PHM INITIATIVE

PHMI Statewide Learning Session, Day 2

March 6, 2025

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PHMI Food is Medicine

Foundations & Project Kick-Off

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Learning Objectives

By the end of the session, attendees (including FQHC leaders and PHMI coaches) will be able to:

- Describe the new **PHMI Food is Medicine SME support.**
- Describe the **range of food is medicine (FIM) interventions and their clinical benefits** to patients, including populations of focus.
- Identify at least three concrete opportunities through PHMI to **increase access to FIM interventions** and improve clinical outcomes through partnerships.
- **Provide input on PHMI Food is Medicine Supports.**

Why Food is Medicine (FIM) in PHMI?

Launching of the Kaiser Permanente's Food is Medicine Center of Excellence

- The goal of the **Food is Medicine Center of Excellence** is to treat and prevent diet-related diseases and reduce hunger to accelerate the uptake of Food is Medicine programs at KP and nationally.
- Opportunities to leverage KP's Food is Medicine resources in PHMI:
  - Patient education for healthy eating
  - Care team education on nutrition
  - Lessons learned for screening and connecting to medically tailored meals and groceries and optimizing SNAP and WIC

How Food is Medicine Supports PHMI's Populations of Focus

1) Supporting CHCs focusing on **Adults Living with Chronic Conditions** to: Implement chronic care management activities

Children

Pregnant People

Adults with Preventative Care Needs

Adults Living with Chronic Conditions

People with Behavioral Health Conditions

Foundational Competency: Implement Chronic Care Management Activities (Chronic Condition PoF)

A documented approach or evidence of care teams supporting goal-setting and self-management support among attributed populations with poor A1c control and/or high blood pressure

PHMI Core Measures: FIM Targets

PHMI Populations of Focus	Core PHMI Measures (note: not necessarily defined the same as HEDIS measures)	The Case for Food is Medicine
Adults living with chronic conditions: **hypertension**	**Controlling High Blood Pressure** Percentage of 18-to 85-year-old people with hypertension whose blood pressure was adequately controlled (<140/90 mm Hg)	**Diastolic blood pressure significantly improved** for participants in a study (n=80) who accessed food assistance at least four times and who had high blood pressure. The FIM intervention included a food package, educational booklet and recipe cards provided during a medical appointment. Participants were eligible to receive another food package during clinic hours six additional times with visits limited to once per month. Study: Wetherill et al. (2018)
Adults living with chronic conditions: **diabetes**	**Comprehensive Diabetes Care** Percentage of 18-to 75-year-old people with diabetes whose hemoglobin A1c was not under control (>9.0%)	Participants (n=69) experienced **a mean three-month change in HbA1c** (primary outcome) nearly a half point lower with meal delivery (-0.44% [95% CI: -0.85%, -0.03%]; P = 0.037) in a randomized control trial to study the impacts of a diabetes-designed meal delivery program. Study: Farford et al. (2024)

How Food Is Medicine (FIM) Supports PHMI's Chronic Conditions PoF

Enhancing Chronic Disease Management

FIM provides **nutrition education and food-based interventions** tailored for patients with **diabetes and hypertension**, key chronic conditions prioritized by PHMI.

Access to **medically tailored meals and nutrition prescriptions** supports disease management and improves patient outcomes.

Patient Education for Self-Management

FIM **curates and develops patient education resources** that are culturally and linguistically appropriate, helping CHCs empower patients to make **informed dietary choices** to manage their conditions.

Education materials address **meal planning, sodium reduction, glycemic control, and healthy cooking**, reinforcing PHMI's focus on **preventive and proactive care**.

Integrating Social Health with Clinical Care

CHCs using FIM resources can incorporate **food prescriptions and grocery assistance** into **care planning and follow-up**, aligning with PHMI's **whole-person care** approach.

