COMMUNITY BENEFIT PROGRAMMING TO IMPROVE HEALTHY FOOD ACCESS AND REDUCE RISK OF DIET-RELATED DISEASE

A National Survey of Hospitals

Health Care Without Harm

Support provided by

Robert Wood Johnson Foundation

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PROJECT INTRODUCTION, OVERVIEW OF SURVEY METHODS, AND KEY FINDINGS

U.S. Department of Agriculture

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Project Introduction

Changes to IRS regulations governing nonprofit hospitals' community benefit obligations have created a new impetus for hospitals to collaborate with other stakeholders to implement community health improvement plans that address social determinants of health, including increasing access to quality, affordable food.

Health Care Without Harm has undertaken a three-year project, with support from the Robert Wood Johnson Foundation, to examine hospital community benefit programming to increase healthy food access, promote healthy and sustainable food systems, and reduce risk of diet-related health conditions. The project includes primary research as well as developing and disseminating tools and resources to support replication of promising community benefit practices.

The study involves a national survey of not-for-profit hospitals, analysis of survey respondents' Community Health Needs Assessments (CHNAs) and implementations strategies, in-depth interviews with key informants, case studies, and a literature review.

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This chartbook summarizes findings from a survey of a random sample of community benefit directors at not-for-profit, general medical and surgical hospitals throughout the United States. The sample was drawn from the American Hospital Association (2014) hospitals database. This report also includes selected data from survey respondents' CHNAs.

This report is the first in a series of research reports and other resources that will be released in 2017. These will include a comprehensive research report that will discuss in depth the findings from the survey and other research methods and present recommendations. Also forthcoming is a toolkit of guidance resources that will support hospital community benefit professionals and community partners in developing initiatives to promote healthy food access and healthier food environments.

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Survey methodology

- The survey was developed in summer 2016 to investigate how hospitals organize community benefit activities and how they include food insecurity, healthy food access, and diet-related disease in their community health needs assessments and implementation strategies
- Invitations to participate in online survey were e-mailed to community benefit managers at a random sample of 930 private, not-for-profit, general hospitals throughout the United States
- Survey in field from August 16 - December 8, 2016
- 215 completed surveys returned
- Response rate 23.12%
- Survey respondents' community health needs assessments (CHNAs) were also analyzed in conjunction with survey data

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Survey sample characteristics

Characteristic	Survey Respondents	Population
Geographic Region		
Midwest	36%	35%
South	22%	29%
Northeast	22%	18%
West	21%	19%
Rural/Urban		
Urban	62%	64%
Rural	38%	36%
Hospital Size		
Small (<100 beds)	43%	44%
Medium (100-399 beds)	46%	44%
Large (400+ beds)	11%	12%
Other Characteristics		
ACO hospital*	44%	37%
Children's hospital	2%	2%
Critical access hospital	28%	25%
Major teaching hospital	7%	7%
Minor teaching hospital	40%	39%
System affiliation	67%	69%

*Accountable Care Organization

Respondents fairly closely matched the population surveyed. The Northeast over-responded while the South under-responded. Accountable Care Organization hospitals also over-responded.

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Key findings about community health needs assessments (CHNAs)

- Obesity was identified as a health need in 71% of respondents' CHNAs, while food insecurity or healthy food access was identified as a health need in 13% of CHNAs.
- 57% of hospitals' CHNAs utilized food environment measures. The most common measures were County Health Rankings & Roadmaps' Food Environment Index and the U.S. Department of Agriculture's (USDA) food desert measures.
- Data on diet-related behaviors, such as fruit and vegetable consumption, was included in 40% of CHNAs.
- 45% of hospitals reported including at least one food-related organization on their CHNA committee. Having a food-related organization on the CHNA committee was strongly correlated with having a community benefit program that targeted healthy food access or food insecurity.
- Collaborating with other hospitals in the CHNA process was common, with 59% of hospitals reporting collaboration with other facilities (within and/or external to their hospital system) in their CHNAs. Urban hospitals were more likely to collaborate with other facilities than rural hospitals (67% for urban vs. 46% for rural).

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Key findings about implementation strategies

- Multiple initiatives targeting obesity, diet-related disease, or food access were common, with nearly half of hospitals reporting two or more such community benefit activities.
- Most community benefit support for obesity, diet-related disease, or food access initiatives was provided through staff time or other in-kind contributions. About a third of programs have received community benefit support for more than three years.
- Of all reported community benefit programs addressing obesity, diet-related health conditions, or healthy food access, diet and nutrition education and exercise promotion were the most common intervention types (50% and 37%, respectively). For programs targeting obesity as a health need, 56% intervened through diet and nutrition education while only 20% addressed healthy food access.
- Program participation was the dominant program evaluation measure utilized (85%). The next most frequent evaluation measures were surveys of participants' health knowledge (44%) and biophysical health indicators (41%).

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Key findings about community benefit support for local food systems

- For those respondents who reported having a community benefit program that targeted food insecurity or healthy food access, 43% said including local or organic producers in the program was very important.
- 48% of all respondents said that it was very or somewhat likely that their facility would provide community benefit support in the next 3 years to an initiative involving community agriculture (e.g. urban farm or community supported agriculture).

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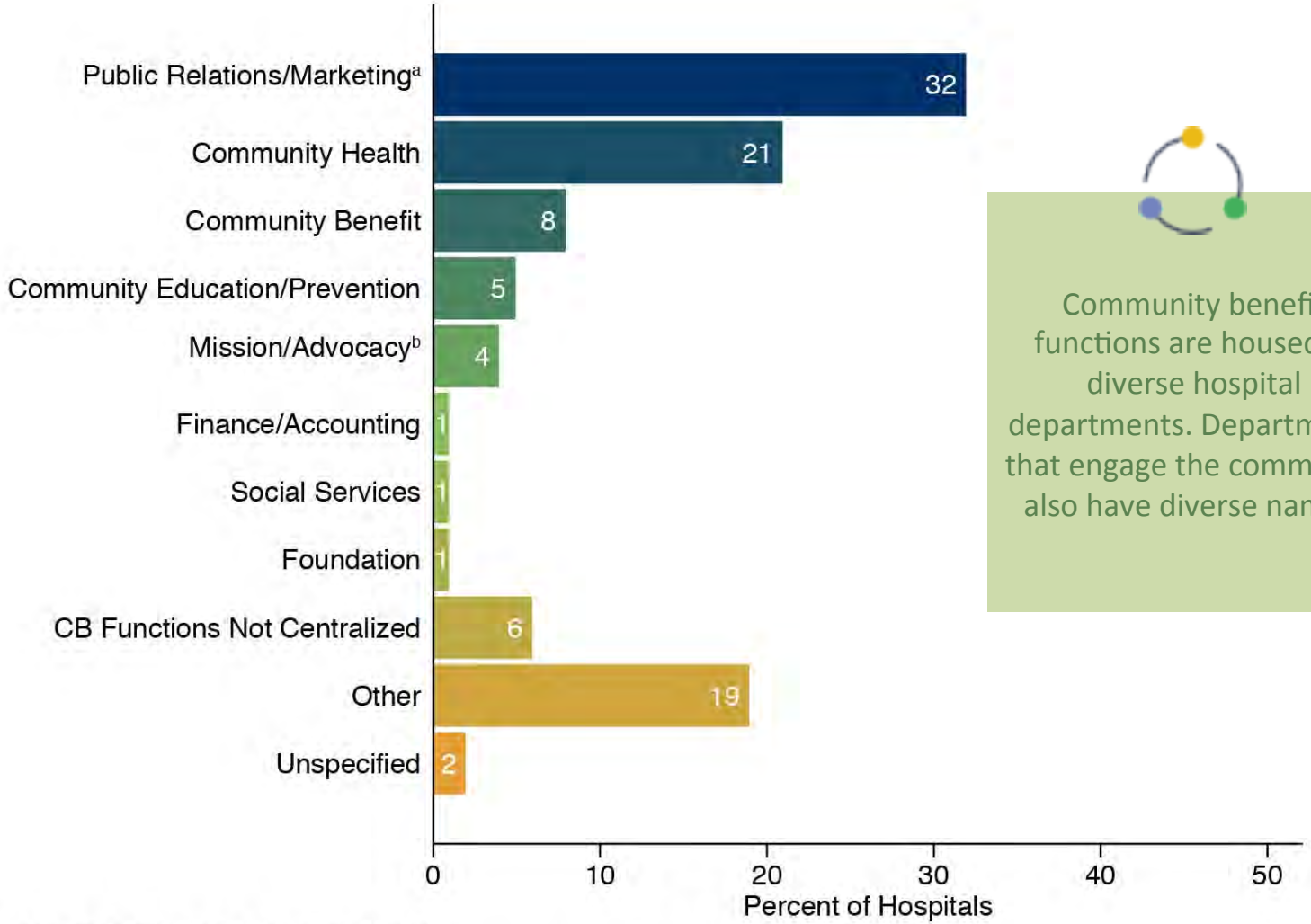
Department in which most or all community benefit functions are located



Community benefit functions are housed in diverse hospital departments. Departments that engage the community also have diverse names.

a. Includes Outreach and Communications
b. If "mission" occurred with other key terms, the other term was counted

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Hospitals reported using resources from the following organizations to inform community benefit activities

Organization	Utilized **online** or **print** re-sources	Attended an online **webinar**	Attended a **conference or in-person** training
American Hospital Association (e.g. Association for Community Health Improvement or Hospitals in Pursuit of Excellence)	60%	**26%**	18%
State hospital association	54%	23%	**26%**
Catholic Health Association	49%	**28%**	17%
CDC (e.g. Community Health Improvement Navigator or Healthy People 2020)	**73%**	17%	5%
ASTHO (Assoc. of State and Territorial Health Officials) **or NACCHO** (National Assoc. of County and City Health Officials)	19%	2%	2%
Community Commons (chna.org)	42%	11%	2%
County Health Rankings & Roadmaps	**79%**	20%	7%
Community Benefit Connect	20%	8%	3%
Public Health Institute (www.phi.org)	39%	10%	3%

CDC and County Health Rankings & Roadmaps are the most widely used sources of online or print materials.

AHA and CHA provide key resources through webinars and in-person trainings or conferences.

