



# Community benefit and healthy food

A NATIONAL ASSESSMENT



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# Foreword

Not-for-profit health care organizations were established in response to community need. Civic and religious leaders contributed their time and resources to bring health care to America's early communities. Through the years, hospitals have continued this mission to serve their communities.

Not-for-profit hospitals provide community benefit for two primary reasons. One is to fulfill their charitable purpose and demonstrate they deserve tax exemption. To maintain tax exemption, these hospitals must work with public health agencies and community partners to assess community health need, plan how to address these needs, and provide community benefits.

But the more important reason hospitals respond to community health needs through their community benefit programs is to carry out their tradition of service and mission to serve their communities.

Hospital community benefit programs have evolved. Early on, they were often planned and carried out by a single staff person to address a specific problem, such as the need to immunize school children or to provide education on health issues. These were hospital programs, developed with the hope they would be successful and reported in terms of their cost and attendance.

Today's community benefit programs are in sharp contrast to those early efforts: they are nearly always collaborative efforts with public health and community partners, they respond to carefully assessed and prioritized community health needs, they are grounded in public health principles and in evidence of what works, and they are evaluated based on impact.

The "Community benefit and healthy food" research report and associated ["Delivering community benefit: Healthy food playbook"](#) reflect the progress community benefit programs have made. They focus on the assessment of need: how obesity, diabetes, nutrition-related chronic illness, and food insecurity reflect not only problems for individuals but also for their communities. They discuss how food is an equity issue, showing how unhealthy food and food instability is an economic issue faced by vulnerable communities. In discussing program planning and implementation, this work highlights collaborative, multi-sectoral and multi-factor approaches, not the work of a single organization working on a single project.

Most importantly, this work looks ahead. It challenges community benefit programs with emerging and innovative practices and opportunities for deeper engagement with their communities to address food-related needs. It suggests ways to fund food access interventions and urges involvement with local food councils. It also discusses climate co-benefits of healthy food access initiatives. In short, this work by Health Care Without Harm will help community benefit programs grow and reach a new level.

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# Executive summary

## Investment in community health improvement

An ever-increasing body of research demonstrates that social and environmental determinants of health – factors such as income, employment, safe housing, healthy food, clean water and air, education, and neighborhood conditions – exert a powerful influence on health. Although the impact of medical care on health may be as low as 10 percent, much of the health care system in the United States has focused exclusively on providing clinical care to individuals.

Several provisions of the Affordable Care Act sought to promote an important shift in focus for the U.S. health care community – from treating sickness and disease to promoting prevention and wellness. As hospitals and health systems strive to achieve the “triple aim” of improving the patient experience of care, improving the health of populations, and reducing per capita health care costs, a new perspective is gaining traction. Improving health outcomes and reducing health care costs requires addressing the social and environmental determinants that are frequently at the root of health and health inequities.

## Healthy food access as a social determinant of health

In the United States, the four leading causes of death and largest sources of health care expenditure are directly [linked to food and diet](#): stroke, diabetes, cancer, and cardiovascular disease. While growing prevalence of obesity puts millions of Americans at increased risk for chronic health conditions, in 2016 12.3 percent of U.S. households experienced food insecurity. Families throughout the United States are affected by obesity and diet-related health conditions, however food insecure and low-income individuals are especially vulnerable.

## Community benefit and healthy food

All private nonprofit hospitals in the United States are required to maintain community benefit programs to qualify for tax exemption. Hospital community benefits are services, activities, and initiatives to improve health in these hospitals' communities. The principal form of this public benefit historically has been – and continues to be – the provision of free or reduced-cost care to patients unable to pay for health care (also known as patient financial assistance or charity care).

Recent changes to community benefit regulations have encouraged hospitals to become more involved in community health promotion and disease prevention initiatives, including those that address social and environmental determinants of health. Inspired by this growing commitment to respond to community health

needs, [Health Care Without Harm](#) carried out a national research and resource development project to support hospital community benefit professionals and community partners in developing initiatives that promote healthy food access and healthier food environments.

Hospitals around the country are embracing the fact that access to healthy food is critical not just to preventing and treating diet-related health conditions, but also to building thriving communities, strong local economies, and sustainable food systems. Community benefit represents a powerful opportunity to promote community well-being through healthy food.

## National assessment of community benefit programming to improve healthy food access and promote healthier food environments

This report discusses the findings from Health Care Without Harm's national study of community benefit practices to increase healthy food access, promote healthier food environments, and reduce the risk of obesity and diet-related health conditions. Conducted from 2016 through 2017, the study included a national, random-sample survey of community benefit directors; analysis of survey respondent hospitals' community health need assessments (CHNAs) and implementation strategies; more than 120 key informant interviews; and 10 case studies.

Central study questions included:

- How are assessments of the community food environment, food access, food behaviors, and diet-related health conditions included in CHNAs?
- What food-related organizations and community groups are collaborating in the CHNA process and in implementation strategies?
- What is the national landscape of community benefit initiatives to address healthy food access and diet-related health conditions?
- How are these programs being evaluated?
- What are facilitators and obstacles to community benefit investment in initiatives to improve community food environments, including initiatives with food system sustainability objectives?

In this report as well as the companion “[Delivering community benefit: Healthy food playbook](#),” we identify emerging and innovative practices and determine opportunities to support the health care sector to deepen its engagement with healthy food access and healthier food systems. While this report underlines some best practices for community benefit in general, we focus more specifically on opportunities for community benefit investment in healthy food.



## Key findings

### Food and diet-related health needs identified in CHNAs

Our national survey found that obesity and diet-related health needs are among the health concerns most commonly identified in CHNAs across the United States.

Selected health needs identified in CHNAs:

<b>71%</b>	<b>Obesity</b>
<b>40%</b>	<b>Diabetes</b>
<b>45%</b>	<b>Other diet-related diseases</b>
<b>13%</b>	<b>Food insecurity or healthy food access</b>
<b>22%</b>	<b>Poverty, economic security, or unemployment</b>

If a facility has identified obesity, food access, or diet-related chronic health conditions among the priority health needs in its CHNA, then initiatives to promote healthy food access and increased consumption of fruits and vegetables can be important components of an implementation strategy to address these needs.

### Data on food and diet-related health needs

Hospitals today can draw on a wide variety of secondary data sources from federal, state, and local government agencies, especially public health agencies; nonprofit and advocacy organizations; schools of public health; and other organizations. See the playbook resource “[Data sources to assess food access, environments, and behaviors in CHNAs](#)” for a review of useful data sources.

In our review of survey respondents’ CHNAs, we found that data on obesity, diet-related disease, and food access were frequently utilized:

<b>94%</b>	<b>Obesity and/or diet-related disease</b>
<b>57%</b>	<b>Food environment</b>
<b>52%</b>	<b>Food insecurity</b>
<b>40%</b>	<b>Diet-related behaviors</b>

In order for hospitals to adopt community benefit programs that seek to improve healthy food access, food- and diet-related health needs have to be identified in their communities. And in order for food and diet-related health needs to become prioritized in CHNAs, hospitals need to collect data on these issues.



The Go Fresh Mobile Market delivers fresh produce to multiple neighborhoods in Springfield Massachusetts. (LiveWell Springfield)

Hospitals that used Department of Agriculture data on food-related health needs in their most recent CHNA were 2.5 times more likely to have at least one community benefit program that targets food security or healthy food access as a health need.

### Collaborative community health assessments

It is becoming increasingly common – and considered best practice – for health care facilities to conduct collaborative community health assessments with other hospitals and health systems, local public health agencies, community health organizations, and other stakeholders.

In our national survey, 59 percent of respondents reported that they had collaborated with other hospitals (within or external to their hospital system) in their most recent CHNA.

Such collaboration enables partner organizations to more effectively utilize staff and financial resources, draw upon combined expertise, and avoid duplication of efforts, particularly when their service areas overlap. It enables the collection of better quality and more extensive data and can build a community-wide approach to health improvement.

### Community food organizations in the CHNA process

Including community organizations that work on food access and food system advocacy issues in the CHNA process can lead to a more nuanced understanding of food-related health needs and resources and opportunities to address to these needs.

In our national survey, community benefit directors reported that they engaged community food organizations in their CHNAs in several ways:

- Included community organizations in inventory of community resources to meet health needs
- Participated in primary data collection
- Participated in identifying priority health needs
- Participated in the CHNA steering committee

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

Involvement of food-related organizations was strongly correlated with facilities having a community benefit program addressing healthy food access or food insecurity.

We recommend that facilities conduct a robust landscape assessment of existing community food organizations and resources and engage community food system stakeholders in the CHNA process. The playbook resource “[Engaging the community to understand food needs](#)” provides further discussion and examples of best practices.

## Initiatives to address diet-related health needs

Survey respondents provided information on their community benefit programs addressing obesity, diet-related disease, or food access. Fewer than half of these community benefit programs were aimed at addressing food insecurity or healthy food access, while 81 percent targeted prevention or treatment of obesity.

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

A key finding from the national survey was that the majority of community benefit interventions to prevent or treat obesity and diet-related health conditions centered around nutrition education and exercise promotion – and that fewer interventions focused on increasing access to healthy foods.

More can be done to address healthy food access in our communities. Health professionals may educate overweight or diabetic community members to eat five servings of vegetables and fruits each day, but if there are no places to buy affordable fresh produce in the neighborhood or families are struggling with food insecurity, then it will be difficult to adhere to the recommendations.

Making access to healthy foods both convenient and affordable in our communities is an effective way to impact the social and environmental determinants that are the primary drivers of health or illness.



An HonorHealth care coordinator delivers a diabetes wellness box to a patient. Desert Mission Food Bank developed a diabetes wellness program to foster healthy food access for patients with diet-related diseases. (HonorHealth)

## Varied forms of community benefit support and diverse hospital roles

Hospitals support community benefit programs promoting healthy food access and healthy eating in numerous ways, including providing staff time to contribute to or manage a program, contributing other in-kind resources such as hospital land or equipment, and providing financial support. Our national survey found that most community benefit support was provided through staff time or other in-kind contributions.

Many community benefit directors emphasized the limits of their ability to contribute financially to community benefit initiatives. As a result, it can be important to seek and obtain diverse funding sources for sustainable financing of programs. It may be possible to secure a mix of federal, state, local, and private funding for healthy food initiatives. Including multiple partners is also valuable to engage and leverage different kinds of resources and expertise.

There are many ways that hospitals can support and add value to healthy food programs. We identified nine common role categories that hospitals are playing in support of healthy food initiatives. The guidance brief “[Hospital roles in healthy food access initiatives](#)” discusses diverse roles, such as providing support for program evaluation and advocating for healthier food policy.

## Collaborating with community partners

Health care facilities can't improve the social and environmental determinants of health alone. Such change requires a collaborative, community-wide effort.

Community benefit professionals emphasized their reliance on partnerships with community organizations in the design, implementation, and evaluation of successful healthy food programs. Collaboration with community partners is essential to:

- Reveal gaps, areas of need, and opportunities to strengthen current assets
- Align with existing community efforts or bring groups and organizations together for greater coordination and synergy
- Develop more effective and appropriate strategies and approaches by consulting experts in the field with years of experience addressing food system and equity issues
- Strengthen relationships to help improve reach, impact, and long-term sustainability of efforts
- Avoid duplication of programs and services

The “Delivering community benefit: Healthy food playbook” guidance brief “[Identifying community partners](#)” can help facilities identify community organizations that can be critical partners in healthy food access initiatives.

## Evaluating healthy food access programs

Hospital community benefit professionals reported that program evaluation is one of their biggest challenges. Interviewees shared a number of obstacles in conducting program evaluation, including:

- Insufficient expertise, staff time, or other internal resources to develop and carry out robust evaluation plans
- Lack of funding to contract an outside evaluator
- Time frames of interventions are often too short to demonstrate health impacts that may take longer to achieve, with the related challenge of showing return on investment
- Challenges in collecting, sharing, and tracking confidential participant information among collaborating organizations

Chapter 5 of this research report, on program evaluation, discusses in detail the approaches to evaluating healthy food access programs taken by community benefit professionals across the United States and offers numerous recommendations.

Key recommendations include:

- Commit to and budget up front for the strongest evaluation design that is feasible. Evaluation is a critical component of community health improvement programs, requires a significant commitment of budget and program resources, and should be planned at the same time as programs are developed.
- Consider your evaluation goals and develop an evaluation plan with one or more implementation and outcome indicators appropriate to those assessment goals. For food access and healthy eating programs, it is useful to collect data on changes in food and nutrition knowledge and eating behaviors, which may be easier to identify than changes in weight, blood pressure, or health care costs, which may take longer to observe.
- Align the evaluation methods used and data collected with programs that have a similar design. The guidance brief [“Evaluating healthy food access interventions”](#) contains guidance for evaluation planning and links to validated, frequently used surveys and data collection tools, with recommendations for common indicators, measures, and methods that can help establish common evaluation frameworks for assessing healthy food access programs.

## “Triple win” strategies can address multiple determinants of health

In this report we highlight innovative examples where hospitals employ their community benefit resources to:

- a) improve access to healthy, affordable food, and at the same time
- b) support economic and workforce development in low-income communities, and
- c) strengthen local and sustainable food systems.

When working to create healthy food access programs, strategies can be integrated to support locally and sustainably produced foods, which can increase the health benefits, support regional farmers, and promote a more resilient food system. The “Delivering community benefit: Healthy food playbook” features a variety of community benefit [programs and strategies](#) that promote healthy food access while [investing in healthy places and economies](#).

The goal of this research and resource development project is to support and inspire hospital community benefit professionals and community partners in developing initiatives to promote healthy food access, healthy eating, and healthier food systems.

Interventions that address healthy food access with a “triple win” strategy can address several social and environmental determinants of health as part of a transformative community development framework. Initiatives such as community-supported agriculture, fruit and vegetable prescription programs, mobile farmers markets, and farm to school programs increase access to healthy and affordable food, promote sustainable food systems, and can support local economic growth and workforce development in underserved communities. These “win-win-win” initiatives support local and sustainable food production while working to eliminate health disparities and empower and improve the lives of community residents.



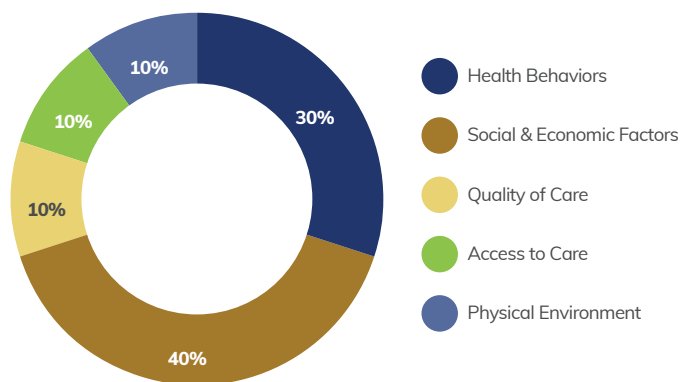
# Chapter 1. Introduction

## Hospital community benefit: Investment in community health improvement

Several provisions of the Affordable Care Act (ACA) sought to promote an important shift in focus for the U.S. health care community – from treating sickness and disease to promoting prevention and wellness.

As health care delivery gradually moves toward a population health paradigm that incentivizes keeping people healthy, hospitals and health systems are increasingly recognizing the importance of addressing social and environmental determinants of health, which account for 40 percent of health outcomes.

DRIVERS OF COMMUNITY HEALTH



Source of data: County Health Rankings, University of Wisconsin Population Health Institute

All private nonprofit hospitals in the United States (approximately 2,900, or 60 percent of hospitals) are required to maintain community benefit programs to qualify for tax exemption. Hospital community benefits are services, activities, and initiatives to improve health in these hospitals' communities. The principal form of this public benefit historically has been – and continues to be – the provision of free or reduced-cost care to patients unable to pay for health care (also known as patient financial assistance or charity care).

Recent changes to community benefit regulations have encouraged hospitals to become more involved in community health promotion and disease prevention initiatives, including those that address social and environmental determinants of health. Inspired by this growing commitment to respond to community health needs, [Health Care Without Harm](#) carried out a national research and resource development project to support hospital

community benefit professionals and community partners in developing initiatives that promote healthy food access and healthier food environments. The project was supported by a grant from the Robert Wood Johnson Foundation.

## Historical development of hospital community benefit

In 1956, the IRS ruled that hospitals could qualify as tax-exempt if they provided charity care to patients unable to pay for services.<sup>1</sup> In 1969, several years after Medicare and Medicaid were enacted and employer-sponsored health insurance had greatly increased health care coverage in the United States, the IRS expanded the range of allowable community benefit activities to include not just charity care but also operating an emergency room open to the whole community and participation in professional education, training, and research.<sup>1</sup>

The IRS again refined the meaning of community benefit in 2009 by further defining the term and embedding it in a detailed reporting instrument, IRS Form 990, Schedule H, that tax-exempt hospitals must file with their annual tax returns. The IRS does not establish minimum community benefit spending, but Schedule H requires hospitals to report in detail about the kinds and amounts of community benefit contributions they provide. Categories of community benefit reportable on Schedule H include providing free and discounted care to uninsured and low-income patients, reimbursement “shortfalls” associated with participation in means-tested government programs such as Medicaid, health professions education, health research, and community health improvement activities.

In 2010, provisions in the ACA established additional requirements that tax-exempt hospitals must meet, which were codified in IRS Code § 501(r). These included providing financial assistance according to published policies; complying with limits on charges and collection practices for patients eligible for financial assistance; complying with federal law regarding providing emergency care; and conducting a community health needs assessment (CHNA) every three years, along with an implementation strategy to address priority health needs.<sup>2</sup> The IRS published a final rule with detailed guidelines on implementing these requirements in 2014.<sup>3</sup>

These changes to IRS community benefit regulations – particularly the requirement that tax-exempt hospitals conduct CHNAs that identify local health needs and develop implementation strategies to address priority needs – build on a movement by health industry leaders to promote greater community engagement and a population health orientation in community benefit practices.

<sup>1</sup> Rev. Rul. 56-185, 1956-1 C.B. 202, modified by Rev. Rul. 69-545, 1969-2 C.B. 117. See Joint Committee on Taxation, “Present Law and Background Relating to the Tax-Exempt Status of Charitable Hospitals,” (2006), available at <http://www.jct.gov/x-40-06.pdf> (Accessed August 31, 2017)

There is now a new impetus for nonprofit hospitals to collaborate with other stakeholders to implement community health improvement plans that address determinants of health such as housing, environmental and safety conditions, and the availability of quality, affordable food. Hospitals are increasingly adopting a range of strategies to address social and environmental determinants to improve the health and well-being of their communities.

Yet while there is growing interest in and commitment to directing community benefit resources toward community health improvement initiatives, including those that address social determinants of health, the lion's share of community benefit expenditures continue to be dedicated to charity care and coverage of uncompensated Medicaid costs. In 2011, support for direct patient care accounted for 92 percent of community benefit spending.<sup>4</sup>

Community health advocates had hoped that the proportion of community benefit resources directed to community-based health promotion would increase as health care coverage expanded under the ACA and the number of uninsured patients fell.<sup>ii</sup> New research finds only modest changes in these expenditures.<sup>5</sup> Average spending by tax-exempt hospitals on community benefit grew 0.5 percent between 2010 and 2014, and most of that increase went toward unreimbursed care rather than toward broader community health initiatives. The recent repeal of the individual mandate penalty and other actions that destabilize the ACA may increase the burden on hospitals to cover growing unreimbursed costs of patient care, potentially limiting other community benefit programs and expenditures.

While Schedule H does document community benefit expenditures, interviews for this project as well as research recently conducted by the New York Academy of Medicine<sup>6</sup> find that Schedule H data is likely to present an incomplete picture of hospitals' activities that promote community health. Community benefit responsibilities and activities are often fragmented and can lack full coordination across hospital departments. Schedule H reporting is typically done via periodic review of completed activities, and collecting information on diverse activities that can be reported can be difficult. In addition, the expense of community health improvement programs that hospitals undertake by securing external funding support for that purpose – such as public or private grants – can't be "counted."<sup>iii</sup> Finally, mission-driven health systems may take a wide approach to population and community health improvement, supporting initiatives that promote the health and wellbeing of staff, patients, visitors, and the wider community, and only a portion of these activities may be reportable as community benefit.

## Community benefit as part of a larger commitment to community health

Community benefit is only one of many ways that hospitals and health systems invest in the health and well-being of their communities. As anchor institutions – large, nonprofit organizations that, once established, tend to remain rooted in place – hospitals are increasingly recognizing their "[anchor mission](#)" to harness their significant economic and other resources to address social and environmental determinants of health in the communities they serve.

This can include:

- A commitment to local hiring and workforce development
- Employee wellness programs to support the health of the more than 5.5 million Americans who work for hospitals and health systems and are likely to struggle with their own health
- Purchasing local, sustainably produced, and/or non-toxic materials and products
- Investing in green buildings and clean energy
- Improved waste management
- Directing grants and social investment funds to local and regional initiatives that will promote equitable economic development and healthy, vibrant communities
- Advocating for local, regional, and national policy, systems, and environmental change

## Healthy food access as a social determinant of health

In the United States, 36 percent of adults and 17 percent of youth are obese.<sup>7</sup> Obesity puts millions of Americans at increased risk for chronic health conditions such as heart disease, stroke, type 2 diabetes and certain types of cancer and contributes to billions of dollars in preventable health care spending.<sup>8,9</sup> Reducing obesity, improving diet and nutrition, and increasing physical activity can reduce health care costs by reducing the need for doctors' office visits, prescription drugs, and hospital admissions.

<sup>4</sup> [Community Benefit Insight](#), a web search tool, provides access to community benefit spending information from tax-exempt hospitals throughout the United States, and is a valuable resource for reviewing and comparing expenditures reported on Schedule H.

<sup>ii</sup> Hospitals' reportable expenses for community health improvement activities must be offset by any restricted grant or other philanthropic revenue dedicated to those programs. For example, a hospital securing \$100,000 from a philanthropic foundation to deliver a community health program costing \$100,000 would report \$0 in net community benefit, even though the hospital delivered tangible community health improvement activities to the community. The Catholic Health Association is among those who have expressed concern that having to offset external funding support could discourage hospitals from seeking and using grants to advance community health improvement goals.

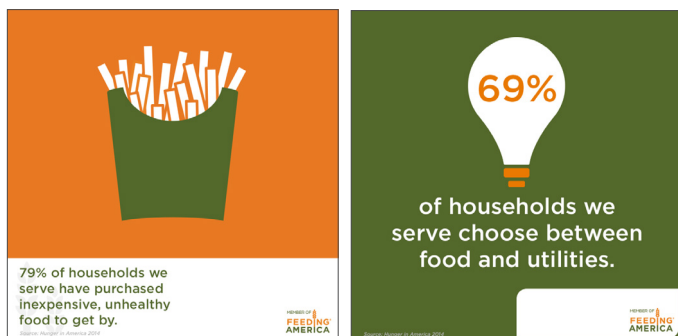
While families and communities throughout the United States are affected by obesity, food insecure and low-income individuals are especially vulnerable.

Food insecurity – or the lack of consistent access to enough food for an active, healthy life – is an important and often hidden problem. In 2016, [15.6 million U.S. households](#) (12.3 percent of the U.S. population) were food insecure for at least some time during the year.

Food insecurity and obesity can be linked consequences of low income and the resulting inability to purchase healthy, affordable foods. Both are correlated with cycles of food deprivation, disrupted eating patterns, and overeating; greater exposure to inexpensive, highly processed, calorically dense, and obesity-promoting food products; under-resourced communities with few opportunities for physical activity; and the stresses of poverty.<sup>10</sup>

People experiencing food insecurity generally have poorer quality diets. Food insecure children and adults are at higher risk of obesity, diabetes and other diet-related health conditions, anxiety and depression, and reduced academic achievement.<sup>11,12,13,14</sup> Food insecurity may put people in the position of making trade-offs between healthy food, medicine, and other essential needs and makes it more difficult to manage chronic health conditions.

A [Feeding America study](#) found that 66 percent of food bank client households choose between paying for food and medicine or medical care each year, while 55 percent choose between paying for food and housing.



Families in predominantly minority and low-income neighborhoods are more likely to have limited access to supermarkets, grocery stores, farmers markets, or other sources of healthy and affordable food, making it more difficult to maintain a healthy diet. In the United States, 29.7 million people, or 9.7 percent of the population, live in “food deserts,” or areas where a substantial number of the residents are low income and live more than a mile from a grocery store (or for rural areas, more than 10 miles).<sup>15</sup>

## National landscape assessment of community benefit programming to improve healthy food access: Goals and approach

Food is central to individual health and an important economic driver to support a healthy community. Yet our dysfunctional food production, distribution, and consumption systems and patterns result in both food insecurity and overweight and obesity, particularly for vulnerable communities.

The Health Care Without Harm Healthy Food in Health Care program engages the health care sector to advance the development of a healthy and sustainable food system. An “[Environmental Nutrition](#)” framework informs Health Care Without Harm’s work, with a perspective that healthy food is not just the sum of nutritional qualities but also the result of a food system that conserves and renews natural resources, advances social justice and animal welfare, builds community wealth, and fulfills the food and nutrition needs of all eaters now and into the future.

Motivated by concern about the unhealthy, inequitable, and unsustainable food system in the United States and by interest in the emerging opportunity for hospitals to respond to community health needs, Health Care Without Harm undertook a national study of hospital community benefit initiatives that promote healthy food access and healthier food environments.

While this project takes a broad look at how hospitals are assessing healthy food access, obesity, and diet-related health needs in their CHNAs and how facilities are addressing these needs in their implementation strategies, we particularly focus on initiatives that promote affordable and convenient access to fresh, healthy foods. If a facility has

### Health needs identified in survey respondents’ CHNAs

**71% Obesity**

**40% Diabetes**

**45% Other diet-related diseases**

**13% Food insecurity or healthy food access**

**22% Poverty, economic security, or unemployment**

See Appendix A for dates of survey respondents’ CHNAs.



identified obesity, food access, or diet-related chronic health conditions as health needs in its CHNA, then initiatives to promote healthy food access and increased consumption of fruits and vegetables (which are often combined with diet and nutrition education) can be important components of an implementation strategy to address these needs.

The factors that have driven increased prevalence of obesity and diet-related health conditions in the United States and around the world are multiple and complex. A growing consensus among obesity prevention and public health nutrition experts is that there is no “silver bullet” for reducing obesity rates, that [multi-sectoral and multi-faceted approaches](#) are required, and that interventions need to rely less on individual choice and more on changes to the environment.<sup>16</sup> Research continues to demonstrate a positive relationship between access to healthy food and community health.<sup>17,18,19,20</sup> Living closer to outlets for healthy food “is among the factors associated with better eating habits and decreased risk for obesity and diet-related diseases.”<sup>21</sup>

In this report and in the associated “[Delivering community benefit: Healthy food playbook](#),” we further call attention to innovative examples where hospitals employ their community benefit resources to

- a) improve access to healthy, affordable food and at the same time
- b) support economic and workforce development in low-income communities, and
- c) strengthen local and sustainable food systems.

We highlight as “promising practices” initiatives that include local food producers as part of a multi-pronged effort to increase access to fresh, affordable, and sustainably produced food; promote health equity; and stimulate the local economy – particularly through creating well-paid jobs in low-income communities. These “win-win-win” initiatives support the local food system while working to eliminate health disparities and empower and improve the lives of community residents.

Hospitals can extend the reach of their contribution to health by collaborating with community partners to build strong, local economies and vibrant, resilient communities. Investing community benefit and other resources in local and sustainable food initiatives and enterprises can be a pillar of a local economy framework that addresses multiple social determinants of health by supporting economic growth, workforce development, access to healthy and affordable food, social cohesion, and personal well-being.

## Support for food systems initiatives and the community benefit standard

A current challenge for community benefit professionals is the fact that while hospitals are being encouraged to address some social and environmental determinants of health, confusion remains about what kinds of initiatives can “count” as community benefit toward meeting the requirements for tax exemption.

On the one hand, new IRS guidance language states that hospitals should not focus only on access to care but also consider “the need to prevent illness, ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community.”<sup>22</sup>

On the other hand, IRS Form 990, Schedule H – where tax-exempt hospitals annually document and claim “credit” for their community benefit contributions – does not clearly recognize activities that address the social determinants of health as a reportable community benefit.

The IRS distinguishes between community health improvement activities that should be reported in Part I of Schedule H (those that support exemption under the community benefit standard) from “community building” initiatives that should be reported in Part II (community development activities, which are relegated to a separate category of expenditures that does not support exemption).

### Key terms in Schedule H (Form 990)

**Community health improvement services [Part I]:** activities or programs, subsidized by the health care organization, carried out or supported for the express purpose of improving community health.

To be reported, **community need** for the activity or program must be established.

Community benefit activities or programs also seek to achieve a **community benefit objective**, including improving access to health services, enhancing public health, advancing increased general knowledge, and relief of a government burden to improve health.

**Community building activities [Part II]:** Physical improvements and housing, economic development, community support, environmental improvements, leadership development and training for community members, coalition building, community health improvement advocacy, workforce development, and other.

– 2016 Schedule H (Form 990) Instructions, p. 17-18; 2016 Schedule H (Form 990), p. 2

<sup>16</sup> Schedule H instructions suggest that some community building activities reported in part II of Schedule H can be reported, and “count,” as community benefit-community health improvement activities in part I. In order for hospitals to report community building expenditures as community benefit, hospitals need to be able to separately justify the community health relevance and impact of these expenditures. However Schedule H reporting instructions do not specify standards for justification or how these will be reviewed or audited.

Yet a substantial body of research demonstrates that a clean, safe place to live, reliable access to healthy food, and employment opportunities have a profound effect on health. For low-income communities, support for these basic needs can be as important as providing free medical care.<sup>iv</sup>

The American Hospital Association has requested that the IRS provide clear and authoritative guidance that addressing social determinants is a community benefit and eliminate the distinction between community benefit (part I) and community building (part II):

*“There is no basis ... for treating hospital expenditures on affordable housing, economic development, violence prevention, public health emergency prevention, workforce development and the like as anything other than community benefit expenditures. Part II of Schedule H should be eliminated. Expenditures for the full range of community benefit activities, including anything that the current form instructions suggest or require be reported in Part II, should be reported in Part I.”<sup>23</sup>*

There is wide acceptance that initiatives that increase access to healthy food for low-income or food-insecure individuals and communities can be appropriate, evidence-informed strategies to address a variety of diet-related community health needs. In this research report and the companion [“Delivering community benefit: Healthy food playbook,”](#) we provide information about numerous healthy food access initiatives throughout the country that are supported by hospital community benefit resources – from fruit and vegetable “prescription” vouchers that reduce economic barriers to healthy food to mobile farmers markets that bring affordable fresh produce to areas with limited access to healthy foods to gleaning programs that collect leftover produce from farms to donate to food pantries.

Under the current standard, many forms of support provided to these kinds of initiatives can be counted as community benefit.

The triple-win initiatives that we hold up as “promising practices” in this project have additional dimensions that strengthen local and sustainable food systems and support economic and workforce development in low-income communities. Until the IRS provides updated guidance, some components of hospital support for multi-faceted community food initiatives may need to be reported in separate sections of Schedule H.<sup>v</sup> See the guidance brief [IRS reporting for healthy food access programs](#) for recommendations on how to report community benefit support for multi-faceted healthy food access initiatives on Schedule H.

<sup>v</sup> For example, specific support for workforce and economic development activities may need to be reported in Part II (community building) and specific support for development of local and sustainable food systems may need to be reported in Part VI (a section for narrative reporting of supplemental information, which includes space for additional comments about how the facility “further its exempt purpose by promoting the health of the community.”)

## Study overview

This report discusses the findings from Health Care Without Harm’s national study of community benefit practices to increase healthy food access, promote healthier food environments, and reduce risk of obesity and diet-related health conditions. This research includes assessing the community benefit landscape, identifying emerging and innovative practices, and determining opportunities to support the health care sector to deepen its engagement with healthy food access and sustainable food systems. Key recommendations are presented in this report as well as the [playbook](#), which includes a set of guidance briefs, case studies, and other resources to support hospital community benefit professionals and community partners in addressing food access and diet-related health needs.

Key study questions included:

- How are assessments of the community food environment, food access, food behaviors, and diet-related health conditions included in CHNAs?
- What food-related organizations and community groups are collaborating in the CHNA process and in implementation strategies?
- What is the national landscape of community benefit initiatives to address healthy food access and diet-related health conditions?
- How are these programs being evaluated?
- What are facilitators and obstacles to community benefit investment in initiatives to improve community food environments, including initiatives with food system sustainability objectives?



Participants of a Cooking Matters program learn about the benefits of label reading during a grocery store tour. (Share Our Strength)

## Data and methods

The research findings and discussion in this report are drawn from a national mixed-methods study of community benefit practice that Health Care Without Harm conducted from 2016 through 2017.

The study included a national survey of a random sample of 930 community benefit directors at private, tax-exempt, general/acute care hospitals. The survey had a 23.12 percent completion rate. The research team obtained the CHNA and implementation strategy for the survey respondent facilities and collected a set of data from them. Descriptive statistics and logistic regression were conducted to analyze patterns and correlations in the survey and associated CHNA and implementation strategy data.

The research team also conducted more than 120 in-depth interviews with key informants including hospital community benefit directors, public health officials involved in collaborative CHNAs with hospitals, CHNA consultants, and representatives of hospital associations. The interviews were recorded, transcribed, and analyzed for salient themes.

In addition, the research team developed a set of ten case studies on hospitals across the country, examining their community benefit programming to support healthy food access.

Additional information about the study's research methods and data can be found in Appendix A.

## Report overview

In the chapters that follow, we discuss the research findings and recommendations that emerged from our national study. The structure of the research report essentially follows the key research questions.

Chapter 2 discusses data sources to assess food insecurity, food access, and food behaviors in CHNAs. Chapter 3 reviews our findings regarding engaging public health and community organizations in the CHNA process to understand food and diet-related health needs and opportunities. Chapter 4 presents our review of community benefit implementation strategies to address healthy food access and healthy eating. Chapter 5 discusses how facilities evaluate healthy food programs. Chapter 6 summarizes the project's central research findings and insights regarding facilitators and obstacles to community benefit programming to improve healthy food access and promote healthier community food environments. Here we also share recommendations and some considerations for "what's next" for hospital support for healthy, sustainable, and equitable regional food systems. A series of appendices provide additional information and resources.



