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CARING FOR THE WHOLE PERSON

INTEGRATED HEALTH AND NUTRITION

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EDITOR'S COLUMN

Dear Readers: You will have noticed upon receiving this magazine that *Charities USA* is coming to you in a "smaller package." We are always grateful for the heartfelt feedback we receive, praise and criticism alike. It helps us serve you better. One comment we have received from more than a few readers is that the handsome look of *Charities USA* must come at a price. We interpreted this as a subtle way of saying, "Cut your costs." So we did. The present size of the magazine has substantially reduced the costs of production and postage.

Nevertheless, inside this leaner version you still get the same good news about what the Catholic Charities ministry is doing to reduce, alleviate and prevent poverty in communities and neighborhoods across our country: everything from innovative programs and intelligent, informed advocacy for those people in our society that have dire needs and no voice.

The current issue focuses on Integrated Health and Nutrition. There are two main sections (along with our regular features): one focusing on the area of healthcare and one on nutrition. Each section contains three articles: an overview of the particular area (either healthcare or nutrition) within the Catholic Charities ministry, followed by two examples of Catholic Charities agencies working in the same area. Integrated Health and Nutrition is also one of the Strategic Priorities announced at the 2016 Annual Gathering. Watch the "CCUSA Update" section in future issues as we keep you informed about all the strategic priorities. ■

David Werning, Managing Editor
To comment on this issue, please write to David Werning at dwerning@CatholicCharitiesUSA.org.

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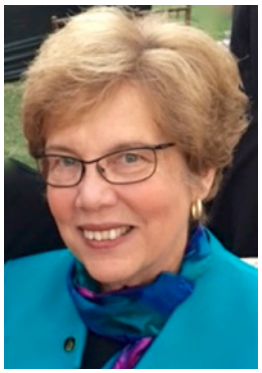
"Our Catholic Charities agencies become touch points for people in need across the country and our territories. As we say so often about the work of charity, this is all about need, not creed."

– Sister Donna Markham OP, PhD

PRESIDENT'S COLUMN



We know that healthy communities are key to ensuring a vibrant, productive society. Throughout Catholic Charities, we are committed to fostering the spiritual, emotional and physical well-being of those who come to us for assistance. Access to primary care physicians, behavioral health specialists, pastoral care and healthy nutrition are all components of developing healthy families and communities.

Clearly, those who are most in need of these services often are not aware of local community resources. Our Catholic Charities agencies become touch points for people in need across the country and our territories. As we say so often about the work of charity, this is all about need, not creed. In the pages that follow, you will have an opportunity to see snapshots of some of the incredible work our agencies are doing to meet areas of basic needs in population health management.

Keys to success with this strategic initiative of Catholic Charities are our partnerships with healthcare providers, parishes, corporations and foundations that, when working in concert, can make a significant difference in the lives of those who are most vulnerable. One major effort underway is our collaboration with Catholic Healthcare providers to develop creative ways to address the mental health crisis in our country. We are exploring solutions to this crisis that are financially viable and yield positive treatment outcomes. Lack of access to primary care for chronic health issues and to healthy nutrition often exacerbate emotional problems. We are convening thought leaders throughout the Catholic Charities ministry to develop and pilot creative programs that we hope to spread over the course of the next 5 years.

Thank you for your prayers and support of those who are so in need. Count on our prayers for you as we move forward in mercy and faith.

Gratefully,

Sr. Donna Markham OP, PhD
President & CEO, Catholic Charities USA

INTEGRATED HEALTH AND THE CATHOLIC CHARITIES MINISTRY:

AN OVERVIEW

By David Werning, Managing Editor, Catholic Charities USA

The Catholic Charities ministry in the United States under the leadership of Sister Donna Markham OP, PhD has established seven strategic priorities for the next five years. One part of this bold vision is to innovate in the field of integrated health, which is a positive new trend in health care systems. The integrated health model seeks to treat the whole human person and refers to the coordinated service approach of both primary and behavioral healthcare care so that the patient receives the help he or she needs without having to see multiple health care providers at multiple locations. It also gives due attention to the spiritual well-being of the person.

The need for integrated health care becomes clear when one confronts two important realities facing the overall health care system. The first reality is that people with behavioral issues are less likely to be treated because the overall system consists mostly of primary care providers. According to the Patient-Centered Primary Care Collaborative (PCPCC), "67 percent of people with a behavioral health disorder do not get behavioral health treatment" (and many of these same individuals do not receive care for chronic physical conditions). This is exacerbated by the fact that "two-thirds of primary care physicians report not being able to access outpatient behavioral health for their patients [due to] shortages of mental health care providers, health plan barriers, and lack of coverage or inadequate coverage." And even if a patient is referred from primary care to a behavioral health clinic, the patient often does not follow through on the appointment.[1] Quite often, patients end up going to an emergency room, not knowing where else to go, which has the dual effect of driving up costs and overburdening ER departments, not to mention the fact that the patients may not get the care they need.[2] If there were more collaboration between primary and behavioral healthcare providers, then more patients would be seen and treated.

A second reality that augurs persuasively for the need of an integrated health care system is the scarcity of funds and, on this point, integrated health models can help. The American Psychiatric Association (APA) found that "effective integration of medical and behavioral care could save $26-$48 billion annually in general healthcare costs," which makes working toward a fully integrated

Contact the following agencies for other integrated health models within the Catholic Charities ministry:

Catholic Charities Diocese of Trenton: Certified Community Behavioral Health Clinic (CCBHC)

Contact: Marlene Lao Collins
Email: mlaocollins@cctrenton.org

Catholic Charities Archdiocese of Hartford: Center for Medicare and Medicaid Innovation Practice Transformation Network subcontractor

Contact: Bob Muro
Email: bmuro@ccaoh.org

Catholic Charities Archdiocese of Chicago: Accountable Health Communities grantee

Contact: Kathy Donahue
Email: kdonahue@catholiccharities.net

system worth the effort.[3] Indeed, the APA's conclusion is supported by the PCPCC's discovery that the "use of health care services decreased by 16 percent for those receiving behavioral health treatment, while it increased by 12 percent for patients who were not treated for their behavioral health care needs."[4]

The benefits of an integrated health model are evident and achievable for every community and health care system. What is needed is the willingness to operate outside of the status quo and to adopt certain principles and behaviors. For example, segregated behavioral health care delivery, which is often separated from overall health care, needs to move toward an inclusive, strengths-based model of delivery that treats the whole person. The goal includes not only treating the disease but also facilitating a return to a healthy life for the patient, including access to healthy food choices (see the Nutrition section beginning on page 14). Ideally, a patient would be under the care of a team that would coordinate services. There are challenges, of course, with setting up such a system, the issue of reimbursements, and establishing sound evidence-based practices tools to measure effectiveness. However, the benefits outweigh the challenges.

The Catholic Charities ministry in the United States certainly would benefit greatly from an integrated health model. Across the country, Catholic Charities agencies provide a diverse array of health services: health and dental clinics, home health services, skilled nursing facilities, pastoral care, and hospice to name just a few. Moreover, a little less than 150,000 adults received counseling and mental health services and a little more than 70,000 received addiction services. Some of the agencies already maintain a partnership with external networks, but more can be done.

Catholic Charities USA (CCUSA), the national office of the Catholic Charities ministry, has responded to meet the need for integrated health. As was already mentioned, CCUSA has identified integrated health and nutrition as one of seven strategic priorities to focus on for the next five years. In order to lead the effort on integrated health, CCUSA has hired a Chief Health Integration Officer, Ramona Ivy. Ramona will facilitate network-wide training in integrated health systems through webinars, teleconferences and future regional or face-to-face meetings. She will also serve in an advisory role to a "Community of Practice" comprised of member agencies that are interested in (or already participating in) an integrated health model. Ramona can be reached at rivy@CatholicCharitiesUSA.org.

What follows are two integrated health models currently in place at two Catholic Charities agencies: the Health Guardians program at Catholic Charities New Orleans and the Behavioral Health Home model at Catholic Charities Maine. ■

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[1] "Benefits of Integration of Behavioral Health." *Patient-Centered Primary Care Collaborative*. 2015. Web. 22 Dec 2016. <www.pcpcc.org/content/benefits-integration-behavioral-health>

[2] Luthra, Shefali. "Scarcity of Mental Health Care Means Patients – Especially Kids – Land in ER." *Kaiser Health News*. Kaiser Family Foundation. 17 Oct 2016. Web. 22 Dec 2016.

