Eat for Your Health

Behavioral Health Services, Inc. Health Center Network

Carolina Rodriguez Orozco, Bruce Kinley, Michael Ballue, Dr. Evelyn Chang, Shirley Summers, Debby Levan, Michelle Venable, Kerry Deeney, Erik Salazar, Jesus Chavez

March 23, 2020

BHS HEALTH CENTER NETWORK

BHSHealthCenterNetwork.com

Sra. Maria

Age: 73
Location: Wilmington
Frequency: Monthly

- Type 2 Diabetes
- High Cholesterol
- Vitamin D Deficiency
- Mixed Hyperlipidemia
- Major Depressive Disorder
- Chronic Gastritis

- Husband died last year
- Lives off $300/mo.
- Has CalFresh
- Doesn’t have transportation

The Problem

- Lack of established screening tool for SDoH, specifically for Food Insecurity.
- Lack of staff availability to help enroll clients into CalFresh and initiate referrals.
- Lack of established system to close the loop on referrals.

Exploring South Bay's Food Insecurity Problem

Focus Groups

- Medical Assistants, Front Office, Enroller, and Office Manager provided insights into perception of Food Insecurity.
- Patients helped us understand how they were being impacted and what resources they need.

Draw Your Experience

- "Draw a time when they felt secure about the food they had and when that was not the case."

Pilot Testing

- Implemented PRAPARE screener at one health center for a week. Informed decision to switch to HVS, include question about CalFresh enrollment status, and incorporate screening into workflow for vitals.
- PRAPARE not targeted to Food Insecurity

Food Insecurity Assessment of the South Bay

“My monthly **CalFresh** would be $500. Which sounds like a lot, but when it's like a **family of three** and then you want to kind of **go for the healthier things**. It just …**wipes the entire like 500 out**.”

Project:
Eat for Your Health

Changes Due to the COVID-19 Pandemic

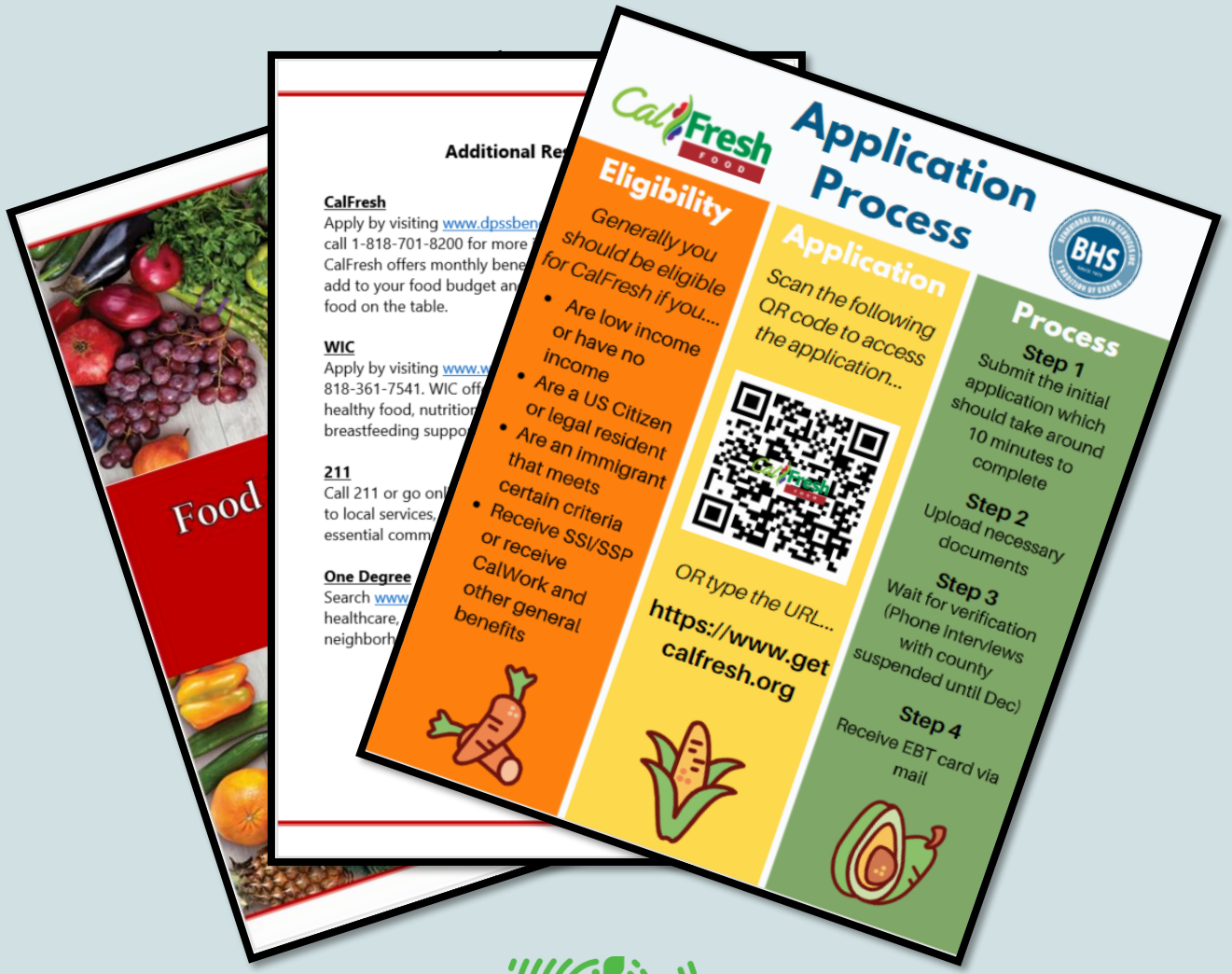
- Resources shifted to developing **COVID-19 safety protocol** and transitioning to **Telehealth** to ensure clinics could continue to provide care to patients while maintaining employee and patient safety.

- Due to staff shortages and the transition to Telehealth **HVS screening is done over the phone** vs in person.

- Through a partnership with **Wholesome Wave**, we were able to provide **$25 gift cards** for fresh fruits and vegetables **by mail.**

Eat for Your Health

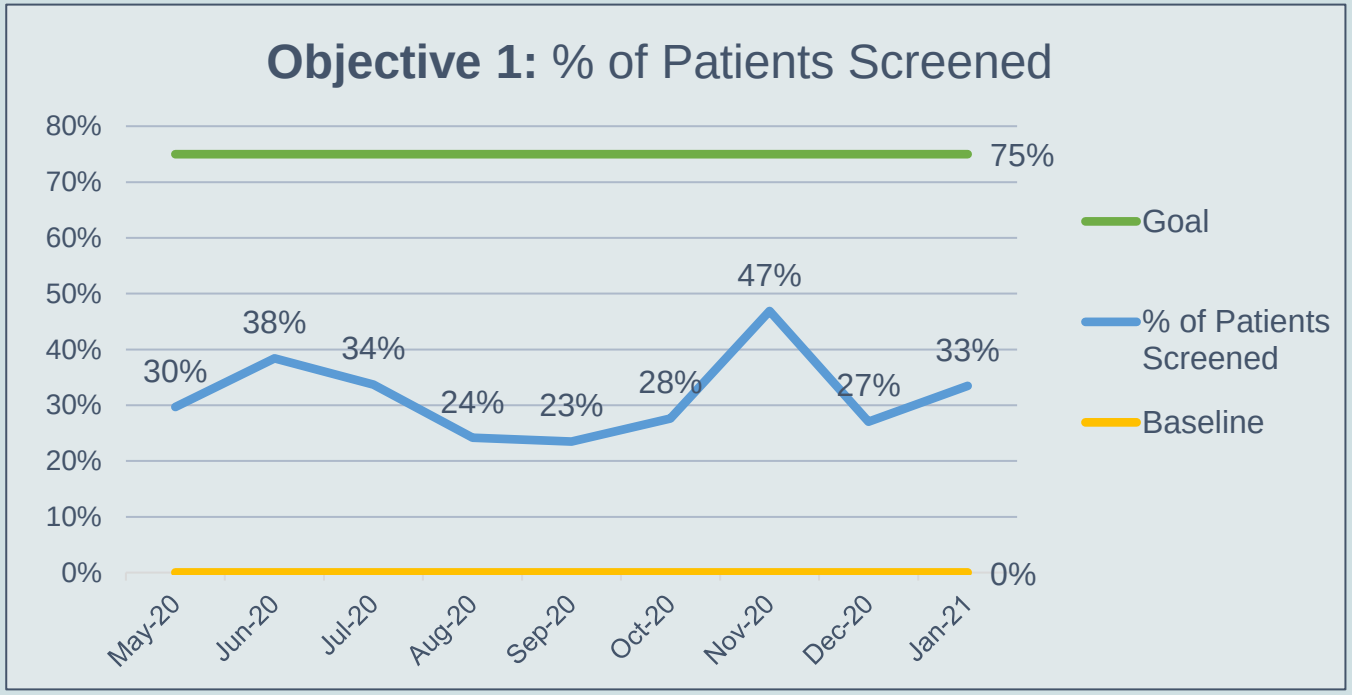
- **Staff involved**: Medical Assistants, Front Office, Office Managers, Specialty Care Coordinators, AmeriCorps Health Fellows, and Quality Improvement Team.
- Developed series of **educational materials** including brochures and **resource pocket guides**.
- **HVS** tool used for screening, **CalFresh** enrollment provided, and referrals to **additional resources**.
- **Wholesome Wave** partnership to provide $25 gift cards for fresh fruits and vegetables.



wholesome wave

Eat for Your Health Impact- WINS!