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COMMUNITY HEALTH NEEDS ASSESSMENTS

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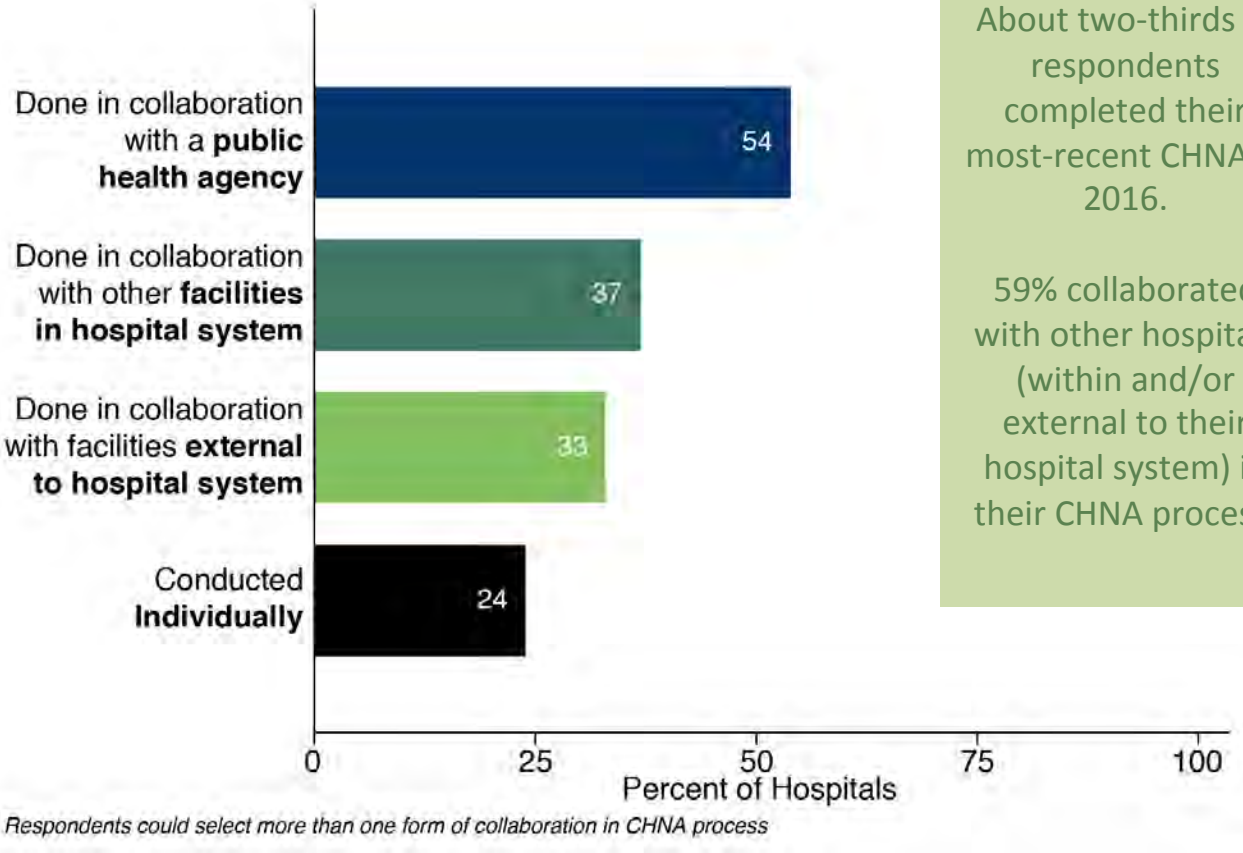
CHNA dates and collaborative process

Conducted first CHNA in	
2011 or earlier	29%
2012	27%
2013	42%
2014 or later	2%

Conducted most-recent CHNA in	
2013 or earlier	1%
2014	4%
2015	30%
2016	65%



Respondents could select more than one form of collaboration in CHNA process

About two-thirds of respondents completed their most-recent CHNA in 2016.

59% collaborated with other hospitals (within and/or external to their hospital system) in their CHNA process.

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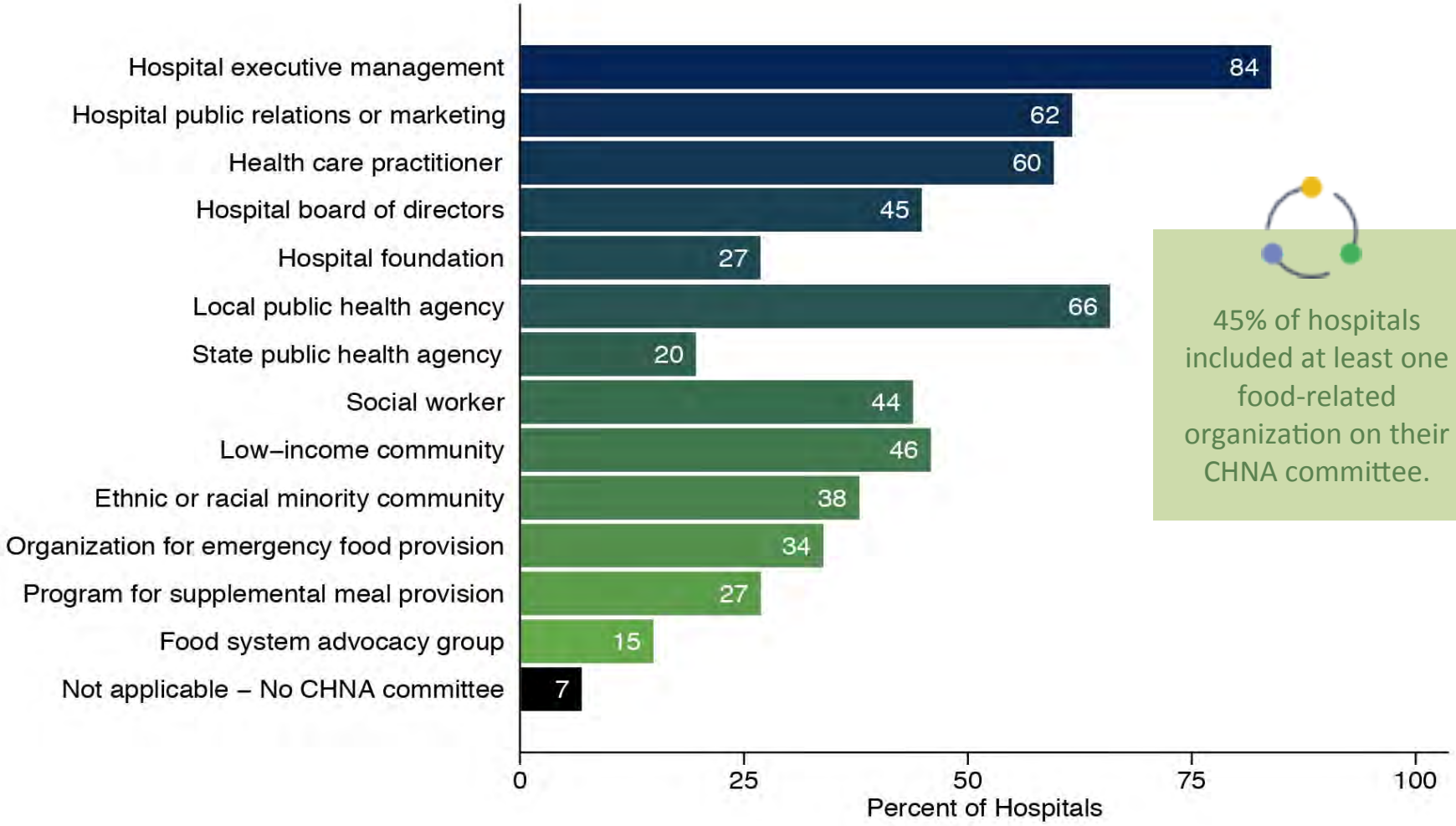
Roles or groups represented on CHNA committee



45% of hospitals included at least one food-related organization on their CHNA committee.

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Relationship between CHNA committee membership and reported community benefit programs

CHNA Committee Members	Having **any** reported programs addresing obesity, diet-related **Signif.** [a]	Programs targeting **food security** and/or healthy food access **Signif.** [a]	Programs targeting prevention or treatment of **obesity** **Signif.** [a]	Programs targeting prevention or treatment of **diet-related disease** **Signif.** [a]
Hospital Admin. Staff†	--	--	--	--
Healthcare Practitioner	Pos **	--	--	--
State Public Health Agency	--	--	--	--
Local Public Health Agency	--	--	--	--
Low-income Community	Pos *	Pos *	--	--
Ethnic/Racial Minority Community	--	--	Pos **	Pos *
Org. for Emergency Food Provision	--	Pos ***	--	Pos **
Prog. for Supplemental Meal Provision	--	Pos **	--	--
Food System Advocacy Group	--	Pos ***	Pos ***	--

[a] Direction and significance of correlation between committee partic. and program type based on simple logistic regression
*** p<0.01; ** p<0.05; * p<0.1

† Hospital executive management, public relations or marketing, board of directors, or foundation

Having a food organization represented on the CHNA committee was associated with having a community benefit program that targeted healthy food access or food insecurity.