[3] "Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry. Milliman Report Summary." American Psychiatric Association. April 2014. Web. 22 Dec 2016. <www.achp.org/wp-content/uploads/milliman-report-summary-20141.pdf>

[4] "Benefits of Integration of Behavioral Health."

CATHOLIC CHARITIES MAINE

BEHAVIORAL HEALTH HOMES

By Jeffrey Tiner, MBA MSW, Chief Clinical Officer, Catholic Charities Maine

For decades, community health providers have emphasized the need for, touted the benefits of, and demonstrated occasional success in developing, implementing and sustaining truly integrated approaches to health wellness. The need for integrated care is great, and even more critical for individuals whose challenges are compounded by the presence of both medical and mental health issues. Difficulties in accessing and utilizing treatment for those with co-morbid conditions often increase their vulnerability to ill health, poor quality of life and escalating costs.

However, the traditional service delivery models, payment structures, and regulatory requirements that define both physical and behavioral healthcare practices have presented some unique challenges in advancing the goals of comprehensive healthcare reform, of which integrated care is a critical component.

The Affordable Care Act (ACA) has changed the game. In addition to supporting the expansion of both private and publicly sponsored healthcare coverage, this legislation has ushered in a new era of healthcare integration efforts as well. This is particularly true for state Medicaid systems, for which funding incentives, leveraged technology and regulatory mandates wield much influence when it comes to animating good ideas.

Maine has been at the forefront of this healthcare reform effort, and for good reason. According to the 2016 America's Health Rankings (Americashealthrankings.org), Maine currently ranks significantly lower than most states in many key health categories, including rates of cancer deaths (39th), heart disease (46th), heart attacks (44th), high cholesterol (40th), and hypertension (36th). While there are also some encouraging rankings to be found in this annual report, the level of need these data points underscore is sobering.

Rising costs in Maine's Medicaid program also have highlighted the need for a more effective and efficient system of care. For example, the per capita cost of Maine's Medicaid in 2009 was $8,521, the fifth highest in the nation. The total 2009 healthcare expenditure represented 22.4 percent of the Gross State Product (GSP), which was second only to West Virginia and just ahead of Mississippi. Although a number of factors contributed to this (including the disproportionate number of elderly in Maine, stagnant tax revenue

base, and comparatively broad Medicaid eligibility criteria at the time), reform was clearly needed. Despite a narrowing of eligibility criteria in 2014 (childless, non-disabled individuals lost coverage), data shows that as of June 2016, 272,568 residents, 20 percent of our population, were eligible for and received coverage through the Children's Health Insurance Program (CHIP) or MaineCare (the state Medicaid program). The need remains significant.

Maine has taken steps in recent years to address this growing concern, including: contracting with an Administrative Service Organization to manage authorizations and data tracking for behavioral health services; the introduction of the Patient-Centered Medical Home model (PCMH) and Pioneer Accountable Care Organization pilots; and other healthcare initiatives that embody the concept of Value-Based Purchasing. These efforts helped to reshape healthcare delivery in Maine.

In fact, Maine's commitment to transforming healthcare was recognized nationally when it was awarded one of six State Innovation Model-testing (SIM) grants in 2013. This 42-month federal grant opportunity was part of the ACA, totaled $33 million dollars, and specifically targeted efforts to support innovation, promote integration, and achieve alignment of services to improve outcomes and reduce the cost of care in the state of Maine. To facilitate comprehensive and effective reform, the state mapped out a three-pronged approach that included the key areas of Service Delivery Reform, Payment Reform, and Data & Analytics.

While the SIM grant supports the transformation of healthcare efforts as a whole, it was the emergence of the integrated health home models in particular that changed the direction of Catholic Charities Maine's Behavioral Health Network services.

The rollout in Maine took place in two distinct phases, both geared toward more effective, integrated support for high-risk, high-cost populations. The difference between the two is simply a matter of emphasis. The first, or "Stage A," was the medical home model launched in 2013. This included a Primary Care Practice (PCP) provider, along with a Community Care Team (CCT) to provide support for those individuals with high medical needs. While qualifying individuals may indeed have a behavioral health issue, it is considered secondary. The CCT receives a Per-Month Per-Member (PMPM) payment, and the PCP receives a modest administrative payment in addition to the ability to bill for all medical services rendered.

The second phase, or "Stage B," was the Behavioral Health Home program (BHH) launched in 2014. This multi-disciplinary team approach is designed to work with individuals that have a qualifying be-

"Maine has been at the forefont of the healthcare reform effort..." – Jeffrey Tiner

"...it was the emergence of the integrated health home models...that changed the direction of Catholic Charities Maine's Behavioral Health Network services." – Jeffrey Tiner

havioral health condition which is considered the primary focus of need, as well as at least one (or at risk of having one) chronic health condition. The introduction of health and wellness groups, peer support services and closely coordinated care with PCPs are key elements of this service. BHH teams are required to have at least one formal Memorandum of Understanding with a primary care provider, facilitate coordinated care of shared clients, and exchange health information and leverage PMPM payments provided for integrated care activities. BHH providers receive a monthly payment for qualifying services, and provide the modest pass-through payments to affiliated PCPs.

The BHH rollout also included a range of contracted, specialized support organizations to assist in development, implementation and management of the integrated BHH service model. These resources include a statewide learning collaborative to provide technical assistance, coordination of provider forums for information sharing and resource development, online provider quality reporting, and oversight of a structured quality component that includes 10 mandatory core standards that frame the BHH Integration model. A significant component of this effort is the health information exchange known as HealthInfoNet. This system was already in place, and has emerged as one of the most critical links for our integrated care system. This online system provides select provider staff with access to member health data, including services engaged, lab results, and automated alerts for emergency department contacts or hospital admissions of assigned BHH members.

Catholic Charities Maine had several advantages when assessing its readiness to move forward with the BHH model. We have a broad continuum of behavioral health services, with locations across the state. In Portland, where we have our highest concentration of behavioral health programming, we had access to existing staff resources to accommodate the interdisciplinary BHH team for our initial pilot. Our agency was also an early adopter of technology in the delivery of behavioral health services, with the shift to electronic health records allowing for remote laptop access for community-based services beginning in 2002. We also have a longstanding commitment to data-driven service management, positioning us well to meet the data and performance metric requirements of the BHH service. We were also among the first behavioral health providers to pilot the HealthInfoNet system, and to pursue bi-directional capacity. Last, our initial BHH partnerships with primary care providers included a Catholic hospital and a regional Federally Qualified Health Center. These traditionally have been our strongest partners, as our mission-driven commitment to the community health safety net is a common theme that resonates with our organizational core values.

The first BHH services in Maine opened in April 2014, at which time Catholic Charities Maine launched its BHH pilot for adults in Portland. From that point on, the growth of this service accelerated considerably. In December 2014, eight months into the pilot program, we had 44 BHH members, representing roughly four percent of the total number of case management clients served by our agency statewide. By December 2015, that number had more than doubled to 110 members, and by December 2016, we had 714 BHH members or 65 percent of our entire client base statewide. This substantial increase was due to the addition of one adult and three children's BHH sites statewide in May 2016, as well as revisions in adult case management eligibility criteria that required a large number of

clients (as well as a large portion of our workforce) to move from the traditional model to the BHH service. This dramatic transformation has not been an easy process, but we are very encouraged by the outcomes we are beginning to see as this BHH model gains traction in the lives of those we serve.

BHH teams are strongly encouraged to select and track one or two outcomes that they consider meaningful for their membership in terms of quality of life. The two outcome measures we selected are emergency department (ED) contacts and inpatient hospitalizations. While other measures are certainly important, we considered these high acuity measures to be strong indicators of member well-being. Member hospitalization rates for the 12-month period prior to entering BHH services served as the baseline. Hospitalization rates for the 12 months following BHH service engagement were then compared to the baseline. This year-over-year comparison showed an average 63 percent decrease for BHH member admissions. In addition, it is also noteworthy that the average number of prescribed medications for this same cohort decreased by 50 percent for this same time period. This represents a significant increase in stability for the members in the community, as well as a significant reduction in costs.

Another recent Quality Improvement project focusing on a cohort of identified high users of ED services showed even more impressive results. The data showed that 78 percent of the BHH members had fewer ED contacts after entering the BHH service. Of those experiencing a decrease, the average decrease in actual ED contacts was 72 percent. Again, this demonstrates significantly reduced distress and disruption in the lives of the members, as well as substantial cost savings in our healthcare system.

