diagnosis: hunger

THE ROOT CAUSE COALITION
the alliance to end hunger
Angel Heart
COLORADO PREVENTION ALLIANCE
Food Insecurity among Elderly Members of Kaiser Permanente Colorado

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Institute for Health Research, Kaiser Permanente Colorado

May 18, 2017
Food Insecurity in Older Adults

• In 2015, 8.3% of households in the US with an elderly member reported food insecurity
  • 9.2% among elderly individuals living alone

• As in other age groups, food insecurity is associated with adverse health outcomes and higher health care costs
  • But is food insecurity the cause or the consequence of those adverse outcomes?
Care for the Elderly in KPCO

• In 2015, KPCO cared for 110,000 members age 65 and over
  • Mostly Medicare Part C (Medicare Advantage)
  • 7-8% dual eligible for Medicaid programs (traditional or Special Needs Program)

• KPCO offers a no-cost Annual Wellness Visit as an option for Medicare members
  • Personal prevention plan
  • Identification of functional concerns (bathing, shopping)
  • Geriatric syndromes (falls, urinary incontinence)
  • Identification of some social needs
Medicare Total Health Assessment

• Patient survey in advance of Annual Wellness Visit
• Available on line (kp.org), with IVR (telephone) assistance, or in person
• Caregiver or staff can help with survey completion
• Multiple survey domains: self-rated physical and mental health, geriatric syndromes, ADL/IADL, nutrition, social isolation...
Food Insecurity Question

“Do you always have enough money to buy the food you need?”

- Yes/no
- From the DETERMINE Your Nutritional Health scale developed by the Nutrition Screening Initiative *

Evaluation Framework

Members, Resources → Screen, Assess → Refer, Connect → Fulfill, Confirm → Health & Care Behaviors → Health & Function → Utilization & Cost, Satisfaction

Inputs  ← Community-Clinic Integration →  ← Outcomes →
Evaluation Questions for Today

• How prevalent is food insecurity among elderly KPCO members?

• What clinical characteristics are associated with food insecurity?

• What self-reported characteristics are associated with food insecurity?

• Can we identify high-risk members for assessment of social needs?

• What other social needs are present in members with food insecurity?
130,316 Elderly Members
1/2012 – 12/2015

50,131 Members Surveyed
(38%)

2,863 members with food insecurity
(5.7%)

47,268 members without food insecurity
(94.3%)
How you ask affects what you learn...

<table>
<thead>
<tr>
<th>Mode of completion</th>
<th>Prevalence of food insecurity</th>
</tr>
</thead>
<tbody>
<tr>
<td>On line</td>
<td>3.1%</td>
</tr>
<tr>
<td>Telephone-assisted</td>
<td>6.7%</td>
</tr>
<tr>
<td>In person</td>
<td>9.5%</td>
</tr>
</tbody>
</table>
## Clinical Characteristics and Food Insecurity

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Prevalence of food insecurity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male / female</td>
<td>5.0% / 6.0%</td>
</tr>
<tr>
<td>Age: 65-74 / 75-84 / 85+</td>
<td>5.5% / 5.9% / 4.6%</td>
</tr>
<tr>
<td>White / African-American / Latino / Other</td>
<td>4.8% / 15.5% /10.0% /6.8%</td>
</tr>
<tr>
<td>Medicaid: Yes / No</td>
<td>24.0% /5.1%</td>
</tr>
<tr>
<td>Married or partnered / single</td>
<td>4.5% / 7.9%</td>
</tr>
<tr>
<td>Diabetes: Yes / No</td>
<td>7.8% / 5.1%</td>
</tr>
<tr>
<td>BMI: Underweight / normal weight/ overweight / obese / extremely obese</td>
<td>7.2% / 4.9% /5.2% /6.3% /10.0%</td>
</tr>
</tbody>
</table>
## Health Status and Food Insecurity

