



MHCU Policy Learning Lab 2018

Policy Learning Lab Compendium of Research & Technical Assistance Memos



Moving Health Care Upstream (MHCU) is a collaborative effort co-led by the Nemours Children’s Health System and the University of California, Los Angeles (UCLA) Center for Healthier Children, Families & Communities. MHCU was launched in 2014, with generous support from the Kresge Foundation.

Moving Health Care Upstream (MHCU) creates, tests, and disseminates strategies for producing large-scale, sustainable population health improvements. The focus is on helping health care providers to collaborate with other community-based organizations to help children, patients, and families access new resources to address upstream drivers of health. While the lens is children and families, the work applies generally to communities, and learnings are available to the field at large at movinghealthcareupstream.org



HYPERLINKED TABLE OF CONTENTS

→ Introduction	1
→ Summary of Research and Technical Assistance Requests	3-7
→ Policy Learning Lab focused on <i>Food Insecurity</i>	3
→ Policy Learning Lab focused on <i>Root Causes of Asthma</i>	7
→ Webinars and Calls	8
→ Hunger Vital Sign National Community of Practice (CoP)	8
→ Moving Health Care Upstream: Identifying & Addressing Food Insecurity in Healthcare Settings	8
→ Parkland Center for Innovation	9
→ All In, Data for Community Health: Research and Application, Measuring Social Needs and Outcomes	9
→ Center for Health Care Strategies: Advancing Health Care and Community-Based Organization Partnerships to Address Social Determinants, Lessons from the Field	10
→ Additional Resources	11
→ Screening Response Options	11
→ Staff Training: Food Insecurity Screening	11
→ Veggie Rx	11
→ Return on Investment (ROI) Resources	11
→ Delivering Community Benefit: Healthy Food Playbook	12
→ Screening for Other Determinants of Health	12
→ Appendices A-F: Full Memoranda for All Teams	13-63
→ APPENDIX A – Food Policy Toolkit Resources (Team Lead: Central Louisiana Economic Development Alliance; Louisiana)	13
→ APPENDIX B – Developing an Assessment Methodology for Grocery Siting & Closing Impact (Team Lead: Atlanta Regional Collaborative for Health Improvement; Georgia)	26
→ APPENDIX C – Food Insecurity Screening, Workflow Design, Multi-Site Expansion, and County-Wide Examples (Team Lead: Los Angeles County Department of Public Health; California)	37
→ APPENDIX D – Food Insecurity Screening, Workflow, Compliance, and Measuring Success (Team Lead: Nemours Children’s Health System; Delaware)	44
→ APPENDIX E – Identification Requirements at Food Banks (Team Lead: Children’s Healthcare of Atlanta; Georgia)	58
→ APPENDIX F – Implementing Food Rx Partnerships (Team Lead: Central Louisiana Economic Development Alliance; Louisiana)	61

Introduction

This document was prepared as part of Moving Health Care Upstream’s Policy Learning Lab. For more information, please also see the documents bulleted below, which are available at movinghealthcareupstream.org

- Policy Learning Lab Overview and Lessons Learned;
- Compendium of Research & Technical Assistance Memos (2017 Policy Learning Lab);
- Policy Learning Lab Resource Directory;
- Policy Process Playbook; and
- Policy Learning Lab Social Media Best Practices.

Moving Health Care Upstream (MHCU) is based on the belief that health systems can address persistent and costly health inequities by moving “upstream”—beyond the walls of hospitals and clinics and into the communities, collaborating with community-based organizations to address the root causes of disease. The various areas of work within MHCU share a common focus—supporting hospitals and community stakeholders in testing and spreading strategies to move upstream, and sharing “what works” to inform the field and accelerate the upstream movement in the field as a whole. Policy Learning Labs are one example of MHCU’s work to spread knowledge and accelerate action in the field.

Nemours Children’s Health System (Nemours) piloted the Policy Learning Labs under the auspices of MHCU in 2017. They were created to address inter-related challenges in the field:

- 1) **Sustainability, Spread, Scale:** For sustainability, program work must be combined with policy development. Without this connection, even the strongest programs are at risk of becoming one offs and of disappearing with shifts in funding or staffing. Policy can institutionalize good ideas, yet MHCU and others doing similar work have observed that many organizations and communities have not yet developed policies to institutionalize and grow their programs addressing upstream causes of disease and disparities.
- 2) **Capacity:** Local public policy and institutional policy is often developed by groups and coalitions whose members are unpaid volunteers or by those taking on the work on top of their formal accountabilities at work. This has implications for the capacity of those involved.
 - a. **Knowledge & Skill:** Often, clinicians and other practitioners who develop and implement programs are not “policy people,” and don’t have a high level of knowledge or skills related to developing local public policy and/or institutional policy.
 - b. **Dedicated Time:** Despite the potential effectiveness of learning collaboratives, MHCU staff have repeatedly heard that allocating dedicated time for participation is a challenge. Dedicating time to conduct targeted policy research and scans is also challenge for groups and coalitions



The 2017 Policy Learning Lab pilot converted these challenges into opportunities by using a short-term (4 month) process to increase knowledge and skills of members and to provide teams with targeted policy tools (such as research and scans). These skills and tools are intended to accelerate the development of evidence-informed local public policy strategies and/or institutional policy strategies to target upstream causes of disease and disparities.

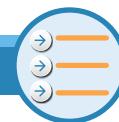
Topics for 2017 Policy Learning Labs (root causes of asthma and food insecurity) were chosen based on the input of health systems already associated with MHCU and were intended to fill a white space in the field. Our 2017 pilot involved seventeen teams: five in the Policy Learning Lab focused on root causes of asthma and twelve in the Policy Learning Lab focused on food insecurity (broken into two groups with six teams per group). The 2018 Policy Learning Lab was a continuation of work focused on food insecurity, and included five teams. Each team consisted of a health care organization plus an entity from at least one other sector. A list of teams in each Lab is available at movinghealthcareupstream.org.

Nemours contracted with [ChangeLab Solutions](#) as our lead partner in this pilot based on their subject matter expertise on our chosen topics as well as their expertise in providing technical assistance on the development of local public policy and institutional policy. The expertise of ChangeLab Solutions was supplemented by additional subject matter experts who were involved on an as-needed basis, based on the needs of teams.

- Root Causes of Asthma (2017)- Experts for teams focused on root causes of asthma included [Green & Healthy Homes Initiative](#) and [Nemours Health & Prevention Services](#).
- Food Insecurity (2017)- Experts for teams focused on food insecurity included [Feed1st at the University of Chicago's Lindau Lab](#), [Root Cause Coalition](#) and [Prevention Institute](#).
- Food Insecurity (2018)- Experts for teams focused on food insecurity included the [Food Research & Action Center \(FRAC\)](#) and [Children's HealthWatch](#), under the auspices of the [Hunger Vital Sign National Community of Practice](#)- which is co-facilitated by these two organizations.

To learn more about Moving Health Care Upstream, please visit movinghealthcareupstream.org and follow us on Twitter [@MHCUpstream](#).

For questions, please email MHCU@nemours.org.



Summary of Research and Technical Assistance Requests

Policy Learning Lab focused on *Food Insecurity*

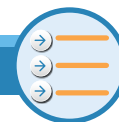
Team Location	Key Point of Contact	Specific Technical Assistance Requested
Alaska <i>Anchorage</i>	Cara Durr cdurr@foodbankofalaska.org	<p>2017 REQUEST—Food Insecurity Screening in Clinical Settings. Provide assistance with adopting organizational and/or system-wide policies for food insecurity screening, with a specific focus on: 1) Outcomes and best practices for referrals provided through the screening process; 2) Detailed materials that answer the “then what” question.</p> <p>State-level Funding Mechanisms Related to Food Insecurity. The team requests resources that identify 1) state-level policies that address food insecurity; and 2) how states have expanded Medicaid coverage to address food insecurity.</p> <p>Click here to access the technical assistance materials provided to this team during 2017.</p>
California <i>Los Angeles</i>	Fatimah Darwish fdarwish@ph.lacounty.gov	<p>2017 REQUEST—SNAP-Ed Support for Food Insecurity Initiatives. Provide examples of any health care-based food insecurity screening-and-referral initiatives outside of Los Angeles County that have received funding through the Nutrition Education and Obesity Prevention Grant Program (SNAP-Ed) to support their work.</p> <p>Public Benefits and Undocumented Residents in California. Summary of public benefits that undocumented people can access to help them address food insecurity.</p> <p>Click here to access the technical assistance materials provided to this team during 2017.</p> <p>2018 REQUEST—TA Related to Scaling Food Insecurity Screening & Referral Processes to Multiple Clinics. 1) Provide a “skeleton” model of screening/referral process (focus on warm handoffs). 2) Provide examples of county-wide resources; 3) Help connecting to San Diego group doing similar work; 4) Offer examples of other resources to recommend to patients (examples: nutrition education, financial literacy training, housing issues).</p> <p>Click here to jump to the technical assistance provided to this team during 2018.</p>
California <i>San Diego County</i>	Elly Brown elly@sdfsa.org	<p>2017 REQUEST—SNAP’s Restaurant Meals Program (RMP). Provide information to make the case for county- or state-level policies that facilitate the use of restaurant meals program (RMP) benefits at food establishments that offer healthy, affordable, culturally appropriate, and accessible options.</p> <p>Click here to access the technical assistance materials provided to this team during 2017.</p>



Summary of Research and Technical Assistance Requests (continued)

Policy Learning Lab focused on *Food Insecurity* (continued)

Team Location	Key Point of Contact	Specific Technical Assistance Requested
Colorado <i>Denver Metro Region</i>	Sharon Crocco sharon.crocco@state.co.us	<p>2017 REQUEST—Local Policy that Promotes the SNAP Use at Farmers Markets in Colorado.</p> <p>The City of Golden, Colorado recently passed an ordinance that promotes SNAP use at farmers markets. Examine the jurisdictional issues related to implementing similar ordinances in other communities in Jefferson County, CO.</p> <p>Click here to access the technical assistance materials provided to this team during 2017.</p>
Delaware <i>Wilmington</i>	George Datto george.datto@nemours.org Mary Gavin mary.gavin@nemours.org	<p>2018 REQUEST—TA on Establishing Scalable Food Insecurity Screening & Referral Processes at Initial Sites; Demonstrating ROI; Best Practices in Soliciting/Incorporating User Feedback into FI Screening & Referral Protocols.</p> <p>Provide detailed “how to” information and potentially replicable examples in all areas. Provide examples of comprehensive, start-to-finish models and best practices for each step in screening & referral processes- workflow, training, implementation, evaluation, etc.</p> <p>Click here to jump to the technical assistance provided to this team during 2018.</p>
Georgia <i>Atlanta</i>	Wendy Palmer wendy.palmer@choa.org	<p>2017 REQUEST—Food Insecurity Screening in Clinical Settings Specific to Communication Strategy and Outcomes.</p> <p>Provide resources to support communications and messaging, with a specific focus on developing internal communications to increase buy-in. Provide information on outcomes being tracked in similar programs, including financial benefits to healthcare organizations as well as health and social benefits to patients and their families. Provide examples of hospital-affiliated food pantries in the United States and connections to relevant networks.</p> <p>Click here to access the technical assistance materials provided to this team during 2017.</p> <p>2018 REQUEST—TA Related to Scaling Food Insecurity Screening & Referral Processes to Multiple Clinics.</p> <p>1) Provide a “skeleton” model of screening/referral process (focus on warm handoffs). 2) Provide examples of county-wide resources; 3) Help connecting to San Diego group doing similar work; 4) Offer examples of other resources to recommend to patients (examples: nutrition education, financial literacy training, housing issues).</p> <p>Click here to jump to the technical assistance provided to this team during 2018.</p>



Summary of Research and Technical Assistance Requests (continued)

Policy Learning Lab focused on *Food Insecurity* (continued)

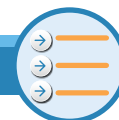
Team Location	Key Point of Contact	Specific Technical Assistance Requested
<p>Georgia <i>Atlanta Metro Region (Fulton & DeKalb counties)</i></p>	<p>Kathryn Lawler klawler1@gsu.edu</p>	<p>2017 REQUEST—Incentives and Policies to Increase Healthy Food Retail in Georgia. Provide examples of incentive programs and policies to increase healthy food retail in underserved areas, as well as financing options for advocates and stores participating in these efforts. The research is broken out into three main sections: 1) Review of Healthy Food Financing Activity in Georgia including a review of state legislation; 2) Financing opportunities for healthy retail interventions at the local, state, and federal levels, with links to further information on specific programs, other organizations in the field, and resources; and 3) Methods for communities to incentivize healthy corner store development.</p> <p>Click here to access the technical assistance materials provided to this team during 2017.</p> <p>2018 REQUEST—TA to inform a pending needs assessment around grocery stores locations and the drivers that influence where stores are, and are not, located. 1) Provide a review of economic data resources for supermarket/grocery store industry; 2) Provide research and resources on structural racism and grocery store locations; 3) Provide a review of local agency data sources that may help understand grocery store closures.</p> <p>Click here to jump to the technical assistance provided to this team during 2018</p>
<p>Louisiana <i>Central Louisiana</i></p>	<p>John Cotton Dean jdean@cenla.org</p>	<p>2017 REQUEST—Strategies to Promote Local Healthy Food Procurement. Provide examples of food procurement policies, contracts, and requests for proposals (RFPs) that require or encourage institutions to purchase local, healthy food.</p> <p>Click here to access the technical assistance materials provided to this team during 2017.</p> <p>2018 REQUEST—TA to Inform the Structure and Form of the Central Louisiana Food Policy Council’s Toolkit. TA to Inform Early Plans for a Veggie Rx Program. <i>For Toolkit:</i> 1) Provide menu of options for structuring and disseminating policy toolkits; 2) Provide policy toolkit examples from a range of food-related sources; 3) Provided examples of evaluation-related information and tools.</p> <p>Click here to jump to the technical assistance provided to this team during 2018.</p> <p>For Veggie Rx Program: 1) Facilitate connections to rural hospitals operating Veggie Rx programs, and information about such programs- case studies, evaluations, reports, toolkits, etc.</p> <p>Click here to jump to the technical assistance provided to this team during 2018.</p>



Summary of Research and Technical Assistance Requests (continued)

Policy Learning Lab focused on *Food Insecurity* (continued)

Team Location	Key Point of Contact	Specific Technical Assistance Requested
Louisiana <i>New Orleans</i>	Melanie McGuire mmcguire1@secondharvest.org	<p>2017 REQUEST—Analysis of Whether SSA's Beneficiary Inducement Provisions Apply to Hospital-Based Food Pantries. Provide a general overview of the beneficiary inducement prohibitions in the Social Security Act for purposes of assessing whether and how those prohibitions impact health care providers' ability to refer patients to on-site food pantries.</p> <p>Food Insecurity Screening in Clinical Settings. Provide examples of hospital-affiliated food pantries in the United States and connections to relevant networks.</p> <p>Click here to access the technical assistance materials provided to this team during 2017.</p>
Montana <i>Blackfeet Reservation</i>	Pharah D. Morgan pharah.morgan@rmtlc.org	<p>2017 REQUEST—Funding Sources for Tribal Food Access Projects. Provide a general overview of funding resources for food access projects organized by the following categories: resources for tribal communities; foundation grants; federal grants and loans; and state grants and loans.</p> <p>Click here to access the technical assistance materials provided to this team during 2017.</p>
Texas <i>Fort Worth and other Tarrant County municipalities</i>	Linda Fulmer lindafulmer@sbcglobal.net	<p>2017 REQUEST—Incentives and Policies to Increase Healthy Food Retail in Texas. Provide examples of incentive programs and policies to develop healthy corner stores in underserved areas, as well as financing options for advocates and stores participating in these efforts. The research is broken out into two main sections: (1) Methods for communities to incentivize healthy corner store development, with links to resources and examples; and (2) Financing opportunities for healthy retail interventions at the local, state, and federal levels, with links to further information on specific programs, other organizations in the field, and resources.</p> <p>Click here to access the technical assistance materials provided to this team during 2017.</p>
Texas <i>Harris County</i>	Katie Chennisi cchennisi@hcphes.org	<p>2017 REQUEST—Policies that Support Urban Agriculture in Texas. Provide examples of cities that have successfully enacted laws to encourage and support urban agriculture, and resources that propose strategies to overcome legal barriers to urban agriculture.</p> <p>Click here to access the technical assistance materials provided to this team during 2017.</p>
Washington <i>Seattle</i>	Kelly Fisher kelly.fisher@seattlechildrens.org	<p>2017 REQUEST—Food Insecurity Screening in Clinical Settings. Provide assistance with adopting organizational and/or system-wide policies for food insecurity screening, with a specific focus on: (1) Outcomes and best practices for referrals provided through the screening process; (2) Detailed materials that answer the “then what” question; and (3) Making the business case for addressing food insecurity and for examining hospitals' role in social determinants of health, particularly for subspecialty care vs. primary care.</p> <p>Click here to access the technical assistance materials provided to this team during 2017.</p>



Summary of Research and Technical Assistance Requests

Policy Learning Lab focused on *Root Causes of Asthma*

Click here to access the technical assistance materials provided to this team during 2017.

