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Health Care Sector Support for Healthy Food Initiatives

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Abstract

Unhealthy diets in the United States contribute to chronic diseases and their treatment costs. Health sector organizations are beginning to support initiatives that promote healthy eating in their community as a result of incentives for prevention in the Patient Protection and Affordable Care Act (ACA). The ACA's emphasis on prevention coincides with new farm policy programs intended to improve health and nutrition. Despite these synergistic opportunities for collaboration between health care and food organizations, few reviews have been undertaken to assess the extent to which they are occurring, the types of partnerships that have been formed, and impediments to collaboration that exist. We solicited examples from food policy councils of their experiences with health sector organizations. We also reviewed community benefit reports from non-profit hospitals in Maryland and discussed opportunities with health sector personnel. We found that while hospitals, health insurers, and health centers have begun to support efforts to increase the affordability and accessibility of healthy food, these partnerships are in nascent stages, and the health sector's familiarity with food policy councils, farm policy, and opportunities to collaborate with food-based organizations is not widespread.

"Let food be thy medicine and medicine be thy food" -- Hippocrates

Introduction

The United States (U.S.) health care system accounts for 18% of U.S. gross domestic product, making it the most expensive in the world (World Bank 2014). Chronic diseases in particular are a significant contributor to U.S. health care expenditures. According to the Center for Disease Control, about half of all adults have one or more chronic health conditions, which account for the majority of U.S. health care costs (Ward, Schiller, Goodman 2014; Robert Wood Johnson Foundation 2010). The high incidence of these chronic diseases can be prevented through diet and lifestyle choices. In particular, food intake in the U. S. is, on average, not aligned with dietary guidelines. Fruits and vegetables are under consumed, while the consumption of red meat and ingredients like solid fats and added sugars is in excess of what is recommended (USDA HHS 2010).

The Patient Protection and Affordable Care Act (ACA) provides incentives for health sector organizations to initiate activities that prevent diseases in an attempt to reduce treatment costs. Food system innovations intended to promote healthier diets and reduce inequalities related to accessibility and affordability could provide opportunities for health organization support. Partnerships between the health care sector and implementing agencies could be an effective strategy since lower-income populations confront greater constraints in maintaining a healthy diet than others, and the health care industry interacts directly with the most disadvantaged populations. Some hospitals have made on-site improvements in procurement for staff and patients, including instituting farm-to-hospital programs to source healthier food and establishing on-site farmers markets (Smith II, Kaiser, and Gomez 2013;

Cromp et al. 2012). Nonetheless, the involvement of hospitals and health insurers with improving food environments in the community is not widespread.

Despite these emerging opportunities for collaboration between health care and food organizations, few reviews have been undertaken to assess the extent to which it is occurring, the types of partnerships that have been formed, and impediments to opportunities that exist. To examine this topic in greater depth, we solicited examples from members of a food policy council (FPC) listserv for examples of their experiences with health sector organizations. We also reviewed community benefit reports from non-profit hospitals in Maryland and discussed opportunities with health sector personnel.

We found that health sector organizations, including hospitals, health insurers, and health centers, have begun to support these efforts in various capacities. However, the health sector's familiarity with food policy councils, food and farm policy, and knowledge of opportunities to collaborate with food-based organizations was not widespread. In this document, we review our findings, provide specific examples of partnerships, and summarize ways by which further support for healthy food initiatives from the health care industry could occur.

Background

Although the ACA is more popularly known for increasing access to health insurance, constraining health care costs is also a major priority (Koh and Sebelius 2010). Incentives to constrain treatment costs include financial assistance, such as community grants that can be used to invest in prevention initiatives, as well as penalties, such as restrictions on

reimbursement to hospitals if Medicare patients are readmitted within 30 days for some types of diseases, including heart attacks or heart failure.

In addition, the ACA provides new guidance with regard to “community benefit” expenditures from non-profit hospitals, which comprise 51% of total hospitals in the U.S. (AHA 2014). Non-profit hospitals received tax exemptions that were equal to $12.6 billion nationally in 2002 (CBO 2006). In turn, they are required to report initiatives they undertake that support “community benefits” under the rationale that these services would otherwise have to be addressed using public funds. Historically hospitals have had considerable discretion in quantifying and defining the types of services that constitute community benefits (U.S. GAO 2008). There is no threshold community benefit expenditure requirement at the federal level, and states and localities have the discretion to develop their own standards (Folkemer et al. 2011). Nationally, 8% of expenses for nonprofit hospitals are for community benefits (Young et al. 2013b). Of those expenditures, 85% were for subsidized patient care (e.g., charity care, unreimbursed Medicaid costs, subsidized health services), with just 5% directed toward prevention efforts such as screening, education, or immunization (Young et al. 2013b). The remaining 10% of community benefit expenditures were for health-professions education, cash or in-kind contributions to community groups, and research.

