Board Vision Exchange

October 23 and 24, 2017

Second Harvest Food Bank, 411 Mercy Drive, Orlando, FL 32805

Board Vision Exchange Overview

SESSION #3 - October 23 & 24

Second Harvest Food Bank of Central Florida

October 23, 5:30 – 8:30: Social, tour of the food bank, and dinner.

At 5:30 we will have a tour of the facilities. We will use the points of interest to discuss tactical and strategic thinking, why we are doing things one way versus another, opportunities and challenges.

October 24, 8:00 – 3:00 – Program at Second Harvest Food Bank of Central Florida. At our Houston Vision Exchange, Brian Greene challenged us to consider how we aim our "engine" at more than just food security. In our St. Paul conversation, it was argued that our future isn't just in the "food industry" at all – but, perhaps even predominantly in the next 5-10 years, in Health and Wellness.

The conversation in Orlando will go further into the topic of Health and Wellness. We'll share with you what initiates we have in the works and what's on the drawing board in terms of Health & Hunger in Central Florida.

Kate Leone, Sr. VP of Government Relations for Feeding America will join us to discuss policy and how it may relate to furthering this work. Kate oversees public policy, government relations and advocacy teams as well as leading the efforts to advance Feeding America's policy priorities through legislative and regulatory initiatives—working with Congress, federal agencies and the White House.

Prior to joining Senator Reid's staff, Leone served as counsel to the previous Senate Democratic Leader, Tom Daschle (D-SD), and worked as a senior policy advisor on the Senate Democratic Policy Committee. Her previous experience includes working on health care matters as an attorney for the U.S. Department of Justice's Antitrust Division.

Also on the agenda, we'll have an interactive session on what's next in Health & Wellness, how can we clarify our path and vision? What are our challenges and opportunities? And a recent insight on how we might be funded through Medicaid will be revisited with updates.

In the afternoon, we'll have a series of "Beg/Brag/What If "presentations. These topics will be specific to foodbanking, but apart from the Health & Wellness space.

Registration
It is important that you register online. If you have not registered your attendance through the Eventbrite link online, please contact Judy Odom, jodom@feedhopenow.org, 407-514-1015. She will provide you with the link.

Airport
Orlando International airport is reasonably convenient to the suggested hotel and Second Harvest Food Bank.

Accommodations
Hotel – Courtyard Marriott Orlando Downtown, 730 N. Magnolia Avenue, Orlando. The link to the hotel is found on the Eventbrite Registration Page. A special rate of $149.00 has been confirmed (ending on October 15th) under "Orlando Visionary Group."

Transportation
A bus will be at the Courtyard Marriott (hotel) on October 23rd at 4:45 p.m. The bus will bring you to the dinner and return you to the hotel at the conclusion of dinner.

A bus will be at the hotel at 7:15 a.m. on October 24th. It will bring you to Second Harvest for the 8 a.m. breakfast.

Please note: You will need your own transportation from the airport to the hotel on October 23rd and from Second Harvest to the airport on October 24th.

Next Board Vision Exchange
Please mark your calendars for the next Board Vision Exchange session:
Columbus – November 27 & 28

Board Vision Exchange
Monday Evening, October 23

Location: Second Harvest Food Bank of Central Florida Community Room

---

AGENDA

4:45	I. Bus will be at the Courtyard Marriott Orlando Downtown
5:30	II. Cocktail reception
6:00	III. Tour of the food bank
7:00	IV. Dinner

Note: After dinner, the bus will take attendees back to the hotel

Dinner choices:

- Beef Wellington
- Lemon Rosemary Buerre Blanche Chicken
- Eggplant Napoleon (vegetarian)

Important: Please email Judy Odom at jodom@feedhopenow.org with your dinner selection by Wednesday, October 18th. If we do not receive your dinner choice, we will select a dish for you.

