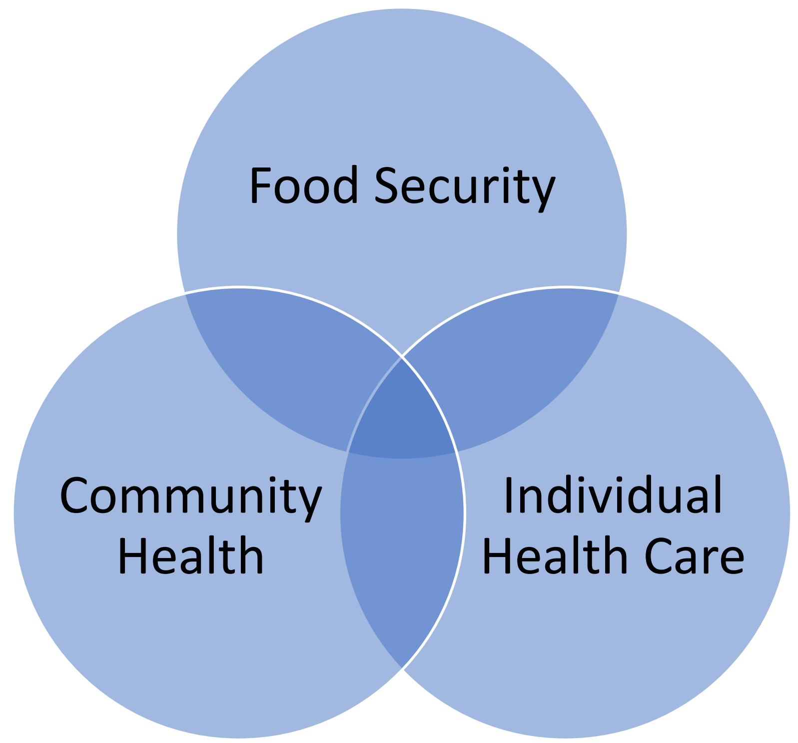
Network Planning Summary

In the 2020-2022 planning period for the Vermont Food Access and Health Care Consortium, the group reviewed current literature, evidence base, and model programs that integrated food across the continuum of patient care. Programs were mapped across three overlapping domains that described how health care practices interact with food and food access. We found that rural Vermont programs clustered in food security and the food security / community health domains with fewer in the Individual Health Care section. Tailored health care services integrating food were more common in the urban region of the state.



Enough Food Is Available for Basic Daily Calorie Requirements

Food Access Barriers Do Not Prevent Patients from Participating in Clinical Nutrition Services

Patients Systematically Screened for Food Insecurity Risk & Connected Needed Resources & Collected Data Reviewed for Population Health Insights