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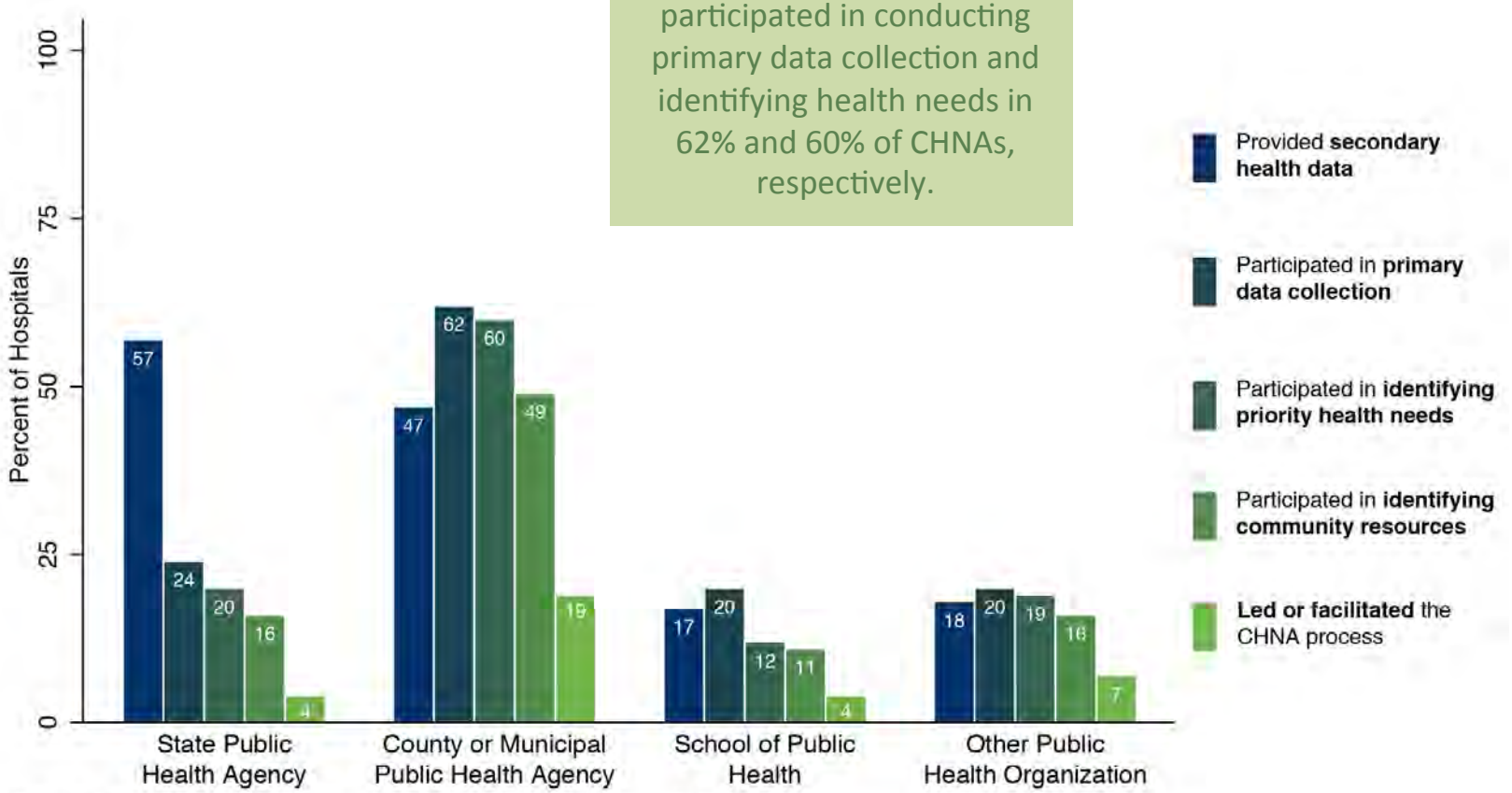
Different ways public health participated in the CHNA process

Local public health agencies participated in conducting primary data collection and identifying health needs in 62% and 60% of CHNAs, respectively.



Respondents could select more than one form of support with their CHNA process

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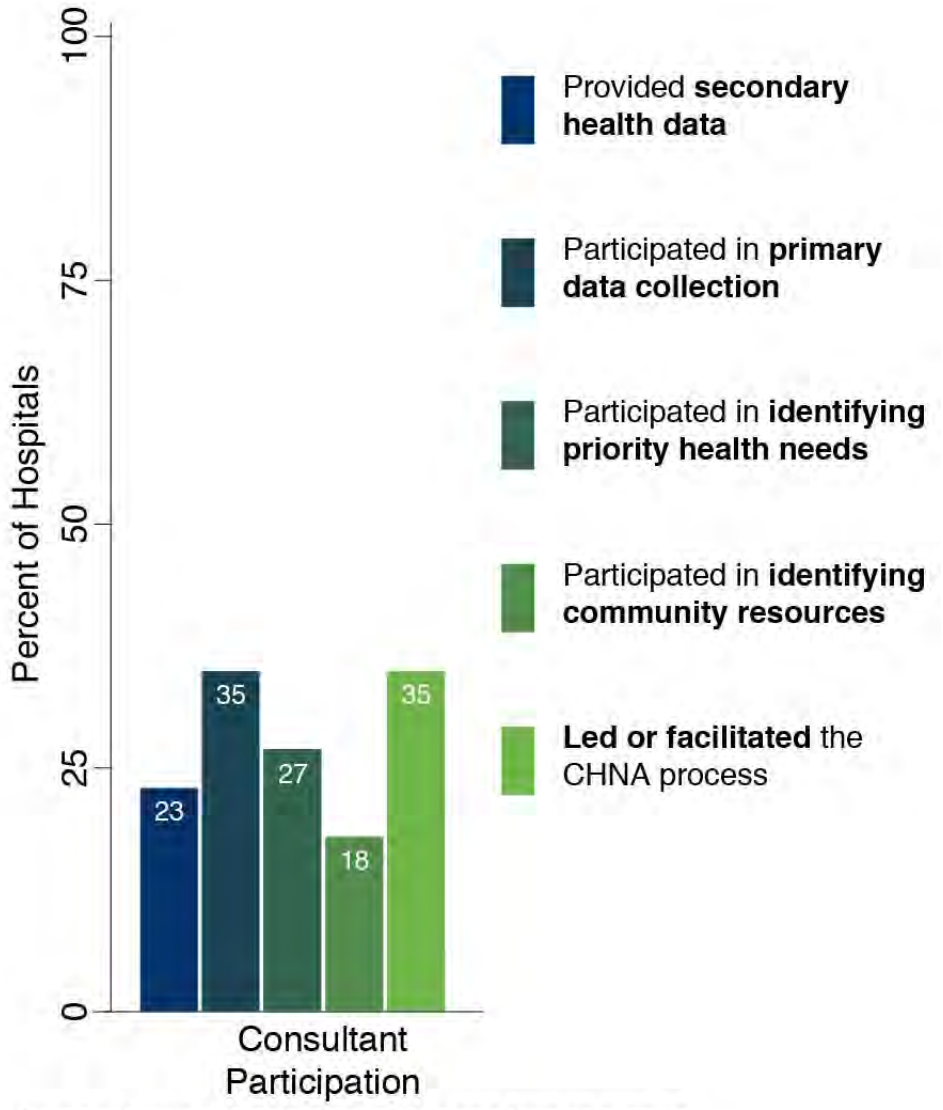
Consultant participation in the CHNA process



Respondents could select more than one form of support with their CHNA process

52% of hospitals utilized a consultant for one or more of these CHNA activities. Consultants were most heavily relied upon for primary data collection and facilitating the CHNA process.

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Food organizations in the CHNA process

Organization	Included in our inventory of **community resources** to meet health needs	Participated in **primary data** collection	Participated in **identifying priority health needs**
Organization for **emergency food provision** (e.g. food bank, food pantry, soup kitchen)	**68%**	**25%**	**35%**
Program for **supplemental meal provision** (e.g. school-based, summer meals, Meals on Wheels)	**60%**	19%	29%
Food system advocacy group (e.g. food policy council, food justice coalition)	26%	7%	11%
Agency that links food-insecure people to food resources	45%	16%	25%
Community group promoting healthy food access (e.g farmers' market, urban farm, healthy corner store)	49%	21%	28%
College/university program addressing food/nutrition issues	22%	11%	13%
Other group(s) addressing food/ nutrition issues	18%	6%	8%

Emergency food organizations, such as food pantries, were the most commonly involved organizations, followed by supplemental meal programs, such as summer meals.

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Health needs identified in survey respondents' CHNAs

Health Need	On List of **Identified** Health Needs†	On List of **Prioritized** Health Needs$^{\Delta}$
Obesity prevention or treatment *	71%	54%
Diabetes	40%	28%
Other diet-related diseases	45%	24%
Food insecurity or healthy food access	13%	1%
Poverty, economic security, or unemployment	22%	7%
None of these health needs identified or prioritized	21%	32%

** Includes need for improved diet/nutrition and need for increased physical activity*

† of 205 facilities for which CHNAs were available

$^{\Delta}$ of 166 CHNAs that listed priority needs

Obesity was the most common of these health needs identified and prioritized in CHNAs.

13% of CHNAs identified food insecurity or healthy food access as a health need.

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Diet-related health conditions data sources utilized in CHNAs

Obesity, Diabetes, and other Diet-Related Disease Secondary Data & Sources

Includes data collected on prevalence of obesity, diabetes, cardiovascular disease, high blood pressure, and high cholesterol

Percent of CHNAs using at least one diet-related disease measure	**94%**
Obesity	*88%*
Diabetes	*78%*
Other Diet-Related Disease	*75%*

Top data sources included

CDC (e.g. Behavioral Risk Factors Surveillance System, Youth Risk Behavior Surveillance System, WONDER)

Local and State sources (e.g. city, county, or state public health department surveys)

Data on prevalence of obesity and diet-related diseases were collected in nearly all CHNAs.

The CDC and state or local public health agencies were the most common sources for data.

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Food insecurity metrics and data sources utilized in CHNAs

Food Insecurity Secondary Measures & Sources

Includes data collected on food insecurity, utilization of free or reduced-price school meals, and SNAP & WIC usage.

Percent of CHNAs using at least one food insecurity measure	52%
*Food insecurity**	*34%*
Free/reduced-price school meals usage	*25%*
SNAP usage	*22%*
*Child food insecurity**	*13%*
WIC usage	*5%*

Top data sources included

Map the Meal Gap, Feeding America
National Center for Education Statistics
Community Health Rankings & Roadmaps (citing Map the Meal Gap)

*Feeding America's food insecurity measures are an indirect estimate of the total number of individuals or children under age 18 who are food insecure in a county during the year. Estimates are based on data from the Current Population Survey (U.S. Census Bureau and the Bureau of Labor Statistics). See FeedingAmerica.org for details.

52% of facilities' CHNAs used at least one measure of food insecurity.

Map the Meal Gap from Feeding America and the American Community Survey from the Census Bureau were the most common sources of data.

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Food environment metrics and data sources utilized in CHNAs

Food Environment Secondary Measures & Sources

Includes measures collected on prevalence of food deserts and/or different kinds of food outlets

Percent of CHNAs using at least one food environment measure	**57%**
*Food environment**	*33%*
*Food desert**	*27%*
Fast food restaurants density	*16%*
Grocery store density	*15%*
Low food access	*14%*
Farmer's market density	*6%*
Stores accepting SNAP	*8%*
Stores accepting WIC	*3%*

Top data sources included

Food Access Research Atlas, USDA
Community Business Patterns, US Census
County Health Rankings & Roadmaps (their Index & USDA data)

Food environment measures were utilized in roughly 60% of hospitals' CHNAs.

The most common measures were CHRR's Food Environment Index and the USDA's food desert measures.

*Food Environment Index is County Health Rankings and Roadmaps' own index, which combines USDA's Food Desert data and Feeding America's Food Insecurity data into one Index that is used to rank counties. Food Desert data is exclusively from USDA's Food Access Research Atlas and is a composite of income level and proximity to a grocery store. Low Food Access is also from the USDA and is just the geographic portion of Food Desert data, or proximity to grocery stores.

