ROOTS Program
June 7, 2018
Idea Sharing Webinar – Sharing Workflow Experiences
Upcoming Events

Thurs., July 12, 2018 @ 12-1pm

Title: Early Lessons Learned from the ROOTS Program Webinar
- Faculty: CCI Staff + Others
- Focus:
  - Share the evaluation results & get reflections
  - Share agenda & prep needs for August in-person session
  - Have teams give a brief update on progress & challenges

Thursday, August 23

- What: Last In-Person Session
- What: Team sharing & sustainability
ROOTS Roadmap
<table>
<thead>
<tr>
<th>Month</th>
<th>In-Person</th>
<th>Remote Support</th>
<th>Milestones &amp; Program Deliverables</th>
<th>Evaluation Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept</td>
<td>Session #1 10/5/17 Bay Area</td>
<td>Kickoff Webinar 9/14/17</td>
<td>Milestone #1: Team Build, Data Review, Finalize Target Population &amp; Need, Consider Staff &amp; Partners, Initiate Metrics</td>
<td>Interviews w/ Leads 10/17-11/17</td>
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<tr>
<td>Nov</td>
<td>Session #2 3/8/18 Los Angeles</td>
<td>Idea Sharing Webinar 12/7/17</td>
<td>Milestone #3: Analyze Progress, Redesign, Formalize Sustainable Operations</td>
<td>Midpoint interviews (phone) 4/18 (instead of coaching call)</td>
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<td>Dec</td>
<td></td>
<td>Program Update Call 1/10/18</td>
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<td>Surveys to gauge satisfaction with sessions, webinars, TA, etc</td>
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<tr>
<td>Jan</td>
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<td>Content Webinar 2/8/18</td>
<td></td>
<td>On site Interviews, FUP surveys + project metrics 9/18-10/18</td>
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<td>Feb</td>
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<td>Idea Sharing Webinar 4/5/18</td>
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<td>Mar</td>
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<td>Content Webinar 5/10/18</td>
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<tr>
<td>Apr</td>
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<td>Idea Sharing Webinar 6/7/18</td>
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<tr>
<td>May</td>
<td></td>
<td>Content Webinar 7/12/18</td>
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<td>June</td>
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<td>Sept-Dec</td>
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<tr>
<td><strong>Session #1</strong> 10/5/17 Bay Area</td>
<td><strong>Coaching: Monthly Team Calls</strong></td>
<td><strong>Milestone #1</strong>: Team Build, Data Review, Finalize Target Population &amp; Need, Consider Staff &amp; Partners, Initiate Metrics</td>
<td><strong>Interviews w/ Leads</strong> 10/17 - 11/17</td>
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<tr>
<td><strong>Site Visits</strong> 1/3/18: ROOTS Clinic 2/22-23/18: KKV &amp; WHC</td>
<td><strong>Kickoff Webinar 9/14/17</strong></td>
<td><strong>Milestone #2</strong>: Start Project Operations**, Design Project Workflow and Marketing, Form Partnerships</td>
<td>Security surveys 12/17 - 1/18</td>
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<td><strong>Share Lessons Learned</strong> 8/18 - 10/18</td>
<td><strong>On-site interviews, FUP surveys + project metrics</strong> 9/18 - 10/18</td>
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**Remote Support**
- **Kickoff Webinar 9/14/17**
- **Content Webinar 11/16/17**
- **Idea Sharing Webinar 12/7/17**
- **Program Update Call 1/10/18**
- **Content Webinar 2/8/18**
- **Idea Sharing Webinar 5/10/18**
- **Content Webinar 6/7/18**
- **Content Webinar 7/12/18**

**Milestones & Program Deliverables**
- **Milestone #1**: Team Build, Data Review, Finalize Target Population & Need, Consider Staff & Partners, Initiate Metrics
- **Milestone #2**: Start Project Operations**, Design Project Workflow and Marketing, Form Partnerships
- **Milestone #3**: Analyze Progress, Redesign, Formalize Sustainable Operations

**Evaluation Activities**
- **Interviews w/ Leads** 10/17 - 11/17
- **Provider/Patient Surveys** 12/17 - 1/18
- **Midpoint Interviews (phone)** 4/18 (instead of coaching call)
- **Surveys to gauge satisfaction with sessions, webinars, TA, etc**
Empathic Inquiry: Additional Support

• Customized onsite training or group webinar on empathic inquiry or empathic inquiry related training.

