Rural Initiatives Addressing Community Social Needs

Madeleine Pick, MPH; Megan Lahr, MPH; Ira Moscovice, PhD

GOAL

Optimal health is determined by many factors that go beyond access to quality health care. As a result, hospitals in the U.S. have started to address the immediate social needs of their patients (such as food access or safe housing). The goal of this case series is to describe Critical Access Hospital (CAH)-based initiatives addressing social needs and to provide best practices for CAHs and communities that may wish to emulate these programs.

BACKGROUND

The Medicare Rural Hospital Flexibility (Flex) Program has an optional Program Area dedicated to CAH Population Health Improvement. Through this Program Area, State Flex Programs have the option to provide CAHs with resources to help them improve population health in their communities. This case series provides examples of CAH-driven initiatives addressing social needs that fall under the Population Health Program Area that can serve as examples for State Flex Coordinators looking to address social needs through Flex Program activities.

It is important to note that non-profit and community-owned hospitals, including CAHs, have obligations to improve the health needs in their communities. These obligations include the Internal Revenue Service requirements for reporting community benefit activities which may include programs and services to promote health in response to identified community needs,[1] community health needs assessments, as well as other commitments hospitals may make through their hospital mission statements. This case series illustrates how CAHs can improve their communities above and beyond the federal requirements.

CASE SERIES

We conducted key informant interviews with leaders in two CAH social needs programs:

- Food Access Initiatives, Lakewood Health System, Staples, Minnesota
- NEK Prosper, Northeastern Vermont Regional Hospital, St. Johnsbury, Vermont

DATA AND METHODS

These two CAHs were selected from a survey of CAHs identified by State Flex Programs as having initiatives to address social determinants of health. Of the 28 respondents to the survey, 14 CAHs that were currently operating a program in this area were interviewed. These two examples were selected from the group because they were the most developed programs and had been in operation for several years. Primary data for this case series was collected through semi-structured interviews with several leaders and stakeholders in the above rural programs in Vermont and Minnesota. Interviewees were asked about the goals and impact of their programs, the role of partnerships, and about the implementation of their initiatives. Interviews were recorded and analyzed for key themes using inductive methods.

KEY FINDINGS

- Both programs highlighted here are working to increase awareness of the needs in their community while demonstrating the role a CAH can take to assist with social needs. They emphasized that there are various strategies for CAH-based initiatives to address these needs. Lakewood Health System provides a focused approach on food access and support, while NEK Prosper addresses a range of social needs in their community.
- Key themes for successful initiatives emerged from our interviews, including strong partnerships, committed hospital leadership, and the importance of data to inform this work.
- Lakewood's major successes stem particularly from their strong hospital leadership and their ability to track measurable outcomes of their initiatives, while NEK Prosper's successes stem from a collaborative Accountable Health Community model that depends on relationships among community partners from a broad range of organizations.

LAKEWOOD HEALTH SYSTEM CASE STUDY

BACKGROUND

Lakewood Hospital is an independent Critical Access Hospital (CAH) that opened in 1936 in Staples, MN. Staples is located in Todd County, which was ranked 34th for health outcomes and 77th for health factors (out of 84 counties in MN) in the 2020 County Health Rankings. In their efforts to improve access to healthy food for residents in the community, Lakewood launched their "Food Farmacy" as a pilot project in 2015. This need was identified through the hospital's community health needs assessment (CHNA) and the program was inspired by the rich agricultural community surrounding the hospital. Since its inception, the Food Farmacy program has expanded, and Lakewood has launched additional food access initiatives including delivering fresh food to residents in senior housing, providing meals to patients upon hospital discharge, and supplying backpacks of food for students to bring home for the weekend.