Objective	Metric Description	# of Unique Individuals
1	Total Screened for Food Insecurity	652
3	Total Served	446
7	Total Wholesome Wave Distributed	416

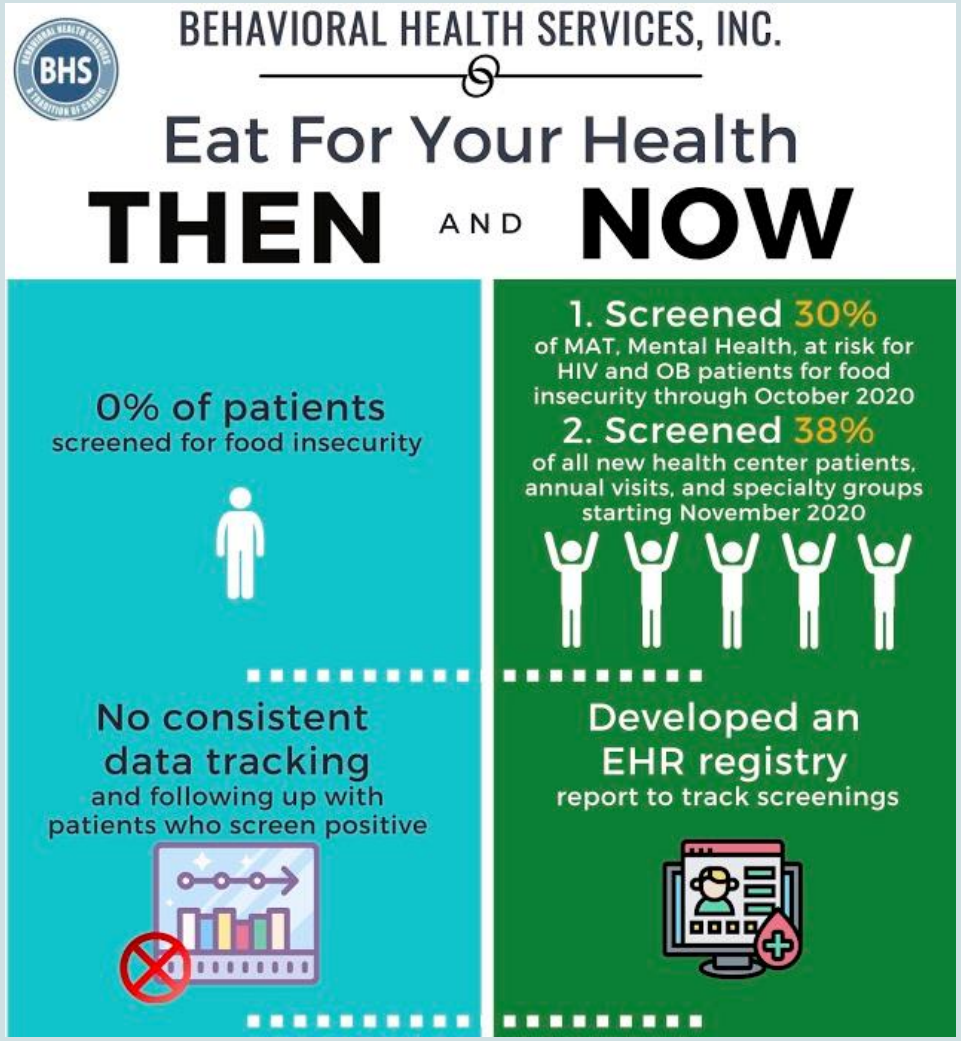


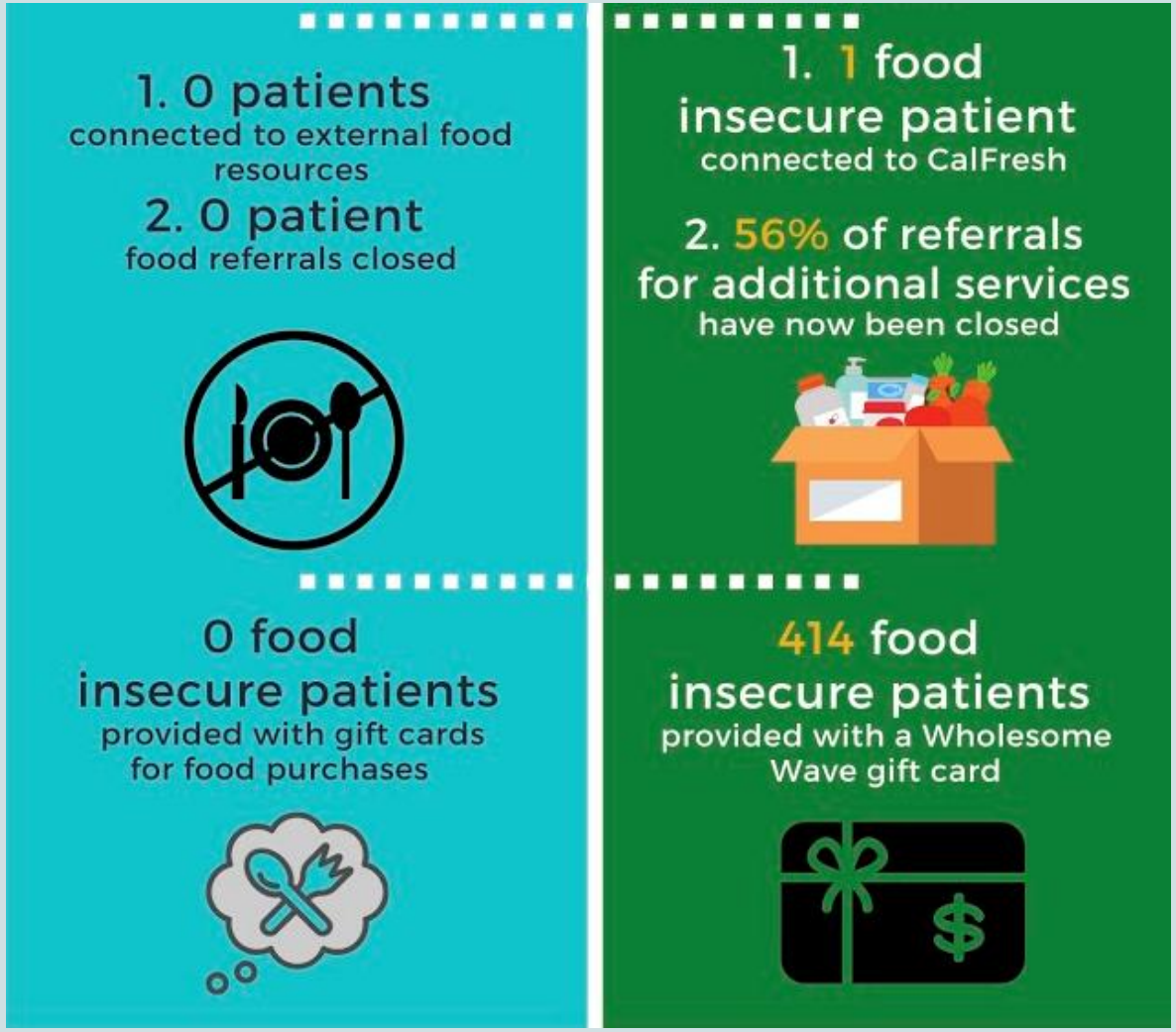
Target Populations

May-Oct: Medication Assisted Treatment, Mental Health, and Pregnant Patients

Starting late Oct: Expanded to New Patients and Annual Visit Appointments

Then and Now


BEHAVIORAL HEALTH SERVICES, INC.
Eat For Your Health
THEN AND NOW
0% of patients
screened for food insecurity
No consistent data tracking
and following up with patients who screen positive
1. Screened 30%
of MAT, Mental Health, at risk for HIV and OB patients for food insecurity through October 2020
2. Screened 38%
of all new health center patients, annual visits, and specialty groups starting November 2020
Developed an EHR registry
report to track screenings


1. 0 patients
connected to external food resources
2. 0 patient
food referrals closed
0 food insecure patients
provided with gift cards for food purchases
1. 1 food insecure patient
connected to CalFresh
2. 56% of referrals for additional services
have now been closed
414 food insecure patients
provided with a Wholesome Wave gift card

Maria

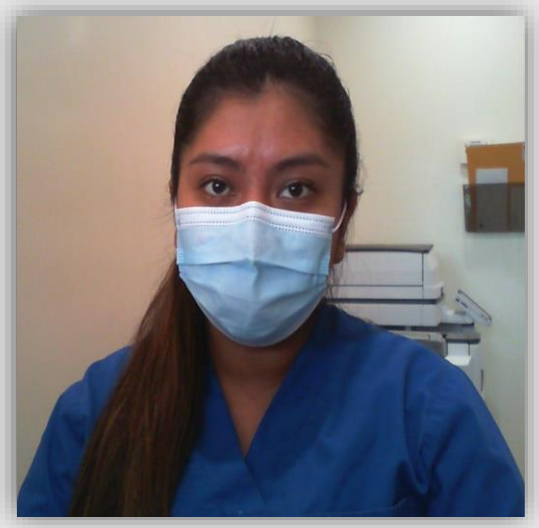
- **73 Years Old**
- **Wilmington**
- **Patient Since 2017**
- Type 2 Diabetes, High Cholesterol
- Vitamin D Deficiency, Mixed Hyperlipidemia, Chronic Gastritis
- Major Depressive Disorder

“**Food stamps has helped me for so long. I am very grateful** because of how much it has helped. I don’t know what I would do without it. I have a lot of despair because of my health and fear of getting COVID19 but **I don’t have to worry about food**.”

Melissa

- **35 Years Old**
- **Inglewood**
- **Patient Since 2018**

“This opportunity was part of **helping me get my life back together**. I was able to eat **healthier**. **My family would also definitely benefit** from getting help with food.”



Graciela

- **Medical Assistant** at Bayani Health Center
- **2 Years**
- **Food Insecurity Screener**

“**It felt great** to see them get the chance to **prepare healthier food** because we were screening for food insecurity. One patient brought up that this was a **great opportunity to start living a healthier lifestyle** because of the increased access to fruits and veggies provided by the gift card.”

