HEALTH BEGINS

PARTNERSHIP TOOLKIT

Advancing Food and Nutrition Security Through Community Partnerships

By:
Kathryn Jantz, *HealthBegins*
Alexandra Lewin-Zwerdling, *Fruitful LLC*
Eva Batalla-Mann, *HealthBegins*

Table of Contents:

Introduction

Across the nation, healthcare organizations are increasingly recognizing that food and nutrition security are essential to achieving health equity and improving outcomes for patients with diet-related chronic conditions. Community Health Centers (CHCs) are uniquely positioned to lead this transformation—serving as trusted access points for patients, particularly those most affected by social and economic barriers to health.

This toolkit reframes and updates the content in the Feeding America Food Bank-Health Care Partnerships toolkit for CHC decision-makers who are interested in partnering with food banks or pantries and have already made a commitment to screening for and addressing food and nutrition insecurity as part of a broader Food Is Medicine (FIM) strategy. It provides practical guidance to help CHCs integrate food insecurity and FIM approaches such as produce prescriptions, medically tailored groceries, and in-clinic food pantry partnerships into clinical workflows and community care networks. CHCs may also consider joining FIM or anti-hunger coalitions in their state to support broader conversations about transforming and strengthening the food safety net.

Together, CHCs, managed care organizations (MCOs), hospitals, and food system partners can build a coordinated network of care that treats nutritious food as essential medicine—transforming how health is delivered and sustained across communities.

This work was supported by a sub-award through Tufts University from the Kaiser Foundation Health Plan, and in collaboration with HealthBegins and the project team at the Food is Medicine Institute at the Friedman School of Nutrition Science and Policy at Tufts University.

Acknowledgments: This work was supported by a sub-award through Tufts University from the Kaiser Foundation Health Plan, and in collaboration with HealthBegins and the project team at the Food is Medicine Institute at the Friedman School of Nutrition Science and Policy at Tufts University. This material is based on Feeding America's Healthcare Partnership Toolkit with permission from the Feeding America National Organization. Thank you to Perri Kramer, Senior Manager, Health Initiatives, Feeding America for her thoughtful feedback and support of this project. In addition, thank you to our reviewers Meaghan Butler, Senior Director of Food is Medicine for Federation of Virginia Food Banks and Maria Bowman, Blue Ridge Area Food Bank, Director of Health Initiatives.

The Charitable Food System

Advancing Food is Medicine

Addressing food and nutrition insecurity and implementing Food is Medicine (FIM) interventions are deeply interconnected strategies that together strengthen health outcomes and reduce health disparities. Food insecurity—limited or uncertain access to foods—creates barriers to managing, treating, and preventing chronic diseases like diabetes, hypertension, and cardiovascular disease. Many Food is Medicine interventions target people who meet both social and health criteria—typically those experiencing food insecurity and living with one or more diet-related chronic diseases. These interventions are time-bound and usually don't resolve food insecurity permanently. However, effective programs connect participants to ongoing food resources that can sustain both the food security and health improvements achieved during the intervention. Many patients are best supported when provided with food resources within an integrated/multi-prong/comprehensive FIM framework/program that includes both long-term strategies for food security and intensive short-term interventions to support remediation of acute clinical need and behavior change.

Key Definitions

Low food security:
Reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake.

Very low food security:
Reports of multiple indications of disrupted eating patterns and reduced food intake. (USDA Definitions of Food Insecurity)

Nutrition security:
Consistent access, availability, and affordability of foods and beverages that promote well-being and prevent (and if needed, treat) disease (Prioritizing Nutrition Security)

Health Outcomes

In 2023, about 13.5% of U.S. households—roughly 18 million households—experienced food insecurity at some point during the year within that population, 5.1% (6.8 million households) of U.S. households experienced very low food security in which the food intake of some household members was reduced and normal eating patterns were disrupted. Among low-income households (below the federal poverty line in 2023), the rate was even higher—nearly 38.7%. Moreover, food insecurity is inequitably higher among Black (23.3%) and Hispanic (21.9%) households, which were more than twice as likely to experience food insecurity compared to non-Hispanic white households (9.9%)
Food insecurity is inextricably linked with adverse health outcomes, particularly when combined with nutrition insecurity (insufficient access not just to enough food, but to nutritious food).

Food-insecure households score lower on measures of dietary diversity, fruit and vegetable intake, and micronutrient adequacy compared to similarly low-income but food-secure households. Adults from food-insecure households have about a 21% higher risk of hypertension compared to their food-secure peers, and the prevalence of clinical diabetes is significantly higher among food insecure adults (10.2%) compared to those with access to adequate food (7.4%). Among people with diagnosed diabetes, those who are food insecure tend to demonstrate higher HbA1c levels and poorer glycemic control compared to adults with food security who have a diabetes diagnosis.

Beyond metabolic conditions, food and nutrition insecurity are associated with a cascade of negative outcomes: higher rates of obesity, cardiovascular disease, poor mental health, lower immune resilience, anemia, developmental and cognitive delays (especially in children), and worse functional health as adults age. Because food insecurity often coincides with other socioeconomic stressors (low income, housing instability, limited healthcare access), it acts as a potent social driver of health that amplifies health disparities between racial, ethnic, and geographic lines.

Food Insecurity in California: The Gap to Close

- More than **1 in 5 Californians** (~ 8.8 million people) struggle with food insecurity. (California Association of Food Banks)
- In 2023, **1.8 million households** (≈ 13% of all households) in California experienced food insecurity; ~700,000 of those had "very low food security" (i.e. cutting back meals). (Public Policy Institute of California)
- Among low-income adults (below 200% of the federal poverty level), **45%** reported that they could not always afford enough food. (UCLA Center for Health Policy Research)

- In Los Angeles County in late 2024, **1 in 4 households** (≈ 832,000) were food insecure; among low-income households, the rate was 41%. (USC Dornsife)

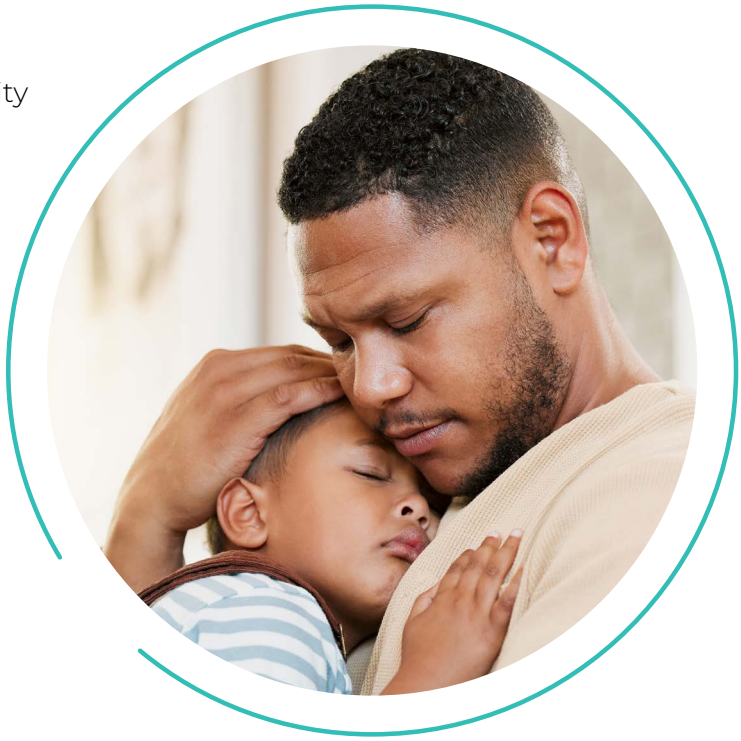
Food insecurity persists despite programs like CalFresh (California's Supplemental Nutrition Assistance Program (SNAP)), which means that many households remain unable to purchase nutritionally appropriate foods (e.g., for chronic disease management) after receiving benefits since benefit amounts often do not fully cover the higher costs of nutrient-dense foods.

