RHIP Clinical Diabetes Workgroup
Deschutes County Health Services—Stan Owen Room
2577 NE Courtney Drive, Bend

Agenda: February 8, 2018 from 9:00am-10:30am

Goals

Clinical Goal: Improve control of type 2 diabetes.

Prevention Goal: Decrease the proportion of adults and children at risk for developing type 2 diabetes.

Health Indicators by 2019	QIM Measure	State Measure	Healthy People 2020
1. Decrease the prevalence of adults who are overweight (BMI 25 to 29.9) from 33% to 31% (Baseline: Oregon BRFSS 2010-13).			√
2. Decrease the prevalence of 11th graders and 8th graders who are overweight from 14% and 16%, respectively, to 13% and 14%, respectively (Baseline: Oregon Healthy Teens, 2013).			√
3. Decrease the percentage of OHP participants 18-75 years of age with diabetes who had HbA1c >9.0% from a baseline of 14.7% to 11% (Baseline: QIM NQF 0059 - Diabetes: HbA1c Poor Control, 2014).	√		√
4. Increase the percentage of OHP participants 18-75 years of age with diabetes who received an annual HbA1c test from a baseline of 77% to 87% (Baseline: NQF 0057 - Oregon State Performance Measure, 2014).	√	√	√
5. Decrease the percentage of OHP participants with BMI greater than 30 from 31.5% to 30.9% (Baseline: Oregon State Core Performance Measure, MBRFSS 2014).		√	√

1. 9:00-9:05 **Introductions—All**
2. 9:05-9:40 **Finalize Algorithm Development of A1C of > 9—All**
   - **Finalize Back of Algorithm**
3. 9:40-10:05 **Compare/Contrast Potential Algorithms—All**
   - **A1C of 6.5-7?**
   - **A1C of 7-8?**
   - **A1C of 8-9?**
4. 10:05-10:30 **HDFFA Veggie Rx Proposal—Marielle Slater (15 minutes)**
   - **Member Discussion & Vote (10 minutes)**
5. 10:30 **Action Items—All**
   - **Next steps**

Next Meeting: **March 8, 2018 from 9-10:30am**

Diabetes - Clinical (12)	Organization
Megan Bielemeier, MSN, BSN, RN, CCM	Caravan Health
Patty Kuratek, RN, MSN, CDE	La Pine Community Health Center
Therese McIntyre	Mosaic Medical
Eden Miller, DO	High Lakes Healthcare - Sisters
Kevin Miller, DO	High Lakes Healthcare - Sisters
Albert Noyes, PharmD, CDE, BC-ADM	Mosaic Medical
Kelly Ornberg, RD, LD	St. Charles Health Systems
Marielle Slater, PhD	High Desert Food & Farm Alliance
Shiela Stewart, RN, BSN	Central Oregon IPA
Crystal Sully, BSN, RN	Deschutes County Health Services
Ginger Walcutt, MPH	PacificSource
Sarah Worthington, MPH, RD	Deschutes County Health Services

TYPE 2 DIABETES A1C > 9 ALGORITHM:
CENTRAL OREGON

ORIGINATING VISIT

- Non-PCP screening (i.e. dentist, specialist, community event)
- Labs:
  - A1c > 6.4
  - Blood glucose >200
- Refer to PCP

DIAGNOSIS

- PCP visit
- A1c >9
- PCP Diagnosis of uncontrolled diabetes

PCP ROLE

- Review medications/associated labs and clinical findings
- AACE recommended medications (refer to reverse side)
- Assess comorbidities
- Address hypertension, hyperlipidemia, renal function (microalbuminuria, G.F.R., serum creatinine) cardiovascular risk reduction
- Referral to Specialty Care where needed:
  - Behavioral Health
  - Certified Diabetes Educator
  - Dental
  - Endocrinologist
  - Opthamologist
  - Podiatrist
  - Registered Dietitian Nutritionist
- Provide Key Advice (e.g.):
  - Motivational Interviewing
  - Lifestyle advice
  - Nutrition & exercise
- Orders During Visit:
  - Order next A1c: 3 months out
  - Schedule care team or PCP visit in 4-6 weeks
  - Place order for Registered Dietitian Nutritionist visit

CARE TEAM ROLES

CARE COORDINATION

- Assess for Social Determinants of Health:
  - Food insecurity
  - Ability to pay bills
  - Stable housing
  - Social support
  - Interpersonal Safety
  - Language/literacy
  - Culture
  - Transportation to appointments
- Ensure patient has/obtains glucose monitor
- Confirm A1c test is ordered every 3 months until A1c<7
- Schedule Care Team appointment in 4-6 weeks

EDUCATION

- Provide High Level Education:
  - Medication adherence
  - Glucose targets
  - Hypoglycemia prevention
  - Risk reduction
  - Goals & treatment plan
  - Lifestyle
  - Tobacco cessation
  - Self-monitoring of blood glucose

