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Braiding and Layering Funding to Address Food Insecurity: Access to Food

Introduction

Access to healthy food is essential for promoting the health and wellbeing of marginalized populations, including children and the elderly. Food insecurity at any level has both physical and mental consequences, including chronic health problems such as diabetes, high blood pressure, and heart disease; acute physical hunger; depression; worry and anxiety; feelings of alienation; and adverse changes in family and social dynamics.[1,2] As a result, food-insecure households spend an average of 45% more on healthcare than food-secure households.[3]

In 2020, 10.5% of (or over 12 million) U.S. households experienced food insecurity, with 3.9% (or over four million households) experiencing very low food security.[4] Food security also is more prevalent for particular racial and ethnic groups. In 2020, 7.1% of White non-Hispanic households experienced food insecurity, compared to 21.7% of Black non-Hispanic households and 17.2% of Hispanic households.[5]

What is Food and Nutrition Insecurity?

Food Insecurity: Individuals or households are at times unable to acquire a sufficient quantity of food for one or more household members due to economic and social constraints.

Very Low Food Insecurity: Food intake is reduced for an individual or at least one member of a household, disrupting eating patterns due to economic and social constraints.

Nutrition Security: Consistent access, availability, and affordability of foods that promote wellbeing and prevent disease, particularly among vulnerable and remote populations.[1]

State/territorial health departments (S/THAs) play a vital role in addressing food insecurity, from directly administering federal programs to building coalitions with other agencies and private organizations to playing a role in policy development. These evidence-based recommendations give S/THAs concrete starting points for the state level to reduce food insecurity as well. This paper serves as a guide for S/THAs, to give them a starting place to take action. This paper, and its companion paper, *Braiding and Layering Funding to Address Food Insecurity: Proximity to Food Retailers*, provide that starting point by identifying models and case studies to show braiding and layering of funding to reduce food insecurity.

The American Heart Association has pointed to evidence-based recommendations for federal policy change that could increase the impact of federal programs on food and nutrition security. These recommendations include extending eligibility for federal food programs, increasing the ability for recipients to buy fresh fruit and vegetables, increasing funding broadly, and making certain COVID-19 flexibilities permanent. These recommendations are included throughout the paper where applicable.

What is Braiding and Layering?

Braiding: Funds from different sources are laced together to support a common purpose. Each source retains its “awards-specific identity,” which requires S/THs to track and report on each individual source. Statutory authority is not required.

Layering: Funds are grouped together, losing their individual identity. Officials administering layered funds are only required to issue a single set of reporting requirements. Layering must be statutorily authorized.[11]

Because food access funding is so often separated by characteristics of people (e.g., children, seniors), this paper is similarly organized: low-income individuals and families (Supplemental Nutrition Assistance Program (SNAP), Medicaid); children (Women, Infants, and Children (WIC), Child Nutrition Programs including school lunch, Temporary Assistance for Needy Families (TANF)); and seniors (Older Americans Act nutrition programs). Each section includes case studies highlighting opportunities for S/THAs to maximize funding and build successful coalitions to combat food insecurity and key takeaways from those case studies that S/THAs can use to make decisions about how to address the same issues in their own jurisdictions.

Braiding Funding: Supplemental Nutrition Assistance Program

The SNAP program provides monthly benefits to low-income individuals (under 100% of the federal poverty level for an individual or household) with which to purchase SNAP-approved food items.[6] Benefits are fully funded by the U.S. Department of Agriculture (USDA)’s Food and Nutrition Service and administered at the state level, most commonly by the department of human or social services but in some few jurisdictions by the health department (DE, ID, ME, MD, MI, MT, NE, NV, NH, WI, and WV).[7] Unlike some other federal programs, SNAP is an entitlement program, meaning that all who qualify and apply will receive benefits.[8]

SNAP participation has been shown to improve food security, improve nutrition, reduce healthcare costs, and have an association with improved long-term health outcomes.[9] In 2020, SNAP served 41.6% of food-insecure households and 42.5% of very low food security households, reaching over 39 million Americans, almost 10% of the total domestic population.[10,11] This average represents wide variation in participation between states, from 100% coverage in Oregon, Illinois, and Delaware to 54% coverage in Wyoming.[12] Low participation rates are attributed to the stigma of receiving SNAP benefits, difficulties visiting SNAP offices due to child care, work, or transportation, and the variance in states income eligibility to participate in SNAP.[13]

