FOOD Rx

+ SECOND HARVEST HEARTLAND

Hunger in Minnesota

+ One (1) in 8 individuals experience the stress of hunger on any given day
+ Food insecurity creates long-term costs for our community

About Second Harvest Heartland

+ Second Harvest Heartland's mission is to end hunger together.
+ Finding creative solutions to connect the full resources of our community with our food insecure neighbors.
+ We provide, on average, 74% of the food that is distributed through nearly 1,000 partners and programs in 59 counties in Minnesota and 18 counties in western Wisconsin.

Hunger and Health are Strongly Connected

HUNGER & HEALTH

For Second Harvest Heartland clients, lack of food means a higher likelihood of chronic disease and poor health. Client households have:

one member with diabetes

one member with high blood pressure

chosen between paying for food & paying for medicine or medical care

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Hunger and Health are Strongly Connected

Diet is a major risk factor for numerous chronic diseases, and food insecure populations are:

1.7X

More likely to have diabetes

1.4X

More likely to have heart disease

2X

More likely to have a stroke

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Many of our hungry neighbors make tough decisions between food and other necessities

63% CHOOSE HOUSING

67% CHOOSE MEDICINE/ MEDICAL CARE

VS. FOOD

71% CHOOSE TRANSPORTATION/ GAS

71% CHOOSE UTILITIES

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FOODRx Vision

+ Provide millions of nutritious meals for patients who can't afford to buy enough healthy food.

+ Build meaningful connections between patients, health care systems, and food security solutions, to achieve better health outcomes (TRIPLE AIM) for those who are face hunger

+ Provide food insecure patients with the tools they need to manage their health condition and live well.

+ Connect low-income patients who are lacking in one or more social determinants of health to needed resources.

FOODRx Value Proposition

+ Value based (Triple Aim) focused
+ Demonstrated by FOODRx participant's:
  + Increased engagement
  + Improved experience
  + Better health outcomes
  + Lowered medical costs
  + Lower readmission rate

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FOODRx Services

Build a set of products and services to address different patient need states

CHRONIC NEEDS

STABILITY NEEDS

RESOURCE NEEDS

CLINIC INTEGRATION

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FOODRx Chronic Disease Program

- Chronic boxes provide ~25 meals and include 3 recipe cards.
- Three cultural types available: Standard American, Hispanic, and Somali
- 6, 9, and 12-month program includes enrollment and support through partner integration

* Hispanic

FOODRx Stability Boxes

- Stability boxes provide ~9 meals and includes 3 recipe cards.
- Three cultural types available: Standard American, Hispanic, and Somali
- No enrollment necessary: one-time food box for immediate needs

* Standard American

FOODRx Additional Resources

- Addresses broader social determinants of health through care coordination
- Connection to resources such as SNAP/EBT, food shelves, and energy assistance
- Different delivery methods available such as clinic, community partner, or home delivery

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FOODRx Clinic Integration

- Collaboration on program model to work with current partner systems and workflows
- Provide data metrics and evaluation tools to track patient health outcomes
- Ongoing support to partners with process improvements for accuracy and efficiency

FOODRx Program Design

Identify Target Population/ Size

- \+ Coverage /Attribution
- \+ Food Insecurity
- \+ High Risk/Utilization
- \+ Disease State
- \+ Cultural Unmet-needs
- \+ Budget

Determine FOODRx Intervention

- \+ Clinic Integration
- \+ Community Partnership
- \+ Measures and Reporting
- \+ Virtual (non-Clinic)
- \+ Length of Program Enrollment

Execute FOODRx Program

- \+ Eligible Enrollment Registries
- \+ Patient Screening
- \+ Enrollee Onboarding
- \+ Patient Outreach
- \+ Patient Enrollment

Manage FOODRx Program

- \+ Staff Training
- \+ Enrollee Engagement
- \+ Enrollee Evaluation
- \+ Rx Box Fulfillment
- \+ Enrollee Retention