Jill

- **Specialty Care Coordinator** for Medication Assisted Treatment
- **10 months**
- **Food Insecurity Screener**

“**It felt good and rewarding** as I was able to help patients and clients in need of some food. I once had a patient who was food insecure. It turns out all of their family were patients with FHC and I was **able to screen them all and provide a gift card to each of them**.”

If Eat for Your Health were to end…

- **Reduced capacity** in starting new phase of our food insecurity efforts, now that more materials have been created and a series of **brief nutritional workshops are in development**.

- **Reduced time** staff would be able to allocate to perform outreach and promote enrollment into CalFresh.

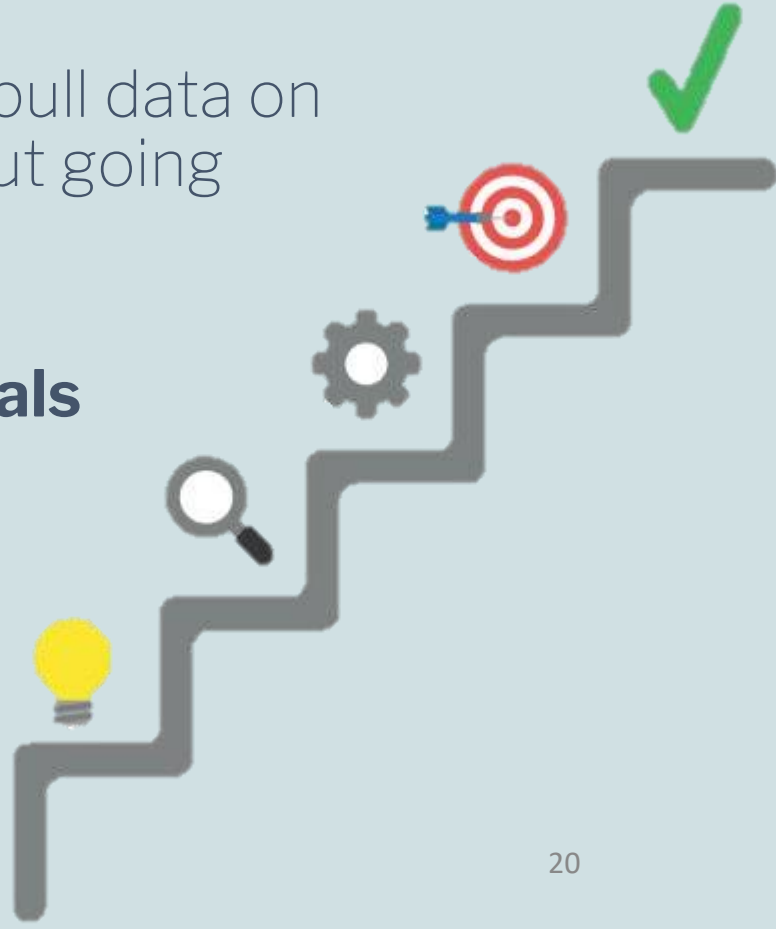
- **Leaving patients without important food resources**, which may negatively impact their health.

Eat for Your Health Next Steps

- **Integrate screening and brief nutritional workshops** into health coaching for patients with hypertension.

- Develop a more **accurate report on eCW** that can pull data on unique patients for food insecurity screening without going through the registry.

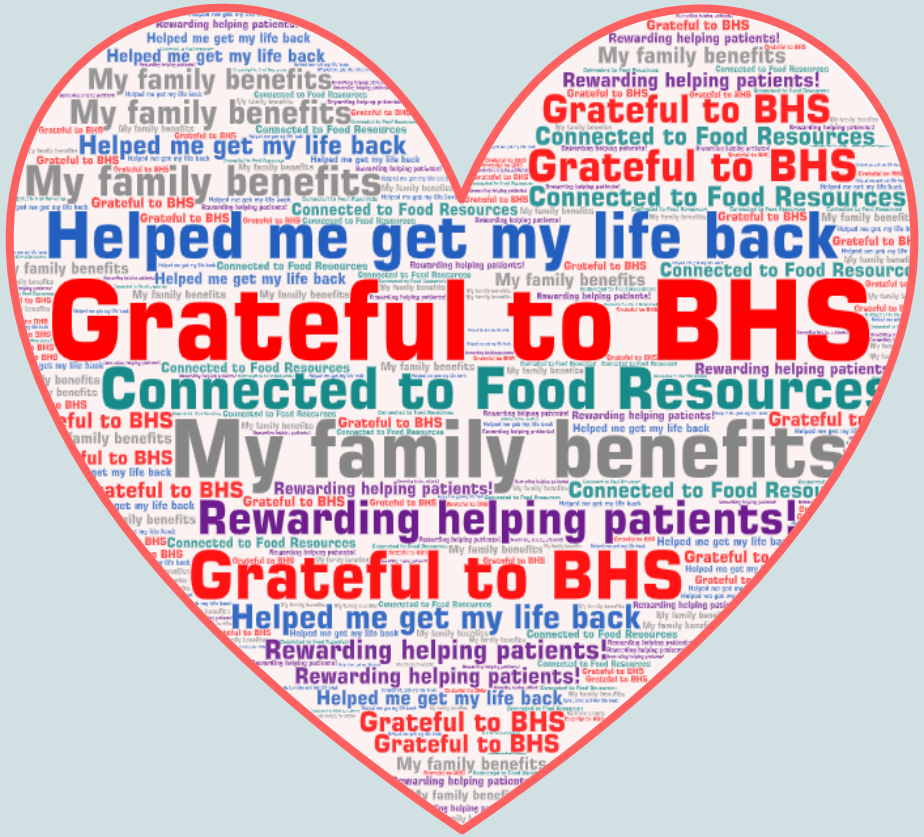
- **Integrate food resources and educational materials** on our health center website.



How to Support Eat for Your Health

- Organizations and entities that have established food distribution processes set up, are willing to **share policies and protocols** on how to do this.

- Staffing: **Dedicate staff** to support with **implementation and sustainment** of food insecurity efforts (less staff due to addressing COVID-19 issues).



Thank you!

Behavioral Health Services, Inc.

Carolina Rodriguez Orozco, Bruce Kinley, Michael Ballue, Dr. Evelyn Chang, Shirley Summers, Deborah Levan, Michelle Venable, Kerry Deeney, Erik Salazar, Jesus Chavez

If you have questions, contact: Carolina Rodriguez Orozco, carodriguez@bhs-inc.org

Clínica Monseñor Oscar A. Romero

HEALTHCARE IS A HUMAN RIGHT

Removing Barriers to Diabetes Health: Addressing Transportation Insecurity

CLINICA MONSEÑOR OSCAR A. ROMERO

LOS ANGELES, CA

TEAM: DR. DON GARCIA, DR. CHISELA JUAREZ, NORMA BUENO, BRENDA ORTIZ, AND TANIA ASTORGA

Patient Story

Play Video

Articulate the Problem

Patients with uncontrolled diabetes (A1c >9) had difficulty getting to the clinic for medical visits

33% of patients with diabetes had an A1c > 9

Needed to identify solutions for patients to get to their appointments for medication adherence, health education, completing labs

Lack of baseline on how many patients needed transportation support

How We Explored the Problem and Key Insights

- The Oscar Romero team administered 150 transportation surveys in September 20219 to understand transportation barriers
- Patients communicated the following concerns
  - Lack of stable transportation to medical visits
  - Public transportation took too much time patients were required to take time off from work or find childcare
  - Patients requested support with medication deliveries
  - Anecdotal feedback during the pandemic: patients shared; they were afraid of going to the clinic due to COVID-19
  - Health plan transportation was not reliable

What types of transportation do you **CURRENTLY USE** to get to your medical appointments?

Have you missed any of your scheduled appointments at Clinica Romero due to transportation issues?

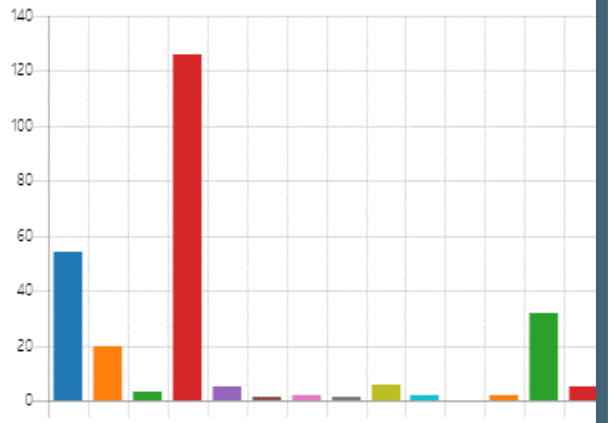
In the past 12 months, has Clinica Romero provided you with any of the following resources to assist you with transportation?

Have you ever solicited transportation services from your health plan?

Have you arrived late to any of your scheduled appointments at Clinca Romero due to transportation issues?

