

Moving Clinics Upstream

Food Insecurity Share Out
December 16, 2019



CEDARS-SINAI®



CCI
CENTER FOR CARE
INNOVATIONS

Webinar Reminders

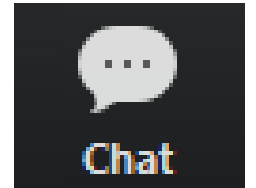
1. This is an interactive webinar! Everyone is unmuted.

2. Join us by video by clicking the



button.

3. Remember to chat in questions along the way! Use the chat window to ask/answer questions.



4. Webinar will be recorded, posted on CCI's website, and sent out via a follow up email.



Agenda

1. Welcome & Introductions
2. Food Insecurity Team Presentations
 1. CHLA-AltaMed
 2. Eisner
 3. APLA
 4. LA LGBT
 5. St. John's
 6. Behavioral Health Services
3. What's Next?
4. Wrap Up & Evaluations

CCI Team



Megan O'Brien,
Senior Program
Manager



Veenu Aulakh,
President



Diana Nguyen,
Senior Program
Coordinator

Also Joining Today!



**Laura
Blumenthal** CCI
Senior Program
Manager



Dr. Jill Rees
MCU Design Thinking
Mentor

Moving Clinics Upstream

In partnership with Cedars-Sinai, CCI is launching 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**.



Moving Clinics Upstream Timeline



Program Activities



Deliverables



Goals

Phase 1: Getting Started & Building Your Foundation

Sept 2019 – Dec 2019

In-Person
Sessions

Sept
26

Virtual
Learning

Weekly
Office
Hours
with Jill
Rees

Site Visits

NEVHC &
WCHC
Jan 2020

National
Site Visits
TBD

Coaching

Monthly

Coaching ends
by Oct 2020.
Coaches
available as
needed.

Project
Plan
Roadmap

By
Oct
15

Baseline
Assessment

By
Nov
1

December
Webinar
Presentation

Dec
9 &
16

- Clarify program team roles
- Assess your organization's strengths & opportunities
- Gather & synthesize patient & community input to inform strategies

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

Jan 2020 – Aug 2020

Mar
11,
2020

Aug
2020

Monthly
(except
Mar &
Aug)

Share &
Learn
Webinars

Feb
&
May

Roadmap
Update

By
Apr
2020

Y1 Program
Interviews

Aug
2020

- Develop or refine a plan for how to identify food insecurity or transportation, via a screening tool or other mechanism
- Start testing approaches to identify & address food insecurity or transportation at least one clinical site
- Assess your partnerships and referrals

Phase 3: Spreading & Sustaining Your Work

Sept 2020 – Feb 2021

Feb
2021

As
needed

Session
Presentation

Feb
2021

Endline
Assessment

By
Mar
31
2021

Final Case
Study

By
Apr
2021

- Address gaps in referrals or partnerships
- Document internal workflows and protocols
- Document impact of efforts
- Spread lessons within organization and to other work to address social needs

Invitation

Come into the program **open-minded** & willing to **modify your proposed solution**



Design Thinking

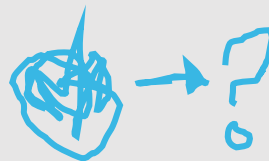
Human-centered design, also known as a “design thinking,” is **an approach to problem solving** that is **collaborative, creative,** and begins by **understanding people’s needs and experiences.**



collaboration



inclusion + empathy



show work early + often



make things tangible



start small + learn fast

Techniques That You Practiced



Open Ended
Interviews



Draw Your
Experience



Observation

Phase 1: Building Your Foundation

September 2019-December 2019

Build your team & clarify roles

- ☐ Establish a regular meeting schedule with your team
- ☐ Clarify who is your team lead and other important roles
- ☐ Set up a monthly time to meet with your coach Vanessa

Assess your organizations' strengths and opportunities, including leadership and staff buy-in

- ☐ Take the baseline assessment within the next month

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

- ☐ Use today to develop a 3-month plan to gather input
- ☐ Sign up to meet with our HCD mentor Jill
- ☐ Report back your findings in December during a virtual session

Inventory current partnerships and relationships to address food insecurity or transportation

- ☐ Start some of this work together during our breakout sessions
- ☐ Continue it through your research

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- Spread lessons within organization and to other work to address social needs



Children's Hospital Los Angeles & AltaMed

Who We Are (1 min)

- 3rd, Alvarado (Westlake) Los Angeles, CA
- Pediatrics
- 2 Co-Branded AltaMed/CHLA clinics, 1 clinic served through grant
- EPIC EHR System



Patient, Staff, & Community Voice (1 min)

Who did you talk to?

- 7 food insecure families
 - Families who have interacted with the Family Advocacy & Support Team
- Social Work Case Manager
 - Food Insecurity Case Management
 - Family Advocacy & Support Team

Methods (2 mins)

What methods did you use or try out? What worked & what didn't? *[Example methods: observation, open-ended questions, draw your experience, survey, focus groups, etc.]*

- AltaMed/CHLA Patient Families
 - Focus Group
 - Questions regarding interaction with FAST
 - “How often does FAST communicate with you? What are those experiences like?”
 - “How helpful was FAST in helping you access food?”
 - Questions regarding general food insecurity
 - “Do you think food insecurity is a problem in your community?”
 - “In your community do you think food is accessible? Available? Affordable?”
- Social Work Case Manager
 - Key Informant Interview
 - Draw Your Experience

Learnings (4 mins)

What did you learn from the patients, staff, and/or community?