While these results are most promising, there remains much work to be done. For example, only individuals covered by MaineCare qualify for BHH services, and we are one of 19 states that have declined Medicaid expansion. This has resulted in a large number of uninsured individuals who would otherwise qualify for and benefit from BHH services. For these individuals, state grant funding that is currently set aside to pay for the uninsured will cover traditional fee-for-service case management, but not BHH services. We are advocating for this funding to be made available for this population to receive BHH services.

There is also a need for a higher level of inclusion and integration with substance use disorder treatment. This needs to be a priority, particularly given the current opiate epidemic. There is now growing interest and support for developing a specific BHH to focus on the unique needs of this population affected by addiction.

Last, the eventual affiliation with an Accountable Care Organization (ACO) will require considerable planning, as this will be a significant step toward completing the last major phase of healthcare integration at the systems level.

Despite the challenges, we are most optimistic about the results thus far, and in the overall direction and potential for this integrated model to expand and become the standard for all healthcare delivery systems. ■

"Maine is also among the first behavioral health providers to pilot the HealthInfoNet system..." – Jeffrey Tiner

HEALTH GUARDIANS:

HELPING PEOPLE REACH WELLNESS ONE PERSON AT A TIME

By David Werning, Managing Editor, Catholic Charities USA

The healthcare system in New Orleans has a significant challenge: providing and paying for care for people who may be homeless, jobless, uninsured, or "all of the above." More often than not, people who fall into one or more of these categories do not have the experience or resources to navigate the healthcare system. When they get sick, they go to an emergency room (ER), not necessarily because their particular health issue requires it, but because the ER is the only place they know. This can create additional problems. On the one hand, the ER may not be the best venue to treat a particular patient, so the patient needs to be referred elsewhere. The loss of time may have a deleterious effect on the underlying condition. Worse, the patient may not follow through with the appointment and forgo treatment altogether. On the other hand, the ER's personnel and resources are spread thin, which is not cost-effective or patient-friendly.

Catholic Charities of the Archdiocese of New Orleans (CCANO) has responded to the situation with the creation and development of its Health Guardians program. According to Ben Wortham, the current director, Health Guardians is "the most effective program in the city for navigating the healthcare system." What distinguishes it is "direct assistance," says Wortham. With four patient navigators, each of whom can accompany up to 25 patients, Health Guardians is lowering the overuse of the ER and helping people reach wellness.

Health Guardians got started through the efforts of Dr. Elmore Rigamer, a psychiatrist who is the medical director of CCANO. In the aftermath of the 2010 BP oil spill, Dr. Rigamer travelled throughout the most-affected communities in order to assess the emotional needs of the people. What he encountered, however, were people with multiple health-related issues, who were without the necessary resources to address them. Dr. Rigamer recognized immediately that helping these people reach wellness meant addressing all their needs, emotional and physical. He asked for and received funds from BP in order to set up a case management system that could assess a patient's situation and help him or her navigate the healthcare system.

Health Guardians builds on this experience in its service to the people of New Orleans. Established in 2012 with start-up funds from the New Orleans Charitable Health Fund and inspired by a similar program in Camden, New Jersey, Health Guardians began with patient navigators visiting emergency rooms in order to iden-

tify "frequent fliers" – those people who overuse the emergency room. "Overuse" is defined as visiting the ER three or more times, or being hospitalized twice for the same disease, within the previous six months. Patient navigators would then engage the patient (not always an easy task if the person happens to be homeless), offering to help him or her develop and follow a plan to wellness over a 90-day period. The plan would include a link to primary care but also direct assistance in the following ways: setting appointments, housing, transportation, understanding medical advice, how to properly take any medication prescribed, enrolling patients in ancillary programs, and follow-up visits. The initial results of the program were significant. Patients had fewer visits to the ER after being enrolled in the program, which led to financial savings to the healthcare system.

Four years later, Health Guardians is continuing to make a difference in the New Orleans healthcare system. With another grant from the Louisiana Public Health Institute (which expires this year), Health Guardians has expanded its outreach by working with 11 Federally Qualified Health Centers. Now, in addition to the legwork of tracking down patients, Health Guardians receives referrals from the centers. The goal is still the same: to help the individual patient navigate the healthcare system and achieve self-sufficiency. Since 2012, Health Guardians has helped 344 patients. Forty percent of the patient base are homeless, and the other 60 percent consist of people struggling with low incomes or lack of employment. The results continue to benefit to both patients and the system overall. Whereas a person may have visited the ER six times in a six-month period, after the same person enrolled in Health Guardians the ER visits dropped to once in six months. Moreover, for each person who completes the Health Guardians program, the savings to the healthcare system is $17,000.

Wortham thinks that the success of Health Guardians is connected to the direct assistance it offers to persons. A case in point, he says, is the story of "Jorge" (the person's name has been changed for the sake of privacy). Jorge lived under a bridge, and he was found by Health Guardians during one of their visits to an ER. The patient navigator explained to Jorge the benefits of the Health Guardians program, but Jorge was unmoved. He could take care of himself. The patient navigator did not give up though. He would visit Jorge under the bridge every Friday in order to renew the offer of help, but also to talk and listen. It soon became clear that Jorge was an amiable fellow and well-liked by others in the homeless community. It was also clear that his health was worsening, despite his intermittent visits to the ER and the heartfelt (but inadequate) care he received from his comrades under the bridge. The situation remained basically the same for two months. Then, on another Friday visit, the patient navigator made the offer once again and Jorge finally accepted. For whatever reason, Jorge had not been ready immediately to receive help, but the perseverance of the patient navigator eventually made the difference. Jorge has since completed the Health Guardians program and now lives in a nursing home.

"Relationship is key," Wortham says. On any given night in New Orleans, the homeless population numbers 1,800. However, that's not how Wortham and the patient navigators of Health Guardians see it. They see 1,800 individuals, each of whom has a particular life story and particular needs. Indeed, that's how Health Guardians see all the people they encounter, whether they are homeless, uninsured, or jobless. They are brothers and sisters who need a helping hand, and if they cannot fit into the overall healthcare system, then the system needs to meet them where they are. ■

NUTRITION AND THE CATHOLIC CHARITIES MINISTRY:

AN OVERVIEW

By Jane Stenson, CCUSA, Senior Director, Poverty Reduction Strategies

Many in the larger community see Catholic Charities as a network that supports individuals and families experiencing crises and/or significant needs. This is true, but it tells only part of the story. The Catholic Charities USA (CCUSA) Annual Survey reports that in 2015, over 3,600 programs run by local Catholic Charities agencies offered services from food distribution via pantries and food banks to prepared meals in congregate dining. These programs often serve as a gateway to more holistic, life-changing services that can stabilize families, change poor eating habits and sometimes launch careers. Consider the following two examples:

(1.) A young man recently came into an agency outreach center. Outside the temperature was very low. The staff learned that the man had just been released from jail with no provisions: no home, no income, not even a winter coat. After receiving a coat and a travel bag from the agency clothing center, the man completed an application for the Supplemental Nutrition Assistance Program (or SNAP, formerly called Food Stamps) which would allow him to purchase groceries.

(2.) A mother with four dependents came to a Catholic Charities pantry in order to get enough food to feed her family until her next paycheck. Pantry staff asked if she was receiving SNAP benefits and learned that she was not. They also learned, after a few follow-up questions, that the family had been moving from motel to motel, paying high monthly, and even weekly, rates. The staff immediately began thinking of ways to turn the situation around.

Sadly, these stories are typical for those who support families and who have trouble meeting the most basic of nutrition needs. Often the needs include much more than food. So, while pantries that help distribute food provide a critical service, they can, and do, so much more. Pantry staff are able to engage families about why the need for food exists, they can address concerns of the larger household, and they can connect families to public benefits and other services.

In the case of the family mentioned above, the local Catholic Charities agency was able to assist them in applying for SNAP benefits. The family was then able to use income for more permanent housing. The agency helped the family save for a security deposit, locate affordable housing options, and even make the first month's rent once housing was obtained. All of these services began with a mother looking for food to feed her children. The formerly incarcerated man was able to turn his attention to job searching and is now working full-time.

Pantries can do more than educate families about existing programs. They can also fill the gaps left by federal programs. One such

gap is the lack of food distribution capacity in rural communities. Almost 15 percent of rural households are food insecure, compared to 12.6 percent of suburban households. In 20 percent of rural counties, families live in neighborhoods that are more than 10 miles from a supermarket. Rural residents also pay an average of four percent more than suburban Americans do for their groceries.

