FEEDING AMERICA

Food as Medicine 3.0

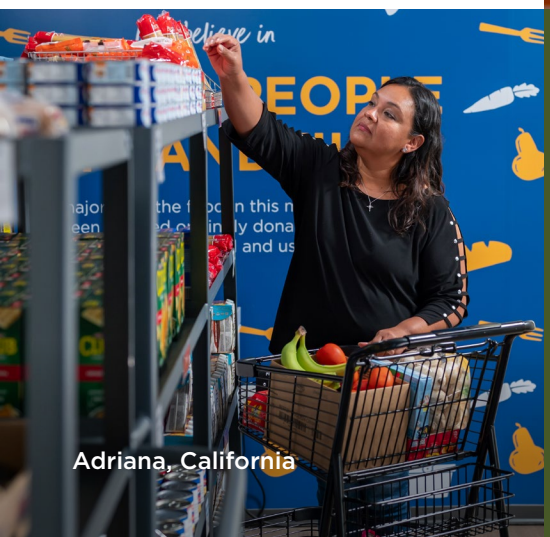
A Cumulative Report on Impacts and Implementation

FINAL REPORT
JULY 2026

FUNDED BY

Elevance Health Foundation

Colton, Virginia



Adriana, California

ACKNOWLEDGEMENTS

This report reflects the dedication and collaboration of many partners working to advance Food as Medicine approaches across the Feeding America network. Twenty-one Feeding America partner food banks participated in the Food as Medicine 3.0 (FAM3) initiative, funded by Elevance Health Foundation, working alongside health care partners to implement innovative programs connecting neighbors to nutritious food and health-related supports. Feeding America extends gratitude to the food bank teams who led this work locally and who contributed insights to this report through grant reporting mechanisms and ongoing collaboration and participation in evaluation activities with the Feeding America and Center for Nutrition & Health Impact (CNHI) teams. Feeding America thanks the neighbors who shared their time and insights, helping ensure the FAM3 program remains grounded in lived experience and delivers resources in ways that remove barriers and respect choice. The CNHI evaluation team included Clare Milburn Atkinson, Eric Calloway, Nicole Cawrse, Ashleigh Floyd Clark, Laura Flournoy, Bailey Houghtaling, Maryan Isack, Christopher Long, Betsy Anderson Steeves, Eliza Short, Gabi Talavera, and Victoria Zigmont. Feeding America and CNHI would also like to thank the team at Carelon Research, Inc., including Martha Johnson, Jeff Romine, Winnie Chi, and Kelly Martinez, for their work analyzing insurance claims data. Feeding America is grateful for their expertise and significant contributions to this report.

ABOUT FEEDING AMERICA

Rooted in the voices of neighbors facing hunger, Feeding America® unites the country to ensure everyone has access to nutritious food and a thriving future. We support tens of millions of people as part of a nationwide network of 250+ food banks; 20+ statewide food bank associations; 10+ regional co-ops; and 60,000+ agency partners, food pantries and meal programs. Powered by leaders and volunteers embedded in local communities, we are one of the nation's most effective food distribution systems driving immediate impact today—and a catalyst for long-term change through advocating for legislation that improves food security and work to address its factors. We partner with people experiencing food insecurity, policymakers, organizations and supporters united with the unwavering commitment to provide nourishing food and work to end hunger at its roots so everyone can live fuller, healthier lives. Visit FeedingAmerica.org to learn more.

ABOUT ELEVANCE HEALTH FOUNDATION

Elevance Health Foundation is the philanthropic arm of Elevance Health Inc. The Foundation works to improve the health of the socially vulnerable through partnerships and programs in our communities with an emphasis on maternal-infant health; behavioral health; and food as medicine. Through its key areas of focus, the Foundation also 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. To learn more about Elevance Health Foundation, please visit www.elevancehealth.foundation or follow us @ElevanceFND on X and Elevance Health Foundation on Facebook.

ABOUT CENTER FOR NUTRITION & HEALTH IMPACT (CNHI)

CNHI is a nonprofit research institute providing expertise in measurement and evaluation to develop, enhance, and expand public health programs. CNHI's research focuses on encouraging healthy eating and active living, improving food security and healthy food access, and promoting local food systems. With expertise in public health nutrition, CNHI is dedicated to building measurement strategies to assess the impact of innovative health-related programs. CNHI works nationally and internationally, partnering with other nonprofits, academia, government entities, and private foundations to conduct research, evaluation, and strategic planning. Visit centerfornutrition.org to learn more.

SUGGESTED CITATION

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PROGRAM SITE MAP

Programs
implemented across

13 states

Food bank case studies included in this report:

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 New York City

Food Bank of Northern Nevada

Food Bank of Northwest Indiana

Freestore Foodbank

Gleaners Food Bank of Indiana

Greater Baton Rouge Food Bank

Greater Cleveland Food Bank

HACAP Food Reservoir

Houston Food Bank

Island Harvest Food Bank

Mid-Ohio Food Collective

Regional Food Bank

Second Harvest Food Bank of Middle Tennessee

Second Harvest of Silicon Valley

St. Louis Area Foodbank

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Thomas, New York Volunteer

Brittany, Maryland

Foreword

Food security is a critical social determinant of health. When neighbors have consistent access to nutritious food, they experience meaningful improvements in health, well-being, and stability. Yet too many neighbors and their families continue to face barriers to accessing the food they need to manage and prevent chronic conditions such as diabetes, hypertension, and heart disease—conditions that disproportionately affect the communities that food banks serve. The Feeding America national network of food banks is uniquely positioned to address these intersecting challenges: most food banks have active health care partnerships, most of which engage in some form of food insecurity screening, referral, and targeted food distribution. Food banks' comprehensive reach into every county, parish, and congressional district—including rural and hard-to-reach communities—has established them as trusted entry points and community connectors, linking people to nutritious food, health services, and other essential supports.

The Food as Medicine 3.0 (FAM3) initiative, funded by Elevance Health Foundation, builds on over a decade of innovation, supporting food banks in creating and strengthening health care partnerships and expanding access to healthy food. This report presents cumulative findings from the three-year initiative (April 2023-December 2025). The report draws on multiple sources of data—including neighbor surveys, clinical data, insurance claims data, and interviews with participants and program staff—to understand how food bank-health care partnerships can improve health outcomes, health care utilization and food security.

Note that people who participate in FAM3 programs are referred to as "participants", "households", or "neighbors" (a term used by Feeding America to describe people who access food and resources through the charitable food system) and people who visit a health care location prior to enrolling in a FAM3 program are referred to as "patients." A participant in a FAM3 program may be, or may have been, any of these four. You will see these terms used throughout the report. For definitions of other key terms used in the report, see the glossary on page 101.

FAM1 (2019-2020) established proof of concept for food bank-health care partnerships.

FAM2 (2021-2022) expanded program reach and validated the model's viability while revealing the data infrastructure and operational investments needed to rigorously measure impact at scale.

FAM3 (2023-2025) scaled the model to more food banks and introduced a more comprehensive evaluation framework. Prior reports are available at https://www.feedingamerica.org/research/hunger-and-health.

Executive Summary

Over three years, Food as Medicine 3.0 (FAM3) grantees across the country connected more than 161,000 households to healthy foods through partnerships between Feeding America food banks and health care organizations. Health care providers screened more than 1.45 million patients for food insecurity, helping identify neighbors who could benefit from additional food and nutrition support. Food banks and health care partners worked together to connect participants to healthy food, nutrition education, and benefits-enrollment support tailored to their health needs. More than 35,000 screened patients were referred to the Supplemental Nutrition Assistance Program (SNAP) — which provides ongoing access to healthy food — and over 12,000 patients were supported through the SNAP application process.

Across participating communities, neighbors who engaged in FAM3 programs experienced improvements in overall health, nutrition security and food security, including reduced reported hospitalizations and emergency department visits, improvements in clinical values (e.g., HbA1c, blood pressure), and greater access to medications and care.

PROGRAM CATEGORIES

FAM3 programs were grouped into the following three categories based on the number of supportive program design characteristics offered:

- **Foundational programs:** Provided participants with a healthy food box or bag after screening positive for food insecurity. The healthy food box/bag was often accompanied by informational materials about nutrition, food pantry locations, and/or public benefits programs.
- **Enhanced programs:** Most frequently provided food at defined intervals and/or actively helped participants enroll in benefits programs.
- **Comprehensive programs:** Provided food at defined intervals and supported participants in multiple ways, such as through structured nutrition education and benefits enrollment. These programs often enrolled participants with a specific diet-related chronic condition (i.e., the program was designed to meet the needs of participants with specific chronic conditions).

> “I felt comfortable with how [the staff member] asked about my food situation because she was very understanding and patient. I appreciated her empathetic and non-judgmental approach.
>
> **36-YEAR-OLD WOMAN FROM NEW YORK**

Ricky, Indiana
Volunteer


Misti, Xavier, Tennessee

KEY FINDINGS

FAM3 programs provided food to over 161,000 patients experiencing food insecurity across the U.S. Programs reached neighbors across a range of age, racial, and ethnic backgrounds.

Hospitalization rates decreased by 3 percentage points (from 19.2% to 16.5%) and emergency department visit rates decreased by 4 percentage points (from 36.7% to 32.7%) from baseline to follow-up across the initiative. Programs offering in-clinic food provision saw the greatest reduction in hospitalization rates.

The frequency of skipped medications and delayed care both decreased by 2 percentage points (from 33.1% to 30.9% and from 31.4% to 28.9%, respectively), particularly in programs with structured nutrition education, active benefits support, or diet-related condition enrollment criteria compared to programs that did not offer these program components.

An insurance claims sub-study found beneficial trends for reductions in inpatient hospital visits, emergency room visits, and clinical lab values, when comparing baseline to follow-up values; however, similar trends were seen among the control group. Foundational programs reached younger patients with fewer diet-related conditions, while comprehensive programs reached older patients with more comorbidities.

Clinical biomarkers improved for patients with complete baseline to follow-up electronic health records data. Improvements were observed for the patients who attended three or more dietitian visits, including improved HbA1c values (a decrease of 1.1%), LDL cholesterol values (a decrease of 5.5 units), and BMI values (a decrease of 0.80 units) over time.

Nutrition security increased from 2.43 to 2.52 (out of a maximum score of 4) from baseline to follow-up across the initiative.

Food security rates improved by nearly 7 percentage points, from 13.7% at baseline to 20.2% at follow-up across the initiative.

Participants emphasized the importance of dignity, choice, and flexibility in FAM programs, highlighting the importance of being treated without stigma, having choice in food selection, and co-locating food access with health care appointments.

Food banks and health care partners reported strong overall capacity to sustain FAM programs. Both demonstrated strong environmental support and leadership buy-in, with opportunities to strengthen communication (e.g., information- and data-sharing), partnerships, and organizational readiness to sustain FAM programs.

IMPACT OF PROGRAM DESIGN ON OUTCOMES

A key aim of the FAM3 evaluation was to understand how program design was associated with participant outcomes. Programs varied across sites, and that variation enabled result comparisons across different approaches. The findings from baseline to follow-up point to several program characteristics that were associated with improvements in participants' health and diet-related outcomes.

- **Structured nutrition education** was the most common characteristic associated with improvements in participants' health outcomes. Over the course of the study, participants experienced statistically significant gains in general health, decreases in missing or delaying medical care, and decreases in being short on medication compared to participants in programs not offering structured nutrition education.
- **In-clinic food provision** was associated with greater reductions in overnight hospitalizations compared to programs without in-clinic food provision.
- **Active benefit enrollment support** (e.g., program staff supporting participants with benefits applications) was associated with reduced rates of missing or delayed medical care.
- **Diet-related condition enrollment criteria** were associated with improvements in fruit and vegetable intake as well as reductions in being short on medication.
- **Higher program engagement** (participating more frequently) was associated with greater improvements in general health.

> "We want to take away the stigma and provide a non-judgmental atmosphere so our patients can meet their basic needs.
>
> **HEALTH CARE PROGRAM LEADER FROM OHIO**

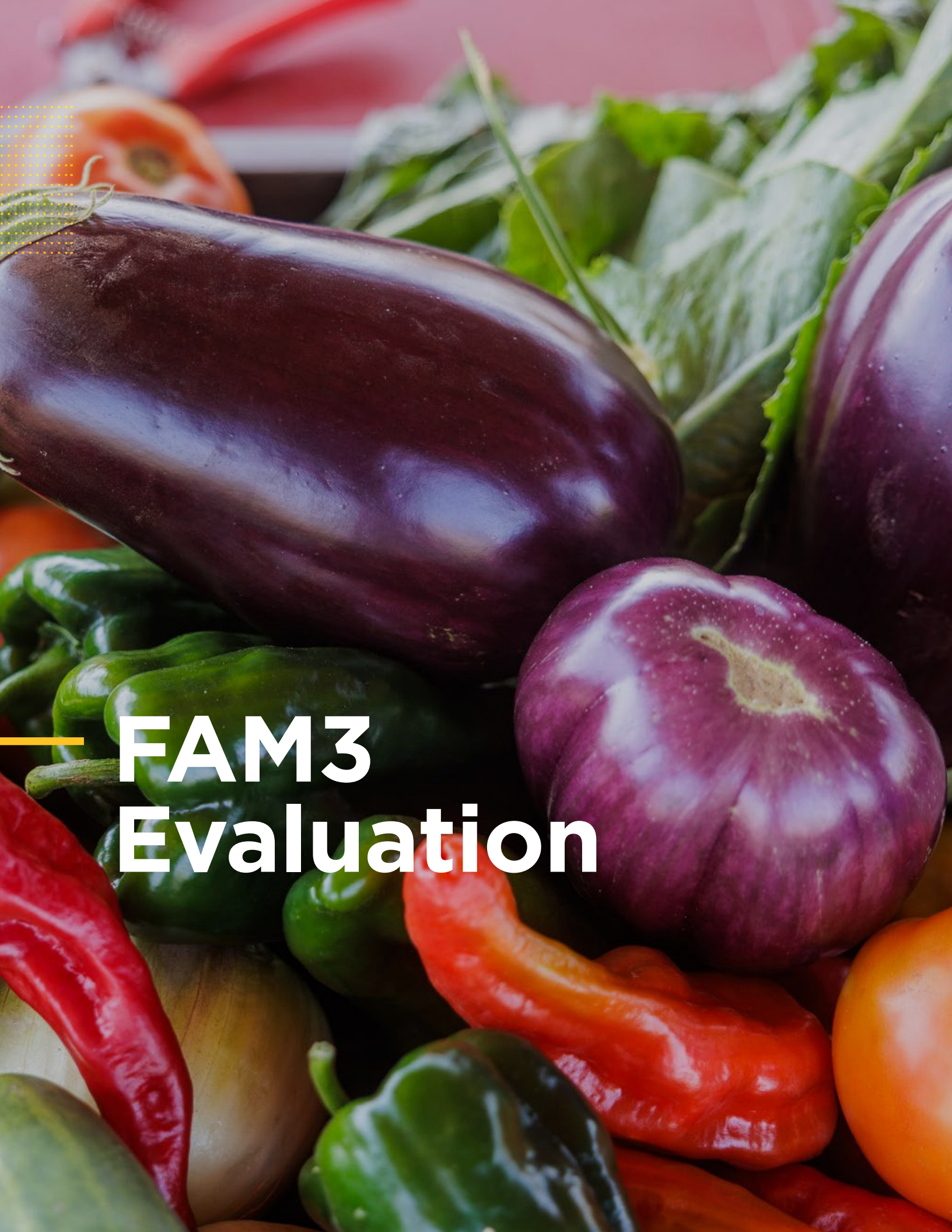
> "Every time I've shared a voucher, you can almost feel a weight lift from the person receiving it – there's a real shift in the energy of the room. Offering support in a way that feels dignified- where someone can make their own choices – truly changes the dynamic.
>
> **HEALTH CARE PROGRAM LEADER FROM INDIANA**

Javier, Indiana

Maryam, New York
Nutrition Coordinator

RECOMMENDATIONS FOR FUTURE FAM PROGRAMS

- Support programs to include structured nutrition and/or health education, which may increase program efficacy and may be associated with health improvements for participants.
- Support the implementation of in-clinic food provision options (e.g., on-site pantries, lockers, mobile markets) where possible to make it easier for participants to access food.
- Encourage programs to include active benefits enrollment, which may provide long-term post-program support.
- Consider tailoring programs for the types of patients reached, such as focusing foundational programs (which, on average, reach a younger/healthier population) on prevention and focusing comprehensive programs (which, on average, reach an older/less healthy population) on disease management.
- Focus on promoting higher participant access and engagement (picking up food more than once), across all program types, as it may be associated with improvements in participants' diet and health-related outcomes.
- Design and test implementation strategies to help food banks and health care partners adopt, implement, and sustain programs in complex real-world settings.
- Plan data-sharing infrastructure between food banks and health care partnerships early in program design, including standardized agreements and shared evaluation goals.
- Fund programs to support health care partnerships with dedicated staff and organizational alignment, not just food provision, to sustain programs over time.



FAM3 Evaluation

Program Overview

FAM3 supported 21 Feeding America partner food banks and their health care partners to address food insecurity as a driver of chronic disease. Food insecurity is strongly associated with diet-related conditions including diabetes, hypertension, and heart disease.[1] FAM3 programs operated a screen-refer-nourish model in which health care partners identified patients experiencing food insecurity, often using the 2-item Hunger Vital Sign[2] screener. Health care partners then referred patients to food bank supported programs where they received nutritious food and, depending on the program design, nutrition education and benefits enrollment support. FAM3 supported food banks to implement this model, and each food bank designed its program in response to local context, community need, and available health care partnerships.

FOOD BANK-HEALTH CARE PARTNERSHIP MODEL

FAM3 is designed as a food bank-health care intervention built on a screen-refer-nourish model:

1. **Screen:** Health care providers screen patients for food insecurity at health care visits.
2. **Refer:** Patients who screen positive for food insecurity are referred to Feeding America partner food bank programming.
3. **Nourish:** Participants receive nutritious food and may also access nutrition education, benefits navigation, and other supportive services.

Programs varied across sites in their design and intensity, driven by unique population needs and organizational capacity. Sites ranged from those offering immediate healthy food access touchpoints at a health care visit to those combining multiple food distributions, nutrition education, benefits support, and condition-specific enrollment criteria. Some programs prioritized broader reach; others focused on more comprehensive programming. Therefore, the evaluation was designed to learn from a range of program models rather than to identify a single best model.

2-Item Hunger Vital Sign

In FAM3, patients are screened for food insecurity by their health care 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). This variable is referred to as food security in this report.

> "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 the money to buy more.[2]

PROGRAM CHARACTERISTICS

FAM3 programs were designed individually by food banks to be responsive to local contexts and community needs, contributing to variation in the ways each of the 21 grantee programs were designed. **The 21 grantees administered FAM3 programming at over 50 health care partner sites**, with some food banks implementing different program models at different health care partner sites, adding further variation in program characteristics.

Not all FAM3 sites participated in the evaluation activities, and some participated in only select portions of the evaluation. A total of 29 individual FAM3 sites participated in the FAM3 Neighbor Survey portion of the evaluation and over 34 sites participated in the assessment of program reach.

Five key characteristics of FAM3 programs were identified (Table 1).[3] These program characteristics included differences in food provision approaches, food distribution, program enrollment criteria, nutrition education, and governmental benefits support. To learn more about each FAM3 grantee's individual program models and highlights of program-level impacts, go to page 58.

All FAM3 programs included eligibility criteria for enrolling individuals experiencing food insecurity, although some programs only enrolled individuals who also had a diet-related chronic condition. Healthy food provision was a primary component of all FAM3 programs. Participants received healthy foods (e.g., whole grains, fruits, and vegetables), often with options available that supported diet-related health conditions (e.g., low-sodium versions of canned foods); however, specific medical tailoring (i.e., food packages designed to comprehensively meet the nutritional needs of a specific diet-related condition, such as type 2 diabetes and/or hypertension) of the provided food was less common. Participants accessed food at the health care site (e.g., on-site food pantry or food lockers), in the community (e.g., a local food pantry or mobile pantry), or a combination of both. Table 1 below provides further details on the characteristics of FAM3 programs.

Mu, New York

> "Being able to offer [participants] nutritious food options to take home with them is a wonderful way not just to help them stay healthy, but also to remind them that they can still experience kindness and warmth.
>
> **HEALTH CARE PROGRAM LEADER FROM TENNESSEE**

> "[I was] pleased with the conversations as well as the types of food that I got from the food program because I do enjoy eating the vegetables that they provided me with. I'm not able to buy a lot of things that I want to buy because of grocery prices increasing. But they actually helped me out a lot...
>
> **NEIGHBOR FROM GEORGIA**

TABLE 1. FAM3 Program Characteristics (n=34 sites across 21 grantees)

VARIABLES	N (%)	DEFINITION
IN-CLINIC FOOD PROVISION	**Yes** 29 (85%) **No** 5 (15%)	FAM3 programs that distribute food directly within the clinical setting, such as a clinic-based food pharmacy, pantry, or box programs. These programs may have also distributed food in other ways outside of the clinic. This is contrasted against models in which there is no option for in-clinic food pick-up.
DEFINED FOOD DISTRIBUTION	**Yes** 15 (44%) **No** 19 (56%)	FAM3 programs that involve multiple standardized or supported/planned food distributions. For this approach, FAM3 program activities are designed to *actively* provide food to participants multiple times (e.g., participants have individually designated refrigerated food lockers that they pick up food from weekly). This is contrasted against models in which food is made available for participants (e.g., a food pantry they can visit if they wish to), but there is no set structure or frequency defined within the FAM3 program in which they are expected to retrieve the food. However, participants in the defined food distribution model may, in some cases, still be able to receive food once or multiple times depending on the program.
DIET-RELATED CONDITION ENROLLMENT CRITERIA	**Yes** 11 (32%) **No** 23 (68%)	FAM3 programs with eligibility criteria that include both food insecurity and the presence of a diet-related condition (e.g., high blood pressure, diabetes, etc.). This is contrasted against models in which only food insecurity is an eligibility criterion.
STRUCTURED NUTRITION EDUCATION	**Yes** 11 (32%) **No** 23 (68%)	FAM3 programs that directly provide guided group classes and/or 1-on-1 nutrition education (e.g., general healthy eating, condition-specific dietary guidance, cooking skills, etc.) as a formal component of their FAM3 programming. This is contrasted against models in which either no materials or static materials (e.g., nutrition informational brochures, healthy recipe cards) are provided.
ACTIVE BENEFIT ENROLLMENT SUPPORT	**Yes** 16 (47%) **No** 18 (53%)	FAM3 programs have food bank or health care partner staff directly help FAM3 participants start and/or complete benefits enrollment applications (e.g., SNAP applications). This is contrasted against models in which participants are provided with no materials or with static informational materials about benefits programs.

PROGRAM CATEGORIES

To strengthen recommendations for program design, one goal of the FAM3 evaluation was to understand which program design characteristics most influenced participant outcomes. Each of the five program design characteristics was hypothesized to be associated with increases in outcome variables (i.e., more active, supportive, and tailored programs are hypothesized to be associated with increases in outcomes).[3,4] Programs were grouped into three categories of roughly even proportions, based on the number of supportive program design characteristics offered (note: Location of food provision was not used for forming groups due to limited variation across projects).

FAM3 Program Categories:

- **Foundational programs:** Provided participants with a healthy food box or bag after participants screened positive for food insecurity. The healthy food box or bag was often accompanied by informational materials about nutrition, food pantry locations, and/or public benefits programs.
- **Enhanced programs:** Most frequently provided food at defined intervals and/or actively helped participants enroll in benefits programs.
- **Comprehensive programs:** Provided food at defined intervals and supported participants in multiple ways, such as through structured nutrition education and benefits enrollment. These programs often enrolled participants with a specific diet-related chronic condition (i.e., the program was designed to meet the needs of participants with specific chronic conditions).

Liam, Colton, Taylor, Virginia

Evaluation Overview

The FAM3 program's goal is that patients experiencing food insecurity, many of whom face diet-related chronic conditions, have access to nutritious food that facilitates better health. The evaluation of FAM3 is an effort to assess how well that goal was achieved.

The FAM3 evaluation achieved four key aims:

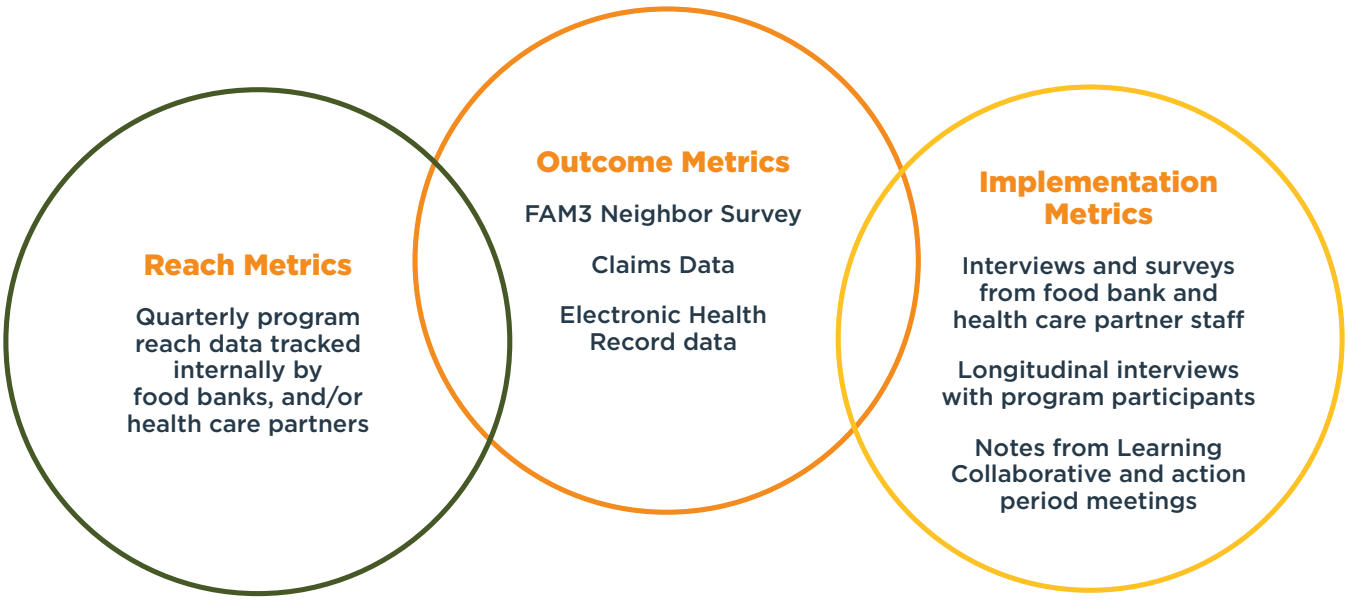
1. Co-create an evaluation and data collection approach with 21 food banks, their health care partners, and Feeding America, as part of the Learning Collaborative.*
2. Assess the effects of FAM3 programs on participants' well-being with respect to diet and related factors, general health, and health care utilization.
3. Explore potential differences in the magnitude of effects across FAM3 program characteristics and models.
4. Evaluate successes and challenges of FAM3 implementation.

*For more information on the Learning Collaborative, see Appendix A.

KEY METRICS

The FAM3 evaluation focused on three types of metrics: reach, outcomes, and implementation. This combination of metrics provides actionable insights about the number and experiences of FAM3 participants; the associations between the FAM3 program and participants' changes in well-being and health care utilization; and the characteristics, challenges, and successes of implementing FAM3 programs. Detailed evaluation metrics are presented in Appendix B.

The figure below presents a comprehensive list of the metrics and their data sources:



REACH

Food bank grantees worked with health care partners to share the total number of participants reached by FAM3 programs across the three-year grant period (Table 2). Health care partners across FAM3 programs successfully screened **1,463,097** patients for food insecurity using the 2-item Hunger Vital Sign.[2] A total of **428,325** patients (29%) screened positive for food insecurity and **225,876** were referred to a FAM3 program after meeting inclusion criteria set by each program and expressing interest in program enrollment. An estimated **161,972** unique patients received food from one of the FAM3 programs across the reporting period (April 2023 through December 2025).

Additionally, when available, reach for Supplemental Nutrition Assistance Program (SNAP) application assistance was tracked. Of the 17 grantees that reported these data, **35,620** patients were referred to SNAP; **12,096** SNAP applications were initiated; and **8,129** applications were completed across the three years.

TABLE 2. FAM3 Grantee Program Reach Data – Years One through Three (Aggregated) [A]

REACH DATA (Aggregated)	YEAR ONE (4/23 - 12/23)	YEAR TWO (1/24 - 12/24)	YEAR THREE (1/25 - 12/25)	TOTAL (4/23 -12/25)
# patients screened for food insecurity	281,236	566,998	614,863	1,463,097
# patients screened positive for food insecurity	93,776	165,042	169,507	428,325
# patients referred to a FAM3 program	44,577	89,237	92,062	225,876
# patients receiving food from FAM3 program	40,232	64,095	57,645	161,972
# patients referred to SNAP[B]	8,190	12,589	14,841	35,620
# SNAP applications initiated	2,126	5,456	4,514	12,096
# SNAP applications completed	1,506	3,690	2,933	8,129

[A] To reflect improved accuracy in reporting, adjustments to the reach metrics in the Year One and Year Two FAM3 report were made as new data from grantees were available. The final reach data reported here reflect the final/most accurate estimates. Food banks have varying ability to track participants at the time of screening; so, in many cases, it is not known how many patients were offered and/or were eligible for a FAM3 program.

[B] Grantees had varying abilities to track the number of individuals assisted, and some grantees assisted participants in different ways (e.g., referral to SNAP vs. helping participants complete applications). Thus, the number of individuals referred to SNAP, number of applications initiated, and number of applications completed are best interpreted independently from one another.

Program reach also varied by FAM3 program design category. On average across 33 months of reporting, across the 34 sites that provided reach data, the eleven foundational sites provided food to more unique participants (n=5,628 per program), than the twelve enhanced sites (n=1,953 per program) or the eleven comprehensive sites (n=1,154 per program). **This finding may be related to comprehensive programs including more structured components that require additional staff support (e.g., structured nutrition education), while foundational programs may be able to more efficiently reach a larger number of participants.** See Table 3 for descriptive information about the median number of unique participants reached per month during the reporting period.

TABLE 3. Median, minimum and maximum numbers of unique participants reached per month by program design category from April 2023 to December 2025

	Foundational	Enhanced	Comprehensive
Median (per month)	171	59	35
Minimum (per month)	43	15	9
Maximum (per month)	789	1,238	158

Gage, Jessica, Johnny, Leila, California

PARTICIPANT CHARACTERISTICS

Table 4 summarizes the demographic characteristics of participants who completed the baseline FAM3 Neighbor Survey. The average age of FAM3 participants was 47, with ages ranging from 18 to 91. Participants were mostly women (73%), and just over half of all participants (53%) had children in their household. The majority (83%) indicated English as their preferred language. Over one-third (38%) received SNAP benefits, and a similar percentage (41%) regularly visited food pantries.

TABLE 4. Characteristics of participants who responded to the baseline FAM3 Neighbor Survey[A] (n=3,134)[B]

AGE	N (%)
18 to 34	763 (24%)
35 to 49	911 (29%)
50 to 64	997 (32%)
65 to 91	429 (14%)
GENDER IDENTITY	**N (%)**
Woman	2,262 (73%)
Man	822 (27%)
Another response	17 (<1%)
RACE/ETHNICITY	**N (%)**
Black or African American	1,165 (38%)
Hispanic or Latino	819 (27%)
White or European American	802 (26%)
Multi-racial/-ethnic	123 (4%)
Asian or Asian American	68 (2%)
American Indian or Alaskan Native	33 (1%)
Middle Eastern or North African	21 (1%)
Native Hawaiian or Pacific Islander	9 (<1%)

LANGUAGE OF PREFERENCE	N (%)
English	2,595 (83%)
Spanish	521 (17%)
Another response[C]	17 (<1%)
CHILDREN IN HOUSEHOLD	**N (%)**
Yes	1,640 (53%)
No	1,438 (47%)
SNAP HOUSEHOLD[D]	**N (%)**
Yes	1,166 (38%)
No	1,886 (62%)
WIC HOUSEHOLD[E]	**N (%)**
Yes	410 (13%)
No	2,642 (87%)
FOOD PANTRY HOUSEHOLD[F]	**N (%)**
Yes	1,260 (41%)
No	1,792 (59%)

[A] The survey results in this report represent changes among the FAM3 Neighbor Survey sample between the baseline and follow-up periods. See Appendix C for complete descriptive statistics of the follow-up survey sample.

[B] Sample size may vary across variables due to missing data

[C] Haitian Creole, Simplified Chinese, and Vietnamese

[D] Current enrollment in Supplemental Nutrition Assistance Program

[E] Current enrollment in Special Supplemental Nutrition Program for Women, Infants, and Children

[F] Currently receives food from a food pantry, food bank, food shelf, or similar site that provides access to free food

FAM3 Neighbor Survey Results

OVERVIEW

Where feasible, a baseline and follow-up FAM3 Neighbor Survey was offered to all FAM3 participants from January 2024 to August 2025. Follow-up periods were tailored to each program's design, in collaboration with the grantees. In addition to demographic characteristics,[5,6] the survey contained questions about food and nutrition security,[2,7] fruit and vegetable intake,[8] general health,[9] quality of life,[10,11] and health care utilization (Appendix D & E).[12] The survey contents and administration approaches were co-developed in a close collaboration between the grantees, CNHI, and FANO. The survey served as the backbone of the evaluation by measuring the same outcomes across all grantees' programs.

METHODS

The FAM3 Neighbor Survey was administered at baseline as closely as possible to when a FAM3 participant was enrolled in the program. CNHI worked with each grantee to design their baseline survey collection approach and assisted during the data collection period. Baseline survey administration was led by the grantees and tailored to each grantee's unique workflow, with some collecting surveys on tablets, web-based links, hard copies, and/or interviewer-assisted administration. Follow-up survey data collection (April 2024 to September 2025) was led by CNHI, with assistance from grantees, via each participant's preferred survey method (e.g., web-based link or mailed paper surveys). Follow-up periods were customized to each grantee's intervention period, ranging from 30 days to 6 months, with an average of 134 days (4 months).

The following analyses were conducted to assess changes in self-reported outcome variables over the course of the study.

1. **Overall Changes:** We describe outcomes across all participants that completed a baseline and follow-up survey using unit change (i.e., follow-up value minus baseline value) or percent change (i.e., total change divided by the baseline value). We also evaluate changes in outcomes using statistical modeling approaches that control for important characteristics (i.e., age, gender, race/ethnicity, participation in federal benefits programs, and program site).