In addition to directly funding food acquisition, SNAP presents an opportunity for agencies to promote statewide economic growth and recovery. During an economic downturn, such as was experienced during the COVID-19 pandemic, ach federal-funded SNAP dollar generates an estimated $1.50 in economic activity and impacts all levels of the food chain, from store clerks to truckers to farmers.[14] USDA estimates that in a slow economy, $1 billion in SNAP benefits could result in a $1.54 billion increase in the gross domestic product, in addition to the health and other benefits discussed above.[15]

S/THA Role

- S/THAs can take advantage of available federal funding for SNAP by maximizing statewide participation in food and other public assistance programs that residents might not be aware they are eligible for.
- Communicate and coordinate with state agencies administering these programs and align their data systems and outreach to ensure that individuals are enrolled in all available public assistance programs for which they may be eligible, such as SNAP, WIC, or Medicaid.

During the COVID-19 pandemic, the federal government responded to an increase in SNAP usage by tying SNAP emergency provisions to the national health emergency. S/THAs could continue some of these practices after the emergency ends, including SNAP emergency allotments, application waiver requirements (e.g., virtual applicant interviews, simplified reporting requirements, electronic signatures), and expansion of eligibility for college students.[16]

Braiding Case Study: FoodRx Program

Combatting food insecurity and improving health also requires addressing nutrition insecurity. Recognizing that food and diet play important roles in disease prevention and management, medical providers and community organizations are increasingly utilizing a "food as medicine" model to address the intersection of health and hunger.[17] In Minnesota, Second Harvest Heartland has developed a FoodRx program to ensure that people experiencing food insecurity and living with a chronic health condition have access to nutritious and culturally appropriate food.[18] Second Harvest employs SNAP coordinators who providers can refer patients to for help with enrollment.

Second Harvest Heartland has successfully integrated FoodRx into Minnesota's healthcare system, partnering with 24 providers and insurance companies, including Minnesota's Medicaid program.[19] Providers and insurers make referrals to FoodRx for patients experiencing food insecurity and one of four chronic diseases: diabetes, hypertension, congestive heart failure, or ischemic heart disease.[20] The dietician-designed boxes of healthy foods are delivered free-of-cost to participants monthly for a period of six months to one year. The programs offer both medically-tailored and culturally-tailored foods, with recipes familiar to Hispanic, Somali, and Hmong patients.[21]

The program uses a value-based payment model and tracks outcomes for patients over time, justifying the payments that the insurers (including the Medicaid program) and healthcare partners pay to the program.[22] With a goal of helping clients continue a healthy lifestyle even after the program ends, FoodRx helps clients address long-term health issues, thereby keeping them out of the hospital and saving money for providers and insurers.[23] In 2021, the program had a 200% increase in revenue, causing it to break even and allow the program to increase in scale.[24] This leveraging of Medicaid and SNAP dollars together to increase food security and improve health outcomes is exactly the kind of partnerships that S/THAs could foster in their own jurisdictions.

SNAP enables FoodRx participants to supplement their monthly food box with fresh produce, meat, dairy items, and other healthy foods. FoodRx's recipe cards and educational materials also help SNAP recipients make the most out of their benefits. Between March 2020 and March 2022, the SNAP Outreach Team received more than 25,000 referrals.[25] S/THAs could facilitate similar partnerships in

their states between food banks and similar hunger-focused organizations, Medicaid and other insurers, providers, and the state SNAP program.

Case Study: SNAP-Ed in Indiana

State agencies administering SNAP have the option to apply for additional monies through SNAP-Ed to use for nutrition education and promotion of physical activity.[26] The goal of SNAP-Ed is to improve nutrition security by educating SNAP participants on healthy eating on a budget.[27] SNAP-Ed grants are based on a formula and are awarded on approval of a state's SNAP-Ed Plan.[28] States are not required to contribute to or match federal SNAP-Ed grants.[29] For 2023, the national SNAP-Ed allocation is estimated at $486,000,000.[30]

Indiana's Department of Health oversees SNAP-Ed through its Division of Nutrition and Physical Activity ("DNPA").[31] The program itself is run by Purdue University, which operates a direct education program targeted at the states' most vulnerable populations that operates on two levels in every county in the state.[32] Most directly, Nutrition Education Program Advisors conduct free classes for SNAP recipients, schools, and communities with high poverty levels tackling food security, nutrition, physical activity, and food access management.[33] On a policy level, the program's Community Wellness Coordinators who collaborate with state agencies and private partners on policy and systemic change to support broader food and nutrition security solutions, such as community gardens, EBT acceptance at farmers markets, and active transportation.[34] The program is funded by federal SNAP-ed grants (over $6 million for Indiana in 2023), plus almost $4,000,000 in outside resources to support CWC projects as described above.[35]