- Overall, patient family interactions with FAST were short and typically one time
- Some families could not receive CalFresh, or if they were enrolled, benefits were not enough to cover all family food needs
- Food banks are used to supplement government benefits
 - Transportation issues
 - Fresh produce not available
 - Food banks open times not always accurate or inconvenient
- Stigma around food insecurity
 - Many families were unaware if food insecurity was an issue in their communities
- Social Work Case Manager
 - Immigration is a major barrier to resource access, CalFresh & Gift Cards
 - Stigma around accessing food banks
 - Public transportation is often a barrier to accessing grocery stores/food banks

Next Steps (1 min)

How will you take what you learned to inform your strategies to assess and address either food insecurity or transportation?

- Will continue to update resource guides and contact food pantries/resources
- Finding more sustainable options to alleviate food insecurity
 - Options that will go beyond a one time gift card
- Improving relationships/partnerships with food banks
- Pilot grocery delivery to mitigate transportation barriers
- Community based interventions
 - Policy advocacy
 - Community civic engagement



Eisner Health

Who We Are (1 min)

- Downtown Los Angeles
- 95% Hispanic
- 9 Clinic Sites
- NextGen
- Current Team Members:
- Haik Janoian – Project Lead
- Luis Lopez MD – Clinician Champion
- Adam Delgado – QI Manager
- Felix Dominguez – Case Manager
- Assisted by – Vanessa Lam - Consultant



Patient, Staff, & Community Voice (1 min)

- Conducted Survey to 30 Parents/Guardians
- Easy to understand Food Security Questions
- Bi-Lingual

Food Security Survey	Encuesta de Seguridad Alimentaria
<p>Please circle the option that applies to you.</p> <p>1. Within the past 12 months we worried whether our food would run out before we got money to buy more.</p> <p>a. Yes b. No</p> <p>2. Within the past 12 months the food we bought just didn't last and we didn't have money to get more.</p> <p>a. Yes b. No</p> <p>Would you like to be contacted with more information?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please provide your Medical Record Number: _____</p>	<p>Por favor circule la opción que aplique a usted</p> <p>1. Durante los últimos 12 meses, nos hemos preocupado de que los alimentos se acaben antes de tener dinero para comprar más.</p> <p>a. Sí b. No</p> <p>2. Durante los últimos 12 meses, los alimentos que compramos no duraron mucho y no teníamos suficiente dinero para comprar más.</p> <p>a. Sí b. No</p> <p>¿Le gustaría ser contactado con más información?</p> <p><input type="checkbox"/> Sí <input type="checkbox"/> No</p> <p>Si contestó "Sí", anote su número de registro médico: _____</p>
<p>If you answered Yes to questions #1 or #2 please answer questions #3 and #4.</p> <p>3. How often should food be offered to meet your needs?</p> <p>a. Once every 1 month b. Once a month c. More frequent than once a month</p> <p>4. It would be most convenient to pick-up food at:</p> <p>a. Corner Health b. A food bank near me c. Other _____</p>	<p>Si contestó "Sí" a pregunta #1 o #2 por favor contesta las preguntas #3 y #4.</p> <p>3. ¿Qué tan frecuentemente se debería de ofrecer comida para satisfacer sus necesidades?</p> <p>a. Cada tres meses b. Una vez al mes c. Más de una vez al mes</p> <p>4. Sería más fácil recoger comida en:</p> <p>a. Corner Health b. Un banco de comida cerca de mí c. Otro _____</p>

Methods

- One on One discussion – Open dialogue (Case Manager)
- Survey – Direct Questions (4 basic questions)
- Results

Food Security Survey				
	a. Yes	b. No	Blank	
1. Within the past 12 months we worried whether our food would run out before we got money to buy more.	23	6	1	
2. Within the past 12 months the food we bought just didn't last and we didn't have money to get more.	22	7	1	
3. How often should food be offered to meet your needs?	a. Once every 3 months	b. Once a month	c. More frequent than once a month	Blank
	5	11	10	4
4. It would be more convenient to pick-up food at:	a. Eisner Health	b. A food bank near me	c. other- home delivery	d. other-blank
	21	4	3	4
	Yes	No		
Would you like to be contacted with more information?	22	8		

Learnings (4 mins)

- More patients require assistance than initially thought
- Patients were forthcoming with their concerns
- Patients preferred to come to the health center to obtain assistance



Next Steps

- Starting to Develop Partnerships with community partners
 - Working with internal Patient Education Dept. – Dovetails into MCU Food Insecurity undertaking
 - LA Neighborhood Trust – Fruits & Vegetables – Wednesday pick up only
 - Partners in Care – thru LA Food Bank – Will deliver food – First delivery 12-04-19
- Challenges:
 - Pick Up / Delivery
 - Storage
 - Refrigeration





Get Your Food On!

APLA Health

Who We Are (1 min)

- Los Angeles, CA
- Persons Living With HIV
- 8 Food pantries/3 clinical sites
- EHR system



**Join us to get started
saving money, eating healthy,
and feeding the soul.**

- Tasty & healthy food available 52 weeks a year
- Fun and informative nutrition education classes
- Special meals offered each month

Find out more at aplahealth.org/NOLP

Call 213-201-1433, or email nolp@apla.org

APLA
Health

Patient, Staff, & Community Voice (1 min)

Who did you talk to? *Remember, we are asking you to talk to at least 3-5 people during phase 1 (Sept-Dec 2019).**

- Bartz Altadonna, Sonia Hicks
- Foothill AIDS Project, Leitza Reilly
- Venice Family Clinic, Arron Barba
- JWCH, Al Ballasteros
- AIDS Food Store, Jean Hartman
- Division of HIV & STD Programs, Mario Perez



Methods (2 mins)

What methods did you use or try out? What worked & what didn't? *[Example methods: observation, open-ended questions, draw your experience, survey, focus groups, etc.]*

- Telephone interviews, open-ended
- Face-to-face interviews, open ended
- Paper-based surveys (clients)

Learnings (4 mins)

What did you learn from the patients, staff, and/or community?