REFERRALS

- Behavioral Health where appropriate: (i.e. depression, comorbidities, tobacco)
- Certified Diabetes Educator
- Clinical pharmacist
- Community classes: Diabetes Self-Management (DSM), etc.
- Community resources (exercise groups, cooking classes, WIC, etc.)
- Dental
- Registered Dietitian Nutritionist
- Retinal Eye Exam

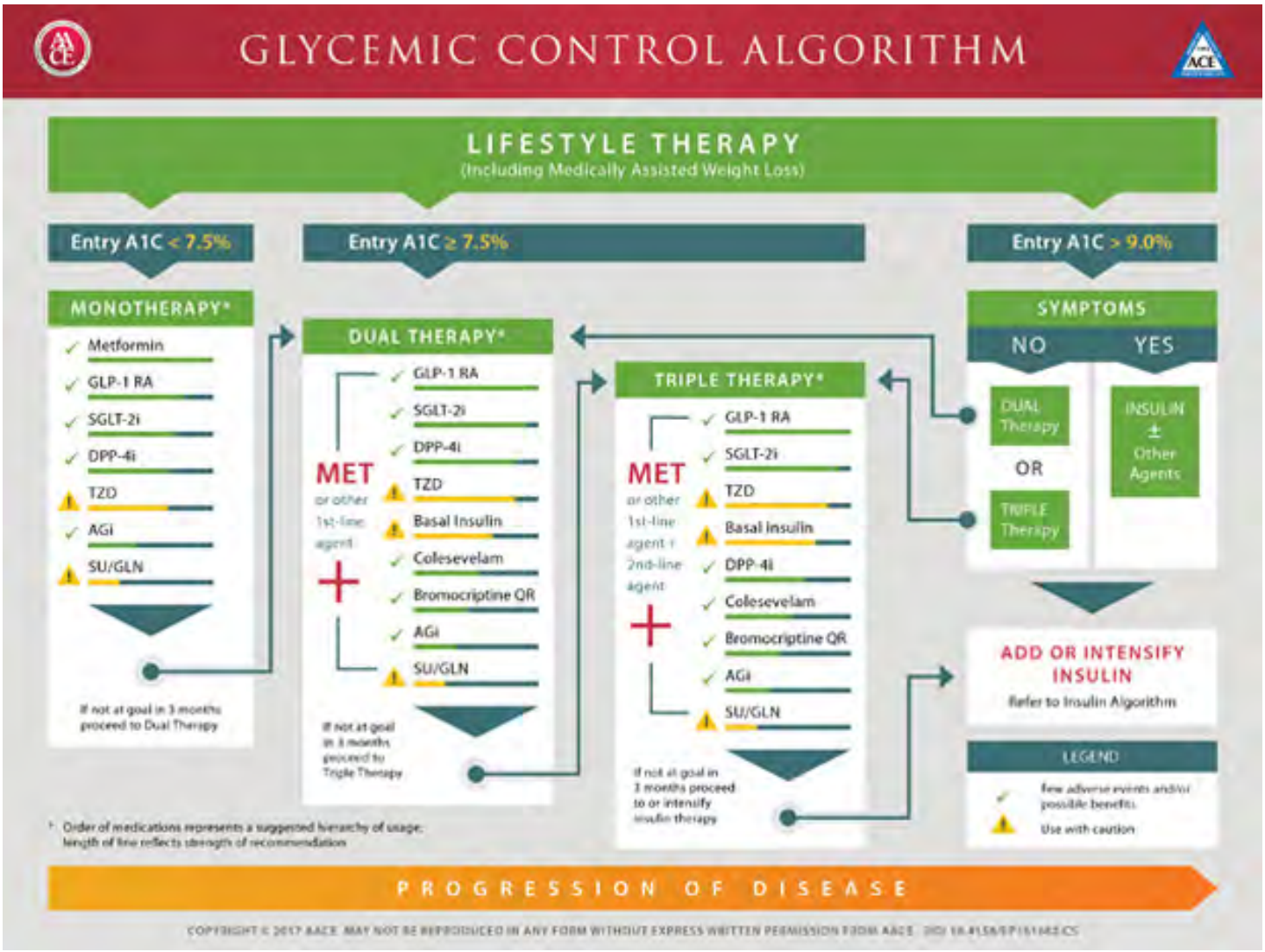
FOLLOW UP

- Ensure follow-up visit with care team is scheduled at 4-6 week intervals
- Review/Continue Education (see relevant education topics above)
- Confirm referrals are scheduled (see relevant referral list above)

Central Oregon Health Council

This document was developed by the RHIP Diabetes Clinical Workgroup. For more information visit www.cohealthcouncil.org/diabetes-clinical, or email: info@cohealthcouncil.org, or call: (541) 306-3523.

