CASE STUDY

Fairview’s 5 tactics for scaling ‘Food is Medicine’

Most health systems can identify food insecurity. Few can solve it at scale. See how Fairview's decade-long co-design approach created a sustainable Food is Medicine model that strengthened equity, access, and outcomes.

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Audience:

- Hospitals and health systems
- Health plans

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Overview

The challenge

Food insecurity is a foundational driver of health inequity,[1] affecting access to care and driving chronic conditions like cardiovascular disease,[2] asthma, and diabetes.[3] Within the Minneapolis-St. Paul metro area, food insecurity rates have been rising, reaching 10% in Hennepin[4] county and 12% in Ramsey[5] county by 2023.

For healthcare organizations, food insecurity impacts health outcomes and clinical needs. Rising food insecurity exacerbates chronic illness rates,[6,7] particularly diet-sensitive conditions where nutrition is a core component of care plans (e.g., cardiovascular disease, diabetes, and maternal health). This in turn increases demand on clinical capacity and undermines efforts to manage total cost of care.

Historically, food insecurity has largely been addressed through community benefit, philanthropy, or grant-funded programs instead of being embedded in core care delivery. Although many organizations include food insecurity as part of screenings for social drivers of health (SDOH), they do not always have a reliable care-aligned way to address patients' food needs. Oftentimes, clinicians recommend dietary changes but lack pathways that align to patient access, affordability, and cultural context.

Connecting food-insecure patients to food assistance is critical to improving population health, managing total cost of care, and improving outcomes. However, while many health systems screen patients for SDOH, including food insecurity, few have developed consistent, clinically aligned, and scalable strategies to connect patients with meaningful nutrition support.

The organization

Fairview Health Services is a Minneapolis-based nonprofit health system serving communities throughout the state. Its Fair Table program is a systemwide Food is Medicine[8] initiative developed through years of collaboration among providers, local producers, and community-based organizations (CBOs) to advance food security and health equity.

The approach

In 2016, Fairview helped launch Fair Table after co-designing the program with CBOs and community members. When it started, the program partnered with the Hmong American Farmers Association (HAFA) and served eight patients at a single clinic. Since then, the program has grown significantly, and Fairview continues to strive to elevate the voices, expertise, and lived experiences of its community partners. Through Fair Table, community partners have developed a comprehensive suite of nutrition programs, such as emergency food support, a fresh food prescription program, medically tailored meals, and vouchers for healthy groceries.

In 2022, Fairview partnered with UnitedHealth Group* (UHG) through its Catalyst program, which enabled Fairview to pilot the food resource navigator (FRN) role. FRNs help patients understand and access Fair Table and other local resources. They also help integrate nutrition initiatives into clinical workflows, expanding the program into a clinically-aligned Food is Medicine model.

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Across this work, Fairview emphasized the importance of measurement and evaluation, using data to inform continuous improvement, demonstrate impact, and support the transition to sustainable funding and care models. UHG's Catalyst program supported these efforts with data evaluation and analysis tools.

The result

In 2025, Fair Table supported over 8,400 patients in enrolled programs and distributed over 6,000 one-time resources across 55 clinics and 9 hospitals in the Minneapolis-St. Paul metro area.

Although Fairview is still evaluating year-over-year impacts of the initiative, there have been clinically significant results from some of its programs. For example, the Fresh Food Prescription Program, which is a foundational Fair Table intervention, has helped reduced A1C levels among cohort participants. While monitoring clinical outcomes, Fairview has also focused on measuring and improving other indicators like food security and nutrition knowledge. In 2024, 86.1% of program participants surveyed said working with a FRN increased their confidence that they will have the food they need for the month.

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Inside the Fair Table program

Fair Table consists of five programmatic components, each designed to address some of the key drivers of food insecurity.



Fairview's **emergency food support** program provides one-time food resources for individuals experiencing immediate need. The program addresses urgent gaps in access and ensures patients have timely support during moments of food insecurity. It serves as a critical entry point into Fairview's broader Food is Medicine programming.



Through the **fresh food prescription program**, Fairview partners with local farmers and a regional food hub to provide patients with weekly meal boxes. These boxes include fresh, locally sourced produce; local proteins such as meats or legumes; and pantry staple items. Each delivery also includes a newsletter with nutrition education and recipes designed to help participants develop new food skills and adopt healthy eating behaviors. Boxes are either delivered directly to patients' homes or made available for pickup at clinics. In 2026, the program will provide over 600 boxes per week. Key partners include The Good Acre — a food hub that coordinates sourcing from more than 40 local farmers and producers — HAFA, Food Connect, and The Sanneh Foundation.