In 2021, 93% of adult participants in the SNAP-Ed program reported an increase in at least one nutrition-supporting behavior or physical activity, while 38% reported increased use of reading food labels when shopping.[36] Despite closures and slowdowns caused by the COVID-19 pandemic, in 2021 Community Wellness Coordinators worked with over a thousand partners on 455 initiatives that reached approximately 569,000 Indianans out of a total state population of 6.7 million people.[37] S/THAs can follow this model by engaging with their state colleagues that run SNAP-Ed to think through opportunities both for better nutrition education, as well as policy interventions that can make a difference on a community or neighborhood level.

SNAP: Takeaways for S/THAs

- S/THAs are in the perfect position to coordinate between the Medicaid and SNAP programs to tackle food insecurity and improve health outcomes. S/THAs can coordinate among Medicaid and other insurers, healthcare providers, and community-based organizations to leverage Medicaid and SNAP dollars toward a common goal.
- In this food-as-medicine model, a value-based payment model can help fund the program and can keep all partners focused on outcomes, not just services. S/THAs can help provide technical assistance and set up data systems to track those outcomes.
- S/THAs can work with other state agencies to develop an annual SNAP outreach plan that targets vulnerable populations and aligns with other state-administered federal social support services.[1] Outreach plans are required by USDA for states to qualify for 50% reimbursement of administrative costs.[1]
- S/THAs can advocate for policy level interventions with SNAP-Ed funds in addition to traditional nutrition education programs.

The American Heart Association has two main recommendations for federal action to improve SNAP and SNAP-Ed:

- **SNAP:** Maintain benefit levels to help cover increased costs, make permanent COVID-19 expansion of online SNAP purchasing, and incentivize nutritious food purchases.
- **SNAP-Ed:** Increase funding and extend opportunities within communities to implement policy, systems, and environmental approaches to nutrition security.[38]

Braiding and Layering Funding: Childhood Food Insecurity

Healthy food is an important determinant of health for children especially. Inadequate early childhood nutrition can lead to lifelong cognitive and health impairments, including acute and chronic conditions, poorer overall health, and developmental and growth issues. [39,40,41]

Of the 10.5% of households that experienced food insecurity nationally in 2020, about six million children (7.6%) lived in households where at least one child was food insecure.[42] A half-million children (0.8%) live in households with very low food security for at least one child.[43] Equity issues persist: non-Hispanic Black households are three times as likely to experience food insecurity than non-Hispanic White household. 18.8% of non-Hispanic Black households with children experienced food insecurity in 2019-2020, compared with 15.7% of Hispanic households with children and 6.5% of non-Hispanic White households with children. Families living with disabilities are twice as likely to experience food insecurity than households without disabilities (19.3% compared to 9.8%). This represents an opportunity for S/THAs to encourage these individuals to seek additional federal funding through health-centered programs such as Medicaid. While childhood hungers is a persistent problem in many areas of the country, multiple dedicated funding sources exist that can be braided or layered. This section outlines two federal programs which provide nutritional assistance for children and examples of those opportunities for S/THAs to layer or braid funds to improve access to nutritious food.

Special Supplemental Nutrition Program for Women, Infants, and Children

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is intended to support healthy nutrition for pregnant and postpartum women and young children through age five.[44] WIC is a federally funded program administered by the USDA that in 2020, served women and children in 8.4% of all food-insecure households. [45,46] Approximately 6.2 million participants per month received about $38 per person to cover monthly costs of food.[47]

USDA requires WIC applicants to meet four eligibility requirements: [48]

1. **Categorical**: Pregnant, postpartum and breastfeeding people; infants (up to first birthday); and children (up to fifth birthday).
2. **Residential**: Must live in the state or territory in which they apply. Applicants served in areas where WIC is administered by an Indian Tribal Organization (ITO) must meet residency requirements established by the ITO.
3. **Income**: Applicants' gross income cannot be greater than 185% of the federal poverty level, but states may set lower limits. Individuals who qualify for other benefits such as SNAP, Medicaid, and TANF automatically meet the income requirement.
4. **Nutrition Risk**: A health professional must certify that an individual is at nutrition risk. This service is usually provided at WIC clinics at no cost to applicants.