2. **Group Analyses:** We evaluate whether one group experienced greater improvements over time than another. We also describe the changes in outcomes for each group variable over time. Group variables include:

    - **FAM3 Program Engagement:** We compare participants with higher program use (reported receiving food multiple times) to participants with lower program use (reported receiving food once or never).
    - **Program Design Characteristics:** We compare participants enrolled in programs offering each of the five program design characteristics (structured nutrition education, defined food distribution, in-clinic food provision, active benefit enrollment support, diet-related condition enrollment criteria) to participants enrolled in programs that do not offer these characteristics.
    - **Program Design Category:** We compare participants across three program categories (foundational, enhanced, and comprehensive).

RESULTS

OVERALL CHANGES

TABLE 5. Changes from baseline to follow-up for the FAM3 initiative overall

	Overall FAM3 Program Follow-up value vs. Baseline value
Nutrition Security*	↑ 0.10 [0.06, 0.13]
Food Security**	↑ 2.39 [1.05, 5.41]
Fruit & Vegetable Intake*	0.01 [-0.08, 0.10] (n.s.)
General Health*	0.01 [-0.08, 0.09] (n.s.)
Overnight Hospitalizations*	↓ -0.05 [-0.09, -0.01]
Emergency Department Visits*	↓ -0.04 [-0.06, -0.01]
Missing or Delaying Medical Care*	-0.04 [-0.11, 0.03] (n.s.)
Being Short on Medication*	-0.03 [-0.10, 0.04] (n.s.)

* = Unit Change [95% Confidence Interval]

** Odds Ratio [95% Confidence Interval]

↑↓ = Statistically significant ($p<0.05$) increase or decrease in a beneficial direction over time

(n.s.) = No statistically significant difference measured ($p>0.05$)

Note: Details about the units of measurement for each outcome variable are provided in each outcome-specific section.

Kesu, Maryland
Volunteer

Rhonda, South Dakota
Food Sovereignty Program Lead

HOW TO READ THE TABLES IN THIS SECTION

"Overall FAM3 Program" row interpretation: The provided numerical value represents the change in an outcome over time for all participants. The arrow (up or down) represents the direction of the change and is present if the change was statistically significant. The lack of an arrow (or "n.s.") represents a change over time that was not statistically significant. All changes are represented in adjusted units or an adjusted odds ratio. For example, across all FAM3 participants, there was a statistically significant increase in nutrition security over time by 0.10 units.

"Program engagement" row interpretation: The program engagement group analysis compares participants who had multiple food pickups (2+ times) to participants with zero or one food pickups. The provided numerical value represents the change in an outcome over time for participants with multiple food pickups. The arrow (up or down) represents the direction of the change and is present if the change was statistically significant. The lack of an arrow (or "n.s.") represents a change over time that was not statistically significant. For example, among participants who picked up food 2+ times, there was a statistically significant increase in nutrition security over time by 0.09 units. The column "change between groups over time (yes vs no)" evaluates whether the change in an outcome over time differed between groups. For example, there was no significant difference in the change in nutrition security over time for participants with multiple food pick-ups versus participants with zero or one food pickups as indicated by (n.s.).

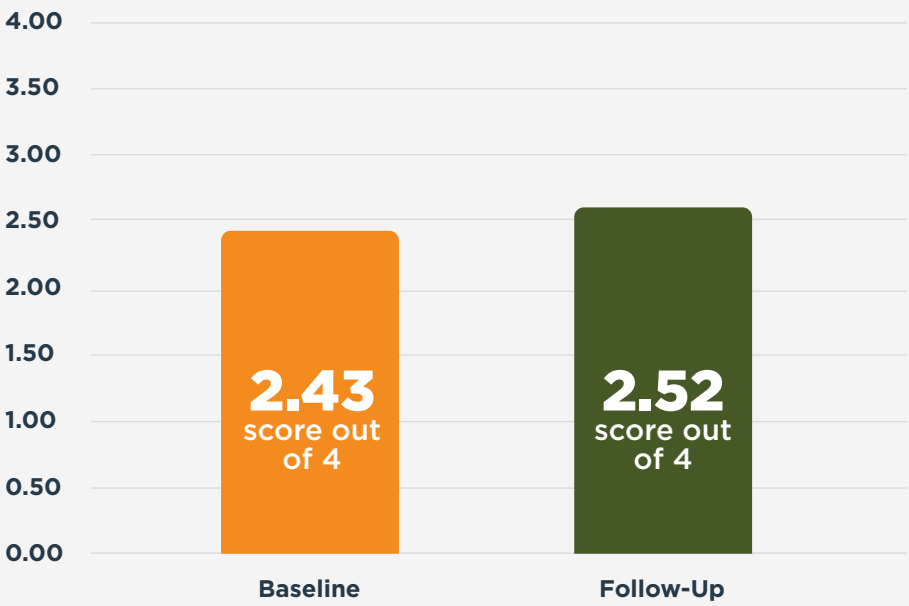
"Program characteristic" rows interpretation: The program characteristic group analyses compare participants who were in programs with all the program characteristics to participants in programs without each of the characteristics. Each characteristic was analyzed separately. The arrow (up or down) represents the direction of the change and is present if the change was statistically significant. The lack of an arrow (or "n.s.") represents a change over time that was not statistically significant. For example, among participants in programs with in-clinic food provision, there was a statistically significant increase in nutrition security over time by 0.11 units. The column "change between groups over time (yes vs no)" evaluates whether the change in an outcome over time differed between groups. For example, there was no significant difference in the change in nutrition security over time for participants with in-clinic food provision versus participants without in-clinic food provision as indicated by (n.s.).

Note: The numerical values provided across all tables in this section can be interpreted similarly, except for food security. Food security is a yes or no variable; thus, an adjusted odds ratio is reported (the odds of being food secure at follow-up compared to the odds of being food secure at baseline). For example, the adjusted odds of being food secure are 2.39 greater for participants at follow-up compared to participants at baseline.

NUTRITION SECURITY

FAM3 participation was associated with increases in participants' nutrition security.

NUTRITION SECURITY SCORES: CHANGES FROM BASELINE TO FOLLOW-UP



There was a

4%

increase in nutrition security scores from baseline to follow-up.

Nutrition security was measured using the 4-item Household Nutrition Security Scale that has been validated among food pantry clients and other low- to medium-income households. Nutrition security ranges from 0-4, where 4 represents high nutrition security.[7,13]

> "This is a great service with the prescription. I get a variety of healthy options and enough to help me get through the week.
>
> **65-YEAR-OLD WOMAN FROM NEVADA**

TABLE 6. Nutrition security (NS) changes from baseline to follow-up for the FAM3 initiative overall and by program engagement and characteristic group

	Nutrition Security Unit Change [95% CI]*	
Overall FAM3 Program NS at follow-up vs. at baseline	↑ 0.10 [0.06, 0.13]	
	Nutrition Security Unit Change [95% CI]*	**Change between groups** over time (yes vs. no)**
Program engagement		
Multiple food pickups (2+ times)	↑ 0.09 [0.02, 0.16]	n.s.
Program characteristic		
Structured nutrition education	↑ 0.15 [0.09, 0.22]	n.s.
Defined food distribution	↑ 0.11 [0.04, 0.17]	n.s.
In-clinic food provision	↑ 0.11 [0.06, 0.15]	n.s.
Active benefit enrollment support	↑ 0.09 [0.03, 0.15]	n.s.
Diet-related condition enrollment criteria	0.11 (-0.02, 0.24) (n.s.)	n.s.

* Unit change in nutrition security score [95% Confidence Interval]

** The group variables are program engagement and program characteristics

↑↓ = Statistically significant ($p<0.05$) increase or decrease in a beneficial direction over time

★ = Statistically significant ($p<0.05$) difference over time compared to the programs that do not offer this characteristic

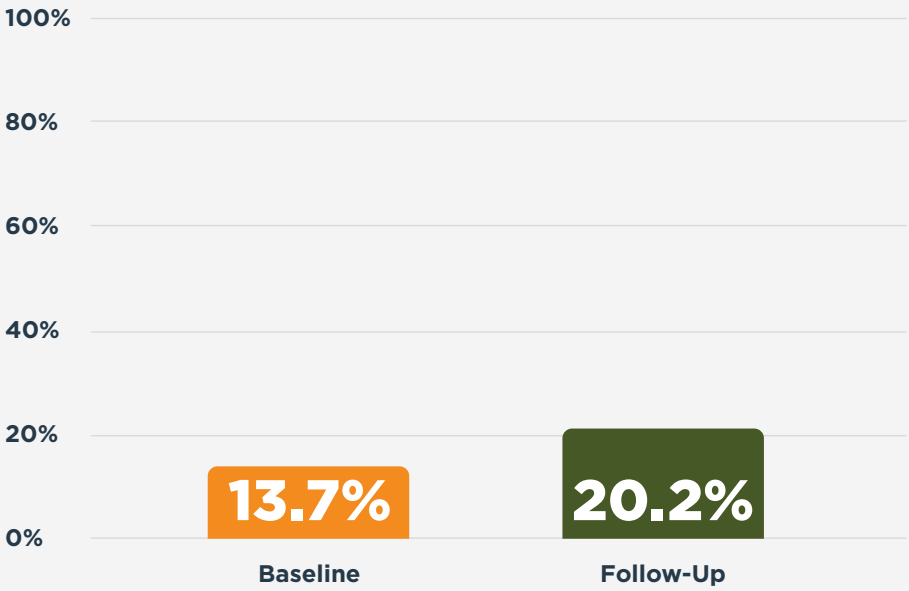
n.s. = No statistically significant difference measured ($p>0.05$)

Across the overall FAM3 initiative, participants reported statistically significant increases in nutrition security scores (Table 6). Participants in programs with defined food distribution, in-clinic food provision, and active benefit enrollment support also saw significantly increased nutrition security, but this increase did not differ significantly from programs without these characteristics. Participants saw improvement in nutrition security, whether they engaged with the program more frequently or not. These findings show that FAM3 program participation was associated with positive improvements in participants' nutrition security.

> "My husband, who is a Navy Veteran, and I look forward to receiving the nutritious food from the food pantry every month. The staff is so courteous and professional.
>
> **62-YEAR-OLD WOMAN FROM INDIANA**

FOOD SECURITY

FAM3 participation was associated with improved food security rates overall.



Food security improved by

7 percentage points

from baseline to follow-up.

Food security was measured using the validated 2-item food security screener that is based on the Household Food Security Module and is commonly referred to as the Hunger Vital Sign™. Participants either screen positive or negative for food insecurity, and those who screen negative are considered food secure.[2]

> "The food pantry has really helped me. I receive disability and food stamps but I never have enough to help me throughout the month.
>
> **52-YEAR-OLD WOMAN FROM NEVADA**

TABLE 7. Food security (FS) changes from baseline to follow-up for the FAM3 initiative overall and by program engagement and characteristic group

	Food Security Odds Ratio Unit [95% CI]*	
Overall FAM3 Program FS at follow-up vs. at baseline	↑ 2.39 [1.05, 5.41]	
	Food Security Odds Ratio Unit [95% CI]*	**Change between groups** over time (yes vs. no)**
Program engagement		
Multiple food pickups (2+ times)	1.33 [0.68, 2.61] (n.s.)	★
Program characteristic		
Structured nutrition education	↑ 5.92 [1.03, 33.93]	n.s.
Defined food distribution	↑ 3.27 [0.76, 14.01] (n.s.)	n.s.
In-clinic food provision	↑ 3.05 [1.14, 8.15]	n.s.
Active benefit enrollment support	3.06 [0.88, 10.63] (n.s.)	n.s.
Diet-related condition enrollment criteria	2.01 [0.75, 5.42] (n.s.)	n.s.

* Odds Ratio [95% Confidence Interval]

** The group variables are program engagement and program characteristics

↑↓ = Statistically significant ($p<0.05$) increase or decrease in a beneficial direction over time

★ = Statistically significant ($p<0.05$) difference over time compared to the programs that do not offer this characteristic

n.s. = No statistically significant difference measured ($p>0.05$)

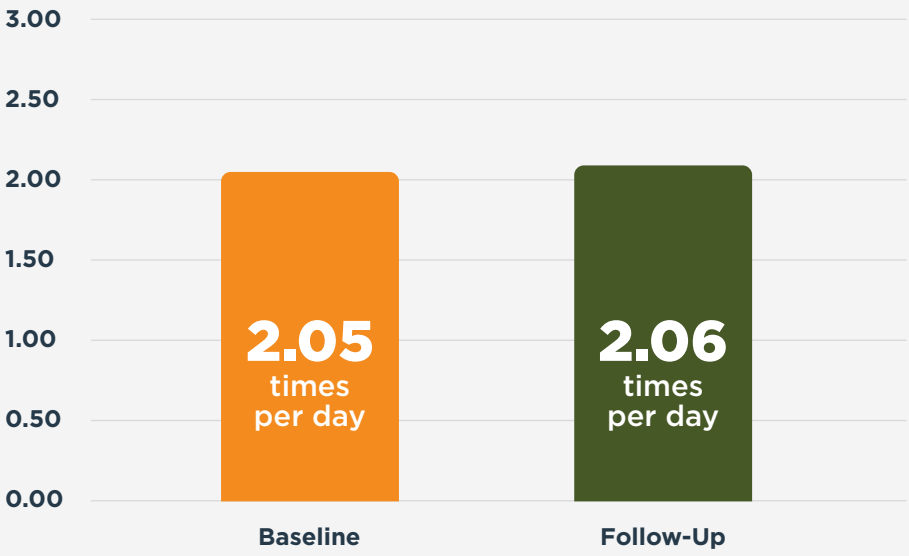
Across the FAM3 initiative, participants reported significant increases in food security (Table 7). Food security increased significantly among participants in programs with structured nutrition education, defined food distribution, and in-clinic food provision. However, the difference in change between participants in programs with and without each of these characteristics was not significant. Interestingly, differences in food security over time were not significant for those who engaged more with the program. This may be because high engagement participants had a higher need for food and support at baseline.

> “
>
> It was very helpful. It took a lot of stress off me. I have anxiety. It helped me out a lot because sometimes I have anxiety about where the next meal is going to come from for my kids. It took some pressure off me.
>
> **38-YEAR-OLD MAN FROM KENTUCKY**

FRUIT AND VEGETABLE INTAKE

Fruit and vegetable intake stayed consistent overall, but FAM3 participants who were in programs with a diet-related condition as an enrollment criterion saw increased intake of fruits and vegetables.

DAILY FRUIT & VEGETABLE INTAKE: CHANGES FROM BASELINE TO FOLLOW-UP



Fruit and vegetable intake remained stable from baseline to follow-up.

Daily fruit & vegetable intake was measured using items from the Feeding America Client Survey (FACS), which are a modified version of the National Cancer Institute's Dietary Screener Questionnaire items.[8]

> "I've been paying attention to eating more vegetables. I was not good with that before, but I am steaming them in the microwave now.
>
> **64-YEAR-OLD MAN FROM NEW YORK**

TABLE 8. Daily Fruit and Vegetable intake changes from baseline to follow-up for the FAM3 initiative overall, and by program characteristic group

	Fruit and Vegetable Intake Unit Change [95% CI]*	
Overall FAM3 Program	0.01 [-0.08, 0.10] (n.s.)	
	Fruit and Vegetable Intake Unit Change [95% CI]*	**Change between groups** over time (yes vs. no)**
Program engagement		
Multiple food pickups (2+ times)	0.12 [-0.01, 0.26] (n.s.)	★
Program characteristic		
Structured nutrition education	0.10 [-0.22, 0.43] (n.s.)	n.s.
Defined food distribution	0.09 [-0.07, 0.25] (n.s.)	n.s.
In-clinic food provision	0.00 [-0.10, 0.10] (n.s.)	n.s.
Active benefit enrollment support	0.06 [-0.08, 0.21] (n.s.)	n.s.
Diet-related condition enrollment criteria	↑ 0.27 [0.04, 0.51]	★

* Unit change in frequency of daily fruit and vegetable intake (times per day) [95% Confidence Interval]

** The group variables are program engagement and program characteristics

↑↓ = Statistically significant ($p<0.05$) increase or decrease in a beneficial direction over time

★ = Statistically significant ($p<0.05$) difference over time compared to the programs that do not offer this characteristic

n.s. = No statistically significant difference measured ($p>0.05$)

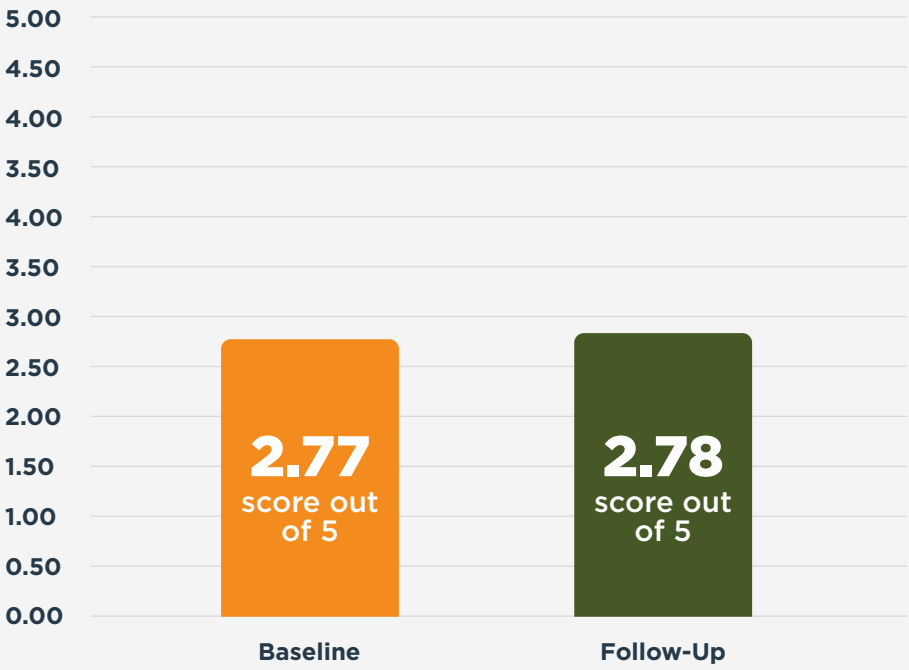
Overall, fruit and vegetable intake remained similar from baseline to follow-up (Table 8). There were significant differences in fruit and vegetable intake over time between program engagement groups (multiple food pick-ups versus 0-1 food pick-ups). However, the changes within each program engagement group were not statistically significant. Notably, among participants in a program that had a diet-related condition enrollment criterion, there was a significant improvement in fruit and vegetable intake over time. Otherwise, participants' changes in fruit and vegetable intake were similar across program design characteristics.

> "The fruits and vegetables I receive from Food as Medicine are generally the only fruits and vegetables I eat because right now I cannot afford it.
>
> **48-YEAR-OLD MAN FROM NEW YORK**

GENERAL HEALTH

General health stayed consistent overall, but FAM3 participants who engaged more with the programs and/or who were in programs with structured nutrition education saw increases in self-reported general health.

GENERAL HEALTH SCORES: CHANGES FROM BASELINE TO FOLLOW-UP



General health remained stable from baseline to follow-up.

General health was measured using a single self-report question that is commonly included in the Centers for Disease Control and Prevention's (CDC) Behavioral Risk Factor Surveillance System (BRFSS).[14]

> I need to get the food that is the right food for my medical conditions.
>
> **77-YEAR-OLD MAN FROM MISSOURI**

TABLE 9. General Health (GH) changes from baseline to follow-up for the FAM3 initiative overall, by program engagement and program characteristic group

	General Health Unit Change [95% CI]*	
Overall FAM3 Program	0.01 [-0.08, 0.09] (n.s.)	
	General Health Unit Change [95% CI]*	**Change between groups** over time (yes vs. no)**
Program engagement		
Multiple food pickups (2+ times)	↑ 0.08 [0.01, 0.16]	★
Program characteristic		
Structured nutrition education	↑ 0.16 [0.08, 0.24]	★
Defined food distribution	0.06 [-0.06, 0.18] (n.s.)	n.s.
In-clinic food provision	-0.02 [-0.12, 0.08] (n.s.)	n.s.
Active benefit enrollment support	↑ 0.07 [0.00, 0.13]	n.s.
Diet-related condition enrollment criteria	0.12 [-0.02, 0.26] (n.s.)	n.s.

* Unit change in general health rating [95% Confidence Interval]

** The group variables are program engagement and program characteristics

↑↓ = Statistically significant ($p<0.05$) increase or decrease in a beneficial direction over time

★ = Statistically significant ($p<0.05$) difference over time compared to the programs that do not offer this characteristic

n.s. = No statistically significant difference measured ($p>0.05$)

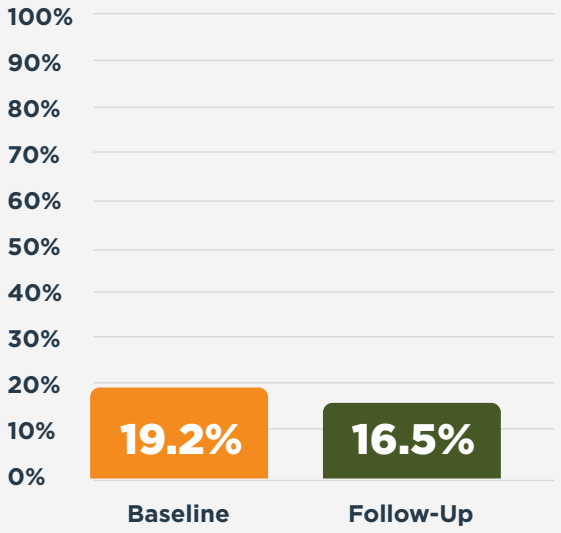
Self-reported general health remained similar from baseline to follow-up (Table 9). However, there were significant improvements in self-reported general health for participants who engaged more with their program and/or for participants in a program with structured nutrition education. While participants in programs with active benefits support experienced improvements, they were not significantly different compared to programs without this characteristic.

> “
>
> This program is excellent to help people like me with their health goals.
>
> **60-YEAR-OLD WOMAN FROM TEXAS**

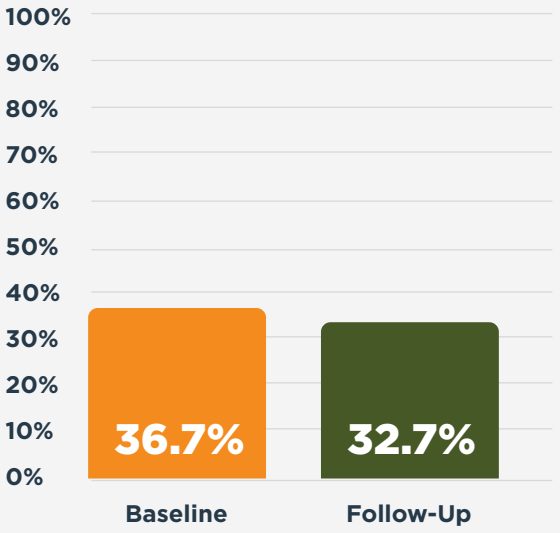
HEALTH CARE USE

Overnight hospitalizations and emergency department visits declined significantly. In-clinic food provision showed the largest reduction in hospitalizations, while structured nutrition education, benefits enrollment support, and diet-related condition enrollment criteria were associated with fewer cost-related barriers (e.g., delayed care, being short on medication).

Percentage Reporting Overnight Hospital Stays: Changes from baseline to follow-up



Percentage Reporting Emergency Department Visits: Changes from baseline to follow-up



Overnight hospitalizations decreased by

3 percentage points

from baseline to follow-up.

Emergency department visits decreased by

4 percentage points

from baseline to follow-up.

To measure changes in **overnight hospital visits** and **emergency department visits**, participants responded to questions in the baseline and follow-up survey about frequency of visits.

TABLE 10. Changes in Reported Overnight Hospitalizations and Emergency Department Visits for the FAM3 initiative overall, by program engagement and program characteristic group over time

	Overnight Hospitalizations Unit change [95% CI]*		Emergency Department Visits Unit change [95% CI]*	
Overall FAM3 Program	↓ -0.05 [-0.09, -0.01]		↓ -0.04 [-0.06, -0.01]	
	Overnight Hospitalizations Unit Change [95% CI]*	**Change between groups** over time (yes vs. no)**	**Emergency Dept. Visits Unit Change [95% CI]***	**Change between groups** over time (yes vs. no)**
Program engagement				
Multiple food pickups (2+ times)	-0.02 [-0.08, 0.04] (n.s.)	n.s.	-0.02 [-0.06, 0.03] (n.s.)	n.s.
Program characteristic				
Structured nutrition education	-0.12 [-0.24, 0.00] (n.s.)	n.s.	-0.06 [-0.13, 0.02] (n.s.)	n.s.
Defined food distribution	-0.07 [-0.14, 0.00] (n.s.)	n.s.	-0.04 [-0.08, 0.00] (n.s.)	n.s.
In-clinic food provision	↓ -0.06 [-0.11, -0.02]	★	↓ -0.04 [-0.07, -0.01]	n.s.
Active benefit enrollment support	↓ -0.07 [-0.14, -0.01]	n.s.	-0.03 [-0.06, 0.00] (n.s.)	n.s.
Diet-related condition enrollment criteria	-0.15 [-0.32, 0.02] (n.s.)	n.s.	-0.08 [-0.18, 0.02] (n.s.)	n.s.

* Unit change in overnight hospitalizations and emergency department use [95% Confidence Interval]

** The group variables are program engagement and program characteristics

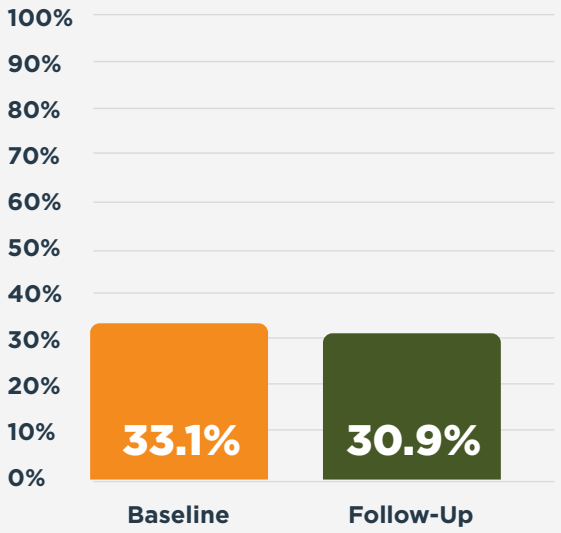
↑↓ = Statistically significant ($p<0.05$) increase or decrease in a beneficial direction over time

★ = Statistically significant ($p<0.05$) difference over time compared to the programs that do not offer this characteristic

n.s. = No statistically significant difference measured ($p>0.05$)

Overall, there was a significant decrease in overnight hospitalizations and emergency department visits (Table 10). Participants in programs that offered in-clinic food provision experienced greater decreases in overnight hospitalizations compared to programs that did not offer in-clinic food provision. In-clinic food provision programs also saw a decrease in emergency department visits, but this was not different compared to programs without this characteristic. Similarly, participants in programs with active benefit enrollment support had decreases in overnight hospitalizations, but this was not significantly different than programs without active benefit enrollment support.

Percentage often or sometimes delaying Medical care: changes from baseline to follow-up

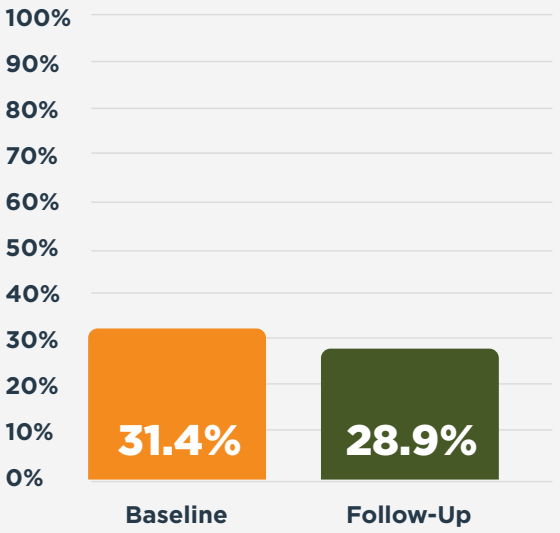


The frequency of missing or delaying care decreased by

2 percentage points

from baseline to follow-up.

Percentage often or sometimes being short on medication: changes from baseline to follow-up



The frequency of being short on medications decreased by

2 percentage points

from baseline to follow-up.

To measure changes in **delayed medical care**, participants answered a question in the baseline and follow-up survey about how often they missed or delayed medical care due to cost. To measure changes **being short on medication**, participants answered a question about how often they were short on medication due to cost.

> I'm thankful for it, because, I look at it differently now...it's not that you can't eat, it's just the way you have to eat it. And as far as my medicine, is how I take the medicine, uh, you know, I was just told to take the medicine...but she [the nutritionist] broke it down, the best way to do it, the best way to eat, and she broke it down so I better understand it to keep everything under control.

47-YEAR-OLD WOMAN FROM GEORGIA

TABLE 11. Changes in reported Missing or Delaying Medical Care and Being Short on Medication for the FAM3 initiative overall, by program engagement, and program characteristic group over time

	Missing or Delaying Medical Care Unit change [95% CI]*		Being Short on Medication Unit change [95% CI]*	
Overall FAM3 Program	-0.04 [-0.11, 0.03] (n.s.)		-0.03 [-0.10, 0.04] (n.s.)	
	Missing or Delaying Medical Care Unit Change [95% CI]*	**Change between groups** over time (yes vs. no)**	**Being Short on Medication Unit Change [95% CI]***	**Change between groups** over time (yes vs. no)**
Program engagement				
Multiple food pickups (2+ times)	-0.03 [-0.12, 0.07] (n.s.)	n.s.	0.02 [-0.07, 0.11] (n.s.)	★
Program characteristic				
Structured nutrition education	↓ -0.15 [-0.23, -0.07]	★	↓ -0.12 [-0.17, -0.07]	★
Defined food distribution	-0.07 [-0.15, 0.02] (n.s.)	n.s.	-0.05 [-0.16, 0.07] (n.s.)	n.s.
In-clinic food provision	-0.06 [-0.14, 0.03] (n.s.)	n.s.	-0.06 [-0.13, 0.02] (n.s.)	n.s.
Active benefit enrollment support	↓ -0.11 [-0.19, -0.02]	★	↓ -0.08 [-0.15, -0.001]	n.s.
Diet-related condition enrollment criteria	-0.12 [-0.24, 0.00] (n.s.)	n.s.	↓ 0.13 [-0.21, -0.05]	★

* = Unit change in how often a participant misses or delays care or how often a participant is short on their medication [95% Confidence Interval]

** The group variables are program engagement and program characteristics

↑↓ = Statistically significant ($p<0.05$) increase or decrease in a beneficial direction over time

★ = Statistically significant ($p<0.05$) difference over time compared to the programs that do not offer this characteristic

n.s. = No statistically significant difference measured ($p>0.05$)

When asked about affordability of care, across all FAM3 programs, there were no statistically significant changes in participants being short on medications or delaying or missing medical care due to affordability (Table 11). However, participants in programs with structured nutrition education, active benefits support, and/or diet-related condition enrollment criteria had significant decreases in both being short on medications and delaying care. Enrollment in programs with active benefit support was associated with a lower frequency of reporting the need for delaying care or being short on medication due to costs.

> “
>
> Since I let my guard down and asked for help about my food situation, me doing that, it like opened up the door for me to see a psychiatrist weekly and get prescribed what I need, and it helped me see the dentist and my own family physician. Overall, it’s been helping me out tremendously. I have someone to talk to who seems like they really care.
>
> **38-YEAR-OLD MAN FROM KENTUCKY**

CHANGES BY PROGRAM ENGAGEMENT

Higher participant engagement with any FAM3 program was associated with greater improvements in general health.

TABLE 12. Patterns of effects across FAM3 participant dietary and health outcomes by program engagement

	Low Engagement (0 – 1 food pick-ups)	High Engagement (multiple food pick-ups)
Nutrition Security	↑	↑
Food Security	↑	★
Fruit & Vegetable Intake	n.s.	★
General Health	n.s.	★↑
Overnight Hospitalizations	↓	n.s.
Emergency Department Visits	↓	n.s.
Missing or Delaying Care	n.s.	n.s.
Being Short on Medication	↓	★

How to read this table: Participants were compared based on the number of food pick-ups reported (multiple food pick-ups versus 0-1 food pick-ups). We evaluate whether one group experienced greater improvements over time than another (★ = statistically significant). We also describe the changes in outcomes for participants in each group over time (↑↓ = statistically significant).

↑↓ = Statistically significant ($p<0.05$) increase or decrease in a beneficial direction for participants within each program engagement category over time

★ = Statistically significant ($p<0.05$) difference over time by program engagement category

n.s. = No statistically significant difference measured ($p>0.05$)

Table 12 shows the effects of participants' level of engagement with their respective FAM3 programs on their dietary and health outcomes. This assessment was independent of program category, only comparing those who engaged more with their FAM3 program to those who engaged less, regardless of program characteristics or category. Participants in the low- and high-engagement groups both experienced positive improvements over time in multiple outcomes. The high engagement participants saw significantly greater improvements in general health than low engagement participants. These findings indicate that greater program engagement may contribute to improved general health.

CHANGES BY PROGRAM DESIGN CHARACTERISTICS

Structured nutrition education was consistently associated with greater improvements in many participant outcomes.

TABLE 13. Patterns of effects for the five program design characteristics tested across eight dietary and health outcomes among FAM3 participants

	Structured nutrition education	Defined food distribution	In-clinic food provision	Active benefit enrollment support	Diet-related condition enrollment criteria
Nutrition Security	↑	↑	↑	↑	n.s.
Food Security	↑	↑	↑	n.s.	n.s.
Fruit & Vegetable Intake	n.s.	n.s.	n.s.	n.s.	★↑
General Health	★↑	n.s.	n.s.	↑	n.s.
Overnight Hospitalizations	n.s.	n.s.	★↓	↓	n.s.
Emergency Department Visits	n.s.	n.s.	↓	n.s.	n.s.
Missing or Delaying Care	★↓	n.s.	n.s.	★↓	n.s.
Being Short on Medication	★↓	n.s.	n.s.	↓	★↓

How to read this table: Participants in programs with each program design characteristic were compared to participants in programs without each design characteristic. There were five program design characteristics: structured nutrition education, defined food distribution, in-clinic food provision, active benefit enrollment support, diet-related condition enrollment criteria. We evaluate whether one group experienced greater improvements over time than another (★ = statistically significant). We also describe the changes in outcomes for participants in each group over time (↑↓ = statistically significant).