Board Vision Exchange
Tuesday, October 24

Location: Second Harvest Food Bank of Central Florida Community Room

---

AGENDA

8:00	I. **Breakfast**	
8:30	II. **Welcome & Introductions**	Cathy Valeriano
9:00	III. **Who Are We Talking About?**	Special Guest(s)
9:15	IV. **Health & Hunger Overview – Central Florida** ➢ Q & A	Dave Krepcho
9:45	V. **Public Policy** ➢ Influence and alignment w/ Health & Hunger	Kate Leone
10:30	VI. **Vote with your feet exercise**	
10:45	VII. **Getting Funded for Food Bank Work in Health & Hunger** ➢ Medicaid update ➢ Food Bank expectations and the Health Care industry	
11:15	VIII. **Table Discussions and Group Sharing** ➢ Messaging re: Food Bank focus ➢ What does this work look like three years out? ➢ What kinds of goals/strategies need to be identified?	
12:30	IX. **Lunch**	
1:00	X. **Table Discussions and Group Sharing** ➢ Board Appetite for organizing collectively ➢ What education & research still needs to be done?	
2:00	XI. **"Beg / Brag / What If" Presentations**	
3:00	XII. **Meeting Adjourned**	

BOARD VISION EXCHANGE – ORLANDO, OCT. 23 & 24 – BACKGROUND PRE-READ

I. Two –thirds of our day on Oct. 24 will be a further discussion on Health & Hunger. This will give us a chance to go a bit deeper into the topics we touched on in Minneapolis/St. Paul. Here are a few topics to ponder in your way to Orlando to help orient around our discussions:
The health impacts are clear on eating more nutritiously, the economic argument continues to build as a benefit for the patient, healthcare system and our communities.

- A RTI International/UNC Chapel Hill study states:
  Potential impact of reductions in food security on Medicaid and Medicare costs:
  - A 10% reduction in food security would reduce Medicaid by $1.2 billion

- The Urban Institute states that food insecure households' health care costs were 49% higher than those of secure households.

II. Included within this pre-read is an article titled "All Policies Are Health Policies". The article is from 2014, however, contains some potent statements that beg the question of looking more closely at the connection between policy and healthcare at the State and Federal levels. Sustainable DC calls for the city to improve in health and wellness, jobs, the economy, ensure equity and diversity and protect the environment. The author states: "But what makes the plan, well, audacious, is that healthcare takes center stage in every one of the initiatives."
- How can the Farm Bill discussions be better informed of the healthcare connection? Also included in this Pre-Read is a "Food Is Medicine" pilot that the Center for Health Law and Policy Innovation of Harvard Law School drafted.
- How can the SNAP and Medicaid application process be tied together seamlessly? How else might we state the case?

III. We are making this session interactive with plenty of room to explore these and other facets of the Health & Hunger topic.

IV. The afternoon will include a series of three to four brief presentations on various topics. We'll move away from Health & Hunger. These will provide a change-of-pace and variety of thoughts and ideas.

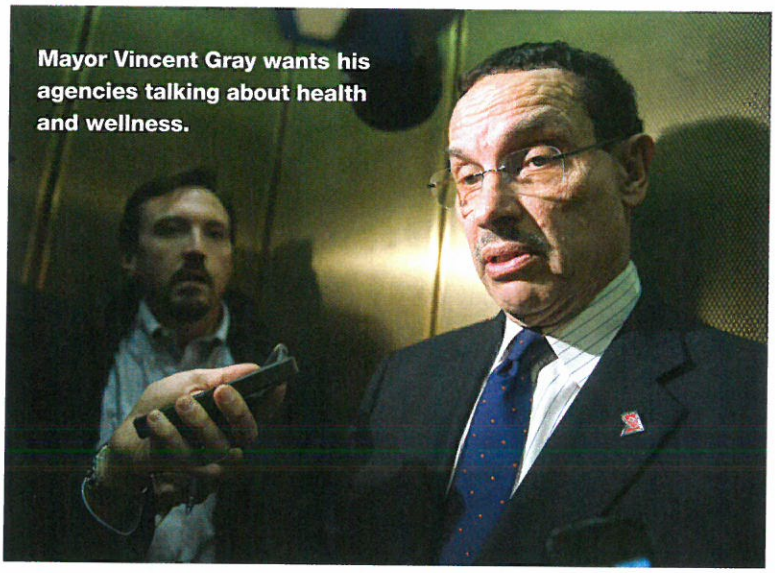
By David Levine

All Policies Are Health Policies

The District of Columbia plans to weigh health factors in all future projects.

Washington, D.C., Mayor Vincent Gray in 2011 set forth an audacious goal for the nation's capital: "In just one generation—20 years—the District of Columbia will be the healthiest, greenest and most livable city in the United States."

The plan, known as Sustainable DC, calls for the city to improve health and wellness, grow jobs and the economy, ensure equity and diversity, and protect the environment. In all, there are nearly one dozen initiatives. But what makes the plan, well, audacious, is that health takes center stage in *every* one of the initiatives.



Mayor Vincent Gray wants his agencies talking about health and wellness.

