HPCA
HAWAIʻI PRIMARY CARE ASSOCIATION

2025

Harvesting Insights: Surveying Produce Access Through Hawaii's FQHCs

Hawaiʻi Primary Care Association

Acknowledgements

We thank all of the Federally Qualified Health Centers (FQHCs) and their staff who contributed their time and insights to this survey. Their commitment to improving access to healthy food and supporting food-as-medicine initiatives is at the center of this work.

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This report was prepared by the Hawai'i Primary Care Association.

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Preface

In early 2025, the Hawai‘i Primary Care Association (HPCA) conducted a statewide survey of Federally Qualified Health Centers (FQHCs) to better understand how clinics are working to expand access to fresh produce and strengthen food-as-medicine interventions. The survey asked about program models, patient populations, partnerships, successes, and barriers, as well as how SNAP and WIC services are being integrated into patient care.

Seventeen respondents from eight of Hawai‘i’s fourteen FQHCs participated, including administrators, program managers, clinical providers, community health workers, and support staff. Their responses provide a window into a system in transition: one that is deeply rooted in cultural traditions around food and health, but also navigating the realities of funding cycles, staffing capacity, and infrastructure constraints.

Table 1. Responses by FQHC

County	FQHC	#of Respondents
Hawai‘i	Hāmākua-Kohala Health (Hāmākua-Kohala)	1
	Hawai‘i Island Community Health Center (HICHC)	3
Honolulu	Kalihi-Palama Health Center (Kalihi-Palama)	4
	Koʻolauloa Health Center (Koʻolauloa)	2
	Waiʻanae Coast Comprehensive Health Center (WCCHC)	3
Maui	Mālama I Ke Ola Health Center (Mālama I Ke Ola)	2
	Molokaʻi Community Health Center (Molokaʻi)	1
Kauaʻi	Hoʻōla Lāhui Hawaiʻi/Kauaʻi Community Health Center (Hoʻōla Lāhui)	1
Total	**8 FQHCs**	**17**

Why a Series of Reports?

As the survey findings were analyzed, it became clear that the scope of information could not be captured in a single document without losing clarity or depth. Instead, HPCA has organized the results into a five-part series under the collective title Harvesting Insights: Surveying Produce Access Through Hawai'i's FQHCs. Together, these reports provide both a detailed examination of specific topics and a comprehensive picture of Hawai'i's progress in advancing food-as-medicine initiatives.

Produce Prescription (PRx) programs emerged as an area deserving special attention. While they are a subset of broader produce programs, PRx represents a unique bridge between healthcare and food access, linking patient care directly to nutrition and laying the groundwork for Medicaid's forthcoming Nutrition Supports benefit. Given its potential impact on chronic disease outcomes, PRx warranted a dedicated report separate from the general landscape of produce programs.

The Reports in the *Harvesting Insights* Series

1	**Cultivating Care: The Current Landscape of Produce Programs in Hawai'i's FQHCs**	A look at the scope, reach, and diversity of produce programs, highlighting models in development, program types, and patient outcomes.
2	**The Landscape and Future of Produce Prescriptions in Hawai'i's FQHCs**	A focused examination of PRx efforts in FQHCs, including target populations, implementation models, patient experiences, data capacity, and opportunities to start or scale up their programs.
3	**Beyond the Clinic: Addressing Food Insecurity through FQHC Interventions**	An exploration of how health centers screen for and respond to food insecurity, including referral pathways, EHR integration, and community partnerships.
4	**SNAP and WIC Integration in Hawai'i's FQHC Produce Access Programs**	An assessment of how FQHCs connect patients with federal nutrition programs, the barriers families face, and opportunities for stronger integration.
5	**Building for Tomorrow: Strategies to Sustain and Scale Nutrition Supports in Hawai'i**	A synthesis of lessons learned and strategies for scaling food-as-medicine interventions, with attention to funding, partnerships, data systems, and workforce needs.

Shared Definitions

For clarity and consistency, the reports use common definitions for produce programs as they operate within FQHCs. These include food distribution, local farm partnerships, produce prescription programs, farmers' market vouchers, community-supported agriculture, and onsite community gardens.