Food Available Includes 3-5 Servings of Vegetables

Food Security

Community Health

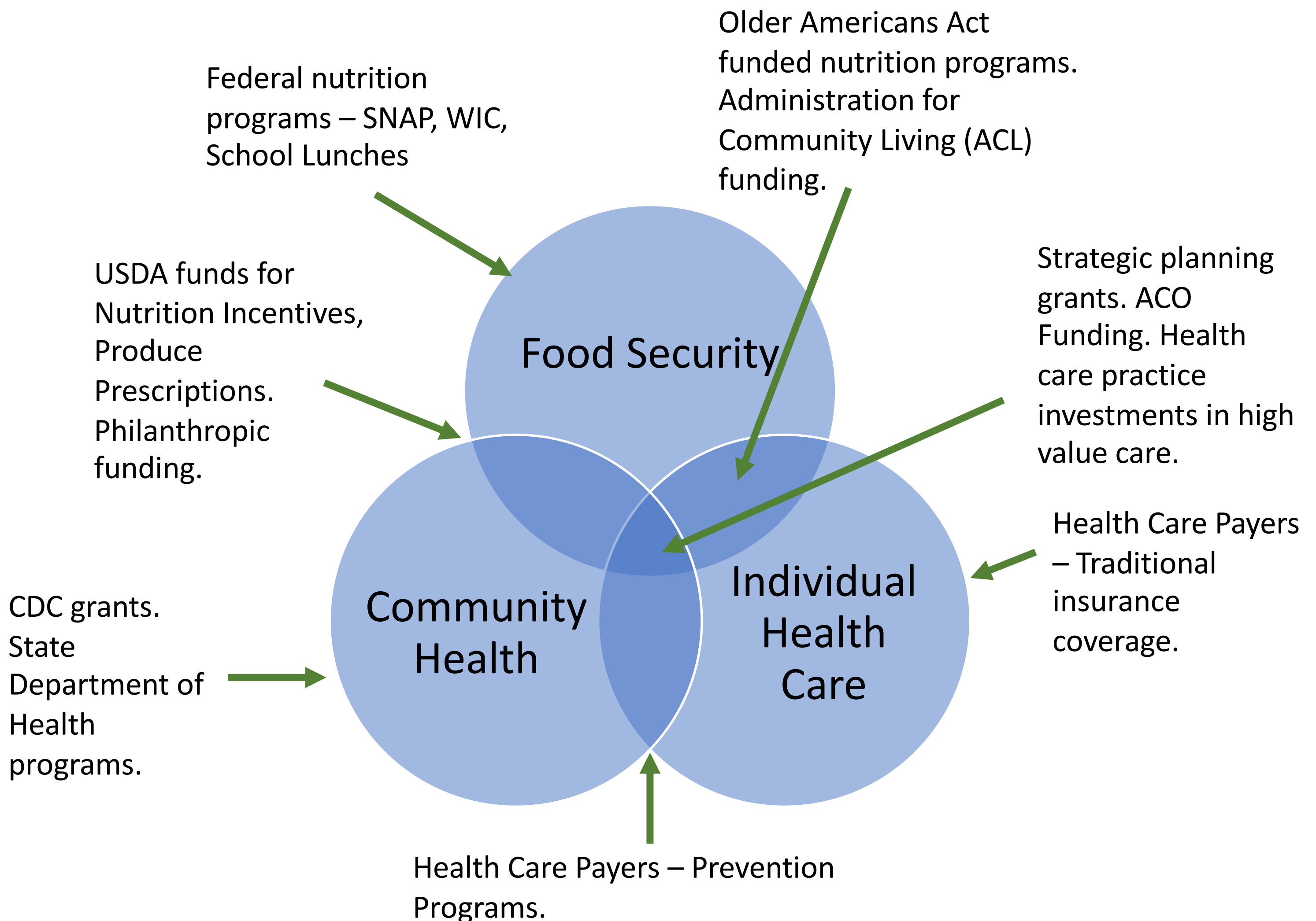
Individual Health Care

Nutrition Services for Diet Change + Medication Adjustment to Reduce A1c Levels for Type 2 Diabetes (or other specific health goal)

People Eat 3-5 Servings of Vegetables, Which Supports Better Health

Patients Who Have Successfully Completed an Intensive Dietary Treatment Have Resources to Sustain a New Diet that Supports Their Health

Thinking about food integration programs across these domains is also useful for conceptualizing funding sources, as their focus areas and evaluation structures tend to align with similar categories. Examples are listed below. Note, these are generic examples, not necessarily funding available to Vermont programs.



It can be challenging, or even impossible, to match up these funding sources into a comprehensive program. Health care practices report obstacles related to the administrative burden of applying for and managing funds from different grant sources, project objectives and evaluation systems that are not aligned, and funding timelines that leave gaps and uncertainty at the close of a particular project. Also, not all sources are available in every state. For example, Vermont lacks foundations that support health care transformation and our ACO does not include food access integration as a goal for funding structures (VT FAHC partners with them in other ways, including waivers, data analysis, and pilot project in-kind support).

Strategic planning work conducted by VT FAHC provides more details on aspects of these challenges, including an overview of common evaluation systems for food and health care projects, a detailed review of the funding structure for Medically Tailored Meals (and what this can tell us about health benefit design more generally), an interview with the CMS Innovation Center on how they approach design for new benefits / rulemaking, and policy analysis by Bi-State Primary Care Association on specific disconnects found between USDA and health care funding in the Gus Schumacher Nutrition Incentive grant program (note: advocacy was not supported by federal grant dollars).

One way to approach this problem is to move from focusing on the full system of successful food integration into health care and instead consider component parts, investing in discrete projects that can eventually be combined into a holistic approach. This strategy is outlined on the following pages.