6. What type of transportation do you CURRENTLY USE to get to your medical appointments?

Personal vehicle	54
Ride from Family member	20
Ride from Friend	3
Bus	126
Metro Subway	5
Taxi	1
Uber	2
Lyft	1
"Access" transportation servic...	6
Health Plan transportation	2
Motorcycle	0
Bicycle/Scooter	2
Walking	32
Other	5



15. In the near future, do you anticipate needing transportation assistance from Clinica Romero?

Yes	134
No, I will not need transportat...	45

16. What resources would you like Clinica Romero to offer?

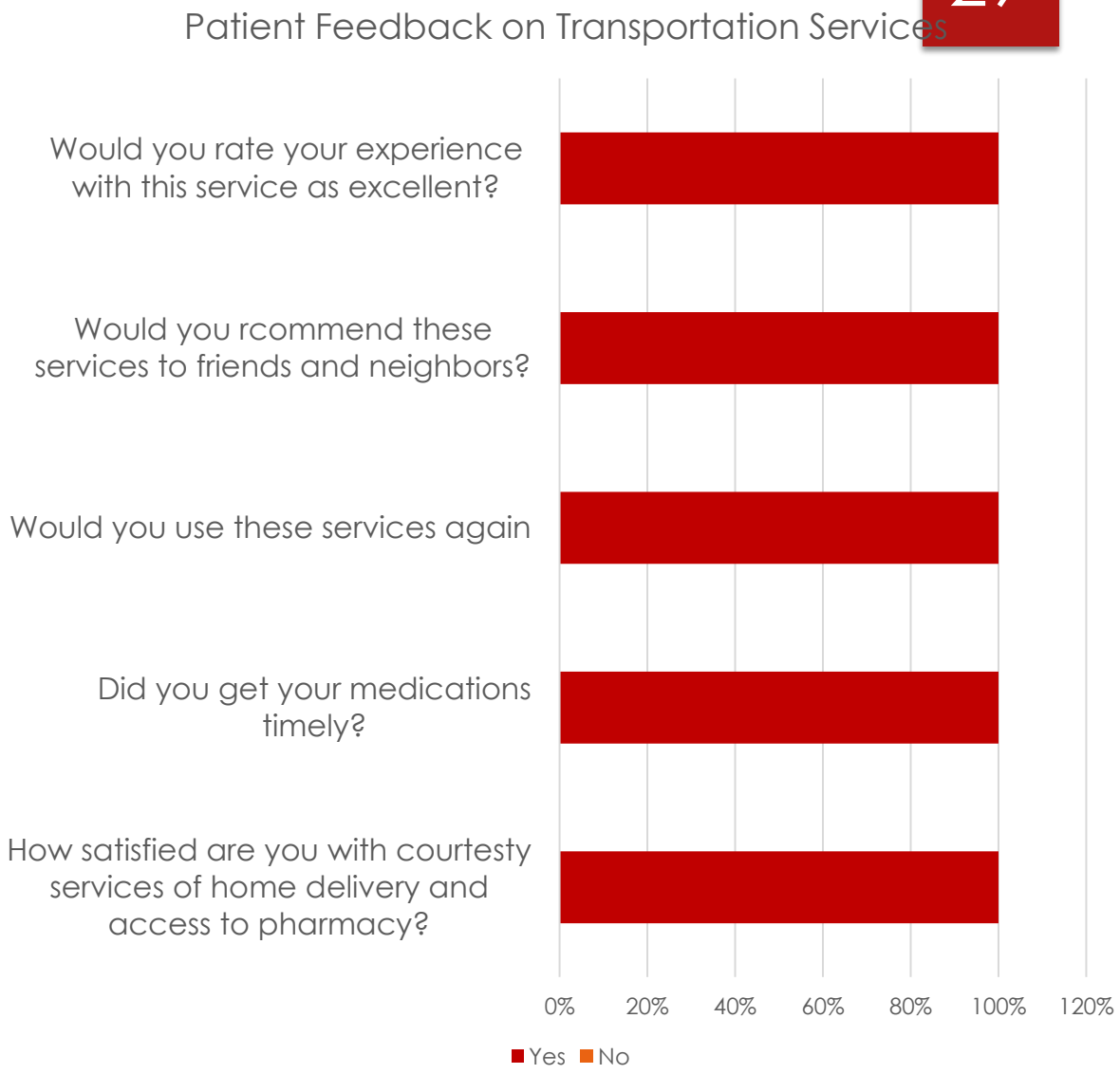
Free Clinic Bus/Van/Car	135
Free Uber	82
Free Lyft	58
Free Metro Bus Cards	73
Other	15

Improving Diabetes Care by Addressing Transportation Insecurity

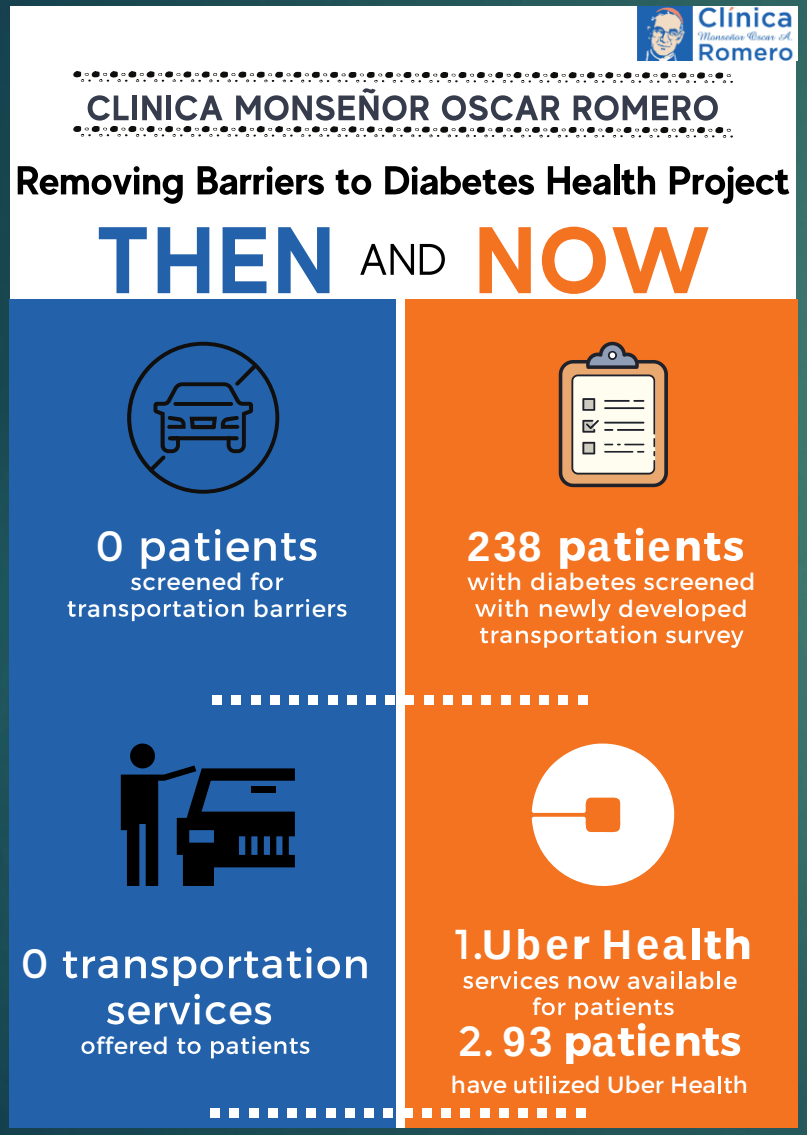
REMOVING BARRIERS AND INCREASING ACCESS

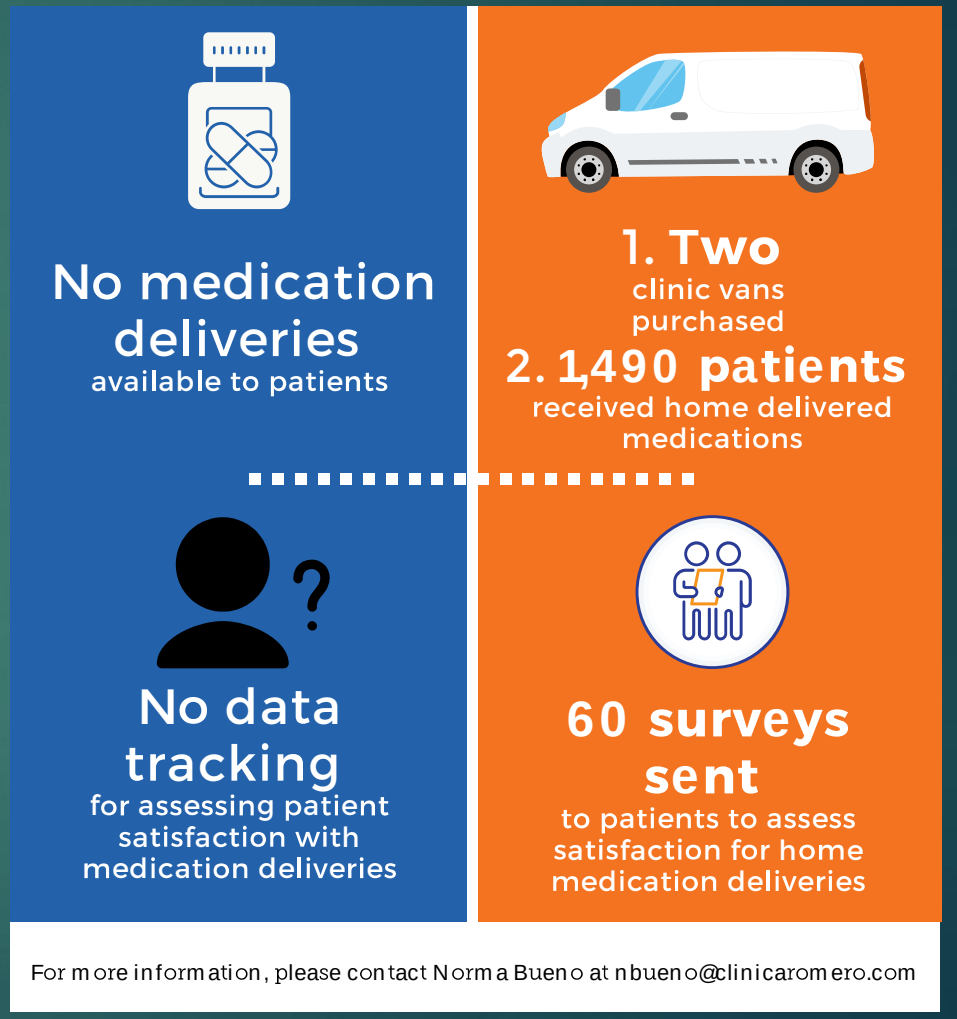
Improving Diabetes Care by Addressing Transportation Insecurity