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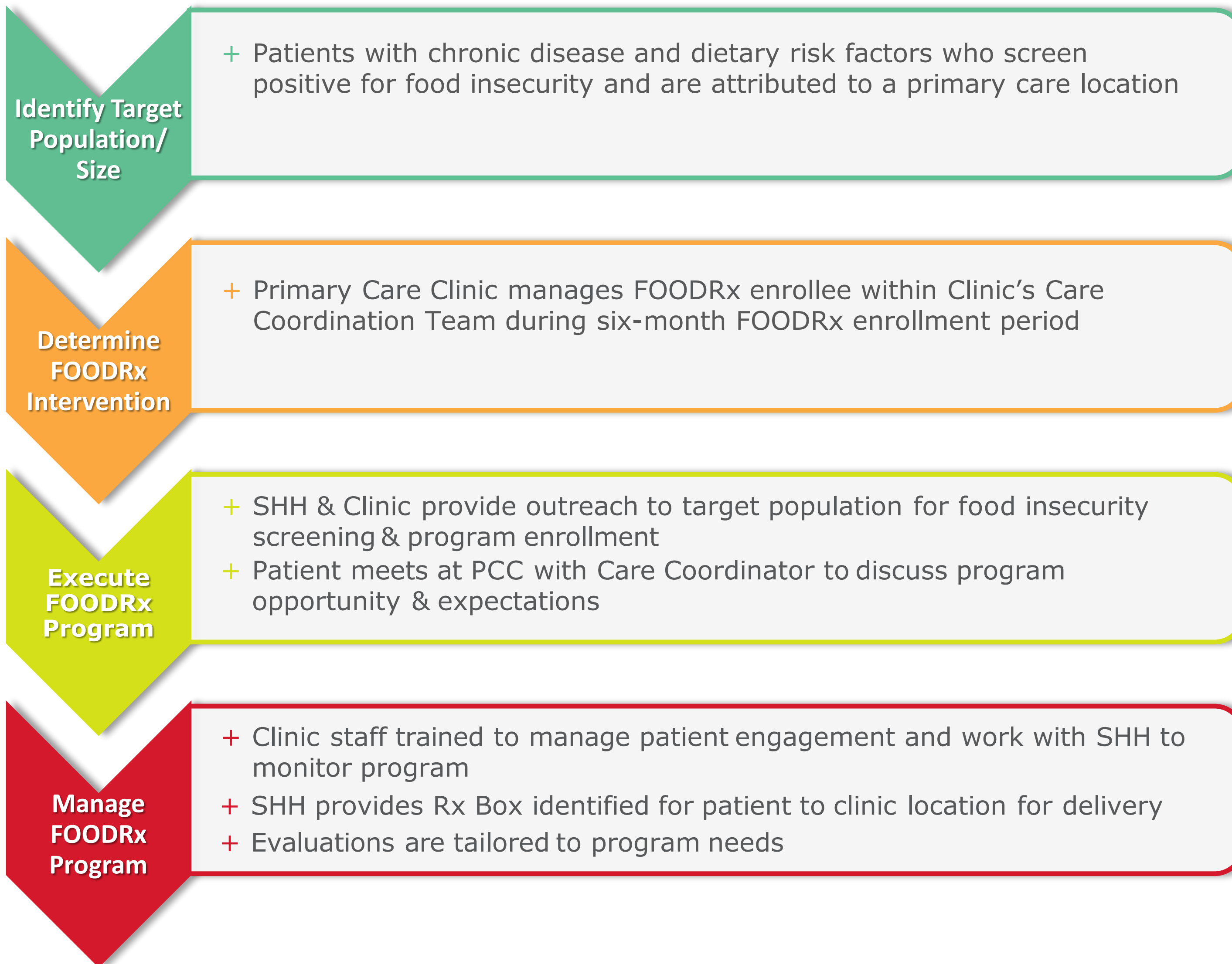
FOODRx Program Design- Integration Example



