Implementing Food Rx Programs to Improve Health Outcomes

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Today's Speakers

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Rural Health Network of South Central NY

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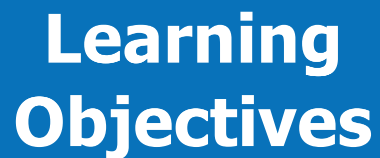

Learning Objectives

- Learn about food prescription program models that address the link between food insecurity and chronic disease
- Develop partnerships between the local food system, the healthcare system, and the patient population to address social drivers of health
- Access resources, including the Food Rx Replication Guide for Health Centers, and gather implementation strategies from successful Food Rx interventions to create their very own personalized produce prescription program in partnership with local organizations

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The Need for Food Rx Programs

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Food Insecurity and Chronic Disease

Links between food insecurity, stress, and chronic disease incidence, including Diabetes and Heart Disease.

Food insecurity increases risk for Type 2 Diabetes 2-3x, and complicates disease management for those with Diabetes

Low access to healthy foods like fruits, vegetables and healthy staples to avoid and manage chronic disease.

Less expensive foods tend to be less healthy.

Stress associated with wondering where your next meal will come from.

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Food Rx for Health Equity

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What are the benefits of a Food Rx Program?

Mentimeter

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Benefits of Food Rx Programs

- Reduce hemoglobin A1c levels in individuals with diabetes
- Improve blood pressure
- Reduce body mass index (BMI) scores
- Decrease food insecurity
- Decrease depressive symptoms and improve overall health management
- Improve patient-provider relationships

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Addressing Food Insecurity in Healthcare

With move towards value-based care, health care providers are looking to:

- improve SDOH,
- improve overall health,
- keep costs down.

Medicare and Medicaid participants receiving a 30% subsidy to reduce the cost of produce would, over a lifetime, result in a $39.7 billion savings in health care costs nationally

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Voucher Programs

- Partnership between a healthcare organization and a produce partner.
- The healthcare organization identifies the patient needing food assistance, provides a voucher or coupon, and refers them to the produce partner.
- Patients “cash in” their vouchers or coupons for fresh produce and other healthy food staples. Examples:
  - Farmer’s markets
  - Farmstands
  - Grocery stores
  - Native trading posts

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Food Delivery Programs

- Partnership between a health care organization and a produce partner who directly delivers produce to an identified location.
- Health care organization identifies the patient and refers them to the produce partner. The partner delivers produce to a residence or centralized location, which could include the org itself. The patients receive their produce or other healthy food staples at that specified location. Examples:
    - CSA box distribution
    - Mobile markets
    - Mobile pantries

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Referral Programs

- A good option for health care organizations with limited resources.
- The healthcare org identifies the patient, connects them to an already-existing source of free produce, and integrates the referral process into their workflow to the greatest degree possible. Examples of referral programs include:
  - Food Pantries
  - Double-up SNAP
  - WIC Cash Value Benefit (CVB)

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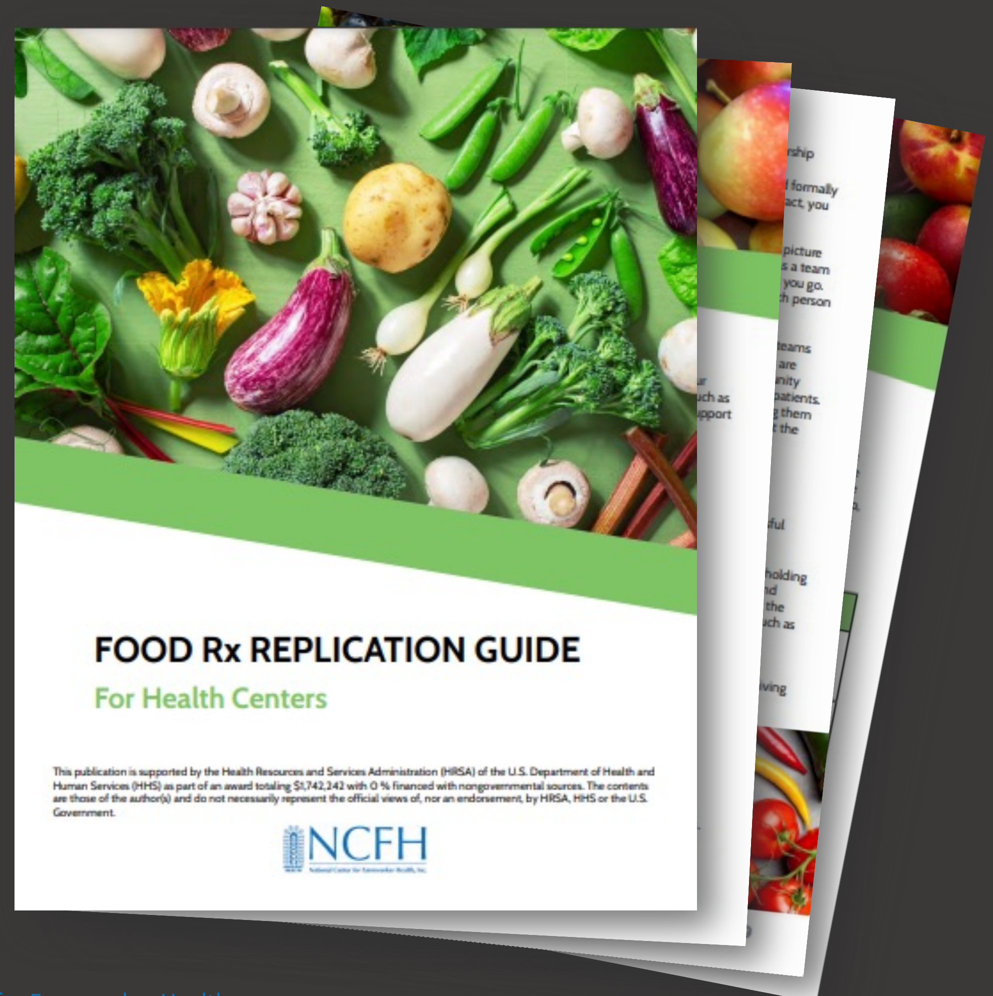
Introduction to the Guide