CHALLENGES	
AGENCIES	CLIENTS
Staffing	Transportation
Storage/space – transporting perishable items	Storage
Administrative paperwork – eligibility	
OPPORTUNITIES	
Shared interest	Interested in expanded food options
Access to the target population	Unlimited expansion opportunities

Next Steps (1 min)

How will you take what you learned to inform your strategies to assess and address either food insecurity or transportation?

- Revision of food menus
- Formulate new strategies with partner agencies (Round 2 of meetings)
- Identifying new partners that have access to the population
- Addressing opportunities to reach homeless clients
- New transportation options





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INNOVATIONS

Questions?





Los Angeles LGBT Center

Who We Are (1 min)

- The Los Angeles LGBT Center is a nonprofit organization located at 1625 N. Schrader Blvd. Los Angeles, CA 90028
- LGBTQ+ individuals and families. Specialties include: HIV/AIDS, Transgender Health, Primary Care, Behavioral Health, Substance Treatment
- Currently, we have one FQHC Clinic and two satellite sites that provide limited services
- Our EHR system is Allscripts



Louis Guitron, MSN, FNP,
PHN, ACRN



Carla Duran, MS,
RD



Nicolaus Garcia, LCSW



Jose Alvarado, RN,
ACRN



Linda Santiman, MA,
LMFT

Patient, Staff, & Community Voice (1 min)

Who did you talk to? *Remember, we are asking you to talk to at least 3-5 people during phase 1 (Sept-Dec 2019).**

- Participants included:
 - 1 medical assistant (MA)
 - 1 Social Worker
 - 1 Clinic Liaison
 - 6 Patients (not currently participating in a nutrition program)
 - 12 Patients (currently enrolled in a nutrition program)

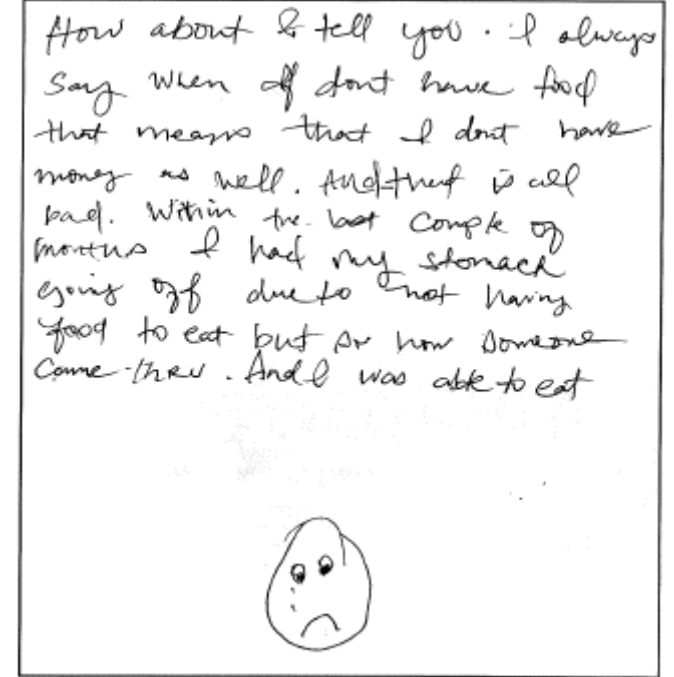
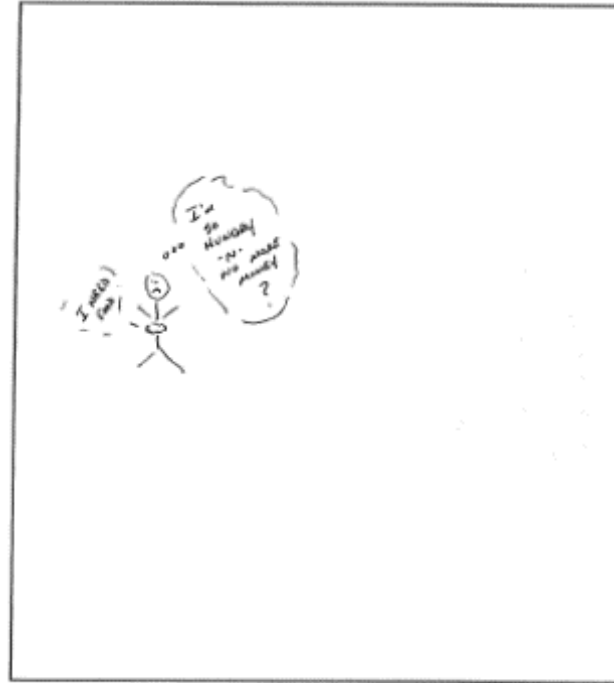
Methods (2 mins)

What methods did you use or try out? What worked & what didn't? *[Example methods: observation, open-ended questions, draw your experience, survey, focus groups, etc.]*

- Surveys
 - Open-ended questions
 - Number scales
 - Multiple choice questions
- Drawings
 - Participants were asked: "please draw what you believe lack of food and hunger looks like to you"
- Focus Group
 - Established nutrition program participants

*All three methods were effective at generating useful data

Drawings



Learnings (4 mins)

What did you learn from the patients, staff, and/or community?