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Prevalence of food insecurity</th>
</tr>
</thead>
<tbody>
<tr>
<td>General health: excellent + very good / good / fair + poor</td>
<td>4.1% / 6.7% / 10.8%</td>
</tr>
<tr>
<td>Quality of life: excellent + very good / good / fair + poor</td>
<td>4.1% / 7.5% / 13.2%</td>
</tr>
<tr>
<td>Eating: do myself / have difficulty or need help</td>
<td>5.5% / 13.1%</td>
</tr>
<tr>
<td>Managing money: do myself / have difficulty or need help</td>
<td>5.1% / 14.6%</td>
</tr>
<tr>
<td>Shopping for groceries: do myself / have difficulty or need help</td>
<td>4.2% / 10.6%</td>
</tr>
<tr>
<td>Lonely or isolated: never + rarely / sometimes, often, always</td>
<td>4.9% / 9.4%</td>
</tr>
<tr>
<td>Someone I could call for help: Yes / No</td>
<td>5.4% / 15.7%</td>
</tr>
</tbody>
</table>
Is there a high-risk profile for food insecurity?

<table>
<thead>
<tr>
<th>Risk quintile *</th>
<th>Prevalence of food insecurity</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-20% (lowest risk)</td>
<td>1.5%</td>
</tr>
<tr>
<td>21-40%</td>
<td>2.9%</td>
</tr>
<tr>
<td>41-60%</td>
<td>3.9%</td>
</tr>
<tr>
<td>61-80%</td>
<td>5.9%</td>
</tr>
<tr>
<td>81-100% (highest risk)</td>
<td><strong>14.4%</strong></td>
</tr>
</tbody>
</table>

* Risk model based on 23 variables from the KPCO electronic health record and MTHA survey

However – almost half of elderly KPCO members with food insecurity are **not** in the highest-risk group
# Evaluation Findings – So Far

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>How prevalent is food insecurity among elderly KPCO members?</td>
<td>5.7%</td>
</tr>
<tr>
<td>What clinical characteristics are associated with food insecurity?</td>
<td>Race/ethnicity, Medicaid, extreme obesity</td>
</tr>
<tr>
<td>What self-reported characteristics are associated with food insecurity?</td>
<td>Quality of life, specific functional limitations, social isolation</td>
</tr>
<tr>
<td>Can we identify a high-risk group of members for assessment of social needs?</td>
<td>Yes, we can identify a subgroup with 3x increased risk, but many members with food insecurity are missed by our prediction rule</td>
</tr>
<tr>
<td>What other social needs are present in individuals with food insecurity?</td>
<td></td>
</tr>
</tbody>
</table>
184 elderly members with food insecurity on MTHA

103 completed detailed survey on other social needs

77 members with food insecurity on Hunger Vital Sign (75%)

26 members with no food insecurity on Hunger Vital Sign (25%)
Other Social Needs and Food Insecurity

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Food insecure (N = 77)</th>
<th>Not food insecure (N = 25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerns about housing</td>
<td>70%</td>
<td>31%</td>
</tr>
<tr>
<td>Concerns about paying for necessities</td>
<td>97%</td>
<td>61%</td>
</tr>
<tr>
<td>Concerns about transportation</td>
<td>29%</td>
<td>4%</td>
</tr>
<tr>
<td>Cost-related medication non-adherence</td>
<td>69%</td>
<td>19%</td>
</tr>
<tr>
<td>Difficulty paying for utilities</td>
<td>76%</td>
<td>39%</td>
</tr>
<tr>
<td>Income &lt; $15,000/yr</td>
<td>53%</td>
<td>12%</td>
</tr>
<tr>
<td>Primary caregiver for child &lt; 18</td>
<td>7%</td>
<td>0%</td>
</tr>
</tbody>
</table>

* All differences except the last are statistically significant
## Evaluation Findings – So Far

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</tr>
<tr>
<td>What other social needs are present in individuals with food insecurity?</td>
<td>Food insecurity is part of a constellation of social needs</td>
</tr>
</tbody>
</table>
Evaluation Framework

- Members, Resources
- Screen, Assess
- Refer, Connect
- Fulfill, Confirm
- Health & Care Behaviors
- Health & Function
- Utilization & Cost, Satisfaction

Inputs: Community-Clinic Integration
Outcomes:
Other Components of Evaluation

• Mapping the referral process and flow of information between KPCO and Hunger Free Colorado

• Collaborating with Hunger Free on a survey of KPCO members who have used their hot line
  • Food resources obtained
  • Duration of use of those resources
  • Alleviation of food insecurity

• Testing measures of food insecurity and other social determinants of health

• Assessing relationship between food insecurity and clinical outcomes for diabetes, hypertension
Conclusions

• “Kaiser Permanente exists to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.”

