



# Food is Medicine Partnership Framework for Community Health Centers

## PURPOSE:

This tool is designed to help Community Health Centers (CHCs) and Food is Medicine (FIM) orgs assess current relationships and identify opportunities for deeper collaboration.

### Target organizations offering..

- Medically Tailored Meals
- Medically Tailored Groceries
- Medically Supportive Groceries
- Produce Prescriptions
- Healthy Food Vouchers
- Food Pharmacies

## Why Should Community Health Centers Partner with FIM orgs?

- **Improve chronic disease outcomes** (diabetes, hypertension)
- **Meet value-based care measures** and incentives
- **Strengthen patient trust** through meaningful closed-loop referrals
- **Address root causes** of health issues beyond clinical care
- **Share capacity** to respond to healthcare and food security challenges (e.g. work requirements)
- **Enhance CHC reputation** as trusted anchors in the community

## What should CHCs and FIM orgs consider to avoid unintended consequences of partnership?

- **Respect organizational boundaries**—partnership doesn't mean merger
- **Address power differentials** between healthcare and social care
- **Recognize funding challenges** in FIM orgs
- **Clarify accountability** for outcomes and activities
- **Avoid overmedicalizing** which may make FIM interventions more costly and undermine effective aspects of FIM interventions

## Three Partnership Levels

This framework is adapted from HealthBegins' Levels of HRSN and SDH Integration Framework and defines three types of partnership from least intensive to most intensive: coordination (getting started), collaboration (strengthening relationships), and integration (deep partnerships). Use this document to assess and strengthen current relationships.

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## How to use the framework:

1. Answer each question for each partnership element honestly. Invite your FIM partner to do the same.
2. Then find your response in the corresponding row of the table to identify whether you're operating at Coordination, Collaboration, or Integration level of partnership.
3. After answering all questions, review with your partner and prioritize specific elements of partnership to improve.
4. Revisit this framework on a regular basis to assess your progress as you develop your partnership.

ELEMENT OF PARTNERSHIP	LEVEL OF PARTNERSHIP		
PARTNERSHIP PROCESS	Coordination	Collaboration	Integration
<p><u>Goals and Vision</u></p> <p>Do you and your partner have written, shared goals for improving community health together?</p>	<p>Shared understanding of overlaps in each orgs goals. Focus may be narrow or time-limited around one population or one measure.</p>	<p>Understanding of each orgs broader vision. Shared goals may be time-limited or focused on one population or measure. Openness to explore redesigning core structures, systems and business relationships.</p>	<p>Clear shared vision with realistic and aligned community health goals and benefits for each org. Long-term commitment to redesign core structures, systems, and business relationships . The</p>
<p><u>Trust and Relationship</u></p> <p>How well do key staff from both orgs know each other personally and professionally?</p>	<p>Awareness of FIM org function and key personnel but no strong personal or organizational relationship or trust.</p>	<p>Relationship between CHC and FIM orgs key personnel that is collegial and allows for open dialogue and consultation on difficult topics.</p>	<p>The CHC and FIM org have shared values. Relationships are strong enough to overcome cultural or professional differences and navigate shared challenges. Orgs coordinate resources to address challenges and provide mutual support.</p>

PARTNERSHIP PROCESS	Coordination	Collaboration	Integration
<p><u>Communication</u></p> <p>How often do you meet in person or virtually to discuss shared patients and coordination?</p>	<p>Communicate periodically about shared patients, driven by specific patient issues. Rarely meet in person.</p>	<p>Communicate as needed, sometimes in person. Regularly collaborate on coordinated plans for complex patients. Have regular, but infrequent face-to-face meetings.</p>	<p>Consistent system, team, and individual communication. Collaboration is built into organizational processes, driven by a shared concept of team care. Hold regular in-person &amp; virtual meetings (both formal and informal).</p>
<p><u>Workflows</u></p> <p>Can patients easily move between your services, or do they have to start over with each organization?</p>	<p>Screening is done according to separate practice models and CHC screening may not align with FIM eligibility. Service delivery is separate and patients may experience organization- specific barriers to services.</p>	<p>Validated screenings are standardized and routine and support effective and efficient bidirectional referrals. Patients receive warm handoffs between providers reducing barriers to access.</p>	<p>Validated and standardized screenings are routine and support effective and efficient bidirectional referrals. Patient administrative burden is reduced through strategies such as co-location, close proximity, clinic-based FIM distribution or starting FIM enrollment at the CHC.</p>
<p><u>Care Planning</u></p> <p>Do clinical care plans reflect or coordinate with the FIM services your patients receive?</p>	<p>Patient health needs and FIM needs are treated separately, with only the FIM referral noted in the medical record.</p>	<p>Patient health needs and FIM are treated separately, but each care plan reflects the care provided by the other org.</p>	<p>Patient/client health needs and FIM needs are treated separately, but each care plan reflects the care provided by the other org. Clinical care plans are modified to align with the FIM intervention. For patients with complex needs, the two orgs collaborate on a shared care plan.</p>

