Disclosures:
- I have no relevant financial relationships to disclose or conflicts of interest to resolve
- I will discuss no unapproved or off-label pharmaceuticals

VERMONT FOODBANK
Promoting Health through Partnerships to Increase Food Access
Michelle Wallace
Director of Community Health and Fresh Food Initiatives
**OUR VISION**
Everyone in Vermont has access to enough food every day.
Everyone in Vermont is healthy.
Everyone in Vermont takes action to eliminate hunger and poverty.

**OUR VALUES**
Dedication
Respect
Teamwork
Compassion

**OUR GOALS**
1. Optimize organizational capacity
2. Employ innovative solutions to food access
3. Inspire and engage people to take action
4. Promote health through food and services

Vermont Foodbank
Vermont Foodbank Network

153K Vermonters served annually

33% of households have a member with diabetes

46% of households have a member with high blood pressure

72% of households purchase inexpensive unhealthy food

2014 National Hunger Study Data.
1:4 Vermonters at risk of hunger & food insecurity

225 food pantries and meal programs

10M pounds of food distributed

1.2M visits annually = 8.3 times per year

2014 National Hunger Study Data.
Access to the Fresh Healthy Local Food
Vermont Foodbank Fresh Food Initiatives

Serving 1 in 4 Vermonters 6 million servings of fruits and veggies each year

2M Pounds of Fresh Produce Annually

Including Locally Sourced Produce and National Surplus Sourcing

465K Pounds of VT Grown Produce

225 Network Partners: Food shelves • Meal sites • Senior centers After school programs • Housing communities + other nonprofits

275 VT Fresh taste tests of 30 different fruits & vegetables

200 VeggieVanGo events at 12 schools & hospitals
VT FRESH :: TRANSFORMING FOOD SHELVES

Increasing availability, access and utilization of fresh produce
FOOD SHELVES IN VERMONT

BEFORE

AFTER
FOOD SHELVES IN VERMONT

BEFORE

AFTER
BEHAVIORAL ECONOMICS RESEARCH offers creative and intuitive strategies to “NUDGE” people in a way that MAKES FRUITS AND VEGETABLES THE EASIER CHOICE.
Displaying healthy foods PROMINENTLY draws attention to them and may increase their consumption
Combining with ATTRACTIVE SIGNAGE draws attention to items and can increase selection of those items.
VT FRESH
COOKING DEMOS AND TASTINGS
Sharing Simple Recipes

Using one vegetable as the primary ingredient

**RUTABAGA FRIES**

4-6 Large Slices

**INGREDIENTS**

- 1 large Rutabaga
- 1/4 cup Oil (Olive Oil works well)
- 1 tsp Rosemary, or other herb/spice mix
- Salt
- Pepper

**DIRECTIONS**

1. Heat oven to 425°
2. Clean and cut the rutabaga into half and size-approximating pieces (like French fries)
3. Put rutabaga pieces in mixing bowl. Add oil, herbs and sprinkle with salt and pepper. Mix with your hands or a spoon until all pieces are coated.
4. Spread out onto a baking sheet.
5. Bake in oven until edges become and rutabaga is tender - about 45 minutes - stirring halfway through so both sides brown.
6. Tips: Can adjust heat for crispier or softer, or for the oven, or microwave to adjust.

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**Eat a Rainbow!**

Make half your plate fruits and vegetables.
“PILOT” PARTNERSHIP MODEL with YMCA’s Diabetes Prevention Program

YOU CAN TAKE CONTROL
REDUCE YOUR RISK TODAY

YMCA’s DIABETES PREVENTION PROGRAM
RESULTS (compared to control group)

- increased program attendance & completion
- increased fruit and vegetable consumption
- increased weight loss
VEGGIE VAN GO :: MOBILE FOOD PANTRY

