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Elevating communities into self-sufficiency through federally-funded health partnerships

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Elevating communities into self-sufficiency through federally-funded health
partnerships

Master of Public Health-Master of Science in Behavioral Health Capstone

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List of Abbreviations

FNS	Food and Nutrition Service
HCHP	Health Center/Health Program
HRSA	Health Resource and Services Administration
PP	Patient/Participant
SNAP	Supplemental Nutrition Assistance Program
SNAP ED	Supplemental Nutrition Assistance Program Education
SNAP E&T	Supplemental Nutrition Assistance Program Employment and Training
USDA	United States Department of Agriculture
WIC	Women, Infants, and Children
WRO	Western Regional Office

Abstract

Purpose: This qualitative study is to identify programming that encourages increased self-sufficiency in SNAP recipients. The goal was to identify themes related to successful self-sufficiency programming at federally-funded health centers/health programs (HCHPs). The study also investigated the role of social determinants of health in relation to achieving self-sufficiency.

Method: A series of 45-minute to 1-hour-long interviews were conducted to explore the perspectives of seven total staff at seven federally-funded HCHPs across the U.S. western region. Using Nvivo, a qualitative data analysis software, responses were categorized into six themes: patient-centered care, one-stop-shop/integrated care model, community partnerships, organizational and staff support, leadership buy-in, and funding. Themes were further broken down into sub-categories to facilitate the process of developing best practices for implementation.

Findings: Results were used to develop 12 best practices for implementation, which included: conducting needs assessments and focus groups, introducing a community health worker (CHW) program, hiring a behavioral health consultant (BHC), the need for wrap-around models of service delivery, coalition development, integrated work planning (external), use of MOUs, cross-departmental trainings, PDSA cycles, having mission and vision-aligned programming, and yearly work planning (internal). Best practices are suggested in order to maximize federal funding for programming that promotes self-sufficiency. The targets of these best practices are federally-funded HCHPs.

Conclusion: By introducing the importance of patient self-sufficiency and its relation to social determinants of health within the HCHP sector, we can begin to conceptualize the integration of self-sufficiency initiatives within federally-funded HCHPs

Executive Summary

Statement of the problem

Despite its status as a first world nation, even in the world's greatest food-producing nation, children and adults face poverty and hunger in every county across America (Feeding America, 2016). As a result, there is a sector of the federal government, the United States Department of Agriculture Food and Nutrition Service (USDA FNS), entirely dedicated to ensuring access to nutritious food for the community. However, food insecurity calls for more than the provision of supplemental food support. It also calls for the opportunity to reach self-sufficiency, or the idea that individuals should be able to economically support themselves, helping them gain "freedom from dependence on government support" (Hong, Sheriff, & Naeger, 2009).

Project aim

The intent of this project was guided by the need to address the FNS Western Regional Office (WRO) 2018 agency priority, "[to] ensure programs pave a pathway to self-sufficiency." The goal was to identify ways to leverage multiple federal funding streams from the USDA and Health Resources and Services Administration (HRSA)-funded health centers/health programs (HCHPs) to align community health, clinical services, and self-sufficiency programs.

Brief description of methods

Seven HCHPs were identified as having programming that could inform this work and were asked multiple questions addressing the structure and funding of their programming. A series of 45-minute to 1-hour-long interviews were conducted to explore

the perspectives of one staff per HCHP helping identify themes related to successful program integration for the purpose of self-sufficiency initiatives at these locations.

Using Nvivo, a qualitative data analysis software, observations were grouped and respondent attitudes and ideas were categorized into six themes: patient-centered care, one-stop-shop/integrated care model, community partnerships, organizational and staff support, leadership buy-in, and funding. After a review of each interview, a total of 241 quotes and phrases were coded into one of six nodes (themes). About 28% of the coded references were coded under patient-centered care, about 26% under one-stop-shop/integrated care model, about 24% under community partnerships, about 13% under organizational and staff support, about 7% under funding, and 2% under leadership buy-in.

Summary of key results

Results were used to develop a guide to suggest best practices for implementation. A total of 12 best practices were developed based on the six identified themes, these include: conducting needs assessments and focus groups, introducing a community health worker (CHW) program, hiring a behavioral health consultant (BHC), and the need for wrap-around models of service delivery, coalition development, integrated work plans, use of MOUs, Cross-departmental trainings, PDSA cycle integration, mission and vision-aligned programming, and yearly work-planning . Best Practices are suggested as a way to maximize federal funding for the development of programming that promotes self-sufficiency. The targets of these best practices are federally-funded HCHP.

Introduction

Despite its status as a first world nation, food insecurity is a common issue in the United States (U.S.). According to Feeding America (2016), “Even in the world’s greatest food-producing nation, children and adults face poverty and hunger in every county across America.” In the U.S., approximately 43 million people (~13% of the population) experience food insecurity in 2016, defined as, “...limited or uncertain access to enough food to support a healthy life” (Feeding America, 2016). Consequently, there is a sector of the federal government entirely dedicated to ensuring access to nutritious food as well as nutrition education for the community.

The USDA, particularly FNS is a program that currently administers a total of fifteen nutrition assistance programs as part of the idea that “No American should have to go hungry” (United States Department of Agriculture Food and Nutrition Services, 2017). All programs generally serve low-income individuals and families who experience food insecurity and are at risk of diet-related chronic illnesses. These multiple programs serve this general population of low-income individuals via specialized and targeted programming, such as the Women, Infants, and Children (WIC) program, Food Distribution Program on Indian Reservations (FDPIR), National School Lunch Program (NSLP), Child and Adult Care Food Program (CACFP), and many more via a continuum of care aimed at reaching multiple communities in need. According to Feeding America (2016), “59% of food-insecure households participated in at least one of the major federal food assistance programs in 2016 — the Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps); the National School Lunch Program and the Special Supplemental Nutrition Program for Women, Infants and Children (often called WIC).

