Health Affairs Blog

How Community Partnerships Can Help End Food Insecurity (Part 2)

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In our previous post, we describe how the policy climate has begun to change in a way that may allow stronger partnerships between medical and hunger-relief organizations. Here, in part two, we take a close look at how the Greater Boston Food Bank (GBFB) has developed a scalable model that community health centers might use to address food insecurity (FI) in their communities.

This model was designed with the Community Health Needs Assessment (CHNA) process in mind, as it affords partnering health centers a clear way to address relevant health priorities within their communities—such as FI, food access, diet-related disease or all three—as identified by the needs assessment. This is critical, as health centers must not only conduct a CHNA at regular intervals but demonstrate ways in which they are putting in place plans and programs to address identified problems.

A Three-Pronged Approach

The process starts with initial contact between GBFB and a community health center. Either organization may be the one to reach out. GBFB may use its own food insecurity and meal distributionmaps or publically available CHNAs to identify regions with particular needs before turning to a community health center in that region. Or health centers may themselves reach out to the GBFB after identifying a food issue through their CHNA. Then, community health centers are offered a three-pronged approach to address FI: mobile market, screening, and a tool kit. Health centers have the choice of implementing just one, two, or all aspects of the program according to their unique needs and internal capacity.

Mobile Market

This monthly farmers' market-style distribution of free fresh fruits and vegetables, is built on the understanding that many community health centers may be reluctant to establish "brick and mortar" food pantries within their walls as the necessary space could be used for more lucrative purposes. To surmount that obstacle, mobile markets take advantage of external spaces such as parking lots. The GBFB also decided to opt for produce-only food distribution rather than a disease-specific food box to simplify logistics.

In establishing a mobile market, the GBFB and community health center work in concert. Upstream logistics such as food acquisition, order volume, and delivery are handled by the GBFB. Once the food arrives on site, health center staff and volunteers orchestrate distribution to clients. The GBFB provides food safety and hands-on logistic training to health center staff so that they are empowered to run the market on-site. Each household is given approximately 25 pounds of produce. Upcoming mobile markets are advertised in multiple formats including flyers, posters, online, and social media and in both English and Spanish where possible.

Screening

The GBFB encourages health centers to screen patients for FI using a simple, two-question tool called the Hunger Vital Sign™ (validated by Children's HealthWatch). Screening can be performed by various personnel, and can thereby be adapted to meet the needs of the health center and their clinic workflow.

Since all health centers have unique infrastructure and internal capacity, some choose to take on systematic screening of all patients in one or more clinics. By systematically screening patients and capturing both positive and negative results, the overall level of food insecurity among the health center's patient population can be ascertained.

On the other hand, a community health center might wish to focus on a sub-population of patients by enhancing the center's community or social service department. Patients who self-identify as needing social services are funneled to this department and, should they need food, are offered enrollment in the mobile market program. In this scenario, the Hunger Vital Sign is incorporated into the program's registration process. Tailoring the program to each site is done early at logistics meetings and in conversation with the health center.

Tool Kit

Ideally, if a patient screens positive for FI, providers, support services or both can help connect patients not only to the mobile market, but to local food pantries, food assistance programs (such as SNAP), and nutrition/cooking education resources. The GBFB works with each health center to determine their needs in this area. Some health centers have long-standing ties to local community resources and are well-equipped to connect patients. Other health centers express interest in increasing their knowledge of and building relationships with local organizations and work with GBFB to create a resource handout to connect patients with needed services.

Case Study

Our partnership with Charles River Community Health (CRCH) in Brighton, Massachusetts, provides a useful roadmap for how this model can be used. CRCH is the area's safety-net provider, serving a predominantly non-English speaking, culturally diverse population — the majority of which (84 percent) are under the 200 percent FPL. Forty-four percent receive Medicaid and another 44 percent do not have any insurance at all. In their most recent 2015 CHNA, CRCH noted inaccessibility to healthy foods as one of their community's five most urgent needs. Key informant interviews revealed that the majority of patients felt healthy produce was too expensive to purchase.

Towards the end of 2015, CRCH was in the midst of a large expansion into a new facility that would dramatically increase its ability to care for its surrounding, low-income community. Given the prominence of FI within its patient population and the financial necessity of addressing priorities as highlighted in its CHNA, the executive director and board members of CRCH approached GBFB to discuss the feasibility of starting a mobile food market. After initial site visits were conducted, a formal memorandum of understanding outlining logistical details on the market itself was agreed upon and signed by both organizations. Broad information dissemination about the market was subsequently performed. Providers, social services, and other relevant staff at CRCH

were made aware of the program and its emphasis on connecting those in need with healthy food resources.

Since its launch in April 2016 the mobile market has distributed more than 15,000 pounds of fresh produce. In July 2016 the mobile market served 118 unique households, reaching 416 people (236 adults, 121 children, and 59 seniors). Of those who registered for the mobile market program and answered the Hunger Vital Sign screen, 99 percent were FI. This figure affirms that the mobile market is achieving the goal of serving those who are FI.

Notably, only 26.8 percent of those who screened positive for FI reported that any member in their household received government food assistance in the form of SNAP benefits. To be clear, SNAP funds are entirely separate from the market; the GBFB mobile market is free for the health center and its patients. The reason that we, nevertheless, inquire about SNAP status upon registration is to assess household needs. Health center staff and/or local organizations can help food insecure households apply for SNAP, where eligible. Possible reasons for low SNAP enrollment could include lack of awareness of the program, ineligibility (due to immigration status, for example), or that the program is not broad enough to cover all individuals who might screen positive for food insecurity. Further study can help ascertain possible barriers.

Lessons Learned

Through the process of program development and implementation, we have learned that every health center is unique with distinctly different capacities, strengths, weaknesses, needs, and preferences. CRCH boasts a well-staffed community health division that not only assisted with patient registration but helped connect families coming to the market with federal food assistance programs like SNAP and provided opportunities for health insurance enrollment to those in need.

Not all health centers have a similarly robust system in place. Health centers are also much smaller entities than their large hospital cousins. As a result, many do not have a department of volunteer services or a pre-established volunteer base to draw from. Since the GBFB mobile markets rely upon 6-8 volunteers per site, this is a barrier. CRCH slowly built its volunteer base over time to include medical school students, patients and community members, local corporations, and local non-profits such as a Community Development Corporation. This groundwork may help form long-lasting ties, bringing the clinical community together and eliciting a feeling of “community ownership”

of the market. Strategically reaching out to large organizations with a regional network may help channel volunteers to health centers in need of assistance.

Efforts to understand how these interventions ultimately affect health are also evolving. Challenges inherent in measuring health outcomes from a broad food distribution program include the length of time needed to demonstrate improvement of health outcomes, such as decreased rates of hospitalizations and improved control of chronic health conditions. In addition, there are limitations in the ability to measure what happens to the food once it reaches the household: Is the food consumed? And by whom? Studies looking at the longitudinal health profiles of patients that have utilized food distribution programs will only serve to bolster the rationale for and longevity of these important initiatives. Additional randomized controlled trials for specific patient populations (like FAITH-DM) will inform whether food distribution directly affects health outcomes.

In addition to supporting research, policy makers should help to create a climate of routine screening. In Massachusetts, several groups have recommended to the Health Policy Commission that Accountable Care Organizations should be required to demonstrate an ability to address FI and housing status as part of their formal certification process. Routine systematic screening is important to better characterize and understand the problem of FI, identifying geographic “hot spots” among clinical sites and subsequent direction of resources.