Published February 2018



Step Therapy
(coming soon)

PacificSource
Community Solutions

POLICY NAME:
Oral Antidiabetic Agents
Effective Date: 02/15/2017
Last Review Date: 01/09/2017

If the patient has tried a Step 1 drug (at least a 30-day supply in the prior 180 days), then authorization for a Step 2 drug may be given. If the patient has tried a Step 2 drug (at least a 30-day supply in the prior 180 days), then authorization for a Step 3 drug may be given.

Step 1 Drug(s): Metformin, Glipizide, Glimepiride, Glyburide

Step 2 Drug(s): Jardiance, Januvia, Janumet, Janumet XR

Step 3 Drug(s): Invokana, Invokamet, Invokamet XR, Tradjenta, Jentadueto, Jentadueto XR

High Desert Food & Farm Alliance, Veggie Rx Pilot Project

Project description

HDFFA proposes to implement, in coordination with health care practitioners, a fruit and vegetable prescription program (Veggie Rx Pilot Study). The goal of this project is to improve food insecurity with patients with diet-modifiable disease by increasing their intake of fresh fruits and vegetables. The three objectives to meet our goal are: 1) implement a Veggie Rx pilot program, 2) provide nutrition education to Veggie Rx recipients, and 3) create community linkages between health care, community partners, and Veggie Rx recipients.

We will partner with clinicians that treat diet-related disease and will perform food insecurity screening and refer identified individuals to the Veggie Rx program. Participant eligibility criteria include 1) food insecurity; 2) chronic disease (heart disease and/or type 2 diabetes); 3) ability and willingness to commit to using the full benefit of the program. Our program will provide $15 fresh vegetable vouchers to 33 individuals for 7-weeks with a bonus for program completion in week 8 of $30/person. A HDFFA staff member (Community Health Worker (CHW)) will facilitate all steps of the pilot and will provide nutrition education. We will partner with the Bend Farmers Market and their farmer vendors where vouchers will be redeemed for locally grown fresh produce.

To determine the feasibility of this program, we are implementing a 1-year pilot project, and are intentionally constraining the program to one location (Bend, OR), one provider team (Cardiac team at St. Charles in Bend), and one vendor location (Bend Farmers Market). Success of the program will be measured through our rigorous program evaluation (see evaluation section). In the future, we anticipate including health biometric measures to evaluate the success of the program on health outcomes.

Objectives and relevant history/baseline data

Objective 1. *Implement a Veggie Rx pilot program for food insecure people with diet-modifiable disease to increase fresh food consumption by participants.*

Sixteen percent of Central Oregonians are food insecure (Oregon Food Bank) who are twice as likely to have diet-modifiable disease (Central Oregon Assessment of Nutritional Programs). Studies show that poor diet is associated with diet-related diseases such as cardiovascular disease and type 2 diabetes and higher amounts of fruit and vegetable intake (FVI) are associated with health benefits and prolonged lives [1]; however the expense of fresh food has been noted as a limiting factor for many food insecure people. A meta-analysis of multiple studies confirms the effectiveness of economic incentives in modifying health behaviors and health outcomes. Specifically, monetary incentives resulted in positive effects on food purchases, food consumption, or weight loss [2].

A systematic review of the literature on policy and environmental interventions designed to improve cardiovascular health concluded that addressing issues related to the availability of nutritious foods and point of purchase are among the strategies with the strongest evidence for promoting good nutritional behaviors [3]. Fresh food prescription voucher programs inherently increase the availability of fresh food for program participants. In addition, participants reported increases in household food security, knowledge about nutrition, and how to buy and prepare fresh local produce (Wholesome Wave; Washtenaw County ‘s “prescription for life”; Oregon Food Bank; La Pine Community Health Center “Healthy Eating Project”).

Outcomes to be evaluated

- Enrollment of 33 program participants
- Increased provider screening and awareness of food insecurity
- Increased referrals to nutritional programs
- Increased consumption of fresh food by patient participants
- Decreased anxiety about availability of food by patient participants
- Participant retention /program completion with >90% voucher utilization

Objective 2. *Provide nutrition education for participants to increase healthy eating habits by program participants.*

The U.S. Department of Agriculture (USDA) has determined that educational interventions to improve American's diets may prevent rising incidence of heart diseases and save health care expenditures. However, nutrition education alone, without additional incentives such as economic incentives, is insufficient to achieve sustained FVI at recommended levels [4]. Veggie Rx provides nutrition education along with nutrition assistance by providing an economic subsidy. As stated above, this program model has been effective not only in increasing fresh food intake but also increasing understanding of the importance of diet in maintaining a healthy lifestyle and positively impacting health outcomes.

Outcomes to be evaluated

- Increased understanding of the impact of nutrition on health by patient participants
- Increased understanding and utilization of available nutrition education and assistance resources
- Increased competence of buying, cooking and eating fresh foods by patient participants

Objective 3. *Create community linkages between health care, community resources, food system, and Veggie Rx participants.*

Veggie Rx –like programs exemplify a model for clinical-community linkages [5]. The models can vary but generally include a number of sectors: health care providers who refer patients to the program, a community organization that administers the program, and a commercial business where vouchers are redeemed.

