

Braiding and Layering Funding to Address Food Insecurity: Proximity to Food Retailers

Introduction

Food insecurity can lead to higher rates of chronic diseases, including hypertension, coronary heart disease, cancer, diabetes, arthritis, and kidney disease.¹ Additionally, food insecurity is associated with higher rates of depression, anxiety, and other mental health issues, particularly in children.^{2,3} Rates of food insecurity have risen with the pandemic to affect more than 23% of all households in the United States, including 30% of households with children.⁴ Food insecurity poses a threat to the health and wellbeing of a large part of the U.S. population, and the pandemic has worsened its effects. Food insecurity affects different households and communities more frequently and intensely, such as immigrants, Black and other racial minority communities, and households headed by single mothers.⁵ These health effects of food insecurity give S/THAs a vested interest in both the problem and in potential solutions. This paper will demonstrate models for S/THAs to take direct action alongside state and local partners to combat the problem.

The federal government's Healthy People 2030 efforts identifies food insecurity as a key component of economic stability as a social determinant of health.⁶ Three objectives in the Healthy People 2030 framework address food insecurity directly, focusing on reducing food insecurity and hunger generally, eliminating very low food insecurity in children, and increasing the proportion of children participating in the School Breakfast Program.⁷ Ensuring that households have sources of healthy food available within close geographic proximity is one essential step toward addressing the first two of these objectives.⁸

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

Food insecurity stems from a number of different factors, including income and distance to the grocery store.^{9,10} For example, households with incomes below the federal poverty line are more likely to experience food insecurity, with over 35% of those households experiencing food insecurity in 2019.¹¹ Solutions that relate directly to addressing income-based factors are the focus of this paper's companion paper, [Braiding and Layering Funding to Address Food Insecurity: Access to Food](#), while this paper focuses on solutions that S/THAs can implement to bring food closer to the people who need it.

More factors than income and geography are at play here. Race and immigration status are also correlated with higher rates of food insecurity, with Black households being three times as likely and

Hispanic households two times as likely to struggle with food insecurity as compared to White households.¹² Immigrants, regardless of race or ethnicity, are highly likely to experience food insecurity, as are households headed by single mothers.^{13,14}

Areas lacking food retailers are most commonly known as **food deserts**, while areas with only low-nutrition foods are commonly referred to as **food swamps**.¹⁵ More recently, food justice advocates have used the term **food apartheid**, which describes the same phenomenon of scarcity of food retailers that more clearly highlights the discriminatory government policies such as redlining that have contributed to higher rates of food insecurity.¹⁶ A related concept called supermarket redlining describes the reluctance of supermarkets, or other major grocery stores, to build in historically redlined neighborhoods (often still with higher numbers of minority or lower income individuals) because of perceived lack of purchasing power.¹⁷

Such practices result in people having difficulty acquiring not just food in general, but specifically **culturally appropriate food**. This is defined as food that people regularly prepare that is connected to their social or racial backgrounds. Food apartheid highlights these intentionally created racial and socioeconomic disparities of food insecurity while acknowledging food insecure people may still have access to food, but not access to the right kinds of food or at prices they can afford.¹⁸ For example, food insecure areas may have convenience or corner stores, but food may be more expensive and less nutritious.¹⁹ A lack of healthy food offerings puts more people at risk of food insecurity, as access to healthy food is key to making healthy decisions. Access to food retailers impacts food insecurity levels, but also impacts health outcomes directly.

Geographic proximity alone, as defined by the literal distance between a person's home and a food retailer, is only one part of the food insecurity puzzle: access to reliable, safe, and affordable transportation makes longer distances more manageable.²⁰ Particularly for low-income households without reliable access to private vehicles, safe and reliable public transportation can be its own powerful social determinant of health.²¹

While S/THAs may not have direct authority over all the programs and funding streams available to solve these problems, they can play supportive and advocate roles in making change, as this paper will discuss. Specifically, this chapter will break down the ways a state or territorial health agency (S/THA) can address geographical barriers to food security by highlighting ways to:

- Direct and support local implementation, where a S/THA can work with local agencies to establish programs and models aimed at reducing food insecurity.
- Innovate with current programs, such as, by changing certain WIC vendor requirements to increase the amount of WIC eligible vendors.²²
- Build coalitions with other organizations who possess a different form of expertise to pursue a model or implementation where a S/THA can incorporate its own expertise.

