American Heart Association.

Health Care Food™

Accelerating the Integration of **Food Is Medicine in Health Care**

ADVANCES IN THE FOOD IS MEDICINE FIELD

Annual Report 2025

Presented by Health Care by Food™, a food is medicine initiative of the American Heart Association

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EXECUTIVE SUMMARY

Food is medicine (FIM) interventions such as produce prescriptions, medically tailored groceries and medically tailored meals are rapidly emerging as promising strategies to improve nutrition-related health outcomes and reduce health care costs, especially for people with chronic diseases. This report reviews developments from July 2024 through June 2025, and highlights recent research, policy progress, community and implementation considerations, and priorities to scale FIM as a sustainable clinical practice. We focused on the past year to provide the most relevant and timely insights, building on prior reports that have already captured earlier advancements.[1-3]

Thanks to the dedication of early champions, food is medicine has gained broader recognition as a critical component of health care. With growing evidence, federal attention and cross-sector commitment, continued progress depends on sustained investment, rigorous evaluation and successful examples of scaled implementation.

Food Is Medicine Definition:

The American Heart Association defines FIM as the provision of healthy food such as medically tailored meals, medically tailored groceries and produce prescriptions to treat, prevent or manage specific clinical conditions in a way that is integrated with and paid for by the health care sector.[2,4]

Research and Evidence

Although rigorous randomized controlled trials remain limited in quantity and often early stage, a growing body of observational and mixed methods studies demonstrates strong feasibility, participant satisfaction and encouraging impacts on diet quality and clinical outcomes.

- **Produce prescriptions** were associated with an increase of fruit and vegetable intake by about half to one serving per day (reported variously as servings/day, cups/day, or times/day), when engagement is sustained.
- **Medically tailored groceries** show health and food security improvements, especially when integrated with clinical care.
- **Medically tailored meals** demonstrate potential for nutritional improvements and reduced health care utilization among high-risk populations.
- **Mixed models** combining FIM interventions (medically tailored meals, medically tailored groceries and produce prescriptions) indicate reductions in hospitalizations and emergency visits.

ABBREVIATIONS

ACA - Affordable Care Act
AI - Artificial Intelligence
BMI – Body Mass Index
BP - Blood Pressure
CBO - Community-Based Organization
CMMI - Center for Medicare and Medicaid Innovation
CMS - Centers for Medicare & Medicaid Services
EBT - Electronic Benefit Transfer
ED - Emergency Department
EMR - Electronic Medical Record
FDA - Food and Drug Administration
FIM - Food Is Medicine
FQHC - Federally Qualified Health Center
GRAS - Generally Recognized as Safe
HbA1c - Hemoglobin A1c
HCBS - Home and Community-Based Services
HCXF - Health Care by Food (American Heart Association initiative)
HHS - U.S. Department of Health and Human Services
ILOS - In Lieu of Services
MA - Medicare Advantage
MAHA - Make America Healthy Again
MCO - Medicaid Managed Care Organization
MTG - Medically Tailored Groceries
MTM - Medically Tailored Meals
NIH - National Institutes of Health
OBBB - One Big Beautiful Bill
PRx - Produce Prescriptions
RCT - Randomized Controlled Trial
SNAP - Supplemental Nutrition Assistance Program
SSBCI - Special Supplemental Benefits for the Chronically Ill
VBID - Value-Based Insurance Design Model

However, how well the results apply to other settings or groups is limited by variability in study designs and populations, and data on cost effectiveness and long-term behavior change remains limited.

Policy and Guidelines

The concept of FIM continues to attract bipartisan support and gain momentum through a national focus on improving health via diet. Growing federal, state and payer involvement is occurring, such as through Medicaid 1115 waivers and "in lieu of services" authorities that enable state innovation in Medicaid and in other avenues through which Medicare Advantage plans are increasingly offering food benefits. However, the One Big Beautiful Bill Act, signed into law in July 2025, could potentially stifle innovation as it repeals portions of the Affordable Care Act (ACA), including sections related to the ACA marketplaces, as well as increased work and reporting requirements for certain Medicaid participants and allows enhanced premium tax credits to expire. The law is the largest federal health coverage funding cut in history. The Congressional Budget Office projects that as many as 10 million people in the United States will lose health insurance over the next decade. In addition, some costs of the Medicaid program will be shifted to states, which will place significant financial strain on their budgets and may lead to reduced state funding for FIM innovation and research. Further focus in the coming years on standardization, accreditation and clear reimbursement pathways are key to scaling and sustaining FIM programs.

Collaborations, Implementation and Community Engagement

Successful FIM programs need culturally responsive, patient-centered care, strong stakeholder collaborations and consideration of the experience of those they aim to serve. Challenges include appropriately identifying patients most likely to benefit, sustained patient engagement, data sharing between entities, supporting smooth graduation from programs and ensuring adequate education for clinicians on the role of nutrition in health. Emerging digital platforms and artificial intelligence (AI) may offer better targeting for patient eligibility, while training and collaborative learning networks are important for implementation support.

Priorities for Action

To advance FIM impact and integration, Health Care by Food™ recommends:

- **Research:** Prioritize rigorous, patient-centered research, scalable metrics, economic evaluations, predictive modeling and implementation science to improve targeting and delivery, while aligning outcomes with payer and policymaker priorities to advance sustainable, clinically integrated interventions.
- **Policy and guidelines:** Protect Medicaid access, expand federal and state funding for research and pilot programs, standardize definitions and evidence-based implementation, strengthen evaluation of funded programs, and support stakeholder engagement and certification frameworks to ensure clinically meaningful, scalable and sustainable FIM programs.
- **Collaboration and community engagement:** Co-design culturally relevant programs with practitioners and community members, invest in infrastructure, establish flexible standards that adapt to local needs and foster clinical-community collaborations to ensure scalable, sustainable and personalized FIM delivery.
- **Adoption and implementation:** Invest in organizational capacity, develop actionable toolkits and flexible guidance for patient enrollment and off-ramping, support peer learning and interoperable systems, and establish frameworks for monitoring, continuous improvement and workforce development to enable effective, sustainable and patient-centered FIM delivery.

These efforts will position FIM as an important approach to addressing diet-related chronic disease with the potential to improve health while managing health care costs effectively.

Photo Credit: Hoag Levins, University of Pennsylvania

INTRODUCTION

Food is medicine (FIM) is rapidly gaining momentum as a strategy to improve health outcomes and reduce health care costs by targeting the nutrition components of diet-related chronic diseases and other conditions. FIM refers to the provision of food-based nutrition interventions to prevent, manage or treat specific clinical conditions in coordination with the health care system. The American Heart Association (Association) defines FIM as the provision of healthy food such as medically tailored meals (MTMs), medically tailored groceries (MTGs) and produce prescriptions (PRx) to treat or manage specific clinical conditions in a way that is integrated with and paid for by the health care sector.[2,4] By integrating interventions such as MTMs, MTGs and PRx into clinical care, FIM is reshaping how health systems, payers, communities and collaborators approach chronic disease management and prevention. Of note, FIM is distinct and novel in its approach, complementary to vital food and nutrition assistance programs and population-level healthy food policies and programs (see Figure 1).