Via the many programs made available to low-income individuals and families, USDA FNS targets food insecurity and provides nutrition education for the prevention, delayed onset, and control of diet-related chronic illnesses within the target population. As stated in the FNS mission, the aim is “to increase food security and reduce hunger by providing children and low-income people access to food, a healthful diet and nutrition education in a way that supports American agriculture and inspires public confidence” (United States Department of Agriculture Food and Nutrition Services, 2017). However, food insecurity does not just stem from one determinant, rather an array of determinants. As shared by Feeding America (2017), poverty and hunger tend to go hand in hand, but they are distinct. Although poverty plays a large role in perpetuating food insecurity, it is not the ultimate determinant. Multiple determinants, including unemployment, limited assets, and race are all contributors. Thus, food insecurity doesn’t just call for the provision of supplemental food support, but also the opportunity to reach self-sufficiency, or the idea that individuals should be able to economically support themselves and reach independence and financial stability (Hong, Sheriff, & Naeger, 2009).

Self-Sufficiency in Public Assistance

Federal programming, such as that provided by the USDA FNS, is changing. There is an evident shift in the way in which public assistance programs are perceived and distributed. In addition to programs solely focused on providing food assistance, federal programming is now reinvigorating the emphasis on capacity building programming. As a result, the idea is that those currently receiving financial support from federal programs should be able to live an economically self-sufficient life without needing continuous government support to make ends meet. Those utilizing programs

such as SNAP, WIC, etc. should be given an opportunity to reach a state of economic self-sufficiency (Cancian & Meyer, 2000), helping elevate individuals and families out of poverty and leading to “freedom from dependence on government support” (Hong, Sheriff, & Naeger, 2009).

A goal of FNS is to determine the best way to maximize federally-funded programming in ways that promote food security and self-sufficiency. The idea is that this will be accomplished via the Supplemental Nutrition Assistance Program Employment and Training (SNAP E&T) opportunities being made available to SNAP recipients at federally-funded HCHPs. SNAP E&T is a program that targets SNAP recipients and provides them with opportunities to gain skills, work, training, and experience needed to apply to employment opportunities that will result in self-sufficient incomes. An example of SNAP E&T would be something like a community health worker (CHW) program, where community members are trained to be health advocates in their own community. SNAP E&T programming at federally-funded HCHPs has the potential to pave pathways towards self-sufficiency. However, it remains an opportunity that has yet to be explored extensively.

How Employment Affects Food Insecurity

There is a clear relationship between earned income and food insecurity and as a result, those households that struggle through food insecurity generally lack the income needed to purchase food for their household. In addition, multiple publications report that many individuals receiving support from government programs generally have insufficient education and training to pursue competitive jobs with higher wages (Cancian & Meyer, 2000; Hildebrandt & Stevens, 2009), preventing them from reaching

a status of self-sufficient food security. Thus, self-sufficiency initiatives are a way to introduce increased employment opportunities and financial support for this audience.

Audiences seeking services at federally-funded health centers are great targets for this initiative. According to Russell (2013), “[h]ealth center patients [being served at federally-funded health centers] are disproportionately low-income, uninsured or publicly insured, and of a racial/ethnic minority, compared to the general population”. These audiences often overlap with those receiving government benefits, making these ideal locations to target these audiences for self-sufficiency initiatives. Thus, targeting spaces such as federally-funded health centers and those with similar characteristics are ideal.

In a review of the literature, the justification for introducing techniques for reaching self-sufficiency to government-dependent households is that these techniques will provide a way for these households to gain freedom from dependence on government support and additionally, a way to gain experience through job training that will lead to economic success (Cancian & Meyer, 2000; Hong, Sheriff, & Naeger, 2009; United States Department of Agriculture, 2017; United States Department of Agriculture, 2018). This can be a result of participating in employment and training programs offered at federally-funded HCHPs, such as a community health worker (CHW) program, which will be further discussed later on in this report.

Using Employment Support as a Path Towards Self-Sufficiency

Cost-effective and sustainable paths towards self-sufficiency have become a goal of the USDA FNS, thus the renewed emphasis on the benefits and use of the SNAP E&T program. SNAP E&T was established in 1985 as part of the Food Security Act (Rowe, Brown, & Estes, 2017) as a means to assist SNAP participants with skill building and

trainings that can prepare them for the work force. Almost two thirds of SNAP participants are exempt from participating in an employment-training program, due to multiple factors such as disability, age, etc. Nonetheless, there is potential for the program to assist the almost 40% of individuals who can benefit from [it] (Rowe, Brown, & Estes 2017).

Project Justification

The intent of this project was guided by the need to address the FNS WRO 2018 agency priority, “[to] ensure programs pave a pathway to self-sufficiency.” We hoped to identify ways to leverage multiple federal funding streams from the USDA and HRSA-funded HCHPs to align community health, clinical services, and self-sufficiency programs while also considering the role of social determinants of health in relation to achieving self-sufficiency. We identified HCHPs that had programming that could inform this work and they were asked multiple questions addressing the structure and funding of their programming.

Methods

Health Center/Program Sampling and Eligibility

Nine HCHPs were selected to be interviewed based on convenience sampling. These nine HCHPs were identified and chosen by FNS WRO and HRSA staff, based on historical knowledge of each HCHP and with a prior understanding of the mutually agreed upon eligibility criteria. HCHPs were identified as eligible participants via the following eligibility criteria: must provide health programming, must serve SNAP-eligible communities, must be part of the western region (Alaska, Oregon, Idaho,

California, Nevada, Arizona, Washington, CNMI, America Samoa, Guam), and must be receiving at least one source of federal funding. This procedure was followed by the identification of interviewees at each health program.

Interviewee Sampling and Eligibility

Potential interviewees at each health center/program were contacted via preliminary emails, used as warm introductions initiated by FNS WRO and HRSA staff. Through warm introductions, a third party (FNS WRO/ HRSA staff) familiar with both parties (interviewee and interviewer) initiated the introduction and this was used as a method to increase reliability between interviewee and interviewer who were meeting for the first time. Via these warm introductions, interviewees were informed about the intent of the project. Follow-up emails were sent by the interviewer in order to answer interviewee questions and secure interview dates and times. These emails were also used as an opportunity to capture verbal informed consent and to ensure interviewees met eligibility criteria. Eligibility criteria included the following: employment status (must be employed at the HCHP), seniority (3+ years at agency) or sufficient organizational knowledge (awareness of funding stream and programming), and ability to participate in a 45-minute to 1-hour interview. Interviewees were excluded if they could not complete the interview in English or Spanish, could not be available for a 45-minute to 1-hour interview, and if no individual on-site had sufficient knowledge about programming and the allocation of funding.