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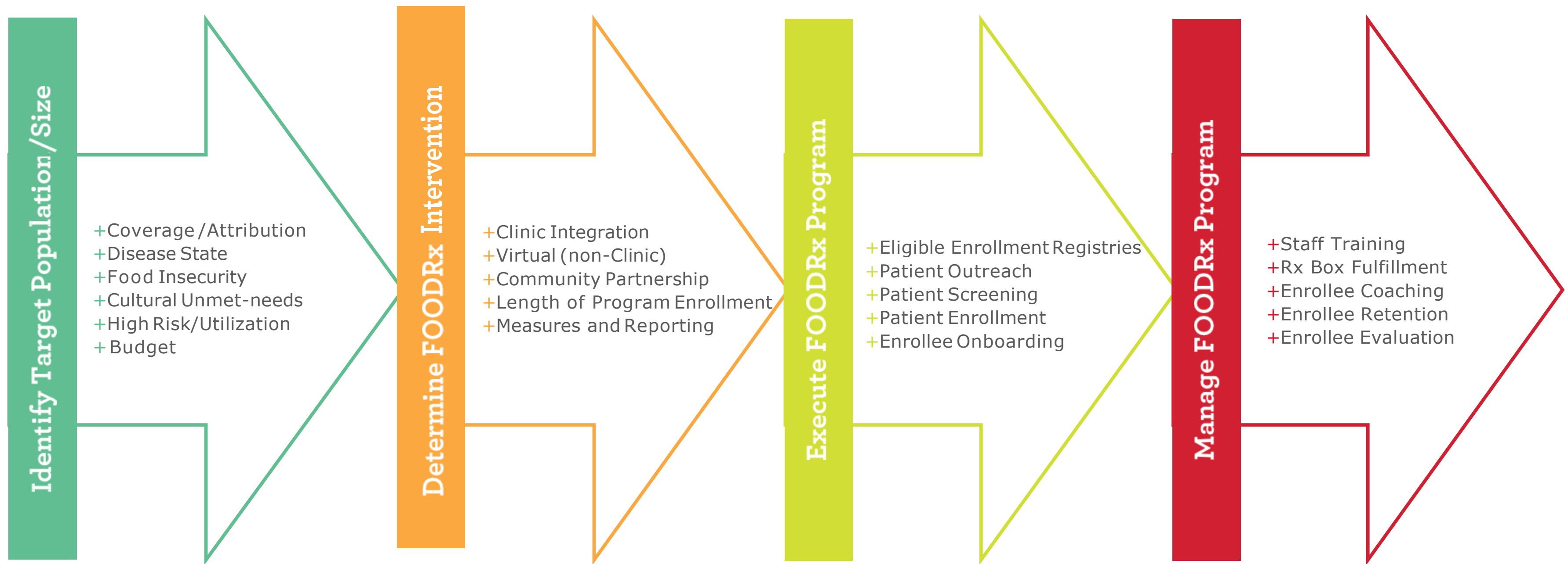
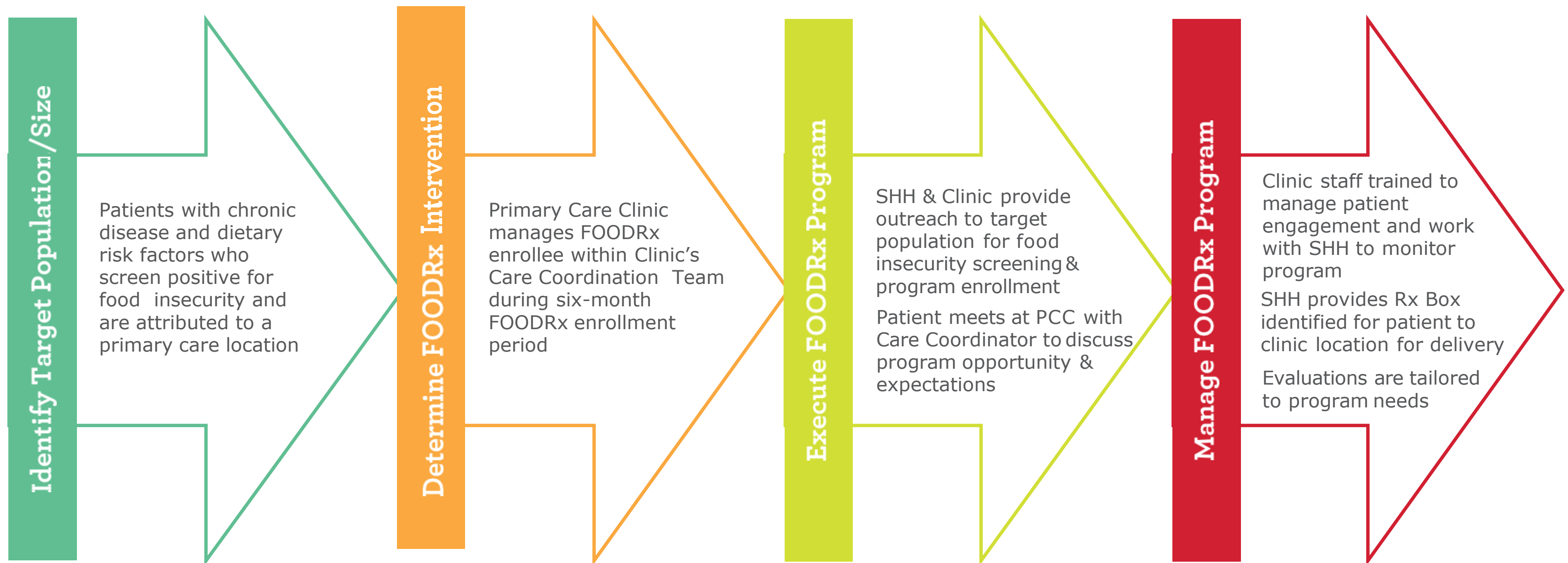
FOODRx Program Design