The Association's Health Care by Food™ (HCXF) initiative was launched in late 2022 to coordinate scientific research, public policy advocacy and stakeholder education to advance FIM interventions that incorporate healthy food into health care to treat, manage and prevent diet-related diseases. The Association's Presidential Advisory introduced the research agenda for the HCXF initiative, emphasizing the urgent need for a coordinated effort to evaluate the clinical effectiveness and cost-effectiveness of FIM interventions. It highlighted FIM's potential to reduce chronic disease and lower health care costs, noting that 90% of U.S. health care spending is tied to chronic conditions. However, it also pointed out that the field has so far relied mainly on small, observational studies with limited generalizability.[2]

This report reviews advances in FIM in the last year — July 2024 through June 2025 — including a look at new research findings, policy developments and the role of the Association's Health Care by Food™ initiative. It analyzes emerging opportunities and implementation barriers while outlining priorities for scaling sustainable, accessible FIM programs. We focused on the past year to provide the most relevant and timely insights, building on prior reports that have already captured earlier advancements.[1-3]

This report is intended for a broad external audience engaged in FIM efforts, including researchers, policymakers, practitioners, community organizations and other stakeholders working to advance the field.

This analysis will be updated annually by HCXF to track progress and evolving priorities.

Figure 1: A visual of how FIM is distinct but complements other food and nutrition programs and policies.

ADVANCES IN THE FIELD OF FIM

STATE OF THE SCIENCE: THE YEAR IN REVIEW

The Association's September 2023 Presidential Advisory summarized current evidence at the time and provided strategic guidance for advancing FIM research.[2] This science review covers research published between July 1, 2024, and June 30, 2025 (see figures 2, 3 and 4 for the total breakdown of publications in the past year). Given the distinct advantages and challenges of each FIM intervention (PRx, MTG, MTM), findings are grouped and synthesized by intervention type. For specific details on the populations, intervention design and results captured within each study, refer to the Supplemental Materials, Tables 1-4, which offer a detailed overview of each of the studies.

Of note, a 2025 Association Scientific Statement provided a comprehensive systematic review of FIM randomized controlled trials (RCTs) through Aug. 1, 2024, identifying only 14 U.S.-based RCTs focused on noncommunicable disease outcomes.[3] Most were early-stage pilot or feasibility studies and efficacy studies done in research settings, which are important to establish potential intervention design parameters and proof of efficacy to inform larger-scale studies. Some studies showed improvements in diet quality and food security, but few demonstrated statistically significant effects on clinical endpoints such as blood pressure (BP), hemoglobin A1c (HbA1c), hospitalizations or mortality. The heterogeneity in interventions (design, duration and intensity), populations and outcome measures limit cross-study comparisons and generalizability.[3] The below updates expand upon this work, and none of the studies described below were included in the systematic review.

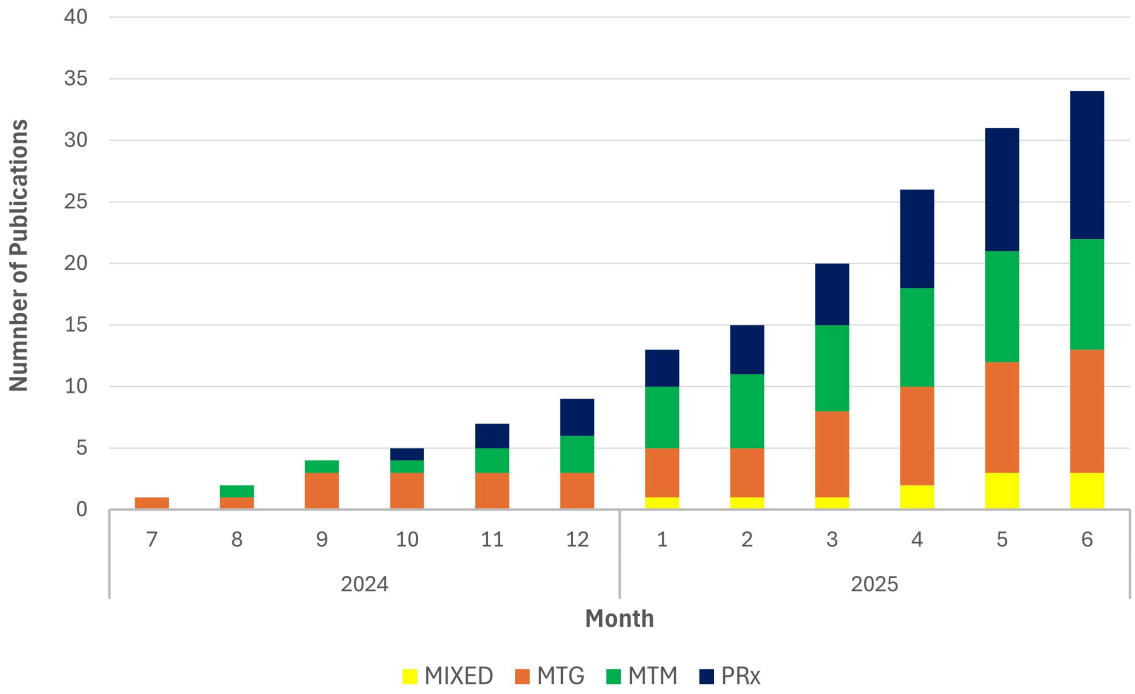


Figure 2. The cumulative number of FIM publications over time, categorized by intervention type: mixed models, MTG, MTM, and PRx from July 2024 to June 2025.

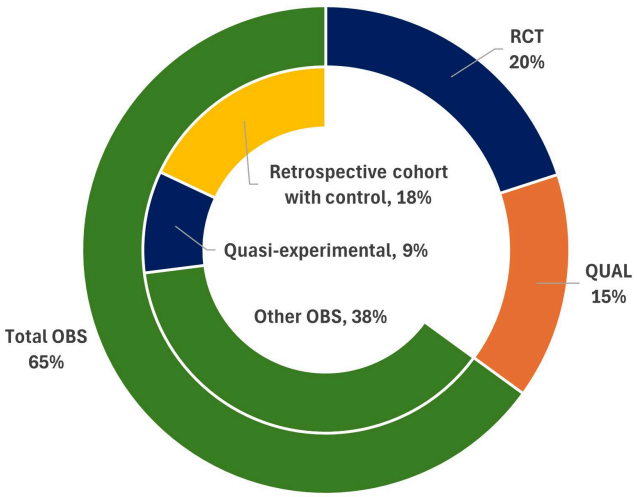


Figure 3. Proportion of study designs among included studies: observational (OBS), RCT, and qualitative (QUAL) designs.

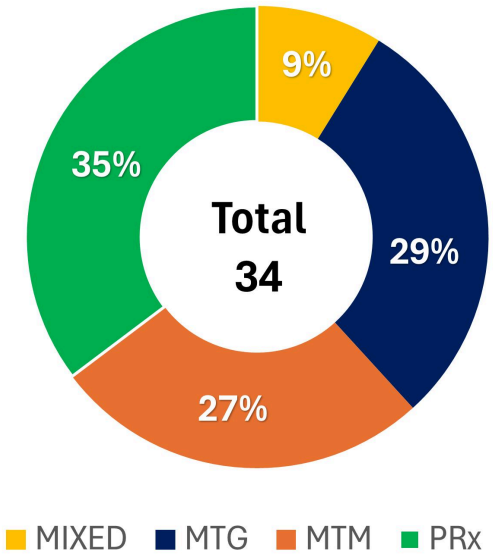


Figure 4. Proportion of included studies categorized by intervention type: MTM, MTG, PRx, and mixed models

The American College of Lifestyle Medicine defines culinary medicine as an evidence-based field that merges nutrition and culinary knowledge with the skills needed to assist patients in maintaining health and preventing and treating food-related diseases by choosing high-quality, healthy food in conjunction with appropriate medical care.[17]

Produce Prescriptions

We synthesized 12 PRx studies, which used a range of methodologies (Supplemental Materials, Table 1). The review included five observational studies (cross-sectional, pre/post or retrospective),[5-9] four qualitative formative studies,[10-13] one mixed-methods study (quantitative surveys and qualitative data),[14] one pilot RCT,[15] and one secondary analysis of a quasi-experimental study.[16]