↑↓ = Statistically significant ($p<0.05$) increase or decrease in a beneficial direction for participants in programs offering each characteristic over time

★ = Statistically significant ($p<0.05$) difference over time compared to the programs that did not offer this characteristic

n.s. = No statistically significant difference measured ($p>0.05$)

Analyses determined whether inclusion of each individual FAM3 program design characteristic impacted changes in self-reported survey outcomes from baseline to follow-up (Table 13). Notably, programs that included a structured nutrition education component were associated with participant improvements in multiple outcomes compared to programs that did not. Additionally, in-clinic food provision, active benefit enrollment support, and having a diet-related condition as part of enrollment criteria each were associated with one or more improvements compared to programs that did not offer these program components. Notably, both programs with and without a defined food distribution model performed similarly well on the outcomes assessed.

CHANGES BY PROGRAM DESIGN CATEGORIES

All program types were associated with improvements in participant health outcomes. Comprehensive programs were associated with improvements in general health and decreases in missing or delaying care.

TABLE 14. Patterns of effects across program category and eight dietary and health outcomes among FAM3 participants

	Foundational	Enhanced	Comprehensive
Nutrition Security	↑	↑	↑
Food Security	↑	n.s.	↑
Fruit & Vegetable Intake	↓	★	n.s.
General Health	n.s.	n.s.	★↑
Overnight Hospitalizations	↓	n.s.	↓
Emergency Department Visits	n.s.	↓	n.s.
Missing or Delaying Care	n.s.	n.s.	★↓
Being Short on Medication	n.s.	n.s.	↓

How to read this table: Participants were compared across program design categories (enhanced vs. foundational, comprehensive vs. foundational). We evaluate whether one group experienced greater improvements over time than another (★ = statistically significant). We also describe the changes in outcomes for participants in each program design category over time (↑↓ = statistically significant).

↑↓ = Statistically significant ($p<0.05$) increase or decrease in a beneficial direction for participants in each program design category over time

↑↓ = Statistically significant ($p<0.05$) increase or decrease in a detrimental and/or unexpected direction for participants in each program design category over time

★ = Statistically significant ($p<0.05$) difference over time. (enhanced vs. foundational, comprehensive vs. foundational)

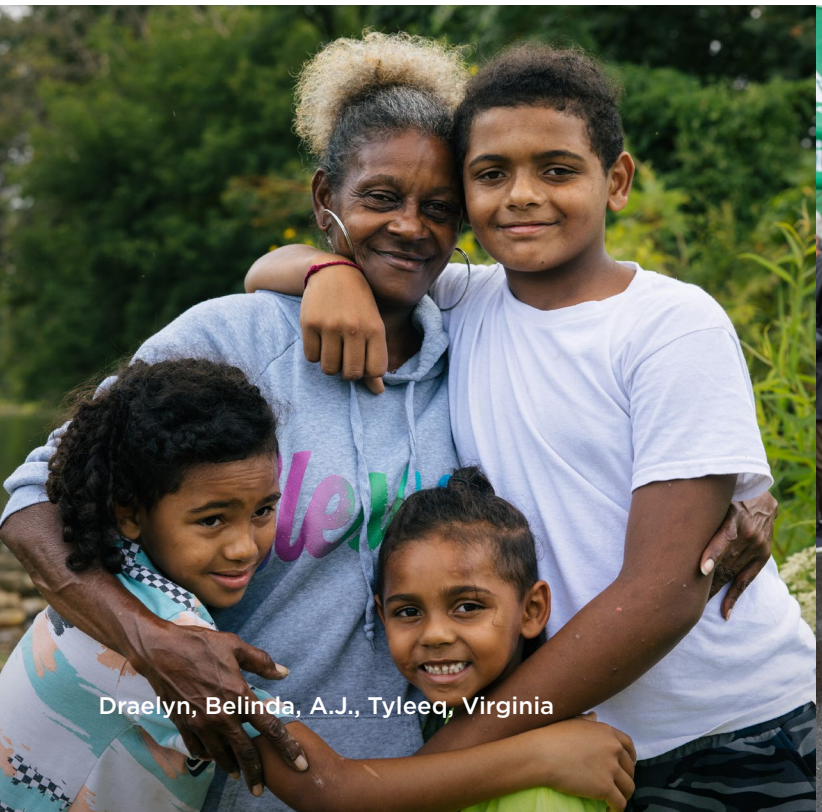
n.s. = No statistically significant difference measured ($p>0.05$)

We also examined differences by program type: foundational, enhanced, or comprehensive (Table 14). When assessing trends over time, participants in foundational programs saw increased food and nutrition security and decreased overnight hospitalizations. Interestingly, fruit and vegetable intake frequency decreased over time for those enrolled in foundational programs, on average. While it is not known exactly what drove this decrease, a variety of factors may have contributed to this finding, including: fresh produce price inflation over the survey period, fruit and vegetable availability, and/or the timing of survey distribution (e.g., taking the survey at the time of receiving a food bag/box vs. at a later date). Participants in enhanced programs reported increased nutrition security and decreased emergency department visits from baseline to follow-up. Lastly, participants in comprehensive programs experienced trends over time for increased nutrition and food security, increased general health, decreased overnight hospitalizations, and decreased reports of missing or delaying care and being short on medications.

When comparing program design categories to each other, there were three statistically significant findings. Participants in foundational programs experienced larger decreases in their fruit and vegetable intake frequency over time, compared to participants in enhanced programs. Participants in comprehensive programs experienced greater increases in their general health as well as decreases in missed or delayed care over time compared to participants in foundational programs. Overall, these findings indicate that all program types were associated with positive improvements for at least two of the assessed outcomes and that the comprehensive program may outperform the other program categories in improving general health and reducing missed or delayed care. Additional graphs showing trend lines for the group comparisons are shown in Appendix F.

SUMMARY

FAM3 participant interviews and surveys both confirmed that the program helped improve participants' overall health and wellness. These findings highlight how program engagement, program characteristics, and program categories are associated with diet and health improvements. Notably, across the whole initiative, improvements were seen for food and nutrition security and measures of health care utilization. Further, participants who engaged more with their individual programs saw better general health improvements. Structured nutrition education was associated with greater improvements in participants' health outcomes compared to programs that did not offer this program component, and all program categories were associated with some positive improvements for participants. See Participant Feedback and Testimonials on page 37 for more information.



Draelyn, Belinda, A.J., Tyleeq, Virginia

Xi La, New York

PARTICIPANT FEEDBACK AND TESTIMONIALS

We interviewed 35 FAM3 participants across 16 food banks over the course of the FAM3 program. We interviewed participants at various touchpoints, from eligibility screening to program engagement to one month after starting the program. The following provides a summary of the information FAM3 participants shared. Refer to the FAM3 Year Two Report for a more in-depth overview of the findings.[15] Participant quotes from these interviews are included throughout this report.

Across conversations with participants, several overarching themes emerged:

1. **Participants face systemic barriers to meeting their financial, mental, physical, and emotional needs.** FAM3 participants described financial uncertainty (e.g., high living costs, low-wage jobs, and expensive groceries) and difficulty managing chronic conditions due to lack of health care, unreliable transportation, or inability to take time off work for medical appointments.

2. **Participants may feel uncomfortable sharing information with health care partners at first.** The FAM3 screening and referral steps can contribute to embarrassment for participants in vulnerable situations. Most participants reported positive experiences with FAM3 and encouraged programs to continue to focus on warm, friendly, and helpful interactions with FAM3 participants.

3. **Participants appreciate detailed and recurring communication.** FAM3 participants appreciated detailed information and orientations to the program, as well as follow-up calls, reminders, and check-ins through multiple modes of communication.

4. **Participants like program flexibility, food choice, and nutrition education.** FAM3 participants appreciated choice in food insecurity screening (e.g., verbal vs. written), program participation (e.g., in-person vs. virtual), and food provision (e.g., choice pantry models or different food options for bagged/boxed food).

5. **Participants were interested in medically tailored and health-promoting food options.** FAM3 participants enjoyed fresh fruits, vegetables, and meat, as well as food that aligned with their specific health conditions.

6. **Some participants experienced logistical challenges that could make program engagement difficult.** Transportation limitations, childcare responsibilities, and inconsistent pick-up scheduling made FAM3 program engagement difficult for some participants.

7. **Participants reported that participation in the FAM3 program helped to ease financial pressure and improve overall wellness.** FAM3 participants noted that the program helped them save money for other necessities and helped with feelings of stress about budgets or their next meal.

Carl, New York
Volunteer

Insurance Claims Sub-Study Results

OVERVIEW

To further understand how the FAM3 program may affect health, health care utilization, and costs, participants were asked to give permission to review their insurance claims. Carelon Research, Inc., who had access to these data, reviewed and analyzed the claims data for consenting participants who were members of Elevance Health's affiliated health plans. The analysis examined participants' health care utilization before and after participation in FAM3. Using a difference-in-difference analysis approach, the study also compared changes with a similar group who did not take part in FAM3.

METHODS

The following steps were used to assess changes in outcome variables over the course of the study.

- **Inclusion Criteria:** We included 213 FAM3 participants who completed surveys, gave consent to share claims data, were Elevance Health members, could be matched in the Elevance Health data, met other study criteria, and had sufficient data before and after participation (127 additional participants had data for baseline descriptive analyses only).
- **Comparison Group:** We included 6,015 patients who were similar to FAM3 participants in sociodemographic characteristics and health status for the comparison group.
- **Analyses:** The analyses described characteristics of the patients reached by the FAM3 program, examined changes over time for FAM3 participants, compared results by program category, and compared changes between FAM3 participants and the comparison group.

PARTICIPANT HEALTH AND HEALTH CARE UTILIZATION CHARACTERISTICS

FAM3 programs connected with patients who face the greatest barriers to care. Foundational programs reached younger patients with fewer diet-related conditions, while comprehensive programs reached older patients with more comorbidities.

FAM3 programs reached a variety of patients, mostly women, across age and racial/ethnic groups (Table 15). FAM3 patients predominantly lived in urban and suburban counties, with fewer than 2% in rural counties. Of those who participated in FAM3 programs, many faced at least one diet-related chronic condition. Interestingly, the three categories of FAM3 programs (e.g., foundational, enhanced, and comprehensive) reached participants with varying sociodemographic and health characteristics. Foundational programs reached, on average, relatively younger and healthier patients (who still had similarly high rates of obesity), whereas comprehensive programs reached older and less healthy participants (e.g., those with higher rates of diet-related conditions). These results showed that FAM3 food bank-healthcare partnerships who designed more tailored/supportive interventions enrolled participants with a high prevalence of health challenges and limited economic resources.

TABLE 15. Baseline Characteristics of FAM3 Participants identified in Elevance Health Insurance Claims Data

	Whole sample (n=340) n (%)/mean (SD)	**Foundational (n=77)** n (%)/mean (SD)	**Enhanced (n=172)** n (%)/mean (SD)	**Comprehensive (n=91)** n (%)/mean (SD)
DEMOGRAPHICS				
Medicaid (n (%))	199 (59%)	68 (88%)	83 (48%)	48 (53%)
Age, mean (SD)	47.0 (14.4)	40.0 (12.8)	47.0 (13.9)	52.9 (14.0)
Age Category (n (%))				
18–24 years	21 (6%)	9 (12%)	7 (4%)	5 (5%)
25–34 years	60 (18%)	21 (27%)	34 (20%)	5 (5%)
35–44 years	72 (21%)	23 (30%)	35 (20%)	14 (15%)
45–54 years	66 (19%)	12 (16%)	37 (22%)	17 (19%)
55–64 years	83 (24%)	9 (12%)	43 (25%)	31 (34%)
65+ years	38 (11%)	<5	16 (9%)	19 (21%)

Table 15. Baseline Characteristics of FAM3 Participants identified in Elevance Health Insurance Claims Data (cont'd)

Women (n (%))	239 (70%)	63 (82%)	113 (66%)	63 (69%)
RACE/ETHNICITY (N (%))				
White, Non-Hispanic	144 (42%)	38 (49%)	71 (41%)	35 (38%)
Black, Non-Hispanic	118 (35%)	20 (26%)	54 (31%)	44 (48%)
Hispanic or Latino	55 (16%)	10 (13%)	34 (20%)	11 (12%)
Other Race, Non-Hispanic	15 (4%)	6 (8%)	9 (5%)	0
AIAN, Non-Hispanic*	<5	0	<5	<5
Asian, Non-Hispanic	<5	<5	<5	0
Unknown or Undisclosed	<5	<5	<5	0
AREA LEVEL CHARACTERISTICS				
SES INDEX CATEGORY (N (%))[A]				
Category 1 (Lowest)	138 (41%)	21 (27%)	67 (39%)	50 (55%)
Category 2	103 (30%)	24 (31%)	59 (34%)	20 (22%)
Category 3	61 (18%)	22 (29%)	24 (14%)	15 (16%)
Category 4 (Highest)	25 (7%)	7 (9%)	13 (8%)	5 (5%)
Missing	13 (4%)	<5	9 (5%)	<5
EDUCATION LEVEL (N (%))				
4-year degree average	77 (23%)	21 (27%)	37 (22%)	19 (21%)
Less than high school	41 (12%)	8 (11%)	22 (13%)	11 (12%)
URBANICITY (N (%))				
Rural	8 (2%)	<5	<5	<5
Suburban	111 (33%)	<5	58 (34%)	52 (57%)
Urban	210 (62%)	73 (95%)	103 (60%)	34 (37%)
Missing	11 (3%)	<5	7 (4%)	<5

Table 15. Baseline Characteristics of FAM3 Participants identified in Elevance Health Insurance Claims Data (cont'd)

HEALTH PROFESSIONAL SHORTAGE AREA (N (%))				
Primary Care	53 (16%)	<5	26 (15%)	24 (26%)
Mental Health	35 (10%)	<5	11 (6%)	20 (22%)
CLINICAL CHARACTERISTICS				
ELIXHAUSER COMORBIDITY INDEX (N (%))[B]				
0-1	120 (35%)	34 (44%)	67 (39%)	19 (20%)
2-3+	220 (65%)	43 (56%)	105 (61%)	72 (79%)
Whole Health Index Score, mean (SD)[C]	40.0 (13.1)	43.9 (11.6)	41.1 (13.7)	34.9 (11.5)
DIET-RELATED CONDITIONS (N (%))				
Obesity	142 (42%)	33 (43%)	65 (38%)	44 (48%)
Hypertension	192 (56%)	31 (40%)	94 (55%)	67 (74%)
Diabetes	116 (34%)	16 (21%)	47 (27%)	53 (58%)
Hyperlipidemia	136 (40%)	24 (31%)	66 (38%)	46 (51%)
DIET-RELATED MEDICATIONS (N (%))				
Statins	97 (29%)	12 (16%)	38 (22%)	47 (52%)
Antidiabetics	85 (25%)	12 (16%)	29 (17%)	44 (48%)

[A] SES Index Category - uses area-level American Community Survey data including income, poverty, education, and housing to estimate the average socioeconomic status of residents

[B] Elixhauser Comorbidity Index - measures physical health using a comprehensive set of 30 comorbidities defined using ICD-9-CM codes

[C] Whole Health Index Score - measures health/health risk using more than 90 data points that fall into the broad categories of physical, behavioral, and social health. These data points range from food insecurity, transportation accessibility, and housing instability to preventive dental exams, immunizations, and treatment for mental health conditions.

* Individuals who identify as American Indian or Alaska Native (AIAN) and are not of Hispanic or Latino ethnicity.

HEALTH CARE UTILIZATION CHANGES

While the FAM3 group showed beneficial trends, there were no significant changes in claims-based outcomes relative to a similar comparison group.

Appendices G and H show the basic pre-to-post program differences and the full models comparing FAM3, and each FAM3 program type, to the comparison group. Overall, findings were not statistically significant: the observed changes from baseline to follow-up among FAM3 participants were not statistically different than changes among the comparison group. However, though not statistically significant, unadjusted changes (Appendix G) were in a beneficial direction, such as lower diet-related medical costs, fewer inpatient visits and ER visits, and better clinical outcomes (i.e., HbA1c, cholesterol, blood pressure, and BMI measurements). Typically, when someone engages with health care, health-related variables improve, and they did improve for both FAM3 participants and the comparison group.

SUMMARY

Overall, these analyses provided a thorough, objective description of the health status and health care utilization of a subset of patients reached by FAM3, with several possible favorable trends in emergency room visits, costs, medications, and lab values after participating in FAM3. However, these are not statistically significant when compared to the comparison group. Also, study limitations, such as the relatively small sample sizes and FAM3 program heterogeneity may have decreased the likelihood of identifying statistically significant differences. These findings reinforce the modest but positive outcomes associated with program participation that were identified by the FAM3 Neighbor Survey.

This insurance claims sub-study shows strong "proof of concept" that partnerships between food banks and health insurance organizations like Elevance Health may be leveraged to evaluate the impact of FAM interventions on health care cost and utilization. This sub-study set a strong foundation for work in this area moving forward. Future evaluations should identify health care utilization and cost variables that are more likely to be impacted by future FAM interventions and consider strategies for increasing sample sizes (e.g., including claims-data-only study-enrollment processes).


Trish, Jake, Wyoming


Catherine, New York
Nutrition Coordinator

Clinical Data Analysis Sub-Study Results

HbA1c, LDL cholesterol and BMI improved, and participants with more dietitian visits saw greater benefits.

OVERVIEW

To understand if FAM3 program participation was associated with clinical changes, FAM3 health care partners with data sharing capability were given the option to share de-identified participant-level or aggregated electronic health record (EHR) datasets. Four FAM3 food banks (one of whom had two separate health care partner sites with data sharing capability) elected to share EHR data and signed Data Use Agreements (DUAs) with CNHI. Only data from consenting participants was shared with CNHI. EHR data was uploaded to and stored in a HIPAA-compliant portal to protect participants' confidentiality.

METHODS

The following analyses were conducted to assess changes in outcome variables over the course of the study.

- **Overall Changes:** We summarized outcome data for the baseline period (six months before enrollment until the enrollment date) and the follow-up program period (six months after enrollment). Outcome variables included HbA1c, blood pressure (SBP and DBP), LDL cholesterol, BMI, and the number of health care visits/appointments.
- **Program Engagement:** We assessed changes in outcomes from baseline to follow-up, and when data were available, we considered the effect of higher or lower program engagement. Program engagement was defined by number of FAM3-related dietitian visits (three or more vs. fewer than three, given the recommended minimum of 3 RDN encounters for patients with diet-related conditions).[16]

Table 16 shows the variety of data that FAM3 grantees shared with CNHI. Grantees varied in their ability to share participant-level or aggregate data, or full baseline to follow-up data vs. only baseline data. Only the grantee-health care partner teams of Grantees A (Comprehensive program type) and B (Enhanced program type) were able to share participant-level baseline and follow-up data for clinical biomarker outcomes (e.g., HbA1c, cholesterol, BMI, etc.). There was wide variation in the ages, races, ethnicities and health conditions of patients at baseline. Refer to Appendix I for a full summary of demographic and clinical data for patients at program enrollment.

TABLE 16. Electronic Health Record Data Shared by FAM3 Program Health Care Partners

	Grantee A	Grantee B	Grantee C	Grantee D1	Grantee D2
Program Type	Comprehensive	Enhanced	Enhanced	Comprehensive	Enhanced
Data Format	Participant-Level	Participant-Level	Participant-Level	Aggregated Data	Participant-Level
Data Time Frame	6 months before to 6 months after FAM3 enrollment	6 months before to 6 months after FAM3 enrollment	Baseline data only (at FAM3 enrollment)	Data summary provided from inception of FAM program at health care site, from 5/28/2019 – 9/30/2025.	Baseline data only (at FAM3 enrollment)
Demographic & Health History Data	Age, Race, Ethnicity	Age, Gender, Race	Age, Race, Ethnicity, Insurance, Diagnoses	None	Diagnoses
Program Participation Data	# dietitian interactions; nutrition education class attendance; SNAP assistance	None linked to EHR data	# food distributions; # clinical food pharmacy distributions	None linked to EHR data	None linked to EHR data
Biometric / Lab Data	HbA1c, LDL, SBP, DBP, BMI	HbA1c, LDL, HDL, Triglycerides, SBP, DBP, BMI	No	HbA1c, LDL, SBP, DBP; % of sample meeting biometric targets*	No
Health Care Use Data	No	Outpatient encounters; Hospital admissions	No	No	No

Abbreviations:

- LDL: Low density lipoprotein cholesterol
- HDL: High density lipoprotein cholesterol
- HbA1c: Hemoglobin A1c
- BMI: Body Mass Index
- SBP: systolic blood pressure
- DBP: diastolic blood pressure

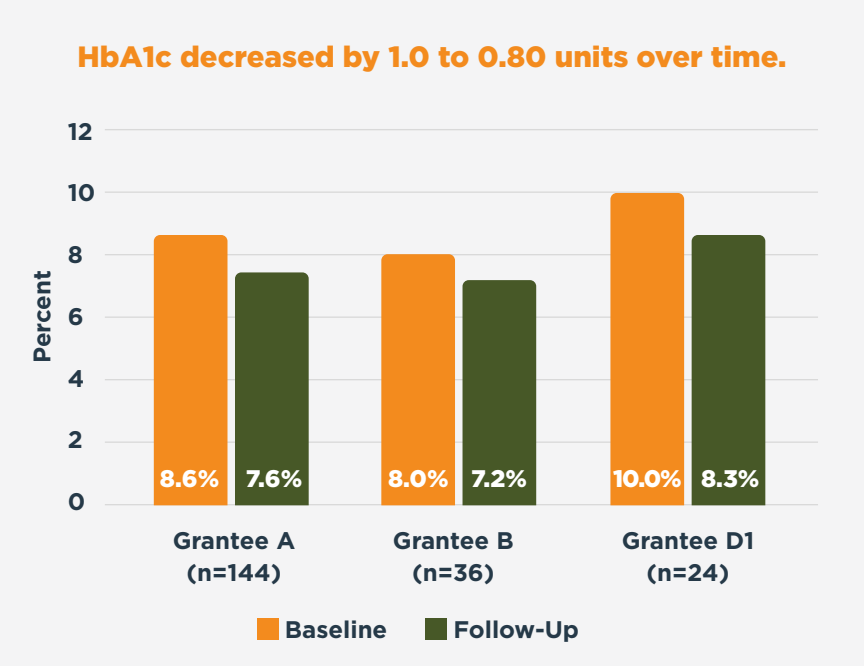
* Biometric targets: HbA1c<7%, LDL<100 mg/dL; BP<130/80 mmHg

CHANGES IN CLINICAL VALUES

There were significant improvements for HbA1c, BMI and LDL cholesterol for programs with sufficient data to assess statistical significance.

TABLE 17. Changes from baseline to follow-up among FAM3 programs with complete clinical data suitable for analysis

Research Question	Interpretation
Did HbA1c improve after the program?	Yes, **HbA1c values decreased over time by 1.0 at Grantee A and by 0.8 units at Grantee B**. Aggregate data were submitted by Grantee D1 – data were not analyzed for statistical significance.
Did BMI improve after the program?	Yes, **BMI values decreased by 0.7 units over time at Grantee A**.



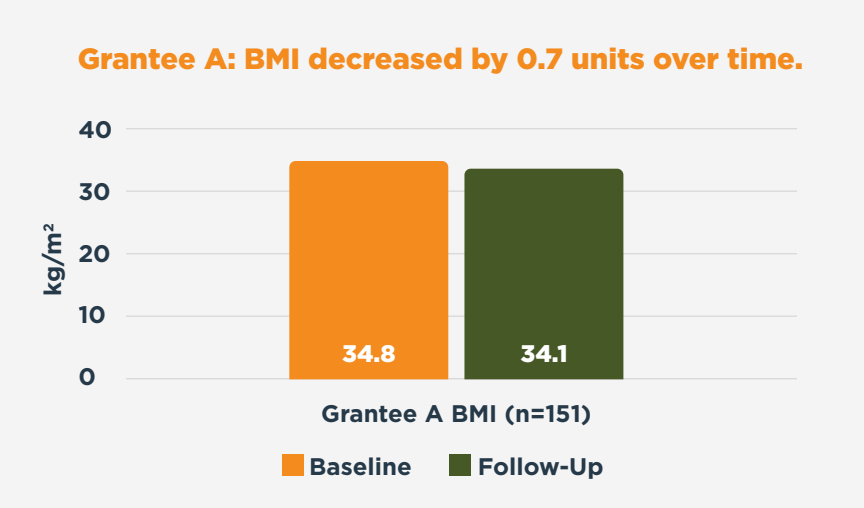
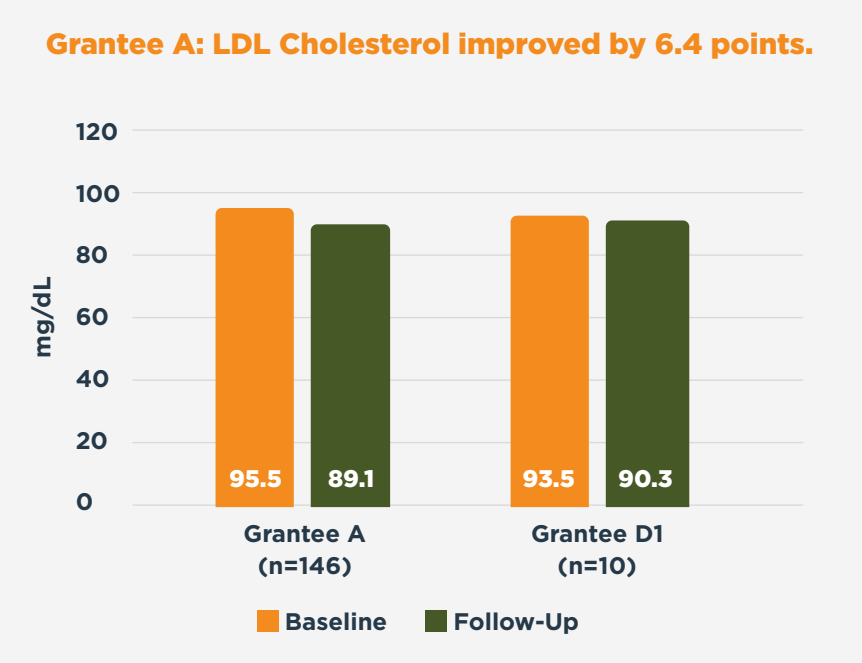


Table 17. Changes from baseline to follow-up among FAM3 programs with complete clinical data suitable for analysis (cont'd)

Research Question	Interpretation
Did LDL Cholesterol improve after the program?	Yes, LDL Cholesterol **decreased by an average of 6.4 points** for patients at Grantee A. Aggregate data were submitted by Grantee D1 – data were not analyzed for statistical significance
Did health care use change after the program for participants overall?	Yes, the number of completed preventive visits (office visits and doctor appointments) **increased by 1.5 visits** after the intervention for all participants at Grantee B.



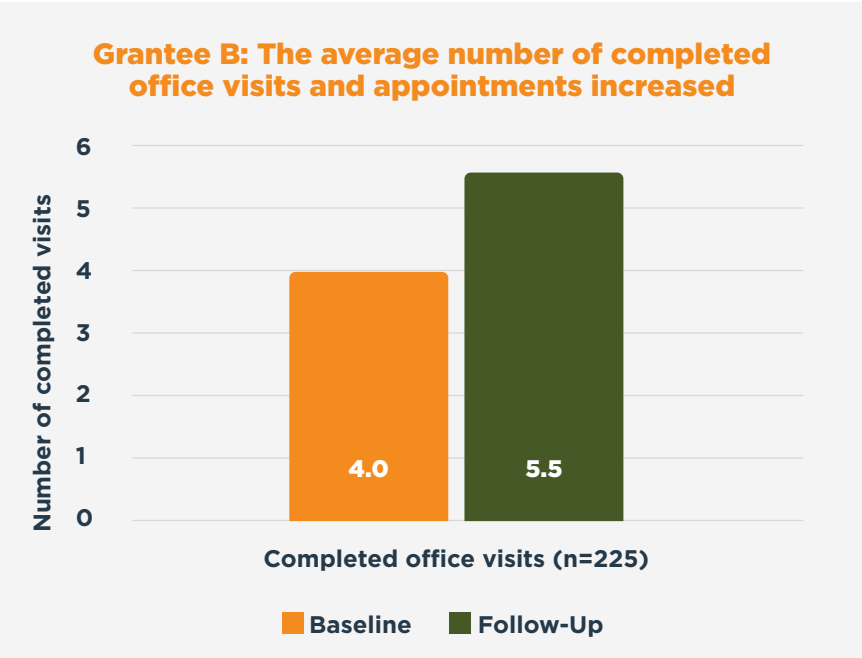
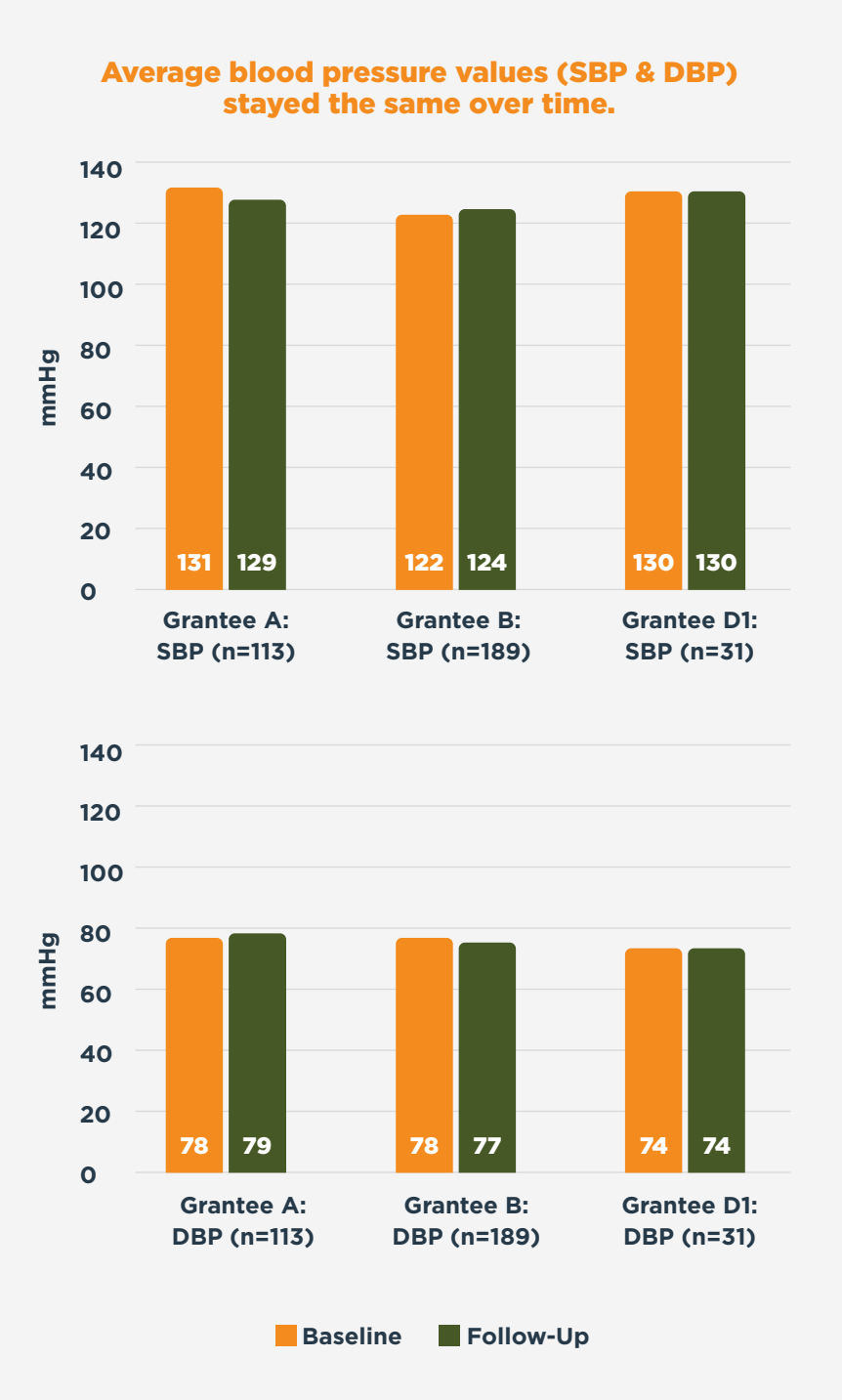


Table 17. Changes from baseline to follow-up among FAM3 programs with complete clinical data suitable for analysis (cont'd)

Research Question	Interpretation
Did blood pressure improve after the program?	Within each project site, **no statistically significant changes in either diastolic or systolic blood pressure were observed** (p>0.05).



CHANGES IN CLINICAL VALUES BY PROGRAM ENGAGEMENT

There were significant improvements in the number of preventative health visits completed by participants for programs with sufficient data to assess statistical significance.

There were significant improvements in clinical outcomes among patients who attended at least three dietitian visits. Most patients (79%) attended 3+ dietitian visits, while fewer patients (21%) attended 0 – 2 dietitian visits.

Patients who attend at least three dietitian visits during the program had statistically significantly improved HbA1c values (a decrease of 1.1%), LDL Cholesterol values (a decrease of 5.5 units), and BMI values (a decrease of 0.80 units) over time. Significant changes in HbA1c, LDL cholesterol, and BMI were not observed for those attending two or fewer dietitian visits over time.

SUMMARY

Overall, the findings from the EHR data analysis indicated that, at least among the few programs that could provide complete baseline to follow-up patient-level data, FAM3 programs were associated with beneficial improvements in HbA1c, LDL cholesterol, and BMI. Effects were observed among patients who attended three or more FAM3-related dietitian sessions. Grantees faced numerous challenges in acquiring these valuable data (e.g., challenges implementing data use agreements and/or no or limited available funding for clinical data sharing activities), a sentiment that was echoed in our interviews with food bank and health care partner staff, summarized on page 52. Further clinical data analysis insights can be found in certain programs' case studies, starting on page 58. However, these findings demonstrate the potential to leverage clinical data to illustrate associations between FAM3 participation and improvements in participant health and well-being.

Monte, Illinois

Amy, Washington, D.C.

