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MCH Innovations Database Practice Summary & Implementation Guidance

Building Capacity for Food Systems and Health Systems to Partner

Food pantries embedded within local communities are essential to the economic well-being of individuals and families whose circumstances make it difficult to access food as evidenced by frequency of individual visits to food pantries.



Location

Milwaukee, WI



Topic Area

Health Equity, Health Screening/Promotion, Nutrition/Physical Activity, Service Coordination/Integration



Setting

Clinical and Community



Population Focus

Child Health, Children and Youth with Special Health Care Needs, Adolescent Health, Health Care Providers, Community Based Organizations



NPM

Medical Home and Nutrition



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Section 1: Practice Summary

PRACTICE DESCRIPTION

Structural inequities are systems, structures, policies, norms, and practices that determine distribution of resources and opportunities. The structures and resources across community-based social service organizations (CBOs) and hospital and health systems are not equitable. This imbalance can affect how food systems and health systems work together in genuine and meaningful ways to address the whole health of children and families.

Cross-sector partnerships between clinics and food pantries are critical to support children and family's connection to nutrition and food resources, as well as to other benefits (e.g., TANF, SNAP, WIC) and even to a medical home. Food pantries embedded within local communities are essential to the economic well-being of individuals and families whose circumstances make it difficult to access food as evidenced by frequency of individual visits to food pantries. According to Feeding America, visits occurred an average 8.5 times a year with two-thirds who routinely accessed a pantry.^{1,2} Community-based organizations (CBOs) may have trusting relationships with individuals who routinely walk through their doors. This relationship can offer the potential to better identify risk factors contributing to poor health beyond the reach of clinicians who often do not go into the community.⁸

Health systems have been increasing their attention, resources, and long-term strategies towards addressing social and economic factors that affect health. This is evidenced by growing initiatives from hospitals and clinics across WI who are in various stages of implementing social needs screening and referral processes that include use of technologies. While organizations like community food pantries are important assets, national reports and local stories indicate variation and limitations in how these organizations are included in planning or implementation of screening and referral structures.

Some CBOs are asked to become recipients of a referral after a technology infrastructure is in place, others may have no awareness of the healthcare system entry into the social services sector. Without inclusion of CBOs experts to inform health systems about how their organization (and the food system operates), and a co-creation of screening and referral processes, misalignment across the clinic and community will occur. Clinical providers looking to implement strategies for addressing food insecurity would benefit from conversations with CBOs.

Hogg-Graham et al provides research, background and unintended consequences (including misalignment) if CBO voice and expertise are not included from the beginning.

Approximately 20.7% of Wisconsin children are food insecure and nearly one in five or 19.1% of Wisconsin children have a special health care need.^{3,4} Children and youth with special healthcare needs (CYSHCN) are at high risk of experiencing food insecurity, and food insecurity places children at risk for adverse health conditions. In Milwaukee, WI, the rates of children experiencing food insecurity has increased to 25.5% in 2022.

Health systems have been increasing their efforts to screen for food insecurity and refer children to community-based organizations. Technology has predominately been the route from a health system perspective to 'solve' for some of the pressing social and economic factors (using a biomedical model) to address. In Wisconsin, a number of health systems have been moving forward with technology but very few are engaging community-based organizations whose mission and expertise is food and nutrition security.



During informal interviews with local health systems about their SDoH efforts and engagement with community-based organizations, many reported that they had not connected with CBOs or were not sure how. During informal interviews with community-based organizations, many had reported little to no knowledge about the role or increasing efforts of health systems to identify and address food insecurity or other determinants of health.

When families are screened in clinical settings and referred to community-based social services, it is important to ensure that the handoff is smooth for families and organizations. This connection can happen when different organization work together to coordinate services. Working together in meaningful ways necessitates that organizations build trust, understanding as a path to co-creating services and supports for families.

What this practice intends to accomplish:

Short-term goal: Strengthened communication across food banks, food pantries and primary care clinics to increase food security and health of children and youth

Long-term goal: Development of integrated community and clinical systems to address the health and well-being of children, youth and their families.

CORE COMPONENTS & PRACTICE ACTIVITIES

The short-term goal of our practice was to strengthen communication across food banks, food pantries and primary care clinics to increase food security and health of children and youth. We did by utilizing a neutral convener/facilitator to bring a small group of organizations together in Milwaukee. The core components of this approach included a neutral facilitator, funding to support partner time and expertise, buy-in and ongoing relationship building with both community based organizational and health care partner leadership, development of a yearlong learning community and an evaluator to conduct baseline evaluation (both qualitative and quantitative), support development of shared goals and ongoing monitoring of progress.