Each section provides case studies of states and communities that are braiding or layering funding and working with cross-sector partners to address food insecurity. While this set of papers is focused on actions that S/THAs can take, the papers also reference recommendations for federal action from national health organizations when 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

Directing and Supporting Local Implementation

The variations in geography, culture, and infrastructure diversity within the United States present similar variations in the shape of food insecurity. Each state structures its public health and human services agencies differently. The tools and funding streams available to S/THAs also vary between jurisdictions. These factors influence how the state and local health agencies interact with one another, including who has authority to make fiscal decisions or expand promising pilot programs or local innovations. This paper provides a range of case examples, so that S/THAs can identify programs that can work well for their jurisdiction’s particular needs and structures.

Many of the geographic proximity solutions involve legal authority often exercised by local governments such as zoning, community development, or local tax incentives. S/THAs can support these local efforts in a variety of ways, including establishing coordination structures to facilitate local efforts, identifying funding sources, and getting federal permissions to use funds as desired. Food security programs that braid or layer funds may include a range of funding streams across various sectors:

- **Health Funds:** Medicaid Section 1115 Waivers, Medicaid Managed Care Organization contracts, Preventive Health and Health Services Block Grant funds, and CDC REACH Grant funds.
- **Community Development Funds:** Community Development Block Grants (CBDG).
- **USDA Funds:** Healthy Food Financing Initiative (HFFI) funds, Specialty Crop Block Grants, Rural Business Development Grants, and Rural Community Development Initiative Grants.
- **Nonprofit, Local, and National foundations:** Including private sector funds, such as local banks or the United Way.

Structural Options

Health Equity Zones and Medicaid Section 1115 demonstration waivers can establish structures to enable local implementation to address food insecurity. The role for a S/THA can consist of creating partnerships, establishing programs, securing federal permission where applicable, and selecting how local organizations, MCOs, or community partners and coalitions will be involved.

Health Equity Zones

Health Equity Zones offer a model for how states can support community-driven priorities and layer and braid funding to direct investments that can address the social determinants of health. Originating in Rhode Island, Health Equity Zones typically direct investments to address health-related needs.²³ These programs are designed to foster community investment and involvement in the process of improving social determinants of health by directing funding to “backbone organizations,” which are the community organizations that help support and oversee the Health Equity Zones and can be selected by

the S/THA through a request for applications.²⁴ Each zone is geographically based and has flexibility to select how it will invest state funding and technical assistance to meet community-determined priorities.²⁵ The variety of funding sources for each local Zone were braided together to address one or more social determinants of health in each Zone.

<p>Funding Sources Braided</p> <ul style="list-style-type: none"> • USDA • Nonprofit/foundation funds • Private donations 	<p>Potential S/THA Roles</p> <ul style="list-style-type: none"> • Create organizational structures • Identify funding sources • Connect with community organizations
<p>Potential Challenges</p> <ul style="list-style-type: none"> • Implementation is mostly local • Networking necessary 	<p>Good For Which S/THAs</p> <ul style="list-style-type: none"> • Smaller, centralized states/territories • Wish to address multiple social determinants of health at once

Within Rhode Island’s Health Equity Zone initiative, Washington County connected food-insecure residents with local farmers and established pop-up markets in areas of need.²⁶ The Cranston Health Equity Zone is organizing cooking demonstrations and bringing farmers markets to address the lack of culturally appropriate food to an area.²⁷ The Pawtucket Health Equity Zone created and supported farmers markets, renovated local greenspaces into community farms, and developed a mobile farmers market that moves around the city to provide healthy foods and opportunities to use SNAP and WIC dollars in a Double Up program, which matches SNAP dollars used to purchase fresh fruits and vegetables.²⁸ Other Health Equity Zones in Rhode Island are implementing similar programs, with some seeing an increase in residents’ access to produce of up to 36%.²⁹

While Rhode Island was the first to implement the Health Equity Zones, Washington state has followed, approving a Health Equity Zones program in the Summer of 2021.³⁰ At the time of writing, Washington state is in the process of identifying funding streams and establishing connections with community members to advise in the process of establishing the Health Equity Zones.

