Food & Health Care

BI-STATE PRIMARY CARE ASSOCIATION

SERVING VERMONT & NEW HAMPSHIRE

Our vision is healthy individuals, families, and communities with equitable and quality health care for all.

Bi-State Primary Care Association is a nonpartisan, nonprofit organization that represents New Hampshire and Vermont's 28 Community Health Centers serving over 300,000 patients at 142 locations across every county in New Hampshire and Vermont. Bi-State works to promote access to quality, affordable primary health care with a special emphasis on reaching those most in need. Bi-State Primary Care Association was founded as a 501(c)3 charitable organization in 1986 with offices in Bow, New Hampshire, and Montpelier, Vermont.

Community Health Centers have always recognized the value of ensuring all members of our communities have access to food for a healthy diet. The first Community Health Center in the 1960s offered food prescriptions for malnourished children. Payment models that reflect the complexity of health-related social needs, including funding structures for health systems to collaboratively address "upstream" prevention, offer critical support for our patients.

While prevention remains core to our work, the dramatic increase of diet-related health conditions, their uneven impact across demographic groups, and clinical evidence base for the efficacy of targeted food-focused health care interventions, makes clear that we must also find better ways to integrate food into treatment options.

Integrating food and health means that access is never a barrier to essential food security, community health, or individual health care.

Among seniors receiving Meals on Wheels assistance, 93% are managing more than 3 medical conditions; 88% say the service helps them stay in their homes (MOW America). Medically Tailored Meals can reduce admissions to Skilled Nursing Facilities by 72% (Food Is Medicine Coalition)

34.2 million Americans have diabetes; one in three has pre-diabetes; the incidence of Type 2 diabetes has increased dramatically in 10-19 year olds, especially Black teens. 1 in every 4 dollars spent on health care goes to caring for people with diabetes (CDC, 2018).

66% of households accessing food assistance choose between paying for food or medicine (Feeding America)

Americans with chronic diet-related health conditions were 12-times as likely to die after contracting COVID-19; these conditions account for a disproportionate amount of deaths in rural areas (CDC, 2018 & 2021)

It is critical to address the role of food access for nutrition security, community health, and individual health care. However, the same approach won't work for every area. The individualized attention needed for treatment may create unnecessary barriers when applied to food security; general nutrition education for community health may be insufficient for clinical nutrition needs; the appropriate timeline for results changes depending on a program's goals. **This issue brief focuses on policy priorities for Community Health Centers to integrate food into individuals' health care.** It reflects how many Americans are now at the treatment stage of diet-related health conditions / pre-conditions.

Support Food and Nutrition Services

Patients with diet-related health needs should never have to choose between medical services or food-based interventions; comprehensive care means finding the best combination for an individual to reach their health goals.

Our Policy Priorities:

- **Food Insecurity Screening:** As screening becomes standard nationally, support health care practices in establishing information management systems that integrate the results into clinical and non-clinical workflows, manage transitions from hospital to home, and complete closed loop referrals to community partners and specialized nutrition services (e.g. RDs, DSMES)
- **Community Infrastructure for Medically Tailored Food:** Build from federal investment tools already in place that support value-added food production, rural distribution / transportation networks, and health IT, to support local and regional medically tailored food fulfillment systems.
- **Regulatory Structure for Food as a Health Service:** Provide regulatory clarity on using food as part of health services, including both meals and ingredients-based food interventions. Allow states the option for Medicaid coverage.
- **Medical Nutrition Therapy (MNT):** Expand Medicaid and Medicare coverage of MNT services, including for all diagnoses with a clinically-indicated course of dietary treatment and without a limit on the number of services received in a year. Research the role of food access in patients' utilization of these services.
- **Workforce:** Many food security programs, notably Older Americans Act funded services, rely on volunteer labor for food production. Build a pathway for expanding a paid workforce with capacity to manage medically tailored meals programs. Support creation of patient care teams that blend licensed medical providers, non-clinical health care staff, social service organizations, and community organizations. Reimburse for telehealth and other modalities that allow for high patient engagement during dietary change.

Farm Bill - Produce Prescriptions (PPR):

- **Clarify Intent of Produce Prescription Grants:** The current language cites the objective as increasing produce consumption to "reduce healthcare use and associated costs." More relevant objectives would be either to reduce avoidable health care use through improving community health or to integrate food access into health care services for diet-related conditions.
- **Allow Health Care Practices to Serve as Partners or Leads:** Grants can support community collaborations with either health care or community groups as lead; for programs targeting specific health outcomes it is most appropriate for health care to serve as lead. Current language requires a health care practice to appear in the "partner" role for grant applications.
- **Use USDA Food Insecurity Measures for Eligibility:** Health care practices commonly incorporate USDA food insecurity tools as part of risk screening. Current eligibility language relies on the income-based SNAP formula; a health-focused program should instead use the screen correlated to health outcomes.
- **Separate Grants for PPR Programs and Funds for PPR Research:** The current Technical Assistance and Evaluation structure combines research and program implementation. This does a disservice to PPR development. It requires keeping all programs in the same basic model, with clear pre- and post-participant cohorts, and limited innovation to respond to community needs. It introduces a high burden for potential applicants who must also serve as researchers, and may redirect a large portion of funds to third party evaluators. It introduces barriers to patients, who may have a need to access produce but no wish to become research subjects. Plus, valid research of PPRs requires much greater health system involvement than is supported by these funds.
- **Support Projects that Value Patient Choice:** PPR grants that emphasize a single community organization providing fresh, whole ingredient produce to a set of patients over a defined period of time unnecessarily limit patient choice. Greater health impacts are possible if grant applicants can invest in program delivery infrastructure that offers patients options for program format or location (including home delivery), how the produce is incorporated into their diet (including lightly processed products), and how the program is integrated with clinical health care services.