HUNGER + HEALTH | FEEDING AMERICA

Food is Medicine 2.0

FINAL PROJECT REPORT

Prepared for the Anthem Foundation

RELEASED
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Acknowledgments

Fourteen Feeding America member food banks participated in the *Food is Medicine 2.0 (FIM 2.0)* project. Teams at each site worked to implement activities with health care partners. Feeding America extends our gratitude to those teams, and to the lead food bank staff who managed local activities and contributed to this report. Feeding America also acknowledges the work and dedication of the health care partner sites, staff and clinicians who partnered with member food banks. Thank you for your partnership and your heroic efforts to protect and care for communities. Most importantly, Feeding America would like to acknowledge and thank the thousands of patients who participated in the project and provided feedback for improving FIM 2.0 activities and strengthening food bank-health care partnerships.

ABOUT ANTHEM FOUNDATION

FIM 2.0 and this report were facilitated through the generous support of the Anthem Foundation, the philanthropic arm of Anthem, Inc. As a Leadership Partner, Anthem Foundation proudly supports the Feeding America network in growing health care partnerships through grants, sponsorships, and employee matching gift and volunteer programs. Learn more about the **Anthem Foundation**.

AUTHORS

This report was written by Feeding America staff: Jessica Hager, Ashley Howard, Fredi Koltes, Karalee Miller, and Hanna Selekman, and reviewed by Feeding America staff across Communications, Finance, Fundraising, Innovation, Research and Strategic Capacity Development. The conclusions and opinions expressed herein are Feeding America's and do not necessarily represent the views of any sponsoring agency or individual food bank.

Report design by Resonate, LLC.

Contents

This report describes results from the Food is Medicine 2.0 (FIM 2.0) project, a fifteen-month initiative that supported food bank-health care partnerships and interventions to serve patients who screened positive for food insecurity in health care settings. Learnings outlined in the report represent the additive knowledge gained during the second phase of the Food is Medicine project. The **Final Report** from the first phase was released in April 2021 and outlined initial learnings which were vital inputs to FIM 2.0.

Visit Hunger + Health to view a short video highlighting the *Food is Medicine 1.0* project.

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Project Overview

In June 2019, Anthem Foundation and Feeding America announced the launch of the Food is Medicine (FIM 1.0) partnership, an effort aimed at connecting people facing hunger to food distribution programs to ensure they have access to healthy food options. The program engaged hospital outpatient clinics to support clinic staff in conducting universal food security screenings, offering referrals and supporting the development of promising interventions and activities to end hunger. These activities varied by food bank but often included enrollment in federal nutrition programs, nutrition education programming and use of "nudges" to further increase participant capacity to adopt healthy food choices and habits.

Food is Medicine 2.0 (FIM 2.0), which began in January 2021, built upon the FIM 1.0 program and expanded to 14 food bank-health care partnerships. FIM 2.0 served more patients, improved support for local data collection and analysis, offered new, nutritious food distribution options, enrolled more participants in multiple benefits programs and continued to help make the healthy choice the easy choice for people served.

FIM 2.0 SUPPORTED FOOD BANKS AND THEIR HEALTH CARE PARTNERS TO:

- Screen patients for food insecurity during patient visits
- Provide access to nutritious food onsite at health care locations
- Enable SNAP and other benefits applications
- Connect people to additional community-based nutrition resources

GOALS

- Collectively screen 100,000 patients
- Support maintenance and expansion of food bank-health care partnerships
- Improve patients' food security, diet quality, and health outcomes

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PROJECT COMPONENTS AND ACTIVITIES

COMPONENTS

1. **Held four-month planning period** to develop and finalize project management activities and timelines; identify external advisors and partners; and complete staffing, evaluation, marketing and communications plans. Feeding America worked with the Anthem Foundation team to identify Anthem priority markets and the Feeding America Member Grants team to oversee the grant application and award process.

2. **Local member grants and a comprehensive orientation** were provided to 14 Feeding America food banks to expand partnerships with local health care organizations, support food insecurity screening and develop and implement nutrition and health promotion interventions.

3. Each food bank was encouraged to lead a **local planning phase, resulting in an intervention period,** that included a range of activities:

   a. Health care partnership management and expansion

   b. Refinement and maintenance of processes—developed with health care partners—such as food insecurity screening and referral, data collection, data sharing, and patient engagement and tracking

   c. Development and deployment of benefits outreach programming

   d. Development and deployment of innovative food distribution models

   e. Related activities to support equity, food access, health and nutrition

4. Food banks were required to **monitor program progress** over the 9-month grant period. To support learnings and overcome challenges through the monitoring process, they also had access to research/evaluation technical assistance, a peer learning community and subject matter experts.

5. Feeding America utilized the expertise of its Research staff and food banks to develop and conduct a **comprehensive project evaluation**.

   a. Priority evaluation metrics considered for inclusion involved both process/reach measures and outcome measures

   b. Food security, dietary intake, and Healthy Days are outcome measures Feeding America has prioritized as part of its board-approved strategies and measurement framework

   c. The Feeding America Client Survey (FACS) was used to create a custom survey to collect data on participant-level outcomes measures (specifically food security status, dietary intake / fruit and vegetable consumption, health conditions, SNAP, and Healthy Days)

The COVID-19 pandemic, similar to during the first phase of the program, contributed to increased rates in unemployment, food insecurity, and medical care, as well as a highly taxed charitable food sector and health care system. As seen below in the New Learnings section and challenges shared by food banks, the pandemic and its impacts continued to play a role in some food banks' ability to effectively and efficiently develop health care partnerships, as well as provide services.

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ACTIVITIES

- Supported health care partner sites to implement universal food insecurity screening
- Tested and refined food bank-health care processes around referral systems, feedback loops, data tracking and data sharing
- Prioritized SNAP eligibility assessment and application assistance activities
- Supported and enhanced existing food distribution programming housed at health care sites
- Piloted and expanded new modes of distribution to meet the needs of participants and advance equitable access
- Supported food bank sites to participate in project evaluation activities and deploy the Feeding America Client Survey (FACS)
- Adapted food bank–health care partnership models to better respond to food insecurity in the context of COVID-19
- Built food bank staff and team capacity to prioritize equity through trainings, engagement and other activities
- Enhanced network capacity and best practices for engagement in food bank-health care partnerships

> **"The food boxes have been very helpful, especially in this time with grocery store prices. All the food and the vegetables came in handy. It made a big impact in our lives."**
>
> Program Participant

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Results

> **“Of all the social determinants of health, food security has one of the most direct and potent impacts on individual health. Compounding the issue, those dealing with food insecurity are disproportionately affected by chronic diseases, which exacerbates adverse effects on health and financial wellbeing. Food bank-health care partnerships are game-changing for patients in providing equitable access to nutritious, disease-appropriate foods and education that drives long-term behavior change and improved health.**

Tom Summerfelt, PhD
Chief Research Officer
Feeding America

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AGGREGATED PROGRAM DATA

Participating food banks collectively surpassed the projected goal of health care partners screening 100,000 patients. They **screened a total of 643,545 patients** for food insecurity, with **50,588 of the patients screening positive**. An important next step was then the referral to appropriate interventions or services and patient's ability to take-up the referral; **12,835 program participants received a referral and engaged.** Food banks and health care partners outlined various challenges, not all within their immediate control, for increasing referral and engagement rates. Please refer to the New Learnings section for more information.

643,545 FOOD INSECURITY SCREENINGS	**50,588** POSITIVE FOOD INSECURITY SCREENINGS	**12,835** PROGRAM REFERRAL & ENGAGEMENT
471 SNAP APPLICATIONS ***DIRECT*** ASSISTANCE	**131** SNAP APPLICATIONS ***INDIRECT*** ASSISTANCE	

Several food banks noted in their final member grant reports anticipation and intention to evolve their health care partnerships to a stage where they can easily track and share health outcomes data. For most, significant operational challenges and legal concerns remained in order for this to be possible during the nine-month grant period. In a few cases, food banks continued tracking health data from FIM 1.0 into FIM 2.0.

Though full reports on collected health data were not available at the time of producing this report, portions of two food bank narratives are featured below.

> **"The last [health outcomes] report shared with Houston Food Bank (HFB), with data collection ending on June 30, 2021, showed a decrease in A1c among clients enrolled in Food Rx at Harris Health. Participation in Food Rx at Harris Health means that patients receive nutritious food distributions and nutrition education twice a month during a nine-month period. As the partnership progresses to incorporate improved technology and data privacy practices, HFB staff will explore efficient, non-manual, and secure ways to share individual level biometric data.**
>
> Houston Food Bank

> **"Out of the 39 applications from our healthcare program partner, 100% of applicants were approved. It can also be noted that at our one-month check-in, 88% of patients reported not being readmitted to the ER and at our three-month check-in, 57% of patients reported not being readmitted to the ER.**
>
> St. Louis Area Food Bank

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FOOD IS MEDICINE 2.0: NEIGHBOR SURVEY RESULTS

For Food is Medicine 2.0 (FIM 2.0), 14 food banks co-developed the Neighbor Survey—using the Feeding America Client Survey (FACS).