Team Location	Key Point of Contact	Specific Technical Assistance Requested
California <i>Watsonville</i>	Henry Martin hmartin@splg.org	Summary of California's 2017 Housing Legislation. Provide a summary of legislation that California passed in 2017 to address the state's housing crisis. Include high-level analysis of the impacts and opportunities this legislation may create for Santa Cruz County and the city of Watsonville.
Florida <i>Orlando</i>	Annette Thomas annette.thomas@FLhealth.gov	State Policies on School-Based Asthma Triggers. Provide information about state policies that require schools to assess asthma triggers.
Illinois <i>Chicago</i>	Sue Ellen Schumacher sueellen.schumacher@presencehealth.org ; Jess Lynch jessica.lynch@iphionline.org	Policies to Address Mold in Rental Housing in Illinois. Provide background on the law in Illinois that addresses mold in rental housing. Lay out local policy strategies to address mold in rental housing.
Michigan <i>Grand Rapids</i>	Paul Haan paul@healthyhomescoalition.org	The Connections Between Housing and Health in Michigan. Prepare a memo that makes the connection between housing and health. Include information and data that will be meaningful for local policymakers and other stakeholders. Focus on asthma triggers and asthma prevention.
Washington, D.C.	Dr. Ankoor Shah anshah@childrensnational.org	The Connections Between Housing and Health in DC. Prepare a memo that makes the connection between housing and health. Include information and data that will be meaningful for local policymakers and other stakeholders. Focus on asthma triggers and asthma prevention.



Webinars and Calls

Over the course of the 2018 Policy Learning Lab (PLL), teams engaged in several webinars and calls. Some were the result of the core MHCU partnership with Children’s HealthWatch and Food Research & Action Center. Others were scheduled or shared in order to connect PLL teams with non-lab health care-community partnerships whose work had been featured at conferences or through other outlets around the country during the period of the Phase 2 lab.

Hunger Vital Sign National Community of Practice (CoP): Virtual Meetings

Co-convened by Children’s HealthWatch and Food Research & Action Center, the CoP works to facilitate conversations and collective action among a wide-range of stakeholders interested in addressing food insecurity through a health care lens. The group seeks to identify research on the connections between food insecurity and health; promote the use of the Hunger Vital Sign™ to screen for food insecurity; and champion effective interventions to address food insecurity both at the practice and policy level. The group includes more than 100 physicians, public health researchers, anti-hunger agencies and advocates, health care professionals, and policy experts.

[Click for more information about the Hunger Vital Sign™ National Community of Practice \(NCoP\)](#)

August 22 meeting materials ([Hyperlink](#)):

- Meeting slides and [audio/video recording](#)
- Hunger Vital Sign, [National Community of Practice contact list](#)
- American Academy of Family Physicians, [EveryONE Project presentation slides](#)
- BlueCross BlueShield of Vermont “[Specific ICD-10-CM for Food Insecurity and Its Sequelae](#)”
- [New innovative pro-produce sections of the 2018 Farm Bill](#)
- Other materials and documents discussed during the meeting

November 28 meeting materials ([Hyperlink](#)):

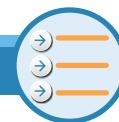
- [Meeting slides](#) and audio/video recording
- [Vermont Child Health Improvement Program presentation slides](#)
- [Public Charge Research Arguments Compendium with citations](#)
- Other materials and documents discussed during the meeting

Moving Health Care Upstream: Identifying & Addressing Food Insecurity in Healthcare Settings

Partners at Children’s HealthWatch and Food Research & Action Center created this webinar for PLL teams, in response to calls with each team and collected questions and issues across all teams. It covers the food insecurity screening and referral process, from start to finish. It includes a review of the evidence for screening, including projected outcomes. It then covers the current state of comprehensive health related social needs (HRSN) screening tools and offers some resources for determining which tool may be right in a given situation (including the “build it or buy it” choice). The webinar also addressed workflow planning, engaging staff, e-referrals & community partnerships, and some notes on the closed loop referral process. Key resources from the webinar are also linked below.

September 12 meeting materials ([Hyperlink](#)):

- Meeting [slide deck](#) and [audio/slide recording](#)
- H. B. Kersten et al. (eds.), *Identifying and Addressing Childhood Food Insecurity in Healthcare and Community Settings*, SpringerBriefs in Public Health, 2018. [Available here.](#)



- Ashbrook, A. and Hartline-Grafton, H. Addressing Food Insecurity: *A Toolkit for Pediatricians*. *Food Research and Action Center*, 2017. [Available here](#).
- Feeding America. *Food Insecurity and Health: A Tool Kit for Physicians and Health Care Organizations*, 2017. [Available here](#).
- Correa, N. and the ACE Coalition Food Insecurity Workgroup. Food insecurity screening in Houston and Harris County: *A Guide for Healthcare Professionals*. *Houston, TX: Baylor College of Medicine and Texas Children's Hospital*, 2017. [Available here](#).
- Social Interventions Research and Evaluation Network. *Tools and Resources*, 2018. [Available here](#).
- Additional resource materials developed specifically for Policy Learning Lab teams can be [accessed here](#).
- Nemours Children's Health System, [Community Care Coordination Systems: Technology Supports](#) (issue brief on closed loop referral systems).

Parkland Center for Innovation: Conference Call

The Parkland Center for Innovation is connecting hospitals and food banks in Dallas, Texas to improve the nutrition of patients who experience food insecurity and have been diagnosed with chronic diseases like hypertension and diabetes. They are developing a network of health care and community-based organizations in the Dallas region that are sharing information through the Dallas Information Exchange Portal. Presenters Yolande Pengetnze, MD, MS, FAAP; Senior Medical Director & Physician Scientist and Dennis Tkach, PhD; PCCI, Director of Connected Communities of Care.

November 11 call materials ([Hyperlink](#)):

- [Slide deck](#) (PPT)
- A recording of the presentation from Parkland Center for Clinical Innovation ([audio + slides](#))
 - o Note: due to issues with sound quality, we edited out the introduction and discussion / Q&A portions of the webinar. Written responses to the discussion / Q&A items are provided as a substitute at the link, above.
- PCCI's [responses to discussion / Q&A items](#) presented by Policy Learning Lab teams
- PCI's work was recently featured on a podcast by *All In: Data for Community Health* (Connecting Hospitals and Food Pantries in Dallas, TX from Jul 30, 2018 in Podcasts, [available here](#))

All In, Data for Community Health Webinar: Research and Application, Measuring Social Needs and Outcomes

During this All In webinar, Caroline Fichtenberg of SIREN reviewed the current landscape of assessment tools and outcomes measures for social needs. Karis Grounds of 2-1-1 San Diego explained how they incorporated social needs assessment into their Risk Rating Scale, which helps them better serve clients while showing the impact of their services.

August 21 Webinar materials ([Hyperlink](#)):

- [Webinar recording available here](#)
- [Webinar Q&A Summary](#)
- [SIREN Tools and Resources](#)
- [Learn more about 2-1-1 San Diego](#)

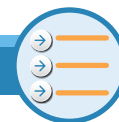


Center for Health Care Strategies Webinar: Advancing Health Care and Community-Based Organization Partnerships to Address Social Determinants, Lessons from the Field

The webinar explored promising strategies for creating and sustaining health care and CBO partnerships that address social determinants of health. It included a panel discussion featuring representatives from three unique health care-community partnerships: Project Access NOW (Portland, Oregon), Hunger Free Colorado, and 2-1-1 San Diego's Community Information Exchange.

August 17 Webinar materials ([Hyperlink](#)):

- Webinar recording ([audio with slides—available here](#))
- Technical Assistance Tool: [Tools for Supporting Social Service and Health Care Partnerships to Address Social Determinants of Health \(2018\)](#)
 - [Integrating to Improve Health: Partnership Models between Community-Based and Health Care Organizations](#)
 - [Value Proposition Tool: Articulating Value Within Community-Based and Health Care Organization Partnerships](#)
 - [Health Care and Community-Based Organization Partnership: What Does It Cost?](#)
- [Supporting Social Service and Health Care Partnerships to Address Health-Related Social Needs: Case Study Series \(2018\)](#)
 - [Project Access NOW's C3 Community Assistance Program: Ensuring Safe Discharge from the Hospital \(Portland, OR, August 2018\)](#)
 - [Hunger Free Colorado: Connecting Vulnerable Patients to Food and Nutrition Resources \(Denver, CO, August 2018\)](#)
 - [2-1-1 San Diego: Connecting Partners through the Community Information Exchange \(San Diego, CA, August 2018\)](#)
 - [Ensuring Healthy Outcomes for Louisville's Vulnerable Children: Health Access Nurturing Development Services Program \(Louisville, KY, October 2017\)](#)
 - [Housing is a Health Intervention: Transitional Respite Care Program in Spokane \(Spokane, WA, October 2017\)](#)
 - [Collaborating to Reduce Hospital Readmissions for Older Adults with Complex Needs: Eastern Virginia Care Transitions Partnership \(Eastern VA, October 2017\)](#)
 - [Meeting the Health and Social Service Needs of High-Risk LGBTQ Youth in Detroit: The Ruth Ellis Health & Wellness Center \(Detroit, MI, October 2017\)](#)



Additional Resources

Teams engaged in periodic calls with TA providers from Children’s HealthWatch, Food Research & Action Center, and ChangeLab Solutions. Where possible, team questions and issues were addressed through memos, webinars, or connections to colleagues in the field. However, sometimes responses were narrow enough to be provided on an ad-hoc basis via email. Other times, experts updated the teams directly with current developments in the field (such as new research, publications, or tools). These additional resources are summarized and linked below.

Screening Response Options

AJPH paper and companion editorial on the 2 Hunger Vital Sign question responses ‘often true, sometimes true, or never true’ instead of versus ‘yes or no.’

- Editorial: [Available Here](#)
- Article: [Available Here](#)

Staff Training: Food Insecurity Screening

Many teams working on food insecurity screening were interested in how to generate support and buy-in among colleagues, and how to broadly orient and train colleagues to the work. The teams led by Los Angeles County Department of Public Health and Children’s Healthcare of Atlanta shared slide decks with others as a resource. Please [CLICK HERE](#) to access copies of these slide decks.

Veggie Rx

This paper describes the framework used for implementing a produce prescription community-clinical linkage program between safety-net clinics and farmers markets for patients with hypertension. Strategies for successful implementation included involving multiple stakeholders throughout the process and limiting dependence on doctors and nurse practitioners in program execution.

- K. Joshi, S. Smith, S.D. Bolen, A. Osborne, M. Benko, & E.S. Trapl, [Implementing a Produce Prescription Program for Hypertensive Patients in Safety Net Clinics, Health Promotion Practice](#)

Return on Investment (ROI) Resources

Most evaluations of VeggieRx programs focus on process outcomes, health/nutrition impacts (e.g., increases in fruit/vegetable intake, changes in HbA1c), and impact on the local economy (e.g., redemptions of prescriptions at farmers markets). The memo provided [see below] includes the Wholesome Wave toolkit, and module 5 of that toolkit details measurement and evaluation strategies that are important to build into VeggieRx programs. To make the case to a hospital, consider highlighting the nutrition/health impacts and the emerging evidence on the cost-effectiveness of these programs (using Geisinger, discussed below, as an example).

Some figures in this NPR piece may be helpful:

- [Fresh Food By Prescription: This Health Care Firm Is Trimming Costs—And Waistlines](#)
“Once you consider that price tag, Geisinger’s program can look like a bargain. Over the course of a year, the company will spend about \$1,000 on each Fresh Food Pharmacy patient... But here’s what it estimates so far: “A decrease in hemoglobin A1C of 1 point saves us [about] \$8,000,” Feinberg says. And many of the participants have seen a decline in hemoglobin A1C of about 3 points. “So that’s [about] \$24,000 we’re saving in health care costs,” Feinberg says. “It’s a really good value.”
- *A more recent piece on the Geisinger program with cost information:*
[Prescribing Food as a Specialty Drug](#)



HealthBegins currently has an ROI calculator in beta testing. It looks quite useful as a planning tool and as a way to generate buy-in. The beta version of the tool is currently available for use. The Presentation slides from the HealthBegins presentation at the [Root Cause Coalition 2018 Summit on the Social Determinants of Health](#) are available [here](#).

Nemours Children’s Health System released a financial simulator tool in Spring 2019. The focus of this tool is on ROI for Medicaid and Medicaid Managed Care Organizations. It is most appropriate for teams that are attempting to engage Medicaid or Medicaid MCOs as partners. Please [CLICK HERE](#) for more information and to access the tool.

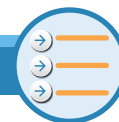
Delivering Community Benefit: Healthy Food Playbook

Health Care Without Harm and partner organizations will host a series of regional roundtables and webinars over the coming months to share the recently released “[Delivering community benefit: Healthy food playbook](#).” This suite of resources supports hospital community health professionals and community partners in assessing community food needs and developing initiatives to promote healthy food access and healthy, local and sustainable food systems.

Note there are best practice guides on all sorts of valuable food-related programming such as F&V prescription programs, double value coupons, on-site gardens and others. These resources speak to how to design the program not only to address the identified diet-related risks but to have the secondary benefit of healthy food access and local food system growth. The resources are applicable outside the hospital community benefit process.

Screening for other Determinants of Health

“[Housing, Food and Friends: One Rural Hospital’s Approach to Population Health](#),” at the Root Cause Coalition’s Summit ([available here](#))



Appendix A – Food Policy Toolkit Resources (Team Lead: Central Louisiana Economic Development Alliance; Louisiana)



ChangeLab Solutions
Law & policy innovation for the common good.

2201 Broadway, Suite 502
Oakland, CA 94612
510.302.3380
changelabsolutions.org

MEMORANDUM

To: c/o John Cotton Dean, Director, Rural Prosperity Initiative, Central Louisiana Economic Development Alliance (CLEDA)
Central Louisiana Team, Nemours' Moving Health Care Upstream


From: Sara Bartel, JD, ChangeLab Solutions

CC: Manel Kappagoda, JD, MPH, ChangeLab Solutions
Kate Blackburn, Senior Program & Policy Analyst, Nemours

Subject: **Structure and dissemination options for a food policy toolkit, with examples**

Date: October 15, 2018

As a part of the Nemours' Moving Health Care Upstream initiative, the Central Louisiana Policy Learning Lab team has asked ChangeLab Solutions for technical assistance to inform the production of a "Food Policy Toolkit" in October 2018. This memo includes:

- Options for structuring and disseminating policy toolkits;
- Examples from a range of food-related sources; and
- Where applicable, notes on evaluation-related information and tools.
[Evaluation icon ]

Toolkit Structure

Underlying the many options for structuring a policy toolkit are some foundational concepts that come from the [policymaking process](#) itself. This section opens with a review of that process, followed by a listing of the main types of [elements](#) that toolkits often include. Finally, it summarizes four examples of principles that can be used to provide the [overarching structure](#) of a toolkit.

[Dissemination information](#) and [examples](#) are provided in sections 2 and 3.

The Policymaking Process

There is a spectrum of different types of policy work, ranging from educational or programmatic support of policy development, to advocacy for institutional and community-wide policies, to evaluation and improvement activities for existing policies. The scope of policy work will vary by issue and by community—there is no one-size-fits-all approach. That said,



ChangeLabSolutions

strong policymaking will incorporate or be informed by the key steps reviewed below. Many policy roadmaps, policy process wheels, or other formats for the “steps” of policymaking are inclusive of some version of the following.

Policy toolkits do not have to address all of these steps, or address all of them to the same degree, but many of the principles for structuring a toolkit are directly or indirectly related to this process.

Relationship Building

Residents. Community members. Partners. Stakeholders. There are many ways of talking about the individuals and groups who will inform and support policymaking. These relationships can shape the entire process, from the first inspiration to ongoing evaluation. The strongest relationships are those built on mutual understanding, shared goals, and a robust structure for on-going responsibility and engagement.

Assessing

Assessments provide the foundational step of understanding a community to inform what the policymaking process should look like, as well as policy selection, drafting, implementation, and ongoing support. A community undertaking a robust assessment process will gather and create both quantitative data that tells a broader community story, as well as qualitative information from a variety of sources to help flesh out that story with people’s lived experiences.

A strong assessment process also contributes to the evaluation process, providing specific community baselines to compare to policy outcomes.