APIMAGES.COM

Driving this goal is a concept known as Health in All Policies (HiAP), which has been gaining momentum throughout the nation. The idea is that all policy is health policy; HiAP advocates recommend scrutinizing any proposed program, project or policy before it is ever implemented for its potential effect on the health and well-being of citizens. Washington, D.C., has created a HiAP task force that will set recommendations to ensure health equity is integral to the sustainability plan.

But setting a health-based threshold for such a broad array of community initiatives isn't easy. To that end, the district's health department is working with the National Association of County and City Health Officials (NACCHO), which comprises 2,700 local health departments across the United States, to promote health and equity, including awareness about HiAP. The association's HiAP outreach efforts started last May with a series of two-day leadership academies, which were funded by the Centers for Disease Control and Prevention and included the local health departments from the district, Fairfax County, Va.; Montgomery County, Md.; and the city of Baltimore. Other jurisdictions involved with HiAP strategies include California and King County, Wash.

Ken Smith, NACCHO's lead program analyst for chronic disease and environmental health, says the academies are an extension of general training they do with other city and county health departments, but are expanded for HiAP training to include cross-sector teams. "We had people from planning, housing; one brought someone from their board of supervisors," he says. "We wanted people from different perspectives, not just within the health sector."

The first component of the curriculum was getting everyone to understand that many of the problems within health are determined by the environment, and the decisions that shape the environment are outside the health sector, according to Smith. The goal is to have "everyone on the same page about the role of other departments in shaping health," he says. "We then cover strategies for integrating the different agencies to address these complex problems."

The D.C. trainees talked about their specific barriers, including competing priorities, systems that don't talk to each other and categorical funding. The district also has some unique benefits, including a number of "in-house experts" that other jurisdictions may lack.

It's now up to the district's HiAP task force to develop a plan, and NACCHO will be there to help. Smith and his team check in regularly to troubleshoot and share stories of what's working in other areas, and "they have access to all our resources and can request any kind of assistance."

A long-term goal of the leadership academies is to cultivate regional leaders. "A lot of issues of environmental health are regional in nature," Smith says. For example, "with D.C. taking a leadership role in air quality, they can help facilitate a more regional way of addressing this problem."

Smith calls Sustainable DC a perfect example of the HiAP approach because it establishes the planning that ensures different agencies talk to each other. "Our position is that local health departments, working in collaboration with other agencies, should take the leadership role in implementing health and wellness policies," he says. "Let city and county governments take the lead. They are at the right level to move health forward as a major policy consideration where people live, work and play." G

Email levkern@nycap.rr.com

THE FOOD IS MEDICINE PILOT: CONNECTING LOW-INCOME INDIVIDUALS WITH SERIOUS HEALTH CONDITIONS TO MEDICALLY APPROPRIATE NUTRITION

Increasing evidence demonstrates that proper nutrition not only helps prevent a number of diseases, but also is an essential part of treatment and management of serious illness. However, 15.8 million households in the United States still face severe food insecurity and many low-income individuals with critical health conditions lack access to adequate nutrition, a reality that impacts their health outcomes and health care costs.[1]

The **FOOD IS MEDICINE PILOT** aims to improve health outcomes and to lower healthcare costs of seriously ill, low-income people by:

(1) Connecting individuals to nutritious food that is medically appropriate for their health conditions; and

(2) Rigorously evaluating the impact of providing therapeutic nutrition on these individuals' health outcomes and health care costs.

Chronically ill people living in low-income households face extreme challenges accessing foods that are recommended by health professionals.

Despite the availability of food assistance programs, many low-income households still struggle with food insecurity. In 2015, approximately 12.7% of American households (15.8 million) were food insecure,[2] meaning that the household's "access to adequate food is limited by a lack of money and other resources."[3] Lack of access to healthy food has a direct impact on the health of an individual, affecting the incidence, management and outcomes of numerous health conditions, including type 2 diabetes, obesity, cardiovascular diseases, hypertension, and certain cancers.[4]

