Q1 Please provide your contact information below.

Name	**Erin Summerlee**
Title and Organization	**Food and Health Network Director, Rural Health Network of South Central New York**
Address	**2663 Main Street**
City/Town	**Whitney Point**
State/Province	**NY**
ZIP/Postal Code	**13862**
Email Address	**fahncoordinator@rhnscny.org**
Phone Number	**607-692-7669**

Q2 Please describe your company or organizations overall goals and mission.

The mission of the Rural Health Network of South Central New York (RHNSCNY) is to advance the health and well-being of rural people and communities. The agency was founded in 1998 and has been providing health-related services for eighteen years. Principal activities are carried out through five program divisions:

Food and Health Network of South Central New York (FaHN):an eight-county coalition of over 90 diverse stakeholders working to build food-secure communities and a strong regional food system through collaboration. FaHN programs support healthy people, farms and communities through the Fruit & Vegetable Prescription Program, farm to school and institutions, assessments and technical assistance.

Community Health Services: Chronic disease prevention; education and case management; and assisting rural residents with health care insurance, access, and navigation. RHN represents rural health interests through Medicaid Redesign (DSRIP) and other reforms. RHN Community Health Services strategies are intentionally aligned with the NYS Prevention Agenda, County Health Improvement Plans, and hospital Community Services Plans. Community Health Services staff perform in four functional areas: health care access, health/well-being screenings, chronic disease education, and case management.

Mobility Management of South Central New York and the GetThere Call Center assists individuals with arranging transportation to meet their basic needs such as employment and health care. Connection to Care provides non-emergency medical transportation to income-qualified rural residents. MMSCNY is currently piloting a voucher program funded through a CCN Innovation Fund grant to assist Medicaid recipients with access to essential services not covered by Medicaid transportation benefits.

Population Health: RHNSCNY is a subcontracted entity (through HealthLinkNY) for the NYS Department of Health's Population Health Improvement Program, participating in a five-county regional health assessment and analysis, and responsible for population health work in Delaware and Tioga Counties.

Rural Health Service Corps:an AmeriCorps National Service Program providing meaningful service and learning opportunities for people committed to improving the health and lives of those living in South Central New York. AmeriCorps members serve at a variety of health and human services organizations and currently focus on food security and opioid abuse prevention, education, treatment and recovery.

RHNSCNY has advocated for health care access by rural residents and equity at the local, county, regional, state and federal levels since incorporating in 1998. Our organization prides itself on convening partners and collaborating across systems and borders.

Q3 Please indicate which category your organization falls under.

Community Based Organization

Q4 Innovation Executive Summary. Please describe the innovation, and how it addresses the social determinants of health. Please identify how the innovation addresses the 6 innovation criteria (i.e. ROI, scaleability, feasibility, evidence based support for innovation, relevance to the Medicaid population and speed to market).

The South Central NY Fruit and Vegetable Prescription Program (FVRx) is a strategy to help prevent and manage chronic diet-related diseases in the adult Medicaid population. The program began as a pilot in 2017 and has expanded significantly for year two due to initial impacts and high demand. Three core goals include:

1) Prevent and manage chronic diet-related disease in the Medicaid population by increasing affordability and access to nutrient dense fresh fruits & vegetables through a prescription voucher program, and referral to nutrition and chronic disease education and support services in the community. Eligibility to participate will specifically target cardiovascular disease, diabetes, and associated risk factors.

2) Develop workflows that effectively screen and connect patients with community-based preventative and management services, and integrate into the EMR.

3) Continue to evaluate the Return on Investment for nutrition-based preventative health care to determine replicability and sustainability.

The program supports healthy behavior change through increased financial and physical access to nutritious food, education, and peer support, thereby improving health outcomes for participants and their families. The program allows clinicians or community health workers to write participants “prescriptions” for fruits and vegetables that are accompanied by nutrition counseling as appropriate, community-based group nutrition and cooking education, chronic disease self-management classes, transportation vouchers, and other support services.