- Initial project: transportation services for patients to and from medical appointments
- Support for patients with an A1c >9
- Agency rate of A1c Poor control was 33% goal was to reduce rate to 23%
- Hired 2 van drivers
- Screened patients for transportation insecurity and acted on responses
- Solicited patient feedback on transportation barriers to inform intervention

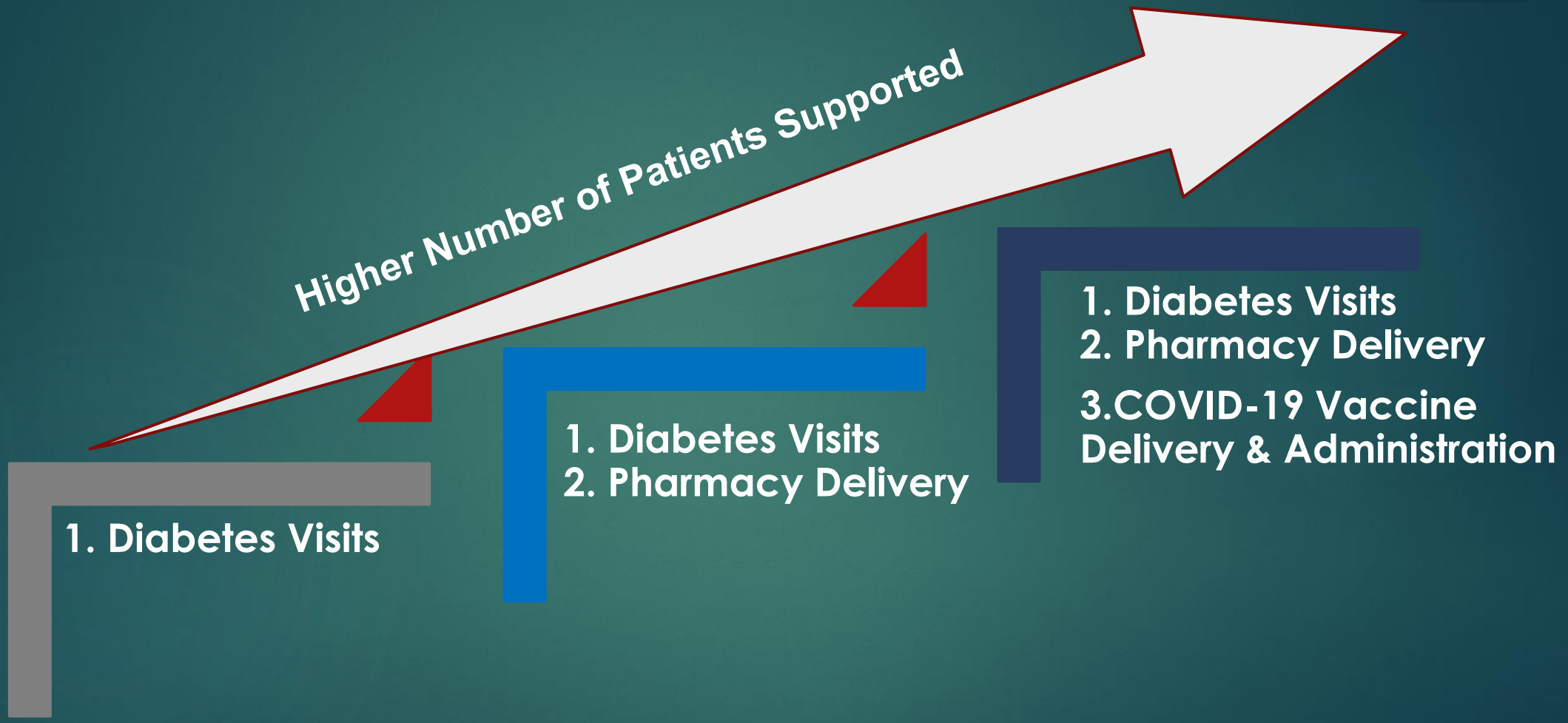


Then and Now


Clínica Monseñor Oscar A. Romero
CLINICA MONSEÑOR OSCAR ROMERO
Removing Barriers to Diabetes Health Project
THEN AND NOW
0 patients
screened for transportation barriers
238 patients
with diabetes screened with newly developed transportation survey
0 transportation services
offered to patients
1.Uber Health
services now available for patients
2. 93 patients
have utilized Uber Health


No medication deliveries
available to patients
1. Two
clinic vans purchased
2. 1,490 patients
received home delivered medications
No data tracking
for assessing patient satisfaction with medication deliveries
60 surveys sent
to patients to assess satisfaction for home medication deliveries
For more information, please contact Norma Bueno at nbueno@clinicaromero.com

Evolution of Transportation Project



- Female
- 73 years of age
- From Los Angeles
- A patient of Clinica Romero for over 15 years
- Diabetic

“It is a lot of help, it is very useful now with covid pandemic. One cannot travel because one of my age. And I struggle to ride the bus, because I don't have someone to drive me around. I am very grateful to be able to receive my medications at home. ”

- Male Patient
- 68 years old
- From Los Angeles
- A patient of Clinica Romero for over 20 years
- Diabetic

“This is a good service. It’s faster and safer. It saves me from being on a bus with lots of other people”

- Jamey
- Pharmacist
- 11 years with Clinica Romero
- Co-Managing the Medication Deliveries

The medication delivery service has made a ***positive impact*** *to many of our CMOR patients.*

Prior to the service, we had a lot of ***diabetic patients that would not come pick up their meds****. Covid-19 made this issue worse. Being able to offer* ***medication deliveries*** *has improved these issues. This service has been* ***essential to patients*** *with chronic illnesses like diabetes.*

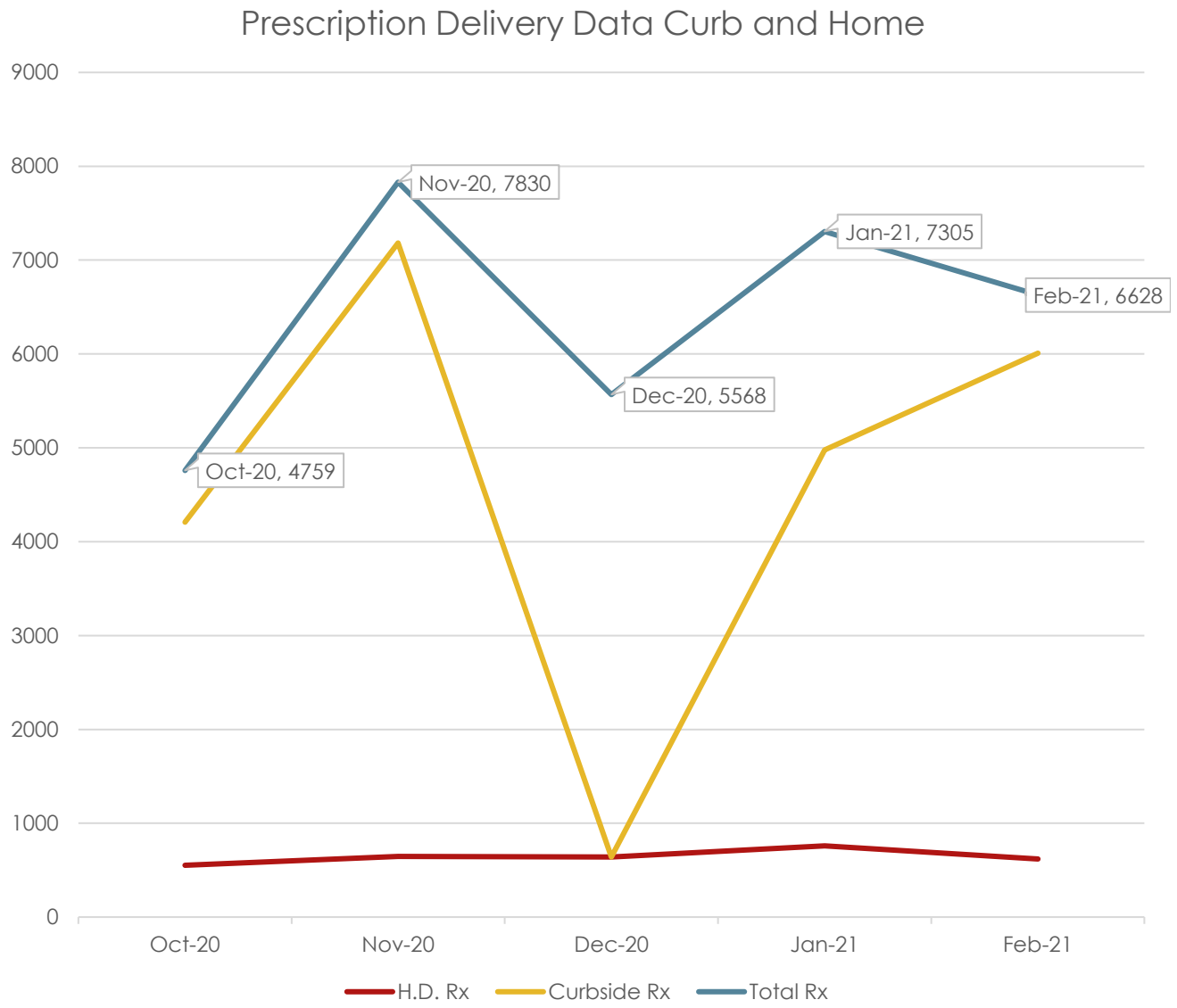
Some of our diabetic patients were worsening their condition by not picking up their medications. ***With this service all of our patients receive their medication and can better manage their health problems.”***

- Jacqueline
- Physician Assistant
- 1 year with Clinica Romero
- Transportation Provider champion

