CulinaryRehab LLC

FOOD IS MEDICINE IN VERMONT REPORT

2024

2025

A statewide unmet-needs analysis on Food is Medicine in Vermont using a value-based medicine lens.

Prepared By:
DEBORAH KENNEDY PHD
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Final Report: Food is Medicine in Vermont: An Unmet Needs Analysis Using a Value-Based Medicine Lens

Acknowledgment & Vision

We extend our sincere gratitude to Bi-State Primary Care Association for providing the funding that made this foundational summary of the unmet needs of Food is Medicine (FIM) in Vermont possible. Our hope is that this report serves as a catalyst for the next steps - bringing together all essential sectors in FIM to establish a shared, centralized mission shaped by the voices, expertise, and lived experiences of everyone involved. This report was written by Dr Deb Kennedy from research collected over a one year period June 25, 2024 to June 24, 2025.

A special thank you to:

- Adriana Stoyanovich – Research assistant extraordinaire
- Katina Cummings – provided expertise, overall guidance and recruitment of community health workers
- Emma Hileman from Rutland Farmacy, and Addison Farmacy– provided expertise, overall guidance and recruitment of food providers
- Jake Claro and staff at Vermont Sustainable Jobs Fund for being the fiscal sponsor
- To all the participants who took part in the survey and focus groups. Without your vision and dedication to the field of FIM, this work could not have taken place.

A huge thank you to Vermont and Vermonters - where have you been my whole life? This place and the people are so gracious, strong, kind and beautiful. It's been an honor to look under the FIM hood. Dr Deb Kennedy

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Executive Summary

This report summarizes key findings from a cross-sector review of Vermont's Food is Medicine (FIM) landscape, with the primary objective of identifying unmet needs across clinical, community, and food settings. Through stakeholder engagement with clinicians, support staff, community health workers (CHWs), registered dietitians (RD), and food system providers, shared priorities, unmet needs, barriers and potential solutions were revealed.

Despite differing scopes of practice, all groups demonstrated a common commitment to improving health outcomes through food-based interventions that are culturally relevant, patient-centered, and rooted in Vermont's values of community, humility, and local connection. Stakeholders highlighted the growing demand for sustainable, integrated FIM programming—but expressed concern over fragmented funding, limited infrastructure, and a lack of standardized workflows to support long-term success.

The "Vermonter Way"—a deeply held preference for locally driven solutions—emerged as a guiding principle across sectors. This report outlines both the opportunities and structural challenges facing FIM in Vermont, and proposes a foundation for coordinated, community-informed strategies moving forward.

Summary of Unmet Needs Across Cohorts

Across sectors, there is broad agreement on core gaps that limit the sustainability and impact of FIM programs in Vermont. These shared unmet needs include:

1. Sustainable Funding & Policy Support

- **Common Thread:** Every cohort named funding instability as a barrier.
- **Combined Needs:**
    - Stable, long-term funding streams, ideally state-backed or integrated into Medicaid reimbursement, supported by insurers and health systems, and focused on value based medicine principles.
    - Sustainable mechanisms that reduce reliance on multiple small grants and annual fundraising.
    - Inclusion of FIM in state policy and Medicaid planning
    - Formal recognition of food as a therapeutic tool and community health workers and food providers as healthcare partners.

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2. Centralized Infrastructure & Coordination

- **Common Thread:** Fragmentation between healthcare, food providers, community programs, and food access.
- **Combined Needs:**
    - A statewide, centralized hub to provide support in and coordinate - fundraising, transportation, tracking outcomes, sharing data and more.

- Standardized eligibility criteria, referral processes, and patient flow to reduce confusion and delays.
- Clear definition of roles and responsibilities across clinical and community partners.
- Advance FIM to included prescriptions – meals, groceries, and produce

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3. Clinical Integration & Provider Engagement

- **Common Thread:** Limited clinician involvement and lack of embedded workflows.
- **Combined Needs:**
  - Integration of FIM into electronic health records (EHR) with "food prescriptions" documented as part of care.
  - Simplified screening and referral workflows that fit into busy clinical schedules.
  - Increased integration of dietitians into the process

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4. Workforce Capacity & Support

- **Common Thread:** All groups are understaffed or under-resourced.
- **Combined Needs:**
  - Adequate staffing for CHWs and program coordinators.
  - Reduced administrative burden to free clinical time for patient engagement.
  - Develop communication pathways between the providers, dietitians, CHWs and the food providers
  - Emotional and logistical support for CHWs who carry high patient loads.

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5. Patient Access & Food Use

- **Common Thread:** Transportation, sign on process, cultural fit, and culinary barriers limit participation.
- **Combined Needs:**
  - Reliable transportation or delivery systems, especially for rural patients.
  - Flexibility and variety in food options (e.g. MTM), with culturally appropriate offerings.
  - Cooking education, tools, and facilities to help patients use the food they receive.
  - Low barrier for access for patients.

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6. Evaluation & Research

- **Common Thread:** Limited ability to demonstrate outcomes.
- **Combined Needs:**
  - Consistent outcome tracking across programs.
  - Combine efforts to increase the sample size.
  - Research capacity to evaluate health impacts and cost savings, strengthening the case for sustained investment.

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7. Training & Education

- **Common Thread:** Across all groups, there is a shortage of training:
- **Combined Needs:**
    - **Dietitians:** Training in integrating FIM into workflows, and tracking outcomes.
    - **Clinicians:** Training on nutrition and referral training to confidently prescribe FIM and communicate its medical importance.
    - **CHWs:** Training on FIM programs, counseling skills, and cultural competency to support patient engagement.
    - **Patients:** Education on the importance of food for their health, and how to prepare/cook the food they receive
    - **Food Providers:** Education on healthcare integration, outcome documentation, and medical tailoring and dietary recommendations for specific conditions.

A Weighted Representation of Unmet Needs Across Cohorts

Unmet Need Category	Weight (1–5)	Reasoning
Sustainable Funding & Policy Support	**5**	Universally cited by all cohorts as the largest barrier to sustainability and scale.
Centralized Infrastructure & Coordination	**4.5**	Consistently raised by hospital systems, food providers, and CHWs as essential for reducing fragmentation.
Clinical Integration & Provider Engagement	**4**	Mentioned often in relation to EHR integration, clinician prescriptions, and referral processes.
Training & Education	**3.5**	Discussed by clinicians, CHWs, and dietitians; noted as critical but secondary to funding and integration.
Workforce Capacity & Support	**3**	Raised by CHWs, dietitians, and food providers in relation to staffing shortages and role strain.
Patient Access & Food Use	**2.5**	Transportation and cultural fit discussed regularly, but framed more as an operational challenge than a core system barrier.
Evaluation & Research	**2**	Noted as important for long-term advocacy but mentioned far less often than other categories.

I. Summary of Food is Medicine (FIM) Survey Results from Clinicians

From November 2024 to February 2025, 118 clinicians were invited to participate in a survey about Food is Medicine (FIM) practices. They were identified through the clinics that are served by the *CSA & Healthcare Community of Practice*, and through other clinician referrals. Fourteen responded, representing a range of healthcare organizations including hospitals, FQHCs, solo practices, and community programs across Vermont. Fourteen participated in the survey. Below are the findings from those survey responses.

Type of Organization Participating in the Survey

- 3 hospital-based systems
- 2 FQHCs
- 1 solo practice
- 1 free clinic
- Other – 2 housing organizations, 1 WIC, 1 Nutrition and Health

Vermont Counties Served

- Two serve statewide; 5 serve Rutland; both Addison and Washington are served by 3; Orleans, Essex, Lamoille, Orange and Caledonia are served by 1; Bennington, Chittenden, Franklin, Grand Isle, Windham and Windsor were not selected. There were multiple entries from various positions in the same hospital.

  This distribution most likely depicts the clinical organizations that were responsive to the survey and do not represent an accurate distribution of counties that have FIM interventions.

Type of FIM Intervention

Respondents were asked to select all applicable FIM interventions that they prescribe or refer to. The results are shown in the table below.

Type of Intervention	Prescribe	Refer – Non Prescribed
Produce Prescription	2	
Fruits & Vegetables		9
Medically Tailored Meals	4	1
Medically Tailored Groceries	1	2
Meals		7
Onsite Farmacy		3
Groceries	1	3
Nutrition Education		10
Cooking education		4
Behavior Health Coaching		4
Food Bank/Pantry		12
SNAP, WIC, CSFP		10

- When a food intervention needed to be medically tailored, either a clinician or dietitian did the tailoring
- 58% of clinicians know how to refer a patient to food services

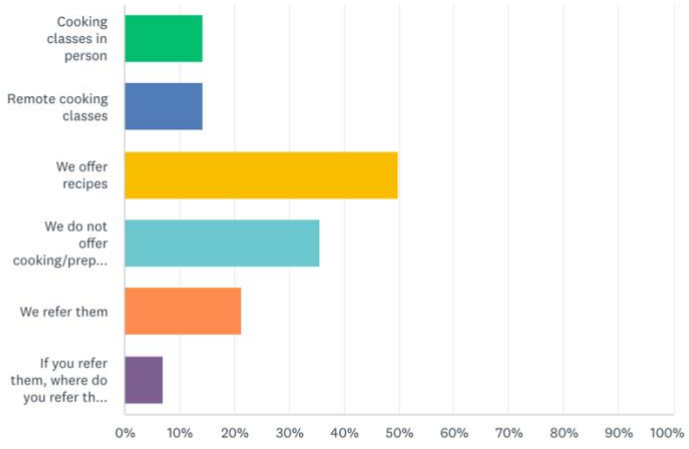
The criteria to receive food interventions included:

- Food Insecurity (86%)
- An individual says they need services (71%)
- A diet related diagnosis (58%)
- Poverty threshold (36%)

The top three criteria are similar from the clinician and food provider perspectives as shown in the table below

	Food Providers	Clinicians
#1	**Poverty threshold**	**Food Insecure**
#2	**Self-identify**	**Self-identify**
#3	**Diet related diagnosis**	**Diet related diagnosis**

The Type of Cooking and Preparation Instructions Offered



Among the 14 clinician respondents, seven offer recipes (50%), five offer no cooking instruction (36%) and three refer them (21%). The table below depicts the different cooking instructions offered between food providers and clinicians. In general, food providers provided more recipes and instruction in cooking and preparation methods than clinicians. Clinicians were slightly higher in the number they referred.

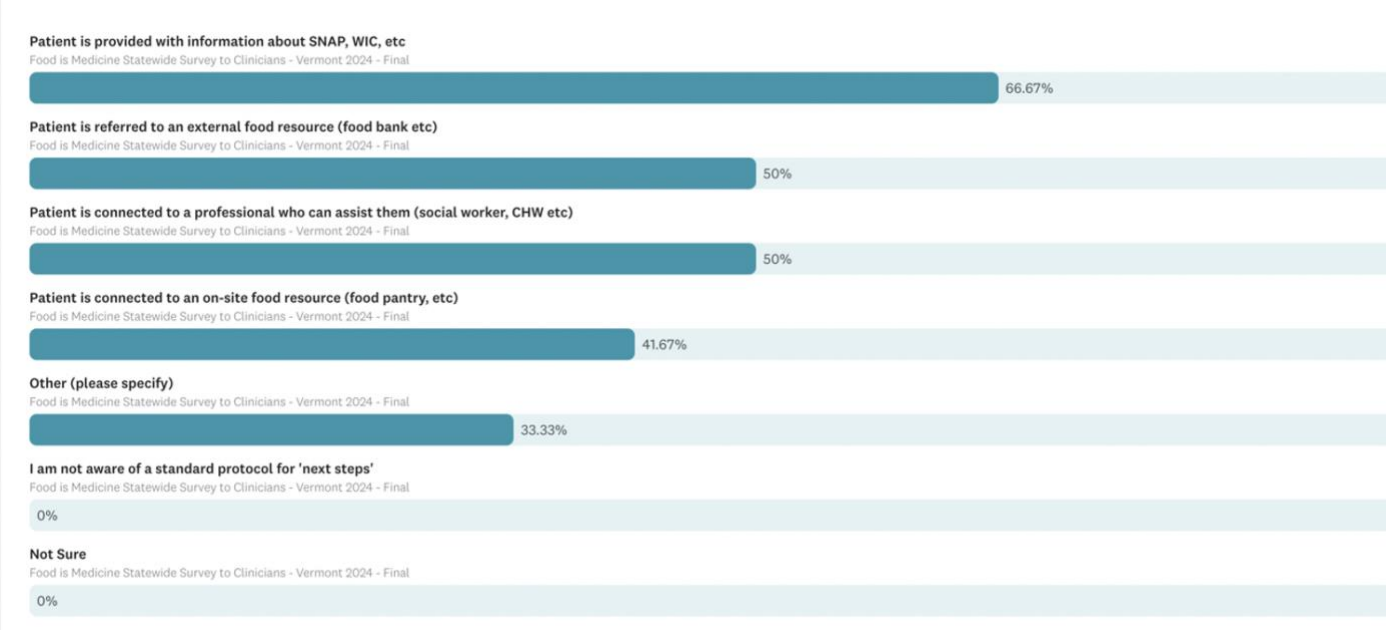
	Food Providers	Clinicians
Provide Recipes	67%	50%
Referral	17%	21%
Cooking classes in person	25%	14%
Remote cooking classes	25%	14%
No cooking guidance	36%	17%

Food Insecurity

Screening: Of the respondents: 10 screened for food insecurity and 3 did not.
Among those who do screen:

- Eight used validated tools such as the Hunger Vital Sign (4) and CMS SDOH (4). Other responses included – *there is a question on admission, not sure, anecdotally, they ask questions, the patient says they are*,
- Of the 10 that screen, 8 record the results in the patient's electronic medical record
- The majority do not use a diagnostic code to record food insecurity. The one that did uses Z59.41 (*although it is not reliably recorded*), which is the ICD-10-CM code for food insecurity

The next steps for when a patient screens positive for food insecurity can be found in the chart below:



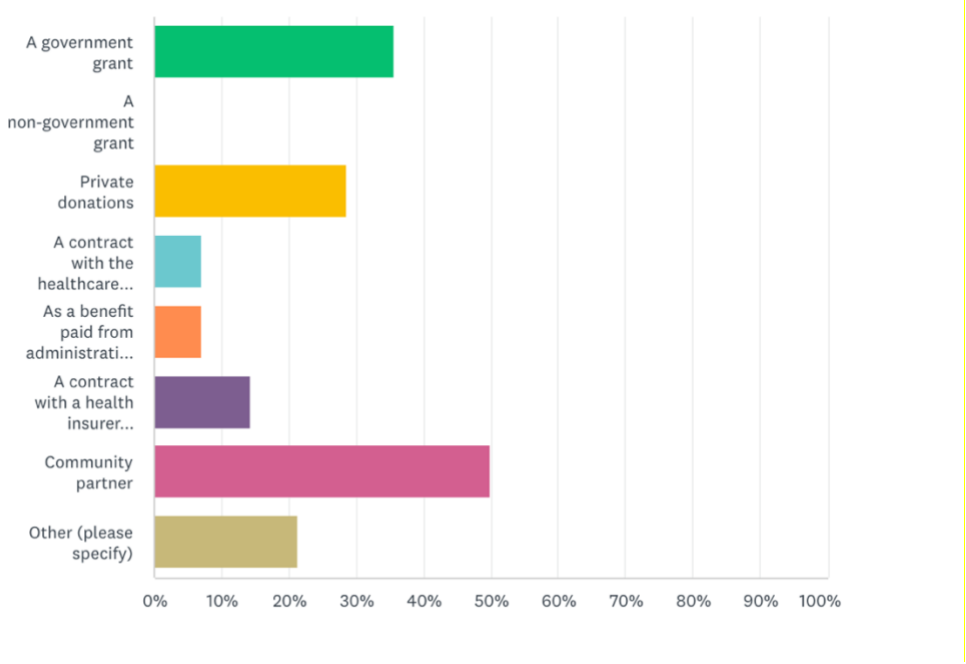
Follow-up actions vary: most commonly, patients are referred to information about SNAP, WIC etc. (67%), external food resources (50%) or to social workers, CHW etc. (50%), while 41% refer to on-site food providers or have other (n=4) or no (n=1) protocol. Additional responses included

support with SNAP applications, providing grocery gift cards annually, or simply giving patients resource referrals, highlighting a lack of consistent, standardized approaches.

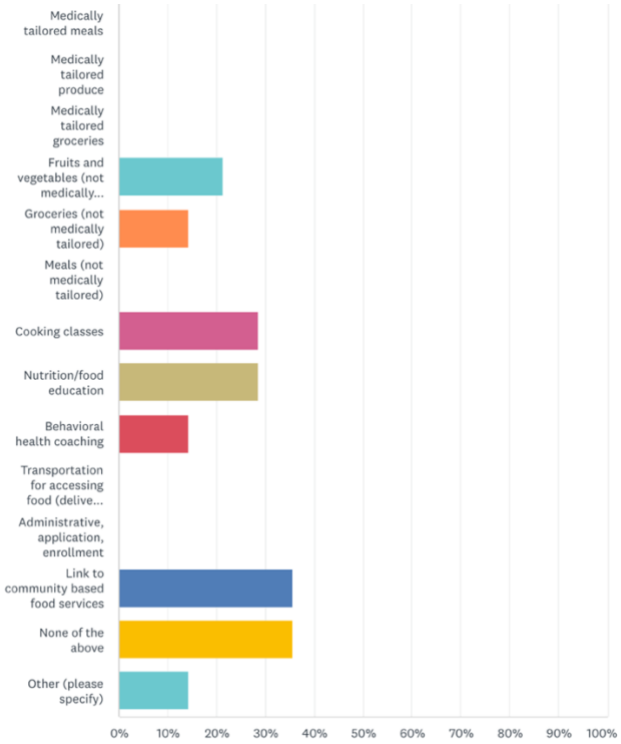
In summary, from the survey data on 13 clinicians, 77% screen for food insecurity, primarily using validated tools like the Hunger Vital Sign and CMS SDOH, while 3 do not us a validated instrument. Of those who screen, most record results in the electronic medical record, but only one uses the ICD-10-CM code for food insecurity - Z59.41.

Funding

How Are Food Interventions Funded?
Food intervention programs are sustained through a diverse blend of funding sources, with 50% of respondents relying on community partnerships—the most common form—followed by 36% using government grants, and 29% receiving private donations. Clinicians rely heavily on community organizations to supply food to their patients.



What Clinics or HCO fund in Vermont:
A small percentage of clinics and healthcare organizations (HCO) fund for food interventions; only two out of 7 clinical organizations pay for fruits and vegetables.



Summary

The clinician survey revealed that most Vermont providers are engaged in identifying food insecurity and connecting patients to food-related support, though practices and infrastructure remain inconsistent. Among the 14 clinicians who responded, the majority refer patients to Food is Medicine interventions based on food insecurity, self-identification, or the presence of diet-related conditions. However, only about half reported knowing how to formally make a referral, and fewer have standardized protocols embedded in electronic medical records (EMRs). While most screen for food insecurity, only one respondent reported using the ICD-10 code Z59.41 to document it, signaling a missed opportunity for tracking.

Cooking and nutrition education were identified as significant gaps. Only half of clinicians provide recipes, and very few offer or refer to cooking classes. Dietitians and community-based partners carry the bulk of patient education around food use. Most FIM programming is sustained not through the clinical system, but through government grants, community partners, and donations. These findings suggest that **while clinicians see value in Food is Medicine approaches, their ability to act is limited by time, training, and system-level support**. There is a clear need for standardized pathways, EMR integration, and more sustainable funding to ensure that food becomes a reliable part of therapeutic care.

Implications for Practice

- Clinicians are vital first-touch points in identifying food insecurity, but they depend heavily on referrals and external partners for intervention.
- There is no standard pathway for follow-up after a positive screen, highlighting the need for stronger clinical protocols.
- Most clinicians lack funding or capacity to sustain FIM programs independently.

Next Steps

1. **Standardize EMR integration** and diagnostic coding for food insecurity.
2. **Train providers** on referral processes and condition-specific food supports.
3. **Increase investment** in team-based care and direct funding for fresh food.
4. **Build stronger bridges** between clinicians and community-based FIM partners.

II. Summary of Food is Medicine Survey Results from Food Providers

Food providers were identified through the *CSA & Healthcare Community of Practice*, which is under Vermont Sustainable Job Funds. The lead for referrals was Emma Hileman, Program Director of Vermont Farmers Food Center. Twelve participated in the survey from September 2024 through January 2025. Below are the findings from that survey:

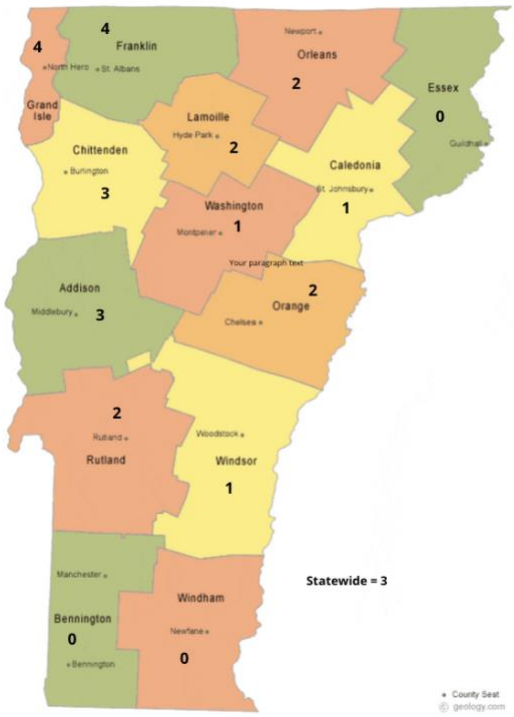
Type of Organization

- The most common organization was a tie between healthcare organizations and food hubs. A significant number of respondents identify with hybrid organizational roles, including healthcare systems integrating food access and education.
- Food hubs and pantries represent a strong portion of participants, indicating direct food distribution roles are also prevalent.
- No responses were recorded from food banks or congregate meal providers.

Vermont Counties Served

A total of 11 counties (plus 3 serving "Statewide") were selected by respondents, showing a broad geographic reach. Here's a breakdown:

- Respondents are serving a diverse spread of Vermont counties, with the northwestern region (Franklin and Grand Isle) most commonly reported. However, there are noticeable gaps in coverage in Bennington, Essex and Windham counties.



Type of FIM Intervention

Respondents were asked to select all applicable FIM interventions their organizations provide. The vast majority are not medically tailored. The medically tailored meal was actually the food served to inpatients at the hospital, which is not technically a FIM intervention as currently defined. Here's a breakdown of the most and least common interventions:

Most Common:

- Fruit and Vegetables (not medically tailored): 91.67% (11 organizations)
- Cooking Education: 66.67% (8 organizations)
- Nutrition Education: 58.33% (7 organizations)
- Groceries (not medically tailored): 41.67% (5 organizations)
- Onsite Food Pharmacy/Farmacy: 41.67% (5 organizations)
- Meals (not medically tailored): 25.00% (3 organizations)
- Behavior Health Coaching: 25.00% (3 organizations)

Least Common:

- Medically Tailored Groceries: 16.67% (2 organizations)
- Medically Tailored Meals: 8.33% (1 organization)
- Medically Tailored Produce: 0.00% (0 organizations)

What are the criteria to receive food interventions?

While some organizations apply specific medical or social criteria, many also serve individuals based on broader needs, referrals, or partnerships.

Among the 12 respondents, eligibility for food interventions varied:

- 33% (4) require a poverty threshold to be met.
- 33% (4) accept individuals who self-identify as needing services.
- 25% (3) provide services based on diet-related diagnoses (e.g., hypertension, obesity, diabetes).
- 25% (3) require a referral from a community/state organization.
- Other criteria included clinician referrals (5) social isolation, age, or limited daily functioning, though each was selected by fewer respondents (1 to 2)

Additional comments clarified that:

- Some organizations do not provide food directly, instead support through educational outreach or working with partner organizations who may have their own criteria.
- One program required prior participation in the Comprehensive Pain Program and the ability to pick up food at designated locations.
- Another accepted referrals from clinicians, care coordinators, or community health workers following a positive food insecurity screening.

What Type of Cooking and Preparation Instructions are Offered to Individuals and Who Teaches it?

Among the 12 respondents, the majority (67%) indicated that they provide recipes to individuals receiving food. A smaller number offer cooking classes, either in-person (25%) or remotely (25%). Only 17% do not provide any cooking or preparation guidance, while another 17% refer individuals to outside resources such as SNAP-Ed, EFNEP, WIC, food shelves, and community programs.

Additional comments highlighted the use of recipe card decks, notebooks, and video content (like the "What's That Food" series) to support participants. Two others were also noted for including nutrition and cooking education. Overall, while recipe provision is common, hands-on or virtual cooking instruction is less widely offered.

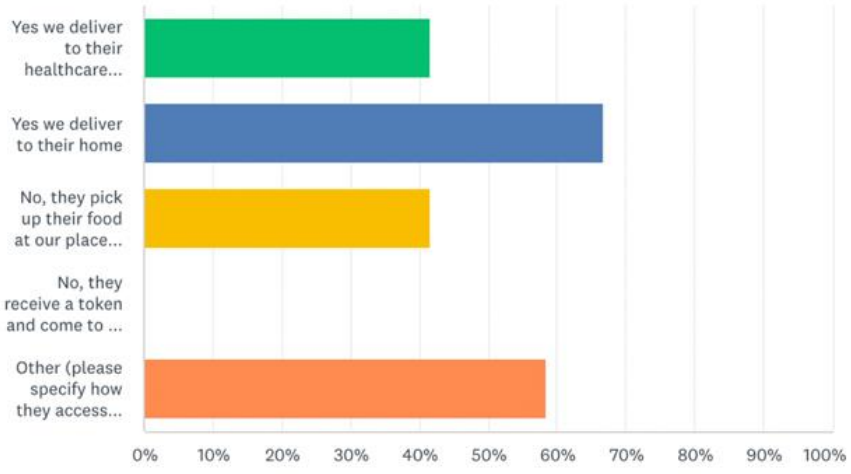
Most cooking instruction is delivered by internal staff, with some programs utilizing trained chefs or dietitians, particularly in specialized culinary medicine settings.

Sourcing and Providing Food

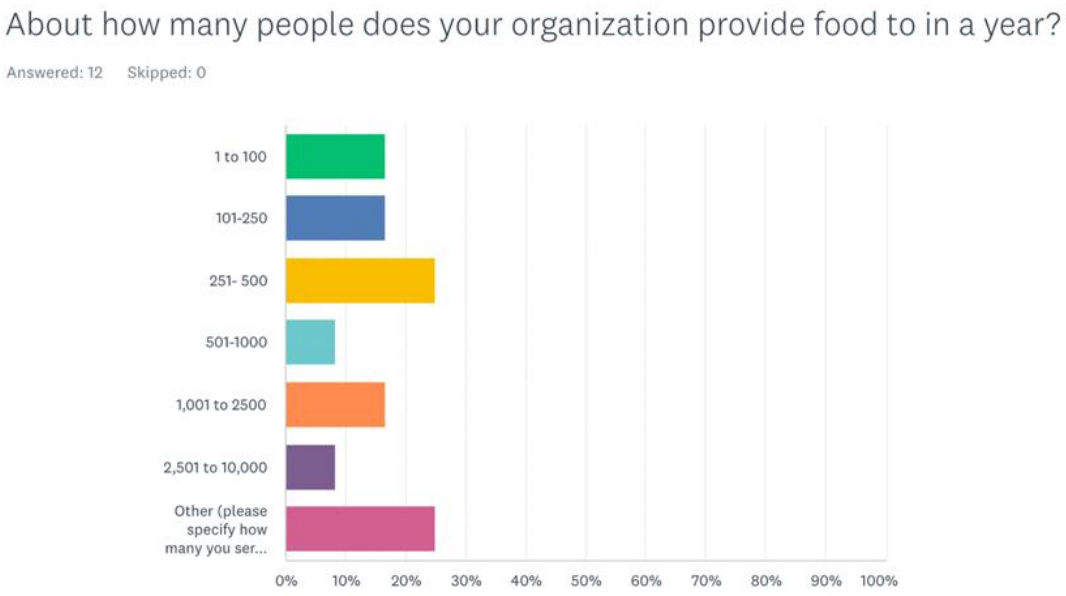
Local: All food provided is either partially local (58%) or completely local (50%).

