

# Catalyzing Action for Pharmacist-Provided Food Is Medicine Care

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# Contents

1	Introduction
2	Food Is Medicine Landscape
6	Methodology and Scope
7	Findings on the Value of Pharmacists in Food Is Medicine
11	Recommendations and Action Steps for Integrating Food Is Medicine in Pharmacies
13	Payment Policies
25	Pharmacy Workflow
34	Technology Infrastructure
42	Future Opportunities
44	Conclusion
45	Appendix
58	References
62	Acknowledgments
63	About the Authors

# Introduction

Pharmacies have long served as key health-care access points; 90 percent of the US population lives within five miles of a pharmacy. The pharmacist's role reaches far beyond medication dispensing and counseling to providing a range of clinical services. From standalone drug stores to those located in mass merchants and grocery stores, pharmacies are cornerstones of local health care, providing access to immunizations, screenings, treatments, and health-related social needs across communities. Pharmacists are highly trained in clinical care and effective in supporting chronic disease prevention, management, and treatment. They are well positioned, therefore, to deliver Food Is Medicine (FIM) interventions.

FIM interventions present an approach to whole-person health, connecting qualifying patients to foods and nutrition supports that meet the unique dietary needs of their health and food security status. Since food alone is often insufficient to improve diet-related health conditions, FIM combines a comprehensive and consistent approach to care delivery with other modifications in medication and lifestyle. A coordinated effort across a patient's care team is necessary to connect patients to FIM interventions, monitor their progress, track key health indicators, and adjust the intervention as needed in response to changes in health status. As the most frequently visited health-care touchpoints, particularly in rural areas, pharmacies are optimally positioned to support patients, payers, and other health-care providers

in initiating, maintaining, and adjusting FIM interventions to meet patients where they are in their care journey, ultimately to support better health.

**This report provides background, insights, and recommendations for pharmacies and key partners, including health-care payers and policymakers, to scale FIM interventions in their communities. The following 12 recommendations, supported by 34 actions, were developed from extensive research, interviews, and roundtable discussions with key stakeholders representing current FIM providers, public and private payers, technology companies, researchers, dietitians, retailers, and pharmacists.**

Each recommendation addresses key barriers in the FIM landscape through actionable steps that pharmacies, health-care payers, state and federal agencies, policymakers, and other key stakeholders can implement to improve FIM-supportive reimbursement pathways, workflow processes, and technology infrastructure. Although the recommendations are not exhaustive, they highlight important steps that would enable pharmacies to catalyze FIM care delivery and improve patients' ability to access these nutritional interventions.

# Food Is Medicine Landscape

Over the past few years, FIM has accelerated as a method to address the significant burden of diet-related chronic diseases in the US, as well as to advance food and nutrition security. Around half of all adults in the US have one or more preventable, diet-related chronic diseases, including cardiovascular disease, type 2 diabetes, and overweight or obesity.<sup>1</sup> Evidence has been building to support the efficacy of FIM interventions in improving health outcomes in ways that benefit patients, payers, and the health-care system at large. FIM is associated with lower hemoglobin A1C levels, increased fruit and vegetable intake, decreased food insecurity, lower rates of cardiovascular events, and reduced overall health-care expenditures.<sup>2</sup>

FIM encapsulates a range of nutrition interventions intended to prevent, treat, and manage diet-related health needs along a continuum of care, leveraging the health-care ecosystem to incorporate the power of nourishing food into care plans. Diet-related conditions such as diabetes, cancers, and cardiovascular disease not only rank among

the leading causes of death in the US but also disproportionately affect Black, Indigenous, and Latin American populations and people experiencing food insecurity.<sup>3</sup> FIM interventions, including produce prescriptions, medically tailored groceries, and medically tailored meals, have become increasingly valued methods for addressing these health conditions as well as household food insecurity. Screenings for food insecurity and eligibility for nutrition assistance programs often accompany FIM interventions.

However, unlike other nutrition security programs, such as the Supplemental Nutrition Assistance Program (SNAP) or emergency food distributions, FIM focuses on the direct link among patients, food, the health-care system, and health outcomes. FIM interventions are not intended to replace nutrition security programs or reduce funding for them; rather, these interventions address specific gaps in nutrition and health for different populations.

## Categories of FIM Intervention

Each category of FIM intervention is intended to meet the nutritional needs of different populations and health conditions. FIM interventions can be redeemed by using vouchers, debit cards, or other forms of payment to offset the costs to the patient of accessing the foods at a variety of outlets, including direct purchasing from a grocery store or company that supplies FIM interventions to patients, or through free distribution from food pantries and nonprofits.

- **Produce prescriptions** are “prescribed” to patients experiencing food insecurity and a diet-related health risk or condition to procure fresh, canned, or frozen produce (i.e., fruits and vegetables).
- **Medically tailored groceries** are packages of fresh or shelf-stable foods typically selected by a registered dietitian or physician for patients with a specific disease (e.g., diabetes or kidney disease).
- **Medically tailored meals** are ready-to-eat meals designed by a registered dietitian to address the medical needs of patients, particularly those with severe, diet-related illnesses, such as chronic kidney disease and heart disease.

Despite the growing evidence of the efficacy of FIM, barriers to implementation have limited the integration of FIM into health care. The Milken Institute Feeding Change explored the most critical financial and technology barriers to broadening the implementation of FIM and offered solutions in the report [Financial Innovations Lab: Market Solutions for Scaling Food Is Medicine Prescriptions](#). In the report, stakeholders cited the opportunity for greater overarching federal policy, clearer evidence of return on investment, technological and data efficiencies, and sustainable funding that goes beyond small, disaggregated pilot programs. To advance these opportunities, the Milken Institute’s recommendations focused on driving

relationships among multisector stakeholders, streamlining data transfer and improving interoperability, and blending capital to support sustainable funding for FIM.

While no single model for FIM delivery exists, most current models rely on primary care physicians, community-based organizations (CBOs), or health plans to screen for eligibility, connect patients to food and care, and track health outcomes. However, as FIM evolves from pilot programs to the eventual goal of being a coordinated and covered benefit, pharmacies are well positioned to reach and connect more FIM-eligible patients to relevant services, enhance the patient care journey, and ultimately improve



health outcomes (see Appendix B for additional resources on the current landscape of FIM). This report highlights the need for more providers of “FIM care,” the holistic care that accompanies the provision of food in FIM interventions. This term acknowledges that FIM is not a standalone service but is embedded within other disease-management and prevention practices that take an individual’s full care journey into perspective.

Throughout the totality of existing FIM research, pharmacists were mentioned rarely despite being well positioned to help expand access to

FIM interventions if sustainable reimbursement pathways existed. Thus far, pharmacies have been underrepresented in efforts to scale FIM interventions sustainably and promote health for individuals with diet-related chronic diseases. As conversations in FIM shift largely from the provision and coverage of food toward FIM as a critical component of holistic patient care, pharmacies will be essential to integrate FIM effectively within the broader care journey and within the places where patients have the best access.



## FIM on a National Platform

The 2022 White House Conference on Hunger, Nutrition, and Health and the accompanying National Strategy on Hunger, Nutrition, and Health elevated the importance of FIM on a national platform. As part of this historic event, the White House generated \$8 billion in commitments from all sectors to further the goals of ending hunger and increasing healthy eating and physical activity by 2030.<sup>4</sup> The second pillar of the conference, “Integrate Nutrition and Health,” has been key in driving FIM action and encouraging new partners to engage around scaling and implementation. In March 2023, the Biden administration launched the White House Challenge to End Hunger and Build Healthy Communities to further mobilize food-systems stakeholders across sectors in committing to bold action that advances the work of the National Strategy.<sup>5</sup>

Several months later, in January 2024, the US Department of Health and Human Services (HHS) hosted the first-ever Food Is Medicine Summit in Washington, DC, bringing together stakeholders at the intersection of food and health. In February 2024, the White House announced that it had accepted 141 new commitments to the White House Challenge to End Hunger and Build Healthy Communities, representing nearly \$1.7 billion.<sup>6</sup> Pharmacies have supported this work and have the opportunity to continue building on this national momentum to create a movement in which they play a strong role in scaling FIM interventions across communities.

**Figure 1: Building Momentum for Food Is Medicine, 2022–2024**



Source: Milken Institute (2024)



# Methodology and Scope

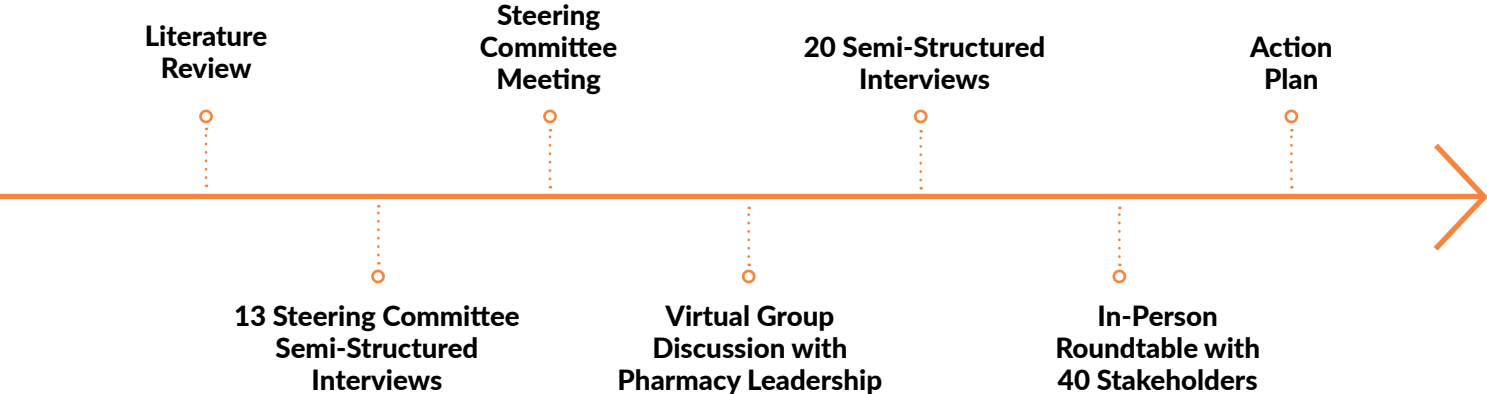
Throughout 2023, the Milken Institute conducted research with diverse stakeholders to understand the key issues and define the role of pharmacies in scaling FIM. This report identifies opportunities for pharmacies to participate in FIM and positions pharmacists as key players in emphasizing the connection between FIM interventions and whole-person care. As the role of pharmacies in the health-care space transforms and as FIM gains traction among patients, payers, and non-pharmacy health-care providers, pharmacies can fill a gap in FIM access.

First, the Milken Institute conducted a literature review to understand the full landscape of FIM and where pharmacies might be best positioned to support implementation. This literature review was used to frame and conduct 45-minute, semi-structured interviews with 13 steering committee members. These steering committee members included key thought leaders from pharmacies, payers, policy research, and patient engagement advocacy (see Acknowledgments). After completing steering committee interviews,

the Milken Institute solidified themes for further exploration in 20 additional 30-minute interviews with key stakeholders, including current FIM providers, public and private payers, technology providers, researchers, and pharmacists.

The Milken Institute used qualitative thematic coding analysis throughout the 33 interviews to identify key recommendations for exploration. This set of proposed action areas was discussed, vetted, and refined during a 40-person roundtable discussion in Washington, DC, with an expanded group of experts representing the pharmacy, retail, policy, advocacy, nonprofit, technology, government, and payer perspectives. This roundtable solidified the final 12 recommendations, with peer review from a select group of diverse stakeholders. The actions detailed below address existing barriers for pharmacies in FIM and are distilled from a multifaceted approach reflecting the learnings that emerged throughout the literature review, interviews, steering committee meeting, and roundtable discussion.

**Figure 2: Stages of Report Development**



Source: Milken Institute (2024)

# Findings on the Value of Pharmacists in Food Is Medicine

The literature review and interviews highlighted opportunities for pharmacy involvement in FIM that harness pharmacies' unique assets. Discussants expressed enthusiasm and a clear value proposition for scaling FIM through community pharmacies, also known as retail pharmacies, which are some of the most accessible and well known types of pharmacies. Most community pharmacies include "front-end" products as well as both prescription and over-the-counter medications, and stores can range from individually owned and operated businesses to large retail chains such as drug stores, grocery stores, and mass merchants with both a national and a regional footprint. Discussants particularly emphasized the community pharmacy's ability to improve FIM access and support more effective, widespread integration of FIM into health care. Findings underscored that pharmacists could bring value to every stage of the FIM care process, from identifying patients for interventions, to connecting patients to resources, to following up on health outcomes.

The Milken Institute identified the following four primary advantages that a range of different types of community pharmacies could bring to the FIM movement. Community pharmacies and pharmacists are:

- **accessible and frequently visited,**
- **trustworthy and relationship-based,**
- **drivers of equity, and**
- **highly qualified and primed for accountable care.**

## Accessible and Frequently Visited

The literature review and interviews emphasized pharmacists' accessibility as a key asset to improving care delivery, access, and reach. Many FIM programs are geared toward patients with one or more chronic conditions, and Medicare or Medicaid beneficiaries, as well as patients with limited access to healthy food. One study of 11 million Medicare beneficiaries with multiple chronic conditions found that patients visited their pharmacies one and a half to two times as often as they visited other qualified health professionals, averaging 13 visits per year to their pharmacy compared to seven visits per year to their primary care provider.<sup>7</sup> The difference was almost twice as large in rural communities and among patients with multiple comorbidities, as reinforced by several discussants: "This brings home the particular role of pharmacies in rural areas or areas that do not have as much easy access to providers at large. Community pharmacies might be the most common health-care provider that someone sees."

Discussants validated and highlighted pharmacists' accessibility as being advantageous to FIM delivery. They stressed the frequency with which many people visit their pharmacists—especially when compared to other health-care providers—citing this as a valuable opportunity for additional engagement beyond medication

pickup: “If you have uncontrolled diabetes, you’re going to see your primary care provider three to four times a year. If it’s moderately controlled, maybe twice a year. Not that often. You see your pharmacist a lot.”

Beyond rural areas, pharmacies are sometimes the only site for patients to receive accessible health care in their communities: “When you’re looking at data, there are so many places where the community pharmacist is the only health provider in a zip code, in a community, in a county.” While many FIM interventions lean on the primary care physician to identify and screen patients, a pharmacist may be more likely to become aware of a change in a patient’s circumstances due to the frequency of patient visits and may provide more timely screening.

## Trustworthy and Relationship-Based

In addition to being highly accessible, pharmacists are known for being trusted health-care providers. A 2023 Gallup poll found that pharmacists were among the top three most trusted health-care providers, alongside nurses and physicians.<sup>8</sup>

Discussants endorsed this reputation, often citing personal experience about the warm relationships they have with their own pharmacists. Several discussants also mentioned that patients were more likely to follow through on referrals when they engaged in-person with a trusted health-care provider: “Relationship-based referrals are what’s getting the patient, who’s comfortable with the community health worker or pharmacist, to a ‘person’ who’s an actual person versus a technology platform.

They’re a great tool, but it’s all digital. Someone has to check their email to receive anything—the follow-up is less personal.” The discussants highlighted the importance of having a reliable health-care provider initiate FIM interventions to ensure optimal follow-through, adherence, and success.

