HEALTHY FOOD PANTRY PARTNERSHIP SCREENING AND REFERRAL EVALUATION REPORT

University of Virginia
Institute for Engagement & Negotiation
Shaping Our World Together

VCU
Virginia Commonwealth University

UVA
School of Nursing

Federation of Virginia Food Banks
Partner State Association of Feeding America

Acknowledgements

We would like to first express our gratitude to all those who participated and helped support this project– your thoughtful insights, experiences, and ideas were inspiring and extremely rich. Thank you for taking the time to share these perspectives with us. We would also like to thank the Virginia Federation of Food Banks for funding and supporting this research project.

Federation of Virginia Food Banks Research Collaborators

Eddie Oliver - Executive Director, Federation of Virginia Food Banks
Meaghan Butler- Health Equity Director, Federation of Virginia Food Banks
Maria Bowman- Director of Health Initiatives, Blue Ridge Area Food Bank
Michelle Hesse- Consultant, Blue Ridge Area Food Bank
Sydney Orgel- Health Initiatives & Client Resource Coordinator, FeedMore

Research Study Team

Dr. Camille Burnett - Principal Investigator
Associate Vice President of Education and Health Equity; Executive Associate Director, Institute for Inclusion, Inquiry and Innovation, Office of Institutional Equity, Effectiveness and Success, Virginia Commonwealth University
Tanya Denckla Cobb - Co-Principal Investigator
Director, Institute for Engagement & Negotiation
Dr. Ha Do Byon - Co-Investigator
Assistant Professor, University of Virginia School of Nursing
Anne Nelson Stoner - Research Coordinator
Principal Student Research Assistant, Institute for Engagement & Negotiation, University of Virginia
Theresa Kreuggeler - Senior Associate
Research Coordinator Y1 and Y2 of project, Institute for Engagement & Negotiation, University of Virginia
Sophie Delzell
Student Research Assistant, Institute for Engagement & Negotiation, University of Virginia
Sarah Rizk
Student Research Assistant, Institute for Engagement & Negotiation, University of Virginia

Table Of Contents

Definitions

Aid to the Aged, Blind, and Disabled (AABD) - a program that provides cash assistance for individuals who are 65 or older, blind, or disabled.

Client Choice Model - model of service that gives pantry clients control over which foods to take home from the pantry.

External Pantry Model - model of service where a pantry client is referred to a nearby food pantry after screening positive for food insecurity at a health care site.

Federation of Virginia Food Banks (FVFB) - The Federation of Virginia Food Banks is a 501(c)(3) nonprofit state association of food banks affiliated with Feeding America. The Federation supports the seven regional Virginia/Washington DC food banks in building partnerships, securing resources, sharing data, and raising awareness of food insecurity throughout the Commonwealth.

Food Bank - non-profit that stores millions of pounds of food that will soon be delivered to local food programs, like a food pantry.

Food Insecurity - a lack of consistent access to enough food for every person in a household to live an active, healthy life.

Food Pantry - a distribution center where hungry families can receive food.

Healthy Food Pantry - a food distribution site that distributes a larger portion of fresh produce and nutritious food, and also provides opportunities to improve health, like health screenings or nutrition education.

Hunger Hotline - a hotline staffed by volunteers, that allows clients to access information about food pantries and additional resources.

In-clinic Pantry Model - model of service where a patient receives food on-site at the health care site after screening positive for food insecurity.

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) - a program that safeguards the health of low-income women, infants, and children up to age five who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care.

Supplemental Nutrition Access Program (SNAP) - formerly called food stamps, a government program that helps people buy the food they need for healthy lives.

Executive Summary

Source: Federation of Virginia Food Banks

In 2020, over 60 million people in the U.S. experienced hunger and food pantries nationwide distributed over six billion meals. The added stress of COVID-19 resulted in a 55% increase in food pantry visitors, and food pantries prepared to serve the equivalent of over 6.5 billion meals in 2021 (1). While initially developed for emergency food aid, food pantries have become essential community resources, serving clients who do not qualify for federal nutrition programs or slip through the cracks of our social service networks. Food insecurity is associated with an increased risk of diet-sensitive chronic diseases, such as diabetes, hypertension, obesity, and nutrient deficiencies and malnutrition. As a result, hunger and health are being seen as increasingly interrelated issues.

Unfortunately, the charitable food system was designed to prioritize quantity over quality, and historically has not prioritized the nutritional quality of foods distributed (2). In response to this, Virginia's food banks and their pantry partners are working to ensure that their services are contributing to improved health outcomes for people facing hunger through programs like the Healthy Food Pantry Program and in-clinic food pantries (3). At the same time, the health sector is doing more to address patients' social needs, or social determinants of health, by screening their patients and connecting them to the services and resources they need. For example, many health providers are screening their patients for food insecurity, and referring patients that screen positive for food insecurity to their local food pantry (external referral), or to an onsite, health care-operated food pantry (in-clinic referral). **This evaluation identifies opportunities and differences in screening and referral processes used to provide in-clinic pantry versus external referrals and their impacts; explores health care provider partners' considerations for in-clinic pantry interventions; and identifies best practice approaches and recommendations for in-clinic interventions, partnerships, screening and referral.**

A collaborative partnership between the research team and the FVFB was forged to guide and support the successful implementation of this evaluation project. Due to COVID-19, the evaluation and its scope were paused, revised and redesigned. The redesigned study began in September 2021 and was completed in August 2022.

Summary of Results and Conclusions

Five pantry sites were recruited by the FVFB to participate in this study. Interviews and focus groups of health care professionals and pantry clients were complemented by secondary pantry data to provide multi-dimensional insight. In total, 15 health care professionals across five sites and three pantry clients were interviewed. Each pantry program's client demographics and pantry use indicators were summarized over three months. While the evaluation was designed to engage with at least five to seven food pantry clients from each of the five sites, this was not accomplished due to difficulty recruiting participants.

(1) *The Food Bank Response to COVID | Feeding America.* (n.d.). Retrieved September 13, 2021, from https://www.feedingamerica.org/hunger-blog/food-bank-response-covid-numbers

(2) Wetherill, M. S., White, K. C., & Seligman, H. K. (2019). Nutrition-Focused Food Banking in the United States: A Qualitative Study of Healthy Food Distribution Initiatives. *Journal of the Academy of Nutrition and Dietetics*, 119(10), 1653–1665. https://doi.org/10.1016/j.jand.2019.04.023

(3) *Healthy food initiatives in food pantries.* (2020, December 7). County Health Rankings & Roadmaps. https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/healthy-food-initiatives-in-food-pantries

The following themes emerged from interviews and focus groups:

- Clients and health care providers recognize the importance of food for health
- Food choice is important to clients, as is access to fresh fruits and vegetables
- Health care providers play a critical role in identifying and addressing food insecurity
- Using caring approaches to detect food insecurity, build trust, and combat stigma is important
- Collaboration, education, and training are critical to success
- Convenience and accessibility are key for clients
- Programs must be designed to be sustainable including planning for staffing and space
- Data tracking and measuring impact are challenging

Recommended Next Steps based on insights gathered from interviews and data analysis:

- Integrate recommendations from this report into practice and processes.

Enhance and sustain communication

- Identify clear program goals and objectives that can be measured and operationalized.
- Create formal partnership agreements between food pantries and clinics that are reevaluated annually and contain data sharing requirements as well as shared goals.
- Provide onboarding, training and support for each partner including educational materials for the clinical staff and for the pantry clients.
- Identify key contacts for each partner site who will maintain regular contact and provide frequent updates.
- Expand the Hunger Hotline to allow clients to connect via phone with pantries and additional resources.
- Hire more Spanish-speaking staff to assist with the referral process.
- Use educational events and community outreach to destigmatize food insecurity.
- Develop proactive plans for maintenance and support of the program into the future including standardized workflows and stable sources of funding.

Improve data tracking, reporting, and sharing across all pantry sites

- Standardize the screening, referral, and data tracking processes across sites.
- Identify and implement a standardized data collection/analysis tool and strategy across sites to perform ongoing and systematic data collection about client characteristics, food distribution, and referral.
    - Generate and share timely, automated reports with all partners.
    - Standardize measurements of characteristics of interest.

Offer food choice and fresh food where possible

- Move toward a patient choice model and offer more fresh, less packaged food. Emphasize food quality instead of just quantity.

Access and address clients' knowledge about healthy food and their ability to access food

- Provide more client education and information about nutrition and healthy foods including recipes.
- Prioritize building trust between health care providers and clients.
- Integrate a mechanism for obtaining ongoing client feedback to improve the program.
- Consider working in partnership to address food access and root causes of food insecurity in the region through advocacy, creation of networks, and engagement of clients and their expertise to lead these efforts.

Normalizing and reducing the stigma surrounding food insecurity could make many patients less uncomfortable responding honestly to food insecurity screenings and utilizing food pantries. Clinics that can provide holistic community care including health care, education, food, and other resources would greatly benefit clients. In-clinic food assistance provides immediate benefits to patients and starts to provide this one-stop-shop for health. As one provider stated, "knowing that you could always swing by your clinic [or] your doctor's office and get a bag of food is kind of like a revolutionary idea, right?" The Healthy Food Pantry Partnership has successfully begun addressing the barriers to health equity including access to nutritious food. As food bank/health care partnerships continue to grow and evolve, finding sustainable methods of collaboration and patient feedback collection will be critical. All of those interviewed appreciated the pantry partnership, recognized its importance, and hoped to see it continue in the future.

01

Background

01 Background

Prior to the onset of the COVID-19 pandemic, Virginia's food insecurity rate stood at 9.9%; over 842,000 people had to worry where their next meal would come from on any given day. In 2020, according to a study by Northwestern Institute for Policy, the number of people experiencing hunger in Virginia skyrocketed from 9.9% in February to more than 22% by June 2022. While this evaluation was originally commissioned to start in 2019, it was thwarted by COVID and needed a hard reset in terms of approach and aims that were better suited to the new context. This approach shaped the design of the evaluation. Collecting data in person would have been ideal, however, with time constraints from the evaluation delay and COVID safety considerations, online options were chosen as the best option given the circumstances.

Adequate access to food is a critical contributor to health. Unfortunately, many people suffer long-term health consequences because they were born into communities that lack access to affordable, nutritious food. Diabetes, heart disease, and kidney disease are directly tied to food insecurity, leading to significant health disparities among socially and economically disadvantaged communities. Often, by the time a neighbor has connected with the charitable food system, they have faced spending trade-offs, forced to choose between paying rent or medication and nutritious food. These impossible choices only exacerbate health consequences and perpetuate the vicious cycles of food insecurity and chronic disease (4).

Source: Federation of Virginia Food Banks

There has been increasing emphasis on the social determinants of health and health equity within health care settings, leading health partners to explore new ways to address the social needs of populations that impact health outcomes (food, housing, transportation, etc.). To effectively address these issues, multisector approaches are needed to ensure that everyone has access to culturally relevant, healthy food, quality unbiased health care, and essential resources that improve overall health and well-being. In 2019, the Federation of Virginia Food Banks was one of four nonprofit organizations to receive grants from a pool of $5.5 million from Sentara and Optima Health to address social determinants affecting the health and well-being of low-income Virginians. The Federation received a $1 million Food Is Medicine grant to improve access to nutritious foods through direct-service programs and partnerships throughout the Commonwealth. Each of the Federation's seven member food banks used a portion of the grant funds to implement local programming in conjunction with a statewide strategic plan to improve referral systems, increase the availability of nutritious foods in the emergency food network, and connect low-income individuals with food options that mitigate diet-related diseases (5). Through this grant, food banks established or expanded formal partnerships with health care clinics across the state to begin exploring how to offer pantry food to patients who

(4) Hunger in Virginia| Federation of Virginia Food Banks. (n.d.). Retrieved September 13, 2021, from https://vafoodbanks.org/about-us/hunger-in-virginia/

(5) Federation of Virginia Food Banks Awarded $1 Million Grant from Sentara Health care and Optima Health.| Federation of Virginia Food Banks. (February 22, 2019). Retrieved September 13, 2021, from https://www.brafb.org/wp-content/uploads/2019/03/Sentara-Gift-Announcement.pdf

screen positive for food insecurity. Sentara's funding also catalyzed the development of Virginia's Healthy Pantry model. A healthy pantry is a food distribution site that distributes a larger portion of fresh produce and nutritious food, and provides opportunities to improve health, like health screenings or nutrition education.

In many health care settings, providers have long been aware of their patient's food and dietary challenges but have lacked the necessary resources to provide their food insecure patients with food. Given barriers such as time and transportation, referring them to a nearby food pantry was the best option available.