Study Findings:

- Across these studies, fruit and vegetable intake was increased roughly one-half to one serving of fruit and vegetable intake per day (reported variously as servings/day, cups/day, or times/day),[7,8,14-16] especially when paired with nutrition education, culinary medicine or behavioral support.[8,14-16]
- High program engagement showed significant increases in fruit and vegetable intake frequency (+0.26 cups/day) as well as physical activity (+24.43 min/week) and reduced depression (Patient Health Questionnaire (PHQ) score: - 1.08 points) in participants with both one or more diet-related chronic diseases and food insecurity.[16]
- Some studies showed modest weight-related improvements, including a 2.4% reduction in body weight in a 12-week pilot RCT[15] and a 4.7% reduction in body weight in an 18-month observational study.[5]

- Food security outcomes trended positive, with one study reporting statistically significant increases in participant's household food security status (measured by the USDA 6-item food security survey) after a 16-week intervention and another showing an improvement of 0.8 points in USDA household food security scores (10-item survey) after a 12-week intervention (which was not statistically significant).[14,15]

- Mental health improvements (mainly reduced depression and loneliness as measured by the PHQ-9 survey and UCLA loneliness score) were seen in interventions that included behavioral support[14] or group medical visits.[16]

- In contrast, clinical outcomes such as blood pressure (BP), body mass index (BMI) and HbA1c percentiles were often not assessed or showed no significant changes.[5,15,16] However, one study found significantly greater BP improvements among participants, especially those engaged for over 24 months, suggesting benefits from sustained exposure to FIM interventions.[6]

- Qualitative findings emphasized the importance of cultural relevance,[10,11,13] trusted community organizations and partners[12,13] and flexibility in food delivery methods (e.g., home delivery, local markets).[10-13] Participants valued increased food confidence literacy (which measures meal planning and prepping, shopping, budgeting, nutrition resourcefulness and label reading/consumer awareness),[8] reduced anxiety and worry related to obtaining, affording and preparing food[10] and a greater sense of empowerment.[8,10] Implementers highlighted the need for workflow integration, dedicated staffing and culturally responsive materials.[11]

PRx programs show strong feasibility and high participant satisfaction, with early evidence of positive dietary and psychosocial outcomes. Further rigorous, long-term trials are needed to strengthen the evidence base and inform scalable, sustainable implementation.

Medically Tailored Groceries

We identified 10 studies evaluating MTG interventions, showing consistent improvements in health outcomes and food security across diverse populations (Supplemental Materials, Table 2). Most studies were observational (five were pre/post, two quasi-experimental, one was retrospective)[18-25]; the other two studies were pilot RCTs.[26,27] Studies targeted adults with chronic conditions (e.g., diabetes, hypertension and obesity), children and families experiencing food insecurity.

MTG programs showed adaptability across racial, ethnic and age groups, with culturally tailored interventions especially promising in Hispanic/Latino[23] and Native American[26] communities.

Interventions included three main types of food assistance: hospital-based food pantries,[18,19,21] food vouchers (provided every other week or monthly)[22,26] and home-delivered food boxes (provided weekly or monthly).[20,23-27] Durations ranged from one to 12 months, and interventions were often paired with nutrition education from registered dietitians.

Study Findings:

- Programs co-located in participants' primary place of clinical care showed higher uptake and trust compared to programs located apart from primary place of care.[21]
- Health outcomes varied but generally trended positively. Several studies reported statistically significant reductions in some or all clinical outcomes, including BP, BMI and HbA1c.[20,23,24,27] Others found non-significant changes in clinical outcomes but still noted positive program feasibility.[24,26]
- One study demonstrated a significant reduction in emergency department (ED) visits over the course of the study period,[19] hinting at a potential reduction in health care spending.
- Food security (measured with self-reported food security questionnaires) improvements were notable.[20,25]
- Several studies highlighted the feasibility and acceptability of MTG programs, emphasizing participant satisfaction and the value of cultural adaptations. Others showed the practicality of integrating MTGs with chronic disease management practices.[23,24]

MTG interventions show promise for improving health and food security. Specifically, findings on significant reductions in systolic and diastolic blood pressure among participants with hypertension[18,21,23,27] (though one study found a reduction that did not reach statistical significance[26]) merits more research.

Medically Tailored Meals

Our review of nine studies on MTM interventions shows potential for improving nutritional status, reducing health care use and supporting food insecure populations (Supplemental Materials, Table 3). Both RCTs (four, including two pilot studies) and observational (five, including two prospective cohort, two retrospective cohort, and one quasi-experimental) studies targeted older adults,[28-31] people with chronic conditions (e.g., diabetes, hypertension, heart failure),[28,31-34] and those living in food deserts or with low income.[33,35] MTM interventions included frozen meal deliveries[28,29,31-34] and meal delivery kits,[28,29,31-35] typically paired with nutritional counseling or educational materials. Participants often chose meals from a menu, with some programs allowing customization for health and cultural preferences. Interventions provided 3-21 meals per week (1-2 meals per were most common across 5 studies) and lasted four weeks to six months (most commonly 12 weeks in five studies).

Study Findings:

- Nutritional improvements, measured using either the malnutrition screening tool or the mini nutritional assessment tool, were observed in older adults[30,32] and people with heart failure.[34]
- One study reported significant reductions in ED visits and inpatient hospital stays among adults with food insecurity and chronic disease, with an average health care cost savings of more than $12,000 per participant.[33]
- Several studies showed improved food security.[28,29,35]
- Some studies found no significant changes in clinical metrics such as BMI or HbA1c.[28,32] Though underpowered to perform subgroup analysis, one study found improvements in systolic BP and BMI in a high-risk group.[32]
- Several studies highlighted feasibility and acceptability as primary outcomes[31,35] or in their conclusions,[28,29,36] showing high retention, satisfaction and engagement in MTM programs.
- Challenges such as limited meal variety, lack of freezer space and packaging concerns (ranging from composition of packaging materials, excess packaging waste and packaging that was difficult to open for specific populations) were noted across nearly all studies. One qualitative study of caregivers noted barriers including time constraints and a lack of culturally or child-preferred foods.[36]

MTM interventions show promise for improving nutrition and reducing health care use, especially tailored to individual nutritional needs, integrated with support services and targeted to those with more severe diseases or highest risk. Future research should prioritize large-scale, long-term RCTs to assess sustained nutritional, clinical and economic impacts, while also exploring integration with health care systems and strategies to improve accessibility and engagement.

Mixed FIM Models

Three studies of mixed FIM models, in which participants could choose one of FIM interventions including MTMs, MTGs and PRx, offer growing evidence on health impacts and implementation dynamics (Supplemental Materials, Table 4).

A large retrospective cohort study of more than 22,000 Medicaid beneficiaries in Massachusetts compared participants in Flexible Service Program (offering one or more types of FIM, either MTM, MTG, or PRx, along with supportive services such as housing assistance and nutrition counseling) with eligible nonparticipants. Participation was associated with a 23% reduction in hospitalizations and a 13% reduction in ED visits.

While overall health care cost reductions were not statistically significant over the full study period, significant savings were observed in the post-COVID period (-$1,721 per person), with even greater savings for those who were enrolled more than 90 days (-$2,502). These results suggest sustained FIM engagement may yield cost-effective health improvements.[37]

A quasi-experimental study of more than 13,000 Medicaid beneficiaries in North Carolina evaluated a mixed FIM intervention, including food boxes, PRx, MTM, healthy meals and support services (nutrition education and food and nutrition access case management services). The study observed an initial increase in Medicaid spending at the time of program enrollment (reflecting early implementation and service delivery costs) but found that spending trends declined over time. By month eight, total spending had decreased. The program was ultimately associated with a $85 reduction in total monthly Medicaid spending (both medical and FIM program) per person and six fewer ED visits per 1,000 persons per month, supporting FIM's potential cost-effectiveness. While the number of hospitalization reductions was not statistically significant, the findings align with broader trends of decreased health care utilization and improved cost outcomes (-1 per 1000 person-months, 95% CI, -2 to 0).[38]

Another qualitative study explored FIM program implementation barriers and facilitators.[39]

Four key themes emerged:

1. The importance of strong leadership and collaborative culture.
2. The central role of community collaborations and integrated health education.
3. Logistical and funding challenges to long-term sustainability.
4. The need for ongoing program assessment and evaluation.

