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Social Solutions: A Focus on Food and Housing

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Learning Objectives

- Describe how transitional housing affects houseless patients' emergency department utilization, readmission rates and patient experience.
- Identify impacts of food insecurity on patients' disease progression and healthcare utilization risk.

UC DAVIS HEALTH

Food Is Medicine: Innovations in Social Needs Data, Engaging Communities and Breaking Down Silos

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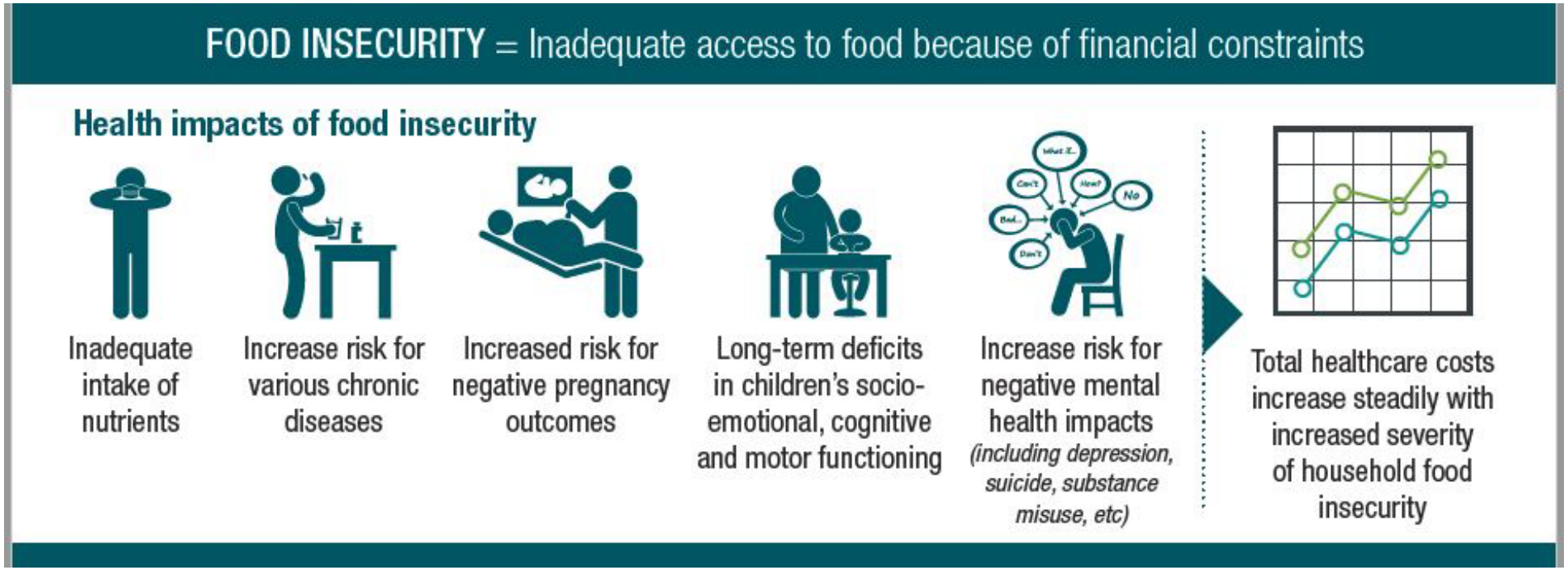
Outline

- Impact of food in patient's lives, health, and healthcare
- Story of UC Davis Health and our approach to food insecurity
- Framework to obtain social needs data, engage communities, and connect patients to food (referral or procurement and dispensing)
- Challenges and new opportunities
- Discussion

Impact of Food Insecurity on Patients

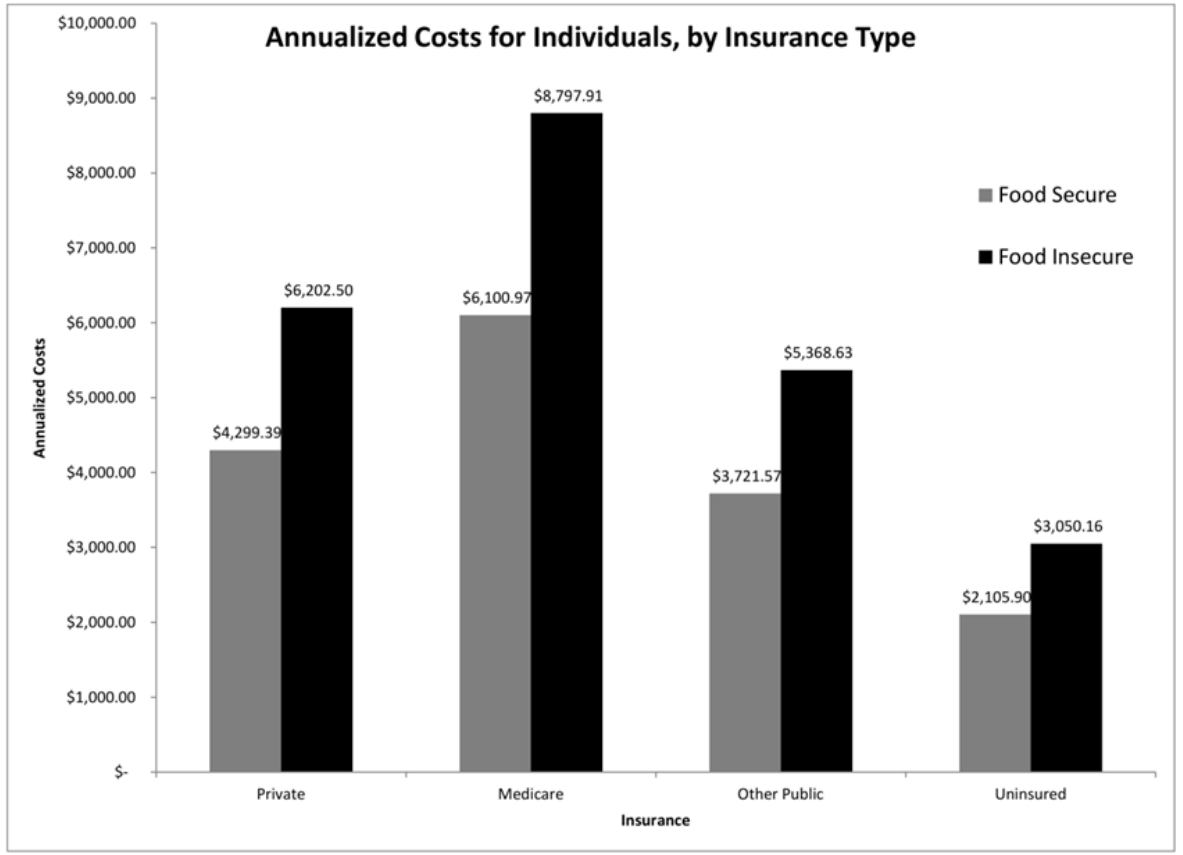


Food insecurity infographic (Wellington-Dufferin-Guelph Public Health)

Impact of Food Insecurity on Healthcare Utilization and Costs

Berkowitz, et al (2018) found that the average annualized health care expenditure is over $1,800 greater for those who are food insecure relative to those who are not.

These costs are linked to a greater number of ED visits, hospitalizations, and days hospitalized.



IDENTIFYING & ADDRESSING FOOD INSECURITY AT A HEALTHCARE SITE

What are your largest challenges?

