Food Banks as Partners in Health Promotion:
Creating Connections for Client & Community Health

CENTER FOR HEALTH LAW & POLICY INNOVATION
Harvard Law School

FEEDING AMERICA

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ABOUT THE AUTHORS

The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI) advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses. CHLPI works with consumers, advocates, community-based organizations, health and social services professionals, food providers and producers, government officials, and others to expand access to high-quality health care and nutritious, affordable food; to reduce health disparities; to develop community advocacy capacity; and to promote more equitable and effective health care and food systems. CHLPI is a clinical teaching program of Harvard Law School and mentors students to become skilled, innovative, and thoughtful practitioners as well as leaders in health, public health, and food law and policy.

Feeding America is a nationwide network of 200 member food banks that serve all 50 states, the District of Columbia, and Puerto Rico. As the largest domestic hunger-relief charity in the United States, the Feeding America network of food banks provides food assistance to an estimated 46.5 million Americans in need each year, including 12 million children and 7 million seniors. The Feeding America national office supports member food banks across the country by securing food and funds for the local food banks; by building partnerships that benefit the network nationally and also provide support for food bank programs; by supporting programs that help improve food security among the people and communities we serve; and by raising awareness about the problem of hunger and advocating on behalf of food-insecure Americans. In turn, food banks distribute food and groceries to 60,000 food pantries and meal programs that directly serve people in need across the U.S..

For the past two years, CHLPI has been deeply engaged in research and analysis on type 2 diabetes policy. This initiative is known as the PATHS Project (Providing Access to Healthy Solutions). This white paper supports Feeding America's efforts to become community-based partners in health promotion in a new health care landscape.

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Food Banks as Partners in Health Promotion: Creating Connections for Client & Community Health is primarily authored by Tommy Tobin, Sarah Downer, Kim Prendergast, and Michelle Berger Marshall, with guidance from CHLPI's Director Robert Greenwald and Deputy Director Emily Broad Leib.

INTRODUCTION

Food banks are embedded in local communities across the country. They are central to the economic well-being of clients, who often struggle to find regular access to food. Food banks partner with government agencies, donors, and private companies to serve the interests of the more than 46 million individuals in the United States at risk of hunger.[1]

The needs of the food banks' clients do not stop at the food banks' doors. According to the *Hunger in America 2014* survey, many clients report significant health concerns. Nearly half (47%) of food bank clients reported "fair" or "poor" health.[2] Across the country, 33 percent of client households have at least one member with diabetes.[3] For hypertension, the number increases to 58 percent.[4] The costs of care are also concerning for food bank clients and their households. Nationwide, 29 percent of client households report having no health insurance coverage, including Medicaid or Medicare.[5] Recent data show that more than half (55%) of food bank clients have unpaid medical bills.[6] Two-thirds (66%) of clients have had to choose between buying food and paying for medicine or medical care in the past year, with 31 percent reporting facing this tradeoff every month.[7]

Recent developments in the health care landscape aim to improve both access to health care and the quality of care received. Food banks are well-positioned to help their clients benefit from these new developments by becoming partners in health promotion. As experts in addressing food insecurity, they can expand on their existing community relationships to craft new collaborative endeavors to address food and nutrition needs with both public and private insurers as well as providers, including hospitals, community health centers, clinics, and private medical practices.

Many of the nation's most prevalent chronic illnesses are diet-related, including obesity, cardiovascular disease, hypertension, and type 2 diabetes. These diseases can be prevented or mitigated by access to and consumption of healthful food.[8] Food bank clients who are low income and struggle with food insecurity often struggle with several factors that increase their risk of developing chronic diet-related health issues and exacerbate these conditions for those who already live with them.[9] These factors include limited financial resources; lack of regular access to healthy, affordable foods; and limited access to basic health care.[10]

As an example, consider the needs of food bank clients with diabetes. Clients who seek out nutritional assistance may face challenges in obtaining foods that are adequate, appropriate, and affordable as they try to meet special dietary needs to manage their diabetes. Such items include foods lower in salt, fat, and sugar, and higher in the dietary fiber, micronutrients, and lean proteins found in fruits, vegetables, whole grains, nuts, and fish. In addition, the same economic hardships that led the client to the food bank in the first place may constrain his or her ability to seek medical care and afford medications and blood glucose testing supplies.

Food banks do not need to be experts in health care, but they can be important partners in health promotion for their clients and local communities. Feeding America has increased national efforts to provide Foods to Encourage *(See Fig 1)*, or foods that align with the 2010 USDA Dietary Guidelines for Americans, at member food banks.[11] Recent changes in health care delivery may enable food banks to play a more formal role in health promotion and tailor some services to food insecure populations with specific health needs. There are new incentives for health providers to increase community engagement in order to improve health outcomes for clients. For food bank directors and partner agencies,[12] this means potential opportunities for partnership and new sources of funding.

Food banks do not need to be experts in health care, but they can be important partners in health promotion for their clients and local communities.

This White Paper aims to describe some shifts in the health care landscape that open up new opportunities for the nation's food banks. It will also discuss several of the ways that food banks can take advantage of these developments to become a partner for health care providers. It outlines some top concerns for food banks seeking to form these partnerships, including capacity to invest resources in building new relationships and/or tailoring and expanding services.

Fig 1: **Foods to Encourage F2E**

Feeding America is dedicated to helping its clients better access fruits, vegetables, lean protein and dairy foods. Foods to Encourage is Feeding America's approach to estimate the nutritional contributions of food categories in food banks' inventories. The goal is to have 75% of food distributed through the Feeding America network classified as F2E by 2025.

Of the nearly 4.1 billion pounds of groceries Feeding America distributed in 2014, 67.8 percent, or 2.8 billion pounds, were categorized as Foods to Encourage.

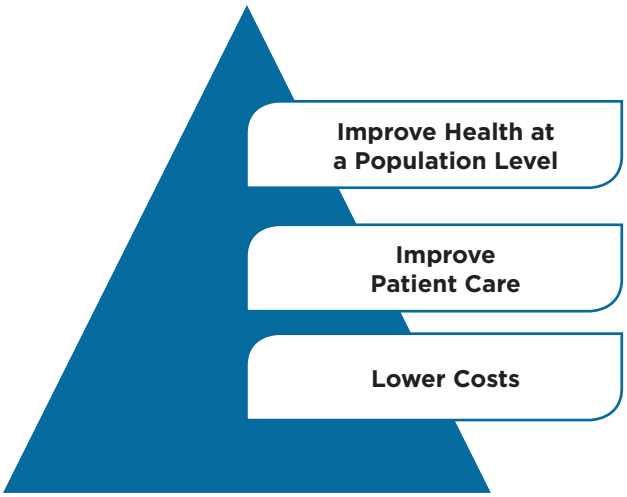
Of all Foods to Encourage, 38.9 percent, or 1.1 billion pounds, was produce.

For more information, visit
http://healthyfoodbankhub.feedingamerica.org/resource/foods-to-encourage-background/

NEW DEVELOPMENTS IN HEALTH CARE

Recent developments in the health care landscape have changed the incentive structures for health care providers, including hospitals, community health centers, clinics, as well as insurers like Medicare, Medicaid, and private insurance companies. Increasingly, reimbursements and payments for health services provided to patients are being tied to achievement of the "Triple Aim." These three aims are: **improved health at a population level, improved patient experience of care,** and **lower costs**[13] *(See Fig 2)*. With increased emphasis on meeting the Triple Aim, there has been increased recognition of the important roles community providers, such as food banks, play in helping patients maintain and/or improve their health, especially when it comes to preventing or managing chronic diseases.[14]

Fig 2 : **The Triple Aim of Health care**



Source: See Donald M. Berwick et al., The Triple Aim: Care, Health, and Cost, 27 Health Affairs 759-769 (2008).