FOODRx Program Design

Provider Integration Example



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FOODRx Program Design

Provider Integration Example

Patients with chronic disease and dietary risk factors who screen positive for food insecurity and are attributed to a primary care location

Primary Care Clinic manages FOODRx enrollee within Clinic's Care Coordination Team during six-month FOODRx enrollment period

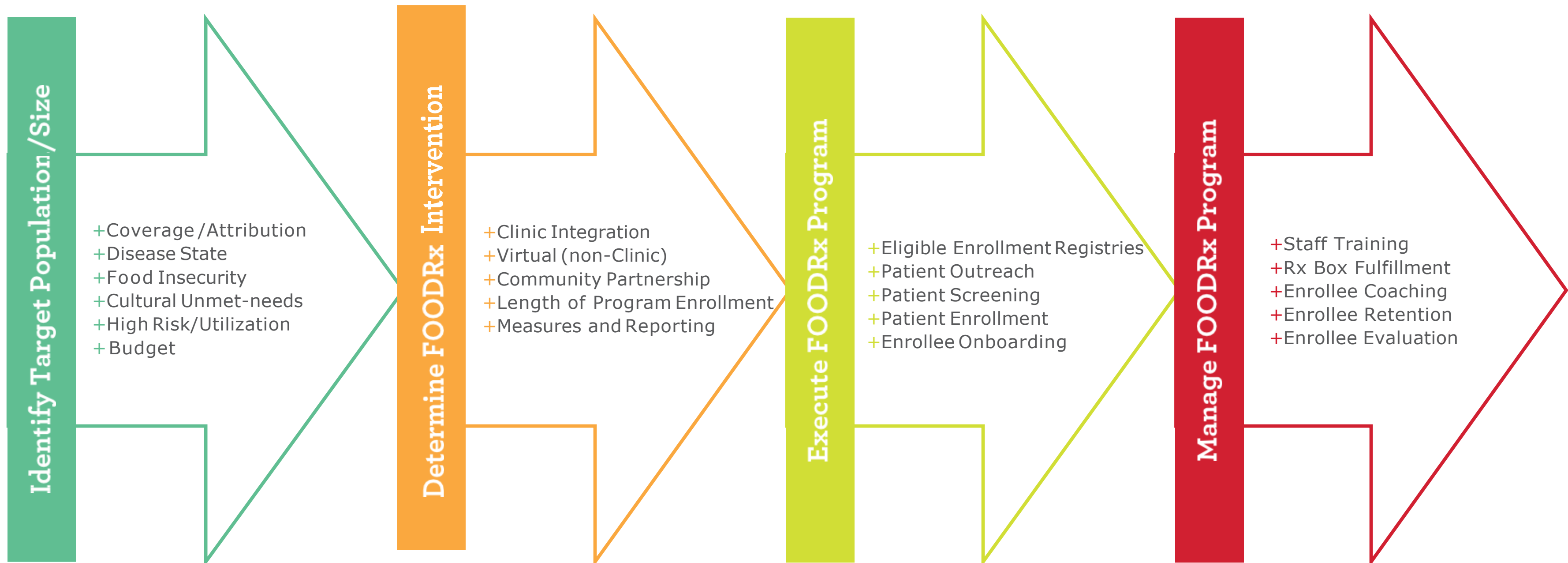
SHH & Clinic provide outreach to target population for food insecurity screening & program enrollment