FOOD ACCESS INITIATIVES

Food Farmacy

Lakewood's food access initiatives started with their Food Farmacy program in 2015. For this program, patients are screened by nursing staff with two questions for food insecurity during each clinic visit, and their answers are recorded in their Electronic Medical Record (EMR). If a patient screens positive for food insecurity, they receive a call from a Community Health Coordinator (CHC) to participate in the Food Farmacy for food pickups either once ("low dose") or twice ("high dose") per month. Food boxes for the Food Farmacy contain 8-10 pounds of lean meat and 12-15 pounds of fresh produce, with much of the produce grown locally. Acute care boxes of shelf-stable food are also available for same-day distribution if a provider identifies an emergent need for food.

In addition to receiving the food boxes each month, all participants receive educational materials and "high dose" participants meet with a Community Health Coordinator every other week. Educational classes are conducted in partnership with the University of Minnesota Extension program and cover a range of topics including budgeting, nutritious meal preparation, and smart grocery shopping. The program also utilizes the Bridge to Benefits screening tool to evaluate participants for eligibility in public support programs and other available resources.

The Food Farmacy serves approximately 140 families with 350 individuals. The goal is to transition "high dose" participants to the "low dose" pick up, but participants can continue with the program as long as necessary. Lakewood's Community Health Coordinator described examples of families that have been able to make ends meet in other areas because they have support from these programs. Other interviewees told stories of participants who were in tears because they were so grateful for the food boxes.

Pax Program

Lakewood has partnered with local schools and businesses to provide "Pax" – backpacks that contain two breakfasts and two lunches for students to take home every Friday during the school year. Not only does this program provide much needed nutritious food for families, but also engages the community by having local businesses volunteer to assemble the backpacks. Approximately 70 students participate in this program annually, identified by the school as having a need for meal support.

Meals at Discharge

Lakewood also provides frozen meals for patients age 55 and older upon discharge from an inpatient stay. After

finding a gap in availability of nutritious meals after discharge due to difficulty getting to the grocery store and/or cooking, Lakewood began providing this service to patients regardless of financial need. Lakewood's Chief Medical Officer (CMO) noted that this is beneficial for patients and their families, particularly for older adults whose children may not live in the area to help care for them while they recover. This program averages about 10 participants per month.

Fresh Delivered

Fresh Delivered is an initiative specifically for seniors (age 55 and older) who live in senior housing. Each month participants receive 8-10 pounds of lean meat and 12-15 pounds of fresh produce. Lakewood has seen a reduction in Emergency Department (ED) visits and hospitalizations for participants who receive these food boxes. It also offers a social opportunity for residents to cook and share meals together. Currently, the program provides food shares to approximately 200 seniors each year.

OTHER CONSIDERATIONS

Adjustments During COVID-19 Pandemic

The COVID-19 pandemic has highlighted the need for nutritious meals, especially for many residents in Lakewood's community who have lost income and for children who previously received meals provided through the school system. Lakewood is continuing operations for their Food Farmacy, with minimal adjustments to food pack pickups and education, and has also adapted their Pax program so students can receive delivered food. They have also started a program to provide meals to individuals and families who have tested positive for COVID-19, to alleviate the challenges associated with grocery shopping while under quarantine and cooking while sick. Surging COVID-19 rates in their community have led to surging rates of families struggling with episodic food insecurity as well. Through the end of November 2020, the "Meals at COVID Positive" initiative at Lakewood was able to distribute over 7,000 meals reaching over 500 individuals who were worried about accessing healthy food during their isolation period.

LAKEWOOD'S CMO BRINGS A FOOD FARMACY PACKAGE TO A PATIENT

Funding

Lakewood's food access programs are supported through funding from a variety of sources. The initial Food Farmacy program was supported by the hospital, hospital foundation, and funds from a Bush Foundation Innovations Award that Lakewood received. Lakewood also participates in the Integrated Health Partnerships (IHP) program through the Minnesota Department of Human Services. The IHP program, a key component of sustainable funding for Lakewood, has the goal to deliver "higher quality and lower cost health care through innovative approaches to care and payment."[2] Some of their other initiatives (Meals at Discharge and Fresh Delivered) are also supported by county public health partnerships and grants from various foundations.

