Spotlight Series: FOODRx

Interview with Alexandra De Kesel Lofthus, Former Director of Health Care Partnerships at Second Harvest Heartland

The NORC Medicaid Managed Care Organization (MCO) Learning Hub shares timely and relevant resources to support Medicaid MCOs and other stakeholders in improving the health of their members and increasing advancements in health equity and health care transformation. We encourage you to share your experiences with us and welcome your feedback on future MCO Learning Hub work to better serve your needs. To start the conversation or join our distribution list, please email us at MCOLearningHub@norc.org.

The Medicaid MCO Learning Hub "Spotlight Series" highlights key initiatives addressing social determinants of health (SDOH) and health equity that are driven by, or in partnership with, MCOs to inform the Robert Wood Johnson Foundation (RWJF) and its grantees. In addition, the series provides MCOs, community based organizations, states, and other key stakeholders with examples of successful models of organizations working together to advance health equity.

The first "Spotlight Series" is focused on an organization working with health care systems to address food insecurity. FOODRx, a program from Second Harvest Heartland, partners with Medicaid MCOs and Minnesota's Integrated Health Partnerships (IHPs) to provide food resources and nutrition solutions for their members or attributed populations. Forthcoming Spotlight Series briefs will center on other existing initiatives and partnerships around SDOH and health equity.

COVID-19 underscores the importance of protecting and strengthening social determinants of health (SDOH). A key SDOH is food insecurity, or the disruption of food intake or eating patterns because of lack of money and other resources.[1] According to the U.S. Department of Agriculture's Economic Research Service, 11.1 percent of households were food insecure in 2018.[2] Those who are food insecure are at increased risk for a variety of negative health outcomes and health disparities, including increased risk for chronic diseases.[3,4,5] Various organizations have been working on addressing food insecurity, including Second Harvest Heartland.

Second Harvest Heartland, one of the largest food banks in the nation, establishes community partnerships, working with manufacturers, farmers, hotels, restaurants, and other organizations to offer meals and food safety to recipients.[6] One of Second Harvest Heartland's programs, FOODRx which launched in 2016, partners with health plans and providers through value-based care arrangements to improve patient health and engage their partners' most at-risk members through culturally-effective food security services. Most FOODRx participants are Medicaid beneficiaries and many have a chronic condition that can be improved through a better diet.

FOODRx is currently integrated into the following health plans and providers: 1) Children's Hospital; 2) Hennepin Healthcare; 3) Lakewood Health System; 4) Marshfield Clinic (WI); 5) MHealth Fairview; 6) North Memorial Health

Care/North Care Collaborative (NMH, Stellis, UMP Broadway, Northwest Family Clinics); and 7) UCare, and is a food insecurity intervention receiving national attention.[7]

NORC's Medicaid MCO Managed Care Learning Hub recently spoke with Alexandra De Kesel Lofthus*, former Director of Health Care Partnerships at Second Harvest Heartland, to discuss how the organization is partnering with health care organizations to address food insecurity and health through the FOODRx program.

Q: Tell us a little bit about the FOODRx program.

FOODRx started about four years ago. The first years were focused on two research studies measuring the impact of food insecurity on health and costs using our program design. FOODRx also focuses on integrating with health care partners to deliver food resources, including a chronic disease program, focusing on the triple aim *[i.e., improving experience of care, lower cost, and improved health]* and adding value to their partners and the individuals that their partners serve.

In 2016, FOODRx developed a plan to enter the health care market as a value-based solution for addressing food insecurity.

> **"Our goal was to introduce FOODRx as an integrated model in partnership with health care providers, delivered where patients get their care. Our planning was very intentional; as a value-based solution FOODRx should directly participate in emerging health care alternative payment models… We were changing the way CBOs plan with and receive revenue through health care relationships."**

At the time, these alternative payment models did not exist to provide organizations like us an opportunity for inclusion in payment model reform. Models being developed in the market were more focused on attribution with primary care and claims-based methodologies.