## Drivers of Health Equity

As accessible and trustworthy health professionals, pharmacists can also deliver equitable health care with reach across vulnerable and diverse communities. The COVID-19 pandemic is a key example, demonstrating how pharmacies adapted to build a workforce and workflow in record time to support testing for COVID-19 and administering millions of COVID-19 vaccines. The Federal Retail Pharmacy Program, launched in February 2021, involved 21 national pharmacy partners and networks of independent pharmacies representing more than 40,000 pharmacy locations across the country.<sup>9</sup> Pharmacist authorities significantly expanded across the country to allow pharmacists to meet the needs of the public health crisis more effectively, with pharmacies providing more than 300 million vaccine doses between early 2021 and May 2023—nearly half of all doses administered in the US.<sup>10</sup> Notably, more than 43 percent of all COVID-19 vaccines in pharmacies were administered to people from racial and ethnic groups other than non-Hispanic White, demonstrating the value and ability of pharmacies to meet the needs of populations that have been historically underserved by the health-care system.<sup>11</sup>

Discussants emphasized the importance of health-care providers being sensitive when discussing topics such as individuals' food security, nutrition security, or socioeconomic status. Several discussants also noted that past pharmacy-based programs have found success in leveraging pharmacies as destigmatizing sites for the distribution of services, when compared to other health-care providers. For example, pharmacies and retail clinics represent a vast, largely untapped potential for the delivery of HIV testing in settings that are more accessible and, for some people, less stigmatizing than traditional testing sites.<sup>12</sup> Many FIM interventions are geared toward individuals with diet-related conditions who are Medicaid beneficiaries or who could benefit from improved access to healthy food, both of which groups may be easier to reach through pharmacies. As seen from other interventions delivered through pharmacies, the pharmacy has a demonstrated ability to drive health in an equitable way, further demonstrating its alignment with FIM objectives.

## Highly Qualified and Primed for Accountable Care

Pharmacists also have the relevant training and expertise to play a central role in FIM care. Since 2000, all entry-level pharmacists are required to complete a doctoral program (PharmD).<sup>13</sup> They must also pass a national licensing exam on general practice knowledge, and most states require that candidates pass a pharmacy law exam to earn their state pharmacist licenses. They must also complete a continuing education

course before each license renewal to ensure their knowledge and skills are up to date.<sup>14</sup>

Many pharmacy graduates may also gain specialized clinical experience, training, or certifications through fellowships, residency programs, or board certifications.<sup>15</sup> Equipped with doctoral-level clinical training and their medication expertise, pharmacists have demonstrated positive impacts on patient experience and outcomes, with reduced downstream health-care costs for patients and the system in general.<sup>16</sup>

Studies have also found improvements in clinical health outcomes when pharmacists are involved in chronic disease prevention and management.<sup>17</sup> Pharmacists have been identified as an underutilized resource for improving primary care access during the shift to value-based payment models as the shortage of physicians worsens.<sup>18</sup> Not only are pharmacists eager to take on more direct patient care responsibilities, but providers have a high level of trust in pharmacists to perform tasks for patients with chronic conditions beyond filling prescriptions.<sup>19</sup> Pharmacists' expertise lends itself well to implementing and scaling FIM interventions as part of chronic disease care, including the prevention, management, and treatment of diet-related conditions. As pharmacists play a larger role in caring for patients with chronic conditions, FIM presents a natural opportunity for pharmacists to support patient health and wellness in addition to—and beyond—medications.

Evidently, pharmacies are poised to play a much-needed role in FIM care in ways that will expand FIM beyond temporary pilots and grant-funded programs, and integrate FIM more consistently

within the broader health-care system. The FIM movement is progressing quickly, and if FIM is to grow equitably and effectively, pharmacies must play a strong role. With significant access to patients when compared to other health-care providers, extensive clinical expertise, and demonstrated effectiveness in improving health and cost outcomes, pharmacists can strategically address FIM needs for patients

with diet-related chronic conditions who already frequent pharmacies to pick up their medications or receive other health-care services such as vaccines. Given their education and training, access to patient medication profiles, and consistent engagement with patients, pharmacists can fill a gap in the FIM landscape and position FIM within the holistic patient-care journey.





# Recommendations and Action Steps for Integrating Food Is Medicine in Pharmacies

This section provides concrete recommendations and action steps to implement and scale FIM through community pharmacies. Analysis for this report illustrated that pharmacists are best positioned to drive care for patients with chronic conditions, providing a connective thread between patients and chronic care resources and partners—including those related to FIM care. Findings also showed that effective care coordination with FIM at the center and pharmacies as a driver would provide greater benefits than either component independently as patients navigate their care journey.

Analysis of the 33 interviews, roundtable discussion, and literature review identified the following three central components that need to be transformed or established to sustain and scale FIM integration in pharmacies: effective **payment policies**, seamless **workflow** integration, and supportive **technology**.

## Pharmacies need:

1. **FIM care to be a reimbursable service for pharmacists across payer types (Medicare, Medicaid, and commercial),**
2. **seamless integration of FIM into pharmacy workflow processes without burden on pharmacy teams, and**
3. **interoperable technology infrastructure to support FIM data sharing throughout the health-care ecosystem.**

These three key themes are the organizing structure for the following recommendations and actions. Within each theme, recommendations outline how to integrate FIM into community pharmacies and are supported by action steps that must be taken for implementation. Every action step identifies the primary stakeholders who can drive change, including pharmacy leadership, pharmacists, current FIM providers, health plans and the Centers for Medicare and Medicaid Services (CMS), among others. See Appendix A for a full map of stakeholders involved in the larger FIM ecosystem.

Recommendations include both systems-level changes to the health-care ecosystem and specific steps that pharmacists and pharmacies can implement to integrate FIM into their operations. The supporting action steps are framed as opportunities to address key barriers in the current FIM and pharmacy landscapes. They are designed to be not only actionable but also visionary, in order to pave the way for a future when FIM is integrated into health care and pharmacists are key to improving health-care delivery, access, and reach. See Appendix C for a comprehensive table of all 12 recommendations and 34 action steps.



## Different Types of Community Pharmacies

- **Drug stores:** Free-standing, brick-and-mortar pharmacies offering “front-end” products that may include food
- **Grocery store pharmacy:** Pharmacy within a retailer that primarily sells food
- **Mass merchant pharmacies:** Pharmacies within retailers that sell a wide variety of consumer goods, including food

## Primary Pharmacy Stakeholders

- **Pharmacists:** Health-care professionals licensed to practice pharmacy, who leverage their clinical knowledge and skills, including medication expertise, to promote optimal health outcomes for patients. (Common pharmacist duties in a community pharmacy setting include supporting disease-state management, initiating preventive measures such as vaccinations, performing point-of-care tests and other screenings, making clinical recommendations to patients and doctors, initiating recommended therapies, dispensing prescription drugs, monitoring drug interactions, and counseling patients and doctors regarding the effects and proper usage of medications.)
- **Pharmacy technicians:** Technicians who assist pharmacists in ensuring the health and safety of patients by preparing and dispensing medications, among other technical tasks such as vaccine administration, under the supervision of a pharmacist
- **Pharmacy leadership:** Professionals in positions of leadership at pharmacy organizations or companies who fulfill decision-making roles concerning pharmacy services and operations
- **Pharmacy associations:** Membership organizations, including trade associations, that represent and advocate for the pharmacy industry, pharmacy professionals, and the patients they serve

# Payment Policies

## VISION:

FIM Care Is a Reimbursable Service for Pharmacists across Payer Types



Reimbursement trends for FIM, pharmacies, and health care in general are shifting. Funding for FIM services is beginning to move away from temporary pilots and grants, pharmacists are increasingly recognized as important members of the patient care team, and health-care payment continues to transition from fee-for-service toward value-based care. Payment for the role of pharmacists and pharmacies in FIM must adapt to this shifting landscape. With pharmacies reaching a large population of individuals who may be eligible for FIM, reliable and consistent payment pathways must be established for reimbursement of pharmacies for FIM care and services across payer types.

FIM has already gained traction across Medicare, Medicaid, and employer-sponsored commercial plans. CMS offers a range of options for Medicaid agencies, Medicaid plans, and Medicare plans to fund FIM programs for individuals living with, or at risk for, diet-related chronic conditions, as well as to encourage the use of FIM to help meet quality goals and requirements of Medicaid and Medicare plans. Some of these options include nutrition supports in Section 1115 demonstration waivers and In Lieu of Services (ILOS) in Medicaid, and Special Supplemental Benefits for the Chronically Ill (SSBCI) and Value-Based Insurance Design (VBID) in Medicare (see “Payment Pathways” in Appendix B).

Subject to some mandatory benefits, employers determine which health-care plans are available for their employees and what the plans cover, with the opportunity to offer various FIM-related supports. Such supports may range from providing food-based health interventions through employee assistance programs to offering programs for specific disease states, such as hypertension or diabetes, where FIM may be included as a covered benefit.

Several barriers still stand in the way of pharmacies being fairly compensated for providing FIM care. For example, most current FIM funding pathways have focused on paying for the food itself rather than supporting the additional costs for successful implementation, including the continuum of health-care services that must accompany FIM programs. In addition, although CMS has created opportunities for Medicare and Medicaid programs to fund FIM-related interventions, federal laws and regulations do not mandate the coverage of FIM programs. Individual states and health plans, therefore, may decide whether or not to take advantage of these levers, leaving coverage inconsistent and incomplete.

Additionally, to date, payment to pharmacies for FIM-related services, such as diabetes management programs and heart health interventions, has typically been driven by specific plans that offer short-term

contract opportunities. This makes scalable implementation challenging because such programs are temporary and highly dependent on each plan's unique goals and infrastructure. Also, pharmacy billing processes and systems historically were developed to support the adjudication of prescription claims, whereas billing for clinical services requires an investment in infrastructure. For pharmacies to engage in medical billing, they must either invest in the implementation of an additional coding and billing system or invest in a vendor to translate and transfer medical claims to the health plan. In addition, there are often longer wait times for payment for clinical services through medical billing, particularly when avoidable claim denials are involved.

However, today, pharmacies have some opportunities to bill the medical benefit, such as the ability to provide certain vaccines covered by Medicare Part B. Some clinical pharmacy programs, such as medication therapy management, allow pharmacists to bill prescription drug plans to provide care services beyond dispensing medications. Currently, this includes pharmacists providing comprehensive medication reviews for patients, in addition to providing patient education and clinical support on topics including preventive care and medication adherence.

Payment for pharmacist-provided services is essential to ensure that pharmacies are fairly compensated for pharmacists' time and clinical expertise, as well as to drive implementation of FIM care, expand access to and reach of FIM, and drive forward innovation in the field. The following recommendations build on

existing payment pathways for pharmacies and FIM—across Medicare, Medicaid, and employer-sponsored plans—to develop viable and sustainable opportunities that leverage the value of pharmacies in advancing FIM care and, ultimately, promote better health for patients.

## Using the Term “Food Prescription”

The phrase “food prescription” or “produce prescription” has been a useful analogy among food policy experts to explain how FIM interventions are typically operationalized, leveraging the term “prescription” as a widely understood health-care intervention. Using prescription in FIM interventions also helps elevate the importance of nutrition in treating and managing diseases. However, it is important to recognize that food prescriptions are not subject to the current payment structure or the specific regulations and requirements that prescription drugs are.

Several discussants, particularly experts across the pharmacy industry, expressed concern with the language of “food prescriptions” and “produce prescriptions” that many FIM interventions, advocates, and policymakers use. These discussants cautioned that designing payment for food prescriptions akin to that for medication prescriptions could inadvertently replicate existing challenges with traditional drug payment structures and make food prescription implementation unsustainable. Further, it is important to recognize that FIM interventions are not intended to replace medication therapies altogether but rather to be used in conjunction with other diet-related chronic disease management strategies and treatments in alignment with evidence-based guidelines to improve health outcomes.

## Recommendation 1:

### Recognize Pharmacists as Eligible Providers under Medicare Part B to Establish Reimbursement for Clinical Services

Medicare has been driving FIM coverage forward through multiple pathways. FIM interventions are gaining traction in Medicare Part C (Medicare Advantage), but opportunities also exist in Medicare Parts B (medical insurance) and D (drug coverage) to support and supplement FIM interventions. Medicare Part B is the portion of Medicare that covers outpatient services from physicians and other health-care providers, as well as home health care, certain medical equipment, and some preventive services. While Medicare Part B does not explicitly provide coverage for FIM interventions, it may cover the services that must be provided alongside FIM to support patient care. This may include nutrition security screening, baseline health screenings, disease state management, and patient education.

However, pharmacists are not recognized federally as health-care providers (HCPs) and, therefore, are not entitled to service reimbursements through Medicare Part B to cover the clinical services that should accompany FIM. This is despite their extensive clinical training and demonstrated benefit to care teams. Other non-physician health-care providers receive payment for both office visits and the services they provide during such visits, and are authorized to bill Medicare Part B for their services. These providers include physician assistants, nurse practitioners, and marriage and family therapists, among others. While many states are starting to recognize pharmacists as

HCPs, allowing them to be more easily integrated into care teams and reimbursed for their services, and recognition of pharmacists at the federal level in Medicare Part B has gained bipartisan support from Congress, such as through the Equitable Community Access to Pharmacist Services Act and the Pharmacy and Medically Underserved Areas Enhancement Act, legislation has yet to be enacted.

Discussants noted that the lack of federal “provider status” in Medicare Part B poses a significant challenge to being compensated for pharmacist services, not only because of lack of coverage under Medicare but also because Medicare often sets the tone for what commercial payers will consider. Discussants noted: “Pharmacists are not federally recognized as providers, so it can be hard to get around reimbursement issues.” Medicare Part B provider status for pharmacists would allow pharmacists to be reimbursed for the clinical services they are trained and authorized to provide through state scope-of-practice laws, as well as allow Medicare patients—who visit their pharmacist more often than their other health-care providers—more access to care. As federally recognized HCPs, pharmacists could be reimbursed for a wider range of FIM-related care for their patients, which would offer a notable opportunity to enhance meaningful access to FIM care.

While advances in Medicare policies are promising for FIM, without policy changes, pharmacies and pharmacists remain constrained

in their ability to provide clinical care, nutrition supports, baseline screenings, and chronic disease management. Expanding reimbursement pathways

for FIM programs to include pharmacies could close major gaps in patient care and increase access to FIM services in Medicare.