Collectively, these studies show that mixed FIM interventions can reduce health care utilization, but their success relies on infrastructure, leadership, sustained funding and rigorous outcome tracking.

Key Takeaways

This year's research added important findings that advance the FIM field. A 2025 systematic review of earlier publications identified 14 RCTs, most in early stages, that consistently demonstrated improvements in diet quality and food security, though impacts on clinical outcomes were inconsistent. This foundational insight remains important context for interpreting emerging studies.

While this year's RCTs remain limited and often early-stage, observational and mixed-methods studies across diverse FIM models consistently show feasibility, acceptability and promising impacts on dietary behaviors, psychosocial well-being and certain clinical parameters. Notably, duration of programs and sustained engagement are associated with incremental improvements in clinical outcomes such as BP and hospital utilization. Furthermore, four studies directly considered health care costs, all of which found significant savings.[33,37-39] Two of these studies reported initially higher costs due primarily to start-up costs.[33,39] To confirm these early findings, large-scale, rigorous, longitudinal trials or quasi-experimental studies are needed, alongside program design optimization, economic evaluation and strategies to ensure equitable access.

Strategies to improve implementation could include culturally tailored interventions, strong leadership, stable funding, stakeholder collaborations and ongoing evaluation to support scalability and sustainability. This growing evidence base helps make the case for integrating FIM into routine, systems-wide clinical practices and policies to address diet-related chronic diseases and health disparities.

POLICY AND GUIDELINES

The policy landscape for FIM is gaining momentum, with national conversations highlighting nutrition's role in addressing chronic disease and health inequities. Over the past year, the increasing national attention on FIM has elevated the potential of integrating FIM into health care.

This section outlines key developments, emerging opportunities and the evolving policy infrastructure positioned to support healthy food as a recognized, reimbursable part of patient care.

This report is current as of August 15th, 2025 and reflects our best possible analysis at the time, given the rapidly evolving policy landscape.

FIM at the National Level

Despite uncertainties for FIM in the new political landscape, the Trump administration continues to spotlight the role of diet in chronic disease and health care.[40,41] **FIM remains a promising area with bipartisan support and potential alignment with the Trump administration's priorities.**

On July 4, 2025, President Trump signed the One Big Beautiful Bill (OBBB) Act—a partial repeal of the Affordable Care Act (ACA) and the largest federal health coverage funding cut in history. The nonpartisan Congressional Budget Office projects up to 10 million individuals will lose health insurance over the next decade,[42] placing significant financial strain on states and potentially limiting their capacity to invest in FIM research and innovation. Additionally, changes in federal guidance on Medicaid's role in addressing individuals' health-related social needs have caused uncertainty about the future of FIM pilot programs.

Funding Opportunities for FIM Research and Implementation

Federal support for FIM includes funding opportunities for research. While bipartisan congressional backing remains, it is unclear how the Trump administration will approach future funding efforts.

Priorities for federal funding include:

- FIM research funded by the National Institutes of Health (NIH) nationwide
- A FIM initiative at the U.S. Department of Health and Human Services (HHS)
- Expansion of produce prescription pilots at the U.S. Department of Veterans Affairs and the Indian Health Service

Despite growing federal attention to the link between poor diets and chronic disease, FIM research remains severely underfunded at the NIH, which had a total research budget of $46.88B in fiscal year (FY) 2023.[44] The underinvestment in FIM reflects a disconnect between NIH funding priorities and the national burden of diet-related disease. The FY26 NIH budget identifies the proposed FIM Centers of Excellence — approved in concept in 2023 but still unfunded — as a way to bridge nutrition support and clinical practice.[45] Note, the Senate recently provided report language encouraging NIH to establish these Centers of Excellence in its FY26 Labor, Health and Human Services, and Education appropriations bill.[46] At the time of this writing, the Senate has not passed nor has the House released its companion FY26 bill. While early research shows FIM's strong potential, significantly more investment is needed to identify the most effective, cost-efficient strategies to improve health for various patient populations.

Since its launch in FY24, the HHS FIM initiative has supported researchers, practitioners and stakeholders by publishing an online knowledge hub, coordinating federal FIM programs across agencies, and building collaborations with community and national leaders. Although the Trump administration's FY26 budget cites the FIM initiative as an Office of Disease Prevention and Health Promotion accomplishment, it does not propose specific funding to continue it.[43]

The proposed reorganization and consolidation of various agencies and offices within HHS into the newly created Administration for a Healthy America, which requires congressional approval, includes $119 million for a new Prevention Innovation Program, with a track focused on chronic conditions.[43] This includes promoting access to healthy foods and implementing nutrition-focused programs with community partners, offering another potential FIM funding opportunity.

Status of the Trump administration's Make America Healthy Again (MAHA) efforts

On Capitol Hill, the congressional MAHA Caucus has identified FIM as a top priority. Key champions include Senator Roger Marshall (R-KS), Chair of the Senate MAHA Caucus and member of the Senate Finance Committee, the Health, Education, Labor, and Pensions Committee and the Agriculture Committee, and Representatives Vern Buchanan (R-FL) and Lloyd Smucker (R-PA), members of the House MAHA Caucus and House Ways and Means Committee, who view FIM as an innovative approach to treating diet-related chronic diseases.

Released on May 22, 2025, the first of two MAHA commission reports outlines HHS Secretary Robert F. Kennedy Jr.'s views on the root causes of rising children's health issues, including diet-related disease, neurodevelopmental and autoimmune disorders, mental health conditions and allergies, largely attributed to ultra-processed foods, environmental toxins and sedentary lifestyles. FIM is not directly addressed.[47] The report cites barriers such as food and beverage industry influence, certain regulations and the inclusion of ultra-processed foods in programs such as Supplemental Nutrition Assistance Program (SNAP) and school meals.[47]

MAHA commission report recommendations include:

- Funding independent studies evaluating the health impact of self-affirmed "generally recognized as safe" or GRAS food ingredients.
- Funding long-term NIH nutrition trials comparing ultra-processed foods and whole foods in children.
- Launching a large-scale lifestyle medicine initiative.

A second report, expected in September 2025, will focus on policy and likely expand on these recommendations.

Status of FIM under Medicare

Medicare does not currently cover FIM, but Medicare Advantage (MA) plans may voluntarily offer food benefits not included in traditional Medicare via general supplemental benefits or Special Supplemental Benefits for the Chronically Ill (SSBCI). In 2025, food benefits were the most popular additional offering among MA plans for SSBCI.[48] However, these benefits reportedly are typically not provided as a FIM intervention; rather, they were largely cash assistance for groceries (i.e.,debit cards similar to SNAP electronic benefit transfer [EBT]

cards) that varied based on what could be purchased, the value of the debit card and duration (e.g., three months to a year). It is unclear if these benefits improved health or food security or were largely used by plans to recruit and retain members.

Opportunities To Improve Transparency, Implementation And Evaluation Of MA Benefits

These recommendations taken together could increase the uptake of FIM offerings by MA plans while helping beneficiaries receive evidence-based FIM benefits.