The One Big Beautiful Bill Act - H.R. 1 made significant changes to SNAP:

- Expanded work requirements to new populations such as adults age 55-65, veterans, individuals who are homeless, and people under the age of 18 who just aged out of foster care.
- Changed eligibility for some legally present non-U.S. citizens
- Reduced the amount of federal funding for administrative support of SNAP
- Institutes new state matching requirements for the cost of SNAP
- Eliminates SNAP-Ed
- Limits the ability to re-evaluate benefits

As a result, by early 2026, CalFresh—which serves over 5 million people—is projected to reduce or eliminate monthly benefits for about 97% of households under the new eligibility restrictions and budget shifts. Many families that already struggle to put food on the table face even higher risk of food insecurity and fewer options for receiving support.

Understanding the Food Safety Net



Health centers seeking to address food insecurity can strengthen their impact by engaging with the local **food safety net**—the network of organizations dedicated to distributing food to people in need. Feeding America is a national network of 250+ member food banks who provide food and various combinations of training, funding, technology solutions, and/or policy advocacy support to 60,000+ organizations and programs that deliver food and other social determinants of health services with the goal of eradicating the causes and drivers of hunger in every county, borough, and parish in America. Together, the 250+ Feeding America member food banks cover every zip code in the United States.

Food Bank ↔ Food Pantry: Roles & Relationship

- **Food banks** act at a regional or network level: they procure, store, process, and distribute large quantities of food (often via warehousing infrastructure). They also coordinate across donor pipelines, logistics, partner types, and inventory systems. Some food banks have community access on site, while others only distribute directly to food pantry partnerships.
- **Food pantries** (or emergency food sites or food shelves) are the front line, directly serving individuals and households. Pantries receive food from food banks, as well as local donations. Pantries are sometimes referred to as "agency partners" within the Feeding America network.
- Because of this structural relationship, a food bank can often help a health center **map reliable food bank programs and/or pantry partners** in its service area. The food bank may have a FIM program that meets the needs of the CHC. Or, the food bank's systems may provide insight into which community food pantries have steady food supply, distribution capacity, and programming (e.g., mobile distribution, choice pantries, nutrition education).

Why Leverage the Food Safety Net

1 Scalable Infrastructure & Reach

Food banks and pantry networks already reach millions across the country. Partnering with these entities allows healthcare organizations to scale FIM interventions (e.g. produce prescriptions, medically tailored groceries) more efficiently than building standalone distribution systems.

2 Embedding Clinical Relevance and Data Linkage

Community food pantries can be access points for:

- Nutritional risk screening and referrals
- Collecting utilization and outcome data
- Closing the loop between clinic and community
- Providing health-related social needs services like housing, childcare and job placement support

In-clinic food pantries (often referred to as “food pharmacies”) can:

- Conduct routine food insecurity screening and referrals to impactful food resources (on-site pantries and/or at community food pantries)
- Leverage trusted relationships with medical professionals to support patient nutrition security
- Provide clinicians with training on FIM and the vital role food plays in preventing and/or managing chronic conditions
- Nutrition education
- Embed on-site access to nutritious, medically-aligned foods
- Track health outcomes to assess value and impact of FIM work

These clinic-food pantry integrations helps increase the health impact of a food insecurity or FIM partnership.

3 Culturally Relevant, Trust-Based Engagement

Food banks and pantries have established deep relationships in underserved neighborhoods rooted in a knowledge of trauma-informed care which can enhance patient engagement and trust. In addition, food banks and pantries often tailor produce and other food offerings to local cultural preferences which can improve adherence to diet-based interventions.

Evidence from Medically Tailored Groceries and other Food is Medicine Interventions

Food banks and pantries provide a range of food interventions from classic food security resources to healthy groceries that may be set for certain conditions to Medically tailored groceries (MTGs) tied to a person-specific care plan created by a registered dietitian. The type of intervention will impact the exact health outcomes of your food bank partnership. However, evidence from MTGs provides some insight into the types of health impacts your program might demonstrate.

HEALTH AND BEHAVIORAL OUTCOMES

✓ Improved diet quality

- MTG programs significantly improve overall diet quality, increasing consumption of fruits, vegetables, whole grains, and lean proteins.
- These dietary shifts align with AHA recommendations for cardiovascular health

✓ Reduced food insecurity

- Participants in MTG programs consistently report lower rates of food insecurity and improved access to nutritious foods, advancing both short- and long-term nutrition security.

✓ Enhanced nutrition self-efficacy and sustained behavior change

- MTG participation improves individuals' confidence in selecting and preparing healthy foods, supporting lasting dietary behavior change.

✓ Clinical improvements in chronic disease markers

- Evidence from the AHA's Systematic Review of Food Is Medicine Randomized Controlled Trials indicates that MTG and related interventions produce modest but measurable improvements in:
    - » Blood pressure
    - » Glycemic control (HbA1c)
    - » Body weight
    - » Mental Health

Benefits are most pronounced among patients with diabetes, hypertension, and cardiovascular disease.