Each of the Health Equity Zones in Rhode Island uses different funding streams based on the social determinants that the community has chosen to address. For example, the AARP Foundation Grant is given to initiatives that help lower income older adults.³¹ Citizens Bank and United Way, with operational support from local nonprofits, provided funds that were used to turn a dilapidated playground into a community garden and weekly farmers market in the Pawtucket Health Equity Zone.³² The Blue Cross & Blue Shield of Rhode Island funds programs addressing social determinants of health, and in this case, it funded a mobile market for the Pawtucket Health Equity Zone that provided access to fresh produce.³³ The Rhode Island Foundation funded the backbone organizations of the Health Equity Zone and community involvement efforts. In Zones where multiple funding streams were used, the funds were braided instead of layered. An allied effort for a “walking school bus” focused on reducing obesity and getting children safely to school was funded in part by a Public Health and Health Services Block Grant for a community partner in South Providence.³⁴

Health Equity Zone Key Takeaways

S/THAs can work with local health departments to establish health equity zones on a county level or smaller. Among the first steps in initiating this model would be identifying and securing initial funding and local partners. The S/THAs would be key in both identifying funding sources and partnering those funding sources with local community organizations that could work to establish similar local programs.

- Health Equity Zones address the food insecurity of an individual zone in a way that can cater to that zone's specific needs. S/THAs can work at the local level to identify local organizations that could implement similar programming that meets the specific needs of that locality.
- Each Zone managed to braid funds specific to the social determinants of health it wanted most to address. S/THAs can help leverage public and private funding alike to meet those specific needs.
- Funding sources can include federal and state funding, grants, and local partner funding. On the ground support can be provided by local organizations as was seen in Rhode Island. S/THAs can help identify and coordinate funds at the federal and state levels, especially funding streams that multiple local Zones wish to use.
- S/THAs can work with community organizations with a direct stake in the process, and implementation of solutions that bend to fit the needs of the community.

Medicaid Flexibility

Medicaid is a federal program governed by federal law, and jointly funded by states, that provides health insurance for low-income individuals.³⁵ States that have expanded Medicaid may also choose to provide coverage for other "optional" populations who meet certain financial eligibility standards, such as low-income individuals. Traditionally, Medicaid has paid for health services only, and not to address social determinants of health. However, states can apply to the federal government for permission to waive some of Medicaid's rules to experiment with new ways of using Medicaid funds.³⁶ One of the permissions that state Medicaid programs are beginning to ask for includes programs to address social determinants of health and the health outcomes that result.

In eight states/territories, the health official has statutory oversight over Medicaid, whereas public health and Medicaid are part of the same umbrella agency in 15 states/territories and totally distinct in 32 states/territories.³⁷ The oversight and management structure for Medicaid in each jurisdiction will help determine the S/THA role in each, from direct management to technical assistance and support.

<p>Funding Sources</p> <ul style="list-style-type: none"> • Federal Medicaid and state matching dollars. 	<p>Potential S/THA Role</p> <ul style="list-style-type: none"> • Submit Medicaid waiver applications to allow Medicaid funding to be used for SDOH, including food insecurity. • If S/THA does not manage Medicaid, assist and collaborate with state Medicaid agencies to design waiver application and implement program. • Suggest or include requirements in MCO contracts to address beneficiaries’ health-related social needs.
<p>Potential Challenges</p> <ul style="list-style-type: none"> • Only some S/THAs have direct authority over Medicaid. • Time-consuming to propose and implement. • S/THAs will need to assess their Medicaid funding, which can differ significantly from states to state. 	<p>Good For Which S/THAs</p> <ul style="list-style-type: none"> • In the process of creating or already have 1115 waivers. • Where S/THAs have authority over Medicaid. • With Medicaid managed care plans.

States provide Medicaid beneficiaries with health insurance either through 1) a system where health providers are paid directly per-service provided or 2) contracting with managed care organizations (MCOs), which get paid a fixed, per-person rate to coordinate and manage Medicaid services. A majority of Medicaid beneficiaries nationally are now enrolled with an MCO. The waivers discussed above can work with either model; the case study below focuses on how state officials can work with an MCO under a type of Medicaid waiver that allows for pilot or demonstration projects to try new things (1115 waivers). These 1115 Demonstration waivers present one opportunity to address community-wide social determinants of health, including addressing geographic barriers to food insecurity.