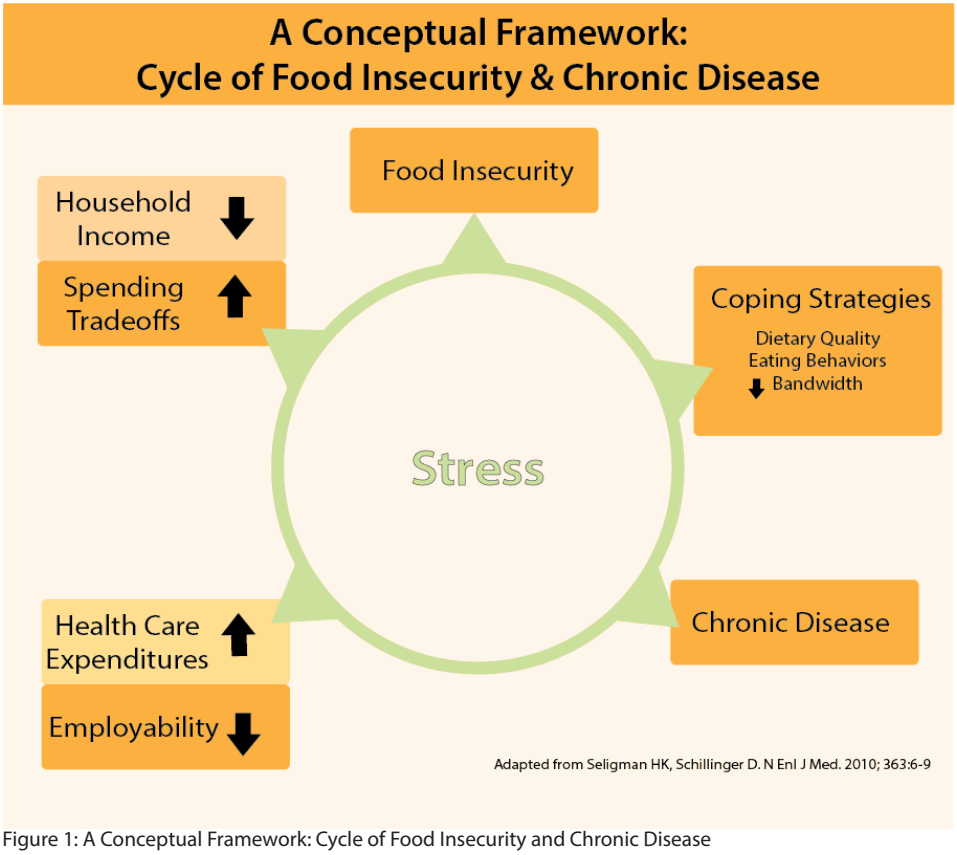


Figure 1: A Conceptual Framework: Cycle of Food Insecurity and Chronic Disease

This framework (Figure 1), created by Seligman and Schillinger (2010), and used by the FVFB, demonstrates the cycle of food insecurity and disease. When someone experiences food insecurity, they often have to sacrifice the quality of their food and their eating behaviors, which increase stress levels. Poor diet and increased stress can lead to the onset or the exacerbation of chronic disease, which results in greater health care costs and decreased employability. Lower household income necessitates greater spending tradeoffs, which then increases the food insecurity and stress leading to lower household income and greater spending tradeoffs, all of which worsens the food insecurity, and the cycle begins again. Establishing food bank and health care partnerships has the potential to connect community members with resources to prevent this cycle.

02
Methodology

02 Methodology

This evaluation seeks to determine which health care-food pantry partnership screening and referral processes facilitate and support improved access to nutritious food for food insecure individuals in Virginia across five diverse health care sites. The fundamental evaluation questions addressed are: a) what are the screening and referral strategies and processes used within the in-clinic sites and at external sites to improve access for food insecure populations?; b) How does the health care providers/food bank partnership relationship provide value, efficiency, and mechanisms to reduce food insecurity for their populations?; and c) What are the impacts and outcomes of screening and referrals at in-clinic and at external sites?

The FVFB commissioned this study and was an engaged partner in its development and design. They formed an advisory team, composed of the FVFB Executive Director and three members of their pantry leadership team who were instrumental in informing and discussing details of the study, answering any questions or concerns related to design and processes, and providing consent for the involvement of each food pantry engaged in the referral-based distribution process that the Federation operates. The research team worked closely with the FVFB advisory team in the overall design of the evaluation, selection and development of descriptive data, interview questions and facilitating retrieval of additional site information and data. The FVFB advisory team and the research team held an information teleconference call on January 27, 2022 with all participating food pantry directors. The meeting intent was to inform the advisory team about the evaluation including the background, purpose, and objectives and to introduce the research team who responded to questions or concerns.

Source: Federation of Virginia Food Banks

Pantry sites were recruited using information known to the FVFB advisory team about the pantries where screening and referral processes were in place or soon to be in place, and those which provided on-site pantry services or referred to an external pantry. Those sites were selected by the FVFB advisory team to participate in the evaluation which yielded five pantry sites. The study team disseminated recruitment materials to the FVFB team to distribute across the five sites, and those individuals contacted the research team coordinator to participate in the study. In total, 15 health care professionals across five sites and three pantry clients were interviewed. Each healthy food pantry program's client demographics and pantry use indicators were summarized over March, April, and May 2022 (three months) through secondary data analysis. The FVFB granted permission for the team to use its extracted de-identified aggregate monthly data for the purpose of the evaluation. The sources of the FVFB data included food bank and health care systems of record, namely Link2Feed databases, Ceres databases, Electronic Health Records, and other records kept by the staff at each site.

03
Methods

03 Methods

The research team, in consultation with the FVFB advisory team, determined that interviews and focus groups would be conducted across five sites. It was felt that interviews, focus groups, and use of secondary pantry data and user data would be most helpful to provide multi-dimensional insight to address the evaluation aims. Therefore, a convergent mixed methods approach was used to generate evaluation findings. At each site, the plan was to interview three individuals and conduct one focus group of pantry users (seven focus group participants). Across all five sites, the research team anticipated 15 total interviewees and 35 focus group participants.

The research team developed an interview guide that was streamlined for use across two specific participant groups (health care providers and pantry decision makers) and as well a focus group guide and demographic questionnaire for customers. The interview and focus group questions examined the experience of either the client, health care provider, or pantry staff involved in screening and referral to identify strengths and opportunities to inform recommendations. In addition to these materials, a short descriptive demographic questionnaire for focus group attendees was developed. Participant consents, recruitment emails, and flyers for interviews and focus groups were developed and all guides and recruitment materials were submitted to IRB for approval, which was granted.

Qualitative information for this project was collected through Zoom interviews with health care providers, food pantry employees, and food pantry clients across five in-clinic and external pantry sites in Virginia. Participants were recruited over the course of eight weeks, which yielded a total of 16 interviews. These interviews were conducted during March and April of 2022, ten with health care professionals, three with food pantry managers, and three with food pantry recipients. Recruitment for the three groups of participants (food pantry managers, health care providers and employees, and food pantry clients) used differing approaches. Food pantry managers were made aware of the opportunity to participate in the project through the FVFB and interviews were scheduled via email. Health care providers and employees were contacted by their food pantry partners and asked to reach out to the project coordinator to schedule an interview if they wished to participate. To recruit food pantry clients, each participating health care clinic posted and/or shared a flier created by the research team advertising a focus group at least one month prior to the focus group date (see Appendix B for a copy of the flier). Each focus group was scheduled for a Thursday from 10:00 AM-12:00 PM and interested participants contacted the study project coordinator via email or telephone to sign up.

Source: Federation of Virginia Food Banks

After two weeks without any sign-ups, the research team reassessed and began offering individual interviews at times that worked best for the participant. A revised flier was shared with all food pantry managers and partnering clinics (see Appendix B for updated flier). Following the posting of this revised flier, a total of three food pantry recipients scheduled interviews. All interviews lasted no more than one hour and

were hosted on Zoom (see Appendix A for a list of interview questions). Consent forms were shared by email prior to the interview and each participant consented verbally at the beginning of the interview after allowing time for questions and review. No focus groups were scheduled.

This qualitative data was analyzed by the study coordinator in consultation with research team members using a process of inductive and deductive coding to increase validity, decrease bias, accurately represent participants, and enable transparency. Verbatim transcripts were created for each interview and then coded with both predetermined and emergent codes. Each transcript was coded, organized into categories and subcategories, coded again, generating emergent themes that formed the basis for the final narrative reflected within this evaluation. Key demographics of the client interviewees were also collected by the research team using a short survey to evaluate the representativeness of the interviewees for the pantry users in general.

In addition to the qualitative data, the de-identified aggregate monthly data provided by the FVFB for each participating food pantry was analyzed. These data did not contain any individual identifiers, minimizing the risk of possibly linking received data to any specific individual and ensuring HIPAA compliance. The data included monthly healthy pantry program user sociodemographics (age, gender, race, education, average income, etc.) and monthly healthy food pantry program use indicators (types and amount of foods distributed, frequency of food distribution, number of referrals, etc.). The data were sent monthly from the FVFB Advisory team to the research team electronically through the University secured servers. These data, quantitative and qualitative, were supplemented with FVFB reports, existing health pantry site data, and a desk review of relevant literature. The information gathered is from the perspectives of participants and does not aim to reflect the diverse lived experiences of all involved individuals.

Source: Federation of Virginia Food Banks

04
Limitations

04 Limitations

While this evaluation was designed to engage with at least five to seven food pantry clients from each of the five sites in the form of focus groups (totaling at least 25-35 client perspectives) this was not accomplished due to difficulty recruiting participants. Despite posting fliers advertising the focus groups over a month in advance at each site, no clients reached out to the study coordinator to sign up. After reflection, the research team pivoted to offering individual interviews during times that worked for both the research team and the client. Following this shift, the study coordinator heard from three food pantry clients, all from a single pantry site, and scheduled individual interviews. It is important to note that the client perspectives have not been sufficiently explored to provide robust insight, however, they can be useful in combination with findings from interviews with staff and health care providers to help guide recommendations.

All three client interviewees were female and white. Two indicated their ages were between 41-60 years old and one was older than 60 years. All were unemployed. Two participants indicated their monthly income was between $1,001-$3,000. These characteristics are similar to those of the health pantry users for the site where the interviewees were recruited (see Site 5 in Table 1 below) although they are not representative of other diverse pantry users.

The research team asked the food pantry managers from each site to reflect on their processes for recruitment and potential reasons why participation was so low. The following reflections were shared about the recruitment process by the food pantry partners, and elaborated on in the Opportunities section below:

- The site that managed to get three participants to sign up for interviews had individual conversations with staff and patients to encourage participation, versus just posting the recruitment flier.
- After the fliers were posted, the majority of patients said they would reach out to the study coordinator that week, but they likely said that to "just to get me to be quiet" (Health Care Provider).
- "Our database, Link2Feed, was used to determine which patients were both referred to and visited the food pantry. The flier and information were shared with these patients via email and those without an email were called. Still, no one signed up" (Food Bank Manager).
- The age of most patients and their sometimes limited knowledge of/efficacy with technology and/or access to the internet may have been barriers to participation.
- "This clinic is very busy and the dietitians we are partnered with split their time between multiple clinics, and I imagine the staff there was working hard just to keep up with their typical workflow. Low patient participation is both a challenge for the study and also a very real challenge that we will need to overcome in order to keep getting patient feedback to improve the program" (Food Bank Manager).
- "They hushed me real quick when I mentioned Zoom or told me they aren't computer savvy" (Health Care Provider).
- "Some folks didn't understand why they were being contacted and were just not interested" (Health Care Provider).
- "It was difficult to get in touch with people. Many do not have email addresses, phone numbers, are out of service, or their voicemail is full" (Health Care Provider).
- More than half of one site's patients are Spanish speaking, which makes recruitment much more difficult.
- "I don't think people understood they were a part of a 'program' so it was difficult to engage them in this evaluation project" (Health Care Provider).

05

Overview of Screening and Referral Process

05 Overview of Screening and Referral Process

The food insecurity screening and referral process varies for each site and health care system. Each site is encouraged to make the process their own and to integrate it into their workflows in the most convenient way possible (see workflows below). Many food pantry sites screened for social determinants of health of the patient population prior to the partnership, and similarly, many health care providers have been screening for food insecurity and have long recognized the link between access to nutritious food and health.

Screening

Health care providers ("providers") begin by screening patients for food insecurity. This is often accomplished with a questionnaire that is given to the patient, either in writing or verbally, during intake or appointments. Patients at some sites are asked to answer "yes" or "no" to the following questions: "within the past 12 months, we worried whether our food would run out before we had money to buy more;" and "within the past 12 months, the food we bought just didn't last and we didn't have money to get more." Some sites assume patients' needs for healthy food using financial information or based on their chronic diagnoses. During interviews, providers emphasized the importance of forming relationships of trust with patients for them to be comfortable discussing food insecurity. Depending on the clinic, different staff members conduct the screening. In clinics with patients struggling with chronic conditions such as diabetes, there is often an on-site dietician who is able to make a referral and provide additional resources. Sites aim to screen all patients on a regular basis and to provide multiple opportunities and avenues for referrals. As one provider shared, "[we] have to be careful not to screen and then not provide a resource."

Referral

Once a patient is determined to be food insecure, providers direct them to food resources. There are two overarching pathways for intervening once a patient had screened positive for food insecurity. In the in-clinic model, a patient receives food on site shortly after screening positive for food insecurity. In the external model, patients are referred to their nearby food bank or food pantry to follow up on their own to receive food. This process also varies based on the site. For clinics with on-site food pantries, either the provider, an outreach worker, social worker, or on-site dietician will provide the patient with a pre-packed box of food for them to take home after their visit. At some sites, these boxes are kept at the clinic, while at others the patients must drive to a different part of the hospital or complex to pick them up. This largely depends on the spatial capacity of the clinic. If a social worker or outreach worker is available, they will often meet with the patient before they leave to assist them in applying for SNAP (formerly known as food stamps) and sharing additional information about nearby food pantries and resources. At some sites with a dietician available and patients with chronic medical conditions such as diabetes, medically appropriate foods will be provided based on the patient's condition and needs. Oftentimes, these boxes include additional information about nearby food banks, recipes, and dietary education. At other sites, they strive to offer a "grocery store model" pantry that allows the patient to select which foods they would like to take home.