Fortunately, food distribution capacity is an area where private partnerships can make a real difference. With the help of a grant from the Walmart Foundation, CCUSA has funded member agencies over the past several years to expand food distribution programs in rural communities. The funds are used to purchase trucks and to expand freezer and refrigeration capacity. These are just two examples of what food pantries can do beyond providing food, and there are many others.

Local agencies run a diverse array of food-related programs. The CCUSA Annual Survey reports real growth in community gardens and farms. Also expanding are federally-supported programs such as senior meals and feeding programs for after school and during the summer, which are funded through the Child and Adult Care Food Program (CACPF) and the Summer Food Service Program (SFSP) respectively.

"A small but growing number of agencies have been able to incorporate workforce development training that can provide needed certification for the food service industry which helps to launch people into food service careers."

– Jane Stenson

Nutrition education is also on the rise with agencies taking many creative approaches, often via partnerships that give individuals and families the skills and knowledge needed to live a healthy lifestyle. For example, Catholic Charities in Atlanta partners with the University of Georgia Cooperative Extension Program to offer several programs (in both English and Spanish) which target limited income families and educates them on how to make healthy purchases and have a healthier lifestyle.

Catholic Charities in Louisville runs a program called Common Earth which helps to empower and improve the quality of life for refugee families through agricultural opportunities. The program provides access to farm land which allows families to grow culturally-appropriate food while providing education and socialization. Some of the excess crops are used to support a Culinary Arts social enterprise, which is designed to train refugees, former inmates, and other Louisville residents in need of job assistance. The program supports itself by selling a hot lunch two days a week.

The integration of health and nutrition has been identified by CCUSA as one of seven Strategic Priorities for the next five years for the Catholic Charities ministry. Access to quality food is fundamental to the ability of people to engage in many of the other life-changing programs offered by Catholic Charities agencies. In support of the strategic priority concerning food and nutrition, CCUSA will launch a Community of Practice in the coming months. This Community of Practice will engage agency staff working in these programs and provide a forum to exchange best practices, raise concerns (which can feed into local and federal policy decisions), engage broader partnerships and stimulate more innovative and life-changing programs that support access to quality food and nutrition education. For additional information about the Community of Practice, please contact Jane Stenson at jstenson@CatholicCharitiesUSA.org.

Food insecurity is a problem for far too many children and families in this country. That's why we need every stakeholder to do what they can to make a difference. ■

CATHOLIC CHARITIES ARCHDIOCESE OF CHICAGO:

BUILDING FAMILIES, BUILDING COMMUNITIES

By Diane Nunley, Associate Vice President of Special Supplemental Food Programs

Proper nutrition is key for children in their earliest, most critical stages of growth and development. Often, low-income women with infants and young children can't afford, or don't have access to, the healthy food needed to maintain a healthy diet.

WIC (Women, Infants, and Children) is a USDA supplemental nutrition program designed to improve health outcomes for low-income mothers, their babies, and their children up to age five. Low-income women and their young children were selected because the nutrients missing in their diets were resulting in negative health consequences and increased medical costs.

"I can say that WIC has helped me enormously," said Tanya, a WIC employee and participant. "It has been a great learning and growing experience not only as a person but as a professional. It provides my daughter with nutritious and healthy foods that have helped her grow and be the healthy little girl that she is today."

Since its inception in 1974, WIC has successfully achieved its goals by providing healthy food, nutrition education, and yearly health-care visits to women and children in need. The WIC program aims to influence a lifetime of nutrition and health behaviors in high-risk populations, not just during their time in the program.

Clients become eligible for WIC benefits after they are assessed by a health professional to be "at nutrition risk." They receive a physical examination and complete a questionnaire about diet and eating habits. If the client is determined to be at nutrition risk, the dietitian selects a food package or prescription for the woman based on her risk factor. She also receives nutrition education on how to lessen the risk factor through the use of WIC foods, WIC coupons, and instructions on how to shop at a WIC Food Center. Clients return to the clinic quarterly to receive nutrition education and three months of coupons. Re-certification occurs annually.

Studies show that for every very low birth-weight incident prevented by WIC, an average of $13,500 is saved in Medicaid costs. Every dollar spent on pregnant women in WIC produces up to a $4.21 return in Medicaid savings for newborns and their mothers.

Traditionally, the foods in WIC centers are the same as those distributed in retail stores nationwide. Also the design of the centers addresses the problems often associated with food shopping in large urban areas.

For example, several major chain supermarkets have closed their stores in these neighborhoods, creating food deserts that leave residents without access to healthy food. Because of this, many families rely on corner stores for their grocery needs: often one-lane "food and liquor" marts where product selection, freedom of choice, and options are few.

Additionally, WIC Food Centers use coupons which are only redeemable at the centers and do not carry any cash value. This model has served a dual purpose; it places the WIC participant at less risk of robbery and reduces unauthorized purchases.

As a final example, the WIC Food Center is no ordinary grocery store. A client can drop off her children in the child care area for supervised play while shopping, taste-testing new food, making an appointment to have her taxes completed, establishing her child's' paternity, or getting a photo ID card all at the same location.

In Chicago, WIC provides safe and accessible shopping in 16 locations. Eight of the 16 centers are co-located with WIC local agencies allowing clients to get their certification, nutrition education, and WIC foods at the same location. The WIC Food Center is a busy place, with the average client shopping once per week. In a typical month, more than 47,635 clients and 122,196 coupons are processed.

The WIC Food Center also stimulates community development in neighborhoods where businesses have left, homes and buildings have been abandoned, and jobs are sparse. Through the centers, local residents receive job training, employment, valuable work experience, and also serve as a support system and mentor to their neighbors.

WIC reflects a successful partnership involving a state agency, a not-for-profit community agency, grocery chains, wholesale suppliers, property owners, and developers.

This unique and innovative program has received numerous recognitions over the years for its positive outcomes. One of the first awards was the 1994 USDA Food & Nutrition Service Administrators' Citation for Innovation. This prestigious national award is conferred annually to the state, territorial or tribal agency exemplifying the highest standards in innovation. Its greatest accomplishment, however, is the success stories of the clients who have lived happier, healthier, and longer lives, thanks to the services offered and the positive impact WIC Centers have had on their communities. ■

"I can say that WIC has helped me enormously."

– Tanya, a WIC employee/participant

CATHOLIC CHARITIES WEST VIRGINIA:

HEALTHY EATING AND LIVING

By Katie Hinerman Klug, Marketing Communications Specialist and Patricia Phillips, Director of Development and Marketing

Building on the foundation of feeding the hungry, Catholic Charities West Virginia (CCWVa) is developing initiatives that create opportunities for people to improve their own well-being through better nutrition and keener awareness of the link between what one eats and how one feels. CCWVa recognizes that food plays a significant role in the health and vitality of the tens of thousands of West Virginians the agency serves per year. Food programs have always been a core piece of CCWVa's work to fulfill its mission. However, in recent years, the agency has begun to shift the way it views the solutions to food insecurity.

West Virginia as a whole ranks poorly in measures of health. The state's rank for overall health is 44th. More than one-third of the state's adults are obese, with the number skyrocketing to 68.8 percent when overweight individuals are included. With 13 percent of the state's residents having been diagnosed with diabetes, West Virginia ranks 49th on this measure.

The rates of poor health and instances of disease such as diabetes tend to be higher in low-income, food insecure households. This is due, in part, to the higher prices of healthier foods, which leaves low-income families with little choice but to purchase cheaper foods high in sugar, trans-fat and refined grains.

Additionally, grocery stores are disappearing throughout Appalachia. Food deserts are a growing problem in West Virginia, and many people do not have access to fresh produce and other healthy whole foods. People in numerous counties in West Virginia have some sort of limited food access, and this number is growing as more local grocery stores are unable to keep their doors open.

The challenge for many is multi-faceted. The major issues for those people dealing with food insecurity are the lack of access to, and little understanding of, the use and benefits of fresh and nutritious food. Thus, CCWVa's approach has to be multi-faceted. The initiatives all center around healthier food options and increased awareness about the benefits of good nutrition. The initiatives range from volunteer-driven 'try this' ideas to improving infrastructure to supporting the delivery of high quality fresh foods.

Providing access to fresh, healthy foods has become an area of increased focus for CCWVa. The agency has shifted the way it views

hunger solutions and is becoming more focused on the quality of food provided rather than the quantity. Moreover, CCWVa has recognized at this moment an opportunity to increase public information and education about healthy eating and why it's important.