Case Studies

CMS approved a five-year 1115 waiver in 2017 in which Oregon has allowed MCOs to use some of their budget for community-level services if they improve healthcare quality.^{38,39} The MCOs must conduct screenings for unmet social needs including food insecurity, housing insecurity, and transportation needs. Based on the screenings, the MCOs refer members to services and build partnerships with community-based organizations to provide those services. Under the waiver, the MCOs can use Medicaid funds to support and assist local food banks, food pantries, or mobile food retailers with things like refrigeration equipment to reach Medicaid members and non-members alike.⁴⁰

Similarly, North Carolina in 2018 received approval of an 1115 waiver to establish the Healthy Opportunities Pilot (HOP). The waiver made North Carolina the first state to receive approval to reimburse social welfare agencies to provide services to MCOs. The state can use up to \$650 million in Medicaid funds over five years to pay for various SDOH services such as healthy food delivery.⁴¹ The waiver includes requirements for MCOs to provide food and nutrition case management and to assist eligible members to enroll in SNAP and WIC.

North Carolina is focusing on reducing the impact of social determinants of health specifically for high risk Medicaid enrollees, with a list of 29 services that Medicaid funds will pay for local Human Services Organizations to provide.⁴² North Carolina's HOP provides funds to already-established organizations, like regional food pantries, to support the work they are already doing.⁴³ The HOP is focused on three regions in the state identified by responses to a Request for Proposals.⁴⁴ The state works with MCOs, which provide 1) technical assistance (such as training in insurance and billing) to these local community organizations to be able to offer services like delivering food boxes to enrollees or 2) travel vouchers to access places like food pantries.^{45,46} Although the waiver itself was approved in 2018, the work to establish regions to prioritize, services to provide, and a means to evaluate the results has taken several years; funding is just now available to the first group of members in 2022.⁴⁷

While Medicaid is jointly administered by the federal and state governments, the program is ultimately governed by federal law and could potentially do more to address SDOH if the law were to provide more flexibility. The American Heart Association, in a 2022 policy statement on food insecurity, recommended that the federal government 1) make funding available specifically for food insecurity initiatives such as produce prescriptions and medically tailored meals, and 2) allow those interventions through regular Medicaid funds, without need of a waiver.⁴⁸

Medicaid Flexibility Key Takeaways:

- A Medicaid 1115 waiver can spur innovations that allow for Medicaid dollars to improve community-wide determinants of health, including food insecurity. S/THAs can work with community organizations to ensure that the waiver addresses the SDOH in those communities.
- S/THAs may have authority over Medicaid; those that do not will need to build connections with state Medicaid agency contacts to collaborate.
- Connect with state Medicaid agency to identify areas of shared interest or explore how food insecurity affects healthcare spending and health outcomes in that state.
- S/THAs can identify and reach out directly to MCOs that employ or could employ community health workers to help identify gaps in food insecurity and help to support and assist local food banks, food pantries, or mobile food retailers.
- S/THAs can help to coordinate streamlined enrollment or other alignment of programming for low-income populations served by Medicaid who may also be eligible for other food assistance and food insecurity programs, such as SNAP and WIC.
- S/THAs will need to plan ahead. Implementing a complex and novel Medicaid pilot takes time and persistence, making it a medium- to longer-term strategy.

Food Assistance Program Innovations

SNAP and WIC have distributed billions of dollars in food assistance funds, with the potential to reach many millions of people. While food assistance programs can directly put food in the hands of people who need it as discussed in the companion paper, attention must also be paid to addressing geographic barriers to access, as well as the importance of ensuring access to healthy and culturally appropriate

food. This section provides examples and lessons learned for working with tribal communities and is intended to provide guidance on ways to constructively engage with Tribal Nations.

Indigenous Food Sovereignty ⁴⁹

Tribal communities, after decades of food policy decisions made by others, are increasingly reclaiming control over their food systems, also called traditional food ways. Federally recognized tribes have long received commodity food products through the Food Distribution Program on Indian Reservations (FDPIR) but have had little control over or choice of the foods supplied, which are often unhealthy and not culturally relevant for Tribal members.⁵⁰ More recently, however, federally recognized tribes are taking advantage of newer flexibilities in food selection through the FDPIR: one small step towards Indigenous Food Sovereignty.