Other sites refer their food insecure patients to off-site food pantry locations. Two sites use the Hunger Hotline, a hotline staffed by volunteers, that allows patients to self-refer. These sites will provide patients with postcards or flyers that have information about the hotline. When a person reaches out to the hotline either through an online form or a call, a volunteer contacts them and refers them to the closest or most convenient pantry. When clients visit the nearby food pantry, they present a voucher that includes their name and household size. The food pantry coordinator uses these vouchers to determine the amount of food they require and to collect data for the program (Figure 2).

5.1 Graphic Workflows

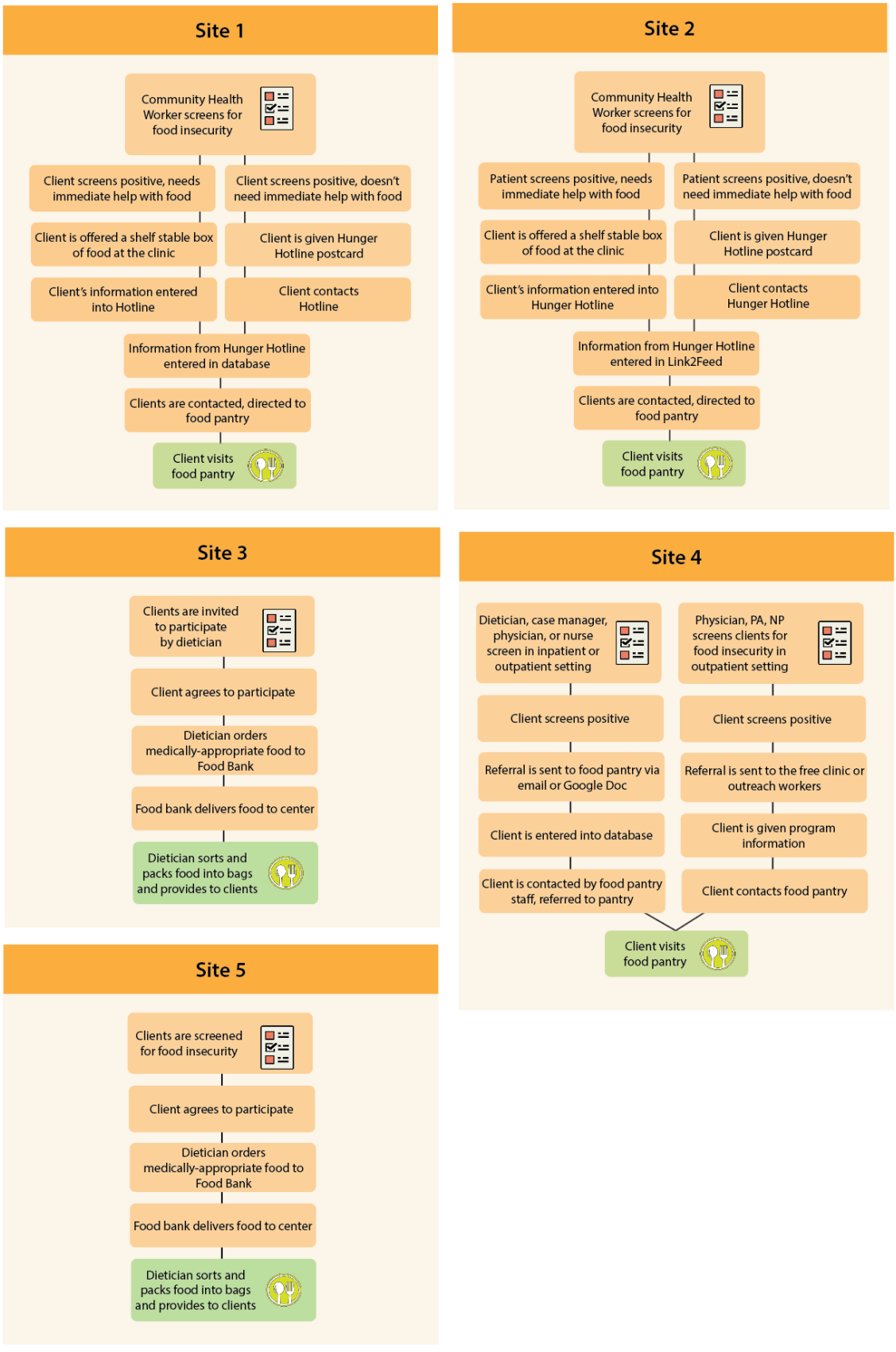


Figure 2: Graphic Workflows

06

Quantitative Evaluation Findings

06 Quantitative Evaluation Findings

6.1 Pantry Site Demographics

De-identified aggregate monthly data provided by the FVFB for each participating food pantry including user sociodemographics and monthly healthy food pantry program use indicators are presented in Table 1. These data reveal the prevalence of various demographics who visit the food pantry sites. Users of the five Health Food Pantry sites average ages range from 35 years to 67 years old. Female is the most prevalent gender across the sites. Most users are Black except at Site 5. Most are not married, unemployed, and use multiple social benefits such as SNAP and AABD.

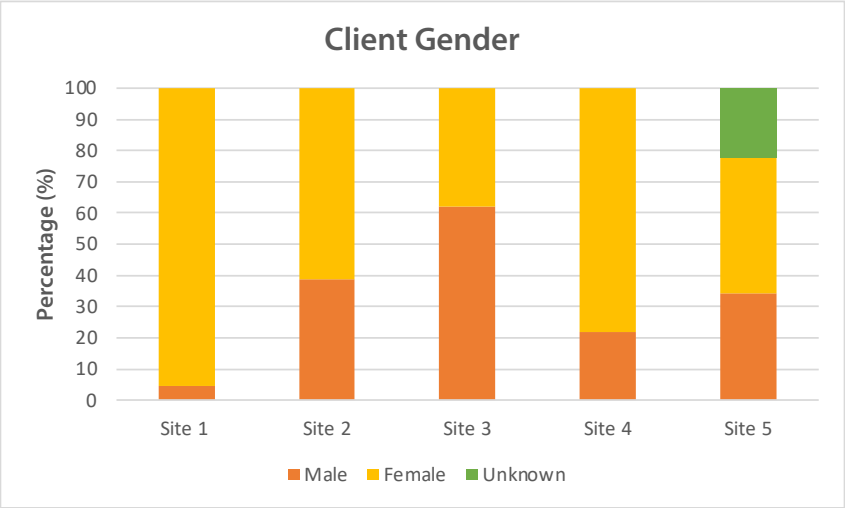


Figure 3: Graph of Client Gender

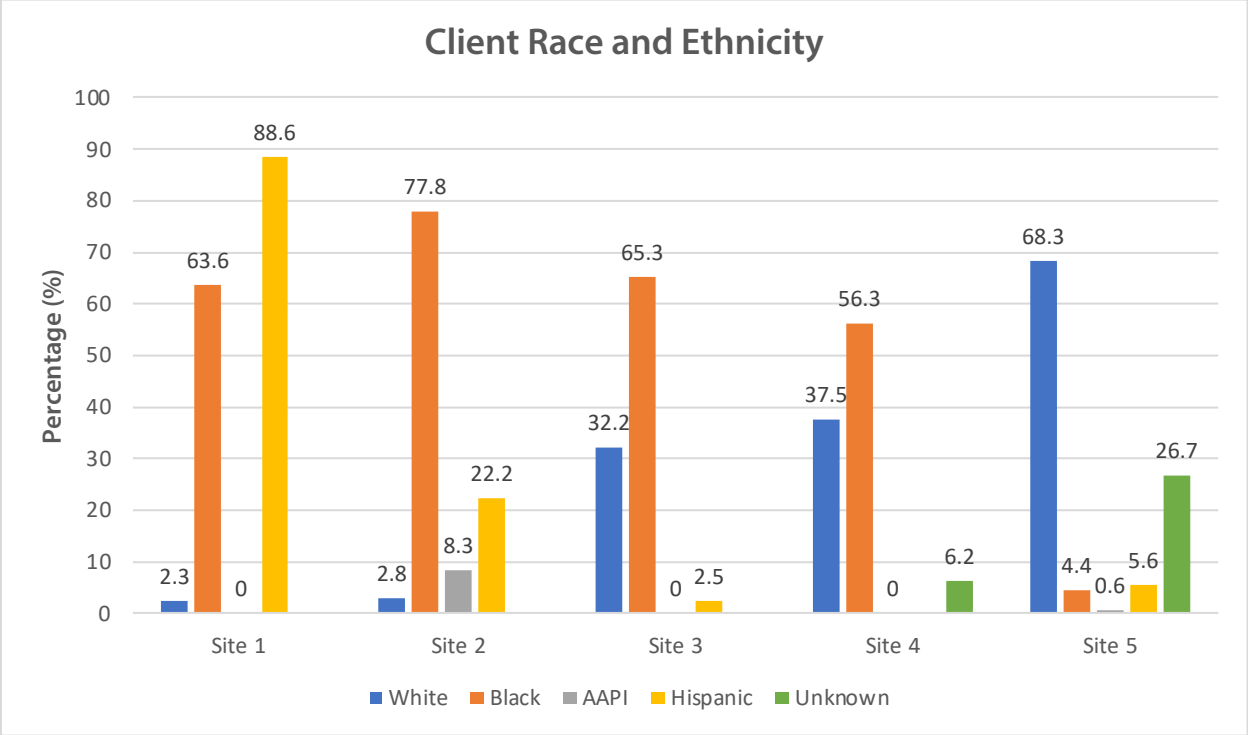


Figure 4: Graph of Client Race and Ethnicity

Table 1. Sociodemographic Characteristics of the Healthy Food Pantry Sites

		Site 1 (n=44)	Site 2 (n=36)	Site 3 (n=121)	Site 4 (n=32)	Site 5 (n=161)
Average age (year)		34.8	55.2	66.4	67.3	UK***
Gender (%)	**Male**	4.6	38.9	62.0	21.9	34.3
	Female	95.4	61.1	38.0	78.1	43.6
	Unknown	0	0	0	0	22.1
Race (%)*12/32	**White**	2.3	2.8	32.2	37.5	68.7
	Black	63.6	77.8	65.3	56.3	4.3
	AAPI	0	8.3	UK	0	0.6
	Unknown	88.6**	22.2**	2.5	6.2	26.4
Hispanic (%)	**Yes**	84.1	22.2	2.5	0	5.6
	No	15.9	77.8	97.5	100.0	71.2
	Unknown	0	0	0	0	23.3
Education (%)	**Less than high school**	27.3	5.6	UK	40.6	UK
	High school or GED	11.3	36.1	UK	18.1	UK
	Some post-secondary	2.3	5.6	UK	0	UK
	College	0	0	UK	6.3	UK
	Unknown	59.1	52.7	UK	25.0	UK
Language (%)	**English**	15.9	94	97.5	UK	76.1
	Spanish	84.1	6	2.5	UK	1.8
	Unknown	84.1	6	2.5	UK	22.1
Marital Status (%)	**Yes**	27.3	22.2	34.7	18.8	25.8
	No	29.5	58.3	65.3	81.2	49.1
	Unknown	43.2	19.5	0	0	25.1
Employment (%)	**Full time**	29.5	2.8	0	6.3	UK
	Part time	18.2	11.1	5.0	0	UK
	Unemployed/ retired	36.4	86.1	95.0	93.7	UK
	Unknown	15.9	0	0	0	UK
Household size (%)	**One**	4.5	38.9	UK	UK	UK
	Two	6.8	33.3	UK	UK	UK
	Three	11.4	16.7	UK	UK	UK
	Four	11.4	0	UK	UK	UK
	Five or more	65.9	1.1	UK	UK	UK
Average income ($)		1272.4	931.2	UK	1086.1	UK
Benefit program (%)*	**Medicaid**	56.8	64	40.5	21.9	20.2
	SNAP	13.6	50	UK	21.9	UK
	AABD	0	5.6	UK	6.3	UK
	WIC	29.5	2.8	UK	0	UK
	None	15.9	19.4	UK	0	UK
	Unknown	9.1	0	UK	3.1	UK

*The total may not add up to 100% because multiple entries were allowed.
**Indicated as Hispanic
*** The clients older than 60 years made up 41%.
Note: n (number of clients) may include individuals who made multiple visits over the 3 months. AAPI = American Pacific Islander; SNAP = Supplemental Nutrition Assistance Program; AABD = Aid to the Aged, Blind or Disabled; WIC = Women, Infants and Children; UK = unknown

6.2 Screening & Referral

Table 2 demonstrates the monthly frequencies (and percentages) of the screenings and referrals at most sites. One site (Site 4) was not able to provide the data. Two sites (Site 1 and 2) measured newly screened clients per month while the other two sites (Site 3 and 5) measured screenings of new and existing clients per month. The percentage of clients who were screened positive for food insecurity ranged from 79% (Site 3) to 100% (Site 2). At the two sites (Site 1 and 2) that used the Hunger Hotline, the majority (60%, and 85%, respectively) agreed to be referred to the Hunger Hotline. About half (81%, and 53%, respectively) of those who were referred to the Hunger Hotline then agreed to be referred to food pantries.