Through the **medically tailored meals** program, Fairview partners with Open Arms of Minnesota to offer meals that meet clinical and nutritional standards and support patients' health goals. The program provides prepared meals for people with specific, complex health conditions (e.g., prediabetes, diabetes, pregnancy, or postpartum status) or barriers to access (e.g., limited mobility, transportation needs, or challenging recoveries) and includes a variety of menu options and home delivery options.



Market Rx, a food voucher program, provides patients with $80 per month to purchase groceries from participating retail grocery programs and farmers markets. The program partners with mobile grocery stores and programs like The Food Group's Twin Cities Mobile Markets and Fare for All to reduce transportation barriers and offer patients flexibility and choice in how and where they access nutritious food.



Food resource navigators (FRNs) support patients experiencing food insecurity, acting as an operational bridge between clinical care and community resources. FRNs function as part of a patient's care team to help patients understand and access food support. FRNs respond to referrals quickly and build trust and rapport with patients to understand their health needs, barriers to food access, dietary requirements, and food routines. This relationship-based approach allows FRNs to connect patients to Fair Table programs, broader community resources, and other appropriate support services. By embedding FRNs into the clinical pathway, Fairview ensures providers are equipped to connect patients to real solutions.

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Fairview's 5 tactics for success

Ongoing investment at the health system level has allowed Fairview to successfully build and scale its Food is Medicine program. By embedding Food is Medicine responses into care delivery, prioritizing community partnerships while also integrating with clinical care, and resourcing internal infrastructure, Fairview illustrates how this work can be sustained over time.

01 **Prioritize community voices by design**

02 **Translate community insight into meaningful data**

03 **Recognize CBO partnerships as foundational resources**

04 **Focus on program sustainability from the outset**

05 **Make it easy for providers to engage**

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01 Prioritize community voices by design

Fairview intentionally paired traditional data sources — such as community health needs assessments, public health datasets, and utilization data — with community insights and knowledge to guide program design and decision-making.

Community members have valuable insight into how food insecurity shows up in people's daily lives or which types of support are most effective for each neighborhood or population. While some people would be best supported with medically tailored meals, others would benefit most from having additional skills or resources to help them prepare healthy meals or transportation support to deliver foods to their homes. Rather than launching a single emergency food response, Fairview and community members co-designed a suite of solutions that reflect a range of community needs.

FRN position modeled after existing cultural broker program

Since 2016, Fairview has employed cultural brokers, embedding them in CBOs to serve as liaisons to the African American, Hmong, Karen, Latine, and Native American communities. Cultural brokers, who understand both conventional medicine and their community's perspective on health and healing, help people navigate healthcare, education, and other systems. Their nimble and individualized support helps strengthen community members' abilities to advocate for themselves.

The FRN role follows the cultural broker model. Embedded in communities, FRNs stay up to date on available food resources in their assigned areas and work to maintain relationships with community organizations. These efforts help FRNs connect patients with programs that best support their unique needs and goals.

Fairview began the co-design process more than 10 years ago, spending six months building shared understanding and broadening perspectives, followed by another eight months actively co-designing with community partners. Meetings incorporated locally sourced food, dedicated time for relationship building, and facilitated conversations to co-develop work plans. To ensure community voices remained centered throughout the process, Fairview strategically engaged third-party facilitators to manage the co-design planning sessions.

By shifting away from the traditional top-down role of a healthcare anchor institution, Fairview demonstrated a more relational way of working with the community. Community partners brought innovative ideas to the co-design process, developed meaningful relationships with one another beyond the partnership through Fairview, and were important co-implementors who helped evolve the Fair Table programs over a decade.

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Recommended actions

1. **Shift from institutional control to shared leadership**. Redefine the organization's role from top-down decision-maker to collaborative partner, ensuring community members are recognized as equal contributors throughout the process. Use neutral facilitators for listening sessions to ensure community voices are leading the conversation rather than institutional priorities.
2. **Leverage trusted community connectors to bridge systems and neighborhoods**. Create or leverage community-facing roles, such as cultural brokers, to maintain strong local relationships and help people access the resources that best meet their needs.
3. **Translate suggestions from community members into action**. Listening sessions should be more than a space for community members to provide feedback. Document participant suggestions and incorporate them into planning and implementation to demonstrate that their ideas and concerns hold weight.

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02 Translate community insight into meaningful data

During program development, Fairview worked alongside community participants to link their insights to existing health system metrics. These quantitative and qualitative measures help make the case to internal health system leadership, funders, and payers that the work is having a measurable impact on both clinical and nonclinical outcomes.

