Harnessing Innovations to Drive Collective Impact

Highlights from April 2019 Summit

In April 2019, representatives from health care, food and nutrition, public health, and community-based nonprofit organizations throughout the metropolitan Chicago area gathered at the ACCESS Center for Discovery and Learning for a day of learning to begin a solutions-oriented dialogue around improving food insecurity.

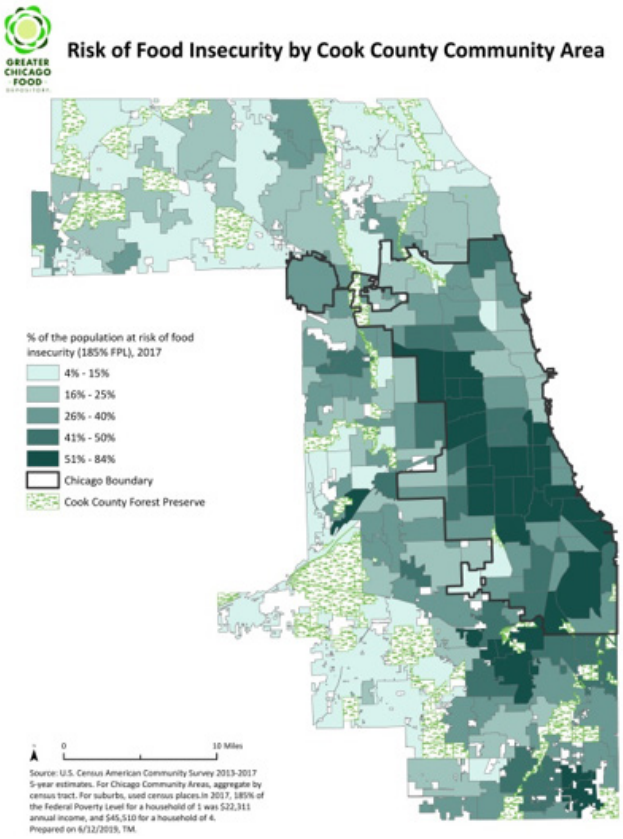
The Summit was a result of work initiated by multiple organizations and researchers, including Access Community Health Network (ACCESS), the Illinois Public Health Institute – Alliance for Health Equity, the University of Illinois Chicago and the Greater Chicago Food Depository – to coordinate across institutions a larger dialogue around food insecurity in the Chicago area. Of critical importance was the sharing of the learnings of the pilots and studies that had been undertaken to help fuel the next stage of addressing food insecurity and the overall health and wellness of our communities.

Discussions focused on how to build on the deep expertise and successful relationships that already exist to better identify and address food insecurity and improve the health of residents in our underserved communities.

Our Goal

As defined by the United States Department of Agriculture (USDA), food insecurity is "a lack of consistent access to enough food for an active, healthy life." Studies show that food insecurity has significant implications on physical and mental health. In 2017, approximately 40 million Americans (12.5 percent) were food insecure. Although the food insecurity rate in Illinois (10.9 percent) is slightly lower than national food insecurity rates, the prevalence varies greatly across states, counties, and even neighborhoods or zip codes. For instance, in some neighborhoods in Cook County, Ill. — which includes Chicago and surrounding suburbs — 50 to 84 percent of households are food insecure (see map on page 2). In addition to lacking economic access, these individuals and families commonly have limited spatial access to healthy food options in their communities.

In recent years, many health care organizations in the Chicago area, including hospitals, federally qualified health centers, and health plans have started to take a proactive role in identifying and assisting patients who are food insecure. These



efforts typically require health care organizations to reach outside traditional silos and partner with food pantries, nonprofits, and other organizations involved in food and nutrition.

To support food insecure individuals and families in Cook County, numerous community-based organizations are working on the front lines to help identify individuals at risk and increase their access to food. Organizations range from large nonprofits and government health agencies (e.g., Cook County Department of Public Health, the Greater Chicago Food Depository) to neighborhood-based food pantries, farmers markets, and other services run by charities and faith-based organizations. Additionally, a growing number of food retail partners are also at the table to further support these efforts.