By providing a financial incentive and offering fresh food retail in more accessible locations, the FVRx program enhances the effectiveness of existing services to address social determinants of health and the barriers of transportation and income. Participants receive short term supports to get them to the long term goals of self-management and reduction of hospital readmissions and ED usage. The FVRx program packages comprehensive strategies to address social determinants of health to offer relatively low-cost interventions to avoid preventable high-cost interventions in the future.

The SCNY FRVx program aligns with the six innovation criteria as follows:

1) Potential Return on Investment: The SCNY FVRx Program includes an extensive evaluation component to determine the potential return on investment. Metrics being evaluated include: change in shopping behaviors, change in knowledge about healthy food sources and importance in diet, food security, fruits and vegetable consumption, BMI, rates of ED usage, rates of hospital readmissions, patient satisfaction with quality of care, provider satisfaction, program completion, FVRx redemption, and participation in community-based education. Research shows that adults with very low food security are 53% more likely to have a chronic illness, and have 47% more emergency room visits and hospital admissions than those with high food security. By evaluating the metrics listed above, we aim to develop the ROI for preventive nutrition and food security interventions.

2) Scalability: The SCNY FVRx program began as a pilot with two primary care offices in urban communities in Broome County, NY and 80 participants. It is now being expanded to 12 primary care offices and two hospitals in Broome, Tioga, and Delaware Counties to reach at least 200 participants. There has also been significant interest in replicating the program in neighboring regions, and 7 trainings have been give to Performing Provider Systems (PPS), hospital research centers, health care providers, and conferences for clinical staff.

3) Feasibility: Based on implementation of the pilot program in 2017, the FVRx program has proven to be feasible in the South Central NY region. By partnering with Registered Dietitians, Wellness Coordinators, and Community Health Workers the program was cost effective to implement and integrated into existing clinic work flows. Broken down by Medicaid member, the program costs approximately $753.42 per member, or $41.86 per month over 6 months.

4) Evidence-based support for innovation: Nationally, 69% of participants increased their fruit & vegetable consumptions, 55% decreased their BMI, 45% of patient households reported an increase in food security, and 92% reported that the prescription was important in their decision to shop at participating retail sites.

We are currently working with Binghamton University for a comprehensive program evaluation of the pilot year. Initial feedback suggests better management of cholesterol, diabetes, and weight loss in FVRx participants; changes in shopping patterns; and changes in cooking and consumption.

5) Relevance to the Medicaid Population: The FVRx program provides relatively low cost, short term interventions to prevent higher cost interventions down the line. The knowledge, skills, and behavior change and the changes in food access build Medicaid members “toolbox” with the end of goal of preventing ED visits and potentially preventable hospital readmissions. The program adds to value-based payment by calculating the return on investment of packaging comprehensive strategies together to address social determinants of health. The program is aligned with a variety of Care Compass Network DSRIP Projects including: 2.b.iv - Care Transitions for Chronic Diseases; 2.c.i - Navigation; 2.d.i - Patient Activation; and 3.b.i - Evidenced based best practice strategies for cardiovascular

disease management in adults.

6) Speed to market: The SCNY FVRx program has already been implemented and is now entering its second year.

Q5 Was your innovation implemented? If so, please explain when, the number of people impacted, and the results.	Yes (please specify when and the estimated number of people impacted): Yes, the first year of the program ran from June 2017 - March 2018, and year two was launched in June 2018. 80 individuals completed the program in Year 1, and it is anticipated that at least 200 individuals will complete the program in Year 2. Full evaluation results on the impact of the pilot program will not be available until fall 2018, clinic staff have reported better management of cholesterol, diabetes, and weight loss in FVRx participants. Farmer's markets and other healthy food retailers have reported that the program is one of the most effective strategies for attracting new customers within this target population, and that many FVRx participants have now become repeat/regular customers. Both participants and clinical staff have reported high levels of satisfaction with the program.
Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)	**Health and Health Care** , **Neighborhood and Environment** , **Economic Stability**
Q7 I give the Department of Health the right to share the information submitted in this application publicly (for example: on the DOH website). I understand that there is no monetary reward/reimbursement for my submission or for attending the summit should my innovation be selected.	**I consent to have my innovation shared**