The previous pages showed general areas of program focus, funding, and policy. Planning also outlined the building blocks within specific evidence-based models that have been developed nationally.

Components of Food & Health Care Models

Basic Systems

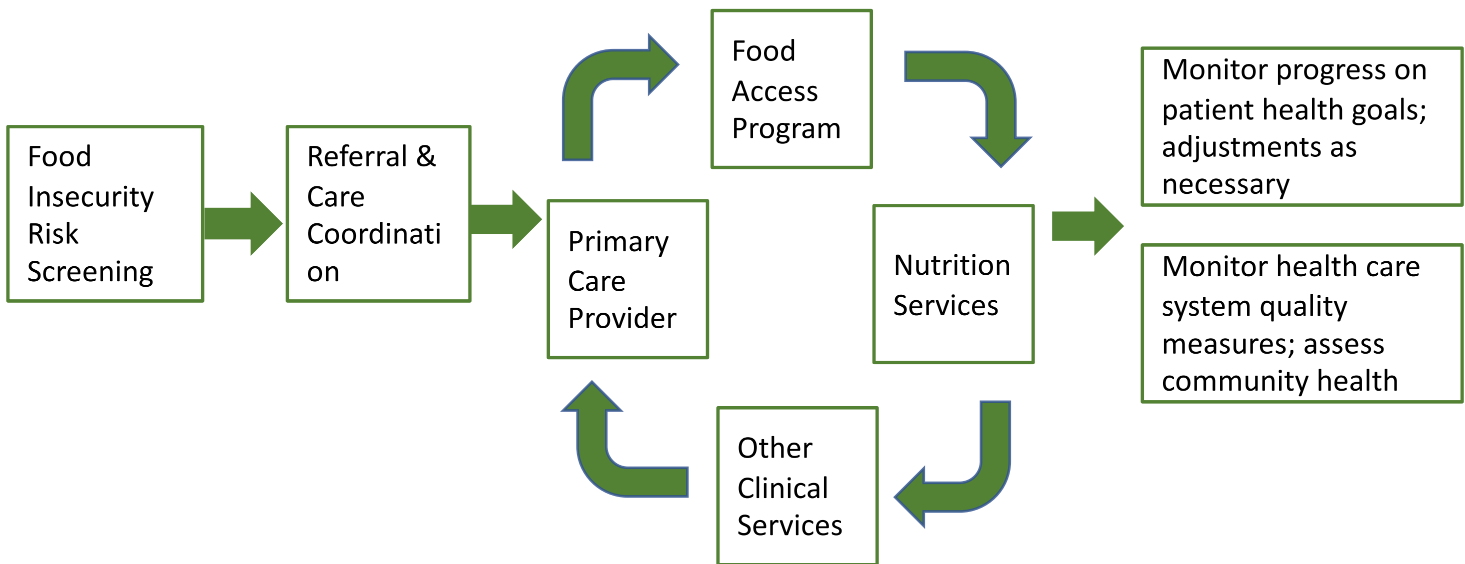
Food Insecurity Screening
Multi-Domain Social Risk Screening
Referral to Social & Community Services
Data Collection & Analysis
Data Exchange
Aligning Community Resources
Funding & Reimbursement
Regulatory Compliance

Food Access Program Structures

Health Service Integration

Medical Nutrition Therapy
Self-Management Programs
Care Management
Medication Management
PCP Engagement
Specialist Access
Health Coaching
Transition in Care Setting
Clinical Referral Systems

These elements can be arranged into a generic food access and health care intervention format.



The following pages show options to build out from the simplified diagram to data collections that measures impact of different components. Programs with limited resources can focus on different areas of implementation / improvement and over time build them into a broader system that successfully integrates food access into health care. Sample dashboards for food insecurity screening implementation illustrate this focused option. The broader mapping also helps organize pilot projects, so that at a given time we are exploring different components of food access and health care integration in different regions of the state. These pilots can then scale across regions, accelerating the development time for the entire system. For example, in 2022 NOTCH focused on process improvement iterations for food insecurity screening and referral to assistance with 3SVT applications while Rutland Community Health piloted a strategy for patient outreach around 3SVT benefits. In 2023, we hope to add patient outreach as piloted in Rutland to complement NOTCH's screening systems.

