FRAC
Food Research & Action Center

FOOD AS MEDICINE SURVEY FINDINGS

How Anti-Hunger Organizations Partner With Health Care Providers to Address Food Insecurity

JULY 2024 | WWW.FRAC.ORG

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To learn more about FRAC's work related to health care providers and screen and intervene, see www.frac.org/screen-intervene.

About FRAC

The Food Research & Action Center (FRAC) improves the nutrition, health, and well-being of people struggling against poverty-related hunger in the United States through advocacy, partnerships, and by advancing bold and equitable policy solutions. For more information about FRAC, visit www.frac.org.

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INTRODUCTION

Food security is widely recognized as a critical social determinant of health.[1] A robust and continually expanding body of research documents how poor access to nutrition has been linked to some of the most severe and costly health problems in the U.S.[2,3]

There has been growing nationwide momentum for anti-hunger organizations and health care providers to partner to address food insecurity and improve health. The Food Research & Action Center (FRAC) conducted a survey to assess how state and local anti-hunger organizations are partnering with health care providers, practices, organizations, and systems to address hunger with an emphasis on learning about partnerships to connect households to the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). This survey focused on learning about current models and activities that organizations are engaged in, as well as identifying challenges faced, and supports that would help to accelerate this work.

Summary of Key Findings

- Many state and local anti-hunger organizations are partnering with health care providers to connect patients to food and nutrition resources.
- While there are similarities across organizational approaches, there is not a standard model for these partnerships. Organizations cited a range of activities, partners, focus populations, and other key factors.
- Organizations face an array of challenges in this work, with the most common being related to staff capacity — theirs and that of their health care provider partners — and funding.
- Additional supports are needed to assist organizations with this work, particularly for funding and capacity, training, technical assistance, and peer learning.
- There are key opportunities to enhance this work through inputs related to the supports needed, as well as through systems change.

Summary of Opportunities for Advancement

- **Capacity and funding:** Build sources of financial support to boost capacity for anti-hunger organizations and their health care provider partners, which will enhance partnerships and allow additional patients to be reached with important health promoting programs.
- **Training, technical assistance, and collaborative learning:** Ensure anti-hunger organizations and their health care partners are utilizing existing trainings, technical assistance, resources, and peer learning spaces, and create new opportunities related to these areas to enhance food as medicine efforts focused on SNAP and WIC.
- **Systems change:** Leverage anti-hunger organizations' and health care partners' expertise to create and implement systems improvements to ensure that patients are automatically connected through health care systems to the federal nutrition programs for which they are eligible.

METHODOLOGY

ELIGIBILITY AND DISTRIBUTION

To participate in the survey, respondents had to meet two criteria: (1) They work at a state or local anti-hunger organization (e.g., advocacy organization, food bank, organization that makes and/or delivers medically or nutritionally tailored meals, or anti-poverty organization that works on hunger) and (2) their organization currently partners with health care providers to address hunger (e.g., by connecting patients to federal nutrition programs or other food resources).

The survey was conducted in late 2023 and early 2024 — distributed to state and local anti-hunger organizations via FRAC's distribution lists and the Hunger Vital Sign Community of Practice. The survey also was posted on social media to reach additional potentially eligible organizations.

A handful of follow-up interviews were conducted with survey respondents to learn more about their models to connect patients referred by health care providers to SNAP and/or WIC. The results of these interviews are included in this report as case studies.

ANALYSIS

There are 56 respondents included in the survey analytic sample. Our analysis of the survey data was primarily descriptive, focusing mainly on frequency measures. Subsequently, to further understand the trends in the data, we used visual aids.

SURVEY FINDINGS

Types of Organizations

As detailed in Table 1, survey respondents represent several key types of organizations that work to address hunger, and some respondents fit into multiple categories when it comes to organization type.

TABLE 1: Respondent Organization Type (n = 56)

Organization Type (multiple responses allowed)	Percent	Frequency
Anti-hunger organization	55%	31
Food bank or pantry	46%	26
Anti-poverty organization with an anti-hunger program/policy area	20%	11
Other (please specify)*	11%	6
Organization that makes and/or delivers medically or nutritionally tailored meals	7%	4

**Responses to "Other": state association (Feeding America-affiliated food banks); unrestricted legal aid; Soup Kitchen and Community Social Services; organizes low-income communities of color and works across health and human services disciplines; supporting small-scale producers to connect to food system markets; state sponsor of the GusNIP program through the U.S. Department of Agriculture (USDA). It works with numerous partners to address food insecurity, including school districts, food banks, health foundations, and farmers and farmer coalitions.*

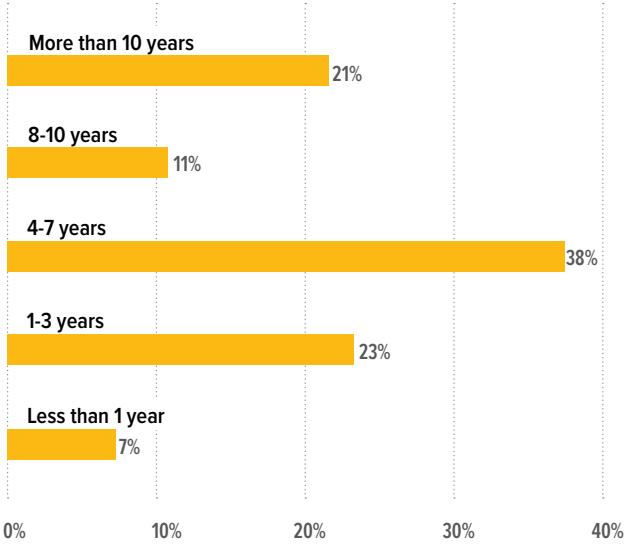
Partnerships Overview

Respondents were asked a series of questions related to their health care provider partners and their partnerships. These were designed to cover key topics and identify whether there are common trends in partnership models. In the event that a respondent had multiple health care partnerships and there were variations in the partnership models, they were asked to respond to the questions through the lens of their most robust partnership.

As shown in Figure 1, when it came to duration of partnerships with health care providers, respondents indicated a variety of years in partnership, with the most commonly cited as four to seven years (38 percent).

> *"Our Food as Medicine and public benefits access work have previously been done in silos. We are actively working towards more intentionally aligning this internally to then feed into our external work."*
>
> **— MICHIGAN SURVEY RESPONDENT**

FIGURE 1: Duration of Partnership With Health Care Providers (n = 56)



Thirty percent of respondents cited that their partnerships have been in place for either one to three years (23 percent) or less than one year (7 percent), meaning these partnerships started after the onset of the COVID-19 pandemic.

