Implementing Food Rx Programs to Improve Health Outcomes

December 5, 2023
Today’s Speakers

Megan Martinez
Health Initiatives Program Coordinator
National Center for Farmworker Health

Kate Miller-Corcoran
Food as Medicine Coordinator
Rural Health Network of South Central NY
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
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
What are the benefits of a Food Rx Program?
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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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.
• 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
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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• 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)
Introduction to the Guide
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.
Implementing Your Food Rx Program
Assessing Readiness

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

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.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Somewhat</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Does your HC currently screen for food insecurity?</td>
<td></td>
<td></td>
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<tr>
<td>2. Is addressing food insecurity a priority for the leadership of your organization?</td>
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<tr>
<td>3. Do staff have the capacity to coordinate a produce prescription program, including tracking program data?</td>
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<tr>
<td></td>
<td>Yes</td>
<td></td>
<td>No</td>
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<tr>
<td>4. Do staff understand the relationship between food insecurity and chronic diet-related diseases?</td>
<td></td>
<td></td>
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<tr>
<td>5. Does your HC have a referral system in place for food insecure patients?</td>
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<tr>
<td></td>
<td>Yes</td>
<td></td>
<td>No</td>
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<tr>
<td>6. Are food insecurity and any subsequent referrals integrated into your Electronic Health Record (EHR)?</td>
<td></td>
<td></td>
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<tr>
<td>7. Does your HC currently offer any diabetes, hypertension, or heart disease education programs?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Yes</td>
<td></td>
<td>No</td>
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<tr>
<td>8. Do any of your community partners offer any diabetes, hypertension, or heart disease education programs?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>9. Does your HC have a Food Rx policy?</td>
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<tr>
<td>10. Has your HC identified food insecurity as a key issue to improve the quality of health amongst their patient population?</td>
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TOTALS: 0 0 0

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• 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

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Developing Partnerships

- Establishing roles
- Building successful partner relationships
### Explore Additional Funding

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

<table>
<thead>
<tr>
<th>Source</th>
<th>Outcome</th>
<th>Unit of measure</th>
</tr>
</thead>
</table>
| 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 |
Implementing your program

MONITOR  SHARE  CONTINUOUS IMPROVEMENT

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POLL TIME

Does your health center currently have a Food RX or Food Prescription Program in place?
Success Stories of Food Rx Programs from the Field
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)
Produce Prescription Program of South Central NY
Counties Served 2023

Tompkins
Population: 105,740
Pop Density: 216
Health Outcomes Rank: 5
Health Factors Rank: 5

Broome
Population: 198,683
Pop Density: 272
Health Outcomes Rank: 52
Health Factors Rank: 44

Tioga
Population: 48,455
Pop Density: 93
Health Outcomes Rank: 23
Health Factors Rank: 20

Delaware
Population: 44,308
Pop Density: 30
Health Outcomes Rank: 46
Health Factors Rank: 38

*Pop Density: people per square mile

RURAL HEALTH NETWORK
Serving South Central New York
**PRx Growth: Pilot to Regional Expansion**

**PRx Pilot:**
- DSRIP PPS Innovation Funding
- 2 primary care clinics
- 80 participants

**2016**
- "Growing Health Forum" with over 100 stakeholders to design PRx program & plan for pilot funding

**2017**
- 230 PRx participants
- 12 clinics
- 3 counties

**2018**
- 400 PRx participants
- RHN Community Health Worker expansion
- Medicaid & non-Medicaid populations

**2020**
- Full-time FaM Coordinator
- GusNIP PPR Award
- 4 counties

**2022**
- 575 PRx participants
- 50+ shopping sites
- 23 healthcare providers

**PRESENT**
<table>
<thead>
<tr>
<th>PARTNER</th>
<th>RESPONSIBILITIES</th>
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<tbody>
<tr>
<td><strong>Healthcare Provider</strong></td>
<td>• Identify patients living with food insecurity who are at-risk or have been diagnosed with diet-related chronic illness.</td>
</tr>
<tr>
<td>(Registered Dietitian, Nurse Navigator,</td>
<td>• Enrollment: Describe the program to the patient, ensure patient completes survey, distribute vouchers, refer to other programming.</td>
</tr>
<tr>
<td>Wellness Coordinator, Community Health</td>
<td>• Maintain contact with the patient throughout their enrollment in the program with at least two follow up appointments.</td>
</tr>
<tr>
<td>Worker, etc.)</td>
<td></td>
</tr>
<tr>
<td><strong>Patient</strong></td>
<td>• Attend appointments with healthcare provider and complete surveys.</td>
</tr>
<tr>
<td></td>
<td>• Purchase fruits and vegetables at shopping locations.</td>
</tr>
<tr>
<td></td>
<td>• Engage with farmers, nutrition educators and other participants to support knowledge of produce, nutrition, seasonal cooking and utilization of prescription.</td>
</tr>
<tr>
<td><strong>Vendor</strong></td>
<td>• Provide a selection of produce for sale, with a program goal to support local and regional farmers.</td>
</tr>
<tr>
<td>(Farmers &amp; Grocers)</td>
<td>• Support participants with education about food</td>
</tr>
<tr>
<td></td>
<td>• Report Monthly PRx Sales Data to Rural Health Network</td>
</tr>
<tr>
<td><strong>Rural Health Network</strong></td>
<td>• Coordinate program by training providers, recruiting vendors and organizing supplemental educational opportunities.</td>
</tr>
<tr>
<td></td>
<td>• Provide onboarding materials: Getting Started Guide, produce vouchers, CSA information, kitchen incentives for staff to share with participants.</td>
</tr>
<tr>
<td></td>
<td>• 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.</td>
</tr>
</tbody>
</table>
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
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 Existing Relationships (F2S/SGF)
- Communication

Goals Moving Forward
- Centering Local
- Transportation/Delivery Options
- Streamlining Redemption & Data Collection
Kate Miller-Corcoran
Food as Medicine Coordinator, Food & Health Network Program
Rural Health Network SCNY
kmillercorcoran@rhncny.org

www.foodandhealthnetwork.org
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.
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 positively associated with voucher redemption.
Statistically significant decrease in HBA1C (-0.71%), though weight and BP did not change between pre- and post-study.

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

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
National Center for Farmworker Health

Population Specific
Population Estimation

Health Education/Patient Education Resources
Resource Hubs
- Diabetes
- Mental Health
- SDOH

Digital Stories
Fact Sheets & Research

Governance/Workforce Training
Health Center ToolBox

Archived Webinars

Board Tools, Resources & Templates

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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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Thank you!

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,742,242.00 with 0 percentage financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

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