Goals and Priorities Setting

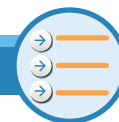
Policy interventions should be shaped by each community’s vision of what a “healthy community” means to its residents and stakeholders. Understanding each other’s diverse needs and strengths will lead to identifying those shared goals and priorities that will lead to the strongest policy solutions. Political, legal, and financial feasibility should also be part of the goal-setting process, both in the short-term and to ensure policy sustainability over time.

Policymaking

Selecting a specific policy and policy provisions bring the relationships, data, and goals all together on paper. Many times the existing laws and policies governing an institution or municipality will shape how a policy is developed and written—it can be helpful to have a lawyer involved not only in reviewing the draft policy, but also in developing and drafting it. Advocating for policy adoption is also made easier when decision-makers, stakeholders, and potential opponents are included earlier in the policy development process.

Implementing

Policy implementation will obviously vary greatly depending on the type of policy, but certain characteristics will ensure that implementation goes smoothly and sustains the policy for the long haul. This includes allocating responsibilities for all of the policy’s activities, setting timelines, providing for initial costs and on-going funding (for maintenance and improvements), programming to support the policy, and monitoring and reporting policy impacts.



ChangeLabSolutions

Evaluating

Policy evaluation most directly involves measuring outcomes against the baseline of pre-policy assessments. Measures should include those related to the stated goals of the policy, as well as any unintended consequences that may result. Ultimately, evaluations must be shared and discussed to be effective—they should prompt celebration of successes and calibration to address any concerns.



Toolkit Elements

Policy toolkits may include a few different types of information. Many advocates find it helpful to have easily identifiable menus and lists, or sets of options. Examples from the field or from related issue areas can highlight best practices or introduce promising new avenues. Finally, toolkits should include copies of or links to tools for doing the work!

Menus, Lists, Options

Menus and lists can provide lots of high-level information in a concise and visually accessible way. While they may miss out on the detail of any given option or tool, they can be a great launch-pad for additional reading and research, particularly when they are hyperlinked or indexed in relation to other available resources. Toolkit menus and lists may be especially appropriate forms for certain times of information, including:

- Glossaries of terms
- Educational materials
- Supporting research
- Intervention options
- Checklists of provisions and considerations
- Sources of community data
- Metrics and measures for specific outcomes
- Process roadmaps
- Funding sources
- Lists of contacts
- Related resources



ChangeLabSolutions

Examples

Real-world examples can be helpful, either when they are directly on-point or when they provide a point of comparison. Advocates can use them to analogize to their own communities and issue-areas to make hypotheses and suggestions about what may work for them, and what may not. All of these examples should be dated, with contact information included where possible, so that their continuing relevance and success can be tracked (and included in the toolkit, where relevant).

- **Case studies** are one way to convey the story of a community's experience, from start to finish: what issues or problems it was trying to address, how it aimed to do so, what resulted, and what lessons it learned in the process.
- **Model policies** provide a less-nuanced form of example, but are more directly applicable for communities farther along in the policymaking process.
- **Documents and forms** make it easy for toolkit users to create their own policy support materials, such as agreements, fee schedules, letters, signage, etc.
- **Reports and evaluations** are particularly valuable examples to include in a toolkit because they often include overarching goals and outcomes, as well as nuts-and-bolts details about examples, such as sample metrics for baseline assessments and policy outcomes.



Tools

Finally, policy toolkits should include tools for doing the work of policymaking. Even if a toolkit doesn't directly incorporate every step of the policy process, it can be helpful to indicate how any given tool may be helpful for the following activities:

- Relationship building and partnership tools
- Assessment tools (sources of data, survey questions, online services)
- Planning and envisioning tools
- Advocacy (including drafting and adoption) tools
- Implementation tools
- **Evaluation tools (measuring, selecting indicators, reporting)**



Sample Structuring Principles

At base, the structure of a toolkit should facilitate easy access and absorption by its intended audience. Toolkit authors should start by asking, for example:

- Who are the intended audience members?
- Who may be tangential/unintended audiences?



ChangeLabSolutions

- At what stages of readiness are audience members?
- What resources do they have? What do they need?
- What types of materials exist to help move them along in the process? (Lists, options, examples, tools?)
- What information is needed to fill any gaps in capacity or knowledge?

It's helpful to clearly indicate a toolkit's structure, for example by providing a detailed, hyperlinked table of contents, a rigorous index, or a chart, map, or other visual way to represent how the materials in the toolkit are presented. Making the structure obvious and easy to navigate can make a huge difference in a toolkit's success: intended readers will appreciate a logical organization and the ability to return to relevant sections as-needed, while tangential audiences can target specific sections or examples that interest them without having to dig through the entirety.

The following four structuring principles are intended as examples; they can be mixed and matched, or may conjure other options for toolkit organization based on analogous structures in other fields.

Policy Process

Using the policy process, itself, as a structure has the added benefit of providing additional information through the toolkit's organization. Not only does it provide materials supporting these activities, it reminds readers of how they might go about doing the work.

- 1. Relationship building**
- 2. Assessing**
- 3. Goals and priorities setting**
- 4. Policymaking**
- 5. Implementing**
- 6. Evaluating**



Each section could include a mix of lists, examples, and tools, depending on what resources are available or most applicable. Some toolkits may want to focus on two or three key activities, or even one step of the policymaking process with the intention of providing additional materials to flesh out an overarching structure, over time.

Sectors/Partners

Structuring a toolkit by sector can help jumpstart the process of partnership development. It can highlight policies to pursue with existing partners, and may streamline possible options for those who know certain partners aren't applicable in their work.

Some policies can be implemented in multiple sectors (for example, institutional procurement policies can happen in government, nonprofit, and private institutions), which means this



ChangeLabSolutions

structure isn't always the simplest way to represent a large collection of policies. That said, it could be useful for contextualizing a narrower set of options, or for reaching a specific audience [see example, right].

*A toolkit aimed at **school districts and schools** can highlight partnership opportunities with government agencies, local businesses, and nearby community spaces. Each section could address coordination and planning with each type of partner, specifically, as well as policy suggestions that align common school goals with the potential partner's goals.*

Sector: Local Government

- Policymakers (for policies implemented through laws and regulations, such as food-establishment-licensing or mayoral resolutions)
- Health departments (for policies that overlap with education or enforcement activities, such as farmers' markets or restaurant inspections)
- Schools and school districts (e.g., shared use or nutrition curriculum)
- Parks and Recreation departments (e.g., community gardens)

Sector: Private Individuals and Industry

- Health care providers (e.g., food insecurity screenings or food Rx)
- Child, elder, and other care providers (e.g., institutional feeding/procurement)
- Universities, colleges, technical schools (e.g., healthy vending)
- Employers and land-owners (e.g., procurement or shared use)

Sector: Nonprofits and Community Groups

- Churches (e.g., wellness policies, community gardens)
- Community centers (e.g., nutrition and cooking classes)
- Food banks/pantries (e.g., gleaning programs or federal benefit uptake)
- Advocacy organizations and affinity groups (e.g., to participate in the policymaking process)

Because this format doesn't provide procedural touchstones for the work of policymaking, each section may include its own, tailored thoughts and resources for undertaking the process along with the partner(s) indicated, starting with focused partnership building and assessment guidance.

Food Interventions

Food policy toolkits, specifically, have an additional structural option to consider using the separate components of the food system. Communities have multiple policy intervention



ChangeLabSolutions

options at every step of the way – from how food is produced to how it gets to the people who need it most.

Growing. To address how food is produced, whether on farms, through urban agriculture, or on a smaller scale in community/school gardens.

Buying. To affect how food is purchased in a variety of sectors, including institutional food purchasing and procurement, or healthy vending.

Selling. To influence the way food is sold, from facilitating farmers' markets, CSAs, and retail distribution (e.g., corner stores, supermarkets), to changing the way institutions provide food (e.g., schools, jails), to establishing requirements for healthier advertising and labeling (i.e., of menus and products).

Prescribing. To support whole-self care, such as hunger screenings in health care and social service settings and food/veggie Rx programs.

Giving. To facilitate food benefits, encouraging use of and supporting food gleaning and donation, banks and pantries, school and summer meal programs, and other federal programs (e.g., increasing uptake and retailer acceptance)

Educating. To embed food education in different settings, from schools and youth groups, to events like farmers' markets and fairs, to job training programs; including farming and gardening skills, nutrition education, and cooking demonstrations and classes.

This structure lacks process-focused sections, similar to the sector-based organization style, above. It can be useful to pay special attention to opportunities for infusing this type of toolkit with resources for the policymaking process.

Stages of Readiness

Similar to the policymaking process, a toolkit can be structured around policy activities geared for specific stages of community readiness. First developed by the [Tri-Ethnic Center for Prevention Research at Colorado State University](#), the community readiness model provides nine steps that indicate how a community, institution, or even an individual, may approach an issue or problem. For our purposes, I've listed the steps below and made notes about toolkit materials that may fit under each.

Stages of Readiness	Toolkit Examples
1. No awareness.	<ul style="list-style-type: none"> Education and assessment activities
2. Denial or resistance.	<ul style="list-style-type: none"> Information gathering and distribution
3. Vague awareness.	<ul style="list-style-type: none"> Programming to support policymaking



ChangeLabSolutions

	<ul style="list-style-type: none"> Relationship building
4. Preplanning.	<ul style="list-style-type: none"> Partnership building Community engagement/learning Policy goals and options Planning tools
5. Preparation.	
6. Initiation.	<ul style="list-style-type: none"> Policy drafting and examples Policy support programming Implementation materials Measurement tools and measures Evaluation tools and examples
7. Stabilization.	
8. Confirmation or expansion.	
9. High level of community ownership.	



Toolkit Dissemination

A dissemination plan should include considerations for how a toolkit is published and when, and should provide support for its release and initial distribution, as well as ongoing support for ensuring its usefulness over time. This includes building in toolkit evaluation measures (which can incorporate lessons from the *policy* evaluation resources/structures throughout this memo).



Publication

Print or Digital: Deciding whether to print a toolkit can depend largely on budget – it can be more costly to print resources than simply to host them online. Correcting mistakes and making updates are also costlier, and risk creating waste down the line. Even for readers who generally enjoy having hard copies of materials, for the purposes of *using* a toolkit they may find a digital version more practical. Text from model policies can be copied and pasted. Pages can serve as individual “tear out sheets” without getting disconnected from the original source. The possibilities for formatting are also much broader in an online setting, rather than a printed form, which can increase user-friendliness.

That said, for some audiences, having a tangible guide makes dissemination and uptake easier. Some potential readers won’t take the time to type out a link from a document or presentation encountered away from their desk. Some may have limited access to a computer.

To decide between print and digital publication formats, toolkit authors should start by exploring and understanding a toolkit’s intended audiences and what would be most helpful for them.



ChangeLabSolutions

Print and Digital: Of course, sometimes the answer is both! These days many readers primarily are consuming content digitally. Even if a toolkit is published in print versus on a website, it should be in a format that's also digitally accessible, with a user-friendly layout and live hyperlinks. For example, using a PDF document type can be useful for preserving formatting on a variety of reading devices, but authors should be sure to include live internet links in the document conversion process, and maintain text-searchability.

Timing: Release timing is generally determined by toolkit completion. The sooner authors can get materials into the hands of the intended audience, the better. However, there are some reasons why authors may want to delay publication dates. When a toolkit's release can coincide with an event, such as a conference, health fair, or partner webinar, it may make sense to use the event as a platform to celebrate the release. On the flip side, if a toolkit will be ready for release just *after* a large event in which many audience members will have participated, it may be good to wait so that the toolkit doesn't get lost in the shuffle. Some authors also hold toolkit publication until after major holiday breaks, or to ensure release doesn't fall on a day in which it could be viewed as inappropriate by audience members (for example, on a holiday in remembrance of a tragedy).

Release Support

There is a suite of options for supporting a toolkit's release, to ensure it is seen by the intended audience and shared widely. These include:

Blurbs: It can be helpful to prepare a few blurbs of different lengths, each "pitching" the goals and intended audience for the toolkit. They can be mixed and matched to support the variety of release products discussed below.

- One is about a sentence, covering only the basics, so that it's twitter-friendly and easy to include as a comment or side note in other contexts.
- Another is a short paragraph to use in email lists to provide a brief introduction to the toolkit – this can also serve as the introductory text on a "landing page" where the toolkit is hosted online.
- Finally, some authors may go a step farther and prepare a mini-article of a few paragraphs, explaining the context and significance of the toolkit, as well as a preview of the contents and more information about the toolkit's creators.

Emails, Lists, and List Serves: In addition to a release email for general distribution (see final blurb, above), it can be useful to reach out to contacts and networks with personalized notes asking people to forward. Prior to publication, authors can reach out to administrators of other organizations and groups, asking if the toolkit can be included in upcoming materials, newsletters, and update calls, or if it can be included in a group email or digest.

Advertising and Press: Advertising can follow traditional print channels, including articles, posters, flyers; as well as digital/social media, including articles, blogs, tweets, ads, infographics, animations, etc.



ChangeLabSolutions

Events: Live/in-person and online (e.g., conferences, webinars, twitter chats, etc.). The more a toolkit-promoting event can incorporate the partners and practitioners who contributed their stories and materials, the broader the network of potential readers will be. Events should take the content to the next level, while providing a basic outline of the toolkit so that participants have an easy time assessing its usefulness for their work.

Experts, Organizations, and Referrals: Toolkit release planning can also incorporate help from outside sources, so that users can follow up with someone (or tap into a group) to get tips and guidance on using the tools. This may include subject matter experts who have agreed to be contacted, or who are funded to provide technical assistance on using the tools. They may be content experts, or process experts, or may represent common partners for certain policies—which is to say, the idea of “expertise” should be understood broadly to represent the breadth of issue areas and skills used in policymaking.

Partner organizations can also provide connections and networking opportunities for practitioners, if they are looped into the release process. It can be a win-win: groups can increase participation numbers and toolkit readers are brought directly into a community that supports their work.

Toolkit authors can link audience members with individuals and other service providers to assist with policymaking work. From legal organizations that provide free or reduced-cost review of policies, to consultants who provide discounted services for nonprofits groups and local governments, technical assistance is a great way to ensure a toolkit’s vitality.

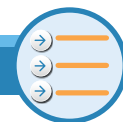
Ongoing Support

Many of the resources for supporting a toolkit’s release can be used in an ongoing way to sustain the reach and use of the product, over time. From sharing updates about models and examples included in the toolkit, to highlighting successes of toolkit users, updates can keep readers (and potential readers) engaged with the material. It can be helpful to select a few support venues/activities and determine regular intervals for updates/outreach.

Creating this dialogue between the audience and the toolkit creators requires that the toolkit include contact information, not only for the authors/compiler, but also for any individuals who prepared stories or examples (with their permission). Often policy advocates will find a story or example that speaks to them, and will want to connect with the originators. The strongest toolkits will not simply provide information; they will facilitate conversations about best practices, lessons learned, and key resources for doing the work.

Evaluation

Contact information can help toolkit users reach out to the content creators for more resources, connections, and other community-building activities. It can also provide a forum for feedback about the toolkit. In this way, including email addresses and phone numbers for related content-owners is the first pathway for evaluation of the toolkit. If there are mistakes, incomplete sections, or additional resources to include, some readers will reach out to let the authors know it.



ChangeLabSolutions

Tracking distribution is one way to measure effectiveness. Authors can create a database to gather information about how many copies of the toolkit have been distributed, where, by whom, etc. Some websites (such as Facebook, Google, and Twitter) and email providers offer digital tracking services, enabling authors to track clicks, time views, and count downloads, providing valuable information about reach (both numerical and geographic).

Surveys provide another method for evaluating toolkits. Asking potential audiences to fill out surveys after reviewing the toolkit can help indicate what seems appealing to them, and where it falls short of their needs. Authors can even include a survey link within the toolkit itself.

Reviewers and evaluators can also provide more rigorous evaluation. Authors solicit feedback on the toolkit from specified individuals and organizations who would bring a valuable perspective on the material. Sometimes this review can take place before toolkit publication, but it can also happen after the toolkit goes “live.”

Policy Adoption can be a very compelling metric of success; the more communities have adopted policies from a policy toolkit, the more successful it has been! That said, policy work can be a long process, and viewing “success” in a narrow sense can result in much of the work going unrecognized. In some cases it can also result in a drive to get policies passed quickly, without a mind toward how valuable, realistic, or effective they may be.