In terms of the type of health care providers that respondents partner with, nearly all respondents partner with a federally qualified health care center or community health center (80 percent) and/or a private practice or health system (73 percent).

TABLE 2: Types of Health Care Providers Engaged in Partnerships (n = 56)

Type of Health Care Providers (multiple responses allowed)	Percent	Frequency
Federally qualified health care center/community health center	80%	45
Private practice or health system clinic/office	73%	41
Public health department-operated clinic	50%	28
Rural health clinic	32%	18
Other (please specify)*	25%	14
Veterans Health Administration center/clinic	18%	10
Migrant health center	14%	8
Indian Health Service center	11%	6

**Responses to "Other": schools and churches and shelters; individual providers; [New Hampshire] Hospital Association, Bi-State Primary Care Association, State Dept of Public Health, and Northern and Southern [New Hampshire Area Health Education Center]; hospitals, health care networks, health insurance plans (in particular Medicaid plans and community benefit foundations); Tribes and migrant health centers; state agencies, universities, and state legislators; state associations of health plans and state agencies, such as Medicaid; [Accountable Care Organizations] include hospitals, [federally-qualified health care centers], community health centers, and health system clinics and offices; payors, Medicaid plans, state hospital associations; clinics involved in prior WIC referral program; any clinics with [Montana-American Academy of Pediatrics] connection; mobile care van through Blue Cross Blue Shield Foundation; Humana, Blue Cross Blue Shield, Aetna; hospitals, cancer care centers, home health, EMS; professional organizations representing providers and health plans; and health care payers, specifically Medicaid managed care organizations.*

To learn about how the partnerships are formalized, respondents were asked about facets of their partnerships such as agreements and funding sources. Fifty-six respondents provided information about the formality of their partnerships. As shown in Table 3A, more than half (63 percent) of respondents have a formal written agreement or memorandum of understanding, while fewer than half (46 percent) have an informal written or verbal agreement with their health care provider partners.

As represented in Table 3B, with respect to funding, 64 percent of respondents have funding from foundations or private donors, and 39 percent have funding from their health care provider partners. Fewer respondents have funding from a health insurer (16 percent), community health needs assessment (7 percent), or Medicaid (4 percent). Twenty-one percent of respondents have joint funding with their health care provider partners.

As Table 4 shows, respondents indicated that they work on a number of food and nutrition programs for their partnerships with health care providers, with SNAP (82 percent) being the most common, followed by emergency food (68 percent), and WIC (57 percent).

> *"It is important that the [Food Is Medicine] space looks holistically at food insecurity and intervention, i.e. beyond [medically-tailored food] intervention — broader advocacy around and connection to federal programs, whole household approach (not individual)."*
>
> **— MASSACHUSETTS SURVEY RESPONDENT**

TABLE 3A: Formality of Partnerships With Health Care Providers: Agreements

Components of Partnership (multiple responses allowed)	Percent	Frequency
We have a formal written agreement, memorandum of understanding, etc.	63%	35
We have an informal written (e.g., email exchange) or verbal agreement	46%	26

TABLE 3B: Formality of Partnerships With Health Care Providers: Funding

Components of Partnership (multiple responses allowed)	Percent	Frequency
We have funding from a foundation(s) or private donor(s) for the work	64%	36
We get funding from our health care partner for the work	39%	22
We have joint funding with our health care partner for the work	21%	12
We receive funding from a health insurer(s) for the work	16%	9
Other (please specify)*	13%	7
We received funding from a community health needs assessment for the work	7%	4
We receive Medicaid funding for the work	4%	2

**Responses to "Other" for Tables 3a and 3b: We receive in-kind services from these providers; we receive state funding for outreach for WIC, SNAP, and other federal nutrition programs. Partnering with health care providers is not a specific requirement of the funding, but those funds are how we support this work; for the SNAP Outreach and Enrollment, we are funded through USDA with a match; we receive Medicaid funding, but as a sub-contractor, through the Flexible Services Program and through the One Care and Senior Care Options programs; part of our work is exploring Medicaid partnerships and funding; It is part of our SNAP outreach work as a targeted community.*

TABLE 4: Programs Patients Are Connected to Through the Partnership (n = 56)

Programs (multiple responses allowed)	Percent	Frequency
SNAP	82%	46
Emergency food	68%	38
WIC	57%	32
Summer meals	43%	24
School meals	41%	23
Grocery cards	36%	20
Older adult nutrition programs (home-delivered meals and/or congregate meals)	32%	18
Produce Rx/fruit or vegetable prescriptions	32%	18
Summer EBT	29%	16
Medically Tailored Groceries	23%	13
Afterschool meals	21%	12
Other (please specify)*	18%	10
Medically Tailored Meals	13%	7

**Responses to other: We do not provide direct referral support (our partnership focuses on advocacy); we connect clients to all of the services listed above, but only via sharing the information (as opposed to directly connecting them to the services); SNAP-matching incentive program at farmers' markets (CT Fresh Match); Nutrition Incentives; Grocery gift cards, kitchen equipment, housing assessment, homelessness prevention, RAFT, shelters, fuel assistance, child care, after school programs, adult ed & ESOL, career training, clothing and household goods; Commodity Supplemental Food Program; education programs that promote and teach culturally significant culinary practices; our organization does not provide direct referrals or assistance with federal programming, but we provide information about eligibility and where to sign up for services; provide shelf-stable meals for medical clinics; In-clinic emergency food.*

In terms of the populations served, there was a wide variety amongst respondents. For number of households served, responses ranged from below 100 to tens of thousands. Some indicated that they were unsure of the number, or that they do not directly serve households (for example because they focus on educating providers). Tables 5A–5D demonstrate the breadth of populations reached by respondent partnerships. Fifty-six respondents provided information on population demographics.