Patient meets at PCC with Care Coordinator to discuss program opportunity & expectations

Clinic staff trained to manage patient engagement and work with SHH to monitor program

SHH provides Rx Box identified for patient to clinic location for delivery

Evaluations are tailored to program needs



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FOODRx is Rooted in Scientific Evidence

PUBLICATION	STUDY	RESULTS
Health Services Research (2017)	*Title: "Food Insecurity and Health Care Expenditures in the U.S., 2011-2013"*	**On average, food insecure people in the U.S. incur an extra $1,800 in medical costs every year**
Canadian Medical Association Journal (2015)	*Title: "Association between household food insecurity and annual health care costs"*	**Severely food insecure households were 1.71x more likely to utilize health care services than those in food secure households**
JAMA Internal Medicine (2017)	*Title: "Supplemental Nutrition Assistance Program (SNAP) Participation and Health Care Expenditures Among Low-Income Adults"*	**People who are enrolled in SNAP have health care expenditures that are, on average, $1,400 less per year compared with similar people not enrolled in SNAP**
Harvard Business Review (2017)	*Title: "How Geisinger Treats Diabetes by Giving Away Free, Healthy Food"*	**Within 12 months of the food intervention, patients experienced drops in HbA1c of over 2 points** **Cost per patient dropped by 2/3 on avg.**
Health Affairs (2015)	*Title: "A Pilot Food Bank Intervention Featuring Diabetes-Appropriate Food Improved Glycemic Control Among Clients In Three States"*	**Diabetes indicators moved in a positive and statistically significant direction for the study participants**

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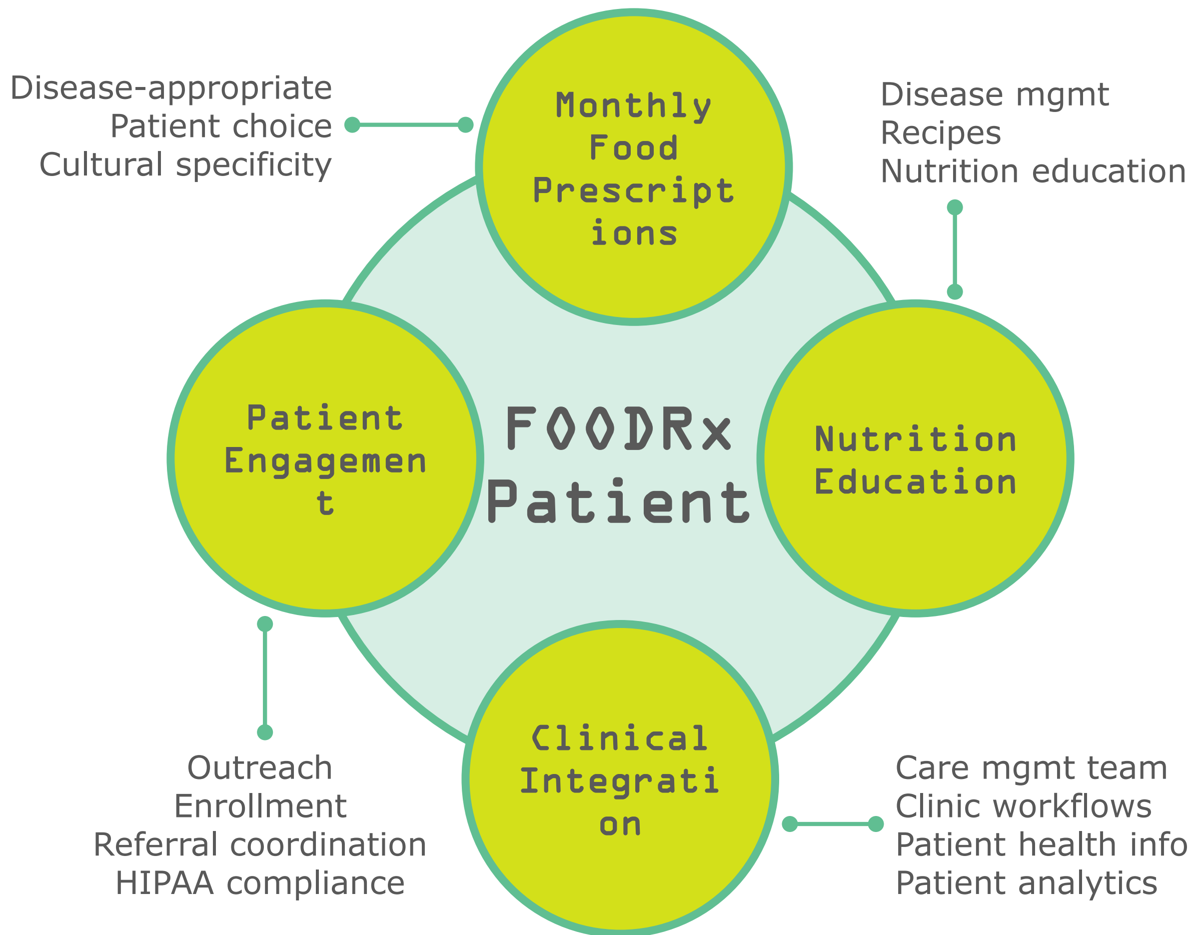
Our Value Proposition was demonstrated with a Care Model for Diabetics (SHH 12-month clinical trial)



