Recent years have seen growing interest in and energy directed toward connecting health care providers with food access initiatives to improve individual health and food security. This comes as both sectors have increased awareness of the social determinants of health and the significant impact their pairing can have on the communities they serve. Nevertheless, the health sector and the food and nutrition sector operate differently and require changes for effective collaboration. The Walmart Foundation’s Healthier Food Access program provides lessons for building health system partnerships to combat food insecurity. This brief presents insights from some of these grantees in an overview of utility, considerations, and strategies for pairing health care with food access and nutrition.

Summary

- Health systems and food system providers can partner in many ways to increase access to healthy foods and improve community health, from referrals across systems for federal benefits like the Supplemental Nutrition Assistance Program (formerly the Food Stamp program), Special Supplemental Nutrition Program for Women, Infants, and Children, and Medicaid to interventions like nutrition counseling and produce prescriptions.

- Initiatives from Walmart Foundation Healthier Food Access Program grantees and partners working in both the food and health systems build insights on developing health systems to combat food insecurity. Interventions such as produce prescriptions, meal kits, community food champions, and farmer’s market produce tokens show promise for scaling these programs. Grantees work in rural, suburban, and urban communities, serving people experiencing food insecurity including families, single or older adults, immigrants, and tribal nations (among other specific populations).
Understanding the specific food and nutrition needs of target populations is critical for planning an effective program, particularly in medically underserved areas. Integrating community voice into program planning and evaluation is necessary for building trust.

Food system partners need to be aware of the intense workload of clinicians and find ways to build capacity for understanding the social determinants of health and integrating screening and recruitment into workloads without overburdening providers. Health system partners in turn can rely on community-based food access providers for connections to residents and specific food access needs.

The work of several grantees indicates that documenting evidence of program success can help make the case to insurance companies and other potential funders to ensure sustainability. When conducting an evaluation, ensuring patient consent and confidentiality is important. There are many options for data sharing and analysis that are compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Food access programs must be sustainable and include multiple levels of the health system in addition to primary care. County and state health departments can play a role in outreach, referral, and funding. Sustainable funding sources may be available for some programs through Medicare and Medicaid.

Social Determinants of Health: Pairing Health Care and Food Insecurity Initiatives

In the past two decades, researchers and communities have provided growing evidence of how social factors, apart from medical care access and quality, affect individual and community health outcomes—an idea that is now more commonly referred to as the social determinants of health (SDOH). The US Centers for Disease Control and Prevention formally defines SDOH as conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes.\(^1\) Consistent access to nutritious food is a major SDOH. In 2020, 10.5 percent of households in the United States experienced food insecurity, defined as lack of consistent access to enough food for every person in a household to live an active, healthy life (Coleman-Jensen et al. 2021). Individuals experiencing food insecurity are also at greater risk of developing chronic diseases such as diabetes and hypertension and are poorly positioned to manage conditions that are diet sensitive (Gundersen and Ziliak 2014; Seligman et al. 2012). Such conditions exacerbate adverse effects on overall health and well-being. Food insecurity has also been found to be associated with higher health care costs (Berkowitz et al. 2018; Boswell-Dean, French, and Mortensen 2020).

Given the association between food insecurity and adverse health outcomes, many health providers and community advocates are calling for a food-as-medicine approach. Health care organizations are already investing more in social and economic initiatives that support communities’ health beyond immediate medical needs.\(^2\) Providers are trained to screen for a range of medical issues and are increasingly screening for housing status and food access (Chhabra et al. 2019). With
screening tools, health care providers are in a unique position to identify patients who need various social supports, including food assistance. These providers also interact with patients in a setting that can lend itself to the informal identification of needed supports.

As recommended by the American Diabetes Association and the American Academy of Pediatrics, many health care settings already screen for food insecurity, often using the Hunger Vital Sign’s two-question screener. However, food insecurity screening and/or discussions of food access between patients and health care providers is still not the norm (Fraze et al. 2019). Medical providers have busy schedules and can find it challenging to integrate additional screening tools or establish environments where patients feel comfortable discussing their food access and habits. And even when screening for food insecurity does occur in a health care setting, it is not the final step. Providers must also connect patients to healthy food, but the follow-up steps to do so require established, well-resourced referral and program options.

This brief presents considerations for pairing health care and food insecurity initiatives, offers approaches to overcome barriers to collaboration, and spotlights real-life efforts of health care systems and food access initiatives working in partnership to reduce food insecurity. We draw on examples from the Walmart Foundation’s Healthier Food Access program grants that support diverse organizations around the United States, including health care institutions, in developing innovative programs to address food insecurity.