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Dietary behavior metrics and data sources utilized in CHNAs

Food-Related Behaviors Secondary Measures & Sources

Includes data collected on food-related behaviors such as fruit and vegetable consumption, sugar consumption, or expenditures on different types of foods

Percent of CHNAs using at least one food-related behavior measure	**40%**
Fruit/vegetable consumption	*38%*
Sugar consumption	*13%*
Fast food consumption	*3%*

Top data sources included

Behavioral Risk Factors Surveillance System, CDC

Local and state sources (e.g. city, county, or state public health department surveys)

Community Commons (e.g. CDC BRFSS data and Nielsen expenditure data)

40% of CHNAs included data on diet-related behaviors, such as fruit and vegetable consumption.

The CDC's BRFSS surveys and state or local public health agency surveys were the most common sources for data.

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Food and diet-related primary data utilized in CHNAs

Primary Data Collection Methods	
Percent of CHNAs using at least one original data collection method	**89%**
Surveys	*61%*
Focus groups	*53%*
Interviews	*40%*

Nearly 90% of CHNAs used at least one source of original data that captured obesity and diet-related health needs, either as part of a set of general questions or through questions focused on obesity and diet-related disease.

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IMPLEMENTATION STRATEGIES

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Partnerships with food-related organizations

Organization	We provide **non-cash support** (e.g. staff time, materials) for an initiative	We provide **financial support** for an initiative	We have a **formal partnership** (binding agreement)	**Not Involved**
Organization for **emergency food provision** (e.g. food bank, food pantry, soup kitchen)	**44%**	**33%**	5%	36%
Program for **supplemental meal provision** (e.g. school-based, summer meals, Meals on Wheels)	40%	23%	8%	48%
Food system advocacy group (e.g. food policy council, food justice coalition)	23%	6%	2%	**74%**
Agency that links food-insecure people to food resources	39%	21%	8%	50%
Community group promoting healthy food access (e.g. farmers market, urban farm, healthy corner store)	**49%**	24%	**14%**	38%
College/university program addressing food/nutrition issues	21%	5%	3%	**76%**
Other group(s) addressing food/ nutrition issues	17%	9%	4%	**78%**

Emergency food organizations were the most commonly supported organizations, followed by supplemental meal programs.

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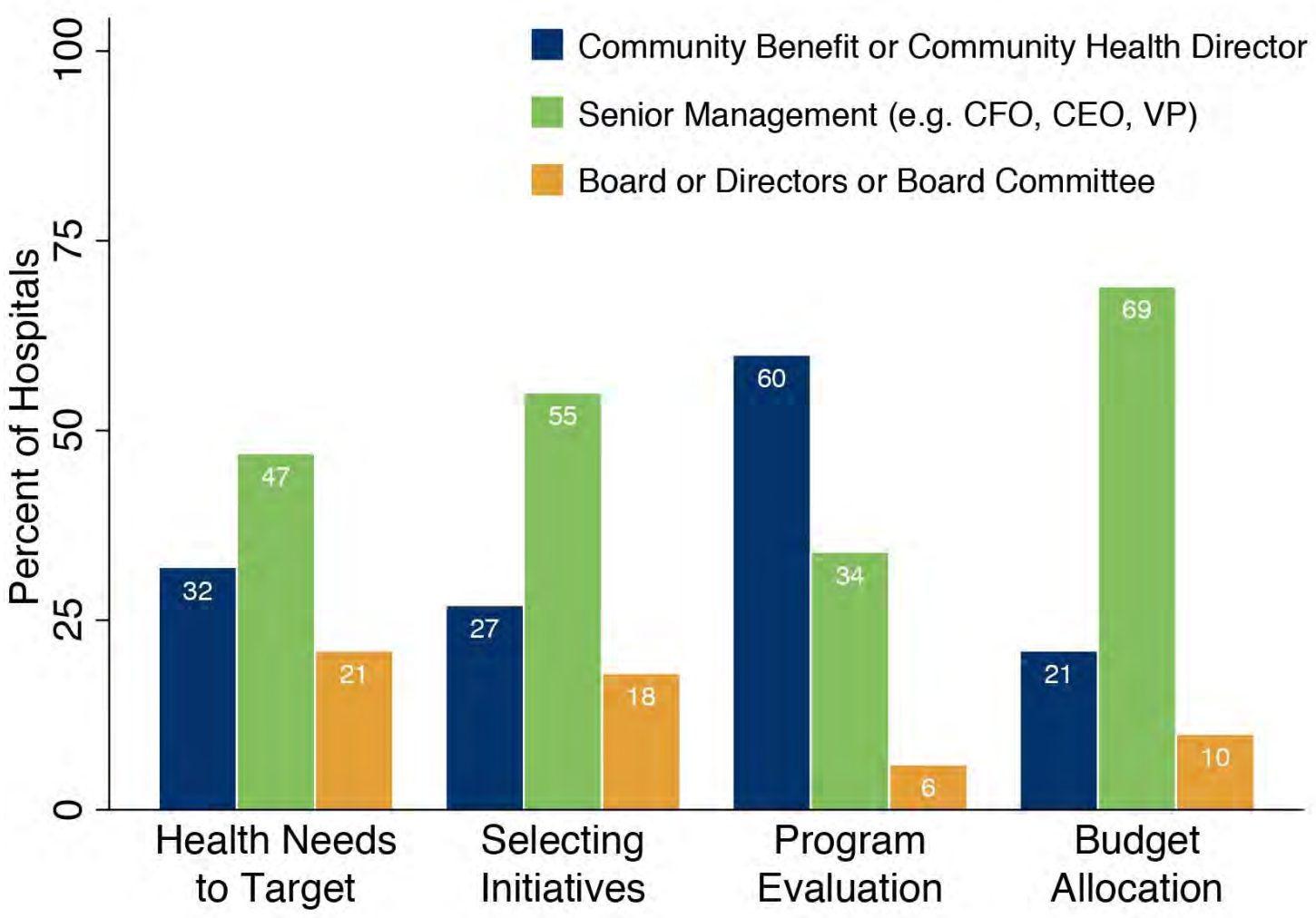
Decision-making authority



The majority of respondents reported that senior management was the ultimate authority for several community benefit programming matters. However, community benefit directors hold authority over monitoring and evaluation.

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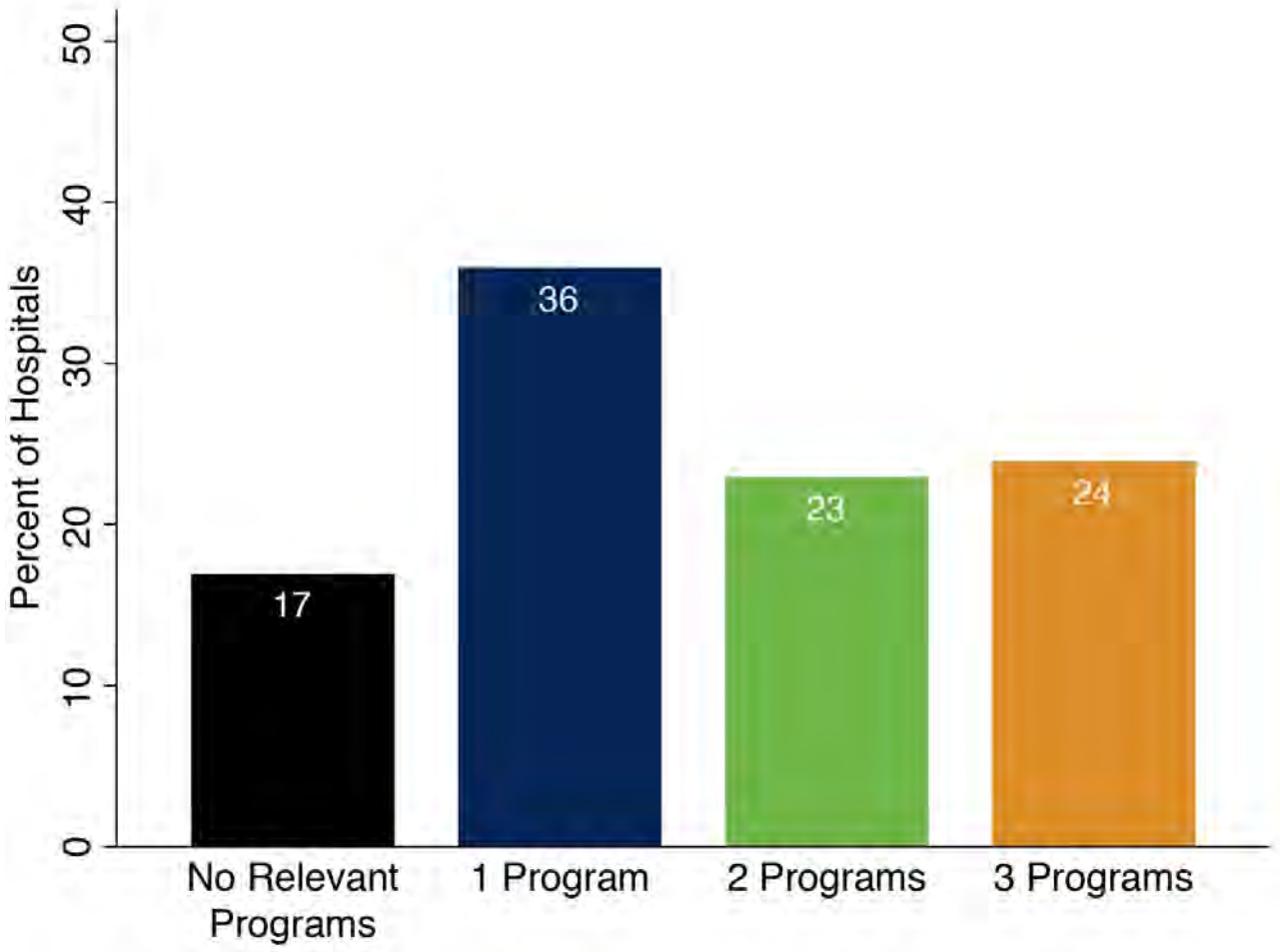
Hospitals reporting 0,1, 2, or 3 community benefit initiatives to address obesity, diet-related disease, or food access



Multiple initiatives targeting obesity, diet-related disease, or food access were common, with nearly half of hospitals surveyed reporting two or more such community benefit programs.