PLEASE NOTE:

Percentages in the report tables may not add to 100 due to not all neighbors answering that question/module and rounding. If an entry contains only a "%" with no number, that entry is zero.

TABLE 1.
NUMBER OF RESPONSES TO THE SURVEY: 709

FOOD BANK NAME[1]	# OF SURVEYS COMPLETED[2]
Atlanta Community Food Bank	248
HACAP Food Reservoir	188
Gleaners Food Bank of Indiana	101
Second Harvest Food Bank of Middle Tennessee	54
Houston Food Bank	40
Food Bank of Northern Nevada	29
Greater Cleveland Food Bank	17
Freestore Foodbank	16
Food Bank of Northwest Indiana	7
St. Louis Area Foodbank	4
Dare to Care Food Bank	2
Feed More	2
Feeding America Riverside I San Bernardino Counties	1
TOTAL	**709**

*Thirteen food banks contributed surveys with a total of **709 participants** completing at least a portion of the survey. The majority of the participants identified as female (67.6%). Almost half of the participants identified as African American (49.1%) followed by white (37.2%) and Hispanic (18.9%). The average age was 50.6 years old, the average number of people in the household other than the participant was 2.3 with an average of one household member younger than 18 years old).*

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TABLE 2.

PARTICIPANT DEMOGRAPHIC AND CHARACTERISTICS DATA

	PERCENTAGE
GENDER IDENTITY	
Female	67.6
Male	28.6
Transgender	1.0
None of these	0
Not reported	2.8
RACE/ ETHNICITY[3]	
Black or African American	49.1
White	37.2
Hispanic	18.9
Asian	1.4
American Indian or Alaska Native	0.7
Middle Eastern or North African	0.3
Native Hawaiian or other Pacific Islander	0
Other race or ethnicity	2.7
Multi race/ethnicity	1.7
Not reported	6.9

	MEAN	STANDARD DEVIATION
AGE	50.6	14.2
missing	48	6.8

TABLE 3.

DEMOGRAPHICS—HOUSEHOLD

	MEAN	STANDARD DEVIATION
# OF OTHERS IN HOUSEHOLD	2.30	2.1
Not reported	67.6	
# OF OTHERS < 18 YEARS OLD IN HOUSEHOLD	28.6	
Not reported	1.0	

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TABLE 4.
FOOD SECURITY

Q: Used the 6-item module from the USDA

FOOD SECURITY CATEGORY	PERCENTAGE
Food Secure	15.7
Food Insecure	84.3

*Only **15.7%** of the participants met the definition of **food secure** and **84.3%** of the participants met the definition of **food insecure**.*

TABLE 5A.
SELF-REPORTED HEALTH STATUS

Q: Would you say that in general, your health is...?

HEALTH	PERCENTAGE
Poor	10.2
Fair	34.3
Good	32.9
Very Good	11.3
Excellent	6.8
not reported/missing	4.7

*Approximately **half of the participants perceived their health positively** and rated their health as good (32.9%), very good (11.3%) or excellent (6.8%). The remaining participants reported their health as fair (34.3%) or poor (10.2%).*

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TABLE 5B.
HEALTHY DAYS

	MEAN	SD
# of physical unhealthy days	9.6	10.9
# of mental unhealthy days	8.3	10.5
# of days poor health prevents activities	8.3	10.6
# of healthy days	16.3	12.3

Healthy Days is a CDC measure *used to identify health disparities and track population trends. The time range used is one month (30 days) because people tend to think about their lives in terms of months, and because this allows for assessing change over time. In 2020 in the United States, the mean number of physically unhealthy days was 3.2 and the mean number of mentally unhealthy days was 4.3.* ***This sample has means well above the national average.***

Participants were asked to calculate how many days they felt physical and mentally unhealthy and the number of days that were not labeled as either were considered 'healthy days' for the month. ***The average number of days that were considered healthy was 16.3 (SD = 12.3).***

TABLE 5C.
DIAGNOSIS[6]

Q: **Has a doctor or other health professional ever told you that you/they have any of the following conditions?** *Please select all that apply.*

Q: **Have you ever been told by a doctor or other health professional that you/they had diabetes during a pregnancy, also known as gestational diabetes?**

	PERCENTAGE
High blood pressure (HBP) / hypertension	52.3
Diabetes / sugar diabetes / prediabetes	41.7
Heart disease	14.1
Stroke	14.1
Gestational diabetes	11.7
Other diagnosis	11.1
None	22.0

High blood pressure (HBP) and diabetes were the most frequently reported health conditions *(52.3% and 41.7%, respectively) followed by heart disease (14.1%), stroke (14.1%) and gestational diabetes (11.7%). Almost one-fourth of participants reported they had no medical diagnosis (22.0%) and 11.1% had another diagnosis.*

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TABLE 5D.
ANHEDONIA AND DEPRESSION

Q: Over the past two weeks, how often have you been bothered by any of the following problems?

LITTLE INTEREST OR PLEASURE IN DOING THINGS Would you say not at all, several days in the past two weeks, more than half the days, or nearly every day?	FEELING DOWN, DEPRESSED, OR HOPELESS Would you say not at all, several days in the past two weeks, more than half the days, or nearly every day?	ANHEDONIA	DEPRESSION
		PERCENTAGE	PERCENTAGE
Not at all		36.2	41.7
Several days		31.0	30.2
More than half of days		10.4	6.1
Nearly every day		8.5	8.5

Anhedonia[7] and depressed feelings were reported by 68.2% and 58.3% of the participants. *Most of the people who reported these feelings described them as occurring several days over two weeks (31.0% and 30.2%, respectively).*

> **"The Fresh Food Cart from GRADY has provided my family with fresh produce, which helps to extend our purchases [and] SNAP benefits! The recipes that are provided are quite helpful also! This boost in produce has helped my family to eat/ feel better, and [feel] more energized! Thank you.**
>
> Program Participant

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TABLE 6.

DIETARY INTAKE

Q: **The following questions are about fruits and vegetables you normally eat. Think about the fruits and vegetables you ate during the past week including all the meals and snacks you ate from the time you got up until you went to bed. Be sure to count fruits and vegetables you ate at home, work, restaurants, or anywhere else.**

	NOT REPORTED	NONE	1-3 X WEEK	4-6 X WEEK	1 X DAY	2 X DAY	3 X DAY
DURING THE PAST WEEK, HOW MANY TIMES DID YOU EAT/ DRINK:							
Fruit	8.2	10.7	38.5	17.1	12.0	9.4	4.1
Juice	10.2	35.4	32.6	8.3	7.3	3.5	2.7
Salad	9.4	22.0	43.0	13.1	8.0	2.8	1.6
Potatoes	9.7	17.9	49.9	11.8	6.6	2.3	1.7
Vegetables	9.2	7.6	41.7	22.3	10.9	6.1	2.3
Beans	11.7	28.2	39.9	10.7	5.4	2.7	1.4

*Participants were asked how many times per week they ate or drank specific items and **one to three times per week** was the most frequent response for fruits (38.5%), salad (43.0%), non-fried potatoes (49.9), vegetables (41.7%) and beans (39.9%). One to three times per week was also the second most frequent consumption rate reported for juice (32.6%), with no juice during the week reported by 35.4%. **No consumption of the item during the week** was the second most frequent response for salad (22.0%), non-fried potatoes (17.9%) and beans (28.2%) but the second most frequent response for fruit and vegetables was 17.1% and 22.3%, respectively. Participants who ate or drank the items **one or more times per day** were as follows: fruit (25.5%), vegetables (19.3%), juice (13.6%), salad (12.4%), potatoes (10.6 %) and beans (9.5%).*

According to the CDC, just 1 in 10 adults meet the federal recommendations of fruit and vegetable intake. Federal guidelines recommend that adults eat between 1.5-2 cups per day of fruit and 2-3 cups per day of vegetables as a part of a balanced diet.[8] Of those who completed the survey, nearly a third report consuming fruits and almost half report consuming vegetables one to three times per week. This is below the recommended federal guidelines for fruit and vegetable consumption.

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TABLE 7.

SNAP PARTICIPATION, BENEFITS AND PROGRAM USE

Q: Does anyone from the household currently receive SNAP or food stamps?

Q: For those with SNAP, how many weeks do your SNAP benefits usually last?