USDA provides grants to states, territories, and reservations, which are typically administered by the state/territorial health department. This is true in each state except Illinois and American Samoa, where WIC is within HHS.[49] States then allocate federal funds to local WIC clinics, including clinics run by health departments, schools, hospitals, and the Indian Health Service, to provide food vouchers, nutrition counseling, breastfeeding support, smoking cessation support, and referrals for healthcare or other social services.[50,51] S/THAs can layer WIC funds with WIC Special Project Grants, which USDA awards to state agencies for special and innovative projects to improve WIC services.[52] States have received grants for programs to streamline services, improve customer service, and refine nutrition education.[53]

While WIC funding is determined by an estimate of expected participation, S/THDs can increase federal funding by maximizing statewide participation. A 2022 USDA report on 2019 WIC coverage revealed that nationwide only 57% of eligible individuals were enrolled in the program.[54] The coverage rate for infants was the highest (98%) compared to 45% for children aged one through four.[55] The following case study highlights New Hampshire's efforts to improve outreach and coordination between WIC and Medicaid to maximize participation and make both programs' funding work together.

Case study: New Hampshire WIC Targeted Outreach

To maximize program visibility and enrollment, New Hampshire's WIC program staff conducts ongoing outreach to identify and enroll WIC-eligible residents.[56] Highlighting the integration between public health and Medicaid to support WIC enrollment, the New Hampshire SHA coordinates with state agencies administering Medicaid and SNAP through an online dashboard to exchange data on households that may be eligible for additional support services.[57] The New Hampshire WIC program developed this targeted outreach strategy in two phases, first through a partnership with the SNAP program in 2018 and then with the Medicaid program 2021.

In the first phase of the program, the state SNAP program dropped daily files into a dashboard accessible to local WIC offices that contains information on households eligible for SNAP.[58] Local WIC staff then created a record and confirms whether the household is enrolled in WIC.[59] If they are not, staff imports information from the dashboard to create a record and then reach out directly to the household by telephone.[60] The New Hampshire WIC program reported that reaching out by phone is labor-intensive but justified by the results.[61] Within the first phase of the program through the partnership with SNAP, the WIC program saw roughly an 11% increase in enrollment. Additionally, they saw a vast decrease in participation drop off after the first year of implementation.

With the success of the first phase, the New Hampshire WIC program received a WIC General Infrastructure grant in 2020 to enhance the project and add Medicaid to the data sharing agreement. Additionally, they used this grant to implement a more intuitive data sharing program that imports all categorically eligible SNAP and Medicaid recipients into the WIC Find Online Application Dashboard. Then, staff are able to sort through the pending applicants and contact them via phone call to set up a WIC certification appointment. This expanded program was implemented in March 2022 and cost a total of $106,500.

Maximizing WIC Participation and Federal Funding: Takeaways for S/THAs

- Target outreach to individuals and households eligible for both SNAP and Medicaid for maximizing and layering the funding for individuals.
- Layer funding from Medicaid to target eligible pregnant women in their first trimester to ensure they are getting services.
- Work within the agency to develop strategies to retain participants, particularly children over the age of one.
- Utilize data sharing agreements with other programs such as SNAP and Medicaid to identify potential WIC enrollees. Initiate direct contact through phone calls or text messages with eligible individuals and households to assess eligibility and assist in enrollment.
- Utilize technology to increase participation. Examples include permitting online submission of certification documents, text message reminders, and the use of telemedicine and videoconferencing.

The American Heart Association's recommendation on federal action for WIC is to extend eligibility for children through six years of age, certify infants through two years of age, extend eligibility for postpartum women to two years, and make permanent increases in cash value vouchers for fruits and vegetables.[62] By providing WIC to more children and new parents, and by providing more money specifically for fruits and vegetables, the program could do even more to improve food security.