How Food is Medicine Supports PHMI's Populations of Focus

1) Supporting all CHCs: Create a health-related social needs screening process that informs patients' treatment plans. (Specific to where FIM intersects: food insecurity)

Children

Pregnant People

Adults with Preventative Care Needs

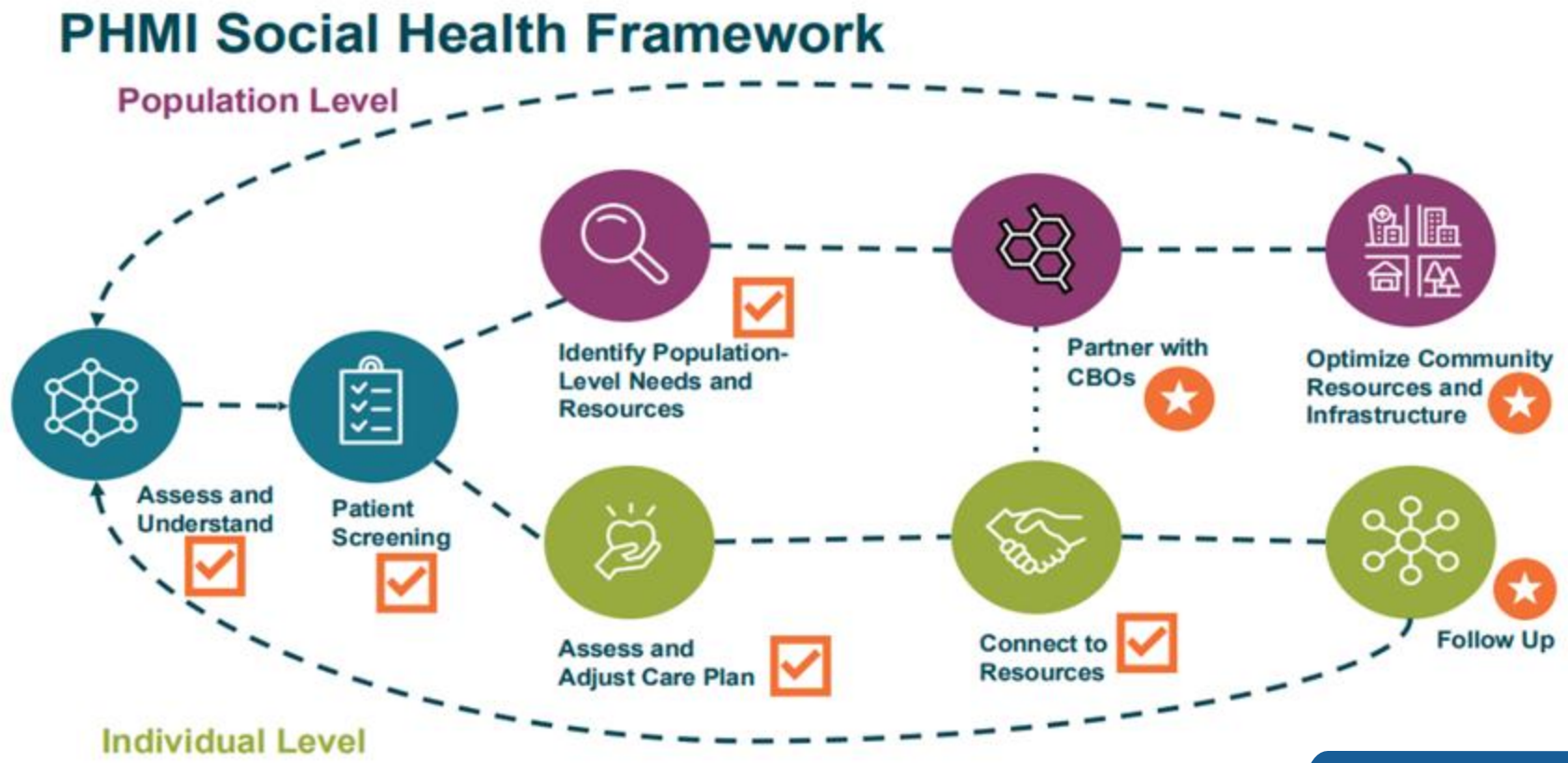
Adults Living with Chronic Conditions

People with Behavioral Health Conditions

Foundational Competency: Create a health-related social needs screening process that informs patients' treatment plans (all PoFs).

- Identify at least 1 social health risk to screen for in PoF, based on assessment of need in PoF and critical barriers to care.
- Determine how the assessment is administered.
- Decide who administers the assessment.
- Clarify what happens to screening results (how they are documented).
- Modify care plan based on screening results.
- Create a process of referral to community resources.