Policy Activities may be better indicators of a toolkit’s reach. The most successful policies come out of a community- and partner-driven process. There are many options for evaluating activities on the way to “adoption,” including the degree to which readers have:

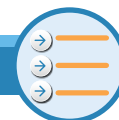
- More familiarity with policy options
- A better understanding of the policymaking process
- Undertaken policy advocacy/outreach/educational activities
- Established # new partnerships
- Scheduled # meetings with possible partners
- Created a coalition to pursue a policy
- Solicited input from # community/organization members
- Set # shared goals with partners/coalition
- Undertaken an assessment process
- Applied for funding to pursue a policy
- Presented about policy options to advocates/partners/decision makers
- Drafted a policy to submit to decision makers
- Attempted to pass a policy



ChangeLabSolutions

Examples and Resources

Example	Creator	Link	Notes
<p><i>City Region Food System Toolkit</i></p> <p>Guidance on how to assess and build sustainable city region food systems.</p>	Food and Agriculture Organization of the United Nations	Website access here: City Region Food System Toolkit	Good web-based model, brevity, tools in shaded boxes.
<p><i>Community Tool Box</i></p> <p>Practical information for community building that both professionals and ordinary citizens can use.</p>	Center for Community Health and Development, University of Kansas	Website Access here: 46 Chapters, step-by-step guidance in community-building skills.	Excellent online toolkit, foundational resource. Chapters on evaluation, here . 
<p><i>Delivering community benefit: Healthy food playbook</i></p> <p>Learn and accelerate best practices to promote healthy food access and healthier food systems.</p>	Health Care Without Harm	Website Access Here: Delivering community benefit: Healthy food playbook—Resources to Support & Inspire	GREAT new resource in this space! Conducting assessments; implementation strategies; evaluating and reporting. Release event example. 
<p><i>Farmers' Market Legal Toolkit</i></p> <p>Legal resources, best practice recommendations, and case studies for market leaders on selecting and enhancing business structures, accepting SNAP benefits, and managing common risks.</p>	Center for Agriculture and Food Systems, Vermont Law School	Website access here: Legal resources for building resilient and accessible markets	Selects three main strategies, includes case studies.
<p><i>Food Systems Toolkit: Action tools aligned with the Community & Regional Food Systems Project framework</i></p> <p>Action-oriented resources to help practitioners and community groups plan, implement and evaluate a variety of community food system initiatives.</p>	University of Wisconsin-Extension Community & Regional Food Systems Project, University of Wisconsin-Madison	Website access here: A curated collection of action-oriented resources to help practitioners and community groups plan, implement and evaluate a variety of community food system initiatives	Web-based, index style archiving.
<p><i>Good Food Toolkit: A Food Sustainability and Justice Evaluation and Planning Guide for Faith Communities</i></p> <p>Aims to mobilize religious institutions to [...] teach and model healthier, more sustainable and just food practices.</p>	Baltimore Food & Faith Project Johns Hopkins Center for a Livable Future Greenfaith	Website access here: A Food Sustainability and Justice Evaluation and Planning Guide for Faith Communities	Compare: Eat, Grow, Donate categories. Evaluation tool is for an initial assessment.



ChangeLabSolutions

Example	Creator	Link	Notes
<p><i>Good Laws, Good Food: Putting Local Food Policy to Work for Our Communities</i></p> <p>Understand the basic legal concepts surrounding local food systems, develop a base of knowledge about the main policy areas, and discover examples and innovations from other localities.</p>	<p>Harvard Law School Food Law and Policy Clinic</p> <p>Johns Hopkins Center for a Livable Future</p>	<p>Website Access here: Putting Local Food Policy to Work for Our Communities</p> <p>A Legal Toolkit from the Harvard Law School Food Law and Policy Clinic</p> <p>2nd edition</p>	<p>Dense - based loosely on intervention type/sector (strong outline in TOC). Evaluation language example (p. 60) and tool (p. 80).</p>
<p><i>Health In All Policies Roadmap</i></p> <p>Provides strategies for collaboration, challenges to consider, and concrete guidance and inspiration from real people who have done this hard and important work.</p>	<p>ChangeLab Solutions</p>	<p>Website access here: A Roadmap for Health in All Policies</p> <p>Collaborating to Win the Policy Marathon</p>	<p>Process-organization, PDF and flow charts</p>
<p><i>Healthy Food Environments landing page</i></p> <p>Tools for attracting grocery stores, improving the corner store environment, making restaurants healthier, building community gardens, creating farmers markets, and more.</p>	<p>ChangeLab Solutions</p>	<p>Website access here: Tools for attracting grocery stores, improving the corner store environment, making restaurants healthier, building community gardens, creating farmers markets, and more.</p>	<p>Landing page, links to key "introductory" materials, lists tools with icons (titles and cover helpful)</p>
<p><i>Healthy Retail: A Set of Tools for Policy and Partnership</i> Playbook, conversation starters, and collaboration workbook.</p>	<p>ChangeLab Solutions</p>	<p>Website access here: Healthy Retail: A Set of Tools for Policy and Partnership</p>	<p>Areas of intervention (5 Ps of retail), by space, rather than by partner or policy step</p>
<p><i>The Complete Parks Suite</i></p> <p>This comprehensive take on parks and its multi-sectoral focus make the Complete Parks approach especially relevant for people who want to advance equity initiatives, community engagement, and multi-agency coordination within local government.</p>	<p>ChangeLab Solutions</p>	<p>Website Access here: No matter where you live, there should be an appealing park nearby.</p> <p>Creating an Equitable Parks System</p>	<p>Strong organizational structure and great example of how to provide evaluation tools</p>
<p><i>Walk This Way: Workplace Wellness</i></p> <p>Developed for wellness promoters, including decision makers, business leaders, health department staff, and other stakeholders.</p>	<p>ChangeLab Solutions</p>	<p>Website Access here: A Guide on State and Local Policies That Support Physical Activity and Wellness in and Around the Workplace</p>	<p>Collected materials and process tools (good categorization of policies). Evaluation tools at pp. 23-24, 40, 56, *58 (general).</p>

E

E

E



Appendix B – Developing an Assessment Methodology for Grocery Siting & Closing Impact (Team Lead: Atlanta Regional Collaborative for Health Improvement; Georgia)



ChangeLab Solutions
Law & policy innovation for the common good.

2201 Broadway, Suite 502
Oakland, CA 94612
510.302.3380

MEMORANDUM

To: c/o Kathryn Lawler, Executive Director, Atlanta Regional Collaborative for Health Improvement (ARCHI)
ARCHI Team, Nemours' Moving Health Care Upstream

From: Manel Kappagoda, JD, MPH, ChangeLab Solutions
Sara Bartel, JD, ChangeLab Solutions
Zachary Hale, JD, MPP, ChangeLab Solutions

CC: Kate Blackburn, Senior Program & Policy Analyst, Nemours

Subject: **Research summaries for data used in grocery siting/closing decisions**

Date: November 1, 2018

As a part of the Nemours' Moving Health Care Upstream initiative, the Atlanta Regional Collaborative for Health Improvement (ARCHI) Learning Lab team has asked ChangeLab Solutions for technical assistance to inform the development of an assessment methodology for gathering data and evaluating grocery store siting and closing decisions in DeKalb County, Georgia. This memo includes:

- [Background information](#)
- [Quantitative and qualitative data gathering resources](#)
- [Economic data research and sources](#)
- [Demographic/race-related data research and sources](#)
- [Agency-collected data research and sources](#)
- [General resources List](#)

Background Information

ARCHI has coordinated a group of stakeholders and experts to develop a methodology for assessing local grocery store siting and closing decisions. Ultimately, the resulting assessments will be used to select solutions and policy interventions to improve grocery store attraction and retention in areas experiencing low or reduced access to healthy foods.

In response to informal stakeholder conversations and the initial input of its members, the coalition has identified three types of data likely to be most relevant to the process of creating an assessment methodology, which align with three primary stakeholder sectors (business, residents, and government).

The following are brief summaries of our research results, including some high-level takeaways and/or helpful context in each case. We have also included links to sources and further reading on specific issue categories.



ChangeLabSolutions

Quantitative and qualitative data gathering resources

There are multiple ways to describe, categorize, and prioritize the different types of information that can be gathered as a part of any community assessment project. One distinction is between secondary and primary data.¹ Secondary data may come from existing sources such as aggregated county, state, and national reports, hospital data, community data from organizations or local initiatives, research organizations and institutions, or local media. Primary data may come from new sources such as community meetings, surveys, focus groups, interviews, and town halls. Each community and each issue will have a different mix of data types available.

Both quantitative and qualitative information should be a part of any assessment, regardless of the sources of data. Statistics and rates alone cannot tell the whole story. People's lived experiences not only flesh out the numbers, connecting them to real life and making them relatable; they can change how the numbers are interpreted, allowing those whose lives are most affected shape how the story is told.

In addition to the data types and sources described in this memo, it can be helpful to think of potential partners in assessment planning—starting with the types of institutions who may have secondary or existing data, and including primary data contributors (i.e., stakeholders on all sides of an issue).

Data Gathering Resources

"The [Community Tool Box](#) is a free, online resource for those working to build healthier communities and bring about social change," and it includes a helpful set of sections (and a "toolkit") on community assessments: <https://ctb.ku.edu/en/table-of-contents/assessment>

Health Care Without Harm has released a food-policy specific resource for hospital community health needs assessments (CHNAs), called the Healthy Food Playbook, which includes a section on data sources and sections on community engagement and other partnership building:

<https://foodcommunitybenefit.noharm.org/resources/community-health-needs-assessment>

Researchers can also be valuable partners in planning, implementing, and evaluating community assessments. Not only are they often experts in data collection and analysis, some have students and other staff available to provide further support and research on related topics. For example, Professor Rodney Lyn at GSU may be a valuable resource on food access issues:

<https://publichealth.gsu.edu/profile/rodney-lyn/>

¹ E.g., see, Community Benefit Connect's webinar slides, "Data Collection Methods for Community Health Needs Assessment: Balancing Rigor and Community Insights," Michael Reece of [Measures Matter](#) (August 23, 2018).



ChangeLabSolutions

Economic data research and sources

Grocery chains consider many economic factors when deciding the location for new stores or when to close existing stores. Data approximating these factors is often processed through opaque analytics software, preventing easy identification of any particular data point.² A survey of relevant literature reveals that grocery chains view economic data related to financial indicators, market viability, population demographics, and other local considerations when deciding whether to open or close stores in a particular location. Below is a list of sample factors in each of these categories.

Summary List of Types of Economic Data

*Financial Indicators*³

- Household income levels
- Consumer expenditure patterns
- Prevalence of SNAP and WIC benefits

Market Viability

- Density of competitor stores
- Proximity to own store locations
- Local workforce readiness*
- Insurance/security costs*

Population Demographics

- Population density
- Household size
- Education levels
- Age

Local Considerations

- Traffic levels
- Transportation infrastructure
- Rent/utility costs

² See, e.g., <http://www.tetrad.com/pub/documents/NAVTEQ-Tetrad-Kroger-case-study.pdf>;
<https://www.washingtonian.com/2015/07/14/how-whole-foods-decides-if-your-neighborhood-is-worthy/>;
<https://www.supermarketnews.com/marketing/using-data-help-retailers-get-closer-customers>;
<https://www.theguardian.com/cities/2015/feb/11/how-supermarkets-choose-where-open-close-tesco>;
<https://pdfs.semanticscholar.org/4207/32cf193809ce97da43b7fb90dd3c3fed6543.pdf>.

³ For a color-coded chart corresponding to this list of types of economic data, see next page.





2201 Broadway, Suite 502
Oakland, CA 94612
510.302.3380

Local Activities and Interventions Related to Economic Data Research⁴

- Understand community spending patterns and facilitate community engagement for potential stores
- Zoning/planning to make available sites, properties more appealing
- Community investment strategies to keep and attract residents and improve quality of life (e.g., education and business opportunities)
- Workforce development/training programs
- Community safety/visibility improvements (e.g., through “crime prevention through environmental design” (CPTED) principles)
- Work with community members to select desired businesses and maintain community collaboration with stores to ensure success
- Land use, real estate, permitting, tax, development incentives
- Work with community members to select desired businesses and maintain community collaboration with stores to ensure success
- Improve transportation infrastructure and walkability
- Transit planning to facilitate use, travel incentives/vouchers for potential customers
- Staff a point of contact in the local government to recruit businesses and spearhead political support

Sample Sources for Economic Data Research

Market/Academic Research

- [Access To Healthier Foods: Opportunities and Challenges for Food Retailers in Underserved Areas – Food Marketing Institute](#)
- [Rural Grocer Store Start-Up and Operations Guide – Illinois Institute for Rural Affairs](#)
- [Downtown Grocery Market Study for the City of Roseburg – Marketek/City of Roseburg](#)
- [Central City Grocery Market Analysis – Marketek/Portland Development Commission](#)
- [Rural Grocery Stores: Importance and Challenges – Center for Rural Affairs](#)
- [Re-Stocking the Shelves: Policies and Programs Growing in Food Deserts – Loyola Public Interest Law Reporter](#)
- [The Impact of Retail Location on Retailer Revenues: An Empirical Investigation - Southern Methodist University](#)

⁴ For a helpful summary of solutions to common challenges, see page 12 of this resource: http://www.policylink.org/sites/default/files/groceryattraction_final.pdf and the other grocery-attraction resources linked at the end of this memo.



ChangeLab Solutions

Industry Publications

- [MAP: Kroger quits competitive Raleigh-Durham “Triangle;” to sell 14 stores – Produce Retailer](#)
- [Tops Markets proceeds with restructuring process, plans to close 10 stores – Produce Retailer](#)
- [Location in Focus as Aldi Expands - Esri](#)
- [How do grocery stores find the right location for expansion? – Food Dive](#)
- [Expansion on aisle 3: How and why grocery stores decide to add more locations – Food Dive](#)
- [Why do you need a feasibility study for your new grocery store? – Uplift Solutions](#)

Popular Media

- [How Whole Foods Decides If Your Neighborhood is Worthy – Washingtonian](#)
- [How supermarkets choose where to open...and where to close – The Guardian](#)
- [Supermarket chains avoid low income neighborhoods, even though they promised not to - Mashable](#)
- [How to Find the Right Location for Your Store - Entrepreneur](#)

Demographic/race-related data research and sources

Introduction to Structural Racism

ARCHI reported that some community members believe that the siting and closing of grocery stores is linked to racism and gentrification. ARCHI would like to know what the social science and public health research tells us about the connection between racism and grocery store location.

Research and scholarship support the residents’ belief and experience that the location of grocery stores may be connected to structural racism - business practices and societal beliefs that perpetuate historical inequities. There is a long history of structural racism in the food system of the United States. While structural racism is a complex concept, at the simplest level it can be defined as:

“[a] system in which public policies, institutional practices, cultural representations, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with “whiteness” and disadvantages associated with “color” to endure and adapt over time. Structural racism is not something that a few people or institutions choose to practice. Instead it has been a feature of the social, economic and political systems in which we all exist.” ([Aspen Institute](#))

Residents in a community that does not have a full-service grocery store may be hard pressed to articulate how the lack of a grocery store can be classified as racism because we tend to think of racism as a set of beliefs held by individuals. In the case of public goods such schools, parks, and grocery stores, their presence and quality in certain neighborhoods is dictated by a complex series of institutional policies and practices rather than an individual’s preferences. The implementation of these policies and practices results in high-quality public goods in some communities and lower quality or limited resources in others. If this system is perpetuating a lack of a public good, such a grocery store, in particular neighborhoods



ChangeLabSolutions

over many years, that is an indication that structural racism is influencing food access in those neighborhoods.

The influence of structural racism on our food system has been well documented in the social science, public health, and popular literature. Below, we summarize research on structural racism broadly as well as research that addresses how structure racism plays out in the siting of grocery stores.

General Resources on Structural Racism

In 2017, the Lancet published a series of articles on health inequities in the United States. One of those papers provides an overview of structural racism that is both comprehensive and concise. [“Structural racism and health inequities in the USA: evidence and interventions”](#) lays out some of the history of structural racism in the United States and discusses research and interventions that address the impact of structural racism.

Professor John A. Powell provides an excellent academic analysis of how structural racism plays out in the United States, in [“Structural Racism: Building on the Insights of John Calmore”](#). He argues for a coordinated approach among institutions in order to address multiple institutional practices that reinforce inequities.

[The Government Alliance on Race and Equity \(GARE\)](#) provides resources to government agencies at all levels on addressing racism. GARE focuses on government agencies because “local and regional government has the ability to implement policy change at multiple levels and across multiple sectors to drive larger systemic change.”

Resources on Racism and the Food System

The Center for Regional Food Systems at Michigan State University has created an [online bibliography of structural racism in the U.S. food system](#). They update the bibliography annually (most recently in 2017) and it is searchable. A noted weakness of the bibliography, in the context of this research request, is a lack of sources that address food systems in southern states. The bibliography includes a policy brief that focuses on the experiences of female farmworkers in Southern states. [This report](#) provides historical context that may be useful for ARCHI as it continues to engage residents on topics related to the food system.