Actions	Primary Stakeholders
<p>Enact provider status legislation that authorizes pharmacists as eligible Medicare Part B health-care providers. Looking ahead, this could include providing FIM-related care and diet-related chronic disease management.</p>	<ul style="list-style-type: none"> <li>● Congress</li> <li>● CMS</li> </ul>
<p>Advocate for CMS to recognize pharmacists as eligible providers, through the annual Medicare Physician Fee Schedule rule proposal process, to support broader access to clinical care, including FIM care, delivered at pharmacies.</p>	<ul style="list-style-type: none"> <li>● Pharmacy leadership</li> <li>● Trade associations</li> <li>● Patient advocates</li> </ul>

### Recommendation 2:

## Include Pharmacies as Reimbursable Service Providers within State Medicaid Section 1115 Demonstration Waivers

In Medicaid, one of the most promising pathways for FIM coverage is through Section 1115 demonstration waivers, which give states additional flexibility to experiment with programs that can better serve their Medicaid populations. As of April 2024, CMS had approved waivers with FIM/nutrition supports in Arkansas, California, Massachusetts, North Carolina, New Jersey, New York, Oregon, and Washington, with approvals pending in Delaware, Hawaii, Illinois, New Mexico, and Pennsylvania (for an up-to-date list, please see Appendix B, *Medicare and Medicaid Trackers and Resources*).<sup>20</sup> CMS has also released guidance on further embedding FIM within federal health coverage, including clarification that enrollees can requalify for an additional six months of nutrition services under Section 1115 waivers and permission to provide nutrition services at the household level for families with

postpartum or pregnant members or a child identified as high risk.<sup>21</sup>

Several states are also leveraging In Lieu of Services (ILOS), a regulatory flexibility primarily aimed at reducing health disparities, wherein states and managed care plans can offer health services as appropriate substitutes for existing services.<sup>22</sup> ILOS is slowly gaining traction for FIM; several states are using ILOS either independently or combined with Section 1115 waivers to offer FIM/nutrition services, including California, New York, and Rhode Island. It remains to be seen whether ILOS offers a viable pathway for pharmacy involvement in FIM care.

As more states leverage Medicaid Section 1115 demonstration waivers to provide FIM and nutrition supports, pharmacies are well positioned to participate in implementation.



Many existing waivers focus on providing services to populations with chronic diseases, who regularly frequent pharmacies. Particularly in rural communities, where access to health-care services can be difficult, pharmacies have a strong case for being involved in expanding reach and access to FIM care. Several discussants highlighted the value of pharmacies to FIM delivery in rural communities: “Pharmacies are a big access point in very rural communities. If we’re thinking outside the box, in rural communities, could pharmacies be a hub of services because they’re an access point anyway?”

In states where new waivers are being developed or existing waivers are being renewed, pharmacy leadership can collaborate with state Medicaid agencies and other stakeholders to design the demonstration proposal to include pharmacies as part of reimbursable and sustainable service delivery. Despite the temporary nature of Section 1115 demonstrations and active waivers in only a handful of states, and the limited new Medicaid dollars afforded by Section 1115 waiver demonstrations, there may be some opportunity for pharmacies and Medicaid collaborations to leverage Section 1115 waivers to pilot pharmacy-based FIM care in practice.

Actions	Primary Stakeholders
<i>In states without waivers:</i> Advocate for Medicaid Section 1115 demonstration waivers, with emphasis in rural communities, to leverage pharmacies as a reimbursable provider to improve access to FIM care.	<ul style="list-style-type: none"> <li>● Pharmacy leadership</li> <li>● Trade associations</li> <li>● Patient advocates</li> </ul>
<i>In states without waivers:</i> Consider and prioritize approval for Section 1115 demonstration waivers that utilize pharmacies in rural communities to connect with harder-to-reach patients and reimburse them as qualified providers.	<ul style="list-style-type: none"> <li>● CMS</li> </ul>
<i>In states where waivers are pending:</i> Submit written comments or participate in public hearings to advocate for including pharmacies as reimbursable providers of health-related social-needs interventions, including nutrition supports.	<ul style="list-style-type: none"> <li>● Pharmacy leadership</li> <li>● Trade associations</li> <li>● Patient advocates</li> </ul>
<i>In states where waivers are already approved:</i> Connect with stakeholders to advocate for including pharmacists as reimbursable providers of health-related social-needs interventions, including nutrition supports, during the waiver renewal process.	<ul style="list-style-type: none"> <li>● Policymakers</li> <li>● Pharmacy leadership</li> <li>● Trade associations</li> <li>● Patient advocates</li> </ul>

### Recommendation 3:

## Incorporate FIM Interventions into Medication Therapy Management Services in Medicare, Medicaid, and Private Insurance

While it is currently challenging for pharmacists to bill for clinical services broadly, Medication Therapy Management (MTM) is a potential FIM-related pathway to reimburse pharmacists for the patient counseling and other clinical care they provide through Medicare Part D, in addition to some Medicaid and commercial plans. Not to be confused in FIM conversations with the acronym for Medically Tailored Meals, MTM is a medication-focused approach to optimizing patient outcomes, from assessing patient needs and creating a treatment plan, to monitoring medication adherence and communicating progress back to the medication prescriber. As part of MTM, pharmacists work with patients to understand their holistic medication needs and follow up to ensure proper prescription management and optimal health outcomes. MTM coverage is relatively widespread: plans with Medicare drug coverage must offer MTM services and focus on Comprehensive Medication Review completion rates within MTM—along with cholesterol, diabetes, and hypertension medication adherence—which are key indicators in the Medicare Star Ratings system that measures the quality of Medicare health and drug plans.

In Medicaid, several states reimburse pharmacist-provided MTM services, with a number of states also addressing pharmacist-provided MTM through statutes, regulations, or other policies.<sup>23</sup> In states that have not implemented MTM programs for Medicaid beneficiaries or defined MTM services in pharmacists' scope

of practice, there is an opportunity for state Medicaid agencies to implement or expand their support of pharmacist-provided MTM to reduce the burden of chronic disease. Some private health plans also offer reimbursement for MTM services. Employer-based health plans provide an opportunity for pharmacists to expand their MTM services beyond the Medicare Part D population. Large employers often have an incentive to leverage MTM to minimize their health-care costs and improve the wellness of their employee base.

With the potential for FIM interventions to improve patient medication adherence and overall health outcomes, aligning plan incentives with pharmacy support might be a promising pathway for reimbursement.<sup>24</sup> Many discussants mentioned that MTM may pair well with FIM, citing alignment between the goals of MTM, especially related to chronic disease prevention and management, and the goals of FIM. However, aside from Medicare Part D and Medicare Advantage plans, coverage of MTM services is inconsistent and fragmented, particularly among private payers. Even when services are covered, financial compensation may be low relative to the complexity of care required. In addition, even though FIM aligns with MTM from an operational and implementation perspective, discussants also flagged potential concerns with reimbursement since MTM is part of the Medicare drug benefit. They emphasized that should FIM become consistently integrated into MTM services, it will be important to ensure that guardrails

exist to separate FIM interventions from being leveraged as criteria that could influence drug reimbursement rates. Because MTM in Medicare is written into statute as part of the drug benefit,

Medicaid and commercial plans may have more flexibility to implement guardrails that fully separate FIM services as part of MTM from the drug benefit.

Actions	Primary Stakeholders
<p>Incorporate FIM-related interventions into pharmacist MTM (Medication Therapy Management) programs. Examples may include opportunities for pharmacists to screen a patient for eligibility into FIM programs, educate eligible patients on FIM programs to promote uptake, and monitor and support adherence to FIM interventions.</p>	<ul style="list-style-type: none"> <li>● <b>Public and private health plans</b></li> </ul>
<p>Encourage private health plans to offer pharmacist MTM services that include FIM care for beneficiaries with diet-related chronic diseases.</p>	<ul style="list-style-type: none"> <li>● <b>Pharmacy leadership</b></li> <li>● <b>Employer health benefit leadership</b></li> </ul>
<p>Offer pharmacist MTM services that include FIM care in private plans for beneficiaries with diet-related chronic diseases.</p>	<ul style="list-style-type: none"> <li>● <b>Private health plans</b></li> </ul>

#### Recommendation 4:

### Incorporate Community Health Workers into Pharmacy Operations to Improve Patient Health-Care Access through Existing Reimbursement Options

Community health workers (CHWs) are frontline public health workers with intimate knowledge of their communities who can help patients navigate the health-care and social-services systems. While they do not provide direct care or services, they act as an important connection point between the community and health-care system, from conducting health assessments and providing health education to helping patients understand their health insurance and referring them to relevant resources.

Because of their ability to support patient-centered care and improve patient outcomes, CHWs have been gaining traction as a valuable resource to payers. Within Medicaid, many managed care plans (MCPs) seek CHW services to address patients' ongoing health-related social needs, such as food insecurity. MCP and CHW partnerships have found success in per-member-per-month, per-engaged-member-per-month, or monthly billable event models due to the longitudinal nature of care coordination.

The 2024 Medicare Physician Fee Schedule introduced new reimbursement codes to pay for Community Health Integration (CHI) and Principal Illness Navigation services, which permit Medicare payment for CHWs' time spent on services that address unmet social determinants of health (SDOH) needs that affect the diagnosis and treatment of a patient's medical problems. Activities may include conducting person-centered assessments to better understand patients' life stories, health-care access navigation, health education and advocacy, and care coordination. In the current model, patients must be identified by a Medicare Part B-recognized health-care provider—typically primary care physicians—for CHWs to intervene and be paid for these services through Medicare. Considering that patients visit their pharmacists more often than their primary care physician, this is an opportunity for health-care providers to collaborate with pharmacies that deploy CHW services to close patient care gaps.

Pharmacists and CHWs collaborate closely in many care settings to support patient needs while reducing health-care costs. Several discussants described their success in integrating CHWs into pharmacy operations as members of a collaborative care team (see Recommendation 8): “We worked to use CHWs to augment the

pharmacists to have a sense of connection to patients.” Other discussants advocated for having pharmacy technicians cross-trained as CHWs, which they found to be an effective model for coordinating longitudinal care planning, while having team members support both the pharmacist's workflow and patient needs as they arise. Discussants emphasized that pharmacy technicians are well positioned to be cross-trained as CHWs because they are often embedded within the community already: “My pharmacy technicians were always there. They're that key person in the pharmacy who mirrors the community already, the local person who really knows how to connect to their community.”

While CHW requirements vary from state to state, the general model covers the same content, and many pharmacies have found that training their technicians is more efficient than hiring external CHWs and giving them pharmacy-specific training.<sup>25</sup> Despite scalability challenges—such as appropriate technology, coding, billing, contracting with health plans, credentialing, enrollment, and revenue cycle management—opportunities exist for CHWs to collaborate alongside pharmacists in support of targeted chronic disease management, including MTM services, that may involve FIM interventions.

Actions	Primary Stakeholders
<p>Cross-train pharmacy technicians as CHWs to support patient needs.</p>	<ul style="list-style-type: none"> <li>● Pharmacy leadership</li> <li>● Pharmacy technicians</li> </ul>
<p><i>For pharmacies that employ CHWs:</i> Collaborate with Medicare Part B providers to provide CHI services to reach more patients and be reimbursed for services.</p>	<ul style="list-style-type: none"> <li>● Medicare Part B providers</li> <li>● Pharmacy leadership</li> <li>● CHWs</li> </ul>
<p>(1) Enact provider status legislation that includes pharmacists as eligible Medicare Part B health-care providers, where pharmacists are authorized to be reimbursed for providing FIM-related care and diet-related chronic disease management.</p> <p>(2) <i>Once pharmacies are recognized as Medicare Part B providers:</i> Authorize pharmacies to deliver and bill for services that qualify as an “initiating visit” for CHI.</p>	<ul style="list-style-type: none"> <li>● Congress</li> <li>● CMS</li> </ul>
<p>Once pharmacies can be reimbursed for leveraging CHWs, integrate CHWs in pharmacy operations to support patient engagement and care with a focus on health-related social needs including FIM.</p>	<ul style="list-style-type: none"> <li>● Pharmacy leadership</li> <li>● CHWs</li> <li>● Pharmacy technicians</li> </ul>
<p>Managed care plans should collaborate with pharmacies to leverage cross-trained CHWs/pharmacy technicians to improve patient access to FIM-related interventions.</p>	<ul style="list-style-type: none"> <li>● Managed care plans</li> <li>● Pharmacy leadership</li> <li>● CHWs</li> <li>● Pharmacy technicians</li> </ul>

## Pharmacy Spotlight: Leveraging Community Health Workers

Pharmacists and CHWs at community pharmacies across the Mississippi River Delta collaborate to provide comprehensive care to patients in the communities they serve, which are among the poorest in the country. These community pharmacists collaborate with the health department, state and local pharmacies, rural health clinics, and food pantries to create a close-knit web that can support the complex needs of each patient. Within the pharmacy, technicians are cross-trained as CHWs to step in and out of the pharmacy workflow as needed to meet patients where they are in their care journey. Pharmacists can work with patients on lifestyle modifications around chronic conditions, while CHWs can refer patients out of the pharmacy to services such as dietitians or nutrition counseling. This model positions the pharmacist and CHW as a connection point for patients in navigating health systems and social services by leveraging relationship-based referrals and peer-to-peer liaisons to improve longitudinal care.

*“We work in collaboration... We work on the medication optimization side and refer out to [social] services. If [a client] needs access to food, we refer them to mission groups, food pantries, etc. We’ve volunteered with them as well when they’re short-staffed. We try to integrate and make sure everyone in the region is involved... so we don’t have to do everything.”—Community pharmacy leader during an interview*

### Recommendation 5:

## Enhance Partnerships between Employer-Sponsored Health Plans and Pharmacies to Include FIM Benefits

Private insurance is another promising avenue to cover payment for FIM care. Employers are uniquely positioned to support innovative health offerings in their employer-sponsored health insurance, with almost 165 million employees in the US workforce and half of the US population receiving health insurance through their workplace.<sup>26</sup> With the growth of value-based care design and more self-funded plans incorporating accountable care strategies that

pay for value over service volume, employers are looking at interventions that would contain employer-sponsored health insurance costs and improve employee quality of life. Employers have a clear incentive to address growing diet-related chronic disease rates among their employees as the costs of providing employer-sponsored health insurance continue to rise, especially for self-funded plans. Five chronic diseases and risk factors—high blood pressure, diabetes,



smoking, physical inactivity, and obesity—cost US employers \$36.4 billion a year in absenteeism alone.<sup>27</sup>

Many companies are beginning to explore food benefits for their employees, providing healthy groceries and medically tailored meal options as part of their covered benefits or through employee assistance programs. Employers already partner with pharmacies on specific disease-state interventions, such as hypertension screenings or diabetes management programs, so there is a significant opportunity for employers to enhance these interventions with FIM components.

Employer-sponsored health plans have far more flexibility than government programs to innovate and customize health benefit

packages, and many already partner with pharmacies on disease-specific programs related to FIM, such as diabetes and cardiovascular disease interventions. Discussants, including those representing pharmacies, also spoke favorably about the private insurance space: “Employers are easier to work with because... they’re going to be more specific on problems to solve, so it’s going to be easier to implement.” Collaborations with employer-sponsored plans around FIM would allow employers to leverage existing relationships with pharmacies and for pharmacists to be reimbursed for additional care. Furthermore, with more than half the US population receiving health insurance through the workplace, employer-sponsored plans can reach a large proportion of the population that may benefit from FIM services.