"Food is one of people's most basic needs, and ensuring that those who are either on the verge of poverty or in poverty have nutritious food is an important part of our mission," said Mark Sliter, executive director of CCWVa.

Several years ago, CCWVa launched an innovative program called WellnessWorks to promote healthier lifestyles among families and individuals requesting food. Staff recognized that many of those requesting pantry services had a limited awareness of the role of diet and nutrition in their quality of life. Literacy issues and lack of knowledge exacerbated the situation. Through WellnessWorks, staff and volunteers are able to have conversations with clients about health concerns and then provide nutritional information and educational pieces about chronic illnesses and ways to manage them through healthy eating.

Another way that CCWVa provides assistance is through its Child Care Food Program, which assists childcare providers with serving healthy, fulfilling meals to the children in their care. The program also educates and assists caregivers in meal planning and applications for meal cost reimbursements through the USDA Child and Adult Care Food Program.

In a similar manner, CCWVa provides a link between government services and private citizens through the agency's SNAP (Supplemental Nutrition Assistance Program) Outreach Program. In 2015, CCWVa was awarded the first USDA SNAP Outreach Grant for West Virginia. This grant, along with funding as a sub-grantee of the Catholic Charities USA (CCUSA) Walmart Foundation grant, enables CCWVa to expand its efforts to educate West Virginia families about the SNAP program and provide eligible families with enrollment assistance.

Finding sustainable ways to increase the amount of fresh produce distributed through the agency's 10 food pantries has been crucial as well. Pantries have partnered with community groups, farmers and farming ventures to secure fresh fruit and vegetables during the growing season. In addition, area residents are encouraged to donate fresh and nutritious food. One CCWVa region even shared their message through a campaign where local residents were asked to "grow a row to end hunger."

"Food is one of people's most basic needs, and ensuring that those who are either on the verge of poverty or in poverty have nutritious food is an important part of our mission." – Mark Sliter, executive director of CCWVa

Through these partnerships and appeals, the volume of fresh produce grew significantly in one growing season at its largest outreach center, Catholic Charities Neighborhood Center. However, this influx of fresh produce created a challenge in properly storing the produce to extend its shelf-life beyond a few days. In order to sustain this initiative, CCWVa invested in their infrastructure and installed a temperature and humidity-controlled chamber so that the produce remains useable for weeks or even months. The chamber and its installation was funded through CCUSA's Walmart grant. The longevity of this investment will allow the outreach center to provide healthier food for many years to come. The humidity and temperature-controlled chamber benefits approximately 425 food pantry families each month. This means it will help the center to serve more than 102,000 families over the next 20 years, which is the expected lifespan of the humidity-controlled chamber. The center is able to set aside a portion of the fruits and vegetables received during the growing season for use and distribution well into the fall and winter months. This prevents waste during the harvesting months and enables the center to offer more nutritious foods throughout the year.

The Catholic Charities Neighborhood Center has taken a further step to provide produce at the peak of its freshness by installing hydroponic walls. These "living walls" allow the center to grow fresh vegetables, including lettuce and spinach, as well as herbs, for the clients of the food pantry, meal delivery program and on-site meal distribution. Staff members have found that growing produce on-site has fostered a sense of ownership in clients about what they are eating. Interested clients are involved with the planting and maintenance process, and they have opportunities to learn about growing healthy and nutritious foods.

Another creative solution to food insecurity in West Virginia is CCWVa's Mobile Outreach Program. CCWVa has created this program to address the needs of the poor and low-income families in rural and isolated communities classified as food deserts by the USDA in a five-county area. The majority of clients served in these counties are more than 40 miles from a supermarket. The mobile food pantry van travels to these remote areas once per month on regularly scheduled days. The Mobile Outreach Program also provides nutritional and educational information. The program relies heavily on volunteer support to accomplish the mobile service provision. The staff and volunteers understand the need for nutritional support and bring their energy and ideas to the program. For instance, one volunteer donated slow cookers and distributed these kitchen accessories through the mobile food pantry along with recipes to help clients recognize and try new ways to cook nutritious meals easily. The Mobile Outreach Program also received a grant that funded the purchases of herbs and spices. These seasonings were distributed to participants as supplements to the commonly used flavorings of salt and sugar. The new spices, including cinnamon, garlic powder, parsley and onion powder expanded the cooking possibilities and food flavoring options for those who receive food assistance.

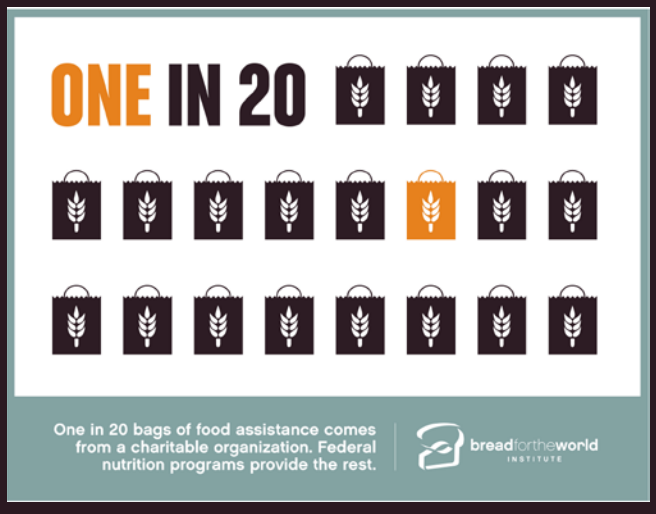
"Providing healthy food in our food pantries, helping people receive the benefits they are eligible to receive, and bringing vital food assistance and nutritional guidance to food deserts in rural communities are important to providing comprehensive outreach services to those that are hungry," said Sliter. "Our programs not only provide food for people, they also help them learn about healthy eating."■

THE IMPORTANCE OF FEDERAL NUTRITION PROGRAMS

By Kathy Saile, Associate Director of Government Affairs, Center on Budget and Policy Priorities

Hunger is what brings many individuals and families to the doors of Catholic Charities agencies for the first time. According to the Catholic Charities Food Service Report, 61 percent of Catholic Charities clients receive food and nutrition services including meals through food banks, pantries, congregate dining, soup kitchens, and home-delivered meals. This is an amazing response to the Gospel mandate to feed the hungry!

These efforts are crucial to the clients whom Catholic Charities and other volunteer agencies serve and help, often at a point of crisis when government cannot pivot quickly. Yet, it's important to understand that the food benefits provided through charity are very small relative to the assistance that struggling individuals, families, and seniors receive through federal food assistance programs.



In the United States, only five percent of food assistance is provided by a charity such as a church, synagogue, mosque, or community center program. The remaining 95 percent of food assistance is provided through government programs, mostly at the federal level. Within this network of food programs, there are good examples of the charitable sector partnering with government to provide this assistance. Yet, the scope and reach of government programs are vast.

Despite the United States being a very wealthy nation, hunger and food insecurity are significant problems. Although declining, hunger and food insecurity remain at pre-recession levels. In 2015, 42 million people were food insecure, and most were adults. Three million households included children who were food insecure at times.

Unfortunately, some people believe public food assistance programs can be cut because private charity can step in and pick up the slack. For the past few years, the House and Senate budgets have proposed significant cuts to federal food assistance, most notably the Supplemental Nutrition Assistance Program (SNAP). These changes never advanced, but, with a new Administration, congressional leaders are likely to try to make a renewed push for deep cuts in food assistance programs. Proposals to undermine the entitlement nature and national standards of the programs could also be threatened. As a community, it's important to understand what a significant role the federal nutrition programs play in the lives of Catholic Charities' clients and for the whole country.

SNAP, formerly known as the "food stamp program," is the foundation of federal nutrition assistance. Today, it helps more than 43 million low-income Americans (or one in seven) put food on the table each day. One in four children are in households that receive SNAP benefits.

SNAP is also one of the federal government's most effective and efficient programs. SNAP beneficiaries receive monthly benefits, based on their income and household size, on an electronic benefits card, which can be used to buy food at most grocery stores. Ninety-three percent of funding for the SNAP program is spent on benefits. The federal government pays the full cost of SNAP benefits and splits the cost of administering the program with the states, which operate the program.

Unlike most means-tested benefit programs, which are restricted to particular categories of low-income individuals, SNAP is broadly available to almost all households with low incomes. SNAP eligibility rules and benefit levels are, for the most part, set at the federal level and uniform across the nation, though states have flexibility to tailor aspects of the program, such as the value of a vehicle a household may own and yet still qualify for benefits. The average SNAP benefit is about $1.41 per person per meal.