As the percentage of uninsured patients is anticipated to decline due to the expansion of coverage in the ACA, hospitals are expected to identify more opportunities to undertake community benefit initiatives that promote prevention. Specifically, the ACA requires tax-exempt hospitals to develop a public “community health needs assessment” (CHNA) every three years that incorporates community input, particularly from the public health sector. The

ACA also requires these hospitals to adopt an implementation strategy by which the health improvements identified in the CHNA will be achieved. Additionally, they must specify in their audited community benefit financial report a description of how the hospital is addressing the needs identified in the CHNA and a rationale for identified needs that are not being addressed.

Because 97% of recipients of Supplemental Nutrition Assistance Program (SNAP) benefits could qualify for Medicaid under expansion (Dorn et al. 2013), health insurers may also have incentives to promote healthier food consumption as a means to reduce treatment costs, particularly in states where Medicaid has expanded. Improving diet-quality among lower-income populations is of particular importance because diet quality often declines with income. For example, the consumption of fruits and vegetables is lower among people in lower-income households relative to those in higher-income households (Lin and Rogers 2013).

The ACA's emphasis on prevention coincides with new programs developed in farm policy intended to improve health and nutrition. The Farm Bill passed in February 2014 contains the Food Insecurity Nutrition Incentive (FINI) program, which offers grants to organizations that are implementing or continuing incentive subsidy programs for the redemption of SNAP benefits for fruits and vegetables. FINI is modeled after incentive subsidy programs that provide recipients of food assistance benefits, such as SNAP or the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), additional vouchers that they can spend when redeeming their benefits. As of 2012, at least 500 farmers markets nationally were offering incentive programs for SNAP, and these incentive programs are starting to be piloted in grocery stores (Community Science 2013). Research has found that they increase the consumption of fruits and vegetables (Freedman et al. 2013; Lindsay et al.

2013; Young et al. 2013a). In order to apply for FINI funds, however, applicants must demonstrate that they have secured matching funds from other sources. Support from hospitals, in the form of a community benefit initiative, and/or health insurers would be a way to leverage resources so that FINI program funds are successfully distributed and used for healthy food purchases.

Methods

We undertook several approaches to assess the ways that community food organizations are working with the health care industry. First, we compiled examples of partnerships that we identified anecdotally through discussions or in the literature. Second, we reached out to FPCs, which consist of food system stakeholders that are working in the community to identify and promote healthy food policy initiatives, to solicit their experience with health sector organizations. We used a FPC listserv to ask subscribers if they had members on their FPC from the health care sector; if so, what kinds of healthy eating policies or programs did they support; and if the FPC had discussed the ACA.

Third, we conducted a systematic review of hospital initiatives in Maryland by reviewing community benefit reports and having discussions with health sector personnel. Maryland was a good location for a case study for a variety of reasons. Maryland has a prominent hospital sector that is required to demonstrate $330 million in Medicare cost savings over the next five years. The Maryland Health Services Cost Review Commission also makes individual community benefit reports publically available for each Maryland non-profit hospital on an annual basis, which provides a greater level of transparency with regard to community benefit expenditures

than exists elsewhere. Through the Maryland Food System Mapping project, the Johns Hopkins Center for a Livable Future (CLF) has played a significant role in identifying areas where food access challenges exist, and has experience collaborating with organizations and personnel working on those challenges throughout Maryland. CLF has also participated in and evaluated initiatives to increase the affordability and accessibility of healthy food throughout the state, particularly in Baltimore (Santo, Yong, and Palmer 2014).

As part of our efforts, we had direct communications, either in-person or on the telephone, with health sector personnel that represented associations (Maryland Hospital Association), hospitals (Johns Hopkins Hospital, Adventist HealthCare, MedStar Harbor Hospital, University of Maryland Medical Center, Mercy Health Services, Holy Cross Health), federally qualified health centers (Health Care for the Homeless), and health care providers (Kaiser Permanente). We also had discussions with food organizations that interact with the health care industry (Crossroads Community Food Network, Maryland Hospitals for a Healthy Environment, Maryland Farmers Market Association).

