Food Insecurity
ICPS Leadership Forum
August 29, 2019

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Priscilla Keith, JD,MS, Director of Community Benefit
Karen Lightbourne, Director of Community Collaboration
Objectives

- Review Social Determinants of Health
- Stats - Food Insecurity in Indiana
- Community Benefit
- Food Pantry
- Recognition and operationalizing on an inpatient unit
Social Determinants of Health are conditions in the environment that affect a broad range of health and quality of life outcomes.

A person’s zip code can be more of a health predictor than genetic code.

Influences:

- Environment
- Access to education
- Safety

Non-traditional partners needed.
Health is more than a Hospital

Figure 1. Modifiable Factors That Influence Health
Where you live, shouldn’t determine how long you live
Community Collaborations:

Creating Accountable Health Communities on Indianapolis’ Eastside
Screening:
- Who: Medicare and Medicaid patients
- Where: Includes Primary Care Offices, CHE Emergency Department, CHE OB, Urgent Care, Jane Pauley, Behavioral Health and other locations
- What: Screening for: Housing, Food Insecurity, Transportation, Utilities, Interpersonal Violence, and Social & Emotional Isolation

Navigation:
- Patients who screen positive receive a community resource sheet
- High-risk patients (2 or more ED visits in past year) who screen positive randomized to just a community resource sheet or community resource sheet + community health advocate

Accountable Health Communities Grant: Five Years – $2.56 million
Community Collaborations – CMS Grant

- CMS Grant Launched - Sept 2018
- +10000 patients screened in ED/Med Check/Residents/Jane Pauley/Inpatient so far...
- What our patients are telling us...

1. Food
2. Housing
3. Transportation
4. Utilities
5. Safety
2015 CHE ED visits

- 3,739 individuals had 4 or more ED visits
- 345 individuals had 10 or more ED visits
- Top 5 high utilizer patients:
  - Patient #1 - 92 visits
  - Patient #2 - 82 visits
  - Patient #3 - 58 visits
  - Patient #4 - 57 visits
  - Patient #5 - 48 visits

8% of patients made up 28% of ED visits
Food Insecurity in Indiana
Indiana Statistics

• 1 in 7 Indiana residents are food insecurity
• Statewide average food insecurity rate 13.3%, national average 14%
• 7 in 10 are eligible for some sort of nutrition assistance program
• Only 31% in Indiana may only be able to turn to government funded help
Food Deserts

- Geographical areas where access to affordable, healthy foods is restricted due to absence of grocery stores within reasonable traveling distances.

% of state population in a food desert

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>29</td>
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<tr>
<td>Hispanic</td>
<td>22</td>
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<tr>
<td>White</td>
<td>11</td>
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Current Trends

% of households unable to provide adequate food for one or more household members due to lack of resources

2015: 14.1%
2016: 14.6%
2018: 15.2%

Community Benefit
Community Benefit

Community Partnerships

Medical Legal Partnership

Food Insecurity

Faith Health Partnership
Community Benefit

- Patient Protection and Affordable Care Act of 2010:
  - Codified Community Benefit Standard with IRS Section 501r
  - Section 501r mandates:
    - Financial Assistance Policies and Procedures
    - Community Health Needs Assessment (CHNA) every three years
    - Emergency Medical Care
    - Limit charges for indigent patients
    - Follow certain billing and collection practices
Define Community Served
- Geographic areas served by hospital
- Target population served (e.g., women, children)
- Principal functions (e.g., particular specialty area or disease)

Described Process
- Solicit and take into account input from persons who represent the broad interests of that community
- Assess additional sources of data
- Hospital can use any criteria to prioritize health needs identified
# Community Stakeholder Focus Group Findings

<table>
<thead>
<tr>
<th>Social Service Needs</th>
<th>Anderson</th>
<th>East</th>
<th>Howard</th>
<th>North</th>
<th>South</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Marion</td>
<td>East</td>
<td>Hamilton</td>
<td>North</td>
<td></td>
</tr>
<tr>
<td>1 Assistance with finding housing</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td>2 Financial assistance/education</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>3 Legal assistance</td>
<td></td>
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<tr>
<td>4 Assistance with getting health insurance</td>
<td>X</td>
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<tr>
<td>5 Job training/assistance with finding a job</td>
<td></td>
<td>X</td>
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<td>X</td>
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<tr>
<td>6 Assistance with transportation</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>7 Services for Women/Infants/Children</td>
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<tr>
<td>8 Food stamps/SNAP</td>
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<tr>
<td>9 Food pantries</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
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<tr>
<td>10 Free or emergency child care</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>11 Nutrition education</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>12 Physical activity programs</td>
<td></td>
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<td></td>
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<tr>
<td>13 Substance abuse services (prevention or treatment)</td>
<td>X</td>
<td>X</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>14 Mental health counseling and support programs</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td>15 Family planning services</td>
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<td>X</td>
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<tr>
<td>16 Walking trails/bike trails/outdoor recreation spaces</td>
<td>X</td>
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<tr>
<td>17 Quick access primary care/retail care</td>
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<td>X</td>
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<tr>
<td>18 Aging and older adult programs</td>
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<td></td>
<td>X</td>
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<tr>
<td>19 Assistance with filling prescriptions</td>
<td>X</td>
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<td>+ Parenting education/support</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<td>+ Awareness of existing social supports</td>
<td>X</td>
<td>X</td>
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18
Food Access