Implementation Study Results

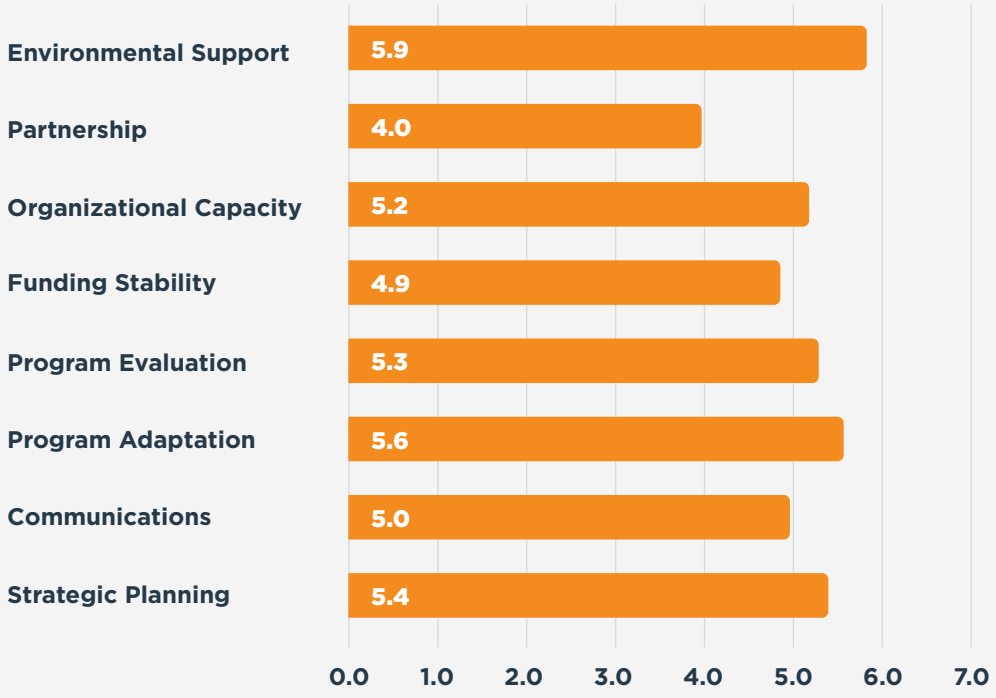
To evaluate implementation progress and FAM3 program sustainability, a mid-point survey was administered in August 2024 to participating food bank leads and health care partner sites. The survey included brief, adapted versions of two validated sustainability measurement tools: the Program Sustainability Assessment Tool (PSAT)[17] for food bank respondents and the Clinical Sustainability Assessment Tool (CSAT)[18] for health care partner respondents. Both tools assess factors linked to sustaining evidence-based programs, such as integration of programs into existing operations, availability of staff and resources, and capacity to plan for sustainability. Survey questions were adapted to better reflect the FAM3 program context and to improve clarity and relevance for survey respondents (Appendix J & K). Project implementation notes, which were structured notes taken during project meetings throughout the FAM3 period to identify challenges and successes, were reviewed and used to supplement sustainability findings. Interview notes with FAM3 participants, food bank staff, and health care partner staff provide context to the sustainability findings.

STRENGTHS AND CHALLENGES OF PROGRAM SUSTAINABILITY FOR FOOD BANKS

Twenty food bank representatives responded to the survey. On average, food banks scored 5.2 out of a possible 7 regarding overall capacity to sustain FAM3 programming using the PSAT. Higher and lower PSAT scores are expanded upon below. There were opportunities to improve capacity for sustainment across all PSAT items. Additionally, given variations in scores across sites, tailored strategies to support sustainment capacity may be needed.

Food banks scored highest on **environmental support** for FAM3 programming: factors like having a program champion, strong leadership support, and strong community support (average score 5.9 out of possible 7). As highlighted in implementation notes, key environmental facilitators described by food banks throughout the funding period included strong health care linkages and flexible, integrated approaches to program delivery and data collection. These factors also contributed to ongoing **program adaptation**, allowing food banks to tailor workflows, expand health care partnerships, and adjust FAM3 implementation across settings in response to partner and neighbor needs.

Average scores for all FAM3 grantee food banks for components of the Short Program Sustainability Assessment Tool*



* For complete definitions of each component, refer to the Glossary on page 101.

Several food banks described having multiple engaged health care partners and the ability to expand programs across new sites, reflecting broad community and clinical support for FAM3. One food bank works with nearly 30 health care sites and continues to explore additional referral pathways to increase program reach. Food banks also highlighted the importance of integrated data systems and alignment with health care partners, supported by leadership buy-in and program champions. One food bank leveraged Epic, an electronic health record system used by health care providers to manage patient information and streamline clinical workflows, supporting expansion across multiple counties. Another food bank's data-sharing agreement with their health care partner facilitated program implementation and positioned the partnership well for future evaluation and growth. Prior interviews with grantees echoed these findings and emphasized the importance of and challenges with tracking and sharing data. See Food Bank and Health Care Partner Feedback and Testimonials on page 37 for more information.

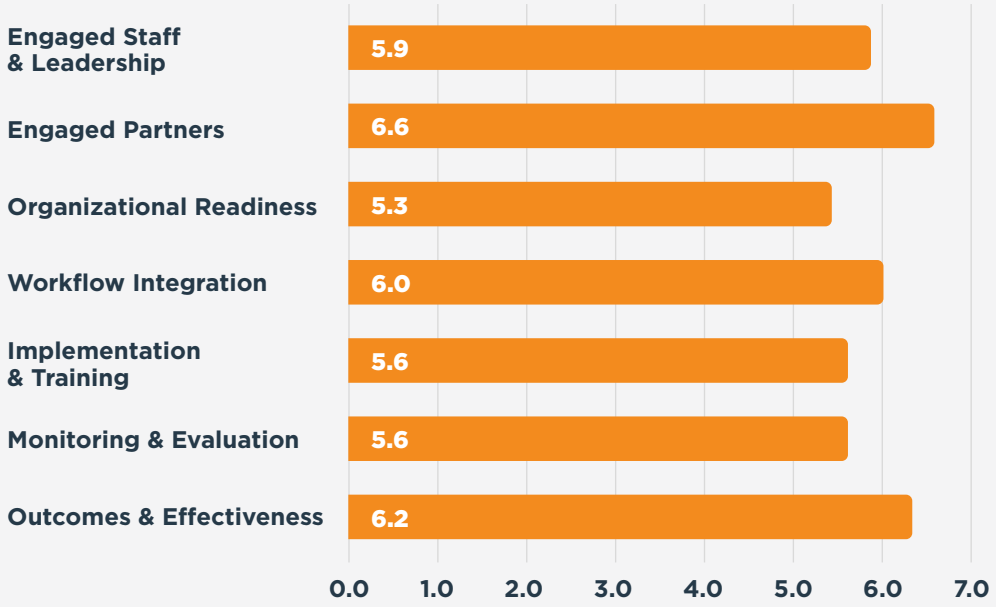
Based on survey results, two areas where sustainability capacity could be strengthened among food banks were **communications** (i.e., efforts to raise awareness and promote the value of FAM3 among community members and partners; average score 5.0 out of a possible 7) and **partnerships** (i.e., collaboration between community organizations, health care partners, and participants in support of FAM3 programming; average score 4.0 out of possible 7). Examples captured from implementation notes regarding barriers to communications and partnerships included challenges with raising awareness of the FAM3 program with participants and challenges with engaging community and health care partners in delivery, despite some strong examples of success, as noted in the paragraph above. Several food banks reported difficulties connecting with health care partners and finalizing program rollout due to slow responses and competing priorities. For instance, one food bank experienced delays in confirming survey distribution logistics with a health care partner, which delayed program implementation, while another food bank faced delays in placing program signage at a partner site, limiting participant awareness of available services. Recommendations from FAM3 grantees to address challenges of FAM programs are described on page 53.

STRENGTHS AND CHALLENGES OF PROGRAM SUSTAINABILITY FOR HEALTH CARE PARTNERS

Twenty-eight clinical partners of 14 food banks responded to the survey. Respondents represented a range of health care settings, including federally qualified health centers, hospital-based and outpatient clinics, mental health treatment centers, dialysis units, and nonprofit clinics. Respondents held varying professional roles, such as clinicians (e.g., registered nurses), registered dietitians, patient navigators, program managers and directors, and community health and outreach staff. CSAT scores were collapsed in this analysis to reflect clinical averages at the level of the shared food bank partner. Similarly, higher and lower CSAT scores are expanded upon below. There were opportunities to improve capacity for sustainment across most CSAT items.

On average, clinical partners scored 5.5 out of a possible 7 on overall capacity to sustain FAM3 procedures in their health care setting. The highest CSAT scores reflected **engaged partners**, including factors like respecting all partners involved and valuing FAM3 procedures, and strong **community engagement** (average score of 6.5 out of possible 7) that supports sustainability capacity. Lower scores were reflected for **implementation and training capacity** (average score of 5.1 out of 7), which refers to clear practice guidelines, feedback and training procedures, and educational support for FAM3 delivery. Additionally, **monitoring and evaluation** (average score 5.0 out of possible 7) scored lower, including factors such as process measurement, data review, and clinical sharing of process metrics.

Average scores for all FAM3 grantee partner food banks for the Clinical Sustainability Assessment Tool*



* For complete definitions of each component, refer to the Glossary on page 101.

> “Physicians and health care providers have thanked us for educating and making them aware of [who uses food pantries and food insecurity].
>
> **FOOD BANK STAFF**

> We need funding to support staff to implement the program and to facilitate distribution since we cover 7 counties…We have seen the immense need in our district for this program and it will significantly impact those most vulnerable in our community to lose this resource.
>
> **HEALTH CARE PARTNER SITE STAFF**

SUMMARY

The FAM3 initiative represents a substantial investment of time and resources from funders, national organizations, food bank partners, and health care partners. Thus, evaluating food bank and health care organization's sustainability capacity over time is important to inform targeted capacity building initiatives. Technical assistance providers and organizations could use the results of the implementation study to design and deliver implementation strategies that help food banks improve partnership coordination, engagement, and communication. Similarly, for health care organizations, strategies to improve organizational readiness for FAM programs, prior to and during implementation, could improve likelihood for sustainment over time. Given that program sustainability is dynamic, understanding how capacity changes over time is important to inform implementation and sustainment efforts. This snapshot provides a useful guide for initial steps to support FAM program sustainment across varied settings.

Food Bank and Health Care Partner Feedback and Testimonials

FAM3 food bank leads, food bank staff, and health care partners shared key insights for planning and implementing a FAM program. The following provides a summary of lessons learned, considerations, and recommendations from grantees' experiences. Refer to the FAM3 Year Two Report for a more in-depth overview of the findings.

1. **Grantees highlighted the importance of designing flexible, participant-centered FAM programs.** FAM3 grantees emphasized the importance of designing and adapting FAM programs with participants' needs front of mind.

2. **Strong partnerships between food banks and health care professionals provide a stable foundation for program implementation.** FAM3 grantees encouraged focusing on the shared mission to frame the mutual benefit of FAM program partnerships.

3. **Successful FAM programs rely on dedicated staff, clear training, and strong leadership at food banks and health care partner sites.** Staff training and capacity building is essential and identifying a staff member at food banks and health care sites to "champion" the program facilitates buy-in.

4. **Tracking and sharing data are essential for understanding impact, but these practices require careful planning, coordination, and clear agreements between food banks and health care partners.** FAM3 grantees reported that while sharing program and participant data is valuable, data tracking and sharing require significant coordination and planning.

Recommendations from FAM3 grantees for implementing Food as Medicine Programs

These recommendations were developed from interviews with grantees on the strengths and challenges of implementing FAM programs and were previously reported in the FAM3 Year Two Report.

1. Program Development

- Explore opportunities to adapt aspects of FAM programming (e.g., food delivery modes, eligibility criteria, service sites, food options) to improve fit, services, and reach.
- Seek opportunities to test and learn from smaller-scale FAM programming before adding more services and sites.
- Design FAM programs so that they align with participant needs, which may extend beyond direct food and nutrition services.
- Use co-creation approaches with food bank, health care, and other key partners to design or adapt FAM programs from current models.

2. Program Partnerships, Funding, and Community Contexts

- Focus on the shared mission of addressing social drivers of health and supporting community members' (participants') health and well-being.
- Plan for health care partnership development and maintenance to take time and resources. Foster open and honest communication throughout the process.
- Support health care partners with guidance and resources for delivering the FAM program.
- Secure external funding from multiple sources (e.g., grants, city) to support FAM programs.
- Have a plan for continuing or adapting FAM3 programming during emergency events (e.g., weather-related disasters).

3. Program Personnel and Participants

- Assess staffing capacity within and between sites that are implementing the FAM program and fill gaps where needed.
- Include a FAM program coordinator or navigator to help participants utilize services offered by the FAM program.
- Identify a "champion" to help generate interest in and drive forward FAM programming at implementation sites.
- Identify barriers to participant utilization of the FAM program (e.g., transportation) and plan for services that overcome such challenges.
- Engage and ensure the support of organizational leadership in food bank and health care sites implementing the FAM program.

4. Program Implementation Processes

- Establish a process and plan for data tracking and sharing within and between the food bank and health care organizations to understand how well the program is being carried out and the impacts of the program on outcomes of interest, like participants' food and nutrition security and health.
- Utilize available guides, toolkits, and resources to help with planning and carrying out a FAM program.
- Support staff and volunteers that are implementing FAM programs with trainings and resources.
- Seek out support and technical assistance to help with implementing and evaluating FAM programs. Feeding America and other food banks can be great resources for this.

Conclusion

The FAM3 initiative involved a wide range of food banks and health care partners across the country supporting over 161,000 households in accessing healthy foods for over three years. The evaluation of FAM3—led by CNHI; supported by the grantees, Feeding America, and Carelon Research, Inc.; and funded by Elevance Health Foundation—collected multiple forms of data to better understand how these programs were implemented, who they reached, and what impacts they had. While some findings were published previously,[19] this report provides an overarching assessment of the Food as Medicine 3.0 initiative (FAM3) and concludes with evidence-based recommendations for future FAM initiatives.

WHO FAM3 REACHED

FAM3 programs successfully enrolled a large and varied group of neighbors who need support to prevent or manage diet-related health conditions.

The FAM3 initiative served over 161,000 unique households. FAM3 programs reached more participants, on average, compared to other FAM models in the literature.[20,21] Additionally, reach varied by program category, with foundational programs reaching more participants, on average, while more intensive program types, like comprehensive programs, reached fewer participants. The participants enrolling in FAM3 were mostly women from various age groups and races/ethnicities. About one in six participants spoke a language other than English (predominantly Spanish), and about half of households included a child. FAM3 reached a population struggling with food insecurity and diet-related conditions such as obesity, hypertension, diabetes, and hyperlipidemia.

HOW FAM3 SUPPORTED PARTICIPANTS

Programs were intentionally diverse and tailored to serve the local needs of neighbors.

Features of FAM3 programs included having an in-clinic (or on-site at health care locations) option for the provision of food, active benefit enrollment support, and defined food distribution. Over half of the FAM3 programs included each of these program characteristics. About one-third of programs offered structured nutrition education and had a diet-related condition as part of the enrollment criteria. While the provision of medically tailored meals or groceries were limited or minimal across FAM3 models, all programs provided fruits and vegetables and/or generally healthy foods. Often, programs provided low sodium or high fiber options for shelf-stable foods, and some programs provided pre-made healthy frozen meals. While many FAM programs are limited in duration, commonly spanning 3-12 months,[22–24] FAM3 models are well positioned for ongoing food provision (through existing food bank infrastructure, food sourcing, and food pantry networks), connection to nutrition professionals who are food bank staff, and expertise in benefits enrollment for continuity of care.

HOW FAM3 IMPACTED PARTICIPANTS

FAM3 program participation was associated with improvements in food security, diet-related outcomes, and some health-related improvements.

Across the initiative, FAM3 participants experienced significant improvements in nutrition security and food security and significant reductions in reported instances of overnight hospitalizations and emergency room visits. Further, those who reported engaging with their FAM3 program more often saw relatively greater improvements in general health. Among the two programs that shared complete baseline to follow-up patient-level EHR data, FAM3 patients saw improved HbA1c, BMI, and LDL cholesterol. While the insurance claims sub-study yielded mostly statistically null findings, directions of effect were generally towards improved healthcare utilization and health. Overall, these findings are consistent with the broader FAM literature that shows the most consistent findings for changes in food security and diet-related variables, and mixed findings for health-related changes, which can take longer to manifest following dietary and lifestyle changes.[22,24]

HOW DIFFERENT PROGRAMS IMPACTED PARTICIPANTS

Structured nutrition education was associated with improvements for participants.

Generally, providing structured nutrition and/or health education was associated with improvements in participant outcomes. Also, having in-clinic food provision options, active public benefit support, and a diet-related condition as an enrollment criterion were associated with positive improvements for different outcome variables. When grouping programs by categories (i.e., foundational, enhanced, and comprehensive), there was some evidence that comprehensive programs may be associated with larger participant improvements in nutrition and health outcomes. Comprehensive programs are more intensive models that had lower overall reach compared to the other program types. The foundational and enhanced programs were also associated with positive improvements for participants. Importantly, the program types tended to reach different types of patients, indicating the feasibility of tailoring programs based on the needs of the participant population. Comprehensive programs reached older participants who often had a diet-related condition, while foundational programs reached younger and relatively more healthy participants, a finding that was somewhat expected because nearly all comprehensive programs had a diet-related condition as an enrollment criterion. The difference in populations reached may make some program models better suited for prevention and others for disease management.

PROGRAM SUSTAINABILITY SUCCESSES AND CHALLENGES

Food banks and health care partners reported strong overall capacity to sustain FAM programs.

Food banks reported moderate-to-strong overall capacity for program sustainability, with greatest strengths being environmental support (e.g., leadership buy-in) and weaker areas being communications and partnerships. Health care partners showed similar overall capacity and reported strengths in partner engagement but scored lower on training, implementation guidance, and evaluation. Findings highlight opportunities for targeted design and implementation strategies that strengthen communication, partnerships, and organizational readiness, allowing continued FAM programming over time.

KEY STRENGTHS OF FAM3

- FAM3 facilitates positive improvements in health care utilization and participants' food and nutrition security, with certain programs being associated with improvements in health metrics including HbA1c, BMI, and LDL cholesterol.
- FAM3 efficiently reaches a large population that is demographically, linguistically, and clinically diverse and that is often considered "hard to reach" or historically underserved by traditional health care pathways.
- Food banks are positioned for effective FAM program delivery due to their strong community-based food infrastructure and staff experienced in nutrition education and benefits support.
- Extensive community-level knowledge means food banks and their networks are well positioned to tailor programming to local needs, strengths, and cultural sensitivities.
- Varied FAM3 program models throughout the Feeding America network consistently demonstrated improvements in participant health and wellbeing, providing evidence that a national program framework can be implemented on a large scale while remaining responsive to local needs.

RECOMMENDATIONS FOR FUTURE FAM PROGRAMS

Based on these findings, we recommend the following for FAM programs:

- Support programs to include structured nutrition and/or health education, which may increase program efficacy and may be associated with health improvements for participants.
- Support the implementation of in-clinic food provision options (e.g., on-site pantries, lockers, mobile markets) where possible to make it easier for participants to access food.
- Encourage programs to include active benefits enrollment, which may provide long-term post-program support.
- Consider tailoring programs for the types of patients reached, such as focusing foundational programs (which, on average, reach a younger/healthier population) on prevention and focusing comprehensive programs (which, on average, reach an older/less healthy population) on disease management.
- Focus on promoting higher participant access and engagement (ie., multiple food pickups), across all program types, as it may be associated with improvements in participants' diet and health-related outcomes.
- Design and test implementation strategies to help food banks and health care partners adopt, implement, and sustain programs in complex real-world settings.
- Plan data-sharing infrastructure between food banks and health care partnerships early in program design, including standardized agreements and shared evaluation goals.
- Fund programs to support health care partnerships with dedicated staff and organizational alignment, not just food provision, to sustain programs over time.

> 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.
>
> **NEIGHBOR FROM NEW YORK**

The FAM3 initiative helped many households across the US who were experiencing food- and health-related disparities. This report highlights important work that was done by food banks and health care sites, and this evaluation would not have been possible without the dedicated support of the grantees and participants who helped us tell the story of FAM3. Applying shared measures across grantees, in combined qualitative and quantitative assessments, added rich data to better understand the impacts, strengths, and opportunities of the initiative. Novel components of the evaluation, such as the EHR analyses and the insurance claims sub-study, provided proof of concept and lessons learned to scale these evaluation approaches in the future. Overall, FAM3 demonstrated that Food as Medicine programs can be scaled, adapted locally, and lead to improved participant well-being. FAM3 identified program characteristics worth scaling nationally to improve participants' well-being, provided flexible support to food banks and health care partners to locally adapt programming, reduced avoidable health care utilization, and built a lasting foundation for food as medicine innovation across the Feeding America network.

Annual reports and additional resources are available at feedingamerica.org/research/hunger-and-health

> For the first time I had some good decent meals, the vitamins that I needed...I'm walking, eating better. My stomach feels better and my sugar is better.
>
> **NEIGHBOR FROM VIRGINIA**

Anthony, Utah

Kianna, California
Riverside Free Clinic Program Lead

Case Studies

The following case studies include data from each grantee's sample of the FAM3 Neighbor Survey, program data and electronic health record (EHR) data, where available. About one-third of food banks included additional site-specific questions in their baseline or follow-up surveys. Some food banks collected program data related to the number of times each participant received food from the program (38%) and a few food banks worked with their health care partners to provide electronic health record (EHR) data for each participant (19%). These case studies reflect the findings of site-level analyses of the data collected and provided by different grantees.

Atlanta Community Food Bank

ATLANTA, GA

PROGRAM OVERVIEW

Since 2017, the Atlanta Community Food Bank has partnered with Grady Health System to connect patients to nutritious food through the "Food as Medicine" program—helping neighbors facing food insecurity access foods that are culturally significant and medically tailored to their diet-related illnesses. Patients are encouraged to visit Jesse Hill Market, adjacent to Grady, to pick up healthy foods, receive assistance with SNAP applications and participate in hands-on cooking classes to aid them in making dietary changes. These supports are especially important as many families are forced to make difficult choices between food and health care, making it harder to maintain their health.

PROGRAM MODEL

The "Food as Medicine" program implements the "screen-refer-nourish" model. All patients are screened for food insecurity during their medical visits. Those who are identified as food insecure and have either high blood pressure* or an elevated A1c level** are referred to Jesse Hill Market to receive medically tailored food and wraparound services. Food packages include whole grains, plant proteins, and a variety of fresh fruits and vegetables. Program participants pick up food every two weeks and attend one cooking class and one nutrition class every three months. Participants graduate from the program after one year but are still able to receive food from Jesse Hill Market and SNAP assistance as needed. The program is designed to deliver services in ways that help remove barriers and respect choice.

* Blood pressure above 140/90
** Hemoglobin A1c above 9

Photo Credit: Atlanta Community Food Bank

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

3,067
patients received food from the program

2,097
patients were referred to SNAP

> "This is the best thing that has happened for people with chronic illnesses. Continue the good work of providing healthy food for the disadvantaged community.
>
> **ATLANTA COMMUNITY FOOD BANK NEIGHBOR**

Atlanta Community Food Bank Impact Report (cont'd)

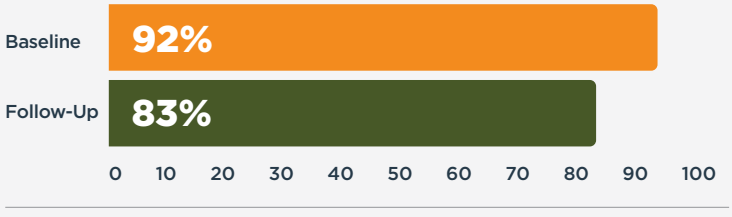
NEIGHBOR SURVEY DEMOGRAPHICS (N=54)*

A total of 54 participants responded to the baseline and follow-up surveys. Most participants were female (80%), all participants were Black or African American (100%), and nearly two-thirds participated in SNAP (60%).

DEMOGRAPHIC	PERCENT
AGE	
18 to 34	16%
35 to 49	26%
50 to 64	53%
65+	5%
GENDER IDENTITY	
Female	80%
Male	18%
Identify some other way	2%
PROGRAM PARTICIPATION	
SNAP	60%
Food pantry	40%
Medicaid	28%
School meals	23%
Medicare	11%
WIC	6%
None of the above	13%

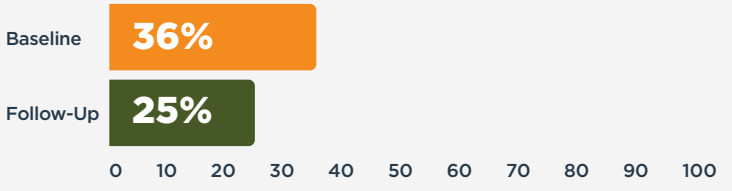
* Total number of participants reflects those who took both a baseline and follow-up survey.

Change in Food Insecurity



Percent of Food Insecure Participants

Change in Overnight Hospitalizations



Percent of participants reporting any overnight hospitalizations in the past 6 months

Participant Outcomes

- ✓ Participants reported an average of **13% increase in their intake of fruits and vegetables**, compared to baseline.
- ✓ The percent of participants **experiencing food insecurity decreased by 9%**.
- ✓ Participants reported a **31% decrease in overnight hospitalizations**, compared to the baseline period.
- ✓ Participants reported an average of **8.3% fewer ER visits**, compared to the baseline period.
- ✓ The percentage of participants who **reported struggling to afford medications, reduced by 12.7%**, compared to baseline.
- ✓ **8% of the participants no longer felt they needed to "miss or delay medical care" due to cost**.

> "I liked the fact that [program staff] gave me the opportunity to take the class so I can better help myself... That shows that [they] care about my health as well as I do, and I appreciate [them] telling me about the program.
>
> **ATLANTA COMMUNITY FOOD BANK NEIGHBOR**

Capital Area Food Bank

WASHINGTON, D.C.

PROGRAM OVERVIEW

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.

PROGRAM MODEL

Children's National Hospital's Diabetes Care Complex medical providers in addition to a few additional departments refer patients with endocrine conditions (prediabetes, type 1 or type 2 diabetes, HIV, kidney conditions, among others) who screen positive for food insecurity to the food pharmacy. Medical providers are responsible for referring and enrolling patients, dispensing food to patients and tracking patients at each visit.

Photo Credit: Capital Area Food Bank

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

2,121

patients received food from the program

> "They [the food pharmacy] give you a lot of food, even fresh produce, which I love because that's one of the hardest things for me to really get my hands on.
>
> **CAPITAL AREA FOOD BANK NEIGHBOR**

Capital Area Food Bank Impact Report (cont'd)

PROGRAM SATISFACTION SURVEY

A survey was administered from September 2022 to June 2025 to participants on their second visit to the food pharmacy (n=464). This survey collected information on program utilization and satisfaction with services and resources, such as food variety, meal recipes, and dietitian consultations.

97%

of participants reported being either satisfied or very satisfied with the **variety** of food received from the food pharmacy.

99%

of participants reported being either satisfied or very satisfied with the **quantity** of food received from the food pharmacy.

> "Being in an area where food is really expensive, and then the food that I need is extra expensive, it has made me feel a little bit scared at times.
>
> **CAPITAL AREA FOOD BANK NEIGHBOR**

CLINICAL DATA

De-identified clinical, demographic, and program use data was collected from electronic health records of a subpopulation of food pharmacy program participants with type 1 or type 2 diabetes.

- From February 2, 2023, to February 26, 2025, a total of 705 participants with type 1 or type 2 diabetes visited the Diabetes Care Complex food pharmacy.
- On average, participants picked up food 4 times from the clinical food pharmacy, with a maximum of 10 visits.
- Most participants (61%) received food 1 or 2 times across the 2-year time frame.

DEMOGRAPHIC	MEAN ± SD OR N (%)
AGE IN YEARS	15.5 ± 4.1
SEX	
Female	375 (53%)
Male	330 (47%)
RACE	
Black or African American	428 (61%)
Other Race	222 (32%)
White or European	46 (7%)
Asian or Asian American	6 (1%)
American Indian/Alaska Native	2 (<1%)
Native Hawaiian/Pacific Islander	1 (<1%)
ETHNICITY	
Non-Hispanic/Latino	427 (67%)
Hispanic/Latino	191 (27%)
Other	42 (6%)
LANGUAGE	
English	418 (81%)
Spanish	101 (19%)
INSURANCE STATUS	
Public	577 (82%)
Private	120 (17%)
Uninsured	8 (1%)
DIAGNOSIS	
Type 1 diabetes	417 (59%)
Type 2 diabetes	288 (41%)

Dare to Care Food Bank

LOUISVILLE, KY

PROGRAM OVERVIEW

Dare to Care Food Bank (DCFB) works with medical providers at local health clinics to address food insecurity through the Food as Medicine program. The program provides patients with nutritious foods to take home as well as education about healthy eating and wellness.

PROGRAM MODEL

Medical providers based in 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. A patient who screens positive for food insecurity is offered access to an on-site food pantry where they can choose food based on their food preference and needs. Patients who screen positive for food insecurity can access the food pantry as often as necessary. During visits, some of the food pantry patients may receive information about wraparound services such as SNAP assistance and cooking/ nutrition classes.

Photo Credit: Dare to Care Food Bank

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

2,874
patients received food from the program

78
patients were referred to SNAP

> "It gave me peace of mind, and I left the office more comfortable that I was going to be able to provide for my kids and feed them a decent meal.
>
> **DARE TO CARE FOOD BANK NEIGHBOR**

Dare to Care Food Bank Impact Report (cont'd)

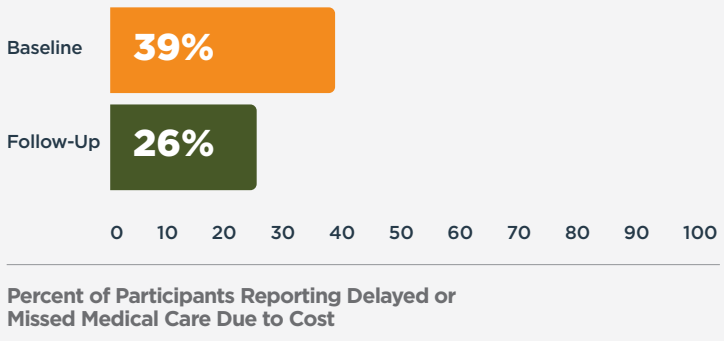
NEIGHBOR SURVEY DEMOGRAPHICS (N=72)*

A total of 72 participants responded to the baseline and follow-up survey. Around three-quarters of participants were women (71%). Almost half of participants were White or European American (45%) and a similar proportion were Black or African American (41%).

DEMOGRAPHIC	PERCENT
AGE	
18 to 34	22%
35 to 49	32%
50 to 64	35%
65+	11%
GENDER IDENTITY	
Woman	71%
Man	26%
Another response	3%
RACE/ETHNICITY	
White or European American	45%
Black or African American	41%
Multi-racial/-ethnic	9%
Hispanic or Latino	4%
Asian or Asian American	1%

* Total number of participants reflects those who took both a baseline and follow-up survey.

Change in Delayed/Missed Care



Participant Outcomes

- ✓ The percentage of participants in Dare to Care Food Bank's FAM3 program who are food insecure **reduced by 7%**, compared to baseline.
- ✓ Participants of Dare to Care Food Bank's FAM3 program reported an average of **9% improvement in their nutrition security**, compared to baseline.
- ✓ Participants of Dare to Care Food Bank's FAM3 program reported an **average of 5% fewer ER visits**, compared to the baseline period.
- ✓ The percentage of participants in Dare to Care Food Bank's FAM3 program who **felt they needed to miss or delay medical care due to cost reduced by 13%**, compared to baseline.

> "Since I let my guard down and asked for help about my food situation... it opened up the door for me... to get prescribed what I need, and it helped me see... my own family physician.
>
> **DARE TO CARE FOOD BANK NEIGHBOR**

Feed More

RICHMOND, VA

PROGRAM OVERVIEW

Since 2018, Feed More has been partnering with local community hospitals, health districts, Federally Qualified Health Centers, and free clinics to provide food as medicine services in the Central Virginia area. Through 30 sites in 16 localities, Feed More's partnerships focus on food insecurity screening to supply food boxes onsite and referrals to ongoing food resources.

PROGRAM MODEL

Health care staff at partnering organizations provide patients who have screened positive for food insecurity with a healthy shelf stable food box to take home. Additionally, staff can refer patients to the Feed More Help Line to connect them with Feed More's network of food resources and programs, including SNAP application assistance.

Photo Credit: Feed More

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

5,858
patients received food from the program

79
patients were referred to SNAP

> "It is so nice to have the ability to receive food when needed weekly instead of waiting for food pantry distribution times.
>
> **A NEIGHBOR RECEIVING MEDICALLY TAILORED GROCERIES FROM CRATER HEALTH DISTRICT**

Feed More Impact Report (cont'd)

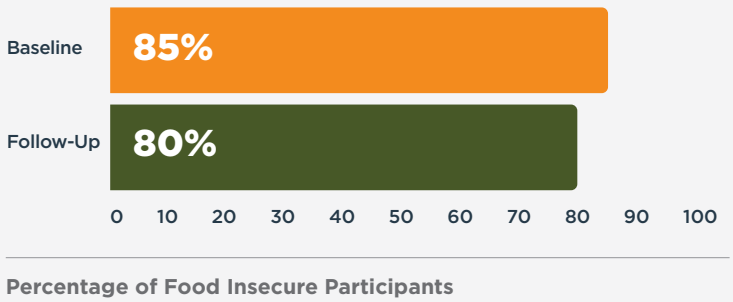
NEIGHBOR SURVEY DEMOGRAPHICS (N=104)*

A total of 104 participants participated in the baseline and follow-up survey. Most participants were women (88%) and around two-thirds were Black or African American (66%).

DEMOGRAPHIC	PERCENT
AGE	
18 to 34	28%
35 to 49	25%
50 to 64	29%
65+	18%
GENDER IDENTITY	
Woman	88%
Man	12%
RACE/ETHNICITY	
Black or African American	66%
White or European American	25%
Multi-racial/-ethnic	6%
Asian or Asian American	2%
Hispanic or Latino	1%

* Total number of participants reflects those who took both a follow-up and baseline survey

Change in Food Insecurity



Participant Outcomes

- ✓ The percentage of **participants who were food insecure at follow-up was reduced by 5%** compared to baseline.
- ✓ Participants of Feed More's FAM3 program reported an average of **4% improvement in their daily intake of fruits and vegetables** compared to baseline.
- ✓ Participants of Feed More's FAM3 program reported **30% fewer overnight hospitalizations** compared to the baseline period.
- ✓ Participants of Feed More's FAM3 program reported **22% fewer emergency room visits** compared to the baseline period.

"Our team is so glad to be able to provide food on-site when patients have a need instead of only giving them a list of food pantries.

A HEALTH CARE PROGRAM PARTNER

Feeding America Riverside | San Bernardino

RIVERSIDE, CA

PROGRAM OVERVIEW

FoodRx 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) partners with local health care organizations to support individuals experiencing food insecurity.

PROGRAM MODEL

Patients identified as food insecure by their health care provider receive a food box at the health clinic. Food boxes are paired with nutritional educational materials to help patients make informed decisions for their diets. Additionally, FARSB refers patients to local food pantries and meal programs, offers CalFresh application assistance, and transitions qualified patients to their homebound relief services.