After unemployment insurance, SNAP is the most responsive federal program providing additional assistance during economic downturns. It is also an important nutritional support for low-wage working families, low-income seniors, and people with disabilities living on fixed incomes.

The research on SNAP over the years has demonstrated very positive health, education and income outcomes, especially for children. Researchers comparing the long-term outcomes of individuals in different areas of the country, when SNAP gradually expanded nationwide in the 1960s and early 1970s, found that disadvantaged children who had access to food stamps (as they were then called) in early childhood (and whose mothers had access during their pregnancy) had better health and educational outcomes as adults than children who did not have access to food stamps.

Another recent study found that participating in SNAP reduced households' food insecurity by about five to ten percentage points and reduced "very low food security," which occurs when one or more household members have to skip meals or otherwise eat less because they lack money, by about five to six percentage points. Food insecurity among children fell by a third after their families received SNAP benefits for six months. Because SNAP allows low-income households to spend more on food than their limited budgets would otherwise allow, it helps ensure that they have enough to eat.

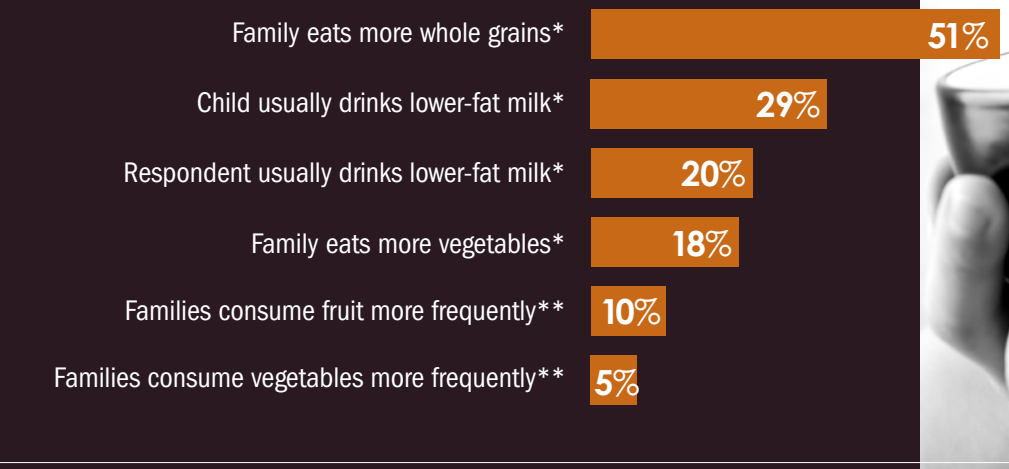
The number of SNAP households that have earnings while participating in SNAP has more than tripled — from about 2 million in 2000 to about 7 million in 2014. The share of all SNAP households that have earnings while participating in SNAP has also increased — from about 27 percent in 2000 to about 31 percent in 2014.

SNAP is one of the very few anti-poverty programs to which adults who are not disabled, not working and do not have dependents have access. This is a very vulnerable population who struggle to meet the most basic needs. The nation's safety net offers meager assistance while they are working, and virtually none when they are out of work.

While the SNAP program is the most important of the federal nutrition programs, there are other nutrition programs that target specific constituencies and augment their nutritional needs. For example, the Supplemental Feeding Program for Women, Infants and Children (WIC) provides nutritious foods, nutrition education, breastfeeding support, and referrals to healthcare and social services for millions of low-income families. It plays a crucial role in improving lifetime health for women, their infants, and young children. Part of the nation's nutrition safety net for more than 40 years, WIC now serves more than 8 million pregnant and post-partum women, infants, and children through their fifth birthday. For a family to participate, it must have gross income of no more than 185 percent of the federal poverty level and be at nutritional risk. Catholic Charities agencies in various part of the country are important partners to WIC because they run and manage the WIC stores in their communities *(see graph on page 23).*

Once in school, children have access to meals throughout the day through the School Meals Program. The federal School Meals Program operates in public and private school settings, including Catholic schools. The meals are available to all children and are offered for free and at reduced prices for children living in low-income households. Children have access to meals so they can learn better in school and acquire the knowledge of what constitutes healthy and nutritious foods. The meals and snacks must meet federal nutritional standards. The School Meals program provides healthy and tasty breakfasts, lunches and snacks for more than 30 million children a day.

Revised WIC Food Package Increased Consumption of Healthy Foods Among California WIC Participants



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*Percentage change in the number of survey respondents or their families who consumed healthy food.

**Percentage change in the number of days in the past week on which survey respondents consumed fruits or vegetables. Source: Whaley, Ritchie, Spector, and Gomez, "Revised WIC food package improves diets of WIC families," Journal of Nutrition Education and Behavior, May-June 2012.

During the summer months, the Summer Meals Program is offered to children throughout the country. Many Summer Meals sites exist within various summer enrichment programs and activities. Catholic Charities agencies and other community-based programs can serve as Summer Meal sites. This program provides essential nutrition to children when they are out of school and their families are unable to afford extra meals.

Older adults not only suffer from food insecurity because of economic reasons, but also because of limited capacity to shop for and prepare food, and from social isolation. Programs such as congregate meals at adult day care centers and Meals-on-Wheels help to ensure not only that older adults are getting good nutrition, but also that they have social contact. Both eating well and socializing lead to better health outcomes and a higher quality of life. Again, these are programs where the federal government and the Catholic community have successful partnerships.

It is important for policymakers to be aware that hunger and food insecurity is a problem in our communities. We need to remind them that federal nutrition programs AND charitable organizations play an important role in alleviating it. These programs work, and our nation should build on their success. Needing to eat and share meals is a fundamental part of every day for everyone. Charitable efforts are helpful and needed, but investments in federal nutrition programs are crucial to feeding tens of millions of people in our nation everyday. Before passing any budget cuts or reforming any nutrition program, we should ask "Does this pass the 'Matthew 25' test?" As a nation, we want to be able to say "For when we saw you hungry, we gave you food." ■

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$2 MILLION WALMART GRANT FOR REDUCING HUNGER

CCUSA has received a $2 million grant from the Walmart Foundation to reduce hunger among people who are struggling with poverty. The grant money will be distributed by CCUSA to Catholic Charities agencies across the United States in support of their poverty reduction efforts in their local communities. Specifically, the grant money will be used to help eligible persons enroll into the Supplemental Nutrition Assistance Program (SNAP), formerly known as the food stamps program; to provide case management for individuals and families on SNAP; to help improve rural food distribution; and to launch several new providers of summer meal programs. The period of the grant extends from November 1, 2016 to October 30, 2017.

Sister Donna Markham OP, PhD, president and CEO of CCUSA, greeted news of the grant award with gratitude to the Walmart Foundation and solicitude for those who will receive the benefits: "Thanks to Walmart a significant number of people will be aided in maintaining a healthy diet, which is such a dire need in our country. More than 50 percent of the people served at Catholic Charities agencies come to us because they are hungry."

It is the mission of the Walmart Foundation to create opportunities so people can live better. It is the responsibility of the Walmart Foundation to make a positive impact in the communities they serve. Whether it is through grants (provided to the thousands of organizations that share the Foundation's mission) or through inspiring volunteer efforts of Walmart associates, the Walmart Foundation is passionate about helping people live better, one community at a time. For more information about the Walmart Foundation please visit their website at www.foundation.walmart.com.

Bishop Emeritus William S. Skylstad, one of CCUSA's 2016 Volunteer of the Year winners.

2017 National Volunteer of the Year Award Nominations

CCUSA is seeking nominations for the 2017 National Volunteer of the Year Award. Through this award, CCUSA thanks the volunteers who have answered God's call to ease the suffering of those in need. Their dedication and commitment in serving their brothers and sisters forges a powerful bond with Catholic Charities in the effort to alleviate, reduce and prevent poverty in America. The finalists of the 2017 National Volunteer of the Year Award will be profiled in the summer issue of *Charities USA*. The winner will be recognized at the 2017 CCUSA Annual Gathering in Houston, Texas, to be held September 28-30 (expenses paid). For more information about the award, send an email to vmn@CatholicCharitiesUSA.org. Nominations are due no later than Wednesday, March 1, 2017.

Strategic Priorities for the Catholic Charities Ministry in the U.S.