As described in more detail on page 4, a landscape scan by the Alliance for Health Equity (AHE) identified 37 unique programs between health care organizations and various food and nutrition entities in Cook County. These partnership efforts are often tied into larger Cook County collaborative initiatives that have aligned to address social determinants of health, including food insecurity and a lack of access to healthy foods. Initiatives include the Alliance for Health Equity, West Side United, Proviso Partners for Health, Family Farmed's Good Food is Good Medicine initiative, Healthy Chicago 2.0, Cook County WePLAN, and the Good Food Purchasing Program.

The idea to launch a regional, cross-sector food security initiative arose out of all the collaborative work going on in the communities. As envisioned, the county-wide coalition brings together health care and food and nutrition organizations to identify best practices and innovative solutions, collectively address challenges, and pursue a common agenda. The collaborative primarily focuses on improving health by reducing food insecurity and improving access to healthier food options.

ACCESS, the Greater Chicago Food Depository, the Alliance for Health Equity, and Angela Odoms-Young, PhD, Associate Professor, Department of Kinesiology and Nutrition, and Associate Director for Research and Education in the Office of Community Engagement and Neighborhood Health Partnerships, at the University of Illinois at Chicago led a subcommittee to plan and organize the Food for Health Summit on April 10, 2019. Approximately 71 individuals from 45 organizations attended, eager to learn from each other and energized to work together around food insecurity.

Shared Challenges and Lessons Learned

During the Summit, attendees discussed challenges related to identifying and addressing food insecurity, shared information about implementation strategies, and discussed needed approaches to evaluating and testing different intervention models. A key focus of the Summit was to identify the primary challenges the group will take on in 2019 to begin collectively addressing food insecurity and addressing food access. "We all have a strong platform on how we can create healthier communities," said Donna Thompson, ACCESS Chief Executive Officer. "I hope we all broaden our lenses and march together towards solutions that really make a lasting impact."

Framing and Defining Food Insecurity

The Summit launched with an overview of current research on food insecurity and its impact on health by facilitator Angela Odoms-Young, PhD.

Key Learnings:

- Food insecurity does not only affect people physiologically (e.g., hunger, nutritional inadequacy) but also has the following impacts:
  - **Psychological:** Food insecure individuals may be filled with shame or may suffer from additional stress related to their worry about not having enough food.
  - **Social:** Individuals may become socially isolated when they cannot afford to join family or friends for meals out.
  - **Financial constraints:** Households may be forced to make difficult decisions to forgo buying medicine or paying bills so they can afford food, or they may need to obtain food in socially unacceptable ways.
- A variety of socioeconomic factors as well as unhealthy eating habits influence food insecurity, including:
  - **Geography:** For example, some neighborhoods may not provide easy access to grocery stores or healthy alternatives to cheap fast food.
  - **Knowledge, skills, and preferences:** Individuals who know how to shop for and cook healthy foods on a limited budget are less likely to be food insecure.
  - **Income level:** In addition to take-home income, households must also address if they are eligible for Supplemental Nutrition Assistance Program (SNAP) benefits (known as Link in Illinois) and the Special Supplemental Nutrition Program for Women and Children (WIC).
- Research illustrates the link between food insecurity and chronic conditions:
  - Food insecure households tend to cycle between having enough food and food scarcity. Body weight and blood sugar levels tend to cycle as well due to a propensity to eat high-fat, refined-carbohydrate diets when food is scarce. People also adopt compensatory strategies that contribute to weight gain and loss, such as overeating when food is available and skipping meals when food is scarce. At the same time, the stress of dealing with food insecurity and other socioeconomic issues can lead to poor self-management (e.g., unhealthy eating), which leads to poor health outcomes.
  - Studies have shown that food insecurity increases the likelihood of hypertension and poor glycemic control in patients with diabetes.
- To address food insecurity, health care organizations are primarily adopting three types of strategies:
  1. Identifying patients living in food insecure households.
  2. Referring or connecting patients to nutrition access points (e.g., food pantries, community gardens and urban farms) as well as SNAP and WIC benefits.
  3. Creating new food distribution channels in the health care system (e.g., an onsite food pantry).

