

# PLENARY SESSION III: BRINGING PRIMARY CARE AND PUBLIC HEALTH TOGETHER: TIME TO GET OUT OF THE TOWERS

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## THE ATLANTA COMMUNITY FOOD BANK: STRATEGIC LESSONS FOR ELIMINATING HEALTH DISPARITIES

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*(Ethn Dis. 2003;13[suppl3]:S3-19-S3-21)*

### INTRODUCTION

Why should a food banker speak to primary care professionals at a primary healthcare convention? For me, as the executive director of the Atlanta Community Food Bank, there are a couple of connections.

First, on a very personal level, my mother passed away 2 years ago. For more than 45 years she was a primary healthcare nurse in a very small town in North Carolina. In a small town, when you are the primary healthcare nurse, often times you are also the doctor, counselor, and the person who does a lot of healing in the community. I know she is proud that I am finally talking to “her” audience today. I know I was probably in my mid-30s before she understood what I was called to do. Though it was a little bit different than her calling, there are a lot of similarities.

The second connection is simple . . . Those of you providing free and affordable health care are serving the same people the Food Bank serves. We are working in partnership with many of the same organizations.

### LESSONS FROM THE ATLANTA FOOD BANK

Now, let me set the context a little bit. I want to share some lessons learned in my years of organizing and feeding the hungry. The mission of the Atlanta Food Bank is to engage, educate, and empower the community to fight hunger. I did not say anything about collecting and distributing food or feeding hungry people. It is to engage, educate, and empower the community to take up that fight with us.

The way you measure our work at the Food Bank is by our level of involvement in the community. There are more than 230 food banks around the country. We have a central collection area, a big warehouse, and we collect food from manufacturers, wholesale retailers, and from the community. We then

distribute it to community-based organizations. We currently partner with 700 community-based organizations just in North Georgia and in the Atlanta area. Most of these organizations are run by volunteers or perhaps one paid staff person. Many of these organizations have a mission that is actually broader than feeding the hungry. It might be childcare, serving the elderly, after-school tutoring programs, housing the homeless, health care, programs for the mentally ill or treatment for substance abuse. In every one of these cases, the common denominator for us—the reason that we are working with them—is that the people they are serving need to eat. If they are not eating and do not get adequate nutrition, then they are more likely to have healthcare issues.

We have a saying in food banking that we centralize the acquisition of food and decentralize the distribution. An interesting part of food banking is in the acquisition. I can tell you stories all afternoon about why we get 15 million pounds of surplus food donated to us every year. It is the wrong color or wrong size. It is damaged. It is out of date . . . but the most important part of our work is in the decentralization at the community level. The key is in distribution, making food easily accessible in neighborhoods where people live. I think the key to primary health care is getting services to people where they live.

Another saying that we often use is: “Things that get counted get done” We have to be very accountable. We have to translate our work into many different languages. I am not talking about Spanish, Vietnamese, or French. I am talking about the language of the listener. I have to translate my program in a way that foundations understand. I have to translate it in a way that corporations understand. I have to translate it in a way that the faith community understands.

One of the real challenges we have in food banking and I think we have in health care is to translate what we do in a way that people understand it. If I tell you that we distribute 15 million pounds of food, what does that mean if I can't translate 15 million pounds into something relative to your

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knowledge? Well, 15 million pounds of food does serve a lot of people. Did you know that a tractor-trailer load is 20,000 pounds? If you think about one tractor-trailer load – 20,000 into 15 million—that is a lot of trucks. If I told you those trucks would line up from here to Florida, you would have a better idea of how much food we distribute annually. Better yet, I can translate that 15 million pounds into 7.5 million meals. I think one of the things we are challenged to do is translate our work in a way that the listener understands what we are talking about.

That translation, I think, is the key to our work. It takes a whole community to raise a child, feed the hungry, or provide primary health care. We all know this, but often times we do not define the whole community. Let me give you an example. At the Food Bank, we use up to 1,000 volunteers a month to get our work done. I also have 58 professional staff members. Now, why would I work with that many volunteers? Well, to get a lot of work done. More important than that is the fact that I am engaging 1,000 people and a lot of those are new to the organization and young people. So, it fulfills my mission to engage.

We do a community gardening program. Although it is not a good return on investment (amount of food vs time it takes to produce the food), the program gets us in neighborhoods, where gardens happen.

We have a Kids In Need Program where we distributed over a million dollars worth of school supplies last year to school teachers. It did not have anything to do with food, but the same kids who need food need school supplies. How does it benefit me to have a relationship with the education community and people who feel passionate about education? There are a whole lot more people who feel passionate about education—usually around their own kids' education—than they do about hunger, because most people have not had to experience hunger themselves. So, I am in a relationship with a whole new sector in the community.