School Nutrition Programs: School Breakfast Program, National School Lunch Program

The School Breakfast Program (SBP) and National School Lunch Program (NSLP) are federally-assisted meal programs operated by the USDA and administered at the state level, most often by state departments of education but in some states by the departments of agriculture (e.g., FL, NJ, TX) or human services (e.g., AR).[63] These state agencies then enter into agreements with participating public schools, charter schools, and participating private nonprofit schools, providing them with cash subsidies and USDA commodities for each eligible meal.[64]

Children are eligible for free breakfast and lunch if their household income is at or below 130% of the federal poverty level.[65] Reduced priced meals are available to children from families between 130% and 185% of the federal poverty line. Children participating in SNAP or Temporary Assistance for Needy Families (TANF) are categorically eligible for free meals, as are foster youth, migrant and homeless youth, and Head Start Participants.[66] Prior to the COVID-19 pandemic, an estimated 14.6 million children per day participated in SBP, and an estimated 28.6 million per day participated in NSLP.[67]

School meals have been found to alleviate food insecurity and poverty; support good nutrition by following federal nutrition standards; improve health outcomes; and boost learning, as hunger often impedes concentration in the classroom.[68]

While S/THAs might not directly administer school lunch programs, they can play an important role in collaborating with other agencies to maximize funding and promote fresh healthy meals, permitting the state and nonprofits to braid and layer funding from a broad coalition of partners, including the federal

government, non-governmental organizations, and private entities to improve childhood food security outcomes, as described in the case study below.

Hybrid Braiding/Layering Case Study: Arkansas No Kid Hungry Campaign

In 2010, Share our Strength (SoS) selected Arkansas as a "proof-of-concept" state to implement a proposed strategy of combating childhood food insecurity.[69] SoS was joined by the nonprofit Arkansas Hunger Relief Alliance, the governor's office, and state agency program staff to set goals of increasing access and enrollment in school lunch and breakfast, SNAP, Summer Meals, and Afterschool Meals with the objective to provide healthy food directly to families and to educate families about available resources and affordable food choices.[70] For example, the Arkansas Hunger Relief Alliance and SoS identified early on the goal of increasing the percentage of kids receiving free breakfast. At the launch of the campaign, only 50% of students receiving free or reduced lunch took advantage of school breakfast, and the campaign almost hit its goal of 70% in 2021 with 67% of students participating in breakfast.[71,72]

No Kid Hungry leadership attributes the program's success to coalition building. The campaign worked with various state agencies, including the Department of Health, Department of Social Services, and Department of Education to align goals and funding.[73] The program has also enjoyed continued support from past and current governors of both political parties.[74]

No Kid Hungry leaders have also targeted private organizations and nonprofits, receiving financial and logistical support from parties such as Walmart, Tyson Foods, Blue and You (Blue Cross Blue Shield), Delta Dental, and the United Way. Partners from the Arkansas Children's Hospital screen patients for WIC and SNAP eligibility; provide patients with bags of healthy produce; and develop medical meal models.[75] The campaign also utilizes excess TANF funds from the Department of Workforce Services, capacity-building grants for food pantries, and state food purchasing funds.[76] For 2022, the program received $2.7 million in TANF funds and Community Development Block Grants; $590,000 from other grants; and $700,000 from third-party donations and events.

Funding for the campaign is layered as the funds are being leveraged collectively; however, the campaign must account for and report on each individual source of funding giving it a braided aspect. At the launch of the campaign, Arkansas led the nation in childhood food insecurity.[77] Over the last 10 years, however, the number of food-insecure children in Arkansas has declined by almost 20%.[78]

School Nutrition Programs: Takeaways for S/THAs

- S/THAs can work with organizations outside of traditional public health infrastructure to reach individuals who are eligible for programs but might not be easily identified.
- S/THAs can work with agencies to streamline data and expand eligibility for programming.
- S/THAs can work with local community leaders and advocates to address the stigma and barriers of school breakfasts and lunches.
- S/THAs can advocate for community programs that address food security as a foundation for health and learning.
- S/THAs can participate in multi-stakeholder coalitions with advocates, healthcare providers, schools, other agencies, and more. The diversity of the coalition means greater coordination and cross-learning as well as potential to layer many different types of funds from federal to state to foundation and private donations.

Braided and Layered Funding: Senior Food Insecurity

In 2020, 5.2 million seniors aged 60 years and older faced hunger, with some seniors more likely to face hunger due to racial and economic inequality. Seniors are more likely to face hunger if they identify as Black, Latinx, or Native American; have lower incomes; or have a disability.[79] Food insecurity in seniors can lead to a wide array of health outcomes, including lower nutrient intakes and a greater chance of diabetes, depression, limitations in activities of daily living, high blood pressure, congestive heart failure, heart attacks, gum disease, asthma, and osteoporosis.[80] In 2019, the last year for which data is available, 7.1% of seniors in the United States (or approximately 5.2 million total) were food insecure and 2.6% were very food insecure.[81] The collective public health impact from this food insecurity is enormous; S/THAs can avoid healthcare costs later by trying to solve the problem "upstream" and increasing food security for seniors.[82] S/THAs can work with community members to assess the needs of the local senior population when it comes to implementation and allocation of funding. S/THAs can work to communicate and educate grantees that this funding can be layered to maximize effective programming.

