American Academy of Pediatrics

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NO KID HUNGRY by SHARE OUR STRENGTH

Building Pediatrician Capacity to Address Food Insecurity

Midpoint Progress

IMPACT REPORT

State-Level Transformation:

AAP Chapter Projects

STATE CHAPTER PROJECTS

By the Numbers

American Academy of Pediatrics

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2022-2023

88 New Partnerships Created

13 Educational Materials Created

16 Educational Opportunities Offered

2,498 Participants at Educational Opportunities

4 Future Educational Opportunities Planned

ARIZONA CHAPTER

2022-2023 COHORT

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Our goals are:

- Educating providers on local and federal food security resources
- Improve provider confidence on screening for food insecurity
- Encourage providers to explore the numerous ways they can be involved in distributing food to patients, including running a food drive or pantry out of their practice

Our project successes:

"We have been able to establish numerous community partnerships, which opens the door to potential projects and membership opportunities."

"I joined a School Nutrition Advocacy group and had a new connection ask me directly in the meeting if we could connect outside of the group to further discuss the partnership! I am excited to continue connecting our members to these resources that they may not have found on their own."

Our key challenges:

- Keeping partners engaged as they work through planning stages of the project

Our future educational opportunities:

Webinar to expand knowledge on current resources to connect patients to

Resource Hub on the AAP Arizona chapter website

Social media campaign on the AAP Arizona chapter twitter page

ARKANSAS CHAPTER

2022-2023 COHORT

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Our goals are:

- Up to ten pediatricians and team will be selected to participate in the AAP's ECHO project focused on improving screening and referral for food insecurity
- Build upon the new relationship with Arkansas WIC; identify areas of the state with lower WIC participation and connect with a local pediatrician
- Continue to collaborate with No Kid Hungry Campaign in Arkansas
- Explore offering 2-3 technical assistance webinars to participants or members at large on issues such as starting a dry-goods pantry on-site, closed loop referrals, or family-focused communication strategies.

Our project successes:

"We have been able to have pediatric clinics participate in the AAP ECHO. We have been able to continue to build a relationship with local WIC offices and pediatricians. We are able to educate our members on food insecurity topics."

"We are proud of the meetings between WIC offices and pediatric clinics. Everyone has learned a great deal from these meetings and we believe that the WIC representatives will have an ongoing relationship with pediatric clinics even after this grant ends."

Our key challenges:

- Many of our clinic and WIC meetings were supposed to be in person but were virtual instead

Our educational opportunities:

Five pediatric teams are participating in the AAP Food Insecurity ECHO

Attended 8 WIC clinic meetings

COLORADO CHAPTER

2022-2023 COHORT

American Academy of Pediatrics

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Our goals are:

- Development of a Health Care/ Colorado WIC (COWIC) Collaborative
- Pediatric Care Network (PCN) Navigation Support
- Disseminate learnings from community organizations and healthcare system to other healthcare teams and providers.
- Partnering with the Colorado School of Medicine Pediatric residency program

Our project successes:

"One of our greatest success stories is the formation of a new relationship between AAP-CO, PCN, and Adams Co WIC. With the help of BTEH connections, AAP-CO, PCN, and Adams County WIC are joining together to apply for a CIAO grant in an attempt to support testing of improved integration of Adams Co WIC with Adams Co PCN offices.

"Another success story has been the growth of membership and depth of discussion at the HC (health care)/COWIC collaborative meetings. With 18 in attendance at our March 6 meeting, we are expanding connections, improving awareness, and working to overcome barriers to connecting families to COWIC.

Our key challenges:

- WIC, healthcare representatives, and connector agency representatives all acknowledge that the current WIC referral to enrollment rates are suboptimal (30-33% per WIC e-referral data). Healthcare and connector organizations are currently undertaking the following: (1) encouraging families to follow-up on referrals with a phone call to the WIC agency, (2) encouraging families to answer all phone calls from unknown numbers after a WIC referral as the caller might be COWIC, (3) providing referred families with up to 4 re-connections from the referring healthcare or connector organization to check on the status of a WIC referral, and (4) incentivizing families (with a grocery gift card) to reconnect with the health navigator for status updates after a referral. These processes are cumbersome and likely unsustainable, and we need to identify and undertake more efficient solutions.

COLORADO CHAPTER CONT.

2022-2023 COHORT

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Our educational opportunities:

Health Care/Colorado WIC Collaborative Meeting (03/06/23)

Health Care/Colorado WIC Collaborative Meeting (12/08/22)

Our educational material:

- Healthcare/COWIC Membership Survey Presentation
  - Link: bit.ly/3z9dMav
- AAP-CO e-newsletter update on 2/1/23
  - Link: http://bit.ly/3TM81Jg
- Bright by Text text messaging on food security (including messaging in partnership with No Kid Hungry- see below example)
  - Link: http://bit.ly/3z8Kgli
- COWIC Focus Group Invitation
  - https://bit.ly/3FZpR5Z

***Pictures are of residents at Children's Hospital Colorado taking the Food is Medicine elective, sponsored by this project.**

D.C. CHAPTER

2022-2023 COHORT

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NO KID HUNGRY by SHARE OUR STRENGTH

Our goals are:

- Create a process for WIC to receive provider referrals and open bi-directional communication
- Implement clinical-community closed loop referrals from a pediatric clinic in a large health system to a community organization

Our project successes:

"Development of an online referral form that is received at the DC WIC State Agency, and processed through the local agencies. Feedback regarding information for pediatricians, the need for a streamlined referral system has impacted some changes to this online referral form, and led to the development of discussions of a more developed online referral system that integrates with the electronic medical record. Without this grant, and the backing of the AAP, this may have not been as welcomed by WIC.

Our key challenges:

- Creating a system that allows for bi-directional communication and access to referrals that are tied to the electronic health record system has proved challenging due to the need to have strict data agreements between organizations
- Staffing at the WIC agencies is limited, and the personnel needed to support a more robust referral process has been challenging for them
- Sustainability of the project was explored through the WIC CIAO Grant. However, DC AAP deferred to DC WIC, who in the end decided not to pursue this this year. This is something DC WIC would like to pursue in the future but could impact longevity of the project
- With a switch to EBT cards at DC WIC, patients had to come in-person for education on the new form of the benefit. This added a barrier of an additional in-person element to receiving the benefit, and may impact overall WIC enrollment during this period of time

D.C. CHAPTER CONT.

2022-2023 COHORT

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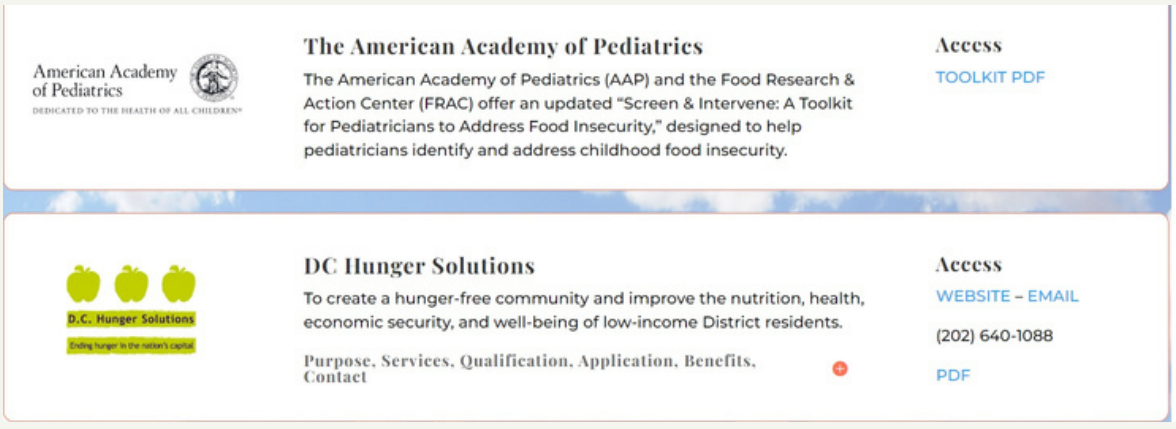
Our educational opportunities:

- DC AAP Food Insecurity Symposium (May 2022)
- PAS (Pediatric Academic Society) 2022 Poster Presentation
- APA platform presentation
- Upcoming PAS 2023 poster

Our educational material:

- Added the food insecurity toolkit and hand out to the AAP DC website
  - DC AAP Website: https://www.aapdc.org/food-insecurity/



FLORIDA CHAPTER

2022-2023 COHORT

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Our goals are:

- Identify and meet with state and local organizations doing work related to food insecurity in children
- Identify existing resources and services to address food insecurity in children
- Create a resource guide / toolkit to help physicians guide their patients who are food insecure to existing resources and services
- Distribute the resource guide / toolkit and educate pediatricians about what is available to them to help their patients

Our project successes:

"Connect with partner organizations working to address food insecurity to collaborate on a collective project"

Our key challenges:

- Identifying representatives from each organization willing/available to meet with us
- Finding times to host collaborative meetings with so many people

*Chapter's contract started January 1st, 2023

GEORGIA CHAPTER

2022-2023 COHORT

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Our goals are:

- Our goal is to explore the capacity of tracking and establishing direct referrals with Georgia WIC
- Provide Food Insecurity resource and outreach materials to pediatricians in the state

Our project successes:

"[Been able to accomplish] The support and credibility to encourage WIC to do more with referrals and show the impact it can make on reducing food insecurity and increasing enrollment for WIC."