Silos

Relationship with Community

Funding

Staff

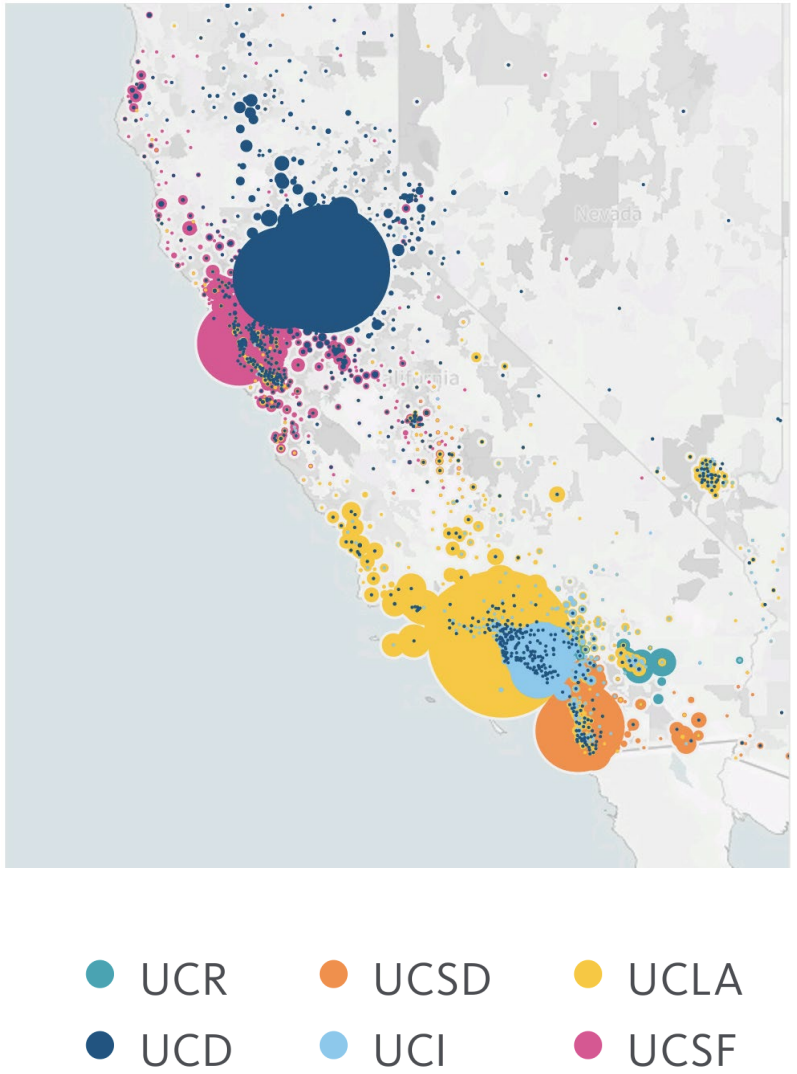
Data Limitations

Training

Not knowing where to start

UC Davis Health

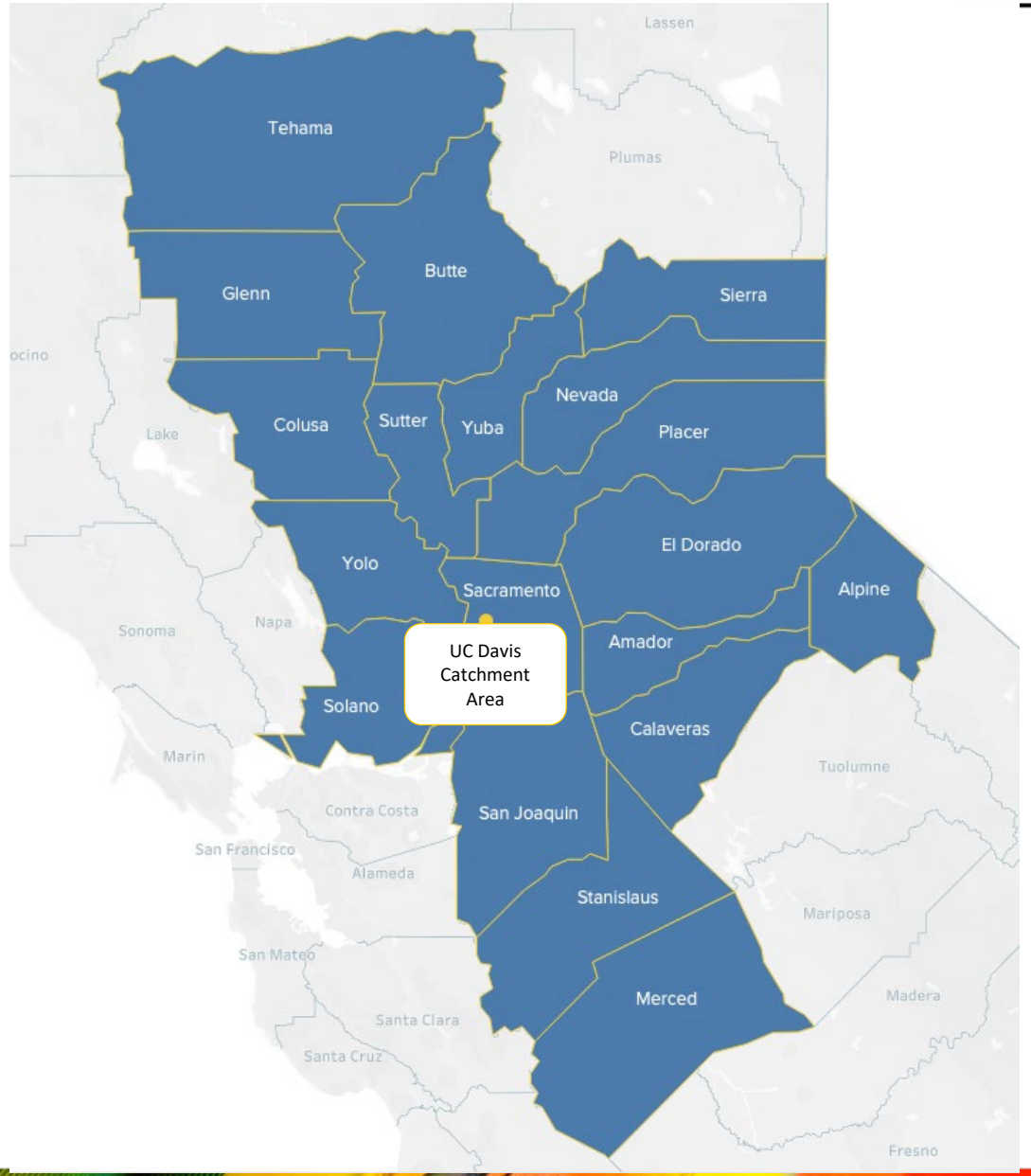
- University of California (UC) Health system includes 6 large academic centers. Combined, we are one of the top 5 largest health systems nationally.
- UC Population Health leadership across all sites began efforts to address food insecurity in 2021.
- UC Davis Health has led in the development of a framework to obtain social needs data, engage community organizations, and reach out to patients to connect them with meals.
- Our local context as the Farm to Fork Capital and as a Land Grant university helps inform these efforts.



Who is Food Insecure?

Regionally our catchment area has approximately 6 million people, with >1.5 million in Sacramento proper.

In Sacramento, an estimated 13.5% are food insecure (up to 17.5% during the pandemic), which is higher than the California average of 12.1%.