- Surveys
 - 12 out of 18 participants screened positive for food insecurity using hunger vital signs
 - 4 out of 18 participants were uncomfortable discussing food insecurity with clinic staff
- Drawings
 - Emerging themes identified from drawings included:
 - Sadness
 - Empty stomachs
 - Empty refrigerator
- Focus Group
 - Community resources
 - Communal support

Next Steps (1 min)

How will you take what you learned to inform your strategies to assess and address either food insecurity or transportation?

- We plan to utilize the collected data to help us develop a patient-centered program that is effective at identifying FI and addresses barriers to food access
- Based on participants' responses, we plan to implement the following interventions to address FI
 - Standardized FI screening
 - Nutrition literacy
 - Cal-Fresh enrollment
 - Food distribution
 - Budget planning
 - Financial incentives



Community Health Center • Centro Medico Comunitario
Medical, Dental and Mental Health Services
Servicios Medicos, Dentales, y Salud Mental
(323) 541-1400

701 S. HOOVER ST

St. John's Well Child & Family Center



Who We Are (1 min)

- South LA
- We Serve low-income, undocumented, MediCal/MediCare uninsured, transgender, people experiencing homelessness and anyone in need of medical and/or mental healthcare.
- # of Clinic Sites: 18
- EHR system: EClinicalWorks



Patient, Staff, & Community Voice (1 min)

Who did you talk to? *Remember, we are asking you to talk to at least 3-5 people during phase 1 (Sept-Dec 2019).**

- Spoke to 68 individuals-
- 35 Experiencing Homelessness (HMLS)
- 18 Housed (H)
- 10 Housing Insecure (HI)
- 5 Unknown/Declined to state housing status (UH)

Question: Within past 12 months were you worried about being able to obtain food?

Never- 13 (4 HMLS, 5 H, 2 UH, 2 HI)

Sometimes- 17 (8 HMLS, 5 H, 0 UH, 4 HI)

Always- 38 (23 HMLS, 8 H, 3 UH, 4 HI)

Methods (2 mins)

What methods did you use or try out? What worked & what didn't? *[Example methods: observation, open-ended questions, draw your experience, survey, focus groups, etc.]*

We used two methods to gather information.

- The first was adapting the Prapare Smart Tool to ask 6 questions. 68 surveys conducted.

What worked- Easy, confidential, informative and can do at large scale.

What didn't work- Not very interactive, not detailed, can't go back to clarify

- The second was draw your experience. 7 participants

What worked- Interactive, able to really get an individual's story, better understand what is currently happening as well as what individual has historically dealt with. Intimate setting so have more participation

What didn't work- Smaller pool of participants available, no-shows and time consuming.

Within the past 12 months we worried whether our food would run out before we got money to buy more.

Always Sometimes Never

Within the past 12 months the food we bought just didn't last and we didn't have money to get more.

Always Sometimes Never

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply

Food

Clothing

Utilities

Child care

Medicine or any health care (medical, dental, mental health or vision)

Phone

Other (please write in notes)

I do not have problems meeting my needs

I choose not to answer this question

What is your current housing situation?

I have housing

I do not have housing (staying w/ others, in a hotel, in a shelter, living outside on the street, a beach, or in a park)

I choose not to answer this question

Are you worried about losing your housing?

Yes No I choose not to answer this question

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

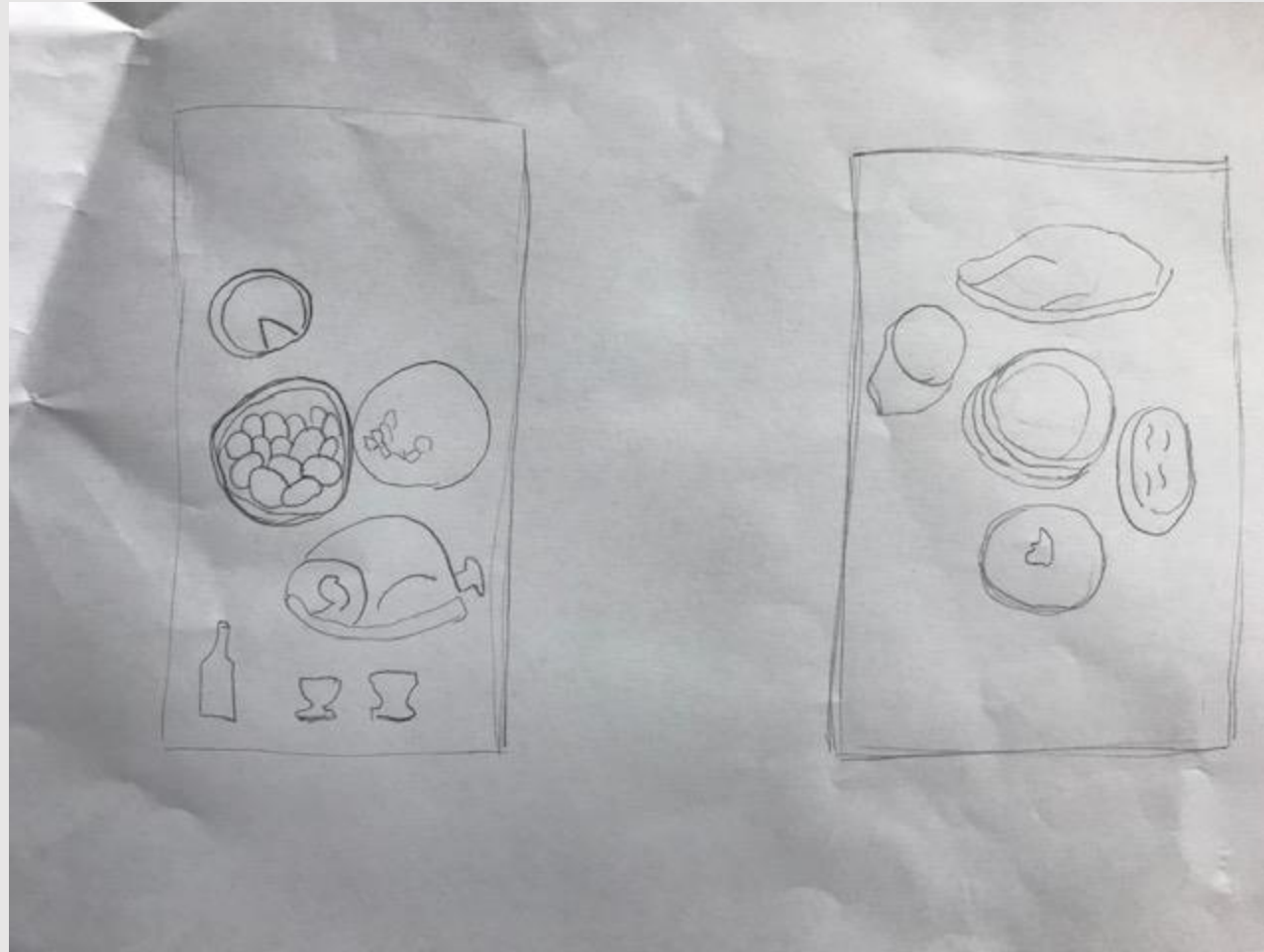
Yes, it has kept me from medical appointments or from getting my medications