+ Lowered key A1c score with statistical significance
+ Substantially lowered annual patient medical expenditures
+ Stronger patient engagement with lifestyle changes related to diet and activities

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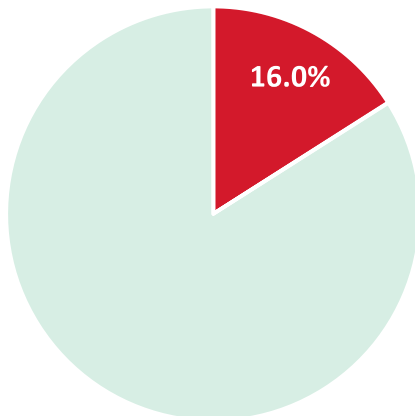
FOODRx Results

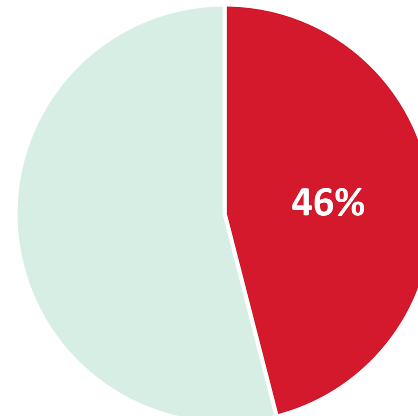
- Targeted populations demonstrate higher costs and risk than overall population:
  - Approximately **16%** would be eligible for FOODRx enrollment
  - Those eligible account for **46%** of the costs of the total population

Total Medicaid/MinnesotaCare Population



■ Those eligible for FOODRx

Total Medicaid/MinnesotaCare Costs



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FOODRx Patient Testimonials

I WOULD LIKE YOU TO KNOW HOW MUCH THESE FOOD BOXES HAVE HELPED ME OUT WITH MAKING SOME VERY HEALTHY MEALS. THESE BOXES HAVE WONDERFUL FOR ME TO GET AND WERE VERY HELPFUL FOR ME WITH FOOD COST.

Thank you for the financial and health boost each month, it really helped.

I VALUE THE PROGRAM FOR THE HEALTH BENEFITS —I AM LEARNING TO ENJOY MORE WHOLE-GRAIN FOODS!

This program is more of what healthcare needs.