	PERCENTAGE
FIRST TIME RECEIVING FOOD FROM THIS PROGRAM?	
No	**48.2**
Yes	**48.7**
Don't Know	**3.1**
CURRENTLY RECEIVE SNAP	
No	**46.4**
Yes	**43.2**
Don't Know	**10.5**
SNAP BENEFITS LAST...	
≤ 1 week	**7.8**
2 weeks	**24.8**
3 weeks	**38.6**
4 weeks	**16.7**
> 4 weeks	**5.2**
Not reported	**6.7**

It isn't possible for us to know how many of the 48.2% respondents not receiving SNAP benefits are in fact eligible to receive them. However, we know that only **82% of eligible people in the US received SNAP benefits in 2018**, *and receipt varied widely by state. The* ***2014 Hunger in America*** *study found 54.8% of all program respondents received SNAP.*

This is consistent with reports from the ***2014 Hunger in America*** *study which found that roughly 86% of all program respondents reported their benefits lasted under 3 weeks. This is also consistent with* ***2017 data*** *from USDA which showed that on average, SNAP households redeemed about 75% of their benefits by the middle of the month.*

Approximately half of the FIM 2.0 participants ***(48.7%) stated this was their first-time receiving food from this program*** *and* ***43.2% were receiving SNAP benefits.*** *Of the 306 participants who received SNAP,* ***71.2% said their benefits lasted less than 3 weeks****.*

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TABLE 8.

DIETARY FACTORS/ CONCERNS

Q: **Does anyone in your household have any of the following dietary factors or concerns?** ***Select all that apply*[9].**

	COUNT	PERCENTAGE
Low sodium (salt) and/or low saturated fat "heart-healthy"	179	25.2
Low sugar and/or "diabetes-friendly"	177	25.0
Low carb (carbohydrate)	104	14.7
Gluten free	65	8.5
Food allergen (e.g., peanut, seafood, dairy)	48	6.8
Soft diet / dental concerns	37	5.2
Vegetarian	24	3.4
Limited diet / no cooking equipment	19	27
Vegan	13	1.8
Kosher	12	1.7
Halal	8	1.1
Other diet	30	4.2
None	283	39.9
Not reported	73	10.3

Dietary concerns were reported most frequently by households with low-sodium/low saturated fat (25.2%) and low-sugar (25.0%) diets. *This is unsurprising given that of the total neighbors who completed this survey, 52.3% describe having been diagnosed with high blood pressure or hypertension, 41.7% have been diagnosed with diabetes, and 14.1% have been diagnosed with heart disease.*

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New Learnings

Food is Medicine (FIM) partnerships are complex, multi-faceted partnerships that continually evolve over time. Challenges are met with ingenuity and determination. The participating organizations and individuals played a key role in program success. As was true in phase one of the FIM project, food banks connected regularly with their health care partners to share challenges and lessons learned informally during monthly calls and formally through project reports. Even with an increased number of food banks participating in the program this year, the following food bank-health care partnership challenges and learning themes remained consistent year over year.

1. **Developing partnerships takes time and resources.**
2. **Data sharing is challenging, but possible.**
3. **Not all patients who screen positive for food insecurity need or want assistance today.**
4. **Hospital and clinic pantries may require new operational models for food banks and might require more money, too.**
5. **Facilitating SNAP Application Assistance in health care settings is challenging and needs dedicated attention.**
6. **Project evaluation plans should be feasible, collaboratively developed and tailored to meet local partnership needs.**
7. **Food bank-health care partnerships can help address food insecurity as a social determinant of health and advance health equity, but more work and research are needed.**

The COVID-19 pandemic had varying impact on FIM 2.0 programs. For some partnerships, the pandemic had little to no affect. For others, the pandemic caused significant disruptions to program participation and efficiencies including health care partner staffing limitations and capacity to perform various program functions. To meet these challenges, partners pivoted to new methods of food distribution and client outreach. For example, SNAP Application Assistance was provided by phone instead of in-person.

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FOOD BANK REFLECTIONS

Spotlighting FIM 2.0 nuances—both solutions and challenges—to the food bank-health care partnership learning themes

Developing partnerships takes time and resources.

Monthly meetings between the food bank and the health care partner included sharing progress updates, discussing concerns, asking questions and brainstorming new ideas. This helped build relationships and trust, improve communication and ensure a smooth process.

GLEANERS FOOD BANK OF INDIANA
Indianapolis, IN

Not all patients who screen positive for food insecurity need or want assistance today.

The food bank utilized grant funds to create a new Root Cause Coordinator for Health Care position, a staff member dedicated to accepting client referrals from health care providers, calling patients back by phone, referring them to emergency food resources, screening them for public benefits, providing additional referrals and applications, as needed, and following up with each client over the next several months.

GREATER CLEVELAND FOOD BANK
Cleveland, OH

Data sharing is challenging, but possible.

In the future, the food bank would like to require more in-depth data collection, perhaps focusing on a particular segment of the patient population—such as high-risk pregnancy, diabetes or hypertension. [Targeted] foods and services would support the unique needs of that population, and impact measurements would be gathered. This effort would be dependent on the health care partner's capacity to support this initiative.

DARE TO CARE
Louisville, KY

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> **“This program taught me a lot and am glad the program was available for myself and my daughters.**
>
> Program Participant

Facilitating SNAP Application Assistance in health care settings is challenging and needs dedicated attention.

The health care partner shifted from using students (in FIM 1.0) to staff (in FIM 2.0) at clinics to complete the screening and referrals. To train and educate, the food bank hosted a meeting for the staff and Community Health Workers to learn about how the food bank’s Hunger Hotline works, what patients can expect at food pantries and how to talk about SNAP.

FEED MORE
Richmond, VA

Hospital and clinic pantries may require new operational models for food banks and might require more money, too.

This grant opened new doors in a very meaningful way and resulted in a new program line for GBRFB, one its nutrition department had discussed conceptually but, until now, could not attain. The food bank is committed to continuing this model and looks forward to hosting it in all 11 parishes served by the organization.

GREATER BATON ROUGE FOOD BANK
Baton Rouge, LA

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Project evaluation plans should be feasible, collaboratively developed and tailored to meet local partnership needs.

Our data collection and reporting activities meet the food bank's needs and those of its health care and pantry partners. The process is continuously evaluated, and adjustments are made as needed. This grant opportunity helped food bank program leaders connect to other organizations doing similar work to refine the program and generate new ideas.

FOOD BANK OF NORTHERN NEVADA
Sparks, NV

Food bank-health care partnerships can help address food insecurity as a social determinant of health and advance health equity, but more work and research are needed.

To build health care partner staff's excitement to focus on the mission, the food bank hopes to develop educational trainings that focus on common questions—including the differences between food insecurity, nutrition security and hunger; SNAP's impact on food insecurity; and how to safeguard a patient's comfort level and dignity when asking personal questions during the screening process.

ST. LOUIS AREA FOOD BANK
Bridgeton, MO

> "Big help, GCFB is why I am still alive today. Thank you!"
>
> Program Participant

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Conclusion

The Food is Medicine project builds on more than a decade of food bank-health care partnership initiatives and experiences at Feeding America. Food is Medicine 2.0 proved to be an instrumental chapter in the movement to address food insecurity as a social determinant of health. We know that continuous learning, testing and evolution are vital ingredients to achieving cross-sector success. By working together to identify food insecure patients and connecting them to vital resources in their communities, we improve our understanding of "what could be" when seeking to better meet the food and health needs of neighbors facing hunger in America. The fourteen member food banks that participated in Food is Medicine 2.0 remain committed to working with their health care partners to meet the needs of the communities they serve. Health care organizations also remain committed to food bank partnerships and continue to support this work through advocacy, thought leadership, resources and funding.

As we look to the future—with Food as Medicine 3.0—the lessons learned around the difficulty of tracking health outcomes and the need to create a unified evaluation method are actively shaping our next steps. As the national partnership evolves and we work towards doubling our local sites and collaborators, we are hopeful that there will be significant progress in our understanding of hunger and health, data and outcomes and the processes involved with capturing and analyzing outcomes.