# Chapter 2. Assessing food and diet-related health needs in CHNAs: Data collection

## Introduction

### Community health needs assessments

Hospitals, public health departments, and other organizations have conducted community-based health assessments for decades as part of community health and development planning. This process was voluntary for hospitals until the Affordable Care Act (ACA) outlined a new IRS requirement that tax-exempt hospitals must conduct triennial community health needs assessments (CHNAs) and make them publicly available.

Federally mandated hospital CHNAs define the community the hospital serves, identify and prioritize community health needs, and evaluate existing resources for community health. Community health needs assessments must include input from people who “represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health.”<sup>24</sup>

Hospitals must also produce implementation strategies designed to address the priority health needs identified in the CHNA.



Produce ready to be distributed to community-supported agriculture members (Healthy Here PR at CWA Communications)



A participant of a Cooking Matters program, which operates in communities throughout the United States, learns about healthy eating and cooking techniques from volunteer chefs and nutrition educators. (Share Our Strength)

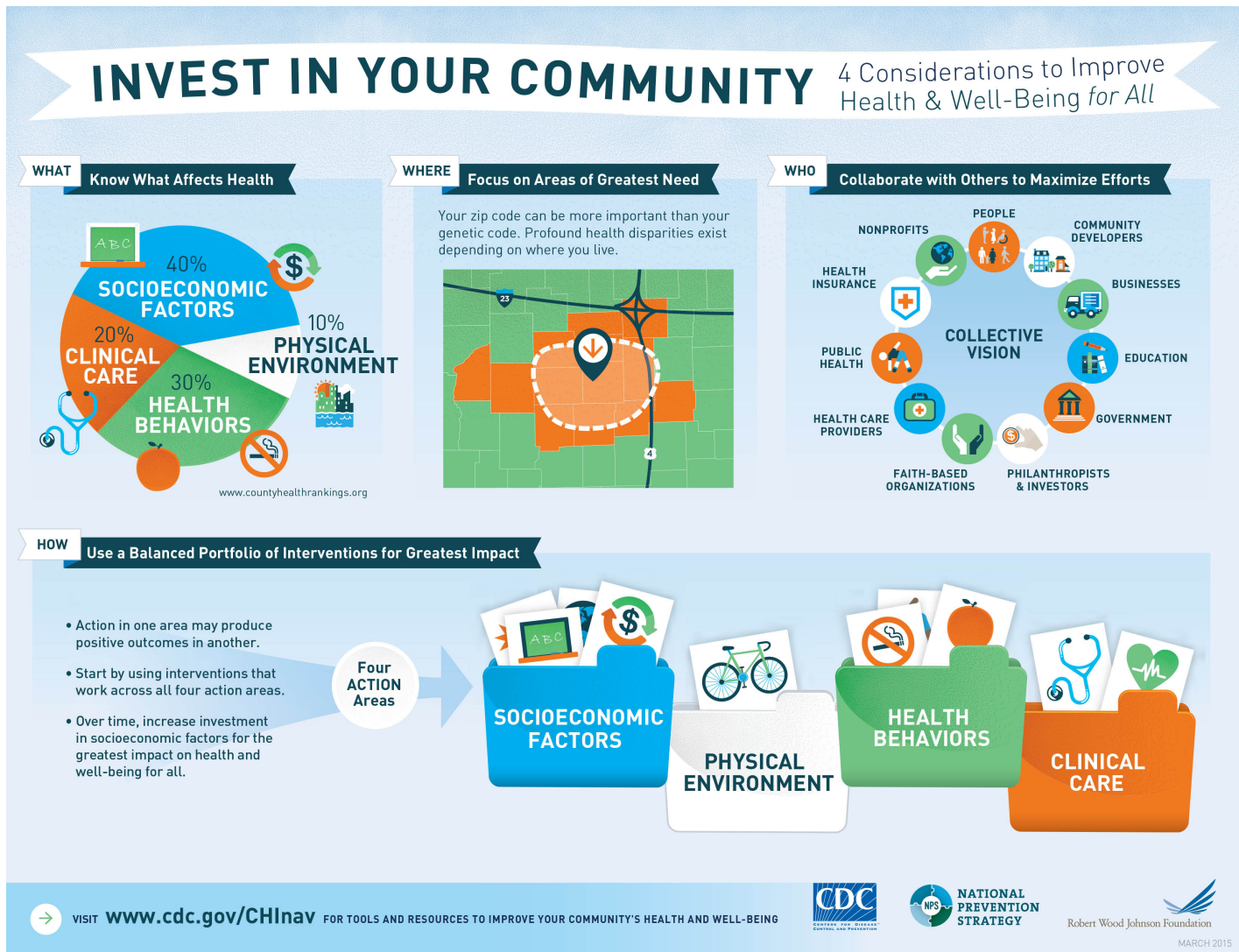
### Community health needs assessments: Key requirements

Community health needs assessments must:

- Be conducted at least once every three years
- Define the community served and assess the health needs of that community
- Solicit and take into account input from the community
- Engage public health departments and/or public health experts
- Describe the priority health needs of the community and the process used to identify and prioritize them
- Describe community resources available to address significant health needs
- Be approved by an authorized body (hospital board or board committee)
- Be made widely available to the public

Hospitals must also adopt an implementation strategy to address the priority health needs identified

– [Internal Revenue Code §501\(r\)](#)



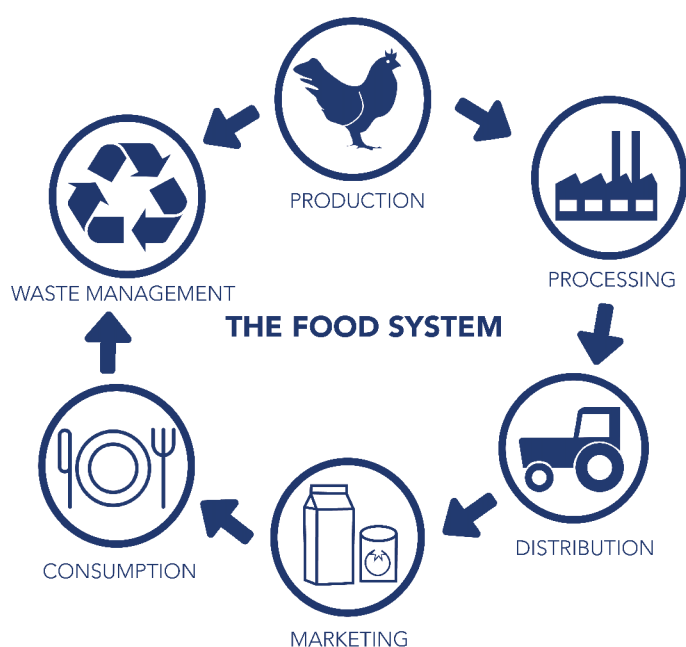
## Social and environmental determinants of health

The CHNA requirements reflect a growing understanding of the importance of social and environmental conditions as determinants of health and health inequities. They also reflect an understanding of the role that hospitals can play not just through providing individual patient care but also through community benefit activities and investments that address “upstream” factors that influence health.

The CHNA regulations highlight the importance of not only addressing access to health care but also opportunities “to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community.” The CHNA process encourages hospitals to think of their sphere of influence and responsibility in wider community and geographic terms rather than more narrowly in reference to their patient population and the activities that take place within hospital walls.

The environments in which we access food influence our dietary behaviors and are an important social and environmental determinant of health. Residents of communities with [convenient access to healthy foods](#) tend to have more healthful diets, yet significant disparities exist in the food environments in low-income and minority communities.

The community food environment can be understood as the distribution and density of different types of outlets or locations to obtain food in a geographically defined community. The community food environment can also include the price, placement, and promotion of food choices; access to food in settings such as schools and workplaces; and food and nutrition information, marketing, and media.



The community food environment is part of the wider food system, which is the network that integrates food production, processing, distribution, marketing, consumption, and waste management. See [“A healthy, sustainable, equitable food system: An imperative for population health”](#) to learn more about the public health impacts of our industrial food system and why it matters for health care.

## Goals of this chapter

Several organizations provide excellent guidance for conducting CHNAs, including the Catholic Health Association’s [“Assessing and Addressing Community Health Needs,”](#) Kaiser Permanente’s [CHNA Toolkits](#) at Community Commons, and the Association of Community Health Improvement’s [“Community Health Assessment Toolkit.”](#) These and other [resources](#) address best practices in the CHNA process, including:

- Defining the community served
- Including low-income and underserved communities and small area analysis data on health disparities
- Active engagement with the community and inclusion of diverse community voices
- Conducting collaborative community health assessments with local public health agencies, other hospitals or health care systems, and community health organizations
- Identifying community assets
- Using explicit criteria for prioritizing needs
- Public dissemination of assessment reports

This chapter focuses more narrowly on understanding how hospitals are including data on food access, obesity, and diet-related health conditions in their CHNAs. The chapter also examines opportunities and challenges that hospitals face in utilizing secondary data as well as collecting primary data about food-related health needs in their communities.



CSA pick-up at South Valley Economic Development Center, one of the La Cosecha distribution sites (Healthy Here PR at CWA Communications)



## Food and diet-related health needs identified in CHNAs

Hospital CHNAs present information on the health status and health needs of their communities, and typically present a list of health needs that have been identified as important in the community. Often CHNAs present an additional shorter list of three to six “priority” health needs. The table below shows the percentage of survey respondent facilities that listed obesity, food access, and diet-related health needs as *identified* or *priority* health needs in their CHNAs. Obesity prevention or treatment or the need to promote healthy body weight was identified as a health need in 71 percent of CHNAs.

**OBESITY, FOOD ACCESS, AND DIET-RELATED HEALTH NEEDS IDENTIFIED IN CHNAs†**

Health need	On list of identified health needs <sup>†</sup>	On list of prioritized health needs <sup>Ω</sup>
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

Ω of 166 CHNAs that listed priority needs

## Secondary data sources regarding food access and diet-related health conditions

Hospitals today can draw on a wide variety of high-quality secondary data sources – or data originally collected by another organization – to complete their CHNAs.

Data on food insecurity, diet-related health conditions, dietary behaviors, and food environments can be obtained from federal, state, and local government agencies, especially public health agencies; nonprofit/advocacy organizations; schools of public health; and other organizations. State and national data provide useful reference points for comparing local conditions. Many government data sources provide county-level estimates, and some provide estimates for smaller areas such as zip codes or census tracts. See [“Data sources to assess food access, environments, and behaviors in CHNAs”](#) for a review of useful data sources.

## Obesity, diabetes, and other diet-related health conditions

Our survey found that almost all hospital CHNAs (94 percent) included data on at least one measure of the percentage of community members experiencing unhealthy weight or diet-sensitive health conditions. The most common data sources utilized to assess obesity and diet-related health conditions came from the Centers for Disease Control (CDC) and local/state sources. CDC sources included the Behavioral Risk Factors Surveillance System (BRFSS) and related Youth Risk Behavior Surveillance System, which use telephone surveys to assess the health behaviors and conditions of hundreds of thousands of Americans each year. The CDC also produces Wide-ranging Online Data for Epidemiologic Research (WONDER), a catch-all web tool for accessing CDC data sets, reports, and statistics. Local and state sources were primarily composed of city, county, or state public health department surveys of health conditions and behaviors. To identify geographic disparities, some urban health departments oversample their communities in BRFSS surveys and some states conduct their own health behavior surveys.



**OBESITY, DIABETES, AND DIET-RELATED DISEASE SECONDARY DATA**

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

<b>Percent of CHNAs using at least one diet-related disease measure</b> .....	<b>94%</b>
<b>Obesity secondary metrics</b> .....	<b>88%</b>
<b>Diabetes secondary metrics</b> .....	<b>78%</b>
<b>Other diet-related disease secondary measures</b> .....	<b>75%</b>

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)

**Food insecurity**

The Department of Agriculture [defines food insecurity](#) as a lack of consistent access to enough food for an active, healthy life. The USDA identifies two levels of food insecurity:

- **Low food security:** when individuals report reduced quality, variety, or desirability of diet, but with little or no indication of reduced food intake.
- **Very low food security:** when multiple indications of disrupted eating patterns and reduced food intake are reported.

Fifty-two percent of survey respondents' CHNAs included a measure of food insecurity, primarily economic factors impacting food access. This includes measures of income and poverty, including eligibility for government assistance programs such as SNAP (Supplemental Nutrition Assistance Program), WIC (Special Supplemental Nutrition Program for Women, Infants, and Children), and TANF (Temporary Assistance for Needy Families) and eligibility for free and reduced-price school meals. Food insecurity assessments may also evaluate food prices.

There were three prevalent data sources utilized to assess food insecurity in survey respondents' CHNAs. Foremost among these was Feeding America's Map the Meal Gap, an indicator that estimates county-level food insecurity by income categories and also estimates the food budget shortfall reported by food-insecure individuals, which can illuminate the severity of food insecurity in a community. Another common source was the USDA Food Insecurity Indicator, which compiles survey data on the number of households with low or very low food security from a questionnaire administered as a supplement to the joint Census Bureau/Bureau of Labor Statistics monthly Current Population Survey (CPS). Finally, USDA data on participation rates in federal assistance programs (SNAP, WIC, and TANF) was prevalent in respondents' CHNAs.

**FOOD INSECURITY SECONDARY DATA**

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

<b>Percent of CHNAs using at least one food insecurity measure</b> .....	<b>52%</b>
<b>Food insecurity</b> .....	<b>34%</b>
<b>Free/reduced price lunch usage</b> .....	<b>25%</b>
<b>SNAP usage</b> .....	<b>22%</b>
<b>Child food insecurity</b> .....	<b>13%</b>
<b>WIC usage</b> .....	<b>5%</b>

Top data sources included:

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



The Healthy Here Mobile Farmers Market is a market on wheels that sells produce from Agri-Cultura in Albuquerque's areas of highest need (Presbyterian Healthcare Services)

## Food environments

The CDC defines the food environment as “the physical presence of food that affects a person’s diet; a person’s proximity to food store locations; the distribution of food stores, food service, and any physical entity by which food may be obtained; or a connected system that allows access to food.” Food environment measures include the distance a consumer needs to travel to reach food outlets or the density of various types of food outlets for a given area or number of residents. While 94 percent of survey respondents’ CHNAs included at least one diet-related disease measure, only 57 percent contained a measure of the food environment (see table below).

A plurality of hospital CHNAs that evaluated their community’s food environments used County Health Rankings & Roadmaps’ Food Environment Index. The index generates a score for the quality of an area’s food environment of 0 (worst) to 10 (best) by equally weighing two components: the percentage of the population that is low income and does not live close to a grocery store, and the percentage of the population that is food insecure. These components are in turn drawn from USDA data estimating the percentage of the population that is low-income and does not live close to a grocery store<sup>vi</sup> and from estimates of the percentage of a county’s population that was food insecure or did not have access to a reliable source of food at any point in the past year.

Many of the remaining CHNAs that assessed food environments drew on USDA data on “food deserts” (or areas with inadequate access to healthy foods), grocery store density, fast-food restaurant density, and low food access. USDA data on food deserts and low food access comes from the Food Access Research Atlas, which identifies census tracts that are both low income (20 percent or more of residents are impoverished) and low access.<sup>vii</sup>

## Food behaviors

Food behavior indicators provide information about the decisions eaters are making in the context of their food environment. The most widely available data sources on food-related behavioral health indicators are those with information on the purchase or consumption of fruits and vegetables, sugar-sweetened beverages, and high-sodium foods; the frequency of family meals; and consumption of fast-food restaurant meals.

Forty percent of survey respondents’ CHNAs captured food-related behaviors in some manner; 95 percent of those used BRFSS data or equivalent state/local data on fruit/vegetable consumption. Some CHNAs collected data on sugar or fast-food consumption, drawing on BRFSS or Nielsen household expenditure data via [Community Commons](#).

### FOOD ENVIRONMENT SECONDARY DATA

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

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

Top data sources included:

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

\* Food environment index is County Health Rankings and Roadmap’s 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.

### FOOD BEHAVIOR SECONDARY DATA

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

<b>Percent of CHNAs using at least one food-related behavioral measure .....</b>	<b>40%</b>
<b>Fruit/vegetable consumption .....</b>	<b>38%</b>
<b>Sugar consumption .....</b>	<b>13%</b>
<b>Fast food consumption .....</b>	<b>3%</b>

Top data sources included:

Behavioral Risk Factors Surveillance System, CDC Local and state sources (e.g. city, county, or state public health department surveys)

<sup>vi</sup> Living close to a grocery store is defined differently in rural and urban areas. “Low income” is defined as having an annual family income of less than or equal to 200 percent of the federal poverty threshold for the family size. See the USDA Food Access Research Atlas [Documentation](#) page for more information on definitions and methods.

<sup>vii</sup> This data is composed of income data from census tract-level estimates taken from American Community Surveys dating from 2010–14; population data from the 2010 U.S. Census; and grocery store data created by combining the USDA’s 2015 STARS (Store Tracking and Redemption System) directory of authorized SNAP retailers and Nielsen’s 2015 Trade Dimensions TDLinx directory of grocery stores. USDA data on grocery store and fast food restaurant density comes from the Census Bureau’s County Business Patterns, an annual collection of subnational economic data sorted by industry.

## Including health risks from climate change and industrial agriculture in CHNAs

A changing climate creates significant health risks.

- Climate change affects the social and environmental determinants of health – clean air, safe drinking water, sufficient food, and secure shelter. Climate-change-related deaths already exceed 150,000 per year according to WHO estimates.
- Health care systems are already experiencing the health impacts of climate change in their communities: increases in heat-related illness, asthma and respiratory disease, insect-borne diseases, and injuries and premature deaths from extreme weather events and sea level rise.
- Globally, climate change is also impacting our ability to produce food through droughts, increases in pests, and other changes in growing conditions.

Industrial-scale conventional agricultural practices have significant community health implications.

- Farmworkers face myriad health risks, including chronic and acute exposure to pesticides, high risk of injury, and limited access to health care.
- Agricultural contaminants, including pesticides, nitrates, and phosphorus, impact ground and surface water quality, affecting both urban and rural communities.
- Emissions and pollution from industrial agriculture affect air quality and are one of the biggest contributors of greenhouse gas emissions.

Two guidance briefs in Health Care Without Harm's "Delivering community benefit: Healthy food playbook," "[Climate co-benefits of healthy food access interventions](#)" and "[Community health risks of industrial agriculture](#)" make the case for including data on climate and industrial agriculture health risks in CHNAs as well as developing community health improvement strategies that consider climate and environmental co-benefits.

## Relationship between food-related data sources used in CHNAs and having food access community benefit programs

The research team analyzed whether or not there was a relationship between the food-related data sources utilized in the CHNA and having a reported community benefit program that targeted food access as a health need.

Hospitals that used USDA as a source of food-access related data in their most recent CHNA were 2.5 times more likely to have at least one community benefit program that targets food security or healthy food access as a health need ( $L=1.1$ ,  $U=5.7$ ,  $p=.038$ ).

There did not appear to be a significant relationship between using other food-related data sources in the CHNA and having food access community benefit programs in our data set.

**In order for hospitals to adopt community benefit programs that seek to improve healthy food access, food- and diet-related health needs have to be identified in their communities. And in order for food and diet-related health needs to become prioritized in CHNAs, hospitals need to collect data on these issues.**

The strength of the relationship between utilizing USDA data in the CHNA and having a community benefit program that targeted food access as a health need may be due to there being individuals involved in the CHNA process who are already predisposed to looking at and working on food issues in their community. In the next chapter, we discuss the value and impact of participation of food-related organizations in the CHNA process.



Five generations of the Baca family have farmed in the South Valley of New Mexico (Healthy Here PR at CWA Communications)

**RELATIONSHIP BETWEEN FOOD-RELATED DATA SOURCES AND COMMUNITY  
BENEFIT PROGRAMS TARGETING FOOD ACCESS AS A HEALTH NEED, INDIVIDUAL MODELS**

PROGRAM TARGETING FOOD ACCESS (n=104)				
HOSPITAL CHARACTERISTIC: SOURCES & MEASURES USED IN CHNA <sup>§</sup>	n	% <sup>¶</sup>	Odds Ratio <sup>†</sup>	95% CI
<b>MEASURES (INDIVIDUAL, N=205)</b>				
Food insecurity, alone	69	51	-1.1	-0.5 - -2.2
Free & reduced price lunch, alone	51	55	1.2	0.6 - 2.5
SNAP usage, alone	44	55	1.4	0.6 - 3.4
Food environment, alone	66	42	-1.8*	-0.9 - -3.7
Food desert, alone	55	45	-1.8	-0.8 - -3.9
Fruit & vegetable consumption, alone	78	58	1.3	0.7 - 2.6
Any food insecurity measure <sup>a</sup>	105	52	1.1	0.6 - 2.1
Any food environment measure <sup>b</sup>	116	47	-1.6	-0.8 - -3.1
<b>SOURCES (INDIVIDUAL, N=203)</b>				
Center for Disease Control	41	54	-1.1	-0.5 - -2.4
US Department of Agriculture	46	67	2.5**	1.1 - 5.7
Community Commons/CHRR <sup>c</sup>	74	43	-1.9*	-0.9 - -3.8
Feeding America	32	56	1.5	0.6 - 3.8
Local government <sup>d</sup>	64	48	-1.0	-0.5 - -2.1

\* P&lt;0.10, \*\* p&lt;0.05, \*\*\* p&lt;0.01; two-tailed

§ Model N given below; robust standard errors

¶ Percent of hospitals in category that have at least one reported program

† Odds Ratios should be interpreted as "Hospitals with characteristic [Source/Measure in CHNA] are X times more/less likely to have outcome [program targeting food access]." A negative sign indicates less likely.

<sup>a</sup> Any one or more of food insecurity, free/reduced price lunch, SNAP, WIC or TANF usage<sup>b</sup> Any one or more of food environment, food desert, low food access, farmer's market counts, fast food restaurant density, grocery store density, or number of stores accepting SNAP or WIC<sup>c</sup> County Health Rankings & Roadmaps<sup>d</sup> Examples include state, county and municipal public health agencies



## Identifying the health needs of sub-populations at greatest risk of poor health outcomes: Sutter Health Eden Medical Center

**Sutter Health Eden Medical Center** (Castro Valley, Calif.) completed its last two CHNAs with help from Community Health Insights (CHI), a CHNA consultancy with deep understanding of the community. Community Health Insights focused on “communities of concern” that had particularly poor health outcomes and were experiencing health disparities, and which merited special attention in the CHNA.

The CHNA defines communities of concern as “geographic areas within the hospital service area that have the greatest concentration of poor health outcomes and are home to more medically underserved, low-income, and diverse populations at greater risk for poorer health.” Four zip codes were identified as communities of concern, representing about 55 percent of the total hospital service area.

Factors that were considered in the identification of these areas included the use of the Environmental Protection Agency’s Community Health Vulnerability Index – a tool that CHI adapted to determine the extent to which health disparities were present in a given geographic area – and

mortality and morbidity rates. Key informant interviews also identified the neighborhoods associated with the four zip codes: Ashland, Cherryland, and San Lorenzo, as areas of highest need, and additionally identified specific racial and ethnic groups within these communities that were experiencing poor health outcomes.

The focus of the 2016 CHNA was to prioritize improving health within those communities.

Key informant and focus group participants pointed to the ubiquity of fast food restaurants, the higher cost of healthy food compared to fast food, and limited availability of fresh food outlets as contributors to chronic diseases in their communities.

As one key informant observed, “We still have a lot of young people that come in here and we are noticing that there are a lot of behavioral issues [that] result from the fact that they haven’t had anything to eat all day. We hear stories of young people who had a bag of Cheetos, went to school, got into a fight, came here, and still haven’t had anything else to eat.”

## Primary data

Secondary sources are an integral part of the CHNA data collection process, but it is also critical for hospitals to gather insights from their own community members. Secondary sources usually provide data collected or estimated at the state or county level. Data for smaller areas such as zip codes or census tracts, when available, are often estimated from larger geographic areas, and to get an accurate picture of community health conditions, particularly for sub-populations within the hospital service area, hospitals should collect data directly from their community members. Enhancing secondary data with primary data allows the assessment to focus on the health needs of the community’s most vulnerable populations, such as low-income residents and members of racial and ethnic minorities.

Primary data collection is critical in evaluating the community food environment, food needs, food resources, and facilitators and obstacles to healthy

eating in the service area. Each community is unique, as are the strengths and weaknesses of its food environment. Primary data is vital to help hospital leaders make difficult decisions about where to direct limited resources to address a community’s most pressing health challenges.

To assess food and diet-related health needs in the community, hospitals employ three main primary data collection practices: key informant interviews, focus groups, and community surveys.

For hospitals looking to understand food-related health needs in their CHNA process, **key informant interviews** with staff at food banks, soup kitchens, other organizations that work with low-income and underserved populations, and food advocacy organizations can provide critical insights into priority issues as well as opportunities and assets to address these needs in the community.

In Florida, [Orlando Health Arnold Palmer Hospital for Children](#) interviewed food bank staff, leaders of racial and ethnic minority communities, local business leaders, school

officials, and advocates for the homeless as part of a CHNA process that investigated three interconnected community health challenges: obesity, poverty, and lack of access to healthy food. Arnold Palmer's selection of a diverse group of key informants helped to identify the serious threat posed by diet-related disease and a lack of healthy food options to the community's youth.

**Focus groups** can elicit vital experiences and insights from community members. The conversational atmosphere of these meetings makes people feel at ease expressing their beliefs and concerns. It is recommended that these not be held at the hospital but at a community location.

In California, UC San Francisco (UCSF) Medical Center's Wylie Liu explained that focus groups formed the backbone of her facility's primary data collection efforts. UCSF Medical Center, in collaboration with San Francisco Health Improvement Partnership (SFHIP), analyzed five years' worth of San Francisco-area CHNAs and identified "missing voices" from previous CHNAs. Eleven communities were then chosen for focus groups that focused on neglected subpopulations. For example, in a focus group that targeted veterans, Liu said that the participants mentioned the importance of social connectedness as it relates to eating well to be healthy.

**Surveys** that ask community members about their health concerns are important tools for collecting data on about food access, food behaviors, or diet-related health conditions. To ensure responses from vulnerable population groups, it is useful to work with community organizations that work with these groups to administer surveys.

The USDA Economic Research Service provides a variety of standardized [survey tools](#) and other resources to assess food insecurity. Using these instruments will strengthen the validity and reliability of the resulting data and maximize comparability with national statistics.

In Oregon, [Providence Hood River Memorial Hospital](#) mailed a food survey to over a thousand households in its service region. In addition, surveys were hand-administered in targeted areas to ensure participation from non-English speaking, elderly, and low-income households.

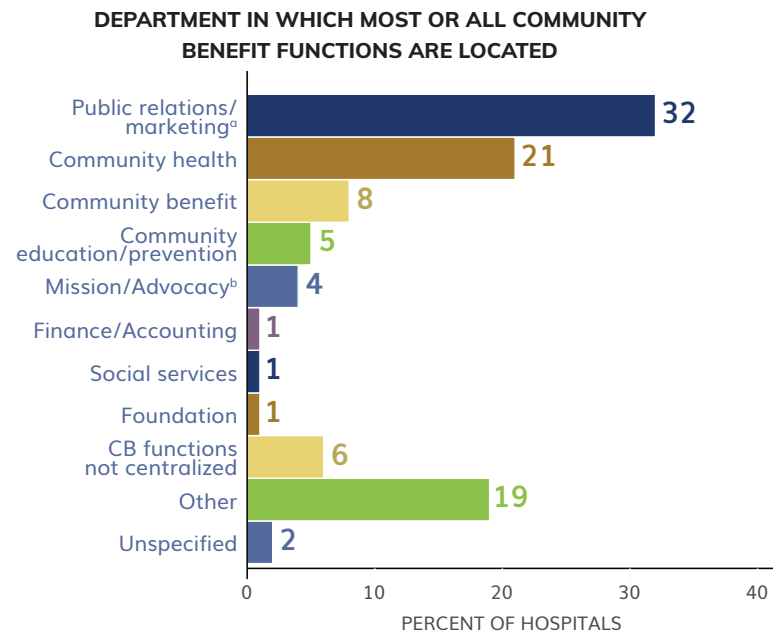
Our national survey found that 89 percent of respondent facilities utilized at least one form of primary data collection in their CHNA, with surveys being the most common method.

## Opportunities and challenges in data collection and analysis

### Community benefit functions fragmented

The community health improvement and community benefit responsibilities that hospitals undertake are diverse. They include community engagement; conducting community health needs assessments, which require expertise in data collection and analysis; community health planning and implementation; program evaluation; financial and tax reporting; and communication with stakeholders. In many hospitals, these and other community benefit functions are carried out in multiple departments within facilities or among facilities in a hospital system. Numerous hospitals reported being challenged with having sufficient dedicated staff time or training to carry out these responsibilities.

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



<sup>a</sup> Includes outreach and communications

<sup>b</sup> If "mission" occurred with other key terms, the other term was counted

### Primary data collection methods

**89% CHNAs using at least one primary collection method**

- 61% Surveys**
- 53% Focus groups**
- 40% Interviews**

## Having sufficient in-house expertise and resources to collect and analyze data

Community benefit staff members have diverse professional and educational backgrounds, and those charged with conducting or coordinating the hospital's CHNA may not have expertise in public health, epidemiology, or related fields. Community benefit staff members can engage relevant expertise from other hospital departments, local public health agencies, schools of public health, CHNA consultants, and community organizations.

It is becoming increasingly common – and considered best practice – for health care facilities to collaborate with other hospitals and health systems, local public health agencies, community health organizations, and other stakeholders in order to effectively utilize the diverse expertise and resources necessary to develop quality CHNAs. In our national survey, 59 percent of respondents reported that they had collaborated with other hospitals (within or external to their hospital system) in their most recent CHNA.

In the next chapter, we will discuss the value that public health agencies, food-related community organizations, and CHNA consultants can contribute to assessing diet- and food-related health needs.

Even when a hospital's community benefit efforts are being led by a staff member with public health experience, many hospitals face institutional constraints in conducting CHNAs. One community benefit director with 14 years' experience in community health commented that the constraints placed by hospital resources make data collection challenging.

*“We are a community hospital. We’re not an academic medical center. I don’t have a research or evaluation department or anything so it’s really difficult. We don’t have the resources to do a lot of our own data gathering, so I am very dependent on what I can find that’s out there.”*

While hospitals that employ community benefit leaders with backgrounds in public health or other related fields benefit from this in-house expertise, there are many important ways that that community benefit departments can draw on expertise from other hospital departments and other community stakeholders.

## Accessing up-to-date secondary data

Food-related secondary data sources that are widely available and searchable can be found with relative ease. See [“Data sources to assess food access, environments, and behaviors in CHNAs”](#) for a review of useful data sources.

However, not all of these data sources may have sufficiently recent data to use in CHNAs. Finding data that meets all of a facility's requirements and is also current enough to include is a persistent challenge for CHNA authors, as interviewees attested.

*“It was largely about what we had access to that was timely. We had some internal thresholds that we set. We agreed that we would use as fresh as possible data and so we were committed to having data that went through calendar year 2015. We were limited to sources that had updated data.”*

*“The perennial problem we have with data is timeliness and reliability. We struggle a little bit with collecting health data from the Department of Health. It’s hard to find and it’s not always updated. We went with the County Health Rankings, but we want to definitely expand that.”*



## The importance of obtaining granular, sub-county data

Numerous community benefit professionals observed that obtaining county-level health data is fairly easy, however county-level data often doesn't convey health conditions and needs for sub-populations within the county. Therefore it is important to collect data for communities or areas whose needs and priorities may not be captured by county-level data.

One community benefit director observed:

*"It's one of the challenges in rural communities where we have small population sizes to get granular zip code or community-level data. We can get county-wide data, but our county is the size of Vermont and has pockets...that are really different from each other. We have native populations and a pretty significant Latino population. [Looking] at county-level data doesn't get to level of granularity that resonates with people and actually describes the community where they live."*

Mark Thomas of [Providence Hood River Memorial Hospital](#) described how his facility's collaborative CHNA designed surveys in Spanish and hand-administered them with partner organizations in order to understand the health needs and priorities of low-income, immigrant, or other hard to reach groups, which may not be as apparent in other data sets.

*"We worked closely with partners in the community and took a deeper dive on some topics. We fielded a survey that was specific to food, and we learned a ton more about hunger.... We have better local data from our own survey effort. A fundamental commitment that we aspire to, and that I think we've practiced very well, is that the people whose needs we're trying to understand and address need to have a stronger voice in the [assessment] process, including in how they're asked, what they're asked. We've taken that very, very seriously."*



Students wearing backpacks stocked with meal supplies (Heywood Hospital)

## Avoiding duplication, filling gaps in subsequent CHNAs

While tax-exempt hospitals must conduct a CHNA at least once every three years, the IRS notes that hospitals can "build upon previously conducted CHNAs." However, facilities must solicit and consider the input of "persons representing the broad interests of the community anew with each CHNA, even if the CHNA builds upon a previously conducted CHNA."<sup>25</sup>

This ruling reinforces both avoiding duplication of data collection and obtaining new community input. Primary data collection is largely seen as "cumulative" by hospitals: each cycle means filling in gaps and "finding missing voices" to refine previous assessments, rather than starting from scratch.

For example, one community benefit director said she listened to stakeholders who requested more information on food access and diet-related disease, and the most-recent CHNA "prioritized this over doing a complete reset of data collection." The interest in filling this gap was reflected in a larger presence of food access and healthy eating in key informant interviews and other forms of primary research.

In addition, some community benefit professionals expressed reluctance to expend unnecessary resources to duplicate data collection when other community organizations were capturing many of the same health trends in their own data. Instead, they looked at how they could focus on identifying insights and perspectives that had not already been recorded.

*"Because we just did one three years ago, we did not feel like we needed to collect a lot of [new] primary data. We collected all the needs assessment done within [the metropolitan area] for the past few years to see what had been done already by public institutions, nonprofits, academic institutions. Based on that information, we made a decision to look at what other voices are missing in all that information."*

Some facilities felt that their communities could do more to harmonize data collection, analysis, and evaluation efforts among all interested organizations. For example, one community benefit director noted that in her community, there is a lack of coordination among organizations working on obesity-related issues.

*"We have some groups that are focused on food policy, we've got some groups that are focused on farm networks and local food resources. We don't really have a centralized hub for discussion around obesity and obesity-related issues."*



She is hopeful that this will improve as the facility focuses on

*“more collaborative efforts, and reduction of duplication, and also really becoming more knowledgeable about tools and resources that we can utilize to better evaluate our efforts in healthy eating.”*

## Avoiding placing excessive demands on community members

While primary data collection is an integral part of every CHNA cycle, it is important to ensure a respectful and ethical approach to data extraction. Some communities may be studied frequently by universities, government agencies, hospitals, and other institutions. It is critical to utilize existing analyses in order to avoid duplication of efforts and over-burdening community members, particularly if there is little or no compensation for their vital contribution to data collection. Community members also should have access to and an active role in stewardship over this data.