Data

As part of their participation in the IHP program, Lakewood tracks participation in each of their food access initiatives. Because their food access program data are integrated into their EMR, they are also able to look at clinical measures before and after enrollment in the Food Farmacy. They found that among 54 patients, ED visits

were reduced from an average of 1.8 visits in the 12 months prior to enrolling in the Food Farmacy program to 0.9 visits in the 12 months after enrolling in the program. Further, the average A1C among 28 diabetic patients dropped below 7.0 (a common clinical benchmark for diabetic patients) after 12 months of enrollment in the Food Farmacy.

BEST PRACTICES

This section highlights common themes and insights discussed in conversations with individuals involved in the food insecurity initiatives at Lakewood.

Increasing awareness and positive workplace culture

By creating these food access initiatives, Lakewood has made it clear to their staff and the wider community that they value improving population health beyond the hospital walls. As Lakewood's Director of Community Health told us, the programs are increasing awareness of food insecurity in Staples and their broader service area, and reducing stigma for individuals who need extra support. This commitment also brings attention to the many factors beyond health care that influence the health of individuals and communities. The food access initiatives have highlighted the role a hospital can play in impacting health beyond traditional hospital care. Lakewood's Chief Executive Officer (CEO) described this philosophy: "Hospital care only impacts about 20% of health in the population. Our vision is to focus on the 100%." Additionally, he said he believes the programs have expanded community members' perceptions about health care and the hospital as an organization.

Some of the Lakewood staff we interviewed discussed how the programs have increased awareness about food insecurity among their physicians and nursing staff. For example, the Food Farmacy program identified some patients who were not taking their medications as prescribed because they did not have enough food to eat with their medications. Prior to screening for food insecurity, providers often did not know why their patients were non-compliant.

Part of the programs' success depends on provider participation and a workplace culture that supports these initiatives, which has been strong at Lakewood. Lakewood's CMO told us "There is a reason doctors work here in this rural, poor area. There is compassion for that." Lakewood's CEO echoed this sentiment, saying, "Providers got into this to make a difference for people. If you can add a program and get involved in social determinants of health, it makes the physicians feel more rewarded for the work they're doing every day." Additionally, the Food Farmacy program offers Lakewood employees food boxes for purchase. Lakewood's CMO noted that this helps reduce stigma of the program, because everyone picks up their food at the same place and time, whether they are receiving it for free or paying for it.

Collaboration

Many key informants emphasized the importance of collaboration and partnerships in the food access efforts. One major partnership is between Lakewood and local produce growers. Lakewood's CMO, who is also a grower, said, "Everybody wants to see their food eaten and not wasted, everybody who grows loves to see people who need it get their hands on that food. And that brings such a sense of accomplishment and that full circle feeling to growing."

"Everybody wants to see their food eaten and not wasted, everybody who grows loves to see people who need it get their hands on that food. And that brings such a sense of accomplishment and that full circle feeling to growing."

Some programs also rely on partnerships with local public health, schools, senior living residences, and other organizations in order to identify needs and provide food. Todd County has been a strong partner for Lakewood and collaborated on funding various aspects of their food access initiatives, and the University of

Minnesota Extension has been instrumental in providing educational classes and materials. The stakeholders we interviewed all agreed that these partnerships were a key component for sustainable programming. As explained by Lakewood's CEO, "This is not a time to be looking at competition… it doesn't matter who's got the money, what matters is what the outcome is."

Leadership and system support

Another theme that emerged in our interviews is the importance of strong leadership and system support. The Community Health Manager at Todd County emphasized the impact of having a CEO commit to these efforts and appoint the right person to create these programs. She said being a small facility definitely helps, and the hospital has established a different mentality that could continue beyond the current executive leadership.

