time & materials.

• Need dedicated space and time over 3 consecutive days.