Final Sample

Of the nine HCHPs, only seven were interviewed based on willingness and/or availability to participate. Table 1 summarizes the characteristics of agencies and

interviewees. Each program displayed a connection to health and/or nutrition services based on preliminary research and confirmation from FNS WRO and HRSA staff. The identified HCHPs included both SNAP-Ed and non SNAP-Ed-funded services. All HCHPs that were interviewed were part of the FNS western region, from both rural and urban settings, particularly in the states of Arizona, California, Nevada, Washington, and Hawaii. Table 2 summarizes each individual agency profile by geographic location and interviewee role at the agency.

Table 1
Agency and Interviewee Characteristics

<i>Participants</i>		<i>n=7</i>
Positions	Executive Director	1
	Chief Executive Officer	2
	Project/Program Manager	3
	Development Coordinator	1
Gender	Male	1
	Female	6
<i>Agencies</i>		
Agency State	Arizona	1
	California	2
	Nevada	1
	Washington	1
	Hawaii	2
Federally Qualified Health Center (FQHC)	Yes	3
	No	4

Table 2
Agency Profiles

<i>Agency</i>	<i>State</i>	<i>Interviewee Position</i>
Agency 1	HI	Executive Director
Agency 2	AZ	Program Manager
Agency 3	NV	Chief Executive Officer
Agency 4	HI	Chief Executive Officer
Agency 5	CA	Development Coordinator
Agency 6	WA	Program Manager
Agency 7	CA	Project Manager

Data Collection Tool

An 18-question interview tool (Appendix A) was developed in-house and approved for internal use by the Senior Integrity Branch Chief within the USDA FNS WRO and a Public Health Analyst with HRSA. The tool was developed to collect information that would inform the development of best practices for implementation. Through the use of this tool we identified strong evidence-based community health service models that use multiple complementary components of USDA and HRSA funding. The goal of data collection was to look at the social determinants of health via the service delivery lens. In addition, from the data we hoped to explore both the social and economic aspects that may be preventing patients/participants from achieving economic self-sufficiency. Our hope was to identify best practices regarding how organizations integrate services in ways that might help patients/participants improve their quality of life and ideally move towards economic self-sufficiency.

The tool was broken down into five sections addressing multiple aspects of each HCHP services. These sections included general information (about the HCHP), nutrition ed./SNAP-Ed, WIC, employment and training, and referrals. This was done to group questions for readability and flow and to easily identify themes across sections during data analysis.

The interview tool underwent multiple stages of editing, considering feedback from a multidisciplinary team, including staff from USDA FNS WRO and HRSA. After a review of multiple drafts, changes were made to question type and script length. Initially questions were written as close-ended questions with very little room for additional probing. After a review of each question, significant changes were made to convert questions to open-ended questions, allowing for additional probing and richer data collection. In addition, feedback was also provided on script length. With the need for brevity in mind, both USDA FNS WRO and HRSA staff recommended shortening the script in acknowledgement of busy interviewee schedules, most of who were in upper management roles. Initially there were a total of 22 questions and these were condensed to 17.

Procedures

The interview tool was administered via 45-minute to 1-hour-long one-on-one phone interviews at a predetermined time set by the interviewer and interviewee between the dates of June 4th 2018-June 18th 2018. The individual conducting the interview was a trained USDA FNS WRO intern from the University of San Francisco's dual-degree Master of Public Health and Master of Behavioral Health program. Responses were recorded as typed notes during the interview. After each interview, notes were further

broken down via the expanded notes method and main themes were extracted for later use in the development of a best practices for implementation.

Data analysis

Qualitative data analysis was conducted in order to group observations and respondent attitudes and ideas into six themes. Nvivo, a qualitative data analysis software, was used to facilitate data extraction by helping store, sort, categorize, and classify interview responses into these six themes. The chosen themes emerged after an extensive review of the seven interviews. After a review of each interview, a total of 241 quotes and phrases were coded into one of six nodes (themes) and then further broken down into sub-themes. Identified themes included: patient-centered care, one-stop-shop/integrated care model, community partnerships, organizational and staff support, leadership buy-in, and funding. Main findings informed the development of a set of best practices for implementation, resulting from the seven interviews that identified successful integration of HCHP funding streams. A detailed breakdown of quotes and phrases by agency and theme can be found in Appendix B.

Themes

By identifying these six major themes, we were given a better understanding of the major successful factors and barriers present at the identified HCHPs when trying to integrate services in ways that might help PPs improve their quality of life and ideally move towards economic self-sufficiency. Themes are listed from most to least prominent.

Theme 1: Patient-centered care

The first and most prominent theme identified was patient-centered care. For the purpose of this project, patient-centered-care is defined as, “providing care that is

compassionate, empathetic, and responsive to the needs, values, and expressed preferences of each individual patient” (Rather, Wyrwich, & Boren, 2012). This theme was expressed in multiple contexts including development of programming, delivery of one-on-one patient care, delivery of group services, needs assessments, program incentivization, organizational mission, awareness of cultural/traditional needs of population, development of a community health worker program, quality improvement, addressing social determinants of health, and policy and advocacy. About 28% of the coded references were coded under patient-centered care. Some of the most prominent phrases for this theme can be found in Appendix B.

Theme 2: One-stop shop/integrated care model

The second theme identified was a one-stop-shop/integrated care model. For the purpose of this project, the one-stop-shop/integrated care model is defined as, “[a type of] care [offered] when health care professionals consider all health conditions at the same time” (Substance Abuse and Mental Health Services Administration, 2012). We will also include the importance of offering services as a one-stop-shop model. According to the Rural Health Information Hub (2018), “[a one-stop-shop is a] model [that] combines multiple health and human service providers in a single location to [efficiently and conveniently] deliver services”. The importance of this theme was expressed in multiple contexts, including merging of disciplines, health as prevention vs. profit, job-readiness, housing assistance, need for case management, food as medicine model, food insecurity, referrals, legal support, budgeting support, medical insurance enrollment, transportation support, dental services, immigration services, re-entry services, pathways model, primary care, mental health services, and youth mentoring. About 26% of the coded

references were coded under one-stop shop/integrated care model. Some of the most prominent phrases for this theme can be found in Appendix B.