Our Framework

Building partnerships that create trust

Accessing data to guide outreach

Training staff

Standardizing tools and platforms to assist workflows

Sustaining funding

Supporting local economy and climate protection

1. Building Internal and External Partnerships

Collaboration between Diversity Equity and Inclusion, Population Health, and Food & Nutrition Services to discuss participating as a provider in the Medi-Cal Medically Tailored Meals program

Diversity, Equity, & Inclusion
– Hendry Ton, MD

Population Health
– Reshma Gupta, MD

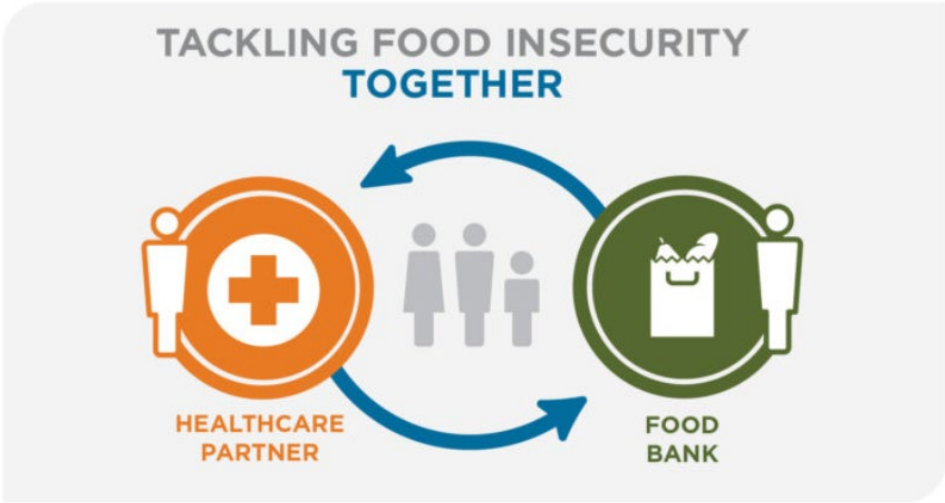
Food & Nutrition Services
– Executive Chef Santana Diaz

Partnerships with Community-based Organizations

Community-Based Organizations (CBO) Food Programs services include:

- Drive-thru Distributions
- Walk-up locations
- The Emergency Food Assistance Program (TEFAP)
- The Commodity Supplemental Food Program (CSFP)
- CalFresh assistance/enrollment
- WIC assistance/enrollment
- Food delivery for elderly or medically fragile
- Clothing/Books/Pet food

Many CBOs have been excited to partner to increase their referrals to create impact.



https://hungerandhealth.feedingamerica.org/explore-our-work/community-health-care-partnerships/

2. Accessing Data: Hunger Vital Signs

1. In the last 12 months, (I/we) couldn't afford to eat balanced meals .
2. Within the past 12 months, you worried that your food would run out before you got the money to buy more.
3. Within the past 12 months, the food you bought just didn’t last and you didn’t have money to get more.

1. Across our primary care population, we had 97.1% missing data for food insecurity using these screening criteria.
2. After surveying efforts, this increased to 8-10%.

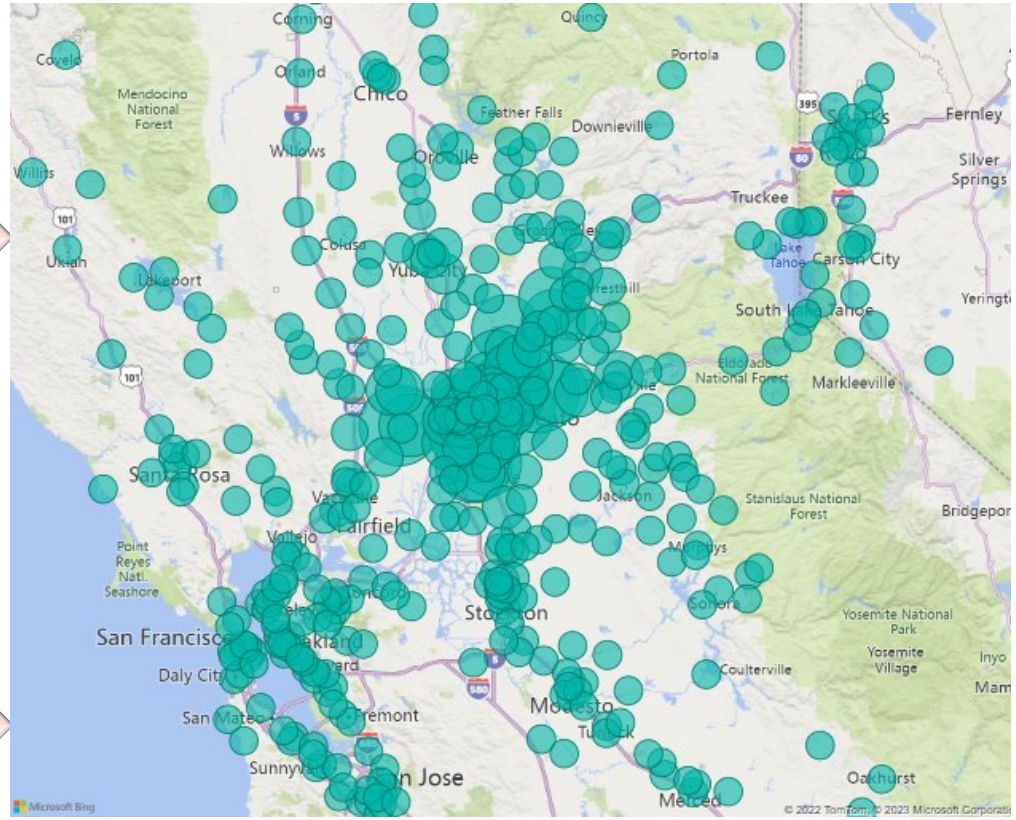
Accessing Data: External Food Insecurity Data

External patient data allows health systems the ability to gather a holistic picture of patients who face social influencers of health that may inhibit their care.

- Food security
- Housing
- Transportation
- Safety

Externally sourced data often comes from hundreds of public and proprietary sources and is specific to socio-economic, lifestyle, community and other relevant data.