Findings

Examples of Health Care Sector Efforts at Promoting Healthy Diets

We identified numerous ways by which health sector organizations are addressing food-related challenges in their community. Some examples include:

Subsidizing healthy food purchases. There are several ways that health organizations are subsidizing healthy food purchases, particularly of fruits and vegetables. Some hospitals and

health insurers are providing funding support to farmers markets that offer nutrition incentive programs for food assistance benefits that we described earlier. In other instances, vouchers for healthful foods are provided without requiring that the recipient also utilize their own cash or benefits. These programs are sometimes referred to as “prescription” programs in instances when a medical doctor issues the food vouchers to patients with diet-related chronic diseases. For example, a federally qualified health clinic in South Carolina offered financial incentives for fruits and vegetables to diabetics, and subsequently found that fruit and vegetable consumption increased (Freedman et al. 2013). In another example, Boston Medical Center primary care providers write food “prescriptions” to patients that they can redeem on-site at BMC’s “Preventive Food Pantry” (BMC 2014). Health care organizations have also partnered with local farmers markets in implementing such programs. Such an example occurred in New York City, where the Lincoln Medical Center and Harlem Hospital Center have partnered with Wholesome Wave to issue “prescription” coupons to families with poor nutrition that they can redeem for fruits and vegetables at local farmers markets (Wholesome Wave 2013).

Financial incentives were also applied to insurance premiums. For example, the FairShare CSA Coalition in Wisconsin works with health insurers to offer health insurance rebates to customers that purchase a share in a community supported agriculture arrangement (FairShare CSA 2014).

Increasing access through the supply chain investments. We did not identify examples of investments in upstream supply chain facilities, such as a “food hub” that could facilitate the sale of food from local farmers to retail institutions that purchase food in larger quantities,

from the health care industry in our review. Nonetheless, it is possible that such investments could occur, as the Internal Revenue Service allows "community building" activities to count as a community benefit for non-profit hospitals provided that a rationale exists on how the building improves community health (Rosenbaum, Rieke, and Byrnes 2014). However, other ways of improving access have been implemented. For example, Indiana University Health subsidizes a "Garden on the Go" program, which is a mobile food truck that stops at low-income and elder care facilities to sell fresh fruits and vegetables from local farms (IUH 2013).

Collaborating with food organizations on outreach and education. Farmers markets can provide an outreach location for health care organizations so that market shoppers can obtain health screenings, culinary education, and other information. Maintaining a consistent presence at a weekly farmers market could offer a greater level of continuity and duration for conducting such outreach as opposed to a health fair scheduled irregularly or infrequently (George et al. 2013). Health organizations could also collaborate with practitioners in evaluating the health impacts of healthy food interventions.

Experience of Food Policy Councils with Health Sector Organizations

Table 1 contains summary information on responses provided by FPCs of the types of activities they are undertaking. Ten FPCs responded to the survey. The table shows that all of the respondents had health care sector representation on their FPCs, although the FCP's that responded to the survey are not necessarily representative of all FPC's, as the FPCs that responded could be the FPCs most likely engaged with the health care industry. Half of the respondents identified that health sector organizations are supporting healthy food access

programs in some capacity. The respondents also indicated that the following activities were occurring with at least one of the FPC's: ACA enrollment was occurring at food pantries, hospitals were funding the FPC, the FPC was actively discussing how the ACA could support food system reform in their community, or hospital counselors were enrolling people in SNAP.

We elaborate further on a select number of responses below:

- The Ozarks Regional Food Policy Council was initiated and funded by its local hospital, CoxHealth, to address pediatric obesity in southwest Missouri.
- The Community Food Council for Del Norte and Adjacent Tribal Lands in California has received funding from its hospital to facilitate a SNAP matching rebate program at its local farmers market.
- The San Francisco Food Security Task Force has discussed opportunities the ACA presents for funding nutrition-related programs to reduce hospital readmissions and support long-term care.
- Through the food insecurity working group, the New London County Food Policy Council in Connecticut coordinated ACA enrollment at food pantries.
- Denver Health has contributed personnel time to the Denver Sustainable Food Policy Council and the development of Denver's Healthy Food Access Plan. It has also advanced grocery store implementation and the evaluation of food policy with the city of Denver through a CDC Community Transformation Grant.
- UMass Memorial Medical Center works with the Worcester Food & Active Living Policy Council, and provided community benefit funding to operate a mobile farmers market for low-income areas, an urban farming summer program for low-income youth, and

Share Our Strength's Cooking Matters classes. It has also trained its financial counselors to enroll people for food assistance benefits.