• Could be scheduled for the organization or held as part of the agenda of a provider, care team, quality improvement, quarterly or other existing meeting.
Idea Sharing on Partnerships

Facilitator:

Jim Meyers, DrPH
Asian Health Services

Linh Chuong
Who We Are

- Oakland, California
- Provide medical, dental, and mental health to >28,000 patients
- Serve in English and 12 Asian languages: Cantonese, Mandarin, Vietnamese, Korean, Cambodian, Mien, Hmong, Lao, Mongolian, Tagalog, Karen, and Burmese
- EHR Vendor: NextGen (anticipated changes)
- Target SDOH Pop.: Elderly, HIV
- Target SDOH Need(s): Housing and food security
## Implementation Teams

<table>
<thead>
<tr>
<th>Organization</th>
<th>Asian Health Services</th>
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<tbody>
<tr>
<td>Teams</td>
<td>Behavioral Health</td>
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<tr>
<td></td>
<td>HIV Intervention</td>
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<tr>
<td></td>
<td>Lowe Medical Clinic</td>
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<tr>
<td>Staff</td>
<td>case workers</td>
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<td></td>
<td>community health workers</td>
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<td></td>
<td>patient navigators</td>
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<tr>
<td>Patient population</td>
<td>Patients with mental health needs and high utilizers</td>
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<tr>
<td></td>
<td>HIV population</td>
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<tr>
<td></td>
<td>Elderly</td>
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</tbody>
</table>
Measuring Impact through Informal Patient Interviews

- 30 patients
- In-language: English, Vietnamese, Chinese (Mandarin, and Cantonese)

Questions around:
- Comfort level with questioning
- Type and degree of support provided
- Helpfulness of resources
- Additional support needed
Results from Informal Patient Interviews

Time

Patient

Screening

+High patient comfort levels
+Trust in AHS and staff
+In-language support

-Some housing needs weren’t ID’d

In-house Referral

+High satisfaction
+High number and quality of support
-Didn’t know what we offered
-Lack of appts/staff capacity

-Between team variability in support

External Referral

--Between team variability in referrals

Follow-up

-Improve or increase follow up
-Ensure loop closure
Original Referral Algorithm

Key

- CalFresh
- Other Food & Housing Resources
- PRAPARE Implementation Teams
- Other Staff

Patient Navigators

HIV Intervention Team

Behavioral Health Case Managers
Original Referral Algorithm

Key

- CalFresh
- Other Food & Housing Resources
- PRAPARE Implementation Teams
- Other Staff

Patient Navigators

HIV Intervention Team

Primary Care Providers

Behavioral Health Case Managers

Member Services
Original Referral Algorithm

Key
- CalFresh
- Other Food & Housing Resources
- PRAPARE Implementation Teams
- Other Staff

Patient Navigators → HIV Intervention Team

Primary Care Providers

Behavioral Health Case Managers

Member Services
Original Referral Algorithm

Key

- CalFresh
- Other Food & Housing Resources
- PRAPARE Implementation Teams
- Other Staff

Patient Navigators → HIV Intervention Team

Primary Care Providers

Behavioral Health Case Managers → Member Services

Staff
Original Referral Algorithm

Key

- CalFresh
- Other Food & Housing Resources
- PRAPARE Implementation Teams
- Other Staff

PatientNavigators

Primary Care Providers

Behavioral Health Case Managers

HIV Intervention Team

Member Services
Risk-Stratified Referral Algorithm

ID social need:
Risk-Stratified Referral Algorithm

ID social need:

Tiered Support Areas:

<table>
<thead>
<tr>
<th>Food</th>
<th>Citizenship</th>
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<tr>
<td>Housing</td>
<td>IHSS</td>
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<td>Transportation</td>
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<td>Employment</td>
<td>Utilities</td>
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- Domestic Violence
- In-House Referrals (incl. mental health)
- Caregiver Support

Insurance
Risk-Stratified Referral Algorithm

ID social need:

Tiered Support Areas:
- Food
- Housing
- Transportation
- Employment
- Citizenship
- IHSS
- Phone
- Utilities

- Domestic Violence
- In-House Referrals (incl. mental health)
- Caregiver Support

Insurance
- Refer to PN or Member Services

Refer directly to case managers
Risk-Stratified Referral Algorithm

**ID social need:**

- Domestic Violence
- In-House Referrals (incl. mental health)
- Caregiver Support

**Tiered Support Areas:**

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**Insurance**

- Refer to PN or Member Services

**Do patients need:**

1. language assistance
2. follow up over multiple visits
3. OR have special needs?