PARTNERSHIP PROCESS	Coordination	Collaboration	Integration
<p><u>Historical and Contextual</u></p> <p>Do staff understand the root causes of food insecurity and how it connects to health outcomes and equity?</p>	<p>CHC has a high-level understanding of the impact of FIM interventions and their role in clinical care.</p>	<p>Both orgs have a shared understanding of the structural drivers of poverty and that understanding is incorporated into workflows.</p>	<p>Both orgs have a shared understanding of the structural drivers of poverty and that understanding is incorporated into workflows. Both orgs partner to address systemic barriers to nutritious food access.</p>
CAPACITY	Coordination	Collaboration	Integration
<p><u>Staff Knowledge and Skill</u></p> <p>How much do clinical staff know about food insecurity, nutrition, and available FIM resources?</p>	<p>Staff have basic knowledge of food and nutrition insecurity, diet, health and FIM. Have limited understanding of each other's roles.</p>	<p>Staff have some knowledge of food and nutrition insecurity, diet, health and FIM. Staff have some knowledge of each other's orgs and a basic understanding of one another's roles and culture.</p>	<p>CHC staff have high levels of knowledge on food and nutrition insecurity, diet and health, and FIM. Both orgs provide relevant cross-training to staff including training on stigma and trauma-informed care. Staff have a robust understanding of each one another's roles and have influenced one another's culture.</p>

CAPACITY	Coordination	Collaboration	Integration
<p><u>Staff Capacity and Accountability</u></p> <p>Is FIM partnership part of anyone's formal job description and protected work time?</p>	<p>CHC staff volunteer to support workflow and partnership activities but do not have it as a named part of their role.</p>	<p>CHC staff have FIM collaboration as a formal part of their role and the time required is protected.</p>	<p>CHC staff have FIM integration as a formal part of their role and the time required is protected. CHC staff are accountable for achieving patient and community level-results of the partnership. May leverage joint staffing models to support partnership activities. For example, CHCs may deliver prescription medication and FIM at the same time.</p>
<p><u>Engaged and Aligned Leadership</u></p> <p>How actively do your organizational leaders support and prioritize FIM partnerships?</p>	<p>Some leadership support of FIM collaboration but it is not prioritized. FIM-related activities are often left up to individual providers as capacity allows.</p>	<p>Org leaders support problem- solving of system barriers of FIM collaboration. More buy-in to concepts of collaboration and integration but it is not consistent across care teams.</p>	<p>Org leaders strongly and strategically support partnership and communicate regularly to ensure alignment. Integration and collaboration is system-wide with all providers active in system redesign.</p>
<p><u>Resources and Resource-Sharing</u></p> <p>Do you regularly share resources (space, staff time, materials) with your FIM partner?</p>	<p>One or both orgs may have inadequate resources. There is occasional or no sharing of resources between orgs. There is some mutual awareness of resource needs of each org.</p>	<p>One or both orgs may have inadequate resources. There is some limited sharing of resources such as conference rooms, staff time, translation services, materials, communication channels, and expertise.</p>	<p>Both orgs have worked together to align resources and goals. There is meaningful sharing of resources. The sharing of resources is considered for the greater good of patients and the community and not considered quid pro quo.</p>

POLICY AND PAYMENT	Coordination	Collaboration	Integration
<p><u>Aligned Budgets</u></p> <p>Do you share any incentive payments or funding with your FIM partner based on joint outcomes?</p>	<p>The CHC has mapped the relationship between the partnership and achievement of incentive measures.</p>	<p>FIM related activities are supported by billing practices. Incentive payments are aligned with the partnership and some of the achieved incentive payments are shared with the FIM org.</p>	<p>FIM related activities are supported by billing practices or payment structures (such as Alternative Payment Models). The FIM org receives adequate funding (may include pooled budgets or transfer of funds). A meaningful amount of the achieved incentive payments are shared with the FIM org. Orgs partner to develop and implement strategies to ensure adequate funding for sustainability and scalability.</p>
<p><u>Contract and Legal Frameworks</u></p> <p>What formal agreements govern your partnership with your FIM organization?</p>	<p>Basic referral agreements or memorandums of understanding (MOUs) outline general cooperation but have limited detail about roles, responsibilities, or shared liability. Legal frameworks are minimal and focus primarily on patient privacy and referral processes.</p>	<p>Detailed partnership agreements clearly define roles, responsibilities, and expectations for both orgs. Contracts address liability, insurance requirements, and compliance obligations. Legal frameworks support coordinated service delivery while maintaining organizational independence.</p>	<p>Comprehensive partnership agreements include shared governance structures, joint liability management, and integrated compliance frameworks. Legal agreements support seamless service delivery, shared decision-making authority, and may include provisions for shared assets or co-location arrangements.</p>