Fairview recognized the importance of bridging both community- and clinically-identified needs to establish metrics that could meet the perspectives of different stakeholders. For example, biometric data may not reflect change in the short term, but it still influences how organizations think about progress and where they adjust their strategy. Evaluation approaches that consider participant input, program goals, and system priorities allow data to support continuous improvement while ensuring that community-driven priorities remained visible and actionable within the health system's measurement framework, including Community Health Needs Assessment and Implementation Strategies.

Core metrics used consistently across programs

- Equity-focused demographic data
- Food insecurity and diet quality measures
- Select biometrics, including A1C and blood pressure
- Inpatient, emergency department, and primary care utilization patterns

Recommended actions

1. **Co-design a shared measurement framework with community partners.** Align key insights from community members' lived experiences, stakeholder goals and objectives, and existing health system metrics. Identify and consistently apply a common group of measures to ensure comparability, reduce reporting burden, and strengthen the case for impact across stakeholders.
2. **Use data to support continuous improvement while preserving community priorities.** Regularly review metric trends with both health system leaders and community partners to guide adjustments, sustain internal and external buy-in, and ensure community-driven goals remain visible and actionable within formal health system measurement processes.

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03 Recognize CBO partnerships as foundational resources

Fairview's community-led approach also strengthened relationships with CBOs, which are often deeply rooted in local communities and include distribution partners, food hubs, and local farmers. Recognizing the depth of expertise and leadership that already existed within CBOs, Fairview listened closely to partner feedback and translated it into real action. To maintain space for CBO voices, Fairview ensured partners were invited to meetings and followed up when they were not present.

While healthcare organizations often feel pressure to develop and implement interventions internally, Fairview intentionally did not recreate existing community initiatives. Many CBOs were already building food distribution systems and coordinating farm partnerships effectively, so Fairview leaned into those partnerships and allowed community expertise to drive implementation. This approach allowed Fairview to support the food ecosystem and dedicate staff time to clinical integration and program management, ultimately supporting more people through long-term programming.

> We don't have endless resources, so we might have some limitations on how we partner. Instead of telling us, 'figure it out,' they lead and support the work. Not all partners show up like that.
>
> STEPHANIE WAGNER
> The Food Group

Sustaining these relationships required an investment of time, funding, and dedicated personnel. In addition to partner grants that enabled CBOs to participate, Fairview ensured that CBO partners were included in grant applications and philanthropic efforts, recognizing that these organizations often operate on slim margins and that prompt, reliable payment for their work is critical. In addition, Fairview dedicated staff to managing CBO relationships and supporting partnership operations. These staff members served as trusted points of contact, helping partners troubleshoot challenges and ensuring projects moved forward smoothly.

Over time, these partners recognized the strength of these relationships, as well as Fairview's commitment to collaboration and sharing power.

Recommended actions

1. **Map and engage existing CBOs** already embedded in the community such as food hubs and local producers.
2. **Treat CBOs as collaborators, not contractors.** Structure partnerships around shared goals, mutual accountability, and long-term relationship building rather than transactional service delivery. Include partners in planning meetings and working sessions and follow up for their input when they are unable to attend.
3. **Leverage and strengthen existing initiatives instead of imposing new or competing efforts.** Assess whether CBOs are already addressing certain needs and avoid building parallel systems that duplicate their work. Invest resources in supporting demonstrated community-led approaches to ensure relevance and responsiveness to the local ecosystem.
4. **Ensure reliable and timely compensation for CBO work.** CBOs operate on thin margins, so prioritize prompt, accessible, and predictable compensation as part of partnership agreements.

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04 Focus on program sustainability from the outset

Building on the early success of innovative pilot interventions, Fairview designed programs to become central, embedded components of the organization with full-time, dedicated staff. This commitment is reflected in Fairview's Center for Community Health Equity, where Food is Medicine represents one of its most established areas of work.

Scalability and sustainability have been core considerations from the outset. Recognizing that meaningful impacts would require full organizational investment and trust-based relationships with CBO partners, Fairview has focused on programs that can be built, expanded, and sustained over time. By integrating existing community resources, Fairview supports both the local food system and its own sustainability.

To create sustainable programs, Fairview built flexible strategies that evolved as community needs changed. While grant funding and philanthropy played an important role in launching the work, Fairview planned for long-term viability beyond these sources. Because no single mechanism can fully fund these programs, success depends on aligning multiple funding sources across clinical care, community services, and social supports and often requires coordination across partners. Investment, payer alignment, and emerging value-based care (VBC) pathways work together to support and scale Food is Medicine as part of care delivery. Through the Catalyst initiative, UHG has supported sustainability efforts by sharing knowledge and hosting conversations around the unique role each organization in an ecosystem can play to help ensure the longevity of programming.

