VIRTUAL
2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Advancing Food is Medicine at the State Level to End the Epidemic

Presenters

- **National Medically Tailored Meal Nutrition Standards and Local Implementation:**
  - Alissa Wassung, Senior Director of Policy & Planning, God's Love We Deliver and Chair of the Food Is Medicine Coalition Policy Committee

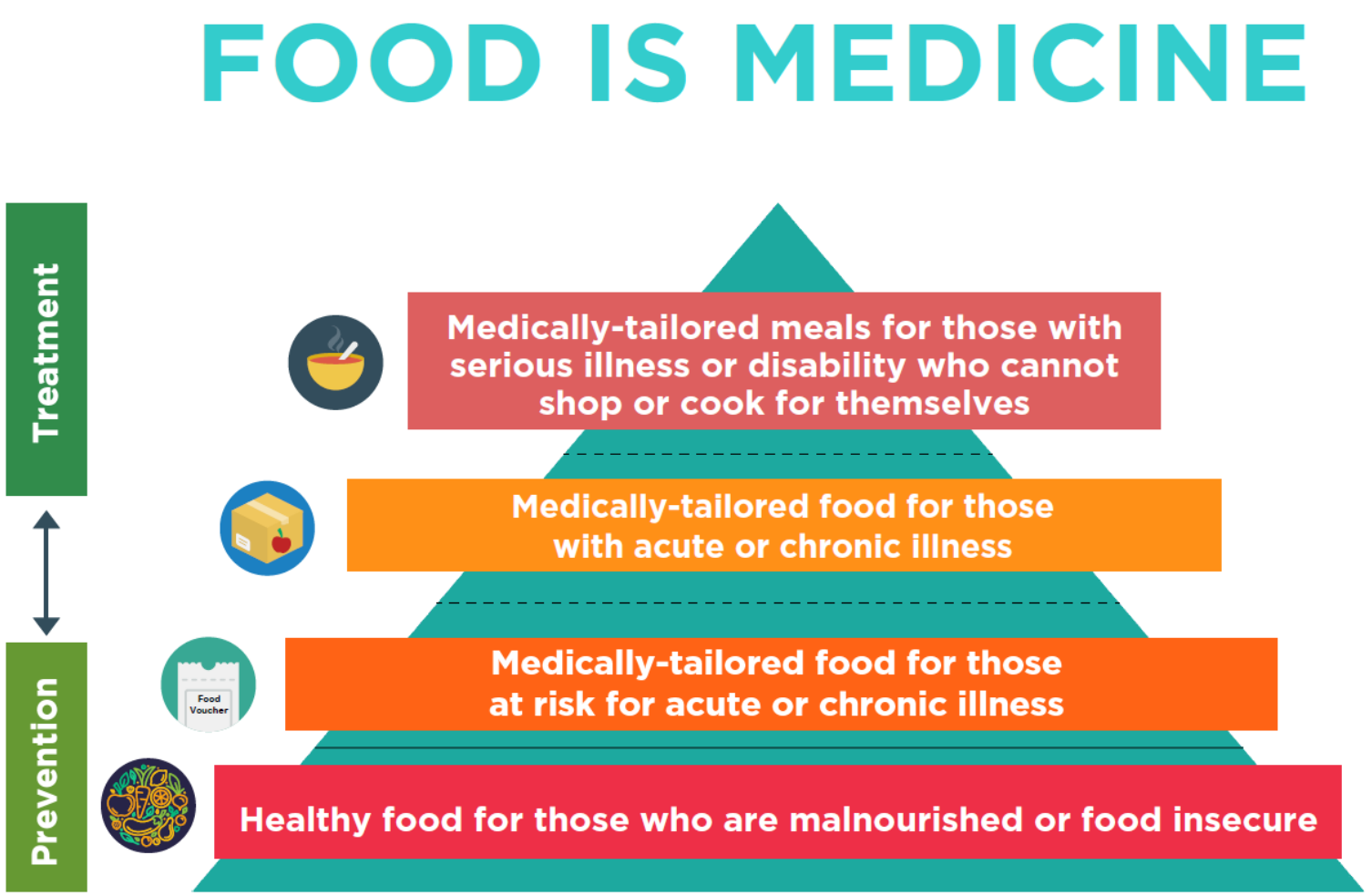
- **Ryan's Meals for Life: A Statewide Medical Nutrition Therapy Approach for Hoosiers Living with HIV**
  - Nick Fennig, Associate Director, Partners in Nutrition Indiana

- **Using Evidence-Informed Interventions to Improve Health Outcomes among People Living with HIV**
  - Thomas Pietrogallo, Chief Executive Officer, The Poverello Center

National Medically Tailored Meal Nutrition Standards and Local Implementation

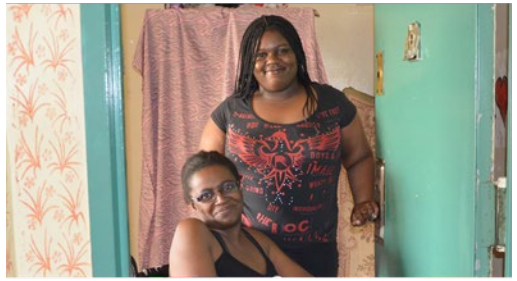
Alissa Wassung, Senior Director of Policy & Planning, God's Love We Deliver and Chair of the Food Is Medicine Coalition Policy Committee

Food Is Medicine: A Spectrum



Our Mission in Action

- Over 2.2 million nutritious meals cooked and home-delivered
- With the help of over 17,000 volunteers
- Over 9,200 clients, children and caregivers nourished
- People living with over 200 different diagnoses
- NY Metro Region → Statewide