Lakewood's Chief Financial Officer told us that as the largest employer in a small town, it was important for the health system to show support for the larger community. By backing these food access initiatives, the Lakewood Health System has demonstrated to the community and its employees that they see the value in addressing health needs beyond traditional hospital care.

Analytics and tracking outcomes

Lakewood has prioritized tracking outcomes related to their food access initiatives. With food insecurity screening integrated into their EMR, they are able to assess the relationship between a patient's food insecurity, their existing health conditions, and measures of physical health. By tracking these measures along with whether an individual participates in a program like the Food Farmacy, Lakewood can quantify the impact of their programs and how they make a difference in the lives of their patients. As Lakewood's CEO told us, "If we can prevent unnecessary admissions, unnecessary ER visits, unnecessary tests, then we know we're making a difference at the end of the day for our patients."

Data collection is ongoing and Lakewood will continue using available metrics to assess outcomes and optimize their food access programs. Lakewood's Director of Community Health pointed out a need to further evaluate what amount, frequency, and type of food achieves the best outcomes. They also hope to do more in-depth analyses of outcomes for particular patient populations, such as those with chronic heart failure or diabetes. She said they are striving to figure out an economic and feasible approach while also wanting to meet participants where they are in terms of health literacy, cooking knowledge, and current habits.

SUMMARY

Lakewood has leveraged their agricultural community and the identified need for food support to provide an array of programs for local residents. They continue to raise community awareness and reduce stigma around food insecurity. Lakewood's data thus far have shown promising results related to these programs, and they plan to continue collecting data to assess their impact. Overall, stakeholders we interviewed stressed the importance of collaboration with other local organizations and growers, as well as having strong leadership and system support.

NEK PROSPER CASE STUDY

BACKGROUND

NEK Prosper is an Accountable Health Community that operates with Northeastern Vermont Regional Hospital (NVRH) as its backbone organization. NVRH is a non-profit, independent hospital located in the town of St. Johnsbury, Vermont and serves residents in Caledonia and Essex counties, the southern half of the region known as the Northeast Kingdom (NEK). According to the 2020 County Health Rankings (CHR), these counties rank among the lowest in Vermont for health outcomes and health factors. NVRH's service area includes 30,000 residents.

The Accountable Health Community Model is a key component of Vermont's statewide Blueprint for Health,[3] which designs community-led strategies for improving health and well-being. The Vermont Blueprint for Health supports Vermont communities that are introducing Accountable Health Communities by offering a curriculum, recommendations, and an evaluation. This model used by NEK Prosper places emphasis on serving everyone who lives in a geographic region regardless of where they receive health care. The model also focuses on addressing social needs and involving partnerships beyond just health care organizations. NEK Prosper was formed in 2014 after the hospital's community health needs assessment (CHNA) found that poverty was a large contributor to health disparities in the region. NEK Prosper operates with five collaborative action networks (CANs): Well Nourished, Well Housed, Mentally Healthy, Physically Healthy, and Financially Secure. Each CAN engages local partners, including community-based committees and coalitions, in their focus area and works with other CANs to ensure they are not duplicating efforts.

OPERATION OF NEK PROSPER

NEK Prosper's five CANs each focuses on a specific area for activities. Meetings for each CAN attract participants from a variety of organizations and community residents who work together toward shared goals. Many organizations are active in multiple CANs. Each CAN is tasked with choosing a strategy or intervention to address their goals and is encouraged to use evidence based or evidence informed strategies. The main goals and activities of each CAN are described below. The funding for NEK Prosper mainly comes from Northeastern Vermont Regional Hospital, and the rest of the cost is attributed to the in-kind and other contributions of CAN members and their organizations.