Theme 3: Community partnerships

The third theme identified was community partnerships. For the purpose of this project, community partnerships are defined as, “[community agencies] [w]orking together to shar[e] resources, and combin[e] talents [to] enhance the opportunities and likelihood for achieving positive health outcomes” (Hann, 2005). This theme was expressed in multiple contexts, including work planning, identifying community champions, working towards parallel goals, program integration, cross-sector collaboration, referrals/awareness of local resources, best practice identification, addressing social determinants of health, filling the gap, efficient program delivery, and leveraging funds. About 24% of the coded references were coded under community partnerships. Some of the most prominent phrases for this theme can be found in Appendix B.

Theme 4: Organizational and staff support

The fourth theme identified was organizational support. For the purpose of this project, organizational support is defined as organizational and staff roles in providing encouragement, engagement, assistance, and approval with program delivery. This theme was expressed in multiple contexts, including organizational policy, communication style, flexibility, innovativeness/creativity, all-staff engagement, organizational culture, staff education/trainings, staff capacity and skillset, successful quality improvement, organizational mission/goals, program delivery, and staff availability to patients. About

13% of the coded references were coded under organizational and staff support. Some of the most prominent phrases for this theme can be found in Appendix B.

Theme 5: Funding

The fifth theme identified was funding. For the purpose of this project, funding is defined as, “a sum of money or other resources whose principal or interest is set apart for a specific objective” (Miriam-Webster, 2018). This theme was expressed in multiple contexts, including sustainability, merged/braided funding, time-limited funding, leveraging of mission aligned goals, and revenue generating initiatives. About 7% of the coded references were coded under funding. Some of the most prominent phrases for this theme can be found in Appendix B.

Theme 6: Leadership buy-in

The sixth and final theme identified was leadership buy-in. For the purpose of this project, buy-in is defined as the agreement to support a decision. In this case, leadership buy-in would include the need for leadership’s agreement to support a decision. This theme was expressed in multiple contexts, including program integration, new initiatives, and patient/participant satisfaction. About 2% of the coded references were coded under leadership buy-in. Some of the most prominent phrases for this theme can be found in Appendix B.

Best Practices

Based on the conducted interviews, theme identification, and an investigation of the literature, a total of 12 best practices were developed. The original themes identified in the interviews were further broken down into sub-themes to better guide our development of best practices (Table 3). These sub-themes emerged via an extensive

review of key informant interviews, each of which highlighted major aspects of their programming focused on the six major themes. These best practices are a set of recommendations for other federally-funded HCHPs working towards successful merging of funding streams to address the social determinants of health and ultimately PP self-sufficiency.

Theme 1 Best Practices: Patient-centered Care

Patient-centered care (PCC) was broken down into the following sub-themes: 1) client-driven services, 2) multiple-modality learning, and 3) culturally relevant care. To ensure that other health centers and health programs are introducing programming focused on PCC, it is recommended that they conduct need assessments of the community and hold focus groups of existing PPs to understand patient needs. As mentioned by Rather, Wyrwich, & Boren (2012), it is ideal to “provid[e] care that is compassionate, empathetic, and responsive to the needs, values, and expressed preferences of each individual patient.” This was further emphasized by Agency 2, who shared, “Understand that no one size fits all...recognize different populations...go to community events, engage with families, listen to their struggles”.

In addition, the introduction of a community health worker (CHW) program is a great way to involve community members in care provision where they can serve as community champions and advocates. Although there is no general definition, CHWs are seen as trusted community members trained to deliver healthcare services while serving as bridges between healthcare consumers and providers within their own communities (Kangovi, Grande, & Trinh-Shevrin, 2015; Singh et al., 2015; Witmer et al., 1995). Based on a study by Cosgrove et al. (2014), “CHWs help deliver...community

interventions to meet differing needs across communities, [they] bridge the gap between health care services and community members, build community and individual capacity...addressing multiple chronic health conditions, and meet community needs in a culturally appropriate manner.” This is further supported by Agency 6 who shared, “CHW program[s] meet people where they are at and help communities and educators connect as peers vs. having someone [an outsider] teach and leave.”

The idea of a CHW program aims to educate, train, and remunerate SNAP participants via SNAP-Ed and/or SNAP E&T. In a review of the literature, training costs for a CHW program are less expensive when compared to other healthcare professions (Singh et al., 2015; Vaughn, Kok, Witter, & Dieleman, 2015; Witmer et al., 1995) and they empower trainees to practice “autonomy, mastery, purpose, and connectedness” while also serving as health agents within their communities (Singh et al., 2018).

Theme 2: One Stop Shop/Integrated Care Model

One Stop Shop/Integrated Care Model was broken down into the following sub-themes: 1) merged disciplines, 2) employment readiness assistance, 3) warm handoffs, and 4) social services support. To ensure that agencies are introducing programming focused on these sub-themes, it is recommended that organizations adopt wrap-around models and hire a behavioral health consultant (BHC) when appropriate.

BHCs hold roles that support patients in identifying root causes of their lifestyle choices. They work with patients to identify small behavioral changes and resources that work to improve their health and well-being across the management of their conditions and needs. In addition, BHCs act as liaisons between patient and health center staff and are the primary providers that engage in warm handoffs. Warm handoffs are defined as “a

transfer of care between two members of [a] healthcare team, where the handoff [of patient to next provider] occurs in front of the patient and family” (Agency for Health Research and Quality, 2017). BHCs are essential in acting as liaisons between patient and physician, but also patient and their need for social service support. By applying practices such as warm hand-offs, patients are introduced to services they would have originally not sought out.

A wrap-around model would allow for a merging and integration of different disciplines within a healthcare center or program. As mentioned by Agency 4, “All needed providers [and services] are located in [the] clinic and made available when the patient is there”. This counteracts the need for a patient to visit multiple providers for their different needs, allowing them to seek and receive services efficiently.