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Experience it for yourself!

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Purpose

- Food Rx / Produce Prescription program aims:
  - Food insecurity
  - Diet-related disease
  - Cost of care
- NCFH has developed this Food Rx replication guide with the purpose of helping health centers to be able to implement their own Food Rx programs.
- Comprehensive, step-by-step, designed for health center staff with limited time and resources.

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Implementing Your Food Rx Program

Contents

Introduction

Step 1: Health Center Readiness Assessment

Step 2: Conduct Asset Mapping

Step 3: Assess Partner Readiness

Step 4: Develop Partnerships

Step 5: Explore Additional Funding

Step 6: Action Planning

Step 7: Implement Your Program

Conclusion

Resources

References

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Assessing Readiness

- Assess how prepared your HC is to implement your program.
- Key foundational areas to ensure program success.
- Identify areas for improvement.

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APPENDIX A:
Health Center Food Rx Readiness Assessment Questionnaire

Directions: Select Yes, Somewhat, or No for each statement below, depending on how often or how well each statement describes your current HC practices and values.

Yes	Things partner does frequently, or statement applies to partner to a great degree
Somewhat	Things partner does occasionally, or statement applies to partner to a moderate degree
No	Things partner rarely or never does, or statement applies to partner to minimal degree or not at all

	Yes	Somewhat	No
1. Does your HC currently screen for food insecurity?	☐	☐	☐
2. Is addressing food insecurity a priority for the leadership of your organization?	☐	☐	☐
3. Do staff have the capacity to coordinate a produce prescription program, including tracking program data? *Note: If you are not sure, read the full Food Rx Replication Guide to get a sense of what a program entails, then return to this question.*	☐	☐	☐
4. Do staff understand the relationship between food insecurity and chronic diet-related diseases?	☐	☐	☐
5. Does your HC have a referral system in place for food insecure patients?	☐	☐	☐
• *If you answered yes or somewhat, where are patients referred to for food insecurity?*			
• *What staff are involved in this referral system?*			
6. Are food insecurity and any subsequent referrals integrated into your Electronic Health Record (EHR)?	☐	☐	☐
7. Does your HC currently offer any diabetes, hypertension, or heart disease education programs?	☐	☐	☐
• *If you answered yes or somewhat, who are the staff responsible for implementing these programs?*			
8. Do any of your community partners offer any diabetes, hypertension, or heart disease education programs?	☐	☐	☐
9. Does your HC have a Food Rx policy?	☐	☐	☐
10. Has your HC identified food insecurity as a key issue to improve the quality of health amongst their patient population?	☐	☐	☐
TOTALS	0	0	0