Outcomes to be evaluated

- Increased connections across sectors
    - New partnerships between HDFFA with clinicians and providers in the health care sector
    - New connections with other nutrition assistance / education programs
    - Patient participants & farmers
- Increased local farms sales
- Post program satisfaction by all sectors involved: health care provider participants, patient participant, HDFFA staff, nutrition resource organizations, farmer participants.
- Estimate the willingness to pay by end user for this type of service to determine the economic value of this program

References.

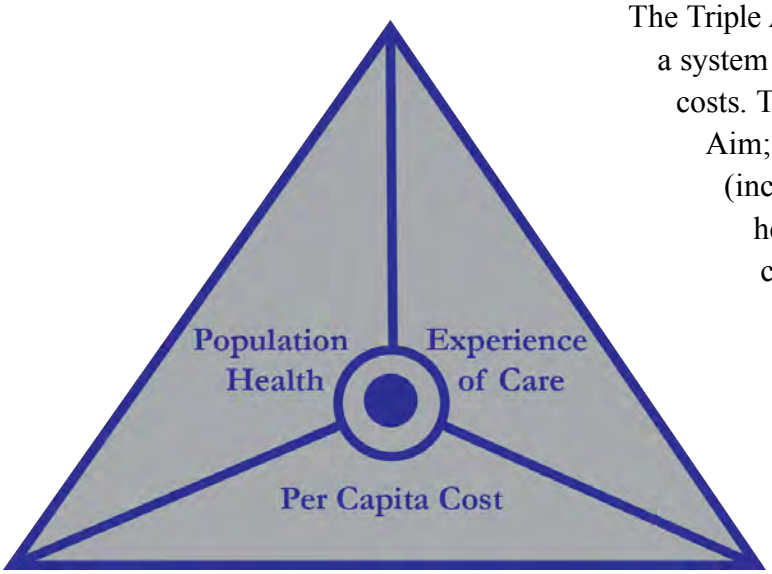
1. Oyebode, O., et al., *Fruit and vegetable consumption and all-cause, cancer and CVD mortality: analysis of Health Survey for England data.* J Epidemiol Community Health, 2014. **68**(9): p. 856-62.
2. An, R., *Effectiveness of subsidies in promoting healthy food purchases and consumption: a review of field experiments.* Public Health Nutr, 2013. **16**(7): p. 1215-28.
3. Matson-Koffman, D.M., et al., *A site-specific literature review of policy and environmental interventions that promote physical activity and nutrition for cardiovascular health: what works?* Am J Health Promot, 2005. **19**(3): p. 167-93.
4. Thomson, C.A. and J. Ravia, *A systematic review of behavioral interventions to promote intake of fruit and vegetables.* J Am Diet Assoc, 2011. **111**(10): p. 1523-35.
5. Goddu, A.P., et al., *Food Rx: a community-university partnership to prescribe healthy eating on the South Side of Chicago.* J Prev Interv Community, 2015. **43**(2): p. 148-62.

The Central Oregon Health Council's Regional Health Improvement Application Overview

Thank you for your interest in applying for funding provided by the Central Oregon Health Council. We are excited to partner with the communities where we all live, play, and work. Our Regional Health Improvement Plan (RHIP) is for the benefit of all Oregonians that call Central Oregon home within Crook, Deschutes, Jefferson and Northern Klamath Counties.

Recognizing and hoping we will have interest and applications from 'non-traditional' funding seekers, we seek to explain some of the requirements included in this application. Although our desire is to fund projects for a minimum of one year, innovative one-time projects will also be considered. This is a rolling application process with no established deadlines; however, we do have limited funding resources.

Triple Aim



The Triple Aim is a framework of designing healthcare into a system without errors, waste, delay, and unsustainable costs. The inset illustration is a depiction of the Triple Aim; improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of healthcare. Although the Triple Aim was created through the healthcare lens, it does not preclude efforts that are not typically considered healthcare related.

We hope you will find this application simple and concise. Should you have any questions, please reach out to any of the Central Oregon Health Council staff at 541-306-3523 or info@cohealthcouncil.org.

Central Oregon Health Council

1 Requestor/Agency

- Please provide project organization and contact information for project lead on this requested investment: High Desert Food & Farm Alliance

  Katrina Van Dis; Executive Director; katrina@hdffa.org; 541-390-3572
- Requestor/agency location(s): Bend, Oregon
- Will your project include all counties in the region: Crook, Deschutes, Jefferson, and northern Klamath County? If not, why? This proposal is an initial pilot field intervention. We plan to intially test the pilot in Bend (Deschutes County) with the intent of expanding the program across Crook, Deschures, and Jefferson Counties. Klamath is outside of HDFFA's target area.