At the 2016 CCUSA Annual Gathering, Sister Donna Markham OP, PhD, president and CEO of CCUSA announced – after consultation with diocesan directors and a steering committee composed of diocesan directors, board members and CCUSA staff – seven national Strategic Priorities for the Catholic Charities ministry for the next five years. They include the following: Affordable Housing; Immigration and Refugee Services; Integrated Health and Nutrition; Leadership Development and Catholic Identity; Social Enterprise Initiatives; Advocacy and Social Policy Initiatives; and Disaster Services. Communities of Practice comprised of staff members from CCUSA and local agencies, and aligned with a strategic priority, are being formed to find innovative practices and/or ways to elevate the ministries that Catholic Charities provide. Two new hires at the national office will be leading the initiatives in their areas of expertise: Ramona Ivy, Chief Health Integration Officer (rivy@CatholicCharitiesUSA.org) and Curtis Johnson, Senior Director of Housing Strategy (cjohnson@CatholicCharitiesUSA.org). ■

Farmer-to-Farmer

Joseph F. Duffy, retired CEO of Catholic Charities Diocese of Paterson (New Jersey), with 45 years experience in senior management and as many years experience as a board member for profit, nonprofit, elected and appointed boards, travelled to Tanzania for three weeks to share his technical skills and expertise with local farmers. Strengthening the Governance, Management, & Organizational Capacity of the Karagwe District Cooperative Union (a coffee cooperative), Duffy's assignment is part of Catholic Relief Services' Farmer-to-Farmer program that promotes economic growth, enhanced nutrition through access to healthy food, and agricultural development in East Africa.

Duffy was invited to provide an assessment and training for both the board members (who are also cooperative members) and administrative staff of the Karagwe District Cooperative Union (KDCU) which consists of more than 22,000 members. The entire board is new with no prior board experience, and the CEO (General Manager) and other senior staff have been on the job less than six months.

Farmer-to-Farmer matches the technical expertise of U.S. farmers and professionals in agri-businesses, farming cooperatives, and universities with farmers in developing countries to assist them in improving agricultural productivity, accessing new markets, and increasing their incomes. Farmer-to-Farmer is funded by the U.S Agency for International Development (USAID).

In a world where 80 percent of food is produced by farmers working on small farms or fisheries,

Retired Diocesan Director Shares Work Experience with Tanzanian Farmers

the movement to share proven farming and business skills can improve the quality and quantity of the world's food supply. For communities in the developing world who often struggle to produce enough food, this can improve access to a reliable source of food and better nutrition. For the farmers, it can strengthen their path to prosperity.

The goal of Duffy's assignment was to provide training to board and management on their roles and offer training to management staff aimed at increasing management's capacity to manage programs and staff efficiently and effectively. He worked with the entire board and 18 senior, mid-level, and support staff on such topics as developing a revised mission statement, table of organization, job descriptions for board and staff, performance review and communication. While staff and board members spoke English, a translator was used in order to better ensure comprehension. "Staff and board members were highly motivated to learn, making my job much easier," said Duffy. Most of Duffy's time was spent in the Karagwe District in the northwest part of Tanzania near Lake Victoria where the KDCU offices are located. Board members and staff expressed thanks for the training, indicating they felt better-prepared to support and advance the mission of the KDCU, which is to enhance the economic and social welfare of its members.

This was Duffy's first volunteer assignment with Farmer-to-Farmer and is one of nearly 500 assignments that focus on improving approaches to local agriculture practices, expanding production of quality food crops and nutrition in Ethiopia, Tanzania, Kenya and Uganda. The program has been running for nearly 30 years.

Catholic Charities Wilmington and St. Francis Healthcare

Catholic Charities Diocese of Wilmington (Delaware) and St. Francis Healthcare, part of Trinity Health, the second largest faith-based healthcare ministry in the United States, have joined forces to create a collaborative partnership that will holistically treat the needs of currently underserved clients, improving their health and welfare as well as the health and welfare of the communities in which they live.

The program will expand services currently provided by the St. Clare Van, a mobile medical office that has offered acute care to the homeless and uninsured since 1992. An older van used by the program will be retrofitted for Catholic Charities to include additional services like financial assistance to maintain or regain permanent housing, financial coaching activities, food, clothing, household goods assistance, immigration services, and mental health counseling.

Richelle A. Vible, executive director of Catholic Charities, said, "Catholic Charities is eagerly anticipating this collaborative relationship with St. Francis Healthcare. Working together will benefit our neighbors in many ways. According to the National Home Care for the Homeless Council, housing can be considered a form of healthcare because it prevents new conditions from developing and existing conditions from worsening. By providing both healthcare and housing support, we can uplift our neighbors, strengthen them, and provide them with support on their journey to self-sufficiency."

The joint venture will provide not only healthcare to those without health insurance or who are underinsured, but also make available additional services like mental health counseling, basic needs help, and immigration support.

The project also would increase both agencies' outreach potential. Catholic Charities will use the retrofitted van to visit established stops one day a week, rotating locations throughout the month so that the agency can expand its outreach to a wider geographic area. Catholic Charities stops will complement the St. Clare's Van schedule to provide additional services to these communities on alternate days. Additional services should attract new clients to both agencies.

The collaboration has three goals: improve the health of those who are uninsured, underinsured, or extremely low-income and who lack medical care; improve the self-sufficiency of homeless, at risk of homelessness, or extremely low-income clients; and improve the health and welfare of low-income communities. The program will target the uninsured, minorities (especially Hispanics and African Americans), the homeless, and transitional housing residents.

25th Anniversary Concert for Commonwealth Catholic Charities was a (jingle bell) Ringing Success

"Music is God's gift to man, the only art of Heaven given to earth, the only art of earth we take to Heaven."- Walter Savage Landor.

For 25 years, the art of beautiful Christmas music has celebrated the beginning of the Christmas season in Richmond, Virginia through the Holiday Festival of Music at the Cathedral of the Sacred Heart. In 1991, Commonwealth Catholic Charities (CCC), in partnership with the Cathedral's music ministry and the Richmond Symphony, began what would become a seasonal favorite the first Monday after Thanksgiving to benefit CCC.

The silver anniversary concert on November 28, 2016 proved to be a joyous Advent evening of music to a sold-out crowd of approximately 900. The Cathedral was filled with the sounds of Christmas Classics & Carols performed by the Richmond Symphony along with the Virginia Commonwealth University Choral Arts Society and members of the Cathedral choir.

Erin Freeman, D.M.A., director of the Richmond Symphony Chorus and director of Choral Activities at VCU, led the evening's festivities with her engaging and energetic musical style. The Cathedral's director of music and liturgy, Daniel Sanez, led the audience in the traditional carol sing-a-long in the playing of the parish's 180-pipe organ. The Knights of Columbus, 4th Degree, welcomed and ushered guests. In a lighter moment of the evening, the Knights distributed jingle bells to all attendees to accompany the Symphony with seasonal favorites.

The concert exceeded its financial goal. The funds raised will help provide services to any number of CCC's programs. "We are privileged to witness lives being changed – a child being adopted; a teen welcomed by a loving foster family; temporary shelter for those with no place to call home on a cold night; a permanent home for a homeless veteran; a family brought together through counseling; protection for a vulnerable senior; and, help to a refugee given a new life in America. All of this is possible because of you and we are especially grateful for your tremendous support," said Joanne Nattrass, CCC executive director, as she welcomed guests for the concert.

Sacramento Food Bank & Family Services Partner Agency Conference

On July 14, 2016 hundreds of individuals representing local partner agencies attended Sacramento Food Bank & Family Services' (SFBFS) inaugural Partner Agency Conference hosted at Arcade Church. The idea originated in early 2016 and grew into a professional conference designed to help partner agencies better serve those in need throughout Sacramento. The end result was nothing shy of spectacular. But let's travel back further than a few months to learn why such an incredible conference needed a home.

Founded in 1976 by Father Dan Madigan, SFBFS now offers 15 programs and services at no cost to families in need throughout Sacramento. SFBFS is a privately funded non-profit organization and a Catholic Charity associated with the Diocese of Sacramento. A staff of 82 and more than 8,000 volunteers are dedicated to assisting those in need by alleviating their immediate pain and problems, and by moving them toward self-sufficiency and financial independence. In December of 2014, SFBFS merged with Senior Gleaners, Inc. to become the main food bank of Sacramento County. Overnight, SFBFS went from serving 45,000 men, women and children per month to providing food for more than 130,000 each month.