AHE's Landscape Scan of Health Care and Food Partnerships

The Alliance for Health Equity is a coalition of Cook County hospitals, the Illinois Public Health Institute, health departments, and community organizations. Since the summer of 2018, AHE has been surveying organizations in Cook County to identify existing health care programs that include a food and nutrition component. At the Summit, Jess Lynch, Program Director of the Illinois Public Health Institute, summarized current findings from the landscape scan:

- The most common goal of the 37 health care and food partnership programs identified in Cook County is to improve access to healthier food options. Other top goals are reducing food insecurity, providing nutrition education and counseling, and managing chronic diseases.
- 21 of the identified programs currently screen individuals or families for food insecurity. Onsite food distribution at the health care organizations and/or referral to offsite food programs and benefits are commonly offered alongside screenings.
- Other program components include diet and nutrition education, cooking demos or classes, chronic disease management counseling, and SNAP enrollment assistance.

Health Care and Food Partnership Examples:

West Side United

Focused on improving neighborhood health while supporting cross-sector collaboration on Chicago's West Side, West Side United works to improve access to healthy food by supporting local food pantries, providing nutrition education in neighborhood public schools, and other tactics.

"On the West Side, we go from a life expectancy of 85 years old in the Loop down to 68 or 69 in the Garfield Park area," said Christopher Nolan, Systems Manager, Community Health and Benefit, at Rush University Medical Center, which is one of the hospitals in West Side United. "When we think about the root causes of these inequities that exist … it's heart disease, cancer, diabetes. It's the chronic conditions that we can work on … [and] food is a really big common denominator." All of the West Side United hospitals (AMITA

Food Insecurity Screening Tools

There are a number of food insecurity screening tools available, including the 18-item questionnaire used by the United States Department of Agriculture (USDA) in its annual food security survey. Because time with patients is limited, health care providers have been testing out shorter screening tools. The following are two shorter tools commonly being used.

The Two-Question Hunger Vital Signs Screening Tool

Families are determined to be at risk for food insecurity if they answered "often true" or "sometimes true" to both of these questions:

1. Within the past 12 months, we worried whether our food would run out before we got money to buy more.
2. Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.

USDA Six-Item Short Form of the Food Security Survey Module (for Adults)

This is a shorter version of the USDA 18-item survey and it includes questions on tough choices households have to make when food insecure.

1. "The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more."
   - ☐ Often true
   - ☐ Never true
   - ☐ Sometimes true
   - ☐ Don't know or refused
2. "(I/we) couldn't afford to eat balanced meals."
   - ☐ Often true
   - ☐ Never true
   - ☐ Sometimes true
   - ☐ Don't know or refused
3. In the last 12 months, did (you/or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know
4. If you answered "yes," to question 3: How often did you cut the size of your meals or skip meals—almost every month, some months but not every month, or in only 1 or 2 months?
   - ☐ Almost every month
   - ☐ Only 1 or 2 months
   - ☐ Some months but not every month
   - ☐ Don't know
5. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know
6. In the last 12 months, were you ever hungry but didn't eat because there wasn't enough money for food?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

Saint Mary, AMITA Saint Elizabeth, Cook County Health, Lurie Children's Hospital, Rush University Medical Center, Sinai Health System, and UI Health) are working with the Greater Chicago Food Depository and community-based partners on food access initiatives.

Advocate Trinity Hospital's Food Farmacy

Located on the southeast side of Chicago, Advocate Trinity serves a patient population with high rates of food insecurity, as well as diabetes, heart disease, and hypertension. "We found that 57 percent of patients admitted to the hospital [on a particular day] had a disease or condition that could potentially benefit from some sort of food-nutritional intervention," said Harold Gatewood, Consultant, Advocate Operating System.