> **"Great program I love it! Was able to eat healthier meals! I hope this program continues.**
>
> Program Participant

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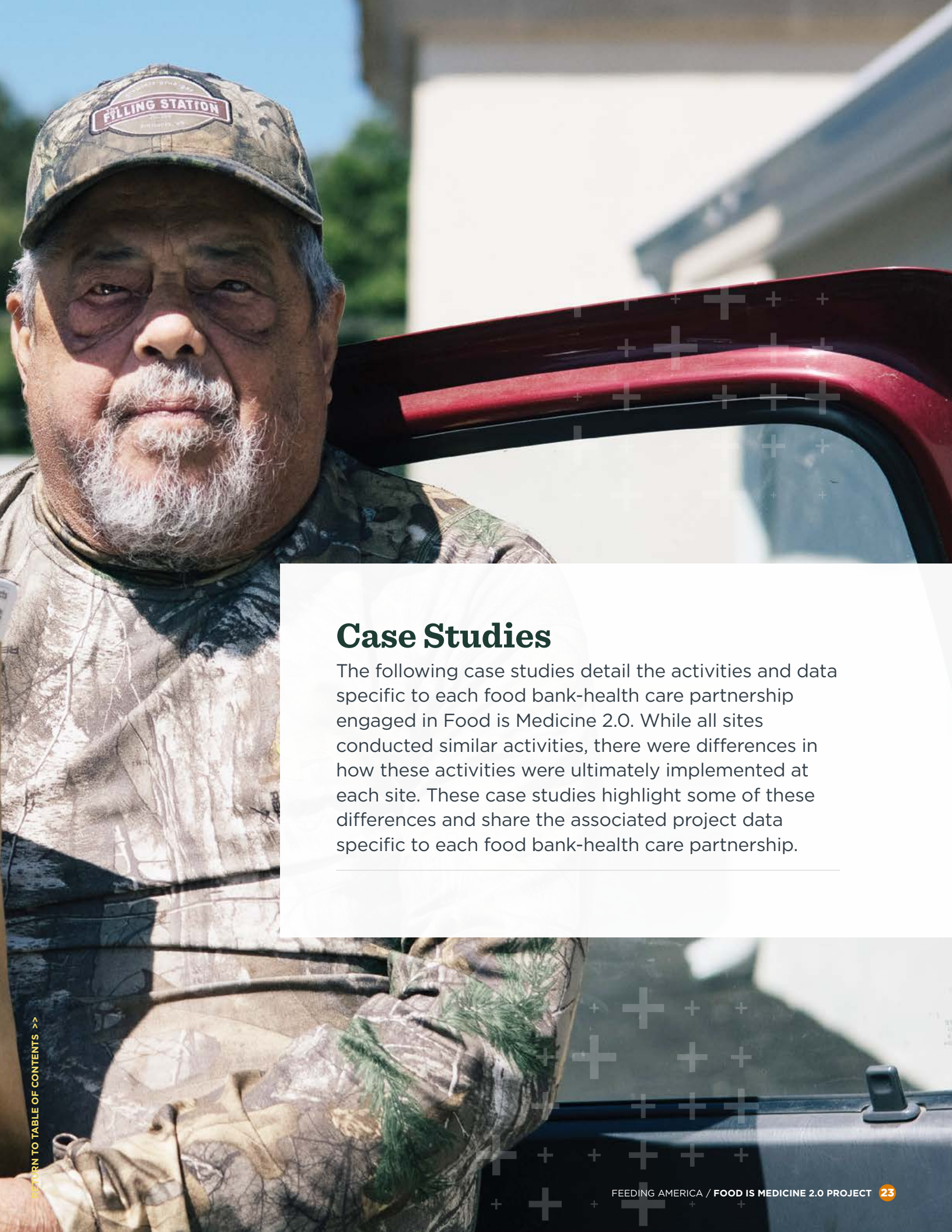

Case Studies

The following case studies detail the activities and data specific to each food bank-health care partnership engaged in Food is Medicine 2.0. While all sites conducted similar activities, there were differences in how these activities were ultimately implemented at each site. These case studies highlight some of these differences and share the associated project data specific to each food bank-health care partnership.

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LOUISVILLE, KY

Dare to Care Food Bank

HEALTH CARE PARTNERS

University of Louisville Hospital

Family Health Centers

PROGRAM HIGHLIGHTS

Grant funds were used to update and expand the Prescriptive Pantry at Family Health Center (FHC) Portland

Dare to Care (DTC) and FHC had frequent check-ins to ensure the initiative was on track

The Nursing Department at FHC, which includes all the Medical Assistants who perform the initial screenings and bring the food bags to patients, experienced staff shortages and expanded assignments to multiple providers at the same time

Because of this, intake processes were truncated resulting in lower food distributions compared to the previous year

FHC recruited students from the local nursing college to help staff the pantry, coordinated the location in their building, oversaw the movement of staff, made sure the social work staff are available, handled the flooring change, set up shelving and stocked the pantry

CHALLENGES & KEY LEARNINGS

- Setting expectations at the beginning of the project and consistently communicating progress and challenges are crucial
- FHC's software change and subsequent technical difficulties resulted in challenges in pulling timely data
- There was not enough capacity at partner agencies to obtain a measurable response rate
- Partner sites currently only provide the number of people they serve, not how many they screen. Because of that, DTC looks to find ways to obtain more and deeper data
- Consider providing financial assistance or another type of capital to health care partners to compensate for the partners' investment of time and effort in the FIM program

SUCCESSES

- DTC is interested in providing SNAP assistance in the very near future
- DTC hopes to continue utilizing frozen meals—prepared by the DTC Community Kitchen—which can be tailored to diets for specific medical conditions
- The relationship between DTC and FHC has been strengthened throughout this grant period because of the amount of interactions that we had to have and the continual updates on our progress

SCREENING AND REFERRAL DATA

39,470	12,520	1,971	1,840	–	–
FOOD INSECURITY SCREENINGS	POSITIVE FOOD INSECURITY SCREENINGS	PROGRAM REFERRALS	PROGRAM ENGAGEMENT	SNAP APPLICATIONS ***DIRECT*** ASSISTANCE	SNAP APPLICATIONS ***INDIRECT*** ASSISTANCE

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RICHMOND, VA

Feed More

HEALTH CARE PARTNER

Virginia Commonwealth University Health System (VCUHS)

PROGRAM HIGHLIGHTS

The program expanded with the addition of two VCUHS adult clinics and four pediatric clinics

VCUHS added a third question to the food insecurity screening: "Are you in need of food today?"

This helped target the immediate need and "qualified" patients for a food box at the clinic, along with a referral to the Hunger Hotline

Patients who screened positive for food insecurity, but didn't identify an immediate need, received a Hunger Hotline postcard for future needs

> **"Being able to provide food to patients and families right away has been a game changer. Our patients and families know that we are listening and that we are here to help them. It's more than just pointing them in the right direction. It's saying, 'I hear you and I can help you right now.'**
>
> Kimberly Lewis, Director of Community Outreach and Administration in the Division of Community Health at VCU Health

CHALLENGES & KEY LEARNINGS

- Purchased seven Foods to Encourage items that only Wellness Pantries could order; since produce is already such a priority for Wellness Pantries, they wanted to see if we could ensure access to other healthy foods
- Implemented a "three attempts" policy on patient outreach in response to ongoing challenges in connecting with patients referred online via the Hunger Hotline form.
- A shared spreadsheet was created in Office 365 for aggregated data so data could be input and viewed at any point
- Feeding America Client Survey (FACS) could be more successful in a partner food pantry setting
- With the expansion to pediatric clinics came new questions: 1) who to refer to the Hunger Hotline—the caregiver or the child/patient, and 2) whether to address the immediate need for the whole household rather than the individual patient, so more than one box of food could be provided

SUCCESSES

- FIM has led Feed More to embed health care partnerships into its strategic plan, create a new Health Initiatives Director position and work with the other Virginia food banks in statewide health equity plans
- The addition of clinics led to an increase of Latino patient referrals and a need for Spanish-language support
- The food bank's Hunger Hotline adopted a translation phone service and started recruiting bilingual Spanish volunteers

SCREENING AND REFERRAL DATA

2,201	637	354	354	–	–
FOOD INSECURITY SCREENINGS	POSITIVE FOOD INSECURITY SCREENINGS	PROGRAM REFERRALS	PROGRAM ENGAGEMENT	SNAP APPLICATIONS ***DIRECT*** ASSISTANCE	SNAP APPLICATIONS ***INDIRECT*** ASSISTANCE

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Feeding America Riverside | San Bernardino Counties

HEALTH CARE PARTNERS

Riverside University Health System (RUHS)

Inland Empire Health Plan (IEHP)

PROGRAM HIGHLIGHTS

Clinic staff use The Hunger Vital Sign™ to screen patients for food insecurity

Patients receive shelf-stable emergency food onsite and referrals to full-service community food distributions for additional resources

The food bank established a new partnership with RUHS and continued its existing onsite pantry (Food Rx) at IEHP

A pediatric clinic will soon be added as a third site

The prioritized metrics were the number of patients who screened positive for FI and the number of patients referred to food pantries and/or SNAP

> **“It has been a tremendous boost for our patients and community, and offered a shining beacon of positivity for our staff during a turbulent time.**
>
> Dr. Moazzum N. Bajwa