Actions	Primary Stakeholders
Expand employer-sponsored, pharmacy-based chronic disease prevention and management programs to include FIM services such as medically tailored groceries or healthy food cards.	<ul style="list-style-type: none"> <li>● Pharmacy leadership</li> <li>● Employers</li> <li>● Employer-sponsored health plans</li> <li>● Health benefit brokers</li> </ul>

# Pharmacy Workflow

## VISION:

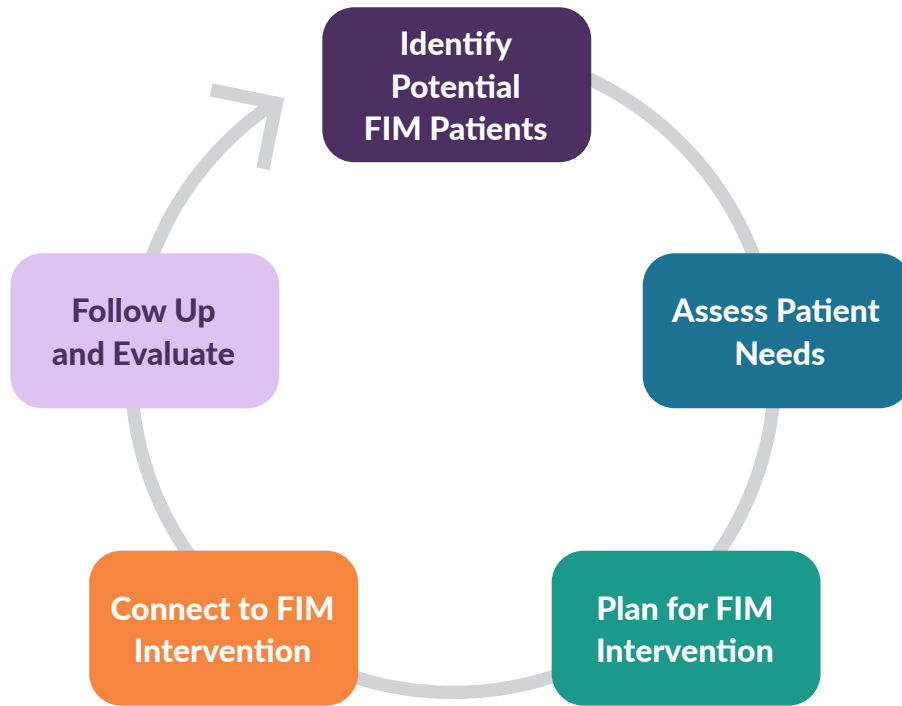
Seamless Integration of FIM into Pharmacy Workflow Processes without Burden on Pharmacy Teams



Pharmacy workflow describes the processes pharmacists and pharmacy technicians follow to ensure that their tasks, such as dispensing medications, administering vaccines, and counseling patients, are completed in an organized, systematic, and efficient way to best meet the needs of their patients. The Joint Commission of Pharmacy Practitioners created a profession-wide patient-centered care model known as the Pharmacists' Patient Care Process in 2014, which is currently being updated to reflect contemporary practices in pharmacy

workflows. In the context of FIM interventions, the Pharmacists' Patient Care Process may include: (1) identifying patients who might qualify for or benefit from an intervention or program; (2) assessing patients' individual needs; (3) planning their care journey to meet current health needs and leveraging available resources; (4) providing interventions and connecting them to FIM resources; and (5) following up, monitoring, and evaluating outcomes (see Figure 3).

**Figure 3: Pharmacist's Patient Care Process**  
(adapted to reflect the pharmacist's role in FIM interventions)



Source: Milken Institute (2024), adapted from the Joint Commission of Pharmacy Practitioners

Generally, pharmacies follow a similar workflow process, although individual pharmacies have unique approaches to fit their specific needs. Pharmacy workflow is typically guided by the pharmacy management system for dispensing prescriptions. As the pharmacy landscape shifts toward providing more patient care, the coordinated workflow must seamlessly integrate both the provision of care services, such as FIM care, and current pharmacy dispensing functions into pharmacy workflow.

Effective pharmacy workflows also consider which pharmacy team members are qualified and best suited to complete any given task. For example, certain pharmacy dispensing functions and clinical care activities require a

pharmacist's license and expertise, while other activities can be achieved by leveraging the skills of pharmacy technicians. Operationalizing new pharmacy-based care services, such as FIM care, while ensuring that pharmacies continue to meet patients' prescription needs, will require the development of an efficient and effortless pharmacy workflow that supports both simultaneously.

An effective workflow must seamlessly initiate and connect patients to FIM interventions without significantly disrupting other pharmacy responsibilities. It should also be sensitive to the time required to complete a given task, including where in the workflow it can most feasibly take place. The pharmacy's computer software system

should be able to send the appropriate prompts at the appropriate time, and the pharmacist should be equipped with knowledge of eligible FIM interventions and resources covered by the patient's insurance, as well as the technology to document and follow up on the FIM intervention.

### **Recommendation 6:**

## **Create a Seamless and Efficient Process to Identify FIM-Eligible Patients So Pharmacies Can Connect Them to Interventions, Either Externally or In-Store**

FIM research has primarily focused on gathering evidence to prove that interventions such as produce prescriptions and medically tailored meals are cost-effective and improve health outcomes. However, there has not been a consistent or focused way to identify patients who might benefit from, or be eligible for, these interventions. FIM-eligible patients with diet-related chronic conditions are likely to visit pharmacies regularly to pick up medications or receive vaccinations, making pharmacies a prime site for identifying individuals who might benefit from FIM.

More than two-thirds of discussants emphasized that pharmacists are a natural touchpoint for identifying FIM-eligible candidates for this reason: "Screening is definitely a place for pharmacies to fit into the FIM landscape, no question. A lot of people go to the pharmacy regularly as a health-care interaction point. Some people just go in to pick up prescriptions, some are getting advice, some are receiving preventative services. These are all potential interaction points for a simple screener."

Discussants underscored that many pharmacists want to understand patients' insurance eligibility for FIM interventions even before they screen.

The following recommendations address how FIM can integrate into pharmacy workflows while recognizing both the pharmacist's operational needs and the patient's personal needs for effective delivery of FIM care.

This is to ensure that patients can access the services to which they are referred, as well as to support the pharmacist's ability to provide meaningful care: "Pharmacists aren't going to be comfortable doing interventions or approaching patients unless they know what they're referring to and that it's going to be covered.... If you start a referral mechanism without an understanding of what programs they can refer to (such as a produce prescription) and if it is covered by the plan, or patients will have to pay, you're not going to have uptake." Having a workflow that prompts the pharmacist based on clear eligibility criteria and insurance coverage is essential to efficient and effective FIM delivery that meets the needs of both pharmacist and patient. Ideally, in the future, there will be more comprehensive and widespread coverage for FIM interventions and care delivery to improve access for patients and mitigate implementation barriers that arise because of the patchwork of offerings.

Discussants identified two primary pathways for patient identification: systems-driven and patient-driven. With systems-driven identification, the pharmacy management system prompts the pharmacist or pharmacy technician that the patient at the counter meets specific

criteria and may be eligible for FIM interventions: “We know a fair amount about the patient, what medications they’re taking. Wherever we have those attributes, we can introduce systematic triggers to prompt a conversation. We’ve done that with other things we’ve introduced.” A systems-driven approach could also incorporate insurance data: using a list of eligible patients provided by a health plan, pharmacy systems could trigger prompts for those patients and/or text messages only to those patients eligible for the FIM intervention.

Patient-driven identification allows patients to initiate conversations about FIM with the pharmacist, often in response to a prompt. This could involve in-store signage that prompts patients to ask their pharmacist about FIM and can indicate that a program is covered for patients on a specific insurance plan. Discussants mentioned that this pathway was particularly effective because patients are already amenable to the program: “We’ve seen success in referrals working with patients who have interest and want to engage in the program.”

Actions	Primary Stakeholders
Identify patients who could benefit from FIM interventions within the pharmacy management system using eligibility criteria determined by plans.	<ul style="list-style-type: none"> <li>● Health plans</li> <li>● Pharmacy leadership</li> <li>● Pharmacy management system providers/ vendors</li> </ul>
Improve patients’ understanding of their benefits and eligibility. For example, eligible patients (identified by a plan) can receive virtual or in-person communication about FIM opportunities and can inquire further with their pharmacist.	<ul style="list-style-type: none"> <li>● Health plans</li> <li>● Technology providers</li> <li>● Pharmacy leadership</li> <li>● Pharmacists</li> </ul>

## Recommendation 7:

### Utilize Front-of-Store Capacities to Serve as a One-Stop-Shop for FIM Interventions

Health-care interventions, including FIM, are most accessible for patients when they involve as much care as possible in the least number of visits. Multiple discussants noted that utilization and adherence rates were often low in programs where patients have multiple follow-up visits, and to-dos after the intervention have been included: “Every time you add in another step, the likelihood that folks will actually do it decreases. The intent should be to make it as easy and convenient as possible for the patient.” Discussants identified that many pharmacies have the unique ability to provide multiple services in one location: “Over the last 10 years in the broader pharmacy industry, pharmacists have become really good at communicating a recommendation and causing action in the same visit. That is one of the things that the pharmacy offers that very few others can. For example, with smoking cessation, the pharmacist can identify someone who is interested in quitting smoking, communicate the recommendation, and start them on smoking cessation right there.” As a comparison, when a patient is identified at a primary care practice and needs to visit their pharmacy separately to access treatment, obstacles may arise between the two visits—from transportation to time—that may prevent the patient from following through with their treatment plan.

In the context of FIM, centering the pharmacy could also streamline the patient’s access to care. For example, when a patient comes to the pharmacy to pick up their medication for

diabetes, the pharmacist could use the diagnosis on their medication profile to identify that the patient is eligible for, and could benefit from, FIM. As part of a broader chronic-care management visit, the pharmacist would then initiate an intervention, including care management with the pharmacist, education from an in-store or virtual dietitian, and a food benefit. If the patient desires, the food portion of the prescription could be “filled” during the same visit to the pharmacy’s front-end grocery offering.

Ideally, the patient’s insurance company would contract with the pharmacy to pay for FIM screening and chronic-care management. Additionally, there is an opportunity to refer people visiting the grocery store to the pharmacy—for example, to get their A1C tested.

Creative solutions that centralize as many FIM interventions as possible at the pharmacy can bolster existing pharmacy services and patient access. Discussants saw significant promise for FIM to drive value for their pharmacy patients and improve customer loyalty: “When you’re talking about pharmacies, if you do anything beyond just normal pharmacy transactions, they’re even more sticky, whether that be vaccines or food prescriptions.” This can be particularly salient in rural communities, where resources such as pharmacies, grocery stores, and health-care providers may be spread far from one another. If capacity permits, utilizing the pharmacy to provide more than just screening and referral can be a valuable way to simplify access and improve behavior change



and utilization among patients. Furthermore, as the FIM movement advocates for the grocery industry to play a larger role in health care,

pharmacies with connections to food and grocery stores may have additional opportunities to support FIM delivery and food access.

Actions	Primary Stakeholders
<p><i>For pharmacies located in grocery stores:</i> Coordinate with front-of-store leadership to set up a process to assist pharmacy patients with redeeming the food portion of their FIM intervention.</p>	<ul style="list-style-type: none"> <li>● Front-of-store leadership</li> <li>● Pharmacy leadership</li> <li>● Health plans</li> </ul>
<p>Host food pickup onsite in partnership with a FIM provider (such as a produce prescription service or medically tailored meals company) so that patients can schedule their FIM pickup in conjunction with medication pickup.</p>	<ul style="list-style-type: none"> <li>● Pharmacy leadership</li> <li>● FIM providers</li> <li>● Health plans</li> </ul>

### Recommendation 8:

## Foster Collaboration between Pharmacists and Dietitians as Part of an Interprofessional Team to Complement a Patient’s Medications with Additional Lifestyle Modifications

Research shows that health outcomes improve when pharmacists are added to care teams, especially for patients with chronic conditions such as cardiovascular disease and diabetes.<sup>28</sup> Many discussants emphasized that patients receive the best care when pharmacists are embedded within a care team of experts, including dietitians. The discussants shared successes they had experienced in having a diverse, collaborative care team: “Instead of just pharmacy-centric, it’s company-centric... providing help so that the pharmacist can lean in, instead of putting it on the pharmacists to do it all themselves when they’re already busy and helping patients.” Discussants noted that a diverse collaborative care team also supports patient needs more effectively: “Where pharmacists and pharmacies could play a critical

role is in connecting patients to other providers who might make a difference in their care. For example, we paired pharmacy screenings for cholesterol, high blood pressure, and A1C with dietitian-led grocery store tours to talk about ‘better-for-you’ options.”

Discussants consistently highlighted the value of collaboration between dietitians and pharmacists, particularly because effective prevention and treatment typically include both medication and lifestyle interventions used in tandem. Because most pharmacists are not trained as nutrition experts, discussants noted how valuable it was having a dietitian on the team to guide patients through specific food choices and behavior change. Dietitians can provide direct support to patients and personalized, disease-specific resources to encourage greater

behavior change related to diet, with chronic-care management support from pharmacists. Discussants also pointed out that CHWs were valuable in supporting patients for more than referrals alone, by helping patients understand

eligibility and navigating the larger health-care system. (See Recommendation 4.)

Actions	Primary Stakeholders
<p><i>For pharmacies with on-site dietitians located in grocery stores:</i> Establish a protocol for pharmacists to refer patients to on-site dietitians. In pharmacies with a grocery division, dietitians can support FIM interventions with “store tours,” providing interactive nutrition education and counseling.</p>	<ul style="list-style-type: none"> <li>● Pharmacy leadership</li> <li>● Dietitians</li> <li>● Front-of-store leadership</li> </ul>
<p><i>For pharmacies with access to virtual dietitians:</i> Refer and set up appointments for eligible patients to meet with virtual dietitians for nutrition counseling.</p>	<ul style="list-style-type: none"> <li>● Pharmacy leadership</li> <li>● Dietitians</li> </ul>
<p><i>For pharmacies located in grocery stores that do not have access to dietitians, whether on-site or virtually:</i> Develop sustainable and viable funding pathways with health plans to incorporate dietitian services into the broader pharmacy care team.</p>	<ul style="list-style-type: none"> <li>● Health plans</li> <li>● Pharmacy leadership</li> <li>● Front-of-store leadership</li> </ul>

## Pharmacy Spotlight: Collaborative Dietitian–Pharmacist Partnerships

One large regional grocer with pharmacies has employed dietitians for more than 20 years. The pharmacy and dietitian teams collaborate closely to support patients with diabetes and connect them to resources. When patients come to the pharmacy to pick up their prescriptions, they are directed to a consultation with a dietitian, which may include store tours through the food aisles and discussions of ways to improve healthy eating choices. Compared to dietitians operating within a health system, dietitians who work on-site colocated within a grocery store and pharmacy provide a successful model for behavioral consultation: Dietitians can point out in-store products and demonstrate real-life examples of label reading in the appropriate environment, while also having access to hemoglobin A1C testing and other measured results, in addition to medication information, from the pharmacy team. Offering more collaborative services in one place makes it easier for patients to receive appropriate and timely care that is immediately actionable and holistic.

*“It’s a lot more repeatable and less academic than ‘Eat less sugar!’— What does that mean? How do I take that home and act on that? Having a dietitian walk them through the store is helpful.”—Community pharmacy leader during an interview*

### Recommendation 9:

## Refer Patients to External FIM Resources through Social-Needs Aggregator Platforms

Connecting patients to services directly at the point of pharmacy care is the most powerful way to sustain program engagement and improve follow-through. However, pharmacists can also connect patients to external FIM resources more broadly when pharmacies are unable to offer FIM interventions directly or pharmacy priorities are at capacity providing other care services. Discussants highlighted that alternative methods of connecting patients to FIM can be helpful:

“It’s not minutes with a patient—it’s seconds.... What’s the fastest, most effective way to identify potential patients, have the conversation, and deliver what they need to do for the next step themselves or get a referral to the next level?”