When food insecure individuals are challenged by chronic illness, circumstances become even more difficult by virtue of an added urgency to the need for not just adequate food, but specific food that will help them regain and maintain health. Almost half of all adults in the United States—117 million people—have one or more chronic health conditions, and 25% have two or more chronic diseases.[5] Individuals with chronic health conditions consume approximately 86% of all health care spending.[6] The cost of some of the most common chronic diseases are high: with cancer costs estimated at $157 billion each year,[7] heart disease and stroke at $314.5 billion,[8] obesity at $147 billion,[9] and diabetes at $245 billion annually.[10] Adults who are food insecure are significantly more likely to report cost-related underuse of prescribed medication, meaning that the health care these individuals receive will not be as effective in achieving desired health outcomes from medical treatment.[11] Data has also shown that a small percentage of Medicaid-only enrollees consistently accounts for a large percentage of total expenditures for the program, with the most expensive 5% accounting for almost half of the expenditures.[12] Enrollees with diabetes consistently constitute almost 20 percent of the high-expenditure group.[13]

Growing research demonstrates that using food as medicine is effective at improving health outcomes and reducing health care costs among individuals living with one or more chronic illness.

Research shows that the provision of medically appropriate food can have a significant impact on health care outcomes and costs. In particular, the provision of medically appropriate meals or food packages has been shown in pilot studies to be effective at improving clinical outcomes, reducing the number and length of hospitalizations, and affecting lifestyle behaviors such as medication adherence and substance use.

In one study, the provision of medically appropriate meals to people at acute nutritional risk who live with serious chronic disease led to significant decreases in overall mean monthly health care costs and inpatient

costs, as well as to reduced cost and frequency of hospital admissions and length of hospital stays compared to a control group.[14] Another program that offered medically appropriate food boxes to clients with diabetes resulted in improved glycemic control, increased fruit and vegetable intake, and higher reports of self-efficacy. It also reduced diabetes distress and the need to make tradeoffs between buying food and medicine.[15]

Improvements in health outcomes also occurred when medically-tailored meals were provided to patients with HIV and/or type 2 diabetes. The provision of medically-tailored food was associated with an increase in food security among participants, a decrease in sugar and fat consumption, a decrease in depressive symptoms, a decrease in binge drinking, a decrease in diabetes distress and a decrease in the need to sacrifice food for health care or health care for food.[16] The same study showed evidence of increased consumption of fruits and vegetables, increased adherence to antiretroviral therapy for participants with HIV and increased diabetes self-management for participants with type 2 diabetes.[17]

Critically, the entities providing the medically-tailored food in all of these studies were community-based nutrition resource providers such as meal-delivery programs and food banks that had the capacity to design and distribute therapeutic meals and food packages. The Farm Bill provides a significant opportunity to: (1) support this vital safety net of nutrition resource providers as they deliver a specialized and much-needed service for some of the most vulnerable members of their communities; (2) capitalize on compelling early data on health outcomes and health care costs and add to the body of research on the impact of therapeutic nutrition on disease; and (3) connect low-income individuals living with chronic disease to the critical nutrition resources they need.

Recommendation:

The next Farm Bill should include a FOOD IS MEDICINE PILOT that supports and rigorously evaluates the provision of medically-tailored food to low-income people living with certain serious diseases.

The **FOOD IS MEDICINE PILOT** will improve the health of low-income individuals with serious illness by ensuring their access to healthy and medically appropriate food. The **FOOD IS MEDICINE PILOT** (the Pilot) will operate as follows:

(1) The Pilot provides funding to community-based nutrition resource organizations and their committed research partners through grants that are used to provide medically-appropriate meals or food packages to low-income people living with serious health conditions. Medically appropriate food, also known as medically-tailored food or therapeutic food, is defined as meals or food packages designed by a Registered Dietitian to be appropriate for someone with one or more specific health conditions and special health-related dietary needs.

(2) Entities eligible for grants from the Pilot are nonprofit organizations, government agencies and any other any other entity that a State designates. The entity must operate a community-based food assistance program that provides, or that has the capacity to provide, medically-tailored food. Eligible entities include but are not limited to meal-delivery organizations, food banks, and food pantries. Eligible entities must have a committed research partner that will provide or can obtain health care outcome, utilization, or cost data that can be used to evaluate the impact of the Pilot.

(3) Grant funding must be used by the recipient entity to serve individuals who (a) qualify as low-income, (b) have one or more serious health conditions, according to a list of eligible health conditions to be established by United States Department of Agriculture (USDA) in consultation with the U.S. Department of Health & Human Services (HHS); and (c) have a recommendation or referral for a medical diet from a health care provider. Eligible health conditions should include at least the following: diabetes, cancer,

renal disease, chronic heart failure, Multiple Sclerosis, Alzheimer's, and HIV/AIDS.