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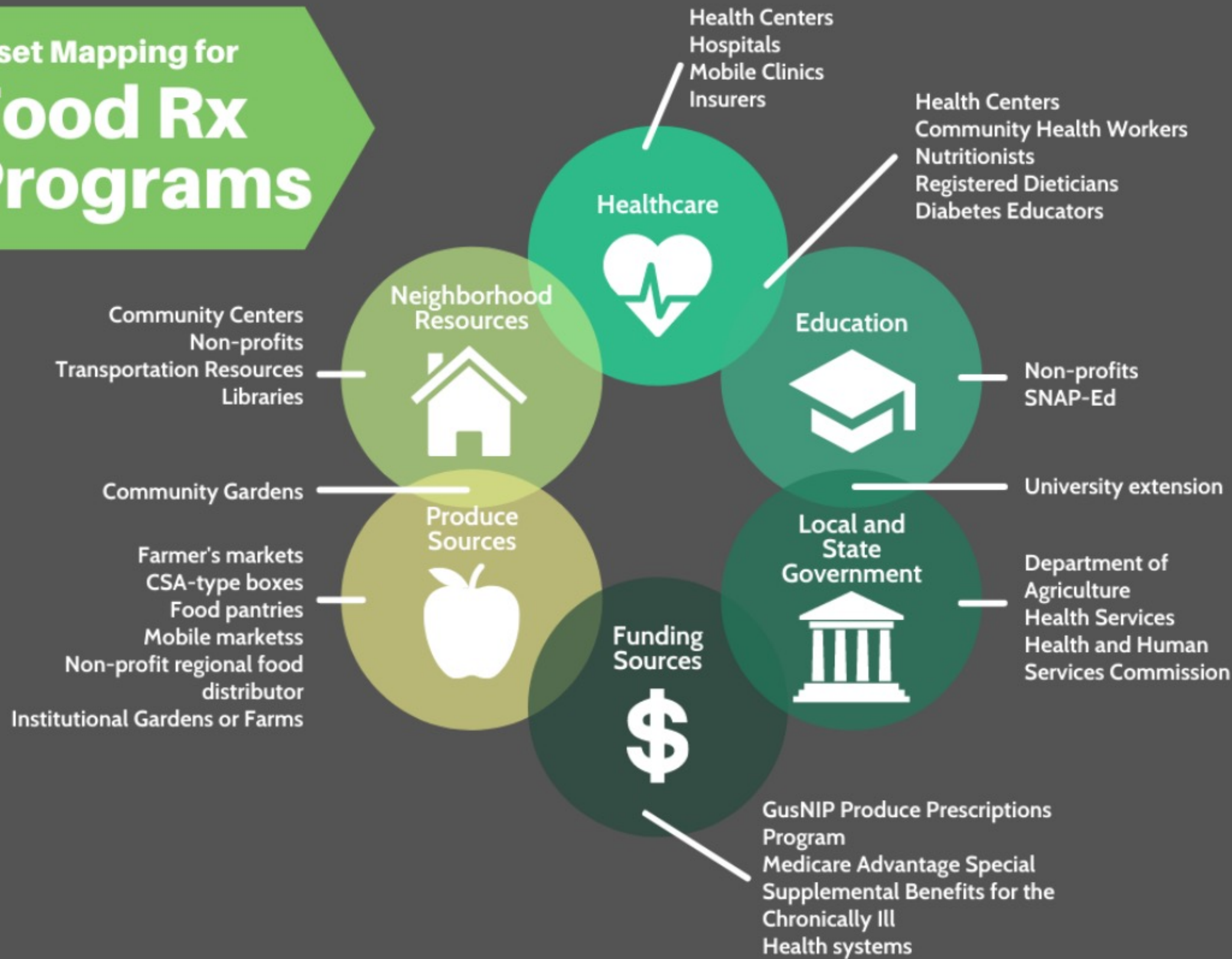

Asset Mapping

- Conduct a scan of your local and regional community resources

What produce sources are available in your area as potential partners?

Assessing Partner Readiness

Assess the readiness of your produce partner to initiate a Food Rx program

Differentiated by program type

APPENDIX C:
Voucher Programs Readiness Assessment

APPENDIX D:
Food Delivery Programs Readiness Assessment

Directions: Select Yes, Somewhat, or No for each statement below, depending on how often or how well each statement describes your current HC practices and values.

APPENDIX E:
Referral Programs Readiness Assessment

Directions: Select Yes, Somewhat, or No for each statement below, depending on how often or how well each statement describes your current HC practices and values.

Yes Things partner does frequently, or statement applies to partner to a great degree
Somewhat Things partner does occasionally, or statement applies to partner to a moderate degree
No Things partner rarely or never does, or statement applies to partner to minimal degree or not at all

	Yes	Somewhat	No
1. Is the location to the existing program accessible for your patients?	☐	☐	☐
2. Do the hours of operation work for your patient population?	☐	☐	☐
3.Does the referral program have a nutrition policy to determine which foods are appropriate for your patients, or are they willing to implement one?	☐	☐	☐
4. Does the referral program have a documentation system for tracking patient use of the program or are they willing to implement one?	☐	☐	☐
5. Are you able to meet any documentation requirements of the produce partner?	☐	☐	☐
6.Have you reached out to the existing program and evaluated their capacity to accept new program participants?	☐	☐	☐
7. Have you discussed a referral plan that works for this existing program?	☐	☐	☐
TOTALS	0	0	0

If you answered mostly Yes, chances are your partner organization is well-positioned to start a Food Rx program in coordination with your HC. As you assemble your team and action plan, notice which questions you may have answered with "somewhat" or "no." Make these your first priorities as you plan your program.

If you answered mostly Somewhat, your partner organization has many of the elements necessary to start a Food Rx program. With some effort and collaboration between the two, you can increase how often and how well these practices are integrated into the program procedures. Make a concrete plan with a policy that addresses these areas of improvement, and you may soon be ready to initiate your program.

If you answered mostly No, your partner organization may not be ready to start a Food Rx program, but they have identified the key areas to work on first. It may be that some of these areas fall outside of their mission, and you may need additional partners from your asset map to fulfill these roles. If questions 1-3 were answered "no," consider other partner options instead.