For the nation's food banks, some of the most relevant changes in the health care industry include:

- (1) Shift from fee-for-service to pay-for-performance;
- (2) Medicaid expansion;
- (3) Hospital readmission penalties;
- (4) Enhanced requirements for nonprofit hospitals seeking to meet the Community Benefit Standard for tax exemption; and
- (5) Demonstration projects funded by the newly created Center for Medicare and Medicaid Innovation.

These developments in the health care landscape largely stem from the Patient Protection and Affordable Care Act (ACA), enacted in 2010. This White Paper will describe each of these developments in turn and demonstrate how these changes may affect health providers' incentives for partnership with community-based organizations such as food banks.

Glossary:

Medicaid: Government program that provides free or low-cost health coverage to many Americans, including some low-income people, families and children, pregnant women, the elderly, and people with disabilities. Medicaid is administered jointly by federal and state governments, with details of program operation varying between states.

Medicare: Federal health insurance program for people 65 and older and certain younger people with disabilities.

Centers for Medicare & Medicaid Services (CMS): Federal government agency that administers the Medicare program and coordinates with state governments to run the Medicaid program. CMS is situated within the Department of Health & Human Services.

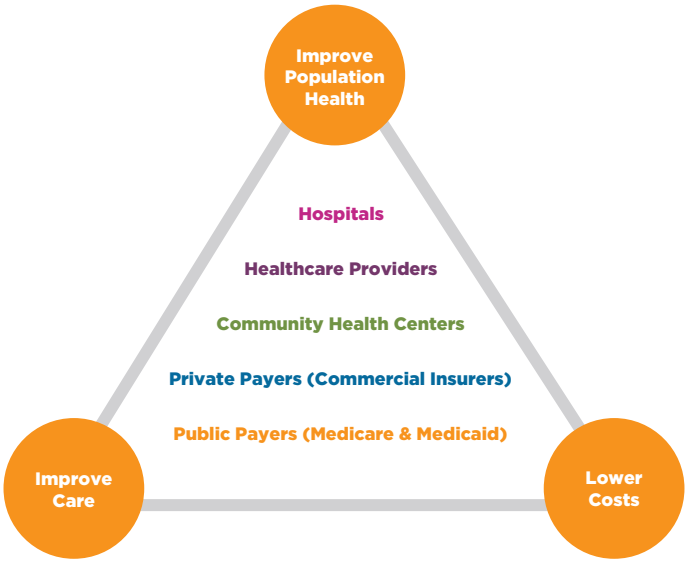
Source: See Ctrs. for Medicaid & Medicare Servs.., Glossary, (May 14, 2006), https://www.cms.gov/apps/glossary/default.asp?Letter=M&Language=English (last visited Apr. 23, 2015).

1) SHIFT FROM FEE-FOR-SERVICE TO PAY-FOR-PERFORMANCE

Traditionally, health services have utilized a fee-for-service payment model, with payments distributed for each defined medical service delivered to a patient. Recently, increases in health care costs and higher rates of expensive-to-treat chronic illness have prompted calls for payment reform, especially for transforming the payment structure so that providers are incentivized to provide evidence-based, coordinated care that results in positive health outcomes for the patient and lower health care costs for the health care system. This idea of tying payment to achievement of certain health and financial outcomes is commonly referred to as pay-for-performance *(See Fig 3)*.

The transition to a system of outcome-based payments aims to improve the quality of service delivery while at the same time reducing the cost of health care *(See Fig 4)*. Health care insurers and providers are looking to new payment models and health care structures, including bundled payments and Accountable Care Organizations (ACOs), to more directly link delivery of care to successful health outcomes *(See Fig 5)*.

Fig 4: **Meeting the "Triple Aim" Changes in the Health care Sector**



This means that in order to maximize outcomes and minimize costs, insurers and providers may seek to partner outside of the traditional medical field with entities that address "social determinants of health," such as housing, financial stability, and of course, food access. Increasingly,

Fig 3: **Payments Models Are Changing Rapidly**

The Centers for Medicare and Medicaid Services (CMS) has recently announced a substantial shift in its reimbursement policy for health care providers that see patients with Medicare. With approximately 50 million Americans participating in Medicare, a transition to a value-based model of payment has the potential to incentivize providers to provide certain non-traditional services. This transition is set to happen over the next three years

Medicare will seek to tie 30% of traditional fee-for-service payments to quality or value models by 2016 and 50% by 2018.

This means that providers who serve the Medicare population (people over 65 or with disabilities) will seek to institute models of care that yield the best health outcomes for their patients. As part of this effort, they may want to incorporate non-traditional services, such as the food assistance provided by food banks, into routine care or as part of care provided to patients with diet-related health conditions.

providers understand that these social determinants are key predictors of the health care costs and outcomes for patients with complex health conditions. Being food insecure, for example, is linked to a 46 percent increased likelihood of becoming a "high-cost user" (defined as top 5 percent user) of health care.[15] Individuals living in food insecure households lack of access to healthy foods to prevent and manage chronic disease. They often make trade-offs between food, medicine, medical supplies, or the ability to access preventive care. Among youth, food insecurity, along with access to health care, has the strongest impact of any of social factor on self-reported health, even more so than housing, substance abuse, educational attainment, or interpersonal violence.[16] A health care provider's ability to understand the relationship between a patient's social situation and their health status and connect patients with services —such as access to food— is often critical to enabling a patient to prevent or manage a serious health condition successfully.

Fortunately, health care systems are transitioning to models of care that promote and manage the health of entire populations and are being rewarded for producing improved short and long-term health outcomes while reducing costs *(See Fig 5)*. As a result, insurers and providers are seeking more formal ways to work with community-based partners to understand the needs of their patients outside of the clinic and address clinical and non-clinical indicators of health. Food banks are natural community-based partners for providers at this phase, with the ability

to educate health care staff about the issues of food insecurity in the community; collaborate with providers to increase referrals from health care facilities to food banks; and encourage food bank clients to visit health providers for preventive care. They can also provide specific health-related services at the food bank or pantry, such as tailored food packages, educational brochures, or health screenings, to clients who meet certain health criteria. Providers and insurers may be increasingly willing to provide funding or other support for such activities.

Fig 5: **Selected New Payment Models and Programs:**

Bundled Payments: A single, "bundled" payment for an episode of a patient's care delivered by multiple providers within a given time, such as surgery and anesthesia.

Accountable Care Organizations (ACO): Groups of doctors, hospitals, and other health providers that join together to coordinate patient care. When an ACO succeeds in delivering high-quality care at a lower cost, it shares in the savings (based on a pre-defined target spending amount). When it fails, it bears some of the risk of over-spending.

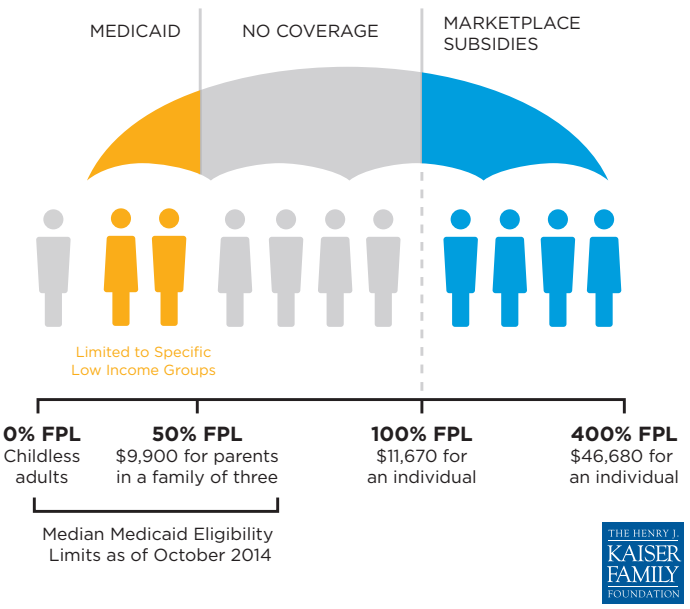
Value-Based Purchasing Program: CMS program that requires hospitals to report measurements on process of care, patient experiences, and outcomes. The program rewards hospitals for achievement and improvement with increased reimbursement rates.