Referring patients to external FIM resources allows the pharmacist to support patients even when they do not have the capacity to create an in-depth patient-care plan. Closed-

loop referral platforms are preferable because they allow providers to coordinate care across sectors and understand whether patients have been connected to additional services across the continuum of care. However, additional databases contain significant amounts of information and can be used to connect patients

to care that fits their individual social needs. Until pharmacists are systematically involved in substantive, consistent workflow models and adequate reimbursement pathways, these social-needs aggregator platforms offer a strong alternative to help connect patients to care.

Actions	Primary Stakeholders
<p>Utilize aggregator databases to connect patients externally to relevant care and health-related social needs resources. See Appendix B for examples.</p>	<ul style="list-style-type: none"> <li>● Pharmacy leadership</li> <li>● Pharmacists</li> <li>● Pharmacy technicians</li> <li>● CHWs</li> </ul>

# Technology Infrastructure

## **VISION:**

Interoperable Technology Infrastructure to Support FIM Data Sharing throughout the Health-Care Ecosystem



“Technology infrastructure” is the term that describes the data and systems supports pharmacists need to document, communicate, and receive information about services needed and provided. Despite pharmacists’ playing a meaningful role in patients’ larger health-care journeys, pharmacy data and systems are relatively disjointed from those used by other health-care providers. Without uniformity and standardization in health-care data systems, community pharmacists generally have limited ability to access clinical data from, and seamlessly share clinical information with, other providers. This is also known as “multidirectional interoperability.”

Pharmacies often rely on third-party vendors for clinical documentation, medical billing, and communication with other health-care providers. Further, electronic health records (EHRs) are optimized for medical settings other than pharmacies; they do not easily integrate, therefore, with pharmacy systems. This lack of interoperability raises challenges in transferring patients’ medical records and other clinical data between pharmacies and other providers. In addition, challenges with multidirectional interoperability are not limited to pharmacy management systems; across the nation’s health-care system, the technology infrastructure

remains fragmented in many ways despite recent improvements in interoperability.

In a shifting health-care landscape where pharmacists are taking on a larger role in clinical care, pharmacists need improved access to health records and the ability to exchange patient information with other providers, with appropriate data privacy measures in place. This is particularly important with FIM, which involves communication among a range of care providers and detailed follow-up on patient health outcomes. To deliver patient care effectively, pharmacists must have sufficient information about patients during each stage of the care process, even when patients are referred out of the pharmacy. This information is vital to closing the loop in patient care and linking interventions with improved health outcomes in a value-based model.

Because FIM can include care from diverse stakeholders—from primary care physicians to community-based organizations—effective data sharing can be challenging, while essential to meeting patient needs. Improving

interoperability throughout the health-care ecosystem will improve care for patients not only as it relates to FIM, but also for other pharmacy-provided services and additional patient-care needs. Health-care data interoperability must also center on the need to address concerns about implementation of Health Insurance Portability and Accountability Act (HIPAA) regulations and data privacy in FIM. Emerging FIM technologies, such as payment platforms that support unique patient needs while tracking outcomes for payers, could help streamline efforts for the patient, payer, and pharmacist when integrated with pharmacy operations. Additionally, implementing new technology systems and upgrades to current technology infrastructure requires meaningful investments and aligned incentives.

The following recommendations describe the actions needed to ensure that pharmacists can easily document the care they provide, exchange information with other providers, and have full access to a patient’s medical records to support a holistic care plan effectively, using FIM.

## Key Technology Stakeholders

- **Pharmacy management system providers:** Vendors in charge of changes to the pharmacy management system that helps pharmacies manage their operations and workflows, including medication inventory, vaccinations, and prescription dispensing
- **Technology providers:** Vendors who support technology used in pharmacies more broadly, from automated SMS prompts to referral aggregators

## Recommendation 10:

### Improve Data Interoperability for Pharmacists to Document Their Services and Exchange Clinical Information

The importance of technology came up in almost 90 percent of interviews. Many discussants, particularly those involved in pharmacy operations, emphasized that limited data interoperability presented a significant challenge for pharmacists to integrate FIM and provide clinical services more broadly. The absence of technological standardization and uniformity across systems inhibits pharmacists' abilities to transmit data between health-care stakeholders. Several discussants spoke about the need to upgrade the technology infrastructure to minimize both human and technology miscommunications: "We send lots of faxes to providers, but they get lost, or they're not seen." Pharmacists are often working with minimal information about patients based on what other providers choose to share with a prescription and, likewise, other health-care providers have limited access to pharmacy information about their mutual patients.

Furthermore, pharmacy systems may have limited capacity for information sharing with other providers' systems and vice versa. One discussant said they could share information with only one provider: "Our system can only accept one doctor. If they're seeing a primary care provider, a nutritionist, and an endocrinologist, we can't send it to everyone."

Technology improvements and upgrades must occur in both the pharmacy management system and other providers' management systems to ensure that they meet existing standards and information-sharing expectations.

In addition, more comprehensive documentation capacities would help the care team understand each patient's full care journey. Several discussants noted that documentation capabilities were limited: "It's not as robust as what I think it could be. They send pretty generic messaging: not so much 'We said this and we're going to follow up,' just 'This is what was done.'" Discussants also emphasized that documentation impacts payment for services: "If you can't document and demonstrate it, it didn't happen. It's all about what you can document and prove... You have to invest in the technology and train your people to go down that path."

Documentation and exchange of social-needs information through Z-code data was another element that surfaced, especially with the integration of community pharmacy-based CHW. Technology that supports thorough documentation—without further burdening the pharmacy team—would improve understanding of patient needs and help ensure appropriate payment for services.



Actions	Primary Stakeholders
<p>Incentivize improvements to pharmacy data systems, similar to the federal Medicare and Medicaid Promoting Interoperability Programs model that incentivizes health-care providers to use certified EHR technology for improved quality of care, to enable more effective data sharing.</p>	<ul style="list-style-type: none"> <li>• <b>Office of the National Coordinator for Health Information Technology</b></li> </ul>
<p>Invest in technology upgrades to ensure pharmacy management systems are equipped to exchange data with other stakeholders, with capacities for more detailed clinical documentation that includes opportunities to document FIM-related services, including referrals to FIM interventions.</p>	<ul style="list-style-type: none"> <li>• <b>Pharmacy leadership</b></li> <li>• <b>Pharmacy management system vendors</b></li> </ul>
<p>Support bidirectional data exchange between pharmacies and existing health-care partner systems, such as hospitals and clinics, ensuring their systems meet the relevant data standards.</p>	<ul style="list-style-type: none"> <li>• <b>Health-care facilities</b></li> <li>• <b>Pharmacy management system vendors</b></li> </ul>
<p>Review statutes and regulations at the state and federal levels to ensure they support pharmacists' ability to access information related to front-of-store food purchasing activity while maintaining patient privacy standards.</p>	<ul style="list-style-type: none"> <li>• <b>Pharmacy legal teams</b></li> <li>• <b>Federal and state policymakers</b></li> </ul>

### Recommendation 11:

## Implement Technology Solutions to Improve and Streamline the Patient Care Experience

Technology can also simplify the care experience for both the patient and the pharmacist. For example, automating tasks that do not need a personalized touch can free up the pharmacist's time for more patient-centered care. Discussants mentioned that many pharmacies are already moving toward using automation to fill prescriptions and dispense medications to reduce costs and support patient safety: "The role of pharmacy is evolving. What they used to do is becoming more automated, and this allows opportunity in the health-care system to utilize clinicians in a new way."

Pharmacies can also use technology to reach patients more effectively and sensitively. For example, several discussants flagged that screening for FIM may involve sensitive questions related to patients' ability to access specific foods or details about their disease state and socioeconomic status. Discussants also noted that screening patients for the same conditions too many times could lead to screening fatigue: "Appropriate screening rates are really important ... There needs to be deeper collaboration around workflows and operationalizing things in a way that it's done effectively, and supports members

in a way that doesn't overburden or over-screen in a counterproductive way.”

One discussant suggested utilizing mobile tablets in convenient locations to give patients a safe space to self-screen. Another discussant suggested including a digital prompt on the check-out screen that asks patients if they want to learn more about FIM. Integrating technology into the screening process can help patients feel more comfortable answering sensitive questions and allow them to engage in private, rather than speaking publicly with the pharmacist at the counter when other patients or pharmacy staff may be nearby.

Technology can also support patient outreach. Communicating with patients can often be time-consuming, particularly when it involves individual phone calls and personalized messaging. Several discussants, particularly those with experience as practicing pharmacists, emphasized that their expertise and skills would be far underutilized if their responsibilities were dominated by the patient outreach process alone. However, many pharmacies already use text or email notifications to remind patients about their prescriptions. A similar model could be used for FIM notifications or reminders, prompting

patients about their eligibility or answering simple questions about interventions.

Discussants also looked to other pharmacy-based interventions for inspiration on streamlining processes. Several discussants mentioned that appointment-scheduling platforms transformed pharmacists' ability to provide millions of COVID-19 tests and vaccines. In the context of FIM interventions, which typically require patients to meet with multiple care providers, discussants suggested leveraging similar scheduling platforms that centralize appointments for multiple care providers to improve customer follow-up: “If somebody walks out and knows they have the appointment and who they have it with, that helps create more skin in the game for that person. Appointment scheduling is simple, but a piece of technology that I think is going to be important, because a pharmacist is going to have to hand them off to a dietitian or nutritionist, so how do you use technology to make that easy?” Building on existing, simple, and successful technology solutions can support pharmacists in their operational workflow and engage patients in more personalized ways.

Actions	Primary Stakeholders
<p>Continue to leverage emerging technologies, such as robotics and AI-assisted software, to automate aspects of the pharmacy dispensing workflow and leverage the skills of pharmacy technicians in supporting dispensing and other technical tasks related to vaccines and testing to allow more time for pharmacists to provide patient care, which requires their clinical expertise.</p>	<ul style="list-style-type: none"> <li>● Pharmacy leadership</li> <li>● Technology providers</li> </ul>
<p>Facilitate FIM screening that is covered by insurance leveraging QR codes, on-site tablets, or a question at check-out for patients to engage with FIM services privately and of their own volition.</p>	<ul style="list-style-type: none"> <li>● Pharmacy leadership</li> <li>● Technology providers</li> <li>● Health plans</li> </ul>
<p>Automate SMS or email reminders for FIM intervention engagement and follow-up appointments based on patient profile, insurance coverage, and health needs.</p>	<ul style="list-style-type: none"> <li>● Pharmacy leadership</li> <li>● Technology providers</li> <li>● Health plans</li> </ul>
<p>Streamline scheduling through user-friendly patient care portals so that pharmacists can help patients confirm appointments on referral. This includes being able to schedule next steps with the full suite of FIM intervention services, including dietitians and follow-up.</p>	<ul style="list-style-type: none"> <li>● Pharmacy leadership</li> <li>● Technology providers</li> <li>● Dietitians and other providers on the FIM care team</li> </ul>

## Pharmacy Spotlight: Synchronizing Patient Nutrition Profiles

National grocery stores with pharmacies are leveraging technology to give customers more control over their health. Loyalty cards, for example, can help inform customers about their purchasing decisions. Many retailers have begun introducing ways to help their customers identify healthier options, such as shelf signage in their stores, and at least one retailer has implemented a nutrition rating system that generates a nutritional score for the customer based on their food purchases.

Companies are looking to leverage food purchasing data or nutritional scoring data further by embedding it within electronic health records to improve the quality of care that patients receive in the store and beyond. By connecting this purchasing and nutrition data to the patient's broader health profile, with their consent and data privacy protections in place, the pharmacy, payers, and other health-care providers can gain greater visibility into the patient's lifestyle and help support lifestyle changes and modify treatment plans accordingly. For qualifying patients, greater insight into their purchasing habits could create a new entry point for care providers to identify eligibility for FIM interventions and initiate conversations.

*"If everything could live in one place...could be integrated into the EHR, and the pharmacy and [FIM] prescription were also part of EHR and [could] talk to each other... that would make a lot more sense."*—FIM program facilitator during an interview

### Recommendation 12:

## Coordinate Evaluation Data throughout FIM Stakeholders to Track Health Outcomes Better and Improve Care Coordination

To effectively track and evaluate the impact of FIM interventions on patients, FIM care providers need to understand the connection between the food provided and health outcomes. Currently, most FIM interventions measure patient engagement rather than patient consumption or purchasing patterns, where choice is a component of the FIM model. In FIM

models where pharmacists are colocated in grocery stores and support patients in purchasing nourishing groceries, purchasing information from the front-of-store must eventually make its way back to the pharmacy system and other health-care providers, with patient consent. As discussed in [Market Solutions for Scaling Food Is Medicine Prescriptions](#), there are often major

hurdles to navigating patient privacy, even within two divisions of the same company. Combining purchasing data with nutrition consumption information has not yet been automated and can be time-consuming, labor-intensive, and prone to human error.

Some discussants proposed standardizing health scores beyond existing measures for foods purchased and those included in FIM-approved packages, using frameworks such as the Healthy Eating Index developed by the US Department of Agriculture Food and Nutrition Service. Of greater concern for other discussants was the need to transfer information between entities where one may not be a HIPAA-covered entity, such as for sending information from the front of the store back to the pharmacy. Discussants also offered creative methods for obtaining consent to share front-of-store data with the pharmacy for more

personalized health services, including utilizing loyalty cards or the store’s app as a platform to request consent.

Additionally, pharmacies have a unique opportunity to close the gap in FIM evaluation by measuring health outcomes frequently and in a way that is not burdensome when patients are in the store to pick up prescriptions. Collecting health outcomes such as blood pressure, A1C, or cholesterol—services that many pharmacies already offer—can be beneficial to payers for demonstrating the impacts of FIM on health outcomes, as well as for the health-care team in monitoring patient progress and adjusting the FIM intervention as needed.

Actions	Primary Stakeholders
Define FIM intervention key performance indicators and standardize across technology systems.	<ul style="list-style-type: none"> <li>● CMS</li> <li>● Health plans</li> <li>● Pharmacy leadership</li> <li>● Pharmacy management system vendors</li> </ul>
<i>For pharmacies located in grocery stores that leverage food-purchasing data:</i> Establish a pathway to connect food-purchasing data and FIM interventions with patient consent, including patient identification, monitoring, and follow-up.	<ul style="list-style-type: none"> <li>● Technology providers</li> <li>● Pharmacy leadership</li> <li>● Front-of-store leadership</li> </ul>
Collaborate with health plans to develop sustainable funding pathways and incentives for pharmacy teams to help measure FIM performance indicators and outcomes as part of pharmacy-based FIM care interventions, ideally as part of broader pharmacy-based chronic care prevention and management programs.	<ul style="list-style-type: none"> <li>● Health plans</li> <li>● CMS</li> <li>● Pharmacy leadership</li> </ul>

# Future Opportunities

Beyond the concrete recommendations proposed in this report, the landscape of FIM in pharmacies will continue to evolve, largely depending on how payment pathways reimburse pharmacists for their time and expertise. One discussant highlighted the importance of appropriate incentives to catalyze the movement: “We had major success with COVID in pharmacies. If you had asked me pre-COVID, I would have been skeptical. But incentives were put in place to make it possible to innovate and staff appropriately. Creating proper incentives will drive innovation in this space to deliver and serve patient needs.” Both private and public payers should consider opportunities to leverage funding pathways to drive innovation, not just in FIM but also in the broader landscape of chronic disease prevention, care, and management in which FIM is located.

