Building Capacity for Food and Health Systems to Partner

Piloting an approach to strengthen communication across food systems and medical home providers to address food insecurity and health of children and youth with special health care needs

Background:

Food insecurity is the limited or uncertain availability of nutritionally adequate and safe foods, and limited or uncertain ability to obtain acceptable foods in socially acceptable ways. Insufficient or uncertain access to food is both an acute need and a chronic issue that can negatively influence the health of children. In 2017, the rate of food insecurity for all populations in Wisconsin was 10%, and the 2018 rate in Milwaukee County was 18.7%.1 In June 2020, around 16% of households with children reported that their children were not eating enough over the last week due to a lack of resources.

Approximately 20.7% of Wisconsin children are food insecure and nearly one in five or 19.1% of Wisconsin children have a special health care need.[2,3] Children and youth with special healthcare needs (CYSHCN) are at high risk of experiencing food insecurity, and food insecurity places children at risk for adverse health conditions.

Partnerships between clinics and food pantries may support children and families connection to nutrition and a supply of food as well as to other benefits (e.g., TANF, Foodshare, utility assistance) and services (e.g., housing, legal assistance). While organizations like food pantries are important community asset, national reports and local stories indicate variation and limitations in how these organizations are engaged by local clinics and health systems.

Across Wisconsin and nationally, heath care systems are investing in technology to create a closed-loop referral process with community based organizations. For example, in Milwaukee local health systems and Impact 211 are planning to implement a digital community health information exchange (C HIE) via Now Pow. This will connect families with identified social needs to community organizations through electronic referrals. Participating community organizations will support 'closing the loop' by providing an electronic verification that referred individuals have been connected to the community resource. Resources include emergency food supplies, housing and transportation, among others.

The Medical Home Initiative and CYSHCN Network will develop and test a pilot in two communities across Wisconsin to learn how to work effectively with community-based organizations (CBOs) and the families they serve. In addition, we will test ways to bridge health care and food systems to coordinate clinical and social health services. Following the 2020-2021 pilot phase, future work may expand to address transportation, housing and others social influencers of health.

Overview of Pilot

This pilot program will support the growing intersection of community-based organizations (CBOs) and primary care clinics. The aim is to build bridges across non-traditional partners to address food insecurity and promote health of children and youth with special health care needs (CYSHCN). The first site will include Children's Wisconsin primary care clinics (medical home), local food banks, and two food pantries in Milwaukee.

Building Capacity for Food and Health Systems to Partner

A second community in Wisconsin will be recruited for participation in the 2020-2021 pilot.

This pilot will begin working with food pantries and food banks to develop their capacity to respond to referrals from clinical partners, with plans to convene the clinical and food system partners. We will also consider how to work with the Regional Centers, food pantries and food banks to connect children and youth with special health care needs to primary care and other needed social health services.

Goals and Objectives:

Goal 1: Strengthen communication between food pantries, food banks and primary care clinics to increase food security and health of CYSHCN

Objective 1: Develop and/or support a system of bidirectional referrals (i.e. NowPow) and information sharing between food pantries, food banks and medical homes by building capacity

Objective 2: Assist with relationship-building between food pantries, food banks and clinic staff members, with emphasis on understanding one another's priorities, areas of focus in working with CYSHCN and their families, and opportunities for improvement

Operational Plan

The first several months will be important for planning and capacity building for this non-traditional type of approach. The capacity-building period will focus on build relationships and open communication between the Medical Home Initiative team, food pantries and food bank partners. This may include hosting joint meetings to discuss shared priorities and opportunities for improvement; assess current work processes in the pantry, identifying champion(s) at the food pantry and food bank, education of staff (clinical and food pantry), and development of workflows in the food pantry to respond to clinical referrals of CYSHCN. Elements of focus may include:

- Create a process for referrals and bidirectional communication (i.e. NowPow)
- Data sharing & review process across food and clinical settings to determine if the screening and referral process is working for families, clinics and food pantries
- Create a process for identification of CYSHCN, either by the medical home or CBO staff
    - Explore current processes in food pantries and food banks
- Create a process with food pantries and food banks for referral of CYSHCN to Regional Centers for additional relevant resources (including connections to a primary care provider)

<u>A quality improvement approach will be used to accelerate shared learning at pilot sites, including regular reporting on identified measures and conducting small tests of change.</u>

Building Capacity for Food and Health Systems to Partner

Quality Improvement measures

Potential outcome measures:

- Perception of strength of communication between food pantries and medical homes from each sectors' view
- Strength of relationship between food pantry and clinic staff
    - Baseline data: gathered before pilot begins, then set goal around increasing from this

Potential process measures:

- CBOs confidence with handling receipt of referral from medical home, including follow up on outcome of referral
- Families' satisfaction with med home to food pantry referral process
- Number of referrals sent from clinics to food pantries
- Number of clinic referrals received by food pantries
- Number of referrals from food pantries received by Regional Centers for CYSHCN

Potential balancing measures

- FP staff's perception of time available to respond to referrals from clinics, screen for CYSHCN, refer to Regional Centers
- Regional Center staff perception of appropriateness of referrals from food pantries

Deliverables:

- Development of work flow/work processes within food pantries to respond to clinical referrals, bidirectional communication, CYSHCN identification and referral to Regional Centers for CYSHCN
- Education of clinical, food pantry, and Regional Center staff regarding the role of health and food insecurity, and particular impact upon population of CYSHCN
- Development of relationships between food pantry staff and clinicians to develop successful closed-loop referral processes

Building Capacity for Food and Health Systems to Partner

References

[1]Feeding America. Map the Meal. Accessed on April 6, 2020 from https://map.feedingamerica.org/county/2017/overall/wisconsin

[2]Child and Adolescent Health Measurement Initiative. 2017-2018 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved April 7, 2020 from www.childhealthdata.org.

[3]Feeding America. Hunger in Wisconsin. Accessed on April 6, 2020 from https://www.feedingwi.org/hunger/

[4]Mattson G, Kuo DZ, AAP COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, AAP COUNCIL ON CHILDREN WITH DISABILITIES. Psychosocial Factors in Children and Youth With Special Health Care Needs and Their Families. *Pediatrics.* 2019;143(1):e20183171

[5]Brookings Institute. Accessed on December 10, 2020 from https://www.brookings.edu/blog/up-front/2020/07/09/about-14-million-children-in-the-us-are-not-getting-enough-to-eat/