TABLE 5A: Demographics of People Served: Race and Ethnicity

People Served (multiple responses allowed)	Percent	Frequency
Latinx households	55%	31
Black households	54%	30
White households	52%	29
Asian/Pacific Islander households	41%	23
American Indian/Alaskan Native households	34%	19

TABLE 5B: Demographics of People Served: Age

People Served (multiple responses allowed)	Percent	Frequency
All ages	73%	41
Older adults	36%	20
Children	34%	19

TABLE 5C: Demographics of People Served: Geographic Location

People Served (multiple responses allowed)	Percent	Frequency
Urban households	55%	31
Suburban households	50%	28
Rural households	43%	24

TABLE 5D: Demographics of People Served: Additional Identity/Characteristics

People Served (multiple responses allowed)	Percent	Frequency
Immigrant households	54%	30
Veteran/military households	41%	23
LGBTQIA+ households	39%	22
Unsure	11%	6
Other (please specify)*	7%	4

**Responses to "Other": We've selected the demographics primarily served, but did attempt to reach and serve outside of those selected; unsure of the demographics; understanding that our SNAP work reaches all of these communities (as well as others, i.e., students in schools, people who are incarcerated, people coming out of incarceration, military families, and people who are unhoused); Jewish households.*

> *"Food is only Medicine when it is accessible to all. The federal nutrition programs reach people in all avenues of life — from urban to rural to Tribal communities and from babies to seniors. Medicine only works when people have access to it."*
>
> **— WISCONSIN SURVEY RESPONDENT**

When it came to identifying patients to refer for food and nutrition assistance, as shown in Table 6, the most frequently selected option was that health care provider partners referred patients to the respondent's organization based on the results of a food insecurity screener.

TABLE 6: How Health Care Providers Identify Patients for Referral (n = 56)

Identification Method (multiple responses allowed)	Percent	Frequency
Based on the results of a food insecurity screener they use	68%	38
Based on the patient having a chronic condition (e.g., diabetes, obesity)	38%	21
Based on the patient's participation in other programs, such as Medicaid	34%	19
Patients contact us based on flyers or other materials they receive from the health care provider	27%	15
Other (please specify)*	23%	13
Patients are referred to us through a field in the electronic health records	16%	9
Based on the patient's household income	13%	7
They connect us with all of their patients	9%	5
Unsure	9%	5
Patients approach our staff/ volunteers at events at the health care provider site	7%	4

**Responses to "Other": Typically social workers and community health nurses; staff referral; patients are not referred to our organization as we are not a direct service provider; N/A; we do not do any direct service; we are primarily encouraging referrals to local WIC agencies, SNAP assistors, or summer meal sites, not direct referrals to our organization; word of mouth; we are working on implementing screening across the state; our statewide toll-free number and through word-of-mouth in the community; through promotions of our programs that we market to the communities we serve around Texas; our organization does not receive direct referrals from partners; we only deal with the clinics. They make the decision who to give them to; we train health providers and enrollers on SNAP and Medicaid issues and troubleshoot problem cases.*

Respondents indicated that they partner with health care providers on additional activities outside of connecting patients to programs, with advocacy/policy work to address hunger (70 percent) and policies to make it easier for health care providers to connect their patients to SNAP, WIC, or other nutrition or food programs (50 percent) being the most common responses.

TABLE 7: Additional Partnership Activities (n = 56)

Activities (multiple responses allowed)	Percent	Frequency
Advocacy or policy work to address hunger	70%	39
Policies to make it easier for health care providers to connect their patients to SNAP, WIC, or other nutrition or food programs	50%	28
Research	36%	20
Fundraising	30%	17
None of the above	14%	8
Other (please specify)*	4%	2

**Responses to "Other": community resource exchange; work with bi-state primary care, Food Security Roadmap and in the Mass Feeding Group.*

> *"Neither anti-hunger groups nor healthcare systems have all of the tools, staff, knowledge, and resources to provide comprehensive disease/health-focused anti-hunger interventions. However, the need for such interventions continue to increase, so multi-modal approaches are becoming more important than ever."*
>
> **— WISCONSIN SURVEY RESPONDENT**

Hunger Vital Sign™ is a validated two-question screening tool that helps health care providers around the nation easily and quickly screen their patients for household food insecurity. The tool was developed and validated by Children's HealthWatch and based on the 18-item U.S. Household Food Security Survey Module. Hunger Vital Sign™ identifies households as being at risk for food insecurity if they answer that either or both of the following two statements is "often true" or "sometimes true" (versus "never true"):

- "Within the past 12 months we worried whether our food would run out before we got money to buy more."
- "Within the past 12 months the food we bought just didn't last and we didn't have money to get more."

Children's HealthWatch and FRAC co-convene Hunger Vital Sign™ Community of Practice, which works to facilitate conversations and collective action among a wide-range of stakeholders interested in addressing food insecurity through a health care lens. Joining the Community of Practice is a great way to engage and share learnings and best practices around screening and intervening, and other efforts at the juncture of food insecurity and health care.

Children's HealthWatch works to achieve health equity for young children and their families by advancing research to transform policy. They are a network of pediatricians and child health researchers embedded in four large medical and public health institutions that engage in a range of projects related to food insecurity, including screening, referrals, and advocacy.

Zeroing in on Efforts: SNAP

Respondents who work on SNAP as part of their partnership with health care providers were asked a series of questions to learn more about their work in this space. Fifty-one respondents answered this set of questions.

As demonstrated in Table 8, respondents reported employing a number of activities related to connecting patients to SNAP, with the most common being respondents receive from health care providers or their staff referrals to provide patients with SNAP application assistance (55 percent). Other commonly used activities included health care provider/staff handing out the organization's SNAP flyers (41 percent) and providing training or technical assistance to the health care provider/staff so that they can screen patients for SNAP eligibility and provide application assistance (30 percent).

TABLE 8: SNAP Partnership Activities (n = 51)

Activities (multiple responses allowed)	Percent	Frequency
The health care provider/staff refers patients to us for SNAP application assistance	55%	31
The health care provider/staff hands out our SNAP flyers	41%	23
We provide training or technical assistance to the health care provider/staff so that they can screen patients for SNAP eligibility and provide application assistance	30%	17
We provide SNAP application assistance as part of our work to provide patients with groceries, Medically Tailored Meals, or other food benefits	29%	16
We provide on-site assistance at the health care partner location to connect patients to SNAP (e.g., eligibility screening, application assistance)	21%	12
We refer people for SNAP application assistance as part of our work to provide patients with groceries, Medically Tailored Meals, or other food benefits	20%	11
Other (please specify)*	11%	6
We don't assist with SNAP	9%	5
We don't currently assist with SNAP but hope to do so in the future	4%	2

**Responses to "Other": SNAP applicants are referred to the County Offices of Temporary Assistance; some of our local SNAP assistors (subcontractors of our organization) may have direct referral relationships with health care providers in their area. We do not have a direct referral system with health care providers at this time; we train health care staff on SNAP, but just so that they are comfortable promoting the program and making a referral. Not so that they are providing application assistance. Also, our Flexible Services staff are not allowed to provide SNAP application assistance, so they connect those patients to our hotline to complete the process; we build relationships between [managed care organizations] and food banks; they help us to inform SNAP policies; are eligible for two for one fresh fruits and vegetables through the GusNIP program that we oversee in 75+ farmers' markets and grocery retailers.*