Coverage for FIM is expanding, and once pharmacists are compensated for the clinical services they provide, they will be powerful in advancing patient access to FIM. As available reimbursement opportunities continue to grow, including Special Supplemental Benefits for the Chronically Ill and Value-Based Insurance Design, authorities should keep in mind the value pharmacists add to FIM access and implementation, as well as the importance of reimbursing providers for the provision of care in addition to the food itself.

Other FIM-related programs, such as the National Diabetes Prevention Program (DPP) and the Medicare Diabetes Prevention Program (MDPP), also have the potential for greater

pharmacy integration. Discussants shared that while pharmacies can be suppliers under the MDPP, for example, there are structural issues around pharmacy involvement with the programs. One primary barrier is the lack of Medicare Part B coverage for pharmacists providing A1C testing, as well as other administrative and reimbursement challenges with the program. However, there is potential for more pharmacies to participate in DPP and MDPP down the line with appropriate reimbursement and FIM integration.

Further, while the health-care system at large has been moving away from fee-for-service and toward value-based arrangements, this transition has lagged for pharmacies. As FIM becomes a pharmacist-provided service, and as pharmacies begin to offer more clinical services in general, payment for services along the continuum of FIM care should strive to adopt an outcome-based payment model centered on improved health for the patient, rather than on the number of services a pharmacist, or any other clinician, provides. Ideally, pharmacists would be reimbursed for assessing patients to understand their current needs and be ready with FIM support, should it be appropriate. An outcomes-based model would more broadly allow for both FIM care and patient care.

The use of technology has been expanding in the FIM landscape and in pharmacy operations. Already, technology is playing a significant role in automating processes to make operations easier for patients and care providers. As technology continues to develop, and as machine learning



and artificial intelligence are increasingly used to help promote patient safety and improve efficiency, stakeholders should stay attuned to the latest developments and consider how new technologies can continue to enhance FIM delivery and take the administrative burden off pharmacists and pharmacy teams.

Ultimately, partnerships are at the heart of effectively integrating FIM into pharmacies. Much work is being done to drive the FIM movement forward, and as the momentum accelerates, it will be critical to ensure that collaboration takes place across sectors and among organizations so as not to create or perpetuate silos. Beyond the stakeholders already involved with FIM, it is essential to continue informing decision-makers and the

broader public about the importance of FIM and the value of the pharmacist in holistic patient care to promote patient health. Raising awareness with elected officials, for example, has been a powerful way to lift FIM on to a national platform, such as with the inaugural US Department of Health and Human Services' Food Is Medicine Summit, which took place in January 2024. Similar education efforts can be used to highlight the value of pharmacies in the FIM movement so that the infrastructure enforced in policies recognizes and compensates pharmacists for their essential role in FIM and, further, in health care.

# Conclusion

For FIM to scale, it must be grounded in the larger context of a patient's health-care journey. More than simply the provision of healthy food, FIM can support patients in their nutrition needs as they follow their medication plans and adopt other lifestyle and behavioral changes. Pharmacists already engage with many patients who could benefit from FIM and collaborate with other providers at the core of the patient care team. As a bridge between patients and FIM resources, pharmacists can advance patient-centered care within the FIM movement and the health-care ecosystem.

The Milken Institute brought together a unique set of multisectoral stakeholders to explore opportunities for integrating pharmacies in FIM. Discussants identified the need for fair and straightforward payment pathways for pharmacists to be compensated for their

time and expertise in providing FIM care. In addition to integrating FIM into the pharmacy workflow without disrupting existing processes, appropriate technology infrastructure must be in place to support interoperability across the FIM ecosystem and among care providers. Addressing all three of these areas will drive the FIM movement forward and expand access to FIM for patients across diverse communities.

The FIM movement is gaining traction in both the public and private sectors, and pharmacists are well positioned to support these efforts as trusted, frequented, equitable, and qualified cornerstones of patient care. As FIM continues to take hold in the larger health-care landscape, pharmacists must be recognized as essential members of the patient's FIM care team, particularly for patients with diet-related chronic conditions.

# Appendix

## Appendix A. FIM Stakeholder Map

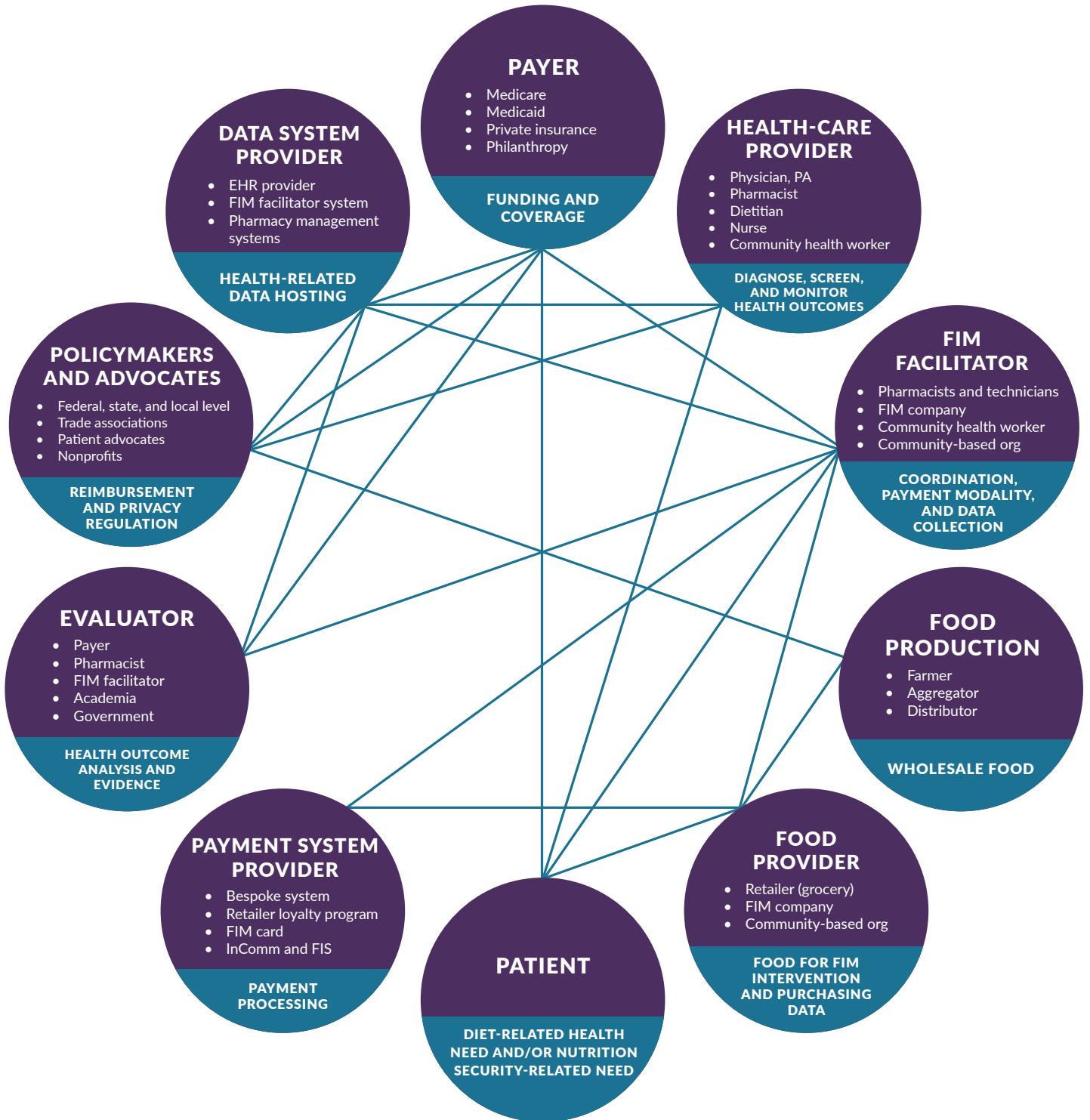
Transitioning patients in and out of FIM programs means implementing a spectrum of interventions and poses a particular challenge because of the numerous stakeholders involved, directly or indirectly, at every stage of the process. What should be simple—connecting a patient to a FIM intervention—blurs into a complex web of interactions, each with its own organizational requirements, operational systems, and implications for the patient.

This stakeholder map shows the 10 key stakeholder roles (the patient, payer, health-care provider, FIM facilitator, food production facilitator, food provider, payment system provider, evaluator, policymaker and advocate, and data system provider), the function each contributes, and how they link to other stakeholders during the FIM intervention process.

Further complicating this web, different interventions and programs involve different stakeholders, and organizations often operate in multiple stakeholder functions. A FIM facilitator, for example, can coordinate between the insurance company and health-care provider, and might also be the organization providing food directly to patients. In other programs, different organizations might fill the service delivery role yet have a separate food retailer supply the food. Conversely, a single hospital or health maintenance organization system might deliver all aspects of the program. To scale FIM interventions, it is necessary to understand the roles, the relationships, and the bottlenecks.

This image is improved and updated from the stakeholder map released in the [Market Solutions](#) report to include pharmacists as key members of the FIM care team.

**Figure A1: FIM Stakeholder Map**



Source: Milken Institute (2024)

## Appendix B. Curated FIM Resource Library

This resource library is a sample of recent reports and articles for pharmacists and other stakeholders to learn more about FIM. This library is intended to expand on topics related to this report and highlight opportunities for involvement in cross-sectoral FIM collaborations. This includes up-to-date tracking tools for state demonstration waivers and recent reports on scaling FIM interventions.

### Background on FIM

These resources are useful for understanding the FIM landscape, shedding light on the challenges and opportunities for scaling, and expanding access to FIM programs.

- [\*Ambitious, Actionable Recommendations to End Hunger, Advance Nutrition, and Improve Health in the United States\*](#) (Chicago Council on Global Affairs, Food Systems for the Future, the Gerald J. and Dorothy R. Friedman School of Nutrition Science and Policy at Tufts University, and World Central Kitchen, 2022). This report provides policy recommendations and actions to advance the goals of the White House Conference on Hunger, Nutrition, and Health in September 2022. It offers recommended actions aimed at Congress, the White House, numerous federal agencies, state and local governments, nongovernment organizations, and the private sector.
- [\*Financial Innovations Lab: Market Solutions for Scaling Food Is Medicine Prescriptions\*](#) (Milken Institute, June 2023). This report identifies opportunities to finance FIM interventions based on contributions from multiple sectors, including health plans, FIM tech companies, CBOs, and policy experts.
- [\*“Food Is Medicine Movement—Key Actions Inside and Outside the Government.” JAMA Health Forum, 2023.\*](#) This paper offers actionable policy recommendations to guide public and private stakeholders on how to push the FIM movement forward beyond short-term pilots and leverage FIM interventions more consistently in health care to address nutrition, hunger, and health effectively.
- [\*Food Is Medicine Research Action Plan\*](#) (The Aspen Institute, 2024). This report captures the evolving body of FIM-related research and describes the opportunities as well as the challenges of scaling, evaluating, and delivering health-promoting food where it is most needed.
- [\*“‘Food Is Medicine’ Strategies for Nutrition Security and Cardiometabolic Health Equity: JACC State-of-the-Art Review.” Journal of the American College of Cardiology, 2024.\*](#) This paper provides a robust overview of FIM policy and programs and shares preliminary evidence of effectiveness. Research gaps and opportunities in FIM are also identified.
- [\*Healthy Eating Rx: Improving Nutrition through Health Care\*](#) (The Bipartisan Policy Center, 2023). This report describes opportunities for scaling FIM interventions, outlines current congressional and administrative movement on FIM initiatives, and contributes FIM policy recommendations.
- [\*“Leveraging Grocery Stores to Deliver Personalized Nutrition: An Interdisciplinary Model of Care in\*](#)

[the Community.](#) American Heart Association. This 75-minute continuing education course, aimed at health-care and nutrition professionals, covers an interdisciplinary, patient-centered approach to delivering nutrition care at the retail level. It is free of cost and accredited.

- [“The Pharmacist of the Future: Unlocking the Profession’s Potential to Improve Patient Care.”](#) Deloitte Insights, 2021. This article not only investigates opportunities for expanding the pharmacist’s role to clinical services but also reimagines the pharmacy business model.
- [PQA Social Determinants of Health Resource Guide](#) (Pharmacy Quality Alliance, 2024). This resource guide profiles services that touch at least one SDOH barrier. Successful FIM programs and other SDOH activities led by pharmacies are also highlighted.
- [True Cost of Food: Food Is Medicine Case Study](#) (Food Is Medicine Institute, 2023). This report shares a “true cost” analysis of FIM programs based on two case studies of medically tailored meals and produce-prescription programs.

## Payment Pathways

The following resources provide background on Medicare and Medicaid, as well as specific pathways for FIM reimbursement. They include tools for tracking Medicaid waivers, reports, and toolkits on potential payment pathways for FIM interventions within Medicaid and Medicare.

### A. Medicare and Medicaid Trackers and Resources

- [“Medicaid State Waivers List.”](#) Centers for Medicare & Medicaid Services. This tool allows users to search for Section 1115 waivers by state.
- [“Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State.”](#) Kaiser Family Foundation. This website tracks the status of Section 1115 demonstration waivers and specifically highlights expanded eligibility, benefit changes, SDOH, and other delivery-system reform provisions.
- [“Medicaid Managed Care Tracker.”](#) Kaiser Family Foundation. This tool tracks individual indicators and can also be used to generate custom reports on Medicaid managed care for one or more states.
- [“Managed Care State Profiles and State Program Features.”](#) Centers for Medicare & Medicaid Services. This site provides the most recent information on Managed Care State Profiles and State Program Features.
- [“Medicaid State Plan Amendments.”](#) Centers for Medicare & Medicaid Services. This site allows users to search for state plan amendments by approval data and effective date.
- [“Nonmedical Supplemental Benefits in Medicare Advantage in 2024.”](#) ATI Advisory. This chartbook details Medicare Advantage nonmedical supplemental benefits, including SSBCI and VBID. See slides 1–16.



## B. Leveraging Medicare and Medicaid for FIM

- [“The Evolution and Scope of Medicaid Section 1115 Demonstrations to Address Nutrition: A US Survey.”](#) *Health Affairs Scholar*, 2024. This article describes the 19 approved and pending Medicaid Section 1115 waivers that include nutrition components (such as food insecurity screening, nutrition education, and Food Is Medicine) as of July 1, 2023, and emphasizes the accelerating pace, scope, and population coverage of interventions since 2021.
- [Mainstreaming Produce Prescriptions in Medicaid: A Policy Toolkit and Resource Library](#) (Center for Health Law and Policy Innovation, June 2023). This report details Medicaid and Medicare pathways for FIM and contains a detailed appendix with additional resources.
- [“State Policy Options: Leveraging Produce Prescriptions \(PRx\) to Treat and Prevent Diet-Related Illness.”](#) National Produce Prescription Collaborative and Center for Health Law and Policy Innovation, 2022. This resource briefly explains state policy opportunities that are relevant to produce prescription coverage, including Medicaid, Medicare, and additional grants or pilots.
- [Mainstreaming Produce Prescriptions: A Policy Strategy Report](#) (Center for Health Law and Policy Innovation, March 2021). This report shares recommendations for integrating produce prescription programs into the current health care, financing, and food systems.
- [Produce Prescriptions as a Novel Supplemental Benefit in Medicare Advantage.](#) Center for Health Law and Policy Innovation. 2021. This issue brief explains SSBCI and VBID pathways as they relate to FIM.

