A Community Health Center's Guide to **Partnering with Food Is Medicine Providers**

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HEALTH BEGINS

Healthier Food, Healthier Patients: **The Growth in Food Is Medicine Partnerships**

Marisol L.[1] understands the consequences of uncontrolled diabetes. Every two months, a doctor injects medication into her eyes to address her diabetes-related retinopathy.

"Every time, she gets anxiety," reports her daughter, Josefina, who takes Marisol to her appointments in Santa Rosa, Calif. "It hurts a lot."

Fearful her eyesight would worsen or that she would develop other complications, Marisol, who is in her early 70s, vowed to arrest the progress of the disease. In May 2025, she and her husband, who both have diabetes and hypertension, started a new treatment: Weekly deliveries of 100% organic medically-tailored meals.

Salmon. Quinoa. Salad. Turkey bean soup. Oatmeal. Corn tortillas.

The transformation has been nothing short of miraculous. Before Marisol started receiving the prepared meals, her A1C was a dangerously high 11.9. Within three months: 8.

Not yet ideal, but "from 11.9 to 8? That's wonderful!" her daughter says.

Even better, mom loves the food. "I feel more energy and I feel better," Marisol explains in Spanish.

Marisol and her husband, who will receive the meals for six months, were referred by Santa Rosa Community Health to Ceres Community Project, a nationally accredited Food Is Medicine (FIM) provider that serves Sonoma, Marin, Napa, and Solano counties in California. The meals are paid for by Partnership HealthPlan of California as part of its Medicaid contract and Community Supports funding, plus philanthropic support.

Alliances between Community Health Centers and FIM providers have accelerated since California's Medicaid system began allowing Medicaid managed care plans to cover medically tailored and medically supportive food interventions, from produce prescriptions to prepared, medically tailored meals.

[1] Names have been changed to protect the identity of interviewed individuals.

But Medicaid dollars aren't the only impetus. There's fast-growing consensus that healthy food can help prevent, treat, and manage a wide range of conditions, including diabetes, hypertension, congestive heart failure, and other chronic diseases — at a fraction of the cost of treatments such as dialysis, prescription medications, and emergency room visits.

"One of our physicians likes to say, 'If there were a drug out on market that had the efficacy that fruits and vegetables have in terms of addressing chronic disease, with zero side effects, it would be so widely prescribed, it'd be ridiculous,'" explains Cissie Bonini, executive director of Vouchers 4 Veggies, a national produce prescription program based at the University of California, San Francisco.

There is no one-size-fits-all approach to partnering with a FIM provider, but there are several steps you can take to prepare for success.

Start with foundational matters, such as identifying the patient pool you're targeting. From there, make IT updates to help your partnership operate more smoothly, from embedding referrals into your workflow to sharing nutritionist notes and health metrics with your partners.

Several experienced FIM providers broke these steps down into bite-sized and understandable best practices, which you'll find in the next section. Following them will reduce unneeded paperwork, save health care dollars, and improve your patients' health outcomes.

Then we'll show you the real-world impacts of the best practices with two case studies, which illustrate how medically supportive and medically tailored food can result in meaningful and lasting change for your patients, their families — and even their communities.

> "A produce prescription enables folks to make small changes that have a big psychological impact on their ability to take care of their health and their ability to address their chronic disease."
>
> **Cissie Bonini**
> Executive Director of Vouchers 4 Veggies

Best Practices For a **Successful Partnership**

PRIORITIZE AND PLAN

- **Focus on one or two specific patient populations** with nutrition-related chronic conditions to start. Consider building on a specialized program you already administer — your diabetes center or hypertension clinic — and expand from there. Layering food insecurity services, such as government benefits, with Food is Medicine interventions may result in greater engagement and impact.

- **Clarify your goals**. Think about how this partnership may advance or support the health center's goals. Is your aim to improve quality measures, reduce disparities in health outcomes, or something else?

- **Identify the appropriate FIM intervention for your population.** Are your patients able to prepare meals but not readily able to purchase fruits and vegetables? Consider produce prescriptions. Or, are they unable to prepare meals or manage their complex medical nutrition needs? In this case, medically tailored meals would be more appropriate.

- **Consider additional supports.** For some patients, support beyond food may be needed to improve their diet and develop skills to sustain behavioral change. Some may need recipes, medical nutrition therapy provided by a registered dietitian, or cooking demonstrations. Engage your patients through routine clinical care and other avenues (feedback surveys or focus groups) to determine what will help them be successful.

- **Consider the patient's comprehensive nutritional needs.** Many patients have both food insecurity and clinical food needs. Develop a Food Is Medicine strategy that ensures eligible patients are enrolled in CalFresh, WIC, or other programs that address food insecurity, support the entire household, and offer long-term support.

"One of the things we were seeing was we were providing meals to folks for their individual health care, and they were in households that were food insecure. They were saying they felt bad eating in front of other family members, even though they knew it was meant for them."