Agencies 2, 3, 4, 5, and 6, all mentioned the importance of housing multiple services at their centers and programs to efficiently and effectively address patient’s health and lifestyle needs. These services include the following: medical support (vision, dental, primary care, case management, on-site pharmacy), job readiness support (CV/resume assistance, cover letter assistance, mock interviews, soft skills trainings, CHW training, financial/lending support), legal partnerships (housing/and eviction notice support, on-site attorney, immigration exam prep), benefits enrollment (SNAP, WIC, Medicaid, SSI), and other (food assistance, youth empowerment programming, drivers license assistance, car seat and diaper program, and reentry services). By having such a rich amount of services being offered in one place, providers can help patients fully address multiple social determinants of health, allowing for patients to seek out the services they need to address their unique lifestyles.

Theme 3 Best Practices: Community Partnerships

Community Partnerships was broken down into the following sub-themes: 1) identifying community champions, 2) identifying other organizations with similar programmatic goals and outcomes, 3) leveraging of funds, 4) non-profit and for-profit partnerships, and 5) shared staff across departments and organizations. Through coalition development, organizations are better able to identify other programs or organizations who are doing similar and/or different work from each other, allowing for complimentary programming and partnerships where appropriate. As mentioned by Agency 1, “[It is important to] [l]ook at what other [organizations] are doing and work together to meet the gaps... [it is ok to] [f]ind partners in the community, we don’t have to do everything”.

In addition this allows for spaces where braiding of funding *across* organizations can be discussed. This must be differentiated from merged/braided funding *within* organizations, which will be discussed in the following sections. By braiding funding across organizations, agencies have a better opportunity to target programs in more sustainable ways. As mentioned by Clary & Riley (2016), “Blending or braiding funding streams [can be used] to promote positive health and social outcome...[this includes] braiding and blending funding [from] many stakeholders, including providers of health care and other services.” Agency 1 and 5 shared the importance of, “Leverag[ing] monies with other orgs...[recognize that you] [d]on’t [need to] do more, [just] be more efficient with what you [have].” This can further be supported by the emphasis and development of integrated work plans with partner organizations. According to Slonim et. al, (2007), “integration [is ideal] because of the potential for efficient use of staff, funds, and surveillance and intervention efforts. Integrated work plans can further enhance

relationships across partnerships, highlight the mutual benefits of traditional and non-traditional partnerships, and establish communication networks across partnerships, leading to efficient use of resources and effective programming.

Lastly, MOUs can facilitate the process of shared staffing across organizations. An MOU is defined as, “a formal agreement that sets forth terms between two or more parties...establish[ing] official partnerships” (Astho, 2018). As shared by Agency 4, “shar[e] staff and have a signed agreement” allowing for shared internal and external staff. An example of this was mentioned by Agency 4 as “[sharing] staff from [their] internal WIC clinic, [which] also supports at other WIC clinics in community,” thus extending the reach of their resources to address patient/participant needs.

Theme 4 Best Practices: Organizational Staff and Support

Organizational and staff support was broken down into the following sub-themes: 1) staff education, 2) elevation of staff skillsets, and 3) allowing for constant program adjustments. It is recommended that agencies create spaces that allow for and emphasize the need for periodic cross-departmental trainings. As mentioned by Agency 3, “From board to staff, [it’s] important to understand and create culture...[e]ducating staff and gaining their buy-in is essential.” This gives staff the opportunity to better understand each other’s programming, building upon the knowledge of, value, and need for each aspect of organizational programming. This fosters a space that allows for easy flow of information across departments, giving providers and program staff an idea of why and where to refer patients/participants based on their different needs. According to Olsen, Saunders, & McGinnis (2011), “It has been shown that a team-based approach adds value

to the learning culture...and improve[es] patient-centered outcomes and chronic disease management.”

In addition, training staff on PDSA cycles allows for a facilitated effort to constantly adjust programming to meet the needs of the population being served. “PDSA cycle is shorthand for testing a change [or new initiative] by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made...(Act)” (Institute for Healthcare Improvement, 2018). When introducing this quality improvement method, it is imperative to have organizational and staff support, as PDSA cycles call for constant restructuring of programming. As mentioned by Agency 5, “[You] can’t sit and wait for success if it’s not there, it’s important to make changes to address [patient] need[s].” A system that calls for the use of PDSA cycles can be beneficial in introducing new E&T methods into HCHPs, further supporting self-sufficiency initiatives.

Theme 5 Best Practices: Leadership Buy-in

Leadership buy-in was broken down into the following sub-themes: 1) support from top leadership, 2) out-of-the-box thinking, and 3) mission-aligned initiatives. To ensure that agencies are introducing programming focused on obtaining leadership buy-in, it is recommended that services offered at health centers and health programs strongly align with the organizational mission and values. As mentioned by Agency 7, “[Remember that] integration starts on top [at the management level].” This was further supported by Agency 1 who shared, “Have an organization at the board/leadership level that also supports [your] initiative.” According to Rather, Wyrwich, & Boren (2012), this can be accomplished by including mission-aligned initiatives into the organizations

strategic mission and values. Doing so fosters a space in which there is increased support and trust from the leadership level, allowing for out-of-the-box thinking and creative patient-centered programming (Jones, 2014).

Theme 6: Funding

Funding was broken down into the following sub-themes: 1) sustainability and 2) braided/merged funding within organizations. For the purpose of this project, braided/merged funding is defined as “blending funding sources that make sense [and are] working towards [the] same objective” (Agency 6, 2018). To ensure that agencies are introducing programming focused on these sub-themes, it is recommended to engage in yearly work planning. Through yearly work planning, staff at organizations are able to identify aspects of programming that can be supported by multiple modes of funding, just in case funding ends for a particular program or a source of funding is not sufficiently meeting the needs of the population being served. Agency 5 mentions the importance of “...integrat[ing] work that is sustainable, particularly considering that funding may end.” This is further supported by Agency 6 who states, “Know how to merge your sources of funding, if you can’t do something with a particular type of funding, figure out how you can do it with another [source] to make sure you are offering what is needed [by] the population you serve.” This then allows for program sustainability through identification of possible areas for merged/braided funding within organizations.