HealthBegins will increase capacity of PHMI stakeholders, including Community Health Centers, to use FIM interventions to improve health at the population and individual level.



How Food Is Medicine (FIM) Supports PHMI's Social Health Framework

Addressing Food Insecurity as an SDOH

- **25 of our CHCs currently track food insecurity data** and FIM helps understand how to optimize your workflows and resources in your community to address **food insecurity** needs.

Partnering with CBOs

- Our FIM SMEs will work to strengthen **collaborations between CHCs and community-based organizations (CBOs)**, ensuring patients have access to **nutrition programs, food pharmacies, and culturally appropriate food resources.**

Modifying Care Plans for Patients with Food Insecurity

- Care plan strategies shift in conditions with food insecurity. Our FIM SMEs will help us understand what to **assess and adjust in care plans** in response to food insecurity data.

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Introducing Our Food is Medicine SMEs from Health Begins

Our Food is Medicine PHMI Team

Rishi Manchanda, MD, MPH

CEO

Kathryn Jantz, MSW, MPH

Senior Associate

Eva Batalla-Mann, MPH, MSW

Program Manager

About Us

HealthBegins is a mission-driven consultancy firm that drives radical transformation in health by helping Medicaid-managed care plans, health systems, and social sector clients advance health equity and improve the social and structural drivers that put patients and communities in harm's way.

HEALTH BEGINS

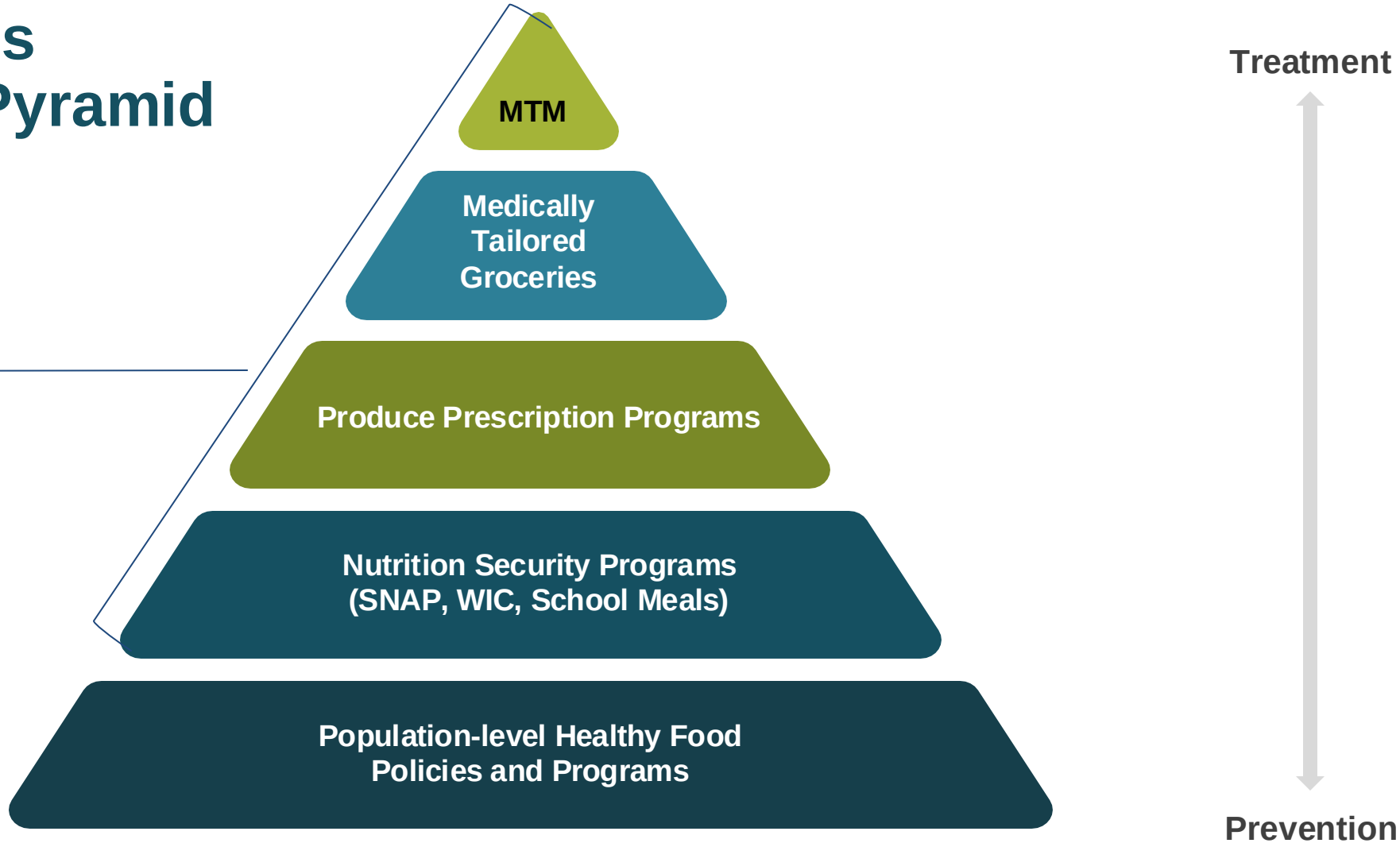
What is Food is Medicine?