> *"I think our health care partners understand the importance of connecting patients with programs like SNAP and WIC or local resources like a food shelf."*
>
> **— MINNESOTA SURVEY RESPONDENT**

> *"From our research, we know that those who struggle with food insecurity also deal, disproportionately with at least one chronic disease. We want to both meet people where they are and provide them with nutritious food in order to thrive."*
>
> **— NORTH DAKOTA SURVEY RESPONDENT**

> *"Food should not be an afterthought in medical care. It is vital to everyone's health, especially children. If it needs to be "prescribed" then let's do it!"*
>
> **— NEW JERSEY SURVEY RESPONDENT**

Respondents were asked a question to identify the process, if any, used so that the health care provider is informed when a patient has been connected to SNAP. More than half (51 percent) of respondents shared that they do not have such a process in place. Others use a mix of systems, including the organization reporting back to the provider (29 percent), and the patient reporting back to the provider or the provider asking at future patient appointments (20 percent). Others indicated that they're working to create a process (12 percent), or could use assistance to do so (10 percent).

TABLE 9: Process to Notify Health Care Provider Partners That the Organization Has Helped a Patient to Connect to SNAP (n=51)

Process (multiple responses allowed)	Percent	Frequency
We do not currently have a process in place	51%	26
We report back to the provider	29%	15
Other (please specify)*	22%	11
Patients report back to the health care provider, or the provider asks at future patient appointments	20%	10
We are working to create a process	12%	6
We need help creating a process	10%	5
There is a field in the electronic medical records to track SNAP participation	6%	3
Provider's office follows up with us	4%	2

**Reponses to other: County [Office of Temporary Assistance] handles all SNAP referrals and applications; our research assistants note in the patient's electronic medical record that they requested food resources (these include info on SNAP). A provider reviewing a patient's chart should see that note; we are only able to report back on patients who we help complete an online application; this is complicated. Even when we complete a SNAP application, our state does not tell us if approved or not; we utilize the FindHelp platform; we piloted the use of the Aunt Bertha [FindHelp] platform with one health care partner; some partners do not have a process or mechanism for this; others do; unsure; we do not work with patients directly; feedback process in place for some food banks, but not all; process varies a bit depending on provider, some use a real-time system like findhelp.org or UniteUs, others wait for our monthly report.*

> *"In our state, food as medicine is defined (in our 1115 waiver) as produce Rx, medically tailored meals, nutrition counseling, and on-site pantries. While there are providers connecting patients to federal nutrition programs, this is not seen as a "core part" of food as medicine work and is often left out of the conversation."*
>
> **— HAWAII SURVEY RESPONDENT**

CASE STUDY

Project Bread: SNAP Assistance and Section 1115 Waivers in Massachusetts

Project Bread engages in a range of work to connect patients to SNAP and other health-supporting nutrition resources by partnering with health care providers.

In their health care referral program, partners screen their patients for food insecurity and refer patients to Project Bread for support in connecting to SNAP and other supports. Project Bread utilizes a secure portal that health care provider partners can use to send key information, such as patient name, contact information, age, and preferred language. This allows staff from Project Bread's hotline to follow up directly with the patient to provide SNAP application assistance — in the patient's preferred language — over the phone or by mail. They also are able to track the SNAP application through completion (interview, enrolled in SNAP, or denial) and report back to the health care provider partner about the services provided through the portal. For patients in WIC-eligible households, staff assist them with starting an online WIC form that triggers follow-up from the local WIC agency. Providers and staff are provided with regular trainings to help equip them with information on federal nutrition programs and making referrals. More than 2,000 provider referrals per year come through this hotline. (The hotline, which has been in service for decades, reaches more than 20,000 people per year across the state.)

Project Bread also is in their state's Medicaid 1115 waiver to contract with six health care accountable care organizations to provide six months of case management services to people diagnosed with food insecurity and another comorbidity. Through this service, patients are provided with connections to SNAP application assistance and community food resources. They also receive grocery store gift cards, kitchen supplies, nutrition counseling, and cooking classes for patients who have qualified for the program. Over four years of this case management project, more than 12,000 patients have been served.

Respondents were provided with an opportunity to share more on their model to connect patients to SNAP through an open-ended question. Common themes for the descriptions of their work with health care providers regarding SNAP included providing: screening and application assistance to patients (in-person or by phone); provider training; materials for distribution; and patient referrals to other partners (such as a SNAP agency) or programs.

Below are core themes and a few examples from the responses.

SCREENING AND APPLICATION ASSISTANCE

- *"[My organization is a] SNAP Outreach partner and offers SNAP application assistance via our statewide food assistance helpline. Our healthcare partner refers patients to our helpline for application assistance, but currently in a more informal manner."*
- *"In our flexible services program, patients who are not on SNAP are referred to our Hotline. Our Hotline team follows up with the patient, screens them for SNAP, and offers to help them apply over the phone. (They can also be mailed an application.) We can then track the application through completion (interview, enrolled in SNAP, denied, etc.). We then report back to the ACO [Accountable Care Organization] through the patient portal."*
- *"They screen for food insecurity and [there] is a warm transfer to our outreach staff. Our outreach staff is embedded in the clinic setting."*
- *"We utilize Find Help and other platforms to receive referrals from healthcare providers and managed care organizations. We then reach out to clients for application assistance."*

TRAINING AND MATERIAL DISTRIBUTION

- *"We train health enrollers about SNAP and how to enroll clients"*
- *"Our statewide SNAP Coordinator offers 2 trainings to health partners: (1) SNAP Basics; (2) SNAP Application Assistance"*
- *"We are available [to] provide information on SNAP, brochures, flyers, trainings, etc. to healthcare partners."*

REFERRALS TO OTHER PARTNERS OR PROGRAMS

- *"When we reach out to referred patients, getting them connected with SNAP is our primary focus. Approximately half of the patients we connect with are already enrolled in SNAP, so we talk about ways to maximize those benefits through things like Market Bucks. Of the patients not already on SNAP, about half of them are screened and likely eligible so we assist them with the application process."*
- *"We refer directly to our county based social services organization as well as have our local SNAP navigators on site."*
- *"Referred to county social services."*

CASE STUDY

Hunger Free Colorado: SNAP Hotline and Partner Supports

Hunger Free Colorado (HFCO) uses a multipronged approach in partnering with health care providers to connect patients to SNAP.