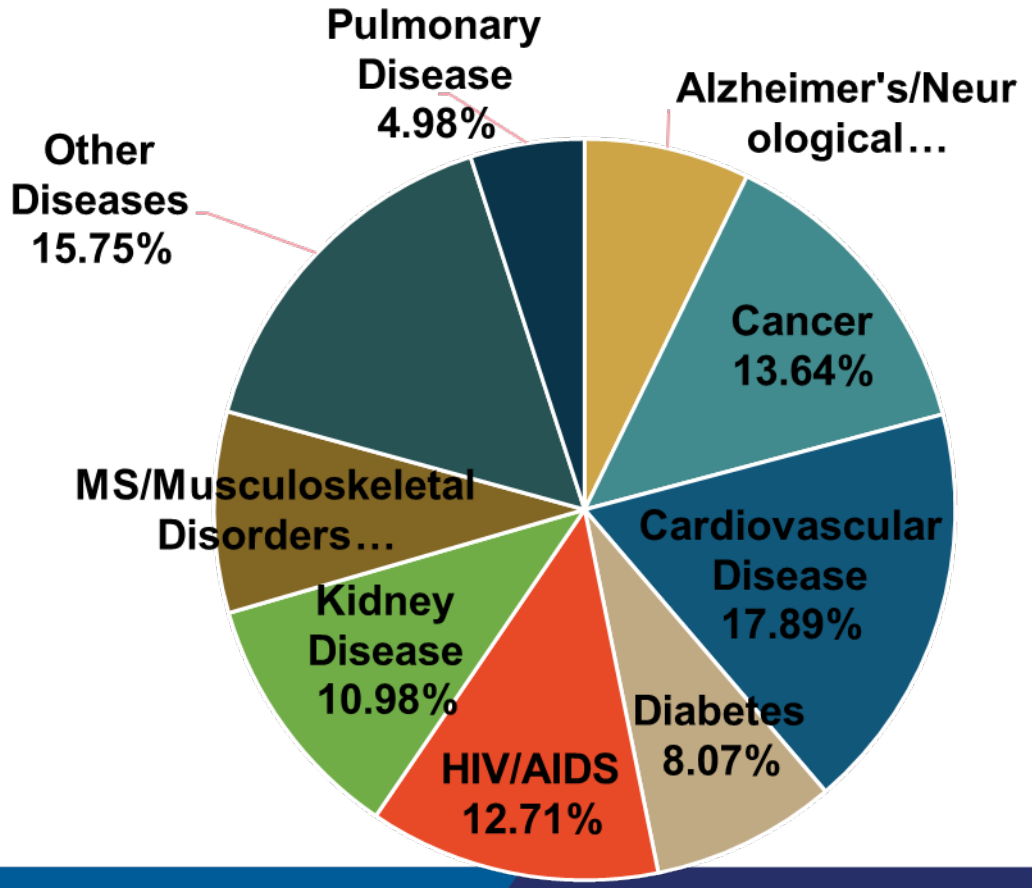
GOD'S LOVE WE DELIVER®

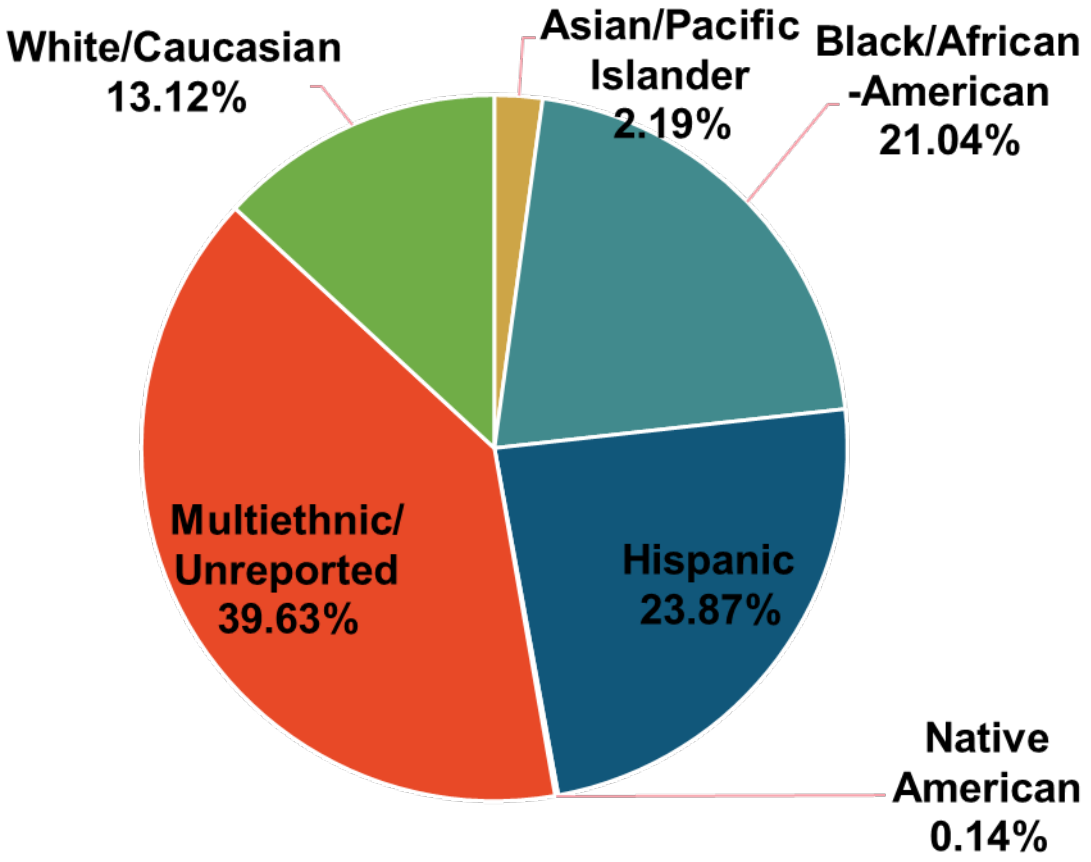
Our Clients

VIRTUAL 2020 NATIONAL RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

9,200+ people served annually, including clients, children, and caregivers

200+ different primary diagnoses





What is a Medically Tailored Meal?

Medical Nutrition Therapy uses assessment and counseling to prevent, delay, or manage diseases and chronic health conditions.

Medically Tailored Meals are delivered to individuals living with severe illness through a referral from a medical professional or healthcare plan. Meal plans are tailored to the medical needs of the recipient by a Registered Dietitian Nutritionist (RDN), and are designed to improve health outcomes, lower cost of care and increase patient satisfaction.

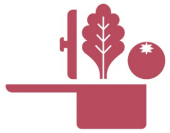
Medically-tailored meal intervention is evidence-based.

Medically Tailored Meal Intervention

GOD'S LOVE WE DELIVER®

Clients are referred by medical personnel/ health plans

Nutrition assessments are conducted by our team of Registered Dietitian Nutritionists (RDNs)



Meals are individually-tailored for specific medical circum-stances and cooked from scratch in our kitchen in lower Manhattan

Meals are home-delivered in our refrigerated vans

Clients enjoy healthy, great tasting meals, and the support of our staff and community

Ongoing nutrition education and counseling


The Food Is Medicine Coalition
Development of National Medically Tailored Meal Nutrition Standards

Food Is Medicine Coalition

FOOD IS MEDICINE™ COALITION

We are an association of medically tailored meal providers.

Our purpose is:

- To provide a complete, evidence-based, medical food and nutrition intervention to critically and chronically ill people in our communities
- To advance public policy that supports access to food and nutrition services for people with severe and/or chronic illnesses
- To promote research on the efficacy of food and nutrition services on health outcomes and cost of care
- To share best practices in the provision of medically tailored meals and of nutrition education and counseling

The Evidence

Provision of Medically Tailored Meals has resulted in:

- 50% fewer inpatient hospital admissions[1]
- 72% fewer admissions into skilled nursing facilities[1]
- 16% net decrease in overall health care cost[1]
- 70% fewer ED visits[2]
- Improvements in all subcategories of the Healthy Eating Index and decrease solid fats, sugar, and alcohol consumption[3]
- Decrease in episodes of hypoglycemia[3]
- Decrease in reported days where mental health interfered with quality of life[3]

[1] https://pubmed.ncbi.nlm.nih.gov/31009050/;
[2]https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0999;
[3]https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6420590/

Why National Standards?