- Vendor purchased data
- Community Health Information Exchange
- Data sharing

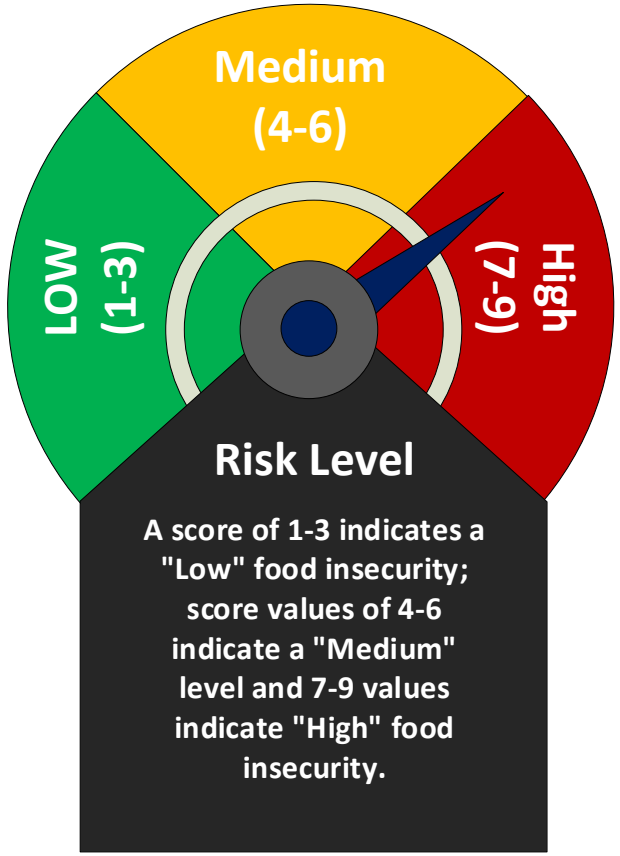


Matched 117k out of 160k sent, increasing available data <3% to 73.2%

Key Findings From Our Food Insecurity Data

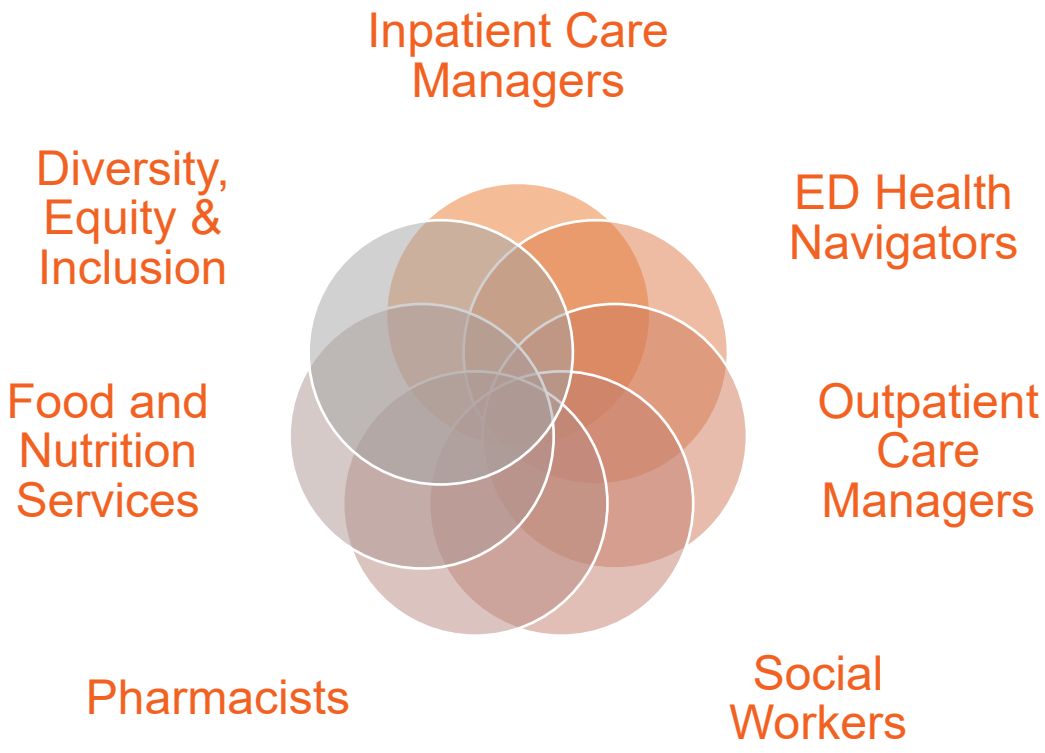
- Our food insecure patients are 1.6x more likely to have an ED visit or hospitalization.
- Our patients 65 and older are 1.7x more likely to be food insecure.
- Older Hispanic, Black, and American Indian patients are more likely to be food insecure.

- **Our target population:**
  - Assigned to UC Davis Health PCP.
  - Age: 65+ with higher risk HPI zip codes.
  - Conditions: Heart Failure, Diabetes, Chronic Kidney Disease, Chronic Liver Disease.
  - Geography: Sacramento County, CA.

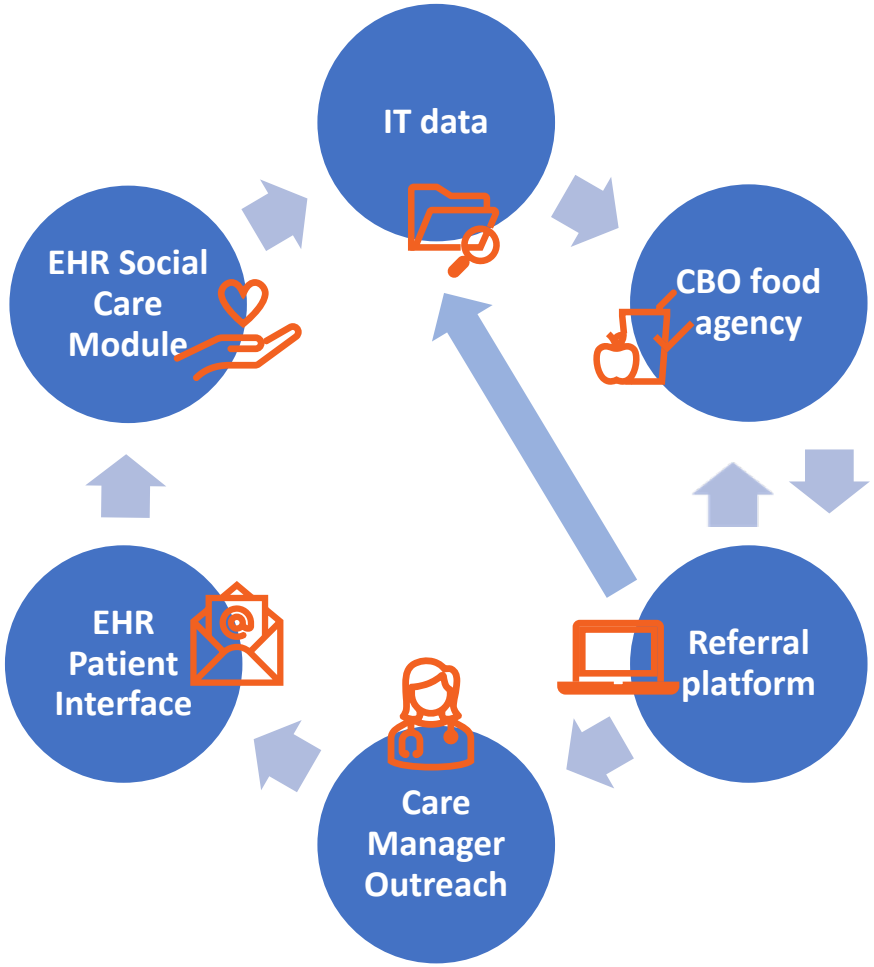


3. Training Staff

- Focus on communication and use of data, knowing its limitations.
- Patients may not realize how this data was collected.
- Develop strategies to have conversations that will cultivate trust with patients.
  - Listen to issues of trust from communities.
  - Start proactive outreach first to patients pre-identified with high food insecurity.
  - In outreach, begin by understanding what is important to patients and their barriers to care.