Photo Credit: Feeding America Riverside | San Bernardino

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

6,040
patients received food from the program

10,237
patients were referred to SNAP

> "[FoodRx] helps me a lot right now because my husband is working very little right now, and I have five kids, so it helps me make snacks and give them something to eat."
>
> **FARSB NEIGHBOR**

Feeding America Riverside | San Bernardino Impact Report (cont'd)

NEIGHBOR SURVEY DEMOGRAPHICS (N=48)*

A total of 48 participants responded to the baseline and follow-up surveys. Around two-thirds of participants were women (61%) and three-quarters of participants were Hispanic or Latino (74%).

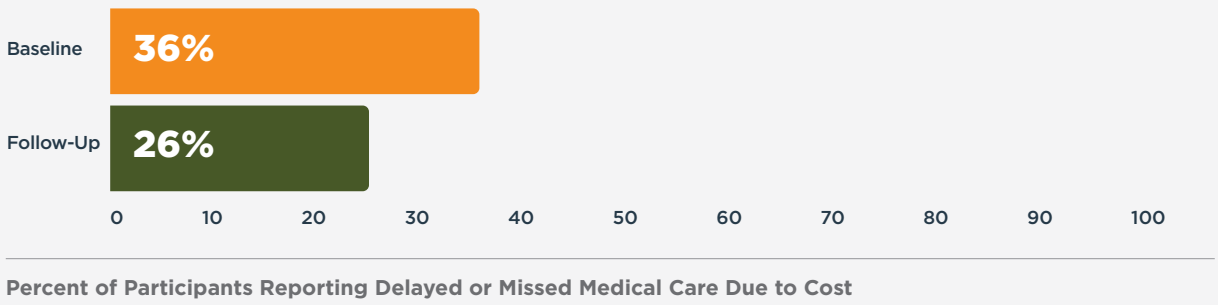
DEMOGRAPHIC	PERCENT
AGE	
18 to 34	36%
35 to 49	44%
50 to 64	16%
65+	4%
GENDER IDENTITY	
Woman	61%
Man	37%
Another response	2%
RACE/ETHNICITY	
Hispanic or Latino	74%
Black or African American	11%
White or European American	7%
Multi-racial/-ethnic	7%
American Indian or Alaskan Native	2%

* Total number of participants reflects those who took both a follow-up and baseline survey

Participant Outcomes

- ✓ Participants of FARSB's FAM3 program reported an average of **9% improvement in their daily intake of fruits and vegetables,** compared to baseline.
- ✓ The percentage of participants who were food insecure at follow-up **reduced by 7%,** compared to baseline.
- ✓ Participants of FARSB's FAM3 program reported an average of **37% fewer ER visits,** compared to the baseline period.
- ✓ The percentage of **participants who felt they needed to miss or delay medical care due to cost reduced by 10%,** compared to baseline.

Change in Delayed/Missed Care



Feeding Westchester

ELMSFORD, NY

PROGRAM OVERVIEW

In 2018, Feeding Westchester began its Food as Medicine Program in collaboration with local medical clinics and hospital systems to reduce barriers to nutritious food access while tracking health outcomes over time.

PROGRAM MODEL

Health care partners screen patients for food insecurity and assess diet-related disease status. Patients with diabetes that indicate a need for food assistance are referred to the Food as Medicine Program. The sites allow patients to share their health information regarding chronic illness indicators with Feeding Westchester through the Link2Feed service insights platform. In addition to food assistance, SNAP coordinators work with neighbors to make referrals. Housing and legal assistance services are also available.

Photo Credit: Feeding Westchester

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

1,181

patients received food from the FAM3 program

> "The fruits and vegetables I receive from Food is Medicine are generally the only fruits and vegetables I eat because right now I cannot afford it.
>
> **FEEDING WESTCHESTER NEIGHBOR**

Feeding Westchester Impact Report (cont'd)

NEIGHBOR SURVEY DEMOGRAPHICS (N=25)*

A total of 25 participants responded to the baseline and follow-up surveys. The majority of participants were women (80%), around half of participants were Hispanic or Latino (52%), and a quarter of participants were Black or African American (28%).

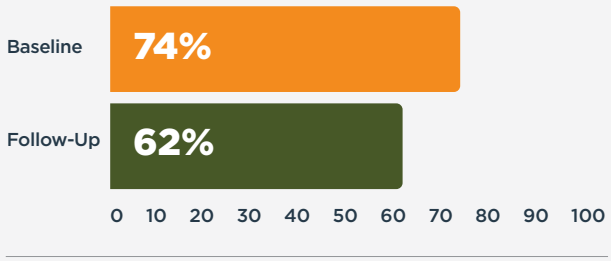
DEMOGRAPHIC	PERCENT
AGE	
35 to 49	16%
50 to 64	40%
65+	44%
GENDER IDENTITY	
Woman	80%
Man	20%
RACE/ETHNICITY	
Hispanic or Latino	52%
Black or African American	28%
White or European American	8%
Multi-racial/-ethnic	8%
American Indian or Alaskan Native	4%

* Total number of participants reflects those who took both a follow-up and baseline survey

Participant Outcomes

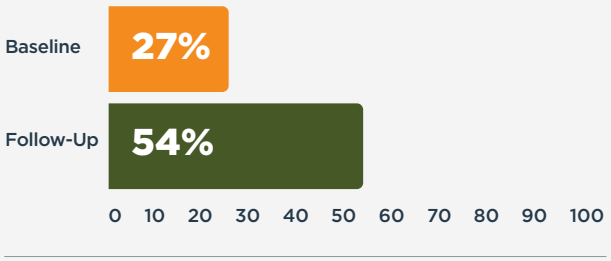
- ✓ Participants of Feeding Westchester's FAM3 program reported an average of **12% improvement in their intake of fruits and vegetables,** compared to baseline.
- ✓ The percentage of participants who were **food insecure reduced by 12%,** compared to baseline.
- ✓ Across the program, **participants received food an average of 9 times** and attended an average of 3 nutrition education classes.
- ✓ Participants who **picked up food 8 or more times had a larger proportion** of individuals with improved food security status, compared to participants who picked up food less than 8 times.
- ✓ The number of respondents who **rated their diet as 'good' or 'very good'—as opposed to 'fair,' or 'poor,'—increased by 19% from baseline to follow-up.**
- ✓ The percentage of participants that reported they **pay attention to nutrition labels 'all the time' or 'quite often' — as opposed to 'rarely,' 'sometimes,' and 'never' — when purchasing food increased by 24%.**

Change in Food Insecurity



Percent of Food Insecure Participants

Change in 'Good' Diet Rating



Percent of Participants Who Rated Their Diet as 'Good' or 'Very Good'

Food Bank For New York City

NEW YORK, NY

PROGRAM OVERVIEW

Since 2018, Food Bank For New York City (FBNYC) and a coalition of other social service providers have 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 health care costs.

PROGRAM MODEL

During medical visits, patients are screened for food insecurity. Patients then receive Social Determinants of Health screenings by Food Navigators, who offer a range of local options based on patient needs and preferences. Patients are then referred to Food Assistance Programs near their homes or neighborhoods they frequent. These programs provide food bags and/or congregate meals. Food Bank Community Nutritionists work with agencies to develop inventory to promote good nutrition and healthy eating, including fresh produce and dietary adherent products.

Photo Credit: Food Bank For New York City

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

2,127

patients received food from the program

> "Thanks to all the people who make this program possible so we can have food on our tables. Because there are so many people who need [this] program.
>
> **FOOD BANK FOR NEW YORK CITY NEIGHBOR**

Food Bank For New York City Impact Report (cont'd)

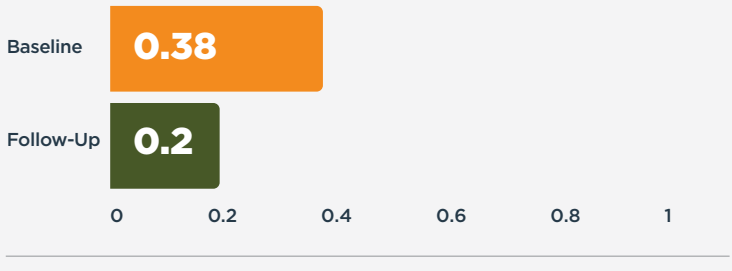
NEIGHBOR SURVEY DEMOGRAPHICS (N=56)*

A total of 56 participants responded to the baseline and follow-up surveys. More than three-quarters of participants were women (79%), nearly half of participants were Black or African American (43%), and two-thirds were Hispanic or Latino (39%).

DEMOGRAPHIC	PERCENT
AGE	
18 to 34	29%
35 to 49	45%
50 to 64	21%
65+	5%
GENDER IDENTITY	
Woman	79%
Man	21%
RACE/ETHNICITY	
Black or African American	43%
Hispanic or Latino	39%
White or European American	9%
Multi-racial/-ethnic	4%
American Indian or Alaskan Native	2%
Asian or Asian American	2%
Middle Eastern or North African	2%

* Total number of participants reflects those who took both a follow-up and baseline survey

Change in Emergency Room Visits



Participant Outcomes

- ✓ The percentage of participants in Food Bank For New York City's FAM3 program who were **food insecure reduced by 6%,** compared to baseline.
- ✓ Participants reported an **average of 6% improvement in their nutrition security** compared to baseline.
- ✓ Participants of Food Bank For New York City's FAM3 program reported an **average of 47% fewer ER visits,** compared to the baseline period.
- ✓ Participants reported an **average of 22% fewer overnight hospitalizations** compared to the baseline period.

"I felt comfortable with how she [the staff member] asked about my food situation because she was very understanding and patient. I appreciated her empathetic and non-judgmental approach.

FOOD BANK FOR NEW YORK CITY NEIGHBOR

FOOD AS MEDICINE 3.0

Impact Report

Food Bank of Northern Nevada

SPARKS, NV

PROGRAM OVERVIEW

The Food Bank of Northern Nevada (FBNN) launched the Prescription Pantry Program in 2017, partnering with health care providers in the Reno-Sparks metropolitan area to provide food as medicine services. In 2021, the project expanded into rural areas, including Nevada's capital, Carson City. The program now includes 14 health care partners and 14 partner food pantries across northern Nevada.

PROGRAM MODEL

Patients are screened for food insecurity and/or identified as having a cardiovascular condition or diabetes. Those who screen positive receive a food prescription for healthy foods that can support conditions such as diabetes and cardiovascular disease. Patients then visit FBNN partner food pantries, access a wide variety of nutritious foods, including lower-sodium options, dairy, lean proteins, and shelf-stable items such as frozen and canned fruits and vegetables. Participants pick up food one time per week. These additional nutrient-dense foods help reinforce health-focused dietary recommendations and support participants' overall wellbeing.

Photo Credit: Food Bank of Northern Nevada

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

40,884+

times patients received food from the program

97

patients were referred to SNAP

> "This is a great service with the prescription. I get a variety of healthy options and enough to help me get through the week.
>
> **FOOD BANK OF NORTHERN NEVADA NEIGHBOR**

Food Bank of Northern Nevada Impact Report (cont'd)

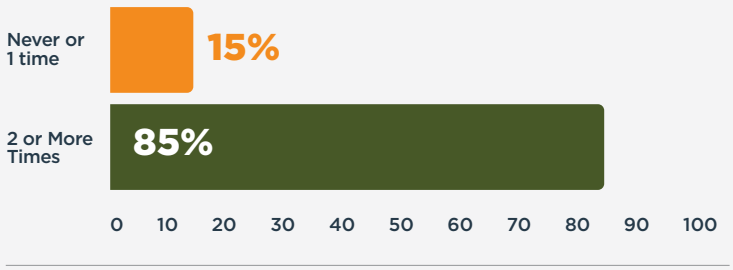
NEIGHBOR SURVEY DEMOGRAPHICS (N=103)*

A total of 103 participants responded to the baseline and follow-up surveys. The majority of participants were women (80%) and around two-thirds of participants were Hispanic or Latino.

DEMOGRAPHIC	PERCENT
AGE	
18 to 34	31%
35 to 49	28%
50 to 64	23%
65+	18%
GENDER IDENTITY	
Woman	80%
Man	19%
Another response	1%
RACE/ETHNICITY	
Hispanic or Latino	66%
White or European American	21%
Multi-racial/-ethnic	6%
Asian or Asian American	3%
Black or African American	3%
American Indian or Alaskan Native	1%

* Total number of participants reflects those who took both a follow-up and baseline survey

FAM3 Program Use



Percent of Participants Who Used the Program Two or More Times

Participant Outcomes

- ✓ Program participants **reported 13% fewer emergency room visits** compared to the baseline period.
- ✓ Among Food Bank of Northern Nevada's FAM3 participants, **85% used the program two or more times.**
- ✓ Program participants who picked up food more frequently were **less likely to report having to miss or delay medical care due to cost,** compared with those who picked up food more often.

> "Because of this food pantry I've been able to get more food and not have to worry especially toward the end of the month. This has been extremely helpful to me. They always have a good variety of fresh food.
>
> **FOOD BANK OF NORTHERN NEVADA NEIGHBOR**

Food Bank of Northwest Indiana

MERRILLVILLE, IN

PROGRAM OVERVIEW

The Food Bank of Northwest Indiana (FBNWI) customizes its partnerships based on health care providers' interest. The food bank offers medically tailored, shelf-stable grocery boxes with health care partners, HealthLinc and CoAction, and onsite food pantries at Methodist Hospitals and Franciscan Health. FBNWI also has onsite food lockers with the capacity to store refrigerated food with its health care partner HealthLinc Valparaiso.

PROGRAM MODEL

The health care provider screens patients for food insecurity. Upon screening positive, patients are enrolled in the clinic's Food is Medicine program where they can receive monthly boxes or visit the clinic's pantry monthly and the ability to work with a trained dietitian. The Order Ahead Locker Model is a client-choice food distribution system in which patients order medically tailored groceries including fresh produce online, by phone, or through the food bank's referral platform. After orders are prepared, food bank staff place them into secure lockers and assign patients a unique PIN code for retrieval. Patients receive a notification with their access code and may pick up their orders during a designated time window. Lockers are located in accessible areas, such as clinic parking lots or outside health care partner sites and include refrigerated and temperature-controlled compartments to safely store both perishable and non-perishable food items.

Photo Credit: Food Bank of Northwest Indiana

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

2,264
patients received food from the program

1,934
patients were referred to SNAP

> "I feel good about them. The program has been real helpful and I've told other people about it to try to get them to use that clinic because it has given some extras, so that's very, very nice.
>
> **FBNWI NEIGHBOR**

Food Bank of Northwest Indiana Impact Report (cont'd)

NEIGHBOR SURVEY DEMOGRAPHICS (N=107)*

A total of 107 participants responded to the baseline and follow-up surveys. Three-quarters of participants were women (78%), nearly half of participants were White or European American (45%), and one-third of participants were Black or African American (38%).

DEMOGRAPHIC	PERCENT**
AGE	
18 to 34	11%
35 to 49	19%
50 to 64	37%
65+	33%
GENDER IDENTITY	
Woman	78%
Man	21%
RACE/ETHNICITY	
White or European American	45%
Black or African American	38%
Hispanic or Latino	11%
American Indian or Alaskan Native	3%
Multi-racial/-ethnic	2%
Asian or Asian American	1%

* Total number of participants reflects those who took both a follow-up and baseline survey

** Percentages may not add up to 100% due to rounding.

Program Satisfaction

Percentage of Neighbors Participating in the Food Bank of Northwest Indiana's Food as Medicine Program Agreed with the Following Statements

Participant Outcomes

- ✓ Program participants reported an average of **3% improvement in their nutrition security scores,** compared to baseline.
- ✓ Program participants reported an average of **71% fewer overnight hospitalizations, compared to baseline.**
- ✓ Program participants reported an average of **42% fewer ER visits,** compared to baseline.
- ✓ The **percentage of program participants who were short on medication due to cost, reduced by 6 percentage points,** compared to baseline.

FOOD LOCKER PROGRAM USE

- ✓ From December 11, 2023, through July 1, 2025, 280 participants picked up food packages from the NW Indiana Food Locker Program.
- ✓ On average, participants picked up a food package around 7 times.

> "My husband, who is a Navy Veteran, and I look forward to receiving the nutritious food from the food pantry every month. The staff is so courteous and professional."
>
> **FBNWI NEIGHBOR**

Freestore Foodbank

CINCINNATI, OH

PROGRAM OVERVIEW

Freestore Foodbank's Food as Medicine program focuses on 15 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. Health care system partners also refer patients to Freestore's direct home-delivery produce program.

PROGRAM MODEL

Health care partners conduct food insecurity screening at patient intake. If a patient screens positive or indicates need, staff provide food through the clinic-based pantry and/or referrals to other Freestore programs. Patients access food through multiple access models, including a self-sign-in and pick-up system at clinic-based pantries or an onsite pantry model in which patients complete a preference sheet and staff fulfill the order within the clinic. Across these models, available foods include fruits and vegetables, and shelf-stable items.

Photo Credit: Freestore Foodbank

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

30,776

patients received food from the program

> "I appreciate that you all have the pantry, this helps a lot. Since I don't have employment yet, this will help my family and I.
>
> **FREESTORE FOODBANK NEIGHBOR**

Freestore Foodbank Impact Report (cont'd)

NEIGHBOR SURVEY DEMOGRAPHICS (N=50)*

DEMOGRAPHIC	PERCENT
AGE	
18 to 34	28%
35 to 49	40%
50 to 64	26%
65+	6%
GENDER IDENTITY	
Woman	88%
Man	12%
RACE/ETHNICITY	
White or European American	50%
Black or African American	46%
Hispanic or Latino	4%

* Total number of participants reflects those who took both a follow-up and baseline survey

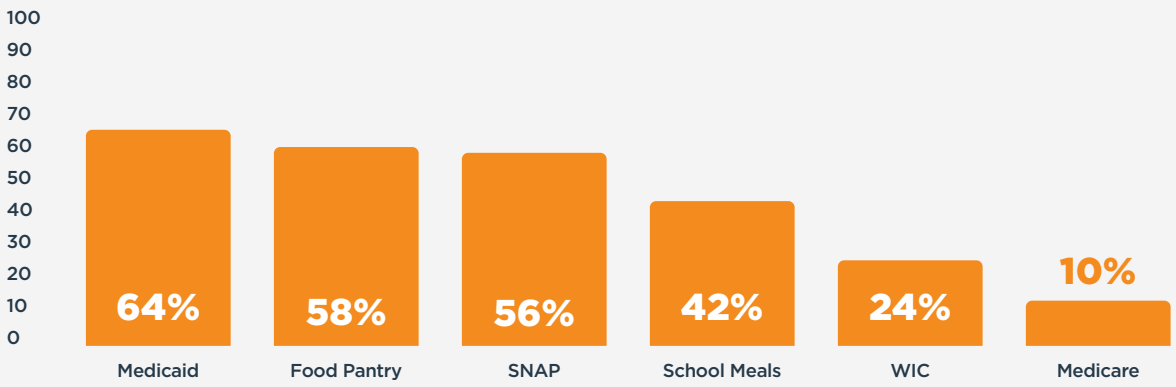
A total of 50 participants responded to the baseline and follow-up surveys. Most participants were women (88%), half of participants were White or European (50%), and almost half of participants were Black or African American (46%). Two-thirds of participants utilize Medicaid (64%) and over half participate in SNAP (56%).

Participant Outcomes

- ✓ Participants of Freestore Foodbank's FAM3 program **reported an average of 8% improvement** in their nutrition security compared to baseline.
- ✓ Participants **reported 30% fewer emergency room visits** compared to the baseline period.
- ✓ Participants **reported 15% fewer overnight hospitalizations** compared to the baseline period.

> "Thank you to all who keep this pantry going! It makes a massive difference in my life and I'm truly grateful.
>
> **ST. ELIZABETH CANCER CENTER NEIGHBOR**

Assistance Utilization and Program Participation



FOOD AS MEDICINE 3.0

Impact Report

Gleaners Food Bank of Indiana

INDIANAPOLIS, IN

PROGRAM OVERVIEW

Gleaners Food Bank of Indiana (GFB), in partnership with Eskenazi Health, supports food-insecure patients with chronic conditions by providing access to nutritious food, nutrition education, and resources for managing their health.

PROGRAM MODEL

Eskenazi Health's Lifestyle Medicine program participants are screened 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 needs, patients can receive vouchers once or twice each month. A new initiative introduced in 2024, Gleaners2Go, allows patients to order food online for pick up at a time that is convenient for them.

Photo Credit: Gleaners Food Bank of Indiana

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

5,215

patients received food from the program

11,336

patients were referred to SNAP

Gleaners Food Bank of Indiana Impact Report (cont'd)

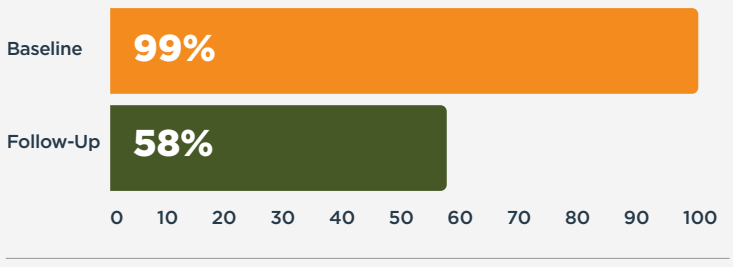
NEIGHBOR SURVEY DEMOGRAPHICS (N=144)*

A total of 144 participants responded to the baseline and follow-up surveys. Three-quarters of participants were women (74%) and around half of participants were Black or African American (45%).

DEMOGRAPHIC	PERCENT
AGE	
18 to 34	7%
35 to 49	27%
50 to 64	47%
65+	19%
GENDER IDENTITY	
Woman	74%
Man	26%
RACE/ETHNICITY	
Black or African American	45%
Hispanic or Latino	41%
White or European American	10%
Multi-racial/-ethnic	2%
Asian or Asian American	1%
Middle Eastern or North African	1%

* Total number of participants reflects those who took both a follow-up and baseline survey

Change in Food Insecurity



Participant Outcomes

- ✓ The percentage of participants who were **food insecure decreased by 41%,** compared to baseline.
- ✓ Participants **reported an average of 39% fewer overnight hospitalizations,** compared to the baseline period.
- ✓ Based on EHR data, **patients' HbA1c decreased by 1 point** (8.6 to 7.6) on average. This change reflects a move from uncontrolled blood glucose to blood glucose levels considered normal.
- ✓ On average, **neighbors' LDL cholesterol decreased by 6 points** (from 95 to 89).
- ✓ The percentage of **participants who felt they needed to miss or delay medical care due to cost reduced by 5%,** compared to baseline.

> "I've been able to use [the vouchers] whenever my Food Stamps would run out before the end of the month. I've been able to get the foods I've learned in my Eskenazi Health Diabetes Class and make the recipes. I've noticed a difference [in my health] with getting access to fresh foods.
>
> **GLEANERS FOOD BANK OF INDIANA NEIGHBOR**

Healthy Blue's Affiliated Foundation | GREATER BATON ROUGE FOOD BANK

Greater Baton Rouge Food Bank

BATON ROUGE, LA

PROGRAM OVERVIEW

The Greater Baton Rouge Food Bank (GBRFB) collaborates with local health care institutions, including hospitals and clinics, to provide food boxes to patients experiencing food insecurity.

PROGRAM MODEL

Medical providers at GBRFB FAM3 partner locations screen patients for food insecurity. Patients who screen positive receive a food box at each appointment, along with information on how to access a nearby GBRFB pantry. Through the FAM3 program, neighbors receive shelf-stable, healthier food options such as whole wheat pasta, low-sodium canned vegetables, and 100% fruit juice to support health-focused dietary recommendations.

Photo Credit: Greater Baton Rouge Food Bank

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

13,895
patients received food from the program

4,477
patients were referred to SNAP

> "Anxiety can creep in sometimes because I don't have [a] job anymore. So, I worry about my bills. I can't afford childcare and rent so it makes it hard to find a job.
>
> **GREATER BATON ROUGE FOOD BANK NEIGHBOR**

FEEDING AMERICA

Greater Baton Rouge Food Bank Impact Report (cont'd)

NEIGHBOR SURVEY DEMOGRAPHICS (N=133)*

A total of 133 participants responded to the baseline and follow-up surveys. Most participants were women (84%) and over three-quarters of participants were Black or African American (79%).

DEMOGRAPHIC	PERCENT**
AGE	
18 to 34	32%
35 to 49	35%
50 to 64	24%
65+	9%
GENDER IDENTITY	
Woman	84%
Man	17%
RACE/ETHNICITY	
Black or African American	79%
White or European American	13%
Hispanic or Latino	7%
Asian or Asian American	1%
Multi-racial/-ethnic	1%

* Total number of participants reflects those who took both a follow-up and baseline survey

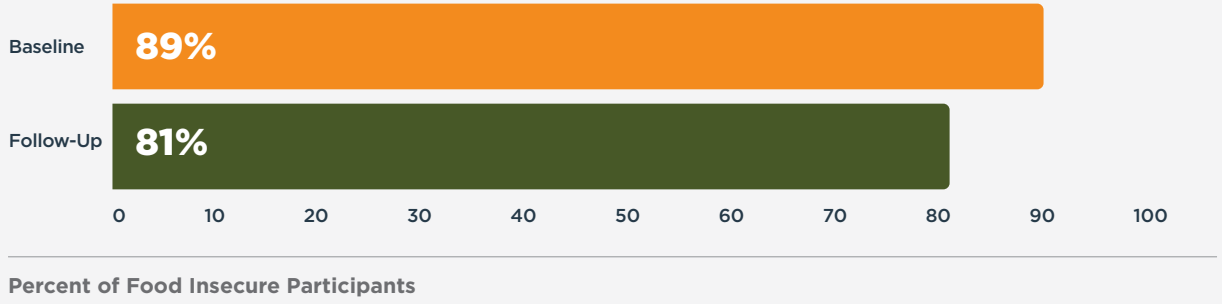
** Percentages may not add up to 100% due to rounding.

Participant Outcomes

- ✓ **8% of participants in GBRFB's FAM3 program were no longer food insecure** after completing the program.
- ✓ Participants in GBRFB's FAM3 program reported an average of **7% improvement in their nutrition security scores** compared to baseline.
- ✓ Participants in GBRFB's FAM3 program reported **10% fewer overnight hospitalizations** compared to the baseline period.

> "It's an absolute blessing that y'all help us out the way that y'all do. It's an absolute blessing and it is welcome and thanked so much.
>
> **GREATER BATON ROUGE FOOD BANK NEIGHBOR**

Change in Food Insecurity



Anthem Foundation | Greater Cleveland Food Bank

Greater Cleveland Food Bank

CLEVELAND, OH

PROGRAM OVERVIEW

The Greater Cleveland Food Bank (GCFB) began its Food as Medicine initiative in 2016. GCFB provides nutritious food in partnership with health care organizations to low-income individuals who have diet-related illnesses like diabetes or hypertension. GCFB coordinates food distribution sites at health care locations, partnering with local hospitals and federally qualified health centers to provide food insecurity screenings for patients as part of their regular health care visits.

PROGRAM MODEL

Health care providers based at partnering hospitals 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 health care partner to visit mobile food pantries. Depending on household need, patients can visit once or twice each month.

Photo Credit: Greater Cleveland Food Bank

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

3,432

patients received food from the program

> "It's helpful - they gave me stuff I didn't have to go buy somewhere else. So, instead of spending 15-20 bucks, it's like somebody giving you 15-20 bucks.
>
> **GCFB NEIGHBOR**

FEEDING AMERICA

Greater Cleveland Food Bank Report (cont'd)

NEIGHBOR SURVEY DEMOGRAPHICS (N=113)*

A total of 113 participants responded to the baseline and follow-up surveys. Most participants were women (84%), two-thirds of participants were White or European American (62%), and a quarter of participants were Black or African American (23%).

DEMOGRAPHIC	PERCENT
AGE	
18 to 34	22%
35 to 49	24%
50 to 64	41%
65+	13%
GENDER IDENTITY	
Woman	84%
Man	16%
RACE/ETHNICITY	
White or European American	62%
Black or African American	23%
Hispanic or Latino	9%
Multi-racial/-ethnic	3%
Asian or Asian American	2%
American Indian or Alaskan Native	2%

* Total number of participants reflects those who took both a baseline and follow-up survey.

PUBLIC ASSISTANCE PARTICIPATION

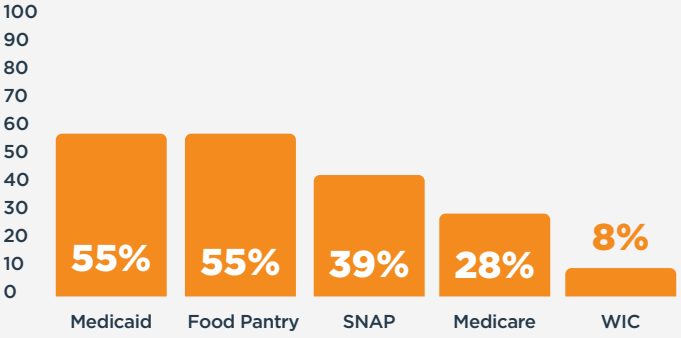
Among FAM3 participants, more than half participated in Medicaid (55%) and/or received food from a food pantry (55%). Over one-third of participants were enrolled in SNAP (39%) and over a quarter were enrolled in Medicare (28%).

Participant Outcomes

- ✓ Program participants **reported an average of 4% improvement in their intake of fruits and vegetables,** compared to baseline.
- ✓ Program participants **reported an average of 10% fewer ER visits,** compared to baseline.

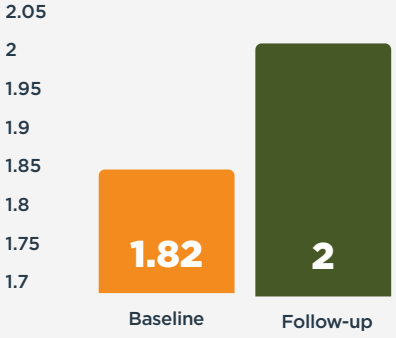
> "Even though to me it is like a 15-minute drive depending on traffic...I'm willing to do it again...because it was very organized.
>
> **GCFB NEIGHBOR**

Assistance Utilization and Program Participation



Public Assistance Program Type

Fruit and Vegetable Intake Frequency



Daily Fruit and Vegetable Intake (Times per Day)

HACAP Food Reservoir

HIAWATHA, IA

PROGRAM OVERVIEW

HACAP Food Reservoir launched their Food as Medicine program in 2021, and it has since grown to include 30 clinic partners across the East Central Iowa region. The program provides shelf-stable nutrient dense food boxes to clinics who then distribute them to individuals who face food insecurity. Patients receive these food boxes at their health care appointments.

PROGRAM MODEL

Health care partners conduct food insecurity screenings using the Hunger Vital Sign™ or their internal screening tool to identify patients who are experiencing food insecurity. Patients who screen positive for food insecurity are offered a shelf stable food box designed to support overall health as well as resources connecting them with their local pantry network, WIC and SNAP.

Photo Credit: HACAP Food Reservoir

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

5,638
patients received food from the program

3,219
patients were referred to SNAP

> "I live alone and my treatments wiped me out. I am grateful for the HACAP box filled with healthy options I could manage. It reduced my stress and helped me stretch my limited budget. I truly believe it played a role in my recovery.
>
> **HACAP FOOD RESERVOIR NEIGHBOR**

HACAP Food Reservoir Impact Report (cont'd)

NEIGHBOR SURVEY DEMOGRAPHICS (N=141)*

A total of 141 individuals participated in both the baseline and follow-up FAM3 survey. Most survey participants were White or European American (65%), and most participants were women (70%). Around two-thirds of participants use Medicaid and almost half participate in SNAP.

DEMOGRAPHIC	PERCENT
AGE	
18 to 34	35%
35 to 49	39%
50 to 64	17%
65+	9%
GENDER IDENTITY	
Woman	70%
Man	30%
RACE/ETHNICITY	
White or European American	65%
Hispanic or Latino	15%
Black or African American	9%
Multi-racial/-ethnic	8%
Asian or Asian American	1%
Middle Eastern or North African	1%
Native Hawaiian or Pacific Islander	1%

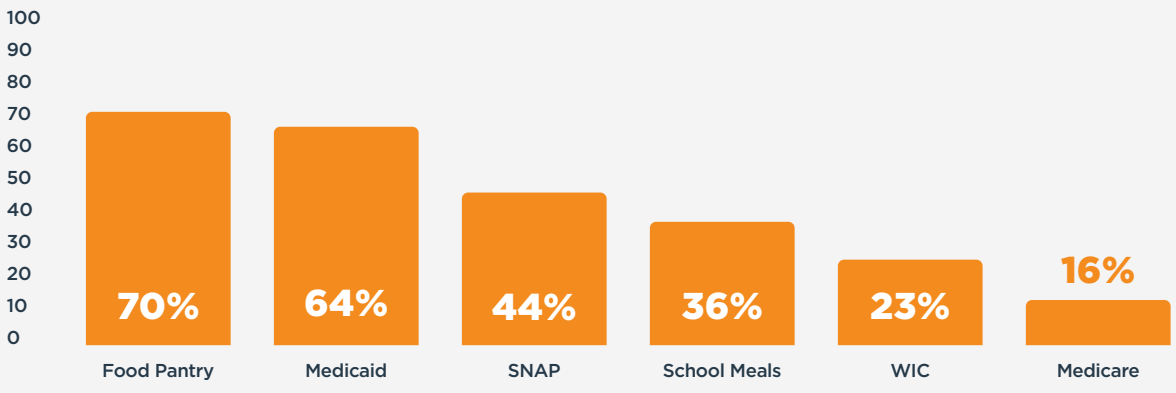
* Total number of participants reflects those who took both a follow-up and baseline survey

Participant Outcomes

- ✓ Participants of HACAP's FAM3 program **reported an average of 4% improvement in their overall physical and mental health,** compared to baseline.
- ✓ Participants of HACAP's FAM3 program had decreases in their health care after participating in the program.
  - Participants **reported 13% fewer emergency room visits.**
  - Participants **reported 27% fewer overnight hospitalizations.**

> "When I was going through chemo, I had no energy to cook or shop. The HACAP food box gave me easy-to-prepare meals that kept me nourished. It wasn't just food—it was a reminder that someone cared.
>
> **HACAP FOOD RESERVOIR NEIGHBOR**

Assistance Utilization and Program Participation



Houston Food Bank

HOUSTON, TX

PROGRAM OVERVIEW

Houston Food Bank (HFB) collaborates with Harris Health, a public health care system and other health care providers to integrate food insecurity screeners into their workflow to increase produce access to improve neighbors' long-term health and economic outcomes.