Duration: 75% provide food twice a month with 25% providing food weekly. 50% provide food seasonally and not throughout the year.

Access: Being able to pick up food is a barrier for many. Of the 12 respondents, 67% deliver to the patient's home, 42% deliver to their healthcare facility and 42% require patients to pick up at their location (CSA/Farm), while others have multiple pick-up sites for patients to access their food.



The numbers:
Responses varied widely, with some organizations serving as few as **1–100** individuals and one reaching over **10,000** annually. The most common service range was **251–500 people** per year (25% of responses).



Two organizations provided additional context:

- Sheldon Methodist Church Food Shelf reported serving 10,516 people in 2023, with an estimate of 11,500 for 2024.
- Another reported serving 30 to 40 patients annually through formal FIM programs, and an additional 1,000+ individuals through free gleaned produce available at clinic sites.

Partnering with Healthcare Organizations

11 of the 12 responders say they partner with a healthcare organization, which is actually the definition of FIM – the partnering of the food source and healthcare. Among the 12 respondents:

- 75% (9) serve as referral partners with healthcare institutions.
- 5 collaborate through grants.
- 2 are contracted to provide prescribed food.
- 1 acts as a research partner.
- No respondents indicated a lack of partnership or unwillingness to partner with healthcare.

In the "Other" category, organizations clarified their unique roles:

- Some are the healthcare provider themselves.
- Others act as contractors linking farms and food providers.
- A few described broad partnerships with both community and food network collaborators, operating independently and alongside food intervention efforts.

Overall, most respondents are engaged in active, multi-faceted partnerships with healthcare, especially as referral and grant collaborators.

Food Insecurity

Screening: Out of 12 respondents: 58% (7 organizations) reported having a policy or practice in place to screen for food insecurity, while 42% (5 organizations) do not currently have a formal policy.
Among those who do screen:

- Several use validated tools such as the Hunger Vital Sign and CMS 10 Screener. All CSAs involved in the *CSA & Healthcare Community of Practice* use the Hunger Vital Signs.
- One organization includes a 2-question screener at intake on their enrollment form.
- Another is piloting the 10-question *Accountable Health Communities Social Needs Screening Tool* at two clinical sites.
- One food provider stated that all their clients are food insecure and that eligibility for services (e.g., home delivery) is based on self-identified barriers like transportation or health conditions.

One respondent noted that while they had no policy in 2023, they began screening in 2024, indicating a shift toward more formalized identification practices. Overall, there's a mix of structured and informal approaches, with increasing movement toward standardized screening tools.

Funding

How Are Food Interventions Funded?
Food intervention programs are sustained through a diverse blend of funding sources, with 92% of respondents relying on non-government grants—the most common form—followed by 75% receiving private donations and 67% using community partnerships or a government grant. A smaller share, fund programs through contracts with healthcare providers (25%). Some organizations also depend on internal hospital departments, such as UVMMC Nutrition Services, or engage in fundraising to support their FIM initiatives. This multifaceted approach underscores the huge number of fundraising efforts required to currently maintain these vital services.

Comparison of Food Provider vs. Healthcare Partner Funding for Food Interventions
Food providers most commonly fund basic, non-medically tailored food items, particularly fruits and vegetables (75%), along with nutrition and culinary education (42%). They also frequently cover general groceries, transportation, administrative support, and links to community-based food services (33% each). While one food provider reported funding medically tailored meals, no others support medically tailored meals or produce.

In contrast, healthcare partners are more selective in their funding. Half (50%) fund non-medically tailored fruits and vegetables, while 25% support nutrition education and administrative services. A smaller proportion (16.67%) fund medically tailored groceries, behavioral health coaching, transportation, and community food connections. Only 8.33% support cooking classes or general groceries, and none fund medically or non-medically tailored meals. Overall, healthcare partners tend to fund fewer categories.

Summary

The survey captured insights from 12 Vermont-based food providers involved in FIM efforts between September 2024 and January 2025 in Vermont. Most participating organizations are healthcare systems or food hubs, often serving hybrid roles that include food access and education. Geographically, they span 11 counties specifically, with three providing statewide coverage. There are noticeable gaps in coverage in Bennington, Essex and Windham counties.

The majority of food interventions offered are not medically tailored, with 92% providing non-tailored fruits and vegetables and over half offering cooking and nutrition education. Eligibility for food interventions varies, including poverty thresholds, diet-related diagnoses, clinician or community referrals, and self-identification of need. Some programs serve only specific populations such as former program participants or those screened for food insecurity.

Most organizations provide recipes (67%), with fewer offering in-person or remote cooking classes. Cooking instruction is typically delivered by staff, sometimes chefs or dietitians. Food sourcing is mostly local, with 75% offering food biweekly and half operating only seasonally. Distribution models vary—67% deliver to homes, while others require pickup from healthcare facilities or farms. The most common service range of individuals served was 251 to 500 people.

Nearly all respondents (92%) partner with healthcare, mainly as referral partners (75%) or grant collaborators. Screening for food insecurity is in place for 58% of organizations, often using standardized tools like the Hunger Vital Sign.

Funding for food interventions is multifaceted: 92% rely on non-government grants, 67% on government grants and community partners, and 58% on private donations. Food providers typically fund fresh produce, education, and support services, while healthcare partners fund fewer categories—mainly fresh produce, nutrition education, and administrative support. Overall, the survey highlights a broad, collaborative, and evolving FIM landscape with varied service models and funding structures. FIM intervention from the perspective of the food providers is mostly in the form of non-medically-tailored fruits and vegetables.

Next Steps

The Food Provider Survey highlights the essential—but often underutilized—role that local food organizations play in Vermont's FIM landscape. Food providers, including farms, food hubs, meal programs, and food shelves, are ready and willing to support healthcare delivery—but need enabling policy and infrastructure to do so effectively. Their feedback underscores the importance of coordinated investment, long-term planning, and equitable recognition within the broader health system.

1. **Commit to Long-Term, Multiyear Partnerships**
    - Move beyond short-term grant contracts to sustainable agreements that allow food providers to plan production, staffing, and delivery infrastructure around stable demand from healthcare and public programs.
2. **Strengthen Cross-Sector Coordination Infrastructure**

- Fund and support shared referral systems, communication protocols, and eligibility processes that reduce administrative burden and foster consistency between food and healthcare sectors.

3. **Invest in Local Food Infrastructure for Health Delivery**
   - Include the broader FIM system in agricultural infrastructure investments: cold storage, processing kitchens, transportation logistics, and aggregation points. Align these with Vermont's existing farm-to-institution and food access strategies.
4. **Create Shared Metrics for Food and Health Outcomes**
   - Establish a set of common indicators across sectors to evaluate FIM interventions—capturing clinical, equity, and food system impact. This is key to justifying future public and private investment.
5. **Support Food Provider Training in Nutrition Security Delivery**
   - Fund technical assistance and training for food providers in cultural food preparation, medically tailored produce/groceries/meals, reporting requirements, and how to operate within integrated care teams.
6. **Codify Food Providers as Essential to Health Infrastructure**
   - Position local food providers as critical public health partners—not just vendors—in state and local food policy. This includes representation in planning, funding, and accountability processes.

FOCUS GROUPS & INTERVIEWS

48 total participants participated in the experience group technology – a specialized form of focus group/interview questioning that determines the unmet needs of patients within a healthcare setting.

Dietitians - 5 5 interviews	**Clinician - 7** 7 interviews	**CHW - 17** 1 interview 4 exp groups	**Food Provider - 16** 4 interviews 4 exp groups	**Other -3** 2 hospital systems 1 clinic

III. Food is Medicine in Vermont: Insights and Unmet Needs from Registered Dietitians

Serving rural communities is very unique. It's not like serving urban communities.

There are some individuals that are so sick they can't cook…To be able to provide them medically tailored meals that are supporting the local economy in one or more ways and to be able to get that to them, with no questions asked, that would be a dream state

This report summarizes insights from in-depth conversations with five Registered Dietitians (RDs) engaged in FIM efforts across Vermont. While each RD operates in different settings—state health departments, hospitals, border programs, and the VA system—they share common observations about the current landscape, challenges, and opportunities for growth. Listed below are their unmet needs in regards to FIM in Vermont from their perspective:

- Dedicated Staffing & Administrative Support
- Sustainable, Long-Term Funding Streams
- Teaching & Education Infrastructure
- Centralized Coordination and Shared Data Platforms
- Provider Engagement & Streamlined Referrals
- Flexibility with Food Options
- Evaluation & Research Capacity
- Destigmatizing the Need for Food Support
- Reliable Transportation of Food

▼ **Foundational Gaps (Systemic and Institutional)**
- Lack of institutional prioritization for nutrition within healthcare settings
- Inconsistent integration of dietitians into care planning and decision-making
- Limited reimbursement pathways for nutrition counseling and food-based interventions

▲ **Program and Policy Barriers**
- FIM interventions are not standardized or consistently funded
- Limited collaboration between clinical dietitians and community food programs
- Absence of clear policies supporting the clinical use of food as a therapeutic tool

▲ **Workforce and Workflow Challenges**
- Time constraints due to administrative tasks
- Gaps in communication between dietitians, CHWs, and providers
- Inadequate support for culturally responsive care in nutrition practice

▲ **Patient-Level Needs**
- Low patient adherence due to food access, cooking skills, or cultural mismatch
- Patients lack clarity on the connection between food and health outcomes
- Insufficient follow-up to assess food intervention impact or modify plan

OVERVIEW

Across Vermont, Food is Medicine initiatives are primarily built around produce prescription models. Most programs focus on CSA-style produce shares, partnerships with local farms, veggie boxes, farmers market coupons, and collaborations with food pantries. There is little evidence of medically tailored meals or insurance-funded meal programs, though most dietitians agree that fresh produce generally supports a wide range of health needs. In some cases, the term "Food is Medicine" does not resonate with everyone; some patients better connect with the idea of "*food is fuel*," meeting them where they are on their journey toward making that connection.

Dietitians consistently stress that simply providing access to food is not enough. Patients need education and support to confidently use the foods they receive. Cooking classes—both virtual and in person—recipes, storage tips, and culturally relevant meal planning advice are essential to reduce food waste and help patients see results. The program at UVM's psychiatry department illustrates this innovation, offering cooking classes for patients with chronic pain that integrate occupational therapy strategies, mental health support, and trauma-informed care.

Most FIM programs in Vermont are anchored in clinics or healthcare centers. Patients are screened for food insecurity and chronic disease during routine visits and then referred to farm shares and community partners. Referrals are often managed by care teams or program staff, with dietitians providing follow-up education. However, there is growing recognition that education and delivery cannot be confined to clinical spaces alone; community centers, libraries, and schools could serve as additional hubs to expand access and engagement.

Despite the challenges, Vermont's dietitians share a deep passion for Food is Medicine as a non-medication intervention that empowers patients and strengthens communities. Yet the system they describe is fragmented—supported by micro-grants, volunteer efforts, and siloed programs that are vulnerable to leadership changes and funding losses. Without a coordinated statewide framework, these efforts remain fragile, underscoring the urgent need for more sustainable structures to fully realize the potential of FIM in Vermont.

Common Barriers

Talk to them upfront about the barriers

Barrier	Details
Transportation & Rural Access	Long distances to pick-up sites; rural constraints – weather, road conditions, limited public transit.
Staffing and Administrative Load	RDs juggling clinical work with administrative tasks.
Lack of Data Infrastructure	Difficulty proving impact; surveys and research often go unpublished or unfunded.

Unstable Funding	Financial assistance decreases when disease/illness improves; Legacy funding streams (e.g., Children's Miracle Network at UVM) end abruptly, leaving programs scrambling.
Stigma & Reluctance	Patients often underreport food insecurity or decline participation due to pride or fear of taking resources from others.
Provider Bottlenecks	Clinicians support the programs but lack time to manage referrals and follow-ups, creating gaps in implementation. Shortage of PCPs in VT.
Cultural Fit	Standard produce shares often don't match the needs or cooking practices of refugee or immigrant populations.
Signing up For Access	Paperwork can be onerous and/or uncomfortable, some do not want to share their identification/personal information.

Unmet Needs

🔷 1. Dedicated Staffing and Administrative Support

Success comes in follow through….its an ongoing relationship

- **Current state:** Dietitians are balancing clinical responsibilities with the administrative demands of FIM programs—tracking participants, coordinating with farms, managing contracts, and handling logistics—on top of their patient care duties.
- **Unmet need:**
  - **Dedicated Program Staff:**
    Coordinators or administrative support to manage paperwork, logistics, and program operations.
  - **Protected Time for RDs:**
    Time built into clinical roles specifically for FIM work, allowing dietitians to focus on patient education and program quality rather than administrative overload.

🔷 2. Sustainable, Long-Term Funding Streams

There is much greater need than we have capacity for…we don't advertise widely because we know we can't get a veggie share for everyone.

It costs $450 to $550 per share for each individual…there are a finite number of people that we are able to serve with these programs.

- **Current state:** FIM programs in Vermont rely heavily on short-term grants, donations, and small partnerships with food banks or farms. This patchwork approach creates ongoing uncertainty, limiting the ability to plan, grow, or maintain services over time.
- **Unmet need:**
  - **Stable, Multi-Year Funding:**

Reliable funding streams that allow programs to operate consistently and scale their reach.

- **Statewide and Insurance-Based Investment:**
  Policies and reimbursement models that integrate FIM into healthcare funding, ensuring these services are recognized and supported as essential parts of patient care.

🔷 3. Teaching & Education Infrastructure

When we are giving food that is wonderful and it eliminates the access point, but a lot of people aren't sure what to do with the food, how to prepare them, how to make them taste good, as often times they go to waste

- **Current state:** Some dietitians are running virtual classes from home or making do with limited spaces. Hands-on cooking sessions are rare due to lack of dedicated facilities, scheduling challenges, and transportation barriers. Since COVID, the number of in-person cooking classes has significantly declined.
- **Unmet need:**
  - **Dedicated Teaching Spaces:**
    Access to permanent teaching kitchens or mobile setups that can bring education directly to communities.
  - **Enhanced Educational Resources:**
    Ready-to-use curricula, culturally relevant recipes, and proper demonstration equipment to support effective teaching.