SUMMARY

Collectively, MTG demonstrate strong potential to:

- Improve **diet quality** and **food security**
- Support **chronic disease management and mental health outcomes**

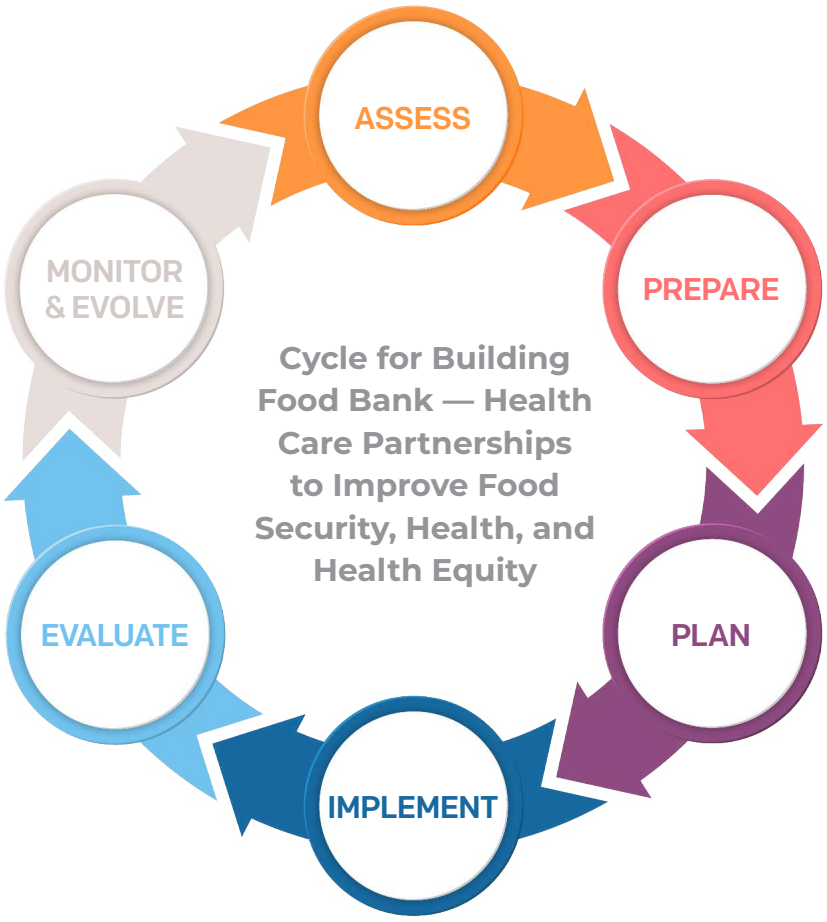
The AHA identifies these interventions as **scalable, patient-centered strategies** to integrate nutrition into healthcare systems and advance population health outcomes.

Partnership Cycle

This toolkit builds upon Feeding America's Food Bank-Health Care Partnership Toolkit (January 2022) and has been updated and tailored specifically for Community Health Centers to support them in meeting the unique needs of their communities.

This toolkit follows the Partnership cycle below:

- **Section Four: Assess and Prepare:** This section helps a CHC determine whether it is ready to embark on a food bank partnership by assessing internal capacity, alignment with organizational goals, funding readiness, and staff preparedness. It also equips CHCs with the context and tools needed to choose the right partners, train staff and understand patient and community food needs
- **Section Five: Plan and Implement:** This section will help a CHC build efficient, patient-centered food access partnership, starting with simple referral pathways and scaling up to in-clinic food pantries, mobile distributions, connection to community food pantries, and integration with federal nutrition programs.
- **Section Six: Evaluate, Monitor and Evolve:** This section helps CHCs build strong, data-driven food access partnerships by outlining how to set goals, choose indicators, collect data, and use evaluation findings. It equips CHCs to demonstrate impact, secure funding, and continuously refine programs to support patient food security and health



The process to develop new partnerships is not always linear. You may need to go back and repeat earlier steps several times to gather more information and refine plans. The process evolves over time as your partnerships, capacity and needs change. This cycle is intended to be an informative and flexible framework to support the development of impactful partnerships between food banks and community health centers.

Assess and Prepare

Assessment

This short assessment will help you determine whether your clinic is ready for a FIM or food bank partnership:

1. How important is addressing food insecurity in your patient population relative to the other key priorities that you have on your to-do list?
   - A. This is one of my top priorities this year
   - B. This is somewhere in the middle after critical or essential activities
   - C. This is near the bottom of this list

2. Do you have food insecurity screening and referral processes in place to identify patients who may be experiencing food insecurity?

   A. Not at all B. Some C. Yes

3. Do you know the percent of community members or patients who are currently experiencing food insecurity?

   A. Not at all B. Some

4. Do you have staff available to do the day-to-day work of collaboration to support FIM partnership activities?

   A. Not at all B. Some C. Yes

5. Do you have a staff champion who will ensure the success of partnership activities and help internal teams and the partnership overcome any issues?

   A. Not at all B. Some C. Yes

6. Do you have a clinic administrator or leader who will advocate for FIM partnership and ensure it remains a priority (allocating staff time and clinic resources)?

   A. Not at all B. Some C. Yes

7. Do you have physical space for an onsite food pantry program?
   - A. No, none and we're not interested in this
   - B. No, not now, but we'd like to consider this in the future
   - C. Maybe, we'd need to think about this further
   - D. Yes, we have a space available or a space we could repurpose for this

To have a successful partnership, you may need to prioritize this work - especially while it is in development - and build strong screening and referral processes, identify a clinic champion, and ensure adequate staff resources. If your responses to the questions indicate areas of opportunity, focus there before starting a partnership process.

Assess Alignment with Organizational Goals

Identifying and naming how your FIM goals align with your organizational goals can help ensure:

- **Mission and vision alignment:** Development of Food Insecurity and Food is Medicine strategies can improve patient retention, staff satisfaction, and community reputation by showing alignment and commitment to a common healthcare vision and goals such as reducing health disparities and improving patient overall health and well-being.
- **Contractual requirements:** Some Value-Based Payment or Alternative Payment Models require that healthcare organizations have strategies such as social needs or connection to social care resources.
- **Achievement of performance measures:** Some value-based contracts have specific process or outcomes measures that can be improved by supporting patients in changing their diet and improved access to nutritious food. Some of the diet-sensitive condition measures that may be impacted are the following:
    - Controlling High Blood Pressure: Measure the percentage of 18- to 85-year-old people with hypertension whose blood pressure was adequately controlled (<140/90 mm Hg).
    - Comprehensive Diabetes Care: Measure the percentage of 18- to 75-year-old people with diabetes whose hemoglobin A1c was not under control (>9.0%) and under moderate control (<8%).

In addition to impacting diet-related disease outcomes, some clinics report that having in-house food resources encourages patients to come to the clinic and may improve measures like those related to seeking postpartum care.

Identify Funding Strategies and Sources

Start by identifying potential funding needs and sources for both the Community Health Center and the food bank. This shared focus can ensure that the program is designed in a manner that maximizes sustainable funding streams for both organizations.

