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
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.

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

Draw Your Experience
- “Draw a time when they felt secure about the food they had and when that was not the case.”
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.
Eat for Your Health Impact - WINS!

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<thead>
<tr>
<th>Objective</th>
<th>Metric Description</th>
<th># of Unique Individuals</th>
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<tbody>
<tr>
<td>1</td>
<td>Total Screened for Food Insecurity</td>
<td>652</td>
</tr>
<tr>
<td>3</td>
<td>Total Served</td>
<td>446</td>
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<tr>
<td>7</td>
<td>Total Wholesome Wave Distributed</td>
<td>416</td>
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**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

414 food insecure patients provided with a Wholesome Wave gift card

1. 1 food insecure patient connected to CalFresh
2. 56% of referrals for additional services have now been closed
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.”

Maria
- 73 Years Old
- Wilmington
- Patient Since 2017
- Type 2 Diabetes, High Cholesterol
- Vitamin D Deficiency, Mixed Hyperlipidemia, Chronic Gastritis
- Major Depressive Disorder
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.”
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.”
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
Removing Barriers to Diabetes Health: Addressing Transportation Insecurity

CLINICA MONSEÑOR OSCAR A. ROMERO
LOS ANGELES, CA
TEAM: DR. DON GARCIA, DR. QUISELA JUAREZ, NORMA BUENO, BRENDA ORTIZ, AND TANIA ASTORGA
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 Clinica 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 service: 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 transportation: 45

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

- Free Clinic Bus/Nav/Car: 135
- Free Uber: 62
- 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

Patient Feedback on Transportation Services

- Would you rate your experience with this service as excellent?
- Would you recommend these services to friends and neighbors?
- Would you use these services again?
- Did you get your medications timely?
- How satisfied are you with courtesy services of home delivery and access to pharmacy?
Then and Now

**Removing Barriers to Diabetes Health Project**

**THEN**
- 0 patients screened for transportation barriers
- 0 transportation services offered to patients

**NOW**
- 238 patients with diabetes screened with newly developed transportation survey
- 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

Increasing Services to our Patients

Higher Number of Patients Supported

1. Diabetes Visits
2. Pharmacy Delivery
3. COVID-19 Vaccine Delivery & Administration
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."
“This is a good service. It’s faster and safer. It saves me from being on a bus with lots of other people”

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

Alvarado Home Delivery April 2020 to Present

Number of Rx

Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21

149 201 377 371 386 497 500 535 753 759 620
Impact of our Program

**Total Number of Patients Supported and Rx Home Deliveries**

- **Jan-21**: 138 Patients Supported, 141 Rx Deliveries
- **Feb-21**: 759 Patients Supported, 620 Rx Deliveries

**Total Revenue**

- **Jan-21**: $32,124.48
- **Feb-21**: $42,823.90
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)

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

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

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

Support our vulnerable patients through a pandemic
Consequences if you discontinue the project

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

that's not an option!
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
HEALTHCARE IS A HUMAN RIGHT

THANK YOU!

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
Nutrition Equity Project
Presented by:
Louis Guitron
Linda Santiman
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

<table>
<thead>
<tr>
<th>Approach</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>1. Patient Survey</td>
<td>1. 85% of patients screened positive for FI</td>
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<tr>
<td>2. Patient Focus Groups</td>
<td>2. Drawings:</td>
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<tr>
<td>3. Staff Focus Groups</td>
<td>3. Need financial and community resources</td>
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<tr>
<td>4. Screening Tools</td>
<td>4. Food Insecurity, HVS, nutrition literacy</td>
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<tr>
<td>5. Technology</td>
<td>5. Outreach</td>
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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
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
### 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 Pantry
- 38,868 outreached and referred to Pride Pantry not screened
- 1,083 clinic patients linked to Pride Pantry
- 2,260 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 Guiron at lguiron@lalgbc.org
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.”
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.”
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.”
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.
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
Consequences If You Discontinue the Project

Discontinuing is Not an Option

• Food Insecurity will continue to impact the health and quality of life of patients

• Increased need of resources

FAILURE IS NOT AN OPTION

☐ SUCCESS

FAILURE
## Project Next Steps

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<tr>
<th>Expand</th>
<th>Expand the HVS screening to all patients, not just case management patients</th>
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<tbody>
<tr>
<td>Sustain</td>
<td>Sustain Pride Pantry</td>
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<tr>
<td>Evaluate</td>
<td>Evaluate the data and demonstrate the value of this work.</td>
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<tr>
<td>Patient Input</td>
<td>Patient feedback, submit for future grant funding and projects</td>
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Your Ask for Specific Support

• Financial Support:
  o Continued funding for our Pride Pantry operations
  o Staff e.g., providers, case managers, medical assistants, nurses
  o Patient Resources e.g., grocery gift cards, food carts, educational materials

• Staff buy in and participation
  o Expand screening and interventions

• Health Information Technology
  o Data analytics
  o Health metrics
THANK YOU!!

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

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