Our key challenges:

- Change in WIC Director and priority of exploring/developing a closed loop referral system for WIC

Our educational opportunities:

Food Insecurity Webinar May 2023

Our educational material:

Physicians Guide to Food Insecurity Resources in Georgia*

***This item was mailed to all Georgia AAP members. A copy of the guide follows this page.**

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Georgia Chapter

Physician's Guide to Georgia Food Insecurity Resources

The following is a brief guide to Federal nutrition programs and regional food banks in Georgia. Connecting patients and their families to the federal nutrition programs and other food resources can make an enormous impact on the health of Georgia's families.

Resource	Target Population	Program Overview	Financial or Other Eligibility Requirements	Contact Information
Federal Nutrition Programs Providing nutrition and high-quality foods to aid families in need				
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	Pregnant, post-partum, nursing mothers, infants & children up to age 5	Special supplemental nutrition program that provides nutrition assessment and education, breastfeeding support, monthly food vouchers and refers applicants to available health and social services.	Georgia residents with Income ≤185% of Federal Poverty Level & have a nutritional risk	800-228-9173 wic.ga.gov Clinic directory available online for each county Or use Georgia Gateway gateway.ga.gov/access/
Supplemental Nutrition Assistance Program (SNAP)	All ages	Monthly benefits to purchase food at grocery stores, farmers' markets, and food retail outlets across the country that accept SNAP Benefits loaded onto an EBT card (much like a debit card) The average benefit is about $29 for the week per person – or about $1.39 per person, per meal.	Gross income typically at 130% of the federal poverty level but can be higher in some states (SNAP income eligibility guidelines at: https://www.fns.usda.gov/snap/eligibility) Many low-income employed individuals SNAP has restrictions on which non-citizens are eligible.	877-423-4746 https://dfcs.georgia.gov/about-us/faq#DFCS14 Or use Georgia Gateway gateway.ga.gov/access/
National School Lunch Program AND School Breakfast Program	Children at participating schools	Free, reduced-priced, or paid school meals in participating schools Meals meet federal nutrition standards, which require schools to serve more whole grains, fruits, and vegetables.	Children of families at low or moderate income levels can qualify for free or reduced-price meals. Free to all students at schools adopting community eligibility, which allows schools with high numbers of low-income children to offer free breakfast and lunch to all students without collecting school meal applications	404-656-6292 https://snp.gadoe.org/Programs/Pages/Lunch.aspx https://www.benefitsapplication.com/program_info/GA/National%20School%20Lunch%20Program

Resource	Target Population	Program Overview	Financial or Other Eligibility Requirements	Contact Information
Child and Adult Care Food Program (CACFP)	Typically, children up to age 5	Up to two free meals and a snack to infants and young children at child care centers and homes, Head Start, and Early Head Start CACFP can provide meals to children 18 and under at emergency shelters. Updated nutrition standards provide healthier meals.	Children attending eligible child care centers and homes, Head Start, and Early Head Start	404-657-1779 http://www.decal.ga.gov/cacfp/Applicant.aspx
Afterschool Nutrition Programs (Available through CACFP or the National School Lunch Program)	Children 18 and under	Free, healthy snacks and/or meals meeting federal nutrition standards in enrichment programs running afterschool, on weekends, or during school holidays	Children can access free meals at participating enrichment programs offered at community sites, including schools, park and recreation centers, libraries, faith-based organizations, or community centers.	404-657-1779 https://snp.gadoe.org/Programs/Pages/Afterschool-Snack.aspx
Summer Nutrition Programs	Children 18 and under	Up to two free meals at approved school and community sites during summer vacation Meals must meet app	Children can access meals at participating community sites, which can include schools, park and recreation centers, libraries, faith-based organizations, or community centers. There is no need to show identification.	404-657-1779 decal.ga.gov Happy Helpings https://www.decal.ga.gov/SFSP/Applicant.aspx#:~:text=Happy%20Helpings%20is%20a%20USDA,schools%20are%20closed%20for%20vacation.
Georgia Food Bank Association Comprised of seven regional food banks working to end hunger in their local communities				
Food Bank of Northeast Georgia	All ages	The Food Bank of Northeast Georgia is a 501(c)3 that gathers donated items and purchased surplus food and distributes it to human-service agencies. These smaller non-profits then distribute that food to local community members in need. The Food Bank works with local, regional, state, and national product partners to bring food into the community. These partner agencies are located throughout our 14-county service area in northeast Georgia. Visit website for food distribution schedule to pantries.	No eligibility requirement	(706) 354-8191 https://foodbanknega.org/network/ SERVING Banks, Barrow, Clarke, Franklin, Habersham, Hart, Jackson, Madison, Oconee, Oglethorpe, Rabun, Stephens Towns, & White
Golden Harvest Food Bank	All ages	They source healthy foods through partnerships with local retailers, farmers, and food manufacturers. They sort, pack, store, and distribute the food at our two warehouse facilities in Augusta, GA and Aiken, SC. They provide food to over 300 partner agencies and programs in 25 counties and serve the hungry directly through our programs. For the closest pantry, visit their website.	No eligibility requirement	(706) 736-1199 https://goldenharvest.org/find-help/food-finder/ SERVING Burke, Columbia, Elbert, Emanuel, Glascock, Greene, Hancock, Jefferson, Jenkins, Johnson, Lincoln, Mc Duffie, Putnam, Richmond, Screven, Taliaferro, Warren, Washington, & Wilkes

Resource	Target Population	Program Overview	Financial or Other Eligibility Requirements	Contact Information
America's Second Harvest of Coastal Georgia	All ages	Gathers donated items and purchased surplus food and distributes it to human-service agencies. These smaller non-profits then distribute that food to local community members in need. The Food Bank works with local, regional, state, and national product partners to bring food into the community.	No eligibility requirement	912.236.6750 https://www.helpendhunger.org/find-food-assistance/ SERVING Appling, Bacon, Brantley, Bryan, Bulloch, Camden, Candler, Charlton, Chatham, Effingham, Evans, Glynn, Jeff, Davis, Liberty, Long, McIntosh, Montgomery, Pierce, Tattnall, Toombs, & Wayne
Middle Georgia Community Food Bank	All ages	Serves 24 counties in middle Georgia that gathers donated items and purchased surplus food and distributes it to human-service agencies. These smaller non-profits then distribute that food to local community members in need. The Food Bank works with local, regional, state, and national product partners to bring food into the community.	No eligibility requirement	478-742-3958 https://mgcfb.org/find-healthy-food/ SERVING Baldwin, Bibb, Bleckley, Crawford, Dodge, Dooly, Houston, Jasper, Jones, Lamar, Laurens, Macon, Monroe, Peach, Pike, Pulaski, Taylor, Telfair, Truetlen, Twiggs, Upson, Wheeler, Wilcox, & Wilkinson
Feeding the Valley	All ages	Feeding the Valley Food Bank is one of eight regional food banks in Georgia and is a member of Feeding Georgia (formerly the Georgia Food Bank Association). We are also a member of the Feeding America network of food banks, the national network of food banks, and our nation's leading hunger-relief organization.	No eligibility requirement	706-561-4755 https://feedingthevalley.org/ SERVING West Georgia: Calhoun, Chattahoochee, Clay, Dougherty, Harris, Lee, Marion, Meriwether, Muscogee, Quitman, Randolph, Schley, Stewart, Talbot, Troup, Terrell & Webster
Atlanta Community Food Bank	All ages	Serves as the central hub in the fight against hunger in Atlanta and north Georgia. Our primary function is collecting and distributing donated food and goods and managing all of the logistics and partner relationships that go with it. But we also offer some social services directly to those in need. And we even have some supplemental food pantries and mobile markets of our own to get food to underserved areas our partner agencies can't reach.	No eligibility requirement	404-892-3333 https://www.acfb.org/get-help/ SERVING Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Floyd, Forsyth, Fulton, Gwinnett, Hall, Haralson, Heard, Henry, Lumpkin, Morgan, Newton, Paulding, Pickens, Polk, Rockdale, Spalding, Union, & Walton

Resource	Target Population	Program Overview	Financial or Other Eligibility Requirements	Contact Information
Chattanooga Area Food Bank	All ages	Gathers donated items and purchased surplus food and distributes it to human-service agencies. These smaller non-profits then distribute that food to local community members in need. The Food Bank works with local, regional, state, and national product partners to bring food into the community.	No eligibility requirement	(423) 622-1800 Northwest Georgia Branch Dalton, GA (706) 508-8591 https://chattfoodbank.org/hungry#panel RECEIVE EMERGENCY FOOD ASSISTANCE If you live in Hamilton County, dial 211 or text your zip code to 898-211 to request a voucher for an emergency food box. SERVING Catoosa, Chattooga, Dade, Fannin, Gilmer, Gordon, Murray, Walker, & Whitfield
Feeding America affiliate serving south Georgia	All ages	Gathers donated items and purchased surplus food and distributes it to human-service agencies. These smaller non-profits then distribute that food to local community members in need. The Food Bank works with local, regional, state, and national product partners to bring food into the community.	No eligibility requirement	229.244.2678 www.feedingsga.org https://feedingsga.org/find-pantry/ SERVING Atkinson GA, Baker GA, Ben Hill GA, Berrien GA, Brooks GA, Clinch GA, Coffee GA, Colquitt GA, Cook GA, Crisp GA, Decatur GA, Early GA, Echols GA, Grady GA, Irwin GA, Lanier GA, Lowndes GA, Miller GA, Mitchell GA, Seminole GA, Sumter GA, Thomas GA, Tift GA, Turner GA, Ware GA, Worth GA
Food Bank of Northeast Georgia	All ages	The Food Bank of Northeast Georgia is a 501(c)3 that gathers donated items and purchased surplus food and distributes it to human-service agencies. These smaller non-profits then distribute that food to local community members in need. The Food Bank works with local, regional, state, and national product partners to bring food into the community. These partner agencies are located throughout our 14-county service area in northeast Georgia. Visit website for food distribution schedule to pantries.	No eligibility requirement	(706) 354-8191 https://foodbanknega.org/network/ SERVING Banks, Barrow, Clarke, Franklin, Habersham, Hart, Jackson, Madison, Oconee, Oglethorpe, Rabun, Stephens, Towns , & White