- **Cabarrus Health Alliance** of Cabarrus County, North Carolina: Cabarrus Health Alliance initiated a partnership between public health, child care, food researchers, and a local food caterer with the goal of mitigating the impact of concentrated poverty, racial disparities, food insecurity, and the decision fatigue faced by working families, especially single mothers, when choosing and preparing healthy meals. The alliance has partnered with three local child care providers to offer easy-to-cook, healthy, and low-cost meals to families.

- **The Hmong American Farmers Association** of the Twin Cities metropolitan area, Minnesota: As part of its mission, the association looks for ways to connect Hmong farmers with the broader community and improve food access to low-income and food-insecure immigrant families, refugee families, and other families of color in the community. It has partnered with child care providers to build capacity to access federal nutrition programs and has connected child care providers with local growers to bolster access to healthy, culturally appropriate foods. The program partners with a clinic to track health outcomes for participants.

- **Oklahoma Foundation for Medical Quality and the Oklahoma Nutrition Information and Education Project** of Oklahoma City: These organizations jointly operate OKFresh, a partnership between health care providers and farmers markets in Lawton, Oklahoma City, and Muskogee to provide fresh fruits and vegetables to Oklahoma households. They have 17 participating clinics that screen patients for food insecurity through regular clinic workflow. Eligible patients pay $20 and receive a $20 monthly match through the program. Participants...
then receive tokens to spend at a market location or produce pickup event in each of the communities to receive fresh, local fruits and vegetables monthly for two years.

- **St. Mary's Nutrition Center**, of Lewiston-Auburn, Maine: The nutrition center, an initiative of St. Mary's Health System, integrates several food access strategies, including community gardens, fresh food access initiatives such as farmers markets and a mobile market, matching market incentive programs, a large food pantry, and a discount membership pilot to support local food access. This work is complemented by partners who lead immigrant farming programs, low-income food access clubs, and traditional emergency food programs. St. Mary's seeks to expand collaboration among these organizations, integrate food access planning into broader community housing and transportation planning, and build the decisionmaking power of those affected by food insecurity.

- **The University of Mississippi** of Oxford, Mississippi, operates a project called HUNGeR in Rural Communities: Integrating Health and Food Systems for a Sustainable Food Rx Approach. The university partners with the James C. Kennedy Wellness Center and the Tallahatchie General Hospital on a produce prescription program. The program aims to develop a systemic referral process, track long-term clinical outcomes, and create sustainable funding for produce prescriptions. Clinicians enroll patients in the two-year program, which offers participants a biweekly produce box with cooking supplies and recipes and provides ongoing nutrition counseling as desired. Every six months of the program, participants receive free health checkups to monitor health metrics like blood pressure and diabetes indicators such as A1c and fructosamine levels.

- **West Virginia University's (WVU's) Appetite for a Healthier Future program**, serving 10 counties in West Virginia, is administered by WVU Extension Service Family and Nutrition Program and the WVU Office of Health Services Research. Through a produce prescription called FARMacy, the initiative provides access to fresh, local produce at health clinics for adults with chronic health conditions and those experiencing food insecurity. Program staff also offer nutrition education and cooking classes and track program success by collecting biometric data from participants at the start and end of the program.

Insights provided in this brief draw from interviews we conducted with staff members of program grantees and their partner organizations in April and May 2021.

**Considerations for Building Health and Food System Partnerships**

As food security programs and health care organizations partner to address client health and well-being, staff should consider their existing knowledge of SDOH and the capacity within the health care system to expand SDOH programming. To develop a target audience for the program, it is important
to understand the characteristics of the population currently served as well as those in need of but not accessing services.

**Expand Health Systems’ Understanding of and Capacity to Address the Social Determinants of Health**

Although SDOH are gaining more attention, awareness of them has not fully filtered through the entire health care system, which can prevent successful patient care. Therefore, gaining buy-in and building appropriate infrastructure are foundational steps for interested health care organizations (NQF and Humana 2020).

**BUILDING PROVIDER KNOWLEDGE ABOUT FOOD INSECURITY**

Health care providers who are looking to pair food programs with their work may need to start with educating colleagues and leadership about SDOH. Some may be unfamiliar with the SDOH concept, and others may want a deeper understanding of the potential return on investment in improved health outcomes and reduced costs. Clinical training programs are being developed to assist with communicating how patients’ social and physical environments impact their health, as well as to provide tools that can be applied throughout health care service provision (Patil, Craven, and Kolasa 2018). Continuing education credits on SDOH are increasingly available, but hosting experts is a great option when such courses are not readily available or do not speak to local conditions. WVU’s Family and Nutrition Program has a “walk with a doc” program where staff talk to medical students about food insecurity. The WVU program is also developing a continuing education course for providers who serve as partners in its produce prescription program. Finding ways to integrate SDOH learnings into existing professional development and daily work flow is critical to reducing burdens on providers, many of whom are already overstretched as a result of the COVID-19 pandemic.