Policy Briefs

For a thorough review of how structural racism leads to reduced access to healthy foods, with specific examples for around the country, we recommend [“How Structural Racism Contributes to the Creation and Persistence of Food Deserts.”](#)

PolicyLink and The Food Trust’s [Who Has Access to Healthy Food and Why it Matters](#) provides a good overview of existing data on how limited access to healthy food options impact Americans living in low-income neighborhoods, communities of color, and rural areas.

In [Has New York City fallen into the local trap?](#), a 2015 study published in Public Health, Kimberly Libman finds that residents of low-income areas of New York City identify food price and consumer environment as bigger barriers to healthy eating than grocery store location. Libman also suggests that certain food policies aimed at low-income areas have actually promoted gentrification.



ChangeLabSolutions

Articles in Popular Media

The Block Project's [Homeownership, Wealth Accumulation, and Segregation: Housing Policy and the Creation of Food Deserts in Columbus, OH](#) ties together historical and contemporary housing and food policy to show how segregation has influenced access to healthy food.

Civil Eats provides two perspectives on the importance of *who* provides access to nutrition in their articles, [America's Food Deserts Need Community Solutions, Not Big Box Stores](#) and [Why Are There So Few Black-Owned Grocery Stores?](#)

The "Stuff Black People Don't Like" blog observes the potential connection between structural racism (in the forms of segregation and racialized perception of crime) and grocery store closures in [Two Kroger Grocery Stores in 98% Black communities in Memphis Closing Because of High Rates of Theft](#).

[Publix, Kroger closings portend 'grocery gap'](#), a local news story, highlights the perception of residents that major grocery chains' differential treatment for communities of color could be rooted in racism.

U.S. News discusses how "classism and racism can play a role in what neighborhoods have access to which foods," in [A Grocery Desert in Central Wyoming](#).

In [Food deserts: Is racism to blame?](#), a Wisconsin newspaper raises the possibility that grocery store closures are motivated by racism.

The Guardian provides an interview with food justice activist Karen Washington about her use of the phrase "food apartheid" to describe the role of systemic racism in reducing access to healthy dietary options. [Food apartheid: the root of the problem with America's groceries](#).

In [How Closing Grocery Stores Perpetuates Food Deserts Long After They're Gone](#), Fast Company discusses how contractual restrictions in grocery store deeds can hinder the opening of a new grocery store at the same location for years after a store closes.

Understanding Local Context

Communities seeking to understand how structural racism may be influencing the lives of their residents have different options for undertaking this research. Each locality will need to determine what may be appropriate and best for its community, given local resources, time, and historical contexts. Some initial research questions are listed below, to get the gears turning:

1. Through surveys and focus groups, ask residents from minority or historically underrepresented populations how they feel their local government and institutions represent, or do not represent, their interests (for example, the departments or divisions of health and mental health, housing, economic development, enforcement and public safety, parks, etc.). For longer-term residents, ask if those feelings have changed over the years.
2. Seek out groups, organizations, experts, researchers, and community leaders who work with minority or historically underrepresented populations and ask for help understanding the issue; ask their perspectives on how community structures and institutions serve, and have historically served, the residents they primarily work with. Do they highlight any great local moments, policies, or people/institutions? Do they recommend any actionable improvements?
3. Gather public data about residents across neighborhoods or blocks, and how those numbers have changed over the course of the 20th Century (or, over the last 25, 50, or 75 years). Data could include, for example: age, race/ethnicity, level of education, rates of employment, rates of



ChangeLabSolutions

incarceration, health statistics, home-ownership, income levels, etc. Some sources for identifying local data include:

- County health rankings: <http://www.countyhealthrankings.org/>
- 500 cities: <https://www.cdc.gov/500cities/> (certain indicators by city, which could be overlaid with racial and other demographic data)
- County Diabetes Data: <https://www.cdc.gov/diabetes/data/county.html> (could be overlaid with racial and other demographic data)
- Opportunity Atlas: <https://www.opportunityatlas.org/>
- Opportunity Insights: <https://opportunityinsights.org/>

Ask how this data might correspond to the timeline in #4, below.

4. Learn about events in U.S. history in which the federal government made large-scale financial and social investments that intentionally or unintentionally focused on some groups of people at the exclusion of others. One place to find resources to help understand this historical timeline is: <http://www.racialequityresourceguide.org/resource/structural-racism-and-community-building>. Then try to understand how those moments played out in the local context (i.e., were there recipients in the community; if so, who, at what percentage, and in what areas?).
5. Are there residual practices or policies in place that unintentionally perpetuate racist structures and systems in your community? Are there opportunities to protect and re-empower people who have been affected by these practices or policies, so they are not harmed in the future?

In addition to the resources linked above, there are many organizations that support the work of local governments to operationalize racial equity for the lives of their residents. One good starting place for resources and contacts is the Government Alliance on Racial Equity: <https://www.racialequityalliance.org>. Another (local) organization and potential contact is Dwayne Patterson at the Partnership for Southern Equity, <http://psequity.org>, which “advanc[es] the cause of equity through a ecosystem-based model for multi-demographic engagement in the City of Atlanta and the surrounding metropolitan region [...]”

Agency-collected data research and sources

Publicly available data inform grocery store siting and closing decisions, and also provide measures for related impacts, which store location teams may or may not consider. These can include resident health data or other indicators that communities may find important in trying to understand the scope and significance of these decisions.

The breadth and depth of publicly available information varies by location, based on the capacity of the state and local agencies that collect and compile the data. The nature of available data also depends on the research approaches adopted by relevant state and local actors. An agency that values community based participatory research, for example, may include information gathered through [community health needs assessments](#) (CHNAs), producing rich qualitative data that can inform long term strategic planning.

What follows is a non-exhaustive list of types of data that state and local agencies collect, and examples of how those agencies provide that data to the public.



ChangeLabSolutions

Examples of Data Collected by State Agencies

Health Data

- General health
- Disease
- Births
- Mortality
- Breastfeeding
- Prenatal care
- Disability status
- Body weight
- Drinking
- Fruit/veggie consumption
- Mental health
- Health care access
- Oral health
- Physical activity
- High school behavioral risks
- Child health indicators (includes economic data)

Economic Data

- Income levels
- Expenditure levels
- Housing availability (supply and demand)
- Homeownership
- Housing costs
- Homelessness rates
- Unemployment
- Workforce readiness
- Industry concentration
- Infrastructure snapshot
- Business incentives and programs
- Sales and taxes
- Cost of living indexes
- Transportation (e.g., infrastructure, use)

General Demographic Data

- Age
- Race
- Marriage status
- Household size
- Education
- Population size and growth
- Crime rate



ChangeLabSolutions

Sample Sources of Data Collected by Local Agencies

Health Data

- [Georgia Department of Public Health – Lead Data and Reports](#)
- [California Department of Public Health and California Conference of Local Health Officers – County Health Status Profiles 2018](#)
- [North Dakota Department of Health – North Dakota Health Profile](#)

Economic Data

- [Georgia Department of Labor – Current Labor Force Data and Graphs](#)
- [Texas Economic Development – Reports and Publications](#)
- [Florida Housing Data Clearinghouse – Maps and Visualizations](#)
- [California Department of Housing and Community Development – Final Statewide Housing Assessment 2025](#)
- [California Employment Development Department – Data Library](#)

General Demographic Data

- [Georgia Governor’s Office of Planning and Budget – Populations Estimates](#)
 - [Texas Demographic Center – Descriptive Tables by Subject](#)
 - [Nebraska Department of Economic Development – Crime & Law Enforcement](#)
-



ChangeLabSolutions

General Resources List

Available Data: Government Health Data

- [Nutrition, Physical Activity, and Obesity: Data, Trends and Maps](#)
- [State Indicator Report on Fruits and Vegetables, 2018](#)
- [Leading Indicators for Chronic Diseases and Risk Factors](#)
- [Food Environment Atlas](#)
- [Health Resources and Services Administration Data](#)
- [The Social Vulnerability Index](#)

Available Data: Other Health and Nutrition

- [Healthy Food Access Portal](#)
- [Big Cities Health Coalition Data Platform](#)
- [Community Commons Website](#)
- [Neighborhood Atlas](#)
- [US News Healthiest Communities \(DeKalb County\)](#)
- [Food Insecurity in the United States](#)
- [Food Policy Legislation Database](#)

Resources about Attracting Grocery Stores and Related Local Efforts

- [Getting to Grocery](#)
- [Grocery Store Attraction Strategies](#)
- [New grocery stores in underserved areas](#)
- [The complicated connection between supermarkets and obesity](#)

Additional Sources of Information about Grocery Stores

- [National Grocers Association Website](#)
- [Supermarket News](#)
- [Progressive Grocer](#)
- [Convenience Store News](#)
- [The Evolution of the Supermarket Industry, From A&P to Walmart](#)



Appendix C – Food Insecurity Screening, Workflow Design, Multi-Site Expansion, and County-Wide Examples (Team Lead: Los Angeles County Department of Public Health; California)



To: Policy Learning Lab team from Los Angeles County Department of Public Health

From: Richard Sheward, Children’s HealthWatch & Heather Hartline-Grafton, FRAC

CC: Kate Burke Blackburn, Nemours Children’s Health System & Sara Bartel, ChangeLab Solutions

Subject: Technical assistance re: food insecurity screening and referral workflow design, multi-site expansion, and county-wide examples

Date: September 7, 2018

Workflow design of food insecurity screening and referral with a specific focus on best practices for “warm hand-off” referrals

The following summary was adapted from the recent book: “Identifying and Addressing Childhood Food Insecurity in Healthcare and Community Settings.”

Citation: H. B. Kersten et al. (eds.), *Identifying and Addressing Childhood Food Insecurity in Healthcare and Community Settings*, SpringerBriefs in Public Health, 2018. Available at: (<https://bit.ly/2MVtDUA>)

Deciding how you want to address food insecurity (FI)

After a positive FI screen, interventions could range from giving families paper or electronic resource listings, providing food or a prescription for a box of food, connecting with on-site staff (e.g., social worker, legal advocate, or community health worker [CHW]), and referring families to community-based programs. Some clinics may even have on-site food pantries. Clearly, these interventions will carry different challenges and opportunities since they vary significantly in scope. Not all of these approaches may be needed, but each provider or clinical setting should decide which tools and initiatives are best suited to effectively meet the needs of their patients.

Health care provider-based approaches to addressing FI

There are many types of in-house providers who can help healthcare providers care for families confronting FI. A team approach is becoming the standard way to approach FI and other social determinants of health (SDH). Some clinics may be “resource-rich,” with a multi-disciplinary team capable of a range of potential actions. Others may be more “resource-limited,” forced to consider those other connectors that may exist outside the clinical walls. Either way, clinics are confronted with the question of “do we buy it” or “do we build it”?

Community-based approaches to addressing FI





Regardless whether or not the FI intervention takes place within the four walls of the clinic or not, healthcare providers should also consider community-engaged approaches that develop and sustain authentic long-term community partnerships with agencies and organizations that are similarly focused on addressing issues of FI. At this level of engagement, collaborative work around shared priority areas should include the presence of shared values, mutually identified strategies, and partnerships that embody shared respect, inclusiveness, equal power sharing, and the possibility of mutual benefit. These partnerships go beyond simple referrals, focusing more on how a multi-disciplinary team can work together to develop and implement innovative collaborative efforts that meet community-identified needs.

Building and Sustaining Community-Based Interventions

Unlike medically-focused interventions that are still within the bailiwick of the healthcare system (e.g., referral from the primary care setting to a cardiologist), linking families to a community-based organization for an intervention focused on the SDH calls for more intentional strategies, processes, and commitment from both sides. Successful clinical-community partnerships require alignment around goals, leadership and resources, effective communication, processes that facilitate meaningful data sharing, and a plan to sustain and grow the collaboration. In essence, this is the “warm hand off”.

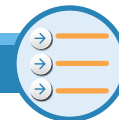
On the frontier: Current state of warm hand off referrals

Given the hectic clinical environment in today’s health care landscape, addressing patients’ FI and other SDH must constantly compete with the multitude of responsibilities health care providers face. The overarching goal of a community-based partnership approach to FI interventions is to make the referral to the community agency as easy and seamless as possible for both the provider and partner.

Option #1 -- Build it: Clinics with access to CHWs, those who can bridge the gap between the healthcare provider’s office and the families’ home to assist with their needs are the most robust provider-based approach. They may meet the family in the office and go into the home to help connect families with services. This more intensive approach has been shown to improve the social needs and the reported health status of families. Some insurance payers have begun to support the utilization of CHWs to address the social needs of the highest healthcare utilizers. In this scenario, the CHW is not only responsible for making the referral, but for ensuring that the necessary follow up is conducted to ensure that the patient was able to access the community partners’ resources.

Option #2 -- Buy it: Increasingly, electronic-based referral platforms that act as an intermediary between the clinic and community partner have filled a gap for clinics that are not able to hire the staff or take on the level of staff support needed to implement robust closed loop referrals. In November 2018, the Social Interventions Evaluation Research Network will release a useful guide for clinics to understand the quickly-changing referral platform landscape. This guide will answer the following questions:

- What are referral platforms and why are health care organizations interested in them?





- How are health care organizations selecting platforms?
- What general functionalities do these platforms offer?
- Comparison of 10+ commonly used referral platforms (Healthify, NowPow, Aunt Bertha, Charity Tracker, Cross TX, Livwell, One Degree, Pieces Iris, Reach, TavHealth, and Unite US)
- How are organizations implementing platforms?
- Recommendations based on experiences of organizations that have implemented referral platforms

For more information, and to request a copy of this resource when it becomes available in November 2018, please contact:

Caroline Fichtenberg, PhD Managing Director, SIREN (Social Interventions Research and Evaluation Network) caroline.fichtenberg@ucsf.edu 415-476-7283 (o) 410-371-3512 (c)

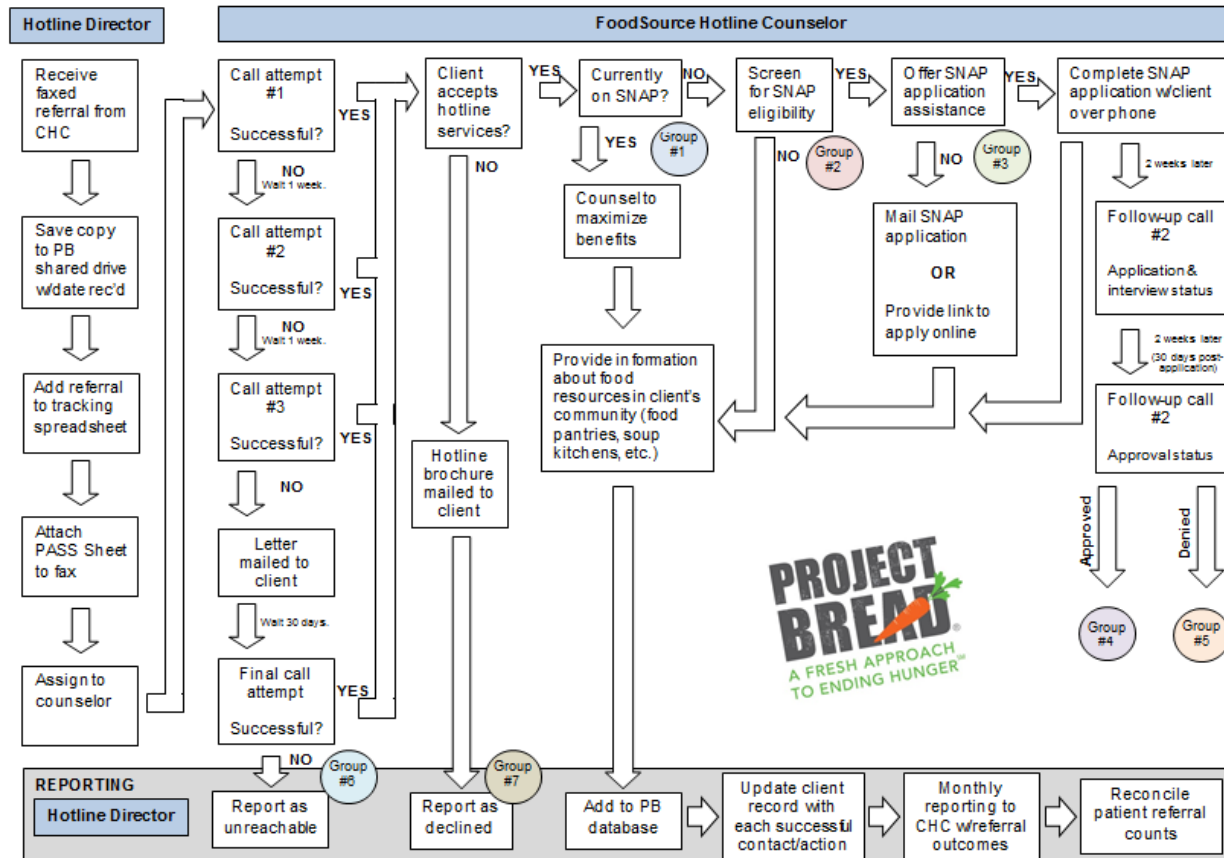
Option #3 -- Build it/Buy it hybrid: The Cambridge Health Alliance (CHA) has recently built an electronic health record (EHR)-based referral tool that results in an auto fax to their community partner agency, which then contacts the patient to offer services. One important feature of this model is the fact that Project Bread (the community partner) receives funding from the Massachusetts Department of Transitional Assistance to conduct SNAP outreach via their FoodSource hotline. Without this sustainable funding mechanism, the partnership would need to identify a funding source for the community partner to absorb the influx of referrals to their hotline. The workflow* for this partnership is as follows:

1. CHA screens patient, if screen is positive CHA provider receive consent from patient to share name and phone number with Project Bread
2. CHA provider sends referral to Project Bread via EHR
3. Referral is auto faxed to Project Bread and arrives in a shared email inbox
4. Project Bread staff contact the patient to provide services
5. A monthly summary of connections made is sent back to CHA

*For more detail, see the Project Bread algorithm below. Also, please feel free to contact the following project leads for more information

Amy	Smith	ammsmith@challiance.org	Cambridge Health Alliance
Lisa	Brukilacchio	lbrukilacchio@challiance.org	Cambridge Health Alliance
Khara	Burns	khara_burns@projectbread.org	Project Bread





Examples of other entities/cities/counties that have implemented food insecurity screening and related components across multiple sites, and examples of who has developed County-wide policies on food insecurity screening and referral.