Distributing food on-site at hospitals and schools
• Central Vermont Medical Center
• Northeastern Vermont Regional Hospital
• Grace Cottage Hospital
• Southern Vermont Medical Center
• Springfield Medical Care Systems
• VA Medical Center
• Mt. Ascutney Hospital
• Brattleboro Memorial Hospital
• Gifford Medical Center
• JFK Elementary, Winooski
• Molly Stark Elementary, Bennington
• Northwest Elementary, Rutland
• Barre City Elementary and Middle
• St. Johnsbury School
• Brattleboro Schools
3SQUARES VT APPLICATION ASSISTANCE

Referring clients to access application assistance and making it easier for people to purchase the food they need.
Vermont Foodbank Application Assistance

Personalized one-on-one application assistance.

- We collaborate with community partners
- We prescreen to determine eligibility
- We provide excellent customer service
- We support the client through the process
Partnership with healthcare organizations

- Hosting VFB staff to table at your location
- VT Foodbank Referral Forms
- Display materials to promote awareness
3SquaresVT helps you pay for food. Text VFBSNAP to 85511 to find out more.

Vermont Foodbank
vtfoodbank.org
KEY TAKEAWAYS
How can our work intersect?

• See it for yourself…. Visit your local community food shelf!
• Refer patients to local food shelf and/or Veggie VanGo events.
• Refer patients to apply for 3SquaresVT
• Explore new types of health care partnerships with us. Integrated programming? Food shelf at your healthcare facility?

vtfoodbank.org
800-585-2265
THANK YOU

Michelle Wallace

mwallace@vtfoodbank.org
802-477-4125
Vermont Food & Healthcare Programs

Bi-State Primary Care Clinical Symposium
May 20, 2019

Suzanne Kelley, Healthy Communities Coordinator
Suzanne.kelley@Vermont.gov; (802)-657-4202

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1. **ASSESS**
   Profile population needs, resources, and readiness to address needs and gaps

2. **BUILD CAPACITY**
   Mobilize and/or build capacity to address needs

3. **PLAN**
   Develop a Comprehensive Strategic Plan

4. **IMPLEMENT**
   Implement evidence-based prevention programs and activities

5. **MONITOR & EVALUATE**
   Monitor, evaluate, sustain, and improve or replace those that fail

---

**Prevention Framework**

**Cultural Competence**

**Sustainability**
1. Assess

3 BEHAVIORS
- No Physical Activity
- Poor Diet
- Tobacco Use

4 DISEASES
- Cancer
- Heart Disease & Stroke
- Type 2 Diabetes
- Lung Disease

LEAD TO
RESULT IN

MORE THAN
50 PERCENT
OF DEATHS
IN VERMONT

healthvermont.gov/prevent/3-4-50
Disparities

Health Behaviors that Contribute to Chronic Disease

- **Currently Smoke**
  - Non-Low SES Adults: 11%
  - Adults of Low SES: 17%

- **Do NOT Get Recommended Physical Activity**
  - Youth: 41%
  - Adults: 77%

- **Do NOT Eat 5 Servings of Fruits and Vegetables Per Day**
  - Youth: 76%
  - Adults: 80%

Data Source: 2015 BRFSS and YRBS

Chronic Disease Diagnosis

<table>
<thead>
<tr>
<th>Chronic Disease Diagnosis</th>
<th>Non-Low SES Adults</th>
<th>Adults of Low SES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung Disease (Asthma/COPD)</td>
<td>12% (9% / 4%)</td>
<td>22%* (15% / 13%*)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>7%</td>
<td>14%*</td>
</tr>
<tr>
<td>Cardiovascular Disease</td>
<td>6%</td>
<td>15%*</td>
</tr>
<tr>
<td>Cancer</td>
<td>7%</td>
<td>8%</td>
</tr>
</tbody>
</table>

(*) notes statistical difference

Data Source: BRFSS, 2016
Diabetes

DIABETES AND 3 BEHAVIORS
• More than one in five (22%) Vermont adults with diagnosed diabetes currently smoke.
• More than half (56%) of Vermonter with diabetes did not get enough physical activity compared to 40% of adults without diabetes.
• 83% of adults with diabetes did not eat the recommended amount of fruits and vegetables.