2 Project Description/Overview

- Brief project overview
  - Overarching goals of the project: To implement, in coordination with health care practitioners, a fruit and vegetable prescription program designed to address food insecurity and increase
  - intake of fresh produce.
  - Target population: 33 food insecure individulas with diet-modifiable disease and their family members (estimated reach: 132)
  - Identified need: Food insecurity, CVD and or T2 diabetes
  - Community support: HDFFA; St. Charles Cardiac Clinic and Providers; Bend Farmers Market and farmers.
  - Project timeline: 1 year
- How will we know if you are successful? Program success will be based on acheiving the project objectives based on metrics and outcomes detailed in the project evaluation section.
- What, if any, are the emerging best practices and/or evidence-based guidelines upon which the project is based? Please see objectives section for background support
- Does your project/program have any national affiliation(s)? No
- If your program is evidence-based or best-practice will it be reviewed for fidelity? We have based our pilot on an extensive review of many prescription voucher programs and lessons learned communicated by the authors of those programs. We have adapted our project to include strategies to acheive program success. Through our evaluation plan, we will determine which strategies are effective or are not in order to modify the program and ultimately identify best-practices for a Central Oregon Veggie Rx program.
- Are you seeking any funding matches or additional contributions to support your project? Yes. We have a pending application to Pacific Source for funds to implement Veggie Rx for the OHP

population. If funded, the Pacific Source grant and this request would create a full-time position to implement this Veggie Rx program, and enable us to meet the needs of more residents.

- What is your sustainability plan? Our plan is to implement a pilot project that will help us determine best practices for a Veggie Rx program that could be implemented otuside of Bend with site-specific modifications as needed. The sustainability of a Veggie Rx program is dependant on 1) the findings from this project, 2) the outcomes of the project and 3)ultimately a Veggie Rx program is by its nature, a subsidy program and is dependant on outside funding. The implementation of a Veggie Rx program in Central Oregon could benefit a wide range of Central Oregonians across multiple sectors including health care (providers, patients, CCOs), community partners that provide support for nutritional programs (non profits, public health) and the food system (local farmers). If successful, we will seek additional funding for vouchers and program administration but not for detailed evaluation, thereby decreasing the total cost of the program.

  This project addresses the Triple Aim by providing better patient experience of care (prescription for fresh food to use at a local market), improving the health of our region (increasing FVI in patients and family members) and decreasing the cost of health care (healthier patients have lower medical care costs). As such we propose that one part of program sustainability will be achievable if vouchers are funded by community care organizations while maintaining program implementation support through traditional and non-traditional funding sources.
-
- What is your evaluation plan? Please see detailed table for evaluation plan

3 Measurement

- Please complete the "Objectives Chart" that accompanies this application, which can be found here. Grantees are required to complete the Objectives Chart at the start of the project, and at the conclusion so progress can clearly be demonstrated. Please ensure that objectives are written in SMART format, (specific, measureable, attainable, realistic and time-bound).
- Grantees are also required to complete a narrative report annually and at the conclusion of your project. the form can be found here.

4 Project Budget

Part I: Projected Project Revenue from COHC	
	$0

Other Project Revenue (e.g., funds from the Global Budget; outside sources of revenue such as grants or support from other community partners; etc.)*	Planned	Requested /Pending	Committed	$
Total Project Revenue	$133649	$70120	$0	$

Personnel Costs

Name	Position (FTE dedicated to this project)	Salary	Benefits	Total Cost	Amount Requested
Health Care Worker	.5	$24440	$2445	$ 26885	$26885
Program Director	.25	$10400	$1040	$ 11440	$11440
		$	$	$	$
		$	$	$	$
	Sub-Total: Personnel	$	$	$ 38325	$38325

Materials & Supplies	Total Cost	Amount Requested
Veggie Rx vouchers	$5000	$5000
Sign up genius	$270	$270
Printing, marketing and computer	$3000	$3000
Sub-Total: Materials & Supplies	$8270	$ 8270

Travel Expenses	Total Cost	Amount Requested
Central Oregon and state-wide travel	$400	$400
	$	$
	$	$
Sub-Total: Travel Expenses	$400	$400

Consultants & Contracted Services	Total Cost	Amount Requested
Evaluation Consultant	$20000	$20000
	$	$
Sub-Total: Contracted Services	$20000	$ 20000

Meeting Expenses	Total Cost	Amount Requested
	$	$
	$	$
	$	$
	$	$
Sub-Total: Meeting Expenses	$	$

Professional Training and Development	Total Cost	Amount Requested
	$	$
	$	$
Sub-Total: Training and Development	$	$

Other Budget Items	Total Cost	Amount Requested
Direct Expenses / Overhead	$3125	$3125
	$	$
Sub-Total: Other	$3125	$ 3125