ILLINOIS CHAPTER

2022-2023 COHORT

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Our goals are:

- Implement food insecurity screening and referral at a pediatric residency clinic
- Present training on food insecurity and distribute associated resources to increase pediatrician efficacy to address food insecurity and connection to local food resources
- Partner with Illinois Department of Human Services (IDHS) to maximize utilization of nutrition programs and associated benefits
- Increase the Illinois Partnership for Child Nutrition Security's collective impact by collaborating with and advancing equitable systems change prioritized by Partnership organizations

Our project successes:

"ICAAP has been able to expand on the work done in the previous year that would not have been possible without this grant opportunity. In year one of the grant, ICAAP formed over 30 partnerships with organizations working in the food security sector. In year two, we have been able to strengthen those partnerships, form new ones, and identify new and innovative ways that pediatricians can support food security in Illinois. ICAAP has been able to provide food insecurity education and also develop WIC education specifically for pediatricians through this grant."

Our key challenges:

- We have found it challenging to find practices that have an established process for implementing food insecurity screening and referral

ILLINOIS CHAPTER CONT.

2022-2023 COHORT

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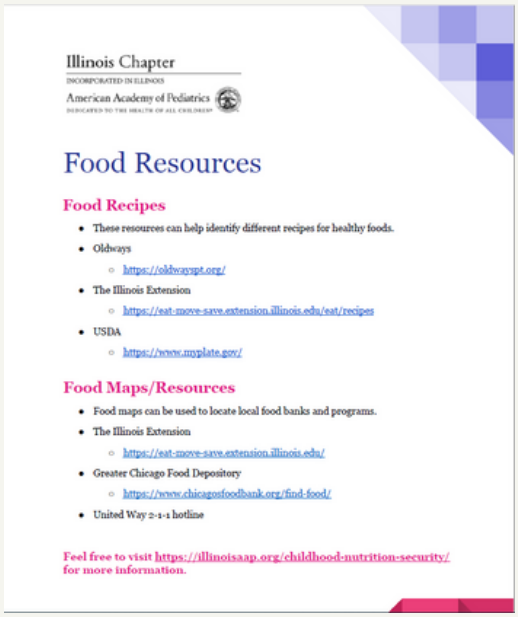
Our educational opportunities:

- SIU School of Medicine Grand Rounds Presentation by Dr. Enas Shanshen
- Presentation to Cook County Health Residents by Dr. Alisa Seo-Lee
- ICAAP At-Large Webinar Presented by Dr. Alisa Seo-Lee

Our educational material:

- Article in January 2023 Edition of Illinois Pediatrician
- Illinois Partnership for Childhood Nutrition Security Collective Impact Plan
- Food Resources in Illinois Flyer (still in development)

*These items will follow this page



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Food Resources

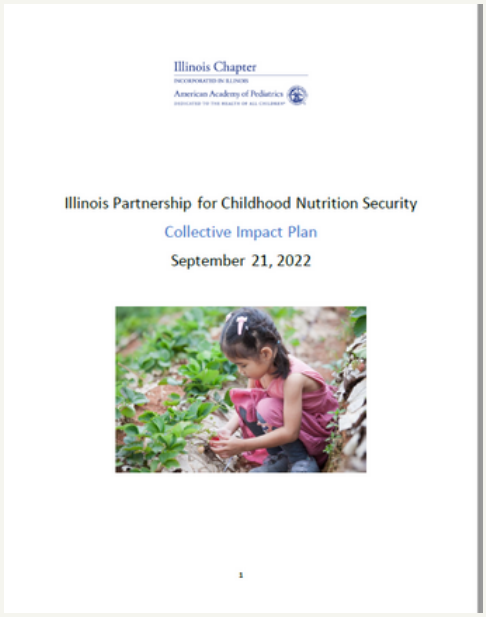
Food Recipes

- These resources can help identify different recipes for healthy foods.
- Oldways
  - https://oldwayspt.org/
- The Illinois Extension
  - https://eat-move-save.extension.illinois.edu/eat/recipes
- USDA
  - https://www.myplate.gov/

Food Maps/Resources

- Food maps can be used to locate local food banks and programs.
- The Illinois Extension
  - https://eat-move-save.extension.illinois.edu/
- Greater Chicago Food Depository
  - https://www.chicagosfoodbank.org/find-food/
- United Way 2-1-1 hotline

Feel free to visit https://illinoisaap.org/childhood-nutrition-security/ for more information.



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Illinois Partnership for Childhood Nutrition Security

Collective Impact Plan

September 21, 2022

1

Illinois Partnership for Childhood Nutrition Security Elevates the Role of Pediatricians in Statewide Food Delivery and Family Support Systems

Maggie M. Chen, MPH

Currently, one in seven children in Illinois is considered food insecure.[1] Because food quality is often overlooked, "nutrition security" is a more comprehensive concept of food security and defined as having "consistent and equitable access to healthy, safe, and affordable foods that promote optimal health and well-being."[2,3]

Food/nutrition insecurity can manifest in various ways, including food anxiety, diet monotony, decreased nutrition quality, and inadequate food intake.[4] There is a broad range of adverse health effects associated with children living in food/nutrition insecure households.[5] Thus, screening and early intervention may reduce a child's risk of developing chronic health problems, developmental issues, and mental health illness in the future.

Pediatricians can play a critical role in identifying families experiencing food/nutrition insecurity and connecting them to appropriate resources.

Further increasing pediatrician engagement with statewide and community-based organizations can inform pediatricians about the changes in the local food landscape, improvements to service delivery, and opportunities to weigh in on childhood nutrition at the policy level.

Illinois Partnership for Childhood Nutrition Security

Since 2021, ICAAP and other Chapters have participated in a national learning collaborative with the AAP and Share Our Strength's No Kid Hungry Campaign to end childhood hunger. Through this initiative, ICAAP developed the Illinois Partnership for Childhood Nutrition Security to foster collaboration between pediatricians, state food delivery, and family support partners to improve pediatrician food/nutrition insecurity screening, referral mechanisms, and family connection to resources. The vision of the Partnership is to ensure every child in Illinois is nutrition secure through partnerships and collaboration.

Illinois Partnership for Childhood Nutrition Security Elevates the Role of Pediatricians in Statewide Food Delivery and Family Support Systems

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"To me the Childhood Nutrition Security Partnership means hope," stated Alexandra Vaughn, the Family Advisor to the project. "It means for those that are struggling, no matter what side you fall on, you'll have someone here that will find a way to help you and others like you. It means progression in that we aren't stopping where the line says 'you don't make enough' or 'you make too much' because we know those numbers don't say everything. We care about families' health and nutrition, and we care about you. This is what the Childhood Nutrition Security Partnership means to me."

The Food Security Leadership Team comprises ICAAP physician champions:

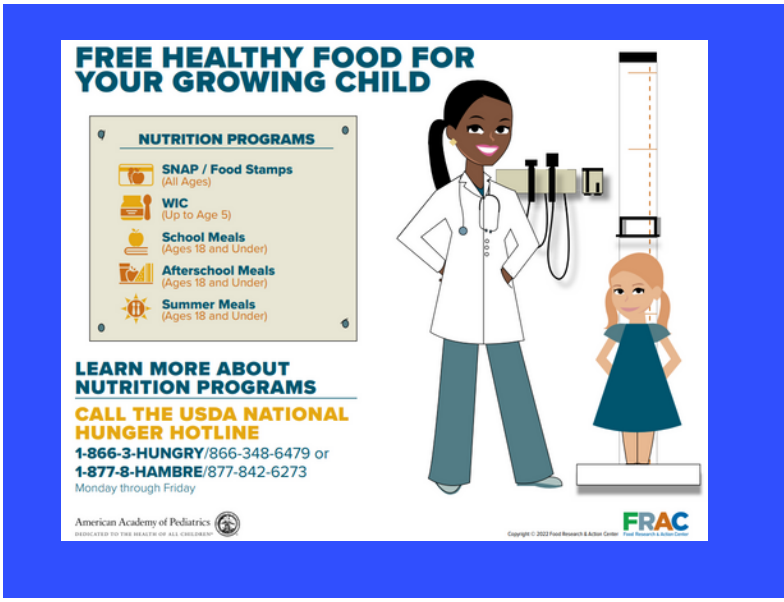
- Wendy Burdo-Hartman, MD, FAAP
- Amy Christison, MD, FAAP
- Vera Goldberg, MD, FAAP
- Zohra Moeenuddin, MD, FAAP
- Alisa Seo-Lee, MD, FAAP
- Enas Shanshen, MD, FAAP
- Family Advisor Alexandra Vaughn
- ICAAP staff members: Mary Elsner, JD, and Abby Creek, MPH
- Public health practitioners: Maggie Chen, MPH, and Jabari Taylor, MPH
- Public health intern Ayaan Ahmed

A total of thirty-five organizations across the state were recruited to advise the development of the collective impact and sustainability plans. The Partnership identified and prioritized best practices for food/nutrition insecurity, screening, referring, and connecting, families to food resources, and the development of education about federal, state, and local nutrition programs. Knowledge and insights from the discussions were integrated into a collective impact and action plan.