Health Behaviors that Contribute to Chronic Disease

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Adults with Diabetes</th>
<th>No Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently Smoke</td>
<td>22%</td>
<td>18%</td>
</tr>
<tr>
<td>Do NOT Get Recommended Physical Activity</td>
<td>40%</td>
<td>56%*</td>
</tr>
<tr>
<td>Do NOT Eat 5 Servings of Fruits and Vegetables Per Day</td>
<td>83%</td>
<td>78%</td>
</tr>
</tbody>
</table>

(*) notes statistical difference

Data Source: BRFSS 2015
Finding local data

- Health Department
- Community Health Needs Assessment
- Local or regional health/prevention coalitions
- Hunger Councils
- Your practice!
2. Build Capacity
Partners - State

- Vermont Nutrition Education Committee (VNEC)
- Farm to Plate Food Access and Health Cross Cutting Teams
- Includes:
  - Vermont Foodbank
  - VYCC
  - Rutland
  - Hunger Free Vermont
  - Hospital Food Service/Food is Medicine
  - State – VDH, DAIL
  - EFNEP
  - Lots More!

Partners - local

- Office of Local Health
- Food hubs, Farmers
- Hunger Councils
- Local grocery stores or co-ops
- Local non-profits
- RISE VT
- Community Health Teams, ACHs
- Who else?
3. Plan

• Funding
• Who is eligible?
• How to identify?
• What is the benefit:
  • CSA
  • Coupons
  • Actual food
• How, how much, how often?

• Who are the point people?

• Will there be follow-up?
  • By who, when, why?
4. Implement

State Examples

• Federal Programs
  • 3 SquaresVT/SNAP
  • WIC

• SNAP-Ed
  • Vermont Nutrition Education Committee (VNEC) [Grid for Families](#)

• Farm to Plate Health Cross Cutting Team
  • Vermont Food & Health Program Inventory

Local Examples

• Vermont Foodbank: Veggie Van Go; Self Management Collaboration

• VYCC: Health Care Shares

• Rutland: Food Farmacy (Vermont Farmers Food Center)

• Hunger Free VT: Hunger screening in Health Care

• VDH: Fruit and Veg Rx
5. Monitor and evaluate

- Number of people (families) served
- Amount of food distributed
- Health outcomes (if you can)
- Process:
  - What worked
  - What needs improvement
Improve outcomes in six priority health and social conditions:

- Child Development
- Chronic Disease
- Mental Health
- Oral Health
- Substance Use
- Social Determinants: Housing, Transportation, Food, Economic Security
Challenges....

• Who pays?

• Lots of great programs – what really “works”?

• How do we make food access a priority to health systems, payers?

• Can these ideas be systemized?

• What about primary prevention? We wait until people are sick....

• Who else needs to be at the table and how do we get them there?
Next Steps

• Partnerships and programs continue
• SHIP work plan
• Presentations like this
• You tell us!
New Hampshire Food Bank

Bi-State Primary Care Association
Clinical Quality Symposium Network
Food Insecurity Panel
5.20.19
Overarching Strategy for the NHFB Team......

Feed the hunger and nourish the health of New Hampshire’s food insecure.

Over 14 millions pounds of food distributed in 2018

425+ partner agencies throughout the state

Programming:
- Culinary Job Training
- Granite State Market Match
- SNAP Outreach
- Cooking Matters Classes
- Production Garden
- USDA Summer Feeding
The State of Hunger in the United States

Trends in prevalence rates of food insecurity and very low food security in U.S. households, 1995-2017

Note: Prevalence rates for 1996 and 1997 were adjusted for the estimated effects of differences in data collection screening protocols used in those years.