**EXPANDING SYSTEM CAPACITY TO ADDRESS FOOD INSECURITY**

On-the-ground insights about SDOH and initiatives to advance food security can be paired with data to create a compelling case to executive leadership. The Commonwealth Fund has created a tool to calculate the return on investment of SDOH-focused partnerships as a resource to help assess the potential impact of food insecurity initiatives. Further, health care organizations and their partners must consider budgetary, staffing, spatial, and other operational needs to support desired initiatives. Providers have competing demands and may wrestle with how to launch a new initiative without creating further staff burden.

Partners should explore the required time and costs of screening, outreach, and recruitment strategies. Understanding this scope can help to determine the initiative’s scale—deciding whether to provide internal programs or referrals, have patients answer self-assessments in the waiting room, hire a social worker or community health worker, or identify an existing staff member to spearhead the program. After reviewing internal resources, some health systems may conclude that they lack the infrastructure necessary for effectively engaging in SDOH initiatives. Organizations should research
whether state, federal, or philanthropic funding is available to help build capacity and support desired initiatives. (Funding strategies are explored later in this brief.)

**Consider Unique Needs of Program Target Populations**

Organizations working to combat food insecurity and increase access to healthy foods often serve populations with poor health and who may or may not frequently use health services, depending on accessibility. Working with these populations presents an opportunity for local municipalities, states, and regions to foster food and health system partnerships in order to reach more families and address SDOH. Nevertheless, some communities have limited or unpleasant experiences with health care systems that can hinder the reach of health and food system collaborations. Some populations present special opportunities as well as considerations when providing health and food system services. However, medical practices should tailor initiatives to the health needs of the specific communities they serve.

**CHILDREN**

Nutritious food is particularly important to promote healthy development among young children and adolescents. Children experiencing food insecurity are more likely to suffer from anemia, stomachaches, colds, and chronic health conditions, and to have worse general and oral health (Gundersen and Ziliak 2014). These poor health conditions can contribute to adverse behavioral and mental health problems that undermine children's school performance and overall well-being (Gundersen and Ziliak 2014; Meisenheimer 2016). Concurrently, the COVID-19 pandemic created significant economic challenges for parents with young children. In one nationally representative survey, 40 percent of parents with children younger than age 6 experienced negative economic impacts during the pandemic—major challenges that can persist and create long-term food insecurity (Waxman and Gupta 2021). Among grantees we spoke with, many of their programs target children and their families, especially those that also include child care partnerships like at Cabarrus Health Alliance and the Hmong American Farmer's Association.

Screening children directly for food insecurity can be tricky because it requires access to minors, consent from parents, and privacy to avoid exposing children to potential ridicule or shame at the doctor's office (Bernal, Frongillo, and Jaffe 2016). More typically, providers screen the child's caregiver using questions designed to detect household food insecurity (Barnidge et al. 2017; Palakshappa et al. 2017). Although adults may forgo preventive care checkups, young children's pediatric wellness visits have a more defined schedule. Regular pediatric visits enable pediatricians to meet with children and their caregivers and to monitor changes in food security and the health impacts of food program referrals.

When possible, health systems should include resources for the entire family when making food program referrals. Serving families through children is a great strategy to increase healthy food access for more individuals, since children experiencing food insecurity usually live in food-insecure households (Coleman-Jensen, McFall, and Nord 2013; Feeding America 2020). Moreover, including
the entire family in food supports can also help mediate chronic stress associated with food insecurity (Martin et al. 2016; Wolfson, Garcia, and Leung 2021).

Health care systems that are considering screening children for food insecurity should build trust with both children and parents. Because some parents may be worried that Child Protective Services will be alerted if their family is flagged as experiencing food insecurity, it can be beneficial for pediatricians to remind parents or other caregivers of the specific purpose of screening and of provider confidentiality (Knowles et al. 2018). It is also possible that parents or caregivers cannot or will not accurately report a child’s experience of food insecurity, either because they lack the knowledge needed to answer screening questions or to protect their child from stigma. In addition, children in food-insecure households often take on adult roles as they perceive their parents struggling to provide for them (NRC and Institute of Medicine 2013).