This finding led to the creation of the Food Farmacy, which is a twice-a-month event at the hospital for patients referred by their physicians. Participants receive free bags of fruits and vegetables provided by the Greater Chicago Food Depository. Event attendees also learn how to cook or prepare produce they receive and taste pre-prepared recipes. "The produce is kind of what gets people through the door, but then it gives us the opportunity to engage patients on how they can manage their diseases," said Gatewood.

VeggieRx

The Chicago Botanic Garden operates 13 urban farms through its Windy City Harvest department, explained Eliza Fournier, Program Director, Windy City Harvest Department, Chicago Botanic Garden. Through the farms, the Garden aims to build a local, sustainable food system and offer job-training opportunities to area residents, including at-risk youth and formerly incarcerated adults.

Since 2016, the farms have also been supplying free boxes of farm-harvested produce to SNAP recipients at risk of food insecurity, primarily during the months of June through November. The program, called VeggieRx, is currently working with three Cook County health care organizations: Proviso Partners for Health/Loyola University Health System, PCC Community Wellness, and Lawndale Christian Health Center. In addition to free boxes of produce, patients receive coupons to purchase produce at a discount at local farm stands, using their SNAP cards. VeggieRx participants also attend weekly cooking demonstrations to learn how to prepare inexpensive and easy meals, which are put on by staff from the Chicago Partnership for Health Promotion in the Office of Community Engagement and Neighborhood Health Partnerships at the University of Illinois at Chicago.

Key Learnings:

- Providing e-referrals to food and nutrition events or e-prescriptions for food through the electronic medical record (EMR) helps improve program effectiveness and evaluation.
- Many organizations have found that successful programs include cooking and food preparation components alongside access to healthy food.
- Program champions are critical to launching and spreading the programs.
- When programs are designed specifically to serve populations that participate in federal nutrition programs, such as SNAP, those who are ineligible for those programs are left out. Therefore, programs need to acquire supplemental funds to ensure that undocumented immigrants and others who don't qualify for SNAP can participate.
- It's important to support existing food access systems and emergency food systems (e.g., food pantries, SNAP benefits) as well as local food businesses.
- Grant funding is currently the primary way programs are funded. The road to more sustainable funding through Medicaid, Medicare, and commercial insurance reimbursement is complex.
    - To convince payers to cover these programs, health care organizations need to demonstrate the value of addressing food insecurity. A more robust and shared evaluation strategy is needed.

ACCESS Meal Delivery Program for Priority Populations

The Greater Chicago Food Depository and ACCESS partnered to deliver pre-cooked, frozen meals to high-risk, food insecure patients in Cook County. ACCESS's Thomas Sanchez, Health and Community Integration Project Manager, and Emily Daniels, Senior Manager, Programs, Greater Chicago Food Depository, provided an overview of this year-long pilot.

41 ACCESS patients received 10,948 home-delivered meals as well as fresh produce between February 2018 and January 2019. The majority had hypertension and/or diabetes. All of the adult participants already had an ACCESS care coordinator, which made communication and engagement easier.

Once a week, a driver with the Greater Chicago Food Depository dropped off seven days of frozen meals, which were precooked at the Food Depository. All the meals met nutritional guidelines (e.g., low salt, low in saturated fats) for preventing and managing chronic diseases. When participants did not own a freezer and/or microwave to store and cook the meals, ACCESS purchased the appliances for them.