• Understanding the role of social determinants of health in the 600,000+ KPCO members and our Colorado communities is mission-consistent.

• The only way to address social needs is through collaboration between health systems and community organizations.

• We have much to learn both within our own organization and about effective strategies for clinic-community interventions.

• And we have begun...
Thank you!

• Organizers and sponsors of today’s meeting
• Research team in the Institute for Health Research
  • Andrea Paolino
  • Andy Sterrett
  • Chan Zeng
  • Tina Kimpo
  • Sandy Stenmark
  • Marisa Allen
  • ... and many others
• Kaiser Permanente Community Benefit program for funding this evaluation
Food as Medicine

Erin Pulling
President & CEO
epulling@projectangelheart.org

#FoodIsMedicine | @proj_angelheart | Projectangelheart
What would you choose?

1 in 3 people coping with a chronic or life-threatening illness have to make this choice.
Food Insecurity & Health

60% of patients are malnourished upon admission to the hospital

7% are diagnosed with malnutrition
Food Is Important

Proper nutrition leads to better health outcomes for people with severe and chronic illness.

Malnourished patients have:

- MORE Missed Doctors Visits
- 3X LONGER Hospital Stays
- 3X HIGHER Inpatient Costs
- 2X MORE LIKELY Rehospitalization

Delivering Food as Medicine

Average of 18-20 variations of each meal
Made from scratch
Culturally diverse
Project Angel Heart
Medically Complex Clients

Top 5 Diagnoses:
1. Cancer
2. COPD
3. Kidney Disease
4. HIV/AIDS
5. Congestive Heart Failure

69% require a modified diet

Average of 7 co-occurring illnesses

45% have a behavioral health diagnosis

42% are age 65+
Treatment

Box of medically tailored food

Fully prepared medically tailored meals that are home delivered

Fruit/Vegetable Voucher

Prevention

Diagnosis: Hunger

Addressing Hunger as a Health Issue
## Qualitative Impact

<table>
<thead>
<tr>
<th>98% report improved adherence to health regimen</th>
<th>93% report better able to afford their healthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Checklist" /></td>
<td><img src="image" alt="Red Cross with Dollar Sign" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>97% report able to remain independent in their home</th>
<th>96% report improved quality of life</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Walking Person" /></td>
<td><img src="image" alt="Meditating Person" /></td>
</tr>
</tbody>
</table>
Food as Medicine

A key component of health care, particularly for people with critical illness
Achieving the Triple Aim

+ Triple AIM

- Improve Health
- Lower Costs
- Better Care

Addressing Hunger as a Health Issue
Meals for Care Transitions

- Partnering with healthcare providers statewide
- Comprehensive nutrition to support recovery for a specific period of time
- Medically tailored meals
- Delivered to patients’ homes within 24-48 hrs. of referral
# Cost of Care

## Average Cost of Hospital Stay by Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF</td>
<td>$13,000¹</td>
</tr>
<tr>
<td>COPD</td>
<td>$8,400²</td>
</tr>
<tr>
<td>Cancer</td>
<td>$16,400³</td>
</tr>
<tr>
<td>ESRD</td>
<td>$7,925⁴</td>
</tr>
</tbody>
</table>

## Cost of Meals for Care Transitions

- $650-$760 per patient for a 30 day contract

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² [https://www.hcup-us.ahrq.gov/reports/statbriefs/sb121.pdf](https://www.hcup-us.ahrq.gov/reports/statbriefs/sb121.pdf)

³ [https://www.hcup-us.ahrq.gov/reports/statbriefs/sb125.jsp](https://www.hcup-us.ahrq.gov/reports/statbriefs/sb125.jsp)

⁴ [http://jasn.asnjournals.org/content/11/8/1526.full.pdf](http://jasn.asnjournals.org/content/11/8/1526.full.pdf)
Initial Pilot

- HealthONE’s North Suburban Medical Center
- Congestive heart failure & chronic obstructive pulmonary disease patients
- Patients screened for malnutrition
- 3 meals/day for 30 days within 48 hours of being discharged
- Intake and exit surveys
Meals For Care Transitions Results

ZERO

30-Day Hospital Readmissions
Pilot Outcomes

How would you rate your health this week?