ADULTS WITH CHRONIC HEALTH CONDITIONS

For adults living with or at risk for heart disease, hypertension, and other diet-related chronic health conditions, access to nutritious food is imperative for treatment and prevention. Chronic illness can be associated with and exacerbated by insufficient intake of certain foods, such as fresh vegetables and fruits. Yet some patients may not have the physical access or financial resources to maintain the balanced diet needed for disease management. Unfortunately, lack of access to nutritious food can create a cycle of health complications, as worsening chronic disease symptoms require more acute health care services. The potential increase in health care expenses—particularly those associated with repeated hospital stays—further strains budgets, forcing patients to delay treatment and/or make unhealthy but inexpensive food choices (Phipps et al. 2016).

Providing food resources and referrals through health care settings could significantly benefit patients with chronic illness. A growing pool of practitioners are adopting the food-as-medicine approach. The Oklahoma Foundation for Medical Quality, St. Mary’s Nutrition Center, University of Mississippi, and WVU have all found success using health care settings as a food assistance referral and resource point especially for adults with chronic health conditions. Organizations offer produce prescriptions, in-house pantries, or referrals to partner programs to increase healthy food intake. These options can also be integrated into preventive care, since all patients can benefit from healthy eating.

In-house pantries, much like most local charitable food pantries, can highlight which grocery items are most beneficial for certain diagnoses to provide more targeted assistance to patients with chronic illness. Clinics may also choose to partner with food pantries, farmers’ markets, and other organizations working on food access to facilitate connections with food that is appropriate for chronic disease management (see, for example, Seligman et al. 2018 for a randomized controlled trial that improved food insecurity among low-income individuals living with diabetes.) Staff seeking to build food access programs within health systems should focus on educating themselves about strategies for improving healthy food access as an important self-management support for patients living with chronic health conditions.
COMMUNITIES OF COLOR AND IMMIGRANT COMMUNITIES

People of any background can experience food insecurity. But Black, Latinx, and Native American communities experience food insecurity at disproportionately higher rates than their white counterparts, both before and during the COVID-19 pandemic (Jensen-Coleman et al. 2021; Morales, Morales, and Beltran 2020; Odoms-Young and Bruce 2018). A long history of harmful policies and practices have made communities of color more vulnerable to food insecurity by limiting their financial resources and general access to nutritious food. Racially driven residential segregation has created neighborhoods that lack quality housing, robust employment opportunities, full-service grocery stores, and convenient and affordable health care. Each of these is a social determinant of health that directly impacts the well-being of many communities of color. Many of the grantees we spoke with, including the Hmong American Farmer’s Association, Oklahoma Foundation for Medical Quality, St. Mary’s Nutrition Center, and the University of Mississippi serve Asian, Black, Latinx, and Native American populations, some of whom are immigrants.

Universal screening for food insecurity and referring patients to food access initiatives could begin to address some of the service gaps that exist in some neighborhoods that largely comprise communities of color. In doing so, health systems must develop intentional strategies to increase preventive care visits and build trust. Many communities of color are underserved or not well integrated into health systems (Williams and Rucker 2000). Historical and contemporary medical abuse and racial bias in health care may prevent patients from being open about experiencing food insecurity. Moreover, shifting public charge rules have sowed distrust and chilled access to public benefits like Medicaid among immigrant communities in the United States (Bernstein et al. 2019; Bernstein, McTarnaghan, and Gonzalez 2019).

Communities of color often have strong leaders and community-based service providers. Partnering with local organizations and community leaders can be an effective step toward increasing awareness of services and building better relationships with the individuals served by the health care system. Many local service providers can provide important insights on culturally appropriate foods and traditions and may also offer translation, which can further assist institutions in connecting with various communities of color—especially institutions that offer services only in English. St. Mary’s Nutrition Center engages with many local community organizations led by and serving local immigrant populations, many of whom come from east and central Africa. These partnerships enabled them to serve more culturally appropriate foods during Ramadan as part of the programs. During the COVID-19 pandemic, the Hmong American Farmer’s Association reached out to local Black leaders in the community to develop outreach plans and recruit program participants from those in need.

For immigrant communities, the revised public charge rule in effect from mid-2019 through early 2021 had a chilling effect on people’s willingness to seek food benefits for which they may be eligible, including both programs that were covered by the rule (the Supplemental Nutrition Assistance Program) as well as those that were excluded from the rule (Pandemic-EBT; the Special Supplemental Nutrition Program for Women, Infants, and Children; and school meals) out of concern that participation would hamper their ability to become permanent residents. Organizations may need to
reassure potential participants that receiving food assistance will not have a negative impact on their immigration status, and local leaders with established community relationships may be in the best position to do so. (The power of such partnerships is further explored later in this brief.)