PROGRAM MODEL

Neighbors are enrolled into HFB's Food Rx program by a health care practitioner, during their health care visit. Neighbors who face food insecurity with a pre-existing condition or are at risk for a diet-related chronic health condition are eligible. Enrolled participants may redeem their produce prescription at the onsite food pharmacy, if available, where staff enters the participants visit into Link2Feed, a software that connects food pantries and health care partners within HFB's network. Food Rx participants can also redeem their prescription at any HFB-affiliated pantries, also known as Food for Change Markets, that are healthy pantries designed with nutritional nudges and education and access to other social services. In addition, Harris Health refers their participants to HFB's referral program, FIRST Link, which connects participants to federal benefits assistance such as SNAP and other social services.

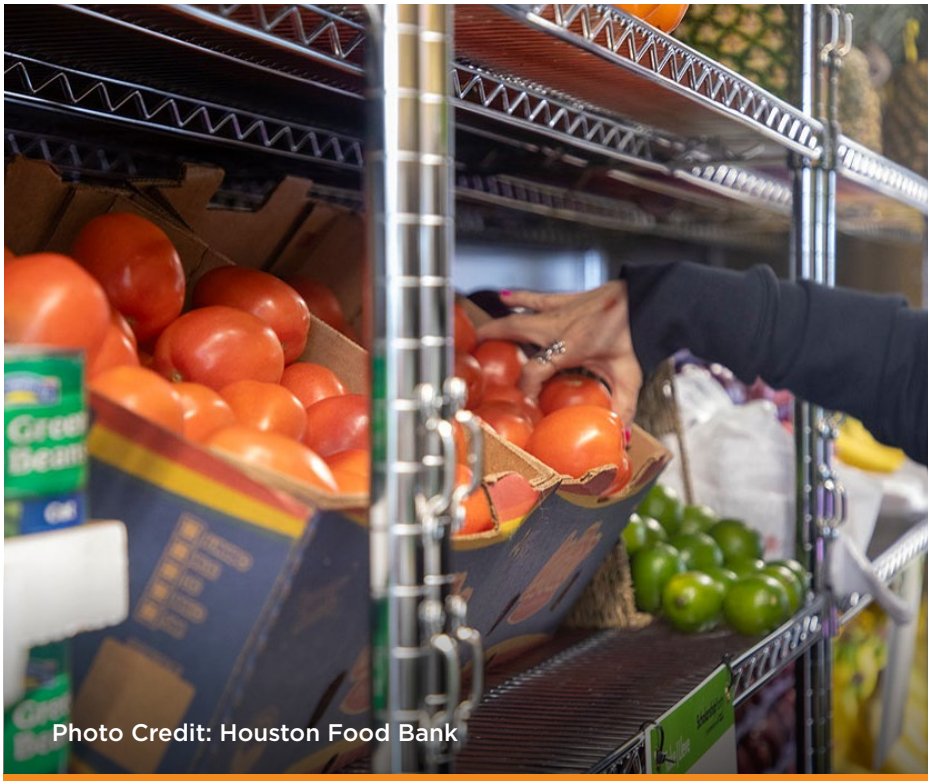


Photo Credit: Houston Food Bank

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

1,732
patients received food from the program

519
patients were referred to SNAP

> "This program is excellent to help people like me with their health goals.
>
> **HOUSTON FOOD BANK NEIGHBOR**

Houston Food Bank Impact Report (cont'd)

NEIGHBOR SURVEY DEMOGRAPHICS (N=49)*

A total of 49 participants responded to the baseline and follow-up surveys. Three-quarters of participants were women (74%). Most participants were Hispanic or Latino (81%) and a smaller percentage of participants were Black or African American (13%).

DEMOGRAPHIC	PERCENT**
AGE	
18 to 34	6%
35 to 49	35%
50 to 64	47%
65+	12%
GENDER IDENTITY	
Woman	74%
Man	27%
RACE/ETHNICITY	
Hispanic or Latino	81%
Black or African American	13%
Asian or Asian American	2%
White or European American	2%
Multi-racial/-ethnic	2%

* Total number of participants reflects those who took both a follow-up and baseline survey
** Percentages may not add up to 100% due to rounding.

CLINICAL DATA ANALYSIS FINDINGS

Data were shared from two health care partners:

- **Health care partner 1 (Aggregate Data):** Average Hemoglobin A1c improved by 1.7% for the 24 participants, from 9.99% at baseline to 8.29% at follow-up.
- **Health care partner 2 (Baseline chronic disease status data):** Most patients had one diagnosis present (64%) and these patients had either type 2 diabetes (37%), prediabetes (37%) or hypertension (25%). Over a quarter of participants (27%) had two diagnoses of either type 2 diabetes and hypertension (55%) or both hypertension and prediabetes (46%).

HEALTH CARE PARTNER 2 DATA: CHRONIC DISEASE DIAGNOSIS AT BASELINE	FREQUENCY	PERCENT
NUMBER OF DIAGNOSES		
0	7	9%
1	52	64%
2	22	27%
ONE DIAGNOSIS PRESENT		
Type 2 diabetes	20	38%
Prediabetes	19	37%
Hypertension	13	25%
TWO DIAGNOSES PRESENT		
Type 2 diabetes & Hypertension	12	55%
Hypertension & Prediabetes	10	45%

Participant Outcomes

- ✓ Program participants **reported an average of 7% improvement in their nutrition security score,** compared to baseline.
- ✓ Program participants **reported an average of 12% improvement in their intake of fruit and vegetables,** compared to baseline.
- ✓ Program participants **reported a 12% improvement in self-reported general health,** compared to baseline.
- ✓ The percentage of program **participants who reported struggling to afford medications, reduced by 15%,** compared to baseline.
- ✓ The percentage of program **participants who felt they needed to miss or delay medical care due to cost, reduced by 9%,** compared to baseline.

> "I am thankful for the food and veggies that [have] helped me take care of myself. I am doing better now.
>
> **HOUSTON FOOD BANK NEIGHBOR**

Island Harvest Food Bank

MELVILLE, NY

PROGRAM OVERVIEW

Island Harvest Food Bank partners with Harmony Health care 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 Health care 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. For each of the 12 weekly or bi-weekly sessions, the patient receives a healthy food bag with three to four days of food, including fresh produce, dairy, meat, fish, whole grains, and shelf-stable items.

Photo Credit: Island Harvest Food Bank

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

302
patients received food from the program

69
patients were referred to SNAP

> "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."
>
> **SPECIAL SUPPLEMENTAL NUTRITION PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC) DIRECTOR**

Island Harvest Food Bank Impact Report (cont'd)

NEIGHBOR SURVEY DEMOGRAPHICS (N=18)*

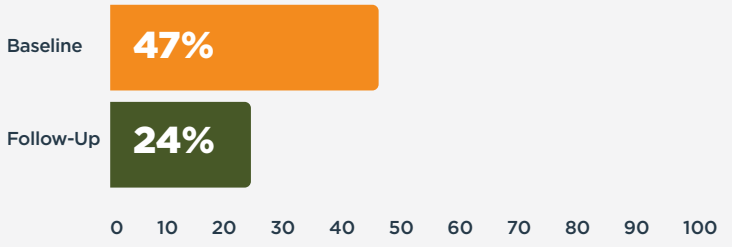
A total of 18 participants responded to the baseline and follow-up survey. Most of the participants were women (94%) and three-quarters of participants were Hispanic or Latino (74%).

DEMOGRAPHIC	PERCENT**
AGE	
18 to 34	56%
35 to 49	11%
50 to 64	28%
65+	6%
GENDER IDENTITY	
Woman	94%
Man	6%
RACE/ETHNICITY	
Hispanic or Latino	74%
Black or African American	13%
Middle Eastern or North African	13%

* Total number of participants reflects those who took both a follow-up and baseline survey

** Percentages may not add up to 100% due to rounding.

Change in Delayed/Missed Care



Percent of Participants Reporting Delayed or Missed Medical Care Due to Cost

Participant Outcomes

- ✓ Participants of Island Harvest's FAM3 program reported an average of **16% improvement in their intake of fruits and vegetables,** compared to baseline.
- ✓ Participants reported an average of **40% fewer overnight hospitalizations,** compared to the baseline period.
- ✓ The percentage of **participants who felt they needed to miss or delay medical care due to cost, reduced by 24%,** compared to baseline.
- ✓ Participants reported an average of **11% improvement in their overall physical and mental health,** compared to baseline.
- ✓ The percentage of **participants who reported struggling to afford medications reduced by 21%,** compared to baseline.

> "We all feel better from the food we are eating.
>
> **ISLAND HARVEST FOOD BANK NEIGHBOR**

Mid-Ohio Food Collective

GROVE CITY, OH

PROGRAM OVERVIEW

Mid-Ohio Food Collective (MOFC) has been involved in Food as Medicine projects for more than 10 years. In Food as Medicine 3.0 (FAM3), MOFC has expanded its partnership with the OhioHealth network to implement screening and referral for produce and other nutritious foods at high-capacity pantries within the community.

PROGRAM MODEL

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

Photo Credit: Mid-Ohio Food Collective

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

359

patients received food from the program

Mid-Ohio Food Collective Impact Report (cont'd)

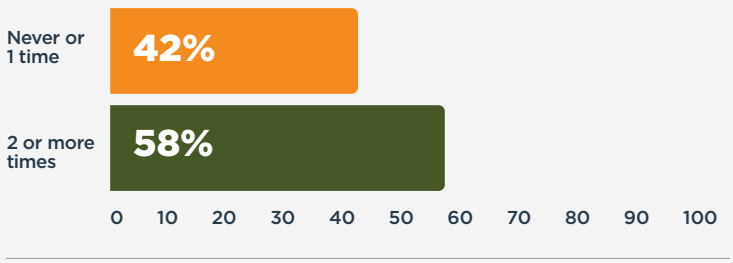
NEIGHBOR SURVEY DEMOGRAPHICS (N=83)*

A total of 83 participants responded to the baseline and follow-up surveys. Most participants were women (78%) and nearly half of participants were White or European American (48%). Nearly half of participants were Black or African American (43%).

DEMOGRAPHIC	PERCENT
AGE	
18 to 34	43%
35 to 49	33%
50 to 64	17%
65+	7%
GENDER IDENTITY	
Woman	78%
Man	21%
Another response	1%
RACE/ETHNICITY	
White or European American	48%
Black or African American	43%
Hispanic or Latino	5%
Multi-racial/-ethnic	4%
Asian or Asian American	1%

* Total number of participants reflects those who took both a follow-up and baseline survey

FAM3 Program Use



Percent of Participants Who Used the Program Two or More Times

Participant Outcomes

- ✓ Program participants **reported 17% fewer emergency room visits,** compared to the baseline period.
- ✓ Among program participants, **58% used the program two or more times.**
- ✓ Participants who picked up food two or more times from MOFC's FAM3 program **had larger increases in their FV intake** compared to participants who picked up food never or once.
- ✓ Participants who picked up food two or more times **had a larger proportion of individuals with improved food security status** compared to participants who picked up food never or once.
- ✓ Among participants with HbA1c data available at baseline and post (n=36), the average value **decreased from 8% to 7%.**

"Just to be able to walk in a place and be able to get some [food] items, that you don't have to worry about paying for, you don't have to worry about, 'Oh, do I have enough for this?' It felt good.

MID-OHIO FOOD COLLECTIVE NEIGHBOR

Regional Food Bank

LATHAM, NY

PROGRAM OVERVIEW

The Regional Food Bank partners with health care sites to deliver Food as Medicine 3.0 (FAM3) programming for patients experiencing food insecurity and living with chronic disease. At St. Peter's Health Partners, patients with type 2 diabetes enroll in a three-month, client-choice food pharmacy and receive weekly pantry packages – including fresh produce, lean proteins, and whole grains – paired with weekly virtual nutrition education. At Ellis Medicine, patients with diabetes and other qualifying chronic conditions participate in a six-month clinic-based food pharmacy with monthly food distributions and one-on-one dietitian visits. At Garnet Health, patients receive medically tailored prepacked food bags at hospital discharge on an as-needed basis, with nutrition education materials included. Across models, programming combine medically appropriate food support with education to improve food security and support chronic disease self-management.

PROGRAM MODEL

Across Regional Food Bank's FAM3 programs, participants screen positive for food insecurity, have a qualifying chronic metabolic condition, and agree to participate in a time-limited nutrition education component. Enrolled participants complete a 12-week, interactive, evidence-based nutrition education program delivered by certified diabetes educators and dietitians, paired with medically appropriate food support to reinforce disease self-management.

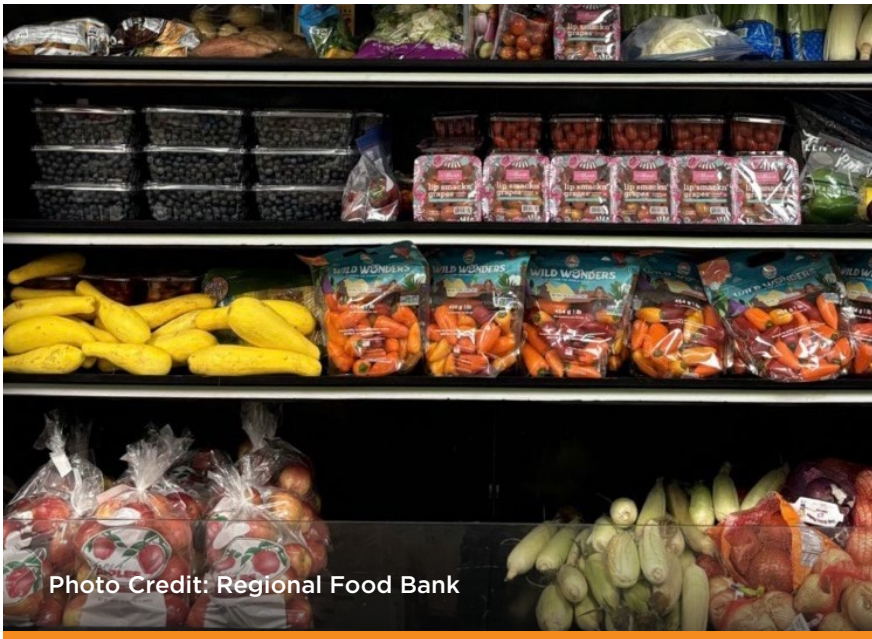


Photo Credit: Regional Food Bank

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

1,840
patients received food from the program

2,685
patients were referred to SNAP

> "I think their services are very good. I wouldn't actually change anything with them... They explain stuff to you, and then they help you, and they give you a choice on different things. I think they're pretty good with that.
>
> **REGIONAL FOOD BANK NEIGHBOR**

Regional Food Bank Impact Report (cont'd)

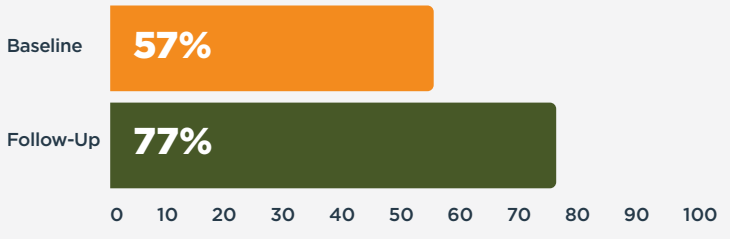
NEIGHBOR SURVEY DEMOGRAPHICS (N=30)*

A total of 30 participants responded to the baseline and follow-up surveys. Three-quarters of participant were women (73%), almost half of participants were White or European American (43%), and one-third of participants were Black or African American (32%).

DEMOGRAPHIC	PERCENT
AGE	
18 to 34	7%
35 to 49	14%
50 to 64	66%
65+	14%
GENDER IDENTITY	
Woman	73%
Man	27%
RACE/ETHNICITY	
White or European American	43%
Black or African American	32%
Hispanic or Latino	14%
Multi-racial/-ethnic	7%
Asian or Asian American	4%

* Total number of participants reflects those who took both a follow-up and baseline survey

Change in General Health



Percent of Participants Reporting Good, Very Good, or Excellent Health

Participant Outcomes

- ✓ Program participants **reported an average 37% improvement in fruit and vegetable intake** compared to baseline.
- ✓ The **percentage of participants who were food insecure at follow-up was reduced by 10%** compared to baseline.
- ✓ Program participants **reported an average of 45% fewer overnight hospitalizations** compared to the baseline period.
- ✓ **20%** of participants who completed the FAM3 program **reported improved general health,** shifting from "poor or fair" to "good, very good, or excellent," compared to the baseline period.

"I made some eggplant parmesan, and they're able to give me food to prepare, you know a meal, and then have leftovers, so I can stretch out what's in my freezer. That's what I really like most about the Food Pharmacy."

REGIONAL FOOD BANK NEIGHBOR

Second Harvest Food Bank of Middle Tennessee

NASHVILLE, TN

PROGRAM OVERVIEW

Second Harvest Food Bank of Middle Tennessee (SHFB) partners with Neighborhood Health (NH) clinics to support their Client Choice Food Pharmacies. NH is a Federally Qualified Health Center comprised of a network of 12 clinics across 3 counties that have provided care for over 45 years, regardless of one's insurance status or ability to pay. Since 2020, each clinic has included a Food Pharmacy where patient navigators help families choose foods that meet their needs and preferences.

PROGRAM MODEL

NH medical staff use a screening tool to ask patients if they want a food box or help applying for Supplemental Nutrition Assistance Program (SNAP). Those who say 'yes' are referred to the onsite pantry, where they receive food and are screened for social needs. Staff record the visit and connect patients to programs like SNAP and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). SHFB also provides culturally relevant nutrition education materials.

Photo Credit: Second Harvest Food Bank of Middle Tennessee

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

26,218

patients received food from the program

Second Harvest Food Bank of Middle Tennessee Impact Report (cont'd)

NEIGHBOR SURVEY DEMOGRAPHICS (N=9)*

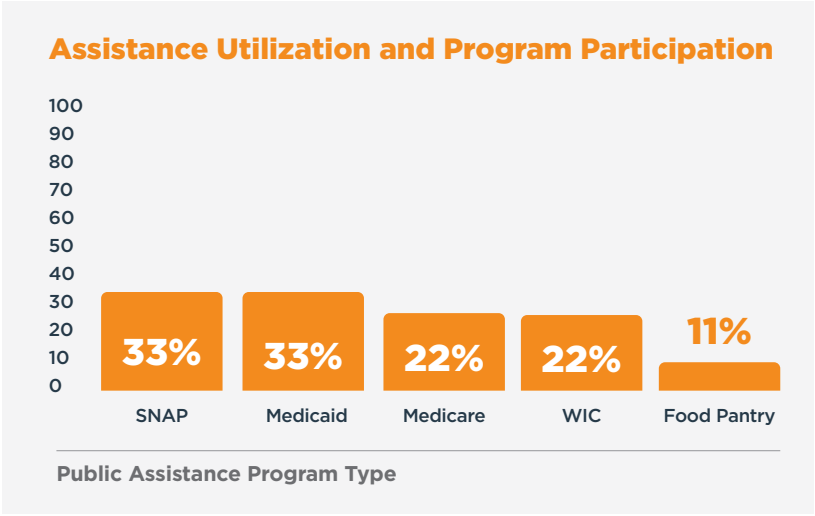
A total of 9 participants responded to the baseline and follow-up surveys. Most of the participants were women (89%) and over half were White or European American (56%).

DEMOGRAPHIC	PERCENT
AGE	
18 to 34	22%
35 to 49	22%
50 to 64	44%
65+	11%
GENDER IDENTITY	
Woman	89%
Man	11%
RACE/ETHNICITY	
White or European American	56%
Black or African American	22%
Hispanic or Latino	11%
Multi-racial/-ethnic	11%

* Total number of participants reflects those who took both a follow-up and baseline survey

PUBLIC ASSISTANCE PARTICIPATION (N=9)

Among survey respondents, one-third participated in SNAP (33%) and/or Medicaid (33%). Nearly a quarter of participants were enrolled in Medicare (22%) and/or WIC (22%). A few participants visited a food pantry (11%).



> "Wanted to get an easy and fast checkup and was told about this clinic. When first walking in, I noticed that they have FREE canned goods and perishable items and also boxed milk and vegetables for patients. Immediately, 5 stars. Spoke to the front desk ladies, who I must say were extremely excited to see me and very helpful with the easy new patient form. They were out of appointments, but I guess with any business if you are kind and polite they will always go over and beyond to help you. I was seen by a nurse practitioner, and I'm glad I followed my first instinct and gave this amazing clinic a try.
>
> **SHFB NEIGHBOR**

> "Very professional and flexible with scheduling. Food available for families if needed, as well as diapers and milk for babies.
>
> **SHFB NEIGHBOR**

FOOD AS MEDICINE 3.0

Impact Report

Anthem Foundation | SECOND HARVEST of SILICON VALLEY

Second Harvest of Silicon Valley

SAN JOSE, CA

PROGRAM OVERVIEW

Since 2016, Second Harvest of Silicon Valley has partnered with local medical providers to improve access to nutritious food and nutrition education for low-income populations. In FAM3, the food bank works with medical entities in Santa Clara and San Mateo counties to integrate food security screening into patient intake to better connect individuals to resources.

PROGRAM MODEL

Physicians use the two-question Hunger Vital Sign tool to screen for food insecurity. If a patient screens positive, providers submit an online referral. Second Harvest staff follow up within two business days to assess needs and connect patients to free groceries, home-delivered food, or eligible government programs. The groceries typically include a balanced mix of fresh produce, protein, and dairy.

Photo Credit: Second Harvest of Silicon Valley

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

283

patients received food from the program

197

patients were referred to SNAP

> Thanks to food banks, many of us have food in our homes, and also thanks to the people who pick vegetables and fruits from the fields.
>
> **SECOND HARVEST OF SILICON VALLEY NEIGHBOR**

FEEDING AMERICA

Second Harvest of Silicon Valley Impact Report (cont'd)

NEIGHBOR SURVEY DEMOGRAPHICS (N=77)*

A total of 77 participants responded to the baseline and follow-up surveys. Almost three-quarters of participants were women (70%) and two-thirds of participants were Hispanic or Latino (66%).

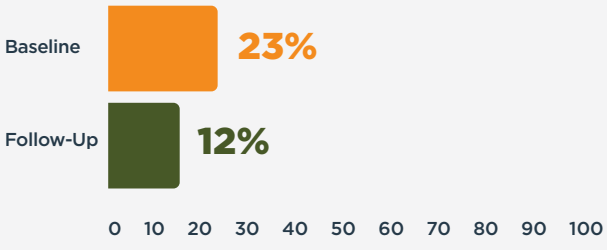
DEMOGRAPHIC	PERCENT
AGE	
18 to 34	25%
35 to 49	35%
50 to 64	32%
65+	8%
GENDER IDENTITY	
Woman	70%
Man	30%
RACE/ETHNICITY	
Hispanic or Latino	66%
Asian or Asian American	12%
White or European American	11%
Black or African American	7%
American Indian or Alaskan Native	3%
Multi-racial/-ethnic	3%

* Total number of participants reflects those who took both a follow-up and baseline survey

Participant Outcomes

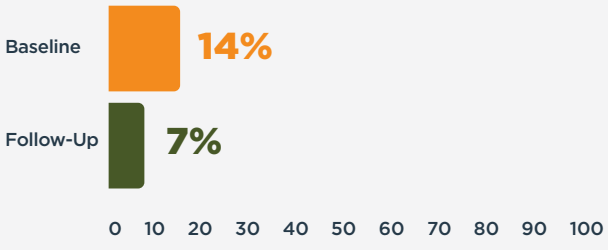
- ✓ Program participants **reported an average of 12% improvement** in daily fruit and vegetable intake compared to baseline.
- ✓ Program participants **reported 40% fewer overnight hospitalizations** compared to the baseline period.
- ✓ **11%** of the participants **reported that they no longer needed to "miss or delay medical care"** due to cost compared to the baseline period.
- ✓ **7%** of program participants **reported that they no longer were "short on medications"** due to cost compared to the baseline period.

Change in Delayed/Missed Care



Percent of Participants Reporting Delayed or Missed Medical Care Due to Cost

Change in Being Short on Medication



Percent of Participants Reporting Being Short of Medications

St. Louis Area Foodbank

BRIDGETON, MO

PROGRAM OVERVIEW

St. Louis Area Foodbank partners with SSM Health System to provide food markets at hospitals across the city's metropolitan area. Participants receive healthy food bags and a referral to the food bank if desired. St. Louis Area Foodbank SNAP outreach coordinators then connect participants to nearby food pantries as well as SNAP, WIC, and government-funded food resources.

PROGRAM MODEL

In partnership with seven hospitals in the SSM Health system, medical professionals screen patients for food insecurity. Those who screen positive are referred to the Bread Basket Program—an in-hospital food pantry, located in a limited-access area within the hospital, that provides low-sodium, shelf-stable foods. Upon discharge, each eligible patient receives a Bread Basket bag containing foods such as canned fruits and vegetables, peanut butter, and shelf-stable milk. Simultaneously, a social worker can refer the patient—via a digital platform—to the St. Louis Area Foodbank, if desired. Within 72 hours, a St. Louis Area Foodbank Community Access Coordinator contacts the patient to share local food pantry locations and provide assistance with public benefits applications.

Photo Credit: St. Louis Area Foodbank

COMMUNITY REACH & ACCESS

(April 2023 – December 2025)

3,397
patients received food from the program

665
patients were referred to SNAP

> "I need to get the food that is the right food for my medical conditions."
>
> **ST. LOUIS AREA FOODBANK NEIGHBOR**

St. Louis Area Foodbank Impact Report (cont'd)

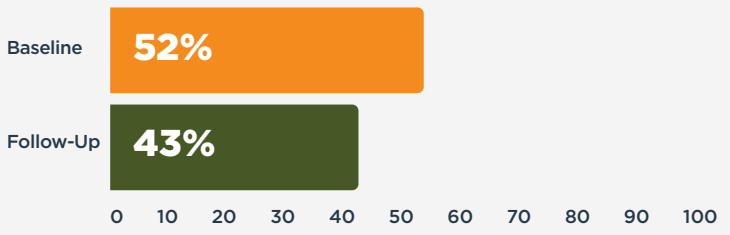
NEIGHBOR SURVEY DEMOGRAPHICS (N=61)*

A total of 61 participants responded to the baseline and follow-up surveys. Three-quarters of participants were women (77%) and over half of participants were White or European American (55%).

DEMOGRAPHIC	PERCENT
AGE	
18 to 34	25%
35 to 49	44%
50 to 64	23%
65+	8%
GENDER IDENTITY	
Woman	77%
Man	21%
Another response	2%
RACE/ETHNICITY	
White or European American	55%
Black or African American	35%
Multi-racial/-ethnic	8%
American Indian or Alaskan Native	2%

*Total number of participants reflects those who took both a baseline and follow-up survey.

Change in Medication Shortages



Percent of Participants Who Reported Running Low on Medication Due to Cost Barriers

Participant Outcomes

- ✓ Program participants reported an average of **17% improvement in their intake of fruits and vegetables**, compared to baseline.
- ✓ Participants reported an average of **7% improvement in their nutrition security**, compared to baseline.
- ✓ Program participants reported an average of **34% fewer overnight hospitalizations**, compared to the baseline period.
- ✓ The percentage of program participants who **felt they needed to miss or delay medical care due to cost, reduced by 8%**, compared to baseline.
- ✓ The percentage of program participants who reported **struggling to afford medications, reduced by 9%**, compared to baseline.

> "Healthy food is expensive, [especially] trying to stay within a diabetic and cardiac diet. Unfortunately, fresh fruits and vegetables are expensive and have a short shelf life.

ST. LOUIS AREA FOODBANK NEIGHBOR

Glossary

TERM/PHRASE	DEFINITION
Neighbor	People who access food and resources through the charitable food system.
Participant	Neighbors enrolled in FAM3 programming at their respective food bank/health care partner site.
Health care partner	Sites that partner with food banks for screening and referral (e.g., clinics and hospitals).
Food bank	Feeding America Network food banks who lead FAM3 projects.
Food as Medicine (FAM)	The provision of healthy food such as produce prescriptions, medically tailored groceries, and medically tailored meals to treat, manage, or prevent diet-related health conditions in a way that is integrated with and paid for by the health care sector.25
PROGRAM DESIGN CATEGORIES	
Foundational	Programs that offer one-time food support (e.g., a food box or onsite pantry at a medical appointment, referral to a food pantry, etc.).
Enhanced	Programs that offer food support multiple times and/or help participants apply for SNAP.
Comprehensive	Programs that offer food support multiple times, offer nutrition education, may help participants apply for SNAP, and/or have diet-related condition enrollment criteria.
PROGRAM CHARACTERISTICS	
In-clinic food provision	FAM3 programs that distribute food in the clinical setting, such as a clinic-based food pharmacy, pantry, or box program. These programs may have also distributed food in other ways outside of the clinic.
Defined food distribution	FAM3 programs that involve multiple standardized or supported/planned food distributions. These FAM3 program activities are designed to actively provide food to participants multiple times (e.g., participants attend a nutrition education course series and get food distributed when they attend each class).
Diet-related condition enrollment criteria	FAM3 programs with eligibility criteria that include both food insecurity and the presence of a diet-related condition (e.g., high blood pressure, diabetes, etc.).
Structured nutrition education	FAM3 programs that provide guided group or individual (1:1) nutrition education alongside food distributions.
Active benefit enrollment support	FAM3 programs that have food bank or health care partner staff directly help FAM3 participants start and/or complete benefits enrollment applications (e.g., SNAP applications).
Program engagement	The number of times participants reported picking up food from their FAM3 program.
Reach	The total number of individuals at key touchpoints from FAM3 program eligibility assessment and referral to enrollment and access.
Health care claims	Administrative billing records documenting health care utilization and services.
Difference-in-differences analysis	A statistical method that compares changes over time between a treatment group and a comparison group to estimate program impact.
Holm Bonferroni procedure	A statistical method that adjusts the significance level used for statistical testing when multiple tests are conducted.

SURVEY OUTCOME VARIABLES	
Fruit and vegetable intake	Frequency of consuming fruits, green salad, and non-fried potatoes during the past week.
Nutrition security	Having consistent and equitable access, availability, and affordability of foods and beverages that promote well-being and prevent (or treat) disease.[26]
Food security	Access by all people at all times to enough food for an active, healthy life.[27]
General health	A state of complete physical, mental, and social wellbeing, not merely the absence of disease or infirmity.[28]
Overnight hospitalization	When a patient receives care in a hospital that requires them to be admitted as an inpatient for at least one overnight stay. The number of overnight hospitalizations were measured within a specific time period.
Emergency department visits	Number of emergency room visits within a specific time period.
Delayed care	Frequency of missing or delaying medical care due to cost.
Short on medication	Frequency of being unable to obtain prescribed medication due to cost.
Program sustainability	The ability to maintain programming over time.[17]
PROGRAM SUSTAINABILITY ASSESSMENT TOOL (PSAT) DOMAINS[17]	
Communications	Communicating strategically with partners and the public about your program.
Environmental Support	Having a supportive internal and external climate for your program.
Organizational Capacity	Having the internal support and resources needed to effectively manage your program.
Partnerships	Cultivating connections between your program and its partners.
Program Adaptation	Taking actions that adapt your program to ensure its ongoing effectiveness.
Program Evaluation	Assessing your program to inform planning and document results.
Strategic Planning	Using processes that guide your program's directions, goals, and strategies.
CLINICAL SUSTAINABILITY ASSESSMENT TOOL DOMAINS[18]	
Engaged Staff & Leadership	Having supportive frontline staff and management within the organization.
Engaged Partners	Having external support and engagement for the clinical practice.
Organizational Readiness	Having the internal support and resources needed to effectively manage the practice.
Workflow Integration	Designing the practice to fit into existing processes, policies, and technologies.
Implementation & Training	Promoting processes and learning that guide the direction, goals and strategies of the practice.
Monitoring & Evaluation	Assessing the practice to inform planning and document results.
Outcome & Effectiveness	Understanding and measuring practice outcomes and impact.

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Supplemental Materials

Appendix

APPENDIX A. Technical Assistance Learning Collaborative

Across all three years of FAM3, Feeding America and CNHI supported grantees through a structured Learning Collaborative designed to build knowledge, strengthen peer connections, and advance implementation across the network. Many sessions included food bank panelists from participating food banks or experts in the field.

- In Year One, CNHI and grantees co-designed the evaluation approach, unique to each food banks program, to support the data collection process. Learning sessions featured panelists from grantees and covered foundational topics including evaluation approaches, neighbor engagement, health care partnerships and data sharing, and equitable program design.

- During Year Two, Learning Collaborative sessions included data visualization led by the Urban Institute, an in-person Food as Medicine Summit in Chicago that situated grantees' work within the broader FAM policy and research landscape, a presentation from CNHI on evaluation findings, and a workshops from the Urban Institute and from the Aspen Institute's Food & Society program on their Food as Medicine Research Action Plan.

- By Year Three, sessions covered culturally preferred foods in FAM program design, best practices for working with external evaluation partners, and the role of registered dietitians in food as medicine programs, including a session offering continuing education credits for Registered Dietitians. A two-day in-person convening in Houston in Year Three brought the full cohort together alongside national experts from UCSF and the Center for Health Law and Policy Innovation at Harvard Law School (CHLPI) for peer exchange, policy discussions, and workshops that showcased innovative and impactful approaches from the different food banks' program models.

Throughout the initiative, technical assistance supported learning in the form of regular Action Period Meetings between each food bank, their health care partners, and Feeding America and CNHI staff. In-person site visits complemented virtual learning, with Feeding America and CNHI's teams, and Elevance Health's local affiliates visiting grantees across the country to observe programs in action and support implementation. Overall, Learning Collaborative activities enabled food banks to strengthen evaluation capacity, learn from one another, and contribute to a growing body of field knowledge.

Further details about the Learning Collaborative are described in reports in the annual FAM3 reports on feedingamerica.org/research/hunger-and-health.

APPENDIX B. Evaluation Metrics

REACH METRICS

Food bank staff and health care partners tracked and reported data on program reach on a quarterly basis from Year One to Year Three. These data included the counts of patients who were screened for food insecurity, referred to a FAM3 program, provided with food from a FAM3 program, and assisted with Supplemental Nutrition Assistance Program (SNAP) applications.

OUTCOME METRICS

CNHI worked with FAM3 participants, food banks, health care partners, and Elevance Health in Years Two and Three to gather data on the impact of FAM3 participation on neighbors' well-being and health care utilization. Data were collected via a baseline and follow-up FAM3 Neighbor Survey, as well as electronic health records (EHR) and insurance claims data among a sub-sample of participants. The diet- and health-related metrics included variables such as self-reported fruit and vegetable intake, food and nutrition security, general health, health care utilization (both reported and observed through insurance claims data), and clinical data among a sub-sample of participants (e.g., Hemoglobin A1c, body mass index, cholesterol, blood pressure, etc.). These data analyses assessed baseline-to-follow-up changes, and comparison to a matched control group in the insurance claims analyses.