- **Medicaid:** Each state's Medicaid agency has flexibility to create financing strategies, programs and policies to support the needs of Medicaid enrollees. The Food is Medicine Coalition (FIMC) and Center for Health Law and Policy Innovation (CHLPI) at Harvard created a Food is Medicine: A State Medicaid Policy Toolkit that outlines key policy opportunities to support FIM. The Medicaid Food Security Dashboard highlights some of the opportunities for aligning FIM and food insecurity strategies with existing programs and payment opportunities.
    - » In California, FIM is funded through the Community Supports program which allows Medicaid Managed Care Organizations to offer eligible individuals MTM, MTG, Medically Supportive Groceries, Healthy Food Vouchers and Food Pharmacies.
- **Medicare:** Some activities related to supporting a clinic-based food strategy may be able to be supported through Medicare Care Management codes. In addition, Medicare Advantage plans are able to offer supplemental benefits or supplemental benefits for the chronically ill which are increasingly including some type of food benefit.
- **Hospital Community Benefit:** Nonprofit hospitals are required to invest in the health of communities, also known as the community benefit standard. Every three years, nonprofit hospitals are required to conduct a Community Health Needs Assessment (CHNA) and develop an aligned Community Health Improvement Plan (CHIP). These hospitals have the most motivation to engage in and pay for FIM partnerships when food and nutrition security are priorities in their CHNA and CHIP.
- **Academic and Philanthropic Partnership:** For most partnerships, not all upfront costs are covered by healthcare pathways. Academic partnerships can be an opportunity to seek funding and support for program design and evaluation. Philanthropic organizations may also be interested in providing upfront or ongoing support of these types of partnerships when FIM aligns with their mission, values, or vision.

Avoid Bias and Reduce Stigma

Bias and stigma around poverty and weight are interrelated, common and harmful. Patients experiencing food insecurity may face judgment or dismissive attitudes, while individuals with higher body weight often encounter negative stereotypes that influence clinical decisions. These biases can reduce trust, discourage patients from seeking care, and contribute to poorer health outcomes. When preparing for a partnership with a local food bank, it is important to include skills-based learning around stigma and bias training for CHC staff - specifically, as it relates to food insecurity and the connection between food and health. Key strategies for reducing stigma and bias include the following:

- **Start with reflection:** Encourage staff to identify their own values and biases before engaging patients. Many healthcare staff may currently or have previously experienced food insecurity. Creating space for addressing staff needs may result in a strategy that more effectively destigmatizes food and other social needs.
- **Normalize social needs discussions:** Make it routine to ask about food, housing, or transportation without stigma. Ask every patient about social needs and do not assume to know the answer they will provide.
- **Use non-judgmental language**: If a patient identifies as food insecure, provide the resources available in a calm, respectful, and professional manner. Replace terms that imply blame (e.g., “non-compliant,” “not willing”) with neutral, supportive phrasing (e.g., patient prefers).
- **Recognize structural barriers:** Implement trainings that drive a deeper understanding of structural barriers to health including social policies that result in disparities in economic security.
- **Use Empathic Inquiry or Motivational Interviewing:** Leverage assessment approaches that are strengths-based and support patient-driven care planning.

Identifying the Right Partner in Your Area

PRACTICAL CONSIDERATIONS

Depending on the partnership type and the specific food bank and food pantry, a CHC may partner with either the food bank or the food pantry or both. It may be best to start a conversation with a food bank who can connect your CHC with the right pantry for your specific partnership goals.

When considering food bank collaborations, consider:

- **Food bank location:** Research which food bank serves the county in which your clinic is located. This Feeding America food bank locator can help. Go to your food bank's website to learn more about the work they do in your community.
- **Food is Medicine focus:** Many food banks and pantries prioritize sourcing nutritious food including fresh produce and recognize the connection between their work and the health of the communities they serve. Food banks with stated FIM, nutrition, and/or health priorities make ideal CHC partners.
- **Healthcare partnership experience & capacity:** Some food banks and pantries have dedicated staff, resources, and programs focused on healthcare partnerships. These food banks and pantriesmay be able to provide a more turn-key Food is Medicine partnership including staff training, clinical workflows, and program options.

When selecting food pantry collaborators, consider:

- **Accessibility & scheduling:** Some food pantries are volunteer-run, operate only certain days or limited hours, and may lack robust digital communication channels. They may not respond to emails or have capacity to engage in frequent virtual meetings.
- **Reliability & capacity:** Evaluate whether the pantry can handle referrals from a clinical partner.
- **Geographic fit:** Proximity to patients (public transport routes, parking, walkability) is vital for uptake.
- **Cultural and linguistic relevance:** A pantry that offers culturally appropriate foods and respects dietary norms can improve patient engagement and acceptability.

Start your outreach with the regional food bank to identify the best next step. The food bank may provide you with information about their own healthcare partnership opportunities. And, they may be able to facilitate introductions, provide capacity assessments, or advise on local community pantries that have experience with health-sector partnerships. Partnerships move at the pace of trust. Consider in-person meetings at the food bank or food pantry to learn more about the opportunities and partnerships that would best meet your patients' needs.

Understanding the Nutrition of Food Bank and Pantry Offerings Through a Multicultural Lens

NUTRITIONAL QUALITY & CHARITABLE FOOD STANDARDS

Feeding America endorses the Healthy Eating Research (HER) Nutrition Guidelines for the Charitable Food System, which classify foods into color categories that help guide food choices based on levels of saturated fat, sodium, and added sugars (For example, green = choose often, yellow = choose sometimes, or red = choose rarely).

As clinical partners, community health centers can **ask questions** about the pantry/food bank's inventory and accessibility protocols such as:

- **Nutrition**
  - **Which foods** do they source at your pantry or food bank?" Many food banks are working to shift distribution toward more whole grains, lean proteins, low-sodium options, and fresh produce.
  - Do they have a nutrition policy to guide food sourcing and donations?
  - Are they applying the **HER guidelines** or a similar standard? Do you use nutrition scoring systems?
  - Is there **nutrition education information** available for community members?
  - How are they supporting clients in making **healthy selections**? Some pantries adopt choice architecture (e.g., positioning healthier foods first, using signage or bundling recipes) to guide selections using tools such as the Supporting Wellness at Pantries (SWAP) toolkit and The Choice Pantry Nudge Toolkit.
- **Choice and Cultural Appropriateness**
  - What foods are **community members requesting**? People often prefer staple foods consistent with their culture (e.g. rice and beans, plantains, tortillas, ethnic greens). Pantries that stock culturally meaningful items can improve uptake and satisfaction.
  - How are they meeting **specific dietary restrictions**? Some communities require halal, kosher, or vegetarian foods; others may have high prevalence of chronic diseases (e.g. hypertension, diabetes). Tailoring offerings and education can reduce any potential hesitance and increase health benefits.
- **Accessibility**
  - How are they supporting community members in using **unfamiliar foods**? Food pantries may offer sampling, recipe cards or education.
  - How are they supporting **linguistic accessibility** such as through multilingual signage?
  - How are they supporting attendees with **other accessibility barriers** including but not limited to vision impairment, hearing impairment, low literacy and others?

Assessing Client Need for Food Is Medicine & Community Food Resources

In order to link FIM and food insecurity interventions with organizations' goals, healthcare organizations must assess the following on an ongoing basis:

- **Patient needs:** Healthcare settings should prioritize interventions that are most appropriate and impactful for their patient needs. For example, if a significant portion of patients experiencing food insecurity are also diagnosed with diabetes, CHCs may want to begin with a referral to a MTM provider or a MTG provider and then combine that with other food bank services.
- **Health outcomes and healthcare utilization:** Assessing the relationship between health outcomes data, healthcare utilization and social needs will allow a healthcare organization to link their social needs strategy with overall organizational goals.