Our intent from the beginning was to move beyond referral and grant-based programming to a scalable and sustaining model. We also needed to bring attention to the role of CBOs, focusing on SDOH and their impact on health care, and how directly they improve health outcomes and address the triple aim proposition through these efforts.

This includes improving the financial performance of health care systems participating in risk-based contracting, such as Integrated Health Partnerships (IHP) in Minnesota. *[In Minnesota's IHP model, participating health care providers work together across specialties and service settings to deliver more efficient and effective health care.]* Our initial stage of planning focused our efforts to bring FOODRx to market serving the needs of Minnesota Health Care Program members with Medicaid by establishing partnerships with health care systems, directly contracting with the Minnesota Department of Human Services (DHS) through the IHP program or with managed care organizations (MCOs) providing service expansion for their Medicaid members.

Early on in our program development, we received interest from the Minnesota Department of Health in our innovated approach to service delivery that aligned with their interest to meet triple aim outcomes for Medicaid and MinnesotaCare recipients by incorporating social and economic determinants into the principles of the IHP program for their 2017 contracting (IHP 2.0). This interest gave us an opportunity to address a key objective for FOODRx, payment model integration, and allowed us to promote concepts of giving providers incentives within the IHP model to formalize relationships with CBOs and include these relationships in their care delivery model. The IHP 2.0 model transformed to allow IHPs to retain more of their gain share if these requirements were met and provided FOODRx with an entry point with IHPs to gain attention to our program.

In 2018, with the introduction of IHP 2.0 inclusive of incentives for community-based partnerships within the care delivery model, we put a lot of focus on contracting directly with IHPs and, with these initial relationships, really learn what it means to integrate and partner with health care systems. These systems are large and complex, and integration does not happen without a lot of thought to planning and building trust that allows Second Harvest Heartland to work directly with these partners. We were open to how we tailored our program with health care partners, but were specific to the delivery model-- that addressing food insecurity for patients with chronic disease was not just about meeting a food gap.

It also consisted of providing nutritious food to patients with dietary risk factors and using care coordination methodologies that give patients the education and tools they need to manage their dietary needs once they have completed the FOODRx program. Data was indicating that individuals we served through our food-shelf partners had a higher rate of diet-related chronic diseases compared to the general population.

> **"Looking at Food as Medicine is not a new concept, but approaching this in a space of working together around this idea was a new concept."**

Q: As the program has expanded, what particular IHPs are you working with?

We have two IHP 2.0 contracts. One is with **Hennepin Healthcare**, an integrated health care system with a safety-net role in the community. We have had a relationship with them from the start, with close to 10 years working with them on food insecurity screening and referrals to Second Harvest Heartland at several of their clinics. Referrals are sent to us electronically and we work directly with their patients. Now, with IHP 2.0, we have expanded that work to all of their clinics. There are two mechanisms of sending referrals to us: 1) a process where providers can screen for food insecurity at any point and submit their referral to us, or 2) staff can screen when they room a patient in one of their facilities.

> **"One of the great things at Second Harvest is that we are a HIPAA-compliant organization; we have our own enterprise data warehouse that we use to collect information to share with our partners, including impact measures. Hennepin Healthcare doesn't just send us a referral; we follow up with them and close the loop."**

We let them know what happened with the patients, if they qualified for SNAP *[Supplemental Nutrition Assistance Program]*, what their needs are, and what food resources they were referred to. We share where we are in the process. Once in the system, a patient can call us back at any point. So it's screen, refer, and then a closed-loop relationship with data sharing back to the health care providers. It's a very interactive and collaborative partnership.

Our other partnership is with **North Care Collaborative** led by North Memorial Health. It is more intensive and there are different services we provide. We work with several clinics within the collaborative and we tailor the FOODRx program to meet the specific needs of the clinic and how they are integrating FOODRx within their care model.