*Improvement defined as moving from “Poor/Fair” categories to “Good/Very Good”

117% Improvement*

267% Improvement*

How would you rate your energy this week?
Other Survey Indicators

67%

• Did receiving meals from Project Angel Heart contribute to your ability to remain at home after your hospitalization?

56%

• Has receiving meals from Project Angel Heart made a difference in your ability to afford your healthcare?
What’s Next?

- HealthONE Expansion
  - Rose Medical Center
  - The Medical Center of Aurora

- Colorado Choice Transitions Program
  - Medicaid demonstration project
  - Helping patients transition from long-term care facility back to independent living
Do Medically Tailored Meals Save Health Care Costs?

• Colorado All Payer Claims Database via Center for Improving Value In Health Care (CIVHC)

• Funds Provided by Colorado Department of Health Care Policy & Financing

• Examining
  • Medical Costs
  • ED Use
  • In-Patient Stays
  • Readmissions
Impact Study Intervention Group

- N=1474 Project Angel Heart Clients; Control Group 5000+
- Average of 7 co-occurring diagnoses

**INSURANCE COVERAGE**

- Med Adv. Duals: 9%
- Commercial: 2%

**PRIMARY DISEASE**

- Diabetes: 5%
- HIV/AIDS: 22%
- MS: 13%
- [CATEGORY NAME] [PERCENTAGE]
- [CATEGORY NAME] [PERCENTAGE]
- [CATEGORY NAME] [PERCENTAGE]
Medical Cost Savings
All Diagnoses, All Payers

Pre: $3041
Intervention: $2881
Post: $2699

Cost per Person per 30 Days
He who takes medicine and neglects diet, wastes the skill of the physician

~Ancient Chinese Proverb
"Let food be thy medicine, and let thy medicine be food."

Hippocrates
Food as Medicine

Erin Pulling
President & CEO
epulling@projectangelheart.org

#FoodIsMedicine | @proj_angelheart | Projectangelheart
diagnosis: hunger
Innovative Partnerships Between Health Care and Food Systems to Increase Healthy Food Access

Moderator: Wendy Peters Moschetti BASW, MCP
Food System Definition

• A food system is the path that food travels from field to fork.

• It includes the growing, harvesting, processing, packaging, transporting, marketing, consuming, and disposing of food. It also includes the inputs needed and outputs generated at each step.

• Influenced by people, culture, economics, politics, and the environment
What do We Mean by Food System?

Environment

Community

Value Chain

Natural resources
Capital and purchased inputs
Farms and ranches
Processors & manufactures
Wholesaler & distributors
Restaurants, institutions, & food retailers
Consumers
### Why Explore Intersections Between Food Systems & Health Care?

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Food Systems</th>
<th>Health Care Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients have access to affordable, nutritious food</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Hospital has local procurement policies</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Community benefit dollars invest in local food systems</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Increased SNAP and WIC enrollment</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sustainable practices that promote environmental protection</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Multiple Benefits for Health Care & Food Systems

- For agriculture...
  - Guaranteed markets
  - Expanded market channels to feed their neighbors
  - Access to land

- For health care providers & employees...
  - Improved food environment at work

- For communities...
  - More dollars in the local economy
  - Community food access
Multiple Benefits for Health Care & Food Systems

- For patients...
  - Food is medicine, prevention and Rx of diet related illness
  - Expanded access to affordable produce

- For hospitals...
  - Cost neutrality or cost savings
  - Meet Community Benefit requirements
A Large Menu of Options...

• Policy
  • Institutional nutritional or geographic procurement policies
  • Collaborative purchasing
  • Participate in local food policy council

• Program
  • Host farmers markets or “Farmacies”
  • Hospital farms
  • Mobile grocery
  • Community gardens, CSA

• Incentives
  • Health insurance incentives to participate in a CSA
  • Workplace wellness challenges

• Assessment
  • Participate in data collection or community food assessments
Menu Continued...

• Practice Integration
  • Conduct food insecurity screenings
  • Provide fruit & veggie Rx,
  • Refer families to food assistance programs
  • Connect patients with education and programming associated with SNAP and WIC
  • Connect populations with severe illness, post-hospitalization, disabilities, etc., to home-delivered medically tailored meals.