Through their SNAP outreach program — supported by a contract with the State of Colorado's Department of Human Services — they partner with health care providers to accept referrals (either by a direct referral from the partner, or a referral to call the hotline) and provide SNAP outreach and application assistance to patients in a range of languages. Using the patient information sent by providers, HFCO staff conduct follow-up to the patients, first by text to prep the patient that a call will be coming as a result of the provider referral, and then by phone to provide more information on SNAP, and if desired, application assistance. Another model HFCO uses is for their mobile outreach team to provide on-site education and application assistance at clinics and hospitals (along with other community sites, such as libraries). HFCO also is working to pilot a closed loop referral system where they are able to both receive referrals and send back information to the provider all through the Salesforce platform.

HFCO also provides trainings to assist health care providers and their staff to learn about SNAP and how to refer patients to HFCO. This includes a recently developed online module that providers can use to learn at the time and pacing that works for them, along with open office hours for dedicated support.

Through their SNAP PEAS (Partners Engaging in Application Services) program, HFCO works with partners around the state, including health care providers and hospitals, to equip them to directly provide SNAP assistance. SNAP PEAS partners receive training and technical assistance on: SNAP education and application assistance; receive access to PEAK (the Colorado SNAP application system) licensure so that can submit applications; and receive access to a community of practice, and more.

Zeroing in on Efforts: WIC

As with work on SNAP, respondents were asked a series of questions to learn more about their models related to WIC. Fewer respondents indicated that their partnership with health care providers includes work related to WIC compared to those who work on SNAP, with 30 percent of all respondents not assisting on WIC. Twenty percent of respondents reported that they do not currently assist with WIC but hope to do so in the future.

As shown in Table 10, respondents who work on WIC engage in a range of activities. One-quarter of respondents noted that they provide WIC information as part of their work to provide patients with groceries, medically tailored meals, or other food benefits. Respondents reported that they provide health care partners with WIC flyers (18 percent) and provide training or technical assistance to the health care provider/staff so that they can screen patients for WIC eligibility and provide WIC referrals (13 percent).

TABLE 10: WIC Partnership Activities (n = 56)

Activities (multiple responses allowed)	Percent	Frequency
We don't assist with WIC	30%	17
We provide WIC information as part of our work to provide patients with groceries, Medically Tailored Meals, or other food benefits	25%	14
Other (please specify)	21%	12
We don't assist with WIC, but we hope to do so in the future	20%	11
The health care provider/staff hands out our WIC flyers	18%	10
We provide training or technical assistance to the health care provider/staff so that they can screen patients for WIC eligibility and provide WIC referrals	13%	7
The health provider is co-located with a WIC clinic	11%	6
We helped the health care provider develop a relationship with a WIC clinic	4%	2

**Responses to "Other": County Office of Temporary Assistance handles WIC applications; we have co-funding with WIC to provide outreach and increase enrollment through the food access coalitions we manage statewide; we work with a statewide association of health care providers to support these partnerships in a variety of ways. We have shared WIC outreach resources, provided training on the basics of WIC eligibility, and encouraged providers to establish referral systems with their local WIC agencies; [Our] WIC Navigator conducted outreach at [Summer Food Service Program sites], child/day care centers, [Illinois Department of Human Services] offices, colleges, churches, and [Community-Based Organizations], and medical clinics; we work with our state agency to help them do outreach and target potential participants; we only assist if a client is unable to get WIC, and is in dire need for supplies; we are working on a project to help the state agency improve access and cross-enrollment between WIC, SNAP, and Medicaid; they help us to inform WIC policies; unsure; this is a more local, Central Texas program, that is exactly the same as the SNAP program. Funding for this comes from Travis County and the City of Austin. No health care partners yet; similar to SNAP, some food banks screen patients who are referred to the food bank for emergency food for other services, including WIC; we will refer patients to WIC if they are likely eligible. Also, one of our clinic partners is a county WIC office who is sending us their clients for help with other food resources.*

CASE STUDY

Hunger Solutions New York: WIC Connections

Hunger Solutions New York (HSNY) integrates connections with health care providers into their wide-ranging work on WIC. As part of their statewide outreach project to expand participation in WIC, HSNY partnered with the Community Health Care Association of New York State to host a panel presentation encouraging more community health centers to establish referral systems with local WIC agencies. The panel featured three WIC agencies that are embedded in Federally Qualified Health Care Centers, lifting up their best practices and encouraging other centers to strengthen referrals to WIC. Additionally, the organization hosts weekly online office hours for medical providers to learn the latest WIC program information and modernizations so they can easily inform families and connect them to the program. Hunger Solutions New York has also engaged health care providers in their work to promote SNAP and summer meals. For example, to promote summer meals, HSNY places advertisements in waiting rooms of pediatrician offices, pharmacies, and lab work facilities to share key information on the program and the meal site finder map. In their broader partnership and advocacy efforts, HSNY also works to ensure that Food as Medicine conversations include and center the federal nutrition programs.

Respondents were asked a question to identify the process, if any, used so that the health care provider is informed when a patient has been connected to WIC. Sixty percent of respondents indicated that they do not have such a process in place. Other processes included the organization reporting back to the provider (17 percent), and the patient reporting back to the provider or the provider asking at future patient appointments (13 percent). Others indicated that they are working to create a process (10 percent) or could use assistance to do so (13 percent).

Respondents were invited to share more on their model to connect patients to WIC using an open-ended question. Common themes for the descriptions of their work with health care providers on WIC included providing: training, education, and material distribution; prescreening or application assistance; systems and partnership development; and referral to, or information sharing with, the WIC agency.

TABLE 11: Process to Notify Health Care Provider Partners That the Organization Has Helped a Patient to Connect to WIC (n = 30)

Process (multiple responses allowed)	Percent	Frequency
We do not currently have a process in place	60%	18
Other (please specify)	20%	6
We report back to the provider	17%	5
Patients report back to the health care provider or the provider asks at future patient appointments	13%	4
We need help creating a process	13%	4
Provider's office follows up with us	10%	3
We are working to create a process	10%	3
There is a field in the electronic medical records to track WIC participation	3%	1

**Responses to other: We track enrollment increases and website visits; we have every patients referred to us who are eligible for WIC and not currently enrolled; we work with the state agency; unsure; our reporting is back to the county and City Public Health Department and Office of Sustainability; some food banks have a feedback process in place, such as through a closed-loop referral system, others do not.*

TRAINING, EDUCATION, AND MATERIAL DISTRIBUTION

- *"Where applicable we provide WIC training to providers and connect them to the WIC clinic. We also provide resources for distribution. This is patchy/developing work."*
- *"We have worked with WIC to create training videos and in person opportunities to explain how to apply and the benefits of WIC."*
- *"We provide information about WIC, but clinics give the patient information about how to apply for WIC directly with the local WIC agency. There is not a closed feedback loop."*