Table 3
Best Practices for Implementation by Theme

<i>Theme</i>	<i>Sub-theme</i>	<i>Best Practice for Implementation</i>
<i>Patient-centered Care (PCC)</i>	<ol style="list-style-type: none"> 1. Client-driven services 2. Multiple-modality learning 3. Culturally relevant care 	<ul style="list-style-type: none"> • Conduct needs assessment • Conduct focus groups • Introduce CHW Program
<i>One-Stop Shop /Integrated Care Model</i>	<ol style="list-style-type: none"> 1. Merged disciplines 2. Employment readiness assistance 3. Warm handoffs 4. Social service support 	<ul style="list-style-type: none"> • Hire Behavioral Health Consultant • Wrap-around model for service delivery
<i>Community Partnerships</i>	<ol style="list-style-type: none"> 1. I.D. community champions 2. I.D. similar goals & programming at other organizations in the community 3. Leverage funding 4. Non-profit & for-profit partnerships 5. Shared staff internally and externally 	<ul style="list-style-type: none"> • Coalition development • Integrated work plans • MOUs
<i>Organizational & Staff Support</i>	<ol style="list-style-type: none"> 1. Staff education 2. Elevate staff skillset 3. Constant program adjustment 	<ul style="list-style-type: none"> • Cross-departmental trainings • PDSA cycle integration
<i>Leadership Buy-in</i>	<ol style="list-style-type: none"> 1. Support from top leadership 2. Out-of-the-box thinking 3. Mission-aligned initiatives 	<ul style="list-style-type: none"> • Mission and vision-aligned programming
<i>Funding</i>	<ol style="list-style-type: none"> 1. Sustainability 2. Braided/merged funding 	<ul style="list-style-type: none"> • Yearly work planning

Discussion

The intent of this project was guided by the need to address the FNS WRO 2018 fiscal year priority, “[to] ensure programs pave a pathway to self-sufficiency.” The goal was to identify ways to leverage funding streams from USDA FNS WRO and/or HRSA-funded HCHP to align community health, clinical services, and self-sufficiency programs. Seven health centers were identified as having programming that could inform this work and were asked multiple questions addressing the structure and funding of their programming. When HCHPs were interviewed, we considered multiple factors including: client needs, cultural differences of the PP populations, management/staff support and

flexibility, staff needs and skillsets, and funding and the availability of resources. An extensive review of the literature in addition to key informant interviews were used to capture major programmatic themes aimed at addressing PP self-sufficiency in relation to programming offered at these seven health centers/programs. These major programmatic themes then helped with the development of best practices for implementation that other HCHP can use to reach the same level of programming.

The responses shared by HCHP staff illustrate the rich variety in programming offered at each location. By identifying this rich variety in programming, it is evident that much of the programming offered at these HCHPs aims to address multiple social determinants of health. This was a unique finding, considering that self-sufficiency initiatives may be best implemented in these types of settings where providers are not only thinking about the physical health of the person, but the overall factors that may be contributing to health issues, such as financial instability. With the additional layer of offering employment assistance, these HCHPs can also find ways to elevate people out of poverty and into a healthier and more self-sufficient lifestyle. This is particularly important, considering “that while many client households seek[ing] charitable food assistance have some form of employment, they still struggle to meet their basic needs” (Babic et. al, 2014).

In understanding that there are multiple social determinant of health affecting a PP, all seven HCHPs had some form of programming that facilitated the process of offering whole person healthcare. This was evident through the identification of the 6 themes in our results: patient-centered care, gaining leadership buy-in, gaining organizational and staff support, the importance of building community partnerships,

funding and its role in service delivery, and the importance of offering wrap-around services. According to Stange (2009), "...improving health...considers the behavior of multiple interacting factors which advance the health of whole people within communities" and the 6 themes identified via our interviews seemed to support this. By placing a particular focus on these aspects of service delivery, it may be more likely that HCHPs understand the importance of offering services beyond basic health care.

Limitations

Despite the multiple strengths of this project, we must also consider the multiple limitations. The first is that limited research exists on the relationship between funding and self-sufficiency initiatives across federally-funded HCHPs. This limitation created a challenge in the development phase of this project, because of the lack of foundational knowledge and data to guide the development of our interview questions. However, it was also seen as a benefit and an opportunity to approach the layout of the project with an open mind. In addition, it will be a great tool to pave the path for future research associated to this topic.

The second limitation was the small sample size ($n=7$) of interviewed HCHPs. The small sample size limits generalizability of our findings due to the possibility that the characteristics of the interviewed HCHPs may differ from those of other HCHPs within the USDA FNS western region and across the additional six regions aiming to do similar work. However, we aimed to address the possible variance of HCHPs in multiple ways, including the identification of health center/programs spanning across a vast geographic location in rural and urban settings, identifying those serving culturally diverse populations, and selecting those receiving multiple sources of federal and non-federal

funding. This helped address diversity across interviewees and increases the possibility for generalizability.

The third challenge was the method used for data collection. Interviews were conducted via phone calls and were not transcribed verbatim, challenging the validity of our data and introducing measurement bias. However, despite our transcription method, expanded notes were used to transform raw notes into narratives that allowed for deeper elaboration of observations and providing for richer data collection and interpretation.

The fourth and final limitation is the assumption of program impact on PP sufficiency. Although a goal of the interviewed health HCHPs is to address patient needs and social determinants of health via their unique styles of program delivery, we cannot assume that participation in HCHP services is the sole reason for increased PP self-sufficiency and thus cannot infer that the delivery of these programs results in self-sufficiency amongst PPs served.

Implications for Practice

Before the completion of this project, there was limited information on federally-funded HCHPs and their role in addressing patient/participant self-sufficiency through targeted programming. This project has laid a preliminary foundation for future and more in-depth work on the topic, highlighting some major factors to consider when the USDA FNS WRO recommends programming focusing on addressing self-sufficiency to other HCHP receiving federal funding. Based on our results, there is clearly no one program that can successfully address the multiple determinants affecting the connection between poverty, food insecurity, and ultimately, PP self-sufficiency. By considering structure, PP needs, staffing, and capacity of each individual HCHP, we have determined that there are

major themes to consider when working towards PP capacity-building programming including: patient-centered care, leadership buy-in, organizational and staff support, community partnerships, and One-Stop Shop/Integrated Care Models.

It's imperative to recognize that if successful programming is developed to address poverty and the challenges of PP self-sufficiency, there is a clear difference between simply providing employment and training opportunities and providing opportunities that actually result in self-sufficient lifestyles. According to one of the nation's leading organizations addressing food insecurity and targeting SNAP-eligible households, Feeding America, "the median household income of people Feeding America serves is \$9,175" (Feeding America, 2017).

