FEEDING AMERICA

Food as Medicine 3.0

Prepared for the Elevance Health Foundation

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Acknowledgments

Twenty-one Feeding America partner food banks are participating in the *Food as Medicine 3.0* (FAM3) program. Teams at each site are working to implement program activities with their health care partners. Feeding America extends our gratitude to those teams, and to the lead food bank staff who manage local activities and contributed to this report through the grant reporting mechanisms and through ongoing meetings with the Feeding America and Gretchen Swanson Center for Nutrition teams.

The evaluation team at the Gretchen Swanson Center for Nutrition included Dr. Eric Calloway, Dr. Christopher Long, Nicole Cawrse, Dr. Bailey Houghtaling, Dr. Eliza Short, and Dr. Betsy Anderson Steeves, Laura Flournoy, and Maryan Isack, who all work extensively on the FAM3 program, evaluation activities, reporting processes and data analyses. Feeding America is grateful for their expertise and work, including their significant contributions to this report.

ABOUT FEEDING AMERICA

Feeding America® is the largest hunger-relief organization in the United States. Through a network of more than 200 food banks, 21 statewide food bank associations, and over 60,000 partner agencies, food pantries and meal programs, we helped provide 6.6 billion meals to tens of millions of people in need last year. Feeding America also supports programs that prevent food waste and improve food security among the people we serve; brings attention to the social and systemic barriers that contribute to food insecurity in our nation; and advocates for legislation that protects people from going hungry. Visit **FeedingAmerica.org**, find us on **Facebook** or follow us on **Twitter**.

ABOUT ELEVANCE HEALTH FOUNDATION

Elevance Health Foundation is the philanthropic arm of Elevance Health, Inc. The Foundation works to advance health equity by focusing on improving the health of the socially vulnerable through partnerships and programs in our communities with an emphasis on maternal child health; substance use disorder; and food as medicine. Additionally, the Foundation also responds to disasters when our communities need us the most. Through its key areas of focus, the Foundation strategically aligns with Elevance Health's focus on community health and becoming a lifetime, trusted health partner that is fueled by its purpose to improve the health of humanity. The Foundation coordinates with the company's year-round Dollars for Dollars program which provides 100 percent match of associates' donations, as well as its Volunteer Time Off and Dollars for Doers community service programs. To learn more about Elevance Health Foundation, please visit **www.elevancehealth.foundation.**

ABOUT GRETCHEN SWANSON CENTER FOR NUTRITION

The Gretchen Swanson Center for Nutrition is a nonprofit research institute providing expertise in measurement and evaluation to help develop, enhance and expand programs focused on healthy eating and active living, improving food security and healthy food access, promoting local food systems and applying a health equity lens in all we do. With expertise in public health nutrition, we are dedicated to building measurement strategies to assess the impact of innovative health-related programs. We work nationally and internationally, partnering with other nonprofits, academia, government and private foundations to conduct research, evaluation and strategic planning.

AUTHORS

This report was written by Elise August, MPH and case studies were authored by Laura Flournoy, MS and Maryan Isack, MS with input and review from participating food banks. Relevant report sections were reviewed by Feeding America staff: Ashley Howard, MPA, Angela Berry, MPA, and Hanna Selekman, LSW; and Gretchen Swanson Center for Nutrition staff: Nicole Cawrse, MS, RDN, PMP, Christopher Long, PhD, Eric Calloway, PhD, RDN, and Eliza Short, PhD, RDN. The content expressed herein are Feeding America's views and do not necessarily represent the views of any sponsoring agency or individual food bank.

PARTICIPATING PARTNER FOOD BANKS

Atlanta Community Food Bank
Capital Area Food Bank
Dare to Care Food Bank
Feed More
Feeding America Riverside and San Bernardino Counties
Feeding Westchester
Food Bank for NYC
Food Bank of Northern Nevada
Food Bank of Northwest Indiana
Freestore Foodbank
Gleaners Food Bank of Indiana, Inc.
Greater Baton Rouge Food Bank
Greater Cleveland Food Bank
HACAP Food Reservoir
Houston Food Bank
Island Harvest
Mid-Ohio Foodbank
Regional Food Bank of Northeastern New York
Second Harvest Food Bank of Middle Tennessee
Second Harvest of Silicon Valley
St. Louis Area Food Bank

Contents

Introduction

This report describes results and key learnings from Year 1 of the *Food as Medicine 3.0* (FAM3) program, a three-year initiative that supports food bank-health care partnerships and interventions to serve patients who screen positive for food insecurity in health care settings.

Food security and health are inextricably linked. Food insecurity impacts health across the lifespan and can lead to increased risk for chronic diseases like diabetes, obesity, hypertension, and heart disease.[1] Food insecurity and poor health have a cyclical relationship; people living in food-insecure households may rely on coping strategies that lead to poor health and reduce capacity for disease management, thus leading to increased health care expenditures which can limit household income and create a pathway for continued food insecurity.[2] Food insecurity has been linked to over $77 billion in additional health care expenditures each year in the U.S.,[3] highlighting the importance of food bank-healthcare partnerships that can address this link. Food insecurity is present in all counties, parishes, and boroughs, with racial and ethnic minorities experiencing disproportionately higher rates contributing to persistent health disparities and inequities in marginalized populations.[4] Over the years, Feeding America and partner food banks have worked to better understand and address the intersections of food insecurity and health. In fact, over 80 percent of partner food banks are engaged in healthcare partnerships. Feeding America is committed to identifying and supporting new FAM approaches and conducting research to evaluate the impact of these approaches.

Feeding America has a bold aspiration for our nation, that "every community and each person within it has access to the food and resources that they say they desire and need to thrive. The food insecurity rate is 5% by 2030 and disparities by race and place are cut in half." In support of this vision, we aspire to ensure that all people facing hunger have the support they need to make healthy choices. In Feeding America's 2023 Elevating Voices: Insights Report, 93% of neighbors surveyed agreed that food is medicine and highlighted the importance of regular access to healthy foods.[5] Programs like FAM3 are critical to ensuring that everyone has what they need to improve their health. Throughout the remainder of the FAM3 program and beyond, Feeding America will continue to explore and test effective approaches of food bank-healthcare interventions.

TABLE OF CONTENTS >>

The Food as Medicine Model

Feeding America defines ***Food as Medicine*** as a food bank-healthcare intervention that follows a screen, refer, and nourish model.

SCREEN

Patients are screened for food insecurity at health care provider visits.

REFER

Patients who screen positive for food insecurity are referred to Feeding America partner food bank programming.

NOURISH

Patients redeem food from a program supported by a Feeding America partner food bank.

FIGURE 1. FOOD AS MEDICINE MODEL

TABLE OF CONTENTS >>

2-item Hunger Vital Sign[6]

In FAM3, patients are screened for food insecurity by their healthcare providers, often using the 2-item Hunger Vital Sign, which identifies households as being at risk for food insecurity if they answer that either or both of the following two statements is 'often true' or 'sometimes true' (vs. 'never true'):

> "Within the past 12 months we worried whether our food would run out before we got money to buy more."

> "Within the past 12 months the food we bought just didn't last and we didn't have money to get more."

If patients screen positive for food insecurity, they are referred to a range of interventions provided in partnership by the food bank and healthcare partner. Examples of those interventions include, but are not limited to, client choice pantries located onsite at hospitals and healthcare clinics, emergency food boxes or food bags available for pickup at a healthcare appointment, or enrollment in a produce prescription program. FAM3 interventions often include wraparound services and benefits assistance including enrollment or enrollment assistance in the Supplemental Nutrition Assistance Program (SNAP), cooking demonstrations, or nutrition education courses. The food and programming provided in FAM3 interventions is often tailored to specific dietary or health conditions such as diabetes or hypertension.

PROGRAM MODELS

Across FAM3, food banks deployed a variety of FAM interventions in partnership with healthcare:

11 FOOD BANKS DEPLOYED//
Onsite Food Pantries

5 FOOD BANKS DEPLOYED//
Mobile Distributions

11 FOOD BANKS DEPLOYED//
Onsite Emergency Food Packages
(Box or Bag)

4 FOOD BANKS DEPLOYED//
Prescription Voucher Program

2 FOOD BANKS DEPLOYED//
Home Delivered Food

TABLE OF CONTENTS >>

Program Overview

The FAM3 program is the third iteration of the Food as Medicine partnership between Feeding America and Elevance Health Foundation. Building on the success of Food is Medicine 1 (FIM1) (2018-2020)[7] and Food is Medicine 2 (FIM2) (2021-2022), FAM3 supports 21 food banks to advance healthcare partnership interventions. Unique to FAM3 is a rigorous evaluation led by the Gretchen Swanson Center for Nutrition (GSCN). FAM3 supports food bank-healthcare partnerships to:

1. Strengthen and expand food insecurity screening in patient populations during health care visits.
2. Reduce barriers for patients to access food assistance, in part by establishing food distribution points at health care sites or referrals to food distribution at health care.
3. Connect patients to short- and long-term nutrition assistance programs, including the Supplemental Nutrition Assistance Program (SNAP) and other wraparound services.
4. Evaluate the impacts of interventions on neighbor health and food security status.
5. Understand the challenges and facilitators to success across various models of FAM interventions.

TABLE OF CONTENTS >>

YEAR 1 PROGRAM ACTIVITIES

21 Feeding America partner food banks, selected through a competitive grant opportunity, partnered with Feeding America and the Gretchen Swanson Center for Nutrition to support year one implementation and evaluation activities. Food banks worked with healthcare clinics to implement processes and procedures for conducting food insecurity screenings and connecting patients to resources.

KEY YEAR ONE FAM3 ACTIVITIES INCLUDED:

- Providing neighbors with nutritious food and educational resources that support neighbor's health and wellbeing.
- Supporting patient enrollment in SNAP and connecting patients to additional food assistance programs and resources.
- Reporting quarterly data to track the reach of FAM3 programs.
- Conducting baseline surveys of neighbors who received food from a FAM3 program.
- Engaging in a learning collaborative (Figure 2) focused on Food as Medicine programming and evaluation, which included four sessions with all 21 food banks, called Learning Sessions. The topics of these Learning Sessions included Evaluation 101, Surveys and Neighbor Engagement, Healthcare Partnerships and Data Sharing, and Feeding America's National Healthcare Strategy. Many sessions featured panelists from participating food banks or their healthcare partners.
- Providing tailored support in bimonthly sessions between each food bank and its healthcare partners, and members of the Feeding America and Gretchen Swanson Center for Nutrition teams. These sessions are known as "Action Period Meetings" (Figure 2).

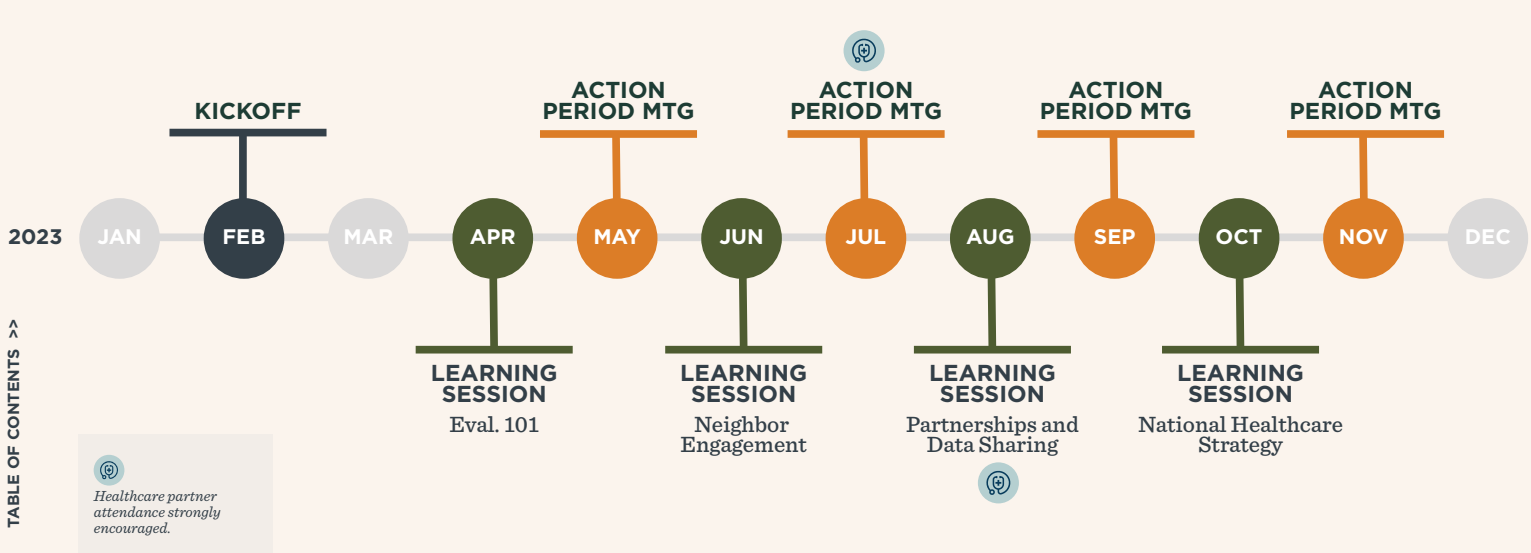


FIGURE 2. 2023 LEARNING COLLABORATIVE

TABLE OF CONTENTS >>

Program Evaluation Overview

The Gretchen Swanson Center for Nutrition applied and was selected as the lead evaluator for the FAM3 program. Throughout the course of the FAM3 program, the GSCN team is responsible for providing evaluation support to food banks and healthcare partners, developing data collection tools, and performing data analysis. The overall FAM3 programmatic goal is that patients with chronic diseases who are experiencing food insecurity have access to nutritious food that facilitates better health. The evaluation of FAM3 is an effort to assess how well that goal is achieved.

THE GSCN TEAM APPROACHED THE FAM3 EVALUATION WITH FOUR KEY AIMS:

1. Co-create an evaluation and data collection approach with food banks, their healthcare partners, and Feeding America,
2. Evaluate effects of FAM3 activities on participating neighbors' health,
3. Evaluate effects of FAM3 initiatives on participating neighbors' food security, dietary factors, and household economic outcomes, and
4. Evaluate successes and challenges of FAM3 implementation.