The State of Hunger & Health in NH

1 in 9 of NH citizens are considered “Food Insecure” meaning they don’t know where their next meal is coming from.¹
That’s 120,851 NH citizens

11% of children under 18 years, live in food insecure homes.¹
That’s 28,507 NH children

7% of our seniors, 65 years and older, are food insecure.¹
That’s 16,543 NH seniors

28% of adults report a BMI of 30 or more²
That’s 375,983 NH adults

8.4% report being told they have diabetes by a health professional³
That’s 113,942 NH citizens

90% of diabetic Medicare 65-75 that receive HbA1c monitoring⁴
That’s 17,100 NH seniors or 7% of seniors

¹ Feeding America: Map The Meal Gap May 2018
² County Health Rankings.org 2018
³ America’s Health Rankings United Health Foundation 2018
⁴ Data USA data set Dartmouth College 2014
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¹ Feeding America: Map The Meal Gap May 2018 and US Census Bureau/quick facts/NH 7.1.17
² County Health Rankings.org 2018
³ America’s Health Rankings United Health Foundation 2018
⁴ Data USA data set Dartmouth College 2014
• Advises providers to:
  – “Evaluate hyper and hypoglycemia in the context of food insecurity”
  – “Propose solutions accordingly”
• Offers suggestions for medication management
• Proposes linkage to community resources
Solution to reach more food insecure:
Partner with Healthcare to Screen and Intervene

The Children’s HealthWatch Hunger Vital Sign™

Drs. Erin Hager and Anna Quigg and the Children’s HealthWatch team validated the Hunger Vital Sign™, a 2-question screening tool, suitable for clinical or community outreach use, that identifies families with young children as being at risk for food insecurity if they answer that either or both of the following two statements* is ‘often true’ or ‘sometimes true’ (vs. ‘never true’):

- “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 and we didn’t have money to get more.”

*In 2010, Drs. Erin Hager and Anna Quigg and the Children’s HealthWatch team developed the Hunger Vital Sign™, a validated 2-question food insecurity screening tool based on the U.S. Household Food Security Survey Module to identify households at risk of food insecurity.
Why not screen for Food Insecurity?

These are the most common concerns raised and reasons healthcare providers give for not screening.

What if they screen positive???

I don’t know how to talk to them without making them feel badly.

But they don’t look food insecure.

Where would I send them for help?

I don’t know what resources are available to them.

I don’t want to ask a question if I don’t have an answer.
A Screening Tool to Intervene

Universally Screen All: Train staff how to respectfully ask the HVS two questions.

Intervene and CODE results in patient’s EMR: Review both sides of the screening tool.

Follow-up: Positive screens are followed up by staff to see if they are accessing their local pantry or applying for SNAP.
Meeting the Nutritional Needs of your Patients.

We believe strong food bank – health care partnerships can:

- help identify more people facing food insecurity
- lead to more effective interventions that support people in need
- ultimately contribute to improving individual and community health outcomes.

Patient initiative + medical care + food = positive health outcomes
What is the NHFB doing right now? *(challenges faced)*

- Forward Contracting with Farmers/Coops to benefit our partner agencies with fresh local product for our food insecure. *(capacity restraint of agencies)*
  - North Country Farmers Coop, Western NH and potential state dollars.
- Partnering with healthcare to design emergency food needs, boxes of diabetic friendly food with recipes and resources. *(no fresh product)*
  - Dartmouth Hitchcock and Manchester CHC
- Establishing Preventative Food Pantries with Hospitals. *(real estate scarce)*
  - CMC started in January and Colebrook is in the beginning phase.
- Targeting Mobile Food Pantries to fall before the last week of the month. *(*)
  - Folks run out of food stamps in the third week so to avoid yo-yo nutrition we target the down time to help fill the nutritional gap.
What can you do with the NHFB now?