Resources

ICAAP physician education on nutrition security presented by Dr. Vera Goldberg, MD, FAAP, and additional resources, including links to culturally appropriate food, food maps of local food resources, and suggestions for screening and referral can be found on the Illinois Partnership for Childhood Nutrition Security webpage: illinoisaap.org/childhood-nutrition-security/

The Illinois Partnership for Childhood Nutrition Security has forged a path for future opportunities to align healthcare with existing nutrition security strategies across Illinois. Due to a grant extension, ICAAP will implement the Partnership's collective impact plan through September 2023. One of its objectives is to engage physician champions in promoting child nutrition security in different settings. If you are interested in improving child nutrition security in your practice or community, please contact Abby Creek, MPH, Manager, Health Equity Initiatives at acreek@illinoisaap.com.



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Illinois Partnership for Childhood Nutrition Security

Collective Impact Plan

September 21, 2022

Introduction

The Illinois Partnership for Childhood Nutrition (Partnership) was convened through a grant from the American Academy of Pediatrics (AAP) to the Illinois Chapter, the American Academy of Pediatrics (ICAAP). The grant period was nine months, from September 1, 2021, through June 30, 2022. ICAAP created an internal ICAAP Childhood Nutrition Security Team (Team) for the project. The following individuals comprised the ICAAP Team: Maggie Chen, Amy Christison, MD, FAAP, Mary Elsner, JD. Vera Goldberg, MD FAAP, Zohra Moeenuddin, MD, FAAP. Alisa Seo-Lee, MD, FAAP, Jabari Taylor, MPH, and Alexandra Vaughn. The project aims were to improve food insecurity (FI) screening and family connections to food resources in the state of Illinois by fostering collaboration between pediatricians, state food delivery, and family support partners. Through facilitated Partnership meetings, the Team compiled best practices from organizational partners, learned about food and educational resources, elicited pediatrician awareness and educational needs about child food insecurity, and drafted the collective impact plan. As an initial step from this plan, the Team disseminated information and resources to pediatricians about FI screening and approaches to connecting patients to nutritious food in their communities.

Executive Summary

In 2019, 1,211,410 or 9.6% of Illinoisans were considered food insecure (Feeding America, 2021). The rate of food insecurity is even higher for children across the state. 336,810 children were identified as food insecure in the state at a rate of 12% in 2019. The COVID-19 pandemic exacerbated this crisis in Illinois for many vulnerable groups. Inaccessibility to healthy food resources and inadequate food options negatively affect the health of children at every developmental stage. Additionally, food insecurity (FI) is associated with poor academic performance, hyperactivity, absenteeism, and inattention in school-age children. Nutrition insecurity is defined as the co-existence of food insecurity and diet-related diseases and disparities as defined by the United State Department of Agriculture. For the purposes of this Collective Impact plan (CI), the Partnership intends to use the more comprehensive definition of nutrition-insecurity interchangeably with food-insecurity.

The primary vision of the Illinois Partnership for Childhood Nutrition Security (Partnership) is to ensure every child in the state of Illinois is nutrition secure through partnership and collaboration. Since the inception of this Partnership, three convenings were held with participating organizations in December 2021, and January and February 2022. To date, thirty-five organizations have participated in the Partnership. During the meetings, workgroups addressed the following questions after initially identifying best practices in the Healthcare, Community Connections, and Resource workgroups: 1) Which best practices should be prioritized in each workgroup, 2) How should best practices be piloted and trialed, and 3) How should progress and success be measured.

First, the Healthcare Workgroup discussed best practices related to effective screening and referrals for food insecurity. The Workgroup gathered input relating to the implementation of FI screening and referrals in multiple clinical settings. Second, the Community Connection Workgroup shared best practices for connecting families to food. This included elevating the community voice by surveying community members about improved access to nutritious food and culturally appropriate nutrition education. This Workgroup also created a tool for suggested best practices to improve nutrition access among those experiencing FI. The tool was divided into the following sections: Processes to Prioritize; Findings from Partners; Insight; Pediatric Network Opportunities. (See Appendix 1.) Finally, the Resource Workgroup discussed the development of online modules that could be easily disseminated and evaluated. These modules would include information about access to federal, state, local nutrition programs, and food resources available in Illinois.

Collective Impact

The byproducts of the workgroup discussions informed the development of the Partnership's collective impact plan. The framework of this collective impact plan includes the following components: common agenda, shared measurement, and proposed mutually reinforcing activities. Given the short time frame of the grant period, we describe the initial work that we hope will be a starting point to grow our collaboration.

Building a Common Agenda

The following organizational partners participated in the development of the common agenda:

Chicago Department of Public Health; Chicago Food Policy Action Council; Chicago Public Schools; Cook County Health; Illinois Department of Human Services; Illinois State Board of Education; Southern 7 Health Department; SNAP Education The University of Illinois Extension; Tazewell County Health Department; ACCESS Community Health Network; American Heart Association; Ann and Robert H. Lurie Children's Hospital of Chicago; Erie Family Health Centers; Esperanza Health Centers; Heartland Health Services; Illinois Academy of Nutrition and Dietetics; OSF Healthcare Children's Hospital of Illinois; PCC Community Wellness Center; Proviso Partners for Health: Veggie Rx; Southern Illinois University School of Medicine; UIC Office of Community Engagement and Neighborhood Health Partnership Station; Illinois 4-H Food Security Communities, Peoria Grown; Beyond Hunger; Catholic Charities of Archdiocese of Chicago; Feeding Illinois; Greater Chicago Food Depository; Marillac St. Vincent Family Services; Midwest Food Bank; Northern Illinois Food Bank; Illinois Public Health Association; Illinois Public Health Institute; Start Early; Illinois Network of Child Care Resource and Referral Agencies.

Our Shared Goal

The shared goal of the Illinois Partnership for Childhood Nutrition Security is to ensure all children in the State of Illinois are nutrition and food secure through partnerships and collaboration. The Partnership recognizes that Black, Indigenous, Latinx, and Immigrant children are disparately impacted by nutrition and food insecurity and acknowledges the need for specific attention to these historically marginalized populations.

Identifying Data and Shared Measures

The ICAAP Nutrition Security Team collected data relating to food system partners, healthcare providers, family experience, and community feedback. The following provides a brief overview of how data was collected, analyzed, and interpreted.

Healthcare Experience

ICAAP pediatrician experiences and interest in training were elicited through the ICAAP Food Insecurity Survey administered to its members.

Partner Feedback

A survey was disseminated to organizational partners during the formation of the Partnership. The survey contained questions about partner food security efforts, healthcare and other partnerships, food insecurity identification and referral processes, community feedback, barriers, best practices, and recommendations for the next steps.

Participant Partnership experiences related to the processes surrounding teamwork, collaboration, and consensus were also elicited at the end of the second and third convenings through online polling. Responses were used to improve the Partnership participant experience.

Family Advisor Feedback

Addressing food and nutrition insecurity in an equitable way requires a fundamental understanding and continuous feedback from those experiencing either type of insecurity in the state of Illinois. The Partnership recognizes that social vulnerability limits a community's access to healthy and adequate food.

Alexandra Vaughn, a family advisor, and active member of the ICAAP Childhood Nutrition Security Team, brought valued perspective and insight that guided the Partnership to ensure the needs of the community were being heard and represented at every meeting. Ms. Vaughn shared her experience navigating nutrition and food access systems in Illinois. Extensive paperwork, mental health stress, and familial issues made accessing benefits difficult for her family. Ms. Vaughn expressed frustration with the ingrained social stigma, administrative burden, and lack of resources available for her family and others facing food insecurity.

Family Advisor Recommendations

1. Creating family-friendly food insecurity questionnaires. Long and intrusive questionnaires and surveys prevent many households, like Ms. Vaughn's, from being properly screened for available services. Screening mechanisms should be drafted to be family-friendly, consistent, and specific to identify households that are food insecure.
2. Updating antiquated screening intake methods and extending the available window of time for families to complete a screening. Digital screening methods would potentially allow providers to expand screening to more households. Screening questionnaires should be mobile-friendly to eliminate barriers such as transportation and changing circumstances. Screening should also take into account fear of state and local interference in family matters.
3. Addressing social stigma is important. Decades of social stigmatization have negatively affected the way many eligible families seek out services. Changing the culture of resource availability is important.

Community Feedback

Various partner organizations, such as food pantries and food system partners, collected community feedback regarding guests' requests for additional culturally relevant foods, fruits, vegetables, and lean meat. A large percentage of respondents in one survey asserted that their cultural needs were met at the food pantries. Additionally, community members expressed that food banks should dispose of unhealthy food offerings and continue to provide more fresh produce, low salt options, and more healthy foods for children. Pantry staff and volunteers alike reported that they are interested in offering healthy eating take-home information. Organizations may have difficulty fulfilling these requests because of storage issues, availability, and funding. Similarly, food pantries and food banks across the state share the same concerns. Widespread feedback also from community members shows that many individuals have transportation barriers. Many individuals struggle to access food resources in the state. Additionally, eligible households report that they struggle with food insecurity despite receiving government benefits.