Table 2. Persons Screened, Percentage Food Insecure, and Percentage Referred to Hunger Hotline and External Food Pantries per Month at Each Site

	Site 1	Site 2	Site 3	Site 4	Site 5
Persons Screened for Food Insecurity, per month	24 (newly screened)	13 (newly screened)	37	UK	54
Percentage of Persons Screened Positive for Food Insecurity	96%	100%	79%	UK	UK
Percentage of Food Insecure Referred to Hunger Hotline	60%	85%	N/A (In-Clinic Pantry)	N/A (In-Clinic Pantry)	N/A (In-Clinic Pantry)
Percentage of Hunger Hotline Referrals Referred to External Pantry	81%	53%	N/A (In-Clinic Pantry)	N/A (In-Clinic Pantry)	N/A (In-Clinic Pantry)

6.3 Pantry Site Food Distribution

Pantries collect data about the frequency of food distribution at each site but it does not fully capture the relative success of each clinic's referral process. When clients are referred to the food pantry, they might visit within days or weeks or not at all. Figure 5 shows the number of food boxes or bags distributed to the healthy food pantry clients which can approximate the frequency of food distribution at each site during the months of March, April, and May 2022. The frequency ranges from 10.7 boxes of food distributed per month (Site 4) to 71.7 per month (Site 5).

Boxes of food distributed at each site often include bread, dairy, fruit, vegetables, meat, and other proteins. Sites 1, 2, and 4 distribute shelf-stable items such as canned proteins and vegetables. Site 3 provides several options for fresh fruits and vegetables in addition to canned foods. Site 5 is the only location that provides a variety of fresh produce that is grown on-site (Table 3). At Site 1 and Site 2, food boxes were provided at the clinics. Any other food items were distributed when the clients subsequently visited external pantries. Site 1 distributed more foods (7,785 lbs. of foods in addition to 23 food boxes per month) than Site 2 did (2768.7 lbs. in addition to 13 food boxes per month). The exact weights of the foods distributed at the other three sites were not available (Table 4).

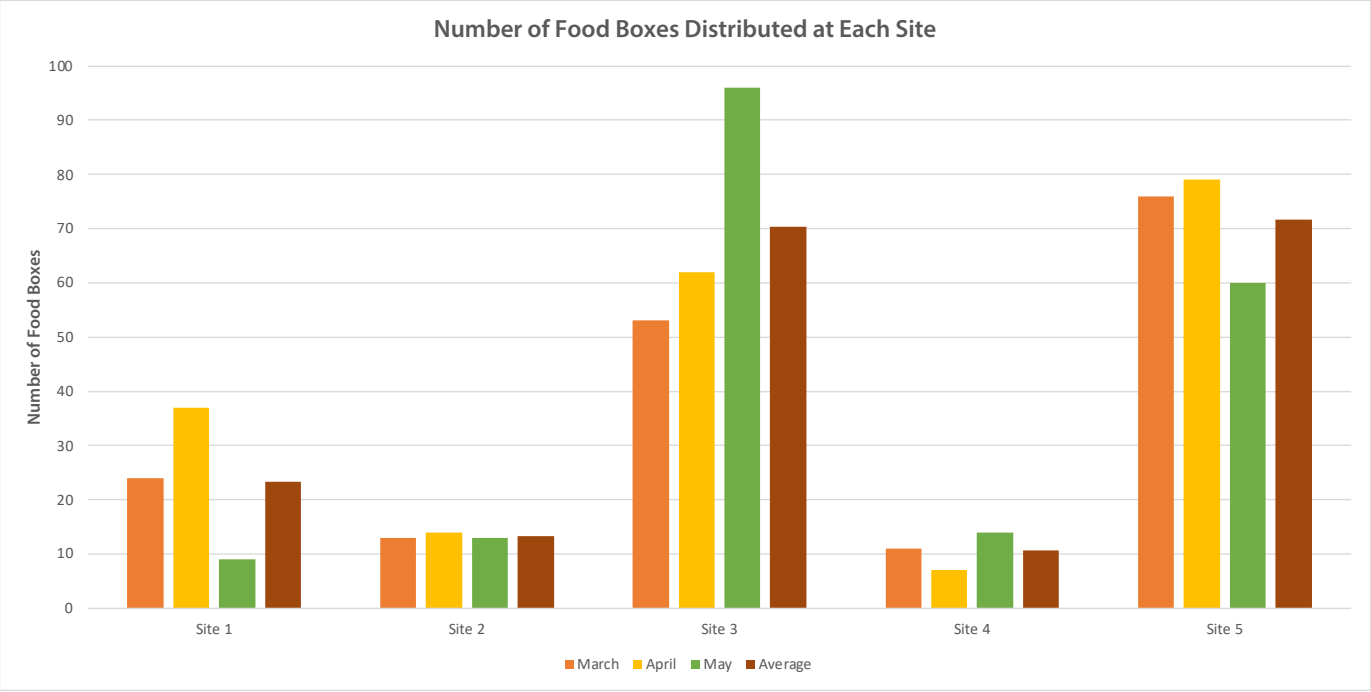


Figure 5: Graph of Frequency of Foods Distribution to Healthy Food Pantry Clients at Each Site

Table 3. Content of Food Boxes at Each Site

Site 1 (External Pantry)	Site 2 (External Pantry)	Site 3 (In-clinic Pantry)	Site 4 (In-clinic Pantry)	Site 5 (In-clinic Pantry)
2 cans of chicken 2 cans of vegetables 2 cans of fruit 1 packet of pasta 1 can of pasta sauce 1 can of beans 2 packets of oatmeal 2 packets of dry milk	2 cans of chicken 2 cans of vegetables 2 cans of fruit 1 packet of pasta 1 can of pasta sauce 1 can of beans 2 packets of oatmeal 2 packets of dry milk	Clients are able to choose from: apples, onions, cabbages, canned tuna, canned chicken, boxed mac & cheese, beef stew, apple sauce, sliced pears, corn, peas, mixed vegetables, green beans, dried pinto beans, white rice, spaghetti, oatmeal, rice crisp, peanut butter, grape jelly, ginger paste, cilantro paste, crushed red pepper flakes.	2 cans of chicken 4 cans of vegetables 2 packets of pasta 1 can of pasta sauce 1 packet of pancake mix 2 cans of beans 2 oatmeal packets 2 packets of dry milk	Shelf-stable bags: beans, mixed vegetables, oats or rice, apple sauce or mixed fruit, tuna or chicken, tomatoes, soup, milk. Fresh Produce from Onsite Farm: 3-6 varieties of veggies including lettuce, spinach, turnips, radishes, bunching onions, summer squash, winter squash, onions, potatoes, kohlrabi, cucumbers, tomatoes, dill, basil, peppers, and carrots.

Table 4. Monthly Average Amount (lbs.) of Foods Distributed to Healthy Food Pantry Clients at Each Site

	Bread	Dairy	Fruit & Veggie (fresh)	Fruit (non-fresh)	Veggies (non-fresh)	Cereal	Meat	Other Protein	Meal	Grain	Juice	Pasta	Mixed Food	Rice	Dough	Snack	Spice/ Sauce	Total
Site 1	874.6	366.7	3780.3	19.7	48.7	15.8	1614.0	130.6	109.0	66.1	3.6	38.7	669.6	3.3	0.0	43.9	0.0	7785.0*
Site 2	354.1	220.2	1146.5	26.8	36.9	6.8	582.3	60.8	74.99	6.9	1.3	9.5	213.0	0.3	0.2	10.0	18.1	2768.7*
Site 3	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK
Site 4	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK
Site 5	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK	UK

*These do not include food boxes.
Note: The monthly average weights were calculated over March, April, and May in 2022. Meat includes red meat, fish, and poultry. Other protein = non-meat protein. Meal = complete meals/entrees.

07

Qualitative Interview Findings

07 Qualitative Interview Findings

Interviews with health care providers, food pantry managers, and food pantry clients shed light on the many benefits of the healthy food pantry program and ways it could be improved. The pantry provides an opportunity for providers to discuss with their client the role of nutrition in overall health, and an opportunity to build relationships. In addition, clients are given a chance to try new recipes and new foods, some with fresh vegetables they otherwise may not have been able to access. The program aims to make food a recognizable factor in overall health and also prioritizes health equity. In the words of one interviewee, the program is successful because it's a "tangible, accessible, tailored, and nearly immediate response to an identified need." While anecdotally, all interviewed participants, food pantry managers, and health care providers view the program as positive and beneficial, measuring success and impact is a challenge.

For many of the reasons that will be discuss later in this report, it is challenging to measure the full impact of the program due to the complexity of the issue and barriers to data tracking. One health care provider discussed the challenge of choosing metrics to indicate success. For instance, a decrease in admissions may seem like an indicator of success but may actually reflect a lack of willingness to seek medical attention. Many of those interviewed in this process hope to address some of these barriers to gain a better understanding of factors that influence patient satisfaction and program success. Below is a list of positive impacts mentioned through interviews with health care providers, food pantry managers, and food pantry clients. This list is not exhaustive but represents the most frequent impacts highlighted by participants.

The following four areas emerged as themes from participant interviews: Food for Health, Caring Approaches, Facilitators of Success, and Structures and Processes. Within these four areas, participants shared the program's many benefits, challenges, and opportunities for the future.

Source: Federation of Virginia Food Banks

7.1 Food for Health

Access to healthy, nutritious food is fundamental to overall health. Many people who suffer from diet-related illnesses including diabetes and heart disease are food-insecure and do not have access to healthy, often more expensive foods. Interviews with program partners and participants revealed the importance of food for health. Related themes are explored in the following section.

Connection Between Food and Health

Source: Federation of Virginia Food Banks

All three of the food pantry clients interviewed in this project shared that they see healthy food being entirely connected to overall health. Many pointed out that without this program they would not have consistent access to fresh produce, and they prefer the produce to canned or processed goods. Participants shared that they recognize the health benefits of fresh food, saying "nutrition plays a big part in healing." One client noted that their increased access to the vitamins and minerals from produce is helping aid in their healing from radiation. Another mentioned that their blood sugar levels are more stable and attributed the improvement to the fresh produce. Many participants also made comparisons to the foods they would be eating otherwise, stating that the fresh produce is significantly better for them than more affordable, but less healthy, options: "It's a whole lot better than cake or whatever. Cake is affordable. Sugar is affordable. Vegetables really aren't. When we have fresh food, we can eat that instead of sugar." Another said the program has helped their entire family since they began participating, making note that the pumpkins, turnips, and radishes were particularly delightful to them.

One health care provider shared that they believe this program has increased patient engagement and overall satisfaction. Clients are able to see that the staff are trying to help holistically, not just when they are sick. For health care providers, there is great satisfaction knowing they are able to provide the foods their patients need, but would otherwise struggle to access.

Ability to Choose Fresh Foods

The clients interviewed were all from Site 5, the only location that grows fresh food on site. They pointed out that fresh produce and vegetables are normally unaffordable and therefore inaccessible. The program gives participants access, and in some cases exposure, to new and exciting foods. One participant scored the program as 5/5 and cited the increased access to fresh vegetables as the primary reason. For another, the fresh produce is the primary reason they participate in the program: "It's quite important to have access to the fresh food, emphasis on the fresh part…We only participate because it's fresh. We would maybe participate if it was canned food, but the fresh food is the important part."

The emphasis on fresh produce also helps to accommodate different dietary requirements. One vegetarian participant was excited to be able to access produce that would normally be unaffordable. This participant mentioned that in the summer months when produce is more plentiful, they are able to freeze and save it for the winter. The program makes clients more excited to cook vegetables. As one participant pointed out, "the cool thing is they grow vegetables I have never even heard of, like kohlrabi. I'll get home and look up recipes and how to cook them on YouTube. Celery root - I love that one."

Although clients saw access to fresh foods as a core program benefit, one person shared that there were times when they needed further assistance to know how to prepare an unfamiliar vegetable. While there were no issues for this individual regarding vegetable amounts or variety, they expressed that it would be helpful to have identification cards and recipes. An additional challenge to food selection is the storage capacity for fresh produce. According to a health care provider, patients would love to have "more fresh foods, milk and meat, proteins not in a can, but we don't have the space to store any of that. It wouldn't be completely out of the realm of possibility to get a storage freezer or refrigerator, but that would be a bigger commitment. We would have to expand...". Lastly, depending on where the clinic patients are screened, patients may not be making their own food selections. This limits choice for the clients and may yield less desirability, particularly for those who are looking for food depending on their chronic disease or diagnosis.

Impacts that Create Change for Food Security

Health care providers play a critical role in identifying and addressing food insecurity. There can be so much stigma surrounding the topic that increasing awareness among providers is an important component of addressing food insecurity. While one health care provider indicated that their staff understood food insecurity was an issue, having a more formalized process has made them more self-aware. Another health care provider saw that most people do not have a concept of how much food insecurity there is and recognized that many patients must choose between buying their medicine and buying healthy foods. These are two issues that go hand-in-hand, so education is paramount in creating meaningful change. This program helps to both educate and alleviate the issue.