Table 2. Produce Program Definitions

Program	Definition
Food Distribution	USDA-supported distribution of food and nutrition assistance to vulnerable populations such as low-income families, children, and seniors.[i]
Local Farm Partnership	Collaboration between an FQHC and local farmers or agricultural producers to increase patient access to fresh, locally grown foods.
Produce Prescription (PRx) Program	A healthcare-based intervention in which eligible patients receive a provider-issued prescription for fresh, frozen, or canned fruits and vegetables redeemable at designated sites.[ii]
Farmers' Market Vouchers	Certificates or coupons that patients can redeem at local farmers' markets for fresh produce.
Community-Supported Agriculture (CSA)	A subscription or share in a local farm that provides patients with regular deliveries of fresh, seasonal produce.[iii]
Onsite Community Garden	A shared garden space maintained by and for the community to grow fruits and vegetables.

[i] https://www.fns.usda.gov/usda-foods
[ii] https://www.cdc.gov/nutrition/php/incentives-prescriptions/understanding-programs.html
[iii] https://www.nal.usda.gov/farms-and-agricultural-production-systems/community-supported-agriculture

Cultivating Care: The Current Landscape of Produce Programs in Hawai‘i’s FQHCs

Landscape

Hawai‘i Primary Care Association

2025

Introduction

Hawai'i's food security landscape has shifted dramatically over time. Once self-sufficient and sustained by traditional agriculture, the state now relies heavily on imported food due to historical changes in land use and settlement. Staple crops such as taro and sweet potatoes once nourished Native Hawaiian communities.[i] Today, however, approximately 90% of Hawai'i's food is imported, leaving the state with only a 5–7 day reserve in the event of supply chain disruptions.[ii]

This dependence underscores Hawai'i's vulnerability during disasters while also highlighting the urgent need to rebuild self-sufficiency through investment in local agricultural systems that promote both food security and community health. Federally Qualified Health Centers (FQHCs) play a critical role in this effort by piloting and sustaining produce programs that directly address food insecurity while supporting patients' health.

This report summarizes the current landscape of produce programming at Hawai'i's FQHCs, drawing on survey findings from early 2025. It highlights active programs, types of interventions, target populations, patient experiences, operations, and lessons learned about sustainability.

Participation and Program Status

The survey captured responses from eight of Hawai'i's 14 FQHCs, with a total of 17 participants representing administrators, program managers, clinical providers, and support staff. Together, their insights provide a meaningful snapshot of the opportunities and challenges in connecting patients with fresh, locally grown food.

Table 1. FQHC Program Landscape as Identified by Participants (N=17 respondents from 7 FQHCs)

FQHC	No. Participants	Status of Produce Programs	Previous Program History	Program Duration	Estimated Reach
Hāmākua-Kohala	1	In Development	Operated previously	3–5 years	<100 patients
HICHC	3	Active (1)	None reported	–	–

[i] https://files.hawaii.gov/dbedt/op/spb/Volume_II_History_of_Agriculture_in_Hawaii_and_Technical_Reference_Document_FINAL.pdf
[ii] https://www.hiphi.org/food-systems/#1732075332657-57e46438-6ffd

FQHC	No. Participants	Status of Produce Programs	Previous Program History	Program Duration	Estimated Reach
Hoʻōla Lāhui	1	No Program	None reported	–	–
Kalihi-Palama	4	No Program	None reported	–	–
Koʻolauloa	2	In Development	Operated previously (1)	Unknown	–
Mālama I Ke Ola	2	Active (2)	Operated previously (1)	1–2 years	100–500 patients
Molokaʻi	1	No Program	None reported	–	–
WCCHC	3	Active (3)	Operated previously (1)	5+ years	500–1,000 patients
Total	**17**	**Active: 6**	**Previous: 4**		

The data show a continuum of engagement: some FQHCs are piloting short-term initiatives, others are in development, and a few have built long-standing, multi-year models reaching hundreds of patients annually.

Program Types

FQHCs have piloted and sustained a wide range of models. Some focused on food access through distribution or vouchers, while others adopted food-as-medicine approaches by prescribing produce or partnering with farms.