Hospitals are becoming strategic in how they manage community data collection from cycle to cycle. As noted above, facilities are increasingly reflecting on their own previous data collection activities as well as those of other community institutions in order to avoid unnecessary repetition. Facilities are also starting to be cognizant of the risk of placing excessive demands on community members by collecting data too often from the same stakeholders.

One community benefit director stated:

*“We decided to collaborate with [the county health department] so that we didn’t have to do a lot of overlapping on data collection and stress the community out and wear out our community resources because we were both collecting the same data.”*

Another interviewee explained that their approach to deciding which community groups to engage and which issues to collect data on hinged on whether or not another community institution was already engaged with these groups and these issues. In these cases, it is preferable for all involved to collaborate and share data.

*“One of the criteria we use is that if somebody else is already working on it we weren’t going to work on it, because this work is all about breaking down silos and not duplicating work.”*

## Coordinated community data collection through a collaborative CHNA: Montefiore Medical Center

As it prepared to conduct its 2016 CHNA, [Montefiore Medical Center](#) (Bronx, N.Y.) examined opportunities to engage other community health stakeholders in conducting a collaborative CHNA. Ultimately, Montefiore developed the CHNA in close collaboration with the New York City Department of Health and Mental Hygiene and other area hospitals. The collaborative assessment actively engaged a number of community partners, including Food Bank for New York City, the Campaign for a Healthy Bronx, Harvest Home Farmers Market, City Harvest, and the Bronx Bodega Work Group. For the 2016 assessment, the health department led a series of “community consultations” to collect primary data through community-based meetings. Eight such events were held in the Bronx, which yielded data and insights that all the institutions participating in the collaborative health assessment were able to utilize in their own CHNA reports and implementation strategy planning.

## Considerations for rural hospitals

Hospitals conducting CHNAs in rural areas experience obstacles and facilitators to developing high-quality assessments that may be distinct from their urban counterparts.

Our national survey found that while 67 percent of urban hospitals collaborated with another health facility in conducting their CHNA, only 46 percent of rural hospitals did. Small, rural facilities may be the sole providers in their communities and may not have other hospitals to collaborate with in conducting the CHNA.

Our interviews and case studies revealed that challenges faced by rural hospitals include finding high-quality data sets that cover their service areas, high barriers to translating CHNA findings into improving food access and eating environments, and a persistent lack of funding. However, hospitals were enthusiastic about the benefits of close working relationships in small communities.

## Data

Finding data sets that include detailed information on rural communities is a challenge for rural hospitals. A community benefit director responsible for collecting data for both rural and urban hospitals across her state said:

*“It was really important to me to use the same data sources for all 15 of my community health needs assessments. Unfortunately, a lot of that data is not available for our hospitals in [the rural part of the state]. When you’ve got such small communities, it was limited, what I could find. I could find an abundance of data on [the largest metro area], but then I couldn’t find it for these smaller locations and the rest of the state.”*

Another described that she worked closely with consultants on a survey so her facility’s CHNA could obtain community-level data, which would not be available “unless we get the data ourselves”:

*“When we became a [Robert Wood Johnson Foundation] Healthy Kids Healthy Communities grantee, we started doing work focused on food access and added questions to the survey about proximity to grocery stores, farmers markets, farm stands, etc. We now have that robust data. I can say how many people in this county claim to live more than 15 miles from a grocery store.”*

## Financial limitations

Small, rural facilities often face budget constraints. A community benefit lead at a small, rural hospital lamented:

*“There’s a perception that we have these buckets of money called community benefit that we can allocate as we wish, or we can generate more buckets of money. The reality is, particularly in a nonprofit health care system working in rural communities with health disparities, we’re operating with very negligible margins. In some cases, like this last year, with a negative margin.”*

## Rural challenges to healthy food access

Many rural hospitals report high community needs, lack of community resources, and transportation barriers that limit the ability to leverage CHNAs to address healthy food access. A community benefit director at a hospital in a low-income rural area reported:

*“We struggle with what many areas with food insecurity struggle with, but here there are a lot of transportation issues. Within these rural communities there is a challenge with access to quality fresh fruits and vegetables. We do our best certainly, but I think access is the hardest part where we are.”*

## Close community relationships

Despite these challenges, rural hospital community benefit staff expressed appreciation for the strong working relationships in the community health sectors of their towns.

*“It’s a small rural community. Ninety percent of the time, you have the same players at the table, because of the size of the community. We’re working together already around many food access and obesity issues, so they were already at the table providing data, providing information, working with WIC and our Head Start programs. We all work together.”*

*“Since our community is small enough it is easy to pick up the phone and call the different food access organizations to get info from them and any data they had for the needs assessment.”*

## Conclusion

In order for hospitals to adopt community benefit programs that seek to improve healthy food access and promote healthier food systems, food- and diet-related health needs have to be identified in their communities.

The CHNA process represents an opportunity for hospitals to thoroughly assess health needs related to food access, food insecurity, obesity, and diet-related health conditions in the communities they serve. This chapter has highlighted several opportunities, as well as some challenges, for achieving this goal.

Including data on food insecurity, food environments, and food behaviors is critical to gaining an understanding of healthy eating in a given service area. Hospitals should make every effort to identify the unique food-related health needs of vulnerable populations in their communities, and especially to include them in the data collection process so that disadvantaged groups can, themselves, describe the health needs and priorities in their communities.

# Chapter 3. Engaging public health and community organizations in the CHNA process to understand food and diet-related health needs

## Introduction

### Why include local public health departments and community-based organizations in the CHNA process?

The Affordable Care Act included new federal [requirements](#) for tax-exempt hospitals, including standards for triennial community health needs assessments (CHNAs) and implementation strategies and public reporting on community benefit programs. The requirements for CHNAs state that hospitals must identify and prioritize community health needs and evaluate existing resources to address those needs. Further, CHNAs must include input from people “representing the broad interests of the community” with each CHNA. This input must include, at a minimum, at least one local, state, regional, or tribal governmental health department and members of medically underserved, low-income, and minority populations or individuals or organizations serving or representing the interests of such populations.

In addition to meeting federal requirements, including public health and community organizations addressing food-related health needs in the CHNA process brings vital expertise and perspectives to the assessment.

Understanding the built and social environments in which community members make food decisions as well as the availability of resources to meet daily nutrition needs is critical to effectively address rising rates of obesity and diet-related health conditions. Engaging public health and community organizations in the CHNA process is important for understanding the community food environment, facilitators and obstacles to healthy eating, and the landscape of community food resources.

### Goals of this chapter

In this chapter, we look at how local public health departments and community-based organizations are contributing to the CHNA process, and in particular, how



The 2017 Healthy Hearts event at Northwestern Medical Center in Vermont.

this participation contributes to more fully understanding the food and diet-related health needs of vulnerable populations as well as opportunities to effectively address those needs.

From our national assessment (national survey, in-depth interviews, and case studies) we found that involving local public health departments and community organizations that work on food access and food system advocacy issues can lead to a more nuanced understanding of social and environmental determinants of health in the community, particularly those related to healthy food access. This involvement can include participating in identifying community resources to address health needs; selecting secondary data; facilitating interviews, focus groups, and community surveys; reviewing and analyzing data; and determining community health priorities. In this chapter, we discuss our findings about these collaborations, including our finding that participation of food-related community organizations in CHNAs was associated with hospitals having community benefit programs that address food access as a health need.



## Public health contributions to CHNAs

Nonprofit hospitals and public health departments operate under similar assessment requirements as they work to improve the health of their communities. Local public health departments conduct community health assessments (CHAs) at least once every five years as part of the process of acquiring and maintaining accreditation from the Public Health Accreditation Board (PHAB). Similar to CHNAs, the assessments must include community input and result in a corresponding community health improvement plan (CHIP) designed to address identified health needs.

Because of the obvious overlap, it is becoming increasingly common for hospitals and health departments to conduct collaborative assessments in order to more effectively use limited staff and financial resources and draw upon combined expertise. Such collaboration can lead to the collection of better quality and more extensive data and establish a foundation for future joint efforts to address health needs, including successful grant applications.

Hospitals, public health departments, and community organizations participating in the CHNA and CHA processes form an important part of local efforts to build a community-wide approach to health improvement.

### Population health perspective

Many public health departments have been conducting community health assessments for years and have more experience doing such assessments than the hospitals in their communities. Several community benefit professionals

commented that they appreciate the valuable expertise and resources that local public health departments bring to community health assessments.

Public health agencies bring a population health perspective to the assessment process that hospitals may lack. Some public health officials who conduct collaborative health assessments with health care facilities observe that hospitals tend to focus on individual health outcomes and patient health care costs, while public health professionals are more accustomed to looking at social and environmental conditions that impact health and consider how to influence the environment to optimally support health.

While hospitals and health care systems have made tremendous progress in recent years in considering social determinants of health, local public health agencies tend to be more deeply grounded in a population and community health orientation.

One public health interviewee commented:

*“Public health operates from a population, whole community mindset and has more of a data-driven agenda. Hospitals tend to come in from their own patient mindset and focus on data from patients. Then hospital boards can have their own priorities. Hospitals look at identifying needs that they can target with interventions that show a clear ROI [return on investment], like reduction in readmittance rates. Sometimes there can be a very hospital-specific set of concerns, like hospital-acquired infections... Sometimes there can be a disconnect between the aims and reimbursement rates-focus of hospitals and a broader community health focus.”*

This same informant went on to observe that, in her experience of doing collaborative CHNAs in her community,

*“Hospitals can have more focus on health priorities that are disease driven. For example, public health might identify healthy food access and food insecurity as a health priority, where the hospitals are more likely to identify obesity, heart disease, diabetes. Public health is also more likely to be interested in interventions that address policy, systems, environmental change... Public health is more likely to look at healthy food access issues where hospitals are more likely to focus on nutrition education or diabetes screening. There also may be an issue with how related health needs are labeled.”*



A vendor sells produce at the Community Farmers Market in New York City. (Montefiore Medical Center)



Another public health interviewee, when asked if hospitals are “on the same page” with public health when it comes to community health assessments, said:

*“With many, yes, but for some, no. Some hospitals still want to focus on small hospital service areas, not the needs of wider county or community. Sometimes it’s hard for them to understand the impact of them defining their community as the whole county. There is also a shift in how they view their role – in terms of moving more toward addressing social determinants of health.”*

A CHNA consultant who facilitates collaborative CHAs/CHNAs said that one of her roles is

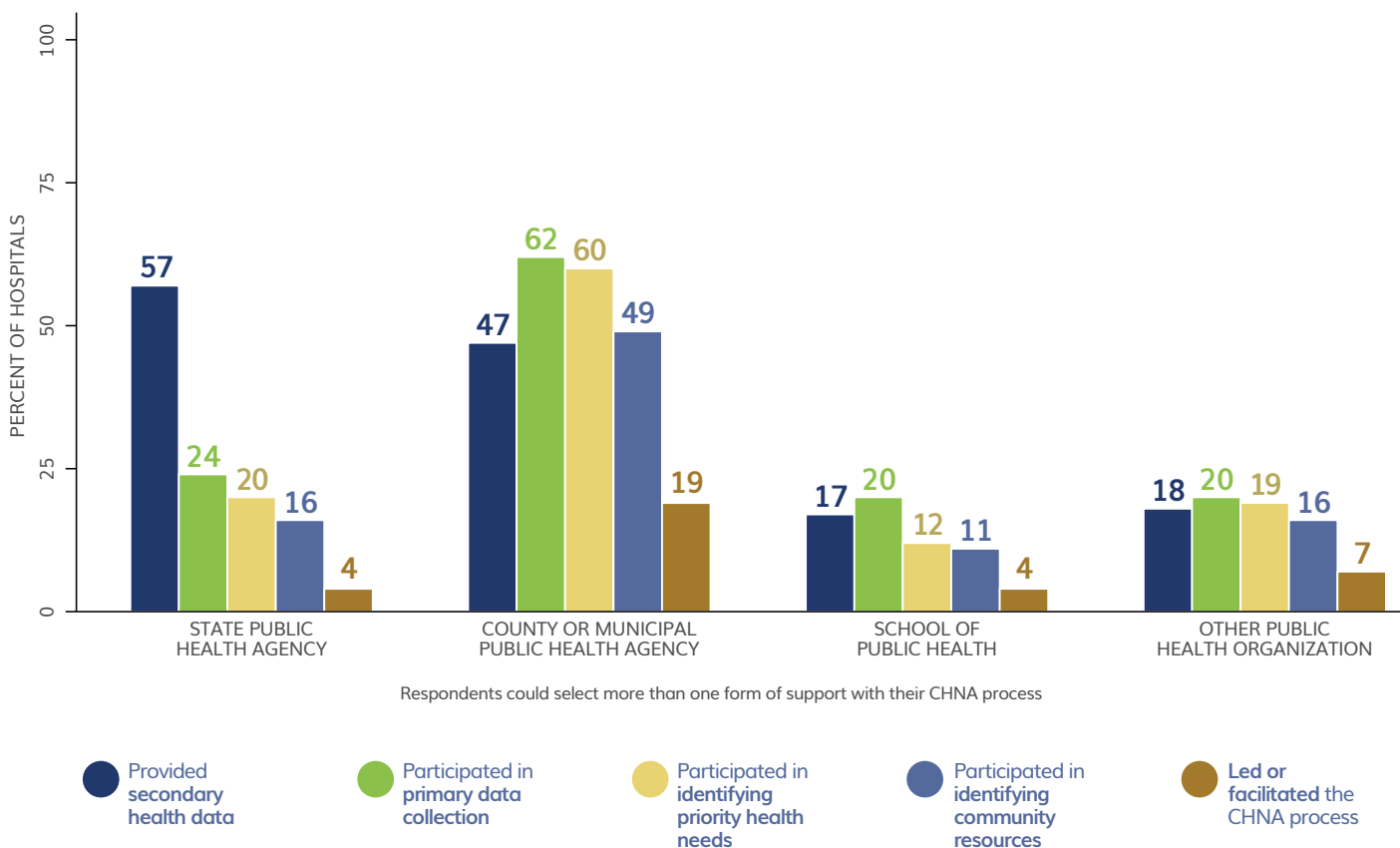
*“helping hospitals to take a broader community health perspective.... There can be a dance, balancing perspectives.”*

Public health can particularly bring expertise regarding identifying health inequities in their communities. A public health informant said:

*“We do evaluations on what are the greatest areas of unmet need, and our focus has been very much on health equity. [In a collaborative health assessment], I called out a 20-year difference in lifespan in two neighborhoods. This really begs the question of what are we doing about health equity? This is one of our [public health department’s] areas of strength.”*

There are several ways that public health organizations can participate in hospitals’ CHNAs, which we discuss below. In our national survey, we asked hospital community benefit leaders how public health organizations had participated in their most recent CHNA. Local public health agencies participated in primary data collection and identifying health needs in 62 percent and 60 percent of CHNAs, respectively.

#### FORMS OF PUBLIC HEALTH PARTICIPATION IN CHNAs



## Public health and data collection

Public health departments frequently help hospitals with selecting and collecting secondary data on morbidity, mortality, and health determinants in their communities. Community benefit professionals reflected on numerous ways that public health had assisted with data collection.

*“The local health department...really took the lead on the data collection. They pulled data from BRFSS [Behavioral Risk Factor Surveillance System], census data, American Community Survey, other critical health indicators.”*

*“The health department has been really good about sharing data and having their epidemiologists look at things for us. Food desert mapping came from a report that the state agriculture department had done. We’ve always had strong support on data from the health department.”*



A volunteer chef and nutrition educator teach an interactive cooking course to participants of a Cooking Matters program, which operate in communities across the United States.. (Share Our Strength)

Hospitals also commented on ways public health had conducted or supported surveys, interviews, and focus groups to better understand health needs, especially diet-related health needs, in their communities.

*“[County] public health did a county-wide survey. It was wonderful to have real-time data instead of data that’s five years old.”*

*“This was our second time doing a CHNA, and this time we listened to some of the stakeholders in our community who requested more information on food access and diet-related disease. We worked with public health to make sure to be more deliberate this time and to have representation in our interviews and research to speak to those topics.”*

In a collaborative health assessment in California, public health staff conducted key informant interviews and focus groups designed to triangulate key findings from the secondary data related to food access and food behaviors.

Another hospital reported that they worked closely with their local health department on understanding food access needs in the community. Both the hospital and the health department were developing community health surveys, and they coordinated to address key topics and verify findings while minimizing duplication.

*“We’re asking these questions in our phone survey; let’s take those questions out of yours, and cross-share data. What are people perceiving about food issues? We really sat down and looked at those questions together as partners.”*

## Public health as leaders or facilitators of collaborative assessments

It is not uncommon for public health departments to serve as the facilitator or leader of collaborative health needs assessments in their counties or metropolitan areas, in some cases for assessments that include multiple hospitals, health systems, and community stakeholders.

A community benefit lead in the Midwest described how her local health department coordinated a collaborative CHNA through a community health improvement initiative that included thirty community organizations and various subcommittees to address key issues:

*“The [local] health department was a very valuable resource. We relied on their expertise, enthusiasm and particularly their existing coalitions... They served as a hub for coordination, communication, and community engagement in various parts of the CHNA process.”*

And another explained that a public health officer provided a lot of input into her community's collaborative health assessment, including taking a lead role in educating board members about the importance of food-related health issues:

*“The state health officer serves on the board of directors for the [city health collaborative]. During board meetings, he would often make comments and educate the board members about food insecurity, food policy, breastfeeding impact on obesity, and those types of things.”*

### Alignment with public health on health priorities

Some state and local public health agencies encourage hospitals to align some of their community health improvement efforts with public health priorities in order to improve coordination of hospital community benefit activities with other efforts to improve community health.

An example is the [New York State Prevention Agenda](#) (NYSPA), which is a framework for coordination on community health improvement strategies by local health departments, hospitals, and other community stakeholders. The New York State Department of Health requires hospitals' community benefit implementation strategies to coordinate with local public health and community partners in addressing at least two priority areas identified in the NYSPA.

In our interviews, we found a range of experiences regarding hospitals' aligning CHNA priorities with the health priorities of state or local public health agencies.

Some hospitals reported strong encouragement from public health partners to align priorities. For example, a community benefit lead in the Northeast described how the health department is funding health equity zones in the state, with coalitions that assess health and economic development needs and opportunities in the community and develop action plans to respond to place-based needs. She explained:

*“The department of health did strongly encourage not just [our hospital] but all the hospitals in the state to look at the needs assessments that were being conducted by those health equity zones and to see how we align. A number of [the health equity zones] have identified food security as an issue and are developing strategies to address that. I participate in one group and stay abreast of what they are working on. We want to contribute to the collective impact effort.”*

Another hospital community benefit interviewee explained that her facility had looked for ways to align with public health on both priority health needs and implementation strategies:

*“There was encouragement to align, but not a strong push. There was a clear discussion around where it was strategic and possible to align and support what public health is doing. We asked, ‘Is it feasible for us to align there? What is our capacity? What’s our scope? What’s our opportunity for scalability?’ For example, public health leads the implementation of a program around food access and food insecurity, and we included support for that in our implementation plan.”*

In another case, a community benefit informant said that public health had not encouraged the hospital to align on priority health needs or strategies, but rather that it had been a “mutual process.” This community benefit professional had been leading a community health coalition's efforts focused on food access and healthy eating, “and so public health actually aligned with us on that.”



A staff member of Montefiore Medical Center volunteers at the Community Farmers Market. (Montefiore Medical Center)

### Challenges of collaborating with public health agencies on CHNAs

While joint CHNA/CHAs are becoming more common – enabling hospitals and local public health agencies to more effectively use limited resources, draw upon combined expertise, and collect better quality and more-extensive data – interviewees also reported that there can be challenges to conducting collaborative health assessments.

## Different timelines

The Public Health Accreditation Board (PHAB)'s national system of public health [accreditation](#) requires health departments to complete CHAs every five years, while the IRS requires tax-exempt hospitals to complete CHNAs every three years.

Several interviewees highlighted obstacles related to the fact that hospitals and public health departments have different health assessment requirement timelines.

*“A big issue that I’m sure you will hear nationwide is not having the health departments and the hospitals on the same timeframe together for CHNA processing. We just finished our CHNA for 2016 and now the health department is starting over because they’re on a five-year turn and we’re on a three-year turn. We’re trying to keep close ties on the community needs priorities that we share because we would like to keep collaborating.... We’re only hoping that the health department comes back with the same initiatives for their next round.”*

## Different agendas

Other hospitals found that while they saw the value of collaborating with public health on health assessments, differing reporting and institutional requirements sometimes made collaboration more difficult than anticipated.

*“I went into it thinking this will be great. We both have to do needs assessments and we’ll just do them together. But it’s not really that easy. Public health has certain things that they need to do for their accreditation. Nonprofit hospitals have different reporting requirements. Then there are institutional barriers that prevent our projects from aligning perfectly. Neither organization is nimble and able to just redirect what we’re doing quickly. It takes time to get through those layers of organizational bureaucracy and infrastructure to figure out how we can align our assessment. There’s a real commitment to work together but every meeting that we have is learning about how to work together better.”*

Other community benefit leads observed that hospitals sometimes focus on specific health issues or populations that are distinct from public health’s broader focus. For example, a children’s hospital reported:

*“We always work with the [city public health commission]... Unfortunately, their data’s not always pediatric specific. We have a more pediatric*

*lens and [look] more at interventions to improve pediatric health and family health. Sometimes the way that they decide to look at the data makes it a little bit challenging for us to use.”*

## Including food-related community organizations in the CHNA process

Beyond satisfying community benefit requirements, there are a number of benefits to conducting a robust landscape assessment of existing community food organizations and resources and engaging community food system stakeholders in the CHNA process. Community-based organizations that work on food access or food systems issues can provide expertise on food-related resources and needs that hospital staff may be unfamiliar with.

### Federal requirements to engage the community in the CHNA process

Community benefit [regulations](#) specify that a hospital's CHNA report must:

- Include a description of the community resources potentially available to address significant health needs
- Take community input into account when identifying and prioritizing health needs and identifying resources to address those needs

After completing the CHNA, hospitals must develop an implementation strategy that describes how the hospital will use its resources and the assets of the local community to address prioritized health needs.

Conducting a robust assessment of existing community food system resources and engaging community stakeholders in this process, as well as in needs identification and prioritization and in implementation strategy development, provides an opportunity to satisfy multiple community benefit obligations.

In our national survey, respondents reported that several different types of food organizations played a role in their CHNAs. Emergency food organizations, such as food pantries, were the most commonly involved organizations, followed by supplemental meal programs, such as summer meals.



## FOOD ORGANIZATIONS PARTICIPATION 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
<b>Organization for emergency food provision</b> (e.g. food bank, food pantry, soup kitchen)	68%	25%	35%
<b>Program for supplemental meal provision</b> (e.g. school-based, summer meals, Meals on Wheels)	60%	19%	29%
<b>Food system advocacy group</b> (e.g. food policy council, food justice coalition)	26%	7%	11%
<b>Agency that links food-insecure people to food resources</b>	45%	16%	25%
<b>Community group promoting healthy food access</b> (e.g. farmers' market, urban farm, healthy corner store)	49%	21%	28%
<b>College/university program addressing food/nutrition issues</b>	22%	11%	13%
<b>Other group(s) addressing food/nutrition issues</b>	18%	6%	8%

The research team used logistic regression to analyze whether there was a relationship between food organizations participating in the CHNA process in the three ways noted in the table above and hospitals having a reported community benefit program that targets food insecurity or healthy food access.<sup>viii</sup> The table below shows that involvement of organizations for emergency food provision (such as food pantries or soup kitchens) and community groups promoting healthy food access (such as farmers markets or healthier corner stores) was strongly correlated with facilities having a community benefit program addressing food access.

Hospitals with involvement of organizations for emergency food provision in the CHNA process were 5.5 times more likely to have a community benefit program targeting food insecurity or healthy food access. Hospitals with involvement of community groups promoting healthy food access were 3.7 times more likely to have a community benefit program targeting food insecurity or healthy food access.

<sup>viii</sup> The national survey asked hospitals to provide information on up to three community benefit programs that target obesity, food access, or diet-related health conditions.

**RELATIONSHIP BETWEEN FOOD ORGANIZATION INVOLVEMENT IN CHNA AND COMMUNITY  
BENEFIT PROGRAMS TARGETING FOOD ACCESS AS A HEALTH NEED, COMBINED MODEL**

PROGRAM TARGETING FOOD ACCESS (n=106)				
HOSPITAL CHARACTERISTIC: INVOLVEMENT OF FOOD ORGANIZATION IN CHNA <sup>§</sup>	n	% <sup>**</sup>	Odds Ratio <sup>†</sup>	95% CI
<b>Organization for emergency food provision (e.g. food pantry, soup kitchen)</b>	165	59	5.5***	2.0 - 15
<b>Program for supplemental meal provision (e.g. school-based, summer meals, Meals on Wheels)</b>	150	59	1.6	0.6 - 4.3
<b>Food system advocacy group (e.g. food policy council, food justice coalition)</b>	66	68	1.9	0.7 - 4.7
<b>Agency that links food insecure people to food resources</b>	115	61	1.1	0.5 - 2.5
<b>Community group promoting healthy food access (e.g. farmers market, healthy corner store)</b>	124	65	3.7***	1.8 - 7.9
<b>College/university program addressing food/nutrition issues</b>	59	56	-2.6**	-1.0 - -6.5

\* P<0.10, \*\* p<0.05, \*\*\* p<0.01; two-tailed

§ Model based on 215 observations; Involvement of food org in community resource inventory, primary data collection, and/or needs prioritization; robust standard error

\*\* Percent of hospitals in category that have at least one reported program

† Odds Ratios should be interpreted as "Hospitals with characteristic [Involvement of food organization in CHNA] are X times more/less likely to have outcome [program targeting food access]." A negative sign indicates less likely.

**Hospitals with involvement of organizations for emergency food provision, supplemental meal provision, and food system advocacy groups on the CHNA steering committee were more likely to have a reported community benefit program targeting food insecurity or healthy food access.<sup>ix</sup>**

The tables above look at the inclusion of food-related organizations in the community resource inventory, primary data collection, or health needs prioritization. Our survey also asked hospitals about the involvement of a subset of these food organizations on the CHNA steering committees – a more robust form of involvement in the CHNA process. The table below shows that participation of organizations for emergency food provision, supplemental meal provision, and food system advocacy groups on the CHNA steering committee was strongly correlated with facilities having a community benefit program addressing food access.

<sup>ix</sup> Once all three organization types were combined into one model, food advocacy remained the strongest predictor with emergency food organizations still second and supplemental food organizations no longer being a significant predictor (results not shown). Because of the strong correlation between all of these organization types and relatively small sample size, the coefficients on food advocacy organizations and emergency food organizations were only significant at the 10 percent level.

### RELATIONSHIP BETWEEN FOOD-RELATED ORGANIZATIONS ON CHNA STEERING COMMITTEE AND COMMUNITY BENEFIT PROGRAMS TARGETING FOOD ACCESS AS A HEALTH NEED, INDIVIDUAL MODELS

HOSPITAL CHARACTERISTIC: FOOD ORGANIZATIONS ON CHNA COMMITTEE <sup>§</sup>	PROGRAM TARGETING FOOD ACCESS (n=100)			
	n	% <sup>¶</sup>	Odds Ratio <sup>†</sup>	95% CI
<b>Organization for emergency food provision (e.g. food pantry, soup kitchen)</b>	74	65	3.1***	1.5 - 6.6
<b>Program for supplemental meal provision (e.g. school-based, summer meals, Meals on Wheels)</b>	58	69	2.7**	1.2 - 5.8
<b>Food system advocacy group (e.g. food policy council, food justice coalition)</b>	32	78	4.6***	1.6 - 13

<sup>†</sup> P<0.10, \*\* p<0.05, \*\*\* p<0.01; two-tailed

<sup>§</sup> Individual models based on 200 observations; robust standard error

<sup>¶</sup> Percent of hospitals in category that have at least one reported program

<sup>†</sup> Odds Ratios should be interpreted as "Hospitals with characteristic [food organization on CHNA steering committee] are X times more/less likely to have outcome [program targeting food access]." A negative sign indicates less likely.

## Landscape assessments and community resource identification

There are numerous benefits to conducting a robust landscape assessment of existing community food organizations and resources and engaging community food system stakeholders in the CHNA process. It can lead to a more detailed understanding of community needs and underlying determinants of health, increase knowledge of existing community food resources, develop more effective and appropriate strategies by consulting experts in the field with years of experience addressing food system issues, and illuminate opportunities to align with existing community efforts or bring groups and organizations together for greater synergy.

Various strategies and techniques exist for conducting a landscape assessment of existing community food resources. Inventorying community resources could be as simple as a group of stakeholders gathering to discuss and list community food assets including programs, services, and resources, as well as identifying gaps or weaknesses.

Seeking out local groups or agencies with expertise such as county extension services, a local food policy council or food coalition, the local public health department, a university partner, city planners and sustainability managers, or others can be valuable to identify if a food system assessment or mapping effort already exists, or to consider partnering to conduct or commission a robust community food assessment.

A medical center in the Midwest worked closely with a regional food bank to identify community food resources, as well as the causes of and possible solutions to food insecurity, obesity, and diet-related disease. The facility's community benefit director highlighted the value of drawing on the food bank's expertise:

*"They're the professionals when it comes to understanding food needs and resources. We know that they're the ones on the front lines, and we're just a hospital. We're trying to come alongside and help them. They've been doing it for years. We're pretty much relying on their information and their data and their research. They're keeping us up to speed on what they're doing."*

[Community food assessments](#) can be scaled up to become valuable as a standalone tool and resource for the community. Assessments may use formal instruments to compile specific food environment and food security-related data to provide a comprehensive view of the food system relative to community health.

The "Delivering community benefit: Healthy food playbook" resource "[Engaging the community to understand food needs](#)" discusses methods, tools, and example assessments, all of which hospitals can draw on to incorporate community food assessment components into a CHNA.

## Mapping the community food environment

Physically putting **community assets** on a map provides a visual aid that can increase insight and identify patterns regarding the availability of resources. This may lead to focusing on a particular neighborhood or tailoring the intervention approach to accommodate specific environments and circumstances.

The **Maryland Food System Mapping Resource** is one example of incorporating data on the food system, public health, and the environment to better understand geographic patterns and community trends to inform planning, interventions, advocacy, funding, policies, and research. This food system data mapping informed an array of valuable **projects, resources, and reports** including a robust **food environment assessment** for Baltimore City. Johns Hopkins Hospital used the **Mapping Baltimore City's Food Environment** report in their **2016 CHNA** and to inform implementation strategies.

Whatever strategy or approach a hospital may take to identify and inventory stakeholder groups, organizations, and existing community food system resources, key questions to consider include:

- Which organizations are working on food access, healthy eating, and food insecurity issues in your community?
- Which groups or neighborhoods experience disproportionate rates of food insecurity or lack access to healthy foods, and which agencies or organizations work closely with these communities?
- Which organizations are involved with local food promotion or community development through food initiatives?

## Community resource identification index

The research team reviewed the community resources to address health needs listed in survey respondents' CHNAs,<sup>\*</sup> focusing particularly on food and diet-related health issues. The analysis assessed the **number** and **diversity** of the following types of community resources listed in each CHNA:

- Food banks and pantries
- Other emergency food organizations
- School-based food programs
- Other supplemental food organizations or programs
- Women, Infants, and Children (WIC) or Supplemental Nutrition Assistance Program (SNAP) affiliated programs
- Health organizations and clinicians
- Grocery stores
- Farmers markets
- Other local agriculture groups
- Food-related policy or advocacy organizations
- Other organizations addressing healthy eating or active living

The two pieces of information were combined into a community resource identification (CRI) index to assess the extensiveness of each CHNA's inventory of food and diet-related disease resources. The index is simply the number of individual organizations listed multiplied by the number of organization types.<sup>xi</sup>

Excluding CHNAs that did not list any resources, the average number of distinct organizations listed averaged around seven per CHNA. The average diversity of groups and organizations listed was about three different types per hospital.



Baltimore Mayor Stephanie Rawlings-Blake speaks at a press conference on the release of Johns Hopkins' Food Environment Report and Map in 2015. (Johns Hopkins University Center for a Livable Future)

<sup>\*</sup> For all survey respondents for whom we could obtain CHNAs (n=206). Of these, 184 listed community resources.

<sup>xi</sup> The index is further explained in Appendix A.



We then created index categories for further analysis:

<b>7.6%</b>	<b>“Highly extensive” CHNAs with CRI index scores of 4.0 or higher</b>
<b>21.7%</b>	<b>“Moderately extensive” CHNAs with CRI index scores from 2.0 to 3.9.</b>
<b>36.9%</b>	<b>“Minimally extensive” CHNAs with CRI index scores from 1.1 to 1.9.</b>
<b>33.7%</b>	<b>CHNAs that listed no resources (considered separately).</b>

We used logistic regression to analyze the relationship between the CRI index categories and having a reported community benefit program that targets food insecurity or healthy food access as a health need. Hospitals categorized as “Moderately extensive” or “Highly extensive” in our index were more likely to have a food access community benefit program than hospitals that did not list any food organizations (Moderate  $P=0.069$ ; High  $P=.100$ ).<sup>xii</sup>

A few insights emerge from this analysis. First, many hospitals could do more to collect information on and list food-related community resources in their CHNAs. For example, while nearly a third of CHNAs that listed community resources included farmers markets, 85 percent of survey hospitals have at least one farmers market registered with the Department of Agriculture in their area.<sup>xiii</sup> Hospitals may not think very broadly about what might constitute a community resource for addressing food and diet-related health needs.

Our finding that hospitals that listed more community resources were more likely to have community benefit programs targeting food access is also interesting. What we observed may be a statistical anomaly due to the small size of the dataset. However, it is logical that hospitals that more thoroughly review food-related community resources also more carefully assess food-related health needs – thus motivating food access interventions. Another possibility is that hospitals with existing food access programs are more aware of food-related community resources. The research interviews suggest that both scenarios occur.

Hospitals can engage community organizations that work on food issues in underserved communities in the CHNA process in several ways. This can include participating in

data collection and review, in health needs prioritization, in a community health coalition, or on the CHNA steering committee. These forms of engagement are not mutually exclusive, and generally, the greater the level of community engagement, the greater the resulting understanding of community health priorities and opportunities.