4. Using Standardized Tools and Workflows



5. Sustaining Funding

Grants and Donations

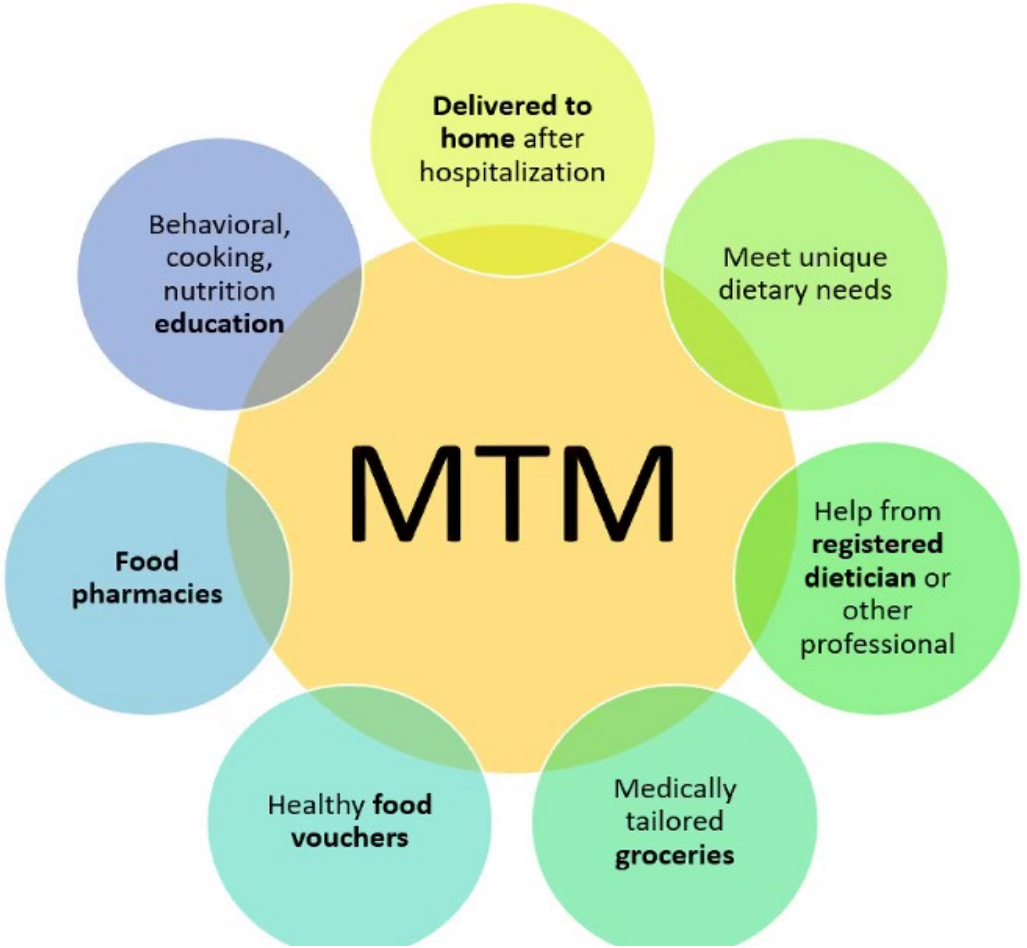
Medicaid Innovation Programs (e.g. MediCal)

Other Payers Jumping In (e.g. Medicare)

White House Conference: Hunger, Health, Nutrition

- Pillar 2: Integrate Nutrition and Health
- Pillar 5: Enhance Nutrition and Food Security Research

CalAIM Medically Tailored Meals Program



- CalAIM is a multi-year Department of Health Care Services initiative in California to improve the quality of life and health outcomes of the Medi-Cal managed care population.
- 14 Community Supports/In Lieu of Services (ILOS) programs including Medically Tailored Meals or Medically Supportive Food.

Medically Tailored Meals Eligibility

Service Limitations

- Up to **two (2) meals per day for up to 12 weeks** (longer if medically necessary).
- Meals that are eligible for or reimbursed by alternate programs **are not eligible.**
- Meals **are not covered** to respond solely to food insecurities.

Who is eligible to receive MTMs?

Individuals with **chronic conditions**, including diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, HIV, cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

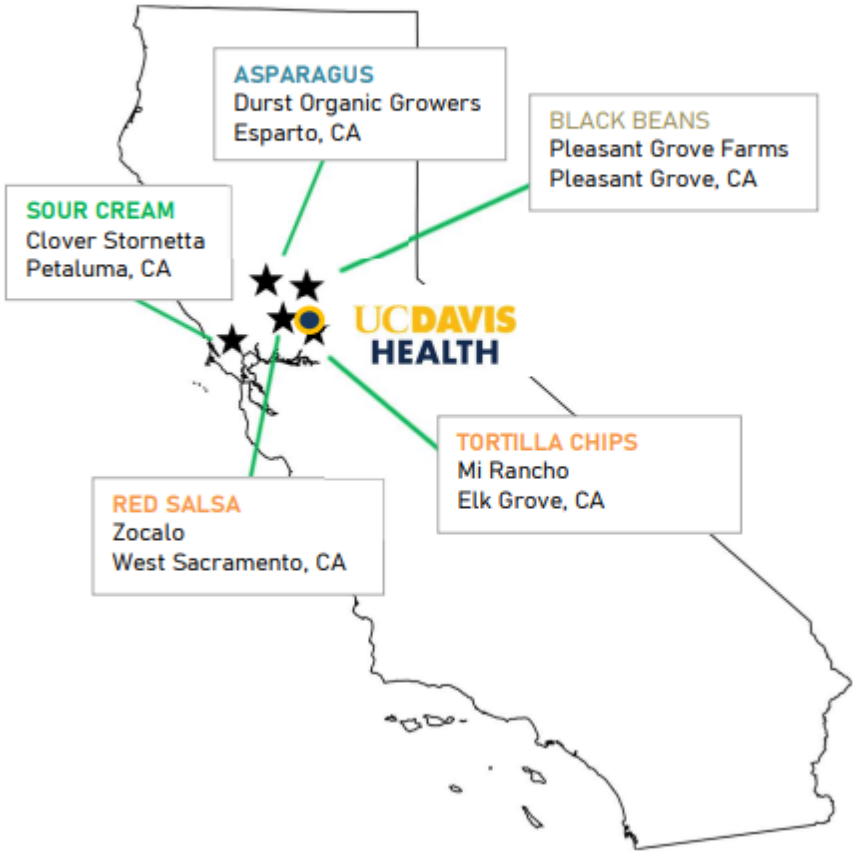
Individuals being **discharged from the hospital** or a skilled nursing facility or at **high risk of hospitalization** or nursing facility placement.

Individuals with extensive **care coordination needs**.

6. Focus on the Community, Economy, Environment

- Community engagement
- Regional Produce and Sourcing
- Sustained Economy for Regional Farmers
- Foods that Focus on Cultural Belonging

: : Source Map : :



Lessons Learned

- Learn the history of your institution with various communities in your region, including what has been tried before.
- Partner with community leaders and DEI experts for guidance on how to facilitate trust, communication, and understand what will work with community-based organizations.
- Validate external data against multiple sources and from different perspectives to ensure equity.
- Explore local, state and national programs that support the provision of medically tailored meals.
- Grants can only sustain this work for so long – policy change is needed in the long term.

Key Takeaways

- Food insecurity has many short- and long-term negative impacts on patients' health, and is associated with increased healthcare costs and hospital utilization.
- Addressing food insecurity requires trusting, collaborative partnerships across disciplines, with health equity, diversity and inclusion experts, and with the community.
- Leveraging screening data along with external data can help identify patients at risk for food insecurity for focused intervention.
- Partnering with community-based organizations and local food suppliers helps meet patients' individualized needs, support the community, economy, and environment.
- Funding for this work may be available through grants and government programs.

Questions?