Review of Maryland Hospital Community Benefit Initiatives

The nonprofit hospitals in Maryland, along with their location, community benefit service area (CBSA), and operating expenses, are listed in Table 2. Only the CBSA regions within Maryland are listed. Hospitals do not define their CBSA in a standard way. For example, the CBSA definitions for some urban hospitals are at the zip code level, while the CBSA definitions for rural hospitals might encompass multiple counties.

The location and size of hospitals in Maryland reflects the variation in population density within the state. Nine of the eleven largest hospitals are clustered in Baltimore City. In particular, Johns Hopkins Hospital and the University of Maryland Medical Center are the two largest and each have annual operating expenses in excess of one billion dollars. In rural regions, however, there may only be one hospital that services the entire county and some of these have annual operating expenses of less than $50 million. Figure 1 shows community benefit expenditures within Baltimore City. These were reported by plotting the total community benefit expenditures of each hospital over their entire self-reported community benefit service area (CBSA), as we cannot allocate exactly within a CBSA where the expenditures occurred. The parts of Baltimore City with high levels of community benefit expenditures coincide with areas with the highest percentage of people using SNAP benefits, the highest degree of heart disease mortality, and the greatest food access challenges.

At least 7 hospitals in Maryland have an on-site farmers market that administer nutrition assistance programs and a number of hospitals have improved sourcing of healthier food options by participating in "farm-to-hospital" programs with assistance from Maryland Hospitals for a Healthy Environment. While these initiatives were typically not identified in community benefit reports since these efforts are primarily implemented for staff and patients, they can be a first step for a hospital to become engaged with promoting healthier eating options.

As part of their community benefit initiatives, 80% of hospitals in Maryland have implemented screening and/or education programs that are relevant for general nutrition or a diet-related chronic disease, such as cardiovascular diseases, diabetes, or obesity. However, some of these initiatives are modestly funded, and except in a few instances, community benefit efforts by hospitals are generally not promoting healthy food programs beyond this stage. In contrast, one health care provider, Kaiser Permanente, has supported some of the more progressive projects in the state. These include funding a nutrition incentive program for SNAP and WIC benefits at the Crossroads Farmers Market in Takoma Park, which was one of the first farmers market nutrition incentive programs (Winch 2008). Kaiser Permanente also provided a grant to the United Fresh Produce Association to install salad bars in neighboring Washington, DC elementary schools (UFPA 2014).

Conclusions and Recommendations

We identified various ways by which health sector organizations are improving diets and nutrition. We also found there is a growing awareness among food organizations of the

importance of the health sector support for healthy food initiatives to either complement or substitute for funding from governments or philanthropic foundations. Nonetheless, there numerous challenges that must be resolved in order for these efforts to expand. These include:

- Evidence has found that health care cost expenditures decline with improved nutrition (Gurvey et al. 2013). However, health sector organizations confront multiple risk factors in their community. Besides poor nutrition, other risk factors can include smoking, mental illness, substance abuse, inactivity, poor prenatal and infant care, domestic violence, and a lack of implementing simple cancer screenings. This implies that focusing prevention efforts to address any one risk factor can have high opportunity costs.
- Healthy diets are just one component of lifestyle choices needed to mitigate the incidence of chronic diseases like cardiovascular disease and obesity, and interventions to rectify diet-related chronic diseases may require a long time to be successful. These can present impediments to the effectiveness of healthy food interventions, increase the challenges with evaluating them, and imply that any resulting health benefits and medical care cost savings may require a long timescale to occur.
- The population that could be targeted by a healthy food intervention may not overlap with CBSA boundaries for hospitals. This can be a particularly vexing challenge in large municipalities. For example, the largest farmers market in Baltimore is the Downtown/JFX market, and it attracts shoppers from all across the city. Thus, supporting a financial incentive program at Downtown/JFX would result in improved diets for populations in CBSA's for several hospitals. This implies that an individual

hospital may not have as great of an incentive to support the project if some of the benefits accrue to citizens of neighborhoods that patronize other hospitals.