**Refer directly to case managers**
Risk-Stratified Referral Algorithm

ID social need:

Tiered Support Areas:
- Food
- Housing
- Transportation
- Employment
- Citizenship
- IHSS
- Phone
- Utilities

Do patients need:
1. language assistance
2. follow up over multiple visits
3. OR have special needs?

If no:
Tier I: provide/ explain handouts

If yes:
Tier II: refer to case managers

Refer directly to case managers

Insurance
- Domestic Violence
- In-House Referrals (incl. mental health)
- Caregiver Support

Refer to PN or Member Services

1. language assistance
2. follow up over multiple visits
3. OR have special needs?
Our Story

• Where we started:
  – planned to develop new interventions
  – Planned to overhaul EHR (delayed by transition)

• Workflow changes along the way and why:
  – training up staff to offer consistent resources to patients
  – redeveloping referral algorithms to do tiered resource support

Not a question of how but when
Our Story

• Why we ended up with this workflow:
  – listening to patients and staff
  – balancing with competing clinic demands
• Impact now and in the future on those who do the primary SDOH work:
  – reduce burden on case management team
One Question for the Group Today
– How have you captured loop closures?
Northeast Valley Health Corporation

Jessica King, MPH, RDN
Associate Director, Quality and Health Education
jessicaking@nevhc.org
Who We Are

• Where We Are Located: Northeast San Fernando and Santa Clarita Valleys
• Operates: 15 licensed health centers, 1 mobile, 4 dental clinics, and 13 WIC sites
• In 2017, NEVHC served 74,608 low-income patients
• EHR Vendor: NextGen
• Target SDOH Population: Adolescents ages 12-17 at Pacoima and Santa Clarita Health Centers
• Target SDOH Need/Needs: Food Insecurity
Addressing Food Insecurity

• NEVHC’s ROOTS Food Insecurity Screening with Technology (FIST) project aims to:
  – Develop a process to identify pediatric patients ages 12 through 17 who are food insecure and link them to resources to address their needs
  – During a Well Child Exam visit, patients will be given an O-tech tablet to complete the Hunger Vital Sign, a 2-question validated food insecurity screening tool
Screening Process: Medical Assistant

**MA Vitals the patient**

- Distributes the tablet and introduces the PHQ-9 and Hunger Vital Sign
- Generates template in EHR. Alert indicates positive screen.
- Places Food Rx Guide in provider’s outbox as a “tickler”.

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**Food Rx Guide**

- **Nutrition Prescription**
  - Get free food in your neighborhood
  - Learn how to get extra money to purchase food
  - Learn how to stretch your food dollars
  - Delicious, healthy and easy recipes

Welcome to “NEVHC’s FOOD Rx GUIDE!”

Your NEVHC provider has prescribed this nutrition guide to help you and your family access healthy, delicious and affordable food. Using One Degree, a trained professional will help you find food in your area. For more information, contact our Community Resource Help Line at 818-879-7400, EXT 42002.

**One Degree**
You can also find additional community resources near you! Search 1degree.org for thousands of social services in your neighborhood. Create a free account to find, save, and review resources for healthcare, food, jobs, housing and more.

**Community Resources**

- WIC offers families checks to buy healthy food, nutrition and health information, breastfeeding support and referrals to health care and other community resources. Apply by visiting www.wicnevahc.org or call 1-818-391-7541 OR 1-800-313-4942 to see if you qualify.
- CalFresh offers monthly benefits that can add to your food budget and be used at many markets and food stores to put healthy and nutritious food on the table. Apply by visiting www.dpabenefits.ca.gov or online at www.calFresh.org and call 1-818-701-6200 for more information.

**Choose Healthy Recipes**
The recipes in this booklet are tasty, healthy, and easy to make. Some of the ingredients are available at your local food pantry. In addition, a three-day meal plan with nutritional information is provided.

To speak with a trained professional who can help you find resources, call NEVHC’s Community Resource Help Line at 818-879-7400, EXT 42002.
Assessment and Referral: Provider

Positive Screen indicated by EHR alert and Food Rx Guide

Discuss results, Food Rx Guide, and follow-up with nutrition. Assess and treat as indicated.