Key Learnings:

- Strengths of the pilot:
  - While challenging, the delivery logistics were manageable. The Greater Chicago Food Depository worked with participants to identify a two-hour window each week for food deliveries. Meals were successfully delivered 89 percent of the time.
  - While the pilot was unable to measure health outcomes, participants said they thought the program helped them manage their health. Anecdotally, a few participants reported health improvements, including weight loss and diabetes control.
  - Patients liked the meals, and they reported making healthy eating changes, such as eating more fresh foods. They also said the program had an overall positive financial impact by reducing their household food expenses.
- There were a high number of address changes, which made consistent meal delivery challenging with some participants. Of the 41 participants, six participated sporadically, only receiving a total of 12 meals.
- Patient engagement with the health care system was an additional benefit. Many participants stayed in touch about address changes to ensure their meals continued to be delivered.
  - Patients formed a relationship with food delivery staff/volunteers, which played a key role in their engagement.

ACCESS' Food for Health Study

ACCESS conducted an evaluation study to determine if integrating food insecurity screenings and then referring patients to a range of support services could assist patients with diabetes improve their diabetes control. The primary question was:

Do food insecure diabetic patients provided with access to food resources (e.g., SNAP benefits and food pantries) achieve improved glycemic control compared with food secure diabetic patients?

The study was presented by Danielle Lazar, Executive Director, Research, Evaluation and Innovation, Access Community Health Network; Jonathan L. Blitstein, PhD, Public Health Psychologist, RTI International; and Caroline Rains, Public Health Analyst, RTI International.

Between January and November 2017, ACCESS patients with diabetes were recruited to participate in the study. During a primary care visit, a medical assistant screened the patients for food insecurity. Patients identified as food insecure were given basic nutritional education by their provider, as well as an educational flyer about eating right on a tight budget. In addition, a benefits specialist helped the patients with SNAP enrollment. Participants also received referrals to a local food pantry and a calendar that listed mobile FRESH truck visits. The screening and referrals were documented in the patient's EMR.

Study participants were invited back to the health center for a follow-up visit in fall 2018 to determine if the food interventions had improved their diabetes control. Of the nearly 1,000 patients initially enrolled in the study, 215 completed a follow-up hemoglobin A1c test.

After follow-up visits, diabetes control results were better for both food insecure and food secure patients. Average hemoglobin A1c results improved from 8.00 at baseline to 7.77. However, it is difficult to know whether this improvement was due to increased food access, SNAP benefits, or other supports.

Why Are Health Care Organizations Actively Addressing Food Insecurity?

Providers, nurses, dietitians, and other clinicians have long understood the connection between food security and health. But, historically, health care organizations have had a limited role, primarily related to nutritional counseling, in helping patients improve their diets.

However, a number of developments over the past decade have caused health care providers and payers to recognize the importance of investing resources (time, staff, and money) in helping individuals and communities they serve to overcome food insecurity. These include:

- **A renewed focus on population health:** Across the country, health care organizations have embraced the Institute for Healthcare Improvement's Triple Aim approach to performance improvement: enhance the patient experience, improve population health, and reduce total costs of care. This is causing them to step outside the clinical care arena to address nonmedical contributors to poor health in their communities, including food insecurity.
- **Recognition of social determinants of health:** Research shows that 50 percent of a population's health can be attributed to socioeconomic factors, including poverty, lack of transportation, and food insecurity. In comparison, only 20 percent is due to clinical care.
- **Value-based payment models:** Payers, including Medicare, Medicaid, and commercial insurers, are well aware of the research on social determinants of health and, in some cases, are leading or involved in community-based efforts to address non-medical contributors to poor health and high health care costs. Payers are also experimenting with provider payment approaches that either directly reimburse or cover the cost of initiatives to address social determinants, including food insecurity.
- **Community health benefit assessments:** To maintain their nonprofit status with the Internal Revenue Service, hospitals must regularly assess and improve community health needs. This has led many hospitals and health systems to partner with other community entities to address a variety of community needs, including food insecurity.