- **Screen/Refer:** Partners provide IHP data files and the Demographic and Care Management Report (CMR) to us; we then create a patient registry for each clinic-based identified criteria for FOODRx enrollment, such as diagnosis and clinic attribution. Depending on how the clinic manages the program, the care coordinator works from the registry to contact and screen patients for food insecurity and FOODRx eligibility and then refers those patients to us to enroll in the Chronic Disease Program and/or provide additional food resources and support as needed.

- **Outreach:** Another option for FOODRx enrollment is that we work from the IHP files to identify attributed patients who are eligible for the program and we do the initial outreach and screening of the patients. We then notify the clinic of patients who have been enrolled in the program that are attributed to their clinic.

- **Hybrid:** For example, the care coordinator contacts the patients in care coordination and we take the ones not involved in care coordination.

For the screen and refer, we typically share either an aggregate report of the volume and outcome of the referrals; for specific partners, we provide the data back at a patient level.

For diet-related chronic disease management, we have a six-month program with a nutritious food prescription box provided every month with approximately 30 pounds of shelf-stable food.

> **"The food boxes are culturally-appropriate, including Standard American, Hispanic, and Somali/ vegetarian boxes. This gives participants access to foods and recipes that are culturally-specific and appropriate and provides nutrition education based on the specific disease state they have… The participant chooses the box they receive, knowing not everyone will choose based on their cultural background."**

The education materials and recipes are translated as well. It is a six-month program, and we exchange data with North Care Collaborative.

For the chronic disease program, we send program data, health measures, and claims cost to the partner; but this is all depending on the partner and how the program is designed.

Telehealth has been a helpful way to connect to patients that are not coming to the clinic and being screened. There are different ways to get information out to the community since they are not coming out to clinic. These include mailings sent by our health care partners and messages that play when you are on hold to contact Second Harvest if you are in need of food support.

Since 2018, FOODRx has expanded to non-IHP contracts with different groups. With the **Lakewood Health System**, we provide a third service – the stability box. They have a robust food security program with a lot of options including our stability box. If a patient is screened and identified as having a food need, they can send the patients home right then and there with a 12-pound box of nutritious, shelf-stable food. One of our clinics is considering the box for post-discharge so that a patient can have available food, especially if they have to take medications with it. It can help stabilize that member post-discharge.

Q: Do your partners use a standard food insecurity assessment tool?

It's not standard. Outside of the IHP partnerships, not all of the clinics require their members to be food insecure to participate in the FOODRx program. They can screen and refer if they have a diagnosis of diabetes or other condition like heart disease. Most of these other partners include the Hunger Vital Sign™ 2-question screener. It is a validated question set and, if the response is *sometimes* or *often* for either question, the patient is considered food insecure. It is up to the clinics to determine if and how they want to screen their patients and send referrals to us; everyone screens their own way.

Q: How are you partnering with MCOs?

UCare is the first health plan we work with where we took a lot of time upfront to understand how to most effectively meet member needs and develop a long-term partnership.

For UCare, we have different programs and continue to assess other opportunities to work with them; for example, as a direct service provider to members. We have a screen and refer program, where the plan calls members through an [interactive voice response] IVR-call system and members have the option to talk to someone at Second Harvest or leave a message for a later call back. We have been able to test out different geographies and populations with them over the years. We are able to evaluate data on outcomes and connection rates and make adjustments, as

needed. Our shared outcomes have been good and I think it's in part because Second Harvest Heartland is a trusted partner in the community around food resources and providing SNAP application assistance.

We also implemented a hypertension pilot that had positive results. There was a pre-registry of patients and someone from the plan's team did an initial call followed by a monthly check-in call to keep members engaged. We managed home delivery of the food boxes, which had great results in both food secure and insecure populations. There were reductions in health care costs and increased levels of confidence in chronic disease management. The focus was hypertension and there was improvement in how patients were managing and tracking blood pressure. It's helpful when a health care partner does the introduction of the program so members are aware that we're a partner and are integrated into their care plan.

In addition to UCare, we have had ongoing conversation and program development planning with other MCOs and we are hoping to bring additional FOODRx program online with them in the near future.