The first year of the FAM3 evaluation was heavily focused on the co-creation of an evaluation and data collection approach, in addition to studying barriers and facilitators to program implementation across the 21 participating food banks.

TABLE OF CONTENTS >>

KEY YEAR 1 EVALUATION ACTIVITIES INCLUDED:

- Conducting intake interviews at the start of the grant with food banks and their healthcare partners to assess implementation activities.
- Co-creating a tailored evaluation plan with food bank and healthcare staff at each site through guidance provided during full cohort Learning Sessions and one-on-one meetings with each food bank.
- Co-creating a baseline/follow-up neighbor survey with food banks, healthcare partners, and the Feeding America and Gretchen Swanson Center for Nutrition teams to evaluate the effects of FAM interventions on neighbor health and food security status.
- Partnering with authorized translation services to translate the pre/post neighbor surveys into five non-English languages: Arabic, Chinese, Haitian Creole, Spanish, and Vietnamese.
- Consulting with staff at food banks and their healthcare partners to implement survey administration into their workflows.
- Developing a protocol for submission to the Western Copernicus Group Institutional Review Board to ensure that research and evaluation activities are conducted ethically.
- Partnering with Elevance, the insurance provider, to develop an aligned approach to accessing and analyzing claims data for consenting neighbors who are Elevance Covered Lives (Elevance members).
- Analyzing quarterly quantitative data to track the reach of FAM3 programs across the cohort.

TABLE OF CONTENTS >>

METRICS OVERVIEW

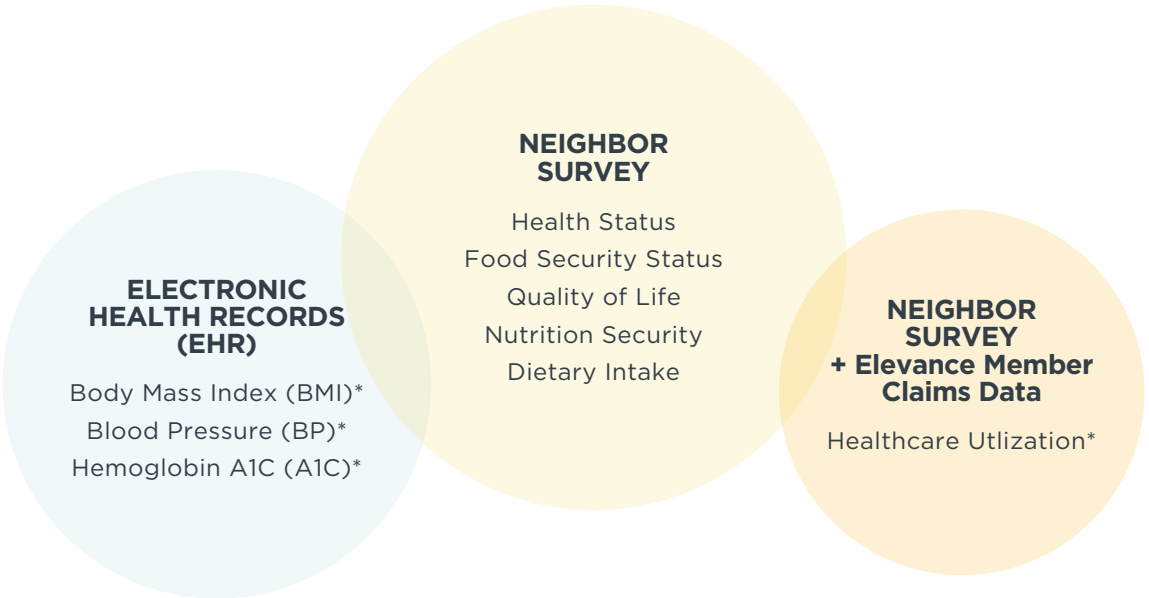
FOOD INSECURITY SCREENING AND REFERRAL METRICS (REACH DATA)

Food bank staff and healthcare partners tracked and reported data on program reach on a quarterly basis. This data was submitted directly to the GSCN team for analysis and review via a Smartsheet form:

- Number of patients screened for food insecurity
- Total number of patients who screened positive for food insecurity
- Total number of patients who screened positive and were referred to a FAM3 program
- Total number of patients who screened positive and then received food from a FAM3 program (redeemed their referral)
- Total number of neighbors referred to SNAP.
- Total number of SNAP applications initiated.
- Total number of SNAP applications completed.

OUTCOME METRICS

Beginning in year 2 of the FAM3 program, food banks and healthcare partners will report on a variety of metrics through neighbor surveys and through clinical data collected from the electronic health records (EHR) and from Elevance member claims data. Examples of these metrics and their data sources include:



**We will only receive these metrics from a sub-set of participating partnerships due to data availability and partnership capacity.*

TABLE OF CONTENTS >>

Our Year in Review

TABLE OF CONTENTS >>

Summary

IMPACTS AND CHALLENGES

GRANT IMPACT

The FAM3 grant has had a profound impact on food banks, revolutionizing their capacity to serve communities in need. Through this grant, food banks have successfully expanded partnerships to new healthcare providers, ranging from major health systems to federally qualified health centers and free clinics. Additionally, the grant has facilitated the introduction and expansion of innovative program models, such as onsite pantries and voucher programs, which have diversified access points for individuals seeking assistance. To support the implementation and sustainability of these programs, food banks have been able to hire dedicated staff, enhancing the efficiency and effectiveness of FAM initiatives. Furthermore, through refined screening and referral processes, food banks have optimized their ability to identify and assist individuals who can benefit most from these programs, ensuring resources are allocated strategically. Importantly, the grant has enabled food banks to reach neighbors in underserved areas, thereby reducing barriers to accessing nutritious foods and essential wraparound services related to housing, transportation, SNAP, and WIC. Overall, the Food as Medicine grant has been instrumental in empowering food banks to provide comprehensive support, promoting health and well-being among vulnerable populations while fostering collaboration across sectors to address systemic issues of food insecurity.

TABLE OF CONTENTS >>

GRANT CHALLENGES

Food banks in FAM3 reported on challenges related to collecting data from their healthcare partners, staffing capacity to support FAM programs, providing neighbors with desired and culturally relevant foods, and overcoming language barriers between staff and neighbors. To enhance data collection from healthcare partners, many food banks have implemented more regular meetings and streamlined communication channels to ensure efficient and timely sharing of information. In efforts to provide patients with a diverse array of desired and culturally relevant foods, many food banks have proactively surveyed neighbors to gather insights into their preferences, enabling them to tailor food assistance more effectively. Recognizing the importance of overcoming language barriers, several food banks have hired translators and developed multilingual program materials in partnership with the Feeding America and GSCN team. These efforts will effectively improve communication between staff and neighbors, fostering greater inclusivity and accessibility to essential food resources. Through these proactive measures, all stakeholders are committed to strengthening the impact and reach of the *Food as Medicine 3.0* program in communities across the nation.

TABLE OF CONTENTS >>

By the Numbers REACH DATA

TABLE OF CONTENTS >>

CUMULATIVE REACH DATA (4/01/2023-12/31/2023)

During year one of FAM3, a total of 287,949 unique individuals were screened for food insecurity at partner health care sites. The data presented here represents cumulative estimates of unique individuals that have been screened and referred since data collection began in April 2023, aggregated across the 21 food banks.

REACH DATA (AGGRAGATED) APRIL 2023—DECEMBER 2023	**RESULTS**
# patients screened for food insecurity	287,949
# patients screened positive for food insecurity	94,494
# patients referred to a FAM3 program	45,295
# patients receiving food from FAM3 program	40,950
# patients/neighbors referred to SNAP	8,190
#SNAP applications initiated	2,126
#SNAP applications completed	1,506

QUARTERLY REACH DATA

The data presented here represents metrics of screenings and referrals reported on a quarterly basis, aggregated across the 21 food banks. These data include some duplicated counts for the total number of patients receiving food, since a patient may receive food multiple times within one quarter. Therefore, if this metric is added up across quarters, it will result in a much higher number than the cumulative number receiving food reported above. We began data collection in Q2.

SCREENING AND REFERRAL DATA QUARTERLY	**RESULTS**		
	Q2 4.23-6.23	**Q3** 7.23-9.23	**Q4** 10.23-12.23
# patients screened for food insecurity	64,278	88,772	134,899
# patients screened positive for food insecurity	20,367*	32,130	41,997
# patients referred to a FAM3 program	10,780	16,390	18,125
# patients receiving food from FAM3 program	9,745	15,922	24,714
# patients/neighbors referred to SNAP	1,479	2,219	4,492
#SNAP applications initiated	725	902	499
#SNAP applications completed	328	580	589

** Quarter 2 reach data for the counts of patients screening positive for food insecurity was adjusted after clarifying reach definitions during individual grantee meetings in September 2023; Quarterly data reported in this table, and cumulative data in the table above, reflects these adjustments.*

REACH DATA INTERPRETATION GUIDANCE

Some projects do not have the capacity or infrastructure to track all the metrics described above. In those cases, decision rules are used to provide conservative estimates. For example, a few projects cannot track how many participants screened positive for food insecurity, but they can track how many participants were referred to their FAM3 program. In that case, we replace the missing data for the number screened positive for food insecurity with the numbered referred. Additionally, not all projects assist with SNAP enrollment, and for those who do assist with SNAP enrollment, not all assist with each step in the process (e.g., referral to SNAP, initiating applications, and completing applications). FAM3 grantees report counts that fit best with their own model of assisting FAM3 participants with SNAP. Therefore, the counts for each step of SNAP assistance are not necessarily linked (e.g., a project might only track and report the number of completed applications, even though they likely referred and initiated many more applications, but do not have tracking data for this). Only a few projects assist FAM3 participants through each step and are able to track and provide these numbers. For these reasons, the reach numbers for each type of SNAP assistance are best interpreted independently from one another, as separate counts.

TABLE OF CONTENTS >>

By the Numbers SURVEY DATA

TABLE OF CONTENTS >>

The below table summarizes baseline data from the first 331 participants across 9 food bank-healthcare partnerships that were enrolled in the FAM3 survey evaluation at the time that this report was written (March 2024). These participants may not be representative of the population of participants across all 21 regional partnerships, from which additional data are forthcoming. Each food bank is aiming to complete 200 baseline surveys.

FAM3 BASELINE SURVEY DATA COLLECTED NOVEMBER 2023-MARCH 2024 (N=331)

AGE (YEARS)[a]	MEAN	RANGE
	42.3 (15.4)	**18-88**
GENDER IDENTIFICATION	**N** (%)	
Female	**260** (78.6%)	
Male	**69** (20.9%)	
Some other way	**0** (0%)	
Don't know or prefer not to answer	**0** (0%)	
Not reported	**2** (0.6%)	
RACE/ETHNICITY[b]	**N** (%)	
Black or African American	**108** (32.6%)	
Hispanic or Latino	**97** (29.3%)	
White or European American	**79** (23.9%)	
Multi race/ethnicity	**17** (5.1%)	
American Indian or Alaskan Native	**6** (1.8%)	
Asian or Asian American	**5** (1.5%)	
Middle Eastern or North African	**1** (0.3%)	
Another race or ethnicity not mentioned[c]	**5** (1.5%)	
Don't know or prefer not to answer	**11** (3.3%)	
Not reported	**2** (0.6%)	

[a] *n=327; 2 participants had missing data, 2 participants selected "Don't know or prefer not to answer."*

[b] *Participants who selected more than one race or ethnicity are included in the "multi race/ethnicity category."*

[c] *Open-response answers to "Another race or ethnicity not mentioned" included 'Mestizo' (n=2), 'Indian' (n=1), 'Haitian' (n=1), and 'Bi' (n=1)*

SURVEY ADMINISTRATION METHODS

Many food banks are deploying multiple ethods of survey administration.

TABLE OF CONTENTS >>

Centering Equity

Culturally Relevant Foods

In addition to providing nutritious foods, food banks in the FAM3 program are committed to providing food that is culturally relevant for the neighbors they serve. Several food banks are collecting feedback via neighbor surveys or direct counseling with neighbors who participate in their FAM programs to improve their ability to provide culturally relevant and desired food. These efforts have resulted in new offerings like coconut milk, masa flour, and spices. Early survey data shows that FAM participants are predominantly Black or African American (32.6%) or Hispanic or Latino (29.3%), highlighting the need to accommodate a diverse range of preferences that could improve neighbor comfort with FAM programs, increase their likelihood of participation in FAM interventions, and reduce stigma.

Healthcare Partnerships

Food banks in the FAM3 program partnered with a wide range of healthcare entities, including Federally Qualified Health Centers (FQHCs) and Free Clinics. Both FQHCs and Free Clinics reach medically underserved populations who often have unmet social needs like food access. Through partnerships with these clinics, food banks can effectively reach populations who are disproportionately affected by food insecurity and provide them with increased access to nutritious food that may facilitate better health.

Neighborhood Surveys

In recognition of the diverse communities that are served across the FAM3 program, the Feeding America and Gretchen Swanson teams partnered with verified translation services to translate neighbor baseline and follow-up surveys, as well as all survey materials (including recruitment materials, neighbor consent, etc.) into the languages most frequently requested by participating food banks: Arabic, Chinese, Haitian Creole, Spanish, and Vietnamese. Neighbor surveys are administered through a variety of formats to promote accessibility, including paper surveys with mail-in options, virtual options through links provided over text or via QR codes, phone interviews, and in-person administration via tablets. Feeding America and GSCN lent out a total of 24 tablets to support this method of survey administration. Neighbors also receive a $30 incentive after completion of the pre-survey and an additional $30 incentive after completion of the post-survey. These incentives are provided via physical or electronic gift cards.

Health Equity Training

In January 2024, Feeding America launched an e-learning Health Equity training series available on Feeding America's Learning Hub, an internal training platform for food bankers. The Heath Equity in Food Banking training series is a tools-based educational program that includes the history of structural racism and social determinants of health to help participants understand the current health disparities that affect communities we support across the country. It includes nationally recognized expert speakers, workshops, networking, toolkits, and readings to support and build the pathway towards equity. This training builds on three years of live health equity training series organized by Feeding America and packages the information into a course that can be accessed by the network any time. A significant portion of the training series is focused on integrating health equity into healthcare partnership programs like Food as Medicine interventions. Feeding America hosted 100 food bankers, including many FAM3 food bank staff, at a webinar to launch the training series and other updated health and nutrition resources.