PRESCREENING OR APPLICATION ASSISTANCE

- *"We help patients who are eligible, but not yet enrolled in WIC, complete a pre-application form online (available from our state's WIC office). This prompts WIC staff to reach out to families to complete the enrollment process."*
- *"Provider connects patients with our staff who assist them in applying for WIC."*

SYSTEMS AND PARTNERSHIP DEVELOPMENT

- *"We partnered … to encourage more of our state's CHCs [Community Health Centers] to establish referral systems with local WIC agencies."*
- *"[W]e were part of a coalition that worked to co-locate WIC staff at several healthcare locations to increase warm referrals. We provided some strategic and financial support to the work. We also create brochures that include information on WIC and other programs; those brochures are available for healthcare organizations to request so they can share with their patients."*

CASE STUDY

Montana Food Bank Network: Advocacy and Partnerships

Montana Food Bank Network (MFBN) has engaged in several key partnership activities with health care providers, including on SNAP outreach, food distribution, and advocacy.

MFBN provides supports to enable health care providers to promote SNAP to patients, including through brochures, flyers, and trainings. They also are available to accept referrals from health care providers for patients to receive assistance with SNAP. To reach extremely rural communities, MFBN partners with a health care provider to distribute food resources from a mobile care van. When a patient seen through the mobile care van screens positive for food insecurity they are able to receive a food box, and information on the benefits of SNAP and how to get SNAP support from MFBN.

MFBN also partners with the Montana Chapter of the American Academy of Pediatrics to provide presentations, distribute SNAP and WIC resources, and partner on advocacy to support SNAP, child nutrition programs, farm to food bank programs, and other topics. Through a past project, they also collaborated to create a warm referral system for multiple sites, including a WIC-staffed and hospital-supported screening and referral system on a mother/newborn floor.

REFERRALS TO OR INFORMATION SHARING WITH THE WIC AGENCY

- *"If we receive a referral from a household that has children under 5 or a pregnant person, we will talk to them about WIC and refer them to their local WIC office if they are likely eligible and interested in enrolling."*
- *"The patient's medical record is transferred to WIC through the marking of the electronic medical record and viewed in real time."*

Additional Nutrition Program

While the survey was primarily focused on SNAP and WIC, respondents were asked about their work on additional nutrition programs to help identify the range of programs organizations may be working on in partnership with health care providers.

Respondents were provided with an opportunity to share more on their model to connect patients to programs and/or food resources — such as emergency food/food boxes, medically tailored meals, home-delivered meals, congregate meals, produce prescriptions, and more — through an open-ended question. Examples of the programs and types of work respondents shared are below.

FOOD DISTRIBUTION/EMERGENCY FOOD

- *"We supply numerous providers with emergency food boxes that they store to be able to give to patients in need. We also receive referrals from two managed care organizations where we then provide home delivered boxes to those patients. We also support a Fresh Food Farmacy with one of our provider partners."*
- *"When providing SNAP application assistance, we are also able to connect folks to local food pantries and food banks across the state in their communities."*
- *"We refer to other food resources like local food shelves, meal sites or discount grocery programs as relevant to the patient's situation."*
- *"We have a warm transfer to the food bank and provide referrals to our network, we also have box programs that are tailored to specific populations (diabetic, black maternal health, etc)."*

MEDICALLY TAILORED MEALS/MEDICALLY TAILORED GROCERIES/MEAL DELIVERY

- *"If we are not able to provide tailored groceries we refer to other providers in our network."*
- *"We refer to Meals on Wheels."*
- *"The healthcare providers refer directly to the programs that offer medically tailored meals, home delivery services, and produce prescriptions. We do not provide these services directly to patients but review research and advocate for broader accessibility to these programs."*

PRODUCE PRESCRIPTIONS/MATCHING DOLLARS

- *"We are in the process of meeting with a medical provider to expand the produce prescription program."*
- *"[W]e provide outreach materials to connect patients to SNAP, and then SNAP-doubling programs at farmers' markets."*

SUMMER MEALS

- *"While not formalized, we have leveraged health care providers' offices for outreach for summer meals. We've placed paid advertisements in waiting rooms, pharmacies, and labwork facilities. The ads refer families to the summer meals site finder map."*

NON-FOOD RESOURCES

- *"Clients are referred both internally at the food bank and to external partners in the community (housing, utilities, workforce, etc.)."*
- *"Our education program is designed to work with these partners to offer culturally significant cooking classes that focus on three curriculums Diabetes, Heart Disease, Home cooking for the entire family; these classes are taught in both English and Spanish."*

CASE STUDY

The Food Group: Flexible Models Creating Lasting Partnerships in Minnesota

The Food Group partners with health care providers around the state to accept referrals and connect patients to SNAP, as well as to WIC, food shelves, meals, and other important resources.

In their health care provider partnerships, The Food Group prizes flexibility and creates partnership systems tailored to the health care provider. This approach has allowed them to support provider partners as they create a referral process that fits their system and builds buy-in that leads to lasting partnerships.

Many of their health care provider partners use the Hunger Vital Sign™ tool to screen patients for food insecurity. Patients who are identified as possibly food insecure are offered a referral to The Food Group's Minnesota Food HelpLine. Some provider partners send referrals to The Food Group via platforms such as EPIC or UniteUS, while others provide referrals via secure web form or by promoting the HelpLine.

HelpLine staff then work to make contact with referred patients via phone. For patients with smart phone or computer and internet access, HelpLine staff can walk them through the process of completing and submitting a SNAP online application. For those who prefer a paper application, HelpLine staff can help complete the application by phone and then mail the application to the patient to sign and submit it. During the COVID-19 pandemic, Minnesota utilized a waiver to allow telephonic signatures to be used on SNAP applications. This allowed HelpLine staff to provide application assistance and submit a SNAP application on behalf of the patient, completely by phone rather than having to mail a hard copy application to the patient to sign and submit.

In the event a patient referred to the HelpLine is already participating in SNAP, The Food Group shares information on ways to maximize SNAP benefits, such as through Market Bucks (a matching dollars program), and other resources, including local food shelves, meal sites, or discount grocery programs as relevant to the patient's situation. If they receive a referral from a household that has children under age 5 or a pregnant person, HelpLine staff will talk to the household about WIC and refer them to their local WIC office for assistance enrolling.

For many of their partnerships, The Food Group has developed systems to report back to the provider on whether a patient was provided with assistance.

Support Needed to Address Challenges

Respondents were asked to share the challenges they face in partnering with health care providers to connect patients to SNAP and WIC, as well as supports that would help enhance the partnership.