- Clinical Committee: Collaborative FIMC Agency RDN Effort
- Evidence -Based Practice Guidelines
  - *Professional Medical Associations*
  - *Academy of Nutrition and Dietetics Evidence Analysis Library (EAL)*
  - *Nutrition-sensitive medical conditions*
- Ensure Standardization and Quality
- Ability for Agency Individualization

FOOD IS MEDICINE™
COALITION

Nutrition Standards

http://www.fimcoalition.org/our-model

Nutrient	DASH TLC Heart Healthy (Standard Diet)	HIV/AIDS	HIV/AIDS + HLD (hyperlipidemia)	Elderly	Kidney Chronic Stages 1-5 (non-dialysis)	Kidney ESRD/Dialysis	Diabetes/Pre-diabetes	Heart Failure
Calories	As per individual needs	Needs vary similar to healthy individuals	Needs vary	Needs vary	23-35 kcal/kg	25-35 Kcal/kg	Needs vary	Higher if catabolic
Protein *% of total daily calories*	18% Daily calories Lean meats/plant-based sources	*10-35% of daily calories Individualized	10-35% of daily calories individualized	N/A	N/A	N/A	Individualized macronutrient composition addressed in practice.	N/A
Protein *g/kg body weight*	N/A	N/A	N/A	1-1.25g/kg (NCM)	GFR<50=0.6-0.8g/kg	HD 1.2 g/kg PD 1.2-1.3 g/kg		1.1g/kg is stable 1.3 g/kg if depleted for CHF
Carbohydrate *% total daily calories*	55% daily calories Emphasize whole grains + vegetables	N/A	N/A	45-65% daily calories	N/A	N/A		N/A
Total Fat *% total daily calories*	25-35% daily calories	N/A	25-35% of total daily calories	20-35% of daily calories	N/A	N/A		N/A
Saturated Fat % total daily calories	6-7% daily calories	<10% **	<7% total daily calories	<10% daily calories	N/A	N/A	<7%	<7%
Sodium (mg)	2300 mg for standard 1500 mg for lower NA DASH	DGA	DGA	2300 mg/day	<2400 mg/day	<2400 mg/day	<2300 mg/day	CHF: 2000-3000 mg/day *
Cholesterol	150	DGA	<200 mg/day	<300 mg/day	N/A	N/A	N/A	<200mg/day
Fiber (g)	25-31g	*14g/1000	*14g/1000	30 g Male 21 g female 14g/1000 Kcal	N/A		N/A	Female: 21-25g Male: 25-28 g Soluble fiber 7-13 g
Vitamin D (IU)	N/A	600 IU**	600 IU	800	N/A	N/A	RDA	600 IU
Calcium (mg)	1000-1200 mg	1000 mg **	1000 mg	1200	Stages 3-5 not to exceed 2000 mg /day		RDA	1000 mg
Potassium	4700 mg	DGA	DGA	4700	Stages 3-5 <2400 mg/day	<2400 mg/day	DGA	N/A
Phosphorus	N/A	N/A	N/A	700	Stages 3-5 800-1000mg/day or 10-12 mg P04/g protein	800-1000 mg or 10-12 mg/g protein	RDA	N/A
Reference for Evidence Based Guidelines	DASH TLC	*EAL **DGA (link)	EAL	NCM	EAL	NKF-K/DOQI EAL AND Nutrition care Manual	ADA EAL	EAL

N/A= not applicable because guidelines do not exist for this value, is not relevant for condition or listed elsewhere on chart
NCM= Academy of Nutrition and Dietetics Nutrition Care Manual (member only site) https://www.nutritioncaremanual.org
DGA= Dietary Guidelines for Americans – https://health.gov/dietaryguidelines/2015/guidelines/
NKF KDOQI = National Kidney Foundation Kidney Disease Quality Initiative – https://www.kidney.org/professionals/guidelines -
RDA/DRI Reports- https://www.nal.usda.gov/fnic/dri-nutrient-reports
DRI's Interactive - https://www.nal.usda.gov/fnic/interactiveDRI/
EAL = Evidence Analysis Library from AND and the Evidence-based Nutrition Practice Guideline -(member only access) https://www.andeal.org

* Refers to the EAL (Updated from AND November 2017)

Maintenance

- Continually updated as practice guidelines evolve through updated research
  - Clinical Committee to review 2 times per year or as updates become available
  - Clinical committee co-chairs are responsible to finalize and communicate updates
- Additional guidelines as committee determines the need

Local Implementation

NYC Health and Human Services Planning Council

NYC Ryan White EMA

Local Context

- In 2014, NYS formulated a statewide blueprint to End the Epidemic (ETE) in NYS by 2020 - one of the first of its kind in the nation.
  - NYS is approaching the ETE goals - http://etedashboardny.org/metrics/
- The NYC Eligible Metropolitan Area (EMA) continues to have the largest HIV epidemic in the United States
  - 6% of all HIV diagnoses (2015)[1]
  - 12% of the nation's PLWH (2016)[2]
- The NYC EMA has robustly funded support services, including food and nutrition services (FNS) from the beginning of the epidemic
- Race to Justice: NYC DOHMH is committed to the elimination of health inequities due to racism and other forms of systemic oppression

1,2: NY EMA, the New York City Department of Health and Mental Hygiene (2018). 2019 Ryan White Part A Grant Application

Snapshot of HIV in NYC

- In 2017, among new HIV diagnoses
  - 79% were male
  - 86% were Black or Latinx
  - 68% were younger than 40
  - 58% were men who have sex with men (MSM)
- In 2017, 3% of new HIV diagnoses were among transgender individuals
  - 98% of whom were transgender women
  - 86% were Black and Latinx
  - 51% were ages 20-29
- In 2017, among people living with HIV
  - 72% were male
  - 79% were Black or Latinx,
  - 43% were MSM.
  - 56% were aged 50 and older, underscoring the importance of addressing the complex service needs of older PLWH

Source: NYCDOHMH RFP for FNS Services, 8/19/19

Racial Disparities and SDH

- Healthcare disparities continue to plague communities of color, placing them at risk for long-term health conditions including chronic diseases and mental health issues.
- Social determinants of health (SDH) are complex, structural, and societal factors that are responsible for most health inequities, and are by-products of racism.
- SDH create differences in quality of care received, access to health care, opportunities, and exposures to stressors that underlie health status.
- Historically, the HIV epidemic has largely affected Black and Latinx communities.
  - Racial disparity of HIV is apparent in the health outcomes experienced by Black and Latinx PLWH
  - Includes lower rates of viral suppression and higher rates of HIV-related mortality
- Disparities exist and continue to persist due to poverty, racial and social injustice, food insecurity, and unemployment, enabling the spread of the disease and the loss of lives to HIV, even in the context of highly effective care and treatments.