Total Project Budget	$ 70120	$ 70120

Application Checklist

5 Application Checklist

- Did you complete all portions of the application? Yes☒ No ☐
- Did you include a proposed budget? Yes ☒ No ☐
- Does your proposal align with the Triple Aim? Please briefly explain how: yes, this project addresses the Triple Aim by providing better patient experience of care (prescription for fresh food to use at a local market), improving the health of our region (increasing fruit and vegetable intake by patients and family members) and decreasing the cost of health care (healthier patients have lower medical care costs).
- Does the project have reach to all counties in the Region (Crook, Deschutes, Jefferson and Northern
- Klamath) Yes ☐ No ☒ If not, why? This is a pilot project for Bend with the intention to implement within HDFFA's region of Crook, Deschutes and Jefferson counties.
- Was your project solicited by a RHIP workgroup as part of an A3 process? Yes ☒ No ☐
- Did you present your project to the appropriate RHIP workgroup? Yes ☒ No ☐
- Is your proposal outside of a RHIP workgroup? Yes ☐ No ☒
- What component(s) of the RHIP does your proposal impact (please select all that apply)

☐ Behavioral Health Identification and Awareness
☐ Behavioral Health Substance Use and Chronic Pain
☒ Cardiovascular Disease: Clinical
☒ Diabetes: Clinical
☐ Cardiovascular Disease and Diabetes Prevention
☐ Oral Health
☐ Reproductive & Maternal Child Health
☒ Social Determinants of Health: Education & Health
☐ Social Determinants of Health: Housing

OR

☐ My proposal addresses a pillar 10 vital condition:

☒ Education
☒ Equity, Social Connection & Civic Muscle
☐ Jobs & Wealth
☒ Preventative Services & Policies
☐ Stable Housing
☐ Child Abuse Prevention
☐ Safe Neighborhoods
☐ Physical Activity
☒ Nutritious Food
☒ Healthy Environment
☐ Arts & Recreation

☒ Mental Health Care

6 Application Submission

- Completed applications and attached budget proposals must be submitted via email to Donna.Mills@cohealthcouncil.org.
- If you have questions or need any assistance, please contact any member of the COHC staff at 541-306-3523.

7 Process Following Submission

- Projects will be assigned a RHIP Project identifier.
- Projects will be reviewed for minimum requirements as indicated in the application checklist.

Central Oregon Health Council

INVESTMENT OBJECTIVES CHART

Date: 1/29/2018

Organization High Desert Food & Farm Alliance **Investment/Project Name** Veggie Rx pilot project

RHIP Applicability

If your proposal was submitted through a RHIP Workgroup's A3 process, it must contain at least one metric that corresponds with a RHIP workgroup's A3.

If your proposal was submitted outside of a RHIP workgroup, you must select at least one pillar 10 vital condition that it addresses.

Select RHIP Workgroup:

- ☐ BH Identification/Awareness
- ☐ CVD: Clinical
- ☐ Oral Health
- ☐ Substance Use & Chronic Pain
- ☐ SDOH: Milestones Ed/Health
- ☒ Diabetes: Clinical
- ☐ Reproductive/Maternal Child
- ☐ CVD/Diabetes Prevention
- ☐ SDOH: Housing

Select workgroup metric that your proposal addresses (select all that apply):

- ☐ Increase screenings for depression/anx/s.i/SUD
- ☐ Improve hypertension control
- ☐ Normalize public's perception of behavioral health
- ☒ Improve control type II diabetes
- ☐ Create bi-direc/integrated approach for SUD
- ☐ Keep children cavity free
- ☐ Responsible prescribing Opioids and Benzos
- ☐ Kindergarten readiness
- ☒ Increase awareness of risk factors for CVD
- ☐ Third grade reading scores
- ☒ Decrease the # of those at risk for type II diabetes
- ☐ Stabilize 200 chronically homeless
- ☒ Improve oral health pre/post-natal women
- ☐ Prevent unintended pregnancies
- ☐ Reduce prevalence of low birth weight infants
- ☐ Improve primary care response when behavioral health screen is position

☐ My proposal is outside of a RHIP Workgroup and addresses a pillar 10 vital condition

Please select pillar 10 vital condition (select all that apply):

- ☒ Education
- ☐ Physical Activity
- ☒ Equity, Social Connection & Civic Muscle
- ☐ Jobs & Wealth
- ☒ Preventative Services & Policies
- ☐ Stable Housing
- ☐ Child Abuse Prevention
- ☐ Safe Neighborhoods
- ☒ Nutritious Food
- ☐ Healthy Environment
- ☐ Arts & Recreation
- ☐ Mental Health Care