Yes, it has kept me from non-medical meetings, appointments, work, or getting things needed for daily living

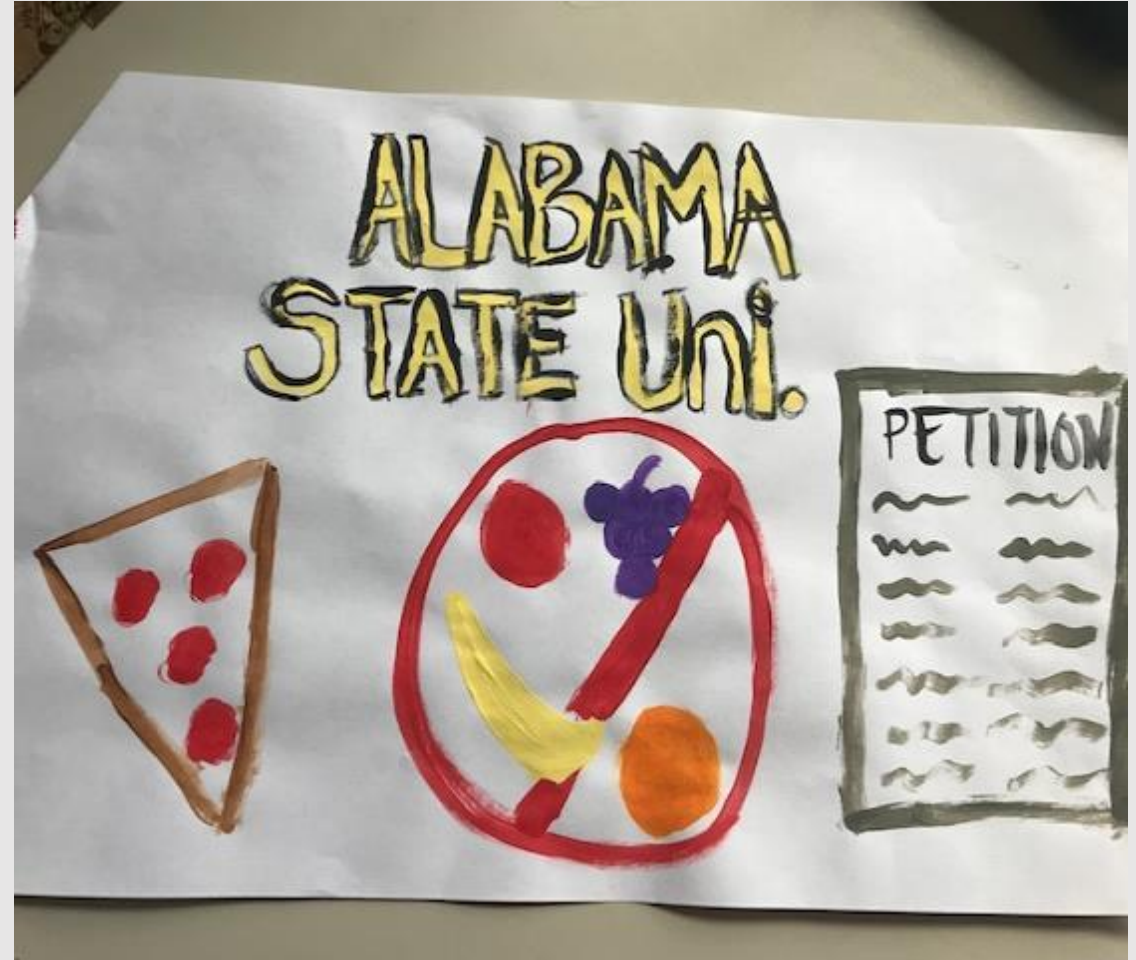
No

I choose not to answer this question

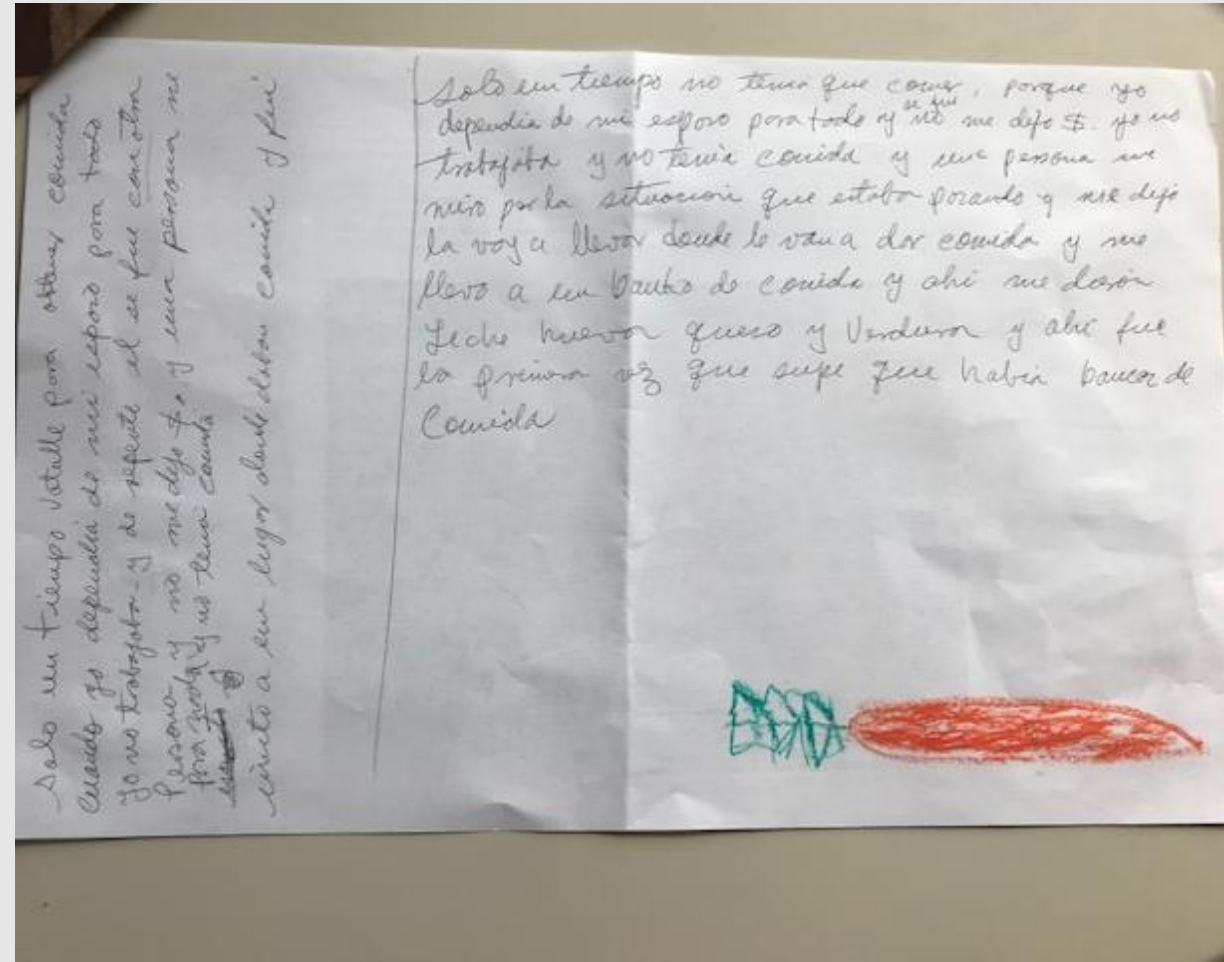
Participant #1



Participant #2



Participant #3



Participant #4

BEST EXPERIENCE ACCESSING FOOD WAS ON SATURDAY
LAST MONTH WHEN I RAN INTO KOREANS FROM A CHURCH
PASSING OUT MONGOLIAN BEEF AND RICE - PLATES WERE HUGE
AND OVERFLOWING - I WAS SATISFIED TO LAST THE DAY. THEN
WHEN I LEFT I RAN INTO SOME BIKERS - LA DODGERS FANS
WHO WERE PASSING OUT PIZZA AND SOUPS AND CLOTHING.
THEN WHEN I LEFT THAT GROUP I RAN INTO ANOTHER church
GROUP PASSING CHICKEN AND STEAK TACOS AND SOUPS AND CLOTHING.
IT WAS THE FIRST TIME I WAS ABLE TO OVEREAT TO SATISFACTION
I FOUND OUT THAT THESE GROUPS COME ON 1ST OF LAST
SATURDAY OF THE MONTH SO I PUT ON SEEING THEM EVERY
MONTH.

LAST SUNDAY NORMALLY ON SUNDAYS THERE ARE
A LOT OF Church Groups PASS OUT FOOD - I NORMALLY HIT
SALVADORENS AT 8:30AM AND 9:00AM THEN ANOTHER GROUP
AT 10:00 PASS OUT BURRITOS AND CLOTHING, AND ANOTHER GROUP
DOES FRIED CHICKEN. BUT LAST SUNDAY - NO BODY SHOWED UP
I SUPPOSE BECAUSE IT WAS RIGHT AFTER THANKSGIVING SO THEY
PROBABLY TOOK DAY OFF I DIDNT GET ANYTHING UNTIL I
HIT UNION MISSION AT 1:30PM AND GOT 2 DAY PORTION
PLATE IT WAS ALL I GOT THAT DAY - VERY FRUSTRATING.