- Hospitals and health insurers are large bureaucracies, and engaging with these institutions can impose high transaction costs on community food organizations with limited resources.

Even though the health sector's support for healthy food initiatives is just beginning, a framework exists to help the future success of these partnerships. Greater coordination among non-profit hospitals when developing CHNA's and ensuring that CHNA's include a food systems analysis can ensure that hospitals have a greater understanding of opportunities that are available for healthy food interventions. Outreach facilitated by FPCs and food organizations can be a way to increase the health sector's understanding of mutual opportunities for healthy food interventions. This would also enable food organizations to obtain a better understanding of how health care organizations implement prevention initiatives; priorities confronting health sector organizations; and logistical issues that would require cooperation for successful partnerships, such as ones relating to administration, budgeting, and evaluation.

Table 1. Examples of Food Policy Council Engagement with Health Sector Organizations

Food policy council (FPC)	Health care representation on FPC	Support healthy food access programs	ACA enrollment at food pantries	Hospital funding for FPC	Actively discussing ACA opportunities	SNAP enrollment by hospital counselors
Kansas City (MO) FPC	X					
Ozarks Regional (MO) FPC	X	X		X		
St. Louis FPC	X					
Community Food Council for Del Norte and Adjacent Tribal Lands (CA)	X	X				
San Francisco Food Security Task Force	X	X			X	
Homegrown Minneapolis Food Council	X					
San Bernardino (CA) FPC	X					
New London County (CT) FPC	X		X	X		
Denver Sustainable FPC	X	X		X		
Worcester (MA) Food and Active Living Policy Council	X	X			X	X

Table 2 –Community Benefit Service Area and Operating Expenses of Maryland Acute Care Hospitals