> This work benefits the local farming community and patients experiencing food insecurity and a variety of health conditions. That's been a huge selling point to funders, especially local funders. It's a win, win, win, win.
>
> ANNA RICHARDSON
> The Good Acre

In addition, Fairview supports sustainable care models through data collection and analysis. Evaluation informs continuous improvement and demonstrates impact, supporting the transition to sustainable funding.

Recommended actions

1. **Anchor equity work within formal organizational structures.** Build initiatives with the intention of making them embedded, core components of your organization so you can grow beyond short-term pilots. Make sure to have full-time staff and show clear ownership of the initiatives.
2. **Plan for scalability and sustainability from day one.** Design approaches and programs that can be expanded and sustained over time, Recognize that long-term impact requires full organizational commitment and consistent community partnerships.
3. **Move beyond grant funding toward more sustainable financing models.** Use grants and philanthropy to launch programs, but proactively develop long-term funding pathways, such as VBC, to sustain the work.

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05 Make it easy for providers to engage

Fairview started with a model clinic selected based on where the data said need was high and there were clear provider champions. By focusing on clinics that were ready and supportive, Fairview was able to use these early successes to build momentum and bring others on board.

Fairview's providers have expressed a strong desire to offer meaningful resources when conducting SDOH screenings. Historically, providers have lacked clear resources to recommend to patients facing food insecurity. This gap made it difficult to address patients' needs, lowering provider morale and increasing burnout.

There is strong support for integrating FRNs into care teams to help providers connect patients to nutritious food and other resources in the Twin Cities. FRNs may attend clinic meetings or join morning huddles to learn the nuances of specific clinics and providers and ask directly how they can best support patient care. Providers refer patients directly to FRNs assigned to their clinics through electronic health record (EHR) workflows, further advancing the integration of Food is Medicine into the standard of care.

FRNs serve as an additional layer of connection and continuity for patients, reducing the risk that their food needs go unaddressed. They also provide practical support to care teams by reducing provider burden and burnout, helping translate SDOH screening and food-related care plan goals into responsive action, and strengthening the sustainability of the model. By supporting operations and cultivating long-term patient engagement, FRNs can help reduce care gaps and reinforce efforts to develop supportive funding structures like VBC arrangements.

Recommended actions

1. **Recruit and support clear provider champions in areas of need.** Identify where the need is high and empower respected clinicians to advocate for the model internally and help align the initiative with real clinical workflows and needs.

2. **Design referral pathways that fit existing workflows.** Enable providers to refer patients easily, both directly to navigators (like FRNs) and through EHR-based workflows such as secure messaging or inbox referrals.

3. **Integrate community resource roles directly into care teams.** Embed navigators into day-to-day clinic operations by having them attend meetings, join huddles, and learn clinic-specific practices. Encourage them to ask providers how they can best support patient care and help clinicians act on SDOH screening results with meaningful resources.

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Results

Fairview sites with Food is Medicine programs (2025)

Includes enrolling, ordering, or distributing



- 45 primary care clinics
- 10 specialty clinics
- 9 acute care sites

Program results (2025)



Emergency food support

- 5,106 Every Meal shelf-stable food bags distributed across 40 clinics, providing 24,424 meals to patients experiencing an immediate need
- 292 food resource packets distributed across 13 clinics and acute care sites
- 420 one-time fresh produce boxes distributed



Fresh food prescription program

- 362 participants in Fresh Food Prescription
- Participants enrolled across 31 clinics
- Sourced from more than 40 local farms and producers through The Good Acre food hub
- 11.3% decrease in food insecurity
- 24.5% increase in participants who reported feeling they were eating a well-balanced diet



Medically tailored meals

- 110 participants received meals
- Participants enrolled across 19 clinics



Market Rx

- 478 participants
- Participants enrolled across 52 clinics
- $231,982 redeemed by participants, who spent an average of $326 annually
- 25.2% increase in participants who reported feeling they were eating a well-balanced diet



Food resource navigators

- 3 FRNs
- 610 participants
- 44 sites

Early clinical results

From the first cohort in the food insecurity and chronic conditions initiative (165 individuals)



- 71% had reductions in A1C level
- A1C level was reduced from an average of 8.5 to 7.9

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Endnotes

1. Unless otherwise noted, all information in this case study came from Advisory Board interviews with officials from Fairview Health Services, Fair Table, and The Good Acre.
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