Core Components & Practice Activities		
Core Component	Activities	Operational Details
Buy-in from leadership in clinical and community organizations	Building awareness with entities about the why they should dedicate time and staff as well as the value proposition	Meeting with population health leaders at health systems to build their awareness of why the approach is important and how it aligns with their strategic and business goals Meeting with Community Based organizations who are trusted by the population and take a holistic approach with community



<p>Learning Community</p>	<p>Create space for partners to learn about one another, how each 'system' works, and how each works with and serves kids and families</p>	<p>Develop virtual or in person meetings over the course of the first year of bringing partners together. The goal is for partners to teach others about their organization and their work to build awareness and break down perceptions.</p> <p>A) This should be guided with questions from the facilitator. B) Questions for each sector should be parallel and include how each sector might see themselves leveraging the expertise of the other sector (for example: What are your challenges for referral and screening; How might food system partners help address the challenges?)</p>
<p>Partnerships with community-based organizations and health/hospital systems</p>	<p>Ongoing relationship development with partners to learn about them, their organization and what capacity building means for them</p>	<p>1) Create monthly check-in's which can be in person/virtual to build awareness of each partners work and how their work connects to another 2) Connect with food system experts in the local community to learn about their priorities, strengths and areas they are focused on</p>
<p>Funding</p>	<p>Provide funding for community partners time, expertise, and commitment</p>	<p>Title V MCH funding provided funding through contract for 2 years of this project (2021&2022)</p>
<p>Project Lead/Champion</p>	<p>1) Provide structure, framework, serve as lead for the learning community 2) "translate" information across sectors 3) develop roles and responsibilities for group 4) create communication channel across all partners</p>	<p>1) Provide background, the why along with goals and objectives 2) Create a timeline/meeting for a calendar year to support the structured learning and sharing 3) Monthly meetings with individual partners 4) Work in partnership with evaluator to plan and make changes based on evidence 5) Facilitate conversations with partners</p>
<p>Evaluation</p>	<p>Support planning of pilot 2) conduct baseline interviews to gauge perceptions/experience 3) guide development of shared goals and measures 3) conduct annual surveys and monitor</p>	<p>1) Meeting every 2 weeks with project director 2) Planning evaluation and measurement components 3) Sharing/analyzing data and guiding next steps based on data</p>



progress towards goals 4)
development of 5 year evaluation

4) Meeting planning

HEALTH EQUITY

The practice is working several ways towards addressing structural inequities:

- Funding for community-based organization time, expertise
- Taking a relational approach to build and improve the quality of connections and communication, especially among those with differing histories and viewpoints. This approach means bringing different voices to address the same problem
- Shared decision making in programmatic approaches (working with partners to connect to one another and co-design approaches)
- Creating a space that elevates as each partner as both experts with much to teach as well as those with much to learn

EVIDENCE OF EFFECTIVENESS

In year one (2021):

- Signs of commitment to building relationships
- By the end of 2021, the partners had developed shared goals and shared commitment to working together in 2022
- Children's executive leader joined Friedens Food Pantry Board
- Partners took time to visit each other sites and to have open conversations about their strengths and opportunities to improve
- Partners showed up at each other's event (i.e. fundraiser for Friedens Food Pantry, Children's WI event where Friedens Food Pantry joined; Feeding America EW was able set up food distribution at Children's WI clinic site following 4-5 day summer power outage in the city)

In the second year (2022):

- Partners are working on shared goals, and figuring out how to create processes together
- The partnership applied for a 3-year grant together. While not funded, all were committed to planning and working together for a longer time period
- Trust and willingness to share data across sectors, using a neutral evaluator



Section 2: Implementation Guidance

COLLABORATORS AND PARTNERS

Practice Collaborators and Partners		
Partner/Collaborator	How are they involved in decision-making throughout practice processes?	Does this stakeholder have lived experience/come from a community impacted by the practice?
Children's WI Health System and Hospitals (CW)	This organization has a focus and interest on addressing food insecurity for the kids and families they serve. Several of the primary care clinics had some experience screening children for food insecurity and working to determine how they could 'close the loop'. In addition, CW purchased technology to support screen and referral processes for a community information exchange that is being developed in Milwaukee	This organization works with children from across WI to provide healthcare. They have initiatives focused on addressing the experience of food insecurity of families who come into the emergency department; with their health plan, and in primary care.
Friedens Food Pantry	This organization is one of the largest food pantries in the city of Milwaukee; it has a holistic (and relational) approach to address hunger, food security and the health of their community. The model in the food pantry has components of the Canadian community food center	This organization runs four community food centers and has been around since 1978. The Executive Director and key partner is a community organizer by background and works closely with community members that the organization serves. Friedens strives to leverage food to build relationships and address the holistic needs of community members
Feeding America Eastern WI (FA EW)	FA EW has expertise and focus in public policies (food/nutrition), statewide connections to member	This organization works with families who have lived experience and works directly