Clarify that defined FIM interventions meet the criteria for "primarily health related" to be offered as general supplemental benefits.	Specify defined FIM services may be exempt from the SSBCI bibliography requirement, given established research on their impact.
Increase transparency about food benefit debit card administration for MA participants.	Improve encounter data (utilization rates) for FIM in MA plans, including what type of FIM intervention was the food benefit (e.g., PRx, MTM or MTG), the dose and duration and for MTGs, which food types were purchased (via EBT cards).

Value-Based Insurance Design Model (VBID):

Center for Medicare and Medicaid Innovation (CMMI)'s VBID model provided an additional pathway for plans to offer FIM as part of supplemental benefits. VBID enabled high-risk enrollees to access high-value, evidence-based benefits, including FIM, alongside other flexibilities. However, the model's rollout during the height of COVID and other factors limited its success. RAND's evaluation of VBID's first three years found no link to improved health outcomes and noted increased costs (though these findings apply to the overall model, not food benefits specifically).[49] This model will be discontinued at the end of 2025, meaning MA must use other pathways to offer FIM or await a new CMMI model.

Photo Credit: Hoag Levins, University of Pennsylvania

CMMI:

CMMI has shared a vision for developing Medicaid and Medicare models that includes:

> "functional and lifestyle medicine interventions to promote physical activity and good nutrition, addressing cardiovascular risk .... model tests may include options for working directly with people as well as with community-based organizations (CBOs) to resolve nutrition needs, provide disease management counseling and lifestyle education and services (e.g., exercise and nutrition support) or offer access to evidence-based alternative medicine. Additionally, models will test recipient engagement incentives tied to health promotion and prevention, such as sustained lifestyle changes that measurably improve health status and outcomes." [50]

It is worth exploring how CMMI could integrate FIM into an existing model, establish a new model or encourage testing of FIM in other ways.

Centers for Medicare & Medicaid Services (CMS):

In the spring and summer of 2025, CMS proposed to remove metrics related to screening for social drivers of health (including food insecurity) from quality reporting metrics for hospitals and other settings in the Medicare program. However, it has also requested feedback on potential metrics that could be added related to nutrition and well-being.[51] As the field evolves, some researchers and FIM practitioners are exploring nutrition insecurity screening as a way to identify patients who may benefit most from tailored interventions. **A well-designed, validated nutrition security screening tool, paired with implementation incentives such as quality reporting metrics, could help health care professionals target higher-need populations and connect patients to both clinical nutrition interventions and broader community or hospital-based food programs.**

Medically Tailored Home-Delivered Meals Demonstration Pilot Act (proposed legislation, has not been enacted into law):

The bipartisan Medically Tailored Home-Delivered Meals Demonstration Pilot Act (not yet reintroduced this congressional session) was passed out of the House Ways and Means Committee last year under Rep. Vern Buchanan's (R-FL) leadership. The bill would authorize a four-year demonstration program in Medicare Part A, allowing hospitals to provide medically tailored, home-delivered meals and nutrition therapy to beneficiaries with diet-impacted conditions (e.g., kidney disease) post-discharge.

FIM Innovation in Medicaid

States have played a key role in advancing FIM innovation through Medicaid. Although federal law does not explicitly authorize the direct provision of food in Medicaid (except in limited cases), CMS has encouraged states to use available flexibilities to integrate time-limited, medically appropriate nutrition services into health care delivery and financing.

Medicaid Policy Pathways Supporting FIM: **An increasing number of state Medicaid programs are implementing FIM interventions using a variety of policy pathways, including:**	
Section 1115 Demonstration Waivers: Advance experimental, pilot or demonstration projects that further the objectives of the Medicaid program	• Requires independent evaluations at the midpoint and end of each five-year waiver period to assess impact and effectiveness. Evaluation plans must be CMS-approved and include qualitative and quantitative methods, privacy protections, data collection strategies and approaches to address confounding variables. • Grants states the flexibility to expand eligibility, test new delivery models and include non-traditional services such as FIM in Medicaid benefits. • Enables states to access federal funding for infrastructure development.
In Lieu of Services (ILOS) Authority: Allows Medicaid managed care plans to offer medically appropriate and cost-effective alternatives to state Medicaid benefits	• Approved without time limits and minimal evaluation requirements. • Allows states to authorize Medicaid Managed Care Organizations (MCOs) to offer cost-effective, medically appropriate alternatives to traditional services, such as MTMs and other nutrition support services. • Offers flexibility and scalability, but lacks infrastructure funding, does not require MCO participation and has fewer evaluation requirements than 1115 waivers.
Home and Community-Based Services Authorities: Allows states to provide additional supports to keep eligible beneficiaries in their home or community, rather than institutional settings	• Approved in two-, three- or five-year increments with evaluation requirements. • Allows states to provide nutrition supports for individuals with complex needs. • Several HCBS waivers exist: 1915(c) Home and Community-Based Waivers, 1915(i) State Plan Home and Community-Based Services, 1915(j) Self-Directed Personal Assistance Services Under State Plan and 1915(k) Community First Choice. The 1915(c) and 1915(i) waivers are most commonly used to provide food and nutrition services to Medicaid beneficiaries.

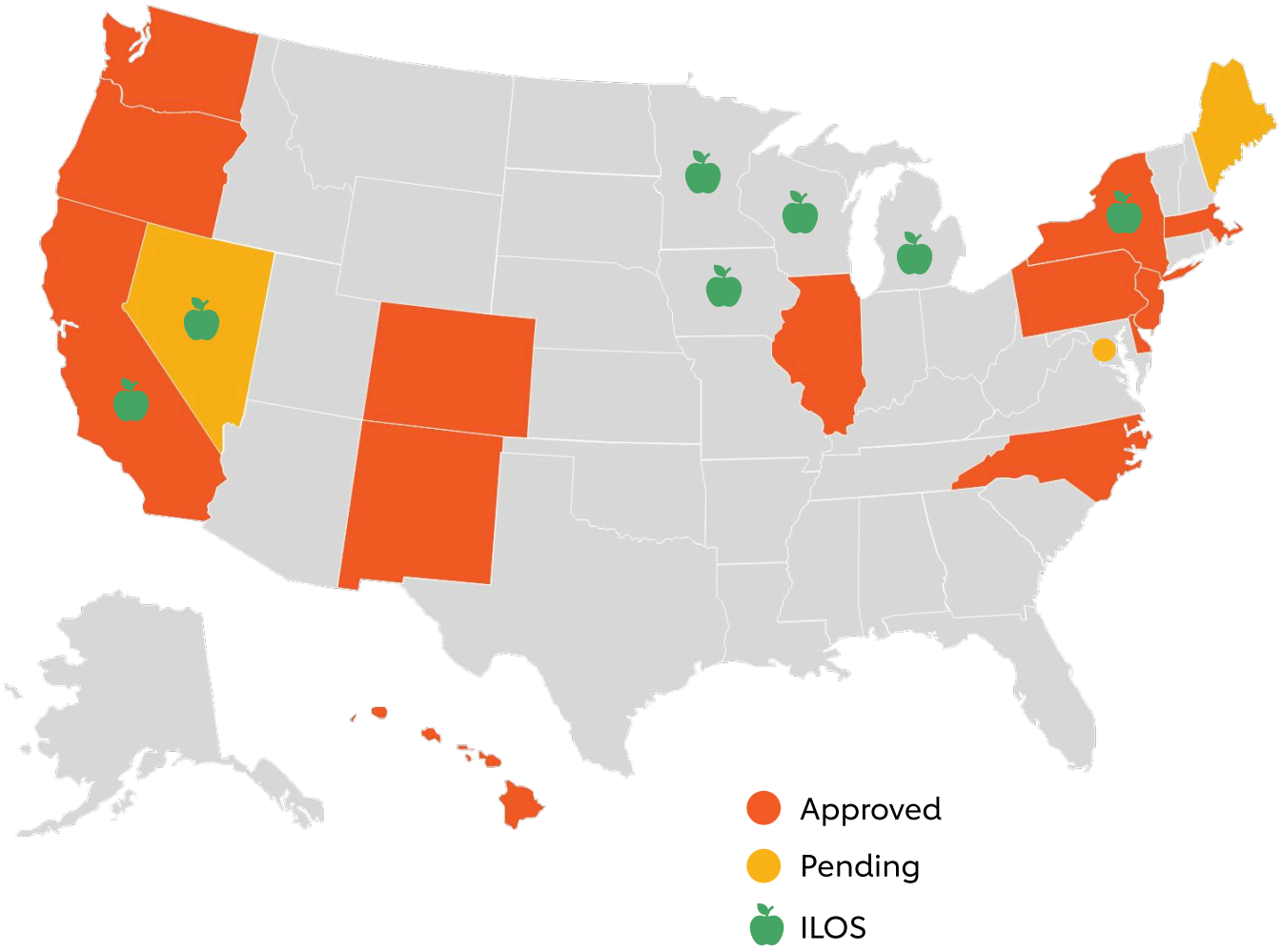
Most of the state-based FIM innovation to date has occurred through 1115 waivers. **As of June 2025,** 13 states have approved 1115 waivers that include FIM interventions: California, Colorado, Delaware, Hawaii, Illinois, Massachusetts, New Jersey, New Mexico, New York, North Carolina, Oregon, Pennsylvania and Washington.