CHALLENGES & KEY LEARNINGS

- IEHP was unable to fully track the number of patients screened for food insecurity during health care visits due to a high volume of patients
- Challenges in tracking the number of submitted SNAP applications specifically referred by the health care partners
- The food bank plans to create a user-friendly data survey for its second FoodRx site to make reporting easier for that health care partner
- Due to COVID-19, the food bank shifted the food distribution process at two community centers from onsite food access to, instead, asking patients experiencing food insecurity to call ahead to pick up a food box; this change may have discouraged some patients from obtaining food
- The COVID-19 pandemic delayed progress at IEHP and RUHS’s FoodRx program for several months, impacting the referral rate and resulting in a backlog of food boxes at their pantries

SUCCESSES

- Added new partners and increased public awareness
- County medical offices have shown increased interest in the program
- Nutrition information, including recipes and general information on eating healthy on a budget, was included with each food box
- Educational flyers explained how to read food labels in both English and Spanish and helped participants understand expiration dates, differentiate between “Use by” and “Sell by” and the meanings behind nutritional labels
- Will be changing IEHP’s delivery times from monthly to quarterly to better match the partner’s caseload capacity
- Enabled patients to get food and medical assistance all in a single trip
- The food bank has interest in 11 new sites

SCREENING AND REFERRAL DATA

355	347	285	312	11	–
FOOD INSECURITY SCREENINGS	POSITIVE FOOD INSECURITY SCREENINGS	PROGRAM REFERRALS	PROGRAM ENGAGEMENT	SNAP APPLICATIONS ***DIRECT*** ASSISTANCE	SNAP APPLICATIONS ***INDIRECT*** ASSISTANCE

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SPARKS, NV

Food Bank of Northern Nevada

HEALTH CARE PARTNERS

Renown Health
Community Health Alliance
Ross Medical Clinic
University of Nevada Rural

PROGRAM HIGHLIGHTS

Funding allowed Food Bank of Northern Nevada (FBNN) to hire a Health and Nutrition Partnership Supervisor to manage and expand the Prescription Pantry program, and create new partnerships with pantries and health care providers

New rural Prescription Pantry locations received the full Healthy Pantry Initiative training with their staff and volunteers

Recipes, posters and nutrition handouts were given to the pantries to put in high traffic areas

Provided materials in Spanish for Ross Medical Clinic, the only Spanish-speaking provider in that county

Three pantries joined the Prescription Pantry program in partnership with a rural health clinic, including the Agai-Dicutta Food Pantry on The Walker River Paiute Tribe Reservation, which works closely with the Tribal Health Clinic

CHALLENGES & KEY LEARNINGS

- Would opt to use physical gift cards to hand out or mail instead of the digital gift cards via Rybbon; roughly 70% of the people surveyed did not have an email address, therefore disqualifying them from receiving a gift card
- Patients in rural areas who screened positive for food insecurity received a completely new rural-specific prescription that was created for these health care agencies and pantries

SUCCESSES

- The survey was easy to use and helpful to collect information on clients who utilize this program; it was beneficial to be part of the survey creation so the questions would be applicable to our work
- Leveraged Anthem's support to garner additional funding from other sources in order to further expand the program in rural northern Nevada

> **"A neighbor who had recently been diagnosed with diabetes received a prescription for healthy food from her doctor. At the pantry, she received information on fruits and vegetables, MyPlate messaging, a Healthy Eating with Diabetes brochure, and the healthy food she needed. She expressed to the pantry staff that she felt like she has the tools to get better.**

SCREENING AND REFERRAL DATA

–	–	–	8,187	126	–
FOOD INSECURITY SCREENINGS	POSITIVE FOOD INSECURITY SCREENINGS	PROGRAM REFERRALS	PROGRAM ENGAGEMENT	SNAP APPLICATIONS ***DIRECT*** ASSISTANCE	SNAP APPLICATIONS ***INDIRECT*** ASSISTANCE

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MERRILLVILLE, IN

Food Bank of Northwest Indiana

HEALTH CARE PARTNERS

Franciscan Health Hammond

Community Health Net Gary

PROGRAM HIGHLIGHTS

Expanded the partnership with Franciscan Health Hammond (FHH), which screens patients for food insecurity using the Hunger Vital Signs™ and documents data in EPIC

FHH operates a Food Pharmacy so patients who screen positive for food insecurity can receive food onsite

The food bank texts patients, after receiving consent/opt-in, with additional pantry and mobile food distribution information

The initiative prioritizes pregnant and postnatal patients and households to receive medically tailored food packages for six months

The food bank provides shelf-stable, pre-packed boxes for patients with diabetes mellitus or cardiovascular disease

Food bank is launching medically tailored food packages with FHH to support new mothers

CHALLENGES & KEY LEARNINGS

- Information from the neighbor survey is valuable, but a simplification and streamlining of the process would be beneficial
- Lack of funding would be the only barrier to continuing the FIM partnerships

SUCCESSES

- The process to conduct food insecurity screenings, provide patient referrals and collect data for both Franciscan Health Hammond and Community Health Net Gary was consistent and efficient
- The success of the program is directly connected to the commitment and involvement of the health care partners
- The grant opened up the opportunity for the food bank to work with health care partners in an unprecedented way—bridging the gap between hunger and health

SCREENING AND REFERRAL DATA

199	100	100	96	25	–
FOOD INSECURITY SCREENINGS	POSITIVE FOOD INSECURITY SCREENINGS	PROGRAM REFERRALS	PROGRAM ENGAGEMENT	SNAP APPLICATIONS ***DIRECT*** ASSISTANCE	SNAP APPLICATIONS ***INDIRECT*** ASSISTANCE

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CINCINNATI, OH

Freestore Foodbank

HEALTH CARE PARTNER

University of Cincinnati Medical Center (UCMC)

PROGRAM HIGHLIGHTS

Patients who screened positive for food insecurity were directed to the onsite pantry and received a $25 produce prescription to be redeemed at the food bank's Healthy Harvest Mobile Market

The food insecurity screening infrastructure had been implemented in FIM 1.0, so it was easy for UCMC to continue to use it, while being able to expand the infrastructure when an additional clinic was added

The food bank incorporated Freestore Direct—a direct delivery program in partnership with Amazon where individuals can receive weekly, biweekly, or monthly deliveries of fresh produce to their homes—as another food access point for patients who are food insecure and have transportation issues

The grant allowed Freestore to establish a referral process for Freestore Direct with its health care partners

Moving forward, Freestore plans to continue to offer both clinic pantries and Freestore Direct to potential health care partners based on what would work best for them and their patients

> "As recipients of the first and second rounds of funding, it has been great to see how far our partnership with UCMC has come since we began working with them in March 2019. This grant opportunity has provided us with best practices and resources from other food banks and Feeding America to create more structure with our Food Is Medicine programs moving forward.

CHALLENGES & KEY LEARNINGS

- Provided SNAP Call Center information to health care partners to distribute to patients
- For FIM 2.0, Freestore chose not to track health outcomes because it has been difficult for UCMC to pull from the EMR (EPIC)
- In the future, Freestore may prioritize working with one health care partner to pilot collecting health outcomes; incorporating health outcomes could strengthen program support and potentially increase funding opportunities
- Clinic contacts had to request IT to pull reports, which delayed the data sharing process
- Survey response rate was lower than anticipated
- The Freestore Direct program experienced challenges because of third party delivery service errors
- In the future, the food bank may include flyers in food boxes on a weekly basis to improve survey response rates

SUCCESSES

- Patients enrolled in Freestore Direct received recipes and other nutrition related flyers in their food boxes, based on what produce was in the boxes
- Incorporating the Rybbon gift card allowed the food bank to seamlessly provide an incentive to individuals who completed the survey

SCREENING AND REFERRAL DATA

FOOD INSECURITY SCREENINGS	POSITIVE FOOD INSECURITY SCREENINGS	PROGRAM REFERRALS	PROGRAM ENGAGEMENT	SNAP APPLICATIONS ***DIRECT*** ASSISTANCE	SNAP APPLICATIONS ***INDIRECT*** ASSISTANCE
–	–	–	–	–	–

**Data not available at the time of report publication*

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INDIANAPOLIS, IN

Gleaners Food Bank of Indiana

HEALTH CARE PARTNER

Eskenazi Health

GLEANERS

PROGRAM HIGHLIGHTS

This grant project allowed Gleaners to test new methods of food distribution, including medically tailored food boxes and personalized home delivery, which may not have occurred without the funding

The project solidified the value of pairing food distribution with nutrition/health education to maximize benefits to neighbors

Eskenazi Health has already secured funds for a new project to provide cultural, medically tailored food boxes to patients through a food pantry located on-site at one of its clinics

The Eskenazi Health team is taking learnings to inform elements of this new initiative