IMPLEMENTATION METRICS

CNHI pursued several activities to understand barriers, facilitators, and best practices for implementing FAM3 programs. Food bank program staff and their health care partners were interviewed following the Consolidated Framework for Implementation Research (CFIR) to learn more about their FAM3 programs, including the barriers and facilitators to implementation.[19] Longitudinal interviews were conducted with some FAM3 participants to better understand their experiences across the program, from screening and referral through food access and program impacts.[15] Quotes from these interviews are woven throughout the report. These findings were previously reported in the Year Two Report[15] and are highlighted on page 37. Also, FAM3 food bank leads responded to a survey to understand program and clinical capacity for sustaining FAM3 programs. In this survey, leads also reported on strategies used to facilitate FAM3 and identified resources and supports needed to improve their capacity to sustain the program. Lastly, implementation successes and challenges were documented via meeting notes during quarterly meetings with each of the 21 food banks to offer a long-term perspective on implementation to complement interview and survey data. This report presents selected data from the FAM3 sustainability assessment and implementation notes and highlights findings from interviews with FAM3 participants, food bank staff, and health care partners.

APPENDIX C. Descriptive Statistics for Post-Survey Sample (n=1,490)

CATEGORY	n (%)
AGE	**n (%)**
18 to 34	361 (24.5%)
35 to 49	456 (31.0%)
50 to 64	459 (31.2%)
65 to 91	196 (13.3%)
GENDER IDENTITY	**n (%)**
Woman	1,151 (78.0%)
Man	317 (21.5%)
Another response	7 (0.5%)
RACE/ETHNICITY	**n (%)**
Black or African American	538 (37.1%)
White or European American	446 (30.7%)
Hispanic or Latino	363 (25.0%)
Multi-racial/-ethnic	59 (4.1%)
Asian or Asian American	26 (1.8%)
American Indian or Alaskan Native	10 (0.7%)
Middle Eastern or North African	9 (0.6%)
Native Hawaiian or Pacific Islander	1 (0.1%)
LANGUAGE OF PREFERENCE	**n (%)**
English	1,262 (84.8%)
Spanish	224 (15.0%)
Another response	3 (0.2%)
CHILDREN IN HOUSEHOLD	**n (%)**
Yes	809 (55.2%)
No	657 (44.8%)
SNAP HOUSEHOLD[D]	**n (%)**
Yes	621 (42.6%)
No	838 (57.4%)
WIC HOUSEHOLD[E]	**n (%)**
Yes	229 (15.7%)
No	1,230 (84.3%)
FOOD PANTRY HOUSEHOLD	**n (%)**
Yes	693 (47.5%)
No	766 (52.5%)

APPENDIX D. FAM3 Neighbor Pre-Survey

DEMOGRAPHICS[5,6,8]

1. How many total people (adults and children) currently live in your household, including yourself?

a. 1
b. 2
c. 3
d. 4
e. 5
f. 6
g. 7
h. 8
i. 9
j. 10 or more
l. Don't know or prefer not to answer

2. Of the people who live in your household, how many of them are children under the age of 18?

a. 1
b. 2
c. 3
d. 4
e. 5
f. 6
g. 7
h. 8
i. 9
j. 10 or more
l. Don't know or prefer not to answer

3. Do you describe yourself as a man, a woman, or in some other way?

a. A man
b. A woman
c. Some other way
e. Don't know or prefer not to answer

4. Can you please write your age?

a. Enter your age in years: _____
b. Don't know or prefer not to answer

5. How would you describe your racial or ethnic background?
(Select all that apply)

☐ American Indian or Alaskan Native
☐ Asian or Asian American
☐ Black or African American
☐ Hispanic or Latino
☐ Middle Eastern or North African
☐ Native Hawaiian or Pacific Islander
☐ White or European American
☐ Another race or ethnicity not mentioned (please specify):
_____
☐ Don't know or prefer not to answer

HEALTH CONDITIONS[14]

6. Has a doctor, nurse, or other health professional ever told you that you had any of the following?
(Select all that apply).

☐ High blood pressure
☐ High cholesterol
☐ Heart disease
☐ Stroke
☐ Kidney disease
☐ Diabetes or pre-diabetes
☐ Cancer
☐ None of the above
☐ Don't know or prefer not to answer

GENERAL HEALTH[9]

7. Would you say that in general your health is...

a. Excellent
b. Very good
c. Good
d. Fair
e. Poor
f. Don't know or prefer not to answer

ASSISTANCE UTILIZATION[8]

8. Which of the following do you or anyone in your household currently participate in?
(Select all that apply)

☐ Free or reduced-price school lunch or breakfast program, or summer meals program.
☐ Food pantry, food bank, food shelf, or other similar place that helps with free food.
☐ Food stamps, SNAP EBT, or [INSERT STATE-SPECIFIC NAME]
☐ WIC (Program for Women, Infants, & Children).
☐ Medicare, for people 65 and older, or people with certain disabilities.
☐ Medicaid, [INCLUDE STATE NAMES AS APPLICABLE], or any kind of government-sponsored health plan based on income.
☐ Other: _____
☐ None of the above
☐ Don't know or prefer not to answer

HEALTH CARE UTILIZATION[12]

9. In the past [INSERT TAILORED PROGRAM LENGTH], how many different times did you stay overnight at a hospital due to health issues?

a. None
b. 1 time
c. 2 to 3 times
d. 4 to 5 times
e. 6 to 7 times

f. 8 to 9 times
g. More than 10 times
h. Don't know or prefer not to answer

10. In the past [INSERT TAILORED PROGRAM LENGTH], how many times were you a patient in an emergency room?
a. None
b. 1 time
c. 2 to 3 times
d. 4 to 5 times
e. 6 to 7 times
f. 8 to 9 times
g. More than 10 times
h. Don't know or prefer not to answer

11. In the past [INSERT TAILORED PROGRAM LENGTH], how often were you short on medications because you could not afford them?
a. Never
b. Rarely
c. Sometimes
d. Often
e. Not applicable
f. Don't know or prefer not to answer

12. In the past [INSERT TAILORED PROGRAM LENGTH], how often have you missed or delayed medical care because you could not afford it?
a. Never
b. Rarely
c. Sometimes
d. Often
e. Not applicable
f. Don't know or prefer not to answer

DIETARY ITEMS[8]

13. During the past week, how many times did you eat fruit like apples, bananas, oranges, melon, or any other fruit?
Include fresh, frozen, canned, and dried fruit.
Don't count juices.
a. I did not eat fruit during the past week
b. 1-3 times in the past week
c. 4-6 times in the past week
d. 1 time a day
e. 2 times a day
f. 3 or more times a day
g. Don't know or prefer not to answer

14. During the past week, how many times did you eat a green salad with lettuce and with or without other vegetables?
a. I did not eat green salad during the past week
b. 1-3 times in the past week
c. 4-6 times in the past week
d. 1 time a day
e. 2 times a day
f. 3 or more times a day
g. Don't know or prefer not to answer

15. During the past week, how many times did you eat any kind of potatoes that are not fried. Include baked, boiled, or mashed potatoes, or potatoes in soups and stews.
a. I did not eat non-fried potatoes during the past week
b. 1-3 times in the past week
c. 4-6 times in the past week
d. 1 time a day
e. 2 times a day
f. 3 or more times a day
g. Don't know or prefer not to answer

16. During the past week, how many times did you eat vegetables that are not deep fried? Include vegetables like carrots, broccoli, collards, green beans, corn, or other vegetables that are not deep fried.
Include canned, frozen, or fresh vegetables.
Include vegetables that are raw, boiled, broiled, baked, grilled, stir-fried, or microwaved.
a. I did not eat non-fried vegetables during the past week
b. 1-3 times in the past week
c. 4-6 times in the past week
d. 1 time a day
e. 2 times a day
f. 3 or more times a day
g. Don't know or prefer not to answer

17. During the past week, how many times did you eat cooked beans, like refried beans, baked beans, pinto beans, black beans, or other cooked beans?
Include canned or dry beans.
Don't count green beans or string beans.
a. I did not eat beans during the past week
b. 1-3 times in the past week
c. 4-6 times in the past week
d. 1 time a day
e. 2 times a day
f. 3 or more times a day
g. Don't know or prefer not to answer

FOOD SECURITY[2]

18. In the last 30 days, (I/we) worried whether (my/our) food would run out before (I/we) got money to buy more.
a. Often true
b. Sometimes true
c. Never true
d. Don't know or prefer not to answer

19. In the last 30 days, the food that (I/we) bought just didn't last, and (I/we) didn't have money to get more.
a. Often true
b. Sometimes true
c. Never true
d. Don't know or prefer not to answer

NUTRITION SECURITY[7]

20. In the last 30 days, (I/we) had to eat some foods that were not good for (my/our) health and well-being because (I/we) couldn't get other types of food.
a. Never
b. Rarely
c. Sometimes
d. Often
e. Always
f. Don't know or prefer not to answer

21. In the last 30 days, (I/we) knew there were things (I/we) should or should not eat for (my/our) health and well-being, but could not get healthful food.
a. Never
b. Rarely
c. Sometimes
d. Often
e. Always
f. Don't know or prefer not to answer

22. In the last 30 days, (I/we) worried that the food (I was/we were) able to eat would hurt (my/our) health and well-being.
a. Never
b. Rarely
c. Sometimes
d. Often
e. Always
f. Don't know or prefer not to answer

23. In the last 30 days, (I/we) had to eat the same thing for several days in a row because (I/we) didn't have money to buy other food.
a. Never
b. Rarely
c. Sometimes
d. Often
e. Always
f. Don't know or prefer not to answer

QUALITY OF LIFE[10,11]

Under each heading, please check the ONE box that best describes your health TODAY.

24. MOBILITY
a. I have no problems walking.
b. I have slight problems walking.
c. I have moderate problems walking.
d. I have severe problems walking.
e. I am unable to walk.

25. SELF-CARE
a. I have no problems washing or dressing myself.
b. I have slight problems washing or dressing myself.
c. I have moderate problems washing or dressing myself.
d. I have severe problems washing or dressing myself.
e. I am unable to wash or dress myself.

26. USUAL ACTIVITIES (e.g., work, study, housework, family or leisure activities)
a. I have no problems doing my usual activities.
b. I have slight problems doing my usual activities.
c. I have moderate problems doing my usual activities.
d. I have severe problems doing my usual activities.
e. I am unable to do my usual activities.

27. PAIN / DISCOMFORT
a. I have no pain or discomfort.
b. I have slight pain or discomfort.
c. I have moderate pain or discomfort.
d. I have severe pain or discomfort.
e. I have extreme pain or discomfort.

28. ANXIETY / DEPRESSION
a. I am not anxious or depressed.
b. I am slightly anxious or depressed.
c. I am moderately anxious or depressed.
d. I am severely anxious or depressed.
e. I am extremely anxious or depressed.

APPENDIX E. FAM3 Neighbor Post-Survey

PROGRAM EXPOSURE

1. **In the past [INSERT TAILORED PROGRAM LENGTH], how many times did you or anyone else in your household get [INSERT NAME FOR MODE/TYPE OF FOOD DISTRIBUTION] from [INSERT NAME OF PROGRAM THE PARTICIPANT WOULD KNOW] [OR A FOOD PANTRY YOU LEARNED ABOUT FROM THE PROGRAM]?**
   a. Never
   b. 1 time
   c. 2-3 times
   d. 4-5 times
   e. 6-10 times
   f. More than 10 times
   g. Don't know or prefer not to answer

2. **In the past [INSERT TAILORED PROGRAM LENGTH], did [INSERT NAME OF THE ROLE/ PERSON THEY WOULD KNOW] at [INSERT NAME OF PROGRAM THE PARTICIPANT WOULD KNOW] help you or anyone else in your household get connected to any government food assistance programs?**
   For example, programs like food stamps or SNAP EBT, or [INSERT STATE-SPECIFIC SNAP NAME], free or reduced-price school lunch program, or WIC (Program for Women, Infants, & Children).
   a. Yes
   b. No
   c. Don't know or prefer not to answer

3. **In the past [INSERT TAILORED PROGRAM LENGTH], did a staff person at your healthcare clinic give you information about other food banks, food pantries, or similar places or programs that offer free food in your area?**
   a. Yes
   b. No
   c. Don't know or prefer not to answer

4. **In the past [INSERT TAILORED PROGRAM LENGTH], did you or anyone in your household learn about [INSERT RELEVANT NUTRITION TOPIC OR ACTIVITY] from [INSERT MODE AND/ OR NAME OF PROGRAM THE PARTICIPANT WOULD KNOW]?**
   a. Yes
   b. No
   c. Don't know or prefer not to answer

GENERAL HEALTH

5. **Would you say that in general your health is…**
   a. Excellent
   b. Very good
   c. Good
   d. Fair
   e. Poor
   f. Don't know or prefer not to answer

HEALTH CARE UTILIZATION

6. **In the past [INSERT TAILORED PROGRAM LENGTH], how many different times did you stay overnight at a hospital due to health issues?**
   a. None
   b. 1 time
   c. 2 to 3 times
   d. 4 to 5 times
   e. 6 to 7 times
   f. 8 to 9 times
   g. More than 10 times
   h. Don't know or prefer not to answer

7. **In the past [INSERT TAILORED PROGRAM LENGTH], how many times were you a patient in an emergency room?**
   a. None
   b. 1 time
   c. 2 to 3 times
   d. 4 to 5 times
   e. 6 to 7 times
   f. 8 to 9 times
   g. More than 10 times
   h. Don't know or prefer not to answer

8. **In the past [INSERT TAILORED PROGRAM LENGTH], how often were you short on medications because you could not afford them?**
   a. Never
   b. Rarely
   c. Sometimes
   d. Often
   e. Not applicable
   f. Don't know or prefer not to answer

9. **In the past [INSERT TAILORED PROGRAM LENGTH], how often have you missed or delayed medical care because you could not afford it?**
   a. Never
   b. Rarely
   c. Sometimes

d. Often
e. Not applicable
f. Don't know or prefer not to answer

DIETARY ITEMS

10. During the past week, how many times did you eat fruit like apples, bananas, oranges, melon, or any other fruit?
Include fresh, frozen, canned, and dried fruit.
Don't count juices.
a. I did not eat fruit during the past week
b. 1-3 times in the past week
c. 4-6 times in the past week
d. 1 time a day
e. 2 times a day
f. 3 or more times a day
g. Don't know or prefer not to answer

11. During the past week, how many times did you eat a green salad with lettuce and with or without other vegetables?
a. I did not eat green salad during the past week
b. 1-3 times in the past week
c. 4-6 times in the past week
d. 1 time a day
e. 2 times a day
f. 3 or more times a day
g. Don't know or prefer not to answer

12. During the past week, how many times did you eat any kind of potatoes that are not fried. Include baked, boiled, or mashed potatoes, or potatoes in soups and stews.
a. I did not eat non-fried potatoes during the past week
b. 1-3 times in the past week
c. 4-6 times in the past week
d. 1 time a day
e. 2 times a day
f. 3 or more times a day
g. Don't know or prefer not to answer

13. During the past week, how many times did you eat vegetables that are not deep fried? Include vegetables like carrots, broccoli, collards, green beans, corn, or other vegetables that are not deep fried.
Include canned, frozen, or fresh vegetables.
Include vegetables that are raw, boiled, broiled, baked, grilled, stir-fried, or microwaved.
a. I did not eat non-fried vegetables during the past week
b. 1-3 times in the past week
c. 4-6 times in the past week
d. 1 time a day
e. 2 times a day
f. 3 or more times a day
g. Don't know or prefer not to answer

14. During the past week, how many times did you eat cooked beans, like refried beans, baked beans, pinto beans, black beans, or other cooked beans?
Include canned or dry beans.
Don't count green beans or string beans.
a. I did not eat beans during the past week
b. 1-3 times in the past week
c. 4-6 times in the past week
d. 1 time a day
e. 2 times a day
f. 3 or more times a day
g. Don't know or prefer not to answer

FOOD SECURITY

15. In the last 30 days, (I/we) worried whether (my/our) food would run out before (I/we) got money to buy more.
a. Often true
b. Sometimes true
c. Never true
d. Don't know or prefer not to answer

16. In the last 30 days, the food that (I/we) bought just didn't last, and (I/we) didn't have money to get more.
a. Often true
b. Sometimes true
c. Never true
d. Don't know or prefer not to answer

NUTRITION SECURITY

17. In the last 30 days, (I/we) had to eat some foods that were not good for (my/our) health and well-being because (I/we) couldn't get other types of food.
a. Never
b. Rarely
c. Sometimes
d. Often
e. Always
f. Don't know or prefer not to answer

18. In the last 30 days, (I/we) knew there were things (I/we) should or should not eat for (my/our) health and well-being, but could not get healthful food.
a. Never
b. Rarely

c. Sometimes
d. Often
e. Always
f. Don't know or prefer not to answer

19. In the last 30 days, (I/we) worried that the food (I was/we were) able to eat would hurt (my/our) health and well-being.

a. Never
b. Rarely
c. Sometimes
d. Often
e. Always
f. Don't know or prefer not to answer

20. In the last 30 days, (I/we) had to eat the same thing for several days in a row because (I/we) didn't have money to buy other food.

a. Never
b. Rarely
c. Sometimes
d. Often
e. Always
f. Don't know or prefer not to answer

QUALITY OF LIFE

Under each heading, please check the ONE box that best describes your health TODAY.

21. MOBILITY

a. I have no problems walking.
b. I have slight problems walking.
c. I have moderate problems walking.
d. I have severe problems walking.
e. I am unable to walk.

22. SELF-CARE

a. I have no problems washing or dressing myself.
b. I have slight problems washing or dressing myself.
c. I have moderate problems washing or dressing myself.
d. I have severe problems washing or dressing myself.
e. I am unable to wash or dress myself.

23. USUAL ACTIVITIES (e.g., work, study, housework, family or leisure activities)

a. I have no problems doing my usual activities.
b. I have slight problems doing my usual activities.
c. I have moderate problems doing my usual activities.
d. I have severe problems doing my usual activities.
e. I am unable to do my usual activities.

24. PAIN / DISCOMFORT

a. I have no pain or discomfort.
b. I have slight pain or discomfort.
c. I have moderate pain or discomfort.
d. I have severe pain or discomfort.
e. I have extreme pain or discomfort.

25. ANXIETY / DEPRESSION

a. I am not anxious or depressed.
b. I am slightly anxious or depressed.
c. I am moderately anxious or depressed.
d. I am severely anxious or depressed.
e. I am extremely anxious or depressed.

SITE-SPECIFIC QUESTIONS

Items customized to each site's program and questions of interest

APPENDIX F. FAM3 Neighbor Survey Results

	All Participants	Participant Engagement	Participants with Each Program Characteristic				
	Overall FAM3 initiative (all programs)	**Multiple food pickups (2+ times)**	**Structured nutrition education (Yes)**	**Defined food distribution (Yes)**	**In-clinic food provision (Yes)**	**Active benefit enrollment support (Yes)**	**Diet-related condition (Yes)**
Nutrition Security	0.10 [0.06, 0.13]	0.09 [0.02, 0.16]	0.15 [0.09, 0.22]	0.11 [0.04, 0.17]	0.11 [0.06, 0.15]	0.09 [0.03, 0.15]	0.11 [-0.02, 0.24]
Food Security	2.39 [1.05, 5.41]	1.33 [0.68, 2.61]	5.92 [1.03, 33.93]	3.27 [0.76, 14.01]	3.05 [1.14, 8.15]	3.06 [0.88, 10.63]	2.01 [0.75, 5.42]
Fruit and Vegetable Intake	0.01 [-0.08, 0.10]	0.12 [-0.01, 0.26]	0.10 [-0.22, 0.43]	0.09 [-0.07, 0.25]	0.00 [-0.10, 0.10]	0.06 [-0.08, 0.21]	0.27 [0.04, 0.51]
General Health	0.01 [-0.08, 0.09]	0.08 [0.01, 0.16]	0.16 [0.08, 0.24]	0.06 [-0.06, 0.18]	-0.02 [-0.12, 0.08]	0.07 [0.00, 0.13]	0.12 [-0.02, 0.26]
Overnight Hospitalizations	-0.05 [-0.09, -0.01]	-0.02 [-0.08, 0.04]	-0.12 [-0.24, 0.00]	-0.07 [-0.14, 0.00]	-0.06 [-0.11, -0.02]	-0.07 [-0.14, -0.01]	-0.15 [-0.32, 0.02]
Emergency Department Visits	-0.04 [-0.06, -0.01]	-0.02 [-0.06, 0.03]	-0.06 [-0.13, 0.02]	-0.04 [-0.08, 0.00]	-0.04 [-0.07, -0.01]	-0.03 [-0.06, 0.00]	-0.08 [-0.18, 0.02]
Delay Medical Care	-0.04 [-0.11, 0.03]	-0.03 [-0.12, 0.07]	-0.15 [-0.23, -0.07]	-0.07 [-0.15, 0.02]	-0.06 [-0.14, 0.03]	-0.11 [-0.19, -0.02]	-0.12 [-0.24, 0.00]
Short on Medications	-0.03 [-0.10, 0.04]	0.02 [-0.07, 0.11]	-0.12 [-0.17, -0.07]	-0.05 [-0.16, 0.07]	-0.06 [-0.13, 0.02]	-0.08 [-0.15, -0.001]	-0.13 [-0.21, -0.05]

[A] Adjusted regression coefficients are presented for nutrition security, fruit and vegetable intake, and general health; Adjusted odds ratios are presented for food security

NUTRITION SECURITY

Program characteristic	Change in NS (95% CI)
Overall FAM3 initiative (all programs)	0.10 (0.06, 0.13)
Multiple food pickups (2+ times)	0.09 (0.02, 0.16)
Structured nutrition education (Yes)	0.15 (0.09, 0.22)
Defined food distribution (Yes)	0.11 (0.04, 0.17)
In-clinic food provision (Yes)	0.11 (0.06, 0.15)
Active benefit enrollment support (Yes)	0.09 (0.03, 0.15)
Diet-related condition (Yes)	0.11 (-0.02, 0.24)

Differences in Nutrition Security by Group Membership

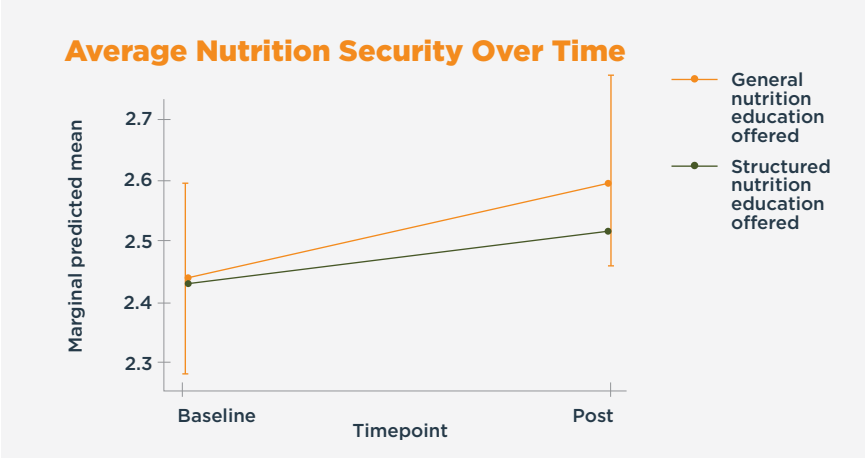
INTERPRETATION

Structured nutrition education

The improvement in nutrition security scores were larger for participants who enrolled in programs offering structured nutrition education compared to those who offered general nutrition education.

The average improvements were relatively small for both groups – this is seen looking at the y-axis of the graph.

GRAPH



FOOD SECURITY

Program characteristic	Adjusted Odds of FS (95% CI)
Overall FAM3 initiative (all programs)	2.39 (1.05, 5.41)
Multiple food pickups (2+ times)	1.33 (0.68, 2.61)
Structured nutrition education (Yes)	5.92 (1.03, 33.93)
Defined food distribution (Yes)	3.27 (0.76, 14.01)
In-clinic food provision (Yes)	3.05 (1.14, 8.15)
Active benefit enrollment support (Yes)	3.06 (0.88, 10.63)
Diet-related condition (Yes)	2.01 (0.75, 5.42)

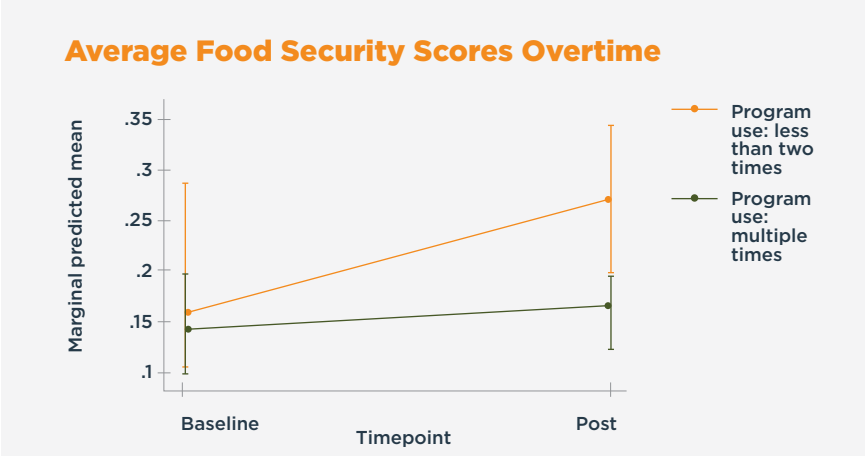
Differences in Food Security by Group Membership

INTERPRETATION

Program Use / Multiple Food Pickups

The improvement in food security scores was larger for participants who used programming less than 2 times compared to those who used programming multiple times.

GRAPH



DAILY FRUIT & VEGETABLE INTAKE (FVI) FREQUENCY

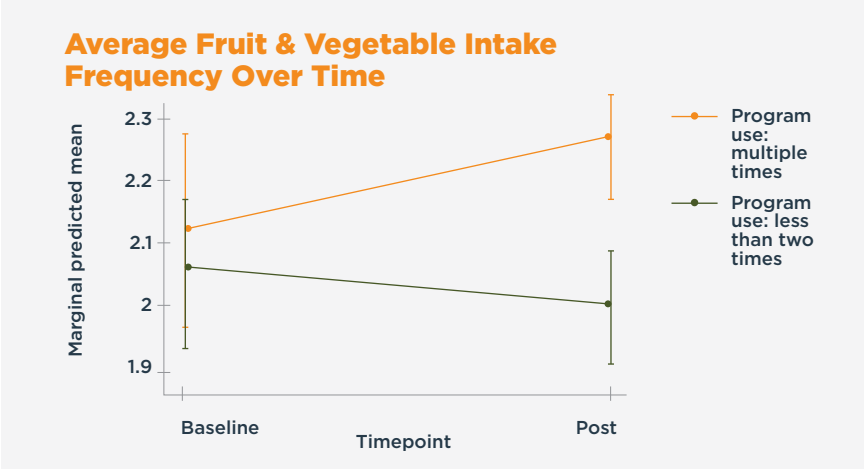
Program characteristic	Change in FVI (95% CI)
Overall FAM3 initiative (all programs)	0.01 (-0.08, 0.10)
Multiple food pickups (2+ times)	0.12 (-0.01, 0.26)
Structured nutrition education (Yes)	0.10 (-0.22, 0.43)
Defined food distribution (Yes)	0.09 (-0.07, 0.25)
In-clinic food provision (Yes)	0.00 (-0.10, 0.10)
Active benefit enrollment support (Yes)	0.06 (-0.08, 0.21)
Diet-related condition (Yes)	0.27 (0.04, 0.51)

Differences in FVI by Group Membership

INTERPRETATION **GRAPH**

Participant engagement

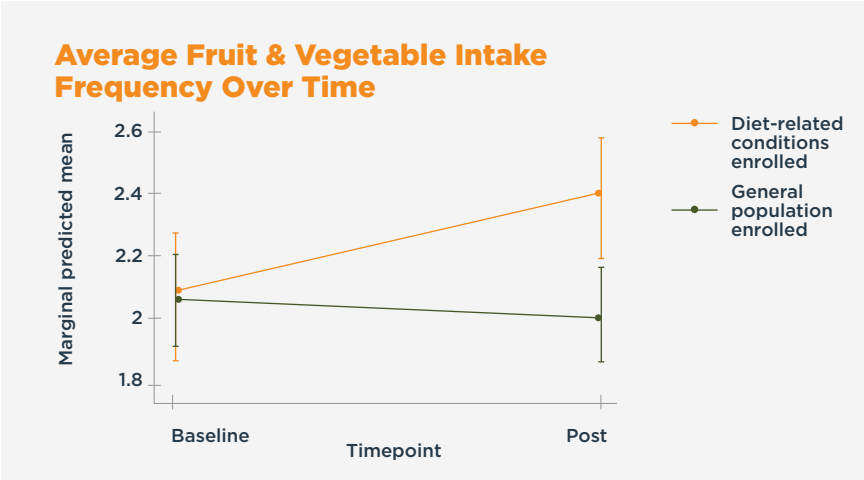
The improvement in fruit and vegetable intake frequency was larger for participants who used the programming multiple times vs. those that used the program less than 2 times.



Diet-related condition

The improvement in fruit and vegetable intake frequency was larger for participants who enrolled in programs focusing on diet related conditions vs. those that enrolled a general patient population.

Overall, participants who enrolled in programs focusing on diet-related condition enrollment reported increases in their fruit and vegetable intake frequency over time.



GENERAL HEALTH

Program characteristic	Change in General Health (95% CI)
Overall FAM3 initiative (all programs)	0.01 (-0.08, 0.09)
Multiple food pickups (2+ times)	0.08 (0.01, 0.16)
Structured nutrition education (Yes)	0.16 (0.08, 0.24)
Defined food distribution (Yes)	0.06 (-0.06, 0.18)
In-clinic food provision (Yes)	-0.02 (-0.12, 0.08)
Active benefit enrollment support (Yes)	0.07 (0.00, 0.13)
Diet-related condition enrollment criteria (Yes)	0.12 (-0.02, 0.26)

Differences in General Health by Group Membership

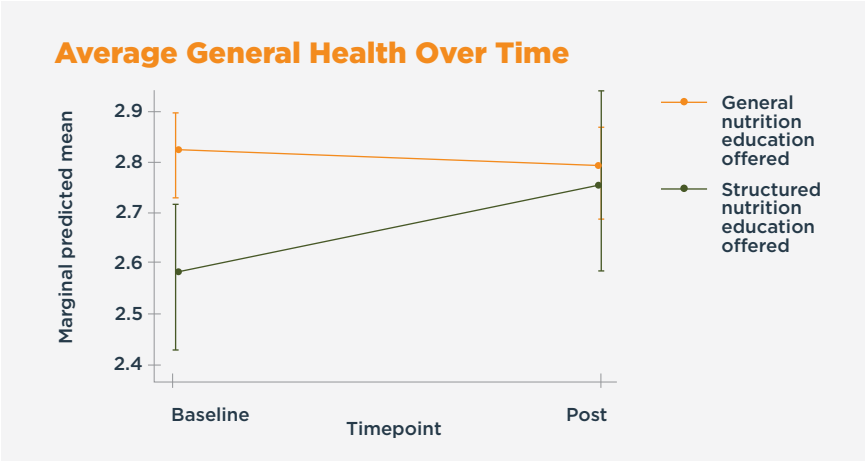
INTERPRETATION

Structured nutrition education

The improvements in general health scores were larger for participants who enrolled in programs offering structured nutrition education vs. those that offered general nutrition education.

Overall, participants who enrolled in programs offering structured nutrition education reported improvements in their general health over time.

GRAPH



OVERNIGHT HOSPITALIZATIONS

Program characteristic	Change in Overnight Hospitalizations (95% CI)
Overall FAM3 initiative (all programs)	-0.05 (-0.09, -0.01)
Multiple food pickups (2+ times)	-0.02 (-0.08, 0.04)
Structured nutrition education (Yes)	-0.12 (-0.24, 0.00)
Defined food distribution (Yes)	-0.07 (-0.14, 0.00)
In-clinic food provision (Yes)	-0.06 (-0.11, -0.02)
Active benefit enrollment support (Yes)	-0.07 (-0.14, -0.01)
Diet-related condition enrollment criteria (Yes)	-0.15 (-0.32, 0.02)

Differences in Overnight Hospitalizations by Group Membership

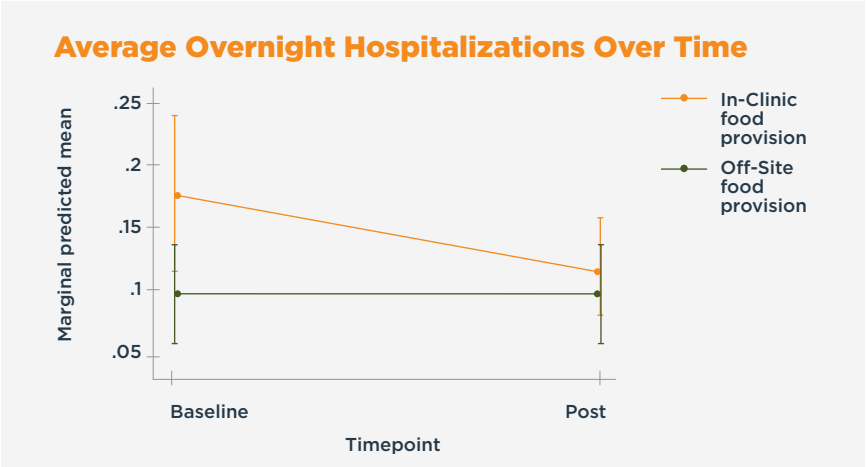
INTERPRETATION

In-clinic food provision

The decreases in average overnight hospitalizations were larger for participants who enrolled in programs offering in-clinic food provision vs. those that offered off-site food provision.

Overall, participants who enrolled in programs offering in-clinic food provision reported decreases in their average overnight hospitalizations over time.