🔷 4. Centralized Coordination and Shared Data Platforms

It doesn't do the unhoused any good to give them fresh produce and tell them to go and do something with them when they don't have the tools…they need a hot meal.

Their needs are much greater than just food…need to encompass the whole person and everything they need

- **Current state:** Many programs operate in silos. Dietitians spend significant time reaching out to farms, clinicians, and community partners on a case-by-case basis, which leads to duplicated efforts and inconsistent communication.
- **Unmet need:**
  - **Statewide Coordination Hub:** A centralized framework to streamline referrals, facilitate partnerships, and align efforts across programs.
  - **Integrated Communication and Data Systems:** Shared platforms—linked with electronic medical records (EMRs)—to track referrals, outcomes, and resources in real time.

🔷 5. Provider Shortage and Streamlined Referrals

The doctor needs to be the voice of 'this is important to you' and 'I support you' and that's it…we need everything else to come from different team members

- **Current state:** Clinicians across Vermont recognize the value of FIM programs, but many are overwhelmed by heavy caseloads and limited staffing. The statewide provider shortage leaves little time for consistent screening or referrals, even when clinicians want to help connect patients to resources.
- **Unmet need:**
    - **Simplified Screening and Referral Workflows:**
      Easy-to-use processes that integrate into routine visits without adding to providers' workload.
    - **Targeted Training for Clinicians:**
      Guidance on how and when to refer patients to FIM programs, ensuring referrals are both appropriate and efficient.

🔷 6. Flexibility with Food Options

Produce prescription is not right for everyone … for some patients a debit card for produce or medically tailored meal is what they need for their limitations.

If you don't have teeth, raw vegetables are not an answer for them

- **Current state:** Standard produce shares often fail to meet the needs of diverse patient populations. Refugee and immigrant communities may not be familiar with certain vegetables, and some patients face physical limitations—such as difficulty chopping or chewing—that make standard items unusable. This leaves dietitians with limited flexibility for how they can meet individual needs.
- **Unmet need:**
    - **Culturally Relevant Food Choices:**
      Partnerships with culturally specific markets and suppliers to provide foods that align with patients' traditions and preferences.
    - **Procurement Support and Guidance:**
      Tools and systems to help dietitians customize shares for different communities without overburdening staff or farmers.
    - **Alternative Food Formats:**
      Options like pre-cut or frozen vegetables for patients with limited dexterity, chewing difficulties, or other functional barriers.

🔷 7. Evaluation and Research Capacity

- **Current state:** Dietitians see positive changes in patients and communities through FIM programs, but these successes are largely anecdotal. Many programs lack the staff time,

tools, or standardized systems to consistently collect data, evaluate outcomes, or share results.

- **Unmet need:**
  - **Outcome Tracking Support:**
    Tools and staff resources to track key health metrics, participation rates, and program reach over time.
  - **Standardized Reporting Systems:**
    Clear frameworks to document what's working, what's not, and how programs can be improved statewide.
  - **Grant and Research Collaboration:**
    Assistance with writing grant reports, conducting formal evaluations, and partnering with research institutions to demonstrate measurable impact and secure future funding.

🔷 8. Destigmatizing the Need for Food Support

- **Current state:** Many Vermonters hesitate to acknowledge or seek help for food insecurity. A common sentiment is, *"someone else needs it more than I do,"* which prevents them from signing up for programs that could significantly improve their health and well-being.
- **Unmet need:**
  - **Anonymous or Low-Barrier Enrollment Options:**
    Develop systems that allow individuals to access food support without having to disclose extensive personal information, reducing the fear of judgment or exposure.
  - **Healthcare Workforce Training:**
    Equip healthcare providers and care managers with compassionate, stigma-reducing training for approaches when asking about food access.

🔷 9. Reliable Transportation of Food

- **Current State:** Access to food support in Vermont is often limited by geography and transportation challenges. Many patients live in rural areas far from clinics, food hubs, or pick-up sites. Public transit options are sparse in places or nonexistent, and some individuals face physical limitations that make travel difficult. This often results in missed pick-ups, inconsistent participation in food programs, and increased food insecurity.
- **Unmet Needs:**
  - **Expanded Delivery Options to patients' homes when necessary:**
    Develop or fund reliable delivery services (through community health workers, volunteers, or contracted services) to bring food directly to patients' homes—especially for those with mobility issues or no vehicle access.
  - **Regional Transportation Solutions:**

Create coordinated transportation plans or partnerships (e.g., shared vans, ride-share programs, or collaboration with existing rural transit) to connect patients with pick-up sites.

- **Integration with Program Design**
  Build transportation solutions into FIM program planning from the start, ensuring food support is truly accessible to the populations it aims to serve.

The Role of the Dietitian

We want to be educators, not just the middle people handing out produce.

We know this works—we see the changes. But we're doing all of it: logistics, teaching, documentation. We need support to scale.

Dietitians across Vermont are passionate about the role they play in FIM programs—and they envision a system where their expertise is used to its fullest. Ideally, dietitians see themselves as **educators and advocates** who can focus on what they do best: empowering patients through nutrition knowledge, cooking support, and culturally responsive care. They want to move beyond simply distributing food to creating meaningful, sustainable behavior change—personalizing nutrition guidance to patients' health needs.

To function in this role effectively, dietitians say they need infrastructure that frees them from logistical and administrative burdens. Many are currently pulled into program coordination, data tracking, and farm partnerships—all while managing full clinical loads. Ideally, these responsibilities would be supported by dedicated program staff, allowing dietitians to concentrate on patient-facing support and education. They also want access to teaching kitchens, resources tailored to Vermont's diverse populations, and a statewide system that connects referrals, partners, and outcomes. Their vision is clear: with proper staffing, structure, and funding, Vermont's dietitians are ready to turn food access into health transformation.

In conclusion, dietitians in Vermont view themselves as clinical educators and translators—making the link between prescribed foods and long-term health outcomes understandable and achievable for patients. Their role is not simply to hand off nutrition guidelines but to equip patients with the knowledge, skills, and confidence to apply those guidelines in real life.

1. Turning Food into Function
Dietitians emphasize that simply receiving a food box or produce prescription is not enough. Their responsibility is to teach patients how to use that food—how to prepare it, store it, and integrate it into meals that align with medical needs. As one shared, *"We have to meet people where they're at. If they get a beet and don't know what it is, they're not going to eat it."*

2. Condition-Specific Nutrition Guidance

They tailor education to specific diagnoses like diabetes, hypertension, or GI conditions—helping patients understand why certain foods support their condition and how to modify recipes or meals accordingly. One dietitian put it simply: *"I translate the science into the plate."*

3. Building Long-Term Habits
Beyond immediate food use, dietitians see their role as teaching sustainable strategies—meal planning, label reading, budgeting, and cooking skills that help patients maintain changes after the program ends. *"We have to prepare them for what happens when the free food stops,"* one noted.

4. Personalizing the Journey
They adapt recommendations to a patient's reality—considering cultural food preferences, cooking equipment, oral health, and access. Their focus is on practical and usable nutrition, not idealized diets.

In essence, dietitians view themselves as the bridge between access and action in FIM: helping patients make sense of what they receive, guiding them in how to use it, and setting them up for sustained success beyond the program.

Summary

Vermont's FIM initiatives are making an impact but remain in early stages. The shared vision among dietitians is clear. Access isn't enough—education, cultural fit, and ongoing support are essential to turn produce into better health. With coordinated hubs, sustainable funding, expanded education, and flexible delivery models, Vermont has the opportunity to grow FIM into a robust, equitable system that empowers communities statewide.

VII. Food is Medicine in Vermont: Insights and Unmet Needs from Clinicians

Clinicians have the patient's best interest at heart. The issue is time. When you have a 20- or 30-minute visit and you have 5 or 6 things you need to cover, you triage and do what's most important

It's going to have to be very, very simple and they are going to need to feel that it is going to be accepted...it's what their colleagues want...they are not out on their own doing it

The average clinician doesn't have enough confidence to say 'look, you gotta do these things, it will be very powerful, you will enjoy it, you can afford it and it will make a huge difference.

This analysis is drawn from in-depth interviews with seven clinicians (MD, APRN, RN, LSW) working across Vermont in a variety of settings, including federally qualified health centers, primary care practices, hospital-based clinics, and community health programs. These clinicians serve patients in both rural and urban areas, many of whom face significant barriers such as food insecurity, chronic health conditions, and transportation challenges. Their perspectives offer an important window into how FIM programs are currently functioning in Vermont, what is working well, and where critical gaps remain. Listed below are the unmet needs in regards to FIM in Vermont from their perspective:

▼ **Foundational Gaps (System-Level Misalignment)**
- Lack of sustainable funding models for FIM programs
- FIM interventions are not embedded into value-based care strategies
- Misalignment between clinical workflows and community resource infrastructure

▲ **Operational Barriers (Clinical Integration Issues)**
- Absence of standardized screening and referral protocols across teams
- Limited time and competing priorities in busy clinical settings
- Minimal training or exposure to FIM principles in medical education

▲ **Care Coordination Challenges (Workforce and Communication)**
- Inadequate coordination between clinical teams and CHWs or community partners
- Unclear roles and responsibilities in delivering FIM interventions
- Inconsistent documentation or tracking of food-related referrals in EHRs

▲ **Patient-Level Needs (Access and Engagement)**
- Low patient engagement due to cultural mismatch or stigma around food assistance
- Transportation and scheduling barriers for food distribution
- Limited patient education on the therapeutic role of food in chronic disease care

Overview

Clinicians across Vermont are seeing firsthand the impact of FIM programs on patients facing food insecurity and chronic health conditions. From rural community health centers to larger

hospital systems, these providers value FIM as a meaningful, non-pharmaceutical approach to improving health outcomes—particularly for patients managing diabetes, hypertension, and obesity. Many clinicians offer brief encouragement during visits, reinforcing the importance of healthy eating, but rely heavily on other team members—like care managers or dietitians—to handle education, referrals, and program logistics.

Despite their enthusiasm, clinicians describe a system that is still deeply fragmented and under-resourced. They report severe time and staffing limitations, with many stretched too thin to consistently manage FIM activities beyond initial screenings. Programs often operate independently, with each clinic forming its own partnerships with farms or food pantries and building workflows from scratch. Funding is often short-term or seasonal, limiting service continuity and patient enrollment. Transportation and lack of patient education add additional barriers, making it harder for patients to access or effectively use the food they receive.

Across interviews, clinicians emphasized the need for sustainable funding, streamlined workflows, and statewide coordination. They want to see stronger team-based models, with clear referral pathways and shared platforms for data tracking. With better infrastructure and support, they believe FIM could play a powerful role in preventive care and health equity across Vermont.

Common Barriers

Barrier	Details from Clinician Interviews
Time Limitations & Workforce Shortage	Brought up in all 7 interviews. often multiple times in each. It's one of the strongest, most consistent barriers—clinicians want to support Food is Medicine but cannot extend beyond quick screening or a short supportive message.
Funding Instability	Brought up in all 7 interviews, often multiple times in each. Clinicians consistently expressed that without stable, long-term funding Food is Medicine programs remain fragile, seasonal, and limited in reach.
Inconsistent Screening & Referral Workflows	Brought up in all 7 interviews. Screening for food insecurity and chronic disease varies by clinic. Referrals often feel cumbersome, with inconsistent workflows and frequent staff turnover.
Limited Knowledge & Confidence	Brought up in all 7 interviews. Many clinicians lack training and confidence to explain FIM programs or advise patients on nutrition, leading to missed opportunities for impactful conversations.
Lack of Patient Education Infrastructure	Brought up in all 7 interviews. Six specifically mentioned learning how to cook/prepare the food and one said the patient needed guidance on how to manage their condition.
Transportation Barriers	Brought up in all 7 interviews. Clinicians recognize that without reliable delivery options, volunteer networks, or transit

	partnerships, patients may miss out on the food support programs designed to help them.
Fragmented Systems	Brought up in 5 interviews. Clinics manage separate relationships with farms and community partners without a shared framework, resulting in duplicated efforts and data silos.

Unmet Needs

🔷 1. Time Limitations and Workforce Shortage

It's very hard in our challenged healthcare landscape where we are struggling just to fill the straightforward roles and jobs

That one minute (talking about the benefit of the food for their condition) *makes a big difference for our patients*

We used to send it to our care manager and a community health worker but the CHW moved on to another job so now it goes to the receptionist

Current State: Vermont clinics face a significant shortage of clinicians, leaving providers with full schedules and little time to go beyond initial screenings. Although they believe in FIM, they cannot manage ongoing coordination or follow-up without sacrificing other critical patient care.

Unmet Needs:

- **Role Clarity and Team Handoff:** Most clinicians want to offer a brief, supportive message that validates the importance of healthy food access, then rely on care managers, dietitians, and/or program staff to handle education, referrals, and follow-through.
- **Team-Based Infrastructure:** Systems and staffing that allow other members of the care team to carry the work forward after that initial clinician touchpoint.

🔷 2. Sustainable, Long-Term Funding Streams

*We have grown faster than our food donations have allowed (*why a once-a-week food delivery changed to once every 3 weeks*)*

Money should come from insurers and the healthcare system

We had grant funding from a grant...and an 1816 grant...and a donation from a rural health grant...and donations

If you look at the long-term value and make that investment (the system behind it*), it goes a long way. This is what is going to take to keep people healthier, out of the hospitals, out of the emergency rooms. It's a long-term investment.*

Current State: Clinicians described current funding for FIM programs as fragile and pieced together, relying on short-term grants, small donations, and occasional support from rural health initiatives. Because these funds are inconsistent, programs often reduce services—for example, moving from weekly to every-three-weeks deliveries—and limit how many patients they can enroll. Without a stable financial base, clinics cannot plan long-term, and many clinicians believe insurers and the healthcare system should invest to make these programs sustainable. Three mentioned collecting data to support FIM initiatives ,which leads to sustainability.