Two additional states, Nevada and Maine, and the District of Columbia have pending applications awaiting CMS approval.

In addition, seven states are currently using ILOS authority to deliver FIM services such as MTM, MTG and PRx:

California, Iowa, Michigan, Minnesota, Nevada, New York, and Wisconsin

Notably, it remains to be seen what impact the OBBB Act will have on Medicaid and FIM programs at the state level, making this a key area for stakeholders to watch closely.



Only states with services that align with the American Heart Association's FIM definition have been highlighted.

Emerging Insights from State Medicaid FIM Programs

Early evaluations from state Medicaid FIM programs suggest the potential to improve health outcomes and reduce costs. Massachusetts and North Carolina, early adopters of FIM through 1115 waivers, have reported initial trends in reducing ED use and overall spending. However, evaluations of 1115 waiver pilot programs have limitations. **Results vary by population, implementation strategy and program duration, and often do not isolate FIM effects from other social services delivered under the same waiver.** In addition, evaluations typically occur after a substantial time delay at the midpoint and conclusion of the five-year waiver period and typically evaluate uniform program deployment, meaning there is little or no opportunity for rapid cycle learning and testing on a small scale before broader deployment.

As a result, impacts from the FIM components of state Medicaid 1115 waivers need further elucidation. More targeted evaluations are needed to identify which FIM strategies are most effective and cost-effective for specific populations. This evidence is essential for guiding future policy and securing sustained support from state Medicaid agencies, CMS and other decisionmakers.

Population

In Massachusetts, reduced health care spending was observed among adults, but no significant cost impact was found for children.[52]

Implementation

In Massachusetts, Accountable Care Organizations collaborate directly with FIM providers. In North Carolina, Network Leads link MCOs and FIM providers to coordinate referrals and billing.

Duration

In Massachusetts, adults enrolled for more than 90 days saw significant health care cost reductions.[37] In North Carolina, enrollees had lower monthly health care spending than the comparison group after eight months.[38]

The American Heart Association's Health Care By Food Initiative

Since its launch in September 2023, HCXF has grown and contributed to the expanding FIM movement.

Seeding the Science: Building an Evidence Base for Futured Covered Benefits

$11.3M in Strategic FIM Research:

- Funded 23 early-stage studies that examined enrollment, engagement and short-term behavior change, along with two secondary analyses that respectively examined implementation characteristics in GusNIP programs and analyses of the literature base, as of June 30, 2025.
- Launched 12 planning grants in July 2025 to researchers to support development of competitive, rigorous research proposals, laying the groundwork for benefit-defining studies to drive policy change.

Learning Together, Leading Forward: Powering the Future of FIM

- Developed publicly available common data measures to standardize outcome tracking and improve comparability across studies, an essential step to strengthening FIM research.
- Provide practical tools and resources through the HCXF Knowledge Hub, including publications, and tools developed from HCXF task forces. These resources include recordings from Behavioral Science and Human-Centered Design Task Forces' webinars, all designed to help align and strategically advance the field.

Advancing Innovation in Medicaid

- Launched a technical assistance program for state Medicaid agencies to help design and evaluate FIM programs. Through a memorandum of understanding with HHS, HCXF offers tailored, science-based support for states providing FIM through 1115 waivers and ILOS authority. HCXF's multi-level, multi-state approach enables rapid sharing of tools, insights and resources, reducing duplicative efforts, and accelerating development of effective, evidence-informed programs.

Building the Movement: Catalyzing Collaborations to Advance FIM

- Gathered more than 100 national researchers in April 2024 to establish evidence priorities
- Brought together more than 100 cross-sectors leaders in October 2024 to address system changes needed for scalable FIM programs.

EVOLVING LANDSCAPE

As the FIM field grows, new research, policies and implementation models are reshaping how nutrition is integrated into health care. This section provides a snapshot of the current landscape organized across four key areas: **research, policy and guidelines, collaborations and community engagement,** and **adoption and implementation support.** Each highlights emerging opportunities to accelerate impact and key challenges to address scalable, equitable and clinically meaningful programs. These insights lay a roadmap for advancing FIM from promising innovation to standard of care.

Research

A rigorous evidence base is critical for guiding clinical practice, informing program design and policy-shaping reimbursement pathways, and demonstrating FIM's health and economic value.

Emerging Opportunities

- **Strengthening the evaluation and evidence base:**
  Growing national interest in FIM is fueling demand for more rigorous study methodologies, standardized metrics for data collection, robust evaluations and better data-sharing. As research on health and cost impacts grows, so does the case for sustained investment. To support future coverage, aligning outcomes with public and private payer priorities will be key to validating, comparing and scaling effective models. In turn, open dialogue with payers about the priorities and measurements that matter most can help ensure clarity on the factors that inform coverage decisions.

- **Recognition of long-term engagement:**
  Early findings from states such as Massachusetts and North Carolina link longer FIM participation with better health outcomes and reduced ED use.

- **Federal funding pathways:**
  Potential new funding for FIM research could come from the proposed NIH FIM Centers of Excellence, the proposed Administration for Healthy America's Prevention Innovation Program, the NIH Office of the Director or continued bipartisan appropriations. FIM continues to receive strong bipartisan support in Congress and may also align with priorities of the Trump administration.

- **Clinical application across diverse conditions:**
  FIM interventions have strong potential to benefit specific populations, including people with cardiovascular-kidney-metabolic conditions and heart failure, as well as to support efforts in brain health, including cognitive decline, stroke and related neurological conditions. FIM may also complement patient use of GLP-1 therapies by reinforcing healthy eating patterns and supporting sustained behavior change for long-term health outcomes.[53]

- **Expansion in pediatric and maternal health:**
  Medicaid's central role in maternal and child health creates an opportunity to integrate FIM interventions during developmental life stages, while also highlighting the need for more research on these populations and the long-term impacts of early nutrition interventions.