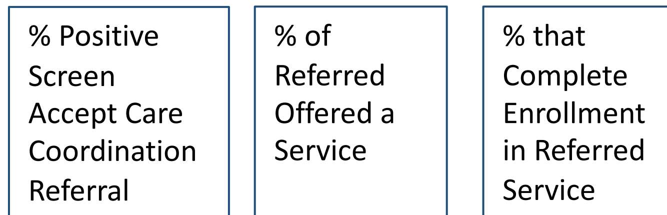
Conceptual Model for Joining Food Access & Clinical Elements

Measures for Patient Program Access

HC Practice Food Insecurity Screening Policy

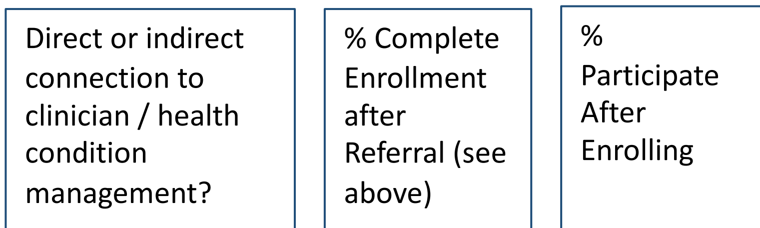
Quality check for screening implemented, results available in EHR, results reviewed by PCP & care team

Referral Pathway for Patients at Risk of FI



Quality check for menu of services available meeting patients' needs, navigation pathways to enrollment meeting needs.

For Non-Health Care Food Partners

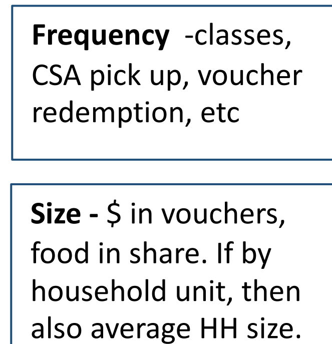


Assumes some level of closed loop referral to community partners for tracking participation in EHR.