A staff member from the food pantry realized that some of the clients did not realize the depth of their own food insecurity, saying "some people who get food every week didn't even realize they would want it every week; they didn't realize things were as tight as they are." Having a greater understanding of food insecurity creates short-term and long-term ways of addressing it. Two of the health care provider interviewees noticed that some patients would initially say no (often more than once), even if there was a need, which speaks to the deep stigma attached to food insecurity within the health care system and beyond. As mentioned previously, many providers found that approaching these conversations in a sensitive and casual manner helped to destigmatize it.

Source: Federation of Virginia Food Banks

One health care provider shared that they believe the program has decreased no-show rates at the clinic, since the opportunity to receive food provides another incentive to show up. The ability to provide an immediate service after asking questions about food insecurity allows providers to build more trust with their patients, which could have a myriad of positive impacts, only one of which is decreased no-show rates. When medical professionals are able to distribute more information to patients about accessing health-related resources, including the pantry system, it allows health care providers to close some of the gaps in patient care and decrease the stigma of food insecurity.

7.2 Caring Approaches

Detecting the Most Food Insecure

While many of the health care providers who were interviewed had confidence in the screening and referral process, detecting the most food-insecure clients still proved to be a challenge for a variety of reasons. According to one health care interviewee, this is not because of the questions being asked, but simply their sensitive nature. Unwillingness to openly talk about food insecurity or reluctance to admit that they need support during screenings often leaves people without resources. For the providers who use online screening systems, data entry is streamlined, but there is less confidence in the ability to detect food insecure clients. One health care provider asserted that the process of detecting food insecure clients using paper screenings was more reliable: "you didn't have to look me in the eye and tell me you were food insecure… Some of my coworkers have said people decline to answer the questions verbally, or they feel they are not being truthful, especially our parents with older kids who don't want to admit it in front of them." Families being screened are often susceptible to not being open to talking about food insecurity, in effort to shield their children.

Additionally, privacy issues make it challenging for providers to detect food insecure clients. There are privacy concerns with screening people in the lobby while they wait, but screening them at the end of their appointment also means delaying their departure time. In rural areas, health care providers have found more stigma and fewer available resources. According to one provider interviewed, rural areas are more likely to be food deserts, and clients often fear confidentiality breaches. Clients are sometimes very hesitant to give truthful answers about food insecurity because they are worried their answers will get out into the community, which may lead to embarrassment in an area that is sparsely populated. One health care provider interviewed explained that there have been situations where a nurse or other staff member knows the clients personally from outside the clinic, and "even though it would be a HIPAA violation, it's still that fear of embarrassment that keeps the patient from answering." Lastly, language and literacy barriers may prevent clients from accessing services and create additional challenges in detecting the most food-insecure clients. Sometimes questions are missed or are left unanswered, and translators or interpreters are not always available. For one provider, screening for food insecurity made the site more aware of the number of non-English speakers who need food assistance. There are a lot of barriers for these families to access resources, so information sheets in their native language that offer a step-by-step process of how to get food assistance would be useful.

> When asked how to minimize negative reactions, one interviewee responded, "It depends on how you frame the question. We ask everyone these questions, you don't have to answer them if you're not comfortable, we are just trying to provide resources to families."

Approaches to Engagement and Building Trust

Many of the food pantry managers and health care providers indicated that the approach taken when broaching sensitive topics was of the utmost importance and attributed to much of the success of the program. The three food pantry recipients interviewed, all from Site 5, indicated that they didn't feel uncomfortable nor did they feel that the program was demeaning. One client made sure to note that because they never discussed their financial situation, there was no need to be embarrassed and another mentioned that food is a basic necessity so embarrassment is futile. Many methods were considered successful when talking about sensitive topics, but the most effective methods mentioned were providing questionnaires in written format as well as creating rapport and trust with patients. One health care provider who sees their patients frequently noted that an already established relationship makes the process feel very informal

and neutral. This allows the patients to feel like much of the stigma is removed. Some health care providers shared examples of what this may look like. Instead of asking "are you food insecure?", they ask "do you need food today?", "do you go hungry?" or "do you have food at home?" Other approaches included asking "have you run out of food?" or "do you fear running out of food?" When asked how to minimize negative reactions, one interviewee responded, "It depends on how you frame the question. We ask everyone these questions, you don't have to answer them if you're not comfortable, we are just trying to provide resources to families." Clients also often refuse to answer some questions.

Stigma could prevent some patients from being transparent about their food security status. Uncomfortable reactions arise from some clients, some with fears that they are being particularly targeted for screening. Many health care providers and food pantry managers shared that the biggest hurdle is people "not wanting to take a handout" or not wanting to take the additional help away from others who may need it more. And, for some, the stigma may also trigger fears of familial displacement, particularly in refugee and immigrant communities. While people are shown to be more honest about food insecurity screenings if it's written rather than verbal, they can run into more issues of literacy in different languages. The COVID pandemic also impacted the stigma of food insecurity as one provider explained. Some of the stigmas actually decreased, for a variety of reasons, but continuing to address food insecurity as a sensitive but neutral topic was beneficial to the clients.

Narrowing it down to questions like "would you like any food resources today?" seems to make the process easier for providers and clients.

Creating less stigma and building relationships is key to having confidence in the process and allowing it to work the way it should. While many providers are aware that some people are going to say "no" even if they have a need, it is still necessary to ask at every visit to allow clients more comfort and flexibility. Because needs can change between visits, building trust and integrating a food insecurity screening into the process at each visit is extremely important. Ensuring that patients are screened often means that providers are mostly confident that most food insecure patients are being detected, and the screening process is normalized. Workflows are different at each site, and therefore, the most convenient way to integrate the screening process may vary. The kinds of questions that are asked during the process are also important. Health care providers found that lengthy questions make the integration of screening and referrals more challenging. Narrowing it down to questions like "would you like any food resources today?" seems to make the process easier for providers and clients. They found that people responded much better to simple and short questions, which also decreases stigma. While there's no perfect way to ask the question and there may always be some level of stigma around it, simplifying the process makes it easier for people to respond.

"One day we got a giant bag of onions dropped off, and one day, the delivery driver was like, 'hey, could I grab one of these?' So, if we could move the pantry outside, people could just come and take what they need without the stigma of walking past others or having to state the need out loud. I think we would get more participation."
- Health Care Provider

Clients depend on health care settings as places for care and support, according to one health care provider, so using the same setting to provide additional, related resources is convenient and logical. Furthermore, it builds in continuity to care that the clients are already receiving. Clients and health care professionals work together and build trusting relationships and rapport. One health care provider indicated that patients can answer intake questions honestly because they have trusting relationships with the health care providers whom they see frequently. This breaks down some of the stigmas of food insecurity. As one provider said, "It just goes back

to building trust, having the resources available, showing them continuity of care, and showing up and being there." At Site 3, providers see patients multiple times in one week and all mentioned that the trust built through continuity of care is a key component to success. It is much harder for patients to open up without an established and trusted relationship, and many staff and providers cited trusting relationships as a reason for success of the program.

7.3 Facilitators of Success

Health care providers, food pantry managers, and food pantry recipients all shared what they thought worked well about the program. Feedback from all interviewees was generally extremely positive, and all three of the food pantry recipients interviewed from Site 5 said there is nothing they would change regarding the program's screening and referral process at their site. Two of the three participants indicated that they usually receive food between two to three times per month, but also indicated they may receive food on an as-needed basis. Fresh vegetables are the primary benefit to many of the participants from Site 5, who cited a variety of foods that were appreciated like green onions, carrots, squash, celery, and pumpkins. For sites that use choice models (informally or formally), it works well, and is preferred by both clients and food pantry managers, so that clients leave with the foods they are excited about trying.

The partnership between the health care providers and the food pantry managers is also viewed as generally positive by both providers and staff. Many emphasized the importance of communication and regular meetings, as well as aligned goals. Working together proves to be the most efficient way of making the program run smoothly and effectively for the participants. This includes integrating the process into existing workflows and understanding the individuality of each participant and each location.

Health care partners and food pantry managers stated the value of being intentional about their approach to screening and referral program creation. As for the partnership, clear communication is key to creating success for the recipients and clients. And lastly, what works well for the clients is particularly crucial to understand. The following section discusses the aspects of the program that emerged from this analysis, including the screening and referral program process, the increased access to fresh produce for clients, and the partnership between health care providers and food pantry managers.

Working Together

Health care providers and food pantry managers who were interviewed as part of this report acknowledged that communication, regular meetings, and discussions of agreed expectations and shared aligned goals were important and successful parts of the program. Having clear and consistent communication keeps all parties working together in sync. Many interviewees recommended that in order to keep communication at the forefront, having a centralized point of contact at each food bank and clinic is extremely beneficial. Characteristics of a key contact would be someone who is passionate about the clients' needs and nutrition, has a good relationship with them, is responsive, and has the capacity to run the onsite clinic.

Additionally, providers and food pantries with annual partnership agreements noted that these agreements were extremely valuable. Not all of the sites have formalized agreements, but those who do noted that the agreements are helpful. The agreement clarifies the roles and responsibilities of each party, and it also recognizes the annual nature of partnership assessment so that partners know the program will be discussed and reevaluated each year.

Training for Providers and Pantry Staff

Pantry staff and health care professionals agreed that more introductory training and resources would improve the program. A comprehensive understanding of the program processes from all those involved is necessary. Health care providers and pantry staff agreed that regular meetings, particularly during the implementation phase were particularly useful for creating this understanding. Providers shared that educational resources, such as information about proper storage, would be extremely helpful, but would have to be site-specific. Site 3 found that a welcome kit and posters were helpful support tools and shared that it was helpful when staff members at the food pantry came over to help pack food bags together.

Source: Federation of Virginia Food Banks

Site and job-specific training for staff is also critically important. For health care providers, training and educational resources on topics such as how to approach sensitive discussions or establishing a referral and screening workflow would be useful. Without the ability to form relationships and have open conversations with patients, providers could make biased decisions or create an uncomfortable environment.

One pantry staff member found two food ordering tools especially helpful: 1.) a spreadsheet showing how to determine how many pounds of produce to purchase and what a mix of canned items looked like, and 2.) a flowchart diagram showing how the food pantry works. The pantry staff member found the flow chart helpful to reference when speaking with health care providers and the clinical teams.

Education for Patients

Educational resources for patients would also benefit the program. Providers mentioned that flyers and pamphlets were helpful to connect clients with other community organizations or resources for social needs. In addition, providers noted that clients would benefit from more education about nutrition and information about the food provided, including recipes.

7.4 Processes and Structures

Program Flow and Ease

Location and accessibility of the food pantry are advantages for many of the participants. The more accessible and simpler the process is, the better for all involved. All three Site 5 participants shared that they do not live further than 20 minutes away, and appreciate the location, as well as the handicap accessibility of the pantry. This allows them to more easily access the resources and make it part of their routine. It is worth noting that at Site 5, a dietician is available to bring their food out to the recipient's car.

For health care providers, creating a screening and intake process that easily fits into an existing workflow is most convenient. One provider noted that anything that doesn't impact the patient's experience also adds to this convenience. Adding things that are easily incorporated into an existing workflow, rather than creating a new one, makes the program move forward with ease. Integrating the screening and referral process into the appointment, and, when possible, into the Electronic Medical Record system, ensures that it is consistently employed.

Sustainability of the Program

Being proactive and maintaining support for the program will be key in ensuring its success long term. As described by one interviewee, "the program is really a team effort." Keeping partners engaged and incorporating their feedback is valuable and necessary for its success. Staff and providers want to make sure this program is as accessible to as many clients as possible, but to do so it must be sustainable for them. One staff member at the food pantry explained that the clients were not involved in the program design or improvement process. And, when considering the sustainability of the program, seeking to incorporate and compensate participants' voices will likely make the future of the program more "accessible, dignified, and impactful."

Almost all of the food pantry managers and health care providers interviewed explained that finding a sustainable funding strategy will be paramount to the program's sustainability as a whole. If the funding ran out, it would certainly inhibit future success. With the observed steady demand, the funding and resources to sustain it become crucial. As one interviewee explained, "Demand is number one…how are we going to feed all of these families? Some families are getting two to three boxes every week. We are referring so many people to food pantries, some of them are small, and they operate on grants. The resources need to be there for it all to work." One provider raised questions about where this funding may come from, exploring the options for program expansion with Medicaid or larger health care entities. These questions suggest that integration of this program into larger streams of health care program funding would be beneficial, because a program that supports multiple aspects of health is proven to decrease the amount spent on health care.

"Demand is number one…how are we going to feed all of these families? Some families are getting two to three boxes every week. We are referring so many people to food pantries, some of them are small, and they operate on grants. The resources need to be there for it all to work."
- Food Pantry Staff Member

Staffing and Space Capacity

Limitations in capacity and staffing resources as well as physical space also affect the sustainability of the program. Having adequate staff capacity to screen and refer patients, inventory food, receive and distribute deliveries, troubleshoot issues, and collect or share data are all necessary to make the program run smoothly. Additionally, having the space to keep all food items on hand and providing clients with additional resources, like fitness or nutrition classes, were all considerations for food pantry managers.