## Community organizations and data collection

Including community organizations and stakeholders that work on food issues in data collection can help ensure the right questions are being asked to capture what is happening in the community, and help ensure the data collection strategies will elicit robust participation from populations of interest. Well-established community-based agencies with strong client networks can be valuable partners for implementing a range of data collection activities.

At the same time, it is important to ensure a respectful and ethical approach to data extraction. Some communities may be studied frequently by universities, government agencies, hospitals, and other institutions. It is critical to utilize existing analyses in order to avoid duplication of efforts and over-burdening community members, particularly if there is little or no compensation for their vital contribution to data collection. Community members also should have access to and an active role in stewardship over this data.

Common ways to engage community stakeholders in CHNA data collection activities include:

- Seek input from food organizations regarding indicators commonly used in their field, as well as recommendations regarding reputable data sources, to include in the CHNA.
- Ask community members to review community surveys and focus group or interview guides to provide feedback on questions as well as appropriateness of language.
- Partner with community stakeholders to host focus groups at familiar community locations; draw on the network and reputation of community organizations to recruit participants.
- Partner with community organizations to disseminate surveys; leverage organizations' networks to increase participation and representation of low-income, minority, and historically underserved populations.
- Conduct key informant interviews with community stakeholders with expertise on food access issues.

A community benefit director in the southern United States explained how her facility counted on community-based food organizations to guide them on secondary data collection on food access issues:

<sup>xii</sup> In the model excluding hospitals that did not provide a list, hospitals categorized as “Moderately extensive” or “Highly extensive” trended more likely than hospitals that scored “Minimally extensive” to report a program targeting food access; however, these results failed to make the 10 percent significance threshold ( $P=.144$  and  $P=.121$ , respectively).

<sup>xiii</sup> From data collected on farmers markets located within 10 miles of survey hospitals' zip code. Department of Agriculture, [Local Food Directories: National Farmers Market Directory](#), data retrieved in December of 2016.

*“We really do look to the lead partners for each of our issue areas to be the data expert and to make sure that we, at the hospital, are looking at the most relevant and most accurate data sources. We let the Hunger Relief Alliance tell us what they see and what they are using, and also how data is guiding the broader conversation around food security in our state.”*

Several hospitals described how they worked with food-related community organizations to better understand food access needs and other obstacles to healthy eating for low-income and underserved community groups.

community survey, assisting with survey administration, and providing input on the community health improvement plan.

*“Community organizations helped select the survey questions that would be asked. Following 2013, when food, hunger was identified as a priority, there was a food-specific survey administered in between the CHNAs. That was a CHIP activity, hugely driven by the state university extension service, and the food partners were pulled in a more deliberate way. [The food assessment] data fed into the next iteration of the CHNA... Now we are about to formalize a coalition to address access to healthy food, with thirty different stakeholders.”*



Our Lady of the Lake Regional Medical Center chef gives a cooking demonstration for community members shopping at the Red Stick Farmer's Market in Louisiana (Our Lady of the Lake Regional Medical Center)

Mercy Medical Center (Mason City, Iowa) used focus groups, interviews, and questionnaires to solicit input from individuals and community agencies serving low-income and underserved residents. The hospital partnered with Community Kitchen of North Iowa to distribute questionnaires and to conduct interviews with their clients. “Healthy food not available” was one of four health needs identified in all of the focus groups and interviews. Obesity and diabetes were two of the top five issues identified in questionnaires.

Another hospital worked with a state university to survey food bank clients' food access issues. The facility also drew on the far-reaching experience of local *promotoras de salud* – trusted community health workers – for information on diabetes and barriers to diabetes management for the county's Latino population. Finally, the facility worked with a community health coalition, utilizing its existing network and survey distribution efforts to gather nutrition and food security data, thereby improving their understanding of the nutrition needs of vulnerable families.

A rural facility described how food organizations played a critical role in their region's collaborative community health assessment, including developing survey questions for the



Dr. Chris Funes, an Our Lady of the Lake Medical Center pediatrician, cooking at the Red Stick Farmer's Market with host Chef Celeste Gill in Louisiana (BREADA)

## Community organizations, data review, and needs prioritization

Community-based organizations have a valuable role to play in reviewing the health data that has been collected and prioritizing the health needs that will be addressed in the community health improvement implementation strategy. Including community stakeholders in the process of identifying and prioritizing health needs can help ensure an accurate understanding of needs and priorities for different groups and neighborhoods in the assessment area. In addition, ensuring community stakeholders





Adrienne harvesting sage as a part of the Healthy Roots Collaborative programming in rural Vermont (Northwestern Medical Center).

participate in needs identification and prioritization will help build community trust and buy-in, while establishing or strengthening relationships that could be fruitful for implementation strategies.

Hospitals can partner with food-related community organizations to convene community members to review the data collected, discuss how well the data matches community perceptions, and participate in a prioritization process.

St. Vincent Indianapolis Hospital convened more than thirty community stakeholders for data review, discussion and prioritization of health needs. This group process included representatives from Gleaners Food Bank of Indiana and Crooked Creek Community Development Corporation, which runs a community farmers market with a SNAP incentive program and a community garden. Community input was integral to identifying obesity and malnutrition, access to healthy food, and awareness about healthy eating habits as top community concerns. These topics did not initially emerge as priorities through analysis of secondary data. Input provided by community leaders with expertise in food access during the needs prioritization convening was critical for identifying nutrition and healthy weight as a top priority.

[Northwestern Medical Center](#) (St. Albans, Vt.) assembled a group of 20 community-based organizations representing a variety of issue areas for its CHNA. Each participating organization carefully reviewed the collected health data to determine priorities. Many of the organizations developed their own action plans to address priority issues based on insights gleaned from the review process. Two local healthy food advocacy groups, Rise VT and the Healthy Roots Collaborative, prioritized key food challenges facing the community.

When engaging the community in understanding and prioritizing health needs, it is valuable to not only include community leaders, but also the voices of residents in underserved neighborhoods. A public health interviewee lauded how a hospital she had worked with in a collaborative assessment had actively involved affected community members in the needs prioritization process:

*“Involving the actual community members is important. It’s easy to say, ‘Oh well we’ve got the Urban League or other leadership groups.’ But what can be missing from the process is actual families in poverty being at the table. That’s the piece that I’m seeing broadly brought in by Children’s hospital. Having family members at the table and putting them through leadership training and really helping them find a role in their community. It can go to this deeper level.”*



In 2016, the Healthy Roots Collaborative in Vermont worked with ten farms and gleaned over 10,600 pounds of produce, which was distributed to 18 area food pantries and meal programs (Northwestern Medical Center).

## Needs prioritization criteria

Communities face many significant health needs, and hospitals are likely to be able to address only a subset. Federal [regulations](#) allow hospital facilities flexibility in choosing how best to prioritize the significant health needs of their particular communities, however, to ensure transparency, hospitals' CHNA report must describe the process and criteria used in prioritizing the significant health needs identified. In addition, facilities are required to take into account community input not only in identifying significant health needs but also in prioritizing them.

*A hospital facility may determine whether a health need is significant based on all of the facts and circumstances presented in the community it serves. A hospital facility may use any criteria to prioritize the significant health needs it identifies, including, but not limited to:*

- The burden, scope, severity, or urgency of the health need;
- The estimated feasibility and effectiveness of possible interventions;
- The health disparities associated with the need; or
- The importance the community places on addressing the need.<sup>xiv</sup>

Our research team reviewed the needs prioritization methods described in the CHNA reports for survey respondent facilities. The dominant method for prioritization was some form of ranking or scoring. Direct voting and consensus-making were also fairly common. In a few cases, the results of prioritization questions asked in a community survey were the sole determinant of priorities.

We identified the following needs prioritization value categories, in order from most-commonly to least-commonly described in the reviewed CHNAs. Hospitals often described using more than one prioritization criterion.

## CHNA NEEDS PRIORITIZATION CRITERIA

PRIORITIZATION VALUE	DESCRIPTION
<b>Community</b>	Either community interests as a criteria or community significantly involved in prioritization process.
<b>Feasibility</b>	Feasibility, capacity, ability, cost, resources
<b>Prevalence</b>	Prevalence, magnitude, difference. How common the issue is in the community as well as the difference between local and state or national rates.
<b>Severity</b>	Seriousness. Criteria often tied to morbidity and mortality rates.
<b>Potential for impact</b>	"Can we make a difference?"
<b>Pre-existing resources</b>	Pre-existing organizations or projects in the community already working on the issue.
<b>Disparity</b>	Criteria considering inequality, disparate impact across income level or in minority communities.
<b>Alignment with mission</b>	Mission, alignment, vision, strategic plan. Alignment of priorities with institutional values or objectives.
<b>Trend</b>	Trends in the issue over time.
<b>No method or criteria described</b>	Prioritization method or criteria not listed.

Several organizations provide useful guidance to hospitals regarding the health needs prioritization process. See the Association for Community Health Improvement's "Community Health Assessment Toolkit," which provides recommendations for [prioritizing community health issues](#). See also the Healthy Community Alliance's guidance and resources for [establishing criteria to determine a priority health need](#) and implementing a process to systematically apply those criteria. Whatever criteria and methods are utilized, it is important that CHNA reports are explicit and transparent about the approach taken.

<sup>xiv</sup> Final [regulations](#) under section 501(r) of the Code providing guidance regarding the requirements for charitable hospital organizations added by the Patient Protection and Affordable Care Act of 2010.



## Community organizations on CHNA advisory committees and community health coalitions

At the most robust level of community engagement in the CHNA process, hospitals frequently appoint food-related community organization members to the CHNA advisory committee or steering committee charged with overseeing the CHNA as a whole. Food advocacy organizations' expertise can be indispensable in informing the entire assessment process to enhance understanding of food and diet-related needs, challenges, priorities, and opportunities in the community.

As noted above, survey responses indicated that 45 percent of hospitals included at least one food-related organization on their CHNA advisory or steering committee. Having a food-related organization on the CHNA committee was strongly correlated with having a community benefit program targeting healthy food access or food insecurity a health need.

A hospital in California explained that it included a number of community-based organization leaders on its community benefit advisory council. Members of the council, including local food pantry representatives, were carefully selected for their expertise on major challenges facing the community. Council members participated in and supported community involvement in data collection and needs prioritization. Local food organizations emphasized the concerns of food-insecure residents and ensured that their voices were reflected in the CHNA.

*"When I picked members of our advisory council, I was very strategic in making sure that we had individuals that represented the needs of the vulnerable, which included food insecurity. They serve a two-year term, and then in addition to that, they had the opportunity to be interviewed and they provided us with linkages to other people in the community that would also be able to address [food access issues]. They are active partners and provide a voice to those issues in the community. They also provide expertise on doing culturally relevant partnerships."*

In some service areas, hospitals participate in larger community health improvement collaboratives that actively inform the CHNA process. These regional alliances enable hospitals to draw on the expertise of organizations that may have years of experience addressing important community health issues, including healthy, sustainable, and equitable food systems. Importantly, community health collaboratives allow the participating organizations to coordinate their intervention activities. Coordination reduces duplication of efforts in developing programs to address health needs, and it encourages partnering organizations to view the effects

of their interventions on a community-wide scale, with each partner playing a role in moving health improvement forward. Hospital roles in community health alliances vary; in some cases, hospitals serve as "backbone" or anchor organizations while in others they play a supporting role.



Fifteen out of 16 schools in Logan County, Ill. participate in the Coordinate Approach to Child Health (CATCH) program, which teaches children healthy eating and promotes physical activity. (Abraham Lincoln Memorial Hospital)

UMass Memorial Medical Center (Worcester, Mass.) participated in a collaborative community health assessment that included representatives from food organizations such as the Community Harvest Project. The Worcester Food and Active Living Policy Council served on the health assessment advisory committee.

Having community members with food system expertise on the committee helped ensure food-related issues and stakeholders were included in each step of the health needs assessment process. Data collection included local farmers market surveys, a review of community gardens and farmers markets with food assistance programs, and measures of food access and produce consumption. Community food system organizations fielded the health assessment survey and participated in focus groups and interviews.

All these forms of community input identified obesity as a priority health issue and highlighted nutrition, access to healthy food, and the cost of healthy food as significant factors needing more attention. UMass Memorial's [strategies](#) to promote healthy weight focus on "addressing food insecurity and increasing the availability of and access to affordable fresh and local fruits and vegetables for low-income residents" through promoting and supporting a variety of community-based programs and city-wide policy efforts.

[Abraham Lincoln Memorial Hospital](#) (Lincoln, Ill.) participates in a 20-year-old community health coalition, the Healthy Communities Partnership. This community coalition includes 33 member organizations, such as the local WIC program and the Community Action Food Pantry.

The coalition was central to the CHNA process. Coalition members comprised the majority of the CHNA advisory committee, and primary data was gathered from local community organizations that participate in the coalition. The expertise on food access and healthy eating brought by coalition members informed the hospital's understanding of community health priorities as well as provided partnerships integral to implementing collaborative community health improvement strategies.

[Genesys Regional Health System](#) (Grand Blanc, Mich.) collaborated with the Greater Flint Area Health Coalition (GFHC) to conduct a collaborative CHNA. The CHNA used the coalition's existing collaborative data collection project and strong network of workgroups and community organizations to collect input from community partners as well as engage community stakeholders in data review, needs prioritization and implementation strategy development.

Community food organizations such as Edible Flint, Flint Farmers Market, Food Bank of Eastern Michigan, and North End Soup Kitchen participated in GFHC committees or as members of the GFHC Community Network and became engaged in the CHNA process.

Chronic disease, including diabetes and heart disease, was selected as a priority health need. Increasing vegetable consumption among students was identified as a community health improvement objective. Healthy food access and food insecurity emerged as factors underlying a number of the top community health needs identified (overweight and obesity, diabetes). Implementation strategies include collaborative initiatives focused on improving access to and consumption of healthy foods.

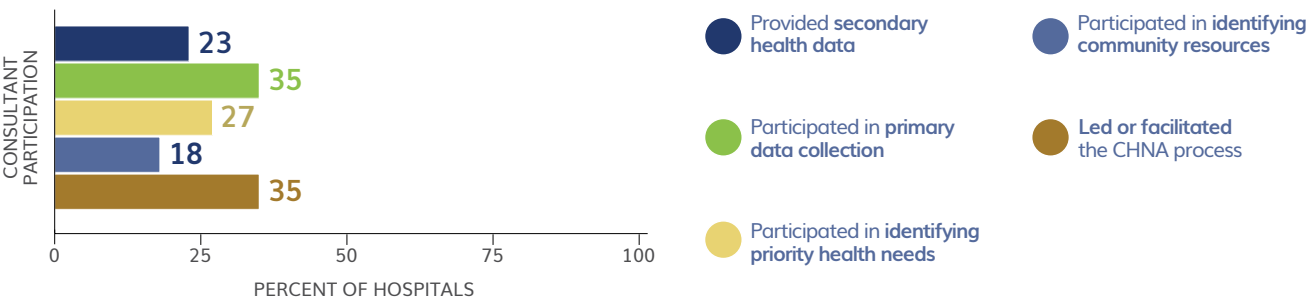
## Engaging food organizations in the CHNA: Orlando Health

[Orlando Health Arnold Palmer Hospital for Children](#) conducted its community health needs assessment as part of the Central Florida Community Benefit Collaboration. The collaboration's participants identified organizations to take part in the CHNA process, looking for both a diverse set of perspectives and for far-reaching presence and impact in the region. Second Harvest Food Bank of Central Florida was among the food-related organizations selected for active participation. Second Harvest works with more than 500 organizations to distribute food across Central Florida. It also runs a culinary job training program, SNAP and WIC benefit enrollment services, and disaster relief programs. With its first-hand knowledge of community food needs and resources, Second Harvest made valuable contributions to the assessment process. The collaboration's assessment identified poverty among its key "areas of concern." Within their discussions on poverty, collaboration members named healthy food access and affordability as significant issues. In the Orange County assessment, obesity, heart disease, diabetes, and food insecurity rose up as key health themes. Throughout the process, children and youth were a shared focal point, as participants deemed them at high risk for unhealthy eating and as having the greatest potential for change.

## CHNA consultants

Our national survey found that 52 percent of hospitals utilized a consultant for one or more CHNA activities. Consultants were most heavily relied upon for primary data collection and facilitating the CHNA process.

CONSULTANT PARTICIPATION IN CHNAs



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

Interviews also revealed valued contributions from consultants in serving as a convener, selecting secondary data, engaging the community and collecting primary data, analyzing data, and developing methods to facilitate health needs prioritization.

Several community benefit professionals emphasized the valuable role of CHNA consultants as facilitators of collaborative health assessments.

*“I think a consultant is needed to facilitate collaborative assessments. More and more nonprofit hospitals are being encouraged to work with public health departments and public health departments are encouraged through their accreditation process to do things in partnership with the community. It’s hard to do that work. I feel like you do need a skilled facilitator to lead meetings to be able to create an environment where that collaboration can happen. Simple things like how people use terms. Because we’re all coming from different backgrounds, a term can mean one thing to one person and something different to another person. I think the consultant helped the CHNA process and also the community collaboration work.”*

Consultants also may bring specialized knowledge of food issues. One community benefit lead said that given the high prevalence of obesity in her metropolitan area, food issues were already a high priority for her hospital. The community benefit team chose to focus on food access and healthy eating data and hired a consultant that had food expertise to facilitate a CHNA that would focus on these issues:

*“The high prevalence of obesity is why we specifically chose the consultant that we chose based on some of their work with healthy eating and physical fitness. We wanted to know the social determinants of health, and we wanted to address food insecurity, access to healthy foods, and healthy living. That was just a high priority.”*



Flint Fresh Mobile Market, a project initiated through the RFSN program, aggregates produce from local farmers and brings fresh produce to neighborhoods lacking fresh food access each week. (Community Foundation of Greater Flint)

## Conclusion

Engaging local public health and community organizations in the CHNA process is important for meeting federal requirements and completing high-quality assessments.

This chapter has discussed numerous benefits, as well as some challenges, for hospitals in collaborating with public health in community health assessments. Public health departments can bring valuable resources to collaborative health assessments, including a population health orientation, a focus on social and environmental determinants of health and health equity, relationships with community stakeholders, and expertise in collecting and analyzing data.

To establish effective collaboration, hospitals and public health departments need to ensure that the target populations and areas served are aligned. They also will need to coordinate on data collection and reporting requirements and timelines, which can be challenging due to differing requirements and standards for tax-exempt hospitals and public health departments (IRS regulations and PHAB standards, respectively).

Collaborative health assessments may identify a variety of important health needs, and different partner organizations may select a different subset of health needs to prioritize in their community health improvement plans. However, when it is possible to align on some health priorities and implementation strategies, greater reach and impact can be achieved. Such alignment can reduce duplication of services, more effectively share and utilize limited resources, develop synergies, and expand or strengthen existing successful efforts.

Community-based organizations and stakeholders that work on healthy food access, food insecurity, or other food system related initiatives are also invaluable resources to help develop relevant, appropriate, and effective data collection strategies. Well-established community-based agencies with strong client networks can be important partners for implementing a range of data collection activities. Including community stakeholders in the process of identifying and prioritizing health needs can help ensure accurate understanding of needs and priorities for different groups and neighborhoods in the assessment area. In addition, ensuring community stakeholders participate in needs identification and prioritization will help build community trust and buy-in, while establishing new connections and cultivating relationships that could be fruitful for implementation strategies. Deeper and ongoing engagement of the community in the CHNA process is becoming more common as hospitals increasingly realize the value in cultivating robust community relationships to improve community health as well as to advance hospital mission and goals.

# Chapter 4. Implementation strategies to address food access and diet-related health needs

## Introduction

### Federal and state requirements and guidelines for community benefit implementation strategies

Federal [requirements](#) for tax-exempt hospitals state that facilities must develop a community benefit implementation strategy that describes how the hospital plans to address the significant health needs identified in the community health needs assessment (CHNA) or explains why the hospital does not intend to address the health need.<sup>xv</sup> Other implementation strategy requirements or guidelines include:

- Comments received on the previously adopted implementation strategy should be considered.
- Significant health needs can include “social, behavioral, and environmental factors that influence health in the community.”
- Collaboration in CHNAs and implementation strategies, including developing joint implementation strategies among multiple hospitals, is allowed and encouraged but not required.
- Implementation strategies must be developed and adopted triennially following each associated CHNA.



Fresh vegetables sold at the Community Farmers Market in New York City (Montefiore Medical Center)

In addition to the federal community benefit requirements, nonprofit hospitals must also comply with the community benefit standards of the state in which they are located. State community benefit requirements may or may not be more specific or more stringent than their federal counterparts. Examples of state requirements regarding implementation strategies include:<sup>xvi</sup>

- Develop community benefit implementation strategies annually rather than every three years (California, New Hampshire).
- Include cost estimates or a budget for planned initiatives<sup>xvii</sup> (New Hampshire, California, Texas).
- Solicit and utilize community input (New Hampshire, Rhode Island).
- Specify communities that are the focus of the plan, particularly racial or ethnic minority populations (Rhode Island).
- Include concrete activities or objectives within specific time frames (California, Rhode Island, Texas).
- Select interventions that are evidence-based (Washington).
- Contain an evaluation plan or list evaluation mechanisms (Texas, California, Washington).
- Include state public health priorities and strategies (New York).

Several states provide recommendations for best practices that are not mandatory. For example, Massachusetts' [Guidance on community benefit](#) from the attorney general's office recommends “making community engagement a regular part of each stage of Community Benefits planning, implementation, and evaluation, with particular attention to engaging diverse perspectives.”

<sup>xv</sup> The Final Rule also states that the “regulations do not prohibit implementation strategies from discussing health needs identified through means other than a CHNA, provided that all of the significant health needs identified in the CHNA are also discussed.”

<sup>xvi</sup> See the Hilltop Institute's [Community Benefit State Law Profiles](#) for more information.

<sup>xvii</sup> Federal law does not specify the amount of community benefit that nonprofit hospitals must provide, however a few states (Illinois, Nevada, Pennsylvania, Texas, and Utah) require tax-exempt hospitals to contribute a specified minimum. For example, Illinois requires that nonprofit hospitals provide charity care or other community benefits in amounts at least equivalent to the value of their property tax exemption.



## Goals of this chapter

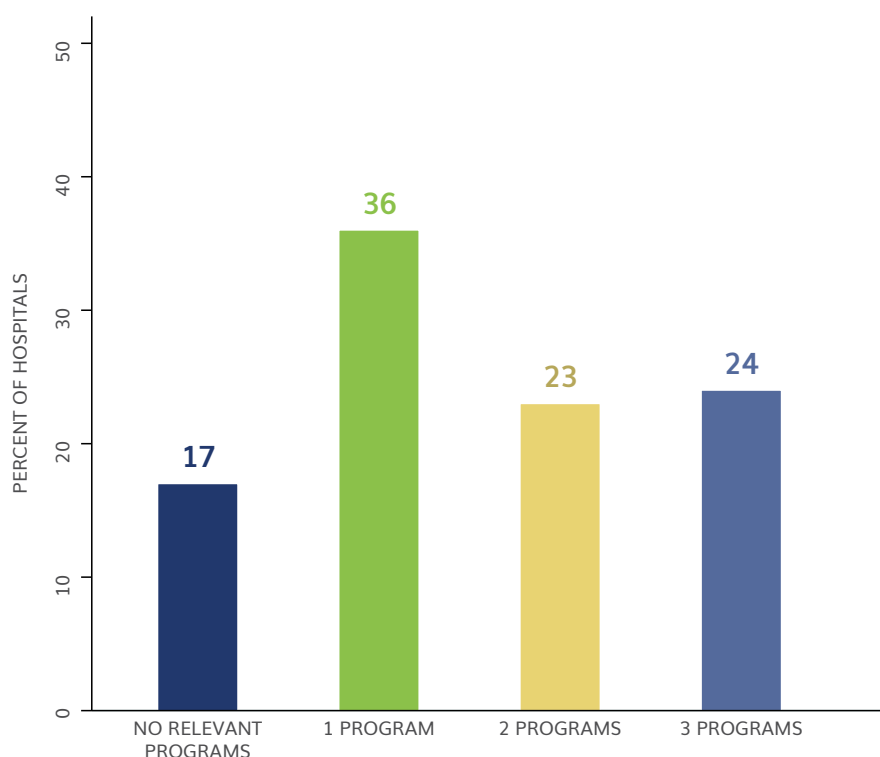
In this chapter, we review the kinds of community benefit programs that hospitals across the country are engaging in to address obesity, healthy food access and healthy eating, and diet-related health conditions. We also review the kinds of support that hospitals are providing these programs and the kinds of community partnerships involved in implementing the programs. Finally, we discuss the factors that shape hospitals' selection of community benefit programs and activities to address food and diet-related health needs identified in their CHNAs.

## Landscape of community benefit programming to address obesity, food access, and diet-related health conditions

Our national, random-sample survey asked community benefit directors to provide information on up to three community benefit activities that address obesity, diet-related health conditions, or healthy food access.

Multiple initiatives were common, with nearly half of surveyed hospitals reporting two or more such community benefit programs. About a third of programs addressing obesity, diet-related disease, or food access have received community benefit support for more than three years.

**HOSPITALS REPORTING 0, 1, 2, OR 3 COMMUNITY BENEFIT INITIATIVES TO ADDRESS OBESITY, DIET-RELATED DISEASE, OR FOOD ACCESS**



**DURATION OF SUPPORT FOR INITIATIVES**

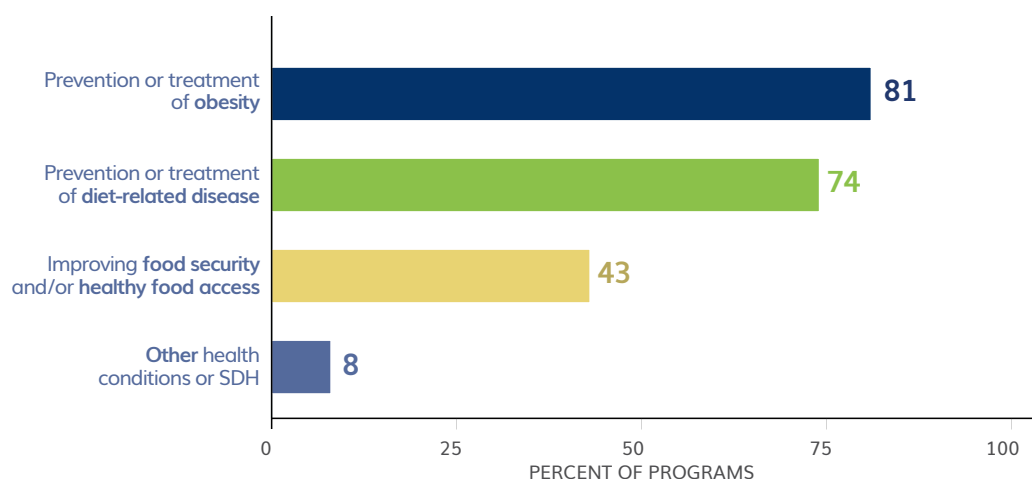


## Health needs targeted and intervention activity types: Survey facilities

Survey respondents identified the health needs targeted by reported programs; programs could address more than one health need. Fewer than half of community benefit programs were aimed at addressing food insecurity or healthy food access, while 81 percent targeted prevention or treatment of obesity.

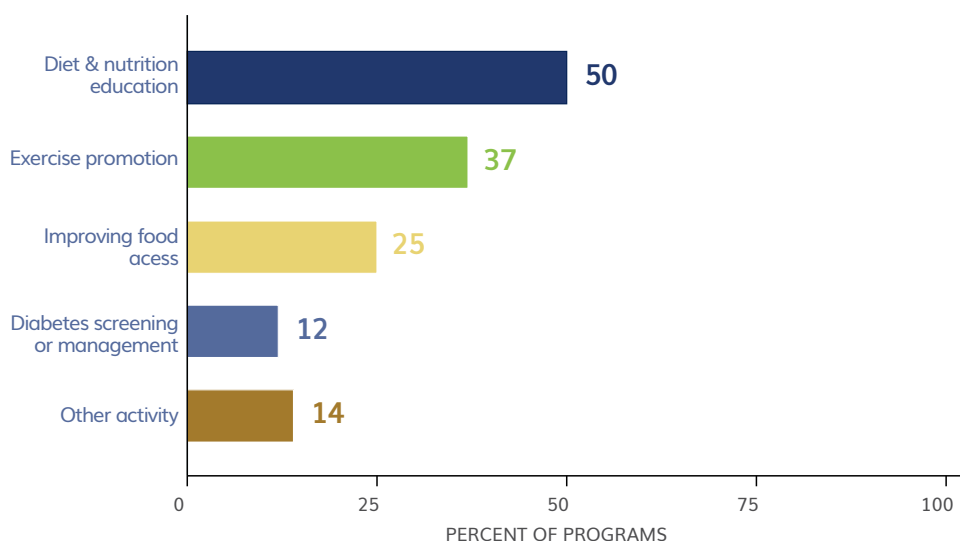
In our analysis of survey respondent facilities' CHNAs and implementation strategies, the research team also reviewed and categorized community benefit programs' intervention activity types,<sup>xviii</sup> for example, diet and nutrition education or improving food access. Diet and nutrition education and exercise promotion were the most common intervention types.

**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

**COMMUNITY BENEFIT INTERVENTION ACTIVITIES**



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

<sup>xviii</sup> More information about this analysis is provided in Appendix A.

The following table looks at community benefit programs' targeted health needs and intervention activity types together. For programs targeting obesity as a health need, 56 percent intervened through diet and nutrition education, while only 20 percent focused on improving food access.

**PERCENT OF PROGRAMS TARGETING DIFFERENT HEALTH NEEDS VIA DIFFERENT INTERVENTION ACTIVITIES**

	INTERVENTION ACTIVITY TYPE				
	DIET & NUTRITION EDUCATION	EXERCISE PROMOTION	IMPROVING FOOD ACCESS	DIABETES SCREENING OR MANAGEMENT	OTHER
<b>Prevention or treatment of obesity</b>	<b>56%</b>	<b>44%</b>	<b>20%</b>	<b>8%</b>	<b>13%</b>
<b>Prevention or treatment of diet-related disease</b>	<b>55%</b>	<b>39%</b>	<b>16%</b>	<b>15%</b>	<b>14%</b>
<b>Improving food security and/or healthy food access</b>	<b>44%</b>	<b>23%</b>	<b>56%</b>	<b>4%</b>	<b>8%</b>
<b>Other health conditions or SDH</b>	<b>63%</b>	<b>41%</b>	<b>15%</b>	<b>7%</b>	<b>33%</b>

From 331 community benefit programs reported by 215 respondents

Each program can have up to two intervention activity types and one to all of the targeted health needs

A key finding from the national survey was that the majority of community benefit interventions to prevent or treat obesity and diet-related health conditions centered around nutrition education and exercise promotion – and that fewer interventions focused on increasing access to healthy foods.



Children receive healthy eating and cooking education from Orlando Health staff at the Orange Center Elementary School in Florida . (Orlando Health)

## Health impacts of increased fruit and vegetable consumption

Obesity is a growing public health problem across the United States and worldwide and is associated with increased risk for diet-sensitive chronic diseases such as type II diabetes and cardiovascular disease. In the United States, 37 percent of U.S. adults and 17 percent of children have obesity, while 9 percent of adults have diabetes and 11 percent have heart disease.

Eating more fruits and vegetables adds nutrients to diets and helps manage body weight. Epidemiological evidence of a protective role for fruits and vegetables in prevention and management of health conditions is substantial. Increased consumption of fruits and vegetables is associated with:

- Healthier body weight<sup>26, 27, 28</sup>
- Reduced risk of high blood glucose and diabetes<sup>29, 30, 31, 32</sup>
- Decreased blood pressure or LDL-cholesterol<sup>33, 34, 35, 36, 37</sup>
- Reduced risk for heart disease<sup>38, 39, 40</sup>

- Reduced risk for dementia<sup>41</sup>
- Overall health benefits or reduced health care costs<sup>42, 43, 44, 45, 46, 47, 48, 49, 50</sup>

This research report and the associated “Delivering community benefit: Healthy food playbook” recommend health promotion programs that increase access to and encourage consumption of a wide variety of fresh fruits and vegetables. These types of initiatives are included among the evidence-supported community health improvement strategies identified by:

- County Health Rankings and Roadmaps, What Works for Health, Approach: Increase Access to Healthy Food Options
- Centers for Disease Control, Prevention Strategies & Guidelines, Guide to Strategies to Increase the Consumption of Fruits and Vegetables
- New York State Department of Health, Prevention Agenda, Focus Area: Reduce Obesity in Children and Adults



Arnold Palmer Hospital for Children created the Healthy Living Garden as a novel way to engage a neighborhood school in obesity prevention efforts. (Orlando Health)

## Healthy food access and healthy eating programs: Interview facilities

Above we provided information on community benefit activities addressing obesity, diet-related health conditions, or healthy food access reported by hospitals in our national survey. In this section, we review the kinds of community benefit programs that promote healthy food access and healthy eating that were supported by research interview facilities.

While the survey was conducted using a national random sample of hospitals to obtain a representative assessment of U.S. community benefit programming, key informants for our interviews were selected purposively. The research team sought out community benefit directors from facilities in all U.S. census regions with promising initiatives that address healthy food access, healthy eating, or community food environments. This group of interviewees, as a result, represents hospitals that are likely to be more engaged or innovative with healthy food access initiatives than is the norm.



In the interviews, community benefit directors provided information about what they perceived to be their most important community benefit programs addressing healthy food access or healthy eating. The research team categorized each discussed program as one of the following types.

Many of the interview facilities participated in healthy eating/active living education and promotion programs, which was also common among the survey facilities. However, the interview facilities also participated in a wide range of initiatives to increase affordable and convenient access to healthy food and improve community food environments. Community gardens, food pantries, and fruit and vegetable incentive programs were the most common types of healthy food access programs supported by interview hospitals. The “Delivering community benefit: Healthy food playbook” includes [guidance briefs](#) on most of the program types identified above, featuring examples and links to learn more.



Orange Center Elementary School's Healthy Living Garden creates an interactive venue for teaching students about good food choices and for promoting overall health and wellness (Orlando Health)

## “Triple-win” strategies

While this project takes a broad look at how hospitals are addressing healthy food access, obesity, and diet-related health needs in their community benefit implementation strategies, we particularly highlight certain kinds of “win-win-win” opportunities. In this report and in the associated playbook, we call special attention to innovative examples where hospitals employ their community benefit resources to improve access to healthy, affordable food, and at the same time support economic and workforce development in low-income communities and strengthen local and sustainable food systems. We highlight as “promising practices” initiatives that include local food producers and businesses as part of a multi-pronged effort to increase access to fresh, affordable, and sustainably produced food; promote health equity; and stimulate the local economy – particularly through creating well-paid jobs in low-income communities. Win-win-win initiatives support the local food system while working to eliminate health disparities and empower and improve the lives of community residents.