UC DAVIS HEALTH

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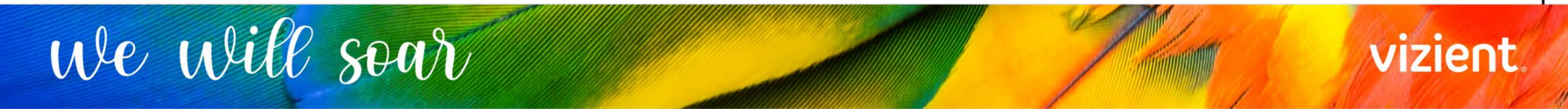

OREGON HEALTH & SCIENCE UNIVERSITY

Transitional Housing Program: Creating a Positive Impact While Improving the Bottom Line

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Carissa Samples, BSW, *Social Work Specialist, OHSU, Portland, Ore.*

Background

Social determinants of health:

- Non-medical factors that affect health outcomes
- Access to housing, basic amenities, food, and affordable healthcare

Housing:

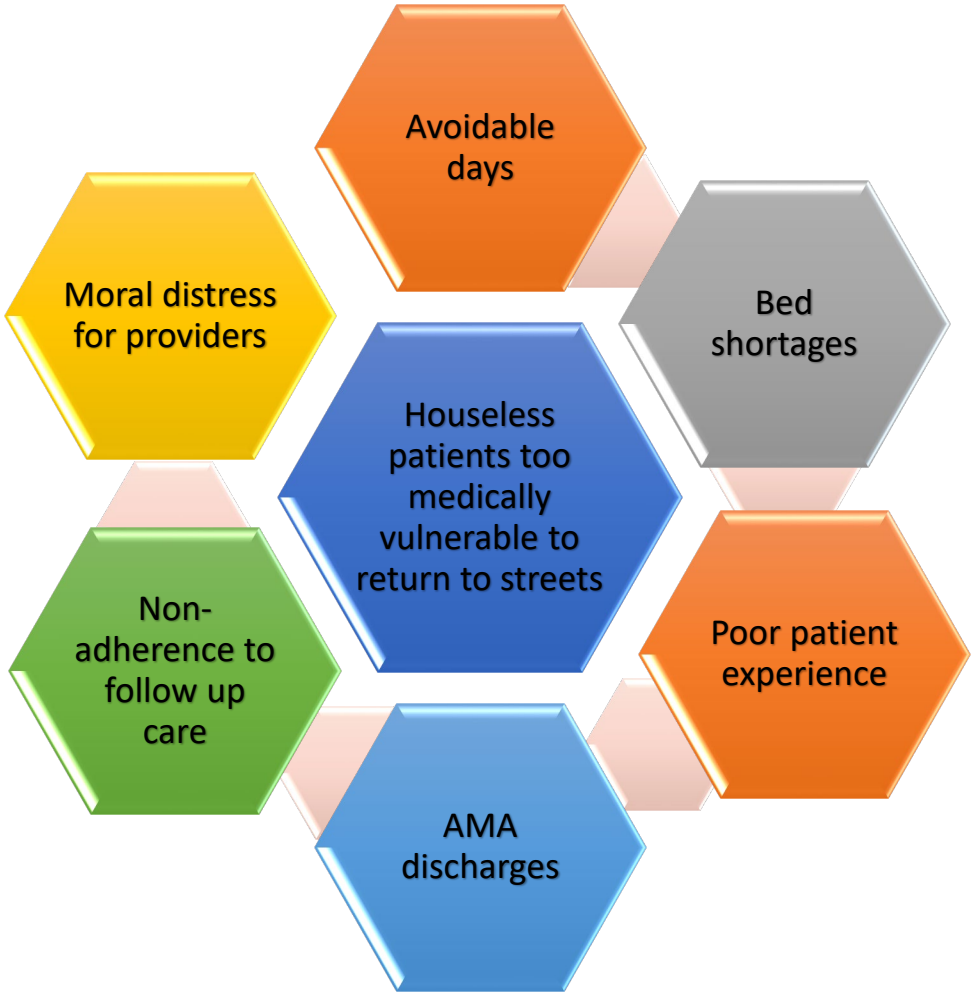
- Homelessness in Oregon has increased by 23% from 2020-2022 (4th in the nation)
- 62% of those experiencing homelessness in Oregon are unsheltered[1]

Impact on healthcare systems:

- Houseless individuals make up a larger percentage of the hospital population than the general US population by six-fold
- Houseless individuals experience higher rates of readmission than non-houseless patients[2]

1. U.S. Department of Housing and Urban Development. (2022). *The 2022 Annual Homelessness Assessment Report (AHAR) to Congress.* Abt Associates.
2. Hoda Neyaz, S., Budzinski, A., & Narayan, L. (2020). *Homelessness and Hospitalizations: Patient Demographics and the Impact on Inpatient Hospital Care.* MCG Health. 2, 9.

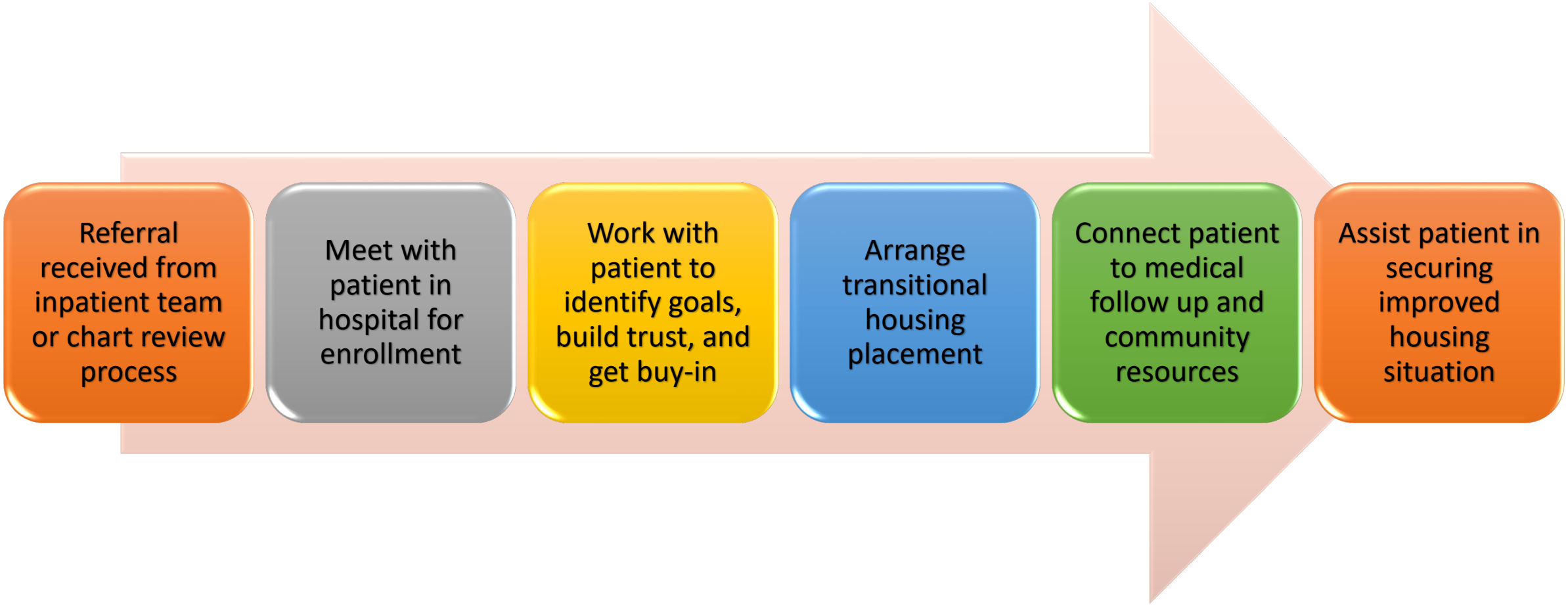
The Problem


Avoidable days
Moral distress for providers
Bed shortages
Houseless patients too medically vulnerable to return to streets
Non-adherence to follow up care
Poor patient experience
AMA discharges