GRAPH



EMERGENCY DEPARTMENT VISITS

Program characteristic	Change in Emergency Department Visits (95% CI)
Overall FAM3 initiative (all programs)	-0.04 (-0.06, -0.01)
Multiple food pickups (2+ times)	-0.02 (-0.06, 0.03)
Structured nutrition education (Yes)	-0.06 (-0.13, 0.02)
Defined food distribution (Yes)	-0.04 (-0.08, 0.00)
In-clinic food provision (Yes)	-0.04 (-0.07, -0.01)
Active benefit enrollment support (Yes)	-0.03 (-0.06, 0.00)
Diet-related condition enrollment criteria (Yes)	-0.08 (-0.18, 0.02)

Differences in Emergency Department Visits by Group Membership

* There were no statistically signficant differences observed in emergency department visits by group membership

MISSING OR DELAYING MEDICAL CARE

Program characteristic	Change in Missing or Delaying Medical Care (95% CI)
Overall FAM3 initiative (all programs)	-0.04 (-0.11, 0.03)
Multiple food pickups (2+ times)	-0.03 (-0.12, 0.07)
Structured nutrition education (Yes)	-0.15 (-0.23, -0.07)
Defined food distribution (Yes)	-0.07 (-0.15, 0.02)
In-clinic food provision (Yes)	-0.06 (-0.14, 0.03)
Active benefit enrollment support (Yes)	-0.11 (-0.19, -0.02)
Diet-related condition enrollment criteria (Yes)	-0.12 (-0.24, 0.00)

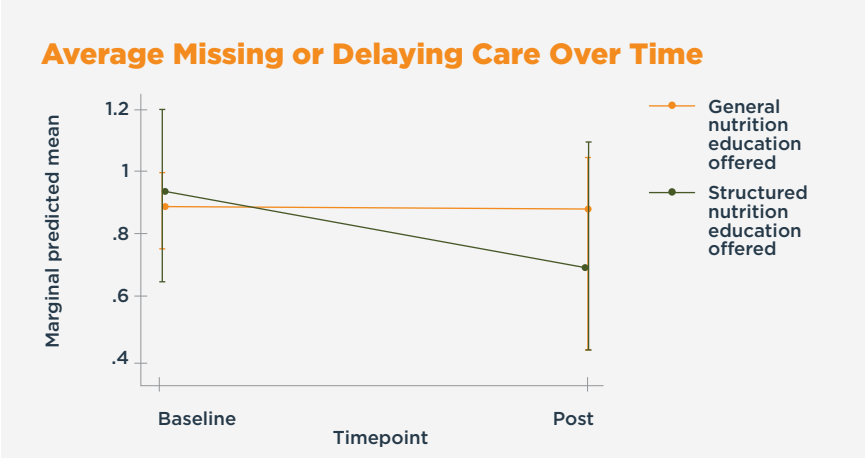
Differences in Missing or Delaying Medical Care by Group Membership

INTERPRETATION **GRAPH**

Structured nutrition education

The decreases in how often participants reported missing or delaying care were larger for participants who enrolled in programs offering structured nutrition education vs. those that offered general nutrition education.

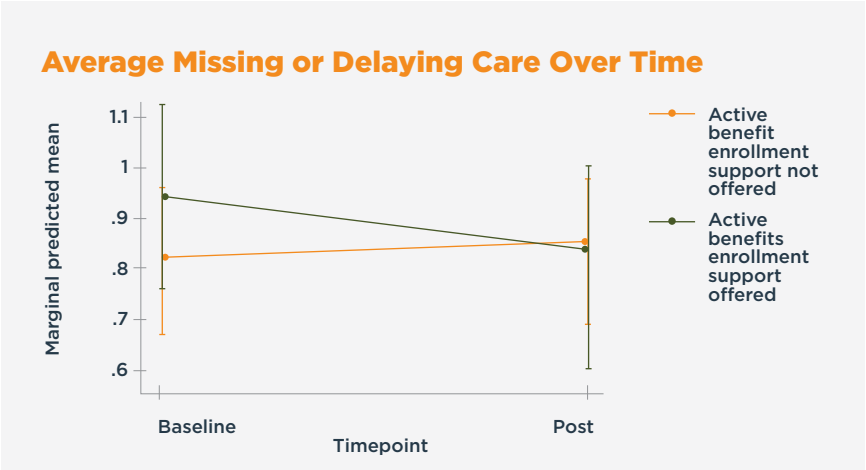
Overall, participants who enrolled in programs offering structured nutrition education reported decreases in how often they missed or delayed their care over time.



Active benefit enrollment support

The decreases in how often participants reported missing or delaying care were larger for participants who enrolled in programs offering active benefit enrollment support vs. those that did not offer active benefit enrollment support.

Overall, participants who enrolled in programs offering active benefit enrollment support reported decreases in how frequently they missed or delayed their care over time.



BEING SHORT ON MEDICATION

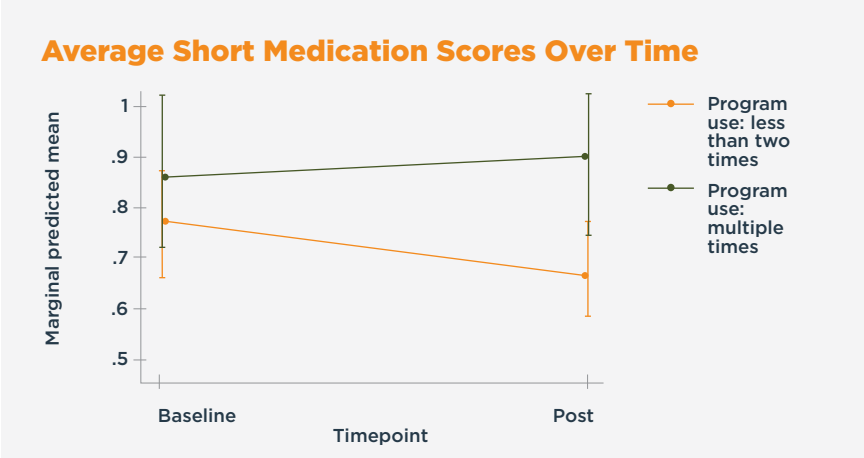
Program characteristic	Change in Being Short on Medication (95% CI)
Overall FAM3 initiative (all programs)	-0.03 (-0.10, 0.04)
Multiple food pickups (2+ times)	0.02 (-0.07, 0.11)
Structured nutrition education (Yes)	-0.12 (-0.17, -0.07)
Defined food distribution (Yes)	-0.05 (-0.16, 0.07)
In-clinic food provision (Yes)	-0.06 (-0.13, 0.02)
Active benefit enrollment support (Yes)	-0.08 (-0.15, -0.001)
Diet-related condition enrollment criteria (Yes)	-0.13 (-0.21, -0.05)

Differences in Being Short on Medication by Group Membership

INTERPRETATION **GRAPH**

Program Use / Multiple Food Pickups

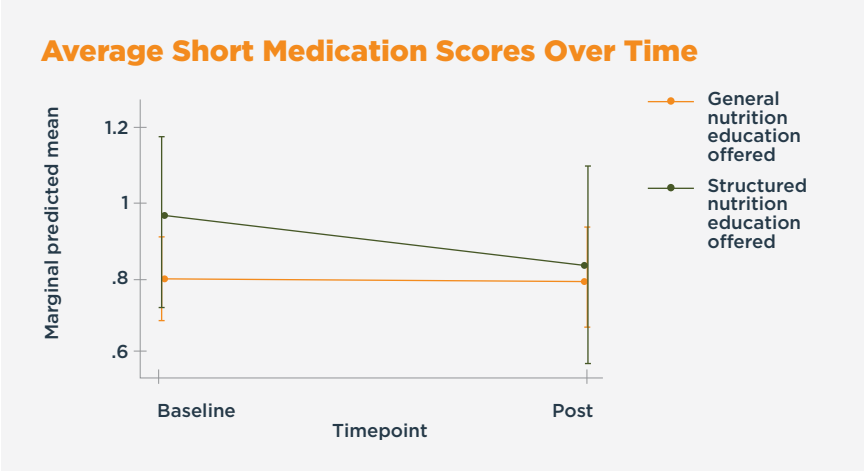
The improvement in short medication scores was larger for participants who used the programming less than 2 times compared to those who used programming multiple times.



Structured nutrition education

The decreases in how often participants reported being short on medication were larger for participants who enrolled in programs offering structured nutrition education vs. those that offered general nutrition education.

Overall, participants who enrolled in programs offering structured nutrition education reported decreases in how often they were short on medication over time.

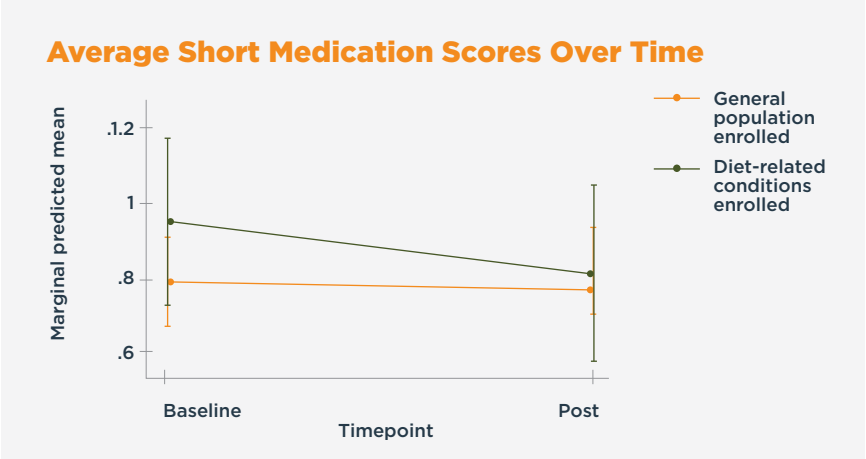


Differences in Being Short on Medication by Group Membership (cont'd)

Diet-related condition

The decreases in how often participants reported being short on medication were larger for participants who enrolled in programs that enrolled participants with diet-related conditions vs. those that enrolled general patient populations.

Overall, participants who enrolled in programs with diet-related conditions as an enrollment criterion reported decreases in how often they were short medication over time.



APPENDIX G. Unadjusted pre-to-post changes in outcomes among FAM3 participants, and by different program types

	Overall (n=213)			Foundational (n=51)			Enhanced (n=99)			Comprehensive (n=63)		
	BI	F/U	n	BI	F/U	n	BI	F/U	n	BI	F/U	n
COST AND UTILIZATION												
All-cause medical costs	1,214	1,519	213	847	1,071	51	1,324	1,795	99	1,339	1,447	63
All-cause pharmacy costs	475	557	182	338	417	45	316	440	75	768	800	62
Diet-related medical costs	355	312	213	75	81	51	441	436	99	444	303	63
All-cause inpatient visits	53	43	213	39	22	51	63	66	99	48	24	63
Inpatient re-admissions	6	10	213	0	3	51	12	19	99	3	0	63
All-cause ER visits	121	115	213	116	117	51	114	107	99	135	126	63
Inappropriate ER visits	60	62	213	54	58	51	48	56	99	85	74	63
Preventable ER visits	10	9	213	12	6	51	8	6	99	13	16	63
All-cause outpatient visits	2.08	2.40	213	2.34	2.73	51	1.79	2.27	99	2.33	2.34	63
Primary care visits	0.49	0.52	213	0.46	0.55	51	0.43	0.48	99	0.61	0.57	63
Preventive care visits	0.03	0.02	213	0.03	0.03	51	0.03	0.02	99	0.02	0.01	63
CLINICAL OUTCOMES												
HbA1c	6.8	6.6	39	6.5	5.8	7	6.1	6.3	14	7.6	7.1	18
Cholesterol (LDL)	107.5	104.0	36	132.7	137.3	6	114.2	99.2	11	94.8	99.9	20
Cholesterol (HDL)	47.4	50.7	36	52.9	60.4	6	50.1	49.2	11	43.8	49.0	19
Blood pressure (systolic)	130.1	127.8	45	124.6	128.4	9	125.7	125.0	17	135.4	130.0	20
Blood pressure (diastolic)	79.1	76.2	45	79.8	80.4	9	75.5	73.9	17	81.6	76.1	20
Body Mass Index	36.3	34.8	48	36.3	34.1	9	34.3	34.0	17	37.6	35.7	23

* Statistically significant at the <0.05 level; BI = Baseline; F/U = Follow-Up; Overall = whole FAM3 intervention. n= sample size

Note: 340 participants are included in the descriptive table, but not all had complete data to be included in regression analyses.

APPENDIX H. Two-fixed effects regression models comparing the whole FAM3 intervention, and each program type, to the comparison group

	FAM3 Intervention vs. Comparison Group				Foundational vs. Comparison Group			
	Beta	Lower Bound	Upper Bound	p-value	Beta	Lower Bound	Upper Bound	p-value
COST AND UTILIZATION								
All-cause medical costs	-530.6	-1575	514.4	0.320	-324.5	-1539	890.6	0.601
All-cause pharmacy costs	86.5	-57.7	230.7	0.240	106.9	-9.1	223.0	0.071
Diet-related medical costs	-495.2	-1138	148.5	0.132	-47.1	-563.2	469.0	0.858
All-cause inpatient visits	-0.05	-0.09	0.00	0.030*	-0.06	-0.13	0.02	0.163
Inpatient re-admissions	0.01	-0.01	0.03	0.497	0.01	-0.01	0.03	0.273
All-cause ER visits	0.04	-0.02	0.09	0.180	0.06	-0.03	0.14	0.201
Inappropriate ER visits	0.02	-0.02	0.06	0.396	0.03	-0.02	0.08	0.255
Preventable ER visits	0.00	-0.01	0.01	0.662	0.00	-0.02	0.02	0.663
All-cause outpatient visits	0.34	-0.04	0.73	0.077	0.93	-0.25	2.11	0.121
Primary care visits	-0.02	-0.15	0.10	0.713	0.06	-0.12	0.24	0.499
Preventive care visits	-0.01	-0.04	0.01	0.296	-0.01	-0.06	0.04	0.769
CLINICAL OUTCOMES								
HbA1c	0.13	-0.01	0.26	0.061	0.05	-0.03	0.14	0.200
Cholesterol (LDL)	-1.28	-6.99	4.42	0.659	0.72	-1.33	2.77	0.492
Cholesterol (HDL)	1.68	-0.69	4.05	0.164	4.13	-4.45	12.70	0.346
Blood pressure (systolic)	-0.54	-3.91	2.83	0.753	4.01	-2.92	10.95	0.257
Blood pressure (diastolic)	-0.86	-2.82	1.10	0.387	1.24	-4.56	7.03	0.675
Body Mass Index	0.29	-0.60	1.17	0.525	-1.12	-2.26	0.02	0.054

	Enhanced vs. Comparison Group				Comprehensive vs. Comparison Group			
	Beta	Lower Bound	Upper Bound	p-value	Beta	Lower Bound	Upper Bound	p-value
COST AND UTILIZATION								
All-cause medical costs	-143.2	-1390	1103.8	0.822	-1275	-2826	275.8	0.107
All-cause pharmacy costs	142.8	-90.7	376.4	0.231	8.8	-241.1	258.8	0.945
Diet-related medical costs	-653.2	-1661	355.0	0.204	-597.5	-1745	550.1	0.308
All-cause inpatient visits	-0.05	-0.11	0.01	0.122	-0.03	-0.09	0.03	0.342
Inpatient re-admissions	0.01	-0.02	0.04	0.660	0.01	-0.01	0.03	0.535
All-cause ER visits	0.03	-0.03	0.09	0.287	0.02	-0.09	0.14	0.679
Inappropriate ER visits	0.03	-0.01	0.06	0.118	-0.01	-0.11	0.09	0.833
Preventable ER visits	0.00	-0.01	0.01	0.994	0.01	-0.01	0.03	0.328
All-cause outpatient visits	0.33	-0.08	0.74	0.112	-0.08	-0.61	0.44	0.763
Primary care visits	-0.04	-0.24	0.16	0.707	-0.06	-0.28	0.15	0.561
Preventive care visits	0.00	-0.03	0.03	0.933	-0.04	-0.09	0.02	0.173
CLINICAL OUTCOMES								
HbA1c	0.10	-0.03	0.22	0.132	0.18	-0.06	0.42	0.136
Cholesterol (LDL)	-6.96	-24.90	10.97	0.447	1.05	-2.70	4.81	0.582
Cholesterol (HDL)	1.39	-3.17	5.95	0.550	1.11	-1.00	3.23	0.303
Blood pressure (systolic)	0.07	-3.68	3.82	0.973	-2.46	-7.17	2.24	0.305
Blood pressure (diastolic)	-0.01	-3.19	3.17	0.994	-2.17	-4.48	0.13	0.064
Body Mass Index	-0.15	-0.95	0.66	0.724	0.84	-0.54	2.21	0.233

* Statistically significant at the <0.05 level; BI = Baseline; Overall = whole FAM3 intervention. n= sample size

Note: 340 participants are included in the descriptive table, but not all had complete data to be included in regression analyses.

APPENDIX I. Description of patients enrolled in FAM3 programs at baseline, and program data availability to examine differences in health changes based on program use.

	Grantee A Comprehensive (Comp.) (n=174)	Grantee B Enhanced (Enh.) (n=705)	Grantee C Enhanced (Enh.) (n=249)	Grantee D2 Enhanced (Enh.) (n=81)
Avg. age (range)	55.4 (27, 90)	15.5 (1.3, 24.3)	40.0 (17, 84)	Unknown
Gender	unknown	Female: 53%	Female: 80%	Unknown
Race	Black or African American: 49% White: 30%	Black or African American: 60% Other race: 31% White: 7%	Black or African American: 50% Caucasian: 37%	Unknown
Ethnicity	Non-Hispanic/ Latino: 63%	Non-Hispanic/ Latino: 67%	Unknown	Unknown
Health Insurance Status Health History at Enrollment	**Average Blood Pressure:** 131/78 (normal) **Average HbA1c:** 8.6% (diabetic) **Avg. LDL Cholesterol:** 95.5 **Avg BMI:** 34.8 (Obese category)	**Public Insurance (Medicaid):** 81% **Type 1 diabetes:** 51% **Type 2 diabetes:** 41%	**# diagnoses present** None: 31%; One: 45%; Two: 14% **Among those with One diagnosis: Pregnancy:** 56% **Type 2 diabetes:** 15%; **Hypertension:** 13% **Among those with two diagnoses: Depression:** 40% **Pregnancy:** 34%; **Hypertension:** 34% **Average Blood Pressure:** 123.8/77.8 (elevated/normal) **Average HbA1c:** 6.9% (diabetic range) **Avg. LDL Cholesterol:** 107.7 (near optimal)	**# diagnoses present** None: 9%; One: 64%; Two: 27% **Among those with One diagnosis: Type 2 diabetes:** 39%; **Prediabetes:** 37% **Hypertension:** 25% **Among those with two diagnoses: Type 2 diabetes & Hypertension:** 55%; **Prediabetes & Hypertension:** 46%
WHAT IS PROGRAM UPTAKE LIKE?				
	Avg # of dietitian interactions: 13 Range: (0, 58); median: 10	**Avg. # of clinic food distributions:** 4.2 Range: (1, 10) **Clinic Food Distributions:** One (40%); Two (21%); Three (15%); Four or more (24%)	Unknown; not linked to EHR	Unknown; not linked to EHR

Note: Comprehensive (Comp.) A provided aggregated data for up to 31 patients. This data did not include any information about participant demographics or program uptake data. Since this data were aggregated, we did not perform any statistical testing for this sample.

APPENDIX J. Food Bank Sustainability Survey

First, we ask about your professional position and FAM3 program. **"FAM3" refers to the program you are running in partnership with health care sites that is primarily funded by your Food as Medicine 3.0 grant.**

1. Please select your organization. This information will help us understand the type of FAM3 program you operate with your health care partners. Your responses will be kept confidential.
   [select box with all food bank grantees]

2. What is your professional title? [Open-ended]

3. For how long has your food bank been carrying out **any** Food as Medicine programming (including FAM3 and any other, similar programs with health care partners)?
   a. Less than 6 months
   b. 6-11 months
   c. Between 1 and 2 years
   d. Between 2 and 3 years
   e. Between 4 and 5 years
   f. Between 6 and 9 years
   g. 10 years or more
   h. I don't know/prefer not to answer

The first few questions ask about support, funding, partnerships, and capacity for FAM3 programs. **"FAM3" refers to the program you are running in partnership with health care sites that is primarily funded by your Food as Medicine 3.0 grant.**

	To little or no extent						To a very great extent	Not able to answer
Our FAM3 program has a strong program champion(s) with the ability to garner resources. *A FAM3 program champion would be internal to the food bank, be committed and diligent in driving programming forward, and have an ability to develop and maintain strong relationships to energize/motivate others.*	1	2	3	4	5	6	7	NA
Our FAM3 program has food bank leadership (e.g., executive director) support or leadership buy-in.	1	2	3	4	5	6	7	NA
Our FAM3 program has strong community and partner support.	1	2	3	4	5	6	7	NA

	To little or no extent						To a very great extent	Not able to answer
Our FAM3 program includes strategies to communicate with community leaders.	1	2	3	4	5	6	7	NA
Community leaders are directly involved with our FAM3 program.	1	2	3	4	5	6	7	NA
Neighbors are or were engaged in the development of our FAM3 program.	1	2	3	4	5	6	7	NA
Our FAM3 program is well integrated into food bank operations.	1	2	3	4	5	6	7	NA
Food bank organizational systems (e.g., structures, processes, policies, procedures) are in place to support various FAM3 program needs.	1	2	3	4	5	6	7	NA
Our FAM3 program has adequate food bank staff and volunteers to complete the program's goals.	1	2	3	4	5	6	7	NA
Our Food as Medicine work in general (i.e., FAM3 and any other similar projects with health care partners) is funded through multiple sources.	1	2	3	4	5	6	7	NA
Our FAM3 program exists in a supportive economic climate in our state.	1	2	3	4	5	6	7	NA
Our Food as Medicine work in general (i.e., FAM3 and any other similar projects with health care partners) has consistent long-term/ multi-year funding.	1	2	3	4	5	6	7	NA

The next few questions are about monitoring and adapting, communications, and strategic planning for FAM3 programs. **"FAM3" refers to the program you are running in partnership with health care sites that is primarily funded by your Food as Medicine 3.0 grant.**

	To little or no extent						To a very great extent	Not able to answer
Our FAM3 program has internal capacity (e.g., enough staff, resources, infrastructure) for quality program monitoring and assessment.	1	2	3	4	5	6	7	NA
Our FAM3 program uses internal data to inform program planning and delivery.	1	2	3	4	5	6	7	NA
Our FAM3 program uses internal data (neighbor data from surveys, testimonials, other programmatic information etc.) to demonstrate successes to current or potential funders and/or other interested parties.	1	2	3	4	5	6	7	NA
Our FAM3 program adapts program delivery strategies and/or program components as needed.	1	2	3	4	5	6	7	NA
Our FAM3 program adapts to new best practices in the field.	1	2	3	4	5	6	7	NA
Our FAM3 program proactively adapts to changes in partner organizations and/or the community to minimize negative impacts to FAM3 activities.	1	2	3	4	5	6	7	NA
Our FAM3 program staff communicates the need for the program to the public.	1	2	3	4	5	6	7	NA
Our FAM3 program is marketed or promoted in a way that generates interest.	1	2	3	4	5	6	7	NA
Our FAM3 program increases community awareness of food and nutrition insecurity issues.	1	2	3	4	5	6	7	NA
Our FAM3 program plans ahead for future resource needs (e.g., money, food, materials) to support the program.	1	2	3	4	5	6	7	NA
Our FAM3 program has a plan to keep the project going long-term.	1	2	3	4	5	6	7	NA
Our FAM3 program clearly outlines roles and responsibilities for all food bank, health care, or other partners involved in the program.	1	2	3	4	5	6	7	NA

Next, we are interested in understanding supports or resources that could improve the ability for food banks to deliver Food as Medicine programs, like FAM3, over time. **"FAM3" refers to the program you are running in partnership with health care sites that is primarily funded by your Food as Medicine 3.0 grant.**

1. Based on your experience delivering FAM3, to what extent do you agree with this statement: You/your staff or your program could be better supported or resourced to deliver FAM3.
   a. Completely disagree
   b. Disagree
   c. Neither agree nor disagree
   d. Agree
   e. Completely agree
   f. I don't know/not applicable

[IF SELECT D or E ABOVE] What supports or resources (e.g., more staff/volunteers, technology, money, materials, training, etc.) are needed to better support the delivery of FAM3 in the food bank setting? [Open-ended]

2. Does your food bank plan to continue to deliver the services offered by your FAM3 program beyond the current funding cycle (Jan 2023-Jan 2026)?
   a. Yes
   b. No
   c. I don't know

[IF SELECT A ABOVE] Are there plans to expand or reduce the scope of the program you are currently running under FAM3 beyond the current funding cycle (Jan 2023-Jan 2026)?

   a. Yes, we will **expand the scope of our food bank-health care partnership work** (e.g., serve more sites, participants, and/or offer additional services).
   b. Yes, we will **reduce the scope of our food bank-health care partnership work**.
   c. No, we do not plan to modify our scope
   d. I don't know
   e. Other [Please describe].

Next, we would like to know about the activities your food bank has used at any time to support FAM3 program delivery at food bank and/or partner health care sites. **"FAM3" refers to the program you are running in partnership with health care sites that is primarily funded by your Food as Medicine 3.0 grant.**

Response options for each of the below questions:

   a. Yes, we have conducted this activity.
   b. No, we have not conducted this activity.
   c. I don't know/not applicable.

The first set of questions ask about training and technical assistance activities to support FAM3 delivery.

3. **Provide training:** Train food bank and/or health care staff or volunteers on the FAM3 program and related tasks.
4. **Provide technical assistance:** Offer guidance to food bank and/or health care staff or volunteers (including through other organizations) on delivering the FAM3 program in food bank and/or health care sites.
5. **Provide resources:** Develop and share resources (e.g., guides, toolkits) with food bank and/or health care staff or volunteers to enhance delivery of the FAM3 program.
6. **Facilitate implementation:** Helping to integrate the FAM3 program into food bank or health care sites using multiple strategies (e.g., coaching, technical assistance) through an ongoing, interactive and supportive relationship.
7. **Create FAM3 project guide:** Create a playbook, blueprint, or guide that describes to staff or volunteers how to deliver the FAM3 program in food bank and/or health care settings.
8. **Train the trainer:** Train food bank and/or health care staff or volunteers to train others to deliver the FAM3 program at their sites.
9. **Facilitate peer learning opportunities:** Set up networking or collaboration opportunities for FAM3 foodbank and/or health care staff or volunteers to learn from peers.
10. **Develop structured curriculum:** Develop and provide food bank and/or health care staff or volunteers with a structured curriculum for delivering program components to neighbors (e.g., lesson plans, educational content).
11. **Connect staff or volunteers with relevant experts:** Connect food bank and/or health care staff or volunteers with external experts or consultants to support them with FAM3 program delivery.

The next set of questions ask about activities to ensure the FAM3 program meets neighbor or partner needs.

12. **Tailor neighbor program recruitment strategies or materials:** Use and adapt multiple recruitment methods that align with neighbors' language, culture, or preferences to improve FAM3 program engagement.
13. **Meet neighbors' needs:** Routinely collect and respond to neighbor feedback (not including the neighbor survey occurring through this project) to improve FAM3 program delivery and neighbor engagement.
14. **Consider expanding FAM3 program eligibility:** Work with partners to reassess neighbor requirements for participating in the program to improve reach and/or engagement (e.g., relaxing specific diet-related disease requirements or changing how we screen for food insecurity).

The next set of questions ask about FAM3 program monitoring and improvement activities.

15. **Use technology for program monitoring:** Use or develop applications, websites, or electronic medical record (EMR) technology to facilitate FAM3 program data collection and/or data sharing.
16. **Conduct program checks:** Assess whether FAM3 program components are being delivered as originally planned in food bank and/or health care sites.
17. **Review FAM3 program delivery performance and provide feedback:** Review food bank and/or health care staff or volunteer performance and provide feedback to help improve FAM3 program delivery at food bank or health care sites.
18. **Develop reminder systems or supports:** Develop reminders (using systems or processes) specific to the FAM3 program to help ensure components of the program are delivered according to plan (e.g., an email to physician partners).

The last set of questions ask about activities to build organizational or staff capacity to deliver the FAM3 program.

19. **Change staff or volunteer roles:** Alter the roles and responsibilities of food bank or health care staff and volunteers to improve FAM3 program fit and support delivery in food bank and health care sites.
20. **Change program delivery site:** Move the FAM3 program to different and/or additional food bank or health care sites to improve program fit with sites and/or to better reach neighbors.
21. **Enhance staffing:** Carry out a staffing or volunteer plan that ensures capacity for high-quality, consistent FAM3 program delivery in food bank and/or health care sites.
22. **Incentivize staff or volunteers:** Provide incentives (e.g., recognitions, rewards, supply budgets, gifts, bonuses) to food bank and/or health care staff or volunteers for delivering the FAM3 program.
23. **Change physical layout and/or equipment:** Change the layout of a room and/or add equipment to best accommodate the FAM3 program in food bank and/or health care sites.

One last question before the survey closes.

24. (Optional) Is there anything else you would like to share with us in general or about how programs like FAM3 could be better supported? [Open-ended]

Thank you for your time taking this survey.
Your responses are valuable.

APPENDIX K. Health Care Partner Sustainability Survey

First, we would like to know about your health care organization and your professional position.

1. Please select your food bank partner organization. Your responses to this survey will be kept confidential and will not be shared with your food bank partner.
2. **This survey is site-specific**. If you oversee FAM3 at multiple clinics or health care sites, please only enter one for the purposes of this survey. This should be the site you have worked at/with the longest or are the most familiar with. [Open-ended]
3. Please select the clinic type that best describes your health care site where the FAM3 program you help conduct is being carried out.
    a. Cardiac Rehab Center
    b. Diabetes Clinic or Diabetes Education Center
    c. Federally Qualified Health Center (FQHC)
    d. Hospital – including Inpatient, Emergency Department, Urgent Care
    e. Mental Health Treatment Center
    f. Outpatient Internal Medicine or Family Medicine Clinic
    g. Pediatric Clinic Only
    h. Women's Health Clinic
    i. Pharmacy Only (e.g., within a drugstore)
    j. Other (Please describe): _____
4. What is your professional title? [Open-ended]
5. For how long has your health care site been carrying out any Food as Medicine programs (including FAM3 and any other screening and referral programs to support food insecurity and healthy diets)?
    a. Less than 6 months
    b. 6-11 months
    c. Between 1 and 2 years
    d. Between 2 and 3 years
    e. Between 4 and 5 years
    f. Between 6 and 9 years
    g. 10 years or more
    h. I don't know/prefer not to answer

The first few questions ask about leadership and staff support, partnerships, and organizational capacity for FAM3 programs. **"FAM3" refers to the program your health care site conducts in partnership with a local Feeding America affiliated food bank, in which patients are screened for food insecurity and/or diet-related chronic conditions, and then are given access to healthy food and other services, as applicable**.

	To little or no extent						To a very great extent	Not able to answer
Our FAM3 program has engaged, ongoing clinical champion(s) of FAM3 on staff. *A FAM3 clinical champion would be internal to the health care site, be committed and diligent in driving programming forward, and have an ability to develop and maintain strong relationships to energize/motivate others.*	1	2	3	4	5	6	7	NA
Our FAM3 program has a leadership team made of multi-disciplinary partnerships.	1	2	3	4	5	6	7	NA
Our FAM3 program has team-based collaboration and infrastructure.	1	2	3	4	5	6	7	NA
There is mutual respect among all partners (e.g., food bank, health care sites, other FAM3 partners) involved in our FAM3 program.	1	2	3	4	5	6	7	NA
Our FAM3 program is valued by a diverse set of interested partners/parties.	1	2	3	4	5	6	7	NA
Our FAM3 program engages external medical teams and community partners (e.g., food bank or other involved partners) as appropriate.	1	2	3	4	5	6	7	NA
Health care organizational systems (e.g., structures, processes, policies, procedures) are in place to support the various FAM3 program needs.	1	2	3	4	5	6	7	NA
Our FAM3 program has sufficient resources (e.g., time, space, funding) to achieve its goals.	1	2	3	4	5	6	7	NA
Our FAM3 program has adequate staff to achieve its goals.	1	2	3	4	5	6	7	NA

The next few questions ask about workflow, implementation and training, program monitoring, and program outcomes. **"FAM3" refers to the program your health care site conducts in partnership with a local Feeding America affiliated food bank, in which patients are screened for food insecurity and/or diet-related chronic conditions, and then are given access to healthy food and other services, as applicable.**

	To little or no extent						To a very great extent	Not able to answer
Our FAM3 program is built into the clinical workflow.	1	2	3	4	5	6	7	NA
Our FAM3 program procedures are easy for health care staff	1	2	3	4	5	6	7	NA
Our FAM3 program integrates well with established clinical practices.	1	2	3	4	5	6	7	NA
The reason for our FAM3 program is clearly communicated to and understood by all the health care staff involved.	1	2	3	4	5	6	7	NA
Staff involved in our FAM3 program receive ongoing coaching, feedback, and training.	1	2	3	4	5	6	7	NA
Our FAM3 program provides ongoing education across professions.	1	2	3	4	5	6	7	NA
Our FAM3 program has measurable procedures, outcomes, and metrics.	1	2	3	4	5	6	7	NA
Internal data from monitoring our FAM3 program are reviewed on a consistent basis.	1	2	3	4	5	6	7	NA
FAM3 program monitoring and outcomes data are routinely reported to the health care team involved in the program.	1	2	3	4	5	6	7	NA
Our FAM3 program has evidence of beneficial outcomes.	1	2	3	4	5	6	7	NA
Our FAM3 program is associated with improvement in patient outcomes that are clinically meaningful.	1	2	3	4	5	6	7	NA
Our FAM3 program is clearly linked to positive health or clinical outcomes.	1	2	3	4	5	6	7	NA

Next, we are interested in understanding supports or resources that could improve the ability for health care partners to deliver Food as Medicine programs, like FAM3, over time.

1. Has your health care site used any supports or resources (e.g., additional staff/volunteers, technology, money, materials, training, etc.) to help staff deliver the FAM3 program, beyond what food bank partners have provided?
    a. Yes
    b. No

[IF SELECT A ABOVE] Please describe the supports or resources used to help staff deliver the FAM3 program at your health care site. [Open-ended]

2. Based on your experience delivering FAM3, to what extent do you agree with this statement: You/your staff could be better supported or resourced to deliver FAM3.
    a. Completely disagree
    b. Disagree
    c. Neither agree nor disagree
    d. Agree
    e. Completely agree
    f. I don't know/Not applicable

[IF SELECT D or E ABOVE] What supports or resources are needed to better support the delivery of FAM3 in the health care setting? [Open-ended]

3. Does your health care site plan to continue to deliver the services offered by your FAM3 program in the future (e.g., through the next few years?)
    a. Yes
    b. No
    c. I don't know

[IF SELECT A ABOVE] Are there plans to expand or reduce the scope of the program you are currently running under FAM3 in the future (e.g., through the next few years) Yes, we will **expand the scope of our food bank-health care partnership work** (e.g., serve more sites, participants, and/or offer additional services).
    d. Yes, we will **reduce the scope of our food bank-health care partnership work**
    e. No, we do not plan to modify our scope
    f. I don't know
    j. Other [Please describe]

One last question before the survey closes.

4. (Optional) Is there anything else you would like to share with us in general or about how programs like FAM3 could be better supported? [Open-ended]

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