Boston Public Health Commission's Boston REACH: Partners in Health and Housing

Boston REACH: Partners in Health and Housing is a partnership between Boston Public Health Commission (BPHC), Boston Housing Authority (BHA), Boston University School of Public Health (BUSPH) and the Partnership in Health and Housing's Community Committee. Funding from US Center Disease and Control and Prevention (CDC) support the development, enhancement and expansion of partnerships with Boston Housing Authority developments and residents. As part of this initiative, four Community Health Centers (CHCs) collectively serving over 27,000 public housing residents (South End Community Health Center, Southern Jamaica Plain Health Center, Upham's Corner Health Center, and





Whittier Street Health Center) have committed to incorporating or sustaining a food insecurity screening for patients, along with making appropriate referrals. Over 565 patients have been screened for food insecurity at these CHCs with over 7,174 healthy affordable on-site food transactions.

Results

With the commitment of 4 CHCs to integrate food insecurity screening (FIS) questions into the workflow of at least one of their departments and with technical assistance from CHW, over 565 residents have been screened for food insecurity in the first several months, with 3 out of 10 being referred to local food resources. Some CHCs chose to integrate screening questions during their intake process and others during a point of contact with a nutritionist or social service department. Additionally, 7,174 on-site free and low-cost healthy food transactions materialized through our non-profit food partners; that's about 800 transactions per month. Screening was made possible through personalized calls and trainings by Children's Health Watch and the development of an operational online Community of Practice (CoP). FIS is the first of its kind in Boston.

Sustaining Success

Identifying a need and targeting resources can be a challenge. Food insecurity screening questions have been built into daily workflow of trusted clinical institutions in regular contact with our priority population. Not only has this helped many families in a sustainable way, this model is scalable to other departments within these CHCs and across the city and state. MassLeague, which convenes all Boston CHCs, is interested in scaling this to other CHCs, with potential to reach patients and BHA residents served at another 22 Boston CHCs. The online MA Community of Practice and virtual library remain open to those interested, and City of Boston colleagues have committed to strengthening food insecurity screening in Boston after REACH: PHH.

You can learn more about Boston REACH: Partners in Health & Housing at www.bphc.org/reachphh. Contact Aileen Shen Boston Public Health Commission 1010 Massachusetts Ave Boston, MA 02118 617-534-2633.

Vermont Child Health Improvement Program (VCHIP) Child Health Advances Measured in Practice (CHAMP) project

The CHAMP program is a unique statewide initiative for all interested Vermont primary care practices dedicated to improving preventive services and health outcomes for children from birth through adolescence. With providers from forty-nine (49) pediatric and family medicine practices now in CHAMP, VCHIP engages practices of all sizes and from all regions of the state. CHAMP is a voluntary network of practices connected by, and focused on, learning about relevant clinical topics, having access to current evidence-based resources and tools, joining their colleagues in quality improvement initiatives, and participating in an important annual data collection program staffed by VCHIP.





VCHIP launched CHAMP in 2012 by building on its long-term partnerships with the University of Vermont College of Medicine, the Vermont Department of Health, the Vermont Chapter of the American Academy of Pediatrics (AAP), and the Vermont Academy of Family Physicians. CHAMP's long-term goal is to increase the efficiency, economy, and quality of care provided to Medicaid-eligible children and families. Building on the momentum of Bright Futures and Vermont's health care reform activities, this initiative has created a multi-year network of practices that engage in collaborative improvement activities to meet the evolving needs of health care professionals, children and families.

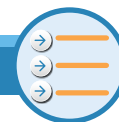
The 2017-18 VCHIP CHAMP project focused on food insecurity screening and interventions. Across the state (see map below) pediatric and family medicine practices began screening patients for food insecurity and offering ways to address their patients' food security needs. With technical assistance and support from VCHIP, the practices participated in PSDA (Plan Act Study Do) cycles to give practices a way to quickly test changes on a small scale in real work settings, observe what happens, tweak changes as necessary, and then test again - before implementing anything on a broad scale. Instead of spending weeks or months planning out a comprehensive change, then putting it into practice only to find it is fundamentally flawed, the PSDA cycle enables rapid testing and learning.

Subsequently, Vermont's statewide ACO, OneCare began developing partnerships to investigate social determinants of health screenings in primary care settings (e.g., ACES, food insecurity, and maternal depression). The overarching goal is to enable the OneCare ACO to provide incentives for preventing and addressing impacts of trauma and for investments in social determinants of health (e.g., developing support capacities that prevent hospital admissions and readmissions, reduce length of hospital stays, improve population health outcomes, reward healthy lifestyle choices, and improve the solvency of and address the financial risk to community-based providers).

To learn more about VCHIP and CHAMP please contact:

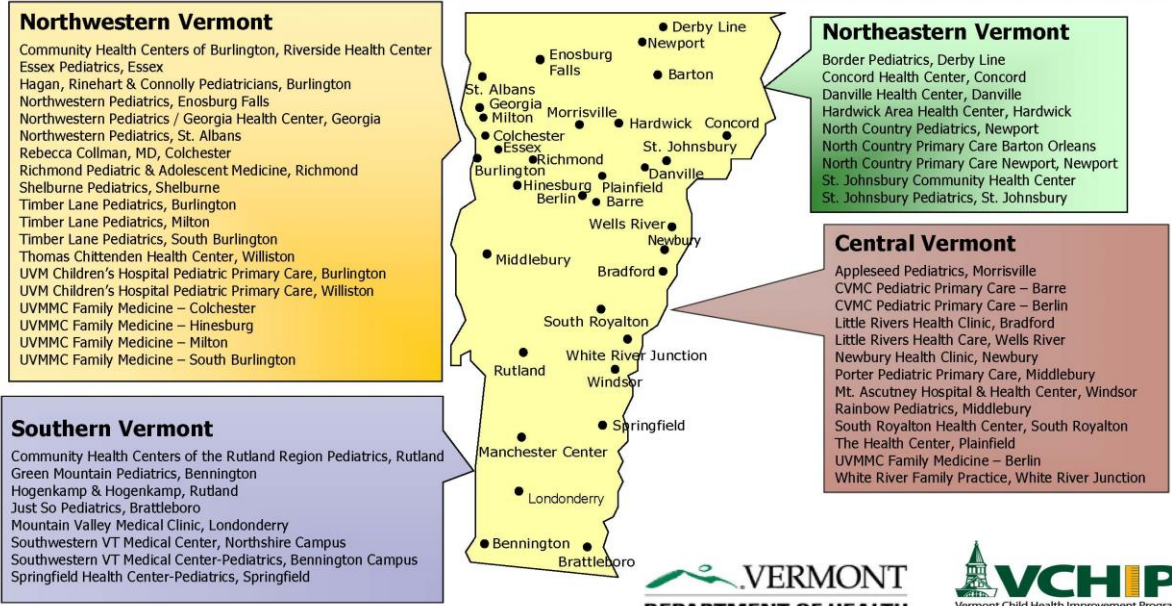
[Christine Pellegrino, MS, ASQ CMQO/E](#)

Quality Improvement Associate, CHAMP Project Director





CHAMP Practices 2018



Appendix D – Food Insecurity Screening, Workflow, Compliance, and Measuring Success (Team Lead: Nemours Children’s Health System; Delaware)



To: Policy Learning Lab team from Nemours Children’s Health System

From: Richard Sheward, Children’s HealthWatch & Heather Hartline-Grafton, FRAC

CC: Kate Burke Blackburn, Nemours Children’s Health System & Sara Bartel, ChangeLab Solutions

Subject: Technical assistance re: food insecurity (FI) screening and referral

Date: September 13, 2018

Screening process

Who is asking the questions/given by whom to obtain more accurate responses?

A team-based approach, including clinicians, trainees, nurses, medical assistants, social workers, and community health workers, is the most effective for FI screening. Collaborate as a full practice team to identify sustainable ways to screen in your setting. This includes a discussion of your setting’s work flow and staff expertise. Then, to maximize success, staff training should specify each individual’s role on the team, related to their area of expertise.

In terms of the timing, screening that maximizes use of downtime during the visit (i.e. waiting room or waiting time in the examination room) may improve potential for success by allowing parents the time to complete the screener without increasing the visit length. It is important to remember that children above the age of 12 years old may be screened directly using one of the pediatric FI screening tools (e.g. 9-item Child Food Security Module, Hunger Vital Sign). In addition, completion of a screening tool prior to the visit allows the clinician to review the responses and plan an intervention with the family. Again, collaboration by the practice team prior to screening implementation is important to identify the most appropriate and effective timing for your setting.

Are there examples of training provided to staff to give the screening tool to obtain buy-in?

When developing a social determinants of health curriculum, it is important to consider several principles of adult learning theory. Since adult learners build on previous lived experience, it is critical to recognize their prior knowledge and experiences that may shape biases and impact learning. Since many medical trainees were not raised in poverty, they have not personally experienced many of the social risks in their patients’ lives, including FI, making it difficult to relate to their patients’ experiences. The often privileged, discordant backgrounds of providers can make tackling questions related to socioeconomic status difficult, contribute to their discomfort screening, and limit their awareness of needs or willingness to screen for and address FI. Thus, creating experiences that simulate patients’ lived





experiences, the so-called “walk in your shoes” experiences, may be beneficial. For example, in the [SNAP Challenge](#), participants live on the average SNAP benefit a week to better understand the struggles of those living with food insecurity.

Essential components of FI curricula should include: (1) Definitions and Epidemiology; (2) Physiologic and Psychosocial Impact; (3) Screening Methods and Strategies; (4) Intervention Strategies and Community Resources; and (5) Associated Social Risks. To maximize effectiveness, it is ideal to develop and implement curricula that incorporate a variety of learning modalities and tasks to appeal to different learning styles. For example, to fully grasp a concept, learners could be expected to complete pre-reading, participate in a case-based, interactive session that allows them to apply their new knowledge and then implement a small project in the continuity clinic. This provides learning opportunities for visual, aural, reflective and kinesthetic learners. This deliberate connection and application to real-life, clinical settings are essential for meaningful learning. However, curriculum design always needs to remain cognizant of the barriers (i.e. lack of time, confidence and motivation) that may be unique to medical trainees.

See “[Identifying and Addressing Childhood Food Insecurity in Healthcare and Community Settings](#)” for existing social determinants of health (SDH) Curricula that include FI. In addition, the Food Research & Action Center (FRAC) and the AARP Foundation developed a free, online course for health care providers - [Screen and Intervene: Addressing Food Insecurity Among Older Adults](#). While focused on older adults, many of the strategies are relevant across the lifespan. The following summary was adapted from the recent book: “Identifying and Addressing Childhood Food Insecurity in Healthcare and Community Settings.”

How do you obtain the buy-in needed to have patients respond accurately?

Both clinicians and families may express unease with FI screening due to the sensitive nature of these questions. Similar to asking about other psychosocial issues, clinicians must learn about the root causes of FI, the family perspective and resources to address FI, so they can effectively and empathetically screen. Parents have reported feelings of shame, guilt, and frustration when they are unable to provide enough food for their families, have concerns that clinicians would consider them neglectful and may fear that child protective services will be notified if they admit to FI. As practices transition to addressing the entire family’s social risks, it may be beneficial to provide information indicating that questions are asked universally and that the responses will be used to help the family and not penalize them. This may create a safe atmosphere for families to disclose. (See pages 12-14 of [Addressing Food Insecurity: A Toolkit for Pediatricians](#), for additional guidance on screening in a sensitive manner.)

What format – electronic or paper?

Written screening tools are accepted by patients, families and clinicians. Ideally, these are quickly reviewed during the visit and used to plan interventions in a family-centered fashion. These screeners





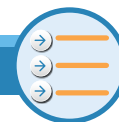
must be provided in the patient's preferred language, administered in a safe and private area and ideally entered into the electronic health record (EHR). Additional procedures need to be in place for patients and families with low literacy levels to obtain accurate responses.

Computer Based Self-Administered Screening Tools are typically accessed by a waiting room kiosk, clinic based tablet or personalized electronic device. They have similar drawbacks to paper-based screeners (e.g., language, literacy, privacy), however, screen protectors may allow for added privacy. And while these tools may provide for cost savings, they may also limit connections between clinicians and families. In terms of benefits, electronic screeners (as well as written screeners) have demonstrated increased transparency in responses and less limitation by social desirability bias compared to face-to-face screening. In general, with issues of increased sensitivity, written and computer based screeners may provide the most safety and protection for families.

Face-to-Face Screening is another method used to identify social risks, including FI. Verbal screening may allow for increased connection between clinicians and families, but may increase shame and underestimate concern due to social desirability bias. With older children present, parents may feel even less comfortable discussing the family's food security status. Although verbal screening may seem the most efficient for screening adolescents when parents leave the examination room, adolescents have reported that they may prefer electronic or computer based screening. Verbal screening also offers the most challenge with maintaining fidelity of questions as questioning style may change, shorten or lengthen based on memory recall or personal biases that one may carry. Verbal screeners are a safe way of screening when identifying one or few SDH but may not be the most effective or efficient when screening for multiple social risks.

Timing, frequency and follow up to screening for FI and other SDOH?

The ideal frequency of FI screening has not been established; however, there have been several different recommendations. Since FI is invisible and often not detected by growth parameters, experts recommend routine, universal screening, despite the additional demand on time. Universal screening can decrease effects of implicit bias and more reliably identify families in need than provider driven screening. In addition, universal screening decreases stigma and isolation for families with FI concerns. Garg & Dworkin provide specific recommendations of screening during initial visits, all visits in the first 6 months of life, annually during routine well-child visits and whenever problems are detected. FRAC, a national anti-hunger policy organization, and the AAP developed a toolkit for pediatricians to screen and intervene for FI. The expert panel proposed screening all patients at all visits due to the hidden and cyclical nature of FI, but in cases where providers must prioritize, screening was recommended at particular visits: (1) Routine well-child care; (2) Nutrition-related concerns (e.g., diabetes, obesity, food allergies); (3) Emergency medicine visits; (4) Hospital admissions; (5) Newborns prior to discharge; (6) As indicated during any other visit (e.g., parent mentions recent job loss, child with anemia or behavioral problems, patient requires a special diet or expensive medication).





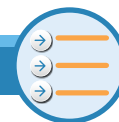
Are there examples of integrating food insecurity screening with the other social determinants of health?

As FI often coexists with other social risks, more comprehensive social risk screening tools may be beneficial. Since a gold standard social screening tool has not been identified, organizations and clinical practices have created social risk screeners tailored to their communities incorporating available validated questions. There are a variety of more comprehensive social risk screening tools that can be incorporated into clinical practice. Below are a few commonly used social risk screeners that contain specific FI questions.