Source: See American Med. Ass'n, ACOs and Other Options: A "How-To" Manual for Physicians Navigating a post-health world, available at http://www.acponline.org/running_practice/delivery_and_payment_models/aco/physician_howto_manual.pdf (4th ed. 2013).

2) MEDICAID EXPANSION

Medicaid provides health care coverage for over 60 million Americans, including one in three children.[17] The program operates as a federal-state partnership, in which states are obligated to cover certain benefits but have wide flexibility in program design beyond that.[18] Under the ACA, states can choose to expand Medicaid from covering a more limited population to providing health care coverage to nearly the entire population of low-income Americans earning up to 138% of the Federal Poverty Line.[19] As of March 2015, 28 states and the District of Columbia have elected to expand Medicaid coverage for residents, meaning that millions of Americans have gained new access to health coverage.[20] In the 22 states that have not yet expanded Medicaid, an estimated 3.7 million low-income Americans do not meet eligibility guidelines for coverage and are likely to remain uninsured[21] *(See Fig 6)*.

Fig 6: **Gaps in Coverage for Adults in States that Do Not Expand Medicaid under the ACA**



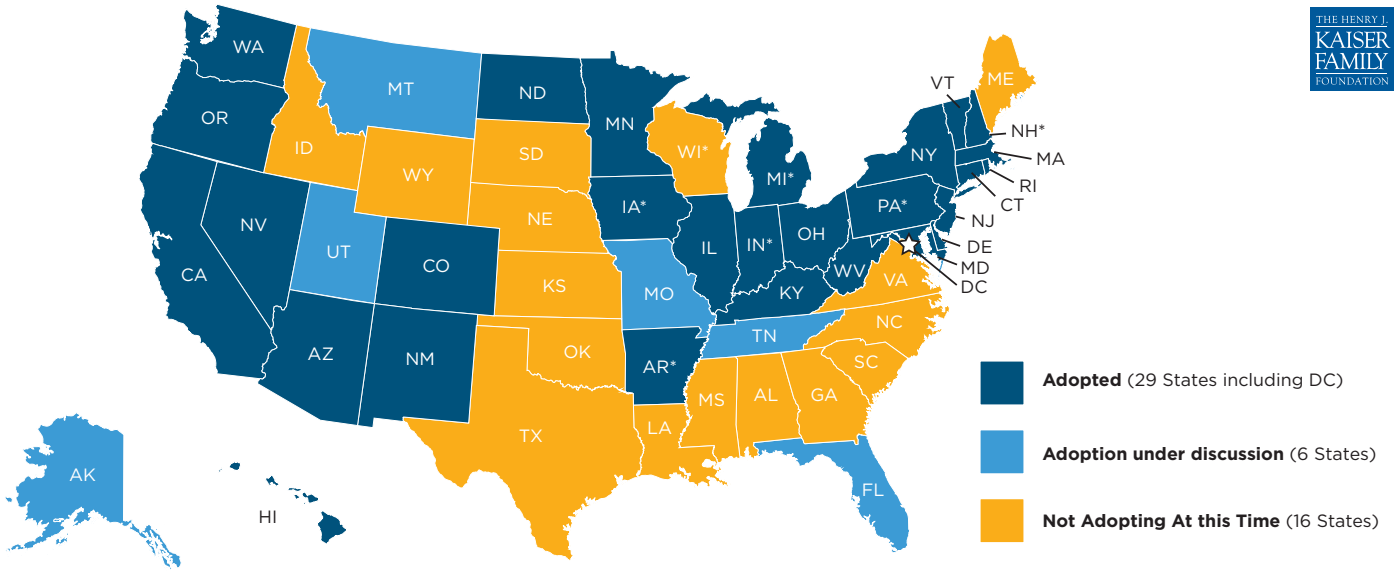
Source: Rachel Garfield, The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid—An Update, Kaiser Comm'n on Medicaid and the Uninsured (Apr. 2015).

In states that have chosen not to expand Medicaid coverage, low-income residents are often subject to the so-called "coverage gap." [22] This means that many very low-income individuals will likely remain unable to afford even basic medical care. In states not expanding Medicaid, the median income limits for program eligibility can be quite low. For parents, the median annual income limit for Medicaid eligibility in 2014 was only $9,893 for a family of three, or an annual income just 50% of the federal poverty line.[23] In virtually all states, childless adults were not eligible for Medicaid without expanded coverage[24]

A recent report by the Kaiser Family Foundation found that this coverage gap disproportionally affects poor uninsured Black adults and that 57% of adults in the coverage gap are adults of color.[25] Moreover, nearly 60% of all adults in the coverage gap live in four states: Texas, Florida, North Carolina, and Georgia[26] *(see Fig 7)*.

Food banks should know whether their home state has expanded Medicaid or is considering doing so, as they can help raise awareness of new coverage opportunities among clients and direct clients to resources that will help them

Fig 7: **Current Status of Medicaid Expansion Decisions**



*NOTES: Under discussion indicates executive activity supporting adoption of the Medicaid expansion. * AR, IA, IN, MI, NH, and PA have approved Section 1115 waivers. Coverage under the PA waiver went into effect on 1/1/15, but the newly-elected governor has stated he will transition coverage to a state plan amendment. Coverage under the IN waiver went into effect 2/1/15. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.*

Source: "Status of the State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated March 6, 2015.

enroll in insurance plans. They can also provide education to the newly insured about how to utilize their insurance and emphasize the importance of receiving regular preventive care. In states where a significant number of clients are likely to remain uninsured, food banks can speak to key officials about the importance of health coverage and bear witness to the difficult choices that uninsured clients must often make between paying for food versus obtaining needed medical care.

3) CHANGES TO HOSPITAL READMISSION POLICIES

In an effort to cut costs and improve the quality of care, the Centers for Medicare and Medicaid Services (CMS), in accordance with ACA requirements, established the Hospital Readmissions Reduction Program. This program decreases CMS payments to hospitals who fail to meet certain metrics regarding patient readmissions.[27] At an average of $9,700 per hospital stay,[28] hospitalizations are a significant driver of costs for private insurers, Medicare, and Medicaid.

Unfortunately, in 2014, approximately 20% of Medicare patients discharged from a hospital were readmitted within one month.[29] CMS sees these excessive readmission rates as indicators of poor quality of services.[30] In response, CMS is incentivizing hospitals to reduce the rate at which patients return to hospital facilities after being discharged through penalties and reduced reimbursement payments for hospitals that fail to demonstrate improvement.

Under the Readmissions Reduction Program, CMS will penalize hospitals that exceed the national average for readmission rates. These hospitals with excess readmissions are sanctioned across all of their Medicare admissions.[31] The rate of penalties is currently set at 3% of payments for all Medicare hospital admissions in that year, and CMS estimates that it will collect $428 million in penalties in 2015.[32]

Beyond cost-savings, two additional primary goals of this program are to increase understanding of the factors that lead to a patient's readmission and prompt actions that address those factors. Hospitals now have increased incentives to be more active in monitoring the health needs of patients in the period following discharge and to fully assess and provide excellent care to patients during and post a hospital admission. As a result, hospitals are attempting to identify high-risk individuals upon initial admission and provide them with extra resources.[33] They are also changing their discharge procedures from simply giving patients written materials to engaging more actively with patients and family members to ensure they understand discharge instructions. They are also taking other steps meant to avoid a readmission, such as

supplying needed medication to the patient and coordinating with outside providers to better ensure successful recoveries.[34]

In reducing hospital readmissions, providers may have particular incentives to work with food-related community partners. Malnourished patients have longer hospitalizations and are more likely to be readmitted within 15 days.[35] In addition, these patients have a higher cost of hospitalization compared with non-malnourished patients, as well as a higher mortality rate.[36]

For food banks, it is important to understand that hospitals will increasingly seek to play active roles in managing the health of patients after discharge. Food banks also have a role to play in helping to improve community health outcomes and reduce hospital readmissions. They can ensure that recently discharged patients are aware of and have access to appropriate nutrition services and healthy food, as improving food security helps an individual manage a chronic disease and mitigates the risk of an acute health issue that may necessitate readmission.[37]

4) ENHANCED REQUIREMENTS FOR NONPROFIT HOSPITALS SEEKING TO MEET THE COMMUNITY BENEFIT STANDARD FOR TAX EXEMPTION

Approximately 51 percent of America's hospitals are nonprofit organizations.[38] As nonprofits, these hospitals are granted tax exemptions from federal and state governments. Traditionally, these tax exemptions have related to the provision of low- or no-cost health services to those unable to pay.[39] The ACA changed the tax law by emphasizing the importance of providing a broader array of services to the community and creating new processes through which hospitals justify the benefit they are delivering to the community in order to retain their tax-exempt status[40] *(See Fig 8)*. These obligations are known as a hospital's "Community Benefit" requirement.