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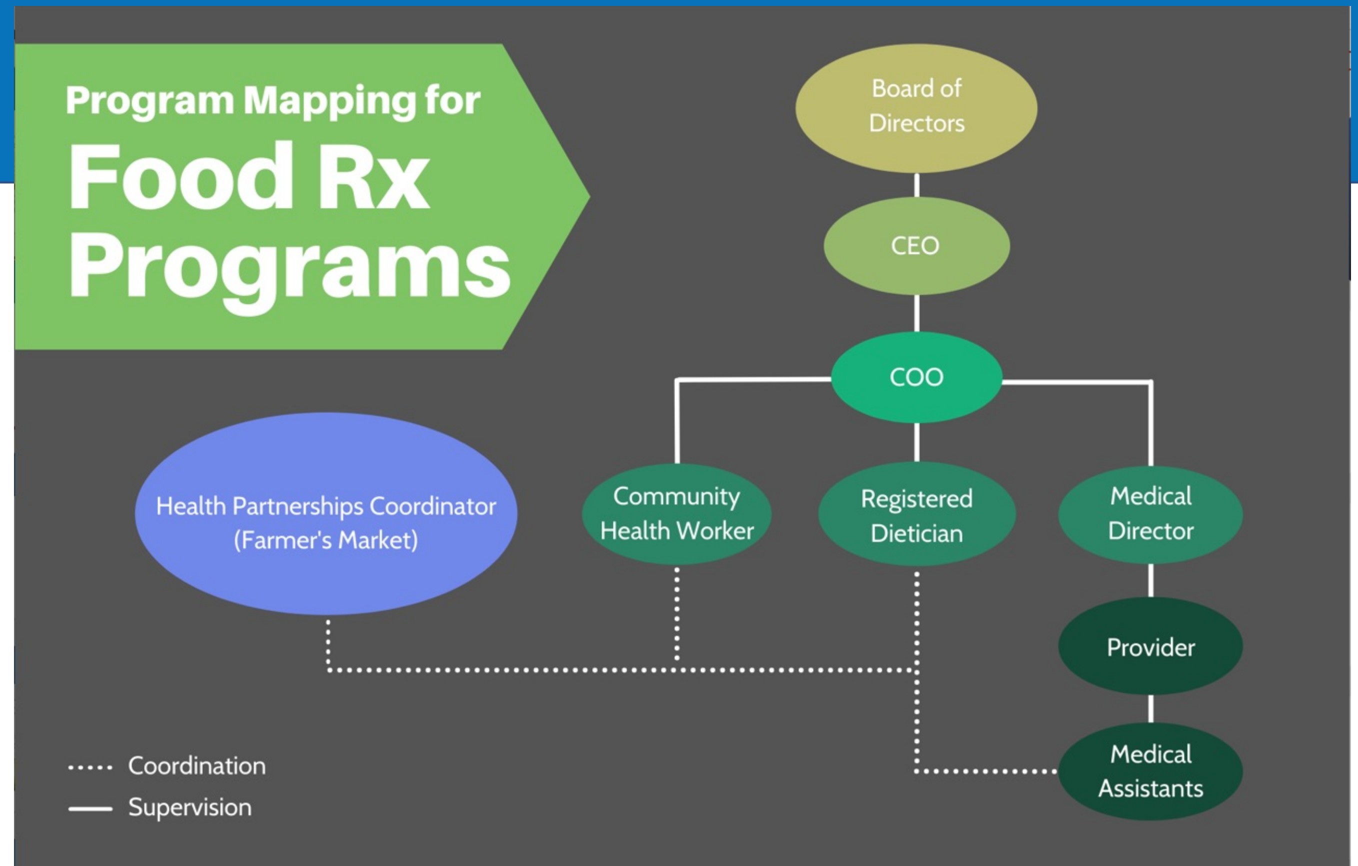
Developing Partnerships

- Establishing roles
- Building successful partner relationships



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Explore Additional Funding

Healthcare Funding	Grant Funding	Private Funding	State and Local Funding
Medicare Advantage Special Supplemental Benefits for the Chronically Ill	Gus Schumacher Nutrition Incentive Program	Insurance companies such as Elevance Health	Community Development Block Grant
Medicaid Managed Care	Feeding America to Grant Funding	National foundations or civic groups (like Rotary, etc.) operating locally	SNAP-ED Policy, Systems, and Environmental Work
Section 1115 Demonstration Waivers		Faith based charity organizations	Double-Up SNAP
		Companies with philanthropic arms such as Shipt	

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Action Planning

- Actionable checklists for each partner involved, and tasks done in coordination
- Individualized by program type
- Key decision points to be made by the partnering organizations

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Health Center	Produce Partner
☐ Decide on a referral system based on patient responses to screener questions and team members involved. ☐ Document and track your referrals. ☐ Distribute a calendar of times where patients can pick up their food prescription. ☐ If delivering to patients' homes, confirm home address during enrollment. ☐ Follow up with patients at their next appointment to see how they are finding the program and to gather disease measures that may show if health outcomes have improved. ☐ Track and communicate patient outcomes.	☐ Provide HC a calendar of places and times where patients can pick up their food prescription or provide schedule for patient home deliveries. ☐ Deliver food prescriptions regularly. ☐ Provide patients a variety of fresh, seasonal produce. ☐ Provide patients a variety of culturally relevant produce.

Done in Coordination

☐ Create a nutrition policy to outline the items that can be distributed at the Delivery Program.
☐ Decide on the quantity of food each patient or household will receive in their food delivery.
☐ Collect patient feedback on delivery site options available, including at home or a centralized location.
☐ Receive, track, and document the pounds of food or produce distributed.
☐ Provide nutrition education to patients.
Decide on when patients "graduate" from the program (based on health outcome ...tc.).
...baseline and post-intervention participant surveys to measur...
...requirements or documentation.