THIS PROGRAM IS HIGHLY BENEFICIALLY TO HELP SUPPORT SUPPLEMENT MY HOUSEHOLD AND TEACH ME PROPER EATING HABITS.

This is such a blessing, because I need the food, but I also know I need to start eating healthy.

THIS GAVE ME THE KICK TO GET STARTED. I HAVE LOST 11 POUNDS SINCE I STARTED. THE RECIPE CARDS WERE VERY HELPFUL.

FOODRx Service Partner Food Banks – providing FOODRx program services throughout MN, Western WI, and Eastern ND

+ Feed My People
  WESTERN WI
+ Second Harvest Heartland Northern Lakes
  MN, WESTERN WI
+ Second Harvest Heartland North Central
  MN
+ North County Food Bank
  MN, ND
+ Great Plains Food Bank
  MN, ND
+ Channel One Food Bank
  MN, WI

FOOD Rx

Our Healthcare Partnerships

- +Served more than 3,000 patients in 2018
- +Serve patients with diet-related chronic diseases
- +Capitation and fee-for-service
- +Value-based partnerships
- +Research partners

Our Wellness Partnerships

- Second Harvest Heartland Agency Partners
- Connect patients with additional community resources
- Provide additional free groceries, fresh produce and other perishable foods including dairy and proteins

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Discussion

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THANK YOU!

ALTERNATE SLIDES TO AUGMENT DECK DEPENDENT ON AUDIENCE

FOODRx Program Design

Virtual Model Example – Health Plan

Health Plan members with diabetes who are MHCP recipients and who are eligible for health plan disease management services

Health Plan member will be managed remotely by SHH and Health Plan Disease Management Team during six-month FOODRx enrollment period

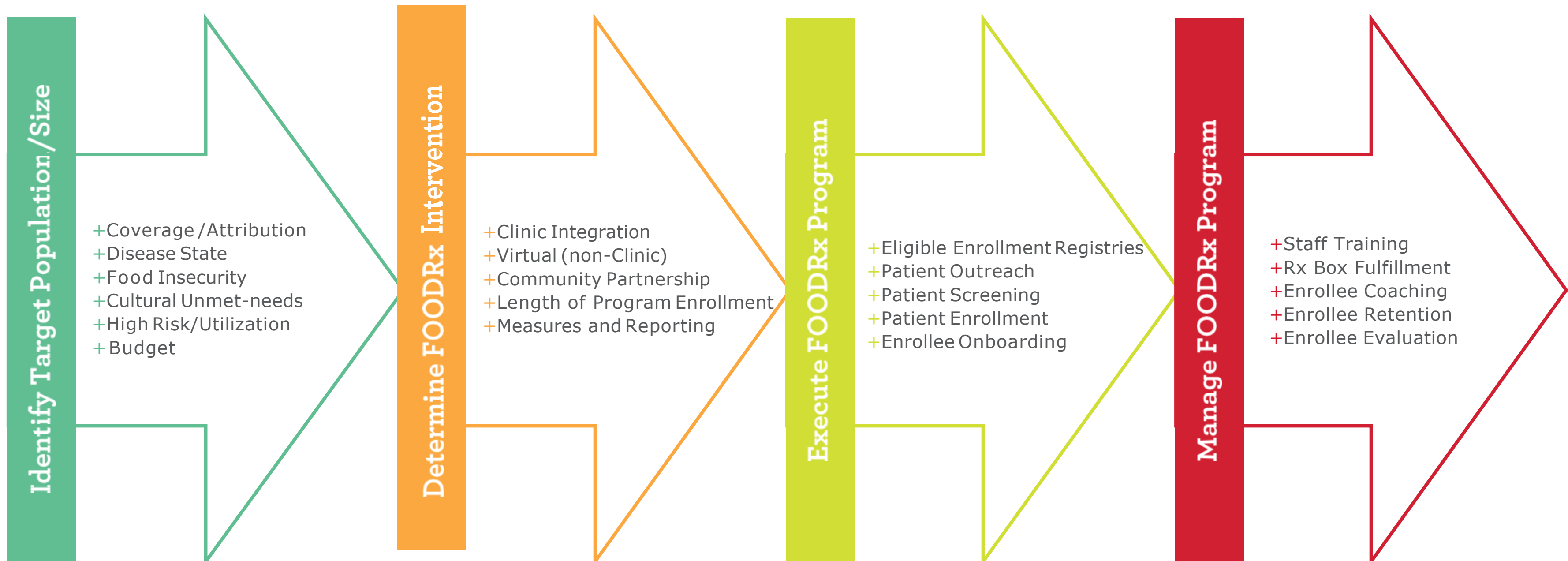
SHH and Health Plan provide outreach to target population for program enrollment