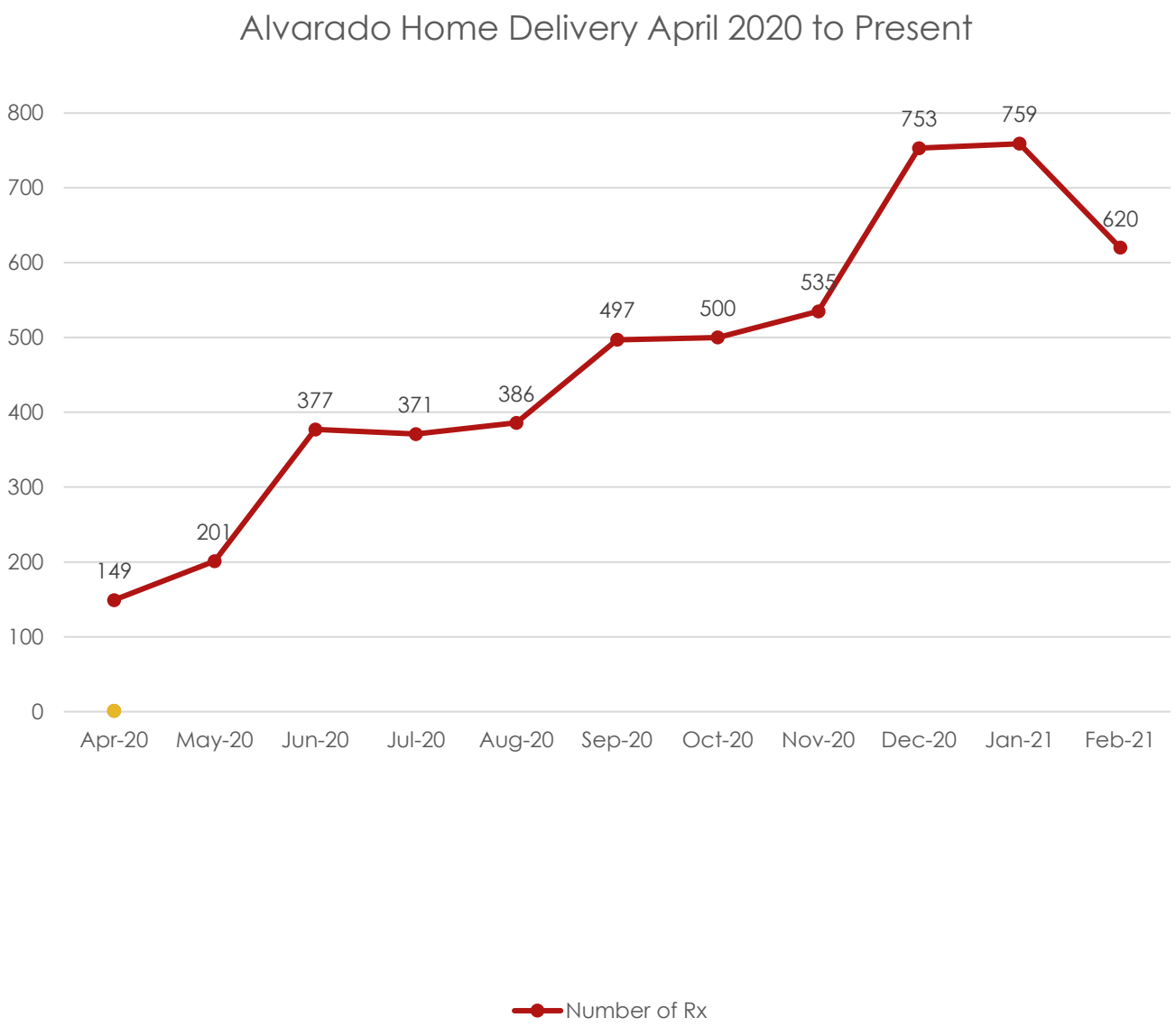
I was thrilled that our organization is offering transportation to services to our patients. Patients have so many obstacles to care. My immediate reaction this is going to help SO much with compliance.

Medication delivery service limits patient's exposure to COVID-19 and this helps great for medication adherence and compliance. Patients are now more compliant. We communicate directly with the pharmacy and review the medications with the patient during the visit.

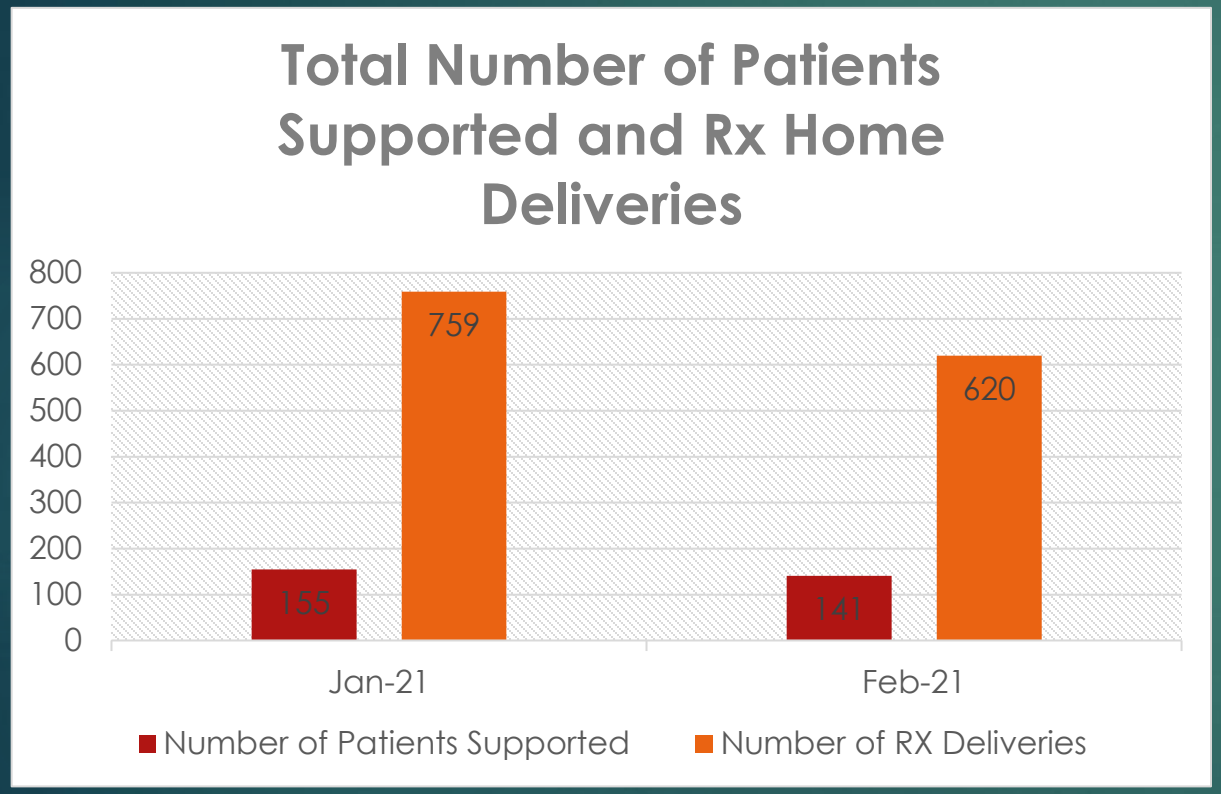
Impact of our Program: Prescription Deliveries

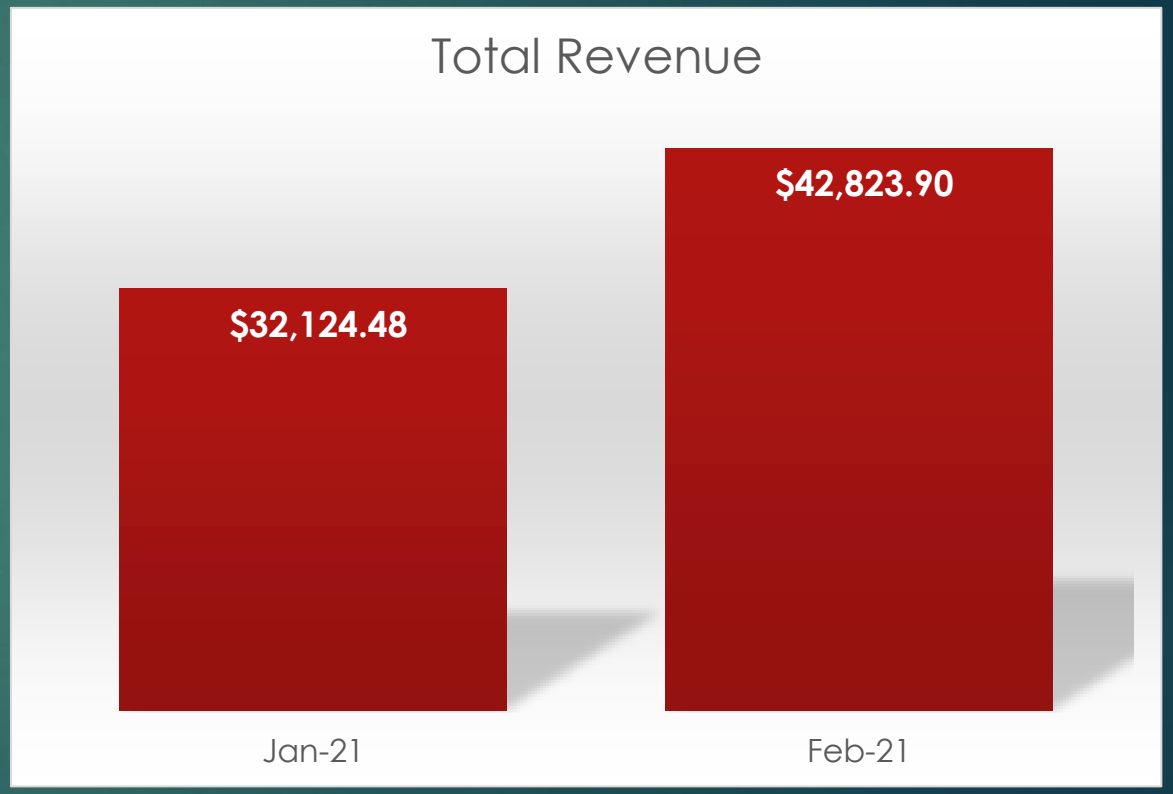


Impact of our Program: Home Delivery



Impact of our Program





Summarize Benefits/Value of Your Project

Support our vulnerable patients through a pandemic

Address social determinants. Not just screen and refer but Do the work. We provide the follow-up

Be innovative!! Pivot to meet the needs of the patient

Adherence to medications increased. We know the patients are getting the medications they need

COVID-19 bringing to light that transportation insecurity is a health equity issue: Vaccines need to be taken to transportation insecure patients (can't leave work, childcare, distance)

Consequences if you discontinue the project

that's not an option!