Action Plan: Voucher Program

Health Center	Produce Partner
...ecide on a referral system based on patient responses to screener questions and team members involved. ☐ Document and track your referrals. ☐ Establish a system for distributing vouchers to patients. ☐ Distribute a calendar of places and times where patients can redeem their vouchers. ☐ Follow up with patients at their next appointment to see how they are finding the program and to gather disease measures that may show if health outcomes have improved. ☐ Track and communicate patient outcomes.	☐ Provide HC a calendar of places and t... where patients can redeem their vouche... ☐ Provide patients a variety of fresh, seasonal produce. ☐ Provide patients a variety of culturally relevant produce. ☐ Train staff on accepting produce prescription vouchers.

Done in Coordination

☐ Create a nutrition policy to outline the items that can be redeemed through the Voucher Program.
☐ Decide the value of your voucher and how many vouchers each patient or household will receive.
☐ Decide on how you will receive, track, and document the circulation of fruit and vegetable prescription vouchers, or decide on an electronic voucher system.
☐ Provide nutrition education to patients.
☐ Decide on when patients "graduate" from the program (based on health outcomes, food insecuri... etc.).
...velop baseline and post-intervention participant surveys to measure program effective...
...lete any funding requirements or documentation.
...hering participant feedback on the program: ease of following the ... ...ality of produce, quality of nutrition education.

...unicate patient outcomes.
...e on when patients "graduate" from the program (based on health outcomes, food insecurity, etc.).

Done in Coordination

☐ Communicate program outcomes such as pounds of food distributed and patient outcome...
☐ Provide nutrition education to patients.
☐ Develop baseline and post-intervention participant surveys to measure program effectiveness.
☐ Consider gathering participant feedback on the program: ease of following the program, room for improvements, quality of produce, quality of nutrition education.

Choosing a FI Screening Tool

PRAPARE Tool (Protocol for Responding & Assessing Patients' Assets, Risks & Experiences)

- Endorsed by NACHC,
- Already used in many HCs
- Comprehensive SDOHs

USDA Food Security Survey Tools

6-, 10-, and 18-question survey options

Hunger Vital Sign

- 2-question screener
- Endorsed by American Hospital Association, the American Academy of Pediatrics, and Feeding America

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Choosing eligibility criteria

- Common diagnoses for eligibility:
  - Diabetes or prediabetes
  - Hypertension
  - Heart disease
- Others to consider:
  - Prediabetes
  - Overweight / obese
  - Cancer
  - Metabolic syndrome
  - PCOS
  - Fatty liver
  - Depression
  - Preeclampsia
  - IBS
  - Asthma
  - COPD / Emphysema
  - HIV

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Patient Experience

Ensure staff are well trained on screening, referral, enrollment, and follow up.

Consider developing enrollment and education **materials including:**

Baseline surveys and screenings

Overview of the program

Distribution times or retail hours.

Pickup or retail addresses.

Important instructions

Lifestyle or disease prevention programming place and times.

Date and time of their next appointment at the HC

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Evaluation and Tracking

Source	Outcome	Unit of measure
EHR	Disease measures and health outcomes	• Blood pressure readings • BMI • A1C
EHR	Healthcare utilization	• Preventative visits • Nutrition education attendance • Disease prevention / management class attendance • Missed appointments • Emergency department usage • Missed appointments • 30-day readmissions
Food Insecurity Screener	Food insecurity and related SDOH	• Food security status • Income • Transportation
Baseline and Post Surveys	Nutrition quality and fruit / vegetable intake	• Frequency of fruit / vegetable intake • Healthy Eating Index • Weight of produce prescription • Dollar value of produce prescription

Baseline and Post Surveys	Participant satisfaction and wellbeing	• Quality of life measurements
		• Post-intervention only:
		  • Open-ended space on survey for suggestions
		  • Satisfaction rating on program quality
		  • Satisfaction rating on program accessibility

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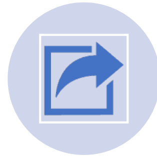
Implementing your program

MONITOR



SHARE

CONTINUAL IMPROVEMENT

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POLL TIME

Does your health center currently have a Food RX or Food Prescription Program in place?