Families in immediate need, ask MA to enroll and make referral to ER food bank using 1 Degree.

Code Z59.4 and document standard phrase
Case Management: Clinical Degreed Nutritionist (CDN)

Generate i2i tracks report for patients who screen positive. Add patients to “registry” (tracking).

Call the family and document the encounter as a telephone visit. Make at least 3 attempts.

Review the Food Rx Guide, refer to SNAP and SNAP-Ed programs, enroll in 1 Degree and make additional referrals as necessary. Family receives resources via text or e-mail.

Refer and schedule patients at *high nutritional risk with a Registered Dietitian. (High nutritional risk = altered nutrition related lab values, FTT, and/or obesity with comorbidity). Nutritional Risk assigned by CDN and documented in encounter.

Ordering Assessment:

<table>
<thead>
<tr>
<th>#</th>
<th>Detail Type</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Assessment</td>
<td>Lack of adequate food and safe drinking water (CSHAP)</td>
</tr>
<tr>
<td>2</td>
<td>Patient Plan</td>
<td>SNVHC Nutrition Referral and Food Rx Guide given to the patient. Enroll in One Degree. Patient can also call the Community Resource Help Line 818-979-7400 extension 42052</td>
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Northeast Valley Health Corporation

1172 W. Nisby Avenue
San Fernando, CA 91340
(818) 808-1388 - www.nevhc.org

**Departamento de Educación de Salud**

**Coma Saludable, Viva Saludable**

*JACOMPANÉNOS! APRENDA COMO PREPARAR COMIDA SALUDABLE Y NUTRITIVA PARA USTED Y SU FAMILIA.*

*Cada mes los talleres de nutrición ofreceran GRATIS demostraciones de comidas en vivo con recetas fáciles y saludables.*

**Día:** Cada 2do Sabado del mes
**Hora:** 10:00 - 11:00 a.m.
**Locación:** NEVHC Pacoima Health Center
12758 Van Nuys Blvd. Pacoima 91331
(La clase será enseñada en inglés)

<table>
<thead>
<tr>
<th>Fecha</th>
<th>Tema</th>
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<tr>
<td>Enero 13, 2018</td>
<td>Año Nuevo, Imagen Nueva: Metas Para su Salud</td>
</tr>
<tr>
<td>Febrero 10, 2018</td>
<td>Coma Saludable al Comer Afuera</td>
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<tr>
<td>Marzo 10, 2018</td>
<td>Comidas Saludables a su Alcance</td>
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<tr>
<td>Abril 14, 2018</td>
<td>Prepara un Plato Saludable</td>
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<tr>
<td>Mayo 12, 2018</td>
<td>Delicioso y Nutritivo: Preparando Platos Saludables</td>
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<tr>
<td>Junio 9, 2018</td>
<td>Estrate sus Dolaros al Comprar la Comida</td>
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<tr>
<td>Julio 14, 2018</td>
<td>¿Qué Hay en las Etiquetas?</td>
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<tr>
<td>Agosto 11, 2018</td>
<td>Reconsidera su Bebida</td>
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<td>Septiembre 8, 2018</td>
<td>Comidas Saludables a su Alcance</td>
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<td>Octubre 13, 2018</td>
<td>Prepare un Plato Saludable</td>
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<td>Noviembre 10, 2018</td>
<td>Delicioso y Nutritivo: Preparando Platos Saludables</td>
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<tr>
<td>Diciembre 8, 2018</td>
<td>Mantengase Saludable Durante los Dias de Fiesta</td>
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Para registrarse y más información, llame o a la línea de mensajes de Northeast Valley Health Corporation al (818) 279-8608 o DemosFocos@NEVHC.org
Our Workflow

Food Insecurity Screening for Patients Ages 12 – 17 Years Old

**Medical Assistant (MA)**
- MA vitals the patient.
- MA provides the patient the tablet and asks them to complete the questionnaires (PHQ-9 and Hunger Vital Sign).
- Patient completes the questionnaires.
- MA opens the template and saves the responses in the E.H.R.
- Did the patient screen positive for food insecurity?
- MA places Food Rx Guide in provider’s box outbox as a “tickler”.
- MA communicates a positive screen to the provider.

**Provider**
- Positive food insecurity screen will generate an alert in the E.H.R.
- Assess and treat, if indicated.
- Refer to Food Resources: NEVHC Food Rx Guide, Community Resource Help Line, Clinical Degreed Nutritionist. Inform patient the nutritionist will f/u.
- Code for Food Insecurity Z59.4
- Document standard phrase in patient plan. Follow-up as warranted.