Objective	**Relevant Historical and/or baseline data**	**Expected Results**	Actual Results (***To be completed at the end of Grant Period.)***	**Source of data**
1. Implement a Veggie Rx pilot program in Central Oregon for food insecure people with diet-modifiable disease to increase fresh food consumption by participants.	No current program exists.	Implement Veggie Rx pilot project by December 31 2018.		Oyebode, O., et al., *Fruit and vegetable consumption and all-cause, cancer and CVD mortality: analysis of Health Survey for England data.* J Epidemiol Community Health, 2014. **68**(9): p. 856-62. An, R., *Effectiveness of subsidies in promoting healthy food purchases and consumption: a review of field experiments.* Public Health Nutr, 2013. **16**(7): p. 1215-28. Matson-Koffman, D.M., et al., *A site-specific literature review of policy and environmental interventions that promote physical*

				activity and nutrition for cardiovascular health: what works? Am J Health Promot, 2005. **19**(3): p. 167-93.
1.a) Enroll 33 program participants in Veggie Rx pilot project	No current program exists.	Work with identified and committed Providers at St. Charles Cardiac Clinic to refer 33-100+ individual that will then be screened for the pilot project (Feb-May) Recruit 33 participants (Feb-May) Implement 6 week (with a 7 week bonus) program during an 8-12 week period (May-Oct)		Base knowledge collected from months of research and discussions with similar organizations and the Oregon Food System Networ, Veggie Rx Workgroup Estimation based on total # of available patients in St. Charles cardiac clinic.
1.b) Increased provider screening and awareness of food insecurity.	Not currently implemented.	Providers increase food insecurity screening by 75% during patient recruitment period as measured by referrals (Feb-May).		Baseline food insecurity screening provided anecdotally by Practioners Post pilot provider survey.

1.c) Increased referrals to nutritional programs	Varies and is based on results reported in CO Nutritional Program Assessment (2017)	100% increase in provider referral to Veggie Rx during patient recruitment period (July-Nov)		Pre and post surveys to Providers and patient participants. Post program survey occurs 4 weeks after program.
1.d) Increased consumption of fresh food by patient participants	Currently unknown	Increase fruit and vegetable intake (FVI) of 33 participants by 1-2 servings/day/ participant during program (May-Oct)		Pre and post surveys to patient participants.
1.e) Decreased anxiety about availability of food by patient participants	Currently unknown	Anticipate overall 50% decrease in anxiety levels about food during program by 33 participants (May-Oct)		Pre and post surveys to patient participants.
1.f) Participant retention /program completion	Currently unknown	90% voucher utilization and participant completion during program implementation, 33 participants (May-Oct)		Health Care Worker will monitor weekly voucher pick up & program completion by patient participants
2.Provide nutrition education for participants to increase healthy eating habits by program participants	See below for objectives	See below for objectives		The U.S. Department of Agriculture (USDA) has determined that educational interventions to

				improve American's diets may prevent rising incidence of heart diseases and save health care expenditures. However, nutrition education alone, without additional incentives such as economic incentives, is insufficient to achieve sustained FVI at recommended levels. Thomson, C.A. and J. Ravia, *A systematic review of behavioral interventions to promote intake of fruit and vegetables.* J Am Diet Assoc, 2011. **111**(10): p. 1523-35.
2.a) Increased understanding of the impact of nutrition and personal health	To be determined	80% of participants express feeling better and attributing that to increased FVI during program period (May-Oct)		Pre and post surveys to patient participants.

2.b) Increased understanding and utilization of available nutrition education and assistance resources	To be determined	80% of participants acknowledge receipt of nutrition resources (May-Oct) Increased utilization of resources by 10-20% of the patient participants during program (May-Oct)		Pre and post surveys to patient participants.
2.c) Increased competence of buying, cooking and eating fresh foods by patient participants	To be determined but many people are already competent in these skills but cannot afford fresh food	50% increase in competence in eating fresh produce after program completion (July-Nov)		Pre and post surveys to patient participants.
3. *Create community linkages between health care, community resources, food system, and Veggie Rx participants*	See below for objectives	See below for objectives		Veggie Rx –like programs exemplify a model for clinical-community linkages. The models can vary but generally include a number of sectors: health care providers who refer patients to the program, a community organization that administers the program, and a commercial business where

				vouchers are redeemed
3.a) New partnerships between HDFFA with clinicians and providers in the health care sector	Commitment from St. Charles Cardic Clinic to perform Veggie Rx pilot	5 more provider's (or group's) partnerships established for future Veggie Rx program implementation after program completion (Aug-Nov)		Identify, monitor and maintain connections with provider partners and generate list of new partnerships
3.b) New connections with other nutrition assistance / education programs	To be determined	Increased awareness of Veggie Rx program by 10+ community program managers after program completion (May-Nov)		Interviews with community program managers
3.c) Patient participants & farmers	None	80% increased knowledge by patient participants of farmers markets and farmers (Jun-Oct) 80% increased knowledge of Veggie Rx participants by partner farmers after program completion (Jun-Oct)		Pre and post surveys to patient participants. Post program survey to farmers
3.d) Increased local farms sales	None	$5000 voucher redemption by local farmers by end of program (May-Oct)		Dollar amount of vouchers redeemed.