"The last time I checked my textbooks, the specific therapy for malnutrition was, in fact, food."

- Jack Geiger MD, Co-founder of the U.S. Community Health Center model

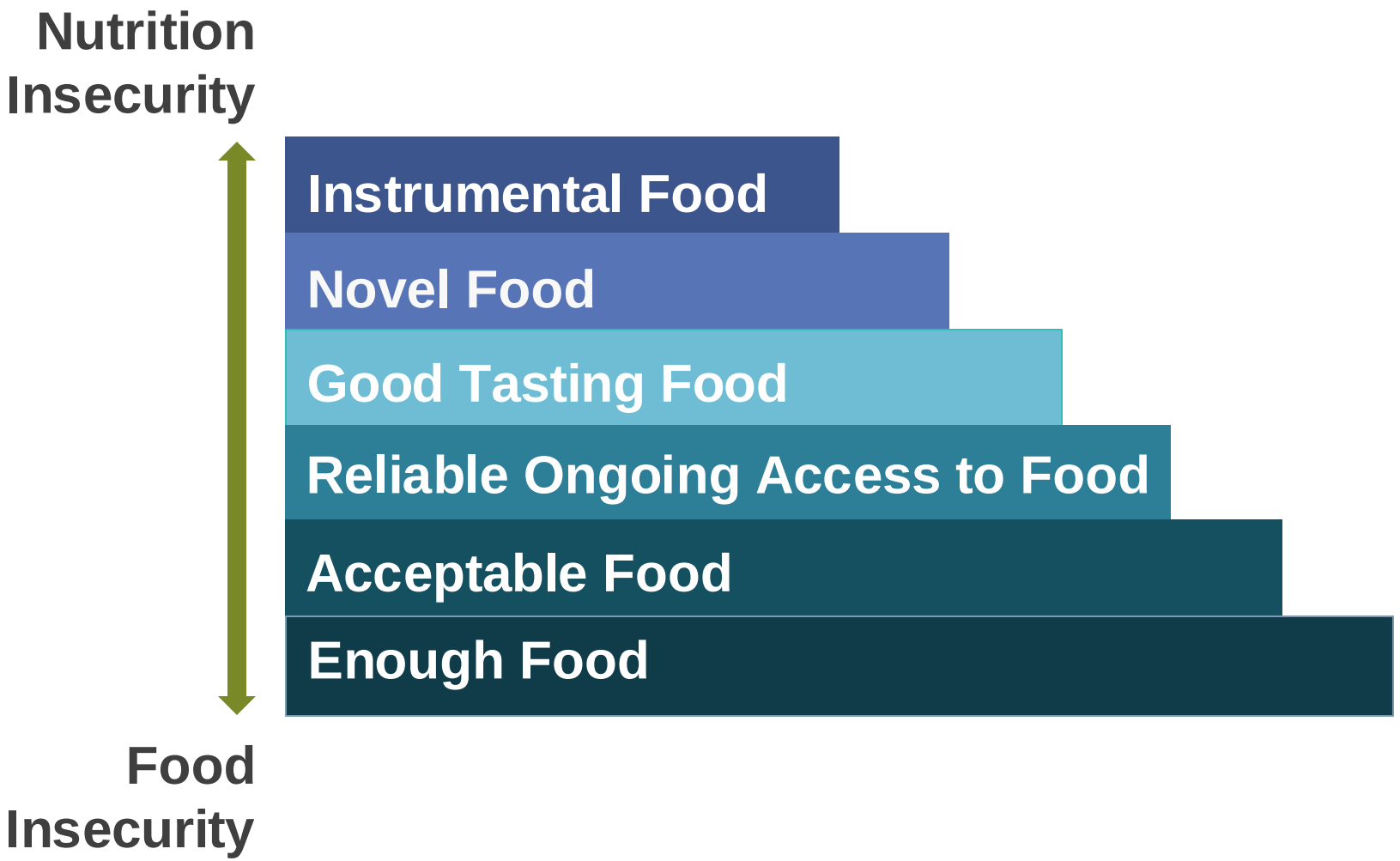
Lubinger, B. (n.d.). *A public health pioneer.* Case Western Reserve University. https://case.edu/think/spring2016/public-health-pioneer.html
Grady, D. (2020, December 28). *H. Jack Geiger, doctor who fought social ills, dies at 95.* The New York Times. https://www.nytimes.com/2020/12/28/health/h-jack-geiger-dead.html