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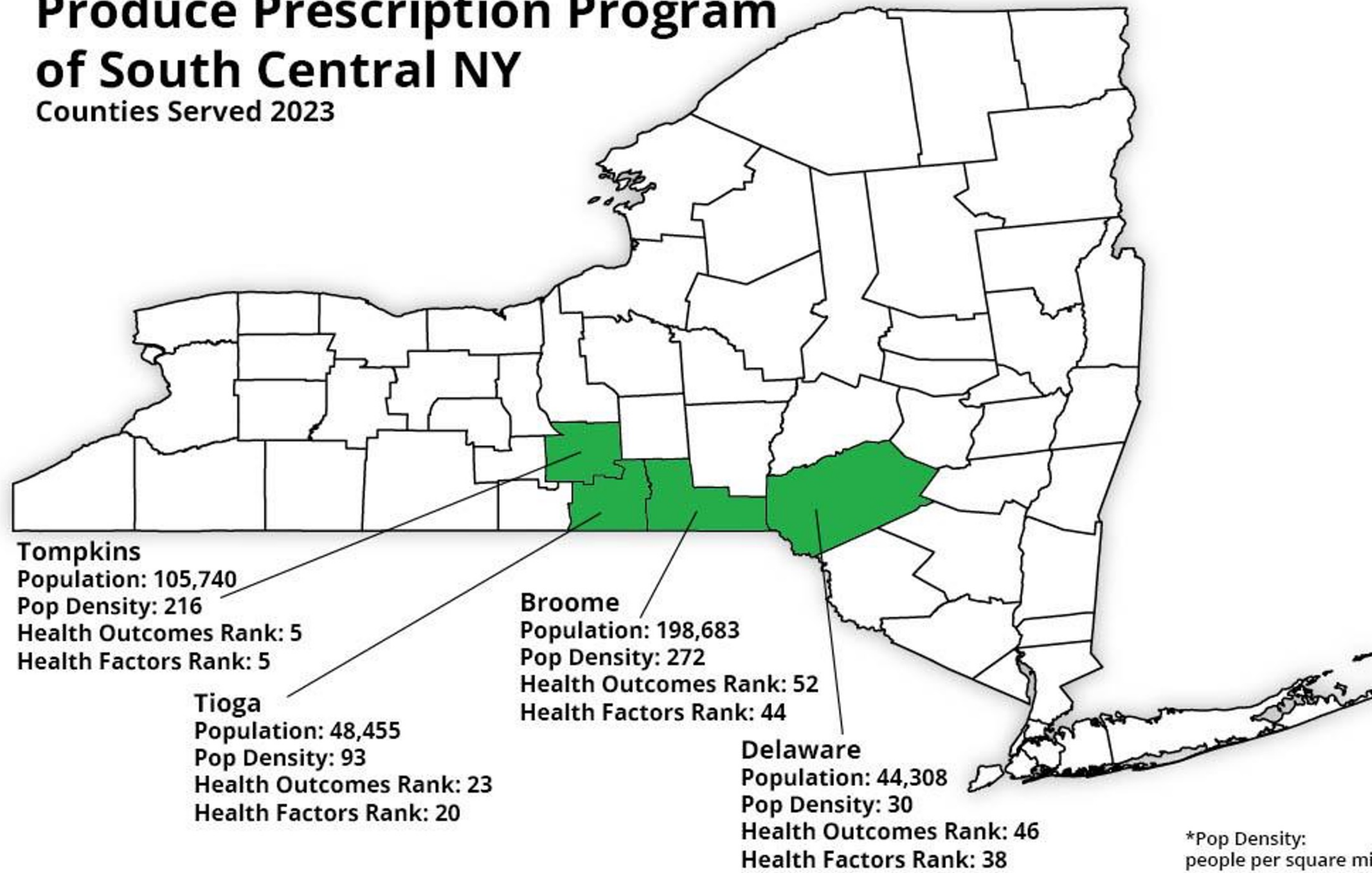
Success Stories of
Food Rx Programs
from the Field

RURAL HEALTH
NETWORK
Serving South Central New York

Mission:
To advance the health and well-being of rural people and communities

- **Rural Advocacy**
- **Community Health**
- **Food and Health Network**
- **Getthere Mobility Services**
- **Rural Health Service Corps (AmeriCorps, VISTA)**



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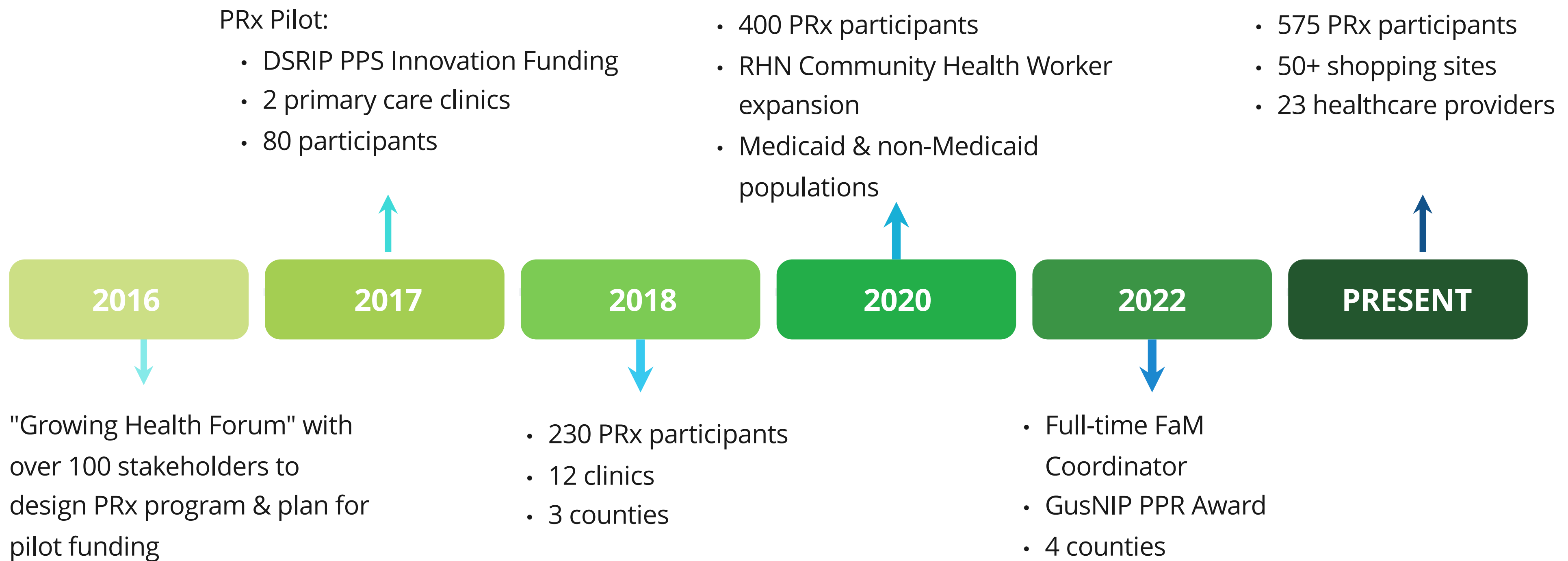
PRx Growth: Pilot to Regional Expansion