In this paper, as in the literature, **food sovereignty** is defined as the ability to make choices about what foods to eat and how the food is distributed.⁵¹ While the Indigenous Food Sovereignty movement includes many important elements, this section focuses on potential change with food assistance programs as a place where S/THAs may be able to be most helpful. Additionally, many indigenous people in the United States live in urban areas and face different proximity challenges, including whether any food retailers nearby carry culturally appropriate food. The solutions proposed in this paper address only some challenges for Native Americans. However, when combined with other policy interventions, they are a step toward greater food sovereignty and food security.

<p>Funding Sources</p> <ul style="list-style-type: none"> • SNAP • WIC • FDPIR 	<p>Potential SHA Role</p> <ul style="list-style-type: none"> • Working with different agencies, such as the CDC Office for State, Tribal, Local and Territorial Support, Department Of Agriculture Office of Tribal Relations, HHS Indian Health Services, and Department of Interior Bureau of Indian Affairs at the federal and state level to help support policies that support food sovereignty. • Connecting directly with tribes that share borders with their jurisdiction to provide potential resources, funding, and support.
<p>Potential Challenges:</p> <ul style="list-style-type: none"> • Complex Tribal Nation governments with complex relations with federal and state agencies. • Different resources at the tribal level for program implementation. • Changes require dialogue with several agencies in potentially multiple states. 	<p>Good For Which SHAs:</p> <ul style="list-style-type: none"> • With more authority over food assistance programs. • With a significant tribal presence and/or good contacts with tribes.

Food retailers can be sparse in Indian Country. For example, despite the Navajo Nation having a population of over 300,000 people across three states and over 27,000 square miles, only a handful of grocery stores exist there.⁵² Federally recognized tribes in Washington state mostly have access to only corner stores, which, as discussed above, do not always provide the healthiest food options.⁵³ In some more remote areas, SNAP and WIC eligible supermarkets can be further away from most tribal community members compared to other supermarkets.

Although FDPIR was created to support good health and nutrition for tribal members, the highly processed food offered through the program can exacerbate rates of chronic disease and illness, especially when coupled with lack of access to supermarkets. Increasing tribal self-determination and involvement will enable tribal groups to select which businesses are SNAP and WIC eligible, supporting better self-determination and involvement – in other words, a move toward food sovereignty. Selecting *tribally owned* businesses will improve the overall economic wellbeing with Tribal communities with more money and customers being directed towards tribal members. Specific solutions are discussed below.

SHAs can get involved tribal food insecurity by connecting directly with Tribal Nations who share borders with their jurisdiction:⁵⁴

- If your state has a state and tribal liaison, reach out to them for assistance in making the introduction. A number of Tribal Nations and Tribal serving organizations, including the Indigenous Food and Agriculture Initiative, are working to increase food security and access to culturally appropriate foods with Tribal communities. Working with Tribal Nations typically involves an official consultation process where state agency representatives speak with Tribal government representatives.⁵⁵ This process works best when state and federal representatives invite Tribal leaders to consult with plenty of time to prepare their priorities for that consultation and treat Tribal Nations as equal partners in developing the agenda and goals of that consultation. Many organizations, such as Indigenous Food and Agriculture Initiative, serve as intermediaries in this process and can help identify the right Tribal contacts and ensure that tribal sovereignty is respected.
- S/THAs can help simplify the process for making changes in food assistance programs in partnership and consultation with Tribal partners. Tribal communities often work with multiple state agencies through an area Indian Health Board, Urban Indian Health Centers, and State and Tribal Liaisons. The Navajo Nation, for example, works with agencies from three different states, as the geopolitical boundaries of their reservation and trust lands are independent of U.S. state divides.⁵⁶ Working with Tribal Nations as equal partners and supporting Tribal Nations work to achieve greater self-determination in these programs will take the burden off of those Tribal Nations to do all of the work to coordinate among agencies.