Table 2. Types of Produce Programs Reported by FQHCs

Program Types (N=5 FQHCs)	Active Programs			Previous Programs	
	HICHC	Mālama I Ke Ola	WCCHC	Hāmākua-Kohala	Koʻolauloa
Food Distribution	✓		✓	–	–
Local Farm Partnership	–	✓	✓	–	✓
Produce Prescription (PRx)	–	–	✓	–	–
Farmers' Market Vouchers	–	✓	✓	✓	–
Community-Supported Agriculture (CSA)	–	–	✓	–	–
Onsite Community Garden	–	–	✓	–	–
Referrals to Other Programs	✓	✓	✓	–	–
Other	–	UHC Catalyst Program	ʻElepaio Social Services	–	–

WCCHC operates the broadest portfolio of services, combining PRx programs, CSA boxes, vouchers, and an on-site community garden, supported by its community-based subsidiary ʻElepaio Social Services. Mālama I Ke Ola has anchored its efforts in a strong farm partnership and the United Health Care (UHC) Catalyst Program, which pairs produce boxes with nutrition education for patients with or at risk for diabetes. HICHC manages a food distribution program and connects patients to outside resources.

> "We have another location in the works. It sits on a largish piece of land, which we hope to use to grow produce for local residents."
> — FQHC staff.

Target Populations and Purpose

Produce programs are driven by clear and consistent goals across participating FQHCs. All respondents identified five shared priorities: improving patient nutrition, reducing food insecurity, supporting local agriculture, strengthening chronic disease management, and honoring Indigenous and local culture. These goals highlight the dual focus of produce programs — addressing immediate food needs while also supporting long-term community health and resilience.

FIGURE 1. PRODUCE PROGRAM GOALS (N=3 FQHCS)

Survey results show that Produce Prescription (PRx) programs focus on serving patients most likely to benefit from improved access to healthy foods. Across sites, several priority populations emerged:

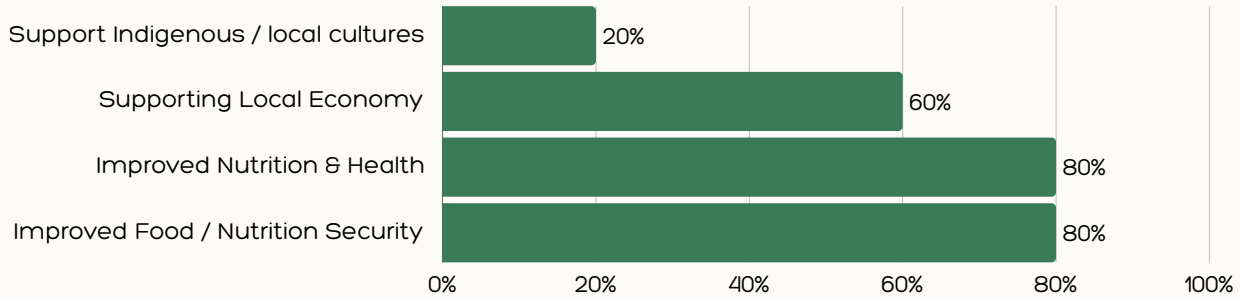
- Patients with or at risk for chronic conditions (e.g., diabetes, hypertension)
- Patients who screen positive for food insecurity
- Pediatric patients and families
- Pregnant and postpartum individuals
- Elderly patients (kūpuna)
- Medicaid and SNAP beneficiaries (identified by one site)

Patient Outcomes

Respondents consistently described produce programs as beneficial for patient health. Families reported greater access to fruits and vegetables, improved food security, and healthier eating habits. For patients with chronic conditions, these programs often strengthened disease management efforts.

Staff noted that patients were not only eating more fruits and vegetables, but also experiencing broader benefits. As one respondent put it, ***"Patients utilize the benefit, eat better, and it also helps the local economy."*** Others echoed similar impacts: ***"Patients are healthier and have access to food,"*** and ***"We've seen a decrease in food insecurity, increased produce consumption, and support for Indigenous and local cultures."*** Another highlighted the ripple effect of these efforts: ***"There has been an increase in fruit and vegetable consumption, strengthened food security status, and increased productivity and sales for our community farmers."*** Collectively, programs were described as having a ***"genuine impact on nutrition insecurity, with significant effects on the local economy through program design."***

Figure 2. Produce Program Benefits (N=5 Responses from 2 FQHCs)



An FQHC staff member explained:

> "Integration of these programs has been extremely beneficial to our patients and community as a whole. We were able to help feed the community during some of the hardest times (pandemic) and have continued to do so in the years after." — FQHC staff.