We would be abandoning our patients. We won't do this!

- This will impact our bottom line. (revenue implications from deliveries and pharmacy fills)
- Remove opportunities of collaborating with external partners such as LA County Department of Public Health, local FQHCs

Project Next Steps

- Develop new project infrastructure due to new patient demands
  - As project matures needs to revise approach and address challenges
  - Increased number of Rx (more deliveries to further areas in LA)
  - Purchase new van and hire new driver
  - Texting campaign to get patient feedback
- Sustain this work
  - Identify additional funding. This will still be sustained but need financial support due to demand.
- Implement COVID-19 vaccine delivery (collaboration with LAC DPH)
- Continue to ensure providers order medications in house (leads to higher revenue)

Your Ask for Specific Support

- Funding to sustain work
- Stronger partnerships with LA County programs and FQHCs (best practice sharing)
- Sustainability of Moving Clinics Upstream cohort

Clínica Monseñor Oscar A. Romero

HEALTHCARE IS A HUMAN RIGHT

Clinica Monseñor Oscar A. Romero
Los Angeles, CA

Team: Dr. Don Garcia, Dr. Guisela Juarez, Norma Bueno, Brenda Ortiz, and Tania Astorga

If you have questions, contact: Norma Bueno email: nbueno@clinicaromero.com

LOS ANGELES LGBT CENTER

Nutrition Equity Project

Presented by:
Louis Guitron
Linda Santiman

Our Story!!

Play Video

LGBTQ and Food Insecurity

Rates of food insecurity are higher for LGBT adults when compared to non-LGBT adults across gender, age, racial/ethnic, and education level groups

1. **LGBTQ adults are 1.7 times more likely than non-LGBT adults to not have had enough money to feed themselves or their family in the past year.**
2. **Same-sex couples are 1.7 times more likely than different-sex couples to receive food stamps.**
3. **More than 1 in 4 LGBT adults (29%), approximately 2.4 million people, experienced a time in the last year when they did not have enough money to feed themselves or their family.**

Exploring the Problem

Approach

1. Patient Survey
2. Patient Focus Groups
3. Staff Focus Groups
4. Screening Tools
5. Technology

Outcome

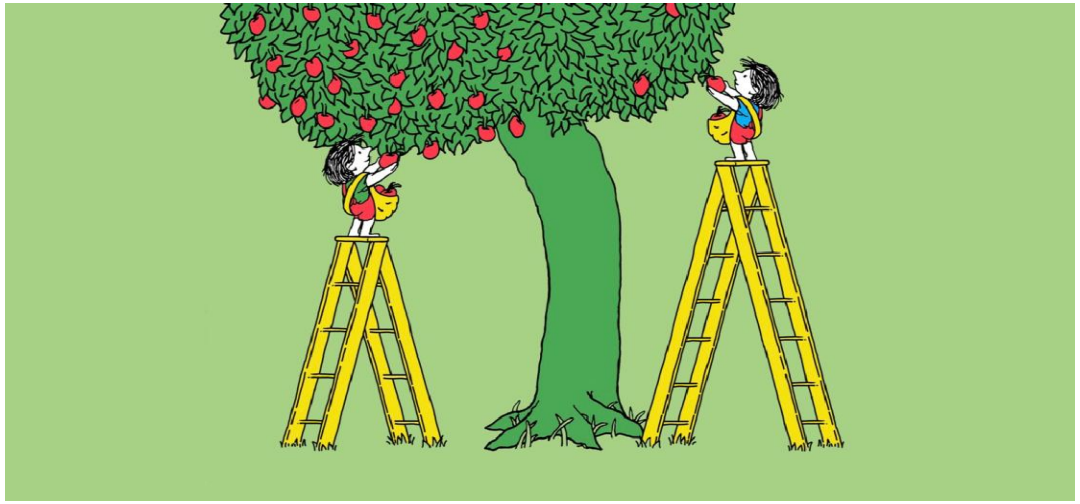
1. 85% of patients screened positive for FI
2. Drawings:
3. Need financial and community resources
4. Food Insecurity, HVS, nutrition literacy
5. Outreach

Patient Voice: Ja-Jah “Pride Pantry User”

“What **Pride Pantry** means to me is an actual **act of love** for the **community** and those in need. When someone can put that much time and thought **without asking for anything in return,** it is an act of love.

The Pantry, has provided **so much help** and I give my hats off to it. We have other programs in the county, but you know you can **depend on the pantry.** There is a God and there are people who care. The demonstration of it is more than just lip service. With everything so cold and so cyber now, there are still places like the Pantry **where people smile and offer help without asking for anything** in return**. It’s a simple act, but it is monumental.”**

Tackling Food Insecurity: Nutrition Equity - Pride Pantry



How We Pivoted During a Pandemic

- Pride Pantry
- Mini Health Fair After Getting the Vaccine→ HVS Screening→ Support
- Screens/tablets for consult rooms
- Implemented Telehealth
- Texting to refer to Pride Pantry
- CalFresh enrollment
- Senior Services: Food delivery for isolated patients
- Increasing access to groceries with gift cards through additional funding sources
- Delivery of cooked meals to patients
- COVID-19 Swag Bag

Nutrition Equity: Program Details

- Screen patients using Hunger Vital Signs
- Patients attend a nutrition class to earn $150 for groceries
- Nutrition class provides nutrition literacy, how to cook, store and shop for food
- Adapted nutrition content due to COVID-19
- Pride Pantry provides free meals to 350-450 clients every Friday
- Used an innovated “appointment model” for food pick-up
- Delivery service available for those with transportation issues

LOS ANGELES LGBT CENTER

Impact: Results to Date

HVS Screening

- 345 unique patients screened
- 649 total screenings: includes both initial screening and rescreening
- 100% rescreened positive
- 286 screened often true (83%)
- 95 Never true (28%)
- 1 declined to answer

CalFresh

- Unable to complete training for staff due to the pandemic
- Used tablets to support patients with applying online safety
- Majority already enrolled in CalFresh

Pride Pantry

- All 345 screened patients referred to Pride Panty
- 38,868 outreached and referred to Pride Pantry not screened
- 1,083 clinic patients linked to Pride Pantry. 2260 Center clients from all clinic programs received Pride Pantry services
- 168 $25 gift cards given

Then and Now

The LA LGBT Center

Food Insecurity Initiative for Low-Income Clinic Patients

THEN and NOW

1. 0 patients
screened for food insecurity
2. 0% of patients
that screened positive for food insecurity received Case Management services
3. 0% of patients
that screened positive for food insecurity screened negative 3 months later

1. 345 unique patients
screened for food insecurity using Hunger Vital Signs tool
2. 649 total screenings
on the HVS tool
3. 100% of patients
that screened positive for food insecurity received Case Management services

No standard data tracking
for patients screening positive for food insecurity

1. Developed integrated EHR templates
for hunger vital sign screenings
2. Data tracking
in Tableau

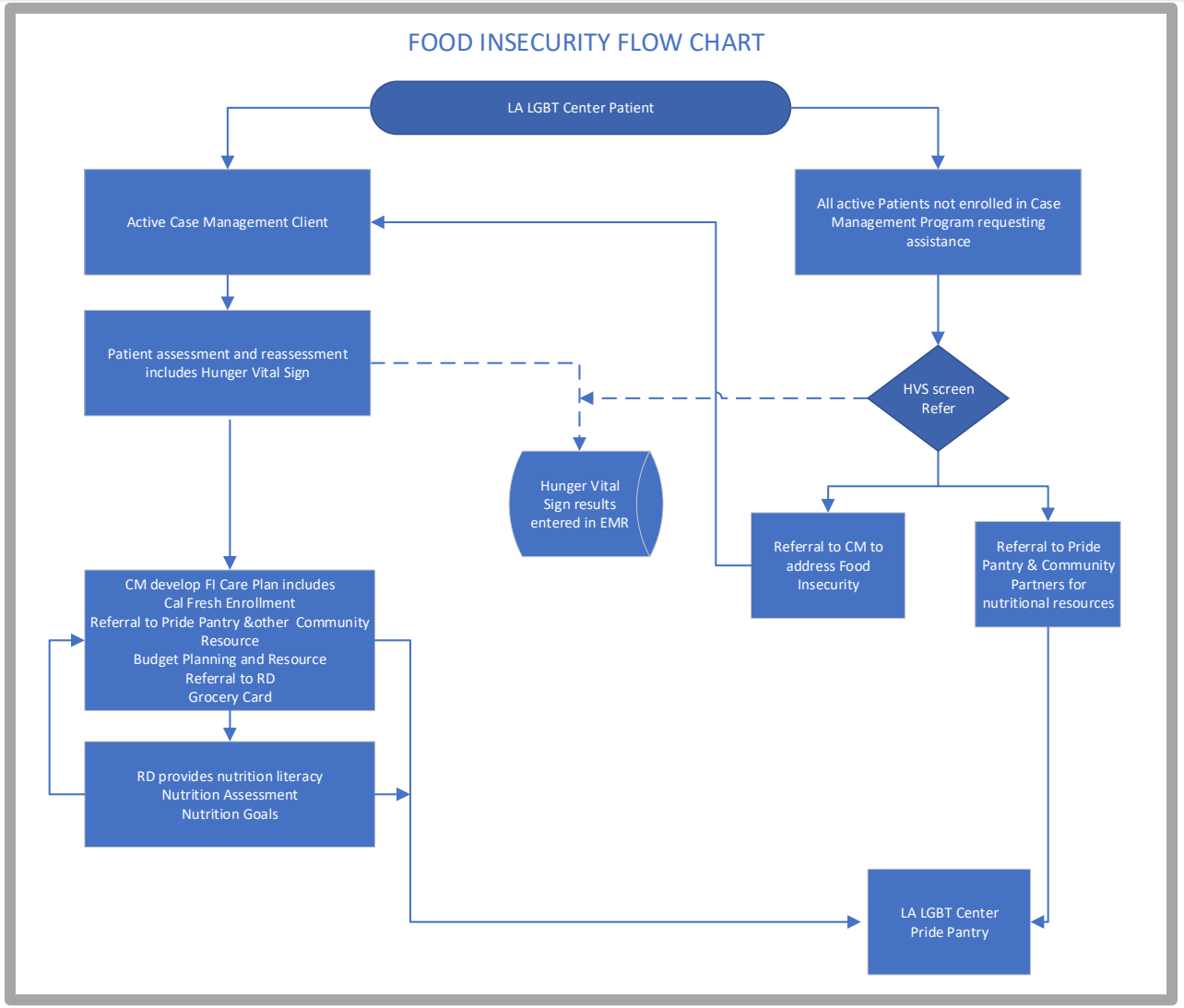
0 staff
supporting with CalFresh enrollment