The Food Is Medicine Pyramid



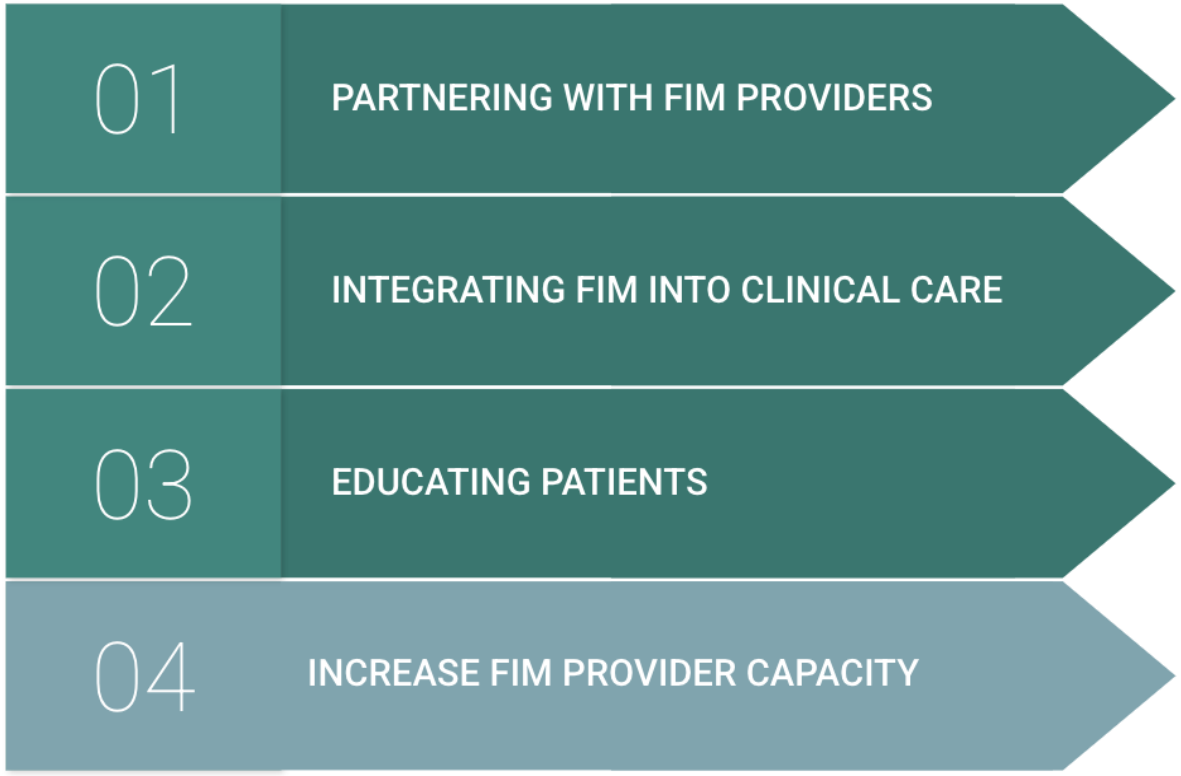
Mozaffarian D, Blanck HM, Garfield KM, Wassung A, Petersen R. A Food is Medicine approach to achieve nutrition security and improve health. Nat Med. 2022 Nov;28(11):2238-2240. doi: 10.1038/s41591-022-02027-3.
Food is Medicine Fact Sheet, Tufts University, August 2023
Seligman, H. K., Smith, M., Rosenmoss, S., Marshall, M. B., & Waxman, E. (2018). Comprehensive Diabetes Self-Management Support From Food Banks: A Randomized Controlled Trial. *American journal of public health*, *108*(9), 1227–1234. https://doi.org/10.2105/AJPH.2018.304528