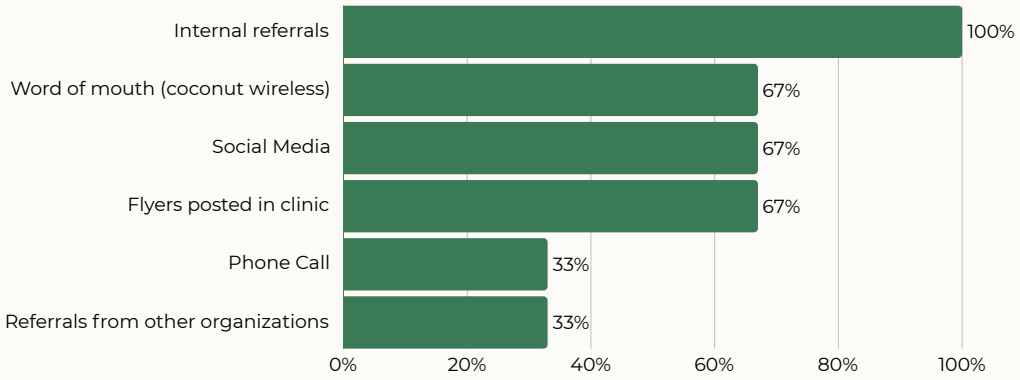
Another perspective highlighted the importance of community context:

> "Working with families and getting feedback from them, these programs are essential to their daily living. However, not all families have a community that will connect them with food when needed." — FQHC staff.

Patient Awareness and Outreach

Awareness of produce programs is a critical factor in participation. Respondents shared that patients most often learn about these programs through referrals within the health center itself. Every participating site (100%) reported using internal referrals as the main channel. Word of mouth, or “coconut wireless,” was also significant, with two-thirds of centers citing it as a key driver. Social media and clinic flyers were commonly used at two of the three reporting centers, while direct phone calls and referrals from external organizations were less frequent.

Figure 3. How Patients Learn About Produce Programs (N=3 fqhcs)



These findings suggest that patients rely most on trusted relationships within the clinic and their community networks to connect with programs, while outreach strategies via social media and flyers extend reach but are less consistently used across centers.

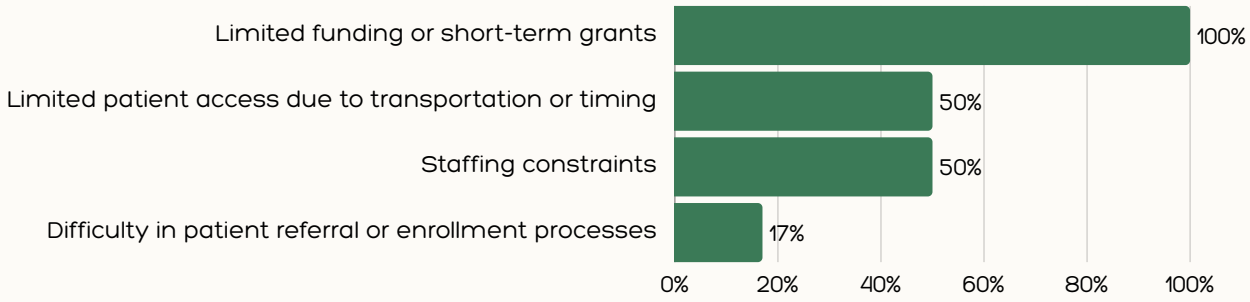
Barriers and Sustainability

Despite positive outcomes, FQHCs face significant challenges. Transportation and scheduling conflicts limit patient participation. Programs themselves are fragile, with many reliant on short-term grants, such as those from United Health Care or federal initiatives like Gus Schumacher Nutrition Incentive Program (GusNIP). For example, two health centers noted that they closed programs when short-term funding ended. One health center was able to sustain its program through a longer funding cycle before grant expiration. COVID-19 disruptions and the loss of key partnerships also contributed to discontinuation at some sites. Even health centers with longer-term funding remain dependent on external sources.