Challenges/Limitations

Various barriers arose during the project, such as the short timeline of the grant cycle, financial resources, unique local issues, and lack of standardized community data. Some organizational partners expressed concerns about our discussions occurring at an accelerated pace, and that the Partnership might generate short-term solutions over long-term sustainable solutions. In response, the ICAAP team debriefed and dedicated the start of the third convening to clarify the project scope and acknowledge project limitations. It was explained that the Partnership was not meant to supplant the expertise, strategies, and roadmap collectively at the state, regional, and local levels. Instead, the Partnership's efforts were a springboard for future opportunities and partnerships and to align healthcare with existing partnership strategies. Based on additional offline discussions, it appeared that these clarifications helped partners better understand the vision and purpose of the project.

Action Plan

The following action plan outlines the activities the Illinois Partnership on Childhood Nutrition will take to address various barriers. Additionally, it provides a structured plan of who will lead these activities and a targeted end date.

Activity	Who Will Lead?	By When?
Implement food insecurity screening and referral at Heartland Health Services	Heartland Health Services-Peoria, IL	September 30, 2023
Community Connection's Best Practice Tool	ICAAP Childhood Nutrition Security Team and Partnership	June 30, 2022
Food Insecurity Training for Healthcare Providers	ICAAP Childhood Nutrition Security Team	September 30, 2023
Market and Maximize Nutrition Programs and Benefits	Partnership Organizations/State Agency	September 30, 2023
Support Equitable Systems Change That Is Prioritized by Project Partners	Project Partners	Ongoing

Appendix 1:

Community Connections Work Group Summary

Illinois Partnership for Childhood Nutrition Security Community Connections Guide			
Processes to Prioritize	Findings from Partners	Insight	Pediatric Network Opportunities
Community Voice Drive Work	Client Advisory Councils		Connect Patients to Culturally Familiar and Nutritious Food Resources
Inventory	Increase Produce and Lean Meat	Preferences for Nutritious Food and Not Junk Food	Partner with Other Local Organizations/Groups for Food Connections and Good Nutrition Education Consider Onsite Availability Client Choice Format
	Culturally Familiar	Micro- Partnerships Rather Than Large Uniform Scaling (e.g., Select Schools and Select Agriculture Producers/Farmers)	
	Locally Procured	1 Year Time Frame to Establish Grower/Distributor Partnership Thoughtful Considerations for Growing Request to Promote Sustainability	

		Consider Variability of Resources based on Location	
Education	Culturally Responsive Nutrition Education and Recipes	Cooking Demonstrations Menu Tasting Dietetic Interns are a Resource	
Choice	Pre-Packed Boxes Via Drive-Thru May Be Preferred for Personal Shopping	Options for Both Options Dependent on Local Preferences	
	Community Familiar Staff/Volunteer Pool		
Evaluation and Data Collection			Elicit Patient Viewpoints
Eliciting Viewpoints	Easy Survey Format: ● QR Codes ● Verbal/Paper Options School-Based Approach ● Send Home in Weekend Backpacks ● Assure Anonymity Among Familiar Staff ● Ask Healthcare Partners and Pantry Staff	Pre-Post Surveying Is Difficult, However, Ask Branched Questions to Elicit More Opinions for Those Who Have Participated Previously in a Pantry or Mobile Pantry Event	● Utilize and Contribute to Searchable Databases ● Survey Your Patients ● Create and Sustain Closed Loop Referral Systems ● Support School-Based Feeding and Nutrition Programs

Appendix 2:

Complied Resource List from Organizational Partners

- Advocates for Urban Agriculture. (2019). Advocates for Urban Agriculture Resource Guide. Retrieved from https://www.auachicago.org/grower-resources/
- Alliance for Health Equity. (2020). VeggieRx Case Study: Health Care and Food Partnership. Retrieved from https://allhealthequity.org/wp-content/uploads/2020/02/Alliance_Case-Study-VeggieRx_final-Jan-2020.pdf
- Center for Good Food Purchasing. (2017). Good Food Purchasing Program: Purchasing Standards for Food Service Institutions. Retrieved from https://drive.google.com/file/d/1DyeD0hPPEE0FvscOm_PPlpzGlaywpRyp/view
- City of Chicago, Healthy Chicago 2025, Greater Chicago Food Depository. (2020). Chicago Food Equity Agenda. Retrieved from https://www.chicago.gov/content/dam/city/sites/food-equity/pdfs/City_Food_Equity_Agenda.pdf
- Chicago Botanic Garden. (2022). Windy City Harvest VeggieRx: Food as Medicine. Retrieved from https://www.chicagobotanic.org/veggierx
- Chicago Food Policy Action Council (2022). Chicago Food Justice Rhizome Network. Retrieved from https://www.chicagofoodpolicy.com/rhizome-home-page
- Chicago Food Policy Action Council. (2022). Selling to Your Community's Institutions. Retrieved from https://www.chicagofoodpolicy.com/producer-manual-directory
- Chicago Urban Agriculture Mapping Project. (2022). Find a Growing Space Near You. Retrieved from https://cuamp.org/
- Chicagoland Food Sovereignty Coalition. (2021). Working to create an equitable and sustainable food system in Chicago. Retrieved from https://www.chifoodsovereignty.com/
- Eat Move Save. Retrieved on November 16, 2022. https://eat-move-save.extension.illinois.edu/
- Find Food Illinois Map. Retrieved on July 12, 2022 from https://eat-move-save.extension.illinois.edu/#find-food-il.
- Greater Chicago Food Depository. (2022) Find Food. Retrieved from https://www.chicagosfoodbank.org/find-food/
- GusNIP NTAE Center. (2021). Impact Findings Year 2: September 1, 2020, to August 31, 2021. Retrieved from https://www.nutritionincentivehub.org/media/fjohmr2n/gusnip-ntae-impact-findings-year-2.pdf

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- Illinois Commission to End Hunger. (2021). From Food Insecurity to Food Equity: A Roadmap to End Hunger in Illinois. Retrieved from https://static1.squarespace.com/static/603fc10fa2120f0be59e5d86/t/604693ade576e13daf9d9fcc/1615238085448/From+Recovery+to+Resilience.pdf
- UCSF NOPREN. (2019). Food System Indicator Database User Guide. Retrieved from https://nopren.ucsf.edu/sites/g/files/tkssra5936/f/Food%20System%20Indicators%20Database%20User%20Guide_8.26.21.pdf
- Urban Growers Collective. (2021). August Program Report. Retrieved from https://urbangrowerscollective.org/2021/09/22/august-program-report/
- West Side United. (2021). Neighborhood & Physical Environment. Retrieved from https://westsideunited.org/our-impact/impact-areas/neighborhood-physical-environment/

Illinois Chapter
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American Academy of Pediatrics
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Food Resources

Food Recipes

- These resources can help identify different recipes for healthy foods.
- Oldways
  - https://oldwayspt.org/
- The Illinois Extension
  - https://eat-move-save.extension.illinois.edu/eat/recipes
- USDA
  - https://www.myplate.gov/

Food Maps/Resources

- Food maps can be used to locate local food banks and programs.
- The Illinois Extension
  - https://eat-move-save.extension.illinois.edu/
- Greater Chicago Food Depository
  - https://www.chicagosfoodbank.org/find-food/
- United Way 2-1-1 hotline

Feel free to visit https://illinoisaap.org/childhood-nutrition-security/ for more information.

LOUISIANA CHAPTER

2022-2023 COHORT

American Academy of Pediatrics

NO KID HUNGRY by SHARE OUR STRENGTH

Our goals are:

- Develop a collective impact plan to improve pediatrician screening and referral to state and local resources such as SNAP, WIC, and food pantries
- Educate providers about food insecurity screening
- Identify chapter champions who will agree to work with chapter on practice improvement
- Establish pediatricians' role as key partners in the food security space

Our project successes:

"Through an unrelated opportunity to provide a resource table at an event, the chapters executive Director was able to establish a relationship with a local organization who has done significant work in the food and nutrition insecurity arena. Chapter staff will be exploring this relationship and opportunities for further collaboration."

Our key challenges:

- The most significant challenge bus bar has been finding competent staff to carry out the tasks associated with goal number one

MARYLAND CHAPTER

2022-2023 COHORT

American Academy of Pediatrics

NO KID HUNGRY by SHARE OUR STRENGTH

Our goals are:

- To characterize practices in screening and referrals to address food insecurity and other social risk factors at Johns Hopkins Harriet Lane Clinic and other pediatric offices and healthcare institutions statewide
- To engage with HLC caregivers with food insecurity to learn about their experience with the screening and Findhelp referral process to Maryland Food Bank and other community resources such as WIC and SNAP.

Our project successes:

"[With this grant we are able to do the below] Distribution of survey statewide, focus group sessions and one-on-one interviews"

"[Due to the grant] We are strengthening our partnership with FindHelp"

Our key challenges:

- The IRB process at our institution
- Identifying pediatric primary care practices statewide

MINNESOTA CHAPTER

2022-2023 COHORT

American Academy of Pediatrics

NO KID HUNGRY by SHARE OUR STRENGTH

Our goals are:

- Work with pediatric care sites to develop a referral system using their electronic medical record or using the existing online WIC referral and medical data form.
- Reduce the number of in person WIC visits needed by pediatric providers sharing height, weight and hemoglobin measurements with WIC via the EMR or the WIC referral and medical data form and increase the number of children returning to WIC after drop off by increasing pediatric clinic referrals of those children to WIC.

Our project successes:

"With this grant funding, we've already been able to identify some creative strategies for local WIC chapters to try with systems and providers - for example, having WIC staff hired on as independent contractors in order to obtain read-only access to relevant EPIC charts. It has enabled us to try out some workable short term fixes, while starting a dialogue about sustainable, statewide, long term solutions."