Fig 8: **The Community Benefit Standard:**

Most US hospitals are nonprofits, with favorable tax exempt status. With this status comes an expectation that hospitals will "promot[e] the health of a class of persons…broad enough to benefit the community." Hospitals can include a variety of services they provide under this umbrella definition, including efforts to address "financial and other barriers to care, the need to prevent illness, to ensure adequate nutrition, [and to address] social, behavioral, and environmental factors that influence health in the community…"(emphasis added).

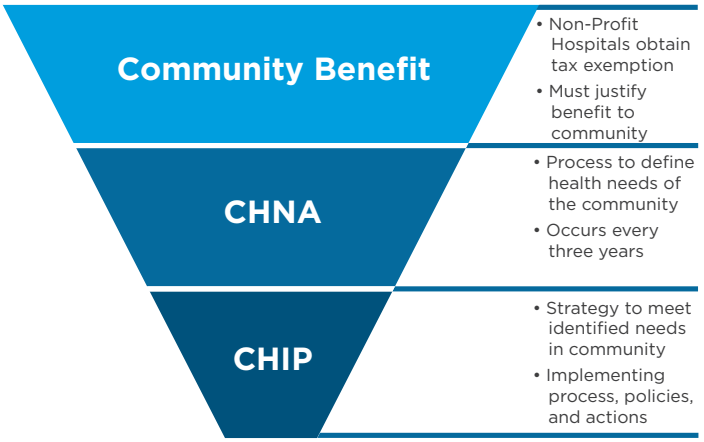
Source: See Additional Requirements for Charitable Hospitals, 79 Fed. Reg. 78953, 79002 (Dec. 31, 2014), available at http://www.gpo.gov/fdsys/pkg/FR-2014-12-31/pdf/FR-2014-12-31.pdf#page=320 (last visited Apr. 23, 2015).

Nonprofit hospitals must comply with the Community Benefit requirement in order to retain their favorable tax exempt status and avoid a $50,000 penalty under § 4959 of the Tax Code.[41] They must conduct a Community Health Needs Assessment (CHNA) every three years.[42] Through a CHNA, the hospital identifies and defines the health needs of the community, and uses this information to set hospital priorities for shaping its Community Benefit activities.

In undertaking a CHNA, a Nonprofit hospital must: (a) define its community; (b) solicit input from community stakeholders; (c) prioritize community health needs; and (d) list available resources to meet the identified needs.[43] Hospitals cannot exclude vulnerable populations in their definition of "community," and the institution must detail the process of soliciting input from these populations.[44] A hospital will likely look to create a coalition of community members to evaluate the needs of the community.[45] In particular, they may seek to include organizations like food banks that are engaged in providing important community services.[46]

After completing the CHNA, a Nonprofit hospital creates a Community Health Improvement Plan (CHIP)[47] *(See Fig 9)*. On the basis of the identified health needs, the CHIP defines steps the hospital will take to address the needs identified in the CHNA.[48] To promote transparency and accountability, implementation plans are available to the interested public on the hospital's Form 990 that is filed with the IRS.[49]

Fig 9: **Community Benefit Process**



For food banks, the CHNA and the CHIP processes represent major opportunities to draw attention to the issue of food insecurity and challenges to accessing healthy food for low-income residents within the hospital's community; to emphasize the link between food and health; to build relationships with hospital staff; and, ultimately, to create partnerships between the food bank

and hospital which may include using hospital resources to address community and individual access to the type of foods that support health. Section II of this White Paper discusses some of the forms that this collaboration may take.

5) DEMONSTRATION PROJECTS FUNDED BY THE CENTER FOR MEDICARE & MEDICAID INNOVATION (CMMI)

As CMS emphasizes a value-based payment structure focused on achieving positive health outcomes for entire populations at the lowest cost, innovative models of care delivery and payment are being tested throughout the country. The Center for Medicare & Medicaid Innovation (CMMI) is a recently-created government office that (a) encourages the sharing of best practices in Medicare and Medicaid, (b) pilots new models of health care service delivery, and (c) engages a range of stakeholders in implementing new data-driven changes to models of care.[50]

CMMI demonstration projects can, for example, include services that Medicare and Medicaid would not traditionally pay for, such as food interventions. For example, two states that have CMMI-funded awards to innovate within their Medicaid programs are using parts of these grants to provide incentives for purchasing healthy food. Minnesota's program provides prediabetic participants with vouchers to subsidize the purchase of food at farmers markets.[51] Texas's program, which is available to patients with both a physical chronic health diagnosis and a behavioral diagnosis, gives each participant a flexible spending account that the participant may use to buy nutritional or medicinal foods that are part of an individually-tailored Wellness Action Plan.[52] Providers, hospitals, and their partners may apply for innovation grants through the office's competitive process. If accepted, these organizations can receive considerable funding and technical assistance to design and implement new models of health-care delivery.[53]

For food banks, it is important to recognize that providers and hospitals may be participating in an innovation demonstration project or consider doing so in the future. Food banks can partner with health providers to provide certain services, such as healthy food or nutrition education, as part of a larger demonstration project. Participation in such an initiative would result in a temporary funding stream for specific food bank initiatives and services. It would also help build the body of research that demonstrates the importance of integrating food and nutrition services into mainstream health care systems and strengthen the case for longer term funding for such interventions.

OPPORTUNITIES FOR FOOD BANKS TO BE PARTNERS IN HEALTH PROMOTION

Given these recent developments in the health care industry, providers and hospitals have numerous incentives to work with community partners such as food banks. Armed with a good understanding of the health care system and these incentives, food banks can engage with health care partners in a number of ways.