POLICY AND PAYMENT	Coordination	Collaboration	Integration
<p>Grant and Funding Coordination</p> <p>How do you coordinate with your FIM partner when applying for grants or external funding?</p>	<p>Orgs pursue grants independently with minimal coordination. May occasionally share information about funding opportunities but do not coordinate application strategies or timing.</p>	<p>Orgs share information about funding sources, coordinate grant applications, and may provide letters of support for each other's applications. Some coordination on grant reporting requirements.</p>	<p>Orgs develop joint funding strategies and submit collaborative grant applications. Both orgs actively participate in grant writing and management</p>
<p>Advocacy and System Change</p> <p>Do you advocate together for policy changes that would support both healthcare and food security?</p>	<p>There is some awareness of systems change needs and advocacy priorities for each org. No active strides are made to collaborate on this.</p>	<p>Both orgs are willing to act as thought partners and channel partners for one another but may not be actively advocating for the policy changes needed to support deeper partnership and system adequacy.</p>	<p>Healthcare and FIM orgs advocate on behalf of one another and work towards systems reforms in order to support deeper partnership.</p>

DATA, ANALYSIS AND QUALITY IMPROVEMENT	Coordination	Collaboration	Integration
<p><u>Data Capture</u></p> <p>Do you collect data specifically designed to measure your FIM partnership's success?</p>	<p>Data capture does not necessarily align with partnership goals.</p>	<p>Data capture is closely aligned with partnership goals and data analysis needs. Some preferred data elements are captured.</p>	<p>Data capture is closely aligned with partnership goals and needs for data analysis. All preferred data elements are captured by both orgs.</p>
<p><u>Data Sharing</u></p> <p>Can you easily see whether patients you refer actually received FIM services and with what results?</p>	<p>There are no processes or regular data sharing to support closed-loop referrals or to resolve issues electronically. Some data sharing occurs sporadically.</p>	<p>Data is shared to support coordination around individual patients such as to enable the referring org to see if service was provided and to resolve issues electronically. Data sharing is supported by patient-level processes such as signed consent.</p> <p>If the partnership decides to use a closed loop referral platform, that platform is identified collaboratively.</p>	<p>Data is shared between clinical and social systems to support coordination around individual patients and population management. Well-developed data use agreements address governance and shared accountability. If the partnership decides to use a closed loop referral platform, that platform is identified collaboratively. Patients have access to their own data related to the FIM intervention and partnership.</p>

<b>DATA, ANALYSIS AND QUALITY IMPROVEMENT</b>	<b>Coordination</b>	<b>Collaboration</b>	<b>Integration</b>
<p><u>Awareness of Community-Level Needs and Gaps</u></p> <p>Do you regularly review combined data and community health assessments to understand food insecurity patterns in your patient population?</p>	<p>CHC and FIM orgs follow one another's publicly available data dissemination. The two orgs may have informal or infrequent conversations about gaps in community needs.</p>	<p>CHC and FIM orgs routinely review data from each org but do not have the data elements (such as closed loop referrals), analysis or data aggregation infrastructure to understand the relationship between the two orgs' data. Data is not combined to understand the health outcomes and utilization impacts of FIM.</p>	<p>CHC and FIM org staff routinely review population-level, community-level and organizational data collected by both orgs to better understand food needs and their intersections with healthcare utilization and health outcomes. Both orgs collaboratively interpret the meaning of the data.</p>
<p><u>Patient Engagement</u></p> <p>Do patients have input into how your FIM partnership works and how to improve it?</p>	<p>Each org has strategies to consult patients for ongoing feedback on their individual services.</p>	<p>Orgs regularly communicate with each other around feedback received from patients on each orgs activities and on their partnership.</p>	<p>A diverse and representative group of patients have a high degree of influence on workflows and approaches used in the partnership. Patients provide input on the interpretation of data and quality improvement activities.</p>

DATA, ANALYSIS AND QUALITY IMPROVEMENT	Coordination	Collaboration	Integration
<p><u>Quality Improvement</u></p> <p>Do you work together on projects to improve how your partnership serves patients?</p>	<p>Quality Improvement activities are housed in each org but are not conducted collaboratively. There are occasional conversations about each orgs disparate approach to quality improvement.</p>	<p>Both orgs routinely partner to collaboratively conduct Quality Improvement activities to improve workflows.</p>	<p>Both orgs routinely partner to collaboratively conduct Quality Improvement activities to improve workflows. Partners may evaluate the coordination itself through tools created for that purpose or standardized tools such as the Patient Activation Measure or the Patient Centered Coordinated Care Experience Questionnaire.</p>
<p><u>Evaluation</u></p> <p>Do you measure success beyond individual patient outcomes to include community and organizational health?</p>	<p>Success is only measured in population-health related clinical utilization and health outcomes captured by the CHC such as diabetes-related clinical outcomes and potentially avoidable utilization. Evaluation includes specific patients who are the focus of the intervention.</p>	<p>Success is measured with population-health related clinical utilization and health outcomes as well as the health of the two participating orgs (as measured by organizational costs/ revenue, staff satisfaction, patient retention and other measures). Evaluation includes whole households.</p>	<p>Success is measured in population health, organizational health, community health &amp; public health domains such as rates of food insecurity, rates of nutrition insecurity, enrollment in government benefits, improved access to food and nutrition resources. orgs work together to complete evaluation and hold each other accountable for high quality data collection. Evaluation includes impact on health of the entire community.</p>