USE EHR DATA TO IDENTIFY AT-RISK PATIENTS

- **Food and Nutrition Insecurity Screening Data:** Embed validated screening tools (e.g., Hunger Vital Sign™) within the EHR. Use standardized coding, like Z-codes to be able to track and share results over time. Screen patients in structured, systematic ways to ensure patient screening quality and consistency.
- **Flag Diet-Related Diagnoses:** Identify the intersection between food insecurity and patients with diabetes, hypertension, obesity, and heart disease.
- **Analyze Utilization Patterns:** Examine ER visits and readmissions linked to diet-related conditions. Patients with repeated hospitalizations may benefit from medically tailored food interventions.

Tip: Always stratify your data by race, ethnicity, language and disability to identify and proactively address disparities. Doing this before and during your program implementation can ensure that your program is meeting the needs of those who are most vulnerable.

LEVERAGE PUBLICLY AVAILABLE DATA

Healthcare organizations may want to supplement their internal social needs data with community-level data. The resources below can provide additional insights into community needs:

- **Community-Level Indicators:** Use national tools to gain insights into community-level indicators:
  - Feeding America Map the Meal Gap highlights statistics on how food insecurity affects your state, county and community.
  - County Health Rankings and Roadmaps from the Robert Wood Johnson Foundation provide a revealing annual snapshot of how health is influenced by where we live, learn, work and play. They provide a starting point for change in communities. Rankings include data on a range of metrics, including Healthy Days, health behaviors, clinical care, social and economic factors, physical environment and other domains.
  - KIDS Count provides data about children's health from the Annie E. Casey Foundation.
  - Neighborhood Atlas and Area Deprivation Index provides data on environmental factors such as income, education, employment and housing quality.
- **California-specific Resources:**
  - CalFresh Data Dashboard provides data on the number of applications received, number of applications approved and number denied.
  - Food Insecurity Data from the California Association of Food Banks tracks food insecurity over time.

Healthcare organizations should also look for information shared by their local public health organization and local non-profit hospital Community Health Needs Assessments.

SOLICIT PATIENT FEEDBACK & ENGAGEMENT

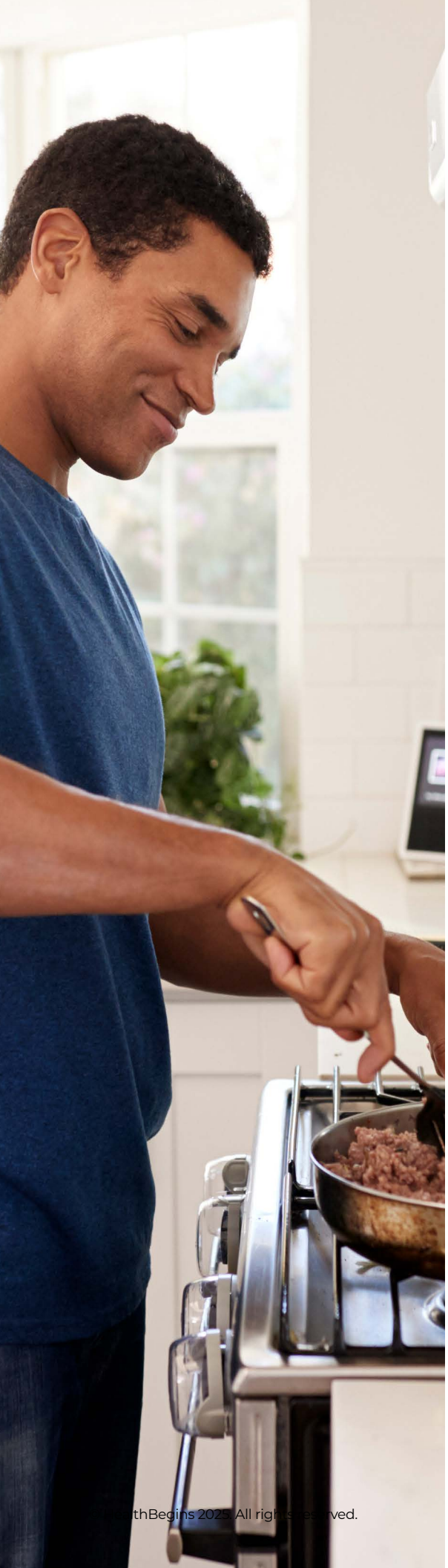
Collect patient feedback both to plan and to assess how your partnership is going. A food bank partnership will only achieve the desired health goals if it works for the patients it aims to serve. Soliciting patient feedback is critical to ensure that the program achieves its goals. A best practice for soliciting input is to compensate patients for their time and effort. You can collect feedback through a number of methods:

- **Conduct Short Patient Surveys or Focus Groups:** Ask patients experiencing food insecurity or who have leveraged your partnership program to provide feedback on their experience and areas for improvement.
- **Gather Lived Experience among Healthcare Staff:** Many healthcare workers have experienced food insecurity. Encourage storytelling or peer-led discussions to understand cultural preferences, trust, and stigma related to food assistance.
- **Leverage Patient Advisory Councils:** Use existing Patient Advisory Councils to solicit input and feedback.

You may want to solicit stakeholder feedback on the following topics:

- Accessibility and logistics:
  - » How easy was it to get to access food at the clinic or food pantry?
  - » Were you able to visit during times that worked for your schedule?
  - » Did you face any barriers to accessing food in-clinic or at the food pantry?
- Food quality
  - » Did the food meet your health needs?
  - » Did the food meet your cultural needs?
  - » Did the food meet your household's needs?
  - » Did you like the food you received?
- Experience
  - » How were you treated by the healthcare or food pantry staff who you interacted with when getting food?
- Impact
  - » How did the food bank partnership help your family's food needs?
  - » Did receiving these services improve your health?
  - » Are there other supports you need in order to have regular access to nutritious food?

Plan and Implement



Introduction to Action Planning

This section of the toolkit includes guides for the following partnership models:

- Referrals to Existing Community-Based Food Programs
- Connection to other Nutrition Programs (SNAP, WIC, etc.)
- Emergency Food
- Pop-Up Food Distribution
- Onsite Food Pantry and Food Pharmacy

These partnership models are listed in order of least administrative oversight and complexity to most administrative oversight and complexity. All healthcare-food bank partnership are built on this partnership model, Referrals to Existing Community-Based Food Programs. Begin your review with your toolkit with this step and then skip to the other partnership models as appropriate for your specific use case. Many referrals start as direct to the food bank but evolve to bidirectional referrals over time.

All partnership models require the following considerations:

- **Staffing and training:** Partnerships may require CHC staff, volunteers or food bank staff. All staff will need necessary data access, training, and oversight. Both organizations can help to develop training programs that cover staff knowledge of food insecurity, diet and health, food resources, referral and data safety/management, and skills around supporting patients effectively. For staff that handle food, additional training on food distribution, safe handling, and data documentation are required.