Table 6. Funding and Sustainability of Produce Programs

Responses (N=5 FQHCs)	Active Programs (N = 3 FQHCs)	Previous Programs (N = 2 FQHCs)
Short-term grants (<2 years)	40%	20%
Long-term grants (>2 years)	40%	-
Private donations	20%	-
Partnerships with local organizations	40%	-
Unsure	20%	20%

Figure 4. Challenges in sustaining or expanding produce programs (N = 6 responses from 3 FQHCs)



"The most significant gap in addressing food insecurity among our patients stems from unstable and unreliable funding streams. Long-term program implementation is hindered by a lack of sustainable models." — FQHC staff.

Lessons from Past Programs

Examining past programs provides insight into what sustains impact and what risks program closure. Several key lessons emerged:

- **Funding is the critical factor.** Two health centers' programs ended when grants expired, highlighting the fragility of relying on short-term support.

- **Community champions matter**. Staff emphasized the need for advocates who reflect the cultural and linguistic diversity of the populations served, similar to promotora models used elsewhere.

> "Communities need champions from various cultures and backgrounds. This would be a new role to build into our food-as-medicine systems."
> — FQHC staff.

- **Integration builds resilience.** Programs tied to broader clinic workflows demonstrated staying power by embedding food access into patient care.
- **Partnerships amplify impact.** Strong collaborations with farms and food hubs increased reach and patient engagement.
- **Education strengthens behavior change.** Initiatives that paired food access with nutrition education were reported as particularly effective.
- **Outreach drives participation.** Trusted relationships and community networks, especially internal referrals and word of mouth, are central to connecting patients with programs. Outreach strategies like social media and flyers extend reach, but it is the trust built within clinics and communities that ensures participation.

Conclusion

The current landscape of produce programs in Hawai'i's FQHCs demonstrates both promise and vulnerability. These programs have shown measurable benefits for patients, from healthier diets to stronger connections with local agriculture and culture. They also highlight the essential role of FQHCs in addressing food insecurity in their communities. Yet sustainability challenges remain, especially reliance on short-term grants and unstable funding streams. Lessons from past programs emphasize that lasting impact depends not only on stable financial models and infrastructure, but also on the ability to reach patients through trusted relationships and community networks. Building stronger partnerships, embedding programs into clinic workflows, and prioritizing culturally grounded outreach will be critical for ensuring that produce programs move beyond pilots and become enduring pillars of patient care in Hawai'i.

The Landscape and Future of Produce Prescriptions (PRx) in Hawai‘i’s Federally Qualified Health Centers

PRx

Hawai‘i Primary Care Association

2025

Introduction Introduction: What are Produce Prescriptions and Why They Matter

Produce Prescription (PRx) programs allow healthcare providers to prescribe fresh fruits and vegetables to patients, who can then redeem these prescriptions through local farmers, food hubs, or retailers. [i,ii, iii] Unlike traditional food access programs, PRx is embedded in clinical care. The model is designed to address two pressing challenges at once: supporting patients in managing chronic conditions such as diabetes and hypertension, and reducing the burden of food insecurity.

Evidence shows this model is effective. National studies report that patients enrolled in PRx programs consistently increase their fruit and vegetable intake, improve blood sugar and blood pressure control, and report lower household food insecurity.[iv, v]

In Hawai'i, these findings resonate strongly. The state faces some of the highest food costs in the country,[vi] coupled with a high prevalence of diet-related disease. At the same time, Hawai'i relies heavily on imported food, which creates additional challenges for access and affordability. PRx programs present an opportunity to address these overlapping issues—improving patient health while strengthening local food systems and agriculture.

The Current Landscape in Hawai'i's FQHCs

While national research highlights the benefits of Produce Prescription programs, implementation across Hawai'i's Federally Qualified Health Centers (FQHCs) remains limited. At the time of the survey, only one FQHC reported operating an active PRx program. Two others had piloted or were exploring initiatives, while most health centers relied on other produce access strategies such as food pantries, CSA-style produce boxes, or grocery vouchers.