3.e) Program satisfaction		>80% are satisfied with program overall (July-Nov) >50% have comments or suggestions to improve the program (July-Nov)		Post program survey by all sectors involved: health care provider participants, patient participant, HDFFA staff, nutrition resource organizations, farmer participants.	
Economic value	To be determined	>80% of participants suggest the willingness to pay, or value amount for the program, recognizing that it is free but trying to place a value on the program (July-Nov)		Post pilot survey of program participants to estimate the willingness to pay for this type of service	

RHIP Workgroup Updates: January 2018

Behavioral Health: Identification & Awareness (Support: Rebeckah Berry & Mike Franz)

- This group meets the fourth Tuesday of every month from 8:15-9:15am and currently has 16 members.
- In January, the group continued their A3 process with the aim of identifying and engaging 100% of individuals in Central Oregon that have a behavioral health need, and ensuring an effective and timely response. The workgroup is hoping to gather baseline data from seven more clinics in the region before they vote on their first A3 experiment. This data will be collected and reviewed at February's meeting.

Behavioral Health: Substance Use and Chronic Pain (Support: Rebeckah Berry & Laura Pennavaria)

- This group meets the third Wednesday of every month from 4-5pm and currently has 22 members.
- In January, the group continued their A3 process with the aim that all Central Oregonians with a substance use disorder who enter the hospital setting, including the ED, will receive engagement, treatment, or harm reduction services. The group is redefining their initial and target state objectives for their A3 and are currently narrowing down their potential experiments through a prioritization survey. The workgroup will vote on their first experiment at their February meeting.

Cardiovascular Disease—Clinical (Support: Rebeckah Berry & Shiela Stewart)

- This group meets the fourth Tuesday of every month from 4-5pm and currently has 11 members.
- In January the group began developing the details of their first A3 experiment which focuses on clinical outreach and engagement to promote youth/family tobacco cessation. The group's A3 was presented to Ops and their A3 received enough support for them to access their funding. The group is currently working through steps to have regional youth action councils review tobacco education materials that the workgroup will disseminate to clinics throughout the region.

Diabetes—Clinical (Support: Rebeckah Berry & Shiela Stewart)

- This group meets the second Thursday of every month from 9-10:30am and currently has 12 members.
- In January, the group continued the development of their second algorithm that focuses on supporting primary care in the management of patients with A1cs >9. They hope to finalize this algorithm in February. The group also notified participating A1c Point of Care (POC) clinics to begin ordering their POC equipment and schedule a time for training before the 3.31.18 deadline.

CVD & Diabetes: Prevention (Support: MaCayla Arsenault, Sarah Worthington, & Steve Strang)

- This group meets the fourth Tuesday of every month from 3:30-5pm and currently has 13 members.
- In January, the workgroup discussed next steps for the Rx to Move pilot at Mosaic Medical and began their second A3 around nutrition.

RHIP Workgroup Updates: January 2018

Oral Health (Support: Donna Mills & Mary Ann Wren)

- This group meets the third Tuesday of every month from 11-12pm and currently has 24 members.
- In January, the Oral Health Workgroup heard a presentation from Kat Mastrangelo, Executive Director, Volunteers in Medicine, relative to a pilot they ran with older adults. The outcomes were striking and the group is very interested in authoring an A3 specifically around this population. There was also a review of a proposed MOU with Oregon Oral Health Coalition, which requests that the workgroup take the lead on a 'chapter' in Central Oregon. A meeting will be brokered with Donna Mills, Mary Ann Wren and Heather Simmons to discuss intent and objectives. The meeting held further discussion relative to the current A3 and Heather Simmons presented a couple of pilot ideas. An agreement was reached to create a couple of subgroups to further determine the details of possible RFPs.

Reproductive Health/Maternal Child Health (Support: Donna Mills & Muriel DeLaVergne-Brown)

- This group meets the second Tuesday of every month from 4-5pm and currently has 22 members.
- In January, the Reproductive Maternal Child Health continues to move through their unintended pregnancies A3. The meeting held feedback on some researched campaigns. Next steps include two specific subgroups around data and focus groups.

Social Determinants of Health

- This group meets the third Friday of every month from 10:30-11:30am and currently has 27 members in Milestones to Health and Education and 24 members in Housing.

Milestones to Health & Education (Support: Donna Mills & Desiree Margo)

- In January, the workgroup reviewed the operational structure of the workgroup, and the subgroups provided updates on their progress (Literacy, Social & Emotional Supports, Access to Integrated Services, and TRACEs).

Housing (Support: Bruce Abernethy, Elaine Knobbs-Seasholtz & MaCayla Arsenault)

- In January, the workgroup discussed proposals aimed to stabilize and transition the chronically homeless in both Sisters and Prineville.