### INTERVIEW FACILITIES' HEALTHY FOOD PROGRAMS

Program / intervention type*	Percent of programs <sup>†</sup>
Healthy food access or healthier food systems initiatives.....	67.6%
Healthy eating/active living education & promotion <sup>‡</sup> (not part of other program types listed here).....	26.5%
Food insecurity screening, may include connecting people to food resources .....	5.3%
Other.....	0.7%

### Healthy food access/healthier food systems initiatives, disaggregated

Community garden or farm.....	9.3%
Food bank or pantry .....	8.6%
Fruit and vegetable incentives .....	8.6%
Farmers market .....	8.0%
Food system coalition and/or food policy advocacy.....	6.6%
Delivered meals.....	5.3%
Summer, weekend, afterschool meals/backpack programs .....	4.6%
Other support for local farmers <sup>Ω</sup> .....	4.0%
Mobile farmers market .....	3.3%
Healthier corner store/food retail.....	3.3%
Farm to school.....	2.7%
Community supported agriculture .....	2.0%
Healthier school meals .....	1.3%

\* Some programs could have been assigned to more than one category; in these cases, the best fit was selected

<sup>†</sup> Of 151 programs discussed in CB facility-level interviews

<sup>‡</sup> Includes National Diabetes Prevention Programs

<sup>Ω</sup> Distinct from the other program types listed here. Includes support for food hubs, new farmer training, technical assistance & infrastructure

## The community benefit “triple win” at Genesys Regional Medical Center

**Genesys Regional Medical Center** serves the residents of Genesee County, Michigan, and its urban core, the city of Flint. Flint has faced significant economic, social, environmental, and health challenges, including deindustrialization and high unemployment and the recent lead contamination [water crisis](#). Genesys’ community benefit implementation strategy includes several food-related initiatives that increase access to healthy, affordable food while promoting economic development, employment opportunities, and a more resilient regional food system.

- **Women in Agriculture Farm Development Center.** Provides education and support for beginning women farmers to achieve viable farming careers and promotes increased access to healthy food in the community
- **Regional Food System Navigation** advocacy coalition. Works toward an equitable, sustainable regional food system in Genesee County. Projects include the Flint Fresh Mobile Market, Flint Fresh Veggie Box Program, Genesee County Food Rescue Program, Flint Family Summer Nutrition Program, and the Nutrition in Community program

“The Women in Agriculture farm is one piece of a much larger campus and economic development vision that’s been identified in our 25-year strategic operating plan. We have acreage on our campus, and that land was one thing that we could contribute and leverage to support job creation and help move Flint and the Genesee County region toward a different type of economic development. The Women in Agriculture farm is a manifestation of that vision, where we can encourage education and the development of new skills. It represents the kind of shift that needs to take place to be able to provide other opportunities for employment and careers in our community.”

– SUSAN TIPPETT, GENESYS HEALTH FOUNDATION DIRECTOR OF GRANT PROCUREMENT

## Support for local farmers

Some community benefit directors described the importance of including support for local farmers in the design of their healthy food access initiatives. “We decided as a health care system that we wanted to support our local farmers” was a theme in several interviews.

Other community benefit leads saw the value of connecting local farmers to community health improvement strategies and were beginning to think about how to approach this.

*“We know that nutrition is a key component to wellness. We want to help people eat non-processed, healthy, fresh foods. We live in a farming community, so we have farmers in our community that are growing food and shipping it elsewhere. We have people here in our community that are eating food that’s being shipped in. It seems logical to try to connect the dots and keep food local.”*

*“Where’s our food coming from? How can we get local food in the schools and make sure we’re eating the good stuff – and supporting the local farmers? There’s so much opportunity there. We haven’t even scratched the surface yet.”*

A university hospital that currently purchases some of its hospital cafeteria food regionally to support local producers described how they were planning to expand community benefit programming to promote local and sustainable food producers as part of broader community development goals:

*“We are looking for more ways to support local producers and tie that to community benefit activities. We are involved in a food hub<sup>xix</sup> that is part of a community development program. It’s not just local vendors and suppliers, but also training folks from the community in food preparation and understanding the importance of sustainability, especially in the food industry.”*

A community benefit director in the Southwest described her facility’s partnership with a farmers’ cooperative. In this community – as in many across the country – farming households are among the most vulnerable. The hospital supports a subsidized CSA program that provides local and sustainably produced food to low-income households while helping to stabilize the livelihoods of local farmers.

<sup>xix</sup> [Food hubs](#) connect producers (farmers and ranchers) with institutional buyers (restaurants, hospitals, schools, etc.) and consumers.

*“The area where the farmers are is traditionally agricultural, and there’s a movement to do more with that as part of an economic development strategy that connects to the cultural heritage of the area. We’re looking at the economics of the farmers and having good jobs because we know that really impacts health. These communities and this farm cooperative in particular care about supporting their farmers and farm workers to be paid well, and also to make sure the food is affordable for families in their community to eat.”*

Similarly, a community benefit director in the Midwest described her hospital’s participation in a CSA program in which seven farms provide the produce, increasing access to fresh, healthy food for the community while also providing vital economic support for local farmers:

*“There has been a big economic impact for several of the producers that supply the food. One of the farmers has about doubled their take-home pay because of participation in the CSA.”*

[Spectrum Health Butterworth Hospital](#) (Grand Rapids, Mich.) described their comprehensive produce prescription and healthy lifestyle program (Nutritional Options for Wellness, or NOW), which includes partnering with local farms to provide program participants with fresh, local produce. The program is now administered by Access of West Michigan. Spectrum and Access are both committed to including support for local producers in the program. Emma Garcia, Access co-executive director, explained,

*“That’s a weekly supply of farm fresh food, mostly organic, and those healthy vegetables go directly to the participants while payment to our farm partners invests in creating a more resilient and robust local food economy, creating jobs and thereby preventing poverty.”*

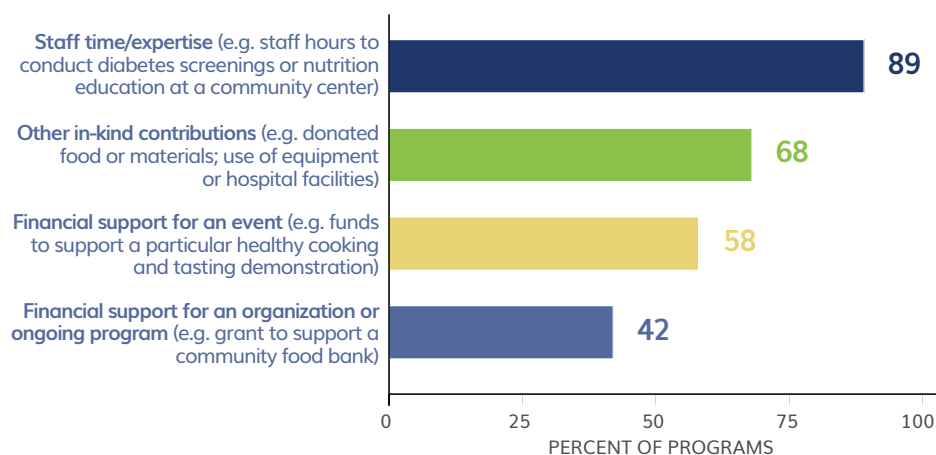


Participants of the Nutritional Options for Wellness (NOW) program get to know their neighbors while selecting fresh produce. (Access of West Michigan)

## Forms of community benefit support

Hospitals support community benefit programs promoting healthy food access and healthy eating in numerous ways, including providing staff time to contribute to or manage a program, contributing other in-kind resources such as hospital land or equipment, and providing financial support. Our national survey found that most community benefit support was provided through staff time or other in-kind contributions.

### TYPES OF COMMUNITY BENEFIT SUPPORT PROVIDED TO 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

Another survey question asked hospitals about the forms of support they provide to, and the kinds of partnerships they have with, community organizations addressing food access issues. Emergency food providers were the most commonly supported organizations, followed by supplemental meal programs.

#### 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
<b>Organization for emergency food provision</b> (e.g. food bank, food pantry, soup kitchen)	44%	33%	5%	36%
<b>Program for supplemental meal provision</b> (e.g. school-based, summer meals, Meals on Wheels)	40%	23%	8%	48%
<b>Food system advocacy group</b> (e.g. food policy council, food justice coalition)	23%	6%	2%	74%
<b>Agency that links food-insecure people to food resources</b>	39%	21%	8%	50%
<b>Community group promoting healthy food access</b> (e.g. farmers' market, urban farm, healthy corner store)	49%	24%	14%	38%
<b>College/university program addressing food/nutrition issues</b>	21%	5%	3%	76%
<b>Other group(s) addressing food/nutrition issues</b>	17%	9%	4%	78%

### Financing of programs

While some states have community benefit regulations that require hospitals to budget in advance for the initiatives in their implementation strategies, salaries for community benefit or community health staff may be the only funding that is set aside at the beginning of the year. Financial support for initiatives, particularly grants for community

partners to implement programs, often depends on the annual variability of hospital finances.

A couple of hospitals explained that one factor inhibiting committing financial resources to community benefit initiatives is uncertainty regarding the need and cost for unreimbursed health care due to changes in health care coverage and reimbursement systems.



*“We are going through a lot of change in our payment structure for hospitals. [The state] operates under a waiver for Medicare and Medicaid, and that system has created a global budget for hospitals as part of its first phase. That uncertainty makes people a little wary, I think, about committing additional dollars toward community benefit.”*

Another community benefit director reflected on the challenge of shifting health care expenditure from treatment toward community prevention within the context of limited resources:

*“We’re trying to transform the way health care is delivered. For example: diabetes prevention. How can we shift resources from a total focus on diabetes management, to now focusing more on diabetes prevention, and be budget neutral? I’m not sure if we can capture that shift in terms of community benefit dollars. How can we steward the resources that we have at our disposal to try and shift from treatment to prevention the best that we possibly can?”*

A community benefit director working at the hospital system level discussed the differences in available resources to contribute to community health improvement initiatives at different hospitals within her system:

*“It’s up to the local facilities to fund community initiatives, and that is what gets reported. But a lot of our hospitals don’t have any kind of margins. Some of our little bitty facilities are purely mission-based, and they’re supported or supplemented in part by our flagship hospital, and larger hospitals, which have better margins. We’re looking at a system-wide fund as well that facilities can access for, say, local food initiatives.”*

Many community benefit directors emphasized the limits of their ability to contribute financially to community benefit initiatives. They discussed looking for ways to maximize the impact of the resources the hospital can provide.

*“Getting resources to support something new is really challenging. Even getting resources to expand or enhance something that already exists is challenging. One of the reasons we really try to stay within two to four priorities for each hospital is knowing that resources are limited and that we want to use them in the most impactful way.”*

## Importance of collaborative funding of programs

A recurring theme in our interviews was the importance of hospitals collaborating with partners to fund community health initiatives. Multiple funding streams were seen as critical for sustainable financing of programs.

*“Hospitals are not going to fix all the problems that we identify in our needs assessments. It’s not something that’s going to be remedied solely by hospitals or solely by your county public health department. It truly does involve collaboration. There are a lot of really great resources that currently exist in the community. It’s about raising awareness of those resources and connecting the dots. I’m very interested in designing sustainable efforts, and we have found that it doesn’t necessarily cost a lot of money to be a strategic partner.”*

*“The health care system is willing to come to the table if there are other organizations contributing resources. The power is in partnering and leveraging resources for program sustainability.”*

Other hospitals emphasized the importance of multiple partners not only to achieve diverse, braided funding, but also to engage and leverage different kinds of resources and expertise.

*“Community benefit is about more than a ‘bucket of money.’ There are many ways hospitals can bring value to community-based groups. We come at issues from different directions, and the more we communicate and collaborate, the greater the impact we will have.”*



Jean Parks, a member of the Community Food Club (CFC), proudly displaying her fresh produce at the CFC retail warehouse in Michigan (Community Food Club of Greater Grand Rapids)

*“It’s not about me designing the interventions, it’s about community organizations designing programs to address community problems in a culturally relevant and specific way that they think will work. Then I look for ways to support them, whether it’s through evaluation or other technical expertise, connecting them with other partners, or funding some of their activities. It’s about raising awareness of the resources and expertise that do exist, making connections.”*



Cafeteria staff in New Orleans prepare lunch bags for students eligible to receive meals under the USDA Summer Food Program. (Our Lady of the Lake Regional Medical Center)

*“The key is lots of partners. We are one little slice of a big community. We connect across disciplines and institutions and across various elements of the food system to really leverage resources. We now we have a better idea of what organizations are providing what services, and where it makes sense to work together on particular projects. We are able to collaborate on grant writing. Frankly there was funding out there, and we had our ducks in a row. The community was organized and we were able to draw in some dollars to support collaborative initiatives.”*

## Collaborative funding to support healthy food access in Baton Rouge, La.

As a stakeholder in Healthy Baton Rouge, a healthy cities initiative, the Big River Economic and Agricultural Development Alliance (BREDA) developed strong relationships with local hospitals. These relationships enabled aligning on goals and collaborating on strategies such as expanding the Red Stick Mobile Market, which is managed by BREDA and supported by regional hospitals in a large collaborative effort.

The mobile market received a three-year \$576,000 Challenge Grant from the Blue Cross Blue Shield Foundation of Louisiana, but the grant required a match for the \$576,000 over three years. [Our Lady of the Lake Regional Medical Center](#) provided crucial support to BREDA in applying for and securing the challenge grant, as well as helping them raise the matching funds.

*“We weren’t interested in just becoming a sponsor and just giving some money. What we were interested in was a partnership where we work together on what it looks like and there is an impact on the community.”*

– COLETTA BARRETT, OUR LADY OF THE LAKE VICE PRESIDENT OF MISSION

*“They [Our Lady of the Lake] provided so much critical support that helped us mentally through the difficult fundraising period. They said, ‘Yes, you can do this.’ It was fabulous to have that support.”*

– COPPER ALVAREZ, BREDA EXECUTIVE DIRECTOR

## Diverse hospital roles in healthy food access programs

As noted above, there are numerous ways that hospitals can provide community benefit support for healthy food access programs, including contributing staff time and expertise, other in-kind contributions, and financial resources. Our research team identified nine common role categories that hospitals are playing in support of healthy food access programs. The guidance brief [“Hospital community benefit roles”](#) discusses these roles, with examples.

- Provide grant support
- Provide use of hospital facilities
- Conduct food insecurity or other health screening
- Conduct nutrition, food, or cooking education
- Provide staff or financial support for program evaluation
- Provide staff support for grant writing or securing sustainable funding of community benefit initiatives
- Manage or coordinate a program or community collaboration
- Participate in a community collaboration
- Advocate for healthier food policies

Here we present a few insights from key informant interviews about how hospitals are making a difference through some of these roles.

### Increasing community access to healthy food through use of hospital facilities

A growing number of hospitals are using hospital grounds or facilities for food-related community benefit activities, including serving as a site for [farmers markets](#), [food pantries](#), and [summer meal programs](#) or distribution of [fruit and vegetable incentive vouchers](#) or [CSA shares](#).

A community benefit director described how her facility dedicates unused hospital land to a neighborhood garden as well as provides other space and facilities for a community partner to operate a vermiculture composting center and a hoop house – providing multiple benefits to the community:

*“We have quite a bit of land that we don’t need, and we’ve devoted about three-quarters of a city block to a neighborhood garden. We provide the water and people can grow whatever food they want with the condition that they donate 10 percent of it to people in need. And we provide a lot of the compost. We work with [a community organization] on a vermiculture composting center, where we have worms turning food waste into compost. The composting center is in a building that we own, and we pay for the heating and the cooling because the worms have to have a pretty specific environment. We also partner with a local university, they bring over a lot of food waste that is used for the vermicomposting. We also have a hoop house, which we own, but [the community organization] does a lot of growing there where they provide plants to different groups who are gardening. They bring over kids from the middle school to learn about growing. We provide the space, or the facility, and they operate the programming.”*

### Hospitals contributing to healthy food access through a community collaborative

Hospitals can be important participants in community health improvement collaboratives, which are often driven by health departments, foundations, or nonprofit organizations that have established common goals and involve engagement of a diverse group of stakeholders.

[Montefiore Medical Center](#) (Bronx, N.Y.) is one of numerous organizations collaborating with the New York City Department of Health and Mental Hygiene to distribute Health Bucks, \$2 coupons that can be used to purchase fresh fruits and vegetables at all NYC farmers markets. Health Bucks provide New Yorkers who receive SNAP benefits with additional purchasing power to buy fresh, locally grown produce. For every \$5 spent at farmers markets using SNAP on an Electronic Benefits Transfer card, shoppers receive \$2 in Health Bucks.

Montefiore distributes Health Bucks to individuals who participate in [health education classes](#) or take part in farmers market walks. These walks, led by Montefiore nutritionists and health educators, have emerged as an ideal way to expose individuals to the availability of fresh produce in the community. Staff share information on seasonal produce, shopping, and storage and discuss recipes and preparation, encouraging participants to try new vegetables. With Health Bucks, individuals are more able to try new items, without concern for cost. Montefiore’s Amanda Parsons emphasized that Health Bucks is an effective way “to get people trying and eating vegetables, without feeling like they will use their entire SNAP allocation.”



Montefiore participates in Health Bucks, a fruit and vegetable voucher program run by New York City. Montefiore has a 98 percent redemption rate for the Health Bucks that they distribute (Montefiore Medical Center)

### Advocating for healthier food policy

Hospitals around the country are using their voices to advocate for better food policy both at the federal, state, and local legislative levels, as well as at the institutional



level. Hospitals are participating in legislative policy advocacy through engagement with [food policy councils](#) and as members of coalitions with food policy goals. At the institutional level, hospitals are advocating among other [anchor institutions](#) to adopt [institutional policies](#) around healthy food and beverage purchasing standards and cafeteria and vending policy.

A community benefit director in the Midwest described her facility's policy advocacy efforts to address food insecurity through policies to expand the reach of school meal programs:

*“We have done some advocacy efforts within the state legislature around school breakfast and alternative models for that. We are working to increase public funding for that as well as helping schools get the community eligibility designation so they can provide more meals without having to get all of their kids enrolled into eligibility for free and reduced-price meals. We’ve been involved in helping develop some of the messaging with some of the other nonprofits who really lead the charge. We’ve done letters of support. We also held a legislative breakfast around summer meals and community eligibility; we were there helping talk to the different legislators and legislative aids and sharing those messages and content.”*

## Importance of community partnerships in identifying and implementing successful programs

Our national survey found that about 75 percent of reported community benefit programs addressing obesity, diet-related disease, or food access are managed by hospital staff, while about 25 percent are run by external organizations. Yet among the hospitals interviewed for this project, community benefit directors emphasized the important role that community partners played in developing and implementing successful programs.

Assessing the landscape of organizations working on food issues in the community is an effective way to identify potential partners and establish or strengthen relationships to improve the reach, impact and long-term sustainability of efforts:

- Illuminates opportunities to align with existing community efforts or bring groups and organizations together for greater synergy
- Strengthens health improvement efforts through increased alignment, coordination or collaboration
- Helps avoid duplication or re-creating programs and services

Several hospitals described how community engagement in the CHNA process led to partnerships with community-based organizations that were doing vital and effective work in the community, and which became an important part of the hospital's implementation strategy.

*“A lot of where we get our ideas [for our implementation strategy] are from our relationships within the community, many of which have developed through the CHNA process. We feel very strongly about aligning our efforts and reducing duplication and also helping to build capacity in organizations that exist in the community. If we can make an investment in an organization that has a promising program or a promising view on food systems, food access, and food insecurity, then we would much rather support that organization in building their capacity than to create a random program out of our hospital. We really emphasize the importance of building up and supporting our community partners, whether that is through financial investment or intellectual investment, such as help developing evaluation plans or help thinking about how they can scale up their efforts.”*



Shoppers at the Abraham Lincoln Memorial Hospital Farmers Market in Illinois, an indoor, producer-only hospital-sponsored and supported market featuring local products (Abraham Lincoln Memorial Hospital)



Another community benefit director described how her hospital had helped to facilitate greater coordination and collaboration among groups doing similar work in the community:

*“I don’t think any of this hunger work could be done without collaboration. We started an advocacy fund about five years ago to fund some of the great work that people are doing in the community. We didn’t want to recreate programs unnecessarily; we would rather fund what they’re already doing well. Then, a couple years into it, we found that there were a lot of competing programs in the community. They would come to us and we would say, ‘Funding is possible but we want you to collaborate with this other agency. We all need to work together on this.’ There’s been a great growth in collaboration in the community.”*

### Hospital review of community food assets leads to vital partnership

The partnership between [Eden Medical Center](#) (Castro Valley, Calif.) and Dig Deep Farms began when community benefit lead Ellen Carroll went online to find out more about the existing food assets in her service area. Her inquiries led her to Dig Deep Farms, a healthy food access and workforce development initiative run by the Deputy Sheriff’s Activities League, the nonprofit arm of the Alameda County Sheriff’s Department. She set up a meeting at the farm to learn about their programming and the gaps that existed that could possibly be filled by a hospital partnership.

*“Ellen worked to fund something that is integral to a community operation’s success rather than starting a new thing. It has been so valuable to work with a funder in that manner because it is supportive of the organization and is a route to successful achievement of goals. She listened and then she fought for it.”*

– HILARY BASS, DIG DEEP FARMS

## Other factors influencing which programs are selected for support in implementation strategies

In addition to getting ideas about effective healthy food initiatives from community partners and coalitions, community benefit leads discussed other factors that influenced which programs and activities were included in their implementation strategies. These included continuing support for existing programs, guidance on evidence-based programs, the influence of hospital senior leadership, hospital system strategic plans, and an interest in programs that address health inequities and serve vulnerable populations.

### Continued support for existing programs

Several community benefit directors explained that their facilities were largely continuing to focus on the same health needs that they had prioritized in their previous CHNA. In many cases, they had begun implementing or supporting programs addressing obesity, healthy eating, and diet-related health conditions that they wanted to maintain. They wanted to continue supporting these programs to have more time to assess their impact or to retain or expand the reach of programs that seemed promising.

*“For the most part, most of our programs continue and build off of our first CHNA and implementation strategy. A lot of our work [related to] obesity and diabetes is a continuation of what we started previously.”*

### Guidance on evidence-based programs

A number of facilities, when asked how they select community benefit activities and programs to address obesity and healthy eating, described seeking out recommended, evidence-based programs from authoritative sources.



Sarah Kirnon, manager of Dig Deep Farms, explains plans for the future of the farm. (Terry Lorant)

Several community benefit professionals said they had referred to the Guide to Community Preventive Services (“[Community Guide](#)”), which provides guidance about interventions aimed at improving population health and includes recommendations on interventions to promote healthy eating to reduce the risk of obesity and diet-related chronic diseases. Several community benefit directors also looked to County Health Rankings’ [What Works for Health](#) for ideas for implementation strategies.

Community benefit leads also looked to other sources of guidance:

*“We look at what evidence-based programs already exist out there and try to do that, basically. To find evidence-based programs we search online. We have used the Robert Wood Johnson Foundation’s case studies. We also look at awards that other organizations are receiving or forward-thinking programs that are being recognized, for example the AHA [American Hospital Association] NOVA awards.*

*“For intervention selection, we look at what has been tried and true around the country and here within the state. We refer to resources from the CDC, Healthy Communities Institute, and others.”*

*“We pulled a lot of strategies from Healthy People 2020.”*

*“Recommendations from the Georgia Health Policy Center.”*

*“We get ideas from ACHI [Association for Community Health Improvement] conferences and meetings.”*

*“Most of our work in the community comes from guidelines in the state prevention agenda or the Take Care New York 2016 agenda.”*

In addition, several community benefit directors said they were interested in further guidance on program selection.

*“What would help is a national standard of best practice for this kind of work, something for us to aspire and look up to.”*

In a similar vein, some hospitals said that they select programs with an eye to the requirement to report impact.

They looked for recommended programs that already have documented effectiveness with the expectation that the facility will be able to track measurable outcomes.

*“Having to report and demonstrate the impact of our work has been a really critical factor in deciding what we’re going to prioritize and work on. We want to make sure we can actually measure the progress. If we are not going to be able to easily measure it, we don’t want to put it in an implementation plan.”*



Fresh produce and healthy living education opportunities are available for participants of the Nutritional Options for Wellness (NOW) program, which was founded by Spectrum Health and administered by Access of West Michigan. (Access of West Michigan)

## Hospital senior leadership influence

Community benefit directors talked about the role senior hospital administrators played in shaping community benefit implementation strategies and selecting programs. Our interviews showed a wide range of involvement, from minimal participation to active engagement.

One community benefit director described the need to educate hospital leadership about food policies, systems, and environments so they could understand the approaches being proposed in the implementation strategy:

*“There was a need to educate hospital leadership about the connection between healthy food access and the chronic diseases we are seeing as top health issues. There needs to be more understanding that addressing healthy eating is something that needs to go beyond focusing on individual behaviors and telling people ‘You’ve got to eat your five fruits and vegetables, otherwise, you’re going to get diabetes.’ We need to shift toward a broader societal responsibility in helping to shape food environments and systems in a more responsible way.”*

In other cases, hospital leadership already had an interest in healthy food access and healthier food systems. Hospitals administrators or board members may have existing relationships with community organizations that are working on food issues and bring these opportunities to meetings to review or approve implementation strategy planning.

*“Our leadership has been really great. We often get our hospital president, the CFO, the COO, and administration for patient care connecting to our projects. They are digging in the dirt, they are planting plants.”*

*“We didn’t need to get C-suite buy-in. In our case, commitment to addressing food security is C-suite driven.”*

### **Mayo Clinic Health System - Franciscan Healthcare (La Crosse, Wis.) has long-standing commitment to healthy food**

A hospital founded in 1883 by Franciscan Sisters with a commitment to feeding the community has supported healthy food access and community gardens and farms for many years. The hospital now participates in multiple programs that promote healthy eating and support local food producers:

“We have a real focus on food, and we have for some time – it predates the first community health needs assessment. We actually have what we call a healthy foods steering committee. It includes our CEO, who chairs the committee. That group has a lot of input on where we invest our resources related to our healthy food programming.

Our commitment to healthy food goes as far back as our founders, who are a group of Franciscan Sisters. We love to tell the story about how back in the 1800s they had a farm outside of town where they grew enough food to not only feed the congregation of sisters, but all the patients at the hospital, and the staff, and many needy members of the community. We have this history of growing food and being self-sufficient.

Then a number of years ago there was a local group that wanted to promote urban agriculture. They wanted to bring people together to

grow food and also create socialization and community building opportunities, especially with seniors and kids. We helped them with their quest for a greenhouse where they could teach people about growing food, and that led to our engagement with several programs.

We sponsor a farm-to-school program that promotes locally sourced foods in our public schools. There is also the Harvest of the Month program, with a focus on a particular food each month and taste testings at schools, employers’ cafeterias, and grocery stores. It gets people tasting different foods, taking them home with them. We also have a mobile teaching kitchen that we take to community events, like food distributions at WIC, and show folks what to do with foods they get in their bag that they may have never seen before. Our goal there is to get people eating more fresh foods, and different fresh foods. Finally, we’re in a collaboration called Get Growing that’s an effort to change the culture of food in our community, and looking at food systems, and food access, and really elevating the conversation in those areas.”

– TERI WILDT, MAYO CLINIC HEALTH SYSTEM-  
FRANCISCAN HEALTHCARE DIRECTOR OF  
COMMUNITY ENGAGEMENT



## Hospital system guidance on implementation strategies

Some hospital systems have established one or more health improvement priorities or strategies that they have adopted system-wide. This can enable the hospital system to provide guidance or resources to the local facilities that can contribute to greater impact. System-level guidance can include encouraging facilities to adopt particular kinds of interventions or providing tools or training to implement and evaluate programs.

A community benefit director in the Northeast described how her hospital system developed two system-wide health improvement goals as well as a catalog of evidence-based strategies and interventions for facilities to choose from:

*“We developed, as a system together, two goals. One had to do with food access and food security. We’re asking every one of our member hospitals to work on at least one of three different food access objectives. This issue rose to the level, across our system, where everybody could be doing some work to address these issues.”*

A community health director for a national hospital system described two system-level health priorities and associated strategies that the system is supporting nationwide, including providing recommendations and technical assistance to promote policy and environmental change:

*“We looked for a couple of system-wide priorities that everybody could try to work on together simultaneously. That way we could provide centralized technical assistance. Reducing tobacco use and obesity prevention are our system-level priorities that trickle down across all our hospitals. Now that we’ve elevated those priorities, what can we do to help guide community benefit staff? We can’t tell folks who may have never done policy, systems, and environmental change work what to go and do. They need technical assistance. We are working with all of our ministries to improve their food and beverage environments. And we are giving our community benefit teams tools to start a community conversation to encourage other anchor institutions and organizations to improve their food and beverage environments also. It’s an environmental change strategy with a great deal of centralized assistance coming from the system office. We give hospitals examples of how they can engage other institutions, including a healthy vending challenge.”*

A community benefit director for a regional hospital system explained that food security had been selected as a priority health issue to address throughout the entire health system. With a coordinated strategy, all the facilities in the system launched an effort to provide eligible students with a weekend backpack of nutritious food for the 2017 to 2018 and 2018 to 2019 school years. The facilities partner with schools to implement the programs as well as with food pantries, grocery stores, and other community-based organizations and businesses to secure support for long-term sustainability. The system provides guidance with planning and implementing the programs, common evaluation tools, and incentives for achieving implementation benchmarks.

*“System-wide, we’re implementing the same program but every local ministry has its own way of doing it according to the resources and partners that they have. The system provides guidance and a specific understanding of what needs to happen quarterly or monthly. We say, ‘Here are the steps through the course of the year and we’ll be there for you.’ We provide status updates and that keeps everyone energized and the local facilities feel they’re not alone. We also have a bonus program within our system, and our weekend backpack program is part of that – a bonus that pays out if we meet and achieve all our strategies and performance measures. That’s an additional thing that really helps everyone understand why helping to reduce hunger is important across our system. It’s an incentive and also a way to say, ‘This is really important. We know that we give you all a ton of things to do every day, every month, but this is something we want you to treat seriously and to prioritize.’”*



Orlando Health volunteers check students' health metrics, part of a healthy eating and cooking education program at Orange Center Elementary School in Florida (Orlando Health)

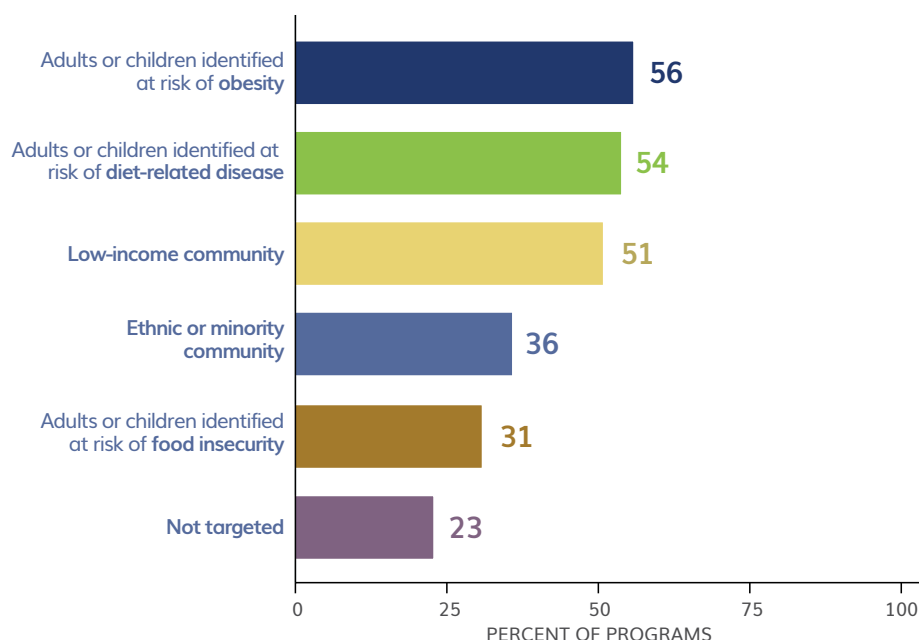


## Targeting underserved communities

Another factor that community benefit interviewees reported influencing their choice of community benefit programs is whether and how initiatives address the health needs of vulnerable and underserved groups.

In our national survey, respondents reported that half of programs to address food or diet-related health needs targeted low-income households.

**POPULATIONS TARGETED BY COMMUNITY BENEFIT INITIATIVES (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 targeted population for each program

A number of community benefit directors discussed how they looked at selecting, designing, and implementing community benefit programs to reach communities with the greatest health needs and challenges:

*“One thing that plays an important role in selecting and developing programs is principles of equity. We’re really trying to reach the people who need this the most. We focus on people who report as low-income. We use the income guidelines for SNAP – but people don’t have to be enrolled in SNAP because we have a lot of families that don’t qualify because of their citizenship status. We don’t have a citizenship requirement.”*

*“We are focused on programs serving low-income and racial and ethnic minority and language minority populations and vulnerable groups. When we select programs, we ask, who is it targeting and is this consistent with our mission and values?”*

*“There are top line threats to equitable health outcomes that are driven by social and class structure, racial dynamics, and racism. When we consider community benefit programs, we call it what it is, as opposed to dancing around those things and pretending that it’s not something we should be engaged in. This is really important if hospitals are going to make a difference in supporting equitable community health outcomes.”*

## Conclusion

In this chapter, we reviewed the kinds of community benefit programs that hospitals across the country are engaging in to address obesity, healthy food access and healthy eating, and diet-related health conditions.

Our national survey provided a representative snapshot of the kinds of programs and activities that hospitals are supporting to prevent or treat obesity and diet-related health conditions in their communities. A key finding from the national survey was that most of these community benefit interventions centered around nutrition education and exercise promotion – and that fewer interventions focused on increasing access to healthy foods.

Our interviewees were selected to gain a deeper understanding of community benefit programming at hospitals across the country that were actively involved in healthy food access interventions and even innovative approaches to supporting local and sustainable food producers and community development. While these hospitals also participated in healthy eating and active living education and promotion programs, they tended to support a wide range of initiatives to increase affordable and convenient access to healthy food and improve community food environments. Community gardens, food pantries, and fruit and vegetable incentive programs were the most common types of food access programs supported by interview hospitals.