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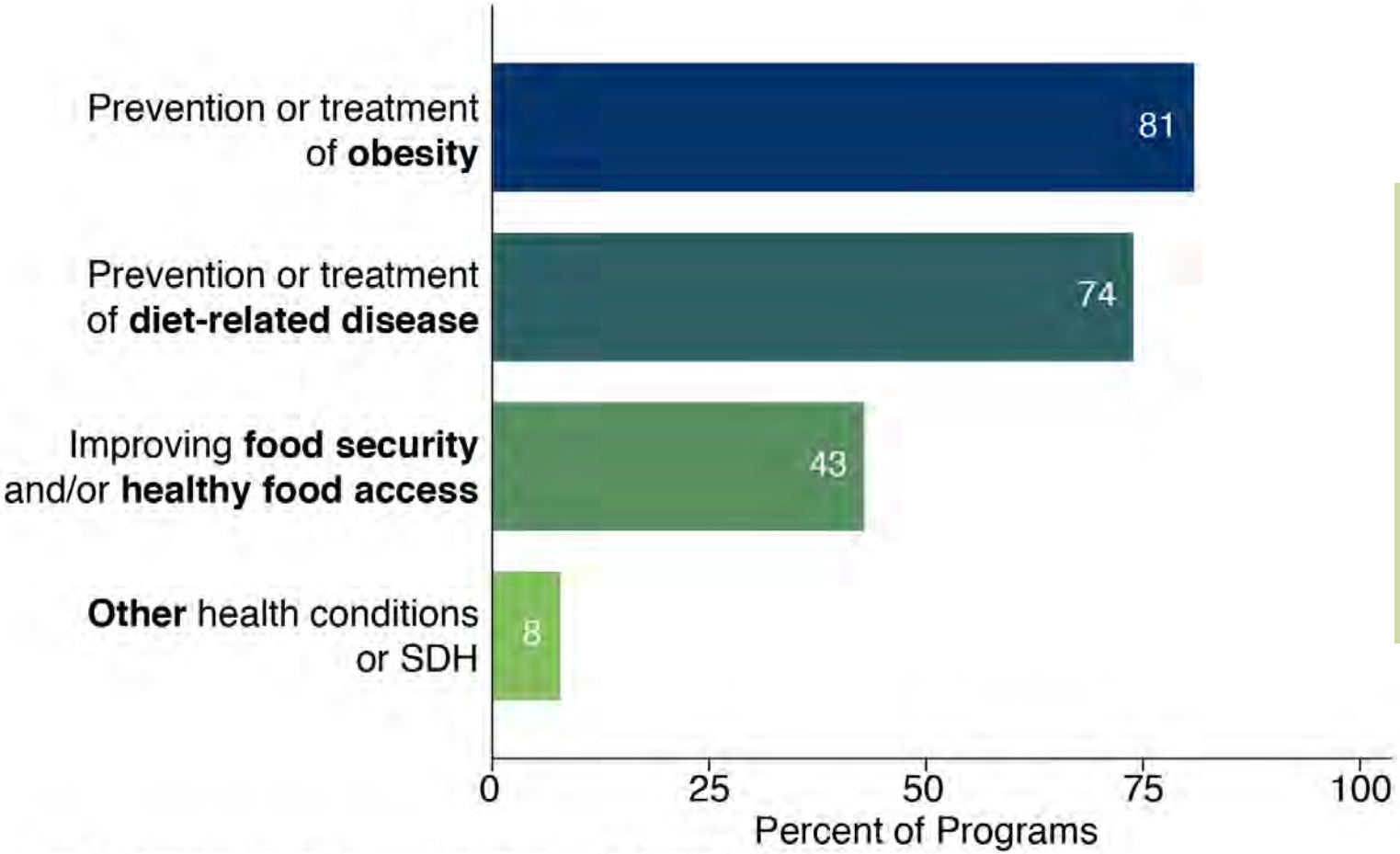
Targeted health needs

(among all reported initiatives addressing obesity, diet-related disease, or food access)



From 331 community benefit programs reported by 215 respondents

Respondents could select more than one targeted health need

Fewer than half of community benefit programs were aimed at addressing food insecurity or healthy food access.

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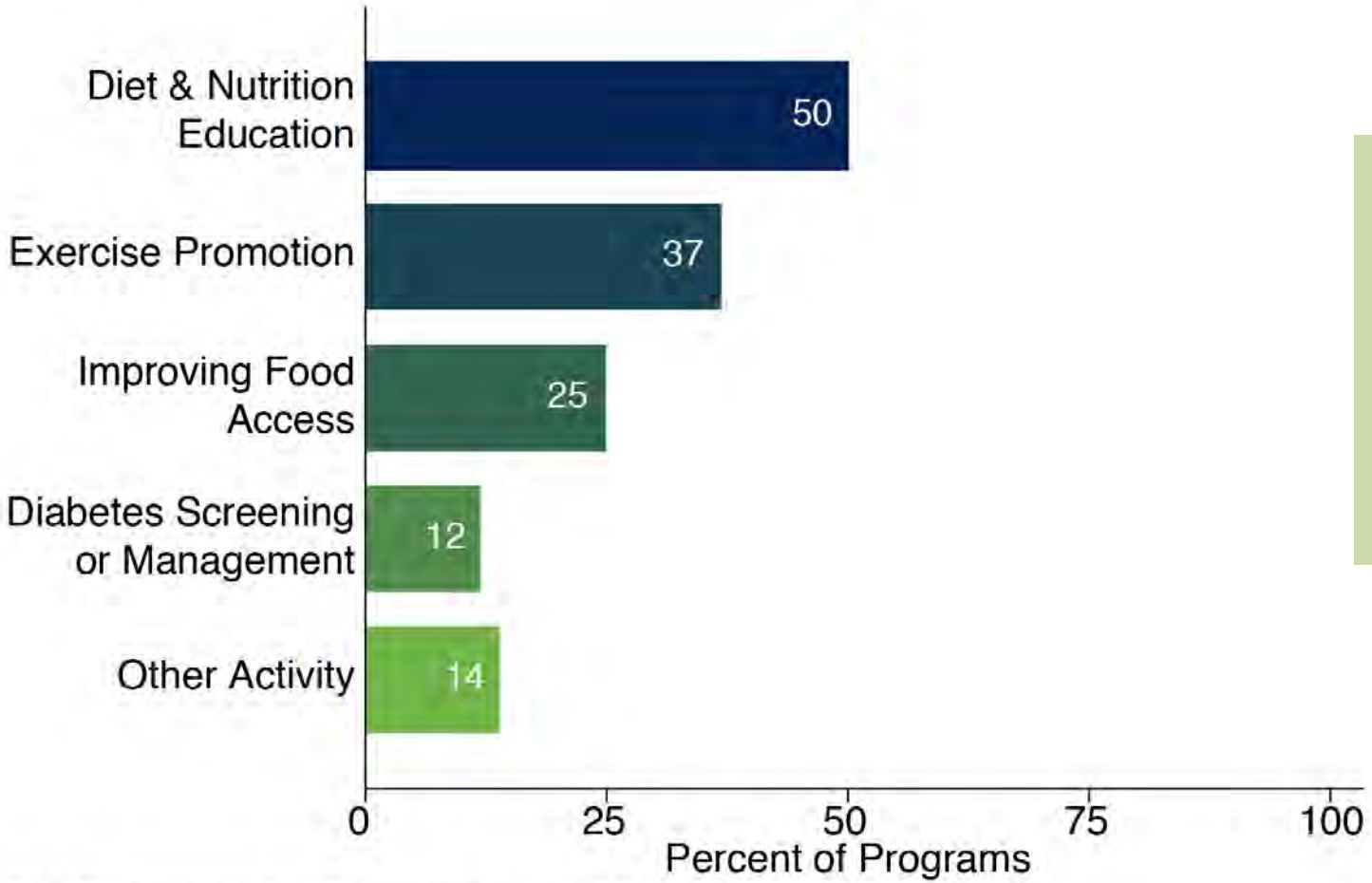
Community benefit intervention types

(among all reported initiatives addressing obesity, diet-related disease, or food access)



From 331 community benefit programs reported by 215 respondents
Programs were assigned up to two activity types

Diet and nutrition education and exercise promotion were the most common intervention types.

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Percent of programs targeting different health needs that engage different intervention activities

Health need targeted	Intervention activity type: **Diet & Nutrition** Education	**Exercise** Promotion	Improving **Food Access**	**Diabetes** Screening or Management	**Other**
Prevention or treatment of **obesity**	56%	**44%**	20%	8%	13%
Prevention or treatment of **diet-related disease**	55%	39%	16%	**15%**	14%
Improving **food security** and/or healthy **food access**	44%	23%	**56%**	4%	8%
Other health conditions or SDH	**63%**	41%	15%	7%	**33%**

From 331 community benefit programs reported by 215 respondents
Programs were assigned up to two activity types
Respondents could select more than one targeted health need

For programs targeting obesity as a health need, 56% intervened through diet and nutrition education, while only 20% addressed healthy food access.