"Throughout the grant period, we have strengthened our partnership with the Minnesota Department of Health. In particular, we have been working directly with the MDH Interoperability team to see if it would be possible to use their ehealth exchange (Koble) to create a statewide closed loop referral system. Though a transformation of that scale is likely a couple of years away, their willingness to engage with us directly is a very positive development."

Our key challenges:

- The most significant challenge we are facing is navigating the distribution of time, capacity, and resources involved in simultaneously pursuing short and long term strategies. The most expedient way to improve our current referral processes is to craft read-only access agreements between local WIC programs and individual health systems, but we are weighing this piecemeal approach against the longer term goal of creating a statewide data sharing system through the Minnesota Department of Health

Our educational material:

- Options for facilitating WIC referrals through MDH toolkit

*This item will follow this page

Situation

The Minnesota Chapter of the American Academy of Pediatrics (MNAAP), through collaboration with the MNAAP Early Childhood Workgroup and the MN State Food Security Workgroup recently secured the 'Building Pediatrician Capacity to Address Food Insecurity Collective Impact Chapter Grant' through the American Academy of Pediatrics. Objectives of this grant are to create a 'closed' loop referral process, integrated into the EHR, between healthcare providers and MDH's Women, Infants and Children's (WIC) program to increase referrals, improve communication and enhance ongoing participation for eligible patients and families in the WIC program.

Background

MN WIC serves an average of 98,000 low-income women, infants and children each month and provides access to affordable food, nutrition services, breastfeeding support and access to other social services for eligible families. Research has shown that participation in WIC during pregnancy is associated with improved birth outcomes, higher breastfeeding rates and increased participation in well-child care visits. It is estimated that 60,000 families with pregnant/postpartum people who are on MA may be eligible but do not receive WIC services each quarter. Additionally, it is estimated that over 20% of WIC participants drop off after just 1-2 years in the program. Black, Somali/Somali-American and Liberian children were noted to be the most likely to drop off despite continued eligibility. Examples of reasons for sub-optimal referral numbers and high drop-off rates include unrecognized patient eligibility for the program by providers, tedious and manual referral process and multiple in person WIC visits required of families to duplicate clinical data that already exists in the EHR (i.e. anthropometric data and hemoglobin levels).

Assessment

By creating a streamlined, closed-loop referral process facilitated through the EHR, pediatricians can make a larger impact on addressing childhood and family food insecurity and infant and childhood health outcomes. By integrating this referral process into the EHR, the total number of referrals could substantially increase by using automatic eligibility triggers and simplifying the referral process into a pediatricians workflow. Additionally, by allowing bi-directional clinical data sharing between the EHR and MN WIC, hemoglobin and anthropometric data can be shared for patients, reducing the need for in person WIC visits and facilitating increased participation in the WIC program over time.

Recommendation

Explore options to improve interoperability and facilitate an electronic referral system between the Minnesota Dept of Health WIC program and Hennepin HealthCare. This system could be easily expanded to other relevant departments at Hennepin such as OB-GYN and Family Medicine. Accomplishing this would improve care delivery and expand the social safety net for our at-risk children and families. Additionally, this collaboration between MN WIC and HHS can serve as a model for partnership between healthcare organizations and state departments, both locally and nationally, aimed at reducing healthcare disparities and improving the overall health of populations.

Project Participants and Contact Information:

Rebeca Gruenes (Project Coordinator): rebecca.gruenes@state.mn.us

Diana Cutts (Subject Matter Expert/Hennepin Clinical Stakeholder):

Vikram Christian (Subject Matter Expert/Hennepin Clinical Stakeholder):

Kate Franken (State WIC Director): kate.franken@state.mn.us

Tami Matti (WIC MIS and Data Supervisor): tami.matti@state.mn.us

Jeff Bauer (MNAAP Chapter Manager): bauer@mnaap.org

MDH Interoperability Contacts:

Tim Jenkins (MDH Interoperability and Data Infrastructure Supervisor)

Aasa Dahlberg-Schmit (MDH Director of Data Strategy and Interoperability)

Blen Shoakena (MDH Interoperability Liason)

Current State: WIC Referral process in MN

Patients and families can access information about WIC and whether they are eligible for services online https://www.health.state.mn.us/people/wic/index.html

There is a self-referral/online application that patients/families can fill out to start receiving services https://redcap.health.state.mn.us/redcap/surveys/?s=4WCPLJL77MLKRPJ3

Healthcare providers can also access a web-based referral application to refer new patients to WIC OR to provide updated medical information to existing WIC participants (Hgb, anthropometrics) https://redcap.health.state.mn.us/redcap/surveys/?s=7F493NRK73RXTXL8

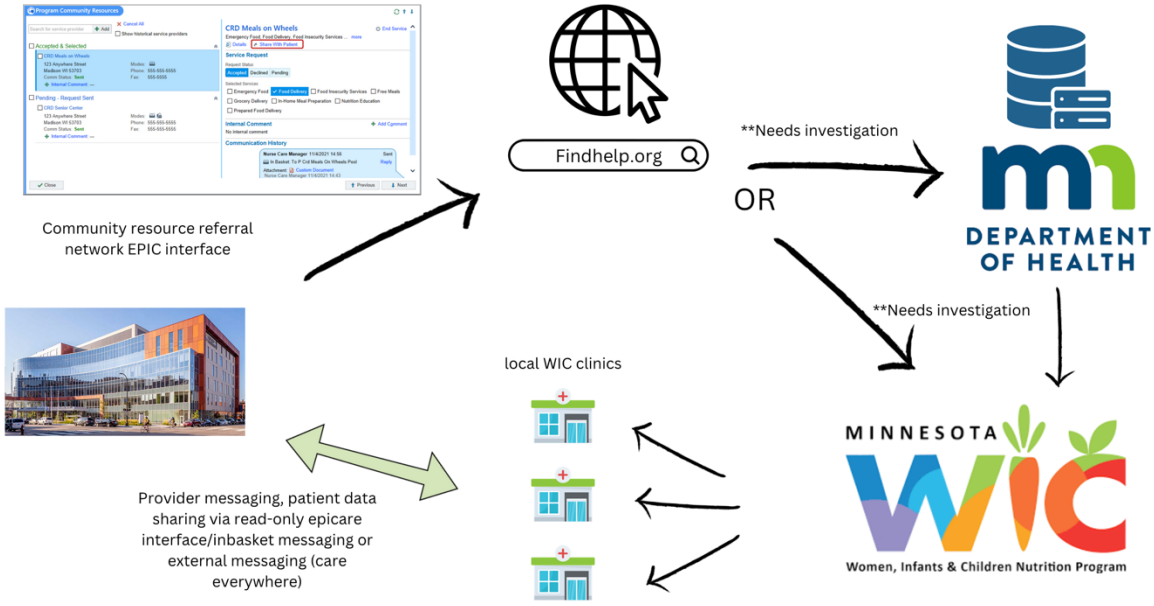
Ideally, the online referral process and necessary information above could be transitioned into an electronic referral process, easily accessible in the workflow of providers in the EHR.

<u>Specific data needed for initial referral (</u> majority of this data exists in the EHR already, generated during well child visits)*

- Name
- DOB
- Phone #
- County or tribal gov't
- Need for breastfeeding support (Y/N)
- Optional * Medical data (Hemoglobin, Hematocrit, Length, Weight)

Option 1: Utilizing community resource referral network

HHS (EPIC) --> Referral network (findhelp.org etc...) --> MDH or directly into WIC (hubert)



<u>Benefits</u>:

- Referral network that can integrate into both EPIC and community organizations information systems (example findhelp.org)
- Standard referral network could be used to facilitate many other referrals between healthcare systems and community organizations or MDH (I.e. one solution for many connections between community resources/MDH and state healthcare institutions)
- Referral recommendation could be facilitated in EPIC to providers for eligible WIC patients using patient characteristics or SDOH documentation

Downsides/Barriers

- To date, there exists no consensus from MDH on formalizing a single vendor for this purpose
- Would very likely take substantial amount of time to set this up since no single vendor has been identified yet
- Hennepin does not yet have a community resource network set up yet in our system, would also likely take time to establish this as Compass Rose implementation has just begun
- Unlikely that WIC HIS would be able to directly connect to this type of network—would still rely upon manual entry of referrals into the system from the health system or custom file sharing from either the health system or MDH
    - Example of how WIC resource is displayed currently on findhelp.org https://www.findhelp.org/hennepin-county--minneapolis-mn--women%252C-infants%252C-and-children/6201078863626240?postal=55414

Example Referral Workflow

This process would NOT generate an automatic referral directly to WIC --This could only happen if WIC was able to coordinate a process for direct referral entry into Hubert with the 3rd party vendor

- **Option 1:** Case managers and care coordinators who use the directory as part of the coordination workflow can use Continued Care and Service Coordination (CCSC) navigator sections to fax requests to the community resources to coordinate setting up the patient with their services
- **Option 2:** The requests can also be sent as an In Basket message if the community resource uses EpicCare Link or Healthy Planet Link.
- **Option 3:** Clinicians who use the directory as part of the recommendation workflow can manually provide the list of community resources to the patient