Unmet Needs:

- **Stable Funding:** Stable funding and planning to offer food support throughout the year, not just during growing months.
- **Reimbursement Models**: Insurance or state-level support that recognizes FIM as part of standard care.

🔷 3**. Simplified Screening and Referral Workflows**

Screening for produce prescriptions… often feels cumbersome, with inconsistent processes and staff turnover across clinics.

I can screen and say a few words about why this could help, but I can't track who got what or if they're using it. That has to be someone else.

Current State: Clinicians described screening and referral processes as necessary but often cumbersome, with inconsistent workflows and frequent staff turnover disrupting handoffs. They emphasized that while they can screen and give a brief message, they need clearer, streamlined referral steps and support from other team members to ensure patients actually get connected to FIM programs.

Unmet Needs:

- **Streamlined Workflows:** Easy-to-use tools integrated into routine visits.
- **Clear Pathways:** Standard referral steps that minimize added burden on already busy clinicians.

🔷 4. **Limited Knowledge & Confidence**

Nutrition just isn't a big part of our training, so we're not sure what to tell them beyond 'eat more vegetables'

Sometimes I don't even know what's in the share myself, so I can't explain how to use it

We don't have the confidence to say 'this is a really good choice and pursuing this is going to make a big difference in your health'.

Current state: Clinicians repeatedly shared that they lack formal nutrition training and feel uncertain about confidently advising patients on the health impact of Food is Medicine programs. Many admitted they hesitate to make strong recommendations without clear talking points or confidence that patients will follow through. They are also unsure of the process to refer patients or explain available resources.

Unmet Needs:

- Targeted Training: Targeted talking points and handouts on the nutritional benefits of the FIM program
- **Referral Education**: Clear instructions on program options and eligibility to help clinicians confidently send patients to the next step in the process.

🔷 5. Patient Education and Culinary Support

We know that if patients learn even one or two ways to use the produce, they'll eat more of it. But right now, we can only hand out a flyer and hope they try.

When we've done cooking demonstrations in the past, patients really responded. They liked seeing how to prepare the food, but we just don't have the staff or time to do them regularly.

Teaching patients to cook is wonderful, incredibly time consuming, and hard to scale but effective. I know that it works....it's very hard in our challenged healthcare landscape where we are struggling just to fill the straightforward roles and jobs

Current state: Clinicians repeatedly noted that patients often receive foods they don't know how to store, prepare, or cook, leading to frustration and wasted produce. While some programs offer recipe cards or occasional demonstrations, these efforts are inconsistent and limited by staff capacity, time, and space. Clinicians agreed that teaching patients how to use the food—through cooking classes, demonstrations, or culturally relevant materials—significantly improves engagement and health outcomes, but they currently lack the infrastructure and resources to provide this support at scale.

Unmet Needs:

- **Culinary skill building support and recipes** to help patients use the food that they receive.
- **Lack of time and training** that current clinicians and staff members have to teach cooking skills

🔷 6. **Reliable Transportation of Food**

Transportation is probably the biggest hurdle. Even when the food is free, people can't always get to where it is.

A lot of our patients can't drive, and there's no bus that goes out to the farm pick-up. They miss weeks just because they can't get there.

During COVID, Advanced Transit was bringing the food to us.

Hannaford donated a van for our Food Farmacy....its not refrigerated as that would cost double.

Current State: Clinicians consistently identified transportation as a major barrier to patients accessing FIM programs. Many patients live far from pickup sites, lack reliable vehicles, or face mobility challenges, which leads to missed pickups and under-utilization of services. Some clinics have experimented with solutions—such as partnering with local transit (Advanced Transit during COVID), using donated vans (like Hannaford's Food Farmacy van), or relying on volunteers for delivery—but these approaches are inconsistent and often unsustainable without dedicated coordination and funding.

Unmet Needs:

- Expanded Delivery Options: A mix of volunteer delivery (like *Meals on Wheels*) and centralized pickup points coordinated by a transportation lead.
- Regional Transportation Solutions: Coordinated ride-share or shuttle services built into program design.

🔷 **7. Centralized Coordination**

We each have to figure out logistics on our own—there's no central system helping us.

It feels like a patchwork of grants and volunteer programs rather than one coordinated effort.

We're duplicating work across clinics, and patients aren't getting the same experience everywhere.

Current state: Clinicians consistently described Vermont's FIM landscape as fragmented, with each clinic or program operating in isolation, building its own farm partnerships, and creating its own referral processes. This lack of a unified framework leads to duplicated effort, inconsistent patient experiences, and difficulty sustaining programs over time.

Unmet Needs:

- **Statewide Coordination Hub**: A framework to manage referrals, track outcomes, and align programs.
- **Integrated Data Systems**: Platforms linked with EMRs to monitor patient participation and program effectiveness.

The Role of the Clinician

We are challenged with a lot of patients needing a PCP and I want to use the PCP for that...the other pieces, other people can handle

The ideal is that all the prep work is done (farm shares, produce access, pick up etc..)..the provider says 'we can give you access and it can target your specific illness..'

Let's make these (produce prescription, food access etc..) *accessible and easy for the provider and we need to have someone else doing the work behind it*

The primary role of the **physician is as a gatekeeper and an influencer**. As a gatekeeper, they need to know about any FIM interventions/food access available to their patients so that they can refer them to the next person in the process who can take it from there: Whether that is a coordinator and/or perhaps a dietitian referral is needed.

As an influencer, their opinion holds a lot of weight. Spending just a brief amount of time "*this is important for you and I support you*"— explaining the power behind consuming healthy food is motivating and valuable to the patient. However, beyond that initial touchpoint, clinicians see the ongoing education and support as work better suited for dietitians, care managers, and/or community health workers.

Summary

I would love to see more folks take advantage of what we have available now (CSA shares, produce prescriptions..) as a first step, then getting to more tailored prescribing of Food is Medicine

Clinicians across Vermont view FIM as a non-pharmaceutical tool to improve health outcomes for patients living with chronic conditions and food insecurity. They described their role as the first touchpoint—screening patients and offering a brief, supportive message that validates the importance of healthy food access. Most rely on care managers, dietitians, or administrative staff to manage referrals, education, and follow-through. There was a shared optimism that FIM programs can help keep patients healthier, reduce hospital visits, and strengthen communities.

Despite this enthusiasm, clinicians repeatedly highlighted systemic challenges that limit the impact of FIM programs. Time and workforce shortages prevent them from doing more than initial screening, while the lack of centralized coordination forces each clinic to build its own partnerships with farms and food banks. Programs operate with unstable funding—dependent on short-term grants and donations—resulting in seasonal services, reduced delivery schedules, and limits on patient enrollment. Patients face additional barriers such as transportation difficulties in reaching pickup sites and limited education on how to use the foods provided, leading to waste and reduced engagement

Clinicians emphasized the need for a statewide infrastructure to unify efforts and support clinics with clear referral pathways, data tracking, and logistical coordination. Building a team-based model—where dedicated staff, care managers, and community health workers take on education and follow-through—would allow clinicians to focus on their core role while ensuring patients receive comprehensive support. Investments in sustainable funding, teaching resources and reliable transportation solutions will be critical to scaling FIM programs and achieving equitable access across Vermont. In summary, any FIM initiative has to be simple and practically turnkey, involving the clinician briefly. They need to spend their time working at the top of their license, especially during a time of clinician and staffing shortages.

VI: Food is Medicine in Vermont: Insights and Unmet Needs from Community Health Workers

We're not just handing out food—we're helping people actually use it and see it as part of their care

Community Health Workers (CHWs) are the heart of many community-based health efforts in Vermont, especially where food and nutrition intersect with chronic disease management. In the evolving landscape of FIM, CHWs are uniquely positioned to support patients through trust, cultural fluency, and lived community connection. This report summarizes findings from one interview and four focus groups involving 17 CHWs working across the state, reflecting their insights, frustrations, and frontline innovations in delivering food-based care.

Throughout the conversations, a consistent theme emerged: CHWs are doing essential FIM work—often without adequate support, training, or recognition. one CHW shared, *"It's hard to keep offering Band-Aids. We want to do more, but there's only so much we can do."* These voices highlight not only the emotional burden CHWs carry, but also the extraordinary commitment they bring to helping patients navigate food access, cultural appropriateness, and health system barriers. This report lifts up their perspectives to inform policy, program design, and investment in Vermont's food-as-health infrastructure. Below are the unmet needs from the CHW perspective as identified from the research:

▼ **Foundational Gaps**
- Lack of formal recognition and integration of CHWs into clinical FIM teams
- Insufficient staffing—CHWs often serve hundreds to thousands with no backup
- Minimal funding for sustained FIM infrastructure in communities

▲ **System-Level Needs**
- Inconsistent referral systems leading to inequitable access
- Rigid eligibility criteria excluding large families or undocumented individuals
- Limited culturally appropriate food offerings

▲ **Program Delivery Challenges**
- Transportation barriers preventing access to food pick-up sites
- Digital access and literacy issues for online ordering or registration
- Language and communication gaps with non-English-speaking clients

▲ **Direct Support Needs**
- No standardized CHW training for FIM programs
- Lack of culturally relevant cooking education for clients
- Emotional strain on CHWs from large panels and offering short-term fixes to systemic issues

Unmet Needs and Barriers of CHWs

Barriers

Barrier	Summary of Barrier
Transportation	Clients without personal transportation struggle to access food pick-up sites.
Limited culturally appropriate food	Provided food often doesn't reflect recipients' cultural preferences or traditions.
Eligibility restrictions	Rigid program rules exclude or underserve large families and certain groups.
Language and communication	Language barriers limit understanding of program benefits and participation.
Inconsistent provider referrals	Uneven referral practices result in inequitable program access.
Lack of formal CHW training	CHWs are not systematically trained for food programs, reducing consistency and impact.
Emotional strain on CHWs	CHWs feel overwhelmed and disheartened when resources are insufficient.
Technology barriers	Clients often lack access or skills for digital sign-ups and ordering.
Food waste due to unfamiliar items	Clients discard foods they don't recognize or know how to prepare.
Single CHWs serving large populations	One CHW is often responsible for an unmanageable caseload.

1. Transportation Barriers

Some clients just can't get to the pickup location. If they don't have a car, they're out of luck.

Current State: Many clients—especially those in rural areas—lack access to reliable transportation, making it difficult to pick up food boxes or attend nutrition programming.

Unmet Need: Community-based distribution models, mobile units, or home delivery systems that eliminate transportation as a barrier.

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2. Culturally Appropriate Foods

They're giving canned chickpeas and beets—my clients don't know what to do with that.

Current State*:* Clients frequently receive unfamiliar foods, especially New American families, resulting in food waste and frustration.

Unmet Need: Food options designed with input from culturally diverse communities, and education around how to use unfamiliar items.

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3. Rigid Eligibility Criteria

The program says one box per household—but I have families of 10. It's not enough.

Current State: One-size-fits-all eligibility models, like "one box per household," fail to consider large or multigenerational families and undocumented residents.

Unmet Need: More flexible program guidelines that recognize the realities of family structures and socioeconomic barriers.

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4. Language and Communication Gaps

We get flyers in English. That doesn't help my Nepali clients

Current State: Outreach materials are often only in English, excluding non-English speakers from fully engaging with FIM programs.

Unmet Need: Multilingual outreach strategies and culturally relevant communication to promote equitable access.

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5. Inconsistent Referral Processes

It depends on the provider. Some give boxes to everyone; others don't refer anyone at all.

Current State: Access to FIM resources is often left to individual provider discretion, leading to inconsistencies and perceived favoritism.

Unmet Need: A standardized, clinic-wide referral process grounded in equity and patient need.

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6. Lack of CHW Training in Food Programs

No one trained us. We just figure it out as we go.

Current State: CHWs are tasked with managing food-related needs without specific training, relying on self-initiative and informal learning.

***Unmet Need**:* Structured, ongoing training in food systems, culinary literacy, and program navigation.

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7. Emotional Burden on CHWs

It's hard to keep offering Band-Aids. We want to do more, but there's only so much we can do.

Current State: CHWs feel overwhelmed by having to repeatedly offer short-term fixes for long-term food and health insecurity.

Unmet Need: Mental health support, reflective supervision, and formal peer support networks.

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8. Digital Barriers for Clients

Some of our clients don't have internet, or they can't navigate the online forms.

Current State: Online ordering or sign-ups are inaccessible for clients without internet, tech skills, or devices.

Unmet Need: Low-tech enrollment systems, assistance from CHWs or navigators, and device access when needed.

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9. Limited Culinary Knowledge Among Clients

We got feedback that people were throwing away things like Bok choy—they didn't know how to cook it.

Current State: Even when food is provided, clients may not have the skills or knowledge to prepare it, especially with unfamiliar ingredients.

Unmet Need: Simple cooking education tied directly to the food provided—offered in multiple languages and formats.

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10. Understaffed CHW Teams

It's just me for over 1,000 patients. I can't keep up with everyone's needs.

Current State: CHWs are often the only one in their organization or community serving hundreds or thousands of patients.

Unmet Need: Increased investment in CHW staffing and integration of CHWs into care delivery teams for food and health support.

CHWs Are At The Intersection of Food Security and Food Is Medicine

FIM and food security initiatives share the common goal of improving health through better access to food, CHWs across the focus groups highlighted important distinctions—and opportunities for integration—between the two. Food security efforts aim to address basic needs by ensuring individuals have consistent access to enough food for an active, healthy life. In contrast, FIM interventions go further, using food intentionally as a therapeutic tool to prevent or manage chronic conditions like diabetes, hypertension, and obesity.

CHWs expressed that **many healthcare institutions conflate the two**, often addressing food insecurity through referrals to food shelves or one-time grocery cards, without linking patients to more sustained, health-oriented food programs. *"We have the food shelf option, but that doesn't mean they're getting food that helps with their diabetes,"* one CHW explained. Another noted, *"Right now, we're treating food insecurity like it's a diagnosis, but we're not always giving people a prescription for food that heals."*

CHWs emphasized that effective care requires bridging this gap—moving beyond emergency food access toward integrated nutrition support that is tailored, culturally relevant, and embedded in clinical workflows. They also stressed that **the emotional and logistical demands of navigating these dual systems often fall on CHW**s, who are left to translate the intent of FIM into practical, usable resources for clients. Without structural investment and policy alignment, these two efforts remain siloed, limiting their collective impact.