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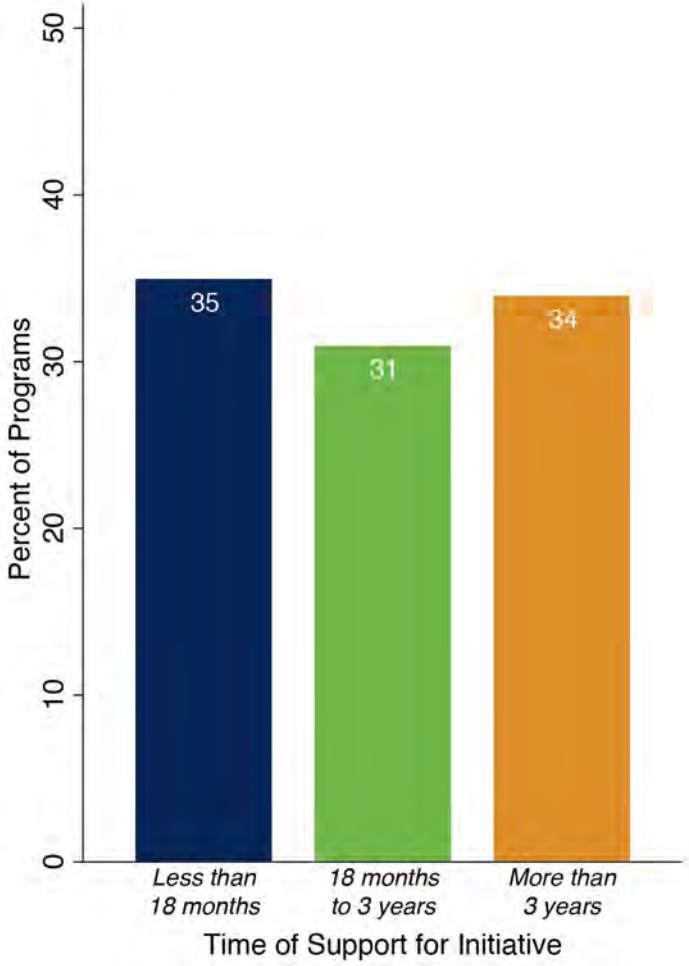
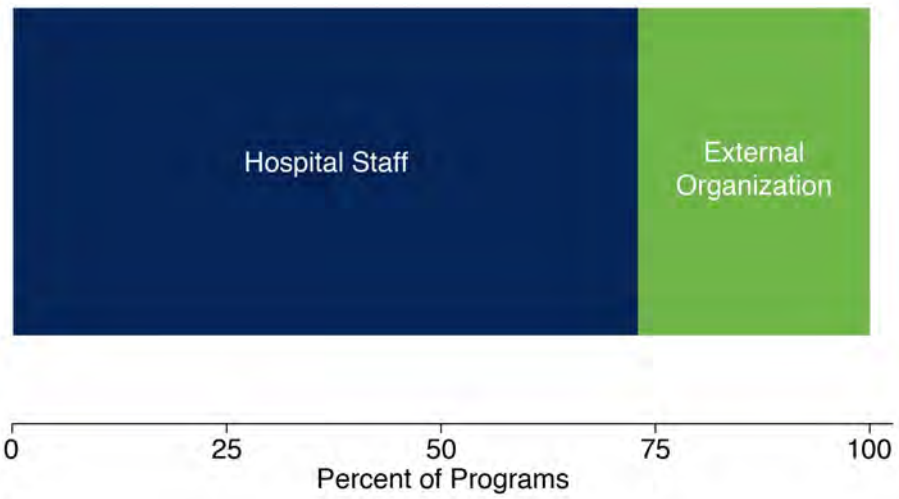
Time of hospital support & internal or external management of initiatives

(for reported initiatives addressing obesity, diet-related disease, or food access)



About a third of programs have received community benefit support for more than three years. About 75% of programs are managed by hospital staff.



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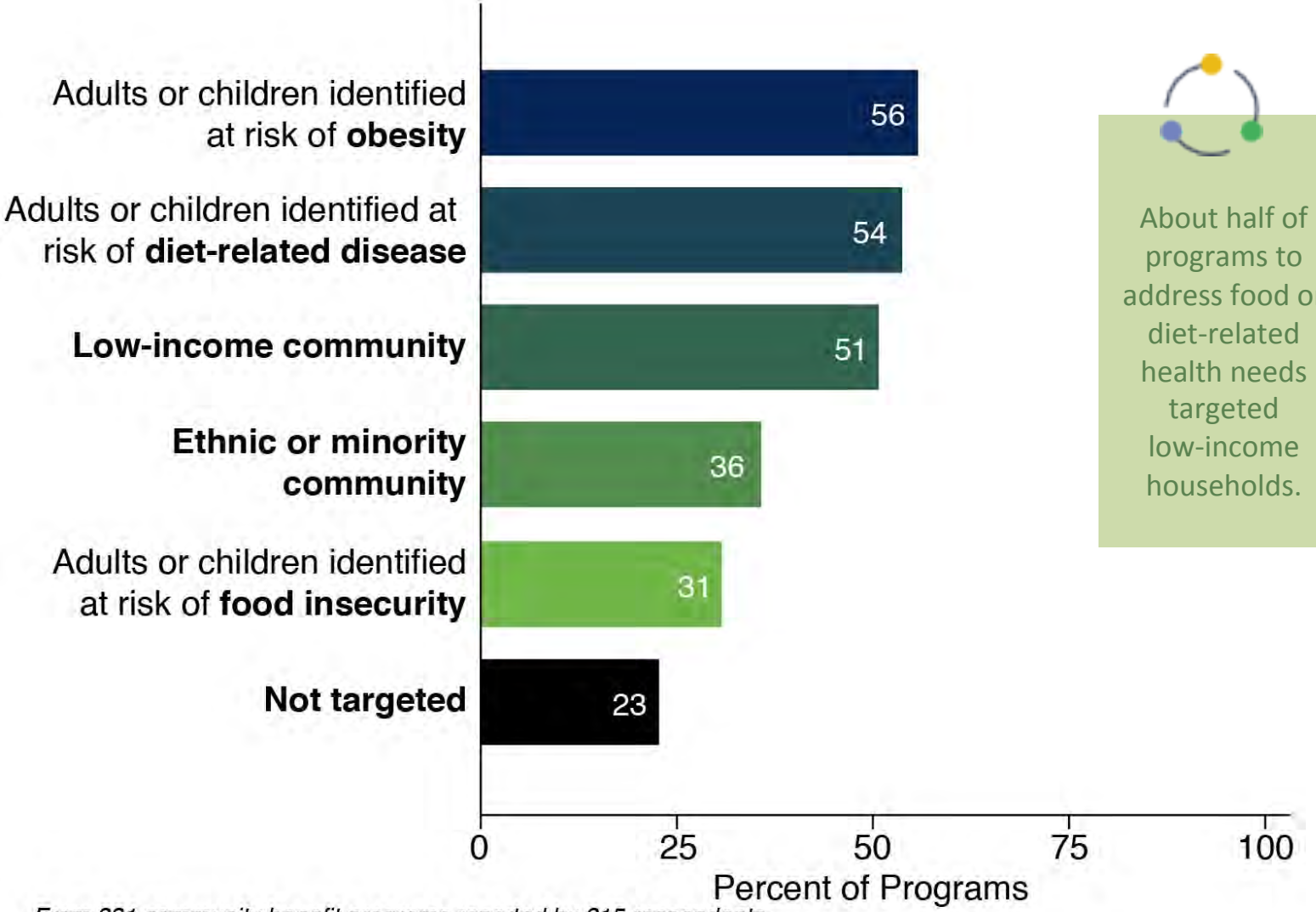
Populations targeted by community benefit initiatives

(among reported initiatives addressing obesity, diet-related disease, or food access)



About half of programs to address food or diet-related health needs targeted low-income households.

From 331 community benefit programs reported by 215 respondents
Respondents could select more than one targeted population for each program

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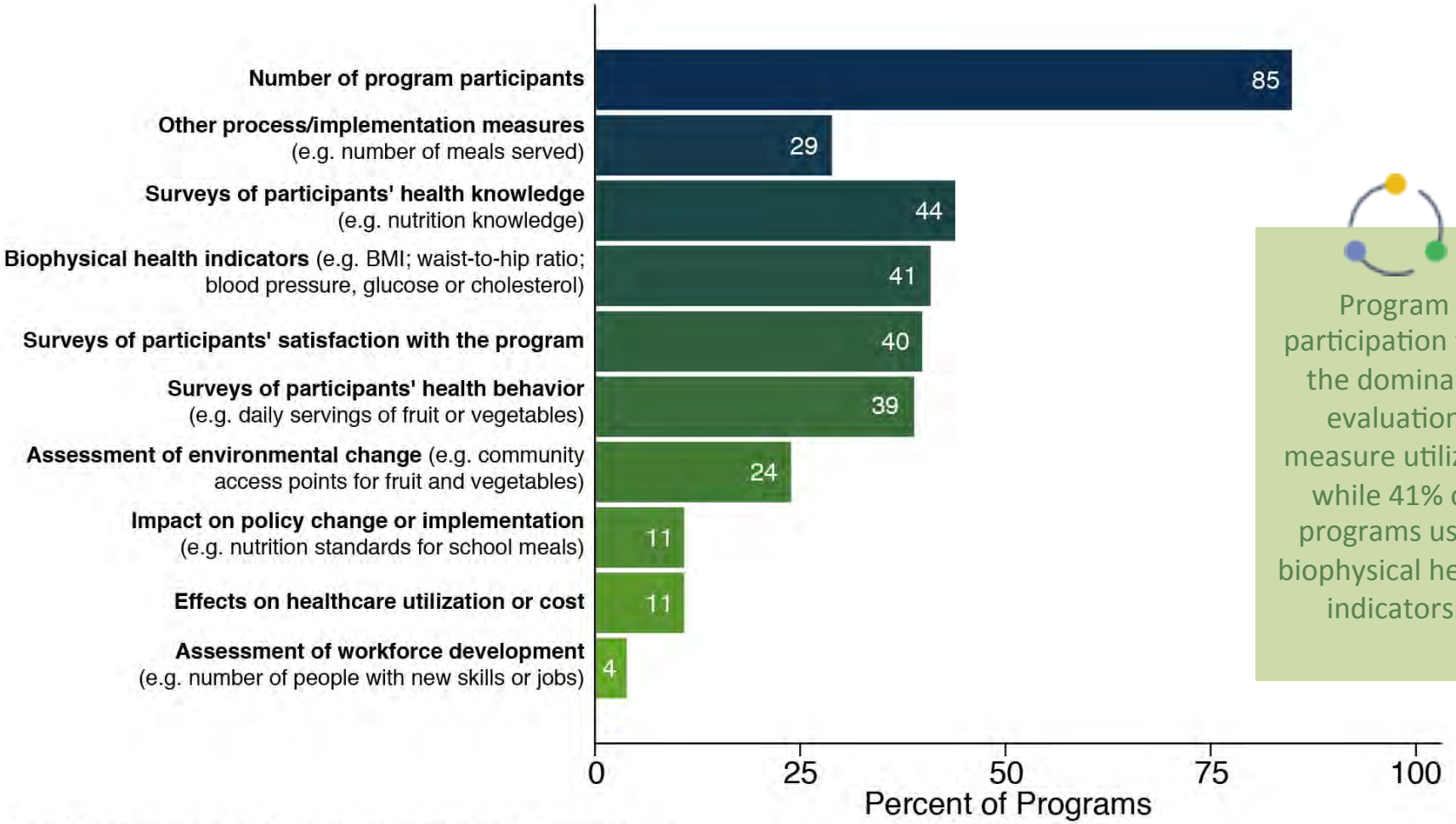
Evaluation methods utilized

(among reported initiatives addressing obesity, diet-related disease, or food access)



Program participation was the dominant evaluation measure utilized, while 41% of programs used biophysical health indicators.