- **Collaboration and Workflow Development:** Each model will require effective communication and collaboration to maximize impact and efficiency across the two organizations. Set up a regular schedule of meetings and a process for identifying process improvements. Sharing the full scope of one another's workflows may help both organizations support one another to navigate challenges.

- **Communications:** Both organizations can communicate to the community through social media, posted signs and flyers and other forums. Collaborate on the important messages about food access and the food partnership opportunities.

- **Funding and Sustainability:** All partnership models may have both up-front and ongoing costs. Assess opportunities to maximize reimbursement opportunities and leverage healthcare funding to support food costs. If funding is unavailable, consider joint fundraising opportunities.

- **Data infrastructure:** Assess documentation and data sharing needs of the partnership. It may be possible to document in the EHR, but in some cases, it may be preferable or necessary to track data in a system designed for tracking food distribution.

- **Food for special populations:** Consider whether the food options you provide are adequate for specific groups such as older adults, families with children, patients with diabetes, renal disease, hypertension, etc. Ensuring that the food meets the clinical needs of a patient will maximize the health impact of the partnership. If special diets are available, consider the process for ensuring that patients are connected to the right diet.

Action Plan: Referrals to Existing Community-Based Food Programs

After identifying patients who screen positive for food or nutrition insecurity, Community Health Centers (CHCs) should make referrals to programs that support the nutrition needs of patient. This may require multiple interventions including government assistance programs such as SNAP or Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), as well as additional community food services. There are three types of referrals: 1) passive referrals 2) active referrals and 3) closed loop referrals

1) PASSIVE REFERRALS

Passive referrals provide patients with information about available food resources (e.g., a paper handout or pamphlet listing food pantries and contacts). For passive referrals you can use the Feeding America Find your Local Food Bank tool.

- Simple, low-resource way to connect patients to community food supports.
- Success depends on patients taking initiative after receiving information.
- Difficult to track whether patients actually access services.
- Less effective for urgent or high-need situations.

2) ACTIVE REFERRALS

Active referrals—also known as warm handoffs—involve direct connection to a food resource (e.g., sending patient information to a pantry or calling intake staff with the patient present).

- More effective at linking patients to nutrition services.
- Requires data-sharing agreements and secure intake processes.
- May demand more staff time and coordination.
- More compatible with closed-loop tracking of completion and outcomes.

CHCs should begin by contacting the local food bank to define workflows and establish partnership pathways.

Tip: The collaboration needed to build a referral process is the foundation for all of the other interventions described below. Start here and then add additional strategies as needed.

3) CLOSED-LOOP REFERRALS

Closed-loop referrals track whether a patient successfully connects with the food resource after a referral. This approach supports continuous communication between the CHC and food provider and enables monitoring of referral completion and patient outcomes.

- Best suited for organizations prioritizing measurable impact and care coordination.
- Builds on and strengthens active referral pathways.
- Supports evaluation of both partnership performance and patient-level nutrition outcomes.

Tip: Having a CHC Champion who is a decision-maker can significantly improve your chances of success.

BUILDING A REFERRAL PROCESS

To develop a meaningful partnership, CHCs and food banks or pantries should meet to discuss all of the components of their shared work, listed below. It may be helpful for both teams visit one another's organization to better understand patient experience and logistics to support seamless referrals. In that meeting it may be helpful for the clinic to share screening population, frequency, tool, staffing, modality, and workflow. It may be helpful for the food bank to share patient access logistics (hours, accessibility by public transportation), capacity to do food delivery, capacity for increased referrals, and service offerings (nutrition education, cooking programs, care coordination, etc.)

DATA INFRASTRUCTURE

- Process for clinical documentation of screening and treatment activities, such as using Z Codes.
- Social Needs Screening data that the Community Health Center could send to the food bank or pantry to inform their strategy (e.g. number of patients screened, rates of food insecurity, prevalence of diet-related conditions within food insecure population)
- Services data or closed-loop referral data that the Community Health Center would like to receive from the food bank or pantry while reducing duplicated data collection

Resource: Data sharing between clinics and food banks needs careful review by legal experts and privacy officers as food banks are not "Covered Entities" (health plans, health care clearinghouses, and health care providers). This Food Banks as Partners in Health Promotion: Navigating HIPAA may be a helpful resource.

Action Plan: Connection to other Nutrition Programs (SNAP, WIC, etc.)

Federal nutrition assistance programs are critical for addressing food insecurity. Building strategies to connect patients to federal nutrition programs into your partnership will improve the impact of your partnership on patient health. SNAP participation can support long-term food security for patients, and there is also evidence that SNAP reduces health care costs and improves health outcomes for participants. Changes to SNAP as a result of One Big Beautiful Act (O.B.B.A) may increase complexity and patient need for support. These partnerships could take many forms, such as:

Who provides the patient with assistance?

- Community Health Center Staff (patient navigators, social workers, medical assistants, dietitians, nutritionists, nurses, community health workers)
- Food bank staff
- Local food pantry staff
- Trained volunteers

What level of assistance is offered?

- Passive Referrals
- Support in completing the benefits application such as by using a web-based application portal

Where is the assistance offered?

- Virtually (phone or telehealth)
- In-person at the Community Health Center
- In-person at the food bank or food pantry
- In-person at other community settings such as recreation centers, health fairs or community events

FEDERAL NUTRITION ASSISTANCE PROGRAMS

Supplemental Nutrition Assistance Program (SNAP): A federal program for low- and no-income households that provides nutrition benefits to supplement their food budget so they can purchase healthy foods

Commodity Supplemental Food Program (CSFP): A program that works to improve the health of low-income persons aged 60 and over by supplementing their diets with nutritious U.S.-grown foods distributed through state and tribal agencies.

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC): A federal program providing supplemental foods, nutrition education, breastfeeding support, and health-care referrals to income-eligible pregnant, postpartum, and breastfeeding women, as well as infants and children up to age five at nutritional risk.

Summer Food Service Program (SFSP): A federally funded nutrition program that provides free, nutritious meals to children during the summer months when school is not in session (via schools, camps, or other approved sites) — supporting continuity of child nutrition outside the regular school year.

Senior Farmers' Market Nutrition Program: A program that provides low-income seniors (age 60+) access to locally grown fruits, vegetables, honey and herbs via farmers markets, roadside stands and CSAs, while promoting increased domestic consumption of agricultural commodities

Action Plan: Emergency Food

When patients screen positive for food insecurity, Community Health Centers can address immediate needs by providing onsite emergency food—typically pre-packed, shelf-stable boxes that supply 2–3 days of meals. Emergency food programs require minimal space, staffing, and resources compared to full onsite pantries. For instance, a clinic might store 15–20 pre-packed boxes in a small closet for quick distribution. Some centers partner with food banks to offer limited "client choice" models, stocking a small selection of shelf-stable foods and allowing patients to choose items. This approach requires slightly more space and planning but remains far less resource-intensive than a full pantry.