MEDICALLY UNDERSERVED PEOPLE
People who already lack adequate access to quality medical care may simultaneously experience greater risk of food insecurity and adverse health outcomes. There are several ways to define “medically underserved,” and it is important to develop the most salient definition at the outset of creating a program. Medically underserved people can include

- people without insurance,
- people who are geographically further from medical services and/or who lack transportation to get to appointments,
- people who do not trust health care providers,
- people without access to medical care in their native language, and
- people living in areas with a shortage of medical staff available.8

Several definitions may be relevant to developing a regional food and health system partnership, and medically underserved people may cut across gender, race, age, and other demographic boundaries. Both the University of Mississippi and WVU serve rural areas with limited medical care access as a result of transportation and income barriers, as well as staffing shortages. Health care partners at the University of Mississippi have also consciously and slowly worked to build trust among the community they serve. It is critical for staff-building programs to recognize who is medically underserved in the community and how a program centered around clinic access can exclude certain groups who may in fact be most in need of support. The next section describes strategies to build partnerships and design programs that overcome barriers to providing food access to medically underserved populations.

Creating Health and Food System Partnerships

Tackling the SDOH, and even food insecurity alone, cannot be done by one system. Collaboration strengthens such efforts. Partnerships can bring diverse experiences and expertise, overcome capacity issues, and expand program reach. This section summarizes some successful strategies and important considerations to keep in mind when developing partnerships between food and health service providers.

Identify Partners

Among food and health program partners working on programs featured in this brief, health system partners represented different entities within the health system, including
primary care clinics, including tribal health centers and federally qualified health centers;
- a philanthropically funded nutrition and wellness center;
- a nutrition center that is part of a larger hospital system;
- a county public health department; and
- public health, nutrition, and medical school departments of universities.

It is imperative that both health care and food system organizations conduct a landscape scan of organizations and community leaders currently working to address food insecurity and/or individual and community health. These current players can offer expertise and a deeper understanding of the lived experiences of food insecurity and health challenges within the community. Conducting this research also helps to avoid duplicating efforts and presents opportunities to collaborate and build upon existing supports. Organizations can start their search by reviewing current partnerships, connecting with community leaders, and surveying patients or program participants.

Several online resources have been developed to help food assistance and health care organizations identify existing multi-stakeholder partnerships, including community coalitions around SDOH. One example is the Centers for Medicare and Medicaid Services’ interactive Accountable Health Communities Model. The Build Healthy Places Network has developed a tool for organizations to find community partners, which allows users to browse multiple directories of community development and health organizations conducting similar work in their region. Some grantees we spoke with are also working to engage insurance companies and managed-care organizations.

Relevant food access initiative partnerships for health systems may include the following types of organizations:

- child care centers
- faith-based institutions such as churches, synagogues, and mosques
- diaper banks
- farmers markets
- food banks
- grocery stores
- pharmacies
- public libraries
- public health departments
- public housing agencies
- recreation centers
community-based organizations that have established ties and trust with residents in need of support around food security and nutrition

For medically underserved areas, using pharmacies as connection and recruitment points can be an effective way to reach people who could benefit from a food program partnered with the health system, since clients may visit the pharmacy more often than they see their medical provider. Partnering with a prescription delivery program to deliver food could also be an option. In order to reach families, two different health centers that are part of the grantees featured in this brief created partnerships with a diaper bank and a child care center to advertise and enroll people in produce box or meal kit programs.

Collaborating with these kinds of local partners can be an effective strategy for larger, regional organizations working in geographic areas where residents have limited access to affordable and nutritious food due to the absence of convenient full-service grocery stores. These partnerships present opportunities to embed food referrals in places that patients already frequent and with institutions that they trust.

**Build Relationships and Trust with Partners and Patients**

Several dimensions of medical distrust and access issues can prevent clients from using services provided through health systems. Ultimately, it is incumbent upon food and health system partners to mitigate any discrimination and to repair trust with communities when implementing programs.11

Partnering with community health workers to navigate community referrals with patients can increase patient buy-in and provide patients enough time to ask questions while freeing up time for clinicians. Community health workers can provide the dedicated attention needed to meet patients in most need, rather than only those deemed likely to be successful program participants. Often, those most in need of a program may struggle to maintain participation due to the same barriers that created those needs in the first place. Further, equipping all providers and other patient screeners with the tools and confidence to discuss food insecurity with patients is critical to avoid stigmatization and mitigate bias in program enrollment.