“I’ve never needed assistance like this, but now I am 75 years old and I realize I need help. I just don’t have the funds and the situation here is very hard. When I didn’t have this program, I wasn’t able to buy so much food, even with the CalFresh money I received, the cost of everything is so high. I had to decide between foods I would choose. Now I have flexibility since I receive so much fresh vegetables and fruit, like onions, I can buy other items like my salmon that I love so much. I am very careful about my health and what I eat, so I am grateful for the fresh food.”

Second Harvest of Silicon Valley

“The food options are great and I discovered parsnips and beets. My A1C is lower, and I have more energy. My endocrinologist and dietitian are very happy with my progress since being a part of the program.”

Regional Food Bank of Northeastern New York

Food as Medicine Interventions are Changing Neighbors’ Lives

“I have a mom that comes to see me every month and thanks me ‘I can’t thank you enough for connecting me to Feed More, they have saved my life and my daughter’s life’ as she says this she cries ‘without the food that I get and the resources from them I don’t know where we would be.’”

Feed More

“The Food Pharmacy at the Lebanon Clinic has been a literal life-saver for patients experiencing food insecurity. A particular patient reported that she had a household of five, but she was fine with just receiving enough food for one person. The patient stated that she didn’t want to be “greedy.” When her order was gathered, she was visibly on the verge of tears and verbalized her thanks because she had several bags of food that would feed her entire family, not just one person!”

Second Harvest Food Bank of Middle TN

TABLE OF CONTENTS >>

CLINICAL NARRATIVES

Over the next two years, FAM3 will conduct an analysis of clinical data received in aggregate from healthcare partners, or from patients' individual electronic health records. Some food banks have received aggregated clinical data from their healthcare partners over the course of their respective partnerships, and have shared the below success stories:

At **Food Bank of Northern Nevada**, patients utilizing the Healthy Pantries have seen improvements in hemoglobin AIC levels. Testing indicates that 55% of all patients with at least two A1C's drawn, show their A1C in a downward trend. The Prescription Pantry also encourages healthy eating habits, with 95% of participants reporting they now eat more vegetables with their families.

Regional Food Bank of Northeastern New York and **St. Peter's Health Partners** expanded their Food as Medicine program over the last 4 years and have seen an overall decrease of 3.35% in participating patient's A1C levels and an average weight loss of 12.3lbs. These clinical improvements are accompanied by an increase in knowledge of healthy food choices and preparation among participants.

Preliminary data from **Island Harvest's Nutrition Pathways Program** in partnership with **Harmony Healthcare** shows that among participants for whom it was appropriate to track BMI, 58% demonstrated an improvement over the course of the program. This was a small sample size as Island Harvest supports participants for whom this is not an appropriate measure, including pregnant people. Additionally, 79% of participants reported increased intake of whole foods, 43% reported a decreased intake of processed foods, and 38% demonstrated improvement in the World Health Organization Five-Well-Being Index, which measures mental wellbeing.[8]

TABLE OF CONTENTS >>

CONCLUSION AND NEXT STEPS

LEARNING COLLABORATIVE

Throughout the next two years of FAM3, participants will continue to engage in a Learning Collaborative consisting of quarterly Action Period meetings, biannual Learning Sessions, and optional Lunch & Learns. Each of these events will continue to provide grantees with technical assistance and support, build community across the participating food banks, and learn from guest speakers that are experts in the field. The goal of this Learning Collaborative is to provide an engaging space for shared learnings and guide the successful execution of each program and its evaluation.

DATA COLLECTION

Grantees will continue to submit screening and referral data on a quarterly basis, deepening our understanding of the number of people who are being reached by FAM interventions and identifying trends in the data. As neighbor surveys continue through August 2025, the Gretchen Swanson Center for Nutrition and Feeding America teams will continuously report on and analyze survey results, linking the findings with clinical data from the electronic health records and patient claims data from Elevance Health where available. The implementation evaluation will continue throughout the duration of FAM3, gathering insights from neighbor interviews and meetings with food bank and healthcare staff. Participating food banks submit narrative reporting on the successes, challenges, and impact of their programs on an annual basis.

PLANNED REPORTS AND PUBLICATIONS

Future annual reports will be released in April 2025 and April 2026, followed by a full program report in July of 2026. Annual reports will include analyses of survey results and clinical and claims data, as well as implementation findings across the participating food banks. The final program report will demonstrate the impacts of FAM3 on neighbor health and wellbeing, as well as its implications for food bank and healthcare partners who implement these interventions. Throughout the duration of the program, Feeding America and the Gretchen Swanson Center for Nutrition will partner to release additional publications to benefit the field.

TABLE OF CONTENTS >>

Case Studies

TABLE OF CONTENTS >>

Atlanta Community Food Bank

For upwards of five years, Atlanta Community Food Bank (ACFB, Atlanta, GA) has been working in the food as medicine space. Today, ACFB is focused on expanding their food pharmacy at Jesse Hill Market, which is located on site at Grady Health System as a patient resource for food, nutrition and cooking education. The market works with registered dietitians to create pre-prepared food boxes that are tailored to a patient's specific needs, such as managing diabetes or hypertension.

PROGRAM MODEL

Physicians in Grady Health's primary care, diabetes, cardiovascular, cancer, or neuro and women's centers can refer their patients to the market. Patients must screen positive for food insecurity and have either a blood pressure greater than 140/90 or have A1c level greater than nine to receive a referral.

Oftentimes, registered dietitians will walk patients directly down to the market to pick up a food box that has been preselected and designed to meet the patient's needs. Staff at the pharmacy can look up each patient to see that they have been referred and then record their visit to the pantry to close the loop. The market also employs a patient navigator who will follow up with patients who have been referred but have not visited the market.

Patients can pick up food every two weeks and must also attend 1 cooking class and medical nutrition therapy visit per three months. Patients can re-enroll for three-month periods and then graduate after 12 months.

MEDICAL PROVIDER SCREENS PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE ARE REFERRED TO THE FOOD AS MEDICINE PROGRAM** → **PATIENTS RECEIVE PRE-PACKAGED FOODS ON SITE**

FOCUS POPULATIONS

This program focuses on serving patients with or at risk of diabetes and/or hypertension.

TECH PLATFORM

Epic is used to track clinic metrics, medications, patient visits and utilizations of the market.

FOODS PROVIDED

Foods can be tailored to accommodate patients' specific dietary needs and include nutritious items such as fresh produce, whole grains and legumes.

WRAPAROUND SERVICES

Benefits Outreach screeners are available on site to connect patients to SNAP, Medicaid and WIC. A year-long nutrition education program is also offered.

TABLE OF CONTENTS >>

Atlanta Community Food Bank

PROGRAM HIGHLIGHTS

1. Successfully expanded the Food Pharmacy, where patients receive food prescriptions that are redeemable for Fresh Produce
2. Expanded the distribution of food at Fresh Food Carts at high-need clinics
3. Increased patient engagement through the Teaching Kitchen, which provides patient and community education on healthy eating
4. Opened a third Community Food Center in partnership with Grady Hospital, offering a client-choice model that empowers individuals to make healthy food selections that are tailored to their needs.

PROGRAM CHALLENGES

1. Continuously adapting services and ensuring consistent food supply to meet the community's changing needs in the aftermath of the COVID-19 pandemic.
2. Atlanta Community Food Bank adapted to these challenges by strengthening their sourcing strategies and modifying program delivery to ensure the safety and accessibility for neighbors.

SCREENING AND REFERRAL DATA

162,280 SCREENED FOR FOOD INSECURITY	**45,180** POSITIVE FOR FOOD INSECURITY	**2,389** REFERRED TO FAM3 PROGRAM

1,344 RECEIVING FOOD FROM FAM3 PROGRAM	**–** REFERRED TO SNAP	**547** SNAP APPLICATIONS INITIATED	**371** SNAP APPLICATIONS COMPLETED

Atlanta Community Food Bank is a partner food bank of Feeding America

TABLE OF CONTENTS >>

Feeding Westchester

Feeding Westchester's Rx Pantry Program began in 2018. This collaboration between Feeding Westchester and healthcare partner sites such as medical clinics and hospital systems reduces barriers to nutritious food access while tracking health outcomes over time. For Food as Medicine 3, Feeding Westchester is expanding the Rx Pantry Program by adding four new partner sites, growing the program from 14 to 16 locations and expanding the use of Link2Feed at these sites to track health information and referrals.

PROGRAM MODEL

Healthcare partners screen patients for food insecurity and refer them to the Rx Pantry Program if they indicate the need for food assistance. The sites allow patients to share their health information regarding chronic illness indicators with Feeding Westchester through the Link2Feed service insights platform. Currently, tracked conditions include hypertension, diabetes, cancer and obesity.

WRAPAROUND SERVICES

Through a United Way partnership, SNAP coordinators make benefit referrals available to neighbors. Housing assistance referrals and legal services are also available.

MEDICAL PROVIDER SCREENS PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE ARE REFERRED TO THE FOOD AS MEDICINE PROGRAM** → **PATIENTS REDEEM REFERRALS TO RECEIVE FOOD ONSITE, AT A FOOD PANTRY, IN THEIR COMMUNITY, ETC.**

FOCUS POPULATIONS

The Prescription Pantry program focuses on serving patients with or at risk of diabetes and/or hypertension.

TECH PLATFORM

Link2Feed tracks distribution, health information and healthcare outcomes over time. Using service and encounter data, the software facilitates enrollment and referral into SNAP and other governmental or community resources. It also helps to facilitate a closed loop referral process, supporting those who face food insecurity.

FOODS PROVIDED

Twice a month, food boxes are provided that include nutritious items such as fresh produce, protein, dairy, baked items and low-sodium and low-sugar shelf stable foods.

TABLE OF CONTENTS >>

Feeding Westchester

PROGRAM HIGHLIGHTS

1. Feeding Westchester received excellent feedback from participants regarding the food and recipes. They enjoyed the food demonstrations and were excited to prepare the produce that they received. Providing demonstrations and recipes with unfamiliar foods and produce items also made them more accessible.
2. Patients are extremely engaged; they ask many questions, share nutrition successes with each other, and often return to future workshops requesting recipes for specific foods.
3. Feeding Westchester conducted 12 nutrition demonstrations and 12 food workshops with patients participating in the Rx Program over the past year. Approximately 200 people participated in these demonstrations and workshops. They also distributed 298 recipe samples and 104 nutrition flyers during the grant period (with additional samples and flyers distributed to other patients not participating in the Rx Program).
4. Over the grant period, Feeding Westchester expanded the use of Link2Feed from 5 to 11 healthcare partner programs, tracking referrals to services like SNAP, mental health counseling, and housing assistance, as well as participants' health indicators over time.

PROGRAM CHALLENGES

1. Even though partner sites were interested in using Link2Feed for their food recipients, they had weaker than anticipated Wi-Fi which delayed or limited access to the system. Feeding Westchester purchased and distributed hotspots for these partners for better access and it was a learning opportunity for us as we onboard additional sites.
2. Feeding Westchester's Nutrition Resource Manager is not bilingual, but many food recipients speak only Spanish. The food bank partnered with a bilingual educator from SNAP-ED/Cornell Cooperative extension to provide bilingual support.

SCREENING AND REFERRAL DATA

71 SCREENED FOR FOOD INSECURITY	**598** POSITIVE FOR FOOD INSECURITY	**598** REFERRED TO FAM3 PROGRAM

2 RECEIVING FOOD FROM FAM3 PROGRAM	**2** REFERRED TO SNAP	**2** SNAP APPLICATIONS INITIATED	**2** SNAP APPLICATIONS COMPLETED

> **"Rx Program participants reported that they looked forward to learning tips on how to prepare healthy foods. They particularly liked this year's Thanksgiving stuffing recipe, with brown rice, chopped apples, cranberries and onions, as an alternative to white bread stuffing. They were able to taste it at a demonstration and then created it for themselves and their families with the recipe provided by our registered dietitian."**

Feeding Westchester is a partner food bank of Feeding America

TABLE OF CONTENTS >>

Food Bank of Northwest Indiana

Food Bank of Northwest Indiana customizes its partnerships based on healthcare providers' interest. For example, the food bank offers medically tailored, shelf-stable grocery boxes with Franciscan Health in Hammond. As part of the FAM3 program, the food bank is setting up food lockers onsite with its healthcare partner HealthLinc. These food lockers have the capacity to store refrigerated food.

PROGRAM MODEL

The healthcare provider screens patients for food insecurity. Upon screening positive, patients are offered a food box or referred to the locker program, depending on which health provider they are visiting. Prescription food boxes are tailored to the patients' medical condition.

MEDICAL PROVIDER SCREENS PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE ARE REFERRED TO THE FOOD AS MEDICINE PROGRAM** → **PATIENTS REDEEM REFERRALS TO RECEIVE FOOD ONSITE, AT A FOOD PANTRY, IN THEIR COMMUNITY, ETC.**

FOCUS POPULATIONS

This program focuses on serving patients with or at risk of diabetes and/or hypertension.

FOODS PROVIDED

Neighbors receive refrigerated foods through pickup at lockers, and/or receive medically tailored, shelf-stable foods in boxes each month.

EVALUATION EFFORTS

Evaluation includes reach data and surveying.

WRAPAROUND SERVICES

In addition to food, interested patients receive SNAP application assistance.

TABLE OF CONTENTS >>

Food Bank of Northwest Indiana

PROGRAM HIGHLIGHTS

1. Food Bank of Northwest Indiana opened their Food as Medicine Click N Collect locker system with our health care partner HealthLinc at their Valparaiso location. The locker system has been used to get healthy food to neighbors with chronic medical conditions who also identify as food insecure.
2. In each locker, patients receive education through recipe cards and literature pertaining to the food they are receiving. Patients also are educated through video and local classroom type teachings about food as medicine.
3. The locker system has allowed the team to provide fresh fruits and vegetables because of the refrigeration and freezer capabilities.
4. This program enabled the food bank and their healthcare partners to deliver food as medicine interventions with dignity and respect to some of the most vulnerable members of the population.