### Interest in supporting local and sustainable food producers in national community benefit survey

For those respondents who reported having a community benefit program that targeted food insecurity or healthy food access, 43 percent said including local or organic producers in the program was very important.

Forty-eight percent of all respondents said that it was very or somewhat likely that their facility would provide community benefit support in the next three years to an initiative involving community agriculture (such as urban farms or community supported agriculture).

Hospitals provide varied forms of community benefit support (staff time and expertise, other in-kind hospital resources, and financial/grant support) and play a variety of roles in healthy food programs (such as providing use of hospital land and assistance with developing grant

proposals). Many hospitals emphasized constraints on their ability to provide financial resources to community benefit programs and underlined the importance of securing diverse funding sources to ensure program sustainability.



Volunteers plant lettuce seedlings in the hoop house at the MIFFS Women-in-Ag Farm Development Center at Genesys Health Park. (Michigan Food and Farming System)

Interviewees enthusiastically endorsed the vital role of community partners in designing and implementing effective programs. Hospitals often learn about community organizations and initiatives working on healthy food access through the CHNA process, which can lead to important collaborations.

Numerous factors shape hospitals' selection of community benefit programs and activities to address food and diet-related health needs identified in their CHNAs. In addition to learning about effective healthy food initiatives from community partners and coalitions, community benefit leads discussed other factors that influenced which programs and activities were included in their implementation strategies. These included continuing support for existing programs, guidance on evidence-based programs, the influence of hospital senior leadership, hospital system strategic plans, and an interest in programs that particularly address health inequities and serve vulnerable populations.

While many hospitals are promoting healthy eating in their communities, there is more opportunity to provide community benefit support to initiatives that increase physical and economic access to healthy foods and also support local food producers and community development through food initiatives. In the final chapter of this report, we further discuss these opportunities and provide recommendations.

# Chapter 5. Evaluating healthy food programs

## Introduction

To comply with federal and (some) state regulations, hospitals must report on the impact of actions taken to address the significant health needs identified in their previous community health needs assessment (CHNA). These requirements are intended to increase transparency and accountability around tax-exempt hospitals' obligation to improve community health.

Evaluating community health interventions also is vital in order to:

- Refine and improve program implementation
- Identify the most effective interventions for expansion or replication
- Provide evidence for funders to maintain financial support of programs
- Communicate the impact of community benefit initiatives to stakeholders and the wider community
- Fulfill the mission of improving community health

The guidance brief "[Evaluating healthy food access interventions](#)" contains recommendations to assist community benefit staff and community partners in conducting program evaluation for healthy food access programs. It covers evaluation planning and includes links to validated, frequently used survey and data collection tools, with recommendations for common indicators, measures, and methods that can help bolster support for programs.



Farmers work in hoop house (Michigan Food and Farming System)

## Federal and state requirements and guidelines for community benefit program evaluation

The only federal requirement for community benefit program evaluation issued thus far is found in the IRS "[Final Rule](#)," a set of requirements for charitable hospital organizations, which states that hospitals need to include in their triennial CHNA reports an evaluation of the impact of actions taken to address the significant health needs identified in their previous CHNA.

Many states also require some form of nonprofit hospital community benefit reporting<sup>xx</sup> State reporting requirements may include language about program evaluation, for example:

- Requirement to describe the measures taken to evaluate the plan's effectiveness or results (California, Connecticut, Indiana, Maryland, New Hampshire, Texas)
- Requirement that evaluation include soliciting views of the community served (California, Indiana, Texas)



Megan from Michigan State University Student Organic Farm teaches new women farmers about soil health during a workshop at the MIFFS Women-in-Ag Farm Development Center at Genesys Health Park. (Michigan Food and Farming System)

<sup>xx</sup> See the Hilltop Institute's [Community Benefit State Law Profiles](#) for more information.

## Goals of this chapter

In this chapter, we provide an overview of the approaches to program evaluation that we observed in the project's national survey, in-depth interviews, and case studies. We look at how hospitals are defining program success and the kinds of evaluation methods that are utilized. Programs commonly use multiple methods and indicators to track and evaluate programs. These include program implementation metrics that assess the quantity and quality of program activities that are carried out, as well as short, medium and longer-term health outcome indicators for program participants. Programs that seek to improve policies and environments also look to assess the impact of these efforts.

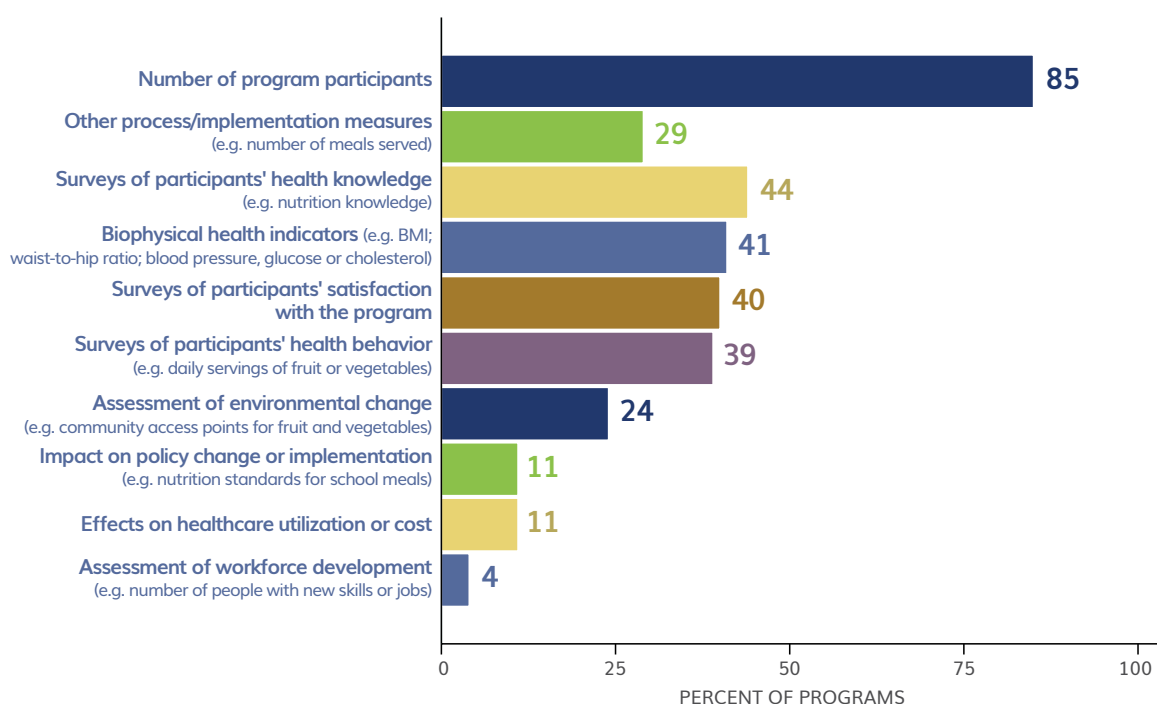
In addition, we discuss some ways that hospitals are approaching the evaluation of local food initiatives that have the additional goals of promoting local economic development, workforce development and job creation, and sustainable food systems.

We also discuss some of the challenges to community benefit program evaluation that key informants described. Finally, we provide some recommendations for evaluating programs designed to increase convenient and affordable access to healthy foods as a way to address obesity, food security, and diet-related health conditions – common health needs identified in CHNAs across the United States.

## How are programs being evaluated?

Our national survey found that program participation was the dominant evaluation measure utilized in assessing community benefit programs addressing diet-related health needs (85 percent), while 41 percent of programs used biophysical health indicators.

**EVALUATION METHODS UTILIZED (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 evaluation method for each program



## Program implementation measures

Implementation or “process” evaluation questions examine how well or how efficiently a program is carried out and if it is reaching its intended audience. Information from program implementation assessment can enable fine-tuning of program design and delivery, such as improving [educational materials and curricula](#) to make them more accessible, engaging, and culturally appropriate, or adjusting the location of program sites (such as mobile farmers market stops or community-supported agriculture (CSA) program pick up sites) for more convenient access for the intended participants.

Community benefit professionals described a variety of ways they evaluated program implementation. Common implementation metrics included the number of program participants served, the number of fruit and vegetable vouchers distributed or redeemed, the number of meals delivered, and the pounds of fresh produce donated. Programs also frequently conduct participant satisfaction surveys. Taken together, these process measures center on the performance of program activities and patrons’ experience of participating in them.

Both our survey and interviews found that program reach – counts of program activities and participation – was the first evaluation information reported. This can include counting activities, program attendance, and even website page visits. For example, one hospital that promoted healthy behaviors on the web and at school events said:

*“We track the number of page visits and other ways that you would track and evaluate the use of an internet resource...Then we track how many different activities are happening each year and how many kids and families attend the events at the different schools.”*

Reach is a particularly useful evaluation measure when program effectiveness is well established – if more people are reached, the program will likely have a greater impact. A Mid-Atlantic hospital discussed how a [summer meals](#) program that the facility supports is assessed, focusing on program participation. This Summer Food Service Program, which enables low-income children to continue to receive nutritious meals when school is not in session, is located near a local housing authority site adjacent to a community health center.

*“I think this is one of those programs where we can say, this is a true community benefit. We would like for participation to be up. That’s pretty much the only thing we [are assessing]. The meals are here. Are the kids coming? Are they getting the meals?”*

Impact can be demonstrated when reach increases over

time. [Presbyterian Healthcare Services](#) (Albuquerque, N.M.), provides financial and other support to La Cosecha, a CSA program that offers subsidized locally grown produce shares for food-insecure community members while also investing in local farms. Feedback from the participants informs quality improvement of the program. Over the six seasons the program has been operating, distribution has increased from 20 families at eight partner sites to 375 families at 17 partner sites.

[Abraham Lincoln Memorial Hospital](#) (Lincoln, Ill.) assesses several implementation components of its farmers market initiative. The hospital supports activities at the market including free monthly health screenings, cooking classes, and the Power of Produce (POP) Club for children in grades K-12. Each week they participate, children earn two dollars’ worth of farmers market tokens that can be used to buy fresh fruits and vegetables.

The market coordinator and volunteers collect evaluation data. In 2017, the market hosted 13,268 visitors who spent over \$48,000 dollars on produce. Nearly 500 free health screenings were conducted. Over 800 POP healthy eating activities were hosted and children earned over \$1,600 in market tokens for produce.

In its first year (2015), the market struggled to attract low-income community members (based on Supplemental Nutrition Assistance Program [SNAP] usage rates at the market), which left double match dollars unused. Program refinements resulted in increased SNAP match use in 2017, and program staff members continue to assess and implement program improvements to better reach and serve low-income families.



Shoppers at the Abraham Lincoln Memorial Hospital Farmers Market in Illinois, an indoor, producer-only hospital-sponsored and supported market featuring local products (Abraham Lincoln Memorial Hospital)

## Program outcome measures

Evaluators also assess impacts on people who participated in programs. For healthy food access interventions, this typically includes both shorter- and longer-term health-related outcomes. Outcome evaluation can also include assessing changes to food environments or policies; increased sales, income, or capacity for local and sustainable food producers; and jobs created for people with barriers to employment.

### Community benefit program goals

The primary goals of community benefit initiatives should be linked to the health needs identified in the hospital's CHNA.

Healthy food access initiatives can impact community health by promoting healthy shopping and cooking, increasing fruit and vegetable consumption and improving nutrition, promoting healthy body weight, and helping to prevent or manage diabetes and other diet-sensitive health conditions.

Additional goals for healthy food access initiatives may include supporting local food systems and promoting economic development, vocational skills, and job creation in underserved communities. Opportunities can be stacked for greater cumulative impact. When developing healthy food access programs, strategies can be integrated to support community development, localize the food economy, and promote a more food resilient system – all of which can amplify positive health impacts.

### Short and medium-term health-related outcomes: Food security, health knowledge and behaviors

Our survey and interviews found that food- and diet-related community benefit programs often assess, through participant surveys, the program's impact on reducing food insecurity; increasing knowledge about healthy diet and nutrition; increasing knowledge, skills, and confidence regarding healthy shopping on a budget and healthy cooking; and facilitating healthy behavior change. Achieving changes in health knowledge and eating behaviors are important steps toward realizing improved health outcomes and reduced health care costs, which typically take a longer time period to achieve.

## ACHIEVING HEALTHIER EATING BEHAVIORS

**Because a growing base of evidence finds that increased consumption of fruits and vegetables contributes to healthier body weight and prevention or better management of diet-related health conditions, an initiative that achieves healthier eating behaviors can be considered a community health improvement success.**

A community benefit director described how her facility assesses short- and medium-term knowledge, attitude, and behavior change resulting from participation in their Healthy Families program. The program serves families with a child in the 80th percentile of body mass index (BMI) or higher, with a referral from a physician. Families work with a dietician and behavioral health expert, learning about healthy cooking and eating and setting goals as a family.

*“Most of our evaluation is more short-term, directly tied to the participants who go through the program. We do pre- and post- assessments around their knowledge, attitude, and awareness of healthy practices. And we ask them, ‘How many servings of fruits and vegetables are you eating? How much activity?’ We also did a six- and twelve- month follow-up evaluation of the program to see how [the families] were doing with meeting their goals and setting new goals.”*

Another community benefit director whose facility supports a lifestyle change program to promote healthy weight described a similar approach to program evaluation, which involves pre- and post- surveys.

*“We do not rate our success by how many pounds the child loses while they’re in the eight-week program. We gauge our success on whether we’ve made an impact on the family’s lifestyle, eating habits, or exercise.”*

Go Fresh Mobile Farmers Market (Springfield, Mass.) – an initiative of a coalition including hospitals, public health organizations, and other partners – serves 12 low-income neighborhoods with weekly stops at locations including subsidized housing complexes, senior centers, and community clinics. Participant surveys found that fruit and vegetable consumption increased by an average of one serving per day after respondents started using the mobile market.

[Spectrum Butterworth Hospital](#) (Grand Rapids, Mich.) supports the Nutritional Options for Wellness (NOW) program, which provides healthy foods, healthy living classes, and connections to other community food resources to low-income adults with a chronic health condition. A primary goal is to nurture healthy habits through nutrition, cooking, and exercise classes for individuals and their families. Ninety percent of participants reported in program surveys that they are cooking healthier for their families and friends because of the NOW program.

### Longer-term health impacts

Promoting healthy weight and reducing health care costs for preventing and treating diet-sensitive chronic health conditions are complex endeavors because the drivers of increased prevalence of obesity and diet-related health conditions are multiple and complex. Interventions that make healthy choices attractive, convenient, and affordable – and that help shift dietary patterns – often take time to result in measurable health improvements or reduced health care usage and costs.

However, achieving these longer-term health impacts is often the goal of community benefit interventions addressing obesity and diet-related health conditions. Our national survey and interviews found that many programs collect data on biophysical health indicators before and after program participation (such as BMI, blood pressure, blood glucose, or blood cholesterol), even if program managers don't expect to see a change in these health indicators over the course of a short-term intervention. Data on hospital readmission rates is sometimes collected as well.

[Nutritional Options for Wellness \(NOW\)](#), a yearlong program supported by Spectrum Butterworth Hospital (discussed

above) collects data on changes in health indicators for program participants. Primary care physicians (PCP) from over 40 local offices affiliated with various health systems refer eligible patients to the NOW program. Patients visit NOW sites weekly to receive 3-4 days' worth of highly nutritive, plant-based food that fits their specific chronic disease dietary needs, in addition to participating in food and nutrition curricula and coaching. Evaluators track impacts on individual health outcomes through health data provided by PCPs and participant surveys. A lipid panel with lab values for each participant is obtained upon referral from their PCP along with follow-up panels one year later at program completion, and again when the patient has been out of the program for a year. Comparison of A1c values, cholesterol levels, and other indicators from beginning to end of the program and one year later are used to help identify health impacts and determine if changes are sustained. Post-program survey data found that 97 percent of participants reported that their overall health improved and 95 percent felt better about self-managing their disease.

In addition, the hospital has seen significant improvement in the way participating patients are using the health care system. Mary Kay Kempker-VanDriel, former Spectrum Health healthier communities director, explained:

*“These underserved patients often use the emergency room to treat their chronic diseases, however, since the NOW program began, among participating patients there are 25 percent fewer emergency room visits and a 44 percent decrease in the number of hospitalizations.”*

A facility that supports a care transitions program, which works with community partners to provide post-discharge support (coaching and links to community resources) for underinsured or vulnerable (including homeless) patients, assesses several program impacts. They have found a reduction in readmission rates as well as decreased vulnerability in participants' nutrition, housing, social support, and other needs critical to maintaining health.

*“We’re focused on reducing readmissions, but the flip-side of that is making sure that patients show up for their preventive care appointments because then they don’t end up in the emergency department. [Our community partner] developed a vulnerability scale. They do an evaluation or intake process at the beginning, and then also once a client completes the program, they do another assessment, and we’re able to see how the program has impacted their vulnerability.”*

Another community benefit director discussed her hospital system's initiatives involving food insecurity screening and a



Fresh produce and healthy living education opportunities are available for participants of the Nutritional Options for Wellness (NOW) program (Access of West Michigan)



“food pharmacy” program, which offers patients who have screened positive for food insecurity several days’ worth of medically appropriate food per visit. Patients can return to the food pharmacy once per month for up to six months and can obtain another physician referral if they are still in need. Patients also receive nutrition counseling and healthy recipes.

*“The holy grail is the data and the ROI [return on investment]. But getting the data and showing the ROI on these initiatives is very challenging. We have some preliminary data with our food pharmacies. For those who regularly get a food prescription filled at our food pharmacy and have gone through the dietary counseling, we’re starting to see trends in lower readmission rates, lower use of the emergency department, which is a huge positive. That’s exactly the kind of thing we want to be able to show.”*

She was careful to emphasize, however, that making a meaningful difference on social determinants of health and demonstrating the health impacts of these investments takes time.

*“In this industry now we all know that 80 percent of what affects an individual’s health comes from the social context and environment in which they live, but that understanding has come about only in the last few years. It’s going to take us a good five to ten years to be able to have the research bear out and show the trends in improved health outcomes.”*



Staff of Montefiore Medical Center volunteer and distribute recipe pamphlets at the Community Farmers Market in New York City.

## Change in food environment or policy

Some hospitals evaluate community benefit activities’ impact on community food environments or policies (governmental or institutional) that improve access to healthy foods. Examples include assessing improvements in the number of SNAP- and WIC-authorized food outlets, including farmers markets; hospital and school campuses that have adopted healthier meal service and vending policies; schools hosting farm-to-school programs; corner stores that offer healthy food options; and improved nutrition standards for food pantries and other emergency food providers. Here, hospitals assess progress in efforts to “change the context to make healthy choices easier,” or initiatives to address policies, systems, and environments, as recommended by the CDC’s [health impact pyramid](#).

### Availability of healthy food

[Montefiore Medical Center](#) (Bronx, N.Y.) supports a [healthy corner store initiative](#), in which it works with neighborhood stores, called bodegas, to improve their inventory and marketing of healthy foods. Montefiore’s evaluation of this initiative includes regular assessments of the stores to see what is being stocked, the quality of the fresh fruits and vegetables, and how it is being displayed and promoted, using an assessment tool developed for this purpose. Montefiore also conducts a survey of store owners to assess where they source inventory from, owners’ knowledge of healthy food, and perceived barriers to stocking more healthy items. Montefiore’s evaluation of this initiative will enable them to understand how healthy food availability has changed in targeted areas – and ultimately, whether or not there are changes in obesity prevalence among patients who live in those neighborhoods.

### Passage of policy or legislation

[Our Lady of the Lake](#) (LOL) Regional Medical Center (Baton Rouge, La.) has worked on policy advocacy efforts in which they have lobbied the city government to create a new bus line to help low-income residents of underserved neighborhoods get to grocery stores. There have been some bus pattern changes, but advocacy continues in order to secure city funding for a dedicated grocery express bus line. Evaluating outcomes of these policy advocacy efforts have focused simply on whether new legislation and policies have been enacted. Our Lady of the Lake’s Coletta Barrett commented:

*“From our perspective, our evaluation is just, ‘Did the legislation pass or not pass? Did you do it or not do it?’ We have not started to use health data as a measurement of the effectiveness of our advocacy efforts. That’s the next step in the evolution of where we’re going as an organization.”*



## Progress along a policy spectrum

Several community benefit directors described their efforts to participate in or support [food policy councils](#) or food system advocacy coalitions. Evaluation of coalition advocacy activities can be challenging due to the many dimensions of these efforts and different levels on which progress can potentially be assessed.

[Providence Hood River Memorial Hospital](#) (Hood River, Ore.), along with other regional partners, founded the Gorge Food Security Coalition to bring together stakeholders from across the food system to work collaboratively to address food insecurity. Projects of the coalition include conducting an inventory of direct service providers in the region, identifying gaps in infrastructure, and developing committees to lead projects. Evaluation of the coalition's work has focused on tracking the number of new food access programs established such as summer meals and backpack programs and produce prescription programs. They also assess project implementation activities, for example, pounds of produce donated to food pantries.

One community benefit director discussed the way her facility was preparing to assess the outcomes of a food and nutrition summit the facility is hosting as well as the continuing efforts of coalition members, which include researchers, health care providers, nutritionists, food policy professionals, government officials, members of food industry, and other community stakeholders. The summit and coalition don't have a single goal but rather engage multiple advocacy opportunities to improve food policies and environments:

*“We want people to be engaged and to participate in one of the task forces. We will follow up with them to see whether or not they were able to implement any of the changes that they learned about. How did they become more active in their community? Did they address the city council? Did they work with the school districts to ensure that they've truly implemented a solid school wellness policy around healthy food? Those are just some preliminary outcome measures that we plan to look at. We're interested in how our efforts have caused a change in the way that they're pursuing food policy.”*

Another community benefit director described her efforts to evaluate the activities of a local Healthy Eating Active Living collaborative that the hospital took a lead in establishing. The collaborative works to increase healthy food options and physical activity infrastructure in the community and supports a subscription-based food co-operative. Evaluating the success of the coalition is multifaceted.

*“We collect information on how many meetings were held, which partners attended. We're looking at recruiting and the strength of the collaborative. For outcomes, I think of products. We made a video. We hold events. We also worked to evaluate corner stores – how many healthy items versus unhealthy items – and piloted a corner store assessment tool for them. How many store evaluations did we do?”*



Veggie Rx has helped over 10,000 food insecure residents in the Columbia Gorge region access fresh fruits and vegetables. The program has over 30 farmers markets and grocery store sites where participants can redeem vouchers for up to \$30 worth of fresh produce (Gorge Grown Food Network)

## Other impacts on social and environmental determinants of health

Some hospitals assess other impacts on social and environmental determinants of health from their healthy food community benefit programs, such as those related to workforce development, localizing the food economy, academic achievement, or reclamation of food waste.

### Volume of food reclaimed

A community benefit director described her hospital system's work to reclaim food from local businesses that otherwise would have gone to waste, rotting in landfills and contributing to greenhouse gas emissions. The food is diverted to food pantries and congregate meals sites, helping to meet the food needs of food insecure individuals. Their evaluation of this initiative is simply to track the pounds of food reclaimed.

*“The food reclamation program is just a number. Community kitchens received 300,000 pounds of food that they didn't have before, that previously was disposed of, that was in the landfill. We've addressed two issues through that process.”*

[Northwestern Medical Center](#) (St. Albans City, Vt.) is the coordinator of the Healthy Roots Collaborative, a food systems coalition that supports regional growers, producers, and consumers by providing programs and services that improve food education, access, and infrastructure. One of Healthy Roots' initiatives is a gleaning program that harvests excess fruits and vegetables left in fields (after the primary harvest) for distribution to food pantries. Northwestern Medical Center assesses the gleaning program by tracking the quantity of reclaimed food; 10,600 pounds of local produce was gleaned and distributed to food pantries in 2016 (its first year) and 15,000 pounds in 2017.

### Student achievement

[Orlando Health Arnold Palmer Hospital](#) (Orlando, Fla.) and Orange Center Elementary School's Healthy Teaching Garden Program is assessing how the garden impacts student achievement. Stephanie Carrington, STEM Coordinator, reported the school has seen improvements in academic achievement related to the garden. Assistant Principal LaTonya Smothers expressed that the garden has been valuable in developing students' understanding of ecosystems. She points out that many students lacked an understanding of the role of insects and have learned that "every being has a role." During the 2017 to 2018 school year, Orange Center is re-designing parts of the garden and students will work on engineering and irrigation design as part of the process.

### Economic opportunity

[Presbyterian Health Services](#) (Albuquerque, N.M.) supports a CSA program (discussed above) run by community partner Agri-Cultura Cooperative Network. The CSA shares are subsidized for low-income community members, providing fresh produce for families in need while also investing in local farms. An important component of the CSA program assessment is evaluating the income gained by participating farmers.

[Sutter Health Eden Medical Center](#) (Castro Valley, Calif.) also supports a CSA initiative designed not only to increase access to fresh, healthy food for low-income community members but also – if not more importantly – to provide job training and employment opportunities for people with barriers to employment. Eden Medical Center partners with Dig Deep Farms, a social enterprise established by two Alameda County communities, the Alameda County Sheriff's Office, and the Deputy Sheriff's Activities League. The core goals of the program are to create job and workforce development opportunities for residents of the two underserved communities (particularly those coming out of the criminal justice system), provide access to healthy food, and expand the local food economy. Program evaluation includes several implementation metrics, including the number of CSA bags distributed, the number of cooking classes provided, and the number of former inmates receiving case management support. An evaluator conducted interviews to identify impacts from Dig Deep program participation among the clients of a reentry program for inmates at Alameda County's Santa

Rita Jail. The analysis found impacts of the program beyond the individual to families and loved ones. For some clients, having a bag of produce to bring home served as a bridge for repairing strained relationships. In addition, clients who worked on the farm received job skills and financial stability, important steps in the reentry process that help reduce the chances of recidivism.

[Genesys Regional Medical Center](#) (Grand Blanc, Mich.) and partner organization Michigan Food and Farming Systems (MIFFS) sponsor the Women in Agriculture Farm Development Center (WIA). The center is an incubator farm located on the Genesys Health System campus that supplies healthy food throughout the region and offers economic development opportunities for women. Beginning women farmers receive education and experience in starting and sustaining a farming business with the goal of becoming successful farm business owners.

The initiative is still in the early phases of implementation and evaluation methods are still being refined. Evaluators collect data on program implementation, including pounds of food produced, number of partnerships created, amount of land in cultivation, pounds of hospital food preparation waste diverted from the landfill to the farm's vermiculture compost system, and number of women newly growing and selling food.

### Enhancing self-esteem and dignity

"We know that people who live in poverty have twice the rate of obesity. And many people who live in poverty feel as though life is preordained, they're chugging down a railroad track and they can't get off. If through our partnership with the [Community Food Club](#) we are providing access to the appropriate foods at a cost structure that allows for people to purchase them, then we're doing the right thing. It is helping to create an enhanced sense of self-esteem and dignity. It's helping to establish a sense of normality. When you walk into this space, it gives off a positive vibe. We are providing food opportunities, creating an enhanced sense of dignity, and nudging people toward healthier food choices while preserving personal choice. We can create a different possibility for tomorrow."

– KEN FAWCETT, SPECTRUM HEALTH VICE PRESIDENT OF HEALTHIER COMMUNITIES

## Evaluating external, grant-funded programs

Hospitals are often uncertain about how to implement the “right” evaluation methods for community benefit programs. Evaluating grant-funded programs run by community organizations can be equally if not more challenging than evaluating programs that hospitals manage themselves.

In some cases, community organizations implementing community health improvement initiatives may have staff capacity to conduct well-designed program evaluation, or they may already be partnering with public health agencies, schools of public health, or consultants to carry out robust program evaluation. In other cases, however, community organizations are focused on delivering services and providing important support to the community and have placed little attention on putting careful evaluation methods in place.

Hospitals offering grant funding often provide evaluation guidelines and sometimes provide support to build evaluation capacity for grantee organizations.

### Evaluation guidelines for grantees

A hospital system described evaluation challenges for six grants provided as part of a Healthy Eating Active Living initiative. The health care system initially wanted to identify changes in health behaviors resulting from the grantees’ program activities. However, they decided that this was an unrealistic target to achieve during the grant-funding period. Instead, they provided guidelines to the grantees focused on two evaluation goals: assessing changes in community environments that could support healthy behaviors and identifying how community collaborations’ working relationships strengthened.

*“The grantee evaluators are helping us to tell a story after the three and a half years [of the grant] of how conditions in the six different communities changed in a way that would influence healthy eating or active living behaviors. We also hope to tell the story of how collaboratives’ working relationships grew or improved. All six of the evaluation plans address those two big questions. We set out trying to show behavior change related to healthy eating or active living, but we know that that is pretty unlikely to happen over three and a half years. So we are looking at interim steps. Most of the interventions are changing the environment wherever the intervention is taking place. We are looking to assess how a community condition has changed, and we’ll be able to show that through evaluations.”*

Another hospital, which is part of a funding partnership committed to addressing community health needs in its metropolitan area, explained that evaluation guidelines are given to grantees. This enables the collaborative to capture the impact on common goals across varied grantee initiatives, such as reducing rates of food insecurity.

*“The collaborative holds all grantees to contributing to community-level outcomes in whatever sector they’re being funded in. For the nutrition sector, the overall community outcome revolves around food insecurity. There are different program strategies and outcomes that each of the grantees speak to. But we look for these [program impacts] to align very well with the impact that we hope to make in the community. We utilize the evaluations for that work to assess our impact as a collaborative. That’s really how we assess how we’re doing there.”*

### Increasing capacity through grant support

Community benefit directors described their process of soliciting and selecting proposals for community benefit grants. Grant proposals often are required to describe how program activities will be evaluated. Several community benefit directors discussed how they provide technical assistance to community-based organizations in developing evaluation plans.

A community benefit director in the Western United States described her hospital’s \$5000 Healthy Living Grants, which



Veggie Rx has helped over 10,000 food insecure residents in the Columbia Gorge region access fresh fruits and vegetables. The program has over 30 farmers markets and grocery store sites where participants can redeem vouchers for up to \$30 worth of fresh produce (Gorge Grown Food Network)



any nonprofit organization addressing priority health needs in the area is eligible to apply for. Many of the applicants are organizations working on access to healthy food. Grantees receive technical assistance throughout the year, including in developing evaluation plans as well as presenting the results.

*“Throughout the year, I provide technical assistance. If they are weak on the evaluation component, then I meet one-to-one with the grantees and discuss their evaluation plan. I will help them design the tools, they will implement the evaluation tools, and then I have them send it back to me and I will analyze the data and talk to them about what their data means. We talk about how we can visualize it and I provide technical assistance to create a poster presenting their findings. This builds up their capacity to tell their story and they can build onto that in subsequent years...It’s really made a difference in the way that they think about their work.”*



Young chefs (Family Cook Productions)

In other cases, community benefit support to grantees includes funding for a program evaluator. A community benefit director whose facility is part of a coalition of funders that support a fruit and vegetable prescription program explained that additional support was provided specifically to design and carry out a rigorous program evaluation:

*“I’m really proud that we had the foresight to fund the evaluation, which was done at a pretty sophisticated level. We brought in a top-tier evaluator who conducted a community-based participatory research design, including a Photovoice approach with four groups, in English and Spanish, led by community health workers. They captured some really surprising information that challenged the perception that low-income people are making bad choices. What we*

*found is that the people who received the vouchers took enormous pride in knowing that they could feed their families healthier food. We found that many of them could have taught cooking classes. They didn’t need cooking classes. They knew what to do. They just couldn’t afford the vegetables. Those were great insights to be surprised by.”*

## Challenges in program evaluation

The preceding sections have discussed a variety of approaches and methods used to evaluate healthy food programs seen in our survey, interviews, and case studies. However, hospital community benefit professionals reported that program evaluation is one of their biggest challenges. Interviewees shared a number of obstacles in conducting program evaluation, including:

- Insufficient expertise, staff time, or other internal resources to develop and carry out robust evaluation plans
- Lack of funding to contract an outside evaluator
- Time frames of interventions are often too short to demonstrate health impacts that may take longer to achieve, with the related challenge of showing return on investment
- Challenges in collecting, sharing, and tracking confidential participant information among collaborating organizations

Another topic that some interviewees discussed was navigating the reality that the factors that drive eating behaviors, obesity, and diet-related health conditions are complex and embedded in multiple social, cultural, economic, and environmental contexts. It can be hard to know if an individual hospital’s healthy food access initiative solely “caused” any impacts observed for individuals directly participating in the intervention – much less moving the needle on population-level indicators.

One community benefit director reflected on several evaluation challenges that her facility is pondering:

*“We always have the population health goals, such as the broader reduction in obesity. Of course, we can’t claim credit for moving those numbers by ourselves. We look at tracking program performance, participation. We just don’t have the resources to evaluate everything to see if it really made a change in their behavior. I know it’s not quite good enough but you need someone to be able to follow up if you are doing pre- and post-intervention surveys. That’s a lot of work and we just don’t have the staff to do that.”*



## Challenges in evaluation design

Randomized controlled trials are considered the “gold standard” for evaluating the effectiveness of interventions, however, they require careful planning and resources to implement, and there can be ethical concerns about withholding treatment from control groups.<sup>xxi</sup> Before and after (pre/post) tests are widely used to obtain vital information about changes in health knowledge, behaviors, and biophysical indicators before and after an intervention, providing evidence that the program contributed to the change observed. However, ideally, such before and after data should be compared to data collected from a comparison group in order to avoid the risk of over-interpreting the effects of one’s intervention when secular trends may also be driving the observed change. Another approach is to implement a program that has already been rigorously evaluated and found to be effective and use selected, simplified evaluation methods to assess one’s own program. If the outcomes from one’s own program are similar to the comparable program, this information can support the case for the effectiveness of one’s program. However, relying on replicating proven programs, while valuable, may inhibit facilities from trying and testing new, promising approaches or programs uniquely tailored to community needs and opportunities. The Social Intervention Research and Evaluation Network ([SIREN](#)) offers a variety of resources that can assist in developing a strong evaluation design.