## FIM State Plans and Reports

The following reports and state plans provide examples of how organizations have developed state-level policy recommendations and implementation plans for FIM.

- FIM state coalitions:
  - [Food Is Medicine Massachusetts](#)
  - [California Food Is Medicine Coalition](#)
- [Integrating Food into Health Care: A Landscape Analysis of Medically Supportive Food and Nutrition Interventions in California](#) (San Francisco Bay Area Planning and Urban Research Association, 2021). This report evaluates Medically Supportive Food and Nutrition (MSF&N) service provider availability in California and shares recommendations for scaling MSF&N initiatives based on surveys of 145 organizations.
- [New York Food as Medicine State Project: Executive Summary and Recommendations](#) (New York Health Foundation, The Food Pantries, The Alliance for a Hunger Free New York, and Center for Health Law and Policy Innovation, 2023).

- [Massachusetts Food Is Medicine State Plan](#) (Center for Health Law and Policy Innovation and Community Servings, 2019).

## Multisectoral FIM Collaboration

There has been tremendous momentum on FIM implementation and scaling across the country. As mentioned at the inaugural FIM Summit hosted by the HHS in January 2024, the private and public sectors must collaborate to drive change. The following organizations are driving FIM initiatives forward through collaboration.

- [Center for Health Law and Policy Innovation](#), founded in 1987, is a leading advocate for FIM-related legal, regulatory, and policy reform, focusing on increasing access to nutritious food and reducing food and health disparities.
- [Food Is Medicine Coalition](#) (FIMC) is a coalition of CBOs from across the country. FIMC leads FIM research, advances policy, and supports the provision of FIM interventions, with a focus on identifying best practices.
- [Food Is Medicine Institute](#) (FIMI) was established in 2023 and is currently leading FIM advocacy and research. FIMI brings together the Tufts Medicine health system, faculty and students from Tufts University, and the private and public sectors. FIMI is collaborating with Kaiser Permanente on three clinical trials on FIM interventions and with Google on the intersection of AI, technology, and improving nutrition information.
- [Health Care by Food™ Initiative](#), first announced in 2022 by the American Heart Association and the Rockefeller Foundation, in partnership with Kroger and Kaiser Permanente, focuses on evaluating the impact of FIM programs on health outcomes, community health disparities, and diet-related health-care costs.
- [Milken Institute Food Is Medicine Task Force](#) leverages the private sector to accelerate the FIM agenda through policy, research, and thought leadership within the larger network of FIM actors, understanding the value of equity and patient-centered needs while being responsive to emerging needs in the FIM landscape.
- [National Produce Prescription Collaborative](#), established in 2019, works towards advancing FIM policy and integrating produce prescriptions into health care. Cofounders of the coalition include Wholesome Wave, Tufts Friedman School of Nutrition Science and Policy, DC Greens, and Reinvestment Partners.
- [#NourishMyHealth](#), part of a commitment by the National Association of Chain Drug Stores to the White House Conference on Hunger, Nutrition, and Health, is a collaboration with the American Cancer Society, the American Diabetes Association, the American Heart Association, and the Food Is

Medicine Institute. The goal of the campaign is to help patients embrace the protective health benefits that nutritious food provides in reducing the risk of diet-related conditions.

## Social Needs Aggregator Platforms

A number of existing databases help patients and providers find more information about community resources that are local and relevant to patients. These range from resource directories to closed-loop referral systems that may incorporate care coordination, case management, social needs screening, and more. Key platforms and resources highlighted by discussants are listed below.

- [211](#), supported by United Way, is a toll-free 24/7 network available by phone or web, directs callers to locally available resources, including information about supplemental food and nutrition programs and other resources to meet basic needs.
- [Community Resource Referral Platforms: A Guide for Health Care Organizations](#) (Social Interventions Research & Evaluation Network, April 16, 2019) helps safety net health-care organizations understand the landscape of community resource referral platforms and learn from early adopters' experiences of using them. The report highlights nine platforms to provide detailed profiles of the platforms' features, as well as lessons and recommendations from user organizations.
- [Findhelp](#) is a closed-loop referral network that connects payers, health-care organizations, government entities, communities, employers, and others in keeping patients at the center of care. Health centers can track search, referral, response, and outcome data to impact patients' overall health and leverage local community organizations and nonprofit programs for social care services and support.
- [Unite Us](#), a closed-loop referral platform that providers can use to share resources, allows organizations to personalize resource recommendations, secure closed-loop referrals, integrate into the web or other platforms, and tailor the workflow to meet the unique needs of populations served.

## Interoperability Resources

For FIM to scale effectively, providers across the FIM care continuum must be able to share and receive information about patients during each stage of the care process, in streamlined ways that comply with HIPAA regulations and data privacy standards. Below are additional resources on interoperability, with a particular emphasis on pharmacies.

- [Final Report of the Health Information Technology Advisory Committee on Pharmacy Interoperability and Emerging Therapeutics](#) (Health Information Technology Advisory Committee, November 9, 2023) presents recommendations and opportunities for improving interoperability among pharmacy stakeholders. In addition, the report identifies use cases, topics, and themes related to the recommendations.

- [Pharmacy Interoperability and Emerging Therapeutics Task Force](#), a subcommittee of the Health IT Advisory Committee, provided recommendations related to supporting increased interoperability among pharmacy stakeholders and information exchange for medication prescription and management.
- [Supporting Pharmacy Data Interoperability: An Imperative for Patient Access and Outcomes](#) (Leavitt Partners, an HMA Company, April 4, 2023) shares policy- and technology-related recommendations that pertain to three themes: eliminating barriers to pharmacies providing clinical services, data storage and sharing that is cost-effective and standardized, and collaboration within the health-care system.

## Appendix C. Summary of Recommendations

### Payment Policies (five recommendations, 15 actions)

Vision: FIM Care Is a Reimbursable Service for Pharmacists across Payer Types		
Recommendation	Actions	Primary Stakeholders
<b>Recommendation 1</b>  Recognize pharmacists as eligible providers under Medicare Part B to establish reimbursement for clinical services	Enact provider status legislation that authorizes pharmacists as eligible Medicare Part B health-care providers. Looking ahead, this could include providing FIM-related care and diet-related chronic disease management.	<ul style="list-style-type: none"> <li>• Congress</li> <li>• CMS</li> </ul>
	Advocate for CMS to recognize pharmacists as eligible providers, through the annual Medicare Physician Fee Schedule rule proposal process, to support broader access to clinical care, including FIM care, delivered at pharmacies.	<ul style="list-style-type: none"> <li>• Pharmacy leadership</li> <li>• Trade associations</li> <li>• Patient advocates</li> </ul>
<b>Recommendation 2</b>  Include pharmacies as reimbursable service providers within state Medicaid Section 1115 demonstration waivers	<i>In states without waivers:</i> Advocate for Medicaid Section 1115 demonstration waivers, with emphasis in rural communities, to leverage pharmacies as a reimbursable provider to improve access to FIM care.	<ul style="list-style-type: none"> <li>• Pharmacy leadership</li> <li>• Trade associations</li> <li>• Patient advocates</li> </ul>
	<i>In states without waivers:</i> Consider and prioritize approval for Section 1115 demonstration waivers that utilize pharmacies in rural communities to connect with harder-to-reach patients and reimburse them as qualified providers.	<ul style="list-style-type: none"> <li>• CMS</li> </ul>
	<i>In states where waivers are pending:</i> Submit written comments or participate in public hearings to advocate for including pharmacies as reimbursable providers of health-related social needs interventions, including nutrition supports.	<ul style="list-style-type: none"> <li>• Pharmacy leadership</li> <li>• Trade associations</li> <li>• Patient advocates</li> </ul>
	<i>In states where waivers are already approved:</i> Connect with stakeholders to advocate for including pharmacists as reimbursable providers of health-related social needs interventions, including nutrition supports, during the waiver renewal process.	<ul style="list-style-type: none"> <li>• Policymakers</li> <li>• Pharmacy leadership</li> <li>• Trade associations</li> <li>• Patient advocates</li> </ul>
<b>Recommendation 3</b>  Incorporate FIM interventions into Medication Therapy Management services in Medicare, Medicaid, and private insurance	Incorporate FIM-related interventions into pharmacist MTM (Medication Therapy Management) programs. Examples may include opportunities for pharmacists to screen a patient for eligibility into FIM programs, educate eligible patients on FIM programs to promote uptake, and monitor and support adherence to FIM interventions.	<ul style="list-style-type: none"> <li>• Public and private health plans</li> </ul>
	Encourage private health plans to offer pharmacist MTM services that include FIM care for beneficiaries with diet-related chronic diseases.	<ul style="list-style-type: none"> <li>• Pharmacy leadership</li> <li>• Employer health benefit leadership</li> </ul>
	Offer pharmacist MTM services that include FIM care in private plans for beneficiaries with diet-related chronic diseases.	<ul style="list-style-type: none"> <li>• Private health plans</li> </ul>

## Vision: FIM Care Is a Reimbursable Service for Pharmacists across Payer Types

Recommendation	Actions	Primary Stakeholders
<p><b>Recommendation 4</b></p> <p>Incorporate community health workers into pharmacy operations to improve patient health-care access through existing reimbursement options</p>	Cross-train pharmacy technicians as CHWs to support patient needs.	<ul style="list-style-type: none"> <li>Pharmacy leadership</li> <li>Pharmacy technicians</li> </ul>
	<i>For pharmacies that employ CHWs:</i> Collaborate with Medicare Part B providers to provide CHI services to reach more patients and be reimbursed for services.	<ul style="list-style-type: none"> <li>Medicare Part B providers</li> <li>Pharmacy leadership</li> <li>CHWs</li> </ul>
	<p>(1) Enact provider status legislation that includes pharmacists as eligible Medicare Part B health-care providers, where pharmacists are authorized to be reimbursed for providing FIM-related care and diet-related chronic disease management.</p> <p>(2) <i>Once pharmacies are recognized as Medicare Part B providers:</i> Authorize pharmacies to deliver and bill for services that qualify as an “initiating visit” for CHI.</p>	<ul style="list-style-type: none"> <li>Congress</li> <li>CMS</li> </ul>
	Once pharmacies can be reimbursed for leveraging CHWs, integrate CHWs in pharmacy operations to support patient engagement and care with a focus on health-related social needs including FIM.	<ul style="list-style-type: none"> <li>Pharmacy leadership</li> <li>CHWs</li> <li>Pharmacy technicians</li> </ul>
	Managed care plans should collaborate with pharmacies to leverage cross-trained CHWs/pharmacy technicians to improve patient access to FIM-related interventions.	<ul style="list-style-type: none"> <li>Managed care plans</li> <li>Pharmacy leadership</li> <li>CHWs</li> <li>Pharmacy technicians</li> </ul>
<p><b>Recommendation 5</b></p> <p>Enhance partnerships between employer-sponsored health plans and pharmacies to include FIM benefits</p>	Expand employer-sponsored, pharmacy-based chronic disease prevention and management programs to include FIM services such as medically tailored groceries or healthy food cards.	<ul style="list-style-type: none"> <li>Pharmacy leadership</li> <li>Employers</li> <li>Employer-sponsored health plans</li> <li>Health benefit brokers</li> </ul>



## Pharmacy Workflow (four recommendations, eight actions)

Vision: Seamless Integration of FIM into Pharmacy Workflow Processes without Burden on Pharmacy Teams		
Recommendation	Actions	Primary Stakeholders
<p><b>Recommendation 6</b></p> <p>Create a seamless and efficient process to identify FIM-eligible patients so pharmacies can connect them to interventions, either externally or in-store</p>	Identify patients who could benefit from FIM interventions within the pharmacy management system using eligibility criteria determined by plans.	<ul style="list-style-type: none"> <li>Health plans</li> <li>Pharmacy leadership</li> <li>Pharmacy management system providers/vendors</li> </ul>
	Improve patients' understanding of their benefits and eligibility. For example, eligible patients (identified by a plan) can receive virtual or in-person communication about FIM opportunities and can inquire further with their pharmacist.	<ul style="list-style-type: none"> <li>Health plans</li> <li>Technology providers</li> <li>Pharmacy leadership</li> <li>Pharmacists</li> </ul>
<p><b>Recommendation 7</b></p> <p>Utilize front-of-store capacities to serve as a one-stop-shop for FIM interventions</p>	<i>For pharmacies located in grocery stores:</i> Coordinate with front-of-store leadership to set up a process to assist pharmacy patients with redeeming the food portion of their FIM intervention.	<ul style="list-style-type: none"> <li>Front-of-store leadership</li> <li>Pharmacy leadership</li> <li>Health plans</li> </ul>
	Host food pickup onsite in partnership with a FIM provider (such as a produce prescription service or medically tailored meals company) so that patients can schedule their FIM pickup in conjunction with medication pickup.	<ul style="list-style-type: none"> <li>Pharmacy leadership</li> <li>FIM providers</li> <li>Health plans</li> </ul>
<p><b>Recommendation 8</b></p> <p>Foster collaboration between pharmacists and dietitians as part of an interprofessional team to complement a patient's medications with additional lifestyle modifications</p>	<i>For pharmacies with on-site dietitians located in grocery stores:</i> Establish a protocol for pharmacists to refer patients to on-site dietitians. In pharmacies with a grocery division, dietitians can support FIM interventions with "store tours," providing interactive nutrition education and counseling.	<ul style="list-style-type: none"> <li>Pharmacy leadership</li> <li>Dietitians</li> <li>Front-of-store leadership</li> </ul>
	<i>For pharmacies with access to virtual dietitians:</i> Refer and set up appointments for eligible patients to meet with virtual dietitians for nutrition counseling.	<ul style="list-style-type: none"> <li>Pharmacy leadership</li> <li>Dietitians</li> </ul>
	<i>For pharmacies located in grocery stores that do not have access to dietitians, whether on-site or virtually:</i> Develop sustainable and viable funding pathways with health plans to incorporate dietitian services into the broader pharmacy care team.	<ul style="list-style-type: none"> <li>Health plans</li> <li>Pharmacy leadership</li> <li>Front-of-store leadership</li> </ul>
<p><b>Recommendation 9</b></p> <p>Refer patients to external FIM resources through social-needs aggregator platforms</p>	Utilize aggregator databases to connect patients externally to relevant care and health-related social needs resources. See Appendix B for examples.	<ul style="list-style-type: none"> <li>Pharmacy leadership</li> <li>Pharmacists</li> <li>Pharmacy technicians</li> <li>CHWs</li> </ul>