PROGRAM CHALLENGES

1. A challenge has been collecting data in a timely manner from some of the healthcare partners. This was addressed by improving communication and connecting with the appropriate people.

SCREENING AND REFERRAL DATA

1,407 SCREENED FOR FOOD INSECURITY	**1,151** POSITIVE FOR FOOD INSECURITY	**1,151** REFERRED TO FAM3 PROGRAM

1,466 RECEIVING FOOD FROM FAM3 PROGRAM	**–** REFERRED TO SNAP	**–** SNAP APPLICATIONS INITIATED	**–** SNAP APPLICATIONS COMPLETED

Food Bank of Northwest Indiana is a partner food bank of Feeding America

TABLE OF CONTENTS >>

Regional Food Bank of Northeastern New York

Since November 2019, Regional Food Bank of Northeast New York has partnered with St. Peter's Health Partners to offer a Food Farmacy for patients with diabetes who face food insecurity. The program provides participants' households with weekly pantry packages that include fresh fruits, vegetables, lean proteins and whole grains, along with weekly group sessions focusing on healthy eating and disease management.

The Food Farmacy Program aims to increase food security amongst participants, improve the health of patients and families, educate participants on the connection between health and wellness, reduce the impact of Type 2 diabetes and related medical conditions, optimize prescription medication and lower medical care costs.

PROGRAM MODEL

Participants must screen positive for food insecurity, have a chronic metabolic condition and be willing to participate in education sessions for 12 weeks. The participants take part in an interactive evidence-based education program offered by certified diabetic educators and dietitians.

MEDICAL PROVIDER SCREENS PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE ARE REFERRED TO THE FOOD AS MEDICINE PROGRAM** → **PATIENTS REDEEM REFERRALS TO RECEIVE FOOD ONSITE, AT A FOOD PANTRY, IN THEIR COMMUNITY, ETC.**

FOCUS POPULATIONS

This program focuses on serving patients with or at risk of diabetes, hypertension and/or obesity.

FOODS PROVIDED

Each week, participants receive three days of foods that include nutritious items such as fresh fruits, vegetables, lean proteins and whole grains.

EVALUATION EFFORTS

Before and after program participation, patients are screened for food Insecurity, blood pressure, weight/BMI, depression, anxiety and diabetes and hypertension metrics. Clients also participate in pre- and post- education surveys to assess knowledge related to managing their condition through diet.

WRAPAROUND SERVICES

In addition to food, Prescription Pantry locations provide SNAP assistance.

TABLE OF CONTENTS >>

Regional Food Bank of Northeastern New York

PROGRAM HIGHLIGHTS

1. Regional Food Bank of Northeastern New York joined multiple regional and state FAM collaboratives to increase their knowledge base, introduce themselves to established players in this space, share best practices and lessons learned, and stay abreast of key developments.
2. This grant enabled Regional Food Bank of Northeastern New York to hear what prospective partners were asking for and was flexible enough to allow them to respond accordingly and create two distinct program models: a one-time emergency food bag that would be distributed during healthcare visits and hospitalizations, and a comprehensive nutrition education program coupled with food provision and supportive group sessions.
3. The Food Bank built a program that fit within their organization's operational model so that it could be scaled without broad workarounds and exceptions. In Year 1, the Food Bank successfully "packaged" the FAM program so that in Year 2 it can be scaled more broadly across the Food Bank's service area. The two program models are replicable for new partners, while maintaining a level of flexibility to meet future partners' unique needs.
4. Over the last 4 years, the St. Peter's Health Partners Food as Medicine program has seen a decrease in A1C of 3.35% and an average weight loss of 12.3lbs among their participants, along with an increase in knowledge of healthy food choices and preparation.

PROGRAM CHALLENGES

1. As newcomers to the world of FAM, the Food Bank faced a learning curve to become familiar with the landscape and how the Food Bank fits into it.
2. Hiring challenges delayed the FAM Manager hire and thus the program launch. The Food Bank now has a Registered Dietitian on staff who supports the FAM program.

SCREENING AND REFERRAL DATA

3,274 SCREENED FOR FOOD INSECURITY	**480** POSITIVE FOR FOOD INSECURITY	**357** REFERRED TO FAM3 PROGRAM

157 RECEIVING FOOD FROM FAM3 PROGRAM	**42** REFERRED TO SNAP	**-** SNAP APPLICATIONS INITIATED	**-** SNAP APPLICATIONS COMPLETED

> **"The food options are great and I discovered parsnips and beets. My A1C is lower, and I have more energy. My endocrinologist and dietitian are very happy with my progress since being a part of the program."**
>
> Patient at St. Peter's Hospital's FAM Program

Regional Food Bank of Northeastern New York is a partner food bank of Feeding America

TABLE OF CONTENTS >>

Second Harvest of Silicon Valley

Since 2016, Second Harvest Food Bank of Silicon Valley has partnered with local hospitals and clinics to increase access to nutritious foods, as well as nutrition education to address diet-related illnesses that disproportionately affect low- income populations.

In FAM3, the food bank will support and strengthen collaborations 19 medical entities and 50 local medical providers in Santa Clara and San Mateo counties.

The food bank will also incorporate food security screening into medical providers' standard patient intake procedures to connect individuals to resources when they screen positive.

PROGRAM MODEL

Partnering physicians use the Hunger Vital Sign two-question screening tool to assess if patients need nutritious food or are food insecure. If a patient screens positive, the medical providers submit a referral form online and provide basic client information.

Once referred, a Second Harvest of Silicon Valley Food Connection staff member contacts the patient within two business days. Staff then conduct an assessment and match patients to free, nutritious groceries and meals where they work and live, or home-delivery grocery program as well as any government-based food programs for which they are eligible.

MEDICAL PROVIDER SCREENS PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE ARE REFERRED TO THE FOOD AS MEDICINE PROGRAM** → **PATIENTS REDEEM REFERRALS TO RECEIVE FOOD ONSITE, AT A FOOD PANTRY, IN THEIR COMMUNITY, ETC.**

FOCUS POPULATIONS

Grocery food programs are open to all. For the SNAP/ CalFresh food stamps program, patients must live in San Mateo or Santa Clara County.

TECH PLATFORM

Staff use Salesforce to track where each patient has been referred from. Second Harvest of Silicon Valley and partners collect basic data points including name, contact information, zip code and preferred language.

FOODS PROVIDED

Participants receive a grocery mix comprised of about 50 percent fresh produce and 25 percent each of protein and dairy.

WRAPAROUND SERVICES

Food Connection staff members screen participants for eligibility for SNAP/ CalFresh assistance. Patients can also call Second Harvest's multilingual Food Connection Hotline for food assistance and access to other integrated resources.

TABLE OF CONTENTS >>

Second Harvest of Silicon Valley

PROGRAM HIGHLIGHTS

1. Medical providers at CareMore Health clinic in San Jose, CA administered the universal food-insecurity screening to their patients. Patients who screened positive for food insecurity were referred by medical providers to Second Harvest of Silicon Valley through the Electronic Referral Form completion in their Salesforce system.
2. Second Harvest hired a Medical Partnership Coordinator who directly contacted the referred patients within 2 business days of the referral.
3. Second Harvest's Food Connection staff screened patients for SNAP/CalFresh (food stamps) eligibility and Free and Reduced-Priced school meals and enrolled all eligible clients to receive these benefits. Patients can directly call Second Harvest's multilingual Food Connection Hotline for food assistance and access to other integrated resources.
4. This program increased access to nutritious food by improving affordable healthy food options among food insecure populations.

PROGRAM CHALLENGES

1. Anthem Blue Cross affiliated CareMore Health clinic closed its doors this past year, however this has created an opportunity to work more closely with existing partners for future collaborations such as Santa Clara Valley Medical Center.
2. High turnover with staff members has led to inconsistency in referrals. This challenge is being addressed through quarterly reports, internal "engagement scores" and checking in more frequently with program updates.

SCREENING AND REFERRAL DATA

175 SCREENED FOR FOOD INSECURITY	**73** POSITIVE FOR FOOD INSECURITY	**65** REFERRED TO FAM3 PROGRAM

121 RECEIVING FOOD FROM FAM3 PROGRAM	**55** REFERRED TO SNAP	**51** SNAP APPLICATIONS INITIATED	**15** SNAP APPLICATIONS COMPLETED

> **"When I didn't have this program, I wasn't able to buy so much food, even with the CalFresh money I received, the cost of everything is so high. I had to decide between foods I would choose. Now I have flexibility since I receive so much fresh vegetables and fruit, like onions, I can buy other items like my salmon that I love so much. I am very careful about my health and what I eat, so I am grateful for the fresh food."**
>
> Participant,
> 75 years old

Second Harvest of Silicon Valley is a partner food bank of Feeding America

TABLE OF CONTENTS >>

St. Louis Area Food Bank

St. Louis Area Food Bank (SLAFB) is expanding its SSM Health System partnership by providing a market at DePaul Hospital. In addition, two other SSM hospitals are interested in establishing market locations, as is the BJC HealthCare system, which operates two hospitals and numerous health care centers. SLAFB has met with BJC HealthCare representatives. The food bank will also continue to educate, screen and register food-insecure patients for SNAP benefits.

PROGRAM MODEL

DePaul Hospital medical professionals screen patients for food insecurity. Patients who screen positive receive an inpatient consultation from a registered dietitian and a social worker. A dietitian then delivers a food bag received from a limited access location within the hospital to the patient at discharge. At the same time, a social worker refers the patient through a digitized platform to SLAFB if desired. A SLAFB community resource coordinator contacts the patient within 72 hours for application assistance.

WRAPAROUND SERVICES

SLAFB SNAP outreach coordinators can connect patients to nearby food pantries as well as SNAP, WIC and government-funded food resources. They can also offer external referrals such as legal resources.

MEDICAL PROVIDER SCREENS PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE ARE REFERRED TO THE FOOD AS MEDICINE PROGRAM** → **PATIENTS RECEIVE FOOD ON SITE AND REFERRALS TO THE FOOD BANK IF DESIRED**

FOCUS POPULATIONS

The program serves patients experiencing food insecurity.

TECH PLATFORM

Epic is used to track patient visits and uses of the hospital food bag program.

FOODS PROVIDED

At discharge, neighbors receive a food bag containing low-sodium, shelf-stable food to last 48 hours as well as connection to SLAFB if desired.

EVALUATION EFFORTS

DePaul Hospital tracks how many patients have screened positive for food insecurity, how many have received a referral for a food bag from the hospital and how many take food bags home. DePaul Hospital and SLAFB also share patient re-admission rates.

TABLE OF CONTENTS >>

St. Louis Area Food Bank

PROGRAM HIGHLIGHTS

1. St. Louis Area Food Bank has expanded their FAM program from one hospital partnership to six partnerships, including the addition of more on-site pantries.
2. The program is helping neighbors in multiple areas of the service territory navigate food insecurity through applying for public benefits and locating food pantries in their area.

PROGRAM CHALLENGES

1. At 1 month and 3-month check ins, most patients fall off. To address this, the food bank has been emphasizing the importance of having multiple ways to connect with patients, either through text, email, or phone.
2. Tracking data and referral connection rates is challenging, but collaborating with the hospital partner and keeping in regular communication has been key.

SCREENING AND REFERRAL DATA

21,987 SCREENED FOR FOOD INSECURITY	**2,580** POSITIVE FOR FOOD INSECURITY	**488** REFERRED TO FAM3 PROGRAM

257 RECEIVING FOOD FROM FAM3 PROGRAM	**174** REFERRED TO SNAP	**25** SNAP APPLICATIONS INITIATED	**16** SNAP APPLICATIONS COMPLETED

St. Louis Area Food Bank is a partner food bank of Feeding America

TABLE OF CONTENTS >>

Second Harvest Food Bank of Middle Tennessee

In Food as Medicine 3, Second Harvest Food Bank of Tennessee (SHFBMT) will continue support to Neighborhood Health Clinic's (NHC) client food pantries, Take Away Cafes. NHC is a network of 10 federally qualified health clinics that have served Middle Tennessee neighbors for more than 45 years without regard to insurance status or ability to pay. In 2020, NHC added client food pantries at their health clinics. At each clinic, a patient resource navigator helps patients select appropriate food for their family's needs and preferences. SHFBMT registered dietitians also create healthy recipes using foods from the food pantries.

PROGRAM MODEL

NHC medical staff screen patients using an action-based tool, asking whether they would like a food box and whether they would like help applying for SNAP. Patients that answer "yes" to either question receive a food pantry referral. Medical staff guide patients directly to the food pantry, where they pick up a food box and are screened for social determinants of health. Staff record their visit.

WRAPAROUND SERVICES

On-site benefits outreach screeners can connect patients to SNAP, WIC or any other federally funded nutrition programs. SHFBMT is creating and distributing nutrition education materials relevant to the communities served.

MEDICAL PROVIDER SCREENS PATIENTS FOR DESIRED ASSISTANCE → **PATIENTS WHO SCREEN POSITIVE ARE REFERRED TO THE FOOD AS MEDICINE PROGRAM** → **PATIENTS REDEEM REFERRALS TO RECEIVE FOOD AT AN ON SITE PANTRY**

FOCUS POPULATIONS

This program focuses on serving patients with low incomes.

TECH PLATFORM

Some food bank partners and agencies use Link2Feed to track neighbor visits, and Neighborhood Health uses another platform.

FOODS PROVIDED

At every appointment, patients can receive a food box containing shelf-stable foods, frozen meals, produce and milk.

EVALUATION EFFORTS

In addition to conducting surveys and reporting on reach data, SHFBMT works with NHC staff to assess program quality and gauge patient satisfaction.