Health care and food assistance organizations can work together to determine the screening tools and methods that work best. Baer and others (2015) have shown that the commonly used two-question Hunger Vital Sign screening tool can be effective for screening teenagers and young adults, in addition to or instead of their caregivers, for food insecurity. The National Quality Forum and Humana have developed a guide to food insecurity and health implementation (2020) that offers several screening options and solutions to potential barriers. Partner organizations should review the pros and cons of each screening strategy to select an assessment that would have the most success for the community they serve and that can be integrated with broader screenings of patient SDOH. Some clinics may be part of the Accountable Health Communities Model or the Community Health Centers as Food Oasis Partners initiative and already screening for SDOH or food insecurity using specific tools, such as the Protocol for Responding to and Assessing Patients’ Assets, Risks, and
Experiences (NACHC 2017). As partners build relationships, they can work together to standardize how food insecurity and other SDOH information is collected.

**Understand Patients’ Comfort with Service Location**

With adequate infrastructure, health care systems can provide in-house services such as an on-site pantry, bagged groceries given at discharge, or home-delivered meals for patients recovering from procedures and surgeries. Health care providers could also host mobile food distributions and benefit outreach administered by other partners. Such programming can enable seamless enrollment and convenience for people who frequent the clinic.

For some entities, partnering to connect patients with outside food resources could be a better option, since some patients, and especially those from medically underserved populations, do not want or are unable to collect food from their clinical care provider. Health care systems should consider this issue, especially during heightened times of illness such as a pandemic. The Cherokee Nation health facility, an OKFresh participating clinic, has been extremely cautious about COVID-19. During interviews, we learned that many people view attending the health facility as potentially exposing elders in their community to the novel coronavirus. Therefore, many patients were forgoing clinic visits to protect their community. Fortunately, the OKFresh program refers patients experiencing food insecurity to monthly produce pickup events in their community. This allows patients to continue accessing food resources without visiting the clinic.

**Practice Good Collaboration**

Be clear and transparent about goals and roles. When seeking out partner organizations, explain the motivation and the request. While it is important to clearly communicate reasons for building a partnership, be open to suggestions from potential partners, and don’t be afraid to change course if needed. As they build their programs, partners should be clear about the specific roles each organization and staff member will play. Clarity is especially important for health organizations that are already overburdened and may have limited dedicated staff time for a new program. Tasks such as data entry and data sharing with partners may place an additional burden on clinic employees.

Make sure the partnership is mutually beneficial. Health care systems may bring networks of patients and payers, data tracking systems, and medical knowledge, in addition to their resources for combating food insecurity. Food access and other community-based organizations may have strong social networks and knowledge of SDOH in their communities. They also bring food resources that can support patients’ health goals. Together, these strengths may yield a more robust, synergistic program that supports community needs and patient well-being.

Know that patience is key. The James Kennedy Wellness Center in the rural town of Charleston, Mississippi, employs several registered dieticians and conducts community and recreational programs, including a produce prescription program paired with nutritional counseling. The center has existed for only about five years, and staff noted that it took several years to build trust with the community. For
example, when the center first offered free programming, many people in the community were skeptical about participating. As staff have continued to offer services each year, they have seen increases in both participation and in the level of rapport between community members and providers. Word-of-mouth referrals are a critical way to build trust within a program, and the process often takes time. Providers continually seek to follow through on and be transparent about their program offerings with the community.

Recognize when to step back. One staff member we interviewed works at a large, white-led health care provider that has access to more resources than the grassroots, immigrant-led community organizations working on food insecurity issues. The interviewee shared that the organization is thinking through ways to redistribute resources to such organizations, especially those working with immigrant communities. For example, when local grants are available for food assistance programs, the health care provider may opt not to apply but instead see how it could serve as a referral or other partner for community-based organizations who receive the grant.

This is a lesson that is not in the literature. It always says to just do this one more thing because we know that our patients need x-y-z. But we have to stop and think more systematically. If everyone adds one more thing to the provider workload, no wonder they can’t do anything, and they still have to address the primary concerns of the person. Having folks like us rethink how we provide these services and who is the best deliverer of these programs is key to strengthening the accessibility component.  
—Food program administrator

Incorporate Community Voice

As much as possible, health care systems and their partners should incorporate into program design the voices of their patients and the communities they serve. Gathering community input can start within a clinic, since many staff may also be members of the broader community or the target population for a program. One clinic partner told us that partners on a produce box program highlighted that several of their administrative staff members were eligible for and enrolled in the program. Having those staff share their firsthand experience within their community has been very helpful for spreading the word and enrolling patients at the clinic. Recognizing health care providers and staff as members of the community is one step toward incorporating community voice.