Common Themes

1. Dual Role of CHWs: Food Insecurity vs. Food Is Medicine
CHWs noted the overlap yet distinction between food insecurity and FIM. Many FQHCs focus more on food insecurity, while FIM programs (like produce prescriptions or meal kits) are less uniformly implemented and vary by site or funding.
2. CHW Autonomy and Training Gaps
CHWs often lacked formal training specific to FIM or food insecurity and were expected to learn on the job. Despite limited support, many self-initiated community partnerships to enhance service delivery.
3. Emotional and Professional Strain
CHWs described emotional difficulty delivering inadequate solutions and managing client disappointment. Many are the sole CHW in their practice, serving large populations with limited resources.

THE ROLE OF THE COMMUNITY HEALTH WORKER

We're not just handing out food—we're helping people actually use it and see it as part of their care.

Community Health Workers see themselves as the **vital bridge between patients, food access and healthcare systems**—particularly when it comes to Food is Medicine initiatives. Their work goes far beyond making referrals or distributing food. They are the first point of contact for many clients, identifying those in need and guiding them through eligibility and enrollment in programs like CSA boxes, produce prescriptions, or medically tailored meals.

Once clients are connected to food resources, CHWs often serve as **informal educators.** They explain what certain foods are, how to prepare them, and how they connect to the client's health. For many patients—especially those from culturally diverse backgrounds—this guidance is essential for making food not just accessible, but usable and meaningful. CHWs are constantly translating materials, explaining program logistics, and making sure the food provided is relevant and not wasted.

Beyond education, CHWs are **problem-solvers.** They help clients navigate transportation issues, fill out paperwork, and access digital tools that may be required to participate in programs. When institutional supports are lacking, CHWs frequently fill the gap by building relationships with local farms, food shelves, or community organizations to get their clients what they need. They do this often without formal training, relying instead on deep community knowledge and the trust they've built over time.

Above all, CHWs see their role in FIM as **relational**. They offer emotional support when clients feel ashamed, excluded, or overwhelmed, and they advocate fiercely on their behalf. However, many feel that their contributions are undervalued by healthcare systems. Despite their central role, CHWs often feel under-resourced and left out of decision-making. They emphasized the need to be **recognized, supported, and trained as integral members of the FIM delivery team.**

SUMMARY

This report synthesizes insights from 17 CHWs across Vermont, examining their role in delivering FIM interventions. CHWs are increasingly called upon to bridge the gap between healthcare systems and community needs by connecting patients to food programs that support both food security and chronic disease management. Their work spans identifying eligible clients, translating program materials, providing culturally relevant food education, and problem-solving barriers like transportation and digital access.

Despite their essential contributions, CHWs report feeling under-resourced and overlooked in the design and implementation of FIM efforts. Participants shared a deep commitment to supporting clients but expressed concern over inconsistent referral systems, lack of formal training, rigid program criteria, and emotional strain from offering inadequate solutions. One CHW noted, *"We're helping people actually use food as part of their care, but we're not always seen as part of the care team."*

In conclusion, the key themes include the disconnect between food insecurity and FIM interventions, the need for culturally appropriate foods, logistical and eligibility barriers, and the structural isolation of CHWs. The findings call for systemic support, including CHW training, integration into care teams, expanded staffing, and equitable program design that centers CHW voices and community realities.

VII. Food is Medicine in Vermont: Insights and Unmet Needs from Food Providers

The burden shouldn't be on us to be sourcing funds to pay ourselves for the work we're doing. We should be able to provide this service—and that funding should be coming from healthcare providers or Medicaid.

What we're doing works—but it's fragile. Imagine if we had reliable funding, clinical champions involved weekly, and patients' food access recorded in their medical charts. That's how we make food as medicine not just a project, but a real part of healthcare.

This report summarizes findings and insights from in depth conversations with 16 food providers – in 3 interviews and 4 focus groups – engaged in FIM and food insecurity in Vermont. They represent CSAs, food banks, community pantries, and medically tailored meal programs. Their efforts range from assembling CSA shares and distributing fresh produce to cooking thousands of meals for those with chronic health conditions. Listed below are their unmet needs working in FIM/food insecurity in Vermont:

Unmet Needs

- Formal recognition as healthcare partners
- Sustainable funding mechanisms
- Inclusion in policy and Medicaid planning
- Lack of standard reimbursement
- Fragmented program eligibility
- Limited outcome tracking
- Minimal communication with clinical teams
- Undefined scope of responsibility
- Overburdened operations
- Delayed referrals
- Food-use barriers
- Mismatch in food offerings
- Sharing the financial risk

Foundational Gaps (System-Level Misalignment)

- **Lack of formal recognition as healthcare partners**: Food providers are delivering essential care without being seen or compensated as part of the health system.
- **Funding instability**: Most programs rely on patchwork fundraising, grants, or donations to cover services intended to support clinical outcomes.
- **Exclusion from policy conversations**: Providers are rarely included in Medicaid strategy or FIM policy planning at the state level.

Program and Policy Barriers

- **No standard payment model for food as care**: Current FIM programs operate outside Medicaid, with no consistent mechanism to reimburse food providers.
- **Inconsistent eligibility and referral criteria**: Programs vary by site, insurer, or funding stream, creating confusion for both providers and patients.
- **Lack of data infrastructure**: Food providers often don't receive patient information or outcome data, limiting their ability to tailor interventions or demonstrate impact.

⚠ **Workforce and Workflow Challenges**

- **Limited coordination with clinical teams**: Most food providers receive referrals without context, and communication with clinicians is minimal.
- **Blurred roles**: Staff are often asked clinical or case management questions without appropriate training or healthcare integration.
- **Administrative burden**: Food providers juggle reporting across multiple grant streams and partnerships, pulling capacity away from direct service delivery.

⚠ **Patient-Level Needs**

- **Stigma and late referrals**: Patients often enter FIM programs after disease is advanced; preventive referrals are uncommon.
- **Lack of follow-up support**: Once food is delivered, there is little coordination with care teams to help patients use it effectively.
- **Missed cultural and practical alignment**: Without patient-level feedback, providers risk sending food that's unfamiliar, hard to prepare, or not medically appropriate.

OVERVIEW

These FIM/food insecurity programs are often deeply embedded in local food systems and rely heavily on grants, donations, and volunteer labor. While motivated by mission, food providers consistently report a lack of integration with clinical systems, limited funding reliability, and a need for formal recognition within healthcare structures.

A recurring theme in food provider feedback was the disconnect between food and healthcare systems. Many reported that once a patient is referred to a food program, communication ends—food providers often don't know the patient's diagnosis, dietary restrictions, or whether the food provided had any clinical impact. This lack of coordination limits their ability to tailor support and demonstrate outcomes.

Funding was another major concern. Most programs are supported through grants, donations, or limited contracts with health organizations—models that are unsustainable for scaling or long-term planning. Food providers spend many hours writing grants to pay for food that will be supplied to patients. They are delivering health interventions and also carry the financial burden. They also noted that patients are often referred too late – after chronic disease has progressed – rather than proactively, which reduces the preventive power of FIM efforts.

Despite these challenges, food providers expressed a strong desire to be more integrated into the healthcare system and included in policy conversations. They want to collaborate more closely with clinicians, receive training on patient-centered nutrition needs, and be compensated in ways that reflect the essential role they play in improving health outcomes. Overall, the findings point to a need for structural alignment, investment, and shared accountability across both systems – healthcare and food providers – to fully realize the potential of Food is Medicine in Vermont.

Key Themes

1. Coordination Gaps with Healthcare

We're expected to fill the prescription, but no one tells us what's actually needed.

Food providers consistently note a disconnect with clinicians. Once a patient is referred, many food providers receive little to no information about health needs, limiting their ability to tailor support.

2. Heavy Reliance on Patchwork Funding

We're fundraising for Porter's patients—it doesn't feel sustainable.

Writing grants year after year to support patients already in the healthcare system is incredibly frustrating.

Nearly all programs are kept afloat through grants, donations, or fee-for-service models negotiated piecemeal with local healthcare partners. Several noted that up to one-third of their budgets must be raised annually to fill service gaps.

3. Desire for Clinician Engagement

If a doctor says its important, patients listen

Providers want clinicians to do more than just prescribe. They envision doctors showing up at CSA distributions, integrating participation data into EMRs, or championing programs internally.

4. Stigma and Missed Opportunities in Referrals

Food providers, especially those working with families or in early childhood, emphasized that food insecurity is often hidden. Stigma and the lack of a preventative mindset mean referrals happen late—when diet-related disease has already developed.

Common Barriers

Barrier	Details
Lack of clinical integration	Food providers receive referrals without medical context (e.g., diagnosis, dietary needs, updates).
Unstable funding models	Programs rely on grants, donations, and short-term partnerships—unsustainable for long-term impact.
No reimbursement mechanisms	There is no standard Medicaid or clinical billing model to pay food providers for services.
Minimal feedback loops	Food providers rarely know if food is used, if patients improve, or how to adjust for future needs.
Inconsistent referral pathways	Clinics vary in how and when they refer patients, leading to unequal access and confusion.
Role ambiguity	Food providers are often asked health-related questions outside their training or scope.
Delayed patient engagement	Patients are often referred after disease onset, missing preventive intervention opportunities.
Overstretched capacity	Administrative burdens (reporting, coordinating with multiple partners) limit time for service.
Food usability gaps	Without direct patient interaction or support, providers struggle to ensure food is practical, familiar, or culturally appropriate.
Exclusion from policy design	Food providers are not consistently included in Medicaid or state-level Food is Medicine planning conversations.
Taking on the financial burden and risk	Food providers are currently shouldering the costs of growing, preparing, and delivering food for clinical interventions—without stable funding or reimbursement.

Unmet Needs

1. Formal Recognition as Healthcare Partners

We're part of the care team in practice, but not in policy or funding.

Current State: Food providers are delivering therapeutic meals and produce for patients with chronic conditions but are not integrated into healthcare teams.

Unmet Need: Recognition as essential health collaborators, with roles defined alongside clinical and community health staff.

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2. Sustainable Funding Mechanisms

We're fundraising for healthcare. That's not how it should work.

Current State: Most programs are funded by time-limited grants, donations, or fundraising—none of which offer long-term sustainability.

Unmet Need: Ongoing, reliable funding streams (e.g., Medicaid, insurance, bundled payments) that reflect the clinical value of food-based interventions.

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3. Inclusion in Policy and Medicaid Planning

We don't find out about changes until they're already in place.

Current State: Food providers are rarely included in the design of state-level FIM strategies or Medicaid innovations.

Unmet Need: Involvement in policy decisions and FIM model design, especially as Vermont explores 1115 waiver options and care coordination reforms.

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4. Lack of Standard Reimbursement

We're delivering what the doctor prescribed—but we're not getting paid for it.

Current State: There is no formal billing or reimbursement pathway for food delivered as care—even when prescribed.

Unmet Need: Defined payment mechanisms for food providers, tied to clinical diagnoses, FIM participation, and health outcomes.

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5. Fragmented Program Eligibility

One clinic sends everyone, another sends no one—and it's the same patients.

Current State: Eligibility for food programs varies by clinic, grant, and funder, leading to confusion and gaps in service.

Unmet Need: Unified eligibility standards that streamline access and reduce administrative burden.

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6. Limited Outcome Tracking

We have no idea if what we sent made a difference.

Current State: Food providers do not receive feedback about patient progress or clinical outcomes after delivering food.

Unmet Need: Data-sharing protocols and EMR integration to close the loop on referrals and track program impact.

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7. Minimal Communication with Clinical Teams

We don't even know who to contact if there's a question

Current State: There's often no follow-up after a referral, and food providers operate without insight into patient needs.

Unmet Need: Regular communication channels and shared tools between food providers and clinical care teams.

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8. Undefined Scope of Responsibility

We get questions about diabetes diets that we're not trained to answer

Current State: Patients sometimes expect food providers to offer nutrition advice or clinical guidance beyond their role.

Unmet Need: Clear definitions of scope, paired with training or partnerships to ensure clients get the support they need.

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9. Overburdened Operations

We need help running the program—not just delivering the food

Current State: Staff juggle complex reporting, partner coordination, and logistics while also trying to serve clients.

Unmet Need: Administrative support and shared infrastructure that lets food providers focus on service delivery.

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10. Delayed Referrals

We should be seeing patients before they get sick, not after.

Current State: Many patients are referred after a diagnosis has progressed, reducing the potential impact of dietary support.

Unmet Need: Earlier intervention and preventive referrals integrated into routine care.

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11. Food-Use Barriers

We're sending food, but we don't know if it's getting eaten.

Current State: Food providers often don't know whether clients can store, cook, or enjoy the food they receive.

Unmet Need: Client education, CHW support, and coordination with dietitians to improve food usability.

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12. Mismatch in Food Offerings

We want to nourish people—but we don't know what they actually need.

Current State: Without feedback, food boxes may include items that are culturally unfamiliar or impractical for some clients.

Unmet Need: Systems to incorporate client preferences, cooking capacity, and health conditions into food selection.

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13. Sharing the Financial Risk

We're fundraising for patients in the hospital system. If this is healthcare, why is the burden on us to pay for it?

The program only covered a portion of the cost—we had to cover the rest through grants or our general operating funds.

Current State: Food providers are currently covering much of the cost associated with growing, processing, and distributing food for healthcare interventions. While their work directly supports patient health, they are not compensated at a level that reflects their essential role and the risk they take on.

Unmet Need: Sharing the financial risk of providing food and being reimbursed for their goods and services.

The Role of the Food Provider

The role of FPs in a FIM program is **foundational**—**they are the delivery system for therapeutic nutrition**. While clinicians screen and refer, and dietitians offer guidance and nutritional prescriptions, it's the food providers who turn those prescriptions/referrals into impact by ensuring that patients actually receive, and ideally use, the food that supports their health. They are not just vendors; **they are partners in care**.

1. Delivering the "Intervention" Itself

The food doesn't just show up. We're the ones making it happen, week after week.