TABLE OF CONTENTS >>

Second Harvest Food Bank of Middle Tennessee

PROGRAM HIGHLIGHTS

1. In partnership with Neighborhood Health Center, the largest safety net provider of primary care in Middle Tennessee, Second Harvest operates eight Food Pharmacies in 11 medical and dental sites.
2. A key success of the Food Pharmacy Program through the past year of the grant period has been the growth and interaction with members of the Nashville community aged 50+. About 30% of the food distribution encounters are with people over 50 years old. These patients are critical to reach, as they are disproportionately impacted by chronic conditions that are exacerbated by food insecurity.
3. Neighborhood Health Clinics reported increases in the number of patients with controlled hypertension and diabetes.
4. These improvements are attributed to the expanded Food Pharmacy Program, the new virtual disease case management program, which provides links and referrals to the Food Pharmacy Program, and efforts to improve clinic-based measurement, which is aided by the return of patients for follow-up visits (who are attracted by the Food Pharmacy Program).

PROGRAM CHALLENGES

1. Many of the patients receiving food items from the Food Pantry declined to identify their race. Without this collection, Second Harvest relies on historic trends and total Neighborhood Health Clinic patient data to understand the population they are serving.
2. Second Harvest identified that neighbor dignity and perceived stigma was a barrier to accessing Food Pharmacies. Second Harvest is working with their partners to combat the stigma that either prevents neighbors from getting food in the first place or makes them feel negatively while they access food.

SCREENING AND REFERRAL DATA

6,713 SCREENED FOR FOOD INSECURITY	**9,956** POSITIVE FOR FOOD INSECURITY	**9,956** REFERRED TO FAM3 PROGRAM
9,956 RECEIVING FOOD FROM FAM3 PROGRAM	**–** REFERRED TO SNAP	**–** SNAP APPLICATIONS INITIATED
– SNAP APPLICATIONS COMPLETED		

NEIGHBORHOOD HEALTH CLINIC HAS SHARED THE FOLLOWING STORY WITH SECOND HARVEST:

A parent and a child visited the Napier Clinic on February 8, 2023 for a medical appointment. The mother advised the staff that the family are refugees and arrived in Nashville less than 30 days ago. The family was just starting out and was in need of resources—including food. Napier Clinic was able to provide them with The Where to Turn in Nashville resource booklet detailing housing, employment, hygiene, and emergency shelter options throughout the city. The Food Pharmacy on-site enabled the staff to provide them with milk, beans, rice, cereal, oatmeal, peanut butter, jelly and canned goods. The mother was very humble and appreciative regarding the child's care, food and resources. The smile alone on the mother's face expressed her heartfelt gratitude and sheer happiness with the assistance she received.

Second Harvest Food Band of Middle Tennessee is a partner food bank of Feeding America

TABLE OF CONTENTS >>

mid-ohio food collective

foodbank | farm | farmacy | kitchen | market

Mid-Ohio Food Collective

Mid-Ohio Food Collective (MOFC) has been involved in Food as Medicine projects for more than 10 years. In Food as Medicine 3, MOFC will renew its partnership with the Ohio Health network. Previously, MOFC partnered with Ohio Health on a small Food as Medicine initiative that featured food on location at an Ohio Health family practice. This expanded partnership will deepen the previous initiative's scope by implementing the current model of screening and referral for produce at pantries within the community.

PROGRAM MODEL

Providers based at Ohio Health Doctor's West Hospital and Columbus West Side Ohio Health practices screen patients for food insecurity using the Hunger Vital Sign screening tool or a food insecurity screening integrated into their EMR. Patients who screen positive receive referrals to the Farmacy, which provides weekly produce access to the patient and their household at no cost. Eligible patients who enroll in the program receive a Farmacy card that allows them access to a site most convenient for them.

WRAPAROUND SERVICES

MOFC's Benefits and Customer Outreach team can connect patients to SNAP and other benefits enrollment resources.

MEDICAL PROVIDER SCREENS PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE ARE REFERRED TO THE FARMACY PROGRAM** → **PATIENTS REDEEM REFERRALS TO RECEIVE PRODUCE AT A CONVENIENT FARMACY SITE**

FOCUS POPULATIONS

The program serves patients who screen positive for food insecurity and receive healthcare provider referrals to the MOFC Farmacy.

TECH PLATFORM

EPIC tracks secure data such as basic demographic information, which also integrates into FreshTrak. The Mid-Ohio Farmacy team sends each healthcare provider a report on food access for each patient they enroll.

FOODS PROVIDED

Patients can access weekly produce at 19 Mid-Ohio Farmacy locations throughout the network.

EVALUATION EFFORTS

Farmacy records patient-level data such as identifiers, date of birth and age, as well as service- level data including service dates, types, locations, days since referral and more.

TABLE OF CONTENTS >>

Mid-Ohio Food Collective

PROGRAM HIGHLIGHTS

1. The Mid-Ohio Food Collective onboarded six new OhioHealth partner sites. OhioHealth is one of the largest healthcare providers in Ohio; this partnership enables MOFC to bolster their reach into the patient population at OhioHealth and serve more neighbors in need of food.
2. MOFC has developed a consistent way to screen and refer patients to develop a holistic understanding of our customers and their needs. The ability to track customer data and service visits, along with the data that their healthcare partners collect, enables the Mid-Ohio Farmacy team to evaluate how the foodbank services impact patients' health outcomes.
3. The Mid-Ohio Farmacy team is currently developing a plan to scale and expand Mid-Ohio Farmacy across OhioHealth's 47 county network, which may involve further expansion within MOFC's 20-county service area and nurturing partnerships with other Ohio foodbanks to implement programming outside of MOFC's footprint.
4. Of the 166 individuals that screened positive for food insecurity and were referred to the program, 26% of these patients had never received emergency food assistance via the MOFC partner network. 43 newly identified patients learned of the resources available through MOFC's partner network, including the cost-free, fresh food.

PROGRAM CHALLENGES

1. Transportation remained a barrier that inhibits neighbors' access to the Farmacy. As a result, the team at OhioHealth is currently evaluating the proportion of their patients that have been screened as both food insecure and transportation insecure.
2. The Mid-Ohio Farmacy team is also collaborating with MOFC's SNAP outreach team to address transportation barriers; the SNAP outreach team can assist transportation insecure Farmacy patients with accessing related resources.

SCREENING AND REFERRAL DATA

1,524 SCREENED FOR FOOD INSECURITY	**389** POSITIVE FOR FOOD INSECURITY	**122** REFERRED TO FAM3 PROGRAM

27 RECEIVING FOOD FROM FAM3 PROGRAM	**3** REFERRED TO SNAP	**3** SNAP APPLICATIONS INITIATED	**–** SNAP APPLICATIONS COMPLETED

> **"Our team and physicians appreciate the ability to offer tangible options to our patients, immediately with this program. Thank you!"**
>
> Ohio Health Site Manager

Mid-Ohio Food Collective is a partner food bank of Feeding America

TABLE OF CONTENTS >>

houstonfoodbank

Houston Food Bank

Since 2017, Houston Food Bank's (HFB) Food for Change (FFC) has addressed upstream causes of food insecurity and promoted sustainable changes in health and economic mobility in Texas. In Food as Medicine 3, the food bank is expanding the program's reach by emphasizing its integration with its Community Assistance Program (CAP), strengthening wrap-around healthcare and social services and closing the referral process' loop.

FFC collaborates with Harris Health and other partners to strategically layer nutritious food provision through a food prescription program (FoodRx) and nutrition education alongside existing social services to improve clients' long-term health and economic outcomes.

PROGRAM MODEL

Harris Health practitioners enroll patients in FoodRx. Patients who face food insecurity are eligible, including neighbors without pre-existing conditions and those who experience or are at risk for diet-related chronic health conditions. Patients who screen positive may visit the onsite food pharmacy as part of the FoodRx program. Food pharmacy staff enroll patients into Link2Feed, software that connects food pantries and health care partners within the HFB network. Patients receive a prescription voucher that they can redeem at any HFB-affiliated FFC pharmacy.

WRAPAROUND SERVICES

Each food pantry can assist with state benefit applications such as SNAP, Medicaid and children's insurance as well as new FoodRx referrals.

MEDICAL PROVIDER SCREENS PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE ARE REFERRED TO THE FOODRX PROGRAM** → **PATIENTS REDEEM VOUCHERS TO RECEIVE FOOD AND WRAPAROUND SERVICES**

FOCUS POPULATIONS

This program serves patients with diet-related chronic health conditions and who screen positive for food insecurity. Patients who screen positive without preexisting health conditions receive referrals to SNAP and other state benefit assistance services as well as immediate food provision.

TECH PLATFORM

Food insecurity screening responses, referrals and redemption rate are built into Epic. HFB uses Link to Feed software to track and share frequency of patient food pharmacy visits.

FOODS PROVIDED

Patients can redeem their prescription voucher through FoodRx twice a month and receive 30 pounds of produce and nutritious pantry staples.

TABLE OF CONTENTS >>

Houston Food Bank

PROGRAM HIGHLIGHTS

1. Houston Food Bank expanded its strong partnership with Harris Health system to an additional clinic site for a co-located Food Farmacy.
2. HFB partnered with a strong pantry partner in the community near the clinic Hearts and Hands of Baytown and was able to ensure adequacy and variety of culturally relevant fresh produce and other nutritious food items.
3. Houston Food Bank was able to relaunch its partnership with San Jose Clinic that was affected by the pandemic. The partnership is strengthened by the Community Health Worker position, which plays a critical role in enrolling patients in the program, following up with them and ensuring they can redeem their food prescription through the Home Delivery program.
4. The home delivery pilot is allowing HFB to overcome commonly cited transportation barriers that patients at San Jose Clinic experience.

PROGRAM CHALLENGES

1. Hiring challenges and logistics delayed the launch of the program with San Jose Clinic.
2. Another significant challenge was reaching maximum capacity at the community redemption site in Baytown (Harris Health Baytown). Unfortunately, despite receiving some initial self-referrals for assistance with SNAP from Little Red Box, the site closed their doors in December 2023.

SCREENING AND REFERRAL DATA

1,746 SCREENED FOR FOOD INSECURITY	**743** POSITIVE FOR FOOD INSECURITY	**714** REFERRED TO FAM3 PROGRAM

447 RECEIVING FOOD FROM FAM3 PROGRAM	**191** REFERRED TO SNAP	**104** SNAP APPLICATIONS INITIATED	**104** SNAP APPLICATIONS COMPLETED

Houston Food Bank is a partner food bank of Feeding America

TABLE OF CONTENTS >>

HACAP Food Reservoir

As part of Food as Medicine 2 in 2021, HACAP Food Reservoir launched a healthcare partnership program that now includes 12 health clinic partners in five surrounding counties in East Central Iowa. The program provides shelf-stable food boxes to clinics who then distribute them to neighbors who face food insecurity. Patients receive these food boxes at their health care appointments. In Food as Medicine 3, HACAP will grow its connection with local health clinics. This will ultimately improve health by reducing the number of people facing food insecurity and improving nutritious food affordability for food-insecure populations.

PROGRAM MODEL

Healthcare partners conduct food insecurity screenings using the Vital Hunger Survey or their internal screening tool to identify patients who would benefit from a food box. Patients who screen positive for food insecurity receive a food box referral. They then receive a food box designed to fit their needs and preferences.

WRAPAROUND SERVICES

Patients who screen positive for food insecurity receive additional resources including information about local food pantries, WIC, and SNAP benefits as well as housing and veteran services. One clinic directly refers patients facing food insecurity to HACAP for care coordination and follow up.

MEDICAL PROVIDER SCREENS PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE ARE REFERRED TO THE FOOD AS MEDICINE PROGRAM** → **PATIENTS RECEIVE A FOOD BOX THAT FITS THEIR NEEDS AND PREFERENCES**

FOCUS POPULATIONS

HACAP's food boxes are distributed in family health and free clinics, high risk prenatal clinics, pediatric offices and mental health access centers to individuals who screen positive for food insecurity.

TECH PLATFORM

Most healthcare partners use Hunger Vital Sign to screen for food insecurity. The results of this screening are stored in Epic.

FOODS PROVIDED

Neighbors receiving food through this program are offered shelf-stable healthy/ low sodium foods that meet their needs and preferences.

TABLE OF CONTENTS >>

HACAP Food Reservoir

PROGRAM HIGHLIGHTS

1. HACAP has wide ranging partnerships, including with free medical clinics, hospital departments, family medicine clinics, pediatric clinics, home health, behavioral health clinics, prenatal and high-risk obstetric clinics.
2. Healthcare staff feel empowered to screen patients for food insecurity, knowing they can offer an intervention. Staff have reported greater job satisfaction from being able to offer resources like immediate food.
3. One healthcare provider has agreed to make direct referrals to the HACAP Food Reservoir so that they may provide follow-up care coordination. HACAP hired a social worker to provide the follow-up and ongoing relationship to ensure connection to services.
4. This program has also raised awareness of food insecurity in the community. Many people report that they see HACAP signs in waiting rooms and exam rooms and have a better understanding of how to find food for families facing food insecurity.

PROGRAM CHALLENGES

1. It remains challenging to receive complete data from health care partners. They are very good at completing the screenings and providing resources for families, but receiving consistent screening data is challenging.
2. HACAP uses all purchased food for the food boxes and are focusing on low-sodium, low sugar canned goods while offering foods that can create a meal including fruits, vegetables and protein. Due to the success of this program, HACAP is exploring adding fresh produce into the program.

SCREENING AND REFERRAL DATA

9,187 SCREENED FOR FOOD INSECURITY	**1,087** POSITIVE FOR FOOD INSECURITY	**924** REFERRED TO FAM3 PROGRAM

653 RECEIVING FOOD FROM FAM3 PROGRAM	**243** REFERRED TO SNAP	**–** SNAP APPLICATIONS INITIATED	**–** SNAP APPLICATIONS COMPLETED

> **“HACAP has given us the ability to provide some essential food items to our most vulnerable patients and families. It has been incredible to be able to give a family a sense of security and hope when they need it most.”**
>
> Coworker at Mercy Pediatric Clinic

HACAP Food Resevoir is a partner food bank of Feeding America

TABLE OF CONTENTS >>

Greater Cleveland Food Bank

Ohio's Greater Cleveland Food Bank (GCFB) began its Food as Medicine initiative in 2016. GCFB provides nutritious food in partnership with health care institutions to mutual low-income clients/patients who have food-related illnesses like diabetes or hypertension. GCFB coordinates 17 food distribution sites at healthcare providers. GCFB also partners with seven hospitals and federally qualified health centers to provide food insecurity screenings for patients as part of their regular healthcare visits.