	<p>pantries across the city of Milwaukee and state.</p> <p>They also play a significant role in assisting with SNAP enrollment for families and have a commitment to address health and hunger</p>	<p>with community members to enroll in SNAP benefits</p>
<p>Children’s Health Alliance of Wisconsin (the Alliance)</p>	<p>The Alliance is a statewide organization that advocates for children. We serve as a convener, facilitator and offer training and technical support to LPHDs, community organizations and health systems. We also serve as recruiter and connector of partners working in different sectors</p>	<p>This organization works with organizations and professionals and has been doing so for 25 years. This organization has been a partner of WI DHS and was developed by WI DHS.</p>
<p>Data You Can Use (DYCU)</p>	<p>Evaluator and the local data intermediary associated with the Milwaukee partner in the Urban Institute's National Neighborhood Indicators Partnership (NNIP), an early partner in the use of RWJ's Places data, as well as being a national leader in engaging residents in the use of data</p>	<p>This partner focuses their evaluation work with local communities and neighborhoods throughout the city and has strong relationships with a variety of community-based organizations and community leaders.</p>
<p>WI Department of Health Services (WI DHS)</p>	<p>This project was made possible through our partnership with DHS who secured 2021 and 2022 contract funds provided by Wisconsin DHS Title V Program</p>	

REPLICATION

This practice has not been replicated at this time. This practice is still in development.



INTERNAL CAPACITY

Personnel types

Health system:

- Population Health Leaders (Manager/Director)
- Primary Care Leadership (Including a physician/Clinic manager/Director)
- Include staff that work directly with families

Community Food Systems:

- Food Pantry leaders (2 different food pantries)
- Food Bank leaders (who have a policy/advocacy role) at least one food bank in the community that has a multi-county footprint

Evaluator: One evaluator whose expertise and practices is in working with community

Supports needed:

- From the Health system: needed buy in from the health system to spend year 1 learning and building relationships with food system leaders. Needed to know that the organization has a commitment to address food insecurity
- Food System: needed food system leaders that were interested in addressing food Insecurity broadly, were open to trying new approaches, had the time to commit to learning/working with a health system
- The Alliance staff built relationships and built understanding with each of the partners individually as part of the recruitment process. There was 6-8 months of time dedicated to this process before launching the pilot work together.

Capacity Needed:

- More diversity in food pantry/food system leaders, each pantry is unique and serves families by zip code. We had two pantry leaders in Year 1 and 1 pantry leader in the second year. Also would have been ideal to have more than one representative from the organizations.
- Communications expert to share stories of progress and build awareness of the importation of the foundation work to build relationships (before co-creating work together).
- Clinic staff or clinicians who are working directly with patients

Time Allocated:

- The Alliance team spent approximately an average of .4 FTEs on this practice
- Partners were asked to dedicate 2-4 hours/month in year one. Over the course of the second year, partners devoted more time to 1:1 with one and to work on shared goals. This was approximately 8-10 hours/month



PRACTICE TIMELINE

Phase: Planning/Pre-Implementation		
Activity Description	Time Needed	Responsible Party
Development of Framework. This should include a background, goals and objectives outlining how partners can work together	1 month	The Alliance
Outreach and recruitment of partners in food system (this includes time to build relationships, build understanding of goals and sharing of framework). As well as building your understanding of their organization	This can take 8-10 or more months and remains ongoing	The Alliance
Outreach and recruitment of partners in the healthcare system (this includes time to build relationships, build understanding of goals and sharing of framework). As well as building your understanding of their organization	This can take 8-10 or more months and remains ongoing	The Alliance
Identify Evaluation partner. Share framework goals and begin planning with the Evaluator.	Once evaluator is identified, this is ongoing	The Alliance
Develop and share 1st year timeline for partners that includes shared learning. Develop and share charter to highlight roles and responsibilities for each partner	1 week	The Alliance



For information on the practice implementation timeline and specific practice activities, please contact Geeta Wadhvani at gwadhvani@childrenswi.org.

PRACTICE COST

These expenses are for Year 1. These expenses changed in Year 2 as more time is being committed to the project.

Budget			
Activity/Item	Brief Description	Quantity	Total
Time and expertise of each food pantry partner	This was based on available funding	1-2 team leads (from 2 different organizations)	\$30,000
Time and expertise of food bank partner	This was based on available funding	1-2 team leads	\$15,000
Time and expertise for Evaluator	This was based on available funding	1 Evaluation expert	\$10,000
Time and expertise for the health care partner	This was based on available funding		\$10,000
Meals for meetings	We were virtual In Year 1. But recommend funding for meals as meetings were scheduled over lunch	3-4 meals/for 15 people	\$600
Total Amount:			\$65,000



LESSONS LEARNED

There have been many lessons learned over the last 2 years. Each partner has lessons to share as well as the Alliance, who serves as the convener/facilitator. A few lessons are highlighted below.