Q: What are the barriers to partnerships between MCOs, IHPs, and organizations like yours?

Our business model allows us to sustain programming and provide consistent access to a nutrition program like ours using contractual agreements with health plans and providers contracted with the state. There are challenges with this approach, but we have been moving away from philanthropic funding and entering into more contracts.

One thing that often comes up is data exchange – it is hard for some partners in health care to feel comfortable releasing data to CBOs. We are HIPAA-compliant and our staff is trained in managing PII and PHI *[Personally Identifiable Information and Protected Health information]*. Data sharing is essential to effectively and successfully manage the individuals and to evaluate the effectiveness and ROI *[return on investment]* of our interventions.

There is also the question of who should pay for such programming – programs take a long time to set up. Pre-COVID, it took a lot of work to engage with health plans and providers. There is a lot of upfront work that we are not getting paid for; we don't get paid until we start providing services to individuals. At this time, we have a grant that helps covers our staff until we get to scale where we can be funded solely through our contracts.

> **"Another barrier is mindset… It's a bigger systems change. We're hoping to slowly break that down, building ROI and proving it's great for members, patients, communities, and for [partners]."**

We have most of the early adopters in our portfolio of partners. Some others are coming around. Everyone is at different stages of acceptance of the impact of SDOH interventions. We continue to grow and prove ourselves.

Q: What has been the impact of COVID on your work?

COVID has changed how quickly partners can respond. Many clinics have furloughed staff or have staff working remotely; in some cases clinics are closed. For established partnerships, because we're already integrated, we've been able to take on some additional case management responsibilities from the clinics.

We are also seeing decisions being expedited because of COVID; decisions are being made faster and allowing for learning and continuous improvement as we go. We've had to quickly pivot to meet changing requirements.

> **"The COVID response has also provided fantastic partnerships for meeting patients where they are– identifying new populations (e.g., seniors at home), home delivery, community paramedic programs, and other additional resources. Partners have done a really fantastic job of pivoting to understand changing needs; there's been good, open communication, it is easier to respond to challenges as they occur."**

The challenge has been, health care staff being furloughed; there are periods of really busy intensive needs and then quiet times. The people that are disproportionately affected by COVID are often under-served, on Medicaid, have multiple chronic diseases, and have access issues exacerbated by transportation limitations or not wanting to leave home. Partners have been fantastic with that. We need to solve for different barriers and are getting creative.

Conclusion

As MCOs, CBOs, and other key stakeholders consider potential examples and models of collaboration to address food insecurity and other SDOH, there are various considerations to take into account:

- **Data sharing between MCOs or health systems and community organizations can provide a more holistic picture of the patient and of how the model is working.** Second Harvest Heartland maintains an enterprise data warehouse that allows the team to collect information and share it back with health system partners, including what type of services a patient has received. This bi-directional data exchange between MCOs or health systems and community organizations allows the partnership to more effectively manage the health of the patient. This type of data collection approach can also facilitate evaluation of the model for potential proof-of-concept.

- **CBOs that understand HIPAA-compliance or are HIPAA-compliant can help engender trust between organizations and facilitate data sharing.** Food banks are generally not Covered Entities or Business Associates under HIPAA and therefore have no obligation to comply with HIPAA requirements.[8] However, models in which CBOs understand requirements under HIPAA and potentially become HIPAA-compliant can help facilitate the development of partnerships between CBOs, MCOs, and health care systems, and facilitate patient-driven information sharing. As a HIPAA-compliant organization, Second Harvest Heartland has a unique model.

- **Consider alternative payment models, such as value-based payment arrangements that incorporate CBOs.** Alternative payment models can create a reimbursement structure that incentivize providers to work with CBOs to advance SDOH to improve patient outcomes and lower cost. Second Harvest Heartland has established a business model that allows them to sustain programming and provide consistent access to a nutrition program using value-based contractual agreements with health plans and providers contracted with the state.

*Interview has been edited for length and clarity.

Acknowledgements

OUR PARTNERS

America's Health Insurance Plans

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