- Screen and Intervene with Hunger’s Vital Signs two questions and our rack card to direct them to our nearest partner agency.
- Identify a food insecure population & host a class series:
  - Cooking Matters Classes with our Recipe for Success Program
    - 6 weeks of nutrition education in cooking classes meet 1x/week.
  - Host a Cooking Matters at the Grocery Store for Adults
    - A guided grocery store tour that teaches low-income adults how to get the most nutrition for their food dollars.

https://www.nhfoodbank.org/programs/recipe-for-success/cooking-matters/
What can you work towards with the NHFB for the future?

- Start your own Preventative Food Pantry – start looking at RE
  - Start small and manageable targeting those clients that test positively for food insecurity and have one of three chronic conditions:
    - High Blood Pressure
    - Diabetes
    - Obesity
  - Identify, visit and engage with local partner agencies of ours.
    - Offer health screenings, a host for classes and other local resources
    - Encourage them to promote healthy choices and offer nutritious product.
Further down on the Horizon….. Medically Tailored Meals

Prescriptions for meals given by healthcare provider, meals prepared by NHFB and distributed through our partner agencies and reimbursed by insurance carriers. Feeding our aging population properly will reduce future healthcare costs.

Community Servings is a not-for-profit food and nutrition program providing services throughout Massachusetts to individuals and families living with critical and chronic illnesses. We give our clients, their dependent families, and caregivers appealing, nutritious meals, and send the message to those in greatest need that someone cares. Our medically tailored meals for diabetic patients with food insecurity study, examining whether our meal intervention changed diabetic patients’ diet in a way that showed improved health, was published in the *Journal for General Internal Medicine*. Results showed that diabetic patients who received our medically tailored meals:

- Ate more vegetables, fruits, & whole grains,
- Decreased their consumption of fats & added sugars,
- Had improved dietary quality & food security; and
- Reduced hypoglycemia.
What we can do together.

Patient initiative + medical care + food = positive health outcomes

The green circle is going to be different for every patient. We can figure it out together.

Thank you 😊
Population Health as a Model for Improving Healthy Food Access:
- a Food Systems Approach
Objectives:

- Differentiate between Public Health and Population Health
- Using population health concepts in food access work
- Case Study

Conflict of interest statement:
The presenter is the owner of Costello Food Systems and Nutrition Consulting. I currently do not see patients or work with any healthcare organizations. I may in the future.
Population Health vs. Public Health

- Public health works to protect and improve the health of communities through policy recommendations, health education and outreach, and research for disease detection and injury prevention. It can be defined as what “we as a society do collectively to assure the conditions in which people can be healthy” (Institute of Medicine, 1988).

- Population health provides “an opportunity for health care systems, agencies and organizations to work together in order to improve the health outcomes of the communities they serve.”

- CDC.gov
Achieving Population Health requires attention to the Social Determinants of Health

- The conditions in which you live, work, play and age affect your health
  - These are impacted by your family structure, social network, community institutions
  - Collective impact of these factors contribute to improving Population Health when working together
  - Utilize strategic partnerships in cross spheres of influence to meet goals
Case Study:

- USDA Summer Food Service Program in Coos County, NH

Background:

- Large program in Berlin but no programs on the western side of the state
- NH Food Bank wanted to engage more programming and food distribution in that part of the state
- There was USDA reimbursement and ample grant funding available
Strategies to bring summer meals to children in Coos County:

- Approached strategic partners
  - Determined the need
  - Logistics of accomplishing the work
  - Shared resources
Summary:

- Four sites were established in the first year
- Since 2015 has grown to 6-7 sites
- Over 250 children in very rural area of New Hampshire receive healthy meals five days a week
- Produce is purchased from a local farmers’ cooperative
- Summer jobs are created
- In the Population Health Model the community is supporting the individual’s social determinants of health
- There is a role for healthcare to participate.
  - Nutrition/health education, functioning as a site, offering health screenings, etc.
Thank you for your kind attention!