Key Challenges

- **Changes in the research environment:**
  Uncertainty about future research funding, including potential shifts in NIH support, may influence the pace and scope of FIM-related studies and the ability to build a strong evidence base for policy and payer engagement.
- **Variability across programs:**
  Differences in target populations, intervention design and implementation, evaluation requirements in pilot programs, and research methods used across publicly, privately and philanthropically funded initiatives pose challenges for comparing data and synthesizing findings across studies and initiatives.
- **Limited and early-stage evidence base:**
  Despite growing interest and increased funding, most published FIM studies are still small, short-term and inconclusive, making it difficult to compare results, conduct meta-analyses, assess clinical impact or generalize findings.
- **Evidence gaps and unanswered questions:**
  Key questions remain about the best practices in intervention design (such as the duration of program needed for clinical effects), clinical effectiveness, cost-effectiveness and long-term impacts of FIM interventions across diverse populations and settings. Closing these gaps will require rigorous, scalable studies that test implementation models and strengthen the evidence base for practical action.

Policy and Guidelines

This section highlights the development and dissemination of policies and clinical guidelines that support integrating FIM into health care. Advancing federal, state and payer policies is essential for reimbursement, consistency and long-term sustainability.

Emerging Opportunities

- **Focus on policy and systems change:**
  Advocates and stakeholders are working to embed FIM into health care systems and policy by advancing Medicaid waivers, strengthening clinical guidelines to ensure medically appropriate use, improving MA transparency and data, and exploring reimbursement pathways for food-based interventions.
- **Innovation in Medicaid:**
  States and health plans are exploring innovative financing models, such as Medicaid Section 1115 and 1915 waivers, ILOS authority and public-private partnerships to support FIM efforts.

- **Cross-sector collaboration and innovative financing:**
  Cross-sector partnerships are growing as health care systems, community organizations, food retailers and public agencies collaborate to support sustainable program implementation.[54] However, many of these partnerships remain small in scale, and further work is needed to understand how best to support their expansion and long-term impact.
- **Accreditation of FIM providers:**
  Ensuring that providers meet established quality and safety standards gives health care systems and payers confidence that programs will be managed appropriately for the needs of their FIM programs. It builds trust, streamlines contracting and supports scalable, sustainable adoption across diverse care settings.
- **Employer and insurer support:**
  Employers and commercial insurers are adopting FIM as part of chronic disease management strategies.
- **Federal-level attention:**
  The growing national attention about the role of nutrition in addressing chronic disease is promising for FIM. Yet it remains unclear how policymakers will prioritize FIM research and funding.
- **Medicare innovation:**
  Food benefits are the most popular SSBCI benefit among MA plans. While Medicare holds strong potential for FIM innovation, greater transparency, data collection and pilot testing are needed to understand which interventions are being delivered, their health impacts and cost-effectiveness. CMMI's proposal to include "lifestyle medicine" and community-based nutrition services may create a pathway for integrating FIM into new Medicare payment models.

Photo Credit: Michael Monti

Key Challenges

- **Uncertain federal policy environment:**
  Congress passed and President Trump signed the OBBB Act into law, a partial repeal of the ACA and the largest federal health coverage funding cut in history. It remains unclear what impact this will have on FIM, in addition to the uncertainty around federal funding for medical research and a potentially austere funding environment.

- **Sustainable financing and incentives:** Many FIM programs depend on grants or short-term pilots, limiting long-term sustainability. Uncertainty remains about who should pay for FIM and under what conditions. Ongoing work across all stakeholders is needed to engage public and private payers.
- **Limitations to Medicaid pathway evaluations:** Current 1115 waiver evaluations bundle FIM with other social services, making it difficult to isolate FIM's impact. Early evaluations also fail to distinguish between different FIM types (e.g., grouping food boxes with MTMs), making evaluation of individual FIM components difficult. Furthermore, ILOS authorities include minimal evaluation requirements.
- **Fragmented standards and definitions:** The field lacks consistent definitions and standards, with wide variation in dose, duration, nutritional quality and complementary services. This limits outcome comparisons, cost-effectiveness evaluations, scalability and policy adoption. Defining best practices for program design, including nutritional standards, appropriate "doses" (e.g., meals per week, program duration) and wraparound services such as nutrition counseling is integral to enhance consistency, support evaluation and improve integration into clinical care. All these components are critical for demonstrating value and securing sustainable reimbursement.

Community Engagement and Collaborations

Strong infrastructure, collaborations and operations are key to scaling programs and keeping them patient-centered and locally responsive.

Emerging Opportunities

- **Collaborative networks and collaborations:** Cross-state learning collaboratives — for example, the Medicaid Health-Related Social Needs Implementation Learning Series led by the Center for Health Care Strategies[56] — coalitions and field-building networks are advancing shared knowledge, advocacy and program design support. Meanwhile, cross-sector collaborations with health care, food systems and agriculture can support local sourcing and sustainability, but thus far have remained small in scale.[57,58]
- **Addressing household-level nutrition:** Programs are beginning to explore interventions that reflect real-world eating patterns by supporting not just individuals, but their households. This includes rethinking both food provision and the way nutrition supports are delivered. Emerging tools, including AI, offer promising avenues to analyze household-level data, tailor interventions and assess impact more efficiently.

- **Personalization of health care:**
  Programs are increasingly tailoring meals and interventions to match individual dietary needs, cultural preferences and health conditions, leading to greater satisfaction, adherence, clinical outcomes and equitable health.
- **Scaling through CBO and federally qualified health center (FQHC) collaborations:**
  CBOs and FQHCs play a critical role in delivering FIM interventions, given their trusted relationships, cultural knowledge and local infrastructure. Strengthening collaborations with these organizations can enhance reach and long-term sustainability of implementation efforts.
- **Rising public awareness and demand:**
  Growing recognition of food insecurity's health impacts, increasing interest in the relationship between food and health and public interest in preventive care have created a supportive climate for expanding FIM access and visibility.[55]
- **Regional approaches to food sourcing:**
  Strengthening local and regional food systems can support scalable FIM implementation by improving sourcing, distribution and coordination. Investing in regional capacity helps ensure programs are responsive to community needs and sustainable over time.

Key Challenges

- **Patient barriers and engagement challenges:**
  Unlike medications, FIM interventions are shaped by personal preferences, behaviors, household dynamics and cultural norms. Stigma, low food literacy and logistical barriers can limit engagement, requiring programs to address challenges more akin to consumer behavior than clinical care.
- **Funding for infrastructure:**
  Implementing FIM programs at scale often requires upfront investment in infrastructure. Availability of funds, such as those allowed under section 1115 demonstration waivers, can be critical for capacity building and helping practitioners cover costs for new technologies, workflows, staffing and other resources needed to participate effectively in health care partnerships.
- **Addressing differential impacts across populations:**
  Without intentional design, FIM programs risk worsening existing disparities or overlooking underrepresented populations. A lack of inclusive language and outcome measures can also hinder efforts to evaluate differences in access and results.

Adoption and Implementation Support

This section highlights the support systems that enable successful FIM adoption and implementation. Tools, training, technical assistance and robust evaluation frameworks are key to ensuring quality, scalability and ongoing improvement.

Emerging Opportunities

- **Digital platforms:**
  Digital tools such as mobile apps, telehealth and benefit platforms are expanding access to FIM by delivering nutrition education, tracking benefit use and boosting engagement through reminders and goal setting.
- **Data advancements:**
  Advances in data systems offer new opportunities for targeting, automation and evaluation. Predictive analytics can identify patients most likely to benefit, improving impact and cost-effectiveness.
- **Coding efforts:**
  Efforts such as Coding4Food[59] aim to establish standardized billing codes for FIM, an essential step for consistent reimbursement, better data capture and smoother integration into health care delivery and financing.
- **Leveraging AI:**
  AI is emerging as a powerful tool in FIM, supporting predictive analytics, electronic medical record (EMR) integration and operational tasks such as eligibility checks, referrals and outcome tracking. It can also synthesize unstructured data, such as clinical notes and metrics of social drivers of health, to improve program targeting and design. In some cases, it has even been used as part of the intervention, such as through the creation of culturally appropriate menus that align with dietary standards. Additional use cases are likely to emerge.