In Food as Medicine 3, GCFB is focused on expanding on improving healthcare partner collaborations and increasing nutritious food access using mobile food pantries.

PROGRAM MODEL

Healthcare partners based at partnering hospitals, including MetroHealth, refer patients who screen positive for food insecurity to their mobile food pantries. However, individuals do not have to have a referral or be a patient of a healthcare partner to visit mobile food pantries. Food pantry staff inquire whether neighbors were referred from a health care provider to determine whether they are eligible to take the survey as part of FAM3.

Depending on household need, patients can visit once or twice each month.

MEDICAL PROVIDER SCREENS PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE ARE REFERRED TO THE FOOD AS MEDICINE PROGRAM** → **PATIENTS RECEIVE FOOD AT ON-SITE MOBILE FOOD PANTRIES**

FOCUS POPULATIONS

The Prescription Pantry program serves patients who screen positive for food insecurity, including those who have health challenges. The mobile food pantry is also open to the public.

TECH PLATFORM

PantryTrak is used to track patient visits and utilizations of the mobile food pantries.

FOODS PROVIDED

Neighbors receive fresh produce and other nutritious items.

WRAPAROUND SERVICES

At health care partner locations, SNAP posters direct neighbors to a food bank help line for application assistance.

TABLE OF CONTENTS >>

Greater Cleveland Food Bank

PROGRAM HIGHLIGHTS

1. Greater Cleveland Food Bank increased their partner sites from 20 sites in Fall 2022 to 24 sites by Fall 2023, enabling the food bank to increase the number of unduplicated neighbors served from 2022 to 2023 by over 45%. Additional sites are currently in the on-boarding process.
2. During this grant period, the Food Bank partnered with various healthcare providers to facilitate 219 produce and food distributions and 24 FAM clinics a month.
3. Greater Cleveland Food Bank, in collaboration with the Ohio Association of Foodbanks and 11 other Ohio food banks, is part of a state-level committee focused on advocating and moving Food as Medicine policy forward.
4. The Nourishing Beginnings program enabled the Greater Cleveland Food Bank team to deepen their partnerships with the Community Health Workers who not only help to facilitate the program, but also provide wraparound services and supports to participants who experience other unmet social needs. This program has identified participants whose needs go beyond food, like access to housing. The Outreach team at GCFB partners with Community Health Worker to find and secure temporary housing for participants, continuously adapting their services and adjusting deliveries and food box sizes to accommodate the needs of the household.

PROGRAM CHALLENGES

1. While programmatic growth is a sign of success, it is also a challenge to meet the increase in demand, specifically regarding staff capacity.
2. During the grant period, GCFB hired a Food as Medicine Coordinator, who has played an integral role in their ability to further focus on Food as Medicine research and food prescription work.

SCREENING AND REFERRAL DATA

229 SCREENED FOR FOOD INSECURITY	**80** POSITIVE FOR FOOD INSECURITY	**57** REFERRED TO FAM3 PROGRAM

41 RECEIVING FOOD FROM FAM3 PROGRAM	**–** REFERRED TO SNAP	**–** SNAP APPLICATIONS INITIATED	**–** SNAP APPLICATIONS COMPLETED

Greater Cleveland Food Bank is a partner food bank of Feeding America

TABLE OF CONTENTS >>

Greater Baton Rouge Food Bank

In Louisiana, the Greater Baton Rouge Food Bank (GBRFB) is entering its second year of Food as Medicine by expanding its relationship with Our Lady of Lake Hospital. GBRFB works with the hospital and its clinics to provide emergency food boxes to patients experiencing food insecurity, and patients receive a food box at each appointment. In addition, GBRFB is also launching an eight-week nutrition education class.

PROGRAM MODEL

Medical providers based in Our Lady of Lake Hospital and their clinics screen ambulatory and in-hospital patients for food insecurity. When an individual or family screens positive, they receive an emergency food box that contains information on how to connect to a GBRFB food pantry in their area.

MEDICAL PROVIDER SCREENS PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE ARE REFERRED TO THE FOOD AS MEDICINE PROGRAM** → **PATIENTS RECEIVE FOOD BOXES ONSITE AT EACH APPOINTMENT**

FOCUS POPULATIONS

This program focuses on serving ambulatory and in-hospital patients who screen positive for food insecurity.

TECH PLATFORM

Oasis is used to record and track patient visits.

FOODS PROVIDED

Neighbors receive shelf-stable, healthier food alternatives such as whole wheat pasta, low- sodium canned vegetables and 100% juice.

WRAPAROUND SERVICES

Each food box contains a flyer with information to contact with GBRFB's SNAP outreach coordinator, who connects patients to SNAP and other government-funded resources.

TABLE OF CONTENTS >>

Greater Baton Rouge Food Bank

PROGRAM HIGHLIGHTS

1. This grant has had a significant impact on the health and wellbeing of the Greater Baton Rouge Community. Food insecurity has been determined to be a major determinant of an individual's health, and the health partners in the community are seeing the need for this partnership.
2. The food bank has taken on more partners, and has a waiting lists of potential partners who are willing to work with them as their capacity grows. They are operating 51 active partnerships and have more than doubled the number of boxes distributed, growing from 2,773 distributed in 2022 to 6,588 in 2023.
3. Multiple local news outlets have shared the news of this partnership after a joint press conference with the Food Bank and Healthy Blue. This news coverage has spread awareness on the importance of health and food insecurity and made more people aware of the services available. New and continued funding will allow more healthcare partners to screen and refer hundreds of more patients into the program over the next three years.
4. The emergency food boxes provided through the program contain specially chosen food that offer more nutritional value, such as whole wheat pasta or low-sodium canned goods.

PROGRAM CHALLENGES

1. Food procurement has been more challenging as donations are down and prices are sky high. Healthier food options do tend to be more expensive, making acquiring the specialty food for Food as Medicine boxes difficult.
2. The interest in this program is fast growing, and the team is working to keep up with the demand. Despite this challenge, this grant enabled the program to have its most successful year to date. The program continues to grow and more people are receiving the resources they need to live healthier lives.

SCREENING AND REFERRAL DATA

– SCREENED FOR FOOD INSECURITY	4,223 POSITIVE FOR FOOD INSECURITY	4,223 REFERRED TO FAM3 PROGRAM

4,223 RECEIVING FOOD FROM FAM3 PROGRAM	2,322 REFERRED TO SNAP	– SNAP APPLICATIONS INITIATED	– SNAP APPLICATIONS COMPLETED

> **"Continuing the 'Food is Medicine' program will give us the ability to reach more individuals that are food insecure. The introduction of the Food is Medicine' program into our 11-parish service area has expanded our reach to approximately 400 more individuals monthly, and we are eager to continue the program's expansion with support from Healthy Blue and its affiliated Foundation."**
>
> Mike Manning, President, and CEO of the Greater Baton Rouge Food Bank.

Greater Baton Rouge Food Bank is a partner food bank of Feeding America

TABLE OF CONTENTS >>

Gleaners Food Bank of Indiana

In Indianapolis, Gleaners Food Bank of Indiana (GFB) is focused on expanding their food voucher program with the Eskenazi Health Fresh for You Market (FFYM) and Ezkenazi Health FFYM on Wheels. The FFYM on Wheels addresses food insecurity and health disparities by providing visitors, patients and community members with access to fresh fruits and vegetables, in addition to snacks, ingredients, prepared meals, kitchen utensils and pantry staples.

The FFYM market on wheels also offers reduced-price food for community members with low incomes and/or who live in a food desert.

PROGRAM MODEL

Eskenazi Health's lifestyle medicine program physicians and registered dietitians screen patients for food insecurity. Patients who screen positive receive a food voucher for redemption at the market or mobile locations. Eskenazi Health's SNAP outreach coordinators also distribute food vouchers, connecting patients in high-need areas to immediate and long-term food assistance resources.

Depending on household need, patients can visit once or twice each month.

MEDICAL PROVIDER SCREENS PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE ARE REFERRED TO THE FOOD AS MEDICINE PROGRAM** → **PATIENTS REDEEM VOUCHERS TO RECEIVE FOOD ONSITE OR AT A COMMUNITY MOBILE MARKET**

FOCUS POPULATIONS

This program serves patients who screen positive for food insecurity, as well as other community members in need.

TECH PLATFORM

Epic is used to track food insecurity screenings and referrals, and the point-of-sale system tracks program voucher redemptions.

FOODS PROVIDED

Neighbors receiving food through this program are offered fresh fruits and vegetables, healthy snacks and pantry staples.

WRAPAROUND SERVICES

At Eskenazi Health, SNAP outreach coordinators and community weavers connect patients to immediate and long-term food assistance resources and other nutrition programs around Indianapolis.

TABLE OF CONTENTS >>

Gleaners Food Bank of Indiana

PROGRAM HIGHLIGHTS

1. Gleaners created a new partnership with Eskenazi Health, with Gleaners having never provided vouchers prior to this grant.
2. Eskenazi staff officially began distributing vouchers to their participating clinics in January of 2023. During that timeframe, staff members were given 1,635 vouchers, of which 989 vouchers (60%) were redeemed. At a $30 value per voucher, that equates to $29,670 in benefits provided to food-insecure neighbors through the Food as Medicine program.
3. The voucher redemption rate grew exponentially during the grant period, from 8% in February 2023 to 183% in January 2024. The largest number of vouchers redeemed was in August (a total of 192 vouchers), which is likely due to the fact that the mobile market was fully operational at this time.
4. According to staff at Eskenazi, screening for food insecurity has increased likely due to the added voucher incentive, leading to more SNAP referrals. Additionally, because patients receive vouchers through Eskenazi's Community Weavers (staff members dedicated to connecting individuals with wraparound services) and Lifestyle Medicine classes, patients can learn about additional resources geared toward low-income households. Overall, patients have expressed their gratitude for the vouchers and Community Weavers, helping them meet their basic needs while also gaining access to SNAP benefits.

PROGRAM CHALLENGES

1. The Eskenazi Fresh for You Mobile Market was out of commission since October 2023, which meant that patients could only redeem their referrals at the Fresh for You Market located on-site at the Eskenazi campus. When in operation, the mobile market visits 5 locations around Marion County, targeting low-income neighbors with limited healthy food options. The bus returned to its normal schedule in early 2024.
2. Staff at Eskenazi have shared that language barriers present another challenge to the program, requiring them to rely on phone interpreters when available.

SCREENING AND REFERRAL DATA

10,836 SCREENED FOR FOOD INSECURITY	**4,251** POSITIVE FOR FOOD INSECURITY	**1,106** REFERRED TO FAM3 PROGRAM

926 RECEIVING FOOD FROM FAM3 PROGRAM	**2,788** REFERRED TO SNAP	**1,328** SNAP APPLICATIONS INITIATED	**935** SNAP APPLICATIONS COMPLETED

> "DH is a patient of Grassy Creek who actively participates in many Lifestyle Medicine groups with a Registered Dietitian at Grassy Greek Eskenazi Health Center. The two have developed a meaningful relationship, as her RD has not only helped her make lifestyle changes but has also helped through her food insecurity and a transportation barrier. Our RD has referred DH to FAM vouchers as part of way to combat her food insecurity. As a result of receiving the vouchers, DH states that her food insecurity has decreased, and no longer has problems purchasing food for herself or her family anymore. DH has found the process to obtain and redeem vouchers to be very easy. Due to her transportation issues, she coordinates with her patient care team to ensure she obtains everything in a single trip to the Hospital and Fresh for You Market. She is very grateful for all the help Eskenazi Health has given her!"

Gleaners Food Bank of Indiana is a partner food bank of Feeding America

TABLE OF CONTENTS >>

Food Bank for New York City

Since 2018, Food Bank for New York City, Public Health Solutions and a coalition of other social service providers developed a food and nutrition services network (FNS Bundle) in the Bronx, Brooklyn, Manhattan and Queens. This network enables hospital and managed care teams to easily and reliably connect patients to the optimal resources to meet their needs, improve their health and reduce their healthcare costs.

PROGRAM MODEL

During patients' healthcare facility visits, clinicians and social workers screen for food insecurity within the scope of managed care. Patients then receive in-depth Social Determinants of Health screenings by Food Navigators, who also offer a full range of local options based on patient needs, eligibility and preferences.

Patients are then referred to Food Assistance Programs near their homes or neighborhoods they frequent. These pantries and soup kitchens provide pantry bags and/or congregate meals. Food Bank Community Nutritionists work closely with agencies to develop inventory to promote good nutrition and health eating, including fresh produce, dietary adherent products, and Foods to Encourage.

HEALTHCARE WORKERS AND FOOD NAVIGATORS SCREEN PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE ARE REFERRED TO THE FOOD AS MEDICINE PROGRAM** → **PATIENTS RECEIVE REFERRALS TO RECEIVE FOOD AT LOCAL FOOD ASSISTANCE PROGRAMS**

FOCUS POPULATIONS

The FNS Bundle network focuses on serving patients who experience food insecurity.

TECH PLATFORM

Food Navigators and Food Assistance Program staff collect data and referrals through UniteUs. Navigators also use UniteUs to provide referrals for services outside the service area or beyond the scope of network services and provide real-time network data reporting.

FOODS PROVIDED

Food Assistance Programs have nutrition policies in place to ensure that neighbors receiving food through this program are offered a wide variety of nutritious foods.

WRAPAROUND SERVICES

The FNS Bundle network offers services including public nutrition benefits, emergency food (pantries and soup kitchens) and other resources.