From 331 community benefit programs reported by 215 respondents
Respondents could select more than one evaluation method for each program

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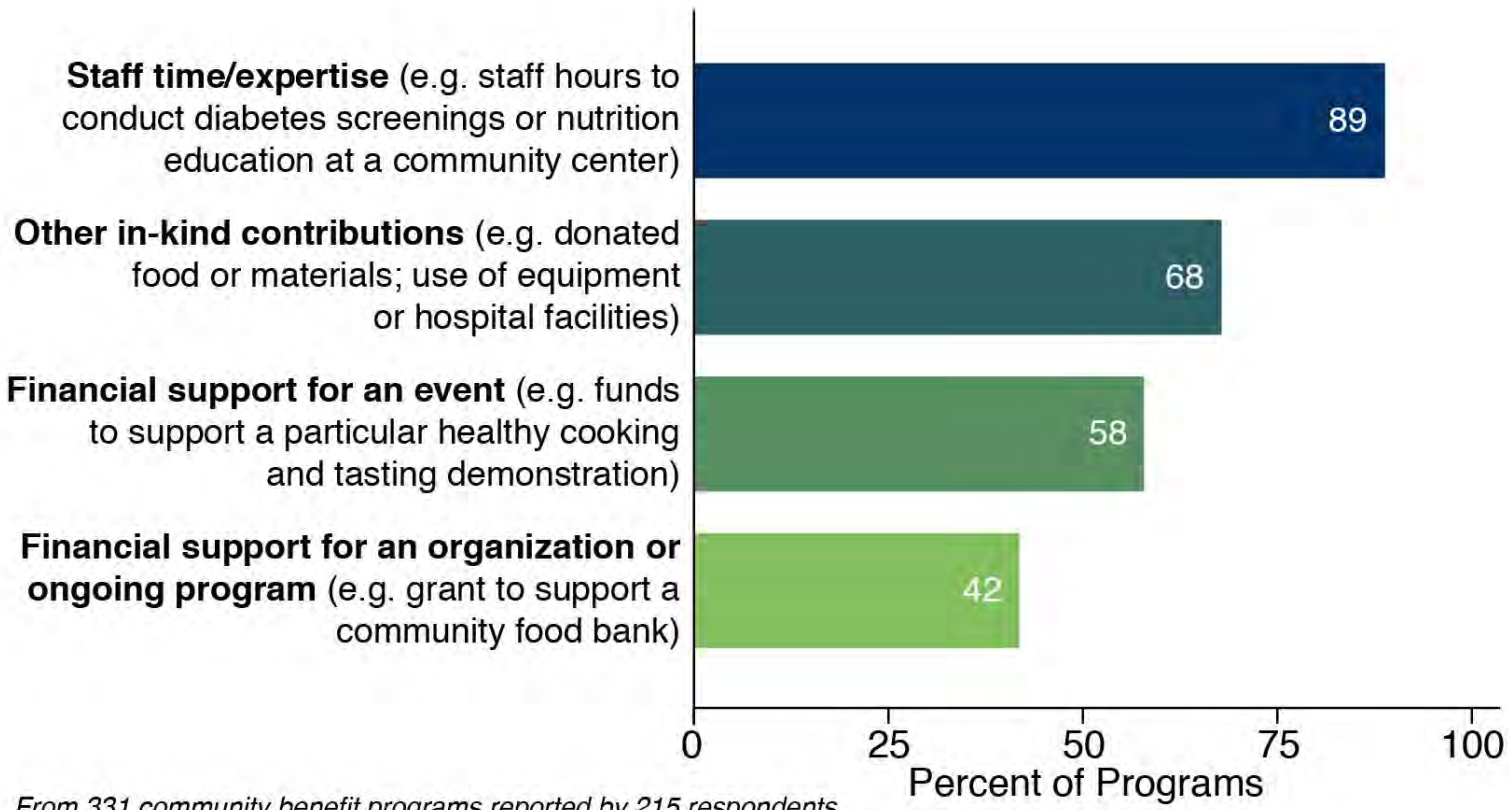
Types of community benefit support provided
(among reported initiatives addressing obesity, diet-related disease, or food access)



From 331 community benefit programs reported by 215 respondents
Respondents could select more than one support type for each program

Most community benefit support was provided through staff time or other in-kind contributions.

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DISTRIBUTION OF REPORTED PROGRAMS BY HOSPITAL & COMMUNITY CHARACTERISTICS

Beaumont Hospital Farmers Market (Hillary Greenwood)

Relationship between hospital characteristics and reported community benefit programs

Hospital Characteristics (n=215)		Having **any** reported programs addresing obesity, diet-related disease, or food access		Programs targeting **food security** and/or healthy food access		Programs targeting prevention or treatment of **obesity**		Programs targeting prevention or treatment of **diet-related disease**	
		% [a]	Signif. [b]	% [a]	Signif. [b]	% [a]	Signif. [b]	% [a]	Signif. [b]
Region	*Northeast*	85.1	--	51.1	--	78.7	--	70.2	--
	Midwest	88.3	--	50.7	--	81.8	--	71.4	--
	South	83.0	--	48.9	--	74.5	--	76.6	Pos *
	West	72.7	Neg **	45.5	--	63.6	--	59.1	--
Size	*Small (<100 beds)*	79.4	--	38.0	Neg *	71.7	--	67.4	--
	Medium (100-399 beds)	84.6	--	53.5	--	77.8	--	72.7	--
	Large (400+ beds)	95.7	--	78.3	Pos **	87.0	--	69.6	--
Other	*Urban*	89.4	Pos ***	55.3	--	80.3	--	74.2	--
	Critical Access	80.0	--	38.3	--	71.7	--	68.3	--
	Teaching †	89.1	Pos *	60.4	Pos **	79.2	--	72.3	--
	ACO §	90.4	Pos **	51.8	--	83.1	--	74.7	--
	System Affiliation	88.8	Pos ***	55.9	Pos **	81.1	--	76.2	Pos *

[a] Percent of hospitals in category that have at least one reported program

[b] Direction and significance of correlation between hospital characteristic and program type based on simple logistic regression

*** p<0,01; ** p<0.05; * p<0.1

† Major or minor teaching hospital

§ Accountable Care Organization

Urban hospitals and hospitals that are part of a hospital system were more likely to report at least one community benefit program addressing obesity, diet-related disease, or food access or insecurity.

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Relationship between county-level health & sociodemographic characteristics and reported community benefit programs

County-level prevalence of health & sociodemographic characteristics for respondent hospitals (n=215)	Having **any** reported programs addresing obesity, diet-related disease, or food access **Signif.** [a]	Programs targeting **food security** and/or healthy food access **Signif.** [a]	Programs targeting prevention or treatment of **obesity** **Signif.** [a]	Programs targeting prevention or treatment of **diet-related disease** **Signif.** [a]
Obesity†	Para[b]***	--	--	Para[b]**
Diabetes†	Para[b]**	--	Pos *	--
Food Insecurity §	Neg *	Pos **	--	--
SNAP Usage Δ	--	Pos ***	--	--
Poverty Δ	Neg **	Pos ***	--	--
Unemployment Δ	--	Pos ***	--	--

[a] Direction and significance of correlation between characterisitc and program type based on simple logistic regression
[b] Parabolic relationship where hospitals in counties with higher and lower obesity or diabetes rates appear to be the least likely to have a CB program addressing obesity, diet-related disease, or food access
*** p<0.01; ** p<0.05; * p<0.1
† 2010-2014 BRFSS (CDC) county-level obesity and diabetes prevalence estimates
§ 2014 Feeding America, county-level food insecurity prevalence estimates
Δ 2010-2014 American Community Survey (US Census Bureau) county-level estimates of SNAP usage, poverty prevalence (% below FPL), and unemployment

Hospitals in areas with higher rates of food insecurity, SNAP usage, poverty, or unemployment seem to be more likely to have community benefit programs targeting healthy food access or food insecurity.

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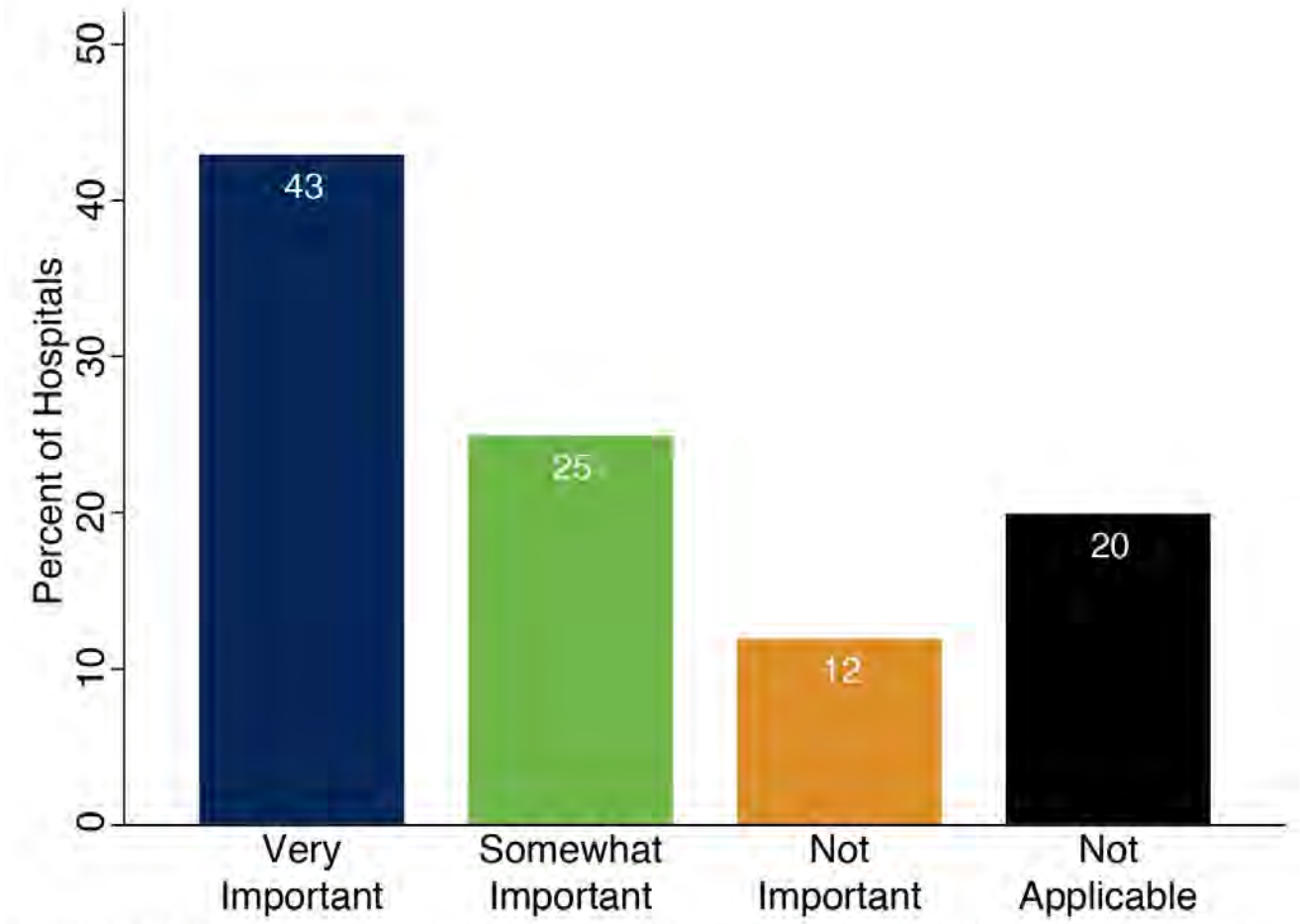
SUPPORT FOR LOCAL FOOD SYSTEMS

Photos by Lindsey J. Scalera

If you have a community benefit initiative to improve healthy food access, how important was it to include support for local/regional or organic producers as part of the program?