Despite the small number of active programs, the direction of interest is clear. Health centers that responded consistently identified the same priority populations for PRx:

- Patients with or at risk for chronic conditions such as diabetes and hypertension
- Patients screening positive for food insecurity
- Families with children
- Pregnant or postpartum individuals
- Kūpuna
- Medicaid and/or SNAP Beneficiaries

[ii] https://www.cdc.gov/nutrition/php/incentives-prescriptions/index.html
[ii] https://nppc.health/
[iii] https://pmc.ncbi.nlm.nih.gov/articles/PMC8369461
[iv] https://pmc.ncbi.nlm.nih.gov/articles/PMC10234740
[v] https://pubmed.ncbi.nlm.nih.gov/37641928/
[vi] https://map.feedingamerica.org/county/2023/overall/hawaii

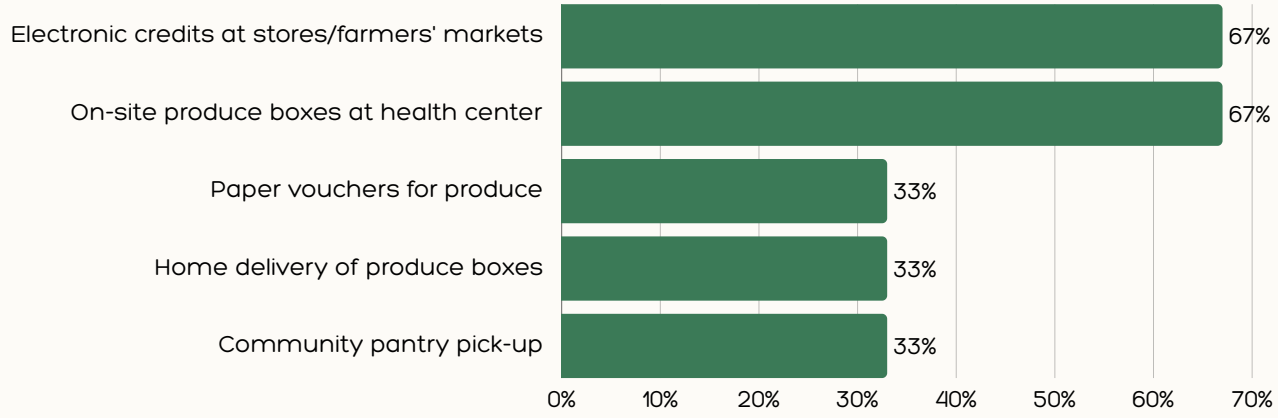
This consistency underscores a shared understanding of where PRx can make the greatest impact: populations most affected by chronic disease and food insecurity.

Implementation Models

Where PRx has been attempted in Hawai‘i, health centers have taken different approaches to fit their local context. Some offer electronic credits that can be redeemed at partner stores or farmers’ markets. Others provide produce boxes on-site at the clinic, distribute paper vouchers, or arrange for home delivery.

This diversity reflects both creativity and necessity. Each model leverages available resources, partnerships, and infrastructure. The variation also suggests flexibility is a strength of PRx; it can be adapted to meet the needs of patients and communities in different settings.

Figure 1. Distribution Methods for PRx Benefits (N = 5 respondents from 3 FQHCs)

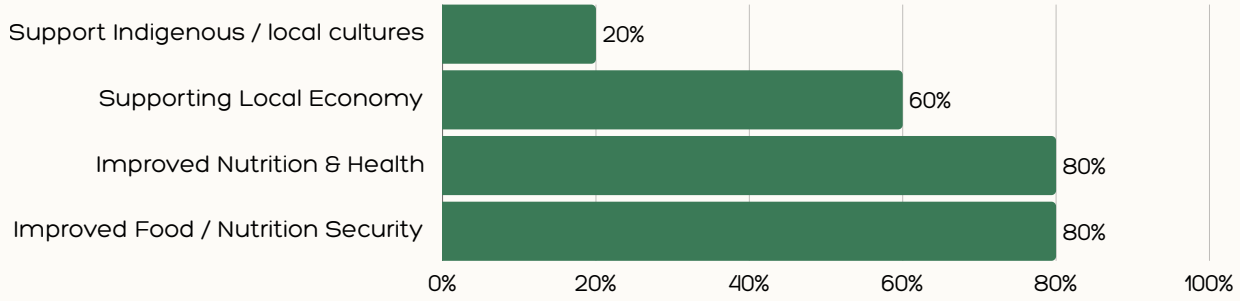


Evidence of Impact

Even at a small scale, PRx programs in Hawai‘i have shown encouraging outcomes. Survey respondents reported that patients are eating more fruits and vegetables, engaging more actively in disease management, and experiencing greater food security. Families also noted that PRx benefits helped them stretch SNAP and WIC resources further, ensuring more consistent access to healthy food.