FPs are the ones **assembling and distributing the food**—whether it's a CSA box, a pantry pack, or a fully prepared, medically tailored meal. Without them, FIM programs are just prescriptions on paper.

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2. Supporting Patient Engagement

Many food providers **build trusted relationships** with clients—especially in rural or underserved areas—and are often the first to hear when food isn't usable, familiar, or appropriate. They play a key role in helping patients feel seen, respected, and connected to their care.

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3. Providing Logistical Expertise

Food systems are complex—seasonality, storage, sourcing, transportation, and packaging all influence how food gets to people. Providers bring **deep operational knowledge** to the table, ensuring the right food gets to the right patient, at the right time.

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4. Filling Gaps in Health Equity

Food providers often serve those who are hardest to reach—homebound patients, undocumented families, or individuals without kitchens or cooking tools. They **adapt offerings** (keeping within nutritional parameters) to meet real-life constraints, often with little to no clinical coordination.

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5. Acting as Feedback Loops

When integrated well, food providers can inform healthcare partners when clients aren't picking up food, are confused by ingredients, or need extra support—creating a **real-time feedback system** to improve outcomes.

In short, food providers are **not just logistics—they are a linchpin** in any functional FIM program. Treating them as true care team members, not just external partners, is essential to the success and sustainability of food-based healthcare.

Summary

The interviews with Vermont-based food providers participating in FIM programs reveal a system filled with potential but hampered by fragmentation, financial precarity, and limited integration with healthcare. One of the most consistent themes is the lack of meaningful engagement from clinicians. While healthcare providers may initiate referrals, the process is often administrative, with care coordinators or front desk staff passing patients along. Communication breakdowns between healthcare systems and food providers frequently lead to reduced program utilization. Once referrals are made, providers rarely receive follow-up or insight into patient progress, and

there's minimal integration of food program participation into electronic health records—creating a disconnect between the prescribed food support and ongoing clinical care.

Equally concerning is the financial burden placed on food providers. Despite being asked to feed patients referred by healthcare institutions, many organizations are left to write grants or fundraise annually to cover the costs of the food and distribution. Some food providers manage to secure partial support from healthcare partners, but many still shoulder up to one-third or more of total costs. This patchwork funding model has led to widespread frustration and calls for more consistent, system-level investment from Medicaid or healthcare payers.

The programs themselves, while valuable, are generally not medically tailored. Most follow a CSA-style model where patients receive general produce shares, regardless of specific health needs or dietary restrictions. Some efforts have been made to offer cooking education and nutritional guidance, often through volunteers or dietitians embedded in the program—but this varies by region and partner capacity.

Despite these limitations, Vermont's food providers are highly committed to their communities and have built impressive models with limited infrastructure. Programs like *Grateful Hearts*, *Veggie Van Go and Feeding Champlain Valley* showcase creative, efficient solutions, often partnering directly with local farms and maximizing resources. However, the system remains fragile, dependent on overextended staff, volunteers, and unreliable year-to-year funding.

There is cautious optimism around emerging policy opportunities. While Vermont holds an 1115 Medicaid waiver that could theoretically support medically tailored nutrition, it remains largely unused beyond *Meals on Wheels*. There is no comprehensive statewide strategy to fully integrate and sustainably fund FIM programs. Without this, the burden will remain disproportionately on the food providers trying to nourish Vermont's most vulnerable patients.

In conclusion, food providers are currently treated as service vendors, but in reality, they are **delivering the therapeutic product.** Without clear placement in the care flow:

- Their capacity to tailor offerings is limited
- Their impact is invisible to clinical teams
- They are excluded from feedback loops and funding structures

By clearly inserting food providers into the FIM model as **care delivery agents**, Vermont can better integrate nutrition into the healthcare system—and fully leverage the power of food to heal.

VIII Food is Medicine in Vermont: Insights and Unmet Needs from Two Hospital Systems and a Clinic

Overview

The three interviews—two with representatives from major hospital systems and one with a community clinic reveal both the promise and the growing pains of implementing FIM in Vermont and the Upper Valley. Each program operates with a strong commitment to improving patient health through access to fresh, nutritious food, whether via CSA shares, produce distributions, tailored grocery prescriptions, or medically tailored meals. The hospital-based programs have developed multi-tiered approaches, integrating partnerships with local farms, nonprofits, and in some cases, national meal vendors. The community clinic model demonstrates how smaller health centers can tailor FIM to target specific chronic disease risks while embedding support from community health workers. Across all three, there is an emphasis on patient screening, partnerships with local agriculture, and the belief that food should be a core part of medical care.

Yet, the interviews also expose systemic barriers limiting scale and sustainability. Funding instability forces all three organizations to rely on a patchwork of small grants, consuming valuable staff time. Clinician engagement is inconsistent, with many referrals coming from care coordinators rather than providers, reducing the medical weight of the intervention. Geographic inequities persist, leaving rural patients—particularly outside Chittenden County—with fewer options. Workforce shortages, underutilization of dietitians, and lack of integrated EHR tracking hinder clinical integration. Transportation challenges, cultural attitudes toward accepting assistance, and patient-level barriers like cooking capacity further restrict impact. Despite these obstacles, each representative voiced a clear vision for a future where FIM is embedded into healthcare systems, supported by stable funding, and fully accessible to all Vermonters in need.

The following are the unmet needs gleamed from these representatives:

- State-level prioritization & funding
- Centralized infrastructure
- Integration into healthcare systems
- Clinician engagement
- Local medically tailored meals
- Transportation solutions

Barriers

Barrier	Description
Funding instability	Programs rely on multiple small grants, consuming significant staff time with constant fundraising and reporting.

Barrier	Description
Geographic inequity	Rural and non-Chittenden County areas have minimal or no access to FIM programs.
Cultural attitudes	Many Vermonters decline help, believing others need it more, which can reduce enrollment.
Workforce limitations	Few clinicians are trained in FIM; registered dietitians are underutilized, and community health workers/health coaches carry most patient engagement.
Data integration	Lack of streamlined referral systems and outcome tracking in electronic health records (EHRs) limits follow-up and program evaluation.
Cooking and storage limitations	Participants may face barriers such as poor dental health, lack of cooking equipment or propane, and inconsistent produce quality, limiting food use.

1. State-level prioritization & funding

There's a lot of interest … but there are barriers around funding and the overall needs of the hospital.

Funding would be from one source would be great because I spend a lot of my time managing funding and data collection… I would like it to cover at least one full-time staff and expand our reach.

Current State: Programs rely on a patchwork of small, short-term grants from multiple sources (e.g., Bi-State, VT Department of Health, Dartmouth) to cover staff, food costs, and operations. Funding is competitive, time-consuming to secure, and often insufficient to meet known patient demand.

Unmet Need: A stable, single-source, state-backed funding stream—potentially via the 1115 Medicaid waiver—to sustain staffing, expand reach, and reduce the administrative burden of constant fundraising.

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2. Centralized infrastructure

The vision is to have a central nourishment hub where clinicians, RDs, chefs, and farms are connected to deliver food as part of care

Current State: Each program operates independently, building its own partnerships with farms, nonprofits, and clinical teams. There is no statewide coordination or central hub to streamline referrals, food sourcing, and outcome tracking.

Unmet Need: A coordinated, statewide FIM infrastructure that links healthcare systems, RDs, chefs, farmers, and food distributors, ensuring consistent access, quality control, and data sharing.

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3. Integration into healthcare systems

Right now it's a side program. We need it embedded into the EHR and care pathways so it's part of the patient's medical record.

Current State: FIM programs exist alongside, rather than inside, core clinical care. Referrals often come from care coordinators or community health workers, and most programs lack integration into EHRs. Participation is not routinely documented in the medical record.

Unmet Need: Full embedding of FIM into care pathways and EHR systems, with documented "food prescriptions" from clinicians to give the intervention medical authority and ensure follow-up.

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4. Clinician engagement

If a clinician says you need to do this, it gives it weight. Without that, it's just another optional program to the patient

Current State: Clinicians are aware of programs but are not consistently involved in referrals or patient education. The "why" behind food prescriptions is often left to food providers to explain, reducing perceived importance.

Unmet Need: Consistent, proactive clinician endorsement and explanation of FIM to patients, framed as part of their treatment plan, to boost enrollment and adherence.

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5. Local medically tailored meals

We had to source from Ohio for our nutritionally tailored meals because we couldn't find a local distributor after an exhaustive search.

Current State: There is little in-state capacity to prepare and deliver medically tailored meals, forcing programs to source from out-of-state vendors (e.g., Mom's Meals in Ohio).

Unmet Need: Investment in local production and distribution of medically tailored meals to keep resources in Vermont and better tailor meals to cultural and dietary preferences.

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6. Transportation solutions

Transportation is always an issue… during the pandemic we delivered to homes, but it wasn't sustainable. Now patients must pick up, which can still be a barrier.

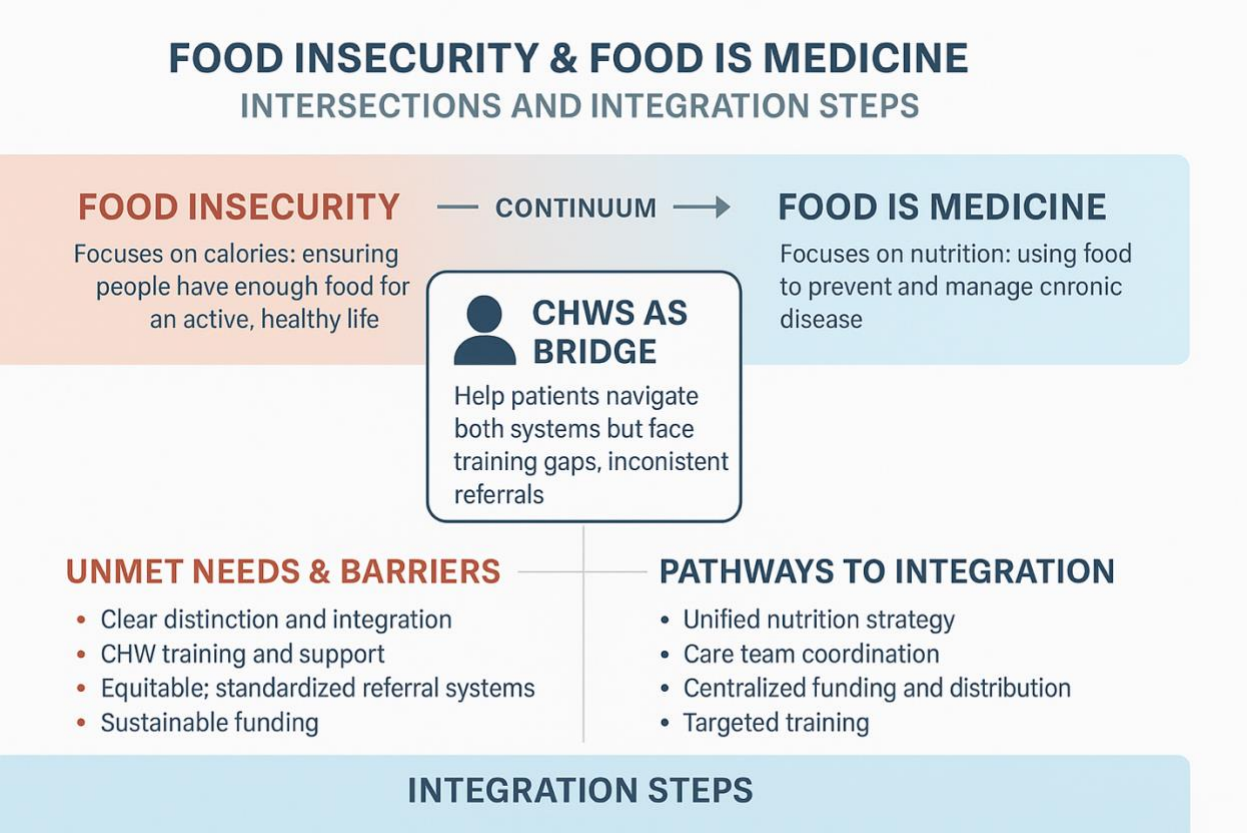
Current State: Many programs require patients to pick up food at clinic sites. While some volunteer delivery exists, transportation remains a barrier, especially for rural patients without reliable vehicles.

Unmet Need: Funded, sustainable transportation or home delivery systems to ensure consistent access for patients who cannot easily travel to pick-up sites.

Summary

Vermont's FIM ecosystem is at a formative stage, with dedicated pockets of innovation but no unifying infrastructure. Leaders see the path forward as creating a coordinated statewide hub, embedding FIM into clinical workflows, securing long-term state-backed funding, and building in-state capacity for medically tailored meals. Transportation, clinician engagement, and cultural acceptance remain cross-cutting challenges.

VIII: Food Insecurity & Food is Medicine in Vermont: Intersections and Insights



The same patients who are food insecure are often also the ones facing four or five 5 other SDOH issues. It's a system-level problem, not just an access problem.

One of the biggest social determinants of health or social drivers of health that patients are expressing is that they have somewhat of a food insecurity, and it really doesn't seem to matter what their social economic status is.

The Intersection of Food Security and Food Is Medicine

In Vermont, food insecurity and Food is Medicine (FIM) are often treated as interchangeable, but voices from the field—including clinicians, dietitians, and CHWs—make clear that while connected, they serve distinct functions. Currently, these two systems operate in parallel rather than in full partnership. On one end, food insecurity initiatives focus on **calories**: ensuring people have enough food to live an active life. On the other, FIM targets **nutrition**: providing medically appropriate foods to prevent and manage chronic disease. While interconnected, they are not interchangeable. Together, they shape the foundation for nutrition security, but they are not synonymous.

Clinicians Input:

We have the food shelf option, but that doesn't mean they're getting food that helps with their diabetes.

Clinicians recognize food insecurity as a major social determinant of health but often feel limited in their role. Most screen for food needs during visits using tools like the Hunger Vital Sign or broader SDOH forms, but time constraints mean deeper engagement is rare. Instead, they rely on referrals to dietitians and CHWs and advocate for better infrastructure and team-based approaches. Notably, several clinicians voiced support for integrating food into chronic disease care—but emphasized that "giving out food isn't enough" if patients can't use it effectively.