Screening tool	Domains covered	Food security/ access questions used
AHC HRSN (Accountable Health Communities Health Related Social Needs) Tool [78] https://innovation.cms.gov/initiatives/ahcm	<ul style="list-style-type: none"> • Housing instability • Food insecurity • Transportation difficulties • Utility assistance needs • Interpersonal safety concerns 	<ul style="list-style-type: none"> • Hunger vital sign (slightly modified)³ “1. Within the past 12 months, you worried that your food would run out before you got money to buy more 2. Within the past 12 months, the food you bought just didn’t last and you didn’t have money to get more.” • <i>Response: Often True, Sometimes True, Never True</i>
WE-CARE (Well-child Care Visit, Evaluation, Community Resources, Advocacy, Referral, Education) [16, 43] www.pediatrics.org/cgi/doi/10.1542/peds.2007-0398	<ul style="list-style-type: none"> • Education • Employment • Smoking/drug/alcohol abuse • Depression • Domestic violence • Child care • Housing • Food supply 	<ul style="list-style-type: none"> • “Do you need help in getting food by the end of the month?” • <i>Response: Yes, No, –If yes, would you like help with this? Yes, No, Maybe Later</i>
Health Leads https://healthleadsusa.org/tools-item/health-leads-screening-toolkit/	<ul style="list-style-type: none"> • Food insecurity • Housing instability • Utility needs • Financial resource strain • Transportation • Exposure to violence • Sociodemographic information 	<ul style="list-style-type: none"> • Question #6 from HFSSM • “In the last 12 months, did you ever eat less than you felt you should because there wasn’t enough money for food?” • <i>Response: Yes or No</i>
Survey of Wellbeing of Young Children (SWYC) https://www.floatinghospital.org/The-Survey-of-Wellbeing-of-Young-Children/Overview.aspx	<p>Family questions domains:</p> <ul style="list-style-type: none"> • Parental depression • Parental discord • Substance abuse • Food insecurity • Parent’s concerns about the child’s behavior/ learning/ • Development 	<ul style="list-style-type: none"> • One question hunger Screener³ [31] • “In the past month, was there any day when you or anyone in your family went hungry because you did not have enough money for food?” • <i>Response: Yes, No</i>
I-HELLP (Income, Housing, Education, Legal Status, Literacy, Personal Safety) [81] https://www.aap.org/en-us/Documents/IHELLPPocketCard.pdf	<ul style="list-style-type: none"> • Income • Housing • Education • Legal status • Literacy • Personal safety 	<ul style="list-style-type: none"> • “Do you ever have a time when you don’t have enough food? Do you have WIC? Food stamps?” • <i>Response: Yes, No</i>





Screening tool	Domains covered	Food security/ access questions used
SEEK (Safe Environment for Every Kid) https://www.seekwellbeing.org/the-seek-parent-questionnaire	<ul style="list-style-type: none"> • Parental depression • Parental substance abuse • Harsh punishment • Major parental stress • Intimate partner violence • Food insecurity 	<ul style="list-style-type: none"> • Hunger vital Sign^a <p>“1. In the past 12 months, did you worry that your food would run out before you could buy more? 2. In the past 12 months, did the food you bought just not last and you didn’t have money to get more?”</p> <ul style="list-style-type: none"> • <i>Response:</i> • <i>Yes, No</i>

^aIndicates clinically validated screening tool

Citation: H. B. Kersten et al. (eds.), *Identifying and Addressing Childhood Food Insecurity in Healthcare and Community Settings*, SpringerBriefs in Public Health, 2018. Available at: (<https://bit.ly/2MVtDUA>)

What is the process: technical integration within EPIC/Healthy Planet

- *MyNemours iPads or Microsoft PRO integrate with EPIC. Microsoft GO tablets will integrate with EPIC. Are there other tech options we should consider to collect FI/SDOH information from patients?*
- *How does it trigger a BPA?*
- *Are FI/SDOH items within the screeners linked to other screenings, such as the readmission screener?*

For these specific questions, we suggest contacting your Epic Healthy Planet liaison. Richard Sheward would also be happy to connect you to the lead Healthy Planet Epic employee, Mateo Verzola (Matteo@epic.com).

Visualization/Dashboard– within EHR/EPIC – Healthy Planet

- *Are there resources available about the type of education and training for providers about how to respond to a highlighted domain within EPIC/Healthy Planet/Examples of next steps by providers when there is a single or multiple SDOHs highlighted?*
- *Should we identify both the need and whether help is wanted from patients within Healthy Planet?*

For these specific questions, we suggest contacting your Epic Healthy Planet liaison. Richard Sheward would also be happy to connect you to the lead Healthy Planet Epic employee, Mateo Verzola (Matteo@epic.com).





Workflow

Once patients screen positively:

- *What information, resources, or interventions are provided and who provides it?*
- *Can referrals/resources be generated within EPIC to provide support?*
- *Are there successful approaches to address a positive screen (i.e., deploy a person or team of SWs, CHWs, care coordinators)?*
- *How to operationalize the warm hand off from clinical staff to the financial or social services?*

Deciding how you want to address food insecurity (FI)

After a positive FI screen, interventions could range from giving families paper or electronic resource listings, providing food or a prescription for a box of food, connecting with on-site staff (e.g., social worker, legal advocate, or community health worker [CHW]), and referring families to community-based programs. Some clinics may even have on-site food pantries. Clearly, these interventions will carry different challenges and opportunities since they vary significantly in scope. Not all of these approaches may be needed, but each provider or clinical setting should decide which tools and initiatives are best suited to effectively meet the needs of their patients.

*short note on referrals/resources generated within EPIC to provide support - this is a feature of Epic Healthy Planet. We suggest contacting your Epic Healthy Planet liaison. Richard Sheward would also be happy to connect you to the lead Healthy Planet Epic employee, Mateo Verzola (Matteo@epic.com).

Health care provider-based approaches to addressing FI

There are many types of in-house providers who can help healthcare providers care for families confronting FI. A team approach is becoming the standard way to approach FI and other SDHs. Some clinics may be “resource-rich,” with a multi-disciplinary team capable of a range of potential actions. Others may be more “resource-limited,” forced to consider those other connectors that may exist outside the clinical walls. Either way, clinics are confronted with the question of “do we buy it” or “do we build it”?

Community-based approaches to addressing FI

Regardless whether or not the FI intervention takes place within the four walls of the clinic or not, healthcare providers should also consider community-engaged approaches that develop and sustain authentic long-term community partnerships with agencies and organizations that are similarly focused on addressing issues of FI. At this level of engagement, collaborative work around shared priority areas should include the presence of shared values, mutually identified strategies, and partnerships that embody shared respect, inclusiveness, equal power sharing, and the possibility of mutual benefit. These partnerships go beyond simple referrals, focusing more on how a multi-disciplinary team can work together to develop and implement innovative collaborative efforts that meet community-identified needs.





Building and Sustaining Community-Based Interventions

Unlike medically-focused interventions that are still within the bailiwick of the healthcare system (e.g., referral from the primary care setting to a cardiologist), linking families to a community-based organization for an intervention focused on the SDH calls for more intentional strategies, processes, and commitment from both sides. Successful clinical-community partnerships require alignment around goals, leadership and resources, effective communication, processes that facilitate meaningful data sharing, and a plan to sustain and grow the collaboration. In essence, this is the “warm hand off”.

Citation: H. B. Kersten et al. (eds.), *Identifying and Addressing Childhood Food Insecurity in Healthcare and Community Settings*, SpringerBriefs in Public Health, 2018. Available at: (<https://bit.ly/2MVtDUA>)

On the frontier: Current state of warm hand off referrals

Given the hectic clinical environment in today’s health care landscape, addressing patients’ FI and other SDH must constantly compete with the multitude of responsibilities health care providers face. The overarching goal of a community-based partnership approach to FI interventions is to make the referral to the community agency as easy and seamless as possible for both the provider and partner.

Option #1 -- Build it: Clinics with access to CHWs, those who can bridge the gap between the healthcare provider’s office and the families’ home to assist with their needs, are the most robust provider-based approach. They may meet the family in the office and go into the home to help connect families with services. This more intensive approach has been shown to improve the social needs and the reported health status of families. Some insurance payers have begun to support the utilization of CHWs to address the social needs of the highest healthcare utilizers. In this scenario, the CHW is not only responsible for making the referral, but for ensuring that the necessary follow up is conducted to ensure that the patient was able to access the community partners’ resources.

Option #2 -- Buy it: Increasingly, electronic-based referral platforms that act as an intermediary between the clinic and community partner have filled a gap for clinics that are not able to hire the staff or take on the level of staff support needed to implement robust closed loop referrals. In November 2018, the Social Interventions Evaluation Research Network will release a useful guide for clinics to understand the quickly-changing referral platform landscape. This guide will answer the following questions:

- What are referral platforms and why are health care organizations interested in them?
- How are health care organizations selecting platforms?
- What general functionalities do these platforms offer?
- Comparison of 10+ commonly used referral platforms (Healthify, NowPow, Aunt Bertha, Charity Tracker, Cross TX, Livwell, One Degree, Pieces Iris, Reach, TavHealth, and Unite US)
- How are organizations implementing platforms?





- Recommendations based on experiences of organizations that have implemented referral platforms

For more information, and to request a copy of this resource when it becomes available in November 2018, please contact:

Caroline Fichtenberg, PhD Managing Director, SIREN (Social Interventions Research and Evaluation Network) caroline.fichtenberg@ucsf.edu 415-476-7283 (o) 410-371-3512 (c)

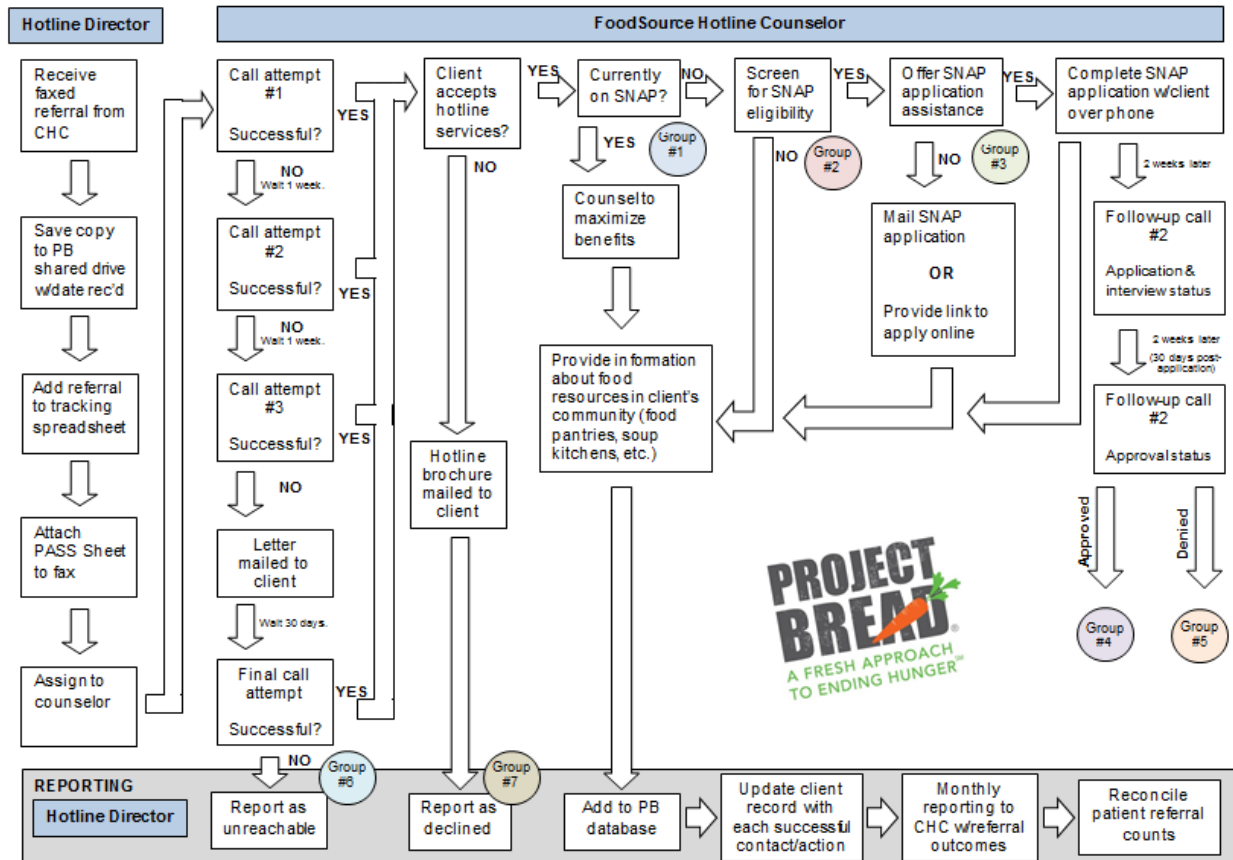
Option #3 -- Build it/Buy it hybrid: The Cambridge Health Alliance (CHA) has recently built an electronic health record (EHR)-based referral tool that results in an auto fax to their community partner agency, which then contacts the patient to offer services. One important feature of this model is the fact that Project Bread (the community partner) receives funding from the Massachusetts Department of Transitional Assistance to conduct SNAP outreach via their FoodSource hotline. Without this sustainable funding mechanism, the partnership would need to identify a funding source for the community partner to absorb the influx of referrals to their hotline. The workflow* for this partnership is as follows:

1. CHA screens patient, if screen is positive CHA provider receive consent from patient to share name and phone number with Project Bread
2. CHA provider sends referral to Project Bread via EHR
3. Referral is auto faxed to Project Bread and arrives in a shared email inbox
4. Project Bread staff contact the patient to provide services
5. A monthly summary of connections made is sent back to CHA

*For more detail, see the Project Bread algorithm below. Also, please feel free to contact the following project leads for more information

Amy	Smith	ammsmith@challiance.org	Cambridge Health Alliance
Lisa	Brukilacchio	lbrukilacchio@challiance.org	Cambridge Health Alliance
Khara	Burns	khara_burns@projectbread.org	Project Bread





For more information and resources, please refer to the Policy Learning Labs webinar slides from 9/12/18, available here: <https://bit.ly/2NFTvcN>

Compliance

- How do you get past the HIPAA privacy concerns for patient referrals to outside agencies?
- If a SDOH domain is positive and something happens in the home and child is neglected is our organization held liable?
- What are the requirements to report caregivers if they are screened positive?

Having patients complete written disclosure requests or authorization forms is likely the most straightforward way for Covered Entity health care providers to share patient information with food banks, food pantries, and other community-based agencies in a manner consistent with HIPAA requirements. Patient-driven methods of information disclosure are consistent with HIPAA requirements. When a patient makes a disclosure request or completes a valid written authorization for





a Covered Entity to share information, the Covered Entity does not need any type of agreement with the external agency in order to share the patient's information.

For more information, Feeding America worked with the Center for Health Law and Policy Innovation (CHLPI) at Harvard Law School to create an overview of the HIPAA legislation, how these regulations apply to food banks and their partners and how to comply. Sample partnership agreements and client waivers are included. This resource can be accessed here: <https://bit.ly/2rJLole>

Regarding questions of liability if a SDH screen is positive and neglect occurs in the home, we recommend you pose this question to Nemours' General Counsel or legal department. To the best of our knowledge, the results of a SDH questionnaire (assuming the questions pertain to the common SDH - food, housing, utilities, transportation, etc.) do not presume liability on behalf of the medical professional. These are simply questions about a patient's health-related social needs being asked in order to offer resources and assistance to address those needs. If your assessment specifically asks about neglect or abuse in the home, we recommend you have your legal counsel review the questionnaire.

Regarding questions of requirements to report caregivers if they are screened positive, we recommend having your legal counsel review requirements of mandated reporters. To the best of our knowledge, the results of a SDH questionnaire (assuming the questions pertain to the common SDH - food, housing, utilities, transportation, etc.) do not require the health care provider to report caregivers.

Measurements of Success

Are there evaluation models? Examples of ROI? User experience feedback?

From "[JAMA Forum: Building Blocks for Addressing Social Determinants of Health](#)" by Stuart Butler, PHD

1. Make the Case With More Research -- The evidence on social determinants of health is growing, but is still insufficient to convince many key decision makers. For instance, there is good research on the link between such [housing problems](#) as mold or substandard accommodations and health, [and between family or social "toxic" stress](#) and long-term mental health and other patterns. But purported linkages between health and other social conditions, such as general poverty, lack reliable evidence. Much more basic research is needed to understand the key determinants.

2. Develop Better Techniques to Show How Increases in Social Services Lead to Better Health -- There is always resistance to change. So jurisdictions and government budget committees, as well as private managers, need strong evidence to build the case that investments in social factors rather than just more medical services results in a good return on investment (ROI). But it is often lacking. In part that is due to the [data collection challenges](#) faced by innovative community organizations that are exploring social welfare strategies to improve health. Meanwhile, few government jurisdictions have well-





developed analytical capabilities to measure the health ROI of addressing social determinants and procedures to incorporate that information into decision making.