Clay Nutting
Co-Founder of Family Meal Sacramento

"Local FIM providers are embedded in the community, often with staff who reflect cultural diversity. Some source from local farms or provide 100% organic and primarily local food like Ceres' does. Community Health Centers should think about the value proposition of providers they refer to. Do those providers reflect and advance shared values?"

Cathryn Couch,
Chief Executive Officer and Founder of Ceres Community Project

PICK A PARTNER — OR TWO

- **Seek a trusted, locally based nonprofit** that has a strong track record in your community. You want a flexible partner that can co-develop a process that fits into your existing clinic workflows, while meeting the requirements of funding streams like CalAIM Community Supports. Understand the full range of interventions this organization provides and how it provides them.

- **Identify a FIM organization that can meet the needs of your population.** Ask your FIM partner how its delivery or pick-up times accommodate working people and how they navigate recipients' transportation barriers. Consider the language and cultural needs of your population by identifying a partner who can provide their preferred foods and support in their primary language.

- **Find a partner** that provides the nutrition support that patients require, such as classes, educational materials, and registered dietitian consults, but that you don't provide.

- **For Medically Tailored Meals, prioritize partners with credentials.** If you can, look for a provider that has been accredited by the national Food Is Medicine Coalition, or belongs to the California Food is Medicine Coalition.

ADDRESS GAPS

- **Identify patient needs** not met by your health center or your partner FIM organizations. Are there other organizations that can be tapped to address those?
- **Respect your FIM partner's funding and sustainability needs.** Health care reimbursement rates and burdensome administrative requirements can restrict a FIM organization's ability to sustain and increase its medically tailored food interventions. You can help by advocating for changes in health care funding policy, or collaborating on grants or other funding sources to address gaps.
- **Develop a plan for how to support patients when FIM ends.** Many patients still need support when their FIM program ends. Create a workflow to refer them to community resources or alternative programs.

START WITH SUSTAINABILITY IN MIND

- **Identify a champion** within the clinic to spearhead the process, take responsibility, and keep it on track. This could be a primary care physician, Quality Improvement Director, or a clinic nurse leader.
- **Identify a work lead** within the clinic who has the capacity, interest, and skill to do the day -to-day work of ensuring IT changes are made, workflows are designed, staff are trained, and the referral process is successfully implemented. This could be the same person as the champion, but could also be a clinic staff member such as a medical assistant or community health worker.
- **Do your research.** If your patient population is on Medicaid, determine what intervention the managed care plans in your area will cover and for what duration. Understand the process for authorization and reauthorization and ensure your workflow includes the relevant referral information and up-to-date lab data, which is often necessary for reauthorization.

CREATE EFFICIENT SYSTEMS

- **Design and test workflows** that automatically identify and refer the right patients, based on eligibility and access to FIM. If possible, embed referrals into your electronic health records at the appointment level or the population health level. For some clinics, referrals at the appointment level may need to be supplemented by other outreach, such as text messages.
- **Your registered dietician's time is valuable,** and some FIM organizations have dieticians on staff. Instead of duplicating efforts, determine where RDN support makes the most sense — in the health center or with your FIM partner. In either case, combine forces and share notes, so that information collected in one setting can be used in the other setting.
- **Use clinician time strategically by working at the top of their scope.** Instead of having clinicians lead screening and referral, engage other staff to support these workflows.
- **Don't forget to get patient consent** early in the process to collect and share data, a process that can be assimilated into patient portals like MyChart. Engage compliance/privacy staff early in the process to get their approval to collect and share data. This will allow your partner organization to connect directly with the patient, reducing the burden on them. If needed, explore HIPAA-compliant platforms designed to support referrals, such as Findhelp or Unite Us.
- **Normalize data sharing between the FIM organization and the CHC** for patients who have given consent, including nutritionist notes, and metrics such as A1C levels and blood pressure readings. This helps show that you're improving quality ratings and keeps all parties apprised of patient progress. It is also critical to demonstrating the success of the FIM and CHC partnership. Existing Qualified Health Information Organizations, like LANES or Manifest MedEx, can facilitate information transfer.

> "It's so nice when you have that A1C data and you can show in numbers the impacts."
>
> **Laura deTar**
> Executive Director of Fresh Approach

COMMUNICATE, COMMUNICATE, COMMUNICATE

- **Have regular internal meetings** to evaluate what is working and what is not and to support continuous improvement.
- **Evaluate the partnership on a regular basis,** after the first month, then at the three-month mark. Agree at the beginning how you will evaluate success; revisit those goals and measures regularly. Most FIM providers conduct client surveys, so ask them to share that data as well.
- **Bidirectional communication is key.** Schedule standing meetings with clinicians and FIM representatives to address obstacles and workshop patient challenges, such as 15-minute huddles on a regular basis.

CASE STUDY 1:

Santa Rosa Community Health and Ceres Community Project

Amid the throes of the COVID-19 pandemic, Santa Rosa Community Health joined forces with Ceres Community Project to battle two other dangerous threats to their community: uncontrolled hypertension and diabetes.

In 2021, they launched a pilot program for nearly 250 patients with either or both of those chronic conditions, offering them seven medically-tailored meals per week for 12 weeks — plus meals for family members. Inside the delivery bags were one-page fliers with recipes and nutrition facts (in English and Spanish) about the benefits of the food.