**Clinical Degreed Nutritionist**
- Generate i2i tracks report for patients who screen positive for food insecurity by provider.
- Call the patient, parent and/or caregiver (document encounter as a telephone visit). Make at least 3 attempts to contact.
- Phone visit includes review of Food Rx Guide, refer to SNAP-Ed programs, enrollment in 1 Degree to make referrals to additional resources as necessary (food, material conditions, etc.). Patient will receive resources via text or e-mail.
- Is the patient high risk (altered nutrition related lab values and/or chronic disease)?
- Schedule an appointment with a Registered Dietitian.
1 Degree Journey

• Contract initiated in October, 2017

• Used by Care Navigators/CHWs and staff as part of the Food Insecurity Screening Project

• Integrated into EHR, provide staff trainings, create goals and objectives on staff participation and status of referrals

• One Degree has been receptive to feedback based on staff and patient usage

• Platform does not allow for staff to share clients.

• Detailed reports on staff participation, referrals, and status are available to admin users.
1 Degree Journey

Status of resources referred

Past 30 days
- Planned: 36.6%
- Accessed: 7.9%
- Rejected: 17.8%
- Unsuccessful: 37.6%

Past 90 days
- Planned: 74.8%
- Accessed: 13.2%
- Rejected: 7.7%
- Unsuccessful: 3.3%
- Utilized: 0.0%

Past 120 days
- Planned: 76.8%
- Accessed: 11.3%
- Rejected: 6.9%
- Unsuccessful: 5.0%
- Utilized: 0.0%

All time
- Planned: 75.9%
- Accessed: 11.3%
- Rejected: 7.6%
- Unsuccessful: 5.9%
- Utilized: 0.0%
Top 10 most referred agencies (CBOs)

- MEND (Meet Each Need with Dignity)
- Valley Food Bank
- Taco Tuesday 4 the Homeless
- Los Angeles Family Housing (LAFH)
- CalFresh

Bar chart showing the number of referrals for each agency, with MEND at the highest.
Our Story

• Pacoima Site
  – Original plan was to follow the roll out of Otech tablet use to administer the PHQ-9.

  – Technical difficulties = simultaneous roll out Otech tablet use for PHQ-9 and Hunger Vital Sign

  – Trained one provider at a time to make rapid changes to workflow as necessary.

  – Too much at once. Suspended MA enrolling patients in 1 Degree as there were staff frustrations with faulty tablet technology.
Our Story

• Valencia
  – Received all new tablets. No Wi-Fi or functionality issues have arisen!
  
  – Providers and MA(s) were trained on Otech tablet use to administer PHQ-9 prior to rolling out the Hunger Vital Sign screening.
  
  – MA(s) were also trained on 1 Degree Enrollment at Valencia for patients who are in need of immediate food assistance.
Our Story

• Original workflow: Enrollment in 1 Degree by Medical Assistants for all patients who screened positive for food insecurity.

• Revised workflow: Enrollment in 1 Degree by Medical Assistants for patients who are in immediate need of food.

  – 1 Degree does not support client sharing among staff.

  – Clinical Degreed Nutritionist is able to view patient referrals, but cannot update the status of the referral on the platform.

  – Future contract with One Degree will allow staff to update any NEVHC patient on the platform.
The Good...the Bad...

**The Good (what is going well):**
- Otech tablets are working!
- Providers have positive feedback – “It’s like social services packaged up into one intervention.”
- Plans to roll out to all pediatrics at all sites – supported by AAP recommendations for Hgb screening.
- Able to identify at-risk families and offer additional support.

**The Bad (our continuing challenges):**
- “Patient screened false positive”.
- Staff need comprehensive training on empathy and communication skills. Limited time is available to offer these trainings.
- Need to improve efficiency and accuracy of documentation.
• One Question for the Group Today
  – How are your staff introducing SDoH questions to adolescents and their parents/caregivers?
    • For example, do you encourage them to answer the questions together?
LifeLong Medical Care

Smriti Joneja
QI Coordinator
sjoneja@lifelongmedical.org
Who We Are

- **Northern California** – Alameda, Contra Costa and Marin Counties
  - Oakland, Berkeley, Richmond, San Pablo, Pinole, Rodeo, Novato