Children from the Boston Medical Center’s Summer Culinary Camp harvested crops on the farm before learning how to cook them in the hospital’s demonstration kitchen (Matt Morris, Boston Medical Center)

A hospital community health director described how her hospital system had started collecting information on unmet social needs in patients’ electronic health records. She expressed interest in how information on social needs and actions to address them could be shared among community clinics, other health care providers, and community organizations working together to help meet food, housing, utilities, legal services, and other needs for vulnerable community members. But she said she knew that data sharing and tracking among collaborating organizations was complicated:

*“I think there is a lot of potential in partnering with other health care providers and community organizations to help tackle some of the needs people face that affect their health. And I think we need to share data to really do that, as well as to evaluate impact. We want to be able to share data with partner organizations but also to be able to connect their information to ours. Or for someone else to do that, in a way that protects confidential information and connects the dots. We are far from being able to do that, but that is where I would like to see us go.”*

A community benefit director in the Northeast discussed two challenges regarding program evaluation – not having enough resources, as a small hospital, to conduct robust evaluation, and the pressure to show results in terms of health outcomes and health care costs to make the case for continued investment in programs:

*“As a small hospital and not an academic center, evaluation is challenging..People are anxious for results, which conflict with the need for long-term investment in programs to understand their effectiveness.”*



“The South Valley has a long history as a farming culture and I look at these gardening classes as producing the next generation of farmers” – Helga García-Garza, co-director of the Agri-Cultura Cooperative Network (Presbyterian Healthcare Services)

<sup>xxi</sup> Randomized control trials also can be designed so that the control group receives the intervention at a later time, or so that different groups receive different treatments – but still receive treatment.

Numerous community benefit directors emphasized that their own experience and expertise had not previously included research and evaluation and that they already wore many “hats” in their roles. Taking on the responsibility of community benefit program evaluation was challenging, and they were interested in guidance, technical support, and ready-to-use evaluation plans and instruments.

*“I’m a community benefit person and a program person. I am not an evaluation person or an epidemiologist, and I don’t have anyone on my team that has that skill set. I would like to rely on best practices about evaluation, have technical assistance, and have evaluation methods that are a little bit turnkey. So you don’t have to have your Ph.D. in data and evaluation to be able to know how to crunch these numbers.”*

*“I’m working on marketing and all of our social media, I’m doing internal communications, and then I’m working on the [Healthy Eating Active Living] program, and I’m also dealing with the heroin issue in our community. And then ‘Oh, by the way, where are your measurements?’ It’s hard to be really great at everything. It would certainly be nice if a measurement outcome process could be handed to me on a silver platter. Give me the survey I should be using and tell me who to give it to. That would be amazing.”*

Other community benefit directors described the importance of contracting an external evaluator to fill gaps in the expertise held by hospital staff until that staff capacity could be built internally:

*“Program evaluation is an area where we have struggled historically. For [a healthy living] initiative, we contracted an external evaluator, but that contract ended. We just hired an epidemiologist on staff for the first time – we now have that capacity on staff! We are thinking about new opportunities to evaluate what we’re doing not only internally, but how we are coordinating evaluation efforts with partners in our community.”*

## Conclusion

Evaluating community benefit programs is important in order to comply with regulations that require hospitals to provide information on the impact of activities undertaken to address health needs identified in the facility’s CHNA. It is also important for refining program implementation, identifying effective programs for continued or further investment, and communicating the impact of community benefit initiatives to stakeholders.

While community benefit program evaluation is both vital and required, federal regulations provide little specific guidance for hospitals about what kinds of and how much information they should collect about program implementation and impacts. Community benefit professionals report that evaluation is one of their greatest challenges.

In this chapter, we saw that program implementation data was the most commonly collected and reported evaluation information. Examples include the number of program participants, the number of produce prescriptions distributed, the quantity of produce donated, and participant satisfaction

with program location or activities. Program implementation data is important to assess whether program managers are meeting program delivery goals and to identify ways to refine and improve program performance.

Evaluators for healthy food access and healthy eating initiatives also commonly collect data on shorter-term health-related outcomes (such as changes in food insecurity, nutrition knowledge, and eating behaviors) and longer-term health outcomes (such as changes in BMI, blood glucose, blood pressure, and blood cholesterol). We found that many programs collect data on BMI and other biophysical health indicators even if they do not expect to see a change in these indicators over the course of the intervention. A desired outcome for many healthy food initiatives is reduced health care costs, including unnecessary use of the emergency department, and some programs’ evaluations are beginning to identify these outcomes.

Some community benefit initiatives target changing institutional or governmental food policies and improving food environments to make healthy choices accessible, affordable, and appealing. Evaluations of these efforts may focus on whether legislation has passed, or may

focus on performance assessments such as the number of advocacy meetings held, number of policymakers engaged, or the number of food environment (retail store) assessments completed.

Programs that seek to not only promote healthy food access and healthy eating but also to improve other social and environmental determinants of health evaluate program impacts such as the number of people with new job skills and the number of new jobs created. Some assessments also look at the value of food economy dollars localized, improved academic achievement, and the amount of food waste reclaimed.

A few insights and recommendations emerge from this study regarding evaluation of healthy food access programs.

First, it is important for community benefit professionals to think realistically about the expected impact of programs in the larger context of population health improvement. Several community benefit directors said that they wanted to see improvements in population health indicators, often at the county level or regional level, as a result of their community benefit programs. However, changes in the health status of populations is the result of many factors, policies, institutions, and conditions – as wide-ranging as financial crises, environmental regulations, school meals standards, food and beverage marketing, safety net programs, and unemployment as well as the funding and effectiveness of local public health, education, community development, and health care organizations. When we see changes in obesity, food insecurity, or diet-related health conditions at the population level, it is typically the result of combined and multisectoral local, state, and federal efforts. For hospitals implementing healthy food programs, it is important to articulate how their initiatives complement the work of other partners in a community strategy to improve population health.

Thus, when evaluating individual programs, it is useful to focus on evaluating program implementation (quantity and quality of program activities) and program outcomes (health-related impacts) for those who participate in or are directly affected by the program. When a produce prescription program is found to reduce food insecurity and lower A1c levels for patients who completed the program, we can articulate how the program may contribute to reducing food insecurity and diabetes prevalence at the population level.

Second, evaluation is a critical component of community health improvement programs, requires a significant commitment of budget and program resources, and should be planned at the same time as programs are developed. It is important to commit to and budget up front for the strongest evaluation design that is feasible.

## Recommendations for community benefit professionals

Consider your evaluation goals<sup>xxii</sup> and develop an evaluation plan with one or more implementation and outcome indicators appropriate to those assessment goals. Starting with a [logic model](#) is a good first step to identify desired impact and outcomes that demonstrate progress.

For food access and healthy eating programs, it is useful to collect data on changes in food and nutrition knowledge and eating behaviors, which may be easier to identify than changes in weight, blood pressure, or health care costs, which may take longer to observe. In addition, it is better to collect data on a few indicators that capture information on key program goals than to collect a lot of data that may not be utilized.

Try to align the evaluation methods used and data collected with programs that have a similar design. The guidance brief [“Evaluating healthy food access interventions”](#) contains guidance for evaluation planning and links to validated, frequently used surveys and data collection tools, with recommendations for common indicators, measures, and methods that can help establish common evaluation frameworks for assessing healthy food access programs.

Draw on community partners' expertise. It is valuable to engage community stakeholders in the parts of the evaluation process that are most relevant to their respective organizations. Public health departments are likely to have staff with training in research methodology and may be able to assist with evaluation design and data collection and analysis.

Communicate evaluation findings to stakeholders and the wider community. Sharing evaluation results is important for transparency and accountability and can build support for program continuation and replication. Communicating results to hospital staff members can also promote pride in the institution and improve employee satisfaction and retention. It is also important to share lessons learned from unexpected or disappointing evaluation results, enabling adaptation to improve programs or identification of ineffective strategies.

<sup>xxii</sup> As noted above, community benefit program evaluation is required to comply with federal reporting requirements, however, the requirements allow hospitals great latitude in how they approach program evaluation. For any given cycle of program evaluation, it is useful to consider whether the primary evaluation goals are to refine program design and implementation or to document the program's impacts, for example, on food environments, eating behaviors, health outcomes, or health care usage and cost. Evaluation goals should determine the evaluation design and the resources necessary to carry it out.



# Chapter 6. Conclusion and recommendations

Hospitals around the country are embracing the fact that access to healthy food is critical not just to preventing and treating diet-related health conditions, but also to building thriving communities, strong local economies, and sustainable food systems. Community benefit represents a powerful opportunity to promote community well-being through healthy food.

This report has presented findings from a national study of hospitals' community benefit practices to address obesity, community food environments, and diet-related health needs. In this concluding chapter, we review some of the key insights that emerged from our national survey, in-depth interviews, and case studies. We also discuss recommendations for best and promising practices to promote greater hospital community benefit engagement in strategies to support healthy food access and healthier food systems.

Several organizations provide excellent guidance for conducting hospital community health needs assessments (CHNAs), developing implementation strategies, and carrying out program evaluation. Appendix C lists selected resources discussing best practices for completing CHNAs and developing implementation strategies to address priority needs and promote health equity. While this report and its companion suite of resources, the "[Delivering community benefit: Healthy food playbook](#)," underline some best practices for community benefit in general, we focus more specifically on opportunities for community benefit investment in healthy food.



Red Tractor Farm: "People come to our farm and see what is produced and watch it throughout the season. They can relate vegetables more to their season and how everything is actually grown." Pictured: Dory Wegrzyn, Emma Ambos, and Casey Holland (Healthy Here PR at CWA Communications)

## Understanding food and diet-related health needs in CHNAs

Our national survey found that obesity and diet-related health needs are among the health concerns most commonly identified in CHNAs across the United States.

If a facility has identified obesity, food access, or diet-related chronic health conditions among the priority health needs in its CHNA, then initiatives to promote healthy food access and increased consumption of fruits and vegetables can be important components of an implementation strategy to address these needs.

### Collect data on food and diet-related health needs in CHNAs

In our review of survey respondents' CHNAs, we found that data on obesity, diet-related disease, and food access were frequently utilized.

Because the four leading causes of death in the United States – and largest sources of health care expenditure – [are directly linked to food and diet](#), it is important that facilities collect quality data about food access, food environments, and diet-related health needs in their CHNAs.

Hospitals today can draw on a wide variety of secondary data sources from federal, state, and local government agencies, especially public health agencies; nonprofit and advocacy organizations; schools of public health; and other organizations. State and national data provide useful reference points for comparing local conditions. Many government data sources provide county-level estimates, and some provide estimates for smaller areas such as zip codes or census tracts. See the playbook resource "[Data sources to assess food access, environments, and behaviors in CHNAs](#)" for a review of useful data sources.

**Hospitals that used Department of Agriculture data on food-related health needs in their most recent CHNA were 2.5 times more likely to have at least one community benefit program that targets food security or healthy food access as a health need.**



Secondary sources are an integral part of the CHNA data collection process, but they usually provide data collected or estimated at the state or county level. In order to obtain an accurate picture of community health conditions, particularly for sub-populations within the hospital service area, hospitals should collect data directly from their community members. This also allows the assessment to focus on the health needs of the community's most vulnerable populations, such as low-income residents and members of racial and ethnic minorities.

Primary data collection is critical in evaluating the food environment, food needs, food resources, and facilitators and obstacles to healthy eating in the community. Key informant interviews, focus groups, community surveys, and food environment assessments are vital to help hospital leaders make difficult decisions about where to direct limited resources to address a community's most pressing health challenges. Recommendations and tools for collecting primary data on food-related health needs can also be found in [“Data sources to assess food access, environments, and behaviors in CHNAs.”](#)



A child displays his summer meal in Arkansas. (Arkansas Children's Hospital)

## Consider health risks from climate change and industrial agriculture in CHNAs

Climate change affects the social and environmental determinants of health and has significant health impacts.

Industrial-scale conventional agricultural practices have significant community health implications and also are major contributors to greenhouse gas emissions.

Two guidance briefs, [“Climate co-benefits of healthy food access interventions”](#) and [“Community health risks of industrial agriculture,”](#) discuss including data on climate and industrial agriculture health risks in CHNAs as well as developing community health improvement strategies that consider climate and environmental co-benefits.

## Conduct collaborative community health assessments

It is becoming increasingly common – and considered best practice – for health care facilities to conduct collaborative community health assessments with other hospitals and health systems, local public health agencies, community health organizations, and other stakeholders.

In our national survey, 59 percent of respondents reported that they had collaborated with other hospitals (within or external to their hospital system) in their most recent CHNA.

Such collaboration enables partner organizations to more effectively utilize staff and financial resources, draw upon combined expertise, and avoid duplication of efforts, particularly when their service areas overlap. It enables the collection of better quality and more extensive data and can build a community-wide approach to health improvement.

Collaborative health assessments may identify a variety of important health needs, and different partner organizations may select a different subset of needs to prioritize in their implementation strategies. However, when it is possible to align on some health priorities and strategies, greater reach and impact can be achieved. Such alignment can reduce duplication of services, more effectively share and utilize limited resources, develop synergies, and expand or strengthen existing successful efforts.

## Include community food organizations in the CHNA process

Community organizations that work on food access and food system advocacy issues can play important roles in the CHNA process, leading to a more nuanced understanding of food-related health needs as well as resources and opportunities to address to these needs.

In our national survey, community benefit directors reported that they engaged community food organizations in their CHNAs in a variety of ways, including participating in data collection and review, prioritizing health needs, and participating in the CHNA steering committee.

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

Involvement of food-related organizations was strongly correlated with facilities having a community benefit program addressing healthy food access or food insecurity.

We recommend that facilities conduct a robust landscape assessment of existing community food organizations and resources and engage community food system stakeholders in the CHNA process. The playbook resource [“Engaging the community to understand food needs”](#) provides further discussion and examples of best practices.

## Develop and support the community benefit workforce

The community health improvement and community benefit responsibilities that hospitals undertake are diverse. They include community engagement, conducting CHNAs which require expertise in data collection and analysis, community health planning and implementation, program evaluation, financial and tax reporting, and communication with stakeholders.

Some hospitals lack sufficient staff expertise and training or dedicated staff time to carry out these responsibilities. It is important to identify gaps in needed skill sets and recruit or develop personnel for this work. Also important is dedicating staff to these roles so people are not “wearing too many hats” and splitting time across multiple jobs.

## Implementation strategies to address food- and diet-related health needs

Initiatives to promote healthy food access, healthier community food environments, and healthy eating can be effective strategies to address obesity, food insecurity, and diet-related health conditions.

Hospitals can extend the reach of their contribution to health by collaborating with community partners to build strong, local economies and vibrant, resilient communities. Investing community benefit and other resources in local and sustainable food initiatives and enterprises can be a pillar of a community development framework that addresses multiple social determinants of health by supporting economic growth, workforce development, access to healthy and affordable food, and social connectedness.



This sign appears on the Flint Fresh vendor stand at the local year-round farmers market and provides information about flavor, nutrition and local economic benefits of buying local produce. (Community Foundation of Greater Flint)

## Adopt healthy food access initiatives to address diet-related health needs

Survey respondents provided information on their community benefit programs addressing obesity, diet-related disease, or food access.

A key finding from the national survey was that the majority of community benefit interventions to prevent or treat obesity and diet-related health conditions centered around nutrition education and exercise promotion – and that fewer interventions focused on increasing access to healthy foods.

While the survey was conducted using a national random sample of hospitals in order to obtain a representative assessment of U.S. community benefit programming, key informants for our interviews were selected purposively – as facilities with promising initiatives that address healthy food access, healthy eating, or community food environments.

Many of the interview facilities participated in nutrition education and exercise promotion programs, however they also participated in a wide range of initiatives to increase affordable and convenient access to healthy food and improve community food environments. Community gardens, food pantries, and fruit and vegetable incentive programs were the most common types of healthy food access programs supported by these hospitals. The “Delivering community benefit: Healthy food playbook” includes [guidance briefs](#) on these and other recommended healthy food access programs, featuring examples and links to learn more.

More can be done to address healthy food access in our communities. Health professionals may educate overweight or diabetic community members to eat five servings of vegetables and fruits each day, but if there are no places to buy affordable fresh produce in the neighborhood or families are struggling with food insecurity, then it will be difficult to adhere to the recommendations.

Making access to healthy foods both convenient and affordable in our communities is an effective way to impact the social and environmental determinants that are the primary drivers of health or illness.



Flint Fresh Mobile Market aggregates produce from local farmers and brings fresh produce to neighborhoods lacking fresh food access each week. (Community Foundation of Greater Flint)

## Consider varied forms of community benefit support and diverse hospital roles

Hospitals support community benefit programs promoting healthy food access and healthy eating in numerous ways, including providing staff time to contribute to or manage a program, contributing other in-kind resources such as hospital land or equipment, and providing financial support. Our national survey found that most community benefit support was provided through staff time or other in-kind contributions.

### Commit community benefit resources

Financial support for community health initiatives, particularly grants for community partners to implement programs, may depend on fluctuating hospital finances. Massachusetts' [Guidance on community benefit](#) from the office of the attorney general presents best practices for community benefit, including budgeting and committing in advance to funding community benefit initiatives:

*"The implementation strategy should include a description of the resources a hospital plans to commit to its Community Benefits program to address the significant needs identified in its CHNA. Hospitals are strongly encouraged to incorporate their Community Benefits budget planning into their hospital-wide budget and fiscal planning processes. This ensures both that funds and resources will be available for Community Benefits programs and demonstrates the hospital's commitment to the Program and its community. The hospital should commit sufficient resources to fulfill its Community Benefits Mission Statement.... The AGO acknowledges that hospitals vary greatly in size, structure and available resources. A hospital should set the level of resource allocation for Community Benefits appropriate for its institution."*

Many community benefit directors emphasized the limits of their ability to contribute financially to community benefit initiatives. As a result, it can be important to seek and obtain diverse funding sources for sustainable financing of programs. It may be possible to secure a mix of federal, state, local, and private funding for healthy food initiatives. Including multiple partners is also valuable in order to engage and leverage different kinds of resources and expertise.

There are many ways that hospitals can support and add value to healthy food programs. We identified nine common role categories that hospitals are playing in support of healthy food initiatives. The guidance brief "[Hospital community roles](#)" discusses these recommended roles, with examples.

- Provide grant support
- Provide use of hospital facilities
- Conduct food insecurity or health screening
- Conduct nutrition, food, or cooking education
- Provide staff or financial support for program evaluation
- Provide staff support for grant writing or securing sustainable funding of community benefit initiatives
- Manage or coordinate a program or community collaboration
- Participate in a community collaboration
- Advocate for healthier food policy

### Advocate for policy, systems, and environmental change

Policy, systems, and environmental change approaches seek to transform the contexts in which we work, live, and play, making them more supportive of individual and community health and well-being. By engaging diverse stakeholders, these efforts can be the most sustainable and comprehensive ways to improve community health.

Hospitals around the country are using their voices to advocate for better food policy at federal, state, and local legislative levels as well as at the institutional level. We recommend that hospitals participate in legislative policy advocacy through engagement with [food policy councils](#) and as members of coalitions with food policy goals. At the institutional level, we recommend that hospitals collaborate with other [anchor institutions](#) to establish [shared standards](#) for healthy food and beverage purchasing and cafeteria and vending policy.



## Collaborate with community partners in implementing programs

Health care facilities can't improve the social and environmental determinants of health alone. Such change requires a collaborative, community-wide effort.

Community benefit professionals emphasized their reliance on partnerships with community organizations in the design, implementation, and evaluation of successful healthy food programs. Collaboration with community partners is essential to:

- Reveal gaps, areas of need, and opportunities to strengthen current assets
- Align with existing community efforts or bring groups and organizations together for greater coordination and synergy
- Develop more effective and appropriate strategies and approaches by consulting experts in the field with years of experience addressing food system and equity issues
- Strengthen relationships to help improve reach, impact, and long-term sustainability of efforts
- Avoid duplication of programs and services

The “Delivering community benefit: Healthy food playbook guidance” brief “[Identifying community partners](#)” can help facilities identify community organizations that can be critical partners in healthy food access initiatives.

An emerging best practice is for hospitals to not only conduct collaborative CHNAs with other hospitals in their area, but also to collaborate on implementation strategies. Achieving measurable improvements in health equity in underserved communities will require overcoming traditional competitive behavior among hospitals serving overlapping geographic areas for strategic alignment and scaling of community benefit resources across health care organizations.



Aspiring women farmers learn about agricultural practices, program activities, and opportunities at the WIA Farm Development Center at Genesys Health Park. (Michigan Food and Farming System)

## Equity considerations

In our research interviews, we found that many community benefit professionals were striving to make community engagement, and particularly, listening to and engaging “missing voices” and underserved groups, an essential part of each step of the community health improvement process.

We recommend that hospitals make every effort to identify the unique food-related health needs of vulnerable populations in their communities, and especially to include them in the data collection process so that disadvantaged groups can, themselves, describe the health needs and priorities in their communities.

Hospitals should design and implement food-related community benefit programs so that they serve and meet the needs of underserved and vulnerable

populations. This entails including low-income and minority groups in the design and implementation of programs, for example, in determining which program sites are most conveniently located for the target groups.

It is also vital to address challenges related to equity in program evaluation. Questions to consider include:

- Who is at the table when the evaluation plan is developed, and whose perspectives are missing?
- How is the program ensuring that it serves hard-to-reach populations?
- How is the program ensuring that its services are culturally appropriate?
- Who is left out of the evaluation methods chosen?



## Experiment and test new approaches

Our survey, interviews, and case studies revealed that while some hospitals rely on replicating “tried and true” health improvement programs, others are testing innovative approaches that may be uniquely tailored to community needs and opportunities. We recommend that, where feasible, health care organizations work with community partners to experiment with promising strategies to improve healthy food access, promote healthy eating, and foster healthier food systems. Hospitals can take advantage of an important opportunity to lead innovation and help develop the evidence base for new strategies.

## Pursue “triple-win” strategies

In this report we highlight innovative examples where hospitals employ their community benefit resources to

- improve access to healthy, affordable food, and at the same time
- support economic and workforce development in low-income communities, and
- strengthen local and sustainable food systems.

When working to create healthy food access programs, strategies can be integrated to support locally and sustainably produced foods, which can increase the health benefits, support regional farmers, and promote a more resilient food system. The “Delivering community benefit: Healthy food playbook” features a variety of community benefit [programs and strategies](#) that promote healthy food access while [investing in healthy places and economies](#).

Interventions that address healthy food access with a “triple win” strategy can address several social and environmental determinants of health as part of a transformative community development framework. Initiatives such as community-supported agriculture, fruit and vegetable prescription programs, mobile farmers markets, and farm-to-school programs increase access to healthy and affordable food, promote sustainable food systems, and can support local economic growth and workforce development in underserved communities. These “win-win-win” initiatives support local and sustainable food production while working to eliminate health disparities and empower and improve the lives of community residents.



Farmers at the WIA Farm Development Center at Genesys Health Park. (Michigan Food and Farming System)

## Anchors in Resilient Communities

One example of an “anchor strategy” to address social and environmental determinants of health through strengthening the local food economy is the work of [Anchors in Resilient Communities](#) (ARC) in northern California.

A multi-sector collaborative co-ordinated by Health Care Without Harm and Emerald Cities Collaborative, ARC leverages the assets and capacities of Bay Area anchor institutions and community-based partners to address social determinants of health in underserved neighborhoods in Richmond and Oakland. The collaborative’s initial project, MyCultiver, is a food production and distribution center that aims to produce 200,000 healthy and locally and sustainably sourced ready-to-eat meals per day to distribute to hospitals, schools, and other institutions through long-term contracts. The initiative will also create union jobs and cooperative ownership opportunities, working with local workforce partners to recruit and train from the Richmond community.

Kaiser Permanente plays a unique role in supporting the development and implementation of ARC and MyCultiver by providing community benefit and other investments and purchasing commitments. Kaiser Permanente also serves on the ARC advisory committee and on several working groups.

## Break down silos and adopt “anchor institution” strategies

Hospitals are increasingly recognizing the potential for a more comprehensive model of community health engagement – one that goes beyond community benefit and population health management to harness the many significant economic and other resources that hospitals can deploy to improve social and environmental determinants of health in the communities they serve. Health care organizations are embracing their “[anchor mission](#)” to more holistically support health and well-being, which can include:

- A commitment to local hiring and workforce development for populations with barriers to employment
- Programs to promote wellness for employees and their families
- Purchasing local, sustainably produced, and non-toxic materials and products
- Investing in green buildings and green energy

- Improved waste management
- Directing grants and social investment funds to local and regional initiatives that will promote equitable economic development and healthy, vibrant communities
- Advocating for local, regional, and national policy, systems, and environmental change

Reaching across departmental boundaries and aligning clinical goals with community benefit strategies to promote healthy food access and healthy eating can result in improved patient, staff, and community health outcomes.

**“We need to bring all of our health systems’ assets to bear on issues in our local communities.”**

– MAUREEN KERSMARKI, ADVENTIST HEALTH SYSTEM DIRECTOR OF COMMUNITY BENEFIT AND PUBLIC POLICY

An important way to connect clinical care with broader community health improvement goals is to make [screening for food insecurity](#) and other social needs a routine part of patient intake, to incorporate food insecurity and social needs data in electronic health records, and to work with community partners to [connect individuals and families with food and other needs to resources](#).

Cross-departmental collaboration among clinical, employee wellness, food service, sustainability, and senior administrative staff can also help craft the overarching narrative of how the facility is working to advance community health by supporting a food system that is healthier for people and the planet.



Teen chefs are “stirring up change” cooking healthy meals at the BeFit NYC Fitness Festival. (Family Cook Productions)

## Evaluating healthy food access programs

Hospital community benefit professionals reported that program evaluation is one of their biggest challenges. Interviewees shared a number of obstacles in conducting program evaluation. Insufficient expertise, staff time, or other internal resources to develop and carry out robust evaluation plans was frequently mentioned. Another common concern was the fact that the time frames of interventions are often too short to demonstrate health impacts that may take longer to achieve, with the related challenge of showing return on investment

Chapter 5 of this research report, on program evaluation, discusses in detail the approaches to evaluating healthy food access programs taken by community benefit professionals across the United States and offers numerous recommendations. Key recommendations include:

- Commit to and budget up front for the strongest evaluation design that is feasible. Evaluation is a critical component of community health improvement programs, requires a significant commitment of budget and program resources, and should be planned at the same time as programs are developed.
- Think realistically about the expected impact of programs. Interventions addressing social and environmental determinants of health have to contend with complex causality and the challenge of connecting health outcomes to specific programs. In addition, the timeframe to see health impacts from interventions addressing food access and food environments is typically longer than the timeframe employed by health care organizations.
- Consider your evaluation goals and develop an evaluation plan with one or more implementation and outcome indicators appropriate to those assessment goals. For food access and healthy eating programs, it is useful to collect data on changes in food and nutrition knowledge and eating behaviors, which may be easier to identify than changes in weight, blood pressure, or health care costs, which may take longer to observe.
- Align the evaluation methods used and data collected with programs that have a similar design. The guidance brief [“Evaluating healthy food access interventions”](#) contains guidance for evaluation planning and links to validated, frequently used surveys and data collection tools, with recommendations for common indicators, measures, and methods that can help establish common evaluation frameworks for assessing healthy food access programs.
- Draw on community partners’ expertise. Public health departments are likely to have staff with training in research methodology and may be able to assist with evaluation design and data collection and analysis.
- Communicate evaluation findings to stakeholders and the wider community. Sharing evaluation results is important for transparency and accountability and can build support for program continuation and replication..

## New horizons for investing in social determinants of health

Overwhelming evidence indicates that social and environmental determinants of health powerfully shape individual and community health outcomes.

However, in an environment in which much of health care operates on a fee-for-service model, in which there are few revenue streams for activities to address social and environmental determinants, and in which the repeal of the Affordable Care Act's individual mandate increases uncertainty about health care reimbursement, some hospitals may be hesitant to commit to further investment in social determinants of health.



Children help the demonstrator during a Farm, Fresh, Fabulous cooking course. (Family Cook Productions)

The good news is that many health care systems are shifting toward value-based care and Medicaid has become more open to reimbursing social services that contribute to health outcomes. As delivery system and payment reform strategies begin to align better with community health objectives, hospitals may be spurred toward greater investment in initiatives that address social and environmental determinants of health – such as promoting healthy food access and healthier food environments.

Still, an obstacle for many hospitals to investing in improving social determinants is the challenge of measuring return on investment in terms of reduced health care utilization and cost.

Some hospitals across the country are beginning to identify these positive impacts but need more time to test and evaluate programs. While challenging, securing continued investment in social determinants of health requires that health care organizations collaborate with community partners to demonstrate impact.

A broader, longer-term approach to identifying social return on investment<sup>51</sup> can be advanced through multisector collaborations in which schools, health care organizations, social service providers, and other community organizations coordinate services and share data. Such collaboration can assess diverse impacts of social determinants of health interventions over a longer time period, potentially capturing improved health status, higher high school and college graduation rates, and increased employment and earnings in underserved communities.

Community benefit professionals can tell the story of the impact of community health improvement initiatives in terms of multiple forms of return on investment. This can also include a more engaged health care workforce. Staff members at hospitals that invest in social determinants of health may feel more inspired, committed, and engaged in their work – proud and enthusiastic to be part of a health care organization that makes a difference in the community.



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# Appendix A: Research methods

This study utilized a mixed-methods research design that included a national survey of hospital community benefit directors, in-depth interviews with hospital community benefit professionals and other key informants, case studies, and a review of key literature.

## National survey

The research team developed a survey in the summer of 2016 to investigate how tax-exempt acute care hospitals organize community benefit programming and how they include food insecurity, healthy food access, and diet-related health conditions in their community health needs assessments (CHNAs) and implementation strategies.

The American Hospital Association's list of hospitals<sup>xxiii</sup> was used to draw a random sample of tax-exempt hospitals to survey. The survey population was defined as all private, tax-exempt hospitals that provide general, acute care services. The database was filtered to include only this relevant set of hospitals (excluding private and public hospitals and primary service types other than general medical and surgical or children's general), yielding a population size of 2,758 hospitals. The list was then sorted by state and hospital size. From this population list, a systematic random sample (with a fixed skip interval used to select units) of 930 hospitals was drawn.

The research team then researched email contact information for the community benefit "lead" at each sampled facility. Invitations to participate in an online survey, conducted via SurveyMonkey, were emailed to the sampled facilities. The survey required about fifteen minutes to complete, and a \$20 gift card was offered at completion to thank survey respondents for their participation.

The survey was in the field from August 16 until December 8, 2016, and 215 completed surveys were returned, resulting in a 23.12 percent response rate. Survey respondents fairly closely matched the population surveyed. Hospitals in the Northeast over-responded while the South under-responded. Hospitals participating in Accountable Care Organizations also over-responded.

### SURVEY SAMPLE CHARACTERISTICS

CHARACTERISTIC	SURVEY RESPONDENTS	POPULATION
<b>GEOGRAPHIC REGION</b>		
<b>Midwest</b>	36%	35%
<b>South</b>	22%	29%
<b>Northeast</b>	22%	18%
<b>West</b>	21%	19%
<b>RURAL/URBAN</b>		
<b>Urban</b>	62%	64%
<b>Rural</b>	38%	36%
<b>HOSPITAL SIZE</b>		
<b>Small (6-99 beds)</b>	43%	44%
<b>Medium (100-399 beds)</b>	46%	44%
<b>Large (400+ beds)</b>	11%	12%
<b>OTHER CHARACTERISTICS</b>		
<b>ACO hospital*</b>	44%	37%
<b>Children's hospital</b>	2%	2%
<b>Critical access hospital</b>	28%	25%
<b>Major teaching hospital</b>	7%	7%
<b>Minor teaching hospital</b>	40%	39%
<b>System affiliation</b>	67%	69%

\*Accountable Care Organization

<sup>xxiii</sup> An AHA hospitals database was obtained in summer 2016, which provided a set of data on hospitals from AHA's 2014 fiscal year survey, the most current information available. Source: [www.AHADataviewer.com](http://www.AHADataviewer.com), Current/FY2014 Data. Copyrighted and licensed by Health Forum LLC

## CHNA data

Survey respondents' CHNAs and implementation strategies were collected (either obtained online or requested from the facility when not yet available at the hospital website). We were able to obtain these documents from 206 of the survey respondents.

Reviewers collected a set of data from these documents, including identified and priority health needs, methods for prioritizing health needs, community resources to address health needs, descriptions of community benefit activities to address food and diet-related health needs, and other data not discussed in this report.

Descriptive statistics and logistic regression were conducted using Stata/IC 14.2 software to analyze patterns and correlations in the survey and associated CHNA and implementation strategy data. A summary report of the survey findings is available as a ["chartbook"](#) and is further discussed in this report.

### SURVEY RESPONDENT CHNA DATES

#### 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%

## Intervention activity types

Survey respondents provided information on up to three community benefit programs targeting obesity, food access, and diet-related health conditions as health needs. In addition to analyzing programs on the basis of *health need targeted*, the research team analyzed programs' *intervention type* – or the kinds of intervention activities the program conducted. Findings from this analysis are reported in Chapter 4 of this report.

Survey respondents' survey comments and CHNAs were reviewed to obtain information on the type of intervention that programs utilized. We assigned up to two intervention types for each program: addressing food insecurity or healthy food access, diet and nutrition education, exercise promotion, diabetes management (specific to managing diabetes for individuals already diagnosed, beyond nutrition education and exercise promotion), and other. Two researchers independently coded the programs and a third researcher reconciled the few differences by reviewing facilities' implementation strategies.

## Community resource identification index

The community resource identification (CRI) index discussed in Chapter 3 analyzes the community resources to address health needs listed in survey respondents' CHNAs, focusing particularly on organizations and resources for addressing food and diet-related health issues. Of the 206 CHNAs we reviewed, 184 listed community resources. The analysis assesses the *number* and *diversity* of the types of community resources listed in each CHNA.

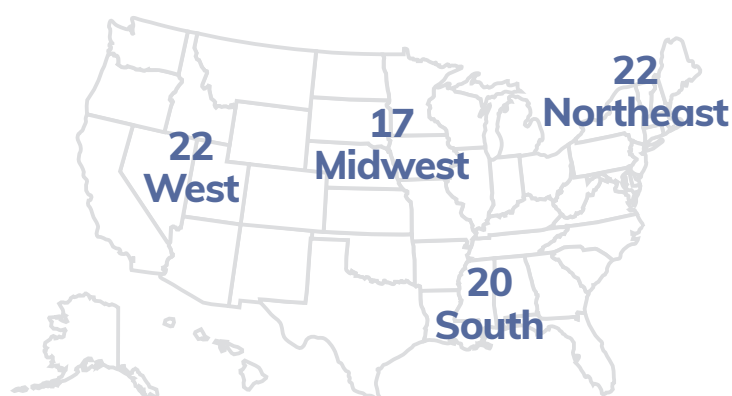
The CRI is the number of individual organizations listed multiplied by the number of organization types. A scalar was then added by dividing the result by 5. While this does not change the order of the final index, the effect is that CHNAs with more than 5 organization types will have their index proportionately increased while CHNAs with fewer than 5 organizations will have their index proportionately decreased. Finally, 1 was added and the square-root of the result taken for the final index values. This was done to reduce the spread from minimum to maximum to a more manageable amount (from 0 to 80 down to 1 to 9).  $CRI\ index = \sqrt{(1 + [\# \text{ individual orgs listed}] * [\# \text{ of org types}] \div 5)}$ . We weighted on region and used robust standard errors. Odds-ratios were not reported due to low statistical power and the challenge of precisely categorizing elements in resource lists.