Effectively addressing racial disparities is key to advancing community health outcomes and achieving public health goals such as Ending the Epidemic.

Source: NYCDOHMH RFP for FNS Services, 8/19/19

Addressing Racial Disparity & SDH with Nutrition

- Among PLWH, food insecurity is associated with:
  - poor engagement with HIV care
  - more emergency room visits and inpatient stays
  - poorer health outcomes including unsuppressed viral load, and
  - increased morbidity and mortality
- In a longitudinal study of PLWH receiving services in NY, those whose food security was resolved through services (compared to those who remained food insecure) were less likely to:
  - Have missed appointments
  - Have a detectable viral load
  - Or use acute care
- "Therefore, linking PLWH to support services like Food and Nutrition programs can help facilitate linkage to and engagement in care, and improve physical and mental health conditions associated with being formerly food insecure."

Source: NYCDOHMH RFP for FNS Services, 8/19/19

Improving Quality: A Response to Consumers

- Started with request from consumers on the Planning Council to improve food quality in the EMA
- Rigorous, thoughtful process of consideration and adoption by Planning Council, including the NYCDOH
- FIMC was tapped to provide information
- Acknowledgment of the research showing the positive impact of food security on healthcare outcomes and cost of care for PWH

Food and Nutrition Services Directive

- Concept paper released by NYCDOHMH – 3/13/19
- Comments made by FNS providers – 4/29/19
- EMA adopts FIMC national standards for new FNS RFP and funding (beginning in March 2020)

> The food and meal services should be nutrient-dense, well-balanced, safe, tailored (whenever possible) to the specific dietary needs of PLWH, and maximize the benefits of medical interventions and care.
>
> When developing menus for meals and the contents of food pantry bags, programs should consult the Food is Medicine Coalition (FIMC℠) nutritional standards.
>
> *- NYCDOHMH RFP for FNS Services*

Conclusion

- Best practices influence decision makers
- Research results matter
- Consumer voice is extremely important
- Clients are benefitting from higher nutrition standards that meet the specific needs of PLWH
- Racial equity in healthcare cannot be achieved without addressing SDoH, especially Food and Nutrition for PLWH

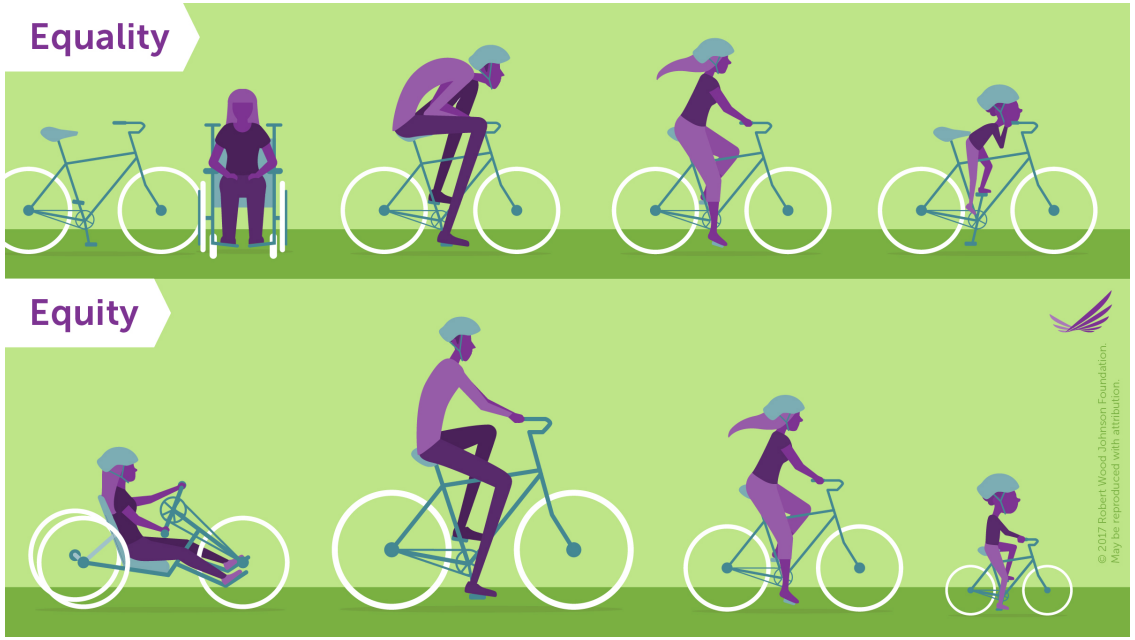


Image: https://www.rwjf.org/en/library/infographics/visualizing-health-equity.html


Nutrition in Pandemic
Why food is so important right now

COVID-19 Response

- God's Love We Deliver has been open and delivering as an essential service provider throughout the pandemic
- Need for our services during this time has drastically increased.
  - Between March and June, we brought on 2,200 new clients, which represents a 25% increase in the number of people we are serving and meals we are cooking. Overall, we are now cooking and home-delivering more than 50,000 meals each week
- Innovating under pressure: In order to keep up with the demand and to keep everyone safe, we have changed many of our protocols:
  - screening volunteers and practicing social distancing
  - implementing no contact deliveries
  - wearing masks in our building and on the road
  - further streamlining our menu to meet the need

COVID-19 Moving Forward

- COVID has exposed the fragility and weaknesses of our society's nutrition safety net; MTMs are a critical service and must be a priority
- There is a desperate need for more coordination of public and private efforts to meet nutrition needs, especially in times of crisis
- Integration with health care (existing partnerships) supports and facilitates the delivery of services to those who need the most
- The more we learn about COVID-19 and who is most at risk, the more we know that food and nutrition interventions in health care are the key to a more equitable system in the future.