• Investment
  • Grant funding to community food access projects
  • Community Benefit dollars
Linda Stetter: St. Mary-Corwin Farm Stand and Prescription Pantry

What Made It Work

• Relationships! And Logistics!
  • Providers
  • Farmers
  • Volunteers
  • Marketing
  • Retail
  • Nutrition services
  • Regulators
  • Medical Records

Population & Funding Sources

• Population defined by CHNA/CHIP for alignment
• Funding from
  • Foundations, providers
  • Incentive Programs like SNAP and Double-Up Bucks
Building the Process Slowly and Making It Easy for Everyone

• Choosing and tracking for accountability:
  * Prescriptees
  * Revenue and Invoices
• Creating Scripts for Providers
• Logistical Scheduling
Growing the Outcomes

- For Providers
  Biometrics: weight, blood pressure, blood sugars
  Decreased no-shows
- For Prescriptees
  Socialization
  Behavior Changes/skills
- For the Public and Hospital Associates
  Affordable Access in a Food Desert/Swamp
The Montrose Community – Demographics

- Montrose County population 40,713 (2013)
- 20.5% Latino (2015)
- Median household income $43,999 (2015)/per capita income $23,144
- 23% of Children are considered food insecure (2015 data)
What is Local Farmacy RX?

• A program to provide assistance and education to families at risk of developing a diet-related disease.
• A partnership between nutrition educators, community food producers, and health care providers.
• A program dedicated to increasing the consumption of local fruits & vegetables and improving the health of individuals.
Goals

- Reduce barriers to fruit and vegetable intake
- Reduce BMI in overweight family members
- Increase knowledge of fruits and vegetables nutritional value
- Increase knowledge of how to cook and prepare fruits & vegetables
- Increase sales of locally-grown produce
- Increase the number of medical providers who prescribe f & v
Components

- **Fruit and Vegetable Prescriptions**: Patients receive LFRx fruit and vegetable prescriptions from Montrose and Olathe Medical Providers.

- **Cooking and Nutrition Classes**: Several recipients of the prescriptions are referred to LFRx family cooking and nutrition classes.

- **Farmacy Bucks**: Families in the classes receive weekly stipends of $30 to purchase local fruits and vegetables at the farmers market or produce stands.

- **Family Network**: After participating in the education families join together at potlucks and gatherings and encourage each other to make healthy choices.
Families who qualify:

- SNAP
- Medicare/Medicaid/CHP+
- Minimum 1 child & 1 adult
- Commit to attending Orientation & 4 of 6 evening classes

Classes:

- Biweekly over 12 weeks
- English or Spanish
- Volunteer cooking & nutrition instructors
- Cooking Matters curriculum
- 2 hour class time: 1 hour cooking, 45 min nutrition/eating
- Lessons include: nutrition, physical activity, shopping on a budget, food preservation
Pre/Post Survey highlights from 2014 & 2015

- Increased Fruit and Vegetable Servings
- Increase in Fruit and Vegetable preference
- Decrease in BMI (167.8 lbs. lost in two years)
- More families cooking together
- Expanded healthy cooking knowledge
Pre/Post Survey highlights from 2016

- 72% of families increased f & v consumption
- 17% of participants lost weight
- Participant who lost most weight lost 13.5 pounds & attributed that to healthier eating
- Increased healthy cooking/eating knowledge
LFRx Numbers to-date

- 62 Families
- 192 Participants
- 6 Classes (3 English, 2 Bilingual, 1 Spanish)
- Nearly $20,000 spent on local produce
- 2017 will be 4th program year and offer 4 classes: 3 in English, 1 in Spanish
- 72% of participants reported sustained increase from Pre-class survey to follow-up 12-24 months later
Partners:

• Govt
• Orgs
• Farmers
• Public health
• Schools
• Hospital
• CSU Ext
• Non-profits
• DHS
• Environ Health

Community Support Work Group
What we know about food insecurity in Routt County

13% of County are food insecure (3030, 2014 data)
46% food insecure and not eligible
Food Pantry serves about 1900 clients each year
28% eligible enrolled In SNAP- Hunger Free CO Impact Report