Based on 102 respondents that reported having at least one CB program targeting food access or insecurity.

For those respondents who had a community benefit program that addressed food insecurity or healthy food access, 43% said including local or organic producers in the program was very important.

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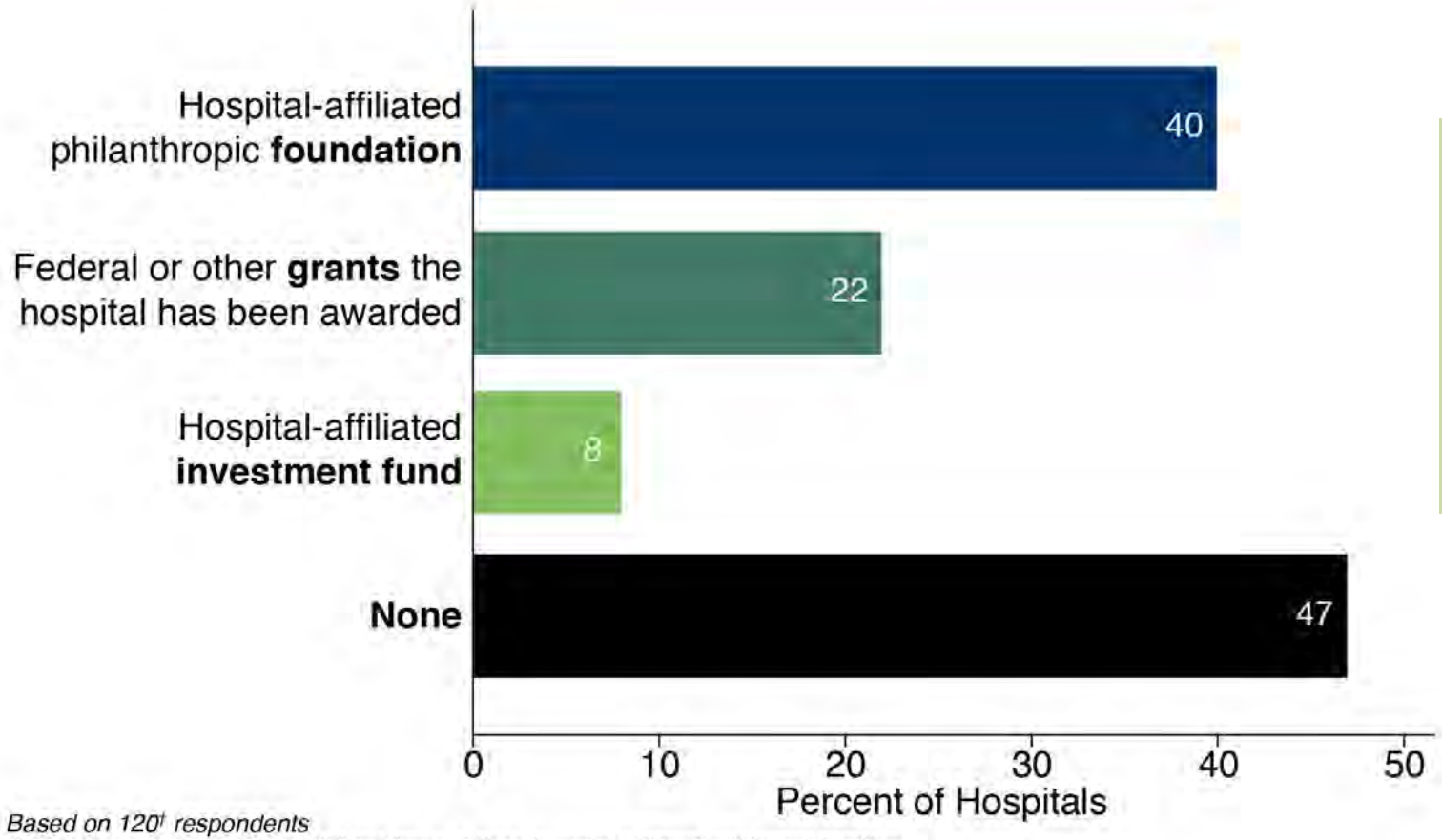
Does your hospital direct other funds to support healthy food access initiatives?



Based on 120† respondents
† 93 respondents said they did not know if their hospital utilized additional funding

40% of hospitals reported hospital foundation support for healthy food access initiatives.

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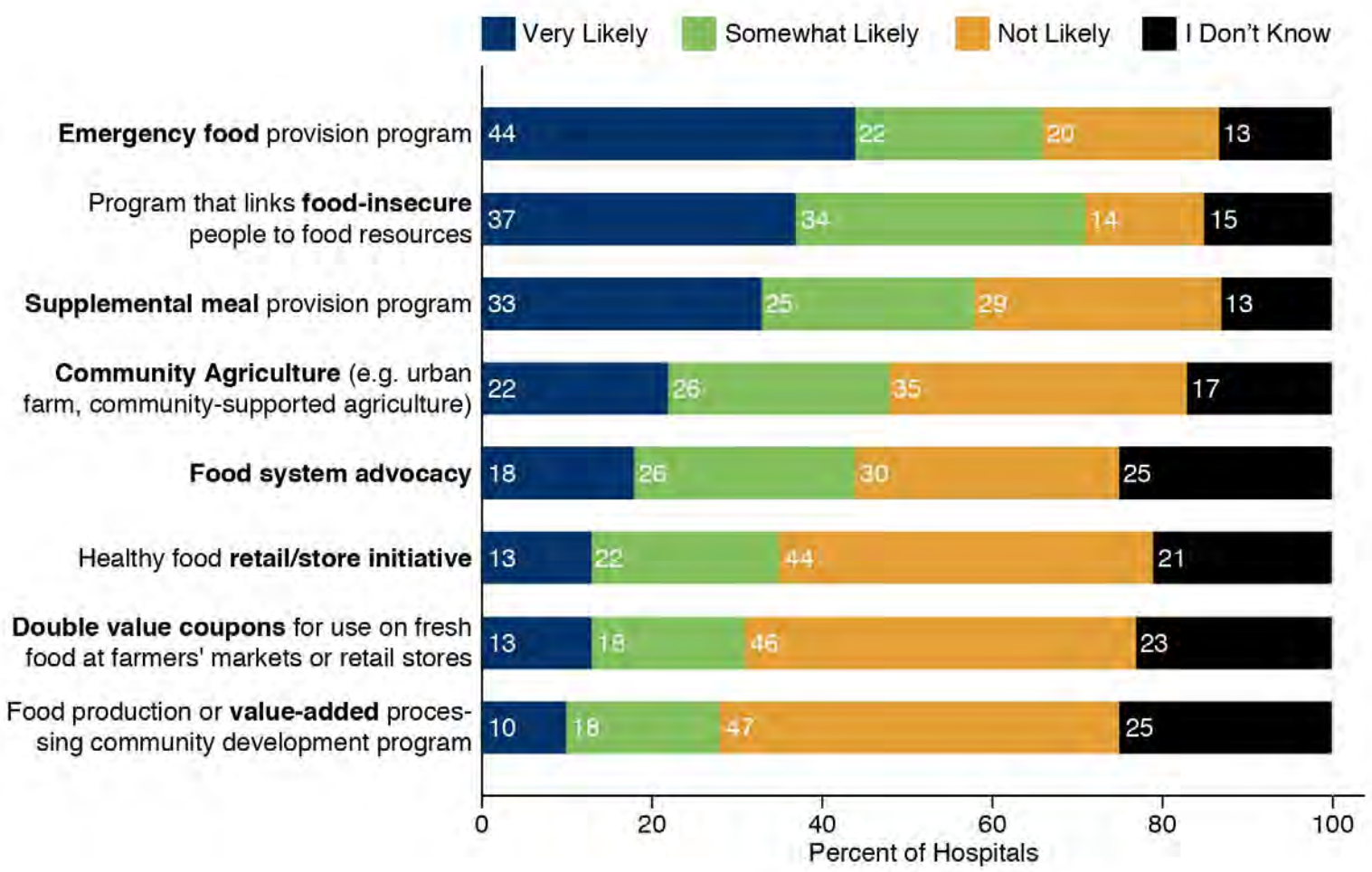
How likely is it that your facility will provide community benefit support to these program types in the next three years?



The majority of respondents reported that it was likely that their facilities would provide community benefit support to programs for emergency or supplemental food provision or that link food insecure people to food resources in the next three years.

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Citation

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This survey is part of a larger project, *Catalyzing Health Care Investment in Healthy Food Systems,* which examines hospital community benefit programming to increase healthy food access, promote healthy and sustainable food systems, and reduce risk of diet-related health conditions. For more information, visit noharm.org/ResilientCommunities

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Health Care Without Harm seeks to transform the health sector worldwide, without compromising patient safety or care, so that it becomes ecologically sustainable and a leading advocate for environmental health and justice.

With offices on four continents and partners around the world, Health Care Without Harm is leveraging the health sector's expertise, purchasing power, political clout, workforce development, and moral authority to create the conditions for healthy people, communities, and the environment.

This report was produced by Health Care Without Harm's national Healthy Food in Health Care program, which harnesses the purchasing power and expertise of the health care sector to advance the development of a sustainable food system.

Visit healthyfoodinhealthcare.org for more information.

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