CHALLENGES & KEY LEARNINGS

- All data input and management was manual for both the health care partner and the Home Delivery team. Most of the data was collected and analyzed by hand in spreadsheets, so it took significant staff time to set up referrals, determine and track start/end dates for deliveries and make sure the correct box type (vegetarian, gluten-free, standard) went to the correct patient
- Perishable food items, such as meat and dairy products, were commonly requested by participants; however, because these items require temperature-controlled storage and handling, they are not available food items at this time
- Food box contents contain the same menu items weekly for eight weeks; challenges with bandwidth to pack, organize, and deliver a different menu each week exist
- An eligibility requirement for a patient to receive home delivery is lack of reliable transportation; the health care partner sometimes had difficulty determining whether a patient would qualify in situations where the patient had a car but no money for gas or the car did not run
- Offered medically tailored food boxes that met several different dietary needs such as vegetarian or gluten-free; however, because this model is not sustainable, the food bank is exploring leveraging its new "Gleaners 2 Go" online ordering system which allows individuals to choose their groceries and pick them up at a time and location that is convenient to them

SUCCESSES

- Surpassed unofficial goal of 100 neighbor survey responses, obtaining 104 responses (56% of eligible patients)
- Health care partner staff walked through the survey with patients who did not have internet/computer access at home and had physical gift cards on-site so those patients could still receive the incentive
- Increased survey responses by texting the survey link to participants with clear messaging that they would be compensated for their time
- The health care partner will continue making referrals to Gleaners Home Delivery and SNAP services both within and outside of the FIM project

SCREENING AND REFERRAL DATA

440,863	11,568	186	168	8	–
FOOD INSECURITY SCREENINGS	POSITIVE FOOD INSECURITY SCREENINGS	PROGRAM REFERRALS	PROGRAM ENGAGEMENT	SNAP APPLICATIONS ***DIRECT*** ASSISTANCE	SNAP APPLICATIONS ***INDIRECT*** ASSISTANCE

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BATON ROUGE, LA

Greater Baton Rouge Food Bank

HEALTH CARE PARTNER

Our Lady of the Lake Regional Medical Center (OLOLRMC)

PROGRAM HIGHLIGHTS

Patients who screened positive for food insecurity could access food immediately through the OLOLRMC's existing Geaux Get Healthy program which includes nutrition counseling, cooking classes, emergency food boxes, vouchers to food bank programs and local pantry information

Once a patient is referred to the Geaux Get Healthy program, they are given a 20-pound box of healthy food choices individually built by the food bank nutrition services team and connected to other food sourcing options at member agencies

CHALLENGES & KEY LEARNINGS

- Greater Baton Rouge Food Bank (GBRFB) was challenged in obtaining health data from OLOLRMC
- Large health systems like OLOLRMC require multi-layer approvals to provide any sort of data related to health, even if it is not attributed to a particular individual
- Becoming an agency partner would enable OLOLRMC to enter client demographic and health metric data as an aggregated means through the food bank's new Service Insights system, Oasis
- GBRFB's survey methodology relied on participants to complete the survey perhaps having a negative impact on the response rate
- Health care staff are extremely busy seeing patients and doing the screenings and the additional layer of distributing food boxes can be a distraction
- Physical space limited the number of boxes that could be stored at a given time and created a logistics challenge for GBRFB in delivering the boxes on a schedule that meshed with the food bank's larger box deliveries to agencies
- Communication between the food bank and health care staff is key to ensuring a smooth process

SUCCESSES

- OLOLRMC is discussing conducting food insecurity screenings at an ambulatory surgical center; GBRFB is working with them to ensure there is not a duplication of services with the health clinics
- GBRFB is committed to growing the Food Is Medicine program
- The pilot's success has opened doors to other potential funders; funding would be used to build food boxes with healthful products, such as whole wheat pasta and low-salt vegetables

SCREENING AND REFERRAL DATA

2,080	334	334	334	–	–
FOOD INSECURITY SCREENINGS	POSITIVE FOOD INSECURITY SCREENINGS	PROGRAM REFERRALS	PROGRAM ENGAGEMENT	SNAP APPLICATIONS ***DIRECT*** ASSISTANCE	SNAP APPLICATIONS ***INDIRECT*** ASSISTANCE

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CLEVELAND, OH

Greater Cleveland Food Bank

HEALTH CARE PARTNERS

The Cleveland Clinic
MetroHealth
NEON
Neighborhood Family Practice
ExactCare

PROGRAM HIGHLIGHTS

The food bank supported three Food Pharmacies aimed at improving health outcomes for individuals with diabetes mellitus or cardiovascular disease

To ensure the continued safe distribution of produce during the pandemic, the food bank moved from bulk produce distributions to pre-boxed produce that included a variety of produce and perishable product for nearly all FIM 2.0 partners

CHALLENGES & KEY LEARNINGS

- Challenges included adjusting to the new software system, UniteUs, finding staff to adequately provide coverage for those referrals, and working with partners to find solutions for obstacles that presented themselves during the onboarding process
- Reporting on specific outcomes such as SNAP applications and individuals further utilizing beneficial programs and services was a challenge
- Challenges related to software capabilities included the inability to indicate whether a referral is a minor or even an infant
- Survey refinement could include determining the top few programmatic types, and then developing survey instruments specific for those types; for example, programs that provide food directly will use very different questions than programs that accept and provide referrals out to community partners for food
- To address low survey completion rates, the food bank changed to an automated call system: Calls went out in small batches, callers who picked up and indicated interest were routed into a live call queue and this revised process resulted in the completion of several surveys

SUCCESSES

- Originally, all GCFB Help Center staff helped to respond to UniteUs referrals; with the creation of the food bank's new Root Cause Coordinator, referrals were directed to one staff member, relieving Help Center staff from sharing this priority

SCREENING AND REFERRAL DATA

122,093	20,402	1,675	–	147	–
FOOD INSECURITY SCREENINGS	POSITIVE FOOD INSECURITY SCREENINGS	PROGRAM REFERRALS	PROGRAM ENGAGEMENT	SNAP APPLICATIONS ***DIRECT*** ASSISTANCE	SNAP APPLICATIONS ***INDIRECT*** ASSISTANCE

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Houston Food Bank

HEALTH CARE PARTNER

Harris Health System

houstonfoodbank

> "Good customer service. Good health educator. Good food. Food has helped me to improve and manage my diabetes.

PROGRAM HIGHLIGHTS

Harris Health System's (HHS) program, Food Rx, targets patients with food insecurity and diagnosed with uncontrolled diabetes

Participants join a nine-month program that includes biweekly "walk and learn" sessions with a diabetes educator and 30 pounds of free fresh fruits, vegetables and proteins from on-site Food Farmacy locations

HHS and Houston Food Bank (HFB) have opened three Food Farmacies and established operating guidelines to help ensure a continuation of services

Data collection ending on June 2021 showed a decrease in A1c among clients enrolled in Food Rx at HHS

HFB and HHS conducted monthly check-in calls which kept staff in close communication as they found ways to problem solve and plan for future changes

CHALLENGES & KEY LEARNINGS

- The Feeding America Client Survey (FACS) has provided the Houston Food Bank team good insight on what standardized questions to use in its internal client surveys, such as the USDA Food Insecurity and CDC Healthy Days modules
- The level of comprehension of the FACS questions were quite high and a bit lengthy, so more clients may have been hesitant to engage with the surveys; HFB suggest simplifying the questions into plain language and reducing the number of questions to allow for greater client participation
- The client survey was administered at two out of the three Food Farmacies
- Lower than expected response rates were obtained from Latino individuals

SUCCESSES

> "The Food Farmacy assisted me in overcoming my hardest time. I am very pleased with that.

- HFB has improved the variety of produce and non-produce food items available for Harris Health and other Food for Change partners by taking a more active role in submitting food selection preferences to the HFB Procurement team
- Because of COVID, Food Farmacies provided curbside distributions and all patients received nutrition education handouts with their food
- Food Rx patients received nutrition education via phone calls from dietitians rather than through in-person education
- Harris Health found that some patients preferred the curbside model and to receive nutrition education telephonically at another time that was convenient for them

SCREENING AND REFERRAL DATA

14,028	2,877	2,877	706	137	–
FOOD INSECURITY SCREENINGS	POSITIVE FOOD INSECURITY SCREENINGS	PROGRAM REFERRALS	PROGRAM ENGAGEMENT	SNAP APPLICATIONS ***DIRECT*** ASSISTANCE	SNAP APPLICATIONS ***INDIRECT*** ASSISTANCE

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NASHVILLE, TN

Second Harvest Food Bank of Middle Tennessee

HEALTH CARE PARTNER

Nashville General Hospital

PROGRAM HIGHLIGHTS

Nashville General Hospital (NGH) screened all patients for food insecurity using the Hunger Vital Signs™ and referred patients who screened positive for food insecurity to its onsite Food Pharmacy

Second Harvest Food Bank of Middle Tennessee (SHFBMT) supports an additional 200 community members through home deliveries