(4) In order to assess the Pilot's impact and to inform future discussions on its expansion and improvement, eligible grantees must commit to researching and evaluating the effects on health outcomes and/or health care costs of those who receive medically-tailored meals or food. Successful applicants will have a letter of commitment from a research and/or health care partner that outlines a research and evaluation plan and speaks to the availability of data on health outcomes and/or health care costs among recipients of the Pilot meals or food packages. A portion of the Pilot's grant funding awarded to recipients can be used to support research and evaluation of the program.

The FOOD IS MEDICINE PILOT would be a critical and innovative step toward improving the health of some of the most vulnerable members of our nation through facilitating access to healthy and medically-appropriate food. The mission and objectives of the FOOD IS MEDICINE PILOT aligns with the USDA's mission to "end hunger and improve health in the United States."[18] Inclusion of this innovative program in the Farm Bill is an opportunity to underscore the powerful role that food—and by extension, our food system—can play in addressing some of our nation's most complex and costly diseases.

Endnotes

1 Alisha Coleman-Jensen et al., U.S. Department of Agriculture, Economic Research Service, *Household Food Security in the United States in 2015* 6-7 (2016), https://www.ers.usda.gov/webdocs/publications/err215/err-215.pdf
2 *Id.*
3 *Id.*
4 Dietary Guidelines Advisory Committee, *Scientific Report of the 2015 Dietary Guidelines Advisory Committee* 1-2 (2015), https://health.gov/dietaryguidelines/2015-scientific-report/pdfs/scientific-report-of-the-2015-dietary-guidelines-advisory-committee.pdf; Dietary Guidelines Advisory Committee, Report of the Dietary Guidelines Advisory Committee on the Dietary Guidelines for Americans, 2010 (May 2010), https://www.cnpp.usda.gov/sites/default/files/dietary_guidelines_for_americans/2010DGACReport-camera-ready-Jan11-11.pdf; Véronique L. Roger et al., American Heart Association, *Heart Disease and Stroke Statistics – 2012 Update: A Report from the American Heart Association* (2012), http://circ.ahajournals.org/content/125/1/e2.extract.
5 According to 2012 data. *Chronic Disease Overview*, Ctrs. for Disease Control & Prevention, https://www.cdc.gov/chronicdisease/overview/, (last viewed Mar. 28, 2017)
6 *Id.*
7 2010 data. *Chronic Disease Overview*, Ctrs. for Disease Control & Prevention, https://www.cdc.gov/chronicdisease/overview/, (last viewed Mar. 28, 2017)
8 2010 data, direct and indirect costs. *Chronic Disease Overview*, Ctrs. for Disease Control & Prevention, https://www.cdc.gov/chronicdisease/overview/, (last viewed Mar. 28, 2017)
9 Eric A. Finkelstein et al., *Annual Medical Spending Attributable to Obesity: Payer-And Service-Specific Estimates*, 28 Health Aff. 822 (2009), http://content.healthaffairs.org/content/28/5/w822.full.pdf+html.
10 American Diabetes Association, *Economic Costs of Diabetes in the U.S. in 2012*, 36 Diabetes Care 1033 (2013), http://care.diabetesjournals.org/content/36/4/1033.full-text.pdf.
11 Seth A. Berkowitz et al., *Treat or Eat: Food Insecurity, Cost-Related Medication Underuse, and Unmet Needs*, Amer. J. Med. doi: http://dx.doi.org/10.1016/j.amjmed.2014.01.002 (Jan. 21, 2014).
12 United States Government Accountability Office, *MEDICAID: A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures* 7 (2015), http://www.gao.gov/assets/680/670112.pdf.
13 *Id.* at 11.
14 Jill Gurvey et al., *Examining Healthcare Costs Among Manna Clients and a Comparison Group*, 4 J. Prim. Care Community Health 311 (2013), http://www.mannapa.org/wpcontent/uploads/2014/07/MANNA-Study.pdf.
15 Hillary K. Seligman et al., *A Pilot Food Bank Intervention Featuring Diabetes-Appropriate Food Improved Glycemic Control Among Clients in Three States*, 34 Health Aff. 1956 (2015), http://content.healthaffairs.org/content/34/11/1956.full.pdf+html.
16 Kartika Palar et al. *Comprehensive and Medically Appropriate Food Support Is Associated with Improved HIV and Diabetes Health*, 94 J. Urban Health 87 (2017).
17 *Id.*
18 *Mission Areas*, U.S. Department of Agriculture, https://www.usda.gov/our-agency/about-usda/mission-areas (last visited Mar. 26, 2017).