Contact

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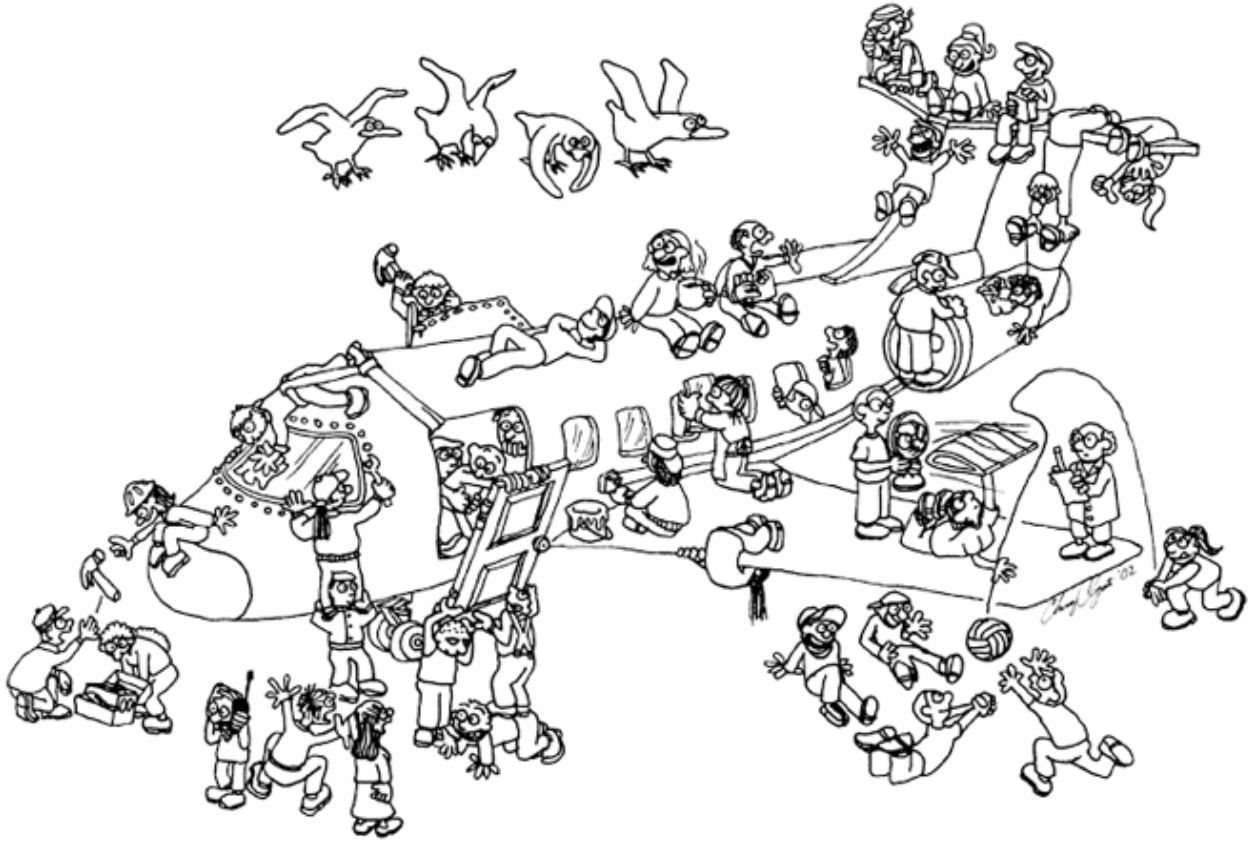
Ryan's Meals for Life

A STATEWIDE MEDICAL NUTRITION THERAPY APPROACH FOR HOOSIERS LIVING WITH HIV

Nick Fennig, Partners in Nutrition Indiana

(Showcases the logos for Partners In Nutrition Indiana and Ryan's Meals for Life)



(Cartoon image of people building a plane in flight)

BACKGROUND ON PROGRAM

(Showing the logo of Indiana State Department of Health)

KEY CHALLENGES

- BUILDING CLIENT RELATIONSHIPS ALL OVER THE STATE
- CONDUCTING NUTRITIONAL ASSESSMENTS WITH EACH CLIENT
- MAKING SURE EACH CLIENT RECEIVES THE RIGHT MTMS
- MAKING SURE EACH MEAL IS HIGH QUALITY AND DELICIOUS
- ACHIEVING WITHIN 9 MONTH STARTUP WINDOW

ESKENAZI HEALTH

- DR. LISA HARRIS, CEO - LEADERSHIP ON NUTRITION COMES FROM VERY TOP.
- REDUCED THEIR SODIUM LEVELS ON ALL MENU OFFERINGS BY 38% THROUGH A PARTNERSHIP WITH THE MARION COUNTY PUBLIC HEALTH DEPARTMENT AND THE CDC.
- COMMITTED TO SERVING FRESH, LOCALLY-SOURCED FOOD AND IS PROUD TO PARTNER WITH MORE THAN 60 INDIANA FARMS AND SUPPLIERS.
- PARTNERSHIP WITH IU SCHOOL OF MEDICINE TO TRAIN DOCTORS ON NUTRITION.

ESKENAZI HEALTH

APPROACHING 60%

OF ALL FOOD PURCHASING DOLLARS SPENT WITH LOCAL INDIANA FARMS AND SUPPLIERS

NEARLY $2.8 MILLION

ANNUAL SPEND ON LOCAL FOOD PRODUCTS

100% OF MAJOR PROTEINS

SOURCED FROM INDIANA FARMS, INCLUDING BEEF, PORK, CHICKEN AND TURKEY

(Showing an image of a traditional farm in Indiana)

PINI'S PROGRAMS WITH ESKENAZI

- FROZEN MTMS
- HOT & COLD MTMS
- READMISSION REDUCTION PROGRAM
- INFECTIOUS DISEASE RYAN WHITE REFERRALS
- EMBRACE PROGRAM

ENSURING QUALITY AND ACCURACY OF MTMS

MEAL PRODUCTION

(Showing image of industrial and professional kitchen)

QUALITY ASSURANCE

(Showing weights pressing down on frozen meal plastic covering)

SERVING CLIENTS AND DELIVERING MEALS STATEWIDE

ROLE OF PINI DIETITIANS

- SETTING MTM NUTRITION STANDARDS
- DESIGNING MENUS WITH ESKENAZI HEALTH
- FROZEN MEAL OPTIONS SATISFY AT LEAST 2 DISEASE RELATED DIETS
- ALL MEALS ARE DASH COMPLIANT
- CO-SIGNING SCRIPTS
- CHOICE OF 18 MEAL OPTIONS, INCLUDING 5 BREAKFASTS
- CLIENTS RECEIVE BOX OF 10 FROZEN MEALS PER WEEK

