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How Community Partnerships Can Help End Food Insecurity (Part 1)

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Widely prevalent but rarely discussed clinically, food insecurity (FI) in the United States is a preventable condition in need of attention and creative, multidisciplinary solutions. Defined as a household-level economic and social condition of limited or uncertain access to adequate food, FI affects nearly 20 percent of all households with children nationally and 14 percent (17.4 million) of all US households.

FI can exacerbate chronic health conditions such as diabetes, may precipitate non-compliance with medical therapy, and puts children at risk for developmental, behavioral, and psychosocial problems as well as increased risk of hospitalization. In

2014 health-related costs attributable to FI were estimated at $160 billion US dollars, nearly equal to direct medical costs associated with diabetes care annually.

Despite this, doctors do not commonly screen for FI and have reported that they do not feel confident in their ability to address the social needs of their patients, such as access to healthy food. Fortunately, that may be changing as recent national and state policies have begun to incentivize the health care system to address patient hunger, collaborate across sectors, and find sustainable solutions.

Clinical-Community Partnerships

By knitting the medical and hunger-relief community together, these policies have the potential to help end hunger and improve health by smartly leveraging existing resources. Food banks, for example, already bring to bear impressive logistic and distribution capacity to get food to areas of need. The *Feeding America* network includes over 200 food banks throughout the nation.

Among them is the Greater Boston Food Bank (GBFB), New England's largest hunger-relief organization which, in 2001, partnered with Boston Medical Center (BMC) to create the first hospital-based food pantry in the nation. Named the *Preventive Food Pantry*, this collaboration is a "brick and mortar" food pantry housed inside the walls of BMC. Providers at BMC screen their patients for FI; their findings are incorporated into the patient's EMR and those who screen positive are given a 'prescription' which they can take to the food pantry in order to receive food.

In this post, part one of a two-part series, we examine the changing policy landscape that is making partnerships like this possible. In part two we will look closer at one particular partnership that might be scaled up in communities across the nation.

A Window Of Opportunity

Rising attention is being given to FI and other social problems by government agencies and academic societies. In 2015, the American Academy of Pediatrics recommended that pediatricians routinely screen patients and families for FI. In 2016, the Centers for Medicare and Medicaid Services (CMS) announced 157 million US dollars in dedicated funding to address social needs, including FI. Meanwhile, payments for health services have been increasingly tied to achieving the triple aim: improvement of population

health, quality patient care, and lower costs. Yet a patient's FI, which is linked to a nearly 50 percent increased likelihood of becoming a high-cost utilizer, can make it harder to provide high-value, low-cost care.

Catalyzed by this policy climate, more partnerships between food banks and medical centers have emerged in states such as Oregon, Colorado, Texas, Ohio, Minnesota, and Massachusetts. Some programs bring health to the food pantries — for example, by providing blood sugar checks when people come to pick up food. Others bring food and hunger screening programs to clinical sites.

Correlating such programs with improved health outcomes is a still burgeoning area of research — but initial results are promising. *Feeding America* conducted a pre-post analysis of nearly 700 diabetic patients who were enrolled in a pilot food bank program in three states. The six-month intervention included food boxes nutritionally — tailored for diabetics, self-management education, blood sugar monitoring, and referrals to primary care physicians. Statistically significant outcomes included improved blood sugar (particularly among those with uncontrolled HbA1c at baseline), fruit and vegetable intake, self-efficacy, medication adherence, and lower rates of diabetic distress. Further research in the form of a randomized controlled trial (FAITH-DM) is currently underway. In addition to food interventions, CMS is also piloting two economic incentive programs for Medicaid patients in Texas and Minnesota to reduce the cost barrier of purchasing healthy food.

The requirements of the Affordable Care Act have created financial incentives for non-profit health centers to address this problem. To retain their tax-exemptions, they must conduct a community health needs assessment (CHNA) every three years and put forward a community health improvement plan (CHIP). This process may help encourage health centers that identify FI, food access, diet-related disease or all three, as problems in their community, which they might address in collaboration with local resource partners.

In addition to national policy changes, state policy and interests may also help fuel innovative partnerships. For example, the state of Massachusetts recently completed its Food System Plan. One of its key goals is that "the roles of health care providers, institutions, and insurers in fostering access to healthy food will be expanded." The plan also suggests several action items including screening and referral to food assistance programs, food prescriptions, and partnerships that allow for direct food distribution at

clinical sites. The Massachusetts Health Policy Commission is also keeping a watchful eye over health care costs in the state and has encouraged the medical system to address social determinants of health as cost drivers.

In the second post of this two-part series, we will describe how the Greater Boston Food Bank and its partners have made the most of this changing landscape in order to develop a new, scalable model to reduce food insecurity in their communities.