Key Learnings:

- The food insecurity screening tool used significantly affected how many food insecure patients were identified. More work needs to be done to understand what is needed to capture accurate results when implementing food insecurity screening in a health care setting. Specifically, how the questions are being asked, who is asking them, if the patient understands why the question is being asked in a primary care setting.
  - The two-item Hunger Vital Signs tool identified 10 percent of study participants as food insecure. In comparison, USDA's six-item screening tool identified 45 percent of participants as food insecure. (For more on these two screening tools, see sidebar on page 4.)
- More than 55 percent of subjects did not have SNAP benefits while almost 60 percent were unaware of the program. Among food secure individuals, the stigma of participating was another common reason for not signing up. Among food insecure, the difficulty of applying or staying on SNAP was cited as a key reason.
- Most subjects, including 70 percent of food insecure patients, had not visited a food pantry in the past month.
- Opportunities were identified for improving the intervention:
  - More context needs to be provided to patients before asking them about food insecurity. Some patients were confused why their primary care medical home was seeking this information, resulting in some patient privacy concerns.
  - Additional training is needed for providers and health center staff on how to discuss food insecurity as well as healthy eating with patients.
  - The light-touch intervention may have underestimated individual and household challenges. Instead of a one-size-fits-all approach, personalized and tailored interventions may be needed.

Panel Dialogue

Kathleen Gregory, Principal, Kathleen Gregory Consulting, facilitated a roundtable discussion with four panelists around how to best align the work of food and health systems to improve health.

Key Learnings:

- Jonathan L. Bilstein, PhD, described an approach to cross-sector community improvement called "Collective Impact," which establishes five conditions: a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone support. The Collective Impact approach typically informs top-down community efforts versus a grassroots approach led by community members. In contrast, the Community Coalition Action Theory is more of a grassroots-driven approach.
- Miriam Virto, Nutrition Peer Educator, Chicago Partnership for Health Promotion, University of Illinois at Chicago, discussed the importance of building trust with the community and personal relationships with patients and community members to help them with food insecurity.
- Emily Daniels and Corey Chatman, Senior Program Manager, Experimental Station, explained the difference between an emergency food relief (e.g., food pantries, soup kitchens) and long-term strategies for helping individuals stay food secure (e.g., educating patients/ consumers on budget-friendly food preparation).
- Other ideas and solutions raised included:
  - It's vital to support community-based organizations working on food insecurity issues, which range from large food banks to small church food pantries. By helping to increase the capacity of these organizations, the health care sector will not only help their patients but the entire community.
  - We need to move from a charity model to an empowerment model that helps people in the community raise themselves out of the need for food services. Empowerment examples include encouraging community residents to advocate for healthy, inexpensive food options in their neighborhood and teaching them how to grow, prepare, and sell healthy food.
  - Lobbying the government to ensure SNAP benefits are not reduced was identified as a key issue. A related issue is ensuring people can easily purchase produce at farmers markets with their SNAP card. Through its advocacy work, the Experimental Station has increased the number of farmers markets and produce stands that accept SNAP cards, as well as increased state funding to farmers markets through Link Match, a program that doubles a SNAP beneficiary's buying power at farmers markets.

Where Do We Go From Here?

From all the information shared and exchanged throughout the Food for Health Summit, the Alliance for Health Equity will work with all the other partners to develop a theory of change and a work plan for collaborative action related to: data and evaluation, screening and referral, and access to food in communities.

Data and Evaluation

The following questions related to data and evaluation were discussed at the Food for Health Summit:

- What are the research questions?
- How can we deploy community-based participatory research, which integrates the community into evaluation and data collection efforts?
- What are the best practices around data collection?
- How can we collaborate around data collection and use a shared platform? Who needs to sit at the table for these collaborations?
- How can we bolster funding to support evaluation?
- What are the primary outcomes that the collaborative should focus on achieving (e.g., increase patient participation in food programs, decrease food insecurity rates, improve dietary quality among food insecure populations)?
- What metrics should we use to measure and evaluate specific initiatives?
- What practices should we use to disseminate evaluation methods and findings?

Screening and Referral

The following questions related to screening and referral were discussed at the Food for Health Summit:

- How do institutions and providers build trust with individuals that are being screened for food insecurity?
- How do we ensure the setting for screening is optimal — including appropriate training for the screener?
- What is the optimal screening tool to use?
- What capacity building is needed for resource organizations to accept referrals, collect data, etc.?
- What other strategies are needed alongside screening and referral to improve food security at the household and community level?