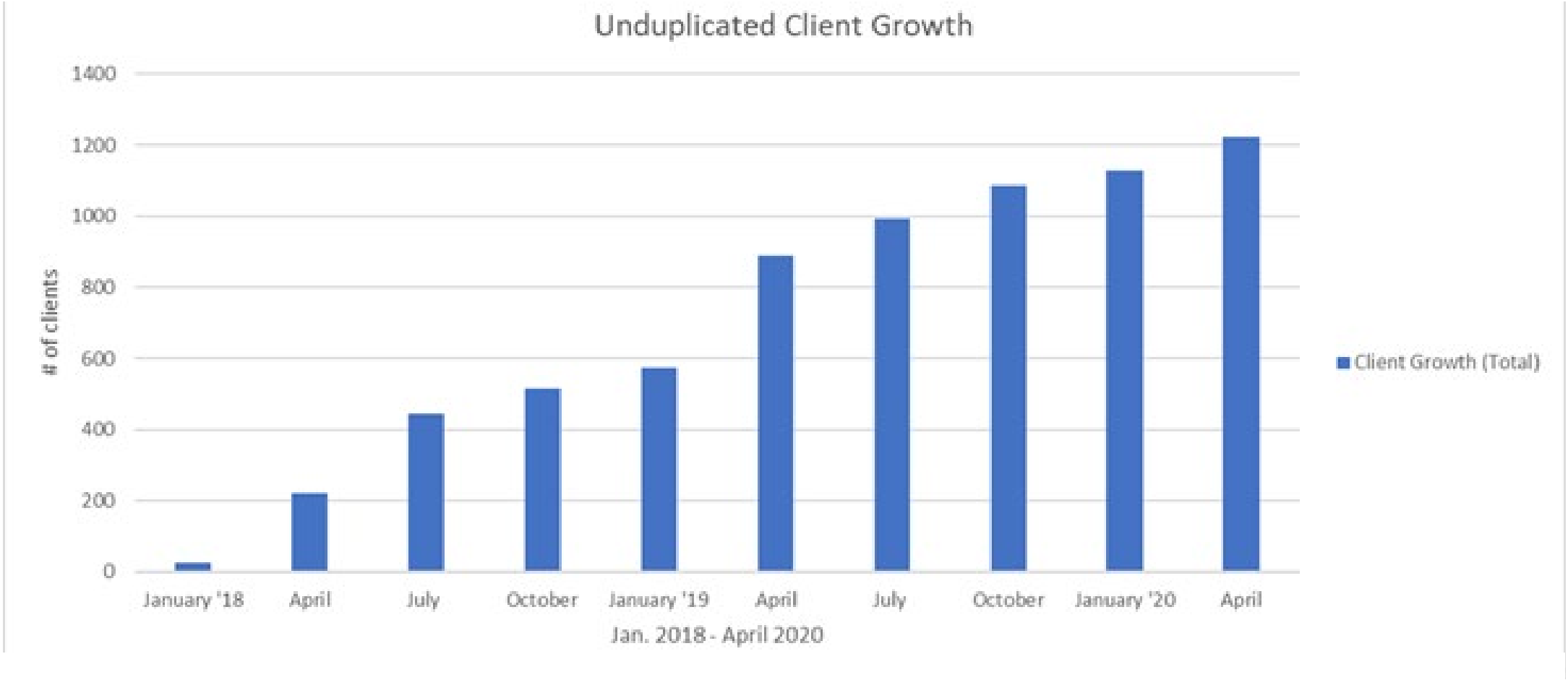
DELIVERY SYSTEMS

- ESKENAZI COOKS, PACKAGES AND FREEZES MTMS
- WAREHOUSE PARTNER TRANSPORTS MEALS FROM ESKENAZI IN REFRIGERATED TRUCK
- PACKING DONE FROM REFRIGERATED WAREHOUSE
- MEALS SHIP THROUGH UPS WITHIN 24 HOURS
- **OVER 6,500 MEALS ARE SHIPPED PER WEEK**
- SATELLITE OFFICES IN HAMMOND (LAKE COUNTY), SOUTH BEND (ST. JOSEPH COUNTY), AND AUSTIN (SCOTT COUNTY)

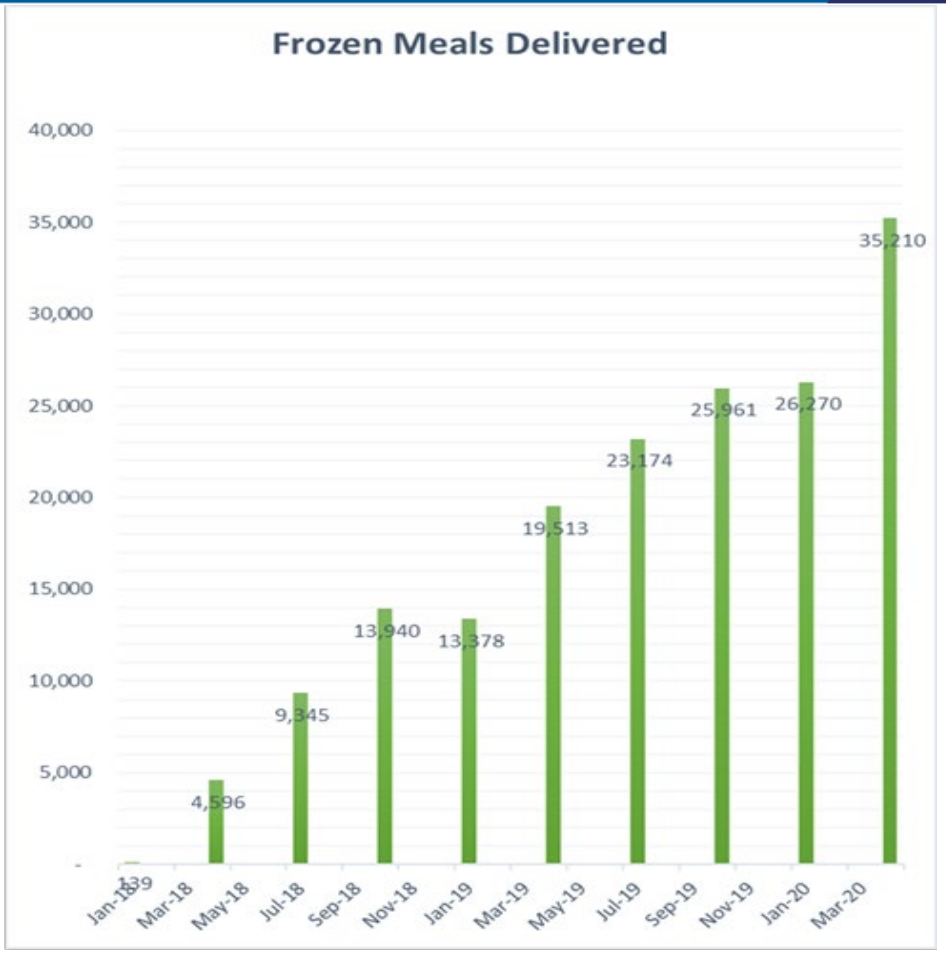
PARTNERSHIPS WITH ASO

INDIANA HIV CARE COORDINATION REGIONS AS OF JANUARY 2018

(Showing an image of the state of Indiana divided into the twelve regions served)



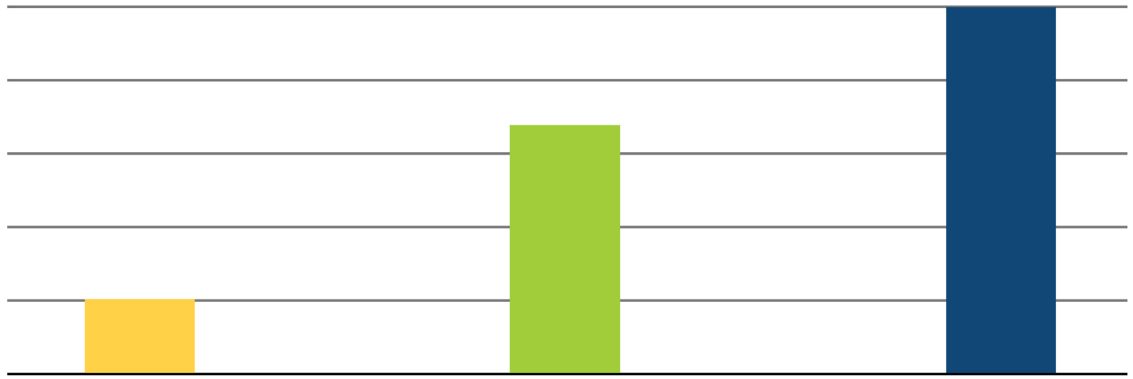
(Showcasing a quarterly chart with increasing client growth between January 2018 through April 2020)