All Case Managers
supporting with CalFresh enrollment

No onsite food pantry
available for patients

1. Established the Pride Pantry
2. Referred 220 patients
to the Pride Pantry

For more information, please contact Louis Guitron at lguitron@lalgbtcenter.org


FOOD INSECURITY FLOW CHART
LA LGBT Center Patient
Active Case Management Client
All active Patients not enrolled in Case Management Program requesting assistance
Patient assessment and reassessment includes Hunger Vital Sign
HVS screen Refer
Hunger Vital Sign results entered in EMR
Referral to CM to address Food Insecurity
Referral to Pride Pantry & Community Partners for nutritional resources
CM develop FI Care Plan includes
Cal Fresh Enrollment
Referral to Pride Pantry &other Community Resource
Budget Planning and Resource
Referral to RD
Grocery Card
RD provides nutrition literacy
Nutrition Assessment
Nutrition Goals
LA LGBT Center Pride Pantry

Hearing From Our Patients

Ja-Jah

- 63 years old
- Korea Town
- Patient of 4 years
- Impaired Mobility and Back Pain

"When I first started using the Pantry, I had **mobility issues, back pain, nerve damage.** I could not carry grocery bags**. The Pantry** came at the just the right time, I went over there, and it was a **life saver**. I thought it was amazing that it **was so fast**, I pulled up in a taxi, got out, gave them my name and they handed me my groceries. **It was amazing.** I have never seen anything like it

At the Pantry you see real people, and those people reaching out to help lets you know that **human compassion still exists at the LA LGBT Center.** I saw the shock and the fear at the beginning of the AIDS pandemic, and then people came together. As a senior, the pride pantry means that not all is lost, **acts of love** are still happening today.

To ask do you have enough food? is the simple, but most meaningful, **loving question you can ask.** It is the most loving and caring thing that you can do in a time of need. It has truly **impacted me greatly**. To be concerned about whether a person is eating or not, to reach out to a person and ask if they have food, it the most significant and **caring** thing that you can do. The decorum and pleasantry of the volunteers didn't make me feel like I was begging. **They treated me better than a store where I pay for food."**

Nathan

- 35 years old
- Hollywood
- Patient of 16 years
- Type 1 Diabetes since the age of 11

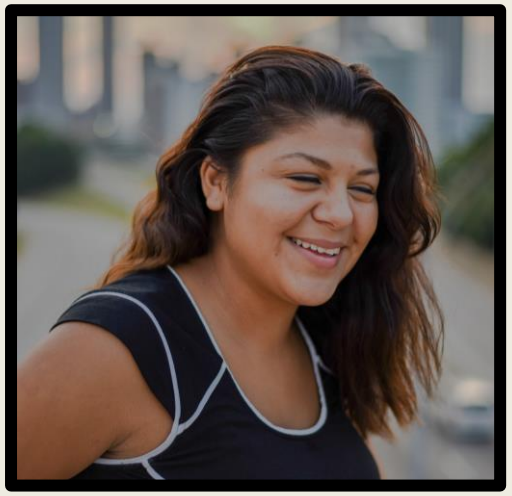
“The **LA LGBT** Center has been a **lifesaver** to me. The **programs are fantastic**.

I have **struggled** with **diabetes** since age 11. I was **afraid of doctors** and confused about medicine, insurance, and pharmacy costs. I ended up in the **ER** for high blood sugar and a **bill of $10,000**, which I couldn’t afford.

The **Food Security program** at the Center **pulled everything together for me**. After talking to a nutritionist, I had **confidence** and felt more relaxed **about my health.** I went shopping with the food voucher and got high-quality food. I was amazed how my cabinets and refrigerator were full and how long it lasted. I’ve **learned** what is good for my **Diabetes** and can now afford foods that benefit my health.

After 17 years of poor, cheap quality food, my health has finally turned around.”

Morgan



- 29 years old
- Van Nuys
- Patient of 6 years
- Genetic Disease Ehlers-Danlos, Migraines, and Bipolar

“The **Food Security program** at the LA LGBT Center has **changed my health outlook.**

For years I’ve **eaten food** that I **couldn’t control** but was all I could afford. I suffer from several genetic disorders which **affect my digestion.**

With the **extra money from the food vouchers** to go shopping, I **worked with the dietitian** to **figure out what works for me**. I have cut out all gluten and am using gluten-free products now.

The **changes** I have made have **improved my stability**, my **mental health,** and allow me to manage my genetic disorder.”

Hearing From Our Staff

Jeff

- Medical Social Worker
- Integrated Care Program
- 1 year at LA LGBT
- Works with patients experiencing Food Insecurity

I **help** our **clients overcome food insecurities**. I have **linked** clients to the **Nutrition Program** where they **earn** up to **$150 in groceries** by attending nutrition classes or individual appts.

Clients learn ways to develop **healthier eating habits.** In addition, I have **linked** many **clients** to the LGBT **Center's Pride Pantry** where clients can receive **free food every Friday**.

It's **fulfilling** to see the difference this makes. Receiving **food assistance** has made our **client's feel safe** and **supported** during these difficult times.

LALGBT helps clients **feel financially secure** as it allows them to use the money saved in other areas such as rent. It **makes me happy** to see our **clients thrive** and move forward in life.

Brittany

- Housing for Health Housing Stabilizer
- 3 years at LA LGBT
- Brittany provides clients with housing support

Since the launch LA LGBT Center's **Pride Pantry**, and the **grocery gift cards** I have felt extremely grateful and appreciative to see my **clients connected with the food services** they desperately needed.

The Pride Pantry, DHS/World Central Kitchen meals and grocery gift cards **made a huge impact** by making **food more accessible** to our clients.

Pride Pantry's appointment model proved to be extremely efficient and accommodating allowing for swift pick-up.

The **grocery gift cards were extremely helpful** to clients with low/no income, no home, or dietary restrictions. The gift cards allowed them to obtain the exact food items they needed to sustain themselves during the Pandemic. These invaluable resources made food available to many who would have gone without.

Summarize Benefits/Value of Your Project

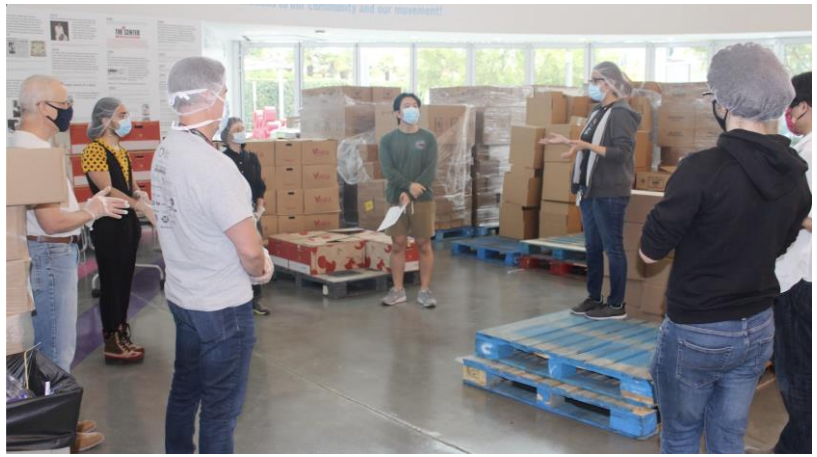
- Bring attention to the need for food in our communities
- Listening to our patients AND responding to their needs
- Partnerships with other County organizations
- Creating a streamlined approach with follow-up
- Documentation at point of care for SDoH issues

Discontinuing is Not an Option

- Food Insecurity will continue to impact the health and quality of life of patients
- Increased need of resources

Project Next Steps

Expand	Expand the HVS screening to all patients, not just case management patients
Sustain	Sustain Pride Pantry
Evaluate	Evaluate the data and demonstrate the value of this work.
Patient Input	Patient feedback, submit for future grant funding and projects



Your Ask for Specific Support

- Financial Support:
  - Continued funding for our Pride Pantry operations
  - Staff e.g., providers, case managers, medical assistants, nurses
  - Patient Resources e.g., grocery gift cards, food carts, educational materials
- Staff buy in and participation
  - Expand screening and interventions
- Health Information Technology
  - Data analytics
  - Health metrics

THANK YOU!!

LOS ANGELES LGBT CENTER

- Nutrition Equity Team:
  - Louis Guitron
  - Linda Santiman
  - Carla Duran
  - Jose Alvarado
  - Kristen Blair

If you have questions, contact Louis Guitron at lguitron@lalgbtcenter.org