Older Americans Act (OAA) funding and SNAP for Seniors comprise the bulk of funding for senior nutrition programs. However, there is a "senior SNAP gap" in which nearly six million eligible seniors, or 3 out of 5 seniors, are not enrolled.[83,84] Many seniors are unaware they are eligible for SNAP, often believing it is only for families with children.[85] Additionally, many are unaware that seniors who spend more than $35 per month in out-of-pocket medical expenses are eligible to deduct those expenses from their gross income, thus qualifying for a higher monthly benefit.[86]

S/THAs can work with state partners to increase SNAP enrollment as a state priority because higher senior SNAP enrollment leads to lower healthcare costs and utilization, which could thereby allow S/THAs, other state agencies, or other healthcare entities to direct savings to other assistance programs or social determinant of health interventions.[87, 88] SNAP senior participants are 14% less likely to be admitted to the hospital than non-participants and 23% less likely to be admitted to a nursing home.[89]

OAA funding focuses more closely on providing meals than providing money to buy meals and falls into two main models: congregate meal programs and home delivery programs.

The OAA provides grants to states for meals for adults 60 and over in group, or congregate, settings, including adult day care facilities and multigenerational meal sites.[90] Under the OAA, the Administration on Aging (AoA), a part of HHS, provides grants to state agencies[91] to support senior nutrition services.[92] The services are intended to 1) reduce hunger, food insecurity and malnutrition of seniors; 2) promote their socialization; and 3) prevent adverse health conditions by ensuring access to nutrition and other disease prevention services.[93]

Home delivered meals, including programs such as "Meals on Wheels," provide healthy meals to homebound seniors through grants to State Units on Aging (SUA). SUAs then provide at least one home-delivered meal on 5 or more days per week to seniors aged 60 or older, their spouses (regardless of age), and in some cases, caregivers, and/or disabled individuals.[94,95] In most cases, home-delivered meals programs serve homebound, isolated, or frail seniors.[96] In 2016, 867,000 meal participants were provided with a total of 145.2 million home-delivered meals.[97] 2021 data reveals that for 55% of

participants, a home-delivered meal provides one-half or more of their total daily food intake.[98] 89% reported that home-delivered meals permitted them to continue living independently.[99]

While the OAA requires that participants in AoA-funded programs be at least 60 years old, state and local government can determine further eligibility criteria.[100] However, the programs are meant to target seniors who are in greatest economic and social need, with a heavy focus on promoting equity.[101] Priorities include low-income seniors, minority seniors, seniors in rural communities, seniors with limited English proficiency, and seniors most at risk of institutional care.[102]

S/THAs also have an opportunity to braid and layer OAA funds with the Act's expansion of eligibility to spouses of seniors, regardless of spouse's age.[103] The OAA gives states the flexibility to transfer up to 30% of funds received between the congregate nutrition and home-delivered nutrition services programs, and .[104] The expansion also creates the option for programs to offer meals to volunteers, disabled individuals living in housing facilities where mainly older adults live which provide congregate nutrition services, and disabled individuals who reside with eligible seniors.[105] These options allow for S/THAs to allocate layered funding to areas where it is needed most. In 2018, states collectively transferred a net total of $104.6 million from congregate nutrition to either supportive services or home-delivered nutrition.[106]

Additionally, the AoA funds both the "Innovations in Nutrition" grants to enhance the effectiveness, quality, and proven outcomes of OAA nutrition service and the Nutrition Services Incentive Program (NSIP) to provide states with additional funds to cover the costs of domestically produced foods.[107] States can elect to receive NSIP funds in the form of funds or food commodities provided by the USDA.[108] S/THAs can layer funding from all of these sources to maximize comprehensive nutrition services for their senior populations, depending on the needs of congregate nutrition or supportive services or home-delivered nutrition. The following case study demonstrates the co-benefits such as socialization and saved administrative costs that can come with creative approaches to using OAA congregate meals funding.