Goals

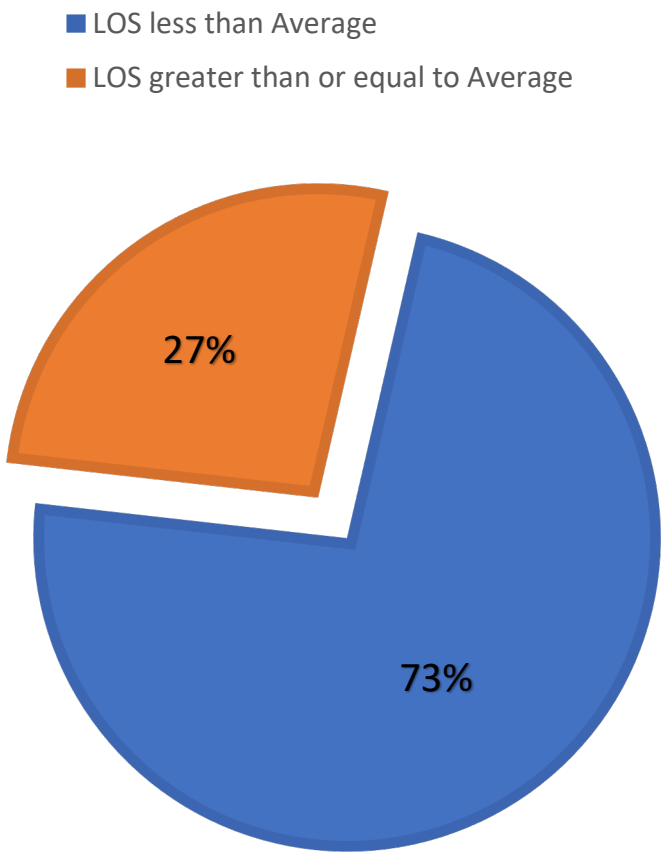
- Decrease average length of stay
- Decrease return to hospital and ED
- Improve patient experience