2016 LiftUp Food Pantry of Routt County Survey data:
- 30% say 10-25% of month’s food comes from food pantry
- 27% say 25-50% of month’s food comes from food pantry
- 62% worried their food would run out before could buy more
- 56% ran out of food before could buy more
- 80% of clients not using SNAP- 54% never applied; SNAP load dropped another 20% more due to new requirements.
- Top food requests: produce, dairy, protein
- Least requested foods: bakery, candy, sugar sweetened beverages
What is out of our control to increase healthy food access?
• Retailers’ donations
• Food from Food Bank
• Random community donations

What is in our control to increase healthy food access?
• Initiatives to increase produce at food pantries
• Incentives to increase healthy food selection
• Community education to increase healthy food donations
• Marketing to increase federal nutrition program enrollment and food pantry participation
Initiatives to Increase Produce

I’m planting a row for Lift-Up. Please share your bounty.

Lift-Up loves donations of fresh locally grown produce from your gardens.
970-870-8804
www.liftuprouttcounty.org
Incentives to Increase Healthy Food Selection: Point system

20 pts/person/month = 20 lbs of food
- can of veggies = 1 pt
- 1 dozen eggs = 2 pts
- fresh produce = 0 pts
- protein = 2 to 3 pts
Adopt a Shelf

How does it work?

It’s easy! Just pick a shelf you’d like to adopt, then decide whether you want to donate food or money. If you want to donate food, our staff can help you figure out how much to bring and when to bring it. If you want to donate money, we can maximize your gift by purchasing food in bulk. You can stock the shelf, if you want to be involved that way. We’ll acknowledge your generosity on the shelf you adopt. Contact our Food Bank to learn more.

Why adopt a shelf?

Your contributions help LiftUp keep food pantry shelves consistently stocked with wholesome foods.

LiftUp can use your monetary donations to buy great food at greatly-reduced prices, maximizing the impact of your contribution.

Adopting a shelf is a great way for you and your organization to get involved in our community in a meaningful way.
Adopt a Shelf- [http://liftuprc.org/adoptashelf/](http://liftuprc.org/adoptashelf/)

<table>
<thead>
<tr>
<th>ITEM</th>
<th>MONTHLY COST</th>
<th>YEARLY COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unswt Applesauce</td>
<td>$29.00</td>
<td>$348.00</td>
</tr>
<tr>
<td>Black Beans</td>
<td>$67.10</td>
<td>$805.20</td>
</tr>
<tr>
<td>Chili Beans</td>
<td>$48.13</td>
<td>$577.56</td>
</tr>
<tr>
<td>Pinto Beans</td>
<td>$51.38</td>
<td>$616.56</td>
</tr>
<tr>
<td>Refried Beans</td>
<td>$42.46</td>
<td>$509.52</td>
</tr>
<tr>
<td>Honey Rings Cereal</td>
<td>$28.65</td>
<td>$343.80</td>
</tr>
<tr>
<td>Corn Flakes</td>
<td>$26.80</td>
<td>$321.60</td>
</tr>
<tr>
<td>Mixed Fruit</td>
<td>$70.31</td>
<td>$843.72</td>
</tr>
<tr>
<td>Peach halves</td>
<td>$76.56</td>
<td>$918.72</td>
</tr>
<tr>
<td>Pear Halves</td>
<td>$54.88</td>
<td>$658.56</td>
</tr>
</tbody>
</table>
Marketing federal & local nutrition programs

Routt County Roadmap to Food Security

HOW LOCAL AND FEDERAL PROGRAMS CAN PUT FOOD ON YOUR TABLE

WHO AM I? WHAT PROGRAMS ARE AVAILABLE TO ME?