Congregate Setting Case Study: Connecticut Senior Dine Program

While congregate meals are usually served at senior centers or other group settings, Connecticut's Senior Dine Program provides participants with the option to go to local restaurants for their meals.[109] The program is funded by the OAA through the Western Connecticut Agency on Aging, state funds, and voluntary donations and is operated by the non-profit New Opportunities, Inc.[110] Funding is provided by the State Department of Aging and Disability Services with funds allocated through the OAA and State funds that are allocated to elderly service providers through a request for proposal services.[111] Requirements include individuals who are 60 years of age or older, homebound, or isolated, and who qualify for home delivered meals. In addition to nutritional services, Area Agencies on Aging provide funds for community-based agencies for services such as adult day care, homemakers, home health aide, and transportation.[112]

Participating seniors receive a contactless card system with a scannable QR code that is loaded with meal credits, which allows for easy payment and tracking.[113] A Senior Dine app stores a copy of the card and tracks usage and other information, such as the number of meal credits remaining, nutrition education, and activity history.[114] As of 2022, six restaurants participate in the program.[115] Seniors with the means to do so are asked to donate $3.50 - $5.00 for a meal that is valued at $10.00 or greater, with the difference paid for with federal funds.[116] Participants and staff believe the program offers advantages over a traditional congregate meal site.[117]

Seniors report enjoying the independence the program allows, the diversity of food options, and the ability to socialize in the community.[118] For state officials, specifically in the State Department of Aging and Disability Services, the funding model is attractive because the participating restaurants cover the costs of preparing and serving the meals, thus allowing the program to put more money towards meals themselves thus expanding its reach to more seniors.[119]

Senior Food Insecurity: Takeaways for S/THAs

- S/THAs can work with other state agencies to make sure federal dollars are not left on the table by taking steps to ensure seniors are enrolled in all benefits for which they might be eligible, including SNAP for seniors. Increasing food security can improve overall health in numerous ways, saving healthcare costs down the road.
- S/THAs can take seniors' unique needs into consideration when designing programs, particularly mobility and transportation limitations, increased likelihood of poor health and disability, dietary restrictions, and challenges with communication methods.
- S/THAs can collaborate with their state counterpart who oversees OAA funding to explore the flexibility built into OAA funding to move funds from congregate to meal delivery or vice versa, depending on the proportions of the most vulnerable seniors in their jurisdiction. Further, the OAA gives enough flexibility to experiment with nontraditional ideas such as restaurant dining for seniors who are independent enough to dine out, outsourcing costs for meal preparation and allowing more dollars to go to meals.

Senior Food Insecurity: Federal Recommendations

In 2019 the Government Accountability Office (GAO) issues recommendations for HHS to improve programs addressing the nutritional needs of seniors. GAO's suggestions include:

- Providing state health departments with information to tailor meals to meet certain dietary needs. Relevant HHS officials should work together to document this information in the 2025-2030 update of the Dietary Guidelines for Americans.
- Centralizing information on senior nutrition programs, including promising approaches and meal accommodations.
- Directing regional offices to monitor providers to ensure meal consistency with federal nutrition requirements for congregate and home-delivered meals.

Conclusion

Food insecurity threatens the wellbeing of millions of Americans every day, causing acute physical hunger and serious, life-threatening conditions. S/THAs can help address food insecurity in their communities by braiding and layering the funding sources described herein. An essential component of the programs and case studies presented is the ability to identify partners within other agencies and the private sector in order to build effective coalitions to address food insecurity amongst the most vulnerable populations. While funding remains often categorical, S/THAs and their partners can increase enrollment in food assistance programs and maximize federal monies by striving to reduce the stigma associated with food assistance, educating their constituents about available food assistance, and reducing barriers to enrollment in assistance programs. S/THAs have the opportunity to take leadership roles in coordinating partners at the state, local, and non-governmental levels to increase food security, improve health outcomes, and braid or layer funding to increase the effectiveness and reach of each of the funds.

The development of this document is supported by the Center for State, Tribal, Local, and Territorial Support (CSTLTS) at the Centers for Disease Control and Prevention (CDC) of the U.S. Department of Health and Human Services (HHS) through the cooperative agreement CDC-RFA-OT18-1802.

Thank you to the O'Neill Institute for Global and National Health Law at the Georgetown University School of Law for their partnership and research in developing this suite of resources.

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