(Showcasing a quarterly chart with increasing frozen meals delivered between January 2018 and March 2020)

FUNDING GROWTH

FUNDING GROWTH - RYAN WHITE PART B
FUNDING THROUGH THE INDIANA STATE DEPARTMENT OF HEALTH



JAN. '18 TO SEPT. '18
(9-MONTH GRANT PERIOD)
= $1,000,000

OCT. '18 TO SEPT. '19
= $3,400,000

OCT. '19 TO SEPT. '20
= $4,500,000

(Presenting a funding chart that begins in January 2018 at one million over a nine month grant period which has increased to 4.5 million through September 2020)

COVID RESPONSE

- MEAL SERVICE WAS NEVER DISRUPTED
- INCREASED DELIVERY OF MEDICALLY-TAILORED PANTRY BOXES
- PROVIDED PANTRY ITEMS TO THE FAMILY MEMBERS
- FACE MASKS, GLOVES, STAGGERED STAFFING
- MOST OF THESE PROCEDURES WILL STAY IN PLACE UNTIL FURTHER NOTICE

CONTACT INFORMATION

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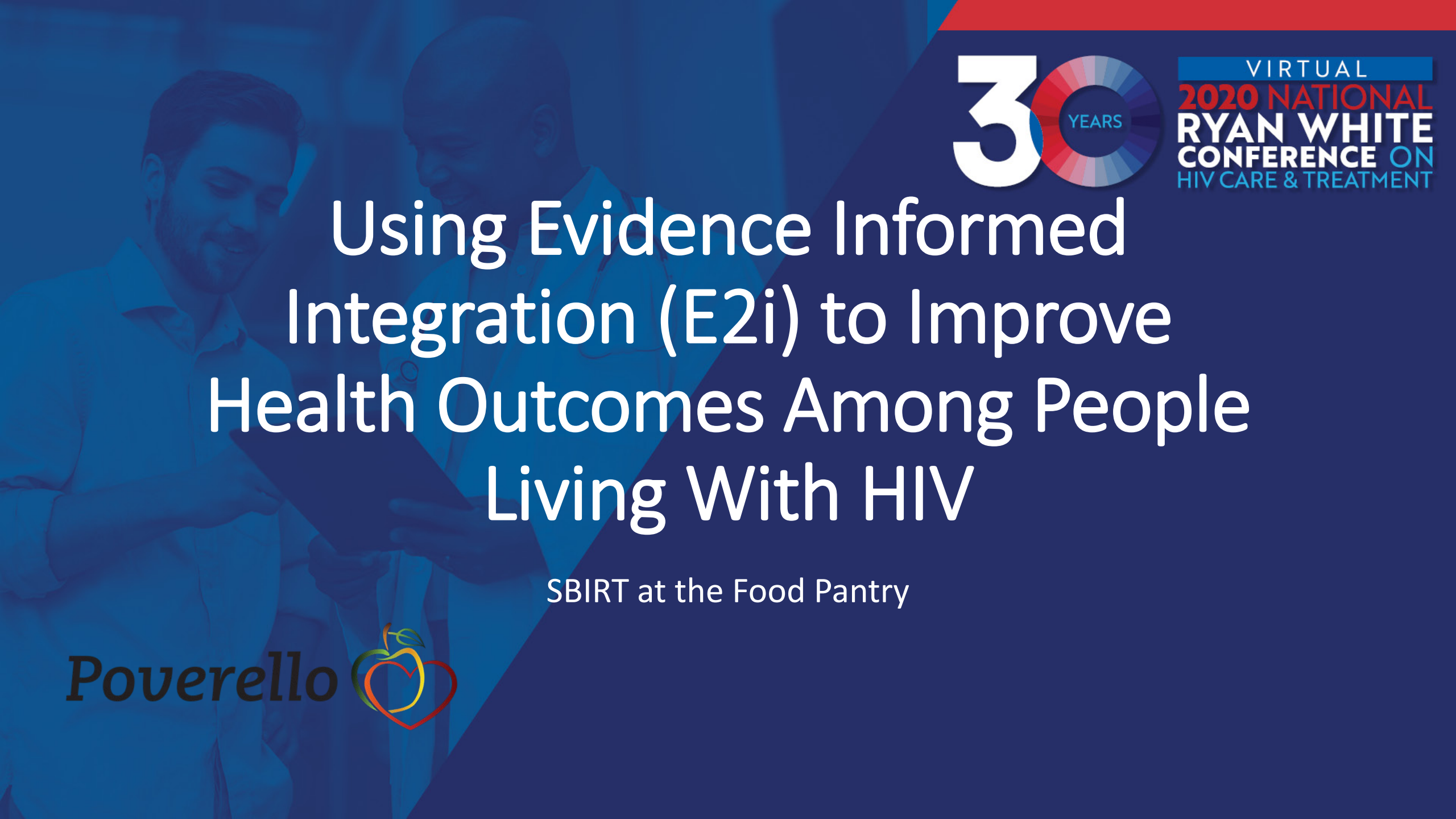
PARTNERSINNUTRITIONINDIANA.ORG

(Showing the Partners In Nutrition Indiana Logo. Thank You.)



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Using Evidence Informed Integration (E2i) to Improve Health Outcomes Among People Living With HIV

SBIRT at the Food Pantry

Poverello

Poverello's Eat Well Center

2765 Program Participants within our Ryan White Part A Food Pantry Program with 89.43% Viral Suppression

112 Grocery Items maintained in our Medically Tailored Client Choice Grocery Program featuring 76 different types of fresh fruits, vegetables and herbs throughout the year. Program participants may select specific health tracts:

- Groceries for a Regular Healthy Meal Plan
- Groceries for a Heart Healthy Meal Plan
- Groceries for a Kidney Friendly Meal Plan
- Groceries for a Diabetic Friendly Meal Plan
- Groceries for a Vegetarian Friendly Meal Plan

Healthy Grocery Gift Card Program features $45 gift cards from various local grocery stores

Poverello also operates:

Social Enterprise Thrift Stores (2) from which our clients may receive clothing, home goods, etc.

Live Well Center which saw nearly 10,000 visits last year for Acupuncture, Haircuts, Massage, Reiki, Chiropractic and gym. This service allowed Poverello to be acquainted with Electronic Medical Records, HIPAA regulations and consents. We use Athena Healthcare through Athena Cares program.

Why Special Projects of National Significance?