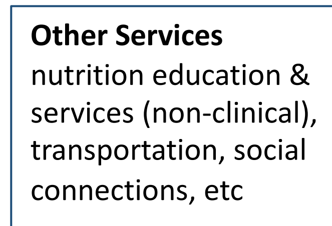
Baseline Measures at Enrollment

Implementation Measures

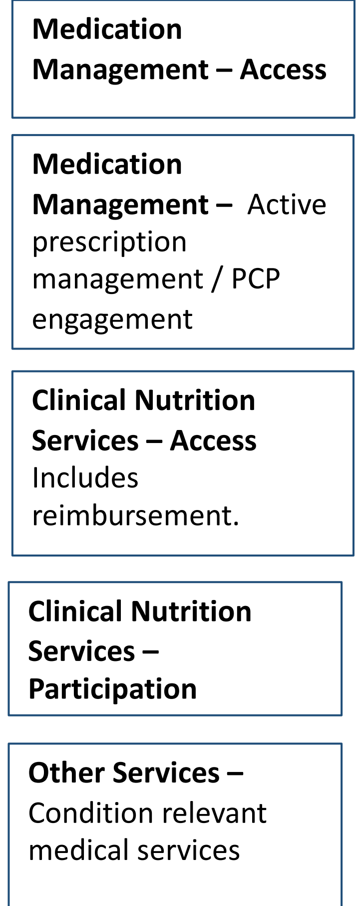
Program Measures



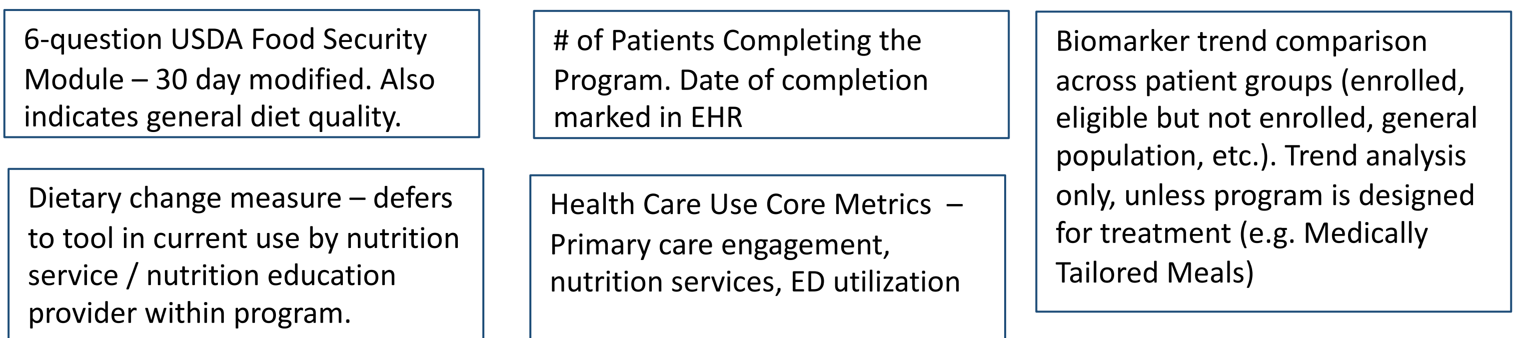
Duration - of the intervention or of phase (for example, MTMs then step down)



Clinical Measures



Measures of Intervention Progress



Sample dashboards from the HRHI Project. Top dashboard shows tracking patients from food insecurity screening through participation in internal food access program. Bottom dashboard shows tracking patients from food insecurity screening through clinical connections. Appendix B provides the full dashboard structure.

Patient Participation Tracker:

Active Medical Patients	Active + Med Visit in Program Year	Active Patients with CVD Risk	Patients Screen Positive for FI in PY	Eligible Patients (Med Visit in PY + FI Positive in PY + Cardio Risk)	Offered Food Interventio n	% of Offered Who Enroll in Food Intervention	Current Participant Enrolled Any Year; Active at Present
Total Active	Subset of Total Active	Subset of Total Active	Subset of Total Active	Absolute # Meeting Three Criteria	# Offered (PY)	Percent (PY)	Total #

FI Screening Tracker:

Active Patients with Med Visit in PY	Patients w/ Med Visit Screened for HVS
# - Subset of Total	Percent (PY)
# Patients Screened Positive in PY	**% Positive Rate**
# - Subset of Total Active	Percent (PY)

Summary Across Grant Years:

Patients Assisted with Food Access Any Year	Days from HVS Screen to Food Program Enroll ment	% Patients Engaged [(# Participating + # Complete / Total # Offered)]
Total # Complete	Average Days	Percent

FI Screening Tracker:

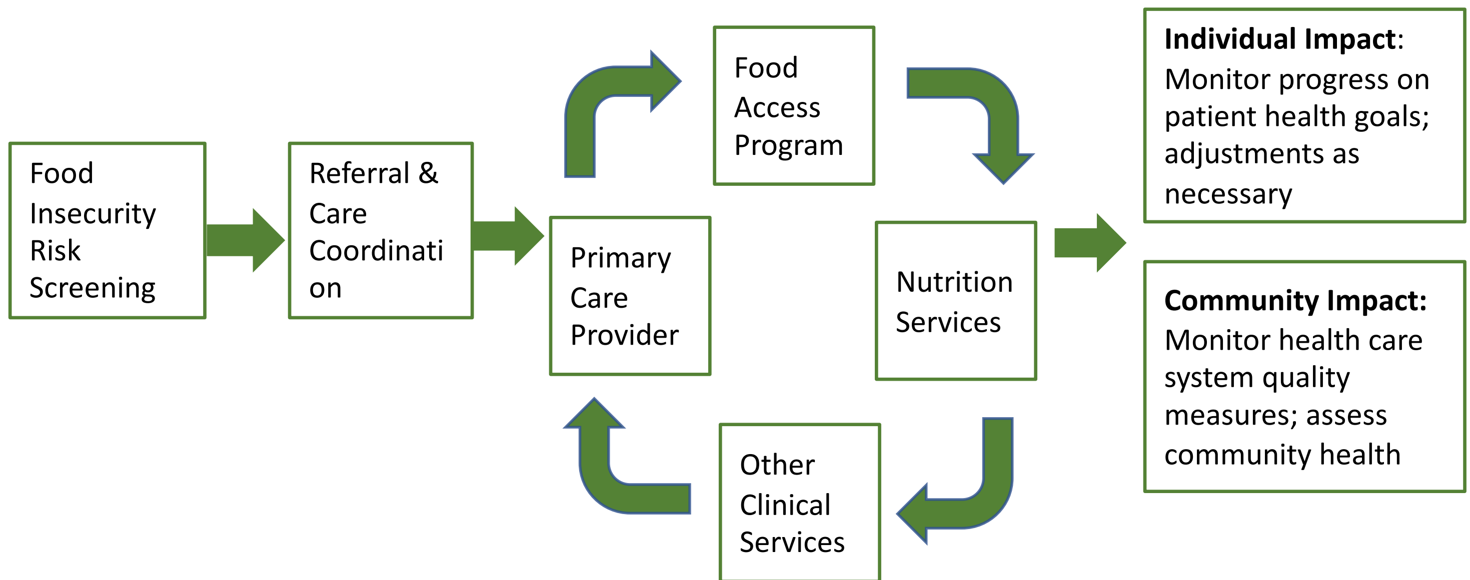
Active Medical Patients	Active + Med Visit in Progra m Year	Patients w/ Med Visit Screened for HVS	% Positive Rate	% with Current FI Screen Available at Office Visit?	% of Patients w/ Medical Visit + Positive CVD Risk	% w/ Med Visit + Negative HVS + Positive CVD Risk	% w/ Med Visit + Positive HVS + Positive CVD Risk
Total Active	Subset of Total Active	Percent (PY)	% of Patients Screened	Current defined as w/in 90 Days	Percent (PY)	Percent (PY)	Percent (PY)