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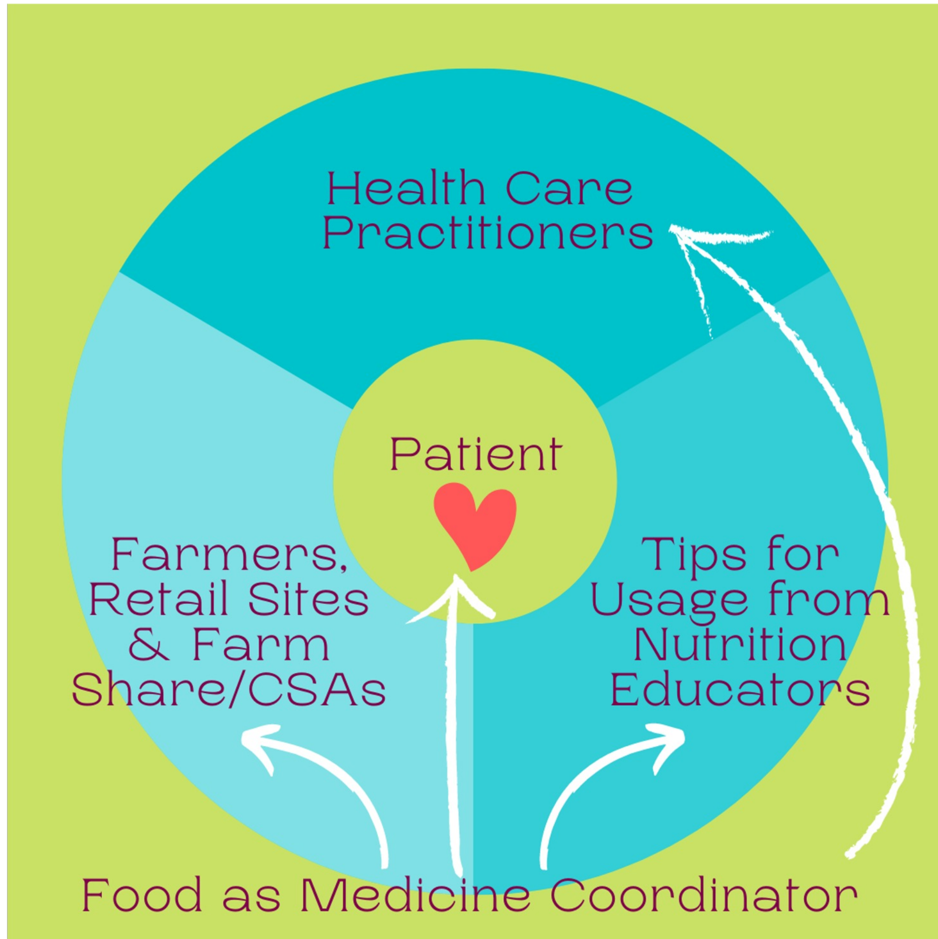

PARTNER	RESPONSIBILITIES
Healthcare Provider **(Registered Dietitian, Nurse Navigator, Wellness Coordinator, Community Health Worker, etc.)**	• **Identify** patients living with food insecurity who are at-risk or have been diagnosed with diet-related chronic illness. • **Enrollment:** Describe the program to the patient, ensure patient completes survey, distribute vouchers, refer to other programming. • **Maintain contact** with the patient throughout their enrollment in the program with at least two follow up appointments.
Patient	• **Attend** appointments with healthcare provider and complete surveys. • **Purchase** fruits and vegetables at shopping locations. • **Engage** with farmers, nutrition educators and other participants to support knowledge of produce, nutrition, seasonal cooking and utilization of prescription.
Vendor **(Farmers & Grocers)**	• **Provide a selection of produce for sale,** with a program goal to support local and regional farmers. • **Support participants with education about food** • **Report** Monthly PRx Sales Data to Rural Health Network
Rural Health Network	• **Coordinate program** by training providers, recruiting vendors and organizing supplemental educational opportunities. • **Provide onboarding materials:** Getting Started Guide, produce vouchers, CSA information, kitchen incentives for staff to share with participants. • **Support participants** in utilizing their prescription with education on storing and cooking seasonal produce, connections to nutrition and cooking classes, community resources and kitchen incentives.