At the Food Pharmacy, patients select foods they want while receiving nutrition education from the Food Pharmacy Manager, who is a Registered Dietitian

Food Pharmacy staff are trained SNAP Outreach partners and distribute additional food resource information to patients

CHALLENGES & KEY LEARNINGS

- SHFBMT will likely prioritize patient visits to the Food Pharmacy and demographic information; ideally, having all health care partners on the Link2Feed online system
- The Feeding America Client Survey (FACS) response rate was slightly lower than anticipated; though of those completed, results suggested a high number of patients experiencing very low food security
- Partner staff were retrained on how to provide onsite SNAP Application Assistance
- SNAP Application Assistance information was publicized through SNAP Outreach flyers and was added to recipe cards provided to the Food Pharmacy
- After reprinting the flyers in hot pink, there was a significant increase in responses
- When this grant cycle ends, SHFBMT can no longer cover purchased food costs or reimburse for staff time or produce purchases
- Dedicated healthcare staff is crucial to the success of the program
- Frequent communication between food bank and the health care partner is important to program success
- Costs for the Food Pharmacy are very high
- Onsite SNAP assistance was limited due to COVID-19 social distance restrictions at the Food Pharmacy

SUCCESSES

- The Rybbon gift card process worked seamlessly for our patients
- Weekly reports were crucial for to tracking progress
- NGH has been screening for food insecurity and referring to their onsite pantry for over three years
- In their Nashville General Foundations director's word, "It is a well-oiled machine"
- The success of this grant and the previous Anthem grant has led to more healthcare partnerships and opportunities
- This grant enabled us to provide transportation support in the form of bus tickets

SCREENING AND REFERRAL DATA

16,540	1,732	1,258	799	–	2
FOOD INSECURITY SCREENINGS	POSITIVE FOOD INSECURITY SCREENINGS	PROGRAM REFERRALS	PROGRAM ENGAGEMENT	SNAP APPLICATIONS ***DIRECT*** ASSISTANCE	SNAP APPLICATIONS ***INDIRECT*** ASSISTANCE

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BRIDGETON, MO

St. Louis Area Foodbank

HEALTH CARE PARTNER

SSM Health DePaul Hospital-St. Louis

PROGRAM HIGHLIGHTS

Prior to FIM 2.0, the St. Louis Area Foodbank (SLAFB) worked closely with SSM Health to launch programming with SSM Health DePaul Hospital

Patients were screened for food insecurity

Patients identified as food insecure were referred to the SLAFB's SNAP Outreach Coordinator for application assistance

Patients also received referrals and information about food distributions located at or near the hospital

CHALLENGES & KEY LEARNINGS

- Staff changes—including staff shortages and the hiring of temp nurses and social workers—and increases in COVID cases resulted in few screenings
- An action plan includes training new staff members to get back to full hospital screenings and patients participating in the programming
- Challenges included gathering data and having EMR (EPIC) access
- A shorter survey may help increase response rates; even with the gift card incentive, some patients who started the survey gave up when they realized the survey length
- After nurses performed screenings, there was not an EPIC reminder to schedule consultations for dietary and social work staff to begin programming
- The food bank and health care partner discussed revising the food insecurity screening questions to move from a current focus on an individual's ability to afford any food to instead focus on their ability to obtain the healthy foods needed for their health and dietary needs
- Pantry food selections—to meet the patients' dietary needs per their disease state—were a combined effort of the health care partner's team of dietitians working with the food bank's two dietitians on staff
- The enthusiasm of the health care partner is pivotal in driving the success of this program

SUCCESSES

- Out of the applications from our health care program partner, 100% of applicants were approved
- At the one-month check in, 88% of patients reported not being readmitted to the ER
- At the three-month check in, 57% of patients reported not being readmitted to the ER
- Community nutrition education flyers and cooking demonstrations were requested by the hospital team of dietitians
- Numerous health care partners have approached the food bank looking to replicate the model into their own network and bring food insecurity solutions to their communities

SCREENING AND REFERRAL DATA

5,716	71	39	39	17	129
FOOD INSECURITY SCREENINGS	POSITIVE FOOD INSECURITY SCREENINGS	PROGRAM REFERRALS	PROGRAM ENGAGEMENT	SNAP APPLICATIONS ***DIRECT*** ASSISTANCE	SNAP APPLICATIONS ***INDIRECT*** ASSISTANCE

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Appendix

PUBLICITY

In promoting Feeding America and Anthem's Food is Medicine 2.0 project, communications efforts spanned a variety of platforms and distribution tactics. In partnership with Anthem, Feeding America wrote and distributed a press release highlighting Food is Medicine 2.0. The press release was distributed in June 2021 on the national wire and reached a potential 76 million viewers. Feeding America also posted the press release on its **website**. In addition, Feeding America developed a comprehensive communications toolkit that was distributed to 14 member food banks to help announce Anthem's grant and promote the project to local media. The toolkit included a customizable press release as well as sample social media posts.

Feeding America reviewed and contributed to Anthem's blog post, **Creating Sustainable Change Across the Health Ecosystem**, which further highlighted the partnership and shined a light on the project's impact. In addition, Feeding America's Hunger + Health blog featured the post, **Food Banks Striving to Meet Neighbor Food Needs and Improve Health**, which underscored the efforts of two member food banks, Gleaners Food Bank of Indiana and Atlanta Community Food Bank, in support of Food is Medicine 2.0.

> **"This program was beneficial. I greatly appreciated and thrived during these months in gaining a better understanding of the benefits of fresh fruits and vegetables.**
>
> Program Participant

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FOOD IS MEDICINE NEIGHBOR SURVEY

You are being asked to complete this survey because you may be participating in a "Food is Medicine" program. This program was developed by the [SITE] and local health care providers. The goal of the Food is Medicine program is to help people get healthy foods to support their health and well-being. By completing this survey, you will help us to better understand the types of people we serve and help us to improve our services and partnerships with health care providers. Thank you for your time.

INFORMED CONSENT

[Food Bank] is inviting you to answer survey questions about you, your household, and your experiences.

The survey takes about 10-15 minutes. Your participation is **completely voluntary**. If you agree to participate, you can always change your mind and stop the survey at any time. You don't have to answer any questions you don't want to. Whether or not you choose to take the survey, it won't change the services you receive from [SITE] now or in the future.

The first ___ people who complete this survey will receive a $10 electronic gift card.

Your name will never be connected to the answers you provide. All of the information we report will be at the group level, never about one individual. We do not ask for your name or other personal information, such as telephone number, that can identify you in the survey results.

LET'S BEGIN!

1A. HOUSEHOLD/RESPONDENT CHARACTERISTICS

The first set of questions are about your household members and you. These questions will help us improve our services by understanding more about the people and families we serve. For these questions, please include any child or adult who lives with you at least 4 days each week. Please include any family members, friends, or roommates who live with you when you answer these questions.

Not counting yourself, how many other people live in your household at least 4 days out of the week?

CODE	LABEL
01	Enter a number (1-20)
02	No one. I live by myself à Q1A-2
98	Don't Know
99	Prefer not to answer

Of the [HH_1] other people who live in your household, how many of them are children under the age of 18?

CODE	LABEL
01	Enter number
04	No one in the HH is under age 18
98	Don't Know
99	Prefer not to answer

Can you please tell me your age?

CODE	LABEL
01	Enter age in years
98	Don't Know
99	Prefer not to answer

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Do you currently describe yourself as male, female, or transgender?

CODE	LABEL
01	Male
02	Female
03	Transgender
04	None of these
99	Prefer not to answer

Are you of Hispanic, Latino, or Spanish origin?

CODE	LABEL
01	Yes
02	No
98	Don't Know
99	Prefer not to answer

What is your race? Are you White, Black or African American, Asian, American Indian or Alaska Native, Middle Eastern or North African, Native Hawaiian or other Pacific Islander, or some other race?

CODE	LABEL
01	White
02	Black or African American
03	Asian
04	American Indian or Alaska Native
05	Middle Eastern or North African
06	Native Hawaiian or other Pacific Islander
07	Some other race or ethnicity
98	Don't know
99	Prefer not to answer

What is the zip code where you are currently living?

CODE	LABEL
01	Enter zip code (5 digit)
02	No fixed address à Q1A-5b
03	I don't know my zip code à Q1A-5b
99	Prefer not to answer

If you're unsure about your zip code, what is the city or town where you live most of the time?

CODE	LABEL
01	Enter city name
98	Don't Know
99	Prefer not to answer
3A.	Food security

3A. FOOD SECURITY[10]

The following are statements that people have made about their food situation. For these statements, please indicate whether the statement was <u>often</u> true, <u>sometimes</u> true, or <u>never</u> true for you and your household in the last 12 months—that is, since last [CURRENT MONTH].

a. The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more.

b. (I/we) couldn't afford to eat balanced meals.