Bi-directional Communication Options

- Healthcare EHR users can communicate with community resources using faxes, External Portal messages, In Basket messages, Care Everywhere's Outside Provider Messaging, or a combination of these options with this set up
- **HHS would likely use Epicare link to be able to facilitate communication between HHS and community referrals (local WIC clinics)
- **custom documents with updated patient information (labs, anthropometrics) could be sent to community providers using these communication modalities
- **Would need to set up local WIC providers with epicare access and read only access—not sure what the workflow of this would be since the WIC office facilitates distributing referrals to local offices
    - Epicare access for local providers would be specific to Hennepin's EPIC (I.e. the providers would have a login for HHS epicare that they would use to see patient data and send messages to Hennepin providers)

More Information

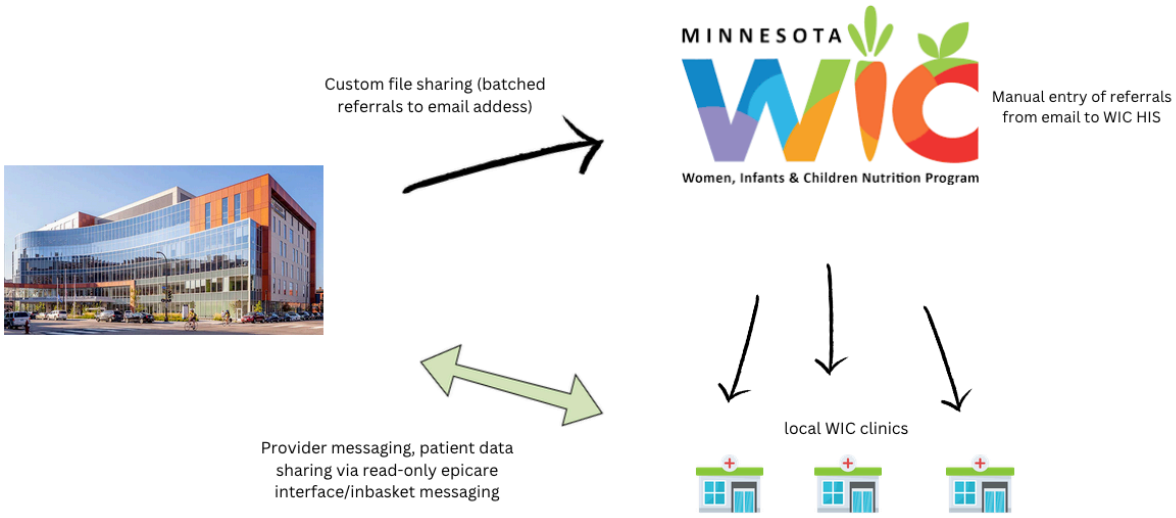
Reference to MDH/MHA project looking into single vendor referral network
https://stratishealth.org/initiative/building-bridges-between-the-community-and-healthcare-addressing-social-determinants-of-health/

Galaxy notes on community referral resource network set up in EPIC:

https://galaxy.epic.com/?#Browse/page=1!68!50!100024237,100024241,100111689&from=Galaxy-Redirect

Option 2: Utilizing Custom File Sharing/Batched Referrals

HHS --> Custom order in EPIC-->Batched referrals to external inbox --> WIC manual entry into Hubert



Benefits:

- Hennepin has successfully executed this workflow before (Second Harvest Heartland community resource for food insecurity)

Downsides:

- This is a custom solution that would have to custom built at other healthcare systems to be able to connect with WIC if replicating this workflow outside of Hennepin
- Unique file sharing for one specific resource (WIC). Addition of other community resources to this workflow would require additional custom build for both Hennepin and the community organization
- Referrals batched to an external email address—still requires manual entry into the WIC health information system (Hubert)
- No way of telling healthcare providers (or EPIC) whether a referral was successful/complete
    - Would make it challenging to implement 'recommendations' or decision support into EPIC surrounding which patients have already been referred

- Could result in duplicate referrals sent to the WIC system

Example Referral Workflow:

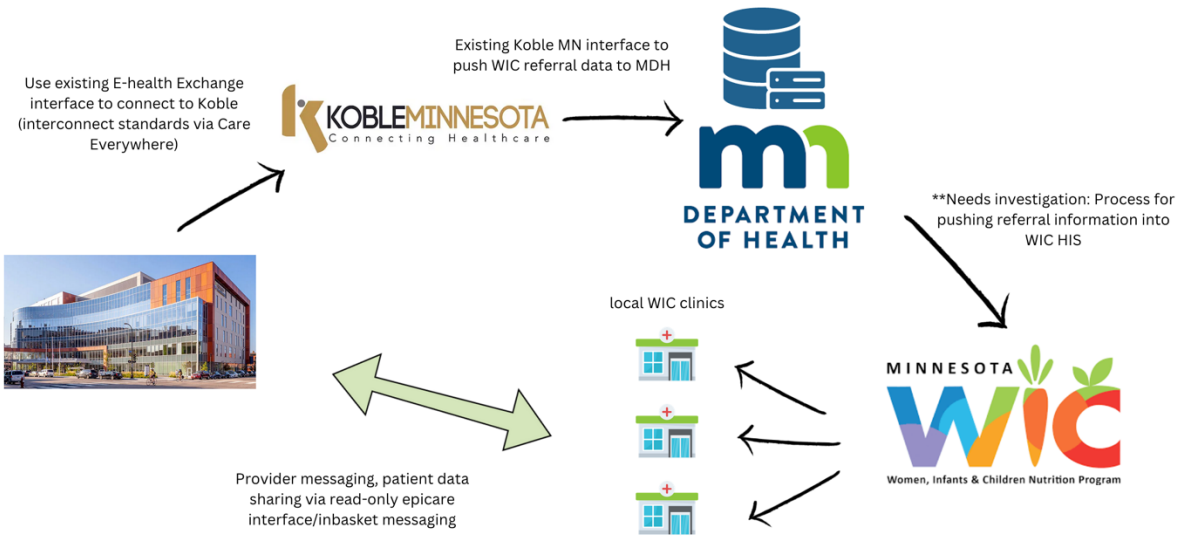
- This process would generate an electronic referral order in Hennepin EHR which providers could fill out and order. All referral orders would be batched daily and pushed to an external email that WIC maintained and checked regularly.
- WIC office would manually enter all new referrals from the email portal into Hubert and then proceed with normal workflow for distributing referrals to local clinics.

Bi-directional Communication Options:

- No bidirectional communication would exist between main WIC office and HHS regarding status of referrals
- Local WIC clinics could connect to Hennepin via Epicare link (similar to option 1) and be able to have read only access to their referred patients Hennepin Charts and send in-basket messages to providers
- **Would need to set up local WIC providers with epicare access and read only access—not sure what the workflow of this would be since the WIC office facilitates distributing referrals to local offices
    - Epicare access for local providers would be specific to Hennepin's EPIC (I.e. the providers would have a login for HHS epicare that they would use to see patient data and send messages to Hennepin providers)

Option 3: Utilizing Existing Health Information Exchange Networks

HHS-->E-health exchange HIE-->Koble Health (HIO) --> MDH --> WIC



Benefits:

- Would leverage existing exchange platforms to share data
    - Theoretically less custom build required for HHS and MDH
    - HIE vendors manage maintenance, security and troubleshooting of these exchange platforms
- Using HIE platforms could be adopted and replicated for other healthcare institutions wanting to develop similar or related processes for WIC referrals
- Many opportunities to expand data exchange between MDH and HHS using HIE platforms outside of this use referral use case
    - Currently MDH using Koble health for public health reporting/syndromic surveillance
    - See following resource for all data exchange capabilities using Koble (Health Information Organization) https://www.health.state.mn.us/facilities/ehealth/hie/certified/koble.html

Downsides:

- Still needs some investigation into how MDH could push referral information to WIC HIS (may still need to be batched information that WIC enters manually to start unless there are other opportunities we have not discovered yet to directly access Hubert)
- Would likely take some work to build new processes between MDH and Koble to leverage this workflow as MDH current use of Koble is limited to syndromic surveillance as outlined above

Example Referral Workflow:

- HHS provider generates an electronic referral order with necessary referral information (see above WIC referral information requirements)
- Referral order flows through HHS existing care everywhere interface using E-health Exchange platform to push referral information directly to MDH (by way of Koble HIO)
    - See following for overview of interoperability standards used by EPIC care everywhere interface https://open.epic.com/Home/Interoperate
- **Needs further investigation: Process for pushing referral information from MDH into WIC information system (Hubert)
    - Seems unlikely that Koble could push/directly connect with Hubert based on current system limitations

Bi-directional Communication Options:

- Referral 'success' to MDH could be communicated back to HHS via same HIE platforms
- Updated Hgb/anthropometric data could be pushed through HIE platforms at subsequent pediatric visits
    - Would require knowledge of which patients were enrolled in WIC—this may also be a limitation of the current Hubert system, still unclear
- Similar to option 1, local WIC agencies could access patient charts/provider messaging via epicare access

- Epicare access for local providers would be specific to Hennepin's EPIC (I.e. the providers would have a login for HHS epicare that they would use to see patient data and send messages to Hennepin providers)
- Also a possibility that local WIC clinics could connect directly to Koble and utilize HIE platform for bidirectional communication

More Information:

E-health Exchange (National health information exchange network that HHS connects to via Care Everywhere/EPIC) https://ehealthexchange.org/what-we-do/benefits-of-participation/

MDH e-health initiative https://www.health.state.mn.us/facilities/ehealth/initiative/index.html

MDH Promoting interoperability/Current HIE use cases
https://www.health.state.mn.us/data/interoperability/reporting.html

NEW YORK 2 CHAPTER

2022-2023 COHORT

American Academy of Pediatrics

NO KID HUNGRY by SHARE OUR STRENGTH

Our goals are:

- Find and use an evidence based screening tool for food insecurity in a pediatric practice
- Use the screening tool in one practice of Allied Health. Provide a point of contact and assist on finding a family coordinator to follow up on families that are identified as being food insecure
- Connect with Long Island Cares Harry Chapin Food Bank to assist with providing resources for families.
- Webinar development by pediatricians in the grant to be able to turn key for other practices to replicate goals and objectives accomplished at the practice in Hampton Bays, NY.