BUILDING AN EMERGENCY FOOD BANK

Following are key considerations for building a for developing an emergency food bank:

- **Space:** Identify dedicated storage space for emergency food packages, or additional space for storing larger quantities/cases of food items for packages that will be assembled on site. If the clinic has dedicated refrigerator and/or freezer space, discuss how to include perishable products like fresh and frozen produce and protein items.
- **Logistics and food options:**
  - » Determine frequency of receiving new food (e.g. monthly, bi-monthly, or weekly.) and whether the food bank can deliver or clinic staff can pick the new food up.
  - » Determine if and how frequently your food bank will deliver perishable products.
  - » Consider whether emergency food will be in prepacked boxes or whether patients will be able to make choices about which services are the best fit for them.

EXAMPLE: SHELF-STABLE, PRE-PACKED FOOD PACKAGE MENU

- ☐ Diced tomatoes, no salt added (2-15.5 oz. cans)
- ☐ Peas, no salt added (1-15.5 oz. can)
- ☐ Green beans, no salt added (1-15.5 oz. can)
- ☐ Mixed vegetables, no salt added (1-15.5 oz. can)
- ☐ Applesauce, no sugar added (1-15.5 oz. can)
- ☐ Tomato sauce, low sodium (2-15.5 oz. cans)
- ☐ Black beans (1-15.5 oz. can)
- ☐ Pinto beans (dry, 1 lb.)
- ☐ Salmon (1-14.75 oz. can)
- ☐ Peanut butter (1-18 oz. jar)
- ☐ Pasta, whole wheat (dry, 1 lb.)
- ☐ Brown rice (dry, 1 lb.)
- ☐ High fiber cereal (dry, 18 oz.)
- ☐ Shelf stable UHT milk (2-1 liters)
- ☐ Ready-to-eat meals and meal kits; whole grain, low sodium

For food bank examples of Emergency Food Programming, review the Food is Medicine Project Final Report.

Action Plan: Pop-Up Food Distribution

Similar to a farmer's market, a pop-up or mobile food distribution program allows community members to efficiently access food at an accessible time and location. Some mobile food distribution programs involve laying pallets of food out in a parking lot which allows hundreds of people to be served far more efficiently than in a food bank setting where the food has to be stocked and space may slow access.

- **Space**
  - » Identify an adequate space (could be inside or outside). If outside, develop strategies for inclement weather.
  - » Ensure adequate parking and accessibility relative to the volume of anticipated attendees.
- **Logistics and Food Options**
  - » Determine frequency of distribution and amount of food distributed to each client.
  - » Identify which foods will be distributed, such as fresh produce, perishables, non-perishables or a combination.
- **Data and Tracking**
  - » Set up registration and data tracking process. Ensure access to power or internet if needed.

Action Plan: Onsite Food Pantry and Food Pharmacy

An onsite food pantry (or "food pharmacy") within a hospital or clinic improves access to nutritious food for patients facing transportation or other barriers to emergency food assistance. These pantries allow patients who screen positive for food insecurity to receive healthy foods immediately. Onsite pantries can address both short and longer-term food needs

Key advantages include immediate access for food-insecure patients; use of existing healthcare infrastructure for tracking and evaluation; integration with nutrition education; reduced stigma by positioning food as part of care; and greater convenience for patients and families.

Challenges include higher start-up and operating costs (especially when purchasing food), limited facility space, complex data integration, and the need for dedicated staff and volunteers. Strong leadership, partnerships, and commitment are essential to successful implementation.

BUILDING AN ONSITE FOOD PANTRY AND FOOD PHARMACY

Key Considerations for building an onsite food pantry of pharmacy:

- **Organizational status:** Review opportunities and implications for a food pharmacy operating as a food bank program vs. as a partner agency (including Agency Partner eligibility guidelines related to a health care organization's nonprofit tax-exempt status)
- **Space and Infrastructure Needs:** In identifying a space for an onsite pantry or food pharmacy consider, demand of clientele, hours of operation, frequency and type of food deliveries, dry storage, freezer and refrigeration requirements, and proximity to the elevator loading dock or other exterior doors, space for registration or consultation
- **Pantry Guidelines and Protocols for Operation:**
  - » Eligibility requirements: Decide whether it will be open to the public/community vs. only open to clinic patients during visits. If an onsite food pantry is receiving any donated food from the food bank, the food bank should discuss options with the health care partner to make the pantry an open site accessible for all community members.
  - » Referral processes: Determine workflows for bidirectional referrals including onsite pantry to community programming, from pantry back to health care providers, and from visiting the pantry to accessing health care services.
  - » Hours: Develop hours for the food ban which might include hours the facility is open, select hours, hours that the facility is not otherwise open.
  - » Additional services: Identify additional services patients need such as nutrition education, cooking demos or SNAP Application Assistance.
  - » Operation model: Decide whether patients will have choice (a grocery-type experience), partial choice or prepared bags or boxes.
  - » Quantity and frequency: Determine much food will recipients receive and how often can they visit.

View examples of onsite food pantries at Geisinger Fresh Food Farmacy and Boston Medical Center Preventive Food Pantry.

Action Plan: Health Screenings and Other Services

In addition to bringing food into your Community Health Center, you can explore how to bring health services in food banks or pantries.

You may consider offering any of the following at your food partner's site:

- Blood pressure and hypertension screenings
- Blood glucose and Hemoglobin A1c (A1C) testing
- Weight and height screenings
- Dental exams
- Health education such as diabetes prevention, diabetes management, fall prevention, and physical activity
- Health insurance enrollment
- Vaccine and immunization information and delivery
- Medication identification and review
- CPR, first aid and emergency preparedness training

There may be an opportunity to pair these services with approaches to increase food insecurity:

- Nutrition education
- Food demonstrations and tastings
- SNAP outreach and application assistance
- Information and referrals to other food assistance programs

Key considerations for developing this model are:

- **Identify community needs:** Use internal and external data to prioritize community needs
- **Staffing:** Identify which food bank or pantry staff will support the Community Health Center staff, which may include community health workers (CHWs), registered nurses, medical assistants, pharmacists, physicians, dietitians, diabetes educators and nursing/medical students
- **Permits:** The Community Health Center may need to receive county health assessment screening permits, medical waste and transportation permits.
- **Promotion:** Promoting the event several months in advance will ensure success.
- **Logistics and space:**
  - Identify locations based on volume clients accessing that site and accessibility
  - Ensure that space meets privacy and HIPAA requirements (if necessary) and has sufficient tables, chairs, dividers, electricity, technology (laptops, tablets, Wi-Fi, etc.), and heat or air conditioning if necessary.

Evaluate, Monitor and Evolve

Purpose of Evaluation

Evaluation enables community health centers (CHCs) to measure the impact of their partnerships with the charitable food system. A well-structured evaluation demonstrates how food access interventions improve patient health, reduce food insecurity, and advance health equity. It also provides the evidence base CHCs need to strengthen partnerships, secure funding, and sustain long-term programming.