Community Needs Assessment for Ryan White Part A services included a mental health focus group **at Poverello with Poverello Clients** in 2016 which in part revealed:

"Providers indicated that it was hardest for them to make successful referrals to the following services: outpatient drug or alcohol treatment, outreach, and mental health services." Clients however, "more often focused on the lack of client information and education and on service-related issues."

The Assessment summarized, "There appears to be insufficient systematic community outreach, education about HIV, and assistance to PLWH in finding the right service provider." They went on to recommend, "Given the data indicating a need for increased outreach, HIV education, and supportive linkage to care, consider the possible value of peer-based Early Intervention Services (EIS) or a similar model."

We already had the clients whose needs were unmet.

Current SAMH Ryan White Part A dollars were underutilized because people weren't accessing SAMH services.

Ryan White Part A Food Pantry reimbursement was $35 per week's worth of groceries, insufficient to meet the costs associated with supplying the service including collection of viral loads and CD4 counts required by the RW Part A program.

Use of peers in service provision created a novel use of the intervention in this intra organizational integration.

Reviewers mentioned their discussions involved words like "either crazy or genius" in contemplating our proposal.

Focus Areas Among 26 Grante

EVIDENCE-INFORMED INTERVENTIONS (E2i)

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Behavioral Health

Buprenorphine	Med Centro, Puerto Rico
	Greater Lawrence Family Health Center
CoCM	Health Emergency Lifeline programs
	La Clinica del Pueblo, Puerto Rico
	Oklahoma State University
	Our Lady of the Lake Hospital, LA
SBIRT	North Jersey Community Research Initiative
	The Poverello Center, Inc.

Black Men who Have Sex with Men

Connect	AIDS Task Force of Greater Cleveland
MI Peers	Broward House, Inc.
	HOPE Center
	University of Mississippi Medical Center
TxTxT	UNIFIED
	SUNY - HEAT

Transwomen

Healthy Divas	Birmingham AIDS Outreach Inc.
	Cal-PEP
	Rutgers New Jersey Medical School
TWEET	Centro Ararat
	CrescentCare
	Henry Ford Health System

Trauma Informed Care

CPT	Positive Impact Health Centers
	Western North Carolina
Seeking Safety	Multicultural AIDS Coalition
	UC San Diego
TIA/CHANGE	Alaska Native Tribal Health Consortium
	Chicago Women's AIDS Project

SBIRT at the Eat Well Center

Poverello Implementation staff met in Boston to receive training at Boston Medical Center's TA MASBIRT team

Screening, Brief Intervention, Referral and Treatment

SAMHSA defines SBIRT:

Screening — a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting

Brief Intervention — a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice

Referral to Treatment — a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services

Patient Flow

1. •Program Participant Signs Into Appointment for Food Pick Up
2. •Peer staff attend to Program Participants assisting them to select grocery items, engaging in conversation, making connections.
3. •**Permission** sought to ask sensitive questions
   - •If Yes > **Begin Screening**
   - •IF no > **Inform** Program Participant information on MHSA is available.
   - •Single Question Screener – Alcohol Use
   - •Single Question Screener – Drug Use
   - •PHQ-2 Depression Risk Screen
   - •Food Insecurity Risk Screening
   - •Smoking Screen/Readiness to Change Ruler
   - •If Risk > Ask **Readiness for Referral**
   - • **If Yes > Make Assertive Referral**

Single Question Screening Test for Drug Use in Primary Care Available:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2911954/

"How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?"

Single Question Alcohol Screening Test Available:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2695521/

"How many times in the past year have you had X or more drinks in a day?" (where X is 5 for men and 4 for women, and a response of ≥1 is considered positive)."

Patient Flow

4
- If Yes > But, **Not Ready for Referral**
- **Ask Permission to Revisit the Discussion Later**

5
- Connect with SAMH provider for follow-up

6
- Connect with program participant to follow-up on referral
- **Collect Medical Data for outcomes analysis**

Hunger Vital Sign
Available: https://frac.org/aaptoolkit
"Within the past 12 months, we worried whether our food would run out before we got money to buy more." - often true – sometimes true – never true – don't' know/refused

"Within the past 12 months, the food we bought just didn't last and we didn't have money to get more." – often true – sometimes true – never true – don't' know/refused

PHQ2 Screening for Depression
Available: https://www.aafp.org/afp/2012/0115/p139.html
"Over the past two weeks how often have you been bothered by any of the following problems? Little Interest or pleasure in doing things Not at all; Several Days; More than one-half the days; Nearly Every Day
Feeling down, depressed or hopeless Not at all; Several Days; More than one-half the days; Nearly Every Day"

Data Challenges

- Food pantry collecting PHI – While it may seem a stretch to handle PHI, because of our Live Well Center's volunteer chiropractors, acupuncturists and our nutritionist's use of Athena Health Electronic Health Record, our intake forms already provided universal compliance with HIPAA consents, privacy practices, informed consent and confidentiality.
- We added a consent for release of medical records specific to Substance Abuse and Mental Health and provided training on this consent in order to talk with referred providers.
- We already are integrated into the Ryan White Part A data collection process, so we add Viral load and CD4 results based upon paper copies of labs already.
- The project required a Data Manager which added infrastructure to the food pantry and can feed data into the SPNS selected system.
- University of California San Francisco is the Evaluation Center for the project and provides technical assistance as well as oversite of our developed systems. They also maintain RED Cap, which is the data storehouse for the project. All data entered there is deidentified (No PHI).

Results (Very Preliminary)

448 Program Participants Screened

Risky Substance Use

"How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?" and "How many times in the past year have you had X or more drinks in a day?" (where X is 5 for men and 4 for women, and a response of ≥1 is considered positive)."

45.04%

Risk for Depression

"Over the past two weeks how often have you been bothered by any of the following problems?
Feeling down, depressed or hopeless

51.08%

Results (Partial and Very Preliminary)

448 Program Participants Screened

Smoking and Readiness to Change

Do you smoke? How motivated are you to make a change?

37.06%

Risk for Food Insecurity

Within the past 12 months, we worried whether our food would run out
before we got money to buy more.
Within the past 12 months, the food we bought just didn't last & we didn't have money to get more.

91.97%

Willing to Continue Discussions

68.02%

Unique Staffing/Work Change Issues & Referral Challenges

Staffing/Work Changes

Staff satisfaction with work increased, “Meaningful” “Better Communication” “Sense of pride working on the project.”

Interaction with clients intensified, improved and valued.

Time spent with client has doubled, but satisfaction of clients has improved.

Weekly supervision in dealing with issues that arise is key to maintaining high sense of competency and decrease burnout.

Clients say they feel more connected.

Referral Challenges

Waitlists at SAMH providers.

Provider challenges e.g. “I have shoes older than that therapist.” “I want a gay therapist” “They don’t take my insurance”

Follow-up with non-Ryan White Part A funded therapy is challenging, because the staff aren’t used to working with the releases of information.

Transportation

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Questions?