Every respondent indicated that they face some type of challenge. The top challenges respondents cited were: limited staff capacity at their organization (55 percent); limited staff capacity at health care provider practice (50 percent); and lack of funding (50 percent). Respondents also cited challenges related to application backlog at the SNAP agency (32 percent) and a complicated SNAP application process (30 percent).

As would be expected, the supports that respondents most commonly reported needing are related to the challenges they face. Eighty percent of respondents identified funding for additional staff time for my organization to do this work as a support needed. Respondents also lifted up a need for funding for their health care provider partners (55 percent) and health care coverage for food insecurity interventions (45 percent). Highlighting opportunities around training and technical assistance, respondents also noted the need for support on closed loop referrals (36 percent), training for health care providers (32 percent), resources on how organizations can do this work (29 percent), and more.

When asked what single support is most needed, respondents overwhelmingly cited funding.

WHEN ASKED WHAT SINGLE SUPPORT IS MOST NEEDED, RESPONDENTS OVERWHELMINGLY CITED FUNDING.

TABLE 12: Challenges Faced in Partnering With Health Care Providers to Connect Patients to SNAP and WIC (n = 56)

Challenges (multiple responses allowed)	Percent	Frequency
Limited staff capacity at our organization	55%	31
Limited staff capacity at health care provider practice	50%	28
Lack of funding for our organization's work	50%	28
Application backlog at the SNAP agency	32%	18
Complicated SNAP application process	30%	17
Lack of funding for health care provider work	25%	14
Challenges with HIPPA compliance	21%	12
Other (please specify)*	20%	11
Lack of understanding of food insecurity and nutrition programs among health care providers	18%	10
Lack of interest or buy-in from health care providers	16%	9
Lack of relationships with health care providers	16%	9
Complicated WIC application process	14%	8
Application backlog at the WIC agency	11%	6
Lack of interest or buy-in from our organization's leadership	5%	3
None	0%	0

**Responses to "Other": More in-depth screening is necessary prior to referral; we cannot navigate applications [as] it goes through the county government. Additionally, less than 40 percent of the people we serve meet the income requirements for these benefits. Most are low-income workers and seniors; telephonic signatures posing a barrier to remote application assistance; unsure funding for WIC has made promotion/outreach inconsistent; reduction in SNAP benefits, and they do not provide sufficient food, still figuring this out; our organization does not have a benefit team dedicated to connecting community members with SNAP and WIC. We do not provide direct programming for patients or community members; we don't do that; difficulty establishing data sharing agreement and referral pathways (legal and regulatory); lack of sustainable funding pathway (i.e., pilot programs funded through philanthropy or one-time funding without pathway to sustainable funding); we are working with our state to design Medicaid waiver plan but there are [challenges].*

TABLE 13: Supports Needed to Enhance Partnership With Health Care Providers (n = 56)

Supports (multiple responses allowed)	Percent	Frequency
Funding for additional staff time for my organization to do this work	80%	45
Funding for health care providers to do this work	55%	31
Health care coverage for food insecurity interventions	45%	25
Support on closed loop referrals	36%	20
Training for health care providers	32%	18
Resources on how my organization can do this work	29%	16
Technical assistance setting up relationships with health care providers	25%	14
Peer-to-peer learning on how my organization can do this work	21%	12
Training for organization staff	20%	11
Other (please specify)	9%	5
None	5%	3
Complicated WIC application process	14%	8
Application backlog at the WIC agency	11%	6
Lack of interest or buy-in from our organization's leadership	5%	3
None	0%	0

**Responses to "Other": [We deliver] to very low-income clients who are also in need of healthier options [that would] require use of personal vehicle and gas. Would be nice if we could get funding for a vehicle and or transportation expenses like gas; data investments to support closed-loop referrals; integrate food access into the Medicaid and ultimately Medicare and private pay insurance structure. Expand SNAP benefits or create a supplemental benefit program to cover a household's monthly food budget; still figuring this out; data support — there has been a lot of work on getting the data to work between the two organizations.*

OPPORTUNITIES FOR ADVANCEMENT

As underscored by the survey findings, anti-hunger organizations recognize the vital role health care providers can play in addressing food insecurity among their patients and promoting access to SNAP, WIC, and other federal nutrition programs. Many providers have increasingly recognized the negative impacts of food insecurity on patient health and the key role federal nutrition programs play in addressing food insecurity and improving nutrition and health.[4] In acknowledgment of this, a growing number of health care providers, often through partnerships with anti-hunger groups, are screening patients for food insecurity and working to address food insecurity via connections to food and nutrition interventions.

A robust set of research documents how federal nutrition programs, including SNAP and WIC, are proven supports for improving nutrition, health, and well-being.[5,6] Patients are able to participate in the programs for as long as they are eligible and these federally funded programs are available in every part of the country.

A wide array of food as medicine interventions are important for improving patient food access, nutrition, and health. However, ensuring eligible patients are participating in the federal nutrition programs — particularly SNAP and WIC — should be the primary intervention for health care systems to address food insecurity and improve patient nutrition and health.

Even with the substantial benefits, too many eligible people are missing out on participating in SNAP and WIC. Contributing to this gap in eligibility versus participation are factors such as lack of information or misinformation about eligibility, benefits of participating, and how to access the programs; stigma; complicated and confusing application systems; and for some, feeling as if the process is not worth it for the level of benefits they may receive or for the amount of time it takes to apply for the programs by themselves.

> *"SNAP and WIC are tried and true methods for improving health and food security. Help is needed in understanding the regulatory barriers and opportunities between Medicaid and SNAP now that so many states are working to secure Medicaid funds for food."*
>
> **— VIRGINIA SURVEY RESPONDENT**

> *"The healthcare system, like schools, captures folks where they already are. Enrolling patients in SNAP and WIC, and connecting them to other food resources, at the same time they are being connected to other social services streamlines supports and improves follow through."*
>
> **— MASSACHUSETTS SURVEY RESPONDENT**

Partnerships between anti-hunger organizations and health care providers are key avenues for addressing barriers and connecting more eligible people to these essential programs. As leaders in addressing food insecurity and in federal nutrition programs, anti-hunger organizations ensure federal nutrition programs remain strong and accessible. Together anti-hunger organizations and health care partners can effectively expand awareness and utilization of federal nutrition programs.

As demonstrated in the survey findings, there are an array of successful models implemented around the country where anti-hunger organizations and health care providers are partnering to ensure that patients are connected to food as medicine interventions, including SNAP and WIC.