Another grantee we spoke with has developed an innovative community food champions program. In this program, staff at St. Mary’s Nutrition Center train community members to share information
with their neighbors and friends about housing, health, transportation, and food access initiatives that are available to them. Community food champions receive information from the health care system about specific services available and how people can enroll, and they help build trust between community members and social service systems while helping people access the supports they need. In some cases, community food champions may also participate in the programs they promote and thus can share their firsthand experience. Because St. Mary's compensates the food champions for their work, the program also contributes to local economic capital building and workforce development. While a community food champions program requires strong existing relationships between a health center and community members, as well as up-front resources to train staff, it can be a sustainable model that strengthens over time.

We’ve confirmed that when you have community members engaged in the project, it’s more successful. We identified three staff members of the clinic that met the eligibility criteria for OKFresh and enrolled those members. They’ve been wonderful ambassadors for the program. They understand how it works and are able to talk to members of the clinic and community more effectively.
—Program administrator

Funding Strategies to Support Program Sustainability

Financing is one of the biggest barriers to expanding health system partnerships to address SDOH, especially food insecurity. Most payment structures (including insurance, Medicare, and Medicaid) are not currently set up to fund services such as produce prescriptions or meal delivery. However, the movement toward value-based care is increasingly incentivizing health care providers to address SDOH to prevent adverse health outcomes and avoidable hospitalizations. The Affordable Care Act mandates coverage of nutrition counseling for patients at risk of chronic disease.12 This section offers strategies for securing financial support for such initiatives beyond the pilot phase.

Documenting Evidence to Make the Case to Insurance Companies

Health care systems should consider sustainability as they partner with food systems to improve healthy food access for patients. Several Walmart Foundation Healthier Food Access grantees are documenting evidence of positive patient health outcomes and health system cost savings to make the case to insurance companies to cover food programs such as produce prescriptions. Increasingly, programs like those at the Cabarrus Health Alliance and the Hmong American Farmers Association
emphasize improved mental health outcomes, in addition to physical benefits, from participation in food assistance, nutrition education, and cooking programs.

In West Virginia, data from the FARMacy produce prescription program showed positive outcomes for client health, and partners there are working to summarize findings to potentially present to the state or local partners that could provide grants, as well as to insurance companies in the future. The program found that over the 15-week program, participant consumption of fruits and vegetables increased, while food insecurity decreased. While 15 weeks is a short period to see major health changes, preliminary data analysis showed a clinically significant decrease in patient blood sugar levels.

The Hmong American Farmers Association’s community-supported agriculture (CSA) program conducted an internal study that found for every dollar spent, $16.12 was generated for farmers, government, agencies, and the health care and insurance sectors. Based partly on these findings, program personnel have proposed to a managed care organization that it provide $50 for patients to participate in the CSA. Program staff also found preliminary evidence of decreased emergency room visits, improved self-reported physical and mental health, and improved biometric data among CSA participants.

DATA SHARING CAPACITY
Documenting evidence of patient health improvements is important for making the case to insurance companies and other payers. However, building a HIPAA-compliant system for data collection and analysis can be challenging. Partners will need to explore options up front for developing data-sharing agreements and tracking participating patients’ data. If data sharing is not possible, it will be important to build capacity for partners to gather their own data and conduct analyses. We spoke with staff at the University of Mississippi and the James Kennedy Wellness Center who used Box for an easy HIPAA-compliant system that allowed the university and its clinic partner to share participant data to assess patient outcomes. WVU uses a shared data system, and the grantee has assigned a staff member to assist partners such as clinics, food pantries, and other providers that are sharing participant data. All of these partners are covered under HIPAA business associate agreements to share confidential data. The Hmong American Farmers Association shares aggregate data with its partners after its evaluation partner, a clinic in-house data team, performs the data collection, analysis, and reporting.

Program staff at health care entities and food access organizations must be mindful of ethical considerations when collecting patient data to build a case for payers. While randomized controlled trials are often considered the gold standard for research, they can raise ethical concerns about sorting eligible clients into a control group when they could benefit from the intervention. There are plenty of effective strategies beyond randomized controlled trials to track client outcomes that build evidence for a program, while also respecting privacy and empowering participants to learn more about their health and nutritious food options.
Program participants should be informed up front regarding how their data will be stored and how staff plan to use their information. Staff should be cognizant of the long history of abuse in medical studies (Byrd and Clayton 2001; Scharff et al. 2010) and seek to repair trust in initial communications with clients and throughout a program. It may be important to thoughtfully acknowledge any past role an institution may have played in misuse or abuse of biometric data and research study participants (Voith et al. 2020). Sharing program results with participants should be part of any program.