How it Works: Clinical

1. Healthcare providers screen for eligibility and enroll participants
2. Participant attends 3 visits over six – eight months (in-person or remote)
3. Participant receives $120 in vouchers per visit, up to $360 OR enrolls in a CSA/Farm Share.

Vouchers

- Three booklets that include $120 (apx 24 $5 vouchers (1/visit)
  - Vouchers Prepped with PRxID
  - Spent at Retail Locations
  - Vendors return monthly for reimbursement

RURAL HEALTH NETWORK
Serving South Central New York

Farm and Food Retail Partners

Who Do We Partner With?

- CSAs/Farm Share
- Farmers Markets
- Independent Retail Farm Stands
- Retail Grocers

What's worked well?

- Trusting collaborations
- Flexibility
- Building Upon Exisiting Relationships (F2S/SRF)
- Communication

Goals Moving Forward

- Centering Local
- Transportation/Delivery Options
- Streamlining Redemption & Data Collection

RURAL HEALTH NETWORK
Serving South Central New York

Kate Miller-Corcoran

Food as Medicine Coordinator, Food & Health Network Program

Rural Health Network SCNY

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RURAL HEALTH NETWORK

Serving South Central New York

Houston Food Bank Food for Change Market

Houston, TX

Patients exposed to Food Rx experienced a −0.28% greater change in A1c than unexposed patients, over six months

Results showed a linear association between visit frequency and clinically meaningful decline in HbA1c

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Veggie Rx
Reading, PA

Studies showed a –1.3% change in HbA1c after 7 months of DSMES and monthly vouchers for fruits and vegetables.

No associations with BMI, but blood pressure was postively associated with voucher redemption.

Photo Credit: Penn State Berks

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Fresh Prescription: Recipe for a Healthy Detroit

Detroit, MI

Statistically significant decrease in HBA1C (-.71%), though weight and BP did not change between pre- and post-study.

93% of participants reported an improvement in managing their chronic health conditions.

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Social Risks Factors: Food Insecurity Learning Collaborative

Social Risk Factors: Food Insecurity Learning Collaborative

4 Once a Week sessions, **February 2024 from 12:00-1:30 pm CST.**

Register:
https://www.surveymonkey.com/r/DDXBZN7

Additional Food Rx Resources

Food Rx Replication Guide for Health Centers

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Additional Food Rx Resources

Produce Prescription Community of Practice

The PPR Community of Practice meets every other month on the 4th Thursday from 1 - 2:30 PM ET/ 10 - 11:30 AM PT. To be added to the recurring meeting invite, please contact Ashley at ashley@mifma.org.

PRAPARE Tool

https://prapare.org/the-prapare-screening-tool/

USDA Food Security Survey Tools

https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/survey-tools/#six

Hunger Vital Sign

https://childrenshealthwatch.org/public-policy/hunger-vital-sign/

Upcoming NCFH Food Rx Webinar and Learning Collaborative!

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Speaker Contact Information

Megan Martinez
Martinez@ncfh.org
512-312-5467

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Upcoming Webinar

Enhancing Language Access: Assessing Bilingual Health Center Staff Competency

December 13, 2023
11:00am PT/1:00pm CT/2:00pm ET

Register at:
https://ncfh-org.zoom.us/webinar/register/WN_LMpFUjGrRmG5K_gzNbDxrg#/registration

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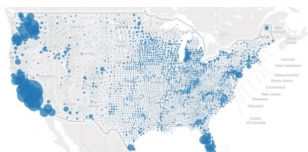
Population Specific



Population Estimation

Fact Sheets & Research

Health Center Learning Collaboratives

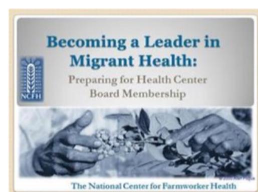
Health Education/Patient Education Resources

Resource Hubs
Diabetes
Mental Health
SDOH

Digital Stories

Patient Education Materials

Governance/ Workforce Training



Health Center ToolBox

Archived Webinars

Board Tools, Resources & Templates

Governance Tools

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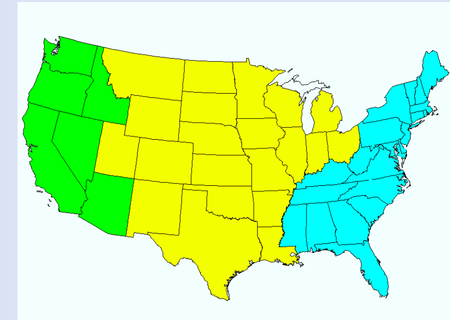
NCFH Additional Resources

		
COVID-19 Resources for Agricultural Workers and Resources for Health Centers and Farmworker-Serving Organizations	Una Voz Para La Salud Call for Health 1 (800) 377-9968 1 (737) 414-5121 WhatsApp	Regional Stream Forums on a year basis (West Coast, East Coast, and Midwest*) **Hosted by NCFH*

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Dedicated to improving the health status of Ag worker families: providing info services, training/technical assistance & and a variety of products to health centers, organizations, universities, researchers, & other Ag worker health advocates nationwide.
The National Center for Farmworker Health proactively supports the work of health centers and the empowerment of

National Center for Farmworker Health, Inc. added an event.
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WEBINAR

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Thank you!

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