Our project successes:

"School districts have also reached out and wanting to assist with helping children and families. They would also like to be included in finding and providing resources. Shared resources will help the areas in need."

Our key challenges:

- Sometimes the speed with which we can get things done or completed is a challenge. There are so many people involved and moving parts, it sometimes feels as though we should be moving forward at a quicker pace.

*Chapter's contract started January 1st, 2023

MONTANA CHAPTER

2022-2023 COHORT

American Academy of Pediatrics

NO KID HUNGRY by SHARE OUR STRENGTH

Our goals are:

- Continue project All Calls, Learning Sessions, and 1:1 QI coaching with current WIC Nutritional Assistance Project sites (Billings, Bozeman and Missoula)
- Monthly Data collection
- Attend Food Security Council Meetings
- Present project at AAP District VIII Meeting

Our project successes:

"MTAAP continues to expand grant and project work; however, sustainable growth takes time and the chapter continues focusing on our stakeholder relationship building. This funding provided the opportunity to accelerate that stakeholder relationship building for nutrition security at the state level. This has allowed MTAAP to participate in a coalition that has strengthened over the course of the project as each organization has supported the others in various ways. MTAAP anticipates that the chapter will continue our involvement with all stakeholders after the conclusion of the project including the Food Security Council, Montana Project to End Childhood Hunger, Montana No Kid Hungry, which will no longer be housed under DPHHS, Montana WIC, Montana Food Bank Network, and Yarrow."

"MTAAP was asked by Montana WIC to be the fiscal sponsor and primary applicant for a FRAC-CIAO grant application in partnership with Montana WIC, Yarrow and Nava Public Benefit Corporation to create an electronic referral tool for Montana WIC and pilot the tool at up to 8 sites. If funded, two of the three original pediatric clinic pilot sites for our current project have already stated interest to continue to participate in the FRAC-CIAO project. MTAAP credits our current food insecurity work with the AAP collaborative over the past year and a half as the primary reason we were a) asked to participate in this new project and b) have received interest from new clinics wanting to join the project expansion if funding is awarded. Though we understand the FRAC-CIAO subgrants are extremely competitive, MTAAP would not have previously been considered if we had not already established a strong partnership with Montana WIC and Yarrow. If the team is awarded a FRAC CIAO sub-grant we are excited to build upon the work already completed over the past two funding cycles."

Our key challenges:

- Staffing: original state WIC director that we worked with has left
- Data sharing: Two clinics has not been able to fully implement data sharing yet

MONTANA CHAPTER CONT.

2022-2023 COHORT

American Academy of Pediatrics

NO KID HUNGRY by SHARE OUR STRENGTH

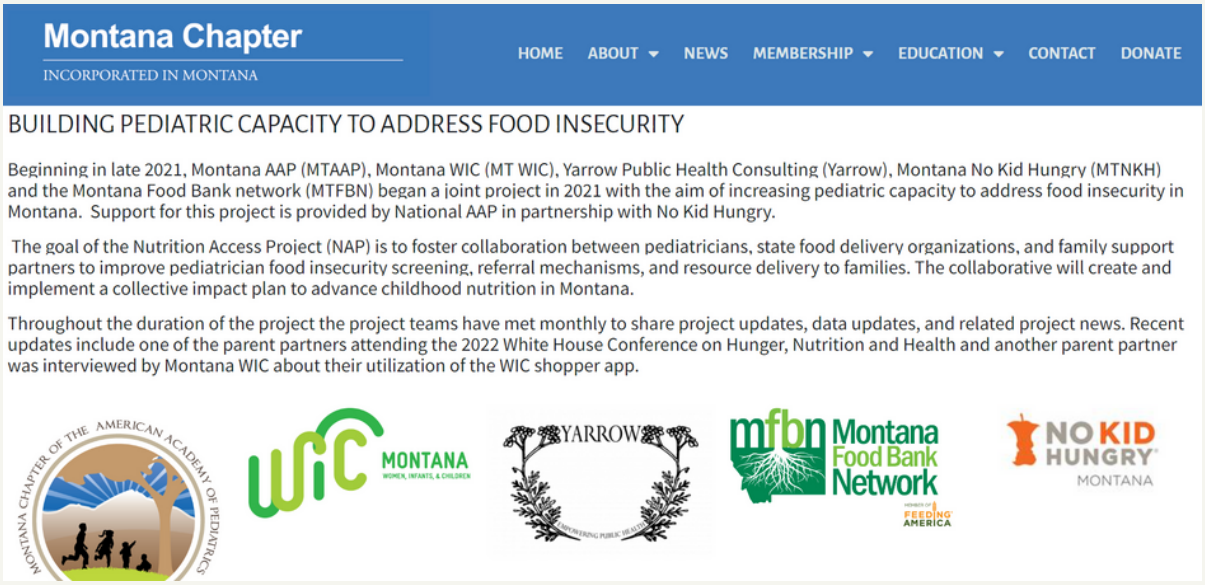
Our educational opportunities:

MTAAP Annual Pediatric CME Conference

September Learning Session

Our educational material:

- Project updates on our website
  - https://mtpeds.org/projects/nutrition-assistance-program/
- Script for food access program education
  - https://bit.ly/3TXyxQg
- Implementation guide
  - https://bit.ly/3KfRE4G



Montana Chapter
INCORPORATED IN MONTANA

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BUILDING PEDIATRIC CAPACITY TO ADDRESS FOOD INSECURITY

Beginning in late 2021, Montana AAP (MTAAP), Montana WIC (MT WIC), Yarrow Public Health Consulting (Yarrow), Montana No Kid Hungry (MTNKH) and the Montana Food Bank network (MTFBN) began a joint project in 2021 with the aim of increasing pediatric capacity to address food insecurity in Montana. Support for this project is provided by National AAP in partnership with No Kid Hungry.

The goal of the Nutrition Access Project (NAP) is to foster collaboration between pediatricians, state food delivery organizations, and family support partners to improve pediatrician food insecurity screening, referral mechanisms, and resource delivery to families. The collaborative will create and implement a collective impact plan to advance childhood nutrition in Montana.

Throughout the duration of the project the project teams have met monthly to share project updates, data updates, and related project news. Recent updates include one of the parent partners attending the 2022 White House Conference on Hunger, Nutrition and Health and another parent partner was interviewed by Montana WIC about their utilization of the WIC shopper app.

MONTANA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS

WIC MONTANA

YARROW

mfbn Montana Food Bank Network

NO KID HUNGRY MONTANA

TEXAS CHAPTER

2022-2023 COHORT

American Academy of Pediatrics

NO KID HUNGRY by SHARE OUR STRENGTH

Our goals are:

- Establish a statewide consortium to examine food insecurity and identify methods for addressing food insecurity needs in Texas
- Engage with families, pediatricians, and community-based organizations to understand successes and barrier
- Develop and disseminate educational resources to pediatric offices
- Provide small stipends to select coalition partners to enhance pediatrician office referral coordination

Our project successes:

"This grant provided TPS with the opportunity to dedicate staff and physician time to investigating each part of the screening and referral process physicians use when addressing food insecurity. Even so far, we have been able to share and compile information about how best to screen (via technology), information about how different food banks have different capacities for partnerships, and specifically the role of the electronic health record plays in making referrals."

"One of the most exciting outcomes from our first stakeholder meeting was the opportunity it provided for networking of partners in different niches of food insecurity work, even if it does not impact physician referrals. While our physicians do not do much direct enrollment or get involved with school meal programs, the stakeholder meeting was a forum in which No Kid Hungry leaders could speak with representatives from the Texas Department of Agriculture, the Episcopal Health Foundation, and the Baylor Collaborative on Hunger and Poverty about some of the issues they are seeing with enrollment in free and reduced price meals, merging direct services organizations with foundations, the state, and research institutions."

Our key challenges:

- Scheduling time with partners is one of the biggest challenges, especially during Texas' legislative session

Our educational opportunities:

- 3-Part Webinar Series with the Michael and Susan Dell Center for Healthy Living
  - Food Insecurity in Texas: An Overview from Public Health and Pediatrician Perspectives: http://bit.ly/3lP8ZIk
  - Food Insecurity in Texas: Clinic and Community - Based Approaches: http://bit.ly/40IJzed
  - Food Insecurity in Texas: State Level Policies to Make an Impact: http://bit.ly/3JRAh94

UTAH CHAPTER

2022-2023 COHORT

American Academy of Pediatrics

NO KID HUNGRY by SHARE OUR STRENGTH

Our goals are:

- Recruit 3 practices to start screening for food insecurity
- recruited a speaker for our large CME in June, and have folks from WIC come to present as well to educate pediatricians on food insecurity
- Creating an ongoing training program on food insecurity screening
- Creating a working group to deal with food insecurity issues in the state

Our project successes:

"The grant allowed us to ask for a seat on the counsel, it gives us direct access to groups and agencies involved in food security in the state"

Our key challenges:

- Reaching folks in the far parts of the state, much of the state is rural and that is where the greatest need is and fewest resources