- Facilitators are important to bring different organization types together. ‘Translation’ of sector language and work important to build understanding of how different sectors can be linked.
- Need for shared language. Each sector has their own terminology leading to ‘acronym soup.’
- There is complexity to bring two sectors together.
- Partners were able to build trust through informal 1:1 conversations.
- Powerful to have honest conversations about each other’s work including what is going well and where things could be better.
- Collaboration across sectors has to start at a very basic level. Questions like what does building capacity mean for you must be asked. For food system, it does not mean needing food.
- Healthcare systems move very fast and jump to conclusions about best ways to create change. “We need to utilize expertise of those already doing the work.”

Connecting with large health systems is difficult if you do not know where to go. For small CBOs, it is easy to identify who to connect with as the information is on website and there is small staff. Some partners did not understand the focus on relationship building vs. ‘doing something.’ In order to address this concern, I had informal conversations to discuss with partners and share the thinking behind the approach. The desire to move faster required reminding team that we were focused on relationship building

It took a lot of time to get buy-in for a health system to want to take this relational first approach. I reached out to at least four other health systems to gauge their interest in participating. It took a number of months before receiving confirmation of interest and participation from Children’s WI. It was much faster to gain buy in with community organizations.

We lost one partner who was not engaged, the organization showed up for scheduled meetings in 2021 but did not engage outside of scheduled meetings. This work requires both formal gatherings to share/learn and informal conversations to go deeper. It requires intentionality and dedication to build the relationships with partners and should not include an agenda. After the first year, I attempted to have conversations with organizational leadership to better understand how they want to be involved but was not successful.

The partner that was ‘lost’ was last to join. We did not have the opportunity to know one another and for the partner to understand what they were getting involved in. Another colleague recommended this organization and they quickly joined, unfortunately, it was more transactional and should have been relational. That is the piece that has created strong bonds between the partners.

We also learned about communication and how that needed to occur both more frequently, that we needed a glossary of terms to help all understand.



NEXT STEPS

We are building upon the trust and understanding of how each of the sector works to figure out how to deepen the collaboration for the benefit of children and families served. In 2023, we will be working on several next steps:

Use Cases will be developed with Children's WI and Friedens Food Pantry. The purpose is to determine how clinics and pantries can work better together. Use cases are a way to start building a case for sharing information. A use case is like a compilation of many case studies but with a structured format that can be compared across organizations. Data You Can Use will conduct the analysis. This process will give organizations insight into what information each has, what they need and don't have and what might be missing.

Data Sharing: Friedens, Feeding America, and Children's WI have agreed to share some data with a goal to learn if/where there are mutually served populations. Data You Can Use will conduct the analysis. We plan to conduct some scoping of the process early in 2023.

FoodShare (SNAP) Outreach pilot: Feeding America will provide training and support to ensure enrollment in FoodShare. An Outreach Specialist will be embedded in primary care to support enrollment as well as a telephonic follow-up model. We will take a quality improvement approach to determine what steps are needed.

Additional Steps include:

- One improvement made in 2022 was on communication. Much of the relationship and trust building work occurred in informal ways, out of which came discussions of how partners would together. This progress was not broadly known and in 2022, we committed to biweekly updates to keep everyone updated on progress, challenges and learning opportunities.
- We will be including a local Public Health Department Strategist whose focus is on food security
- Applying for grant funds together to continue our work
- Another modification we will be making in the future is to gauge interest by additional food system partners to build a broader network of partners.

RESOURCES PROVIDED

Included is a [link](#) to the Project timeline, charter, framework and goals as well as recordings of year one meetings.



APPENDIX

References:

¹State of Minnesota. Income and Health. Retrieved on March 31, 2020 from <http://www.health.state.mn.us/divs/opa/2014incomeandhealth.pdf>

²Feeding America. Hunger in America. Retrieved on April 12, 2020 from <http://help.feedingamerica.org/HungerInAmerica/hunger-in-america-2014-full-report.pdf>

³Child and Adolescent Health Measurement Initiative. 2017-2018 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved April 7, 2020 from www.childhealthdata.org.

⁴Mattson G, Kuo DZ, AAP COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH, AAP COUNCIL ON CHILDREN WITH DISABILITIES. Psychosocial Factors in Children and Youth With Special Health Care Needs and Their Families. *Pediatrics*. 2019; 143(1):e20183171

⁵Hogg-Graham R, Edwards K, L Ely T, Mochizuki M, Varda D. Exploring the capacity of community-based organisations to absorb health system patient referrals for unmet social needs. *Health Soc Care Community*. 2021 Mar;29(2):487-495. doi: 10.1111/hsc.13109. Epub 2020 Jul 27. PMID: 32716100.