The Goal of Food Is Medicine



Satter, E. (2007). Hierarchy of food needs. Journal of Nutrition Education and Behavior, 39(5), S187-S188. https://doi.org/10.1016/j.jneb.2007.01.003

PHMI Food is Medicine Support



Program Outcomes

- **Reduce blood pressure**
- **Improve diabetes management (HEDIS measure)**
- **Reduce depression duration**
- **Improve food security**

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FIM Interventions Can Support PHMI Health Centers

Landscape Snapshot: Increasing Access to Food is Medicine Interventions Using Three Pathways

Maximizing Enrollment

- **Food Benefits**
  - Supplemental Nutrition Assistance Program (SNAP)
  - Supplemental Nutrition Assistance Program for Women, Infants and Children (WIC)
  - Senior Farmers Market Nutrition Program
  - Commodity Supplemental Food Program
- **Medi-Cal Resources**
  - Community Supports Services - Medically Supportive Food and Medically Tailored Meals

Connecting to Community Resources

- **Referrals**
  - Provide information on community resources
  - Develop warm handoffs
- **Partner with community resources**
  - Develop-in house supports like food banks

Nutrition Education and Counseling

- **Healthy Eating Education**
  - Cooking classes
  - Shopping and budgeting
- **Behavioral Coaching**
  - Support patients to make healthier choices that center access and culture

Our Commitment to PHMI

- To provide the PHMI CHCs and their partner Food is Medicine providers with **practical and pragmatic tools, resources and support** to efficiently implement or expand their FIM strategies.
- To **incorporate CHC requests, preferences and recommendations** into our strategy.
- We recognize there are many demands on your time and resources and look forward to **building on your current population health initiatives**.

Optional CHC Participation

- **Provide input** on your KP FIM needs today, through your coaches and through other optional forums.
- **Review and incorporate tools** and materials into your clinic workflow, as appropriate and useful.
- Engage in **optional peer learning opportunities,** as requested and scheduled.

How Can the FIM SMEs Support PHMI CHCs?

For each category below, please take 5 minutes to write down at least one FIM-related topic you'd most like to learn more about this year (1 idea per sticky note).

Categories		Example Learning Topics		Tool Examples Across the PHMI Social Health Framework
		Social Needs Screening ☆	Chronic Care Management Activities ☆	
01	PARTNERSHIP RESOURCES	• Referral Workflows ★ • Memorandums of Understandings with FIM Providers ★ • Data Sharing with FIM providers ★		Process Map Example MOU Case Study
02	CLINICAL TOOLS AND OPPORTUNITIES	• Clinic-based Cooking Curriculum ★ • Coding for Food Insecurity and FIM ★ • Food Insecurity Screening Best Practices ★ • Clinical Decision Tree for FIM ★★		Cookbook Coding Resource Peer to Peer Learning Session
03	PATIENT EDUCATION MATERIALS	• Shopping and Cooking on a Budget ★ • FIM Resource Guide Template ★★ • Engaging Patients in FIM Interventions ★★ • Condition-Specific FIM Information ★		Didactic Live Practice Guide Recorded Training Module

Welcome

March 6, 2025

Photo Credit: RODNAE Productions from Pexels, retrieved 2/14/25 from anthropologyinpractice.com