## Technology Infrastructure (three recommendations, 11 actions)

Vision: Interoperable Technology Infrastructure to Support FIM Data Sharing throughout the Health-Care Ecosystem		
Recommendation	Actions	Primary Stakeholders
<b>Recommendation 10</b> Improve data interoperability for pharmacists to document their services and exchange clinical information	Incentivize improvements to pharmacy data systems, similar to the federal Medicare and Medicaid Promoting Interoperability Programs model that incentivizes health-care providers to use certified EHR technology for improved quality of care, to enable more effective data sharing.	<ul style="list-style-type: none"> <li>Office of the National Coordinator for Health Information Technology</li> </ul>
	Invest in technology upgrades to ensure pharmacy management systems are equipped to exchange data with other stakeholders, with capacities for more detailed clinical documentation that includes opportunities to document FIM-related services, including referrals to FIM interventions.	<ul style="list-style-type: none"> <li>Pharmacy leadership</li> <li>Pharmacy management system vendors</li> </ul>
	Support bidirectional data exchange between pharmacies and existing health-care partner systems, such as hospitals and clinics, ensuring their systems meet the relevant data standards.	<ul style="list-style-type: none"> <li>Health-care facilities</li> <li>Pharmacy management system vendors</li> </ul>
	Review statutes and regulations at the state and federal levels to ensure they support pharmacists' ability to access information related to front-of-store food purchasing activity while maintaining patient privacy standards.	<ul style="list-style-type: none"> <li>Pharmacy legal teams</li> <li>Federal and state policymakers</li> </ul>
<b>Recommendation 11</b> Implement technology solutions to improve and streamline the patient care experience	Continue to leverage emerging technologies, such as robotics and AI-assisted software, to automate aspects of the pharmacy dispensing workflow and leverage the skills of pharmacy technicians in supporting dispensing and other technical tasks related to vaccines and testing to allow more time for pharmacists to provide patient care, which requires their clinical expertise.	<ul style="list-style-type: none"> <li>Pharmacy leadership</li> <li>Technology providers</li> </ul>
	Facilitate FIM screening that is covered by insurance leveraging QR codes, on-site tablets, or a question at check-out for patients to engage with FIM services privately and of their own volition.	<ul style="list-style-type: none"> <li>Pharmacy leadership</li> <li>Technology providers</li> <li>Health plans</li> </ul>
	Automate SMS or email reminders for FIM intervention engagement and follow-up appointments based on patient profile, insurance coverage, and health needs.	<ul style="list-style-type: none"> <li>Pharmacy leadership</li> <li>Technology providers</li> <li>Health plans</li> </ul>
	Streamline scheduling through user-friendly patient care portals so that pharmacists can help patients confirm appointments on referral. This includes being able to schedule next steps with the full suite of FIM intervention services, including dietitians and follow-up.	<ul style="list-style-type: none"> <li>Pharmacy leadership</li> <li>Technology providers</li> <li>Dietitians and other providers on the FIM care team</li> </ul>

## Vision: Interoperable Technology Infrastructure to Support FIM Data Sharing throughout the Health-Care Ecosystem

Recommendation	Actions	Primary Stakeholders
<b>Recommendation 12</b>  Coordinate evaluation data throughout FIM stakeholders to track health outcomes better and improve care coordination	Define FIM intervention key performance indicators and standardize across technology systems.	<ul style="list-style-type: none"> <li>• CMS</li> <li>• Health plans</li> <li>• Pharmacy leadership</li> <li>• Pharmacy management system vendors</li> </ul>
	<i>For pharmacies located in grocery stores that leverage food purchasing data:</i> Establish a pathway to connect food purchasing data and FIM interventions with patient consent, including patient identification, monitoring, and follow-up.	<ul style="list-style-type: none"> <li>• Technology providers</li> <li>• Pharmacy leadership</li> <li>• Front-of-store leadership</li> </ul>
	Collaborate with health plans to develop sustainable funding pathways and incentives for pharmacy teams to help measure FIM performance indicators and outcomes as part of pharmacy-based FIM care interventions, ideally as part of broader pharmacy-based chronic care prevention and management programs.	<ul style="list-style-type: none"> <li>• Health plans</li> <li>• CMS</li> <li>• Pharmacy leadership</li> </ul>

**In total:** 12 recommendations, 34 actions

# References

1. 2015–2020 *Dietary Guidelines for Americans: Eighth Edition* (US Department of Health and Human Services and US Department of Agriculture, December 2015), [https://health.gov/sites/default/files/2019-09/2015-2020\\_Dietary\\_Guidelines.pdf](https://health.gov/sites/default/files/2019-09/2015-2020_Dietary_Guidelines.pdf).
2. Nalini Ranjit et al., “Clinical Outcomes of a Large-Scale, Partnership-Based Regional Food Prescription Program: Results of a Quasi-Experimental Study,” *BMC Research Notes*, 16 (February 10, 2023), <https://doi.org/10.1186/s13104-023-06280-8>; Rachel P. Zimmer et al., “Strategies and Lessons Learned from a Home Delivery Food Prescription Program for Older Adults,” *Journal of Nutrition in Gerontology and Geriatrics*, Vol. 41(3), (June 11, 2022), <https://doi.org/10.1080/21551197.2022.2084204>; Matthew Little et al., “Promoting Healthy Food Access and Nutrition in Primary Care: A Systematic Scoping Review of Food Prescription Programs,” *American Journal of Health Promotion*, Vol. 36(3), (December 10, 2021), <https://doi.org/10.1177/08901171211056584>; Emily Wang, Abby Gilbert, and Anke Wessels, “The Food Pharmacy Network: An Alternative Method for Addressing Food Insecurity and an Assessment of Its Effectiveness (OR02-08-19),” *Current Developments in Nutrition*, Vol. 3(Supplement 1), (June 2019), <https://doi.org/10.1093/cdn/nzz051.or02-08-19>; Lu Wang et al., “Health and Economic Impacts of Implementing Produce Prescription Programs for Diabetes in the United States: A Microsimulation Study,” *Journal of the American Heart Association*, Vol. 12(15), (July 7, 2023), <https://doi.org/10.1161/jaha.122.029215>; Kurt Hager et al., “Association of National Expansion of Insurance Coverage of Medically Tailored Meals with Estimated Hospitalizations and Health Care Expenditures in the US,” *JAMA Network Open*, Vol. 5(10), (October 17, 2022), <https://doi.org/10.1001/jamanetworkopen.2022.36898>; Kristen Deuman, Emily A. Callahan, Lu Wang, and Dariush Mozaffarian, *True Cost of Food: Food Is Medicine Case Study* (Food Is Medicine Institute, Tufts University, September 2023), [https://tuftsfoodismedicine.org/wp-content/uploads/2023/10/Tufts\\_True\\_Cost\\_of\\_FIM\\_Case\\_Study\\_Oct\\_2023.pdf](https://tuftsfoodismedicine.org/wp-content/uploads/2023/10/Tufts_True_Cost_of_FIM_Case_Study_Oct_2023.pdf).
3. James Davis, Janell Penha, Omar Mbowe, and Deborah A. Taira, “Prevalence of Single and Multiple Leading Causes of Death by Race/Ethnicity among People Aged 60 to 70 Years,” *Preventing Chronic Disease*, Vol. 14, (October 19, 2017), [https://www.cdc.gov/pcd/issues/2017/16\\_0241.htm](https://www.cdc.gov/pcd/issues/2017/16_0241.htm).
4. “FACT SHEET: The Biden-Harris Administration Announces More Than \$8 Billion in New Commitments as Part of Call to Action for White House Conference on Hunger, Nutrition, and Health,” The White House, accessed December 15, 2023, <https://www.whitehouse.gov/briefing-room/statements-releases/2022/09/28/fact-sheet-the-biden-harris-administration-announces-more-than-8-billion-in-new-commitments-as-part-of-call-to-action-for-white-house-conference-on-hunger-nutrition-and-health/>.
5. “FACT SHEET: Biden-Harris Administration Launches the White House Challenge to End Hunger and Build Healthy Communities, Announces New Public & Private Sector Actions to Continue Momentum from Historic Hunger, Nutrition, and Health Conference,” The White House, accessed December 15, 2023, <https://www.whitehouse.gov/briefing-room/statements-releases/2023/03/24/fact-sheet-biden-harris-administration-launches-the-white-house-challenge-to-end-hunger-and-build-healthy-communities-announces-new-public-private-sector-actions-to-continue-momentum-from-hist/>.

6. “FACT SHEET: The Biden-Harris Administration Announces Nearly \$1.7 Billion in New Commitments Cultivated through the White House Challenge to End Hunger and Build Healthy Communities,” The White House, February 27, 2024, <https://www.whitehouse.gov/briefing-room/statements-releases/2024/02/27/fact-sheet-the-biden-harris-administration-announces-nearly-1-7-billion-in-new-commitments-cultivated-through-the-white-house-challenge-to-end-hunger-and-build-healthy-communities/>.
7. Samantha N. Valliant, Sabree C. Burbage, Shweta Pathak, and Benjamin Y. Urick, “Pharmacists as Accessible Health Care Providers: Quantifying the Opportunity,” *Journal of Managed Care & Specialty Pharmacy*, Vol. 28 (1), (December 2021), <https://doi.org/10.18553/jmcp.2022.28.1.85>.
8. Megan Brenan, “Nurses Retain Top Ethics Rating in US, but Below 2020 High,” *Gallup*, January 10, 2023, <https://news.gallup.com/poll/467804/nurses-retain-top-ethics-rating-below-2020-high.aspx>.
9. “FACT SHEET: President Biden Announces Increased Vaccine Supply, Initial Launch of the Federal Retail Pharmacy Program, and Expansion of FEMA Reimbursement to States,” The White House, accessed December 20, 2023, <https://www.whitehouse.gov/briefing-room/statements-releases/2021/02/02/fact-sheet-president-biden-announces-increased-vaccine-supply-initial-launch-of-the-federal-retail-pharmacy-program-and-expansion-of-fema-reimbursement-to-states/>.
10. Cherokee Layson-Wolf and Joshua M Sharfstein, “US Community Pharmacies and Public Health—Building on the COVID-19 Response,” *JAMA Health Forum*, Vol. 4(6), (June 2023), <https://doi.org/10.1001/jamahealthforum.2023.2583>.
11. *COVID-19: Federal Efforts to Provide Vaccines to Racial and Ethnic Groups* (US Government Accountability Office, February 2022), <https://www.gao.gov/assets/gao-22-105079.pdf>.
12. “HIV Testing in Retail Pharmacies,” Centers for Disease Control and Prevention, accessed January 24, 2024, <https://www.cdc.gov/hiv/effective-interventions/diagnose/hiv-testing-in-retail-pharmacies/>.
13. “About,” Accreditation Council for Pharmacy Education, accessed January 7, 2024, <https://www.acpe-accredit.org/about/>.
14. “NAPLEX,” National Association of Boards of Pharmacy, accessed January 7, 2024, <https://nabp.pharmacy/programs/examinations/naplex/>; “Educational Programs,” National Association of Boards of Pharmacy, accessed January 7, 2024, <https://nabp.pharmacy/news-resources/resources/educational-programs/>.
15. “Student Residency Resource Center,” ASHP, accessed January 7, 2024, <https://www.ashp.org/professional-development/residency-information/student-residency-resource-center/residency-faqs>; “BPS Specialty Certifications,” Board of Pharmacy Specialties, accessed January 7, 2024, <https://bpsweb.org/bps-specialties/>.
16. Amanda Wojtusik Orabone, Vincent Do, and Elizabeth Cohen, “Pharmacist-Managed Diabetes Programs: Improving Treatment Adherence and Patient Outcomes,” *Diabetes, Metabolic Syndrome and Obesity: Targets and Therapy*, Vol. 15, (June 2022), <https://doi.org/10.2147/dmso.s342936>; *Accelerating the Center for Medicare and Medicaid Innovation’s Mission—Integrating Community*

*Pharmacy Care into Value-Based Programs amid COVID-19 Pandemic Recovery and Beyond* (National Association of Chain Drug Stores and CapView Strategies, November 2021), <https://www.nacds.org/pdfs/pharmacy/2021/MedicareMedicaidInnovationMission.pdf>.

17. Terri V. Newman et al., “Impact of Community Pharmacist-Led Interventions in Chronic Disease Management on Clinical, Utilization, and Economic Outcomes: An Umbrella Review,” *Research in Social and Administrative Pharmacy*, Vol. 16 (9), (September 2020), <https://doi.org/10.1016/j.sapharm.2019.12.016>.
18. John McHugh, Batya Elul, and Sahana Narayan, *The Prescription of Trust—Pharmacists Transforming Patient Care* (Express Scripts Pharmacy, 2022), <https://d17f9hu9hnb3ar.cloudfront.net/s3fs-public/2022-01/The%20Prescription%20of%20Trust-FINAL.pdf>.
19. Elias Mossialos et al., “From ‘Retailers’ to Health Care Providers: Transforming the Role of Community Pharmacists in Chronic Disease Management,” *Health Policy*, Vol. 119(5), (May 2015), <https://doi.org/10.1016/j.healthpol.2015.02.007>.
20. “State Waivers List,” Centers for Medicare & Medicaid Services, accessed December 2, 2023, <https://www.medicare.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html>.
21. “The Biden-Harris Administration Takes Action to Improve Health and Wellbeing by Addressing Social Determinants of Health,” US Department of Health and Human Services, accessed November 16, 2023, <https://www.hhs.gov/about/news/2023/11/16/biden-harris-administration-takes-action-improve-health-and-wellbeing-addressing-social-determinants-health.html>; *Summary of Centers for Medicare and Medicaid Services (CMS) Health-Related Social Needs Medicaid and CHIP Coverage Guidance* (Center for Health Law and Policy Innovation of Harvard Law School, November 16, 2023), <https://www.healthlawlab.org/wp-content/uploads/2023/11/Summary-of-CMS-HRSN-Guidance-CHLPI-11-16-2023.pdf>.
22. “In Lieu of Services and Settings,” Centers for Medicare & Medicaid Services, accessed December 15, 2023, <https://www.medicare.gov/medicaid/managed-care/guidance/lieu-of-services-and-settings/index.html>.
23. *Pharmacist-Provided Medication Therapy Management in Medicaid* (Centers for Disease Control and Prevention, May 2021), [https://www.cdc.gov/dhdsp/docs/MTM\\_in\\_Medicaid-508.pdf](https://www.cdc.gov/dhdsp/docs/MTM_in_Medicaid-508.pdf).
24. Kartika Palar et al., “Comprehensive and Medically Appropriate Food Support Is Associated with Improved HIV and Diabetes Health,” *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, Vol. 94(1), (February 2017), <https://link.springer.com/article/10.1007/s11524-016-0129-7>.
25. Amanda A. Foster et al., “Integrating Community Health Workers within a Pharmacy to Address Health-Related Social Needs,” *Journal of the American Pharmacists Association*, Vol. 63(3), (May 2023), <https://doi.org/10.1016/j.japh.2023.01.006>.
26. Katherine Keisler-Starkey, Lisa N. Bunch, and Rachel A. Lindstrom, *Health Insurance Coverage in the United States: 2022* (US Census Bureau, September 2023), <https://www.census.gov/content/dam/Census/library/publications/2023/demo/p60-281.pdf>; “Total Employment,” US Bureau of Labor Statistics, accessed February 8, 2023, <https://www.bls.gov/emp/graphics/total-employment.htm>.

27. “Workplace Health Promotion,” Centers for Disease Control and Prevention, accessed December 19, 2023, <https://www.cdc.gov/chronicdisease/resources/publications/factsheets/workplace-health.htm>.
28. Terri V. Newman et al., “Community Pharmacist-Led Interventions in Chronic Disease Management on Clinical, Utilization, and Economic Outcomes: An Umbrella Review,” *Research in Social and Administrative Pharmacy*, Vol. 16(9), 1155-1165, (September 2020), <https://doi.org/10.1016/j.sapharm.2019.12.016>.



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Unite Us

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Wholesome Wave

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