- **14 Primary Care Sites**
  - 1 Adult Day Health Center
  - 4 School-Based Sites
  - 2 Dental Clinics, 1 Dental Van
  - 10 Supportive Housing Program Sites
  - 2 Urgent/Immediate Care Sites

- **# FTE Medical Providers**: 70
- **EHR**: NextGen and eCW
- **Target**: East Oakland Location
- **SDOH**: Food Insecurity
Workflow of Patient Visit

Identify Food Insecure (FI) Patient

• Medical Assistant (MA) screens patient using 2-item Hunger Vital Sign™ survey

Determine Referral for FI Patient

• Provider (PCP) assesses FI and refers to
  • Social Worker
  • Food as Medicine Course (Wellness Center)
  • Nutritionist (TBD)

Complete Referral for FI Patient

• Social Worker or Wellness Center staff tracks referral to completion
2-item Hunger Vital Sign™ Scoring

1. “Within the past 12 months we worried whether our food would run out before we got money to buy more.”
   - Often True (2)  Sometimes True (1)  Never True (0)
2. “Within the past 12 months the food we bought just didn’t last and we didn’t have money to get more.”
   - Often True (2)  Sometimes True (1)  Never True (0)

**SCORE COMBINATIONS**

4 = 2 + 2  
3 = 1 + 2  
2 = 1 + 1 or 0 + 2  
0 = 0

Moving forward, we will pilot:
- ‘Sometimes’ = 1-2 times in a year
- ‘Often’ = 3 or more times in a year

Rationale: experiencing food insecurity **3 or more times in a year** points to a pattern, which should be considered higher risk. Note that this is simply an educated guess and will be tested to see if it helps MAs to explain the questions to the patient.
Our Risk Scoring

Risk Stratification – referrals and interventions

COMBINATIONS
4 = 2 + 2
3 = 1 + 2
2 = 1 + 1 OR 0 + 2
1 = 1 + 0
0 = 0

High Risk
HVS Score: 3-4

- **Referral:** Patient referred to Social Worker (high need)
- **Intervention:** SW assesses food insecurity and other related SDOH (e.g. transportation), refers to appropriate services

At-Risk
HVS Score: 1-2

- **Referral:** Patient referred to AmeriCorps (moderate need)
- **Intervention:** AmeriCorps assess food insecurity needs and refer within clinic to Shared Medical Visit series (FAM, DM, HTN) and other groups, or to Social Worker

Low-Risk
HVS Score: 0

- **Referral:** Patient referred within clinic (low/no need)
- **Intervention:** Patient education material (MA or Americorps)
Risk Score Breakdown

HVS Screening Pilot - score breakdown

- Count of Pts
- HVS Screening Score

- 99 points at score 0.00
- 27 points at score 1.00
- 67 points at score 2.00
- 26 points at score 3.00
- 35 points at score 4.00
Workflow of the Tracking Process

1. **Identify Food Insecure (FI) Patient**
   - Medical Assistant (MA) screens patient using 2-item Hunger Vital Sign™ Questionnaire
   - MA inputs answers into Hunger as Vital Sign (HVS) screening tool
   - Score retrievable on PBI
   - Screening interval: Every 6 months

2. **Determine Referral for FI Patient**
   - If positive, ICD-10 code Z59.4 “lack of adequate food and safe drinking water” automatically pulls into Assessment section in SOAP note
   - PCP assesses and inputs referral
   - Retrievable on i2i/PBI

3. **Complete Referral for FI Patient**
   - Social Worker or Wellness Center staff tracks referral to completion

4. **Identify Food Insecure (FI) Patient**
   - Provider (PCP) assesses FI and refers to
     - 1) Social Worker
     - 2) Food as Medicine Course (Wellness Center)

5. **Complete Referral for FI Patient**
   - Social Worker/CHW/AC tracks referral on i2i
     - Procedure/Referral
       - “Referred” or “Complete”
Our Story

• Where we started

• Changes along the way and why

• Why we ended up with this workflow
The Good...the Bad...

• The Good (what is going well):
  – Strong pilot teams
  – Community partners seem invested thus far

• The Bad (our continuing challenges):
  – Which staff responsible for which step?
  – How to engage pts who may need extra hand-holding through the connection process?
One Question for the Group Today

- How do you determine when to stop follow-up and/or outreach to a pt, connecting them with services?
Q&A

Fill out the post webinar survey!