Key Challenges

- **Workforce limitations:**
  There is a shortage of nutrition professionals, care navigators and community health workers who are essential to FIM delivery. CBOs also face sustainability challenges, especially in low-resource settings.
- **Data sharing and privacy barriers:**
  Fragmented data systems, proprietary platforms and privacy rules hinder integration across health care, food providers and CBOs. Many insurers who pilot FIM are not evaluating or sharing outcomes, limiting transparency and shared learning.

- **Need for clearer alignment between payers and implementers:**
  The lack of clear communication and alignment between insurers/payers and program implementers/researchers regarding the primary goals of these interventions and what is needed for coverage decisions creates tension in program design, evaluation priorities and messaging, and can slow the scaling of effective models. Strengthening dialogue and setting shared expectations will be critical to advancement.

- **Prescribing, onboarding and off-ramping challenges:**
  Clear guidance is lacking on how to prescribe, onboard and off-ramp patients in FIM programs. Expanding FIM initiation to frontline staff such as community health workers offers promise but requires new protocols and infrastructure.

- **Scalability and operational complexity:**
  Scaling FIM programs requires coordination across decentralized providers, vendors and systems. Delivering high-quality, personalized services while building strong infrastructure is challenging. Providers face administrative burdens, from billing and outcome tracking to logistics, that require significant tech and staffing resources.

- **Limited nutrition training for clinicians:**
  Most clinicians receive little training in nutrition counseling or food security screening, which hinders their ability to support FIM. Expanding training and clinical guidelines is essential for system-wide competency. Although more medical and allied health programs are beginning to include nutrition science and FIM, long-term integration will require sustained effort to build provider awareness and skills.

PRIORITIES FOR ACTION

As in the previous section, these priorities are organized across four key areas: research; policy and guidelines; community engagement and collaborations; and adoption and implementation support. They represent a strategic response to on-the-ground challenges, and are informed by real-world experience, stakeholder input and emerging opportunities identified over the past year. Together, they provide a comprehensive roadmap for accelerating progress through collaboration, innovation and practical action over the coming year.

Research

- Accelerate FIM impact by prioritizing rigorous, patient-centered research, aligning outcomes with policymaker and payer priorities, and using implementation science to improve delivery and sustainability. Strengthening both relevance and rigor is key to long-term investment, coverage and clinical integration.
- Invest in scalable, clinically relevant metrics to measure changes in diet quality and nutritional status, enabling more consistent evaluation of FIM interventions and their health impacts.
- Design economic evaluations to meet policymaker and insurer needs, generating data that informs policy, payment and program sustainability decisions.
- Use AI and machine learning to create prediction models that increase enrollment of those most likely to benefit from FIM interventions.

Considerations to Increase Rigor and Relevance of FIM Research

- Conduct longer-duration, larger-scale and more methodologically rigorous studies.
- Collect and analyze economic data to support policy translation and payment models.
- Identify populations most likely to benefit from specific FIM interventions, and prioritize research in high-priority populations (e.g., adults with heart failure, high-risk pregnancies, cardio-kidney-metabolic disease and/or children)
- Determine optimal intervention composition (dose, frequency, duration and intensity), including mode of delivery (e.g., home delivery or retail pickup) and whether food is provided at the household or individual level, to achieve meaningful outcomes.
- When feasible, incorporate subgroup analyses to tailor FIM by chronic condition, socioeconomic status and food access barriers.
- Apply research insights from the field of behavioral science to design interventions that support lasting behavior change.
- Use learnings from the field of implementation science to design programs that can be scaled interventions within health care systems.
- Improve data quality through standardized outcome measures, validated tools and robust evaluation designs.
- Integrate participant preferences, cultural relevance, experiences and values into FIM design to boost usability, satisfaction and uptake.
- Invest in longitudinal studies to assess sustained impacts on health outcomes and cost-effectiveness.

- Strengthen FIM evaluation capacity by creating accessible frameworks for CBOs, supporting design and testing of pilots in collaboration with state Medicaid, and facilitating outcome and economic evaluations for MA FIM initiatives.

Policy and Guidelines

- Protect Medicaid funding and access at the federal and state levels.
- Advance FIM research and innovation by: funding FIM focused research, supporting increasing federal funding for NIH FIM research, supporting FIM pilots through Medicaid pathways, supporting federal FIM pilots through appropriations and legislation and offering technical assistance to states on program design and evaluation. Use robust, standardized data collection and evaluation methods to generate actionable insights for policy and coverage decisions.
- Adopt a definition of FIM that is uniform and evidence-based, and is distinct from, yet complementary to, food and nutrition assistance programs and population-level healthy food policies and programs.[4]
- Expand data collection, transparency and evidence-based implementation of FIM benefits in MA.
- Cultivate, convene and engage stakeholders in advocacy campaigns.
- Convene stakeholders to define evidence-informed baseline standards for MTMs, MTGs and PRxs that ensure FIM programs are clinically meaningful, scalable and equitable.
- Support certification frameworks to help payers, providers and policymakers identify effective, well-resourced FIM programs.

Photo Credit: Hoag Levins, University of Pennsylvania

Collaborations and Community Engagement

- Involve community members and organizations and collaborating practitioners in co-design, implementation and evaluation to ensure FIM interventions are culturally relevant, accessible and aligned with population needs.
- Develop funding, training and technical support pathways to help practitioners build the logistics, staffing and data capacity needed to deliver FIM services and meet reimbursement requirements.
- Create flexible implementation standards that maintain program fidelity while adapting to local context and community needs.
- Strengthen clinical-community collaborations and cross-program learning collaboratives to support bi-directional, trust-based dialogue among stakeholders.
- Build pipelines and training programs for community health workers, nutrition professionals and logistical support staff to enable FIM scalability and sustainability.

Adoption Support

- To strengthen FIM organizations, funders and policymakers should support upfront investments for practitioners. Resources should help cover costs for technologies, workflows and staffing, building capacity for sustained engagement with health care systems.
- Develop and promote clear frameworks to monitor fidelity, effectiveness and participant experience, ensuring program consistency and enabling continuous learning and quality improvement.
- Facilitate peer learning and knowledge exchanges through national and regional collaboratives, learning networks and communities of practice to foster innovation and reduce duplication.

- Build and expand a national training ecosystem that equips clinicians, program staff and implementation collaborators with the skills, tools and contextual understanding needed to deliver effective FIM services, while recognizing each group's role in shaping the patient experience and reaching those who need it most.
- Develop clear and flexible guidance for identifying and enrolling patients in FIM programs and thoughtfully transitioning them off programs, ensuring seamless participation and sustained impact.
- Ensure findings from research, policy and community efforts are translated into toolkits with actionable and flexible best practices for operations, intervention design, staffing and workflow integration.
- Foster dialogue between clinical and implementation collaborators and stakeholders to develop interoperable platforms for referrals, service tracking and outcome measurement that promote shared accountability and reflect the needs of both patients and collaborators.

Turning Momentum Into Impact

FIM is at a pivotal point: momentum is building across research, policy and practice, creating significant potential to advance the field, even as the path forward involves complexities and uncertainties. The evidence base is strengthening, though key questions remain and more rigorous research is needed. The policy landscape continues to evolve in ways that may support or challenge progress, and successful implementation will require coordinated efforts across diverse stakeholder groups. This is a moment to build on the gains to date, with focused attention on priorities that can turn potential into lasting impact. This report will be updated by HCXF annually to track progress, highlight new evidence and capture emerging opportunities shaping the future of the field.

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