1) TARGETED INTERVENTIONS FOR HEALTH PROMOTION AND DISEASE SELF-MANAGEMENT

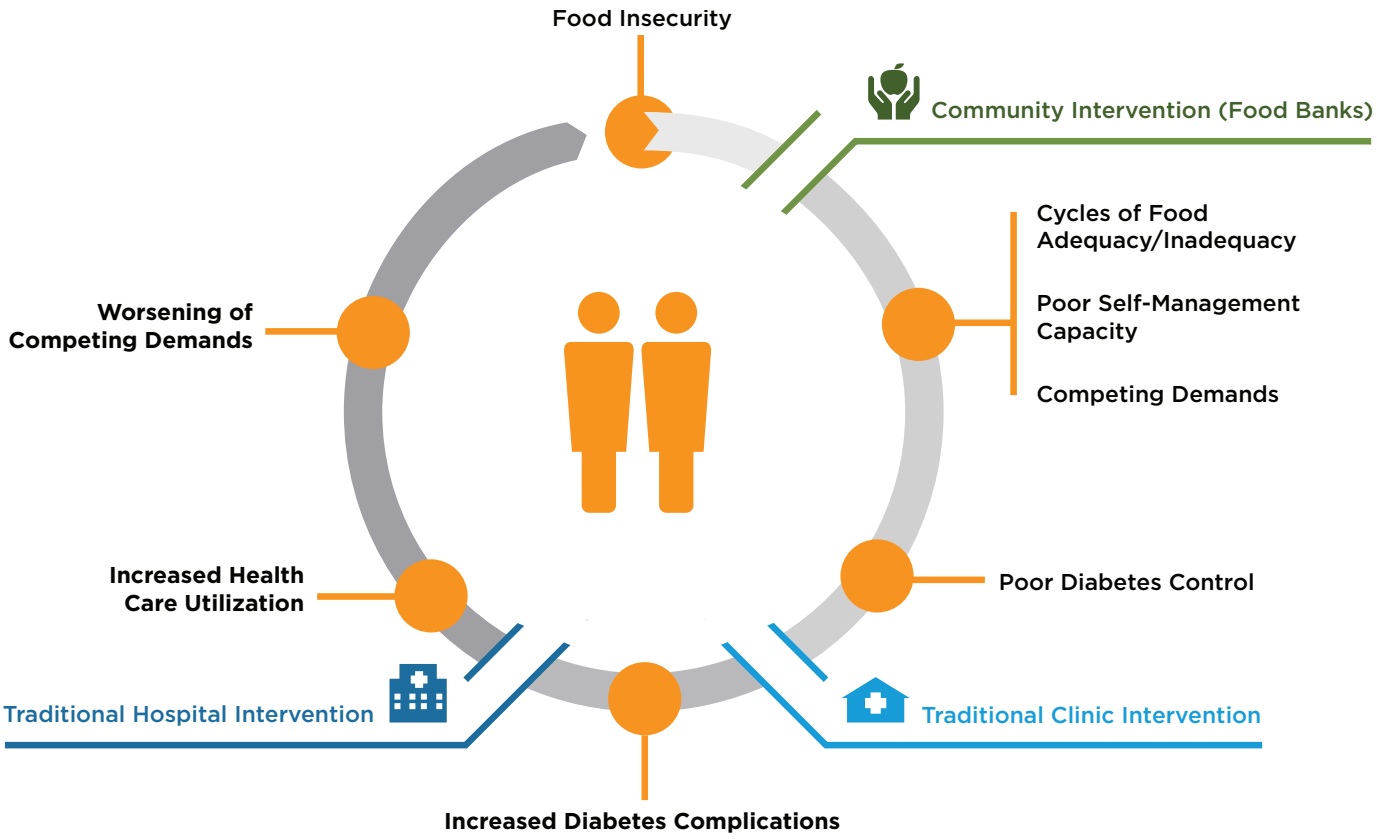
Data from *Hunger in America 2014* revealed the high prevalence of chronic disease in the households that rely on the emergency food bank network. Fifty-eight percent of households reported that at least one member has hypertension and 33 percent report at least one member with diabetes.[54] As such, food banks are well-positioned to play a key role in formal health interventions that address the prevention of diet-related diseases.

a) Providing Healthy Food and Health Resources to Clients at the Food Distribution Site

Feeding America is working with food banks throughout the network to build a base of evidence to support their ability to provide a broad range of food and nutrition interventions such as:

- conducting chronic disease screening in the food pantry setting;
- providing food boxes designed to offer foods more appropriate for disease prevention or management;
- offering targeted nutrition and health education in the food distribution setting;
- making referrals to primary care for food bank clients who lack access to a physician;
- creating joint programming with health care partners in the food distribution setting to address specific health needs.

Fig 10: **Food Insecurity and Diabetes: A New Opportunity for Food Bank Intervention**



Adapted from Seligman HK, Schillinger D. N Engl J Med 2010;363:6-9.

- Food banks can work with both providers and insurers *(See Fig 10)* to develop these initiatives.

Projects that include evaluation of both clinical and non-clinical client outcomes will help establish food banks, pantries, and kitchens as go-to resources for effecting change in the community's health profile.

b) Adding Food Assistance Capacity On-Site at Health care Institutions

Food banks can offer to augment or create services on-site at hospitals and health centers. They can create gardens or stock on-site food pantries. These activities leverage the expertise and capabilities of the food bank and extend the reach of food bank services into a clinical setting. Food assistance partnerships with health care organizations could take several forms including:

- a full choice-pantry agency housed in the health care provider;[55]
- targeted pilot or small projects with food banks and health care providers, in which prepared emergency food boxes are available and given out to families in need and referrals are made to a food pantry for additional support;
- produce distribution in the lobby or parking lot at a health care provider;
- distribution of information about local food banks, pantries, and kitchens; and
- assistance with ensuring access to food purchasing support, such as SNAP enrollment in the clinic setting.

c) Increasing Provider Awareness of Screening Tools

Health care providers may not be fully aware of the link between food insecurity and poor health outcomes. And even if providers are aware of the health implications of food insecurity, few are systematically screening patients for food insecurity to provide them additional services or referrals.[56] Food banks are well-suited to help educate providers and introduce them to simple screening techniques. For example, they can encourage providers to screen patients for food insecurity using the 2-question Clinical Food Insecurity Screen[57] *(See Fig 11)* and refer those who screen as food insecure to the food bank.

Fig 11: **Clinical Food Insecurity Screen:**

"I'm going to read you two statements that people have made about their food situation. For each statement, please tell me whether the statement was often true, sometimes true, or never true for your household in the last 12 months.

(1) We worried whether our food would run out before we got money to buy more. Was that often true, sometimes true, or never true for your household in the last 12 months?

(2) The food that we bought just didn't last and we didn't have money to get more. Was that often, sometimes, or never true for your household in the last 12 months?"

If respondent replies, "often true" or "sometimes true" to either question, the screen is **positive** for food insecurity.

Source: Erin R. Hager et al., Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity, 126 Pediatrics e26-e32 (2010); Feeding America, Clinical Training Brief (May 2014),

d) Enhancing Provider Education about Linkages between Food & Health

Food banks can also encourage or provide continuing medical education about the role of food insecurity and patient health. They can inform health care partners about education opportunities and provide information to clinicians about why food insecurity matters to their practice. State licensures often require health providers to complete continuing medical education, sometimes in specific areas of medicine such as geriatric medicine or HIV/AIDS.[58] Increased education and awareness of the problem and health implications of food insecurity may mean that more health providers are receptive to projects that address food insecurity.

2) PLANNING FOR COMMUNITY BENEFITS WITH HOSPITALS: THE CHNA AND THE CHIP

Every three years, Nonprofit hospitals are required to undertake a CHNA to evaluate the health needs of the community, and must do so by including the input of community stakeholders. Different hospitals will approach this process in different ways, ranging from managing the process in-house, hiring a consulting group to lead the process, or even partnering with other hospitals and health care organizations to conduct a regional CHNA. Food banks can play a valuable role in any of these scenarios, from being an active part of a planning group or simply participating in a focus group. Food banks could:

- present current evidence linking food insecurity to chronic and other health conditions and assist with framing the linkage between healthy food access and health;
- assist with community surveys and data collection on food insecurity by increasing the number of low-income individuals and families included in the needs assessment;
- raise awareness of food bank services and activities among hospital providers and staff; and/or
- offer partnership opportunities to expand or create new programs that will help the hospital implement its CHIP.

Food banks have access to data available in Feeding America's *Hunger in America 2014* or Map the Meal Gap tools they can use to assist and educate hospital partners about the effect of food insecurity on community health. They can also provide key evidence such as studies or other data that support the inclusion of food insecurity as an identified community health need, and the role that "food as medicine" can play in addressing that need.[59]

Even if they have not participated in the CHNA process, food banks can play an active role in helping to develop the Community Health Improvement Plan (CHIP). The CHIP outlines an implementation strategy to tackle the community's identified health needs. For food banks, involvement in the CHIP could take the form of:

- becoming an identified resource that will help the hospital implement CHIP activities related to priorities such as food access, good nutrition, or fruit and vegetable intake;
- partnering with the hospital to implement programs to meet specific needs identified in the CHNA, such as creating new mobile food distribution sites that provide healthy food in areas with a lack of grocery stores or other full-service food vendors;
- conducting health screening and providing health education to food bank clients;
- participating in healthy food pilot programs with a hospital partner, such as initiatives that offer certain foods to clients with specific health conditions; and/or
- providing some food bank services, such as affiliated community gardens, on site at the hospital.