## In-depth interviews

Semi-structured interviews were conducted with 124 key informants across the United States to explore the study's central research questions (discussed in Chapter 1) and probe emerging themes. The majority were conducted with community benefit professionals. Research interviews were also conducted with hospital association directors, public health professionals who are involved in collaborative health needs assessments with hospital partners, CHNA and community benefit consultants, and community-based organizations or other partners involved in collaborative healthy food access initiatives with hospitals. The tables below summarize the key informant categories and distribution of research interview participants.

While the survey was conducted using a random sample of hospitals to obtain a representative assessment of U.S. community benefit programming, key informants for our interviews were selected purposively. The research team sought out community benefit informants in all U.S. census regions with particular experience or expertise with community health initiatives that address healthy food access and community food environments. As a result, insights and perspectives from the research interviews reflect the experience of those who may be more engaged or innovative with healthy food access initiatives than is the norm. The research team adopted this selection strategy to understand the leading edge of community benefit-supported healthy food access programming and to identify case study hospitals. The interviews were 60-75 minutes in length and were recorded, transcribed, and analyzed for salient themes.

## RESEARCH INTERVIEWS WITH HOSPITAL COMMUNITY BENEFIT DIRECTORS BY GEOGRAPHIC REGION



## RESEARCH INTERVIEWS WITH OTHER KEY INFORMANTS

- 8 Hospital associations**
- 8 CHNA consultants**
- 9 Public health**
- 18 Community-based organizations**

## Case studies

In addition, 10 case studies were developed to examine the work of hospitals engaged in exemplary or innovative community benefit initiatives to promote healthy food access, and in many cases, strengthen local food systems and promote community development. The case studies were selected to represent a variety of intervention types as well as regional diversity and variation in hospital type and setting. The case studies explore:

- Key health indicators in the CHNA related to food access, obesity, and diet-related health conditions
- How healthy food access, obesity, and diet-related health conditions became prioritized in CHNAs and implementation strategies
- Hospitals' work with community partners to implement healthy food access initiatives, including
  - Hospital and community partners' roles
  - Program activities
  - Population served
  - Program goals
  - CHNA needs addressed
  - Key outcomes
  - Lessons learned

The case studies can be found in the [playbook](#) and are discussed in this report.

## Literature review

There is a rapidly growing body of literature and guidance regarding health needs assessments and clinical-community interventions to address priority health needs, including social determinants of health. There are also several recent studies and ongoing projects analyzing hospital community benefit expenditures. For this project, researchers reviewed the landscape of existing resources to inform the research analysis and development of recommendations and guidance resources in our associated [playbook](#). This included reviewing federal and state regulations or guidance for best practices

for CHNAs and implementation strategies. It also involved surveying established resources published or assembled by leading hospital associations, public health organizations and other government agencies, and advocacy groups addressing hospital community health initiatives, with a focus on research and resources concerned with food insecurity and healthy food access. References to many of these resources are included throughout this research report and the playbook. An annotated list of key resources can be found in Appendix C.

# Appendix B: Glossary

**A1c (blood glucose):** Hemoglobin A1c is a blood test that reflects the average blood sugar level for the past two to three months and is commonly used to diagnose and manage type 1 and type 2 diabetes.

**Body mass index (BMI):** BMI is calculated as weight in kilograms divided by height in meters squared, rounded to one decimal place. A BMI of 18.5 or less indicates that an individual is underweight; 18.5-24.9 is a normal weight; 25-29.9 is overweight; and 30 or greater is considered obese. While there are some [clinical limitations](#) to using BMI as a diagnostic tool, BMI is valuable for tracking the weight status of populations and identifying potential weight problems in individuals.

**Bodega:** A small urban grocery store, particularly in Spanish-speaking neighborhoods.

**Backpack/meal bag program:** Programs giving students, who are identified by school officials as in need, a bag of food to take home for weekends and school vacations.

**Community food environment:** The distribution and density of different types of outlets or locations to obtain food in a geographically defined community. The community food environment can also include the price, placement, and promotion of food choices; access to food in settings such as schools and workplaces; and food and nutrition information, marketing, and media.

**Community health:** Health promotion and prevention for the whole population within a defined geographic area.

**Community-supported agriculture (CSA):** CSAs provide members with a box or a “share” of goods including fresh, local fruits, vegetables, eggs, bread, and other farm products that are in harvest at the time of distribution. Traditionally, CSAs are programs in which consumers commit to supporting a local producer or group of producers for a growing season, paying up front for a share or membership that provides the producers with needed financial support at the beginning of the growing season. In return, the members receive a box of fresh local produce weekly throughout the season.

**Double Up Food Bucks:** A [program](#) created by the Fair Food Network that matches the value of Supplemental Nutrition Assistance Program (SNAP) benefits “when spent on fruits and vegetables with a financial benefit to local growers.” Double Up is currently active in 18 states.

**Electronic Benefit Transfer (EBT):** [EBT](#) is an electronic system which helps eligible Americans to pay for products using their government benefits. This includes food-related benefits like SNAP and Women, Infants, and Children (WIC) Nutrition Services.

**Equity:** Equity is when all groups have access to the resources and opportunities necessary to eliminate opportunity and resource gaps, and thereby, improve the quality of their lives, and differences in life outcomes cannot be predicted on the basis of race, class, gender, or other dimensions of identity.

**Farm-to-school program:** These programs consist of local food purchasing, hands-on, garden-based learning, farm field trips, cooking demonstrations, and integration of food-related information into classroom curriculum. The types of farm-to-school activities are unique to each school.

**Food Environment Assessment (FEA):** FEAs are studies focusing on the current status of a community’s food system. These assessments are helpful for community leaders seeking to understand how their food environment is impacting residents, before taking steps to improve upon it.

**Food bank, food pantry and food shelf:** Food banks receive, sort, store, and distribute food to smaller agencies that provide food directly to clients. Where food banks source and channel food resources at large scale, food pantries or food shelves provide food directly to food-insecure individuals and families in their communities.

**Food desert:** Food deserts are areas with inadequate access to fresh, healthy foods. The Department of Agriculture defines food deserts as “low-income census tract where either a substantial number or share of residents has low access to a supermarket or large grocery store.”

**Food hub:** A food hub is an organization or company that manages, distributes and markets food from local and regional producers to retailers and other institutions.

**Food insecurity:** The limited or uncertain access to enough nutritious and affordable food for all household members to lead an active and healthy life.

**Food insecurity screening:** A food insecurity screening is a method for identifying individuals facing food access and nutrition challenges. These screenings usually take the form of questionnaires conducted by health professionals with at-risk patients.



**Food policy council (FPC):** FPCs are groups of stakeholders from across the food system that work to address food insecurity, healthy food access, regional economic development, and environmental sustainability, among other goals.

**Food rescue:** The process of saving food from restaurants, grocers, and other retailers that would otherwise go to waste and providing it to food banks and other emergency food providers for distribution to food-insecure individuals and families.

**Food system:** The network that integrates food production, processing, distribution, marketing, consumption, and waste management.

**Fruit and vegetable prescription program:** These initiatives (also called produce prescription programs) partner with health care providers to enroll patients with nutritional needs in programs featuring “prescriptions” with vouchers that can be redeemed for fresh produce.

**Gleaning program:** Similar to food rescue, gleaning involves collecting excess crops from farms and gardens for distribution to food-insecure individuals and families.

**Health inequities:** Systematic, avoidable inequalities in health between groups of people.

**Healthy corner store initiatives:** These programs improve the availability of healthy food items in small stores, an increasingly important retail food source in many communities. The programs may involve collaboration between local government, business owners, and community-based organizations, including health care institutions.

**Hospital service area:** The geographic area where most of a hospital's patients reside.

**Implementation strategy:** A document outlining activities and goals designed to address the health needs identified in a community health needs assessment.

**Local food:** Health Care Without Harm defines “local” as food produced and processed within 250 miles of the health care facility.

**Mobile market:** A mobile market serves as a consolidated farmers market that can be transported in a van or other large vehicle to areas with limited fresh, healthy food options.

**Organic:** To be considered organic a farm or business must be certified by a USDA-approved third party certifier. Organic agriculture is defined by the National Organic Standards Board as “an ecological production management system that promotes and enhances biodiversity, biological cycles and soil biological activity. It is based on minimal use of off-farm inputs and on management practices that restore, maintain, and enhance ecological harmony.”

**Population health:** Health improvement and cost reduction strategies that target a population for which a health care provider or insurer bears financial risk.

**Resilience:** The capacity to recover quickly from difficulties; adapting well in the face of trauma or stress. Specifically climate resilience is the ability of a socio-ecological system function in the face of stresses from climate change and to adapt, organize and evolve into more desirable configurations to improve longer-term sustainability.

**Schedule H, Form 990:** A document that must be submitted to the IRS by all non-government hospitals seeking tax exemption each year.

**Sustainable food system:** A national web of sustainable regional food systems that support and complement each other and connect with the global food system to provide products otherwise unavailable. The full network of interconnected systems produce, process, and distribute food in a way that supports a healthy physical environment and promotes individual and community health and wealth.

# Appendix C: Selected resources for CHNAs and implementation strategies

## PART 1: SELECTED RESOURCES FOR CHNAs AND IMPLEMENTATION STRATEGIES (MULTI-COMPONENT RESOURCES)

This appendix contains a selection of organizations that provide suites of resources for conducting community health needs assessments (CHNAs) and developing accompanying implementation strategies.

ORGANIZATION	CHNA RESOURCES	IMPLEMENTATION STRATEGY RESOURCES (INTERVENTION SELECTION AND/OR PROGRAM EVALUATION)	RESOURCES SPECIFICALLY ADDRESSING FOOD ACCESS, FOOD ENVIRONMENTS, AND/OR OBESITY AND DIET-RELATED DISEASE PREVENTION	DESCRIPTION
<b>ADVOCACY AND RESEARCH ORGANIZATIONS</b>				
<a href="#">African American Collaborative Obesity Research Network</a> (AACORN)	X	X	X	Serves as a clearinghouse for research centering on the connections between race and obesity. Includes a library of academic publications, resources for completing community health needs assessment (CHNAs), a Healthy Community Design Legislation Database, and a variety of physical environment assessment toolkits.
<a href="#">America's Health Rankings</a>	X		X	Provides a useful tool for visualizing the disparities in health status among states across a variety of measures, including fruit and vegetable consumption, obesity rates, hypertension prevalence, etc.
<a href="#">American Planning Association's Food Systems Planning Interest Group</a> (APA-FIG)	X		X	Presents a national overview of sustainable local food systems and a case study focusing on the use of APA-FIG's community food systems assessment tool.
<a href="#">Build Healthy Places Network</a>	X	X	X	Provides assessment resources for a variety of food-related issues, chiefly relating to environments and obesity. Includes a "jargon buster" and case studies of innovative strategies for improving local food systems.
<a href="#">Center for Health Law and Policy Innovation</a> (CHLPI) (Harvard Law School)	X	X	X	"Food Is Medicine" reports and toolkits (available under "Current Projects," "Health Law & Policy" section) provide background and analysis on strategies for integrating nutrition and healthcare. Provides a list of initiatives aimed at combating food insecurity and diet-related diseases (DRDs).
<a href="#">Center for Rural Health</a> (University of North Dakota)	X			Resources to assist rural hospitals in completing CHNAs.
<a href="#">ChangeLab Solutions</a>	X	X	X	"Childhood obesity" section addresses strategies related to physical activity, food policy, healthier schools, and other promising approaches to address childhood obesity.

ORGANIZATION	CHNA RESOURCES	IMPLEMENTATION STRATEGY RESOURCES (INTERVENTION SELECTION AND/OR PROGRAM EVALUATION)	RESOURCES SPECIFICALLY ADDRESSING FOOD ACCESS, FOOD ENVIRONMENTS, AND/OR OBESITY AND DIET-RELATED DISEASE PREVENTION	DESCRIPTION
<a href="#">Children's Health Watch</a>	X	X	X	Provides research reports and policy briefs on food insecurity and its potential solutions, with emphasis on evidence for the effectiveness of programs like Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). Provides tools for health care professionals, including the Hunger Vital Sign screening tool.
<a href="#">Community Benefit Connect</a>	X	X		Multiple resources for community benefit professionals. Features a step-by-step guide to the community benefit process, including guidance on components of assessment, prioritization, and implementation.
<a href="#">Community Benefit Insight</a>	X	X		A searchable tool for community benefit data. Enables assessment of how hospitals allocate resources.
<a href="#">Community Commons</a>	X	X	X	Useful data resources for completing CHNAs, including state and county-level maps and guidance for identifying health inequities. Features several data sources/tools for assessing the food environment.
<a href="#">County Health Rankings &amp; Roadmaps</a>	X	X	X	Compiles easy-to-use data sources for CHNAs, including several data sources/tools for assessing food environments. Includes a "What Works for Health" feature--a library of recommended programs to address community health needs, including several related to promoting healthy eating and combating obesity.
<a href="#">Fair Food Network</a>		X	X	Provides strategies for improving diets for vulnerable individuals by doubling SNAP dollars and by using bodegas and other stores in low-income neighborhoods to promote the availability of healthy foods.
<a href="#">Feeding America. Map the Meal Gap</a>	X	X	X	Provides data and tools designed to assess the severity of food insecurity. In addition to the Map the Meal Gap tool, this site provides evaluation templates for programs to address food insecurity. Includes specific research on the food challenges facing vulnerable populations.
<a href="#">Food Research Action Center</a>	X	X	X	Focuses on federal food and nutrition programs, with emphasis on program impact reports. Includes several interactive tools (notably one designed to map free or reduced price lunch eligibility), a set of best practices for addressing key challenges in healthy food access (HFA), and other pertinent data and reports.
<a href="#">Guide to Community Preventive Services</a> (Community Preventive Services Task Force)		X	X	A library of health interventions providing information on evidence-informed programs. Includes interventions for cardiovascular disease, diabetes, nutrition, and obesity.

ORGANIZATION	CHNA RESOURCES	IMPLEMENTATION STRATEGY RESOURCES (INTERVENTION SELECTION AND/OR PROGRAM EVALUATION)	RESOURCES SPECIFICALLY ADDRESSING FOOD ACCESS, FOOD ENVIRONMENTS, AND/OR OBESITY AND DIET-RELATED DISEASE PREVENTION	DESCRIPTION
<a href="#">Healthy Communities Institute</a>	X	X		Data resources and guidance for identifying health inequities. Includes a multidimensional socioeconomic needs index, which measures underlying structural factors contributing to the health of a community. Offers health indicators and evidence-based interventions for purchase. Paired with consultative support, a CHNA guide, and other specialized tools.
<a href="#">Healthy Eating Research</a>		X	X	Research hub highlighting challenges and successes in improving healthy food access. Features a section with research reports on a wide range of interventions (including policy and regulatory measures to address healthy food access). Offers a number of approaches to community-based healthy food access improvement efforts.
<a href="#">Healthy Food Access Portal</a>		X	X	Information on food policy initiatives and a state-by-state overview of funding sources for healthy food access programs. Includes guidance on identifying the most appropriate healthy food retail/access strategies for a given community.
<a href="#">Johns Hopkins Center for a Livable Future</a>	X	X	X	Offers resources on food policy, food system sustainability, and food production. Includes a Food Communities and Public Health (FCPH) program highlighting a diverse array of successful interventions and offers literature for hospitals seeking to better understand the potential role of their community benefit resources in creating healthy food systems.
<a href="#">LiveWell Colorado</a>	X		X	Provides practical guidance for conducting community food assessments (CFAs), including advice on identifying community partners, defining the community, and guidelines for data collection.
<a href="#">Nat'l Collaborative on Childhood Obesity Research (NCCOR)</a>	X	X	X	Provides descriptions of research projects undertaken by the organization with data and lessons to inform decisions concerning the efficacy of similar programs. Includes the Measures Registry, a searchable list of diet and exercise indicators relevant to children's health.
<a href="#">Prevention Institute: Toolkit for Health &amp; Resilience in Vulnerable Environments</a>	X	X		Provides a framework for assessing, prioritizing, and designing initiatives to address community determinants of health. Applicable to local, state and national interventions and can be utilized in CHNAs and implementation strategies.
<a href="#">Public Health Institute (PHI)</a>	X	X	X	Provides guidance for conducting CHNAs, implementation strategies, program evaluation, and reporting community benefits. Includes a health disadvantages index, which assesses the populations that are most vulnerable to ill health. Resources found under the Tackling Hunger Project provide guidance on "Making Food Systems Part of Your CHNA" and "Creating Health Care and Community Partnerships to Tackle Food Insecurity."
<a href="#">Root Cause Coalition</a>	X	X	X	Data repository with resources and reports addressing the social determinants of health, particularly food insecurity. Forthcoming toolkits will feature a data repository with studies, articles, guides, etc. centered around hunger and food security.



ORGANIZATION	CHNA RESOURCES	IMPLEMENTATION STRATEGY RESOURCES (INTERVENTION SELECTION AND/OR PROGRAM EVALUATION)	RESOURCES SPECIFICALLY ADDRESSING FOOD ACCESS, FOOD ENVIRONMENTS, AND/OR OBESITY AND DIET-RELATED DISEASE PREVENTION	DESCRIPTION
<a href="#">Rural Health Information Hub</a>	X	X	X	Resources for community health improvement initiatives in rural communities. Features a "Rural Community Health Gateway" that allows rural community benefit leaders to search interventions/programs by topic (food insecurity, obesity, diabetes, etc.) and level of evidence. Includes examples of successful implementation and funding sources.
<a href="#">Social Interventions Research and Evaluation Network (SIREN)</a> (University of California, San Francisco)	X	X	X	Provides a library of academic evidence for the effectiveness or lack of effectiveness for a given social intervention. Contains information on nutrition and food system initiatives.
<a href="#">Stakeholder Health</a>	X	X	X	Provides case studies of best practices within each of its five focus areas (strategic investment, integrating care, technical innovation, asset mapping and transformative partnerships), as well as existing publications/tools relevant to them. Includes articles on strategies to promote healthy food within hospitals.
<a href="#">Strategies to Overcome and Prevent (STOP) Obesity Alliance</a>	X	X	X	Resources for obesity prevention efforts. The "Policy Room" includes bulletins for state leaders on obesity-related policy topics, obesity legislation recommendations, and recommendations for community benefit programming. "The "Research Center" features analysis of obesity prevention and treatment interventions, toolkits, and a review of current/best practices.
<a href="#">Wholesome Wave</a>		X	X	Offers toolkits and examples of best practice in creating fruit and vegetable prescription programs to promote healthy food access.

## HOSPITAL ORGANIZATIONS

<a href="#">Association for Community Health Improvement</a> (American Hospital Association)	X	X		Provides a series of instructional webinars and other resources on various community benefit topics, such as engaging community members in the CHNA process, forming effective partnerships with community-based organizations (CBOs), FAQs surrounding CHNAs, etc.
<a href="#">Catholic Health Association</a>	X	X		Offers step-by-step guidance for CHNAs, implementation strategies, program evaluation, and community benefit reporting. Convenes experts to answer questions concerning "what counts" as community benefit. Provides a primer on the social determinants of health and an up-to-date list of federal and state requirements for community benefit activities.
<a href="#">Kaiser Permanente CHNA tools</a> (with Community Commons)	X	X		Includes tools for community benefit reporting, a health indicator library, and a CHNA template for hospital use.

## PUBLIC HEALTH/ GOVERNMENT ORGANIZATIONS

<a href="#">Communities of Excellence in Nutrition, Physical Activity and Obesity Prevention</a>	X	X	X	Provides tools for collecting and measuring the quality, availability, and affordability of food in low-income communities. Includes survey templates, focus group convocation ideas, and sample implementation strategies. Features "Top Picks" for food-related interventions.
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ORGANIZATION	CHNA RESOURCES	IMPLEMENTATION STRATEGY RESOURCES (INTERVENTION SELECTION AND/OR PROGRAM EVALUATION)	RESOURCES SPECIFICALLY ADDRESSING FOOD ACCESS, FOOD ENVIRONMENTS, AND/OR OBESITY AND DIET-RELATED DISEASE PREVENTION	DESCRIPTION
<a href="#">Centers for Disease Control (CDC)</a>	X	X	X	Multiple resources for CHNAs and implementation strategies. The Health Impact Assessment Tool assesses the health impact of a given policy decision. The 500 Cities project developed local-level data on health determinants and disease prevalence in America's 500 largest cities. The 6/18 initiative recommends strategies to address major health problems, including several related to obesity prevention and healthy food access. The Modified Retail Food Environment Index is a useful tool for assessing healthy food access in a given community.
<a href="#">Behavioral Risk Factor Surveillance System (BRFSS)</a> (from CDC)	X		X	A nationwide survey of health behaviors. Data centers on health behaviors and the social and environmental influences on those choices. Includes data on diet and physical activity.
<a href="#">National Cancer Institute, Dietary Assessment Primer</a>	X	X	X	Provides tools for assessing diets/dietary patterns and recommendations for evaluation methods
<a href="#">National Institutes of Health: National Library of Medicine</a>	X			Compilation of resources useful for community benefit practice. Highlights include: an up-to-date section with news articles; nationally applicable population health sources, CHNA guides, community health toolkits, specific health data and policy sources for all 50 states, a list of federal and state community benefit regulations, current and archived webinars, academic articles, and a list of exemplary sample CHNAs.
<a href="#">New York State Dept of Health, Prevention Agenda</a>	X	X		Provides recommendations for program selection, implementation, and evaluation for initiatives to address a set of priority health needs. Includes the "Prevent Chronic Diseases Action Plan" and "Dashboard." Provides an extensive list of secondary data sources for CHNAs
<a href="#">Supplemental Nutrition Assistance Program Education (SNAP-Ed)</a>		X	X	Features a list of 80+ obesity interventions, which are searchable across target demographics, evaluation specifications, setting, and target behavior. Provides information on how to implement and evaluate each intervention.
<a href="#">United States Department of Agriculture, Economic Research Service (USDA ERS)</a>	X	X	X	Food Environment Atlas & Food Access Research Atlases provide data on a variety of food access/food environment measures, including fruit and vegetable expenditures. Houses a variety of "data products," including the Eating and Health Module of the American Time Use Survey, the Food Access Research Atlas, Food Environment Atlas, National Household Food Acquisition and Purchase Survey. The products are grouped by focus areas, namely "Food and Nutrition Assistance" and "Food Choices and Health." Features compilations of studies/evaluations of various types of child nutrition programs, SNAP, and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), as well as reviews of factors driving diet, nutrition, food access, etc.
<a href="#">University of Wisconsin School of Medicine and Public Health, Neighborhood Atlas</a>	X			The Neighborhood Atlas, developed with funding from the National Institutes of Health, is a digital mapping tool that provides users with socioeconomic data at the community level. Socioeconomic measures include income, education, employment, and housing.

**PART 2: SELECTED RESOURCES FOR CHNAs AND IMPLEMENTATION STRATEGIES (SINGLE-DOCUMENT RESOURCES)**

This appendix contains a selection of resources that may be useful in conducting community health needs assessments (CHNAs) and developing accompanying implementation strategies.

PUBLISHER, RESOURCE, YEAR OF PUBLICATION	CHNA RESOURCES	IMPLEMENTATION STRATEGY RESOURCES (INTERVENTION SELECTION AND/OR PROGRAM EVALUATION)	RESOURCES SPECIFICALLY ADDRESSING FOOD ACCESS, FOOD ENVIRONMENTS, AND/OR OBESITY AND DIET-RELATED DISEASE PREVENTION	DESCRIPTION
<b>FOOD-RELATED RESOURCES</b>				
American Hospital Association: <a href="#">“Food Insecurity and the Role of Hospitals”</a> (2017)	X	X	X	Discusses the multifaceted impact of food insecurity on health, with strategies for hospitals to help address the problem (including CHNAs, investing in food systems, and food security screenings). Features case studies of effective hospital interventions in preventing or addressing food insecurity.
Center for Health Law and Policy Innovation at Harvard Law School & Feeding America: <a href="#">“Food Banks as Partners in Health Promotion: Creating Connections for Client &amp; Community Health”</a> (2015)	X	X	X	Provides strategies for food banks to become further involved in health promotion, notably through CHNAs and implementation strategies.
Center for Health Law and Policy Innovation at Harvard Law School: <a href="#">“The Food is Medicine Advocacy Toolkit: Using Advocacy to Expand Opportunities for Food and Nutrition Services in Public and Private Healthcare Systems”</a> (2015)			X	Serves as a playbook to help hospitals advocate for improved healthy food access within their walls and in their service areas.
Center for Health Law and Policy Innovation at Harvard Law School: <a href="#">“Hospital Community Benefit: Addressing Nutrition as a Primary Community Health Need”</a> (2015)	X	X	X	A guide for hospitals seeking to prioritize nutrition within their assessments, this resource includes suggestions for partnerships and an overview of effective implementation strategies.
Centers for Disease Control: <a href="#">“Healthier Food Retail: Beginning the Assessment Process in Your State or Community”</a> (2014)	X	X	X	Provides a detailed overview of how to conduct an assessment of the food retail environment at the state or local level. Contains a number of resources and data sources, guidance on collaboration and methodology, and information on developing a successful implementation strategy after conducting the assessment.
ChangeLab Solutions: <a href="#">“Banking on Health: Improving Healthy Beverage and Nutrition Standards in Food Banks”</a> (2014)			X	Discusses the advantages of crafting healthier nutrition policies for food banks. Suggests implementing nutritional requirements for food bank donations.
ChangeLab Solutions: <a href="#">“Sugar-Sweetened Beverages Playbook”</a> (2013)		X	X	Recommends strategies to discourage consumption of sugar-sweetened beverages.

PUBLISHER, RESOURCE, YEAR OF PUBLICATION	CHNA RESOURCES	IMPLEMENTATION STRATEGY RESOURCES (INTERVENTION SELECTION AND/OR PROGRAM EVALUATION)	RESOURCES SPECIFICALLY ADDRESSING FOOD ACCESS, FOOD ENVIRONMENTS, AND/OR OBESITY AND DIET-RELATED DISEASE PREVENTION	DESCRIPTION
ChangeLab Solutions: " <a href="#">Leveraging Nonprofit Hospital 'Community Benefits' to Create Healthier Communities</a> " (2015)	X	X	X	Discusses ways that community benefit resources can be used to improve access to healthy foods and to combat diet-related diseases.
ChangeLab Solutions: " <a href="#">Dig, Eat, and Be Healthy: A Guide to Growing Food on Public Property</a> " (2013)		X	X	Focuses on potential partnerships between government institutions and other community actors (including nonprofit hospitals) interested in growing healthy and sustainable food on unused or underused public land.
Community Commons: " <a href="#">Environments Supporting Healthy Eating (ESHE) Index: A Benchmarking Tool Overview</a> " (2017)	X		X	An overview of the merits of the ESHE Index. Provides a valuable list of its potential applications and includes an explanation of the measures that make up the index.
Community Food Security Coalition: " <a href="#">Whole Measures for Community Food Systems: Values-Based Planning and Evaluation</a> " (2012)		X	X	A tool for evaluation, planning, and dialogue geared toward organizational and community change. Provides a series of rubrics for evaluating components of food systems based on their equity, environmental sustainability, and contribution to nutrition.
Health Care Without Harm: " <a href="#">Health and Economic Benefits from Hospital Investment in a Sustainable Food System</a> " (2018)			X	Makes a case for hospitals to invest in sustainable food systems, based on the health and economic benefits.
Johns Hopkins Center for a Livable Future (CLF): " <a href="#">Achieving the Triple Aim in Health Care Reform: The Importance of the Food System</a> " (2016)	X	X	X	A concise guide to incorporating food system initiatives to advance the "triple aim," including community benefit implementation strategies.
Johns Hopkins Center for a Livable Future (CLF): " <a href="#">Health Care Sector Support for Healthy Food Initiatives</a> " (2014)	X	X	X	Discusses the opportunities provided by CHNA guidelines for improving the affordability and availability of healthy food and for strengthening community partnerships.
LaClair Consulting Services: " <a href="#">From Farm to Table: A Kansas Guide to Community Food System Assessment</a> " (2016)	X	X	X	Provides a detailed list of common community food-related assets and indicators to consider when inventorying food system resources, as well as data resources, assessment tools, and examples.
National Collaborative on Childhood Obesity Research (NCCOR): " <a href="#">Measures Registry User Guide: Food Environment</a> " (2017)	X	X	X	Detailed guide to measures of food environments. Includes information on the reliability of certain measures, case studies using them, and key considerations for using them.
New York Academy of Medicine (NYAM): " <a href="#">Interventions for Healthy Eating and Active Urban Living: A Guide for Improving Community Health</a> " (2016)		X	X	Presents a collection of physical activity and nutrition programs that could be included in implementation strategies, all of which are placed in the context of federal, state, and municipal law and policy.



PUBLISHER, RESOURCE, YEAR OF PUBLICATION	CHNA RESOURCES	IMPLEMENTATION STRATEGY RESOURCES (INTERVENTION SELECTION AND/OR PROGRAM EVALUATION)	RESOURCES SPECIFICALLY ADDRESSING FOOD ACCESS, FOOD ENVIRONMENTS, AND/OR OBESITY AND DIET-RELATED DISEASE PREVENTION	DESCRIPTION
Public Health Institute (PHI): <a href="#">“Making Food Systems Part of Your Community Health Needs Assessment”</a> (2016)	X		X	Details how hospitals can incorporate food systems into their CHNAs. Provides recommendations for each step of the process.
Strategies to Overcome and Prevent (STOP) Obesity Alliance: <a href="#">“Recommendations for Nonprofit Hospitals Addressing Obesity as a Part of Their Community Health Needs Assessment and Implementation Strategy”</a>	X	X	X	Presents five evidence-based strategies for fighting obesity designed to be incorporated in CHNAs and implementation strategies by hospitals.
Union of Concerned Scientists (UCSUSA): <a href="#">“Hospitals and Healthy Foods: How Healthcare Institutions Can Promote Healthy Diets”</a> (2014)	X	X	X	Provides analysis and recommendations on the role of the health care system in improving food environments. Emphasizes the Food Insecurity Nutrition Incentive (FINI) program as a strategy to address food insecurity and food-related chronic disease.
Virginia Polytechnic Institute and State University, College of Agriculture and Life Sciences: <a href="#">“Community-Based Food System Assessment and Planning”</a> (2011)	X		X	Provides tools and instructions for assessment activities including developing a steering committee, defining goals, inventorying community assets, creating a baseline report, engaging a broad range of community stakeholders, hosting community meetings, and more.

#### SELECTED MORE-GENERAL CHNA, COMMUNITY BENEFIT, OR COMMUNITY HEALTH IMPROVEMENT RESOURCES

Brookings Institute: <a href="#">“Hospitals as Community Hubs: Integrating Community Benefit Spending, Community Health Needs Assessment, and Community Health Improvement”</a> (2016)	X			Presents an overview of efforts to leverage CHNA requirements to support population health improvement strategies.
Community Catalyst: <a href="#">“Hospitals Investing in Health: Community Benefit in Massachusetts”</a> (2016)	X	X		Examines community benefit regulations and guidelines in Massachusetts and associated practices. Provides recommendations for maximizing the impact of community benefit resources.
Community Catalyst/The Democracy Collaborative: <a href="#">“Community Benefit and Anchor Institutions: Linkages and Opportunities”</a> (2013)	X	X		Summarizes the ways in which community benefit requirements can be leveraged to reduce economic and social disparities in vulnerable communities.
George Washington University Milken School of Public Health: <a href="#">“Improving Community Health Through Hospital Community Benefit Spending: Charting a Path to Reform”</a> (2016)	X	X		Overview of the history of community benefit law in the United States. Includes a discussion of the “policy opportunities” that CHNAs and community benefit requirements have created for those seeking to address the social determinants of health.

PUBLISHER, RESOURCE, YEAR OF PUBLICATION	CHNA RESOURCES	IMPLEMENTATION STRATEGY RESOURCES (INTERVENTION SELECTION AND/OR PROGRAM EVALUATION)	RESOURCES SPECIFICALLY ADDRESSING FOOD ACCESS, FOOD ENVIRONMENTS, AND/OR OBESITY AND DIET-RELATED DISEASE PREVENTION	DESCRIPTION
Group Health / Kaiser: <a href="#">“Dose Matters: An Approach to Strengthening Community Health Strategies to Achieve Greater Impact”</a> (2015)		X		Overview of the “Dose” framework to evaluate community health improvement initiatives.
New York Academy of Medicine (NYAM): <a href="#">“Achieving the Triple Aim in New York State: The Potential Role of Hospital Community Benefit”</a> (2014)	X	X		Discusses the potential of New York state’s current community benefit framework to help achieve the “triple aim” in health care.
Public Health Institute (PHI): <a href="#">“Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practices, and Future Potential”</a> (2012)	X	X		Provides background on and advice for conducting the entire CHNA process.
Public Health Institute (PHI): <a href="#">“Supporting Alignment and Accountability in Community Health Improvement: The Development and Piloting of a Regional Data-Sharing System”</a> (2015)	X			Describes effective ways for hospitals operating within the same regions to share data collected in the course of their CHNAs, with the ultimate goal of aligning prioritized health needs among different systems and facilities in order to pool resources in the implementation stage.
Vitalyst Health Foundation: <a href="#">“Connecting the Dots: A Healthy Community Leader’s Guide to Understanding the Nonprofit Hospital Community Benefit Requirements”</a> (2015)	X	X		Provides an overview of community benefit regulations as well as existing and best practices.

# Acknowledgments

[Health Care Without Harm](#) seeks to transform health care worldwide so the sector reduces its environmental footprint and becomes a leader in the global movement for environmental health and justice. Working closely with Health Care Without Harm, [Practice Greenhealth](#) is the leading nonprofit membership and network organization for sustainable health care, delivering solutions to more than 1,200 members throughout the United States.

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 redefine hospital food, activate its potential to heal people and communities, and adopt practices and policies to support a healthy, sustainable food system.

Visit [healthyfoodinhealthcare.org](http://healthyfoodinhealthcare.org) for more information.

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