Infant-5 years: WIC, SFSP, SBP
Pregnant/Breastfeeding Woman: WIC or CSFP
6-18 years: NSLP, SBP, SFSP, At-Risk Afterschool
19-60 years: SNAP, TEFAP

Seniors: CSFP, Meals on Wheels, Congregate Meals
SNAP & TEFAP: Welcome all ages
Local Food Pantry: Welcomes all ages

FOLLOW THE ROAD TO THE OTHER SIDE TO FIND OUT MORE ABOUT EACH PROGRAM

Addressing Hunger as a Health Issue
<table>
<thead>
<tr>
<th>Program Description</th>
<th>INFANT TO 5 YEARS</th>
<th>6-18 YEARS</th>
<th>PREGNANT BREAST-FEEDING WOMEN</th>
<th>SENIOR CITIZENS</th>
<th>ALL AGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>WIC Women Infant and Children</td>
<td>✅</td>
<td>✅</td>
<td>✅</td>
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<tr>
<td>NSLP National School Lunch Program</td>
<td>✅</td>
<td>✅</td>
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<tr>
<td>SFSP Summer Food Service Program</td>
<td>✅</td>
<td>✅</td>
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<tr>
<td>SBP School Breakfast Program</td>
<td>✅</td>
<td>✅</td>
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</tr>
<tr>
<td>CSFP Commodity Supplemental Food Program</td>
<td>✅</td>
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</tr>
<tr>
<td>SNAP Supplemental Nutrition Assistance Program</td>
<td>✅</td>
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<tr>
<td>TEFAP Temporary Emergency Food Assistance Program</td>
<td>✅</td>
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<tr>
<td>Local Food Bank</td>
<td>✅</td>
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</tr>
<tr>
<td>Senior Nutrition Programs</td>
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<td>✅</td>
</tr>
</tbody>
</table>

* CACFP - a program that provides free healthy lunches for preschoolers may be available at local early childhood centers or in-home sites.

** Free family meals are available within the County. See Steamboat Today Happenings for more details.
Success =

Volunteers + Cold storage + Transportation + Communication + Marketing + Administration/Board Support + Community Support =

700%+ increase in produce (4 TONS)
Lessons Learned:

* Goal ID: choose something you can expand, rather than eliminate
* Educate with data - people want to do the “right” thing
* Simplify efforts for donors

BUY ONE, GIVE ONE.

The next time you’re at the grocery store, why not pick up some fresh produce to donate to LIFT-UP? Our clients love fruits and veggies!

Lift Up
2125 Curve Court  |  970.870.8804  |  www.liftupco.org
Resources

• NOPREN  www.nopren.org
• Healthy Food in Health Care Resources
  • http://sfbaypsr.org/what-we-do/healthy-food-in-health-care/
• Health Care Sector Support for Healthy Food Initiatives
  • http://aese.psu.edu/nercrd/publications/what-works-2014-proceedings/health-care-sector-support-for-healthy-food-initiatives-1
• Three Ways Health Care Can Transform the Food System
  • http://altarum.org/health-policy-blog/three-ways-health-care-can-transform-the-food-system
• Health Care without Harm – Hospitals and Healthy Food –
  • http://noharm.org/lib/downloads/food/Healthy_Food_in_Health_Care.pdf
• HCWH- Using Community Benefits to Improve Healthy Food Access
  • https://noharm-uscanada.org/articles/blog/us-canada/using-community-benefits-improve-healthy-food-access
• Hospitals and Healthy Food: How Health Care Institutions Can Improve Community Food Environments (2014)
  • http://www.ucsusa.org/our-work/food-
Get Involved!

Federal and State Policy Efforts

Food Systems
• Live Well Food Policy: wendymoschetti@livewellcolorado.org
• Colorado Food Systems Advisory Council (COFSAC): http://www.cofoodsystemsccouncil.org/

Food Security
• Hunger Free Co: https://www.hungerfreecolorado.org/voter-voice/
• Food Research & Action Center  www.frac.org
• COFSAC Food Security Blueprint Sign Up: wendymoschetti@livewellcolorado.org
Get Involved!

Local Policy Efforts
• HEAL (Healthy Eating Active Living) Cities & Towns Campaign
  https://livewellcolorado.org/healthy-communities/heal-cities-towns-campaign/

Food System Coalitions
• CO Food Policy Network:
  • A collective of 18 state, regional, and local food coalitions.
    • Nutrition Incentive Work Group
    • Farm to Institution Work Group
    • CO Food Systems Digital Hub
      • www.communitycommons.org CO Food Systems Hub
Get Involved!

Health System Coalitions

• Food as Medicine Coalition:
  Lauren@coloradopreventionalliance.org
  Sandra.H.Stenmark@KP.ORG