Because different hospitals' CHNA processes vary, it may not be immediately possible for a food bank to get a seat at the community stakeholder table for an open dialogue. Even so, there are still opportunities for food bank perspectives to be heard, and a food bank could consider submitting written comments on the CHNA or the CHIP that the hospital is required to take into account in its next CHNA process.[60]

CONSIDERATIONS FOR FOOD BANKS

In anticipation of partnerships with health providers, food banks can prepare by conducting internal assessments of capacity for engaging in new endeavors and external scans of the local health care landscape *(See Fig 12).*

Fig 12: **Food Insecurity and Diabetes: A New Opportunity for intervention**

Identify the Opportunity	Prepare for Partnerships	Engage with Partners
Assess Available Data	Assess Landscape	Set Smart Goals
Investigate and Prioritize Needs	Evaluate Internal Capacity	Establish Continuous Opportunities for Communication
Identify Potential Partners	Consider the Food Bank's Role	Plan, Compromise and Evaluate
	Make the Case	

1) IDENTIFY THE OPPORTUNITY

Food banks must identify viable opportunities for partnership that will yield a true benefit to their client communities. A food bank should assess the health care landscape before approaching a health care partner.

Questions to answer include:

- What data is available that the food bank could present to health care providers about the local area's food insecurity and the health concerns of its clients? *Feeding America's Map the Meal Gap and Hunger in America tools are excellent resources for this information.*
- Can the food bank assemble a one-page document for potential partners summarizing the health issues its clients face and detailing some of the services that the food bank provides?
- What is the food bank's process of gathering new information about clients? Are the intake forms used by the food bank capturing information relevant to potential health care partners, such as current insurance coverage? If not, can the forms be changed?
- What are some of the major health care insurers (including private insurers as well as Medicare and Medicaid) and providers (including hospitals, health centers, physician practices) in the local area?
- Has the food bank's home state chosen to expand Medicaid coverage? If so, many of the food bank's clients are likely now eligible for health coverage.
- Are any local hospitals Nonprofit hospitals? *If so, they would be subject to the ACA's revised Community Benefit Standard and will conduct a CHNA every three years.*
- What stage of the CHNA and/or CHIP processes is the local Nonprofit hospital currently undertaking?
- Has the local hospital met its readmission targets? If not, could the food bank help the hospital reduce readmissions by improving access to food or providing nutrition education?
- Are local health providers or state agencies currently participating or planning to participate in a CMMI demonstration grant in which the food bank could play a role?

Food banks must assess their own capacity to work with health care providers and insurers and begin to build evidence for the efficacy of interventions they are able to provide in partnership with health care providers.

2) PREPARE FOR PARTNERSHIPS

Food banks must assess their own capacity to work with health care providers and insurers and begin to build evidence for the efficacy of interventions they are able to provide in partnership with health care providers. The food bank can plan for future activities by asking critical questions about resources, including time, staff, and space, and by working with and collecting data on food insecurity and healthy food access interventions and health outcomes. Questions to answer include:

- What is the capacity of the organization to take on new endeavors and build new relationships?
- What will be the food bank's role in the potential partnership?
- What will be the process to create organizational buy-in for the partnership when communicating the partnership to Food Bank staff and the board?
- What health care services are the food bank's clients currently using?
- Could the food bank martial resources to design or administer a pilot program to demonstrate the efficacy of a specific food access strategy?
- What would success look like in terms of outcomes? What are the outcomes envisioned, and how/what/when will measurement occur? Examples of successful outcomes could include: increased healthy food access, improvements in client/patient health, decreases in hospital readmission, or improvements in a specific community health indicator.
- What is the range of outcomes that can be measured in a given intervention? Self-reported changes in quality of life, including patient satisfaction? Change in clinical measures such as blood glucose levels and blood pressure? What level of engagement from a health care partner is needed to measure each outcome?

3) ENGAGE WITH PARTNERS

Food banks can insert themselves into the community's health promotion conversation by approaching new partners or joining existing coalitions. Defining "success" is critical, and a food bank must be mindful about its outcomes. When engaging with partners, food banks can ask themselves a range of questions, including: How will partners be approached? Who from the food bank will initiate contact?

- How will the relationship with the partner be maintained over time? Who from the food bank will be tasked with maintaining this relationship with the partner organization(s)?
- Based on the partner's Community Health Needs Assessment or Triple Aim incentives, how can the food bank help to address a need of the partner?
- What are the goals of this partnership? How will they be set? How will they be measured? Who will measure them?
- What are the metrics for success in this partnership? Are there milestones or targets? Some metrics relevant for food banks may include: improvement in self-reported health of clients, screenings conducted, SNAP applications completed, or number of referrals made to health providers.
- Will there be an outside evaluator for the project? Will one be required as a condition of particular funding source?

CONCLUSION

In addition to the significant and direct role they play in addressing food insecurity and promoting access to healthy food in a community, food banks have a strong and evolving role to play as partners in a community's health. The recent *Hunger in America 2014* survey provides data to demonstrate the health concerns faced by clients who rely on Feeding America food banks and their partners.[61] Feeding America and its network of food banks are working to build upon the existing evidence base of the connection between food insecurity, healthy food access, and health, as changes to the health care landscape are giving hospitals and health providers greater motivation to work with food banks and other community-based services. Food banks can utilize these recent developments to take on a more formal role in health promotion.

Most health care providers and insurers are looking to improve care while reducing cost, in order to meet the Triple Aim. In other words, major insurers and providers—both public and private, profit and nonprofit—are now interested in structuring payments that reward achievement of health outcomes rather than number of services rendered. These changes are taking shape rapidly. For example, Medicare will seek to tie 30% of payments to performance-based models by 2016 and 50% by 2018.[62] CMMI will continue to fund new Medicaid demonstration projects that emphasize the provision of holistic, quality care for low-income Americans. Hospitals are striving to meet quality metrics and avoid recently introduced readmission penalties. Providers are taking advantage of new health care delivery and payment structures like ACOs, and using the flexibility of these structures to think critically about how to address social determinants of health among patients. As food insecurity and the lack of access to healthy food play a significant role in exacerbating diet-related illness, utilization of food bank services is critical to helping providers and insurers meet care quality and cost-saving goals.

Food banks have many exciting opportunities for enhanced engagement with the health care providers and insurers. Many food banks have developed successful models of partnerships to advance community health, prevent and mitigate the effects of chronic disease, and address food insecurity.

With the recent changes in the health care industry, food banks that appreciate the perspective of their health provider partners can help improve health outcomes for clients and perhaps find new funding sources for food bank services. Creating successful partnerships takes time, planning, and communication. Food banks must ask themselves whether they are ready for such partnerships and think critically about the goals for such a partnership, the form it will take, and the metrics for its success.

Feeding America's food bank network currently serves over 46 million Americans at risk of hunger. Many of these individuals who struggle to find regular access to healthy and nutritious food also face issues obtaining and paying for medical services. Effective partnerships between food banks and health care organizations have the potential to yield significant positive dividends for entire communities and improve health outcomes for food bank clients. Formal partnerships with providers have the potential to raise the profile of food banks as legitimate and indispensable partners in health promotion.