Finding ways to reduce burdens on both participants and providers when collecting biometric and other program data is key. To mitigate transportation barriers and risk of COVID exposure, one group of partners in Mississippi whom we spoke with created a system for families to collect some biometric data at home. While the head of household periodically had blood drawn and measurements taken at a health clinic, the rest of the household took their own measurements at home and returned a document with their metrics to program staff for tracking. Program staff developed a guidebook for participants with instructions on how to take measurements, and they were available over the phone to answer any additional questions.

Using Outcome Evidence for Future Grants

Grants can provide initial support for implementing and/or gathering data from a pilot program. The Patient-Centered Outcomes Research Institute is a research funder with the mission to help people make informed health care decisions and to improve health care delivery and outcomes. It does so by funding private- and public-sector organizations, including hospitals and health care systems, to conduct comparative clinical effectiveness research. It has funded programs like the Vida Sana y Completa Trial, which treats obesity and food insecurity among Latina women. The Centers for Disease Control and Prevention funds many programs to address and prevent chronic conditions like diabetes, and organizations may be able to leverage those funds for evaluation activities or existing partnerships to establish additional health and food programs, as is the case for WVU.

Alleviating Food Insecurity through Medicare and Medicaid Funding

Providers that care for patients covered by Medicare or Medicaid may also be able to leverage incentives from those health insurance programs to sustainably fund health and food system partnerships. Value-based care has emerged as an alternative to fee-for-service reimbursement that rewards providers for both efficiency and effectiveness. In 2015, the Centers for Medicare and Medicaid Services implemented various value-based purchasing models, including one of the largest programs, the Merit-Based Incentive Payment System. This model measures providers on four metrics—quality, promoting interoperability, improvement activities, and costs—which are then used to either penalize or reward providers in payment adjustments for the following two years. Each category offers wide-ranging options that allow health care systems to potentially address SDOH (Horwitz et al. 2020). And because of the beneficial health impact, payers and providers have an incentive to invest in programs that alleviate food insecurity for their patient community.
Medicare Part C allows for some coverage of healthy foods, always through private insurers and on a case-by-case basis. Medicare Advantage Plans were updated in 2019 to enable greater flexibility in using supplemental benefits funded by rebates, enabling Medicare Advantage to fund home-delivered meals, which were one of the most commonly reported patient needs (Skopec, Ramos, and Aarons 2019). Managed care organizations are health plans like those administered by Amerigroup and UnitedHealth that work with state governments to cover Medicaid services. These organizations are increasingly funding and partnering with community organizations and clinics to develop programs that address food security and enhance patient health (Rabinowitz, Smith, and Wang 2021). For example, the Minnesota Second Harvest Heartland food bank works with Medicaid managed-care organizations and the partnerships established through a grant from the State Innovation Models (SIM) initiative to administer the FOODRx program (NORC 2020).

The Affordable Care Act created the Centers for Medicare and Medicaid Innovation, which has piloted many programs that test how health systems can be incentivized and equipped to address SDOH. Efforts toward system transformation are under way that would allow the successful adoption of value-based payment contracts. States can also use many Medicaid authorities to address SDOH, of which food insecurity is a common focus (Hinton and Stolyar 2021). In 2016, the Centers developed a new Accountable Health Communities program, currently active in 21 states, which connects Medicare and Medicaid recipients with local services that support health-related needs. The program funds anchor institutions in communities that develop networks with primary care providers to screen Medicare and Medicaid beneficiaries for health-related social needs and refer them to programs that can address those needs, including alleviating food insecurity. Initial findings from the program show that food needs were the most reported health-related social needs among screened beneficiaries.

Through the SIM initiative, the Centers for Medicare and Medicaid Services partner with states to advance multi-payer health care payment and delivery system reform models. States are encouraged to test strategies for health system transformation that meet the specific needs of their residents, including needs beyond medical services. Minnesota, a SIM recipient, has used its funds to issue a food security grant to support grantees in piloting interventions to capture and subsequently address food security challenges among their beneficiaries. Providers implementing programs in SIM states can connect with state SIM administrators to learn more about and apply for funds.

Conclusion

Communities across the US, including those with stakeholders receiving grants from the Walmart Foundation Healthier Food Access Program, are piloting successful strategies for building health and food system partnerships to combat food insecurity. The experiences of this group of grantees using a variety of interventions to serve different populations in diverse settings provide important insights for other government and social service programs looking to advance health and food system integration.
Notes


4 The listed food access initiatives are part of a larger cohort of 11 grantees that received funding from the Walmart Foundation to develop and test solutions that improve access to healthier foods. See “Healthier Food for All,” The Walmart Foundation, https://walmart.org/what-we-do/strengthening-community/healthier-food-for-all. The Urban Institute provides technical assistance for these grantees.


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