TABLE OF CONTENTS >>

Food Bank for New York City

PROGRAM HIGHLIGHTS

1. Food Bank for NYC partnered with Public Health Solutions, a research and vital services nonprofit, and New York City Health and Hospitals, NYC's public healthcare network, to provide referrals for clinical patients and managed care members to receive emergency food assistance and other services.
2. In partnership with Public Health Solutions, Food Bank for NYC identified multiple neighborhoods in Brooklyn that could benefit from managed care referrals, and established partnerships with two acute care facilities in those neighborhoods.
3. Food Bank for NYC trained clinical and social work staff in both facilities to identify patient needs and priorities, assist them with food and nutrition service eligibility and enrollment, and connect them to a wide range of services in the community via UniteUs, a healthcare and community referral platform.
4. The Food Bank has established a network of six (6) member agencies in close proximity to the acute care facilities to receive referrals. The agencies have been successfully receiving referrals since October 2023. Since that time the agencies have grown comfortable with the referrals and scheduling them to visit their pantries monthly. The referrals are very grateful to have access to nutritious food regularly.

PROGRAM CHALLENGES

1. Some of the agencies have expressed concern with the language barrier that has occurred with some of the referrals which it makes it challenging to connect patients to the services they need.
2. To alleviate this, Food Bank for NYC has been using the Message Care Team Navigator within Unite Us to assist with setting up appointments and translations during the scheduled appointment time. The Unite Us tool has been very helpful to the agencies that only speak English.

SCREENING AND REFERRAL DATA

258 SCREENED FOR FOOD INSECURITY	**106** POSITIVE FOR FOOD INSECURITY	**106** REFERRED TO FAM3 PROGRAM

85 RECEIVING FOOD FROM FAM3 PROGRAM	**–** REFERRED TO SNAP	**–** SNAP APPLICATIONS INITIATED	**–** SNAP APPLICATIONS COMPLETED

Food Bank for New York City is a partner food bank of Feeding America

TABLE OF CONTENTS >>

Freestore Foodbank

In Cincinnati, OH, Freestore Foodbank's Food as Medicine program focuses on 13 clinic-based food pantries across various partner health systems. Most locations have a choice pantry, while others offer patients pre-packed boxes. Some clinics also provide patients with produce vouchers for Freestore's mobile produce truck, or offer pop-ups to their patients and community. Healthcare system partners also refer patients to Freestore's Direct home-delivery produce program.

Freestore Food Bank will use Food as Medicine funding to support current clinic pantry partners with food assistance, as well as expand the clinic pantry program with two additional sites.

PROGRAM MODEL

Health care partners conduct a food insecurity screening upon patient intake. If a patient screens positive or indicates that they are in need, the staff provides them with food from the pantry and/or referrals to other Freestore programs. Patients complete preference sheets to customize the foods they receive.

For each of the 12 weekly or bi-weekly sessions, the patient receives a healthy food bag with three to four days of food.

MEDICAL PROVIDER SCREENS PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE ARE REFERRED TO THE FOOD AS MEDICINE PROGRAM** → **PATIENTS RECEIVE FOOD ONSITE OR REFERRALS FOR OTHER FREESTORE PROGRAMS**

FOCUS POPULATIONS

This program focuses on serving patients who face food insecurity and have diet-related illnesses.

TECH PLATFORM

Health care partners use Epic to track and store food insecurity screening and referral data.

FOODS PROVIDED

Patients complete sheets to customize the foods they receive based on their dietary needs and preferences. Freestore's Healthy Harvest Mobile Market, pop-ups and Direct programs offer participants free, fresh produce.

WRAPAROUND SERVICES

In addition to food, clinic-based food pantries provide patients with SNAP application assistance.

TABLE OF CONTENTS >>

Freestore Foodbank

PROGRAM HIGHLIGHTS

1. Freestore Foodbank provides food support for 22 healthcare partners, primarily through permanent, onsite food pantries at primary care and specialty clinics.
2. For clinics without an onsite pantry, Freestore provides regular deliveries of prepacked shelf stable food boxes to fit the needs of each facility and its patients.
3. Freestore expanded their partnership to six new sites, including three locations of a Federally Qualified Health Center. They also added a number of specialty care clinics to the program, including infectious diseases, cancer, and women's health, creating opportunities to enhance disease specific work with these clinics moving forward.
4. The partnership with clinics has enabled the expansion of another program called Freestore Direct. Freestore has worked with some health care partners to receive patient referrals for biweekly boxes of fresh produce delivered to their home via Amazon.

PROGRAM CHALLENGES

1. Gathering health data or outcomes from healthcare partners is a time consuming process, particularly when many main points of contact at healthcare are social workers or practice managers with limited time.
2. As the program continues to expand, it is challenging to ensure sustainable funding to support that growth.

SCREENING AND REFERRAL DATA

– **SCREENED FOR FOOD INSECURITY**	**1,946** **POSITIVE FOR FOOD INSECURITY**	**1,946** **REFERRED TO FAM3 PROGRAM**

1,914 **RECEIVING FOOD FROM FAM3 PROGRAM**	– **REFERRED TO SNAP**	– **SNAP APPLICATIONS INITIATED**	– **SNAP APPLICATIONS COMPLETED**

Freestore Foodbank is a partner food bank of Feeding America

TABLE OF CONTENTS >>

Capital Area Food Bank

In Washington, DC, Capital Area Food Bank (CAFB) and Children's National Hospital launched a Diabetes Care Complex food pharmacy for children and their families. The food pharmacy program centers on a three-part, one-stop intervention: during appointments, participating patients meet with their medical provider, meet with a registered dietitian and visit the food pharmacy. In Food as Medicine 3.0, CAFB will strengthen its collaboration with the hospital and implement, refine and expand food pharmacy operations to serve more patients.

PROGRAM MODEL

Children's National Hospital's Diabetes Care Complex medical providers can refer patients (and their families) to the food pharmacy. Patients must screen positive for food insecurity and be diagnosed as pre-diabetic or diabetic (Type 1 or Type 2) to receive a referral. Medical providers are responsible for referring and enrolling patients, dispensing food to patients and tracking patients at each visit.

MEDICAL PROVIDER SCREENS PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE ARE REFERRED TO THE FOOD PHARMACY PROGRAM** → **PATIENTS AND THEIR FAMILIES RECEIVE FOOD AT THE FOOD PHARMACY**

FOCUS POPULATIONS

The food pharmacy serves children with certain diet-related diseases who are food insecure, as well as their families.

TECH PLATFORM

Registered dietitians keep a spreadsheet of patients who have been screened for food insecurity, screened positive and received food.

FOODS PROVIDED

At each visit with their medical provider, enrolled patients and families may visit the food pharmacy and receive 35 to 40 pounds of fresh produce and shelf-stable groceries.

WRAPAROUND SERVICES

Upon enrollment, families receive a CAFB toolkit that includes nutritious foods information, a recipe, tools for stretching their food budget and additional local food resources.

TABLE OF CONTENTS >>

Capital Area Food Bank

PROGRAM HIGHLIGHTS

1. Provided food to patients and their families through a partnership with the Diabetes Care Complex at Children's National Hospital. Patients receive 30-40 pounds of food at each visit, with adjustments based on family size.
2. Capital Area Food Bank and Children's National Hospital collaborated on a patient survey to gain feedback on the variety, quantity, and quality of the food provided. Survey respondents indicate that they are appreciative of the produce provided and show a cross-section between those reporting that they are eating more fruits and vegetables from the pharmacy and also self-reporting an increase in their health.
3. Patients are provided with nutrition education resources, including recipe cards and food bank network cards to help them locate additional food resources. The partnership has received positive feedback on these resources.
4. The program is working to expand its availability of culturally relevant foods, as the majority of families seen at the Diabetes Care Complex are Latino, African immigrants, or Black Americans.

PROGRAM CHALLENGES

1. Patients have expressed a desire for more and different fruits and healthy snack options. This is a food sourcing challenge, particularly because some of the fruits and vegetables that are frequently requested can go bad quickly, such as bananas or berries.
2. Plans to expand the program to reach more patients were slowed based on staffing availability and the need to ensure that if the program was expanded, Capital Area Food Bank would be able to keep up with the demand and the high cost of food

SCREENING AND REFERRAL DATA

– SCREENED FOR FOOD INSECURITY	1,269 POSITIVE FOR FOOD INSECURITY	1,269 REFERRED TO FAM3 PROGRAM

990 RECEIVING FOOD FROM FAM3 PROGRAM	– REFERRED TO SNAP	– SNAP APPLICATIONS INITIATED	– SNAP APPLICATIONS COMPLETED

> **"I am so grateful for this program. In my country, there are not a lot of healthy options and food given is very processed and not at all fresh. Thank you!"**
>
> Food Pharmacy Client

> **"So helpful to parents to receive extra help with food supplies."**
>
> The dietitians have noted that families increasingly chose to schedule their appointments at the main hospital (versus satellite locations throughout the region) so that they can access the food pharmacy.

Capital Area Food Bank is a partner food bank of Feeding America

TABLE OF CONTENTS >>

Island Harvest

Island Harvest (Melville, NY) partners with Harmony Healthcare to deliver the Nutrition Pathway Program (NPP). This intensive nutrition support program takes a multi-faceted approach to supporting patients living with low income and food insecurity. The program addresses hunger's root causes by providing access to healthy food, nutrition education and additional resources that help keep patients and their families healthy. Through the NPP, Island Harvest provides tailored nutrition counseling that assists with achieving food and health-related goals.

PROGRAM MODEL

Harmony Healthcare staff screen patients for food insecurity, and those who screen positive meet with Island Harvest's on-site nutritionist for intake. Each patient shares eating habits, dietary needs, allergies, cultural and preferred foods and cooking ability. Using this information, the nutritionist and patient set attainable goals.

For each of the 12 weekly or bi-weekly sessions, the patient receives a healthy food bag with three to four days of food.

WRAPAROUND SERVICES

Island Harvest's Community Empowerment Program Coordinator screens eligibility for additional resources such as SNAP, WIC and housing services.

MEDICAL PROVIDER SCREENS PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE RECEIVE A REFERRAL TO ISLAND HARVEST'S NPP** → **ISLAND HARVEST'S NUTRITIONIST PROVIDES NUTRITION COUNSELING AND HEALTHY FOODS**

FOCUS POPULATIONS

The NPP serves patients who screen positive for insecurity. NPP enrollment is available for all patients experiencing food insecurity.

TECH PLATFORM & EVALUATION EFFORTS

Medical providers use the Hunger Vital Sign screening tool and Harmony Healthcare's electronic medical records to track patient health outcomes and related data. Island Harvest collects BMI, blood pressure, and A1C from patients whenever available/appropriate, as well as information on diet quality and physical activity, at the program's start and end.

FOODS PROVIDED

Patients' healthy food bags rotate a variety of fresh produce, dairy, meat, fish, whole grains and nutritious shelf-stable items. They also provide other available necessities such as kitchen tools, diapers, baby wipes and personal care items.

TABLE OF CONTENTS >>

Island Harvest

PROGRAM HIGHLIGHTS

1. Island Harvest's launched a new Nutrition Pathways Program site in partnership with Harmony Healthcare in Roosevelt, NY.
2. A Registered Dietitian Nutritionist was hired to support the Nutrition Pathways Program. The RDN receives referrals from the healthcare partner, and provides individual counseling around the patient's eating habits, dietary needs, cultural and preferred foods, and cooking ability to help them set attainable health and nutrition goals.
3. At each subsequent nutrition counseling session, the dietitian reviews the patient's progress toward their goals and suggestions for foods in the weekly healthy food package. By working in conjunction with the client to provide this level of choice and feedback, clients are more likely to be engaged and successful in reaching their goals.
4. Preliminary data from the Harmony Health Care Roosevelt site demonstrates the program's impact: 79% of participants reported increased intake of whole foods, 43% reported decreased intake of processed foods, and 38% demonstrated improvement in the WHO-5 well-being index. Among participants for whom it was appropriate to track BMI, 58% demonstrated an improvement over the course of the program.

PROGRAM CHALLENGES

1. Island Harvest faced some challenges in establishing a new site for the Nutrition Pathways Program. While the leadership at Harmony Healthcare was committed to bringing this program to the Roosevelt facility, they had to allocate space within the health center and staff needed to be trained, which took longer than anticipated.
2. Once the program was up and running, there were initial challenges with health center staff inconsistently consistent screening for food insecurity and referring those patients to Island Harvest. Through meetings with clinic administrative staff, presentations at all staff meetings, and increased program advertising, referrals have significantly increased.

SCREENING AND REFERRAL DATA

8,024 SCREENED FOR FOOD INSECURITY	**325** POSITIVE FOR FOOD INSECURITY	**108** REFERRED TO FAM3 PROGRAM

209 RECEIVING FOOD FROM FAM3 PROGRAM	**19** REFERRED TO SNAP	**–** SNAP APPLICATIONS INITIATED	**–** SNAP APPLICATIONS COMPLETED

The Harmony Healthcare WIC director, who has been a champion of the Nutrition Pathways Program and consistently refers potential clients, noted that participants are very pleased with the program and extremely grateful for all it offers.

> **"Participants are so grateful to not only receive information about healthy eating and recipes, but to also receive the foods and kitchen supplies necessary to follow the advice given and to make the recipes."**

She went on to explain that this represents a cost savings, both in terms of the money saved on groceries and transportation, but also time.

Island Harvest is a partner food bank of Feeding America

TABLE OF CONTENTS >>

Feeding America Riverside | San Bernadino

The FoodRx program is a food-prescription-based distribution service established in 2021 to reduce the adverse health conditions associated with food insecurity. Through this program, Feeding America Riverside | San Bernardino (FARSB, Riverside, CA) strategically unites with local healthcare partners to improve patients' diet quality by identifying food-insecure individuals, prescribing standard food boxes and transitioning patients to long-term food services such as CalFresh, local food pantries, and other food bank programs such as Nourish Now, the food bank's home-bound delivery program.

PROGRAM MODEL

Each patient identified as food insecure by their health care provider receives a standard food box, consisting of staple foods items. Food prescriptions are paired with nutritional educational materials to help patients make informed decisions for their diets. Additionally, FARSB offers supplemental food bank intervention assistance such as referring patients to local food pantries and meal programs, offering CalFresh Application assistance and transitioning qualified patients to their homebound relief services through the Nourish Now program.