Fortunately, elements of a data infrastructure are emerging. For instance, the [National Neighborhood Indicators Project](#), based at the [Urban Institute](#), is helping communities and governments build and use better data systems. In addition, the [Washington State Institute for Public Policy](#), created many years ago by the state's legislature, conducts (in conjunction with state universities) cost-benefit analyses of programs and initiatives to inform legislative and agency decisions. But most communities and states still lack such tools, hampering the ability to make the case for a greater emphasis on social determinants.

3. Imagine New Business Models -- Within the health care industry itself, there needs to be new thinking about the business models of key institutions, such as [hospitals](#), as well as the use of [intermediaries](#) to improve the cooperation of health care and other sectors, such as schools and housing. However, the range of potential models being seriously considered is constrained by such barriers as insurance reimbursement and the payment policies of Medicaid and Medicare, since these affect the financial viability of different approaches to improving health. Fortunately, Medicaid is slowly providing more payment and organizational flexibility for approaches that address social factors in health. Such flexibility is encouraged through the use of Medicaid Managed Care Organizations and through experiments made possible through Medicaid [Section 1115 waivers](#), which allow states to experiment with different payment and organizational arrangements.

4. Improve Agency Coordination and Budget Flexibility -- Government at all levels is responsible for much of the funding of services and initiatives associated with social conditions affecting lower-income people. Thus, improving health through a greater emphasis on social determinants for these individuals depends on better coordination and planning between agencies, as well as greater flexibility in the use of funds. That requires strong leadership, but it also needs structures to make coordination and flexibility more routine. [Children's cabinets](#), established in more than half the states, are a possible model for how to coordinate medical and social services to improve health. These groups bring together senior agency officials of departments responsible for programs that provide services to young people to coordinate and jointly plan those services and budgets. Federal and state-level "health cabinets," including departments dealing not just with medical care but also with housing, transportation, social services, and education, could be similar, valuable institutional tools.

Breaking down agency budget silos is particularly challenging, but it is ultimately essential if the United States is ultimately to [rebalance spending](#) between medical and social programs to improve underlying health. As a step toward that goal, the federal government needs to widen the use of waivers to permit more experiments to test the effects of investments in social determinants on health. In the meantime, more states could adopt [versions](#) of Maryland's use of [local management boards](#). These are county-level bodies that have some discretion to blend budgeted money from different departments and private funds, to support innovative local organizations and programs.





The growing attention to the importance of social factors in health is a welcome development. By understanding these factors, and incorporating that knowledge into the design of our health care system, we will be more successful and efficient in improving the health of individuals and families. But getting there requires some very important building blocks.

From “[ACO Technical Assistance: Building Teams for New Roles](#)” Health Management Associates and Massachusetts League of Community Health Centers.

The following table provides an overview of SDOH interventions that have demonstrated cost savings and methods used for evaluation.

INTERVENTIONS – Cost Savings and Quality

Intervention name	Description	Cost savings	Quality and care utilization measures
Adirondack Medical Home Demonstration	The Adirondack Medical Home Demonstration is a five-year pilot across payers and providers in the Adirondack region of New York State in which participating providers become NCOA-certified patient-centered medical homes (PCMHs). The payers distribute \$7 per-member per-month to providers to support an extensive set of PCMH services, including employing care managers and community resource advocates who assist patients with social needs. ^a	The Hudson Headwaters Health Network, a participant in the Adirondack Medical Home Demonstration, has shown 15% to 20% savings for Medicaid beneficiaries. ^b	After implementing a transition program for individuals discharged from the hospital, the Hudson Headwaters Health Network reduced its readmissions rate for targeted conditions from 19% to 7%. Within the Network, patients are assessed upon intake and referred to Community Resource Advocates to provide social supports, including assistance with housing/living conditions, food, and transportation. ^c
Camden Coalition of Healthcare Providers	The Camden Coalition of Healthcare Providers operates a care management program for high utilizers of health care services, where an outreach team assists participants with activities such as connecting to a medical home, obtaining housing and other public benefits, managing their legal needs, and meeting their personal goals. ^d	In the period post-intervention, average total hospital charges per month for 36 high utilizers fell by 56.4%, from \$1,218,010 to \$531,203. ^e	After participating in the intervention, the average total number of emergency department and hospital visits across 36 high utilizers fell by approximately 40%, decreasing from 61.6 to 37.2 visits per month. ^f
Community Asthma Initiative	The Community Asthma Initiative is an intervention operated out of Childrens Hospital Boston and a community health center, in which nurse case managers provide care coordination services for low-income children with asthma. The families receive home visits from nurses or community health workers supervised by nurses, who assess the families' homes for asthma triggers, provide asthma remediation items, and connect families to community-based services. ^g	At two-year follow-up, the intervention saved \$3,827 in decreased emergency department visits and hospitalizations per child when measured against a comparison group. The intervention cost \$2,529 per child, resulting in a return on investment of 1.46. ^h	At 12 months into the intervention, participants experienced a 68% decrease in emergency department visits, an 85% decline in hospitalizations, and a 43% reduction in “days of limitation of physical activity.” In addition, children missed 41% fewer school days and their parents missed 50% fewer days of work. ⁱ





INTERVENTIONS – Cost Savings and Quality

Intervention name	Description	Cost savings	Quality and care utilization measures
Frequent Users of Health Services Initiative	The Frequent Users of Health Services Initiative includes six hospital and community-based case management programs in California providing referrals to medical and social services for individuals who are frequent users of emergency departments. ¹	After two years of program enrollment, average inpatient charges decreased by 69%, falling from \$46,826 at one-year pre-enrollment to \$14,684 at the two-year point. ¹	Two years post-enrollment into the initiative, average inpatient days decreased by 62%. ¹
Geriatric Resources for Assessment and Care of Elders (GRACE)	The GRACE intervention begins with a home visit by a nurse practitioner-led support team to assess low-income seniors' medical and psychosocial needs. The support team reports its findings to a larger group of health care professionals, which develops and implements a care plan to address the individual's needs, including those related to home safety and social support. ^m	For individuals with a high-risk of hospitalization, a randomized controlled trial found similar costs between individuals participating in GRACE and a comparison group receiving usual care during the two years of the study. However, in the year following the intervention, individuals at high-risk of hospitalization participating in GRACE had significantly lower total mean costs than similar individuals in the comparison group; a difference of \$5,088 v. \$6,575, respectively. ⁿ	Individuals receiving the intervention had a significantly lower rate of emergency department visits over a two-year period than individuals receiving usual care (1,445 per 1,000 v. 1,748 per 1,000). In addition, GRACE participants experienced statistically significant improvements on the SF-36 quality of life instrument in the areas of general health, vitality, social functioning, and mental health as compared with the usual care group. ^o
Health Leads	In the clinics where Health Leads operates, physicians and other members of the clinical team can systematically screen their patients for unmet social needs and prescribe resources to meet those needs. Trained student Advocates connect the patients to community resources by leveraging a client management database and resource inventory. They then conduct follow-up to ensure the services were received, and loop back to the referring provider. ^p	After the Dimock Center, a health and human services agency in Boston, instituted Health Leads, their pediatric social worker's average weekly billable therapy minutes increased by 57%. ^q	In fiscal year 2013, 90% of patients with whom Health Leads worked successfully solved at least one need or reported that they are equipped to secure resources with the information provided by Health Leads and without further assistance.

Intervention name	Description	Cost savings	Quality and care utilization measures
Medical-Legal Partnership	In the Medical-Legal Partnership (MLP), lawyers and paralegals work onsite in clinical settings or at locations affiliated with provider institutions and assist patients in addressing legal issues associated with health status. ^r	An MLP between a federally funded legal aid agency and a community health clinic in rural Illinois assisted individuals with appealing Medicaid coverage denials and obtained a 319% return on investment over a three-year period by obtaining reimbursement through health care recovery dollars. ^s	In a small pilot study, adults with moderate to severe asthma who received services through an MLP in New York demonstrated a 91% decline in emergency department visits and hospital admissions. Approximately 92% of participants experienced a decrease of at least two asthma severity classes. ^t
Seattle-King County Healthy Homes Project	The Seattle-King County Healthy Homes Project is an intervention in which community health workers conduct home visits for families of low-income children with uncontrolled asthma. Intervention participants received self-management support services including a home assessment for environmental triggers, help with reducing exposure to asthma triggers, and assistance in developing skills to better control asthma, such as correct use of medications. ^u	Urgent care costs for participants in the high-intensity version of the intervention were estimated to be \$201-\$334 per child less than those in the low-intensity version of the intervention. ^v	For participants in the high-intensity version of the intervention, from baseline to the period post-intervention, the percentage of participants using urgent health services over the past two months declined from 23.4% to 8.4%, a greater decline than observed in the low-intensity group. In addition, symptom-free days and asthma-related quality of life for the children's caregivers improved more among families in the high-intensity group. ^w



Appendix E – Identification Requirements at Food Banks (Team Lead: Children’s Healthcare of Atlanta; Georgia)



To: Policy Learning Lab team from Children’s Healthcare of Atlanta

From: Richard Sheward, Children’s HealthWatch

CC: Kate Burke Blackburn, Nemours Children’s Health System & Sara Bartel, ChangeLab Solutions

Subject: identification requirements at food banks

Date: August 9, 2018

Purpose:

1. Targeted policy research and analysis to better understand what, if any, federal/state/local regulations require families to produce identification/documentation in order to receive food resources.
2. Connection to other teams/resources working with immigrant populations to increase access to food.

Report on regulations re: identification/documentation in order to receive food resources

[Advancing Equity within the Emergency Food Provider Network in Maricopa County](#)

Note: While this report is specific to Arizona, the TEFAP regulations described and policy recommendations are applicable to other states, including Georgia.

Policy on Identification Requirements

Interviewees reported confusion surrounding identification requirements at food banks and pantries in Maricopa County. Arizona TEFAP distribution guidelines do require some form of identification, but it does not have to be government-issued. The guidelines state that any of the following are acceptable for identification purposes: driver’s license, rent, utility, and phone bills, or a document that shows a client’s name and address. The federal TEFAP guidelines prohibit requiring social security numbers. Although no one interviewed had been turned away, many relayed stories of others being turned away from food pantries for lacking U.S. state-issued identification cards. Others heard stories of agencies collecting social security numbers. Many interviewees that were not familiar with the food bank and pantry network did not know that requiring U.S. identification cards or social security numbers was prohibited. This finding indicates that many Latinos are not likely aware of their rights at food banks and pantries. It also indicates that some food pantries are not following TEFAP identification requirements.

Recommendation: Training Staff and Volunteers





The Emergency Food Assistance Program (TEFAP) Civil Rights training addresses the identification requirement barrier. The training curriculum states:

Customers must show an acceptable form of ID:

- TEFAP Card
- Driver's license
- Rent, utility, [or] phone bills
- Document that shows name and address
- You may not ask customers for a Social Security Number.

The research indicates that some frontline volunteers and staff are not aware of these requirements. Therefore, identification requirements should continue to be addressed in the TEFAP Civil Rights training.

Fact Sheet on working with immigrant populations in the context of food banks/pantries

- **[Providing Food Assistance to Immigrant Communities in an Uncertain Political Environment](#)**
Shifts in the current administration have created uncertainty and confusion in many immigrant communities, leading individuals and families to become more hesitant in seeking resources and/or voluntarily withdraw from any resources they are currently accessing. In an effort to provide individuals and organizations more support, the San Diego Hunger Coalition has reached out to local and national immigration organizations to pull together information that can be shared with clients across food assistance programming.

Recommendation: Inclusion of messaging information on food bank/pantry website. Examples:

- [Vermont Foodbank](#)
- [San Francisco Marin Food Bank](#)
- Contact: Marcia@sdhunger.org

Case example: Working with state agencies to provide policy/regulation guidance to food banks re: identification/documentation in order to receive food resources

In 2010, [Massachusetts Food SNAP Coalition](#) received complaints throughout the state that a number of local food pantries were requiring households to produce photo IDs as a condition of food distribution. The demand for a photo ID was affecting a wide range of low income persons - both U.S. citizens and immigrants alike - who lacked a photo ID due to homelessness, theft, domestic violence, fear of showing expired documents, or simply lack of any photo ID even though they had other forms of identification.

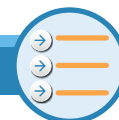
On behalf of concerned Food SNAP Coalition members, Massachusetts Law Reform Institute raised this issue with USDA and the Department of Elementary and Secondary Education and both attended a





Coalition meeting early in 2010 to discuss. DESE is the state agency that administers TEFAP funding. DESE has officially advised all of the food pantries that the practice of demanding photo IDs is prohibited. The [attached letter from DESE](#) was sent to the Greater Boston Food Bank, with identical letters sent to the Merrimack Valley Food Bank, the Worcester County Food Bank and the Food Bank of Western Mass.

Recommendation: If the Inclusion of messaging/information/framing of the policy and regulations governing food banks/pantries, and/or or staff training is not successful, Children's Healthcare of Atlanta or a partner agency may consider approaching USDA and the Georgia state agency that administers TEFAP funding to request that policy guidance be issued to food banks/pantries in similar fashion to the guidance that took place in Massachusetts.



Appendix F – Implementing Food Rx Partnerships (Team Lead: Central Louisiana Economic Development Alliance; Louisiana)



To: Policy Learning Lab team from Central Louisiana

From: Richard Sheward, Children's HealthWatch

CC: Kate Burke Blackburn, Nemours Children's Health System & Sara Bartel, ChangeLab Solutions

Subject: Examples and materials for implementing Food Rx partnerships in rural settings

Date: August 9, 2018

Case Example #1

Gorge Grown Food Network

Gorge Grown Food Network's Veggie Rx is a fruit and vegetable prescription program designed to alleviate food insecurity and increase intake of fresh produce in Oregon and Southwest Washington.

- About the [Veggie Rx Program](#)
- Providence Health & Services' [summary](#) of a community-based participatory [evaluation](#) of the Veggie Rx Program

Contacts:

- Natalie Royal: Natalie.Royal@providence.org

Case Example #2

Boston Medical Center

Since 2001, Boston Medical Center (BMC) has developed three services to enhance patients' exposure to higher nutritional foods:

- [Preventive Food Pantry](#)
- [The Teaching Kitchen](#)
- [BMC Rooftop Farm](#)

Contacts:

- Latchman Hiralall: Latchman.Hiralall@bmc.org
- Lindsay Allen: Lindsay.Allen@bmc.org Melanie.Gnazzo@umassmed.edu





Case Example #3

Farm to Health Care Center Initiative at the Family Health Center Worcester

Since 2013, the Farm-to-Health Center Initiative has been an ongoing project led by University of Massachusetts Medical School students in collaboration with the Family Health Center of Worcester and Community Harvest Project farm in Grafton. The Farm-to-Health Center Initiative is designed to improve patient access to fresh produce by providing free weekly farmer's markets at the health center.

- [Farm-to-Health Center Initiative](#)
- [Related media](#)

Contacts:

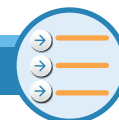
- Dr. Melanie Gnazzo: Melanie.Gnazzo@umassmed.edu
- Blair Robinson: blair.robinson@umassmed.edu

Case Example #4

The University of Vermont Medical Center Healthy Food Access Plan

In fiscal year 2018, the University of Vermont Medical Center established the global aim to improve nutrition, culinary literacy and access to affordable healthy foods to reduce food insecurity and/or prevent obesity. Several culinary medicine programs are currently in place:

- Health Care Shares: Families receive weekly supplies of fresh produce and poultry at their primary care office free of charge, as well as nutrition information, recipes, and demonstrations from their providers and volunteers. 100 families served in Chittenden County.
- Veggie Rx: A physician-led "produce prescription program," which is now being piloted in Pediatrics. Families are screened for food insecurity; upon a positive screen, families are coached on the importance of fruit and vegetable consumption and received coupon booklets that can be redeemed locally. The program has prescribed \$150 in coupons for 410 families in Chittenden County and 270 in Rutland.
 - Additional information from the 2018 [budget report](#)
 - [Progress report](#) on 2016 Community Health Needs Assessment goals





Additional information

Wholesome Wave Fruit and Vegetable Prescription Program Model

[Wholesome Wave](#) is a national nonprofit that partners with doctors to provide patients with innovative fruit and vegetable prescriptions- from seniors in Navajo Nation to mothers & children in Los Angeles.

- Fruit and vegetable prescription program [fact sheet](#)
- The Fruit and Vegetable Prescription Program [Toolkit](#)
 - ❖ Note: This toolkit is a comprehensive resource on this organization's approach to Food Rx

Other Research

- [Veggie Rx: an outcome evaluation of a healthy food incentive programme](#)
- [Caregiver perceptions of a fruit and vegetable prescription programme for low-income paediatric patients](#)





movinghealthcareupstream.org