With high demand, staff capacity may be overwhelmed, and storage and refrigeration space may be limited. Space constraints also limit the ability to expand the program for some providers. One interviewee said, "if we had a space, we could offer other things and possibly expand to other organizations, like housing or offer finance classes." For some food pantries, the work is extremely staff intensive. There is the physical labor of managing the boxes, managing inventory expiration dates, data analytics, the actual screening processes, and managing partnerships in the community to meet these needs. Particularly around the holidays, staffing issues can be exacerbated. Disruptions in the workflow can consume a substantial amount of time, and staff capacity is impacted. One food pantry staff member who was interviewed explained that storage and space capacity change what is accessible to clients. Currently, some partners are grappling with whether it is better to have a centralized location or have more, smaller pantry locations. Staffing capacity also impacts communication in the partnerships. Challenges may arise when there is a breakdown in communication between the food pantry managers and the health care providers. When both parties are busy, the staffing capacity is limited, and it leads to communication challenges and delays in data or updates. For many partners, the key takeaway is the immense value of regular meetings to discuss program updates, changes, and areas for improvement.

Models of Service

Currently, sites provide clients with bags of food without giving them much agency in the foods chosen. Providers, pantry staff, and clients agreed that a choice model is ideal. This creates an atmosphere similar to one in a grocery store, allowing the participant to shop and choose what is important to them. The clients generally agreed that they enjoy seeing what options are available that day and choosing what works for them.

Providing an Immediate and Accessible Resource

Many providers and staff who were interviewed also said the most rewarding and efficient part of the program was being able to send food home immediately. This is in contrast to times prior to the partnership when food insecure clients lacked immediate care and follow-up resources. With this partnership, the clients have a resource to use if they screen positive. Many providers noted that this is a large relief for the clients. One staff member from an external food pantry noted that having an onsite pantry stocked with fresh produce and medically tailored food available would be a huge benefit to the current program.

One staff member from a food pantry noted that having an onsite pantry stocked with fresh produce and medically-tailored food available would be a huge benefit to the current program.

While several of the pantries provide food on site, some participants must drive to an external food pantry. This imposes accessibility barriers for those without cars. Two of the food pantry recipients from Site 5 acknowledged that accessibility to the pantry is nearly impossible without a car. One recipient expressed that they would like to be able to utilize the pantry weekly but are dependent on a family member with a car, so they receive food about two times a month instead. A food pantry managers also acknowledged this barrier, particularly when it comes to ongoing food support for patients. For recipients who do not have frequent clinical appointments at the site, they have to go out of their way to receive their food.

Source: Federation of Virginia Food Banks

Physical disability is also a challenge in accessing the pantry and utilizing the food. For those who cannot personally pick up their food, they are reliant on others, making the access less reliable and less frequent. For one recipient, preparing food is a challenge as a person who is handicapped. While they shared that they always manage to use the vegetables eventually, it is physically challenging to incorporate them into a consistent diet.

Measuring Success and Impact

Many food pantry managers and health care providers who were interviewed explained data tracking is a key challenge, particularly defining and measuring success, impact, and satisfaction. Success is challenging to define because it looks different depending on the scenario. For example, as one health care provider interviewee said, a decreased admittance rate doesn't necessarily mean improvement for a patient. For many of the health care providers interviewed, the best indicator of success is to have built trust and rapport, so that the patient feels comfortable returning and sharing a need. This can be challenging to measure and track, because it is mostly anecdotal or understood through surveys. As mentioned in the limitations of this report, survey data is challenging to obtain and maintain on food insecurity given its sensitive nature. Gathering feedback from pantry clients is challenging, but important to understand. One health care provider explained there is a gap in who actually goes to the pantry after being referred, but there is no data available that helps explain why. As the interviewee explained, "We have ideas around why, but have not figured out the best way to get that feedback." Anecdotally, many understand that transportation and service hours are significant barriers.

Additionally, quantitative data tracking systems would be beneficial to the food pantries and health care providers. For example, it's crucial to create a better understanding of who is going to the pantry (and inversely, who is not), quantifying the demand and utilization, quantifying positive changes in health, and referral rates. For many interviewees tracking this data, but also effectively communicating it, is a challenge many are working through. As one food pantry staff member said, "We aspire to find a more streamlined, digital way to assess program outputs, outcomes, and impact that works for both the health care entity and us [as a food bank]." This interviewee receives monthly data on de-identified aggregate data about the total number of patients seen in the practice, the number of patients screened, and the number of patients referred. While this is currently adequate for the specific site, streamlining and expanding on this data across the program could create large-scale benefits.

"We aspire to find a more streamlined, digital way to assess program outputs, outcomes, and impact that works for both the health care entity and us [as a food bank]."
- Food Pantry Staff Member

There were a few additional key points in this report regarding data. One health care provider indicated that the referral piece is not optimal. Without referrals, a voucher cannot be tracked, which leaves a gap in the data. Without being able to see how many people use the pantry, or their demographics, that tracking needs to be done in individual chart reviews, which can be extremely time-consuming. Lastly, a food pantry manager mentioned that it's challenging to know what data is most helpful to be measuring, such as biometric data or quality of life metrics. Identifying a "digital method that is not cumbersome for [our] health partners and that integrates with [our] food bank platforms" would be ideal for this specific interviewee.

Source: Federation of Virginia Food Banks

08

Opportunities and Recommendations

08 Opportunities and Recommendations

Based on the insights gathered from interviews and data, it is noteworthy to acknowledge the need for the services that the pantry provides across settings and examine how the Healthy Food Pantry partnership can continue to expand and progress in the future. With that in mind, the following sections outline recommendations for consideration by the FVFB.

8.1 Recommendations informed by Clinic and Pantry Staff

Recommendation 1: Improve data tracking, reporting, and sharing across all pantry sites to include:

- Idenification of standard data points for use in routine and systematic collection of data
- Routine data analysis, timely sharing and dissemination of standardized data across programs
- Data collection infrastructure (software), expertise (personnel and training) and process (identified and implemented) for ongoing routine data analysis, timely sharing and dissemination of standardized data across programs
- Identification of strategic indicators/measures of success for programs
- Evaluation of measures

Health care providers and food bank staff identified the need for a better system of data tracking, reporting, and sharing. Currently, the way that partners track and receive data is not uniform across sites and the information that is shared between food banks and clinics requires time-consuming data management. Although clinics track which patients they refer to food pantries, they have no way of knowing whether the patients have visited the pantry after the initial referral. The lack of a single system for data tracking and sharing means that data is often not reported or shared. Moreover, collecting similar data at each site allows for better across-site comparisons in terms of program functionality and operational needs. Consistent data tracking helps with the identification of shared challenges and where alignments can be made.

> "Tracking is difficult. For example, a decreased admittance rate doesn't necessarily mean improvement. Maybe we want them to come in more, to draw them to the clinic more so that the doctor has a greater chance of improving their health? Both could be indicators of success. This is why we don't give them away in the ER- we don't want to incentivize people to go there."
> - Health Care Provider

Agreed upon, shared data metrics including health outcomes, quality of life, and pantry usage would benefit the program. However, interpretation of that data also requires astuteness in analysis and understanding of evaluation of performance in relation to the nuances of the program. One participant mentioned the difficulty of choosing metrics. "Tracking is difficult. For example, a decreased admittance rate doesn't necessarily mean improvement. Maybe we want them to come in more, to draw them to the clinic more so that the doctor has a greater chance of improving their health? Both could be indicators of success. This is why we don't give them [food boxes] away in the ER- we don't want to incentivize people to go there." Identifying clear agreed-upon measures and indicators of program success is needed in order to effectively evaluate the program. These indicators also must be collected and analyzed at consistent intervals across all programs systematically.

An effective program evaluation requires an ongoing systematic data collection about client characteristics, food distribution, and referral process. Routine monitoring of these data using a standardized data collection/analysis tool can help determine whether the program

functions as intended, meets its goals, and identifies areas for improvement. Currently, such a system or tool is largely lacking. Universal implementation of a comprehensive data collection/analysis tool across the sites can improve program evaluation efforts in the future. Such implementation will also require training in how to use the tool, and integration into program operations to ensure its usage. Attention to capacity in terms of workload and process for how this data collection will occur should happen.
Currently, timely reports for characteristics of interest (e.g., age groups of clients in March, fresh fruit distribution amount in May) are not easily accessible to the site staff related to either lack of access to the data themselves or the complexity of extracting data from the database. Automated reports through custom-made templates designed to measure the characteristics of specific interests using a data collection/analysis tool can accelerate this process.

Also, measurements are not standardized across the sites. There is a lack of uniformity in what and how key characteristics of interest are measured. For example, not all sites measure the household income of the clients. Some sites have different categories for foods or do not record the actual amounts of food distributed. Standardizing the definitions and data format of characteristics of interest and building them into a data collection/analysis tool can enable the collection and comparison of data across the sites.

Recommendation 2: Enhance and sustain communication to include:

- Identification and communication of program vision and goals
- Development, dissemination and use of best practices protocol for screening clients
- Providing structured guidance and training to program participants about the program, protocols, and operational processes through consistent onboarding and supportive outreach (point of contact) to ensure program fidelity and sooth functionality
- Establishing mechanisms to obtain routine client feedback with programs and use this feedback to refine and improve programs

Partnership and Communication

Both health care providers and food pantry managers mentioned the importance of shared goals and clear communication. Several partners mentioned that the COVID pandemic and staff turnover impeded communication between sites and made it difficult to arrange meetings. Formal partnership agreements are one tool that can be used to help achieve desired outcomes. However, two of the five sites do not have a formal partnership agreement. Some interview participants from sites with signed agreements mentioned that continually strengthening the partnership is necessary for the program's success. Partners should engage in initial discussions of expectations and desired outcomes to construct formal memoranda of understanding that are continually refined and updated.

> "I've enjoyed working with the food banks so much and watching this program. Obviously there is still work to be done, but it has been amazing watching the program grow and I am so thankful for the team at the food bank, they've been such great support and are always willing to answer any questions. Any bumps in the road we've been able to figure out together as a team, so I am thankful that I get to work with such great people."
> - Health Care Provider

Screening and Relationships with Patients

Providers mentioned the need for a better intake and screening system. There are strengths and drawbacks to both written and verbal questions related to food insecurity. Health care providers agreed that it is important to phrase questions in ways that encourage clients to answer honestly and to form relationships with the patients so that they feel comfortable disclosing this information. It is also helpful to provide repeated access to referrals. Asking patients about food security status frequently, at each visit whether inpatient or out, is ideal. An outreach worker to communicate with families and explore the cause of food insecurity could also assist with the intake process.

Training and Onboarding

Health care providers noted that initial support and training from food banks would improve the program. Providers experienced little to no training at the beginning of the partnership and several discussed the need for training about the extent of food insecurity, how common it is, its relationship to health, and also how to discuss food security with patients. Several participants described the disconnect and lack of shared understanding between pantries and food banks. For instance, partners in the clinic mentioned the need for more information about food pantry logistics including how to store and pack food.

Reducing Stigmas

Asking questions about food insecurity is often complicated by associated stigmas. Several providers mentioned that clients are often hesitant to discuss their food insecurity because of pride, community dynamics, or family presence. Changing community perceptions of food insecurity through shorter, simpler questions that patients are told everyone gets asked, and normalizing visiting the food pantry would encourage patients to self-refer and/or answer questions more honestly during the screening process.

Language and Literacy Barriers

Language or literacy barriers sometimes exist between patients and health care providers. Several providers mentioned the need for more Spanish-speaking staff to assist with the referral process.

Self-referral Options

A self-referral system may reduce barriers to access to in-clinic and external food pantries. Expanding and promoting the hotline website and phone number would allow people to access referrals without an appointment at a health care clinic. Sites 1 and 2 are the only locations which use the Hunger Hotline. Both sites provided food boxes to the same number of individuals that were screened for food insecurity. This indicates that the hotline system may encourage client participation.

Patient Feedback

Food Pantry managers noted the need for more patient feedback. One staff member pointed out that the program was designed without patient input and may have suffered consequently. Without patient feedback and data tracking, it is difficult for partners to measure program success. Additionally, patients value the ability to share their thoughts about the clinic and pantry. One client said, "I really appreciate you asking. Food pantries don't ask. I appreciate being asked." This suggests that feedback might be more attainable if an easy, quick feedback mechanism were integrated to each visit, such as one or two questions at the end about, "What might we do to improve your experience? What could we do better to support others and their families who might also benefit from this service?"

> "I really appreciate you asking. Food pantries don't ask. I appreciate being asked."
> - Food Pantry Client

Additional Considerations to note:

- While it is not currently an issue, long-term and sustainable funding strategies need to be identified to fully utilize the benefits of the program.
- A larger space would allow more storage capacity for fresh foods as well as shelf-stable staples.
- Having children present during screenings may dissuade parents from discussing food security. Likewise, some parents have the impression that admitting food insecurity will lead to their children being taken away.