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APPENDIX

1. *Feeding America, HUNGER IN AMERICA: 2014 NATIONAL REPORT 78, available at http://help.feedingamerica.org/HungerInAmerica/hunger-in-america-2014-full-report.pdf (last visited Mar. 23, 2015).*
2. *Feeding America, HUNGER IN AMERICA: 2014 NATIONAL REPORT 118, available at http://help.feedingamerica.org/HungerInAmerica/hunger-in-america-2014-full-report.pdf (last visited Mar. 23, 2015).*
3. *Feeding America, HUNGER IN AMERICA: 2014 NATIONAL REPORT 78, available at http://help.feedingamerica.org/HungerInAmerica/hunger-in-america-2014-full-report.pdf (last visited Mar. 23, 2015).*
4. *Id.*
5. *Id.*
6. *Id.*
7. *Feeding America, HUNGER IN AMERICA: 2014 NATIONAL REPORT 135, available at http://help.feedingamerica.org/HungerInAmerica/hunger-in-america-2014-full-report.pdf (last visited Mar. 23, 2015).*
8. *See, e.g., Enza Gucciardi et al., The Intersection Between Food Insecurity and Diabetes: A Review, 3 CURRENT NUTRITION REPORTS 324-332 (2014).*
9. *FOOD RESEARCH AND ACTION CTR. Why Low-Income and Food Insecure People Are Vulnerable to Overweight and Obesity http://frac.org/initiatives/hunger-and-obesity/why-are-low-income-and-food-insecure-people-vulnerable-to-obesity/ (last visited Mar. 20, 2015).*
10. *Id.*
11. *Download a list of Foods to Encourage at Healthy Food Bank Hub: Tools & Resources, available at http://healthyfoodbankhub.feedingamerica.org/resource/foods-to-encourage/ (last visited Jun. 8, 2015).*
12. *Partner agencies of food banks include pantries, kitchens, and shelters.*
13. *See Donald M. Berwick, Thomas W. Nolan, & John Whittington, The Triple Aim: Care, Health, and Cost, 27 HEALTH AFFAIRS 759-769 (2008).*
14. *See Keith G. Provan, Leigh Nakama, Mark A. Veazie, Nicolette I. Teufel-Shone, & Carol Huddleston, Building Community Capacity Around Chronic Disease Services Through a Collaborative Interorganizational Network, 30 HEALTH EDUCATION & BEHAVIOR 646-662 (2003) (noting partnerships for chronic diseases involving community members, a local hospital, and a food bank).*
15. *Tiffany Fitzpatrick et al., Looking Beyond Income and Education: Socioeconomic Status Gradients Among Future High-Cost Users of Health care, AMER. J. PREVENTIVE MEDICINE, 2015, available at http://www.sciencedirect.com/science/article/pii/S0749379715000823.*
16. *Catherine Kreatsoulas et al., Social Disparities among youth and the impact on their health, ADOLESCENT HEALTH, MEDICINE, AND THERAPEUTICS 6, 37-45 (2015)..*
17. *KAISER COMMISSION ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUNDATION, MEDICAID: A PRIMER 1 (2013), available at https://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf*
18. *KAISER COMMISSION ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUNDATION, MEDICAID: A PRIMER 5 (2013), available at https://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf*
19. *Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States (March 2015), http://files.kff.org/attachment/issue-brief-the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states (last visited Apr. 7, 2015).*
20. *See Samantha Artiga Jessica Stephens, & Anthony Damico, The Impact of the Coverage Gap in States Not Expanding Medicaid by Race and Ethnicity, KAISER FAMILY FOUNDATION (April 2015), http://files.kff.org/attachment/issue-brief-the-impact-of-the-coverage-gap-in-states-not-expanding-medicaid-by-race-and-ethnicity (last visited Apr. 7, 2015) (finding that 14.4 million uninsured Americans would be eligible if all states expanded Medicare, but approximately 3.7 million fall into the "coverage gap").*
21. *Samantha Artiga Jessica Stephens, & Anthony Damico, The Impact of the Coverage Gap in States Not Expanding Medicaid by Race and Ethnicity, KAISER FAMILY FOUNDATION (April 2015), http://files.kff.org/attachment/issue-brief-the-impact-of-the-coverage-gap-in-states-not-expanding-medicaid-by-race-and-ethnicity (last visited Apr. 7, 2015).*
22. *Samantha Artiga Jessica Stephens, & Anthony Damico, The Impact of the Coverage Gap in States Not Expanding Medicaid by Race and Ethnicity, KAISER FAMILY FOUNDATION (April 2015), http://files.kff.org/attachment/issue-brief-the-impact-of-the-coverage-gap-in-states-not-expanding-medicaid-by-race-and-ethnicity (last visited Apr. 7, 2015); see also Rachel Garfield et al., The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid- An Update, KAISER FAMILY FOUNDATION (Nov. 2014), http://files.kff.org/attachment/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-issue-brief (last visited Apr. 7, 2015).*
23. *Rachel Garfield et al., The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid- An Update, KAISER FAMILY FOUNDATION (Nov. 2014), http://files.kff.org/attachment/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-issue-brief (last visited Apr. 7, 2015).*
24. *Id.*
25. *Samantha Artiga Jessica Stephens, & Anthony Damico, The Impact of the Coverage Gap in States Not Expanding Medicaid by Race and Ethnicity, KAISER FAMILY FOUNDATION (April 2015), http://files.kff.org/attachment/issue-brief-the-impact-of-the-coverage-gap-in-states-not-expanding-medicaid-by-race-and-ethnicity (last visited Apr. 7, 2015).*
26. *Rachel Garfield et al., The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid- An Update, KAISER FAMILY FOUNDATION (Nov. 2014), http://files.kff.org/attachment/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-issue-brief (last visited Apr. 7, 2015).*
27. *CENTERS FOR MEDICARE AND MEDICAID, Readmissions Reduction Program (Aug. 4, 2014 3:53PM) http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html (last visited Mar. 23, 2015).*
28. *Anne Pfuntner, Lauren M. Wier, & Claudia Steiner, Costs for Hospital Stays in the United States, 2010, AGENCY FOR Health care RESARCH AND QUALITY: STATISTICAL BRIEF #146 (2013), available at http://www.hcup-us.ahrq.gov/reports/statbriefs/sb146.pdf (last visited Mar. 23, 2015).*
29. *AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, Medicare's Hospital Readmission Reduction Program FAQ (Apr. 2014), https://www.acep.org/Physician-Resources/Practice-Resources/Administration/Financial-Issues-/-Reimbursement/Medicare-s-Hospital-Readmission-Reduction-Program-FAQ/ (last visited Mar. 19, 2015).*
30. *Id.*
31. *Christina Boccuti & Giselle Casillas, Aiming for Fewer Hospital U-Turns: The Medicare Hospital Readmission Reduction Program, KAISER FAMILY FOUNDATION 2 (Jan. 29, 2015), http://files.kff.org/attachment/issue-brief-aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program (last visited Mar.20, 2015).*
32. *Christina Boccuti & Giselle Casillas, Aiming for Fewer Hospital U-Turns: The Medicare Hospital Readmission Reduction Program, KAISER FAMILY FOUNDATION 3 (Jan. 29, 2015), http://files.kff.org/attachment/issue-brief-aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program (last visited Mar.20, 2015).*
33. *Jenny Minot, Reducing Hospital Admissions, ACADEMYHEALTH.ORG(Nov. 6. 2008), available at http://www.academyhealth.org/files/publications/ReducingHospitalReadmissions.pdf.*
34. *Jordan Rau, Medicare Fines 2,610 Hospitals in Third Round of Readmission Penalties, KAISER HEALTH NEWS (Oct. 2, 2014), http://kaiserhealthnews.org/news/medicare-readmissions-penalties-2015/ (last visited Mar. 19, 2015).*
35. *Su Lin Lim et al., Malnutrition and Its Impact on Cost of Hospitalization, Length of Stay, Readmission, and 3-year Mortality, 31 CLINICAL NUTRITION 345-350 (2012), available at http://www.clinicalnutritionjournal.com/article/S0261-5614(11)00199-3/pdf (last visited Mar. 23, 2015).*
36. *Id.*
37. *Id.*
38. *American Hosp. Ass'n. Fast Facts on US Hospitals (Jan. 2015), http://www.aha.org/research/rc/stat-studies/101207fastfacts.pdf (last visited Apr. 21, 2015) (taking not-for-profit hospitals (2,904) over total registered hospitals (5686) is 51%).*
39. *Gary J. Young et al., Provision of Community Benefits by Tax-Exempt U.S. Hospitals, 368 NEW ENGLAND JOURNAL OF MEDICINE 1519-1527 (2013), available at http://www.nejm.org/doi/pdf/10.1056/NEJMsa1210239 (last visited Mar. 23, 2015).*
40. *See The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007 (2010).*