Well Nourished CAN

The Well Nourished CAN works to increase residents' consumption of fruit and vegetables. The goal is measured through data from the Behavioral Risk Factor Surveillance System (BRFSS), which is a national survey resulting in state and county-specific data about health and health-related behaviors. The Well Nourished CAN supports this goal through a variety of activities. One example is a multi-channel social marketing campaign called Food Hero, a strategy designed at Oregon State University that has seen success in many other communities. The message behind the campaign is that healthy foods can taste good and fit within a household's budget. During the COVID-19 pandemic, CAN member organizations concentrated efforts to get food to people in need. CAN partnerships, such as a mobile produce drop called Veggie Van Go, continued to provide produce for community members during this challenging time.

Well Housed CAN

The Well Housed CAN aims to increase more affordable housing options in the community. This group researched the needs in the Northeast Kingdom and identified a gap in housing for mothers, either pregnant

or with very young children, who are in recovery from substance use. To address this issue, the CAN has established the Families in Recovery Staying Together (FIRST) home, based on research showing that peer-supported housing is a proven, successful model for some individuals struggling with substance use. FIRST Home will provide a safe, affordable place to live and support residents on their journey, while helping them provide for their basic needs. This includes peer-supported housing for four families, with separate bedrooms and bathrooms and a shared kitchen and living space. The FIRST home will not provide substance use treatment or counseling, but has worked with maternity providers, alcohol and drug rehabilitation programs, and NVRH to develop a referral process for potential FIRST home participants. At the time of the interviews, the CAN expected their first residents in spring 2021.

Mentally Healthy CAN

The Mentally Healthy CAN aims to improve the mental health of community members, not just through the absence of mental illness but also by encouraging a sense of belonging in one's community, family, and workplace; coping with life's stressors; and knowing where to reach out for help in challenging times. In addition to these goals, the CAN has done work related to suicide prevention, following two student deaths by suicide in the community. Efforts have included building capacity for suicide prevention trainers, increasing suicide awareness at community events, and supporting a walk for suicide awareness organized by middle school students.

In 2020, the Mentally Healthy CAN conducted a community survey about attitudes and beliefs about mental health in the Northeast Kingdom. They received over 600 responses to the survey and found strong agreement that mental health is as important as physical health. The results also showed agreement that respondents were supportive of others with mental health conditions, but mixed responses on whether they might hide their own mental health concerns from others. The Mentally Healthy CAN hopes to use these results to inform their messaging and future campaigns.

NEK'S ENERGIZE 365 CAMPAIGN KICK-OFF EVENT

Physically Healthy CAN

The primary goal of the Physically Health CAN is to promote daily physical activity. The Physically Healthy CAN has a community-wide campaign called Energize 365, which focuses on the message that being physically active can be fun without requiring a lot of time or money. Energize 365 was launched in summer 2018 with a stationary bike competition, leveraging an existing high school football rivalry between two adjacent towns. Bikes were placed in highly visible areas in local parks for residents' use to see which town could ride the most miles. Free Pop Up fitness classes were also offered in those parks throughout the summer in 2018 and 2019. With the COVID-19 pandemic limiting in-person events, the Physically Health CAN has focused on outreach, maintaining an active Facebook page to keep the community engaged, and sponsored an online Energize Expedition event to encourage local residents to get out and enjoy the outdoors.

Financially Secure CAN

The main goal of the Financially Secure CAN is to raise the median household income by improving employee retention, increasing the employment rate and length of employment, and providing training and education for employees. The CAN sponsored a pilot program for a soft skills development training for NVRH employees. The training was successful, as evidenced by participating employees who saw the value in the training and

managers who saw improvement in skills such as being on time for work, co-worker relationship skills, and self-confidence. The CAN hopes to broaden the program to more businesses in the community.

BEST PRACTICES

In interviews with individuals involved in each of the CANs, as well as some of the NEK Prosper leadership team, several themes emerged that we highlight below.