8.2 Recommendations guided by Client Feedback

Recommendation 3: Offer food choice and fresh food where possible by:

- Exploring the possibility and feasibility of allowing clients to select foods
- Considering the addition of refrigerated space to allow for fresh food options and its implications
- Assessing and implementing community identified need for tailored and cultural foods

> "We only participate because [the food] is fresh. We would maybe participate if it was canned food, but the fresh food is the important part."
> - Food Pantry Client

The importance of food choice and fresh food were themes that emerged repeatedly during interviews with clients. Currently, patients receive pre-packed bags, limiting their choice of food from the pantry. Access to fresh food is limited by food pantry refrigeration capacity. A food choice or store model would allow patients increased agency. Providing more well-rounded food options including proteins as well as shelf-stable fruits and vegetables would be beneficial to patients. Likewise, providing culturally familiar, tailored food options could help families feel more comfortable utilizing the pantry. Pantry recipients repeatedly mentioned the importance of access to fresh produce. One pantry client stated, "we only participate because [the food] is fresh. We would maybe participate if it was canned food, but the fresh food is the important part." Of all sites, Site 5 (the only location with an on-site farm) provides the highest average number of food boxes each month, followed by Site 3. Unlike Sites 1,2, and 4, these provide fresh foods including fruits and vegetables.

Recommendation 4: Access and address clients' knowledge about healthy food and their ability to access food by:

- Assessing client baseline knowledge and health literacy about food and health
- Providing access to information and health education in various forms on the connection between food and health
- Identifying and collaborating with community-based healthy food initiatives such as community kitchen, community gardens, institutes of higher education engaged in food justice research, state Cooperative Extension organizations, and not-for profits to facilitate increased access to and education about healthy foods
- Developing a list of local resources to share with providers and clients about other community-based options to accessing food

Client Education

Patients would benefit from more education about the impact of food on health. Clients shared that they have not had many conversations with their health care providers about the connection between food and health. Some of the health care providers interviewed in this process also mentioned that they also see correlations between healthy food, fresh produce, and other social determinants of health, like housing. Currently, education on these topics is negligible or limited to handouts. Helping patients understand the value of healthy food choices would promote better long-term nutrition decisions. Likewise, information about the types of food that are being provided would help recipients prepare and enjoy the foods that the pantry provides. Some obscure vegetables are unfamiliar and difficult to prepare without prior knowledge. Informational cards with recipes and examples of easy ways to prepare ingredients would simplify cooking for many recipients.

Accessibility

Another theme that emerged was the accessibility of pantry sites. Depending on the clinic at which patients are referred, they may need to drive to a second location to pick up their food. Most patients described the food pantries as accessible, but onsite pantries could promote greater usage. Ideally, each practice would have their own food pantry which could be accessed immediately by patients as they leave the facility. If the pantry is not part of the practice, it should preferably be located nearby. A food delivery service would benefit patients who are homebound or have limited free capacity to visit the pantry. Giving patients more information about food pantry hours and service during the screening and referral would prevent confusion and unnecessary trips to and from the pantry sites.

Additional Considerations to note:

- Clients mentioned that transportation to and from the food pantry would be helpful.
- Access to amenities like a gym and shower would also benefit clients.
- One recipient noted that preparing food is a challenge for handicapped patients. Pre-cut vegetables would be easier to prepare for these individuals. In addition, better outreach and communication about the service could encourage more people to use the pantries.

09

Conclusion and Next Steps

09 Conclusion and Next Steps

9.1 Reflections on Project

COVID had a marked effect on the ability to operationalize this evaluation within the original timeframe and configuration, limiting our capacity and shifting our scope to conduct this research. Still, findings produced important insights as starting points that can be used to guide program modifications and further exploration. One area where more information is needed is directly from the population that the pantry serves.

> "It really does take a village to make something like this happen and we can make a greater impact when you do it with everyone. So it's been really cool to watch everyone come together that cares about food security and make this thing happen. So, I am excited to have it continue to grow and involve more great partners and collaborators."
> - Food Pantry Staff Member

Gathering feedback from pantry recipients using a virtual approach was challenging. Recipients frequently have limited time, lack access to transportation, lack of access to the internet, and may have language barriers, any one of which would make it difficult to participate. Virtual interviews and focus groups are often inaccessible for under-resourced participants. Stationing a member of the research team at both in-clinic sites and external pantries would likely lead to more effective recruitment, as it would remove a number of barriers. However this would be a different research design that encompasses a larger team, longer timeframe needed to gather data at each site, training of interviewers, and travel across the region.

9.2 Lessons Learned

Normalizing and reducing the stigma surrounding food insecurity could make many patients less uncomfortable responding honestly to food insecurity screenings and utilizing food pantries. Clinics that can provide holistic community care including health care, education, food, and other resources would greatly benefit clients. In-clinic food assistance provides immediate benefits to patients and starts to provide this one-stop-shop for health. As one provider stated, "knowing that you could always swing by your clinic [or] your doctor's office and get a bag of food is kind of like a revolutionary idea, right?" The Healthy Food Pantry Partnership has successfully begun addressing the barriers to health equity including access to nutritious food. As food bank/health care partnerships continue to grow and evolve, finding sustainable methods of collaboration and patient feedback collection will be critical. All of those interviewed appreciated the pantry partnership, recognized its importance, and hoped to see it continue in the future.

> "Knowing that you could always swing by your clinic [or] your doctor's office and get a bag of food is kind of like a revolutionary idea, right?"
> - Health Care Provider

9.3 Suggested Next Steps

Based on the qualitative and quantitative analysis of the research team and acknowledging the limited client input, the following next steps are recommended:

- Integrate recommendations from this report into practice and processes.

Enhance and sustain communication

- Identify clear program goals and objectives that can be measured and operationalized.
- Create formal partnership agreements between food pantries and clinics that are reevaluated annually and contain data sharing requirements as well as shared goals.
- Provide onboarding, training and support for each partner including educational materials for the clinical staff and for the pantry clients.
- Identify key contacts for each partner site who will maintain regular contact and provide frequent updates.
- Expand the Hunger Hotline to allow clients to connect via phone with pantries and additional resources.
- Hire more Spanish-speaking staff to assist with the referral process.
- Use educational events and community outreach to destigmatize food insecurity.
- Develop proactive plans for maintenance and support of the program into the future including standardized workflows and stable sources of funding.

Improve data tracking, reporting, and sharing across all pantry sites

- Standardize the screening, referral, and data tracking processes across sites.
- Identify and implement a standardized data collection/analysis tool and strategy across sites to perform ongoing and systematic data collection about client characteristics, food distribution, and referral.
    - Generate and share timely, automated reports with all partners.
    - Standardize measurements of characteristics of interest.

Offer food choice and fresh food where possible

- Move toward a patient choice model and offer more fresh, less packaged food. Emphasize food quality instead of just quantity.

Access and address clients' knowledge about healthy food and their ability to access food

- Provide more client education and information about nutrition and healthy foods including recipes.
- Prioritize building trust between health care providers and clients.
- Integrate a mechanism for obtaining ongoing client feedback to improve the program.
- Consider working in partnership to address food access and root causes of food insecurity in the region through advocacy, creation of networks, and engagement of clients and their expertise to lead these efforts.

> "[The partnership] really is the right thing to be doing... it directly impacts the whole patient and their ability to take care of themselves and follow through with the physician's orders. So, I just think it's great and hope it continues."
> - Health Care Provider

Appendices

Appendix A: Interview and Survey Questions

Health care Partner Interview Questions

Evaluation Question 1: Identify and compare screening and referral strategies and processes used within the in-clinic sites and at external sites to improve access for food insecure populations.

Aim 1.2 Compare screening mechanisms (tools) and referral processes used by in-clinic and external sites for strengths, weakness, and opportunities and identify the core essential elements of each.

1) How do you decide which patients to screen? How long have you been using this process?
2) How confident are you that your screening is able to detect most food insecure patients? Why?
3) What are your thoughts and beliefs about health care providers screening and referring of clients who are food insecure? How have those thoughts and beliefs changed or been influenced since starting this partnership?
4) Can you describe the screening and referral process from start to finish?
    a) What is the next step after you are aware a patient is food insecure and might benefit from specific nutritional products/food?
2) Given your experience with your process for screening and referring people with food insecurity…
    a) What do you think works best about it?
        i) For your practice?
        ii) For the client?
    b) What isn't optimal?
        i) For your practice?
        ii) For the client?
5) Can you describe whether, and if so how, you have seen patients demonstrate an uncomfortable reaction (shame, fear, etc.) to being screened for food insecurity? If applicable, please describe any accommodations you've made to reduce those negative reactions.

a) Self-screening and referral mechanism?

6) If you could wave a magic wand, what would your ideal screening and referral system look like that best serves both the client and your practice?

Evaluation Question 2: Examine the HCP-Food Bank partnership relationship to determine areas of value, efficiency and mechanisms that facilitate food security for their populations.

Aim 2.1 Determine what aspects and inputs are critical to the HCP-Food Bank relationship and essential to its success and sustainability. Derive a set of best practices for the partnerships.

1) Prior to starting the partnership, what motivated you to begin to screen for food insecurity generally in the clinical setting - ie. Was there a transition to value-based care, prevent readmissions, improve patient satisfaction, address Social Determinants of Health more broadly?
2) Can you describe how your relationship (Food Bank-HCP) came about? What motivated you to initiate or pursue this partnership?
    a) Did you sign any formalized partnership agreements? If so, how did this impact your respective goals or partnership, overall?
    b) What aspects of the partnership work well and you would recommend continuing?
3) Which onboarding/support tools (ie. toolkits, group trainings, educational handouts, planning meetings, relevant research, none of the above), did you find to be most helpful as you initiated your partnership with the food bank? Which topics were most helpful? If you did not receive any information, which information would have been helpful?
4) What aspects of the partnership could be improved, and how might they be improved?
    a) What would your ideal partnership look like?
5) Are there best practices you have learned of and want to try, regarding? (Open-ended question and the following are prompts)
    a) Partnership communication? Development of common messages, informational materials? (periodic, frequent, infrequent, email, phone, etc.)
    b) Discussion / agreement on expectations, shared goals and values, and shared indices for success and continuation of the relationship?
    c) Workflow?
    d) Data tracking systems?
    e) Client-centered design, feedback, and/or evaluation systems?
    f) Other (could include program health impact data)

Evaluation Question 3: Identify and examine the impacts and outcomes of screening and referrals in-clinic and at external sites.

Aim 3: 1 Identify structural and operational enablers and barriers to optimal workflows (in-clinic and external, where applicable).

1) What impacts does the provision of screening, referral, and/or in-clinic pantry have on your practice?
    a) Physically?
    b) Staffing?
    c) In terms of your decision-making?
    d) In terms of your overall operations and workflow?
    e) In terms of your administrative or community goals or impact?
2) What impacts have your screening, referral, and/or in-clinic pantry practices had on your patients?
    a) i.e. changes in patient behaviors, patient satisfaction, patient engagement with your service or other supportive services??
3) What, if any, factors may inhibit the future success of your partnership?
4) Is there anything that you would like to share that we haven't asked you?

Food Bank Leadership Interview Questions

Evaluation Question 1: Identify and compare screening and referral strategies and processes used within the in-clinic sites and at external sites to improve access for food insecure populations.

Aim 1.2 Compare screening mechanisms (tools) and referral processes used by in-clinic and external sites for strengths, weaknesses, and opportunities and identify the core essential elements of each.

1) Describe your role in the food bank health care partnership.
2) Given your experience with the HCP referral system in terms of serving people with food insecurity…
    a) What do you think works best about it?
        i) For your in-clinic or external pantry?
        ii) For the client?
    b) What isn't optimal?
        i) For your pantry?
        ii) For the client?
    c) If you could wave a magic wand, what would your ideal screening and referral system look like that best serves both the client and your pantry?
3) Can you describe the process from referral to the patient/client receiving food from start to finish?
    a) How do you track that patient/client was referred by health care provider?
    b) How do you track that services were ultimately provided?
    c) How do you evaluate client/patient needs, desires, and/or satisfaction?
4) Please describe 3 ways your food bank supports the screening and referral process? (Open-ended question, the following are prompts).
    a) Provide training to health care partners on screening and referring
    b) Support health care partner in the establishment of a referral workflow
    c) Support clients in finding local food distribution by staffing a hunger hotline
    d) Provide flyers, pocket pals, or business cards to health care partners to give to patients, containing information on local food distributions
    e) Assist health care partner on measuring and reporting on aggregate health data
    f) Support clients in finding other services that they may need beyond food distribution
    g) Provide food to be distributed on site
    h) Other
5) Does your foodbank send the HCP any disclosure agreements or partnership agreements prior to working together?
    a) If so, how did this impact your respective goals or partnership, overall?

Evaluation Question 2: Examine the HCP-Foodbank partnership relationship to determine areas of value, efficiency and mechanisms that facilitate food security for their populations.

Aim 2.1 Determine what aspects and inputs are critical to the HCP-Food Bank relationship and essential to its success and sustainability. Derive a set of best practices for the partnerships.