Biomarkers: % of Patients with Test in Past 12 Months

	BMI	A1c	BP	Cholest erol
Active Patients				
Active Patients with CVD Risk				
Patients Enrolled in Food Intervention (ever)				

	CVD Risk + Med Visit	CVD + Med + Food Program
Statin Rx (newly active)		
Metformin Rx (newly active)		
Aspirin for CVD (newly active)		
MNT Services (PY)		
Self-Management Program Completion (Any)		

Strategic Planning by VT FAHC – 2020 - 2022



Alongside analyzing the existing models for food access and health care integration, VT FAHC reviewed Vermont's current systems and how they support these models, along with potential modifications for the Vermont rural health system context. This work led to the following collection of resources and emerging project portfolio. Our Healthy Rural Hometown Initiative grant is a major component of these projects and it also benefits from the background work performed by the full VT FAHC using complementary strategic planning grants.

Food Insecurity Risk Screening

2021 Food Insecurity Screening Systems Survey | Hunger Vital Sign Explainer | Data Collection Structure (HRHI) Presentations: Blueprint Community Health Teams, VPQHC Care Coordinators, Hunger Vital Sign Community of Practice, CSA Community of Practice. Hunger Free Vermont offers trainings to health care practices. Bi-State Comments on CMS proposed IPPS Rule (2023).

In Process: 2022 Food Insecurity Screening Survey (will be complete November 1, 2022) | Grant Proposal to NH Children's Health Foundation | Two HVS Explainer Follow-Up Episodes

Next Steps: Connecting to Inpatient Admissions at Hospitals | Implementation Benchmarks (memo available)

Additional Steps (Preliminary): New Hampshire Profiles & Outreach | Collaboration on Community Health Workers Training Units | NACHC Collaboration

Referral & Care Coordination

2020 Review of FQHC Information Systems | 2020 Community Information Roundtable | Podcast Profiles of Care Coordination Elements | Sample Systems from Other Regions | Patient Referral Path Dashboard (HRHI)

In Process: Closed Loop Referral Options for Self-Management Programs | Participation in National Conversations Regarding SDOH Coding

Next Steps: Referral Systems to Area Agencies on Aging | Process Improvement with CSAs

Additional Steps (Preliminary): Work with Care Coordinators to Define Key Features they Want in Referral Platforms | Work with Clinicians to Outline Choice Architecture for Food-Intervention Referrals

Primary Care Provider

HRHI Dashboard Tracking Food Security Information Available at Time of Appointment | HRHI Dashboard Connecting Food Interventions & Clinical Measures | Brief Review of SDOH Coding Systems & Provider Perspectives (memo available)

In Process: See Closed Loops (RDs, Self-Management, Community Partners)