“We're trying to connect the dots” for clients, explains Cathryn Couch, Chief Executive Officer and Founder of Ceres Community Project.

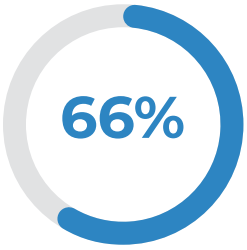
Ceres screened clients for nutrition risk, which helped the organization prioritize which ones needed consultations with a registered dietician. Santa Rosa Community Health monitored patient labs and shared the metrics with Ceres.

Consider the dots connected for Martin F., who hadn’t realized he had diabetes until he woke up one day with blurry vision.

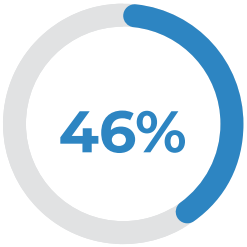
When he started the program in 2021, Martin was in his mid-30s and his A1C was somewhere in the 12s, he says, “super high.” By the time his meal deliveries ended, it had plummeted by half, into the 6s. He had more energy. His symptoms disappeared, and he appreciated that “the meals have flavor,” including vegetable curry with garbanzo beans over brown rice — with a side of steamed broccoli.

“Mentally it helped a lot. Once I got diagnosed, I was like, ‘All right, am I going to die?’” he recalls. “But once you’re able to fight your A1C back and lower it to normal, my brain was like, ‘Maybe it’s possible to be off medicine and continue this diet and keep exercising.’”

Martin was among scores of people whose improved health could be measured during the pilot (incomplete pre- and post-lab data due to COVID restrictions limited the pool of people in the analysis):



Among 148 patients with diabetes, **66%** improved their A1C. The average improvement was **1.7 points**



Among 61 patients with hypertension, **46%** had better blood pressure. The average improvement was **14.1/11.3.**

“That’s a short intervention and not a lot of food, and we still got those kinds of results,” Couch says.

Ideally, she says, clients would receive meals for 24 weeks, which makes them more likely to sustain lasting dietary change, especially if they also receive nutrition education.

“For many patients, you need 24 weeks before they’re like, ‘Oh, I do actually like this food. Oh, I could see how I could do this for myself, and I feel better, now I'm motivated’,” she says.

Martin managed to keep his diabetes in check until a knee injury limited his ability to hike and play soccer in the past year. His numbers rose, and he once again started receiving meal deliveries from Ceres through a referral from Santa Rosa Community Health.

He already felt better just two months in.

“Food is healing,” Martin says. “Some of us don’t really have the time to do good cooking. You’re always grab and go. That is the worst thing you can do.”

Key Takeaways:

- Diabetes and hypertension management through FIM interventions, paired with quality data collection, results in demonstrable improvements in health outcomes.
- Patients will eagerly eat healthy food if it’s made available to them in the form of prepared, medically tailored meals that taste good, and they’ll be motivated to keep their progress on track as they feel better and their metrics improve.

CASE STUDY 2:

Eisner Health and Project Angel Food

Project Angel Food was born out of the AIDS epidemic in 1989 when a group of volunteers delivered lunches to Angelenos suffering from malnutrition and other ravages of the disease. Now, 19 million meals later, "diabetes has become our No. 1 condition that we address," says Alyssa Baldino, the FIM organization's Associate Director of Nutrition Services and Therapeutics.

Project Angel Food's CalAIM clients generally receive two meals per day, which are cooked fresh in its kitchen, flash frozen, then delivered in a batch weekly. A dietician reviews every client's file and flags those who are at high risk of malnutrition. Clients can also request to speak with a dietician.

David O. of Huntington Park, Calif., was referred to Project Angel Food at age 68 with complex medical issues. He had type 2 diabetes, hypertension, heart and liver disease — and was at high risk of hospitalization.

To determine the best meal plan, Project Angel Food mined his Patient 360 record and the LANES health information exchange for David's data and connected him with a registered dietician.

"We're also using LANES for one of our diabetes partnerships to see clients' most recent A1Cs, to see the effectiveness of our meals," Baldino says.

In July 2024, David started receiving 14 meals per week that were diabetic-friendly and heart healthy, covered by his Medicaid managed care plan. Project Angel Food kicked in a weekly bag of fresh fruit at its own cost.

When his initial 12-week session was winding down, Project Angel Food requested a 12-week extension, which was approved.

The meals had a dramatic impact on David's life: He learned portion control and his digestion improved. He lost 30 pounds in three months. His blood glucose level dropped from about 215-280 mg/dL to 135-180 mg/dL.

"I never thought I'd see numbers like this," he says. "I feel lighter and can move better. I think these meals have changed me."

Key Takeaways:

- Mining Qualified Health Information Organizations, such as LANES, to track patient data can help tailor interventions to specific patient needs, and over time can be used to demonstrate impact.
- Medically supportive food interventions, when covered by health plans and combined with effective nutrition education, can dramatically improve patient lives and outlooks.

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.

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