41. Martha H. Somerville, Community Benefit in Context: Origins and Evolution – ACA § 9007. THE HILLTOP INSTITUTE 4 (2012), http://www.hilltopinstitute.org/publications/CommunityBenefitInContextOriginsAndEvolution-ACA9007-June2012.pdf (last visited Mar. 19, 2015).
42. Id.
43. See Community Health Needs Assessments for Charitable Hospitals, 78 Fed. Reg. 20 §523-20,544, 20540 (2013) (to be codified at 26 CFR § 1.501(r)-3(b)(5)).
44. Id.
45. Sara Rosenbaum, Principles to Consider for the Implementation of a Community Health Needs Assessment, George Washington University, (Jun. 2013), http://nnphi.org/CMSuploads/PrinciplesToConsiderForTheImplementationOfACHNAProcess_GWU_20130604.pdf (last visited Mar. 31, 2015).
46. See Sara Rosenbaum, Principles to Consider for the Implementation of a Community Health Needs Assessment, George Washington University, (Jun. 2013), 4 http://nnphi.org/CMSuploads/PrinciplesToConsiderForTheImplementationOfACHNAProcess_GWU_20130604.pdf (last visited Mar. 31, 2015).
47. National Association of County & City Health Officials, Definitions of Community Health Assessments (CHA) and Community Health Improvement Plans (CHIPs), http://www.naccho.org/topics/infrastructure/community-health-assessment-and-improvement-planning/upload/Definitions.pdf (last visited Mar. 30, 2015).
48. Id.
50. CENTERS FOR MEDICARE & MEDICAID, About the CMS Innovation Center, http://innovation.cms.gov/About/index.html (last visited Mar. 20, 2015).
51. MIPCD State Summary: Minnesota, CTRS. FOR MEDICARE AND MEDICAID SERVS., available at http://innovation.cms.gov/Files/x/MIPCD-MN.pdf (last visited Apr. 23, 2015).
52. Kathleen Sebelius, Initial Report to Congress: Medicaid Incentives for Prevention of Chronic Diseases Evaluation 1-5 (Nov. 2013), available at http://innovation.cms.gov/Files/reports/MIPCD_RTC.pdf.
53. In a 2014 round of funding, CMMI gave out grants totaling as much as $360 million for 39 recipients in 27 states to test innovative care models. These recipients included state governments (Wisconsin Dept. of Human Services), public and private universities, and hospitals. See Dep't. of Health and Human Srvs., Health care Innovation Awards to Provide Better Health care and Lower Costs, (Jul. 9, 2014) http://www.hhs.gov/news/press/2014pres/07/20140709b.html (last visited Mar. 23, 2015); See generally Dep't. of Health and Human Srvs., Health care Innovation Awards – Round Two: Frequently Asked Questions http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/faq-round-2.html (last visited Mar. 23, 2015) (noting the following examples of the types of organizations CMMI deemed eligible and expected to apply: Both not-for-profit and for-profit organizations that are recognized as a single legal entity by the State in which they are incorporated are eligible to apply. Examples of the types of organizations expected to apply are: provider groups, health systems, insurers and other private sector organizations, faith-based organizations, state and/or local governments, the District of Columbia, academic institutions, research organizations, public-private partnerships, and for-profit organizations.").
54. Feeding America, HUNGER IN AMERICA: 2014 NATIONAL REPORT 78, available at http://help.feedingamerica.org/HungerInAmerica/hunger-in-america-2014-full-report.pdf (last visited Mar. 23, 2015).
55. See Boston Medical Center, Nutrition Resource Center, http://www.bmc.org/nutritionresourcecenter/foodpantry.htm (last visited Mar. 31, 2015).
56. See Redwood Empire Food Bank, Clinical Training: Food Insecurity Screening, http://healthyfoodbankhub.feedingamerica.org/wp-content/uploads/2014/05/FI-Clinical-Training-Brief.pdf (last visited Mar. 31, 2015).
57. See Erin R. Hager et al., Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity, 126 PEDIATRICS e26-e32 (2010). http://healthyfoodbankhub.feedingamerica.org/wp-content/uploads/2014/05/FI-Clinical-Training-Brief.pdf (last visited Apr. 23, 2014).
58. AMERICAN MEDICAL ASSN., STATE MEDICAL LICENSURE REQUIREMENTS AND STATISTICS 2013 65-69 (2013).
59. See, e.g., Enza Gucciardi et al., The Intersection Between Food Insecurity and Diabetes: A Review, 3 CURRENT NUTRITION REPORTS 324-332 (2014); Su Lin Lim et al., Malnutrition and Its Impact on Cost of Hospitalization, Length of Stay, Readmission, and 3-year Mortality, CLINICAL NUTRITION, 31(3), 345-350 (2012), available at http://www.clinicalnutritionjournal.com/article/S0261-5614(11)00199-3/pdf (last visited Mar. 23, 2015); Hillary K. Seligman & Dean Schillinger, Hunger and Socioeconomic Disparities in Chronic Disease, 363 NEW ENGLAND JOURNAL OF MEDICINE 6, 7 (2010).
60. See Additional Requirements for Charitable Hospitals, 79 Fed. Reg. 78953, 79002-3 (Dec. 31, 2014), available at https://www.federalregister.gov/articles/2014/12/31/2014-30525/additional-requirements-for-charitable-hospitals-community-health-needs-assessments-for-charitable#h-34.
61. See Feeding America, HUNGER IN AMERICA: 2014 NATIONAL REPORT 78, available at http://help.feedingamerica.org/HungerInAmerica/hunger-in-america-2014-full-report.pdf (last visited Mar. 23, 2015).
62. Ctrs. for Medicaid & Medicare Servs., Better Care. Smarter Spending. Healthier People: Paying Providers for Value, Not Volume (Jan. 26, 2015), http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html (last visited Apr. 23, 2015).

ABOUT HEALTHY FOOD BANK HUB

HealthyFoodBankHub.org is a microsite of FeedingAmerica.org providing high-quality information, evidence-based practices and over 400 recipes, tools and resources developed to meet the needs and challenges of those experiencing food insecurity. The site was developed in partnership with food banks, the Academy of Nutrition and Dietetics Foundation and National Dairy Council and has reached over 70,000 unique users seeking information addressing the intersection of food insecurity, nutrition and health. Highlights include:

Quarterly Digest

In July 2015, the first edition Digest for HealthyFoodBankHub.org will be sent to hundreds of subscribers interested in staying connected to the website's content. This publication features the Hub's newest features, content, collaborators and targeted tools and resources. A robust marketing of the Digest will occur to network members, national office staff, partners and other supporters beginning in July, and interested parties can sign up online.

Tools and Resources

Utilize the improved Google Custom Search in the enhanced Tools and Resources section of HealthyFoodBankHub.org which includes 10 refinement categories, a new size-adjusted tag cloud and with over 400 asset that include healthy recipes, curriculum, research, posters and educational materials.

Hub Widget

Add a Healthy Food Bank Hub widget to enhance your website or blog! You can customize your widget(s) with the latest recipes, educational materials, curriculum and/or research reports related to food insecurity, nutrition and health. Follow three easy steps, then press Generate My Widget Shortcode. Be sure to paste the unique code into your website to provide your audience access to ever-growing resources.

Featured Section

The Featured Section on the homepage of the Healthy Food Bank Hub is refreshed at the beginning of each month, and its' spotlights include the latest healthy recipes, nutrition information and news regarding food insecurity and health.

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