Partnerships for Success

An overarching theme that arose during interviews was the importance of partnerships and collaboration. Because the CANs are comprised of individuals who also work for or are involved in other local organizations, NEK Prosper has evolved into a large network that includes schools, the Northeast Kingdom Council on Aging, the Vermont Department of Health, the National Alliance on Mental Illness (NAMI), local housing organizations, maternity care providers, alcohol and drug rehabilitation programs, and more. Together, the organizations involved in the NEK Prosper initiatives were able to learn from each other and maintain momentum to achieve their CAN's goals. A member of the NEK Prosper leadership reported that "[NEK Prosper] allows local organizations to have a place to come together and work through hard problems... they ask the question of 'what's best for our community?' first and 'what's best for our organization?' second."

As the backbone organization, NVRH has provided a great deal of support for NEK Prosper. The hospital led the program's creation and implementation, and continues to provide financial and logistical support, such as offering space for meetings and the use of technology. By supporting the work of NEK Prosper, NVRH and other local health care organizations have demonstrated their commitment to a broader view of health for their community. A local health care CEO and member of the NEK Prosper leadership team also described the backing from his board of directors. He noted that since his involvement in NEK Prosper is written into his organization's strategic plan, his board is supportive if he approaches them with an idea addressing social needs. Another participant noted that NVRH continually supports the work of the CANs, saying "[NEK Prosper] brings people together to have conversations about improving our community and the health and wellbeing of those who live there."

"[NEK Prosper] brings people together to have conversations about improving our community and the health and wellbeing of those who live there."

Through these different types of partnerships, many individuals also brought up how important trust has been in the success of NEK Prosper. For some partnerships, trust may take longer to develop. As one member said, "Before any community tries to do any of this, they've got to spend some time on the trust part because none of this works if you don't trust the people."

Community Impact

The CANs use population level data collected by the Vermont Department of Health, Vermont Agency of Human Services, and other agencies as baseline measures of social needs in the region. With limited designated evaluation staff, tracking measurable outcomes has been challenging. The CANs rely on Results Based Accountability methods to track program performance level measures such as how many people participated and self-report a change in behavior or attitude.

Collectively, NEK Prosper has pushed community members to think about health in a broader way. This initiative has already shown the impact of collective action, using community data to identify areas for potential

impact, and keeping a focus on pinpointing community needs. Some respondents said that their focus on doing many smaller initiatives, rather than attempting to take on a few big projects, has been successful. Others have decided to hone in on specific segments of the population who are at risk for having high social needs. An example of this is the FIRST home created by the Well Housed CAN. The CAN chose to focus on mothers in recovery from substance use who are at risk for not having stable housing. In doing so, they are able to provide peer-supported housing to four families.

SUMMARY

By bringing together a number of organizations with a shared belief in a broader definition of health, NEK Prosper has demonstrated its potential to impact social needs in its community. Support and backing from NVRH has made this possible, and individuals interviewed identified all of the partnerships established through their CANs as essential to the continuation of this initiative. While the COVID-19 pandemic has halted or delayed many of NEK Prosper's activities, members have found creative ways to keep up momentum through digital platforms and are taking this time to reassess some of their planned initiatives.

NEK Prosper has taken a broad approach to addressing social needs in their community and are beginning to demonstrate why the impact of these efforts are important through community feedback and engagement. Furthermore, they have a solid foundation of hospital-community engagement and their efforts to improve data collection related to each of their initiatives will be critically important to document the impact of their work.

REFERENCES

1 "Instructions for Schedule H," Internal Revenue Service, 2019, https://www.irs.gov/instructions/i990sh

2 Integrated Health Partnerships," Minnesota Department of Human Services, last modified August 24, 2020, https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/integrated-health-partnerships/

3 "Accountable Communities for Health," State of Vermont Blueprint for Health, http://blueprintforhealth.vermont.gov/about-blueprint/accountable-communities-health

For more information on this study, please contact Madeleine Pick at pickx016@umn.edu.

This study was conducted by the Flex Monitoring Team with funding from the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services (HHS), under PHS Grant No. U27RH01080. The information, conclusions, and opinions expressed in this document are those of the authors and no endorsement by FORHP, HRSA, or HHS is intended or should be inferred.