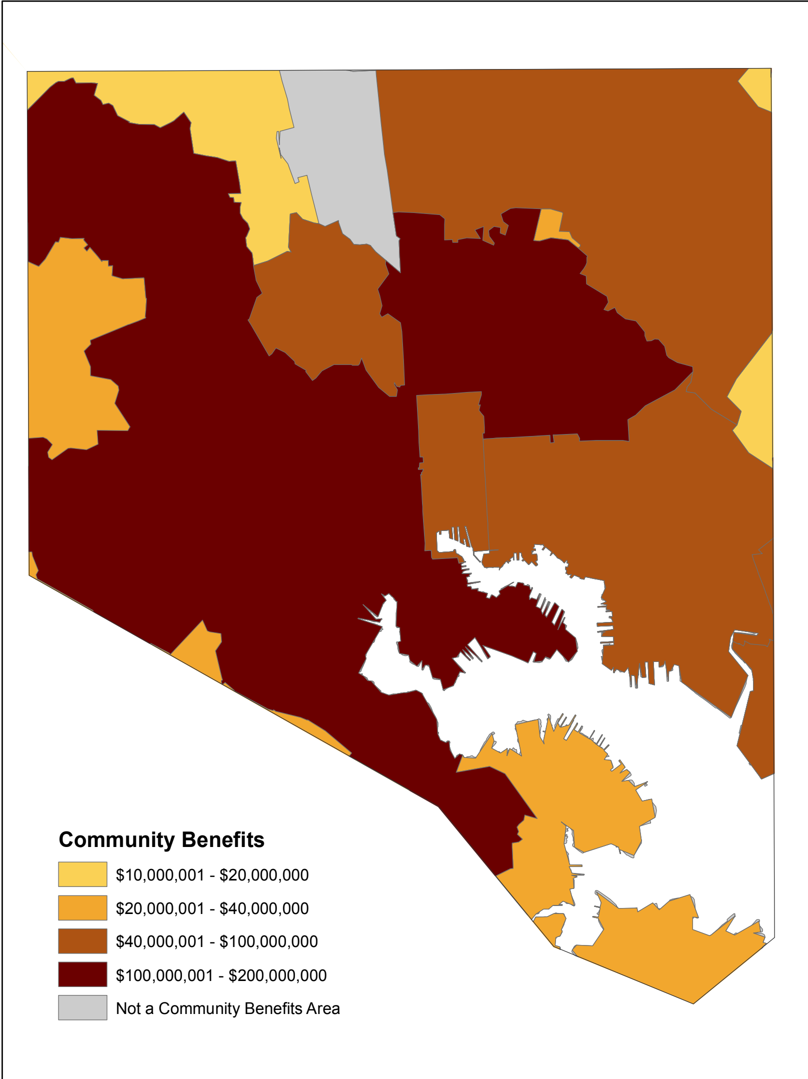
Hospital Name	**Location**	**Community Benefit Service Area**	**FY 2012 Operating Expenses (Million USD)**
Johns Hopkins Hospital	Baltimore	Baltimore City	$1,726
University of Maryland Medical Center	Baltimore	Baltimore City	$1,294
Sinai Hospital of Baltimore	Baltimore	NW Baltimore City, Baltimore County	$691
Johns Hopkins Bayview Medical Center	Baltimore	SE & NE Baltimore City & County	$543
Anne Arundel Medical Center	Annapolis	Anne Arundel County	$501
Franklin Square Hospital Center	Baltimore	SE Baltimore County	$437
Mercy Medical Center	Baltimore	Baltimore City	$400
Union Memorial Hospital	Baltimore	North Baltimore City, Baltimore County	$397
Greater Baltimore Medical Center	Baltimore	Baltimore City & County, Harford County	$394
Holy Cross Health	Silver Spring	Montgomery & PG County	$387
St. Agnes Hospital	Baltimore	Baltimore City & County, Anne Arundel, Carroll & Howard County	$380
Peninsula Regional Medical Center	Salisbury	Wicomoco, Worcester & Somerset County	$374
Frederick Memorial Healthcare System	Frederick	Frederick County	$349
Baltimore-Washington Medical Center	Glen Burnie	Anne Arundel County	$325
St. Joseph Medical Center	Towson	Baltimore County	$318
Western Maryland Health System	Cumberland	Allegany County	$305
Good Samaritan Hospital of Maryland	Baltimore	NE Baltimore City	$300
Shady Grove Adventist Hospital	Rockville	Montgomery County	$293
Meritus Medical Center	Hagerstown	Washington County	$284
Suburban Hospital	Bethesda	Montgomery County	$239
Southern Maryland Hospital Center	Clinton	Southern PG County	$238
Howard County General Hospital	Columbia	Howard County	$230
Washington Adventist Hospital	Takoma Park	Montgomery & PG County	$225
Northwest Hospital Center	Randallstown	Baltimore County	$216
Upper Chesapeake Medical Center	Bel Air	Harford County	$213
Carroll Hospital Center	Westminster	Carroll County	$211
Prince George's Hospital Center	Cheverly	PG County	$204
Harbor Hospital Center	Baltimore	Southern Baltimore City, Anne Arundel County	$202
Doctors Community Hospital	Lanham	PG County	$191
Maryland General Hospital	Baltimore	West Baltimore City	$180
Memorial of Easton	Easton	Caroline, Dorchester, Queen Anne's County	$159
Union Hospital (Cecil County)	Elkton	Cecil County	$144
Montgomery General Hospital	Olney	Montgomery County	$138
St. Mary's Hospital	Leonardtown	St. Mary's County	$122
Bon Secours Hospital	Baltimore	SW Baltimore City	$121
Calvert Memorial Hospital	Prince Frederick	Calvert County	$118

Civista Medical Center	La Plata	Charles County	$104
James Lawrence Kernan Hospital	Baltimore	Baltimore City & County, Anne Arundel & Howard County	$103
Laurel Regional Hospital	Laurel	PG, Anne Arundel, Howard, & Montgomery County	$97
Atlantic General Hospital	Berlin	Worcester County	$91
Harford Memorial Hospital	Havre de Grace	Harford County	$90
Chester River Health System	Chestertown	Kent County	$55
Dorchester General	Cambridge	Caroline, Dorchester, Queen Anne's County	$43
Fort Washington Medical Center	Fort Washington	Fort Washington, Oxon Hill, Temple Hills	$42
Garrett County Memorial Hospital	Oakland	Garrett County	$38
McCready Memorial Hospital	Crisfield	Somerset County	$22

Source: MHSCRC 2012.

Notes: James Lawrence Kernan Hospital is a rehabilitation orthopedic hospital. Dorchester General and Memorial of Easton file the same Community Benefit narrative report under Shore Health Systems. Southern Maryland Hospital Center was a for-profit hospital until 2012.

Figure 1 – Variation in Community Benefit Expenditures within Baltimore City



Source: MHSCRC 2012.

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