Next Steps: Understanding if PCPs Use Food Insecurity Information When Available | Understanding Impact of New SDOH Office Visit Coding Structure

Additional Steps (Preliminary): None at this time

Food Access Programs

Medically Tailored Meals Capacity Review & Presentations | CSA & Health Care Community of Practice | HRHI Program Pilots | 3SVT Outreach & Referral Pilot (memo available) | USDA / GusNIP Policy Proposal | Overview of Program Evaluation Structures | Reimbursement Review (currently being updated) | Promising Practices & Case Studies Overview (currently being updated) | National Communities of Practice Participation

In Process: Consideration of Essential Health Benefits & Medically Tailored Meals | Strategies for Meals on Wheels Support | Overcoming Transportation Barriers Report (Farm to Plate) | Overview Updates

Next Steps: CSA & Health Care Collective Impact Project (Presentation & Memo Available) | Local Vendors in MA Plan Food Contracts | Monitor National MTM Policy Proposals | Monitor Farm Bill

Additional Steps (Preliminary): Produce & Medically Tailored Foods Payment Processing Platform | Pilot of Local Tailored Food in Employee Wellness Plans | Expand 3SVT Pilot | Eternal Search for MTM Start Up Funding

Nutrition Services

2022 Landscape of Nutrition Services | Registered Dietitians in Meals Programs | Culinary Medicine Review

In Process: AHS / DFR Analysis of Medical Nutrition Therapy Utilization Patterns | Closed Loop Referral Options for Self-Management Programs

Next Steps: Targeted Outreach Clarifying Reimbursement | Closed Loop on RD Referrals for HRHI Dashboard | Analysis of Available Data on Food Access as Barrier to Participating in Nutrition Services

Additional Steps (Preliminary): Implement Z91.110 Coding | Training for Non-Clinical Food Program Volunteers on Distinguishing Medical Questions | MA Plan Coverage of Expanded MNT Diagnoses

Other Clinical Services

Next Steps: Medication Management Integration into HRHI Dashboard (PY3)

Additional Steps (Preliminary): Connection to Chronic Condition Management Program | Remote Patient Monitoring Options for Diet-Related Health Conditions | Monitor 1115 Waiver Implementation

Individual Impact

HRHI Dashboard System (see SharePoint files) | Review of Common Evaluation Structures & Patient Assessment Tools | Evidence Libraries

In Process: Review Dashboard Data & Trends with HRHI Partners

Next Steps: Patient Co-Design Project on Sustaining Dietary Changes | Use HRHI Dashboard Components to Assist Other FQHCs in Data Collection Structure

Additional Steps (Preliminary): Patient Co-Design from Proof of Concept to Statewide Project | Community Resource Alignment Based on Results of Scaled Co-Design Project | Share HRHI Lessons Learned

Community Impact

Community Health Indicators | Food System Indicators | Profile of Community Health Applications of HVS | HRHI Community Assessment | Bridge Organization Structure Review (presentation available) | Communications & Outreach – Website, Podcast, Newsletter

In Process: HRHI Cost Savings Estimate Plan | Analysis of Recent CMS Rulemaking & RFIs | Farm to Plate Food Security Strategic Planning | Website Restructuring & Update | Newsletter 1 Year Review

Next Steps: CSA & Health Care Collective Impact Project | Implement HRHI Cost Savings Estimate Plan | Food Funders Conversation Regarding Impact Evaluation Structures

Additional Steps (Preliminary): Dartmouth Institute Collaboration on Prevention-to-Treatment "Heat Map" (memo available) | Engagement in Community Health Needs Assessments & Community Health Benefits | Continued Participation in Farm to Plate Food Security Plan

---

Conclusions for Sustainable Funding of HRHI Projects

The Healthy Rural Hometown Initiative pilot projects have allowed the Vermont Food Access and Health Care consortium to take a detailed look at practical implementation of the broader concepts introduced as part of strategic planning. This insight has helped inform pathways to follow for future planning activities. In our proposed Cost Savings Estimate structure, we continue to build on this opportunity by focusing on the specific case study of the cost – benefit balance for individual health care practices in the period immediately following conclusion of the grant funds. The Cost Savings Estimate narrative describes why we consider this review to be a high priority and how we propose to structure the data collection and analysis.