Contrary to popular belief, individuals receiving benefits and food assistance are in fact employed. About 54% of households served by Feeding America have at least one member that has worked in the past year (Feeding America, 2017). However, many households with employed SNAP recipients do not make enough of an income to live a self-sufficient life. For this reason, it is important to consider the positives and negatives that financial benefits of self-sufficiency opportunities can result in. Although self-sufficiency opportunities can lead to increased incomes in a household, these increased incomes can also unknowingly result in the loss of much needed benefits. This is important to consider in order to limit the amount of individuals who could lose benefits if they earn a little more income than they already do.

To meet SNAP eligibility, eligible individuals must fall into an income bracket based on household size. In many cases, while the threshold to meet SNAP eligibility is low, exceeding that income threshold does not mean that a person is making enough to

live a self-sufficient life. As a result of this, it is easy to fall through the safety net that SNAP assistance can provide, keeping individuals poor enough to need benefits, but not impoverished enough to receive them.

Dissemination of Findings

To facilitate the process of sharing our findings, it is imperative that the USDA FNS WRO secures a method of dissemination to targeted partners. According to Warkentin , Gefen, Pavlou, & Rose (2002), multiple e-government (electronic government) initiatives have worked to improve the efficiency and effectiveness of information sharing of internal and external government operations as well as communication and transactions with individuals and organizations. For this reason, it is recommended that the FNS WRO identify a successful and convenient method for sharing the results of this project, such as an e-government portal. USDA FNS should use PartnerWeb, a secure site for grantees to access USDA FNS updates. Since the majority of this work focused on the western region, WesternWeb can also be used specifically for agencies in the western region. This will initiate the conversation of introducing patient self-sufficiency to the HCHP sector.

Future Research

Despite the significant findings as a result of this project, there is room for further research to be conducted. Because there is limited research that discusses the role of federal funding in relation to community health, clinical services, and self-sufficiency programs, this project has provided solid qualitative data initiate to initiate the conversation about the importance of the topic. This project focused on the collection and analysis of qualitative data providing a source of findings that can further be enriched by

quantitative data. It is suggested that future research look into quantitative outcomes as a result of successfully merged/braided funding at the interviewed health centers/programs to further support the best practices for recommendation that have been suggested.

Conclusion

By introducing the importance of PP self-sufficiency and its relation to social determinants of health within the HCHP sector, we can begin to conceptualize the integration of self-sufficiency initiatives within federally-funded health programs, further supporting SNAP-recipient in achieving self-sufficiency.

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Appendix A: Interview Tool

Agency:

Participant:

Phone number:

Date of interview:

Start Time: End Time:

Location:

Interviewer & note taker:

Introduction

Introduce self and purpose of interview

- Nalleli, intern with the USDA Food and Nutrition Service
- We are reaching out to different organizations to ask about services being offered.

Our goal is to look at the social determinants of health via the lens of how services are offered and, ideally, integrated. We are interested in both the social and economic aspects. We are hoping to identify best practices regarding how organizations integrate services in ways that might help clients/patients/participants improve their quality of life.

Socioeconomic status is one of the most powerful predictors of health, which is why we are looking at creative ways to offer not only access to health services, but additional opportunities to address the multiple barriers that clients/patients/participants experience when trying to achieve a healthy lifestyle.

I'll be asking a series of questions about the services you offer. This interview will take us about **30 minutes** to complete. Please feel free to stop me at any time if you have any questions.

Thank you for taking the time to share this information with us. Do you have any questions before we get started?

General Information

1. Can you tell me about your organization? Mission, goals, target audience, etc.?

2. Tell me about your role within the organization?

Transition: Now that I've gotten the chance to learn a bit more about your organization, let's jump into discussing some of your programs in detail. Do you have any questions before we move on?

Nutrition Ed./SNAP-ED

3. Tell me about programs offered at your agency that are focused on the delivery of nutrition education.
 - What kind of nutrition education, if any, is provided at your organization? (responses may include cooking demonstrations, taste tests/recipes, physical handouts, videos/multimedia, one-on-one or group education/classes, online modules)
 - Who delivers nutrition education at your organization? (responses may include RD, health educator, RN, Physician, PA, CHW/promotoras/es, Intern/volunteer).
 - Tell me about the skillset of your nutrition educators? (probe: are they trained on-site or do they come with a certain training/skillset)
4. How is your nutrition education funded?
5. ***Only ask this question if not funded by SNAP-Ed*** Would you be interested in partnering with SNAP-Ed for nutrition education programs? (SNAP-Ed is provided by health departments, and non-profits to improve the likelihood that persons eligible for SNAP will make healthy food and lifestyle choices that prevent obesity.)
6. Any specific challenges you've faced in trying to develop your nutrition education program?
7. Any advice for other organizations trying to develop a nutrition education program?

Transition: In addition to nutrition education, I'm interested in learning if and how you serve particular populations.

WIC

- What type of WIC services, if any, are provided at your organization?
- If WIC services are not provided, why not?

- How, if at all, is your organization involved with WIC clinics in the community?

Transition: One of most challenging aspects of overall health and wellness is related to socioeconomics and employment. We know this is not in the wheelhouse of most health centers but some have had great success in not only dealing with health care but also with trying to move customers up the economic ladder. So we have a couple questions about whether your organization provides any employment related services.

Employment & Training

- What services, if any, does your organization offer related to employment and training to help clients/patients/participants move into jobs?
- If no:
 - Is this something your organization is considering? If so, what are your plans?
 - Is this something your organization has considered in the past? What challenges or developments prevented you from moving forward?
- If yes:
 - Does your organization provide any type of workforce development related training such as MA training, CHW, medical coding, or other?
 - Tell me about any job search/assistance offered to clients/patients/participants at your organization.
 - What are other supportive services provided/offered/available to clients/patients/participants?
 - How are your employment training (or supportive) services funded?
 - i. Any specific challenges you've faced in trying to develop your employment and training program?
 - Any advice for other organizations trying to develop an employment and training program?

- Do you receive SNAP E&T funding? If not, would you be interested in partnering with SNAP E&T and learning more about FNS' 50/50 third party reimbursement program?