Would you say this statement is often true, sometimes true, or never true?

CODE	LABEL
01	Often true
02	Sometimes true
03	Never true

In the last 12 months, since last [CURRENT MONTH] did you or other adults in your household ever cut the size of your meals or skip meals because there wasn't enough money for food?

CODE	LABEL
01	Yes Q3B-3
02	No Q3B-4

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How often did this happen—almost every month, some months but not every month, or in only 1 or 2 months?

CODE	LABEL
01	Almost every month
02	Some months but not every month
03	Only 1 or 2 months

In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

CODE	LABEL
01	Yes
02	No

In the last 12 months, were you ever hungry but didn't eat because there wasn't enough money for food?

CODE	LABEL
01	Yes
02	No

4A. HEALTH[11]

Would you say that in general, your health is excellent, very good, good, fair, or poor?

CODE	LABEL
01	Excellent
02	Very good
03	Good
04	Fair
05	Poor
98	Don't Know
99	Prefer not to answer

4B. HEALTH CONDITIONS[12]

The following questions ask you about specific medical conditions that you or anyone in your household may currently have or have had in the past.

Has anyone in your household been told by a doctor or other health professional that they have any of the following conditions? Select all that apply.

CODE	LABEL
01	Diabetes / sugar diabetes / prediabetes
02	High blood pressure / hypertension03
03	Heart disease / stroke
04	None
05	Other
98	Don't Know
99	Prefer not to answer

Have you or anyone in your household ever been told by a doctor or other health professional that you/they had diabetes during a pregnancy, also known as gestational diabetes?

CODE	LABEL
01	Yes
02	No
03	Not applicable—no female in the household
98	Don't Know
99	Prefer not to answer

Over the past two weeks, how often have you been bothered by any of the following problems?

a. Little interest or pleasure in doing things
b. Feeling down, depressed, or hopeless

Would you say not at all, several days in the past two weeks, more than half the days, or nearly every day?

CODE	LABEL
01	Not at all
02	Several days
03	More than half the days
04	Nearly every day
98	Don't Know
99	Prefer not to answer

If you are feeling down or depressed and need help, please speak with your health care provider. You can also call the National Suicide Prevention Lifeline at 1-800-273-8255

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4C. HEALTHY DAYS[13]

Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

CODE	LABEL
01	Enter a number (0-30)
98	Don't Know
99	Prefer not to answer

Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

CODE	LABEL
01	Enter a number (0-30)
98	Don't Know
99	Prefer not to answer

During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

CODE	LABEL
01	Enter a number (0-30)
98	Don't Know
99	Prefer not to answer

4G. Dietary intake—fruits and vegetables

4G. DIETARY INTAKE—FRUITS AND VEGETABLES

The following questions are about fruits and vegetables you normally eat. Think about the fruits and vegetables you ate during the past week including all the meals and snacks you ate from the time you got up until you went to bed. Be sure to count fruits and vegetables you ate at home, work, restaurants, or anywhere else.

During the past week, how many times did you eat fruit like apples, bananas, oranges, melon, or any other fruit? INCLUDE fresh, frozen, canned, and dried fruit. DON'T COUNT juices.

Would you say...

CODE	LABEL
01	I did not eat any fruit during the past week
02	1-3 times in the past week
03	4-6 times in the past week
04	1 time a day
05	2 times a day
06	3 or more times a day
98	Don't Know
99	Prefer not to answer

During the past week, how many times did you drink 100% pure fruit juice like orange, apple, grape, or other 100% fruit juice?

DON'T COUNT fruit-flavored drinks with added sugar like Capri Sun, Sunny D, or other fruit-flavored drinks.

Would you say...

CODE	LABEL
01	I did not drink any 100% fruit juice during the past week
02	1-3 times in the past week
03	4-6 times in the past week
04	1 time a day
05	2 times a day
06	3 or more times a day
98	Don't Know
99	Prefer not to answer

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During the past week, how many times did you eat green salad with lettuce and with or without other vegetables?

Would you say...

CODE	LABEL
01	I did not eat any green salad during the past week
02	1-3 times in the past week
03	4-6 times in the past week
04	1 time a day
05	2 times a day
06	3 or more times a day
98	Don't Know
99	Prefer not to answer

During the past week, how many times did you eat potatoes that are baked, boiled, mashed, or in soups or stews (that aren't fried)?

Would you say...

CODE	LABEL
01	I did not eat any other types of potatoes during the past week
02	1-3 times in the past week
03	4-6 times in the past week
04	1 time a day
05	2 times a day
06	3 or more times a day
98	Don't Know
99	Prefer not to answer

During the past week, how many times did you eat vegetables that are not deep-fried? These are vegetables like carrots, broccoli, collards, green beans, corn, or other vegetables that are not deep-fried.

INCLUDE canned, frozen, or fresh vegetables. ALSO COUNT vegetables that are raw, boiled, broiled, baked, grilled, stir-fried, or microwaved.

Would you say...

CODE	LABEL
01	I did not eat any non-fried vegetables during the past week
02	1-3 times in the past week
03	4-6 times in the past week
04	1 time a day
05	2 times a day
06	3 or more times a day
98	Don't Know
99	Prefer not to answer

During the past week, how many times did you eat cooked beans, like refried beans, baked beans, pinto beans, black beans, or other cooked beans?

INCLUDE canned or dry beans. DON'T COUNT green beans or string beans.

Would you say...

CODE	LABEL
01	I did not eat any cooked beans during the past week
02	1-3 times in the past week
03	4-6 times in the past week
04	1 time a day
05	2 times a day
06	3 or more times a day
98	Don't Know
99	Prefer not to answer

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4H2. DIETARY FACTORS AND CONCERNS

For the following questions, please think about the dietary factors and concerns of your household.

Does anyone in your household have any of the following dietary factors or concerns? Select all that apply.

CODE	LABEL
01	Low-sugar and/or “diabetes friendly”
02	Low-carb (carbohydrate)
03	Low-sodium (salt) and/or low saturated fat (“heart-healthy”)
04	Gluten-free
05	Halal
06	Kosher
07	Vegan
08	Vegetarian
09	Soft diet / dental concerns
10	Limited / no cooking equipment
11	Food allergen (e.g., peanut, seafood, dairy)
12	None
13	Other_____
98	Don’t Know
99	Prefer not to answer

5A. SNAP[15]

The following questions are about your household’s participation in the federal nutrition program called food stamps or SNAP.

Does anyone from the household currently receive SNAP [or equivalent name in that state] or food stamps?

CODE	LABEL
01	Yes Q5A-2
02	No Q5B-1
98	Don’t Know Q5B-1
99	Prefer not to answer Q5B-1

How many weeks do your SNAP [or equivalent name in that state] benefits usually last? Do they last 1 week or less, 2 weeks, 3 weeks, 4 weeks, or more than 4 weeks?

CODE	LABEL
01	1 week or less
02	2 weeks
03	3 weeks
04	4 weeks
05	More than 4 weeks
98	Don’t Know
99	Prefer not to answer

7. CLOSEOUT

Is there anything else you would like to share? (open-ended):

Thank you for your time. You have completed the survey.

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End Notes

[1] Greater Baton Rouge Food Bank was omitted from this list due to not collecting any FACS data

[2] # of surveys completed = survey with any data regardless of how much is missing

[3] Multiple responses possible

[4] **The national food insecurity rate** is 10.9%. **The Hunger Study in 2014** found that 83.8% of respondents across all program types were food insecure.

[5] The remaining participants were either unscorable (1.7%) or did not complete this portion of the survey (2.8%). Food security was considered 'unscorable' if the participant's total score was '1' but more than one question was not answered. If the unscorable and missing surveys are removed from the response total, 15.7% of participants are defined as food secure with 84.3% defined as food insecure.

[6] Multiple responses possible for diagnosis

[7] "Anhedonia refers to the reduced ability to experience pleasure and has been studied in different neuropsychiatric disorders." **www.ncbi.nlm.nih.gov/pmc/articles/PMC3181880/**

[8] CDC's Morbidity and Morality Weekly Report (MMWR) (2017). **www.cdc.gov/media/releases/2017/p1116-fruit-vegetable-consumption.html#:~:text=Depending%20on%20their%20age%20and,of%20a%20healthy%20eating%20pattern**

[9] Multiple responses possible for dietary factors/ concerns

[10] Section 3B was adapted from the USDA Household Food Security Survey Module[11] M

[11] BRFSS

[12] Patient Health Questionnaire-2 (PHQ-2)[14] M

[13] Q4A-2 to Q4A-4 were adapted from the CDC's Health-related Quality of Life Measures (HRQOL)

[14] Section 4F is adapted from Feeding America's Fresh Foods Survey

[15] Section 5A is adapted from Feeding America's HIA 2014

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