Distributing millions of pounds of food to those who need it requires a diverse network of church pantries, school programs and small food programs that meet people in their own neighborhoods. SFBFS quickly built relationships with more than 220 partner agencies to help reduce the rate of food insecurity in Sacramento County.

The partner agencies often asked SFBFS about ways to improve efficiency and to connect better with clients. In response a committee of staff and volunteers formulated the concept of a conference and crafted topics to help improve food bank resources throughout Sacramento.

240 individuals representing churches, food closets and feeding programs from across the region attended the inaugural conference at no cost. After a welcome from SFBFS' President/CEO, Blake Young, attendees participated throughout the day in various sessions including Cultivating a Successful Volunteer Program, Food Safety Review, Simple Funding Strategies for Success, CalFresh, Building a Healthy Food Pantry, and Marketing Basics for Your Food Pantry. Speakers included local experts and SFBFS staff.

After a full 8-hour day of learning, our partner agencies headed home with a wealth of knowledge and a rejuvenated purpose for serving Sacramento County's 244,000 food insecure. Volunteers from various agencies expressed appreciation for offering such an innovative conference full of resources and at no cost.

Catholic Charities chosen to partner with HHS and New Jersey on healthcare initiative

Catholic Charities Diocese of Trenton was among seven providers within New Jersey to be selected to partner with the State of New Jersey on a U.S. Department of Health and Human Services two-year demonstration program aimed at improving access to high quality care for all Americans struggling with mental illness and substance abuse disorders. New Jersey is one of just eight states chosen to participate in the federal program. States were selected for participation through a review of their applications by subject matter experts from the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Medicare and Medicaid Services (CMS) and the Office of Assistant Secretary of Planning and Evaluation. The Certified Community Behavioral Health Clinic (CCBHC) demonstration program will operate for two-years and will be evaluated based on data from 21 quality measures including access, outcomes and financial performance.

"The awarding of this groundbreaking federal initiative to the State of New Jersey in partnership with Catholic Charities Diocese of Trenton and six other provider agencies recognizes our ability to create valuable integrated services to improve the health and well-being of individuals who have traditionally been underserved," said Susan Loughery, director of operations, Catholic Charities Diocese of Trenton. "The CCBHC initiative will get started in late January 2017, and through the provision of fully integrated primary health, behavioral health and substance abuse services, will enable Catholic Charities and our hospital and community partners to immediately improve the overall health of both adults and children with serious mental illness and substance abuse disorders." ■

COMMUNITY APPROACHES TO FOOD SECURITY FOR SENIORS

By Tatiana Colon, Division Director Older Adult Services, Catholic Charities of Santa Clara County

According to the Administration on Aging the number of seniors in our population is on the rise, and will continue to rise as the Baby Boom generation gets older. Just three years ago this population represented almost 15 percent of the population (about 1 in 7 Americans), an amount that represented a 28 percent increase from 2004. By 2040 that number will rise to almost 22 percent of the population, or 1 in 5 Americans. In the Bay Area of California we are experiencing senior growth at slightly higher rates. These rates, coupled with high senior poverty rates, have prompted the development of new tactics of addressing senior services. One new effort to address growing senior needs is the San Jose Senior Bites Network, a new pilot project in its first few months of operations funded by the Health Trust (a Silicon Valley-based organization dedicated to increasing the health of all in their community). The Senior Bites Network is also aimed at increasing the number of places that seniors can go for a healthy and affordable meal.

Since November 2016 the San Jose Senior Bites Network has been targeting local, "mom-and-pop" restaurants in selected neighborhoods that have been identified as being home to clusters of low-income seniors. The goal of the project is to increase the accessibility of healthier and affordable food options for seniors in locations close to their homes by targeting neighborhood restaurants that would otherwise not cater to the senior community. Through the Senior Bites Network, Catholic Charities of Santa Clara County is establishing a community of local restaurants offering senior menus (meals with smaller portions and corresponding smaller price points) that will meet the nutritional and budget needs of low-income seniors. Restaurants participating in the Senior Bites Network will also serve as a means for educating seniors about resources and support services in their area via pocket-sized guides available at each Network restaurant.

While the project is still in its infancy, we have already been able to secure five restaurant partners to be part of the Senior Bites Network. Our first restaurant partner, Chaat Café, a small family-owned Indian restaurant in South San Jose, was a very encouraging first step in our efforts to grow the network. Mahesh Pajwani, the business owner, was very happy to support our efforts and sign on to be a partner of Catholic Charities of Santa Clara County in serving seniors in the community. He enthusiastically sat with us to devise possible menu options that would be both nutritious and affordable for seniors, offering to purchase ready-cut apples for seniors as a healthy alternative to other options on the menu. Having been in the location for more than 10 years, Mr. Pajwani was interested in giving back to the community and offered to work with the neighboring restaurants to encourage them to sign on as well: "Tell them I said yes to helping seniors and hopefully they will too."

In addition to Chaat Café we have also secured the participation of an additional Indian restaurant (Spice N Flavor), two Vietnamese restaurants (My Pho Noodles, Chili & Lime), and a bagel shop (Main St. Bagel) to join our efforts.

The concept and practice of senior menus as a marketing tool has been with us for decades, primarily in larger national and regional chain restaurants, with Denny's 55+ Menu being perhaps the most well-known and heavily promoted. Such menus feature smaller portions and lower price points for limited menus served at times that are a) often less busy for the restaurant and b) often preferred by seniors, such as a 4:30pm dinner time. This benefits both the business and the customer; patrons can access a more affordable and appropriately portioned meal, in contrast to the overly large portions served by a majority of restaurants, and restaurants draw business they may not otherwise have at off-peak times, maximizing their staffing and other resources.

The San Jose Senior Bites Network also benefits senior programs such as Adult Day Centers that do not cook onsite and whose only option to date is to buy catered frozen meals from a handful of vendors. These programs will now have the option of ordering various types of food from nearby participating Senior Bites Network restaurants and having the food delivered directly to their site from restaurants that offer delivery service.

The Senior Bites Network is only the beginning of the effort to devise strategies that increase accessibility of food to all seniors. Our goal today is to create new food options for seniors. In this effort we hope to lower the prices of available food options, but seniors will be responsible for the cost of the meal. Nevertheless, we have been using our meetings with the restaurant community to survey their interest for further participation in potential voucher programs where perhaps federal and county funds could pay the establishments directly in situations where seniors could not afford to pay. This is part of establishing the feasibility of increasing food options for seniors who are not able to pay in areas that have few or no senior nutrition programs.

Finding ways to better serve seniors is a good investment. Not only for our restaurant partners as a sales strategy, but as an investment in our future. We all age, and an investment in community infrastructure to address senior needs even on this level is an investment in ourselves. As we talk to new potential restaurant partners we try to remind them of this fact.

Our work is only just beginning. In two short months we have started to build a strong network of enthusiastic community restaurant leaders ready to support seniors. We expect to grow the Senior Bites Network to include many more restaurateurs that seek to make an impact in their community and in the lives of seniors. ■

2017 UPCOMING TRAINING & EVENTS

March 27-29

Diocesan Directors Spring Gathering
Alexandria, Va.

Kristan Schlichte
kschlichte@CatholicCharitiesUSA.org

May 22-26

Leadership Institute
Tampa, Fla.

Scott Hurd
shurd@CatholicCharitiesUSA.org

May 24

CCUSA Community of Practice
Atlanta, Ga.

Jean Beil
jbeil@CatholicCharitiesUSA.org

June 26-29

The O'Grady Institute for Catholic Identity
St. Paul, Minn.

Fr. Mark Pranaitis
mpranaitis@CatholicCharitiesUSA.org

September 28-30

Annual Gathering
Houston, Texas

Amy Stinger
astinger@CatholicCharitiesUSA.org

For more information on upcoming events, please visit our website! www.CatholicCharitiesUSA.org

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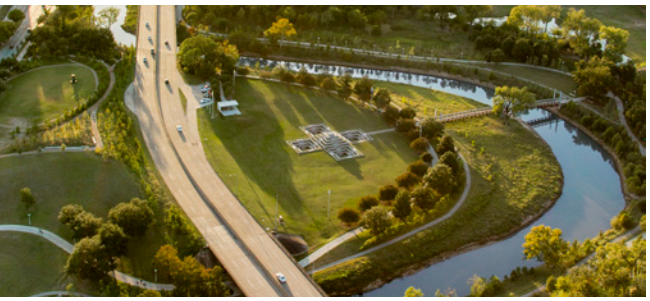

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Please visit our website: www.ccusaannualgathering.org

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