Access to Food in Communities

The following questions related to access to food in communities were discussed at the Food for Health Summit:

- Any definition of success needs to include access and affordability.
- How can people be empowered to grow food for themselves and/or for others?
- How can SNAP and other benefits programs be supported and strengthened?
- How can a community-based approach, such as a community hub model be used to improve access to food?
- How can sectors be better intertwined with each other in this work?
- How can we create a systems shift around supporting healthy food access?

Overarching Themes

Collaborative work is also needed on the following issues going forward:

- The need to improve the sustainability of funding for health care and food partnerships, rather than relying on grants and philanthropy.

  - Possible opportunities include CMS/Medicaid, payers incorporating food service as a member benefit, Medicare Advantage health-related supplemental benefits, and social determinants Z-codes as part of ICD-10 (International Statistical Classification of Diseases and Related Health Problems).

- The need to address the stigma around food insecurity and benefits utilization.
- The need to move towards community-driven solutions, rather than a charity model, and incorporate food justice.
- The need to integrate community-based organizations into the planning and implementation of food insecurity strategies.

The collaborative will also stay on top of other major issues raised during the summit that are being pursued by other advocacy groups, such as SNAP. There is already an advocacy group in Illinois, called SNAP Advocates, that is committed to protecting government funding of SNAP and improving access to these benefits.

To get involved in this collaborative or participate in one of the teams outlined above, please contact: Jessica Lynch, MCP, MPH, Program Director, Illinois Public Health Institute jessica.lynch@iphionline.org or Danielle Lazar, Executive Director of Research, Evaluation and Innovation, Access Community Health Network Danielle.Lazar@achn.net.

Sponsor Recognition

Support for the Food for Health Summit was provided by the Robert Wood Johnson Foundation.

Appendix A: Breakout Session Notes

The following are the key topics and themes that were discussed during the breakout sessions at the Food for Health Summit.

Overarching Themes

- There is a stigma around food insecurity and resource utilization.
- Movement should be made towards empowerment, rather than a charity model while incorporating aspects of food justice.
- There is a need for more sustainable funding for health care and food partnerships, rather than relying on grants and philanthropy. Possible opportunities include CMS/Medicaid, other payers incorporating food service as a benefit, and the ICD 10 codes. (**Here** is more information on new developments with ICD-10 codes for social determinants of health.)
- Community based organizations must be key partners in planning and implementation of strategies

Access to Food Breakout Group

- Understanding the Landscape
  - We need to come to an understanding about how access to food is defined, how affordability is defined and most importantly, how different communities define these things.
  - There appears to be gaps in understanding of what resources are available. Work needs to be done on connecting people to resources, even just informing people that these resources exist. Prescriptions for food may be a component of this.
- Growing Locally
  - Growing one's own food can be a piece of an empowerment model and food justice model. Beyond personal use, growing food can also be a business.
  - Resources, including land, water, funding and trainings, are required for people to realize the goal of growing locally. Container gardening and roof gardens can help address the land barrier.
- SNAP and Benefits Programs
  - SNAP needs support, including through policies that protect and increase SNAP allotments, and community supports for the enrollment process.
  - There is a need to streamline the benefits system, including both SNAP as well as WIC and food vouchers.
- Community-Based Approach
  - The first step is to understand how local families are being impacted or adjusting to their circumstances.
  - Consider utilizing a community hub model and investing in social enterprises in working towards change.
- Cross-Sector Collaboration
  - Systems are needed to close the loop between resources and stakeholders, including health systems.
  - The health care industry may be able to expand their role by having or investing in gardens, farms, food provision, social enterprises etc.
  - What other agencies should be at the table?
- Systems
  - There is a need for a shift in systems and organizational-level culture around "good food".
  - The government is an important institution to leverage resources.
  - We need better systems and policies so that health care resources can go directly toward food as a health intervention (e.g., using ICD-10 codes and reimbursement, SNAP and WIC enrollment).