Member is contacted by SHH or Health Plan Representative to discuss program participation and what is expected from the member with program enrollment

Health Plan staff will be trained to manage member engagement within the program & SHH will work with Health Plan to monitor program persistence

SHH provides Rx Box identified for member to member residence (or other designated location)

Evaluations are tailored to program needs & managed during member calls



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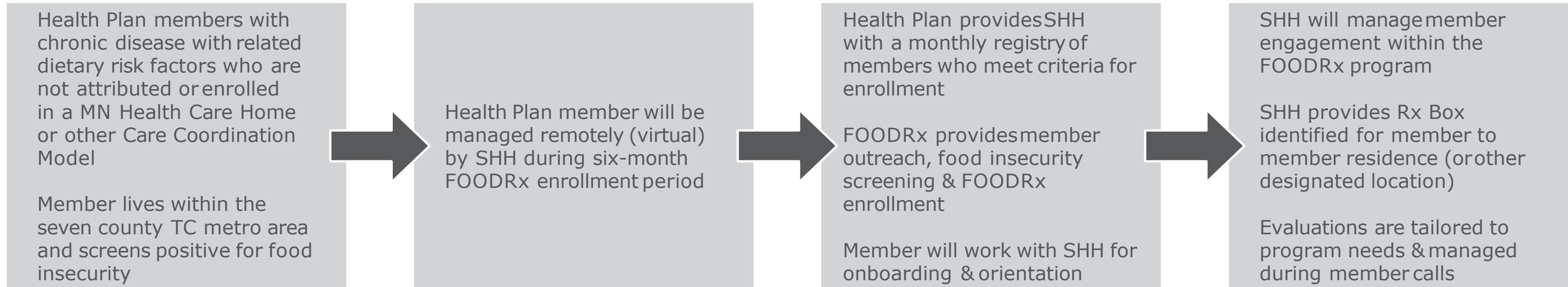
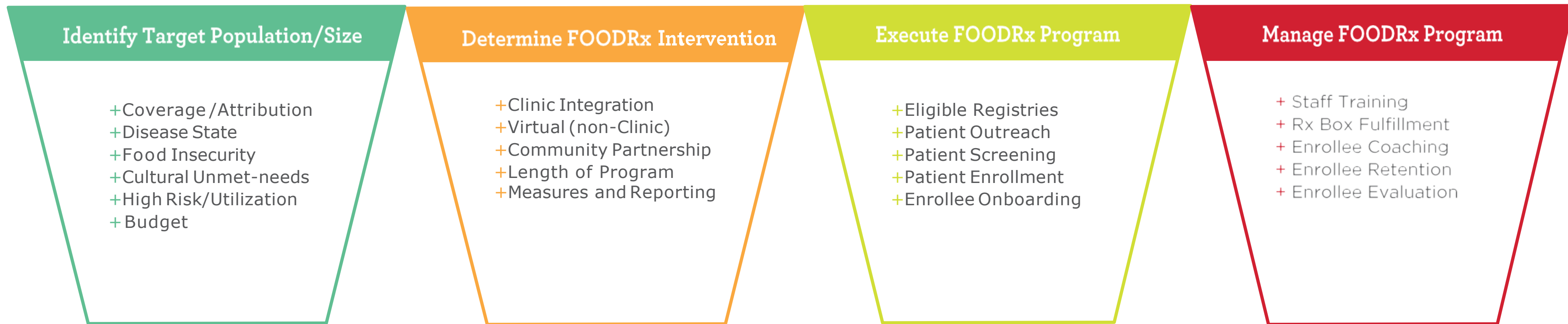
FOODRx Program Design

Virtual Model Example – Attribution





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