Getting Started Together

Today's Agenda: March 6, 2025

01	Breakfast | Optional: Introducing Food is Medicine to PHMI	*50 mins*
02	Improving Health Outcomes in our Populations of Focus (PoF)	*160 mins*
03	Lunch	*60 mins*
04	Managed Care Plan (MCP) Panel: Advancing PHM in Partnership with Health Centers	*45 mins*
05	Break	*10 mins*
06	Breakouts	*90 mins*
07	Break	*15 mins*
08	PHMI Partner Panel: Priorities and Lessons Learned from California's Practice Transformation Initiatives	*60 mins*
09	Closing and Gratitude	*20 mins*

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Improving Health Outcomes in our PoF

Please attend the room assigned to your PoF

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Populations of Focus Breakouts

Children:
Studio 1

Pregnant People:
Studio 2

Adults with Preventive Care Needs:
East Ballroom

Adults Living with Chronic Conditions:
General Session

People with Behavioral Health Conditions:
Studio 3

Facilitators: Chronic Conditions

Dr. Fiona Donald

Chronic Conditions
PoF SME

Dr. Danielle Oryn

Chief Medical Officer/Chief Medical Informatics Officer

Aliados Health

Claire Richardson

Coach

Facilitators: Behavioral Health

Emma Ansara

Behavioral Health PoF SME

Elena Thomas Faulkner

Coach / Project Director

Facilitators: Pregnant People

Dr. Lyn Yasumura

Pregnant People PoF SME

Eugenia Black

Coach

Facilitators: Adult Prevention

Margaret Franckhauser

Adult Prevention PoF SME

Paul Howard

Senior Director, IHI

Lindsay Lozada-Dietz

Coach

Facilitators: Children

Dr. Gena Lewis

Children PoF SME

Denise Armstorff

Coach

Learning Objectives

1. Share wins and points of pride in your PHM work.
2. Identify next steps to "unstick" obstacles to your PoF action plan.

Agenda

01	Welcome and Organizing the Open Space Activity	*20 mins*
02	Sharing the focus of our population health management work	*20 mins*
03	Open Space Discussions	*80 mins*
04	Transition back to plenary room	*5 mins*
05	Sharing Out Across Populations of Focus	*30 mins*

Organizing the Open Space Activity

Our theme: Improving our population health management capabilities and outcomes in our PoF

(5 MINUTES) Review the topics we surfaced yesterday and add other topics. *Your topic can be a problem, an idea, or an emerging solution.*

(10 MINUTES) Write your name on 2 topics you'd like to attend.

What's next:

- While you connect with each other in the pair and share, facilitators will assign locations for each group to meet.

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Pair and Share

Wins and Points of Pride

What are you currently testing with your Population of Focus, and what do you hope happens?

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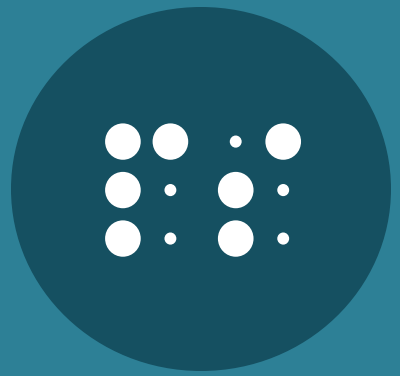
Open Space

Principles of Open Space

- Open sessions are peer-to-peer group discussions.
- Attend sessions that inspire you to contribute.
- The idea is to explore different ideas and deepen connections.

Whoever comes is the right group
Whatever happens is the only thing that could have
Whenever it starts is the right time
When it’s over, it’s over



Launching the Open Space Activity

Our theme: Improving our population health management capabilities and outcomes in our PoF

- There will be 2 rounds of 30 minutes
- Join one of your selected topics
- **Open space sessions work with groups of 2-10 people.** If a table is too full, just move on. If you're leading a session and no one shows up, join another group. If you're done with a session—for whatever reason—leave and check out another group.
- Open Space Discussion group leader role:
  - Kick off the conversation.
  - Complete the capture sheet before we leave this room.

60 Minutes

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Gathering in Plenary Room

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Pairs and Shares

Partner with someone who was not in your PoF breakout room

What We're Taking Home with Us

What's an idea that you are taking back with you?

How will the size of your patient population influence how you may test that idea?

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LUNCH

60 minutes | Return at 12:55 pm