We have a Hunger One on One curriculum where we actually go into middle schools and high schools and teach courses to young people. How does that fit into the food bank? It gets me in schools and schools are where I want to do food drives, where I want to get people to come to the Hunger Walk. It is where I want to engage young people to actually come to

the Food Bank or go to the agencies we serve. So, it serves a greater purpose.

Finally, we have a program called Atlanta's Table. We actually pick up prepared food from restaurants, caterers, and hotels. We have more than 250 restaurants participating. It is a very labor intensive and difficult program to administer, but it puts me in relationship with the hospitality community. In Atlanta, we have the fourth biggest hospitality community in the country and the hospitality industry is what drives business in any city. If I do not have a relationship with the primary business in the city, then I am missing a huge source of donations.

## HEALTH CARE AND COMMUNITY BUILDING

We have a surplus of food; we do not have a surplus of health care. We do not have a surplus of affordable housing or cars to give to people so they can get to work. We do not have a surplus of childcare for folks. We do have a surplus of food and the question is: How can we use that surplus to connect, collaborate, and address the main objectives of this conference? Food is a tool for community building.

In health care, what is your tool for community building? If the food in our case is the tool and community building is our real work, then what is your tool and what is your higher calling for work? Think about these things when working on solutions for better health care: 1) What are the incentives to participate? 2) How does work across different sectors make us more effective? 3) Do we have a clear vision and mission that is understandable to the different sectors of the community? 4) Do we create a win-win approach or is it "I win, I get something, but at your loss"? We have to create win-win.

I want to talk just a moment about some trends from our perspective at the Food Bank. One of the things we see is a growing number of nonprofit organizations in the community—probably too many. They compete with each other for high quality leadership and funding. Many of our community-based services are focused on one charismatic individual and when that individual burns out, wears out, and moves on and they have not institutionalized the idea, the organization fails. Competition for money and services has dramatically increased. Funders are increasingly demanding clear, measurable outcomes. There is a need to reframe much of our work so that funders and the public and private sector better understand and support what we do.

In our area of emergency care, we are finding that a lot of folks are frequently arriving saying, "Folks, we're moving into supplemental work instead of emergency work." What are we finding in health care? When people do not have health care, how do they get it? They go to the emergency room. We have

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millions of people getting health care that way. When there is a surplus of food and people come to ask for food, we always find that the individuals typically: pay too much for rent; have had a healthcare emergency; do not have enough childcare; do not have a way to get to work. In every case, there is a relationship between these issues. In primary health care, you face many of the same trends and challenges of increasing cost, increasing competition, the need to consolidate and work smarter, a lack of capacity for increasing demand, the need to take the long view in this work by building on our assets in each community, and to work and act strategically. Finally, we need to do a better job of marketing. We need to do a better job of telling our story.

In the Regional Leadership Foundation, we sponsor programs that help individuals to see and feel issues. We recently conducted a day-long trip for regional leaders on health disparities; we visited the Dekalb Health Center, Fulton Health

Center, CDC, and the Emory Rollins School of Public Health. Our program guests were awakened that day: they could feel, smell, and touch the problems. They could talk to the people who worked in those facilities and the people receiving the services. This was just one way to tell the story.

Do we, healthcare providers and community programming, have common interest? Do we have common interests? Do we have common issues? I think we do. I think where needs and opportunities meet, there is an opportunity for partnership and collaboration. Why could we not partner on education? Health is all about education and people taking responsibility for themselves. Why could we not partner in collecting information statistics so that we can better tell our story? Why could we not partner in sharing facilities, using food as incentive to bring people together? What I found—and maybe the reason I work in food—is that when you feed people, they come. If you call a meeting and you feed people, they are more likely to come to the meeting. If you are providing a service in health care and you want to hold a class on Saturday, you can offer food. If we can work together to educate the public, work together to tell our story, work together to lobby the government, then we can truly help each other. When you win, we win. When we win, you win.

#### INTERNET INFORMATION RESOURCES

America's Second Harvest  
[www.seconddharvest.org](http://www.seconddharvest.org)

National Center for Children in Poverty  
[www.nccp@columbia.edu](mailto:www.nccp@columbia.edu)

Food Research and Action Center  
[www.frac.org](http://www.frac.org)

Bread for the World  
[www.bread.org](http://www.bread.org)

Children's Defense Fund  
[www.childrensdefense.org](http://www.childrensdefense.org)

Congressional Hunger Center  
[www.ghn.org/chc/](http://www.ghn.org/chc/)

Atlanta Community Food Bank  
[www.acfb.org](http://www.acfb.org)