Greater self-determination can include discussions through the consultation process mentioned above. S/THAs can consult with Tribal Nations and Urban Indian Health Centers well in advance using an intermediary organization to, for example, discuss how WIC could be changed to better support Tribal sovereignty and how a S/THA can assist in that change. For instance, Tribal Nations do not generally control which retailers are considered SNAP or WIC eligible, or what foods are eligible under WIC. For a retailer to be able to accept SNAP, it must meet certain requirements set by the federal government.⁵⁷ WIC-eligible retailers almost always must be SNAP-eligible as well.⁵⁸ Even additional programs like Cash Value Benefits (CVB), which is a voucher that can be exchanged for a certain value of food at any retailer, are under-utilized in tribal communities.⁵⁹ Such restrictions limit the effectiveness of these

programs given the lack of food retailers in these communities.⁶⁰ If the federal government removed these restrictions or offered the opportunity for flexibility, more retailers could be eligible to participate in these programs.

S/THAs can work to remove state-levied restrictions on assistance programs. Washington, D.C. recently passed a bill that prohibits restrictions on WIC retailers which require more than the minimum of store space or cashiers working as prescribed by USDA, essentially allowing retailers like corner stores to accept WIC.⁶¹ In most cases, S/THAs have direct authority over WIC programs in their jurisdictions. Requirements for WIC retailers vary from state to state, but can include a minimum number of hours and days the store is open to the amount of total sales WIC can represent for the store.⁶² Adjustments to these requirements could categorically include more retailers in at least some of these programs.

Tribal Nations can take over administration of some food assistance programs. Tribal Nations, as sovereigns, can operate eligible federal programs such as SNAP and WIC in alignment with the relationship Tribal Nations have with the federal government. Federal law enshrines this power under so-called “638 Authority,” which lays out the process for Federally recognized tribes to take over administration of some federal programs.⁶³ The 638 Authority has most recently been used to enable Federally recognized tribes to select and purchase their own food for the FDPIR program, which increases self-determination and reduces the administrative burden of these programs.⁶⁴ S/THAs could work with tribes and advocate for 638 Authority in ways that support their goals and provide technical assistance throughout the federal process. Without 638 Authority, S/THAs can still work with Tribal Nations and Tribal serving organizations where possible to advocate for changes similar to the Washington, D.C. bill that makes it easier for retailers like corner stores to be WIC retailers.

As discussed above, the American Heart Association has made recommendations for federal action to improve food security. Those recommendations related to indigenous food sovereignty include: 1) provision of more traditional foods for Native American participants in both FDPIR and WIC, and more Native-produced foods in FDPIR; and 2) more robust Tribal self-governance and self-determination.⁶⁵

Indigenous Food Sovereignty Key Takeaways:

- S/THAs can work collaboratively with Federally recognized tribes, Urban Indian Health Centers, and other agencies to promote indigenous food sovereignty and reduce food insecurity.
- S/THAs can leverage their authority, or their connections with other agencies, to change state-level SNAP and WIC vendor eligibility requirements such as the minimum number of cashiers required, or the food offered.
- S/THAs can work directly with Tribal Nations and pass on authority to administer food assistance programs like SNAP and WIC, potentially through 638 Authority.
- S/THAs should be careful to respect Tribal sovereignty in interactions with tribes and tribal leaders by, for example, respecting tribal leaders’ time and expertise and treating them as equal partners in the policymaking process, as well as working to support Tribal Nations’ goals toward greater self-determination.

Partnering Across Agencies and Sectors to Form Local Coalitions

Because some food insecurity solutions can fall outside the scope of a S/THA’s direct authority, S/THAs can partner with state or local agencies and organizations who possess authority or expertise to act, such as agricultural agencies, city or county agencies, or non-profit service providers. For example, because transportation directly impacts food access, and public transit systems could consider food access in planning routes.⁶⁶ A S/THA could work with a local or state transportation agency to find routes that would reach SNAP retailers. Alternatively, S/THAs are not equipped, nor do they have the expertise to approve new building projects or create financial incentives to motivate a retailer in investing in areas defined as food deserts. However, a S/THA can partner with community-based organizations to leverage existing infrastructure, like corner stores, to provide more education and access around nutritious food options. The following case study identifies how S/THAs can work with corner stores to create coalitions dedicated to selling healthy and culturally appropriate food.