Evaluation should be practical and proportionate to capacity. It should be designed before a program begins to ensure that goals, activities, and outcomes are aligned from the outset. Early planning allows program leaders to clearly define what success looks like, identify measurable, realistic and culturally appropriate indicators, and collect baseline data to track change over time. When evaluation is built in from the start, it strengthens accountability, supports continuous improvement, and helps ensure that resources are directed toward strategies that are effective. Ultimately, proactive evaluation design transforms programs from reactive efforts into evidence-driven initiatives capable of demonstrating meaningful impact.

Tip: Start small with a few key indicators and expand over time as systems mature.

1 Develop SMARTIE Goals

SMARTIE goals help focus evaluation efforts and ensure results are meaningful and actionable. Each partnership goal should be:

Specific: Clearly define what the partnership aims to achieve.

Measurable: Identify quantifiable metrics for tracking progress.

Achievable: Ensure goals are realistic given staff and partner capacity.

Relevant: Align with CHC priorities such as chronic disease prevention, food insecurity screening, or care coordination.

Time-bound: Set a timeframe for review and improvement (e.g., quarterly or annually).

Inclusive: Ensure that staff participating in the workflow and patients targeted are incorporated into the design of the evaluation.

Equitable: Identify disparities in your baseline data such as which populations are experiencing the highest rate of food insecurity and set a goal for how that disparity will be closed.

EXAMPLE SMART GOALS FOR CHCS:

By June 2026, increase the number of patients screened for food insecurity using the Hunger Vital Sign™ by 25% compared to FY2024.

Within one year, achieve a 60% referral completion rate among patients referred to partner food pantries.

Over the next 12 months, improve the percentage of patients reporting improved diet quality after receiving MTG by 15%.

By June 2026, 30% of patients with diabetes and food insecurity will have been referred to both food insecurity and FIM resources.

2 Select Key Indicators

Choose indicators that reflect both **process** and **outcome** measures across the care continuum. Depending on your partnership structure, these indicators may need to be collected by different partners at different points in time.

PROCESS INDICATORS:

- Partnership development activities (number and timing of meetings, leadership engagement, identification of shared goals, etc.)
- Partnership documentation activities (drafting memoranda of understanding, scopes of work, data sharing use agreements, etc.)
- Creation of clinical workflows for food insecurity screening, documentation and treatment
- Creation of clinical-community workflows for referrals and feedback loops
- Development of data collection, tracking, monitoring and sharing processes
- Number of patients screened for food insecurity
- Number of patients who screened positive for food insecurity
- Number of patients who screened positive for food insecurity and were referred to programming
- Number of patients who screened positive for food insecurity, were referred to programming, and (when, where, how frequently, for how long) engaged in (what) programming
- Number of patients screened for SNAP (or other federal food assistance program) eligibility, the number of SNAP applications completed

OUTCOME INDICATORS:

- Food security
- Diet quality (e.g., fruit and vegetable intake)
- Healthy Days
- Clinical outcomes
  - » Weight, body mass index, obesity management
  - » Blood pressure, hypertension control
  - » Diabetes management, glycemic control (HbA1c)
  - » Cholesterol, hyperlipidemia management
  - » Oral health
  - » Depressive symptoms, depression management
  - » Pregnancy and birth outcomes (birth weight, gestational age/term, anemia, etc.)
  - » Health care utilization (primary care visits, emergency room visits, hospital admissions, 30-day readmissions, etc.)
  - » Health care costs and expenditures

Tip: Use disaggregated data (by race, ethnicity, language, and geography) to assess reach and equity of partnership activities.

3 Collect Data Strategically

Integrate evaluation into existing CHC workflows to minimize staff burden:

- Embed screening and referral tracking into the electronic health record (EHR).
- Coordinate with food banks for referral feedback or aggregate utilization data.
- Use follow-up calls, text surveys, or CHW outreach to collect patient outcomes and satisfaction.
- Document partnership activities—such as meetings, training sessions, and shared resource distribution—in a simple tracking sheet.

For food pantry partners with limited digital access, establish regular check-ins or shared logs to ensure communication continuity.

4 Support Continuous Learning and Improvement

Regularly review SMARTIE goals and progress with both CHC staff and food safety net partners to identify areas for improvement—such as streamlining referrals, expanding culturally relevant offerings, or addressing transportation barriers.

Even small, data-driven adjustments—like revising screening workflows or updating referral scripts—can enhance patient experience and strengthen collaboration across the local food safety net.

Use Plan-Do-Study-Act or PDSA cycles to test, implement and evaluate process improvements.

5 Communicate Results

Transform data into insights that **drive improvement**, **accountability**, and **sustainability**. Communication is not the final step in evaluation—it is an essential part of continuous learning and partnership building. Data should be translated into clear, compelling narratives that resonate with multiple audiences, from frontline staff to policymakers.

MAKE FINDINGS ACTIONABLE AND ACCESSIBLE:

Create a process to share across the organization —at least monthly —screening rates, referral completion, and patient outcomes. Pair quantitative metrics with qualitative insights—**patient stories, provider quotes, and partner testimonials**—to bring the numbers to life and demonstrate the human impact behind the data.

TAILOR COMMUNICATIONS FOR EACH AUDIENCE:

- **Internal teams:** Share findings in staff meetings or newsletters to celebrate successes, identify barriers, and co-design solutions.
- **Community partners:** Provide short, partner-friendly reports that highlight mutual benefits (e.g., increased referrals, reduced food insecurity, improved patient satisfaction).
- **Funders and policymakers:** Package outcomes into concise briefs showing how partnerships advance state and national priorities, such as the White House National Strategy on Hunger, Nutrition, and Health or Food Is Medicine initiatives.

EMPHASIZE EQUITY AND IMPACT:

Use disaggregated data (by race, ethnicity, language, and geography) to identify disparities and showcase where partnerships are helping close gaps in access and health outcomes. Communicate not just overall success but also how interventions are reaching underserved populations and addressing systemic inequities in food access.

BUILD A FEEDBACK LOOP:

Share findings back with patients, staff, and partners to validate their contributions and promote trust. Transparency builds credibility and strengthens long-term collaboration. By turning evaluation data into shared knowledge, CHCs can foster a culture of learning where every partner sees themselves as part of the solution.

EXAMPLE COMMUNICATION OUTPUTS:

- A one-page “Impact Snapshot” highlighting quarterly achievements and patient quotes
- Brief presentations or storyboards for board meetings and funder updates
- Press releases or community spotlights demonstrating partnership success stories
- Collaborative learning sessions where CHCs and food banks jointly review data and set next-step goals

Ultimately, **effective communication transforms data into action**, ensuring that evaluation findings don’t sit in a report but actively guide program refinement, policy advocacy, and sustained investment in equitable food access.

HEALTH BEGINS