Transition: Lastly, if certain services are not provided at your organization, I want to know if you have a system in place to guide people to the services they seek or could benefit from that would help further help address social determinants of health.

Other

- What kind of referral to social services are provided through your program?
- Tell me a bit more about who conducts these referrals?
- If referrals to social services are not provided, why not?

Depending on how they answer all the questions above

If yes, It seems like your program has successfully integrated health and employment programs in a way that benefits your clients.

OR

If no, It seems like your program is working on trying to better integrate health and employment programs in a way that benefits your clients.

- So, finally, do you have any advice or recommendations for challenges or strategies you've utilized or are utilizing to integrate these services that would be beneficial for other organizations to know?

Thank you for taking the time to answer these questions, I appreciate your participation. We are hoping to use this information to develop a list of best practices we can share with other organizations that are trying to implement integration approaches like that one's we've discussed today. Your responses to will help us develop this document. Once we finalize this document, we will be sure to share it with your organization if you are interested.

Do you have any additional information you'd like to share or any questions for me before we wrap-up?

Appendix 2: Qualitative Data Summary

Factors Helping Health Centers/Programs Pave a Path Toward Patient/Participant Self-Sufficiency

Factors supporting patient self-sufficiency

Agency

Patient-centered care

- Understand that no “one size fits all” when it comes to nutrition education (recognize different populations) • Agency 2
- Plainly ask people what they need • Agency 2
- It’s important to go to community events, engage with families, listen to their struggles • Agency 2
- Look at the whole spectrum of health to determine needs. Holistic practice is imperative • Agency 3
- Services are very client-driven taking into consideration individual patient needs and situations • Agency 3
- Oversee preservation, and perpetuation of traditional healing and non-healing practices • Agency 1
- Integrate multiple modalities of learning • Agency 1
- Consider the patient’s lived-experience • Agency 5
- Community Health Worker program meets people where they are at and helps communities and educators connect as peers vs. having an outsider who is only there for a limited time • Agency 6
- Give/Get Model, it can’t just be information out. Everyone can learn from each other • Agency 6

Leadership buy-in

- Integration of programming starts on top at management level • Agency 7
- CEO is a great out of the box thinker, open to trying new things • Agency 2
- Patients can anonymously text CEO with issues they’d like to raise about programming • Agency 2
- Have an organization at the board/leadership level that also supports initiative • Agency 4

Organizational and staff support

- Organizational policy really comes to mind (plays a big role) in order to equip an organization for success • Agency 7
- It can be as basic as finding language that resonates with clinical health and behavioral health in order to get everyone on board. Identify ways to talk each other’s language • Agency 7
- Be flexible/constantly tweak /staff needs to be flexible • Agency 2

- Educating staff and gaining their buy-in is essential • Agency 3
- From board to staff, important to understand and create culture • Agency 3
- Teach providers that health is more than just medical. • Agency 3
- Anyone who is employed within system conduct referrals • Agency 1
- Agile Design is instrumental, being able to fast track best practices (PDSA cycle-style) • Agency 5
- Can't sit and wait for success if it's not there, it's important to make changes to address need • Agency 5
- All levels of staff respond different to all levels of education. Cross training is important • Agency 5
- Value all staff members regardless of training and background • Agency 5
- Have a provider coalition to help staff stay informed on current events • Agency 5
- Provide access to an internal referral system that all staff can use • Agency 4
- Put forth a solution to issues, but provide staff opportunity to figure out how to work through the "how" • Agency 4

Community Partnerships

- Find champions in community and train them in ways to become more active in community health initiatives • Agency 7
- Identify achievable like-outcomes to those of partner • Agency 7
- Importance in establishing relationships with foundations • Agency 3
- Start with a looking at the best practices and models around the country for ideas • Agency 3
- Work with multiple partners to address issues such as education, housing, culture, etc. • Agency 1
- Find partners in the community, we don't have to do everything and that's ok • Agency 1
- Look at what other are doing and work together to meet the gaps • Agency 1
- Leverage monies with other orgs to help them also • Agency 1
- Partner with educational institutions • Agency 5
- Become a fiscal sponsor for other organizations who need support and compliment your work • Agency 5
- Have partnerships across the board: governmental and non-governmental partnerships, referral network, financial partnerships, employers, coalitions and collaborative tables • Agency 5
- Sharing of staff can be helpful, but be sure to have a signed agreement • Agency 4

Funding

- Important to integrate work that is sustainable, particularly considering that funding may end • Agency 5
- Braid funding. Know how to sustain programs when funding goes away • Agency 5
- Leverage things that are missioned align. As a nonprofit, be ok with not always making money in services that you provide • Agency 5
- Know how to merge your sources of funding (figure out what you can and can't do). If you can't do something with a particular type of funding, figure out how you can do it with another to make sure you are offering what is needed in the population you serve • Agency 6

One-Stop Shop/Integrated Care Model

- Merging public health with behavioral health is innovative and required for successful integration • Agency 7
- Computer stations are set-up to offer assistance with resumes, soft skills training, employer fairs • Agency 2
- Partners are present on-site, such as housing assistance, etc. • Agency 2
- Warm handoffs are commonly used • Agency 2
- Behavioral Health Consultant (BHC) on-site • Agency 2
- Free summer lunch program for kids offered on-site with support from local food bank • Agency 3
- Full-time attorney on site, to help people access employment, assist with eviction notices • Agency 3
- Financial wellness program that targets low-income individuals, working poor who are locked into payday cycle loans preventing them from financial stability • Agency 3
- Case management team located within integrated model • Agency 3
- Additional services offered in-house include: SSI, birth certificates, Medicaid enrollment • Agency 3
- Offer both a health clinic and empowerment center with multitude of social services • Agency 5
- Wrap around model to address social determinants of health. Intake is very intensive in order to refer patients to appropriate services • Agency 5
- Outreach and enrollment for SNAP and Medical (patients get trained as enrollees) • Agency 5

- Job training and whole health support is offered
 - All needed providers are located in clinic and made available when the patient is there
 - Paralegal is present once a week to conduct open clinic for patient needs/questions
 - Gift card is offered for first interview needs (clothing, backpack, transportation, shoes)
 - Youth mentoring program
- Agency 5
 - Agency 4
 - Agency 4
 - Agency 4
 - Agency 4