Healthy Corner Stores

Unlike bringing in a new food retailer, which takes time and large amounts of capital, working with food retailers already built and established in the community gets food into communities more quickly. Efforts to reduce food insecurity can be based in a partnership with larger food retailers like grocery stores, which makes sense given the number of grocery stores in the United States.⁶⁷ However, the United States has approximately three times as many corner stores as larger food retailers.⁶⁸ Corner stores engage with communities on a neighborhood level given the small areas they service and how frequently people from an area visit the store.⁶⁹ Research suggests that bringing in a new food retailer alone may not always reduce food insecurity, however, and works better if combined with increasing the ability to use SNAP or WIC to food insecurity, as discussed in this paper’s companion.⁷⁰

<p>Funding Sources</p> <ul style="list-style-type: none"> • CDC 1305 Chronic Disease Funding • CDBG Funding • Nonprofit and Private Foundation Funds 	<p>Potential S/THA Role</p> <ul style="list-style-type: none"> • Connect with existing corner store coalitions. • Establish a coalition of corner stores. • Develop healthy corner store criteria
<p>Potential Challenges</p> <ul style="list-style-type: none"> • Working with many community partners. • May not be a space S/THAs have expertise. 	<p>Good For Which S/THAs</p> <ul style="list-style-type: none"> • That are more centralized or have strong local networks.

Working with these corner stores to address food insecurity, models like the Healthy Corner Store Initiative bring together coalitions of corner stores to increase consumption of healthy food through marketing and education. The Healthy Corner Store Initiative, run by The Food Trust, works nationally to provide logistical support and operational guidance on how to make healthy food profitable for corner store operators.⁷¹ They offer advertising materials and training to source healthy food if corner stores agree to offer at least a few healthy food items such as fresh produce or dairy, and eventually, corner stores can apply to have their store renovated to increase their ability to offer healthy food through

refrigeration units and displays.⁷² More than 478,000 people have purchased fresh produce from this program in Philadelphia alone, and when fresh produce displays have been the focal point of each store, it led to a 60% increase in produce sales.⁷³

The Healthy Corner Store network is a national initiative, but the Missouri Stock Healthy Shop Healthy (SHSH) program is one example of a state health agency working with a network of rural and urban corner stores to increase access to healthy food.⁷⁴ SHSH provides training to corner store operators on what foods to offer successfully, how to source healthy food products, and how to market these products.⁷⁵ In this way, a S/THA can similarly serve as a coalition builder or educator by assembling a group of corner stores. S/THAs can intervene on a local level to increase food security by providing funding, resources, and support for corner stores and including, for example, a requirement for the minimum number of shelves dedicated to fresh produce and dairy, in addition to nutrition education. Additionally, working to expand which food retailers can accept benefits like SNAP or WIC will lead to increased food security.⁷⁶

Federal recommendations in the American Heart Association's policy statement related to Healthy Corner Stores include 1) better incentivizing nutritious food purchases with SNAP dollars; and 2) strengthening requirements for food retailers to carry and market nutritious foods. Both of these recommendations are highly compatible with the case studies included in this paper.⁷⁷

Healthy Corner Store Key Takeaways:

The above are two models working to bring about better options in existing food retailers, particularly corner stores. Working with existing, hyperlocal retailers can be useful in all types of contexts: rural and urban environments, places where there are and are not other food retailers, and varied income areas. They understand and are more connected with the community as they often operate on a neighborhood level. Any new models could offer benefits contingent on the inclusion of healthy *and* culturally appropriate food. Coupling these changes with an expansion of which retailers can accept either SNAP or WIC will better increase food security.

- S/THA can work with existing retailers to bring in healthy or culturally appropriate food options.
- Expanding retailers that can accept SNAP or WIC can also lead to reduced food insecurity.
- Helping to build coalitions and provide education to existing retailers which can help to reduced food insecurity.

Conclusion

A S/THA has many pathways to get involved in improving food security. The above is intended as a guide to three ways this involvement might work. A S/THA can implement a model that supports a local health agency in reducing food insecurity. They can work with existing state programs to create innovative new solutions. Fundamental to most solutions in food insecurity, a S/THA can create a partnership with other organizations or even build that partnership themselves to change local conditions and reduce food

insecurity. Any of these methods can reduce food insecurity, improve access to nutritious food, and improve health for the state or territory's residents.

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