Data and Evaluation Breakout Group

- Research Questions
  - There are multiple research questions that we need to answer: What are the outcomes/impact? What needs to be measured to see whether a difference is being made? What are the steps we need to take to make the biggest impact with a program?
- Integrating Community
  - It is important for communities to be involved in evaluation. One way to go about this is by partnering with community-based organizations and supporting community-driven research. Understanding the community will build trust, decrease stigma, and increase participation.
  - We need to understand what happens after a community experiences an increase in resources, like a grocery store or farmers market.
- Data Collection
  - Many questions need to be addressed around data collection: Who is collecting data? How are they collecting data? What is the capacity for organizations to collect data? Is data collection being approached systematically? Are rates for food insecurity accurate? How do we understand the gaps in who is being served?
- Collaboration
  - Shared approaches to evaluation and data collection were heavily emphasized. Shared approaches include developing a theory of change and data platform.
  - Sectors that need to be included are managed care organizations, behavioral health, and oral health.
  - Mentor-mentee programs could increase partnerships and shared knowledge.
- Funding/Investment
  - Investing resources and increasing funding toward food access evaluation and data collection are needed.
  - Are there policies that we can use to change the funding and economic infrastructure?

Screening and Referral Breakout Group

- Building Trust
  - Patients having trust in the screener is imperative. Possible gaps in this trust may stem from a lack of cultural sensitivity and implicit bias, these could be opportunities for training.
  - The community and partners could benefit from empowerment as well, such as health literacy training.
- Screening
  - An opportunity for improvement with screening is to look at the context of the screening: Are the screeners appropriately trained? Do they practice cultural sensitivity? Do they feel empowered with next steps for those who screen positive? Is there sufficient time to conduct the screening?
  - There is question regarding the validity of the two question Hunger Vital Signs tool.
- Referral
  - Capturing data in the EMR is valuable.
  - The “ask” of the resource organization being referred to is sometimes too large. There are multiple referral platforms (a common platform would be beneficial). Further, the capacity of the resource organization to collect data on who is utilizing their services is limited.
  - There is a need for capacity building and true partnership between the health care providers that are referring and the emergency food or other agencies that are receiving referrals.

Appendix B: Organizations Represented

Organizers of the Event

Access Community Health Network

The Greater Chicago Food Depository

The Alliance for Health Equity

Angela Odoms-Young, PhD, Associate Professor, Department of Kinesiology and Nutrition, at the University of Illinois at Chicago

Attendees

Access Community Health Network

Advocate Aurora Health

Advocate Children's Hospital

American Academy of Pediatrics

American Heart Association

Ann & Robert H. Lurie Children's Hospital of Chicago

Ann & Robert H. Lurie Children's Hospital of Chicago

Age Options

Catholic Charities

Center for Policy & Partnership Initiatives, Illinois Public Health Institute

Chicago Department of Public Health

Chicago Partnership for Health Promotion

Chicago State University

Claretian Associates

Clinical Research Church

Community Health

Cook County Department of Public Health

Enlace Chicago

Erie Family Health Centers

Esperanza Health Centers

Experimental Station

Faith and Health Partnerships, Advocate Aurora Health

Greater Chicago Food Depository

Humana

Illinois Public Health Institute

IPHI

Kathleen Gregory Consulting

Kimberly Hobson

MacNeal Hospital

Mercy Hospital & Medical Center

Near North Health Services Corporation

Northwest Community Healthcare

Norwegian American Hospital

PCC Community Health Officer

RTI International

Sinai Health Systems

Sinai Urban Health Institute

Swedish Covenant Hospital

TCA Health, Inc.

The Loretto Hospital

Top Box Foods

UIC

UIC Chicago Partnership for Health Promotions

Westside ConnectED

Westside United

Windy City Harvest

Windy City Harvest- Chicago Botanic Garden

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