Participant #5



Participant #6



Participant #7



Learnings (4 mins)

What did you learn from the patients, staff, and/or community?

From Patients:

- We learned that in spite of receiving care at our homeless mobile health clinic and have a close relationship with staff- patients still struggled with disclosing certain information about themselves due to stigma and fear.
- Number of patients experiencing homelessness that feel that they have never worried about obtaining food.
- Need to have more focus groups to address needs and gaps
- Need better & consistent screening tools

From Staff:

- We had some staff (that were also recently patients) participate in “Draw your Experience” and found that they too had struggles with accessing food regularly.
- Staff feels unsure of how to address this need for patients and all would like to help more with this issue
- Figuring out the appropriate screening process and work flows vary from clinic to clinic
- Need better and consistent screening tools

Next Steps (1 min)

How will you take what you learned to inform your strategies to assess and address either food insecurity or transportation?

- Would like to conduct a few more “Draw your Experiences” with other program participants/patients.
- Meet with individual clinic managers and operations to figure out screening workflows.
- Meet with Programs staff to incorporate screening tools
- How to address current need- LA Food Bank partnership at key clinic sites



Behavioral Health Services, Inc.

Who We Are

BHS Family Health Center

2501 W El Segundo Blvd, Hawthorne,
CA

- 5,317 visits in 2019
- 1,675 users/patients in 2019
- 43% Latino; 25% African American
- 65% <200% of FPL; 54% <100% of FPL
- 16% ages 0-17; 84% 18+
- 9% uninsured; 81% Medicaid
- 5 FQHC in Los Angeles County SPA



Patient, Staff, & Community Voice

- Clinic Staff
 - Office manager
 - Receptionists
 - Enroller
 - Medical assistants
 - Referral coordinator
- Patients
 - Parents of patients
 - Patients



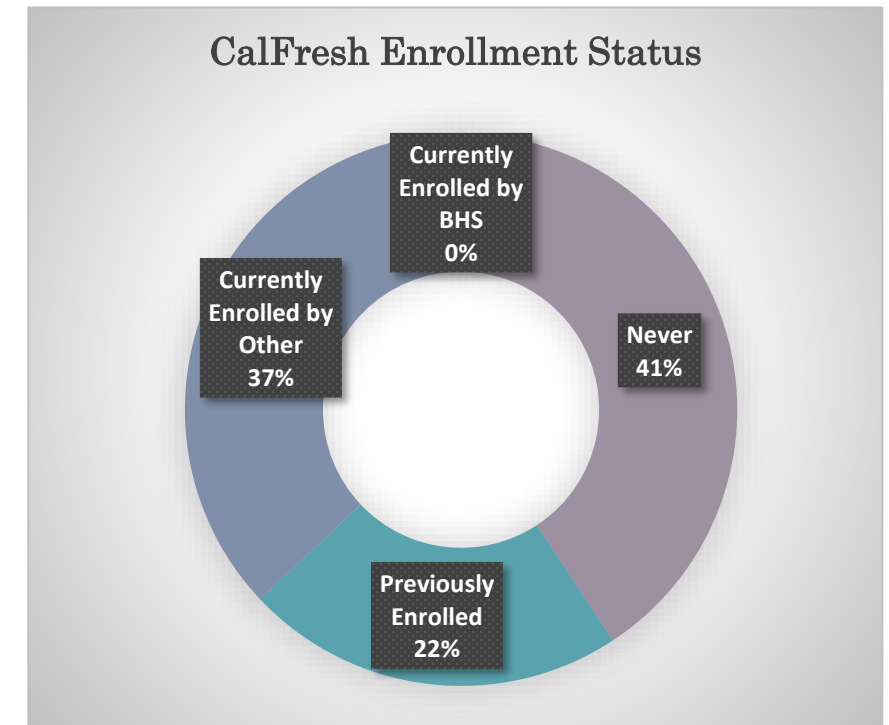
Methods

- **Draw Your Experience**
 - Draw your experience showing a time when you felt secure about the food you had and then draw your experience when that was not the case.
- **Open Interviewing – Focus Group**
 - USDA Discussion Guide for a Key Informant Focus Group (Staff)
 - Where do you get your food?
 - What do you think are the biggest barriers related to obtaining healthy food in your community?
 - Are your needs being met by your CalFresh enrollment? Why or why not?
 - What else can be done to help people have an easier time getting the types of foods that they want or need?
- **PRAPARE Questionnaire and CalFresh Structured Data Pilot**
 - CalFresh Enrollment Status: Never, Previously, Currently

Learnings from PRAPARE/CalFresh Pilot

PRAPARE/CalFresh Pilot

- Ran for 4 days, 11/21-11/26
- 37% of patients are currently CalFresh enrolled
- None of the patients enrolled in CalFresh expressed a lack of ability to obtain food.
- Of those previously enrolled, most are stable with only one patient recently losing CalFresh status due to going over the salary maximum.
- Of those who have never been enrolled, none came up as positive for food insecurity based on screening.



Learnings from Draw Your Experience

"I have two young daughters so secure with having like food, being able to have food to provide for them...to eat like on a daily basis...I associated that was like just happy feeling so how the food, sun, flowers are blooming everything's great, but on the insecure side which I have been there before as well. ...It's the exact opposite so everything's dark, there's a lot of worry, there's a lot of stress that goes into play when you're worrying about not only to feed yourself, and ...your children as well."