The survey results also underscore frequent challenges organizations face in engaging in this work and opportunities for building this work to better help patients connect to vital nutrition programs that improve nutrition, health, and well-being. Key opportunities for improvement are highlighted below.

Bolstering Partnerships Between Anti-Hunger Organizations and Health Care Providers

As demonstrated in the survey, top considerations for bolstering these partnerships to address hunger include additional training, technical assistance, collaborative learning opportunities, and funding and capacity to support these partnerships.

TRAINING, TECHNICAL ASSISTANCE, AND COLLABORATIVE LEARNING OPPORTUNITIES

The survey results reinforced the need for additional training, technical assistance, and peer-to-peer learning opportunities for anti-hunger organizations and health care providers. Key areas of need reported by respondents included: "support on closed loop referrals" (36 percent); "training for health care providers" (32 percent); "resources on how my organization can do this work" (29 percent); "technical assistance setting up relationships with health care providers" (25 percent); "peer-to-peer learning on how my organization can do this work" (21 percent); and "training for organization staff" (20 percent). Efforts to fill these gaps include promoting existing technical assistance and learning opportunities, such as trainings and resources, as well as potential creation of new trainings, resources, and learning opportunities.

There are available resources that anti-hunger organizations can leverage to support their health care provider partners in this work. For example: FRAC and AARP Foundation offer a free, online course[7] focused on older adult food insecurity and interventions; the Social Interventions and Research Evaluation Network (SIREN)[8] has a research library with related resources; the American Academy of Family Physicians EveryONE Project[9] provides materials on social determinates of health; and FRAC and the American Academy of Pediatrics have a screen and intervene toolkit[10] for pediatricians. The Hunger Vital Sign™ Community of Practice is a great place for stakeholders from both organizations and health care providers to share learnings related to this work.

There is a need to build out more trainings, resources, and spaces to support anti-hunger organizations in this collaborative work. Creation of new trainings and resources focused on topics such as establishing partnerships with health care providers; creating sustainable partnership models; and how to create closed-loop referral systems, among many other areas of interest, would help to enhance and accelerate work in this space. Survey respondents also cited interest in peer-learning opportunities. Additional collaborative learning opportunities could be especially impactful since models can vary widely and peer-to-peer discussions would allow anti-hunger organizations to share learnings that could assist others to replicate and tailor work.

> *"I feel that anti-hunger organizations should definitely be at the table for these conversations, but we can't directly do the work. The term "Food as MEDICINE" implies it is the responsibility of the healthcare provider to ensure patients are getting what they need (and since visiting your doctor is a 1:1 experience, I think people will trust their provider first and foremost). Policy work, advocacy, and outreach should be the role of the anti-hunger organizations but the providers need to implement, educate, and refer. Food As Medicine should be integrated into providers' higher-education. I do think more funding and staff capacity is needed on all ends to be able to achieve this. Both providers and anti-hunger orgs are stretched really thin right now."*
>
> **— CONNECTICUT SURVEY RESPONDENT**

FUNDING AND CAPACITY

In the survey, respondents cited as top challenges to this work "limited staff capacity at our organization" (55 percent), "limited staff capacity at health care provider practice" (50 percent), and "lack of funding for our organization's work" (50 percent).

Building sources of financial support for this work would help enhance partnerships and allow additional patients to be reached with these important health-promoting programs. Funding from sources such as private foundations, individual donors, and public entities has been essential to building food as medicine work, and additional support for both anti-hunger organizations and their partners would enable a wider and more sustainable reach. The Hunger Vital Sign™ Community of Practice serves as a clearinghouse on topics like funding. In some communities, anti-hunger organizations and their partners also may be able to access funds through community needs assessments. The Public Health Institute's Tackling Hunger project,[11] *Making Food Systems Part of Your Community Health Needs Assessment*, provides guidance on local food systems and food security that can provide useful information in making the case for funding. For anti-hunger organizations that are part of their state's SNAP outreach plan, federal funds can be drawn down to educate and provide assistance to households, including those who are identified through health care partnerships.

There also are burgeoning opportunities to access funding streams available through Medicaid, Medicare, and health insurance. Of note, the Centers for Medicare & Medicaid Services included a food insecurity and nutrition risk improvement activity in the 2022 Physician Fee Schedule Final Rule to support work on Food Insecurity & Nutrition Risk Improvement Activities. Fewer than 14 percent of survey respondents reported utilizing funds from Medicaid to provide food and meals, showing opportunity for building out this funding source for work that helps to improve patient health and reduce health care costs. The Food Is Medicine Coalition[12] has a range of resources to help providers harness funding.

Systems Change

While partnerships focused on referrals systems across anti-hunger partners and health care providers are essential, systems improvements need to be put into place to ensure the widest and most sustainable reach. The ultimate goal is that everyone who is eligible for Medicaid, SNAP, WIC, and/or other nutrition programs, should be readily connected to these programs before they enter a health care setting. This will require the political will to address hunger and prioritize access to public programs. Key improvements to move toward this goal include improving system interoperability to seamlessly connect individuals to all available programs; streamlining application systems to ensure that when an individual or a household is enrolled in Medicaid that they also are connected to SNAP and WIC when eligible; data sharing to identify potentially eligible households and individuals who are participating in Medicaid and may be eligible for SNAP and WIC but not yet participating; and cross-agency promotion of programs, such as Medicaid agencies promoting the availability and importance of federal nutrition programs to health.

Investments in systems change will result in benefits for patients and help drive reductions in health care costs as more eligible people are connected to nutrition programs. Scores of research demonstrate the damage of food insecurity to health, and conversely the important role nutrition programs play in improving health, as well as in reducing the need for health care services, resulting in substantial savings in health care expenditures.[13]

Anti-hunger organizations and health care provider partners are perfectly situated to play central roles in working with other stakeholders, such as state agencies that administer health and food programs, to identify and move forward such systems improvements.

CONCLUSION

There is growing work among anti-hunger organizations to partner with health care providers to ensure that patients are connected to federal nutrition programs, particularly SNAP and WIC, and other nutrition supports. The results of this survey clearly show that there are strong and tailored models for such partnerships. The survey results also demonstrate that additional inputs are needed to bolster and grow these important partnerships. More investments should be dedicated to support and enhance these partnerships, particularly through growing funding and capacity and by promoting existing and developing new training, technical assistance, and peer-learning opportunities. Central to far-reaching impact for food as medicine efforts focused on SNAP and WIC, is systems change to more seamlessly connect patients and their families to the federal nutrition programs via Medicaid. Harnessing these and other key opportunities to more seamlessly connect eligible households and individuals to SNAP and WIC will benefit patients, providers, and ultimately, result in lower health care costs.

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