The Intervention

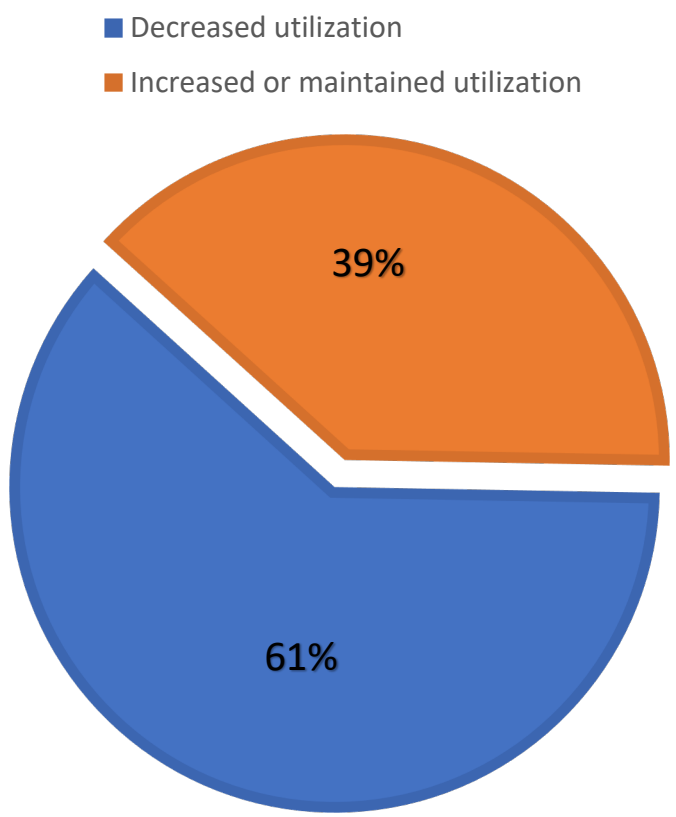


Hospital Utilization Outcomes

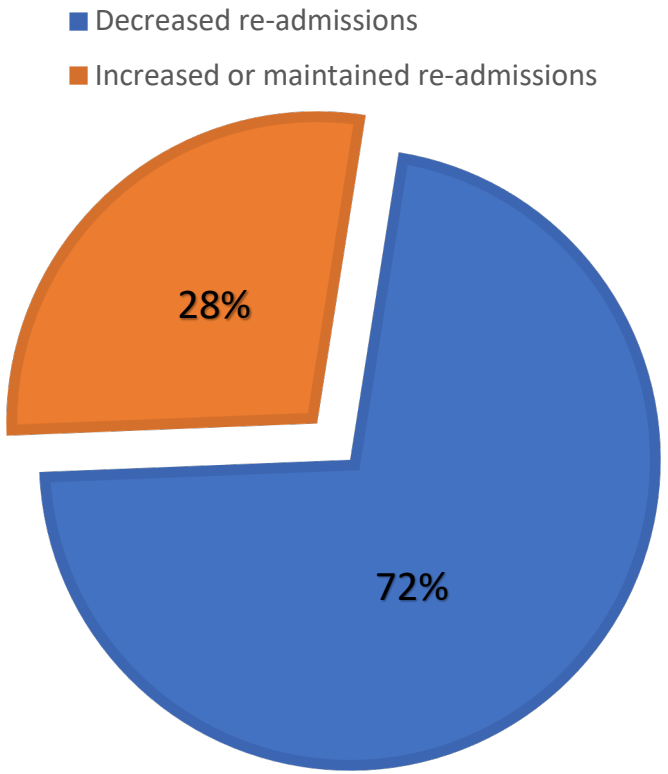
LENGTH OF STAY



RATE OF ED UTILIZATION IN THE 6 MONTHS FOLLOWING ENROLLMENT

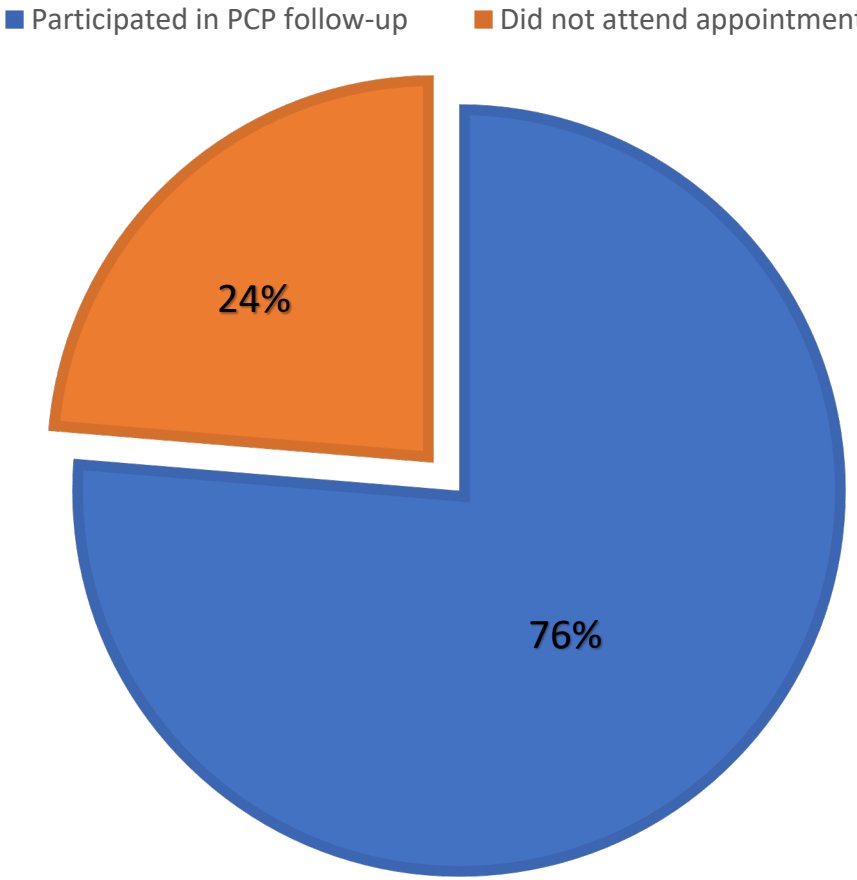


POST DISCHARGE RE-ADMISSION RATE IN THE 6 MONTHS FOLLOWING ENROLLMENT

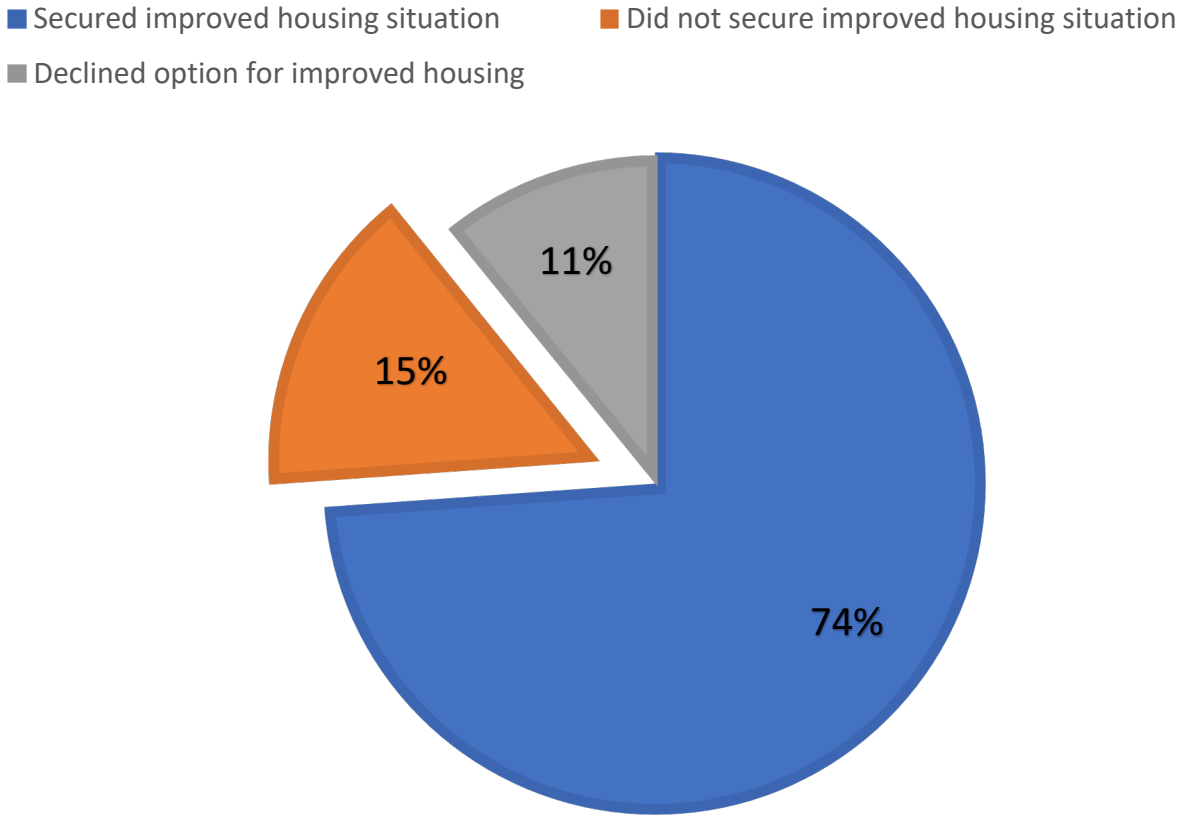


Patient Experience Outcomes

ADHERENCE TO MEDICAL FOLLOW UP



IMPROVED HOUSING SITUATION AFTER ENROLLMENT



Lessons Learned

Early bridge plan and include patient

Relationships with community partners

Partners

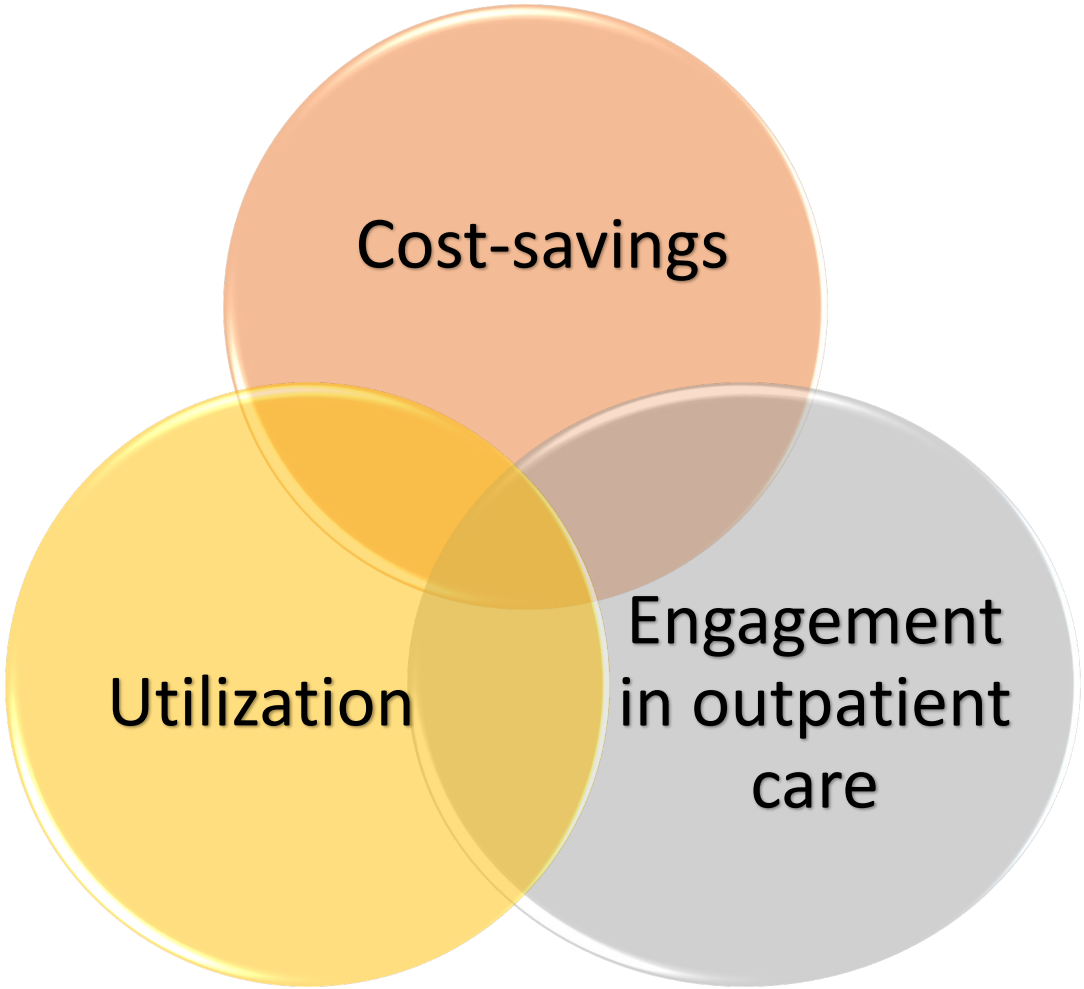
Pets

Phones

Trauma Informed Care

Low-Barrier ethos

Key Takeaways



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