1) Can you describe how your relationship (Foodbank-HCP) came about? What motivated you to initiate or pursue this partnership?
2) What aspects of the partnership work well and would you recommend continuing?
3) How do you define and measure success in this partnership? Can you identify the top 3 factors that contribute to the success of this partnership? The following are prompts, if needed.
    a) The "right" health care staff with adequate capacity (please describe what makes them good partners or what about their capacity works well)
    b) Level on which the partnership exists among health care partner/food bank staff- i.e. senior-level leadership, mid-management, coordinator-level implementors, etc.?
    c) Funding available to pilot or run the program
    d) Foodbank emphasis on the value of health care/foodbank partnerships or health equity efforts via strategic plan, Board or donor support, etc.
    e) Ability to build on a pre-existing relationship with a health care partner
    f) Goals aligned between foodbank and health care partner
    g) Ability to measure and share meaningful data related to the partnership
    h) Other (please specify)
4) What aspects of the partnership could be improved, and how might they be improved?
    a) What would your ideal partnership look like?
5) Are there best practices you have learned of and want to try, regarding the following topics? (Open-ended question and the following are prompts)
a) Partnership communication? Development of common messages, informational materials? (periodic, frequent, infrequent, email, phone, etc.)
b) Discussion / agreement on expectations, shared goals and values, and shared indices for success and continuation of the relationship?
    c) Workflow?
    d) Data tracking systems?
    e) Client-centered design, feedback, and/or evaluation systems?
    f) Other (could include program health impact data)

Evaluation Question 3: Identify and examine the impacts and outcomes of screening and referrals in-clinic and at external sites.

Aim 3.1 Identify structural and operational enablers and barriers to optimal workflows (in-clinic and external).

1) What internal food bank factors contribute to health care partnership successes/challenges? (Please respond with regard to each of the following prompts)
    a) Staffing?
    b) Overall operations and workflow?
    c) Prioritization of nutritious foods in sourcing operations?
    d) Community engagement/fundraising?
2) What are the top 3 factors that have had the most influence in your selection of the pantry model (in-clinic or external)? The following are prompts, if needed.
        i) Staff capacity constraints within the food bank
        ii) Resource or space capacity constraints within the food bank
        iii) Staff capacity constraints within the health care partner
        iv) Resource or space capacity constraints within the health care partner
        v) Our model aims to prioritize patient access
        vi) Our model aims to prioritize patient dignity

vii) This model is evidence-based
viii) In line with HCP goals/strategic plan/Community Health Assessment needs

3) What is the role of the partnership in your food bank's overall strategic objectives?
4) What, if any, factors may inhibit the future success of your partnership?
5) Is there anything that you would like to share that we have not asked you?

Food Bank Client Interview Questions

1) Can you describe your experience with the screening and referral process that was used to get you food assistance? How were you connected with these services?
Prompts: How did you initially inform your health care provider of your need for food assistance? Did you volunteer the information or were you asked questions about your access to food? Were you given a written questionnaire?

2) How comfortable were you in disclosing your need for food assistance directly to your health care provider? Would you have preferred to share this information in another way? Please explain.

3) Can you describe the conversations you have had with your HCP that have helped you understand the impact of food on your overall health? What insights were most helpful to you?

4) How important is having healthy food and being healthy to you? How do you see these two areas being connected?

5) How has having access to healthy food impacted your health and how has it helped you to manage your health?
Prompts: How likely are you to cook a meal with the ingredients you received from the pantry? Types of food choices you make and opportunities (nutritious foods, sharing food with family, enjoying a variety of foods)

6) How frequently do you use the pantry services and are you able to get food from the pantry as often as you need to? Are there any gaps in the availability of the types or amount of food that you need from the pantry?
Prompts: How does the food you get from the pantry compare to the selection and types of food you would usually get?

7) What has your experience been like using and accessing the pantry? How comfortable are/ or were you using the pantry? What are some of the challenges you face in getting access to the pantry?
Prompts: How easy was it for you to find and get to the pantry? What things did you have to consider to access the pantry i.e., transportation, hours of operations, childcare, costs? Had you been to a food pantry before this one?

8) Can you describe your satisfaction with the services and with the offerings of the pantry? What worked well for you and what changes would you suggest to improve it?
Prompts: How satisfied were you with the choices of food offered? How satisfied were you with the amount of food offered?

9) What are some of the advantages of the food pantry location? And what are some of the disadvantages?
Prompts: Would you rather have other option for accessing the food pantry? If so, what might those options be? (local sites, in specific geographical areas)

10) What ideas would you suggest for improving pantry services? What would ideal services look like if you could imagine them any way you want?

11) What, if any, other services do you receive, in addition to food, when you are on site at the health facility? Are there additional services that you think are needed for you to receive on site that are or are not being offered? If so, what are the barriers to getting those services?

12) Are there any additional questions or comments that you have which we might not have asked but you would like to add and are important for us to know?

Food Bank Client Survey Questions

Sociodemographic and Food Assistance Use Survey Questionnaire

We would like to ask about your personal and household characteristics and your use of public food assistance.

Part 1. Demographics

1. Which age group describes you?
   - 30 years or less
   - 31 - 40 years
   - 41 - 50 years
   - 51 - 60 years
   - 61 years more
2. What is your gender?
   - Female
   - Male
   - Other
3. What best describes your race?
   - American Indian or Alaska Native
   - Asian
   - Black or African American
   - Native Hawaiian or Other Pacific Islander
   - White
   - Other
4. Are you Hispanic or Latino?
   - Yes
   - No
5. What is the highest education that you received?
   - Grades 0 - 8
   - Grades 9 -11
   - High School diploma
   - 2- or 4-Year Degree
   - Master's degree or higher
6. What describes best your employment status? Choose one.
   - Retired
   - Unemployed (seeking work or unable to work)
   - Part time worker
   - Full time worker
7. How many family members do you live together (except yourself)?
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6 or more
8. Which best describes your average household income per month?
   - Less than $100
   - $101 - $1000
   - $1001 - $3000
   - $3001 - $5000
   - $5001 - $8000
   - $8001 or more

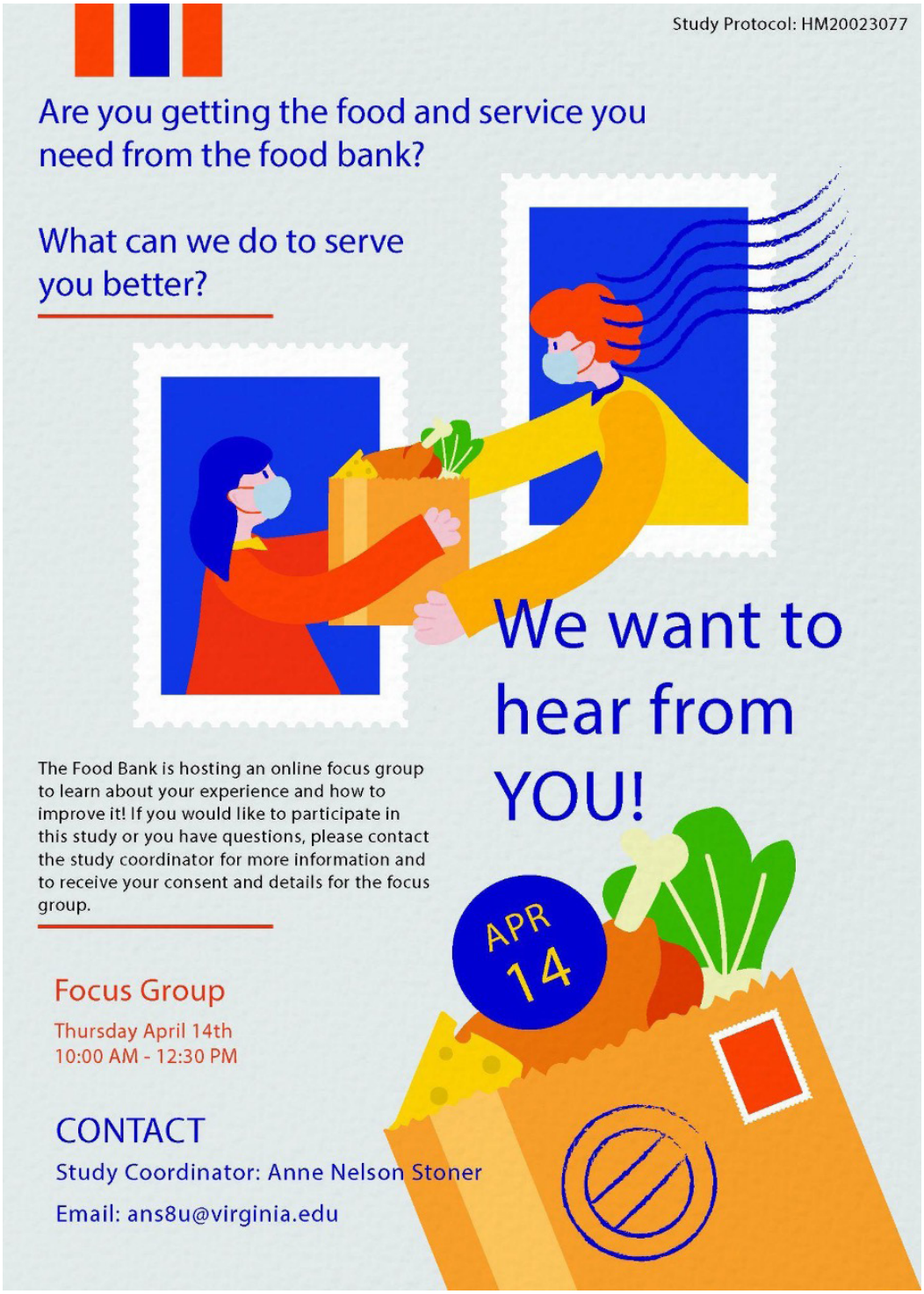
9. Choose ALL social programs that your household members (including yourself) are using.
   - Aid to Families with Dependent Children (AFDC)
   - Aid to the Aged, Blind, or Disabled (AABD)
   - Children's Health Insurance Program (CHIP)
   - Commodity Supplemental Food Program (CSFP)
   - Free/Reduced Lunch
   - Head Start Program
   - Low Income Home Energy Assistance Program (LIHEAP)
   - Medicaid
   - SNAP (Food Stamps)
   - Section 8 Rental Assistance Program
   - Service-Connected Disabilities Compensation
   - Supplement Security Income (SSI)
   - Temporary Assistance for Needy Families (TANF)
   - Women, Infants, and Children (WIC)

Part 2. Use of Food Assistance

1. In the past 3 months, how often did you use ANY public food assistance (any local food pantry or the one in the health system that you used)?
   - 1 time
   - 2 times
   - 3 - 5 times
   - 6 - 10 times
   - 11 times or more
2. In the past 3 months, how often did you use the food pantry in the health system that you recently visited?
   - 1 time
   - 2 times
   - 3 - 5 times
   - 6 - 10 times
   - 11 times or more
3. On average, per one visit, how long did you spend to get the food assistance from the food pantry in the health system that you recently visited?
   - Less than 5 minutes
   - 6 - 10 minutes
   - 11 - 15 minutes
   - 16 - 30 minutes
   - 31 – 60 minutes
   - More than 60 times
4. How did you find out the food pantry in the health system that you visited?
   - Food pantry staff
   - Health service provider (medical doctors, nurses, social workers, nutritionists, etc.)
   - Family members or friends
   - Other
   - Please describe below who the Other was.

Appendix B: Initial Focus Group Flier and Updated Interview Flier

Focus Group Recruitment Flier

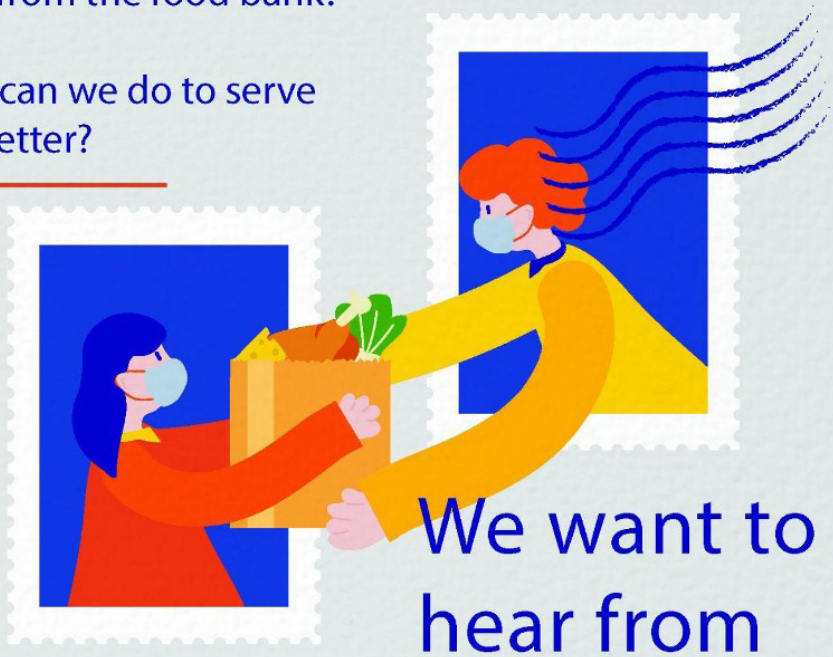


Interview Recruitment Flier

Study Protocol: HM20023077

Are you getting the food and service you need from the food bank?

What can we do to serve you better?



We want to hear from YOU!

The Food Bank is hosting online interviews to learn about your experience and how to improve it! If you would like to participate in this study or you have questions, please contact the study coordinator for more information and to schedule a time for an interview.

CONTACT

Study Coordinator:
Anne Nelson Stoner

Email:
ans8u@virginia.edu

Phone:
434.987.0078