Learnings from Patients

Healthy food as unaffordable

- “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. And then when that's the only like source you have to depend on ... you're kind of pushing that other direction of like not so healthy things.”
- “So I think [healthy food] is available, and I think it's accessible for some people. And I don't think that it's affordable, which is so weird that the healthier things for us is like so expensive to even obtain.”
- “[Healthy food], that's what's really important because that would put us in a healthier state, mentally, physically, I mean, even myself. So it's available. Accessible to some and I don't think it's affordable.”
- “Finances is number one [barrier].”

Learnings from Patients (cont.)

CalFresh

- "So I'm authorized every first of the month...That's when they authorize it but then the actual date that it goes on my card is actually the eighth, and for someone who has young kids it's like, that's still kind of a lot to wait. Like my friend who helped me her day is actually the third."
- "I'm more concerned with like making things last so if I can make meals and we can have them for two, three days maybe rather than a day. But um it's just the amount...It's a zero balance and we're maybe at the 22nd of a month."
- "It's not like it's simple to fill everything out online. It's simple, but that's also a long, a long process and then I think there's just... a lot of like hoops that you have to jump through..."
- "And if you're not like on time with turning in documentation so like every six months you have to ...recertified ...If you're like a day late, you're done you're cut off, and then it's like what do you do about feeding these kids if you're not working."

Learnings from Patients (cont.)

Lack of choice/Feeling limited

- “Whole Foods for example...you see a lot of fresh, fresh fruits fresh vegetables produce all types of things, and it is on the pricier end and but I think like, that's where I would...feel more comfortable ...But being limited ...not working right now, having to go ...seek help. It makes things, limited.”
- “I just believe that [healthy food stores] are just geared towards like upper class people...And then the cheaper stores are, I think...that's where you like maintain the status too ...because you're putting certain stores in certain areas.”

Other things that came up

- Convenience – shopping where it is convenient because of other time demands
- Lack of knowledge/skills – not knowing about resource, how to eat healthy, how to cook
- Need for assistance – a person to guide you through the process
- Stigma – related to asking for help

Learnings from Staff

Barriers to obtaining healthy food

- Not affordable
- Restricted by location
 - due to city planning
- Convenience of unhealthy food
 - it's more affordable, accessible, and available
- Lack of time – other priorities
- Lack of support

Other barriers

- Lack of knowledge/skill – related to cooking healthy and resources

Solutions

- Community garden
- Cooking classes
- Educating patients with chronic illness
- Provide patients resources through insurance

Next Steps

- PRAPARE vs Hunger Vital Sign
 - Explore whether we want to keep using PRAPARE or switch.
 - Assess pros and cons of one vs the other.
 - PRAPARE is able to assess social determinants in general but is less effective at screening directly for food insecurity.
- Develop materials for patients and a resource guide
- Possibly a cooking class
- Educating staff



CCI

CENTER FOR CARE
INNOVATIONS

Questions?



Moving Clinics Upstream Timeline



Program Activities



Deliverables



Goals

Phase 1: Getting Started & Building Your Foundation

Sept 2019 – Dec 2019

In-Person
Sessions

Sept
26

Virtual
Learning

Weekly
Office
Hours
with Jill
Rees

Site Visits

Coaching

Monthly

Project
Plan
Roadmap

By
Oct
15

Baseline
Assessment

By
Nov
1

December
Webinar
Presentation

Dec
9 &
16

- Clarify program team roles
- Assess your organization's strengths & opportunities
- Gather & synthesize patient & community input to inform strategies

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

Jan 2020 – Aug 2020

Mar
11,
2020

Aug
2020

Monthly
(except
Mar &
Aug)

NEVHC &
WCHC
Jan 2020

National
Site Visits
TBD

Share &
Learn
Webinars

Feb
&
May

Roadmap
Update

By
Apr
2020

Y1 Program
Interviews

Aug
2020

- Develop or refine a plan for how to identify food insecurity or transportation, via a screening tool or other mechanism
- Start testing approaches to identify & address food insecurity or transportation at least one clinical site
- Assess your partnerships and referrals

Phase 3: Spreading & Sustaining Your Work

Sept 2020 – Feb 2021

Feb
2021

As
needed

Coaching ends
by Oct 2020.
Coaches
available as
needed.

Session
Presentation

Feb
2021

Endline
Assessment

By
Mar
31
2021

Final Case
Study

By
Apr
2021

- Address gaps in referrals or partnerships
- Document internal workflows and protocols
- Document impact of efforts
- Spread lessons within organization and to other work to address social needs

Asks & Next Steps

- ❑ **Site Visit:** Sign up for a site visit by EOD, December 23, 2019!
 - ❑ **January 27:** NEVHC – Food Insecurity - [Register here.](#)
 - ❑ **January 31:** West County – Transportation - [Register here.](#)
- ❑ **March 11th In-Person Convening:** [Register](#) for the convening by January 24, 2020.
- ❑ **Storytelling Interviews:** Project Leads will be connected with Sarah Henry in early January 2020 to begin documenting your team's progress.

Sarah Henry, MCU Reporter



Sarah Henry is a Bay Area-based writer who covers culture through the lens of food. She has written about food security, food justice, and other social and economic matters on the food beat for publications such as *The Washington Post*, NPR/*The Salt*, and *San Francisco Chronicle*. Sarah is the co-author of *The Juhu Beach Club Cookbook* and the author of *Farmsteads of the California Coast* and *Hungry for Change*, a project with UC Berkeley's Food Institute that showcased 20 food systems changemakers in the Golden State. She covered health issues while on staff at the Center for Investigative Reporting and *Hippocrates* magazine and has written about health and wellness for online outlets such as WebMD, Caring.com, and Consumer Health Interactive.

Thank You!

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webinar
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