Dietitians Input:

Food is not enough," one RD shared. *"If someone can't chew, doesn't know how to cook, or the food isn't familiar to them, they're still nutritionally insecure.*

Dietitians highlight food insecurity as a key reason why FIM programs must exist—but stress that access is just the starting point. They call for a shift toward **nutrition security**: food that is healthy, culturally appropriate, and usable. Vermont's rural landscape, aging population, and lack of infrastructure make this more than just a dietary challenge—it's a systems issue. For dietitians, this underscores the need for FIM efforts that go beyond produce boxes and one-time prescriptions toward integrated, team-based care that meets people where they are.

CHW Input:

CHWs emphasize that while patients may have access to food shelves or SNAP benefits, those options don't necessarily provide the kinds of foods that support chronic condition management. The challenge for CHWs is not just identifying food insecurity, but converting those findings into tailored, health-supporting solutions within programs that often lack flexibility or sustainability. They're also the ones tasked with translating FIM intent into culturally relevant, usable care—often without training or support.

Unmet Needs and Barriers

- **Clear distinction and integration** between food insecurity and nutrition security in language, training, and program design.
- **CHW training and support** so they can effectively link prescriptions to culturally relevant, health-supportive foods.
- **Equitable, standardized referral systems** embedded in EMRs to ensure patients receive the right type of food assistance based on need, not provider discretion.

- **Sustainable funding** to maintain both emergency food access and long-term, therapeutic food programs.
- **Flexible program design** that accommodates cooking skills, equipment, and medical modifications.

Pathways to Integration

- Treating food insecurity and FIM as connected but distinct parts of a unified nutrition security strategy.
- Embedding CHWs, dietitians, and food providers into care teams to ensure that screening leads to medically appropriate solutions.
- Creating centralized coordination for funding, distribution, and evaluation to reduce duplication and expand reach.
- Providing targeted training for all stakeholders to move from identifying need to delivering measurable health outcomes.

Summary

Clinicians, dietitians, and CHWs generally agree on the need to connect food insecurity initiatives and FIM into a more integrated approach, but they also stress that the two should remain **distinct in purpose within a unified system**.

- Clinicians support integration because they see food insecurity as a major social determinant of health and recognize that simply identifying need isn't enough; however, they caution that food distribution must be linked to medical goals.
- Dietitians strongly favor combining efforts so patients move from "calorie sufficiency" to nutrition security, but emphasize that integration must ensure food is culturally appropriate, medically tailored, and usable.
- CHWs are the most vocal about integration — they already bridge both systems in practice and see the benefits of linking them — but they also highlight the need for training, structural support, and consistent processes to make integration effective and sustainable.

The consensus: Integration is necessary for better outcomes, but it must preserve the therapeutic focus of FIM while building on the access foundation of food insecurity programs.

IX: Conclusion and Next Steps

The findings in this report underscore a strong, cross-sector commitment to advancing Food is Medicine in Vermont—rooted in shared values of equity, prevention, and community connection. However, the success of FIM programs statewide is currently limited by critical gaps in funding, research, infrastructure, collaboration, and capacity. Addressing these challenges requires coordinated action across healthcare, public health, and food systems.

To move from fragmented efforts to sustainable impact, Vermont must now focus on the following strategic next steps:

1. **Establish Long-Term Funding Mechanisms**
   Develop financing models that go beyond short-term grants and use braided funding strategies - including Medicaid reimbursement, funding the 1115 waiver in Vermont, national and local grants, philanthropy, and investment from insurers and health systems (with value-based contracts). Plus, design funding models that distribute the financial risk of farming across all stakeholders.
2. **Develop a Coordinated Infrastructure Statewide**
   Create a statewide coordinating center to align referral systems, data sharing, trainings, and workflows across healthcare and food sectors. This will streamline implementation and transportation, align food insecurity and FIM efforts, reduce duplication, and ensure consistent, equitable access to FIM programs statewide.
3. **Create Collaborative and Representative Leadership Across Food and Health**
   Establish a statewide collaborative council to guide the FIM Center's development and policy direction—intentionally including food providers, farmers, community health workers, and other frontline experts. Embedding this diverse, community-rooted expertise at every level of the FIM infrastructure ensures that programs are equitable, practical, and grounded in lived experience.
4. **Align Food Insecurity and Nutrition Security Efforts**
   Develop a coordinated system that bridges food access programs with clinical nutrition interventions. Aligning food insecurity screening, referral, and support services with Food is Medicine initiatives will ensure that efforts to address immediate hunger are integrated with long-term strategies for nutrition security and chronic disease management and prevention.
5. **Clarify Roles and Flow**
   Establish clearly defined roles and flow to ensure each professional works at the top of their license. This approach reduces duplication, promotes team efficiency, and builds mutual accountability across sectors.
6. **Support and Expand the Workforce**
   Invest in workforce development, including the training of CHWs and care teams in FIM, culinary medicine, cultural humility, food insecurity, and food systems literacy. Address capacity constraints by embedding support staff into care models.
7. **Ensure Cultural Relevance and Patient-Centered Design**

Involve patients and community members in program design to ensure FIM interventions are aligned with local food traditions, dietary needs, and lived experience.

8. **Create a Unified Evaluation Framework**
   Develop shared metrics and cross-sector evaluation tools to monitor outcomes, demonstrate impact, and guide policy and investment decisions. A strong, consistent data infrastructure is essential not only for quality improvement, but also to secure larger, long-term funding streams by clearly showing the return on investment of Food is Medicine interventions.
9. **Leverage Vermont's Unique Strength**
   Embrace the "Vermonter Way" by building on the state's deep-rooted culture of generosity, local connection, and respect for the land. Design Food is Medicine programs that reflect Vermonters' instinct to care for neighbors, source from local growers, and sustain the communities and environment they depend on.

X: The Author's Concluding comments:

Vermont is perfectly set up to succeed in providing healthy food to the vulnerable and sick while reducing healthcare costs. It has the land, people, values, and partnerships to lead—but it must act decisively, with support from both state and local stakeholders across healthcare and agriculture. It needs to bring local food providers to the table as critical public health partners. Today, Vermont's FIM efforts remain fragmented. You have farmers spending hours each week writing grants to be able to provide food to patients. You have patients going to the farms asking medical questions about produce prescriptions.

Committing to strengthen and coordinate FIM efforts in Vermont will require upfront investment—particularly in infrastructure and workforce capacity. In a state facing significant healthcare losses and recent layoffs, this may feel like an ambitious ask. But the fee-for-service model has been exhausted. We've reached the limit of what RVU-driven care can deliver. The good news is that there another proven model that can turn a struggling healthcare system around.

This moment calls for a bold change. Vermont must move beyond transactional care and fully embrace value-based models that reward outcomes, not volume. Real transformation will require more than incremental pilots—it demands full-scale commitment and time to realize financial and health returns. Current national research in FIM shows that there is the potential for huge cost savings. Research by Shuyue Deng and colleagues calculates that scaling medically tailored nutrition interventions could save Vermont **$53 million in annual net savings** - calculated as *saving in annual health care expenditures* minus *MTM program costs* for eligible patients (1).

From a state and local perspective, **priority number one is oversight**.

- On a statewide level, a coordinating entity overseen by a diverse committee representing all sectors is essential—and it must be insulated from the financial volatility facing healthcare and academic systems. Establishing **a state-run FIM office** will enable

coordinated policy, sustainable infrastructure, and long-term impact. This office should be supported through a blended funding model— including national grant opportunities, philanthropy, state resources, and contributions from healthcare systems and insurers. This coordinating entity will provide for an economy of scale so that each clinic doesn't have to reinvent the wheel when bringing FIM into its practice.

- On a clinical/local level, there is a need for a **coordinator in a patient's FIM process** who oversees the path the patient takes, which can involve many stops (access to transportation, housing, food, and other services (SDOH), plus making sure that the clinical informational from the clinician and dietitian is being passed to the entity that is fulfilling that prescription/referral (food bank, CSA, Produce Prescription, MTM etc..). A CHW is an ideal candidate for this position as they provide the essential connection-piece (to both the patient and programs).

Other states are taking action. Governor Kevin Stitt of Oklahoma recently signed the Food is Medicine Act (SB 806), creating Medicaid incentives and expanding nutrition services. Oklahoma is also leveraging its 1115 waiver to secure long-term funding—a powerful precedent (2). Vermont can follow suit as it already has an 1115 waiver but needs the funding to be allocated to FIM interventions. A legislative and funding strategy that bridges healthcare and agriculture can position FIM as a core component of care, saving the state millions in healthcare savings.

Vermont must also take ownership of its FIM strategy. Each state's healthcare system, communities, and food traditions are distinct. Success will require tailored approaches grounded in local realities—not national templates. This research aims to be a catalyst: moving Vermont toward a future where its people are healthier, fed in accordance with their food cultures, and supported by a healthcare system and economy that is resilient, equitable, and truly Vermont-grown.

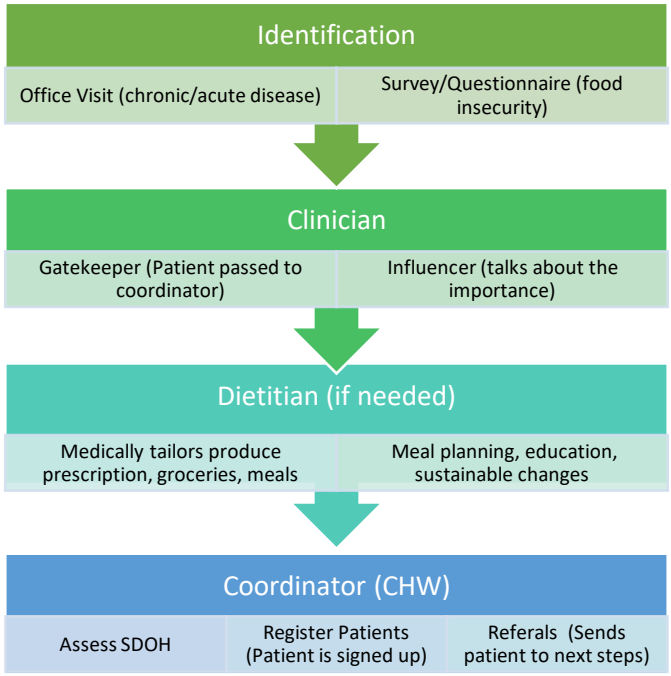
References:

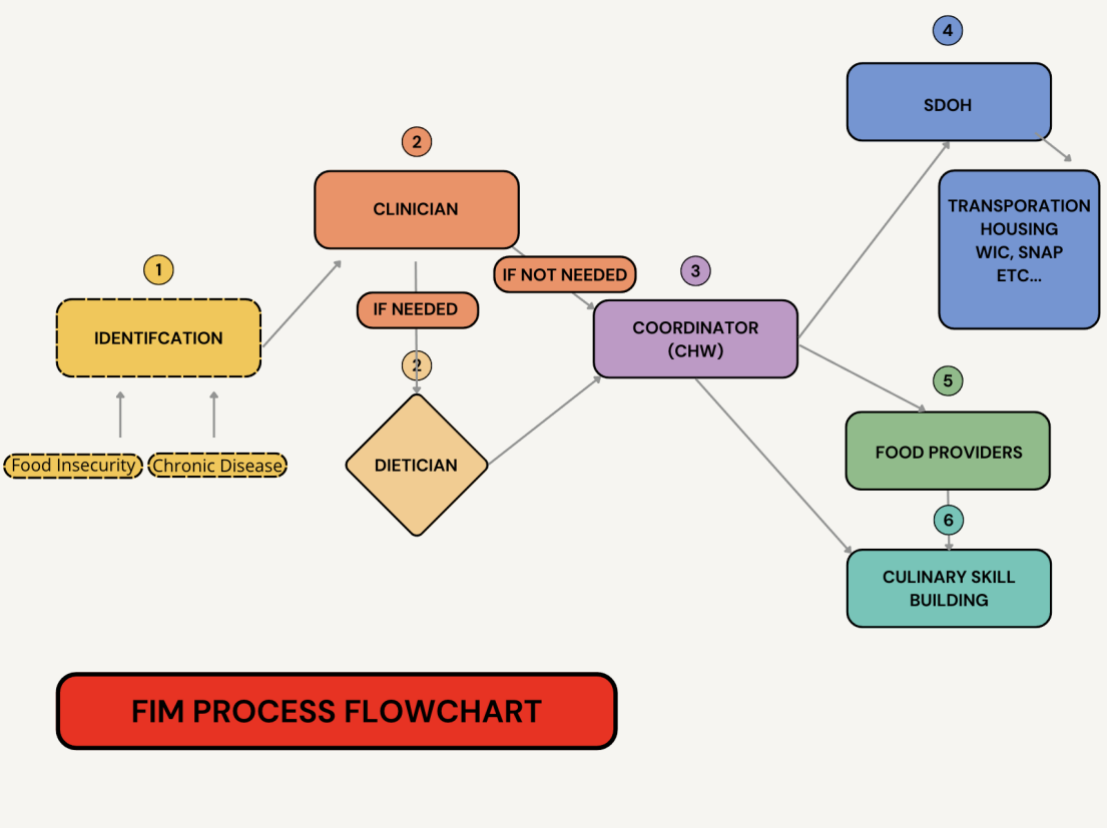
1. Deng F et al. Health Affairs April 2025. Estimated Impact of Medically Tailored Meals on Health Care Use and Expenditures in 50 US States. https://doi.org/10.1377/hlthaff.2024.01307

2. National Governors Associations. June 17, 2025 **Food is Medicine: A Strategic Shift in State Health Policy** https://www.nga.org/news/commentary/food-as-medicine-a-strategic-shift-in-state-health-policy/

XI . FIM Process as Informed by this Research

Clinician starts the process (refer) and refers to a dietitian if needed – gives credibility
Dietitian provides medical tailoring, nutritional guidance and support – ensures nutritional alignment
CHW bridge between patients, food access and healthcare systems
Culinary educators offer culinary skills and confidence
Food Provider ensures food access, logistics, and delivery
A Coordinator is the hub of the entire system - coordinating the flow of patients





Contact Dr Deb Kennedy at culinaryrehab@gmail.com for any questions or comments.