MEDICAL PROVIDER SCREENS PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE ARE REFERRED TO THE FOOD AS MEDICINE PROGRAM** → **PATIENTS RECEIVE A FOOD BOX AND REFERRAL TO FOOD BANK PROGRAMS**

FOCUS POPULATIONS

This program reaches food insecure individuals with an additional focus on seniors, through a partnership with Neighborhood Healthcare Pace (NHP). NHP provides all-encompassing medical care for seniors through solutions ranging from primary care, specialty care, recreational services and dietary and nutritional supplement support.

FOODS PROVIDED

Patients receive a box of dry goods each month.

WRAPAROUND SERVICES

FARSB offers supplemental food bank intervention assistance such as referring patients to local pantries and meal programs, offering CalFresh Application assistance and transitioning qualified patients to our homebound relief services through the Nourish Now program.

TABLE OF CONTENTS >>

Feeding America Riverside | San Bernadino

PROGRAM HIGHLIGHTS

1. A new FoodRx partnership was established with CareMore Health, successfully expanding services and outreach to two new clinics.
2. Existing partnerships with Riverside University Health System and San Bernardino Free Clinic have been strengthened, with plans to extend these partnerships in the near future.
3. FARSB successfully addressed data collection challenges by implementing a comprehensive survey system. The system now enables FARSB to gather vital data every month, ensuring the smooth operation of their program.
4. The CalFresh application assistance program processed 18 direct referrals from FoodRx, underscoring their commitment to facilitating access to vital food support services.

PROGRAM CHALLENGES

1. Initially, it was challenging to collect data from FoodRx collaborators.

SCREENING AND REFERRAL DATA

5,682 SCREENED FOR FOOD INSECURITY	**3,224** POSITIVE FOR FOOD INSECURITY	**3,224** REFERRED TO FAM3 PROGRAM

1,954 RECEIVING FOOD FROM FAM3 PROGRAM	**2,292** REFERRED TO SNAP	**7** SNAP APPLICATIONS INITIATED	**4** SNAP APPLICATIONS COMPLETED

Feeding America Riverside | San Bernadino is a partner food bank of Feeding America

TABLE OF CONTENTS >>

Feed More

Feed More (Richmond, VA) partnered with Virginia Commonwealth University (VCU) Health System in 2018 to launch Food as Medicine. Feed More has since expanded their healthcare partnerships and services within the Central Virginia area. In Food as Medicine 3, Feed More is focused on continuing a meaningful connection with VCU Health System, as well as expanding their partnerships to include community health agencies serving additional urban localities and rural communities.

Feed More's continued partnership with local safety-net hospitals, including VCU Health Richmond and VCU Health South Hill, will focus on food insecurity screening and referrals, supplying food boxes, growing patient access through on-site pantries and providing nutrition education. Additionally, Feed More continues to grow its partnership with local Federally Qualified Health Centers and free and charitable clinics by expanding food insecurity screenings as well as increasing food distribution capacity.

PROGRAM MODEL

Healthcare staff based at partnering organizations can provide patients who have screened positive for food insecurity with a food box to take home. Additionally, staff can refer patients to Feed More's Hunger Hotline to connect patients with Feed More's network of food resources and programs, including SNAP application assistance.

MEDICAL PROVIDER SCREENS PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE ARE REFERRED TO THE FOOD AS MEDICINE PROGRAM** → **PATIENTS RECEIVE A FOOD BOX AND REFERRAL TO FOOD BANK PROGRAMS**

FOCUS POPULATIONS

The program serves all patients who screen positive for food insecurity.

TECH PLATFORM

Feed More and their healthcare partners use Unite Us for referrals and sharing patient information. Feed More uses Link2Feed to track patient referrals, visits and utilizations of the Hunger Hotline and/or the pantry network.

FOODS PROVIDED

Patients received healthy food boxes, including produce and other items.

WRAPAROUND SERVICES

Feed More staff are available to provide patients with SNAP application assistance and can provide referrals to nutrition education services and other social determinants of health supports.

TABLE OF CONTENTS >>

Feed More

PROGRAM HIGHLIGHTS

1. Feed More added five new healthcare partners and 20 new sites to their Food as Medicine program. The food bank built out a healthcare partner application and updated program agreements and addendums to help onboard new partners.
2. Healthcare partners elevated their screening and referral process as well as the understanding of the connection between food and health at new healthcare partner sites. Feed More was able to test and learn from new partnership models such as Free Qualified Health Centers, free clinics, and health departments.
3. Feed More deepened partnerships with existing partners by supporting new food interventions such as testing a temporary mobile pantry with VCU Health in a rural market and implementing a delivery program in Petersburg.
4. To support new and existing healthcare partners, Feed More developed a presentation to train healthcare partners on the intersection of food insecurity and health.

PROGRAM CHALLENGES

1. Onboarding partners with multiple sites and navigating workflows and logistics for each site
2. Communicating across multiple levels of the healthcare organizations, which has been alleviated through establishing reasonable timelines, hosting quarterly meetings, and making visits to the clinics to identify and resolve challenges

SCREENING AND REFERRAL DATA

8,886 SCREENED FOR FOOD INSECURITY	**1,607** POSITIVE FOR FOOD INSECURITY	**1,672** REFERRED TO FAM3 PROGRAM

1,648 RECEIVING FOOD FROM FAM3 PROGRAM	**9** REFERRED TO SNAP	**9** SNAP APPLICATIONS INITIATED	**9** SNAP APPLICATIONS COMPLETED

> **“I have a mom that comes to see me every month and thanks me ‘I can’t thank you enough for connecting me to Feed More, they have saved my life and my daughter’s life’ as she says this she cries ‘without the food that I get and the resources from them I don’t know where we would be.’**

> **“Another Spanish speaking mother shared ‘may God bless you and them (Feed More). I was able to feed my children and now I have SNAP’ as she cried ‘it’s so hard here but I just want my kids to eat that’s all and thanks to you both they can.’”**

Feed More is a partner food bank of Feeding America

TABLE OF CONTENTS >>

Food Bank of Northern Nevada

The Food Bank of Northern Nevada (FBNN, Sparks, NV) launched the Prescription Pantry Program in 2017 with a focus on food as medicine. Initially funded by a grant from the Fund for a Healthy Nevada through the Nevada Department of Health and Human Services, the Prescription Pantry Program launched with health care providers in the Reno-Sparks metropolitan area. In 2021, the project expanded into rural areas, including Nevada's capital Carson City. The program now includes 12 health care providers and 14 partner food pantries across northern Nevada.

PROGRAM MODEL

Health care partners screen patients to determine if they are food insecure using the Hunger Vital Sign tool. If they screen positive, patients receive a prescription for healthy foods that can improve health conditions such as diabetes and cardiovascular disease. Patients then visit FBNN partner food pantries that have been through training to become Healthy Pantries, to work with health care partners and to ensure nutritious food is available to program participants.

Patients are able to visit each pantry once per week and can visit more than one pantry each week if needed.

WRAPAROUND SERVICES

In addition to food, Prescription Pantry locations provide SNAP and Medicaid application assistance.

MEDICAL PROVIDER SCREENS PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE RECEIVE A PRESCRIPTION FOR HEALTHY FOODS** → **PATIENTS VISIT A FOOD PANTRY PROGRAM PARTNER**

FOCUS POPULATIONS

The Prescription Pantry program serves patients experiencing food insecurity, including those at high risk of diabetes and cardiovascular disease.

TECH PLATFORM

Most healthcare partners use the Hunger Vital Sign screening tool, which is built into their electronic medical records. The Prescription Pantry program food pantries use Oasis Insights client tracking software to maintain client intake information, including demographics, patient visits, food prescriptions and utilizations of the pantry.

FOODS PROVIDED

Neighbors receiving food through this program are offered a wide variety of nutritious foods with lower sodium options, including dairy and lean proteins as well as shelf-stable goods like frozen and canned fruits and vegetables.

TABLE OF CONTENTS >>

Food Bank of Northern Nevada

PROGRAM HIGHLIGHTS

1. Food Bank of Northern Nevada increased the number of partner food pantries who operate as Healthy Pantries from 12 pantries to 14 pantries.
2. FBNN continuously gathers input from partner agencies and clients to provide a balance of foods that are nutritious and culturally responsive.
3. FBNN provides SNAP application assistance, nutrition and health information, and referrals for other nutrition programs and support services to pantry clients who present a food prescription at the prescription partner pantry. Their team visits prescription pantry locations and community organizations in targeted counties to provide SNAP and Medicaid application assistance.
4. Patients utilizing the Healthy Pantries have seen improvements in hemoglobin AIC levels. Testing indicates 55% of all patients with at least two A1C's drawn, show their A1C in a downward trend. Prescription Pantry also encourages healthy eating habits, with 95% of participants reporting they now eat more vegetables with their families.

PROGRAM CHALLENGES

1. Marketing the program has been challenging, so the food bank has turned to media outlets and created an informative FAQ flyer to share with partners and community members.
2. Reaching rural communities is challenging due to time constraints and the preference for in-person engagement by partners. FBNN is committed to forging new partnerships and exploring creative solutions to broaden the program's reach and impact.

SCREENING AND REFERRAL DATA

– SCREENED FOR FOOD INSECURITY	11,985 POSITIVE FOR FOOD INSECURITY	11,985 REFERRED TO FAM3 PROGRAM

11,985 RECEIVING FOOD FROM FAM3 PROGRAM	40 REFERRED TO SNAP	40 SNAP APPLICATIONS INITIATED	40 SNAP APPLICATIONS COMPLETED

> **"We love the fruit and veggies, chicken, fish. And we can save things in our freezer at home as needed. Thank you. This means everything to us. It saves us. It is so helpful."**
>
> Client at a FBNN Healthy Pantry

Food Bank of Northern Nevada is a partner food bank of Feeding America

TABLE OF CONTENTS >>

Dare to Care Food Bank

Dare to Care Food Bank (Louisville, KY) works with physicians at local health clinics to address food insecurity through the Food as Medicine program. The program provides patients with education about wellness and healthy eating as well as nutritious food to take home. This year, Dare to Care is focused on expanding the program to reach more food-insecure populations.

PROGRAM MODEL

Medical providers based in Dare to Care's partner health clinics can refer patients to the food pantry. Patients who visit primary care, women's health and pediatrics are screened for food insecurity using the Hunger Vital Sign screening tool. Depending on the site, a patient who screens positive for food insecurity will either receive pre-packaged foods or go directly to the on-site food pantry, where they are able to pick up food based on their preferences and needs.

Patients who screen positive for food insecurity can access the food pantry as often as necessary, with or without a medical appointment.

WRAPAROUND SERVICES

During their visit to the food pantry, patients receive information about additional services such as SNAP benefits and cooking classes that Dare to Care helps provide.

MEDICAL PROVIDER SCREENS PATIENTS FOR FOOD INSECURITY → **PATIENTS WHO SCREEN POSITIVE ARE REFERRED TO THE FOOD AS MEDICINE PROGRAM** → **PATIENTS RECEIVE PRE-PACKAGED FOODS ONSITE OR VISITS AN ON-SITE FOOD PANTRY**

FOCUS POPULATIONS

The Prescriptive Pantry is open to patients in primary care, women's health and pediatrics clinics who have screened positive for food insecurity.

TECH PLATFORM

Medical providers use the Hunger Vital Sign screening tool, which is built into the electronic medical records system.

FOODS PROVIDED

Neighbors receiving food through this program are offered a wide variety of nutritious foods with lower sodium options, including items like whole grain pastas and cereals, canned vegetables and fruits in 100% fruit juice and proteins like canned tuna and peanut butter.

TABLE OF CONTENTS >>

Dare to Care Food Bank

PROGRAM HIGHLIGHTS

1. Healthcare partners like UofL Trager and UofL Physicians Internal Medicine have successfully provided essential food sources to vulnerable families, including those struggling to feed their children and newly arrived immigrants.
2. At UofL Trager, the Prescriptive Pantry program has facilitated access to food for older adult patients during routine visits with their primary care physicians. This initiative eliminates the need for patients to seek transportation to other pantries in the community, thereby easing the burden of food insecurity among this population.
3. The pantry at FHC Portland allows for immediate assistance, reducing financial stress and connecting food resources to patients' health conditions, particularly those with chronic diseases like hypertension, diabetes, and obesity. This immediate support enhances overall healthcare outcomes for the community served.
4. Healthcare professionals demonstrate resilience and compassion by adopting innovative approaches to address food insecurity, enhance staff training, and support patients through complex processes like SNAP applications.

PROGRAM CHALLENGES

1. Some clinics faced challenges related to the availability of specific food items, particularly due to their smaller size or occasional shortages, which impacted their ability to meet patients' preferences.
2. Assisting patients with SNAP applications can be a tedious and complex process for healthcare partners, requiring dedicated efforts to support patients effectively.

SCREENING AND REFERRAL DATA

45,670 SCREENED FOR FOOD INSECURITY	**3,241** POSITIVE FOR FOOD INSECURITY	**2,835** REFERRED TO FAM3 PROGRAM

1,949 RECEIVING FOOD FROM FAM3 PROGRAM	**10** REFERRED TO SNAP	**10** SNAP APPLICATIONS INITIATED	**10** SNAP APPLICATIONS COMPLETED

> **"One neighbor has 5 young children and is a single mom. The food pantry has helped her provide for her children. It has also helped boost her self-confidence and has given her a sense of pride."**

Staff at UofL Physicians Internal Medicine Prescriptive Pantry, revealing what one patient shared with them during a visit.

Dare to Care Food Bank is a partner food bank of Feeding America

TABLE OF CONTENTS >>

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TABLE OF CONTENTS >>

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Feeding America is committed to an America where no one is hungry. We support tens of millions of people who experience food insecurity to get the food and resources they say they need to thrive as part of a nationwide network of food banks, statewide food bank associations, food pantries and meal programs. We also invest in innovative solutions to increase equitable access to nutritious food, advocate for legislation that improves food security and work to address factors that impact food security, such as cost of living, health and employment.

We partner with people experiencing food insecurity, policymakers, organizations, and supporters, united with them in a movement to end hunger.

TABLE OF CONTENTS >>

FEEDING AMERICA

161 North Clark St.
Suite 700
Chicago, Illinois 60601

1627 I Street NW
Suite 1000
Washington, DC 20006

1.800.771.2303
FeedingAmerica.org