The Cupboard of Lawrence Township

Rolling Harvest Program

Meals on Wheels Program

Food Insecurity Assistance Program
- JPCHC
- Women's Clinic

Community/Urban Gardens
- 60 Garden Beds

REACH Grant
Operationalizing Maternity Services
Recognizing the Problem

Community’s CHOICE Program has treated referrals from all over the state including Seymour, Bloomington, Fishers, Greenwood, Rochester, New Castle, Kokomo, Nashville, Anderson, Lafayette and Greenfield

106 OB patients enrolled in Community Health Network medication assisted treatment (MAT) program at Community Hospital East OB/GYN.

51 Patients were enrolled in MOMentum: Addiction & Recovery Support During and After Pregnancy, a partner of Community Health Network.
Our Solution

• Multidisciplinary approach
  o Community Benefit
  o Social Work
  o Nursing
  o Volunteer Services
• Employee Food Drive Kickoff Event
  o 28 Families served during the holiday season
• Food Pantry
  o Bags, Scripts, Recipes
  o Go Live January 15, 2019
• Clothing Pantry
Outpatient CHE OB/GYN Food Insecurity Assistance Process

Resource Coordinator screens patient for food insecurity at initial prenatal visit

Need for food assistance identified

Resource Coordinator checks for existing food script

Resource Coordinator notifies Community Health Advocate and CHE Volunteer Services

If patient qualifies for food script, volunteer delivers bag of groceries and food script to patient in Ritter OB/GYN office

Limited supply of groceries and food scripts will be kept at Speedway and Washington Pavilion locations
CHE Maternity Services Food Insecurity Assistance Process

- **RN screens patient for food insecurity using nutrition screen questions**
- **Need for food assistance identified**
- **Notify Tammy Hartley via Vocera or at 355-5120 (M-F, 8am-4pm)**
- **Volunteer Services checks for existing food script**
- **If patient qualifies for food script, volunteer delivers bag of groceries and food script to patient**
- **Volunteer Services will connect patient with Community Health Advocates**
### Nutrition Screen

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
<th>Comment</th>
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<tbody>
<tr>
<td>Unplanned Weight Loss in Last Three Months</td>
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<tr>
<td>Poor Oral Intake for Four or More Days Prior to Admission</td>
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<td>Difficulty Chewing or Swallowing</td>
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<td>Pressure Ulcer or Non-Healing Wound</td>
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<tr>
<td>Home Tube Feeding or Total Parenteral Nutrition (TPN)</td>
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<tr>
<td><strong>Within the past 12 months, did you worry whether your food would run out</strong></td>
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<tr>
<td><strong>Within the past 12 months, did the food you buy not last and you did not have</strong></td>
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<tr>
<td>Dietitian Consult Needed</td>
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### Diabetes Screening

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<tr>
<th>Question</th>
<th>Yes/No</th>
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<tr>
<td>A1C Assessment</td>
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<tr>
<td>Is Patient Newly Diagnosed Diabetic</td>
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<td>Diabetes Consults</td>
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</table>
**FOOD SCRIPT**

Take this referral to the Community Cupboard of Lawrence to receive access to food for 3 months.

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<thead>
<tr>
<th>Physician/APP/NP/RN/MA Name</th>
<th>Patient Name</th>
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<tr>
<th>Resident Zip Code</th>
<th>Start Date</th>
<th>Expiration Date</th>
<th># in Household</th>
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<tr>
<th>Physician/APP/NP/RN/MA Signature</th>
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**Community Cupboard of Lawrence**
7101 Pendleton Pike | 317.964.0801
Wednesday: 10 am – 4 pm, 6 – 8 pm | Friday: 10 am – 4 pm
Log sheet will be pulled weekly from Maternity Pantry closet. Offsite locations please scan to Tammy weekly so G:Drive can be updated.

<table>
<thead>
<tr>
<th>Food Script #</th>
<th>Last Name</th>
<th>First Name</th>
<th>Staff Member</th>
<th>Date Given</th>
<th>Signature of Patient</th>
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Date sent to Tammy Hartley @ thartley@ecommunity.com:

________________________ by ________________

Date

Staff Member
CHE Maternity Services Food Insecurity Assistance: AFTER HOURS Process

- RN screens patient for food insecurity using nutrition screen questions
- Need for food assistance identified
- Notify OB PCC
- PCC checks for existing food script
- If patient qualifies for food script, RN delivers bag of groceries and food script to patient
- PCC enters food script ID into tracker in CHE Maternity Food Pantry G Drive Folder
Patient’s We Have Served

- April: 9
- May: 17
- June: 5

Total: 34
Questions & Discussion
References


• Indiana State Department of Health. (2018). Indiana State Health Assessment and Improvement Plan [PDF].


• All other pictures used from open source for commercial use websites: pixabay.com, pexels.com and unsplash.com