In addition to health outcomes, respondents emphasized the economic and cultural value of PRx. Several health centers noted that these programs support local farmers and food distributors, linking the healthcare system more directly with Hawai‘i’s agricultural sector.

Figure 2. Produce Program Benefits (N = 5 respondents from 3 FQHCs)



> "Food as medicine has always been one of our highest aspirations for patients and communities." — FQHC staff.

Barriers and Challenges

Survey findings also reveal why PRx has not yet scaled more broadly.

- **Funding instability:** Every responding FQHC cited reliance on short-term grants as a primary barrier.
- **Staffing limitations:** Half reported that they do not have sufficient staff capacity to sustain or expand PRx.
- **Infrastructure constraints:** Many health centers lack refrigeration, storage, or distribution space to handle fresh produce effectively.
- **Patient access barriers:** Transportation challenges and scheduling conflicts were noted as barriers to participation.

Table 1. Challenges to PRx Expansion

Challenge / Barrier (N = 6 responses from 3 FQHCs)	Count	% of Responses
Limited funding or short-term grants	6	100%
Staffing constraints	3	50%
Limited patient access due to transportation or timing	3	50%
Difficulty in patient referral or enrollment processes	1	17%

These barriers highlight the gap between interest and implementation. While health centers recognize the value of PRx, structural challenges make it difficult to sustain programs without additional support.

Perceptions of Integration and Sustainability

Beyond identifying barriers, survey respondents were asked how they perceive the current integration and sustainability of their PRx programs. Results show that patient experiences are rated positively, but funding and staffing remain pressing concerns. This contrast underscores why enthusiasm for PRx has not yet translated into widespread adoption.

Table 2. Perceptions of PRx Program Integration and Sustainability

Responses (N = 6 respondents from 3 FQHCs)	% Strongly Disagree	% Disagree	% Neutral	% Agree	% Strongly Agree
Our PRx program is well-integrated into clinic workflows.	16.7% (1)	-	-	33.3% (2)	50.0% (3)
We have adequate funding to sustain our PRx program.	16.7% (1)	16.7% (1)	50.0% (3)	33.3% (2)	-
We have adequate staffing to sustain our PRx program.	-	16.7% (1)	33.3% (2)	33.3% (2)	16.7% (1)
Patients generally have positive experiences with our PRx program.	-	-	-	33.3% (2)	66.7% (4)
We track patient participation and outcomes effectively.	-	-	33.3% (2)	-	66.7% (4)

Data and Capacity for Growth

For PRx to be treated as a clinical intervention rather than a short-term project, health centers must be able to track participation and measure outcomes. The survey found mixed readiness in this area.

- **57%** of respondents reported that their data systems are capable of tracking PRx outcomes.
- **43%** were unsure about their system's capabilities.

This variation points to uneven infrastructure and limited evaluation capacity across the FQHC network. Without improvements in data tracking, it will be difficult to demonstrate the clinical value of PRx at scale.

When asked about capacity to continue or expand PRx, most health centers rated themselves at "moderate" to "high." Only one reported "very high" capacity. This suggests expansion is possible, but heavily dependent on external resources, workforce development, and technical assistance.

Table 3. FQHC capacity to continue or grow the PRx program.

Rating (N = 6 responses from 3 FQHCs)	Count	% of Responses
3 = Moderate (We are able to maintain our program, but would have difficulty expanding)	1	16.7%
4 = High	4	66.7%
5 = Very High (We have ample resources to expand significantly)	1	16.7%

The Future of PRx in Hawai'i's FQHCs

While implementation is limited today, FQHCs identified clear priorities that point to a future where PRx can become a sustainable component of primary care. These priorities reflect both the challenges reported in the survey and the opportunities on the horizon.

SECURE SUSTAINABLE FUNDING

Every FQHC cited reliance on short-term grants. Aligning PRx with Medicaid's Nutrition Supports benefit (launching in 2026) and expanding access to GusNIP and other grants are essential next steps.

BUILD WORKFORCE CAPACITY

Staffing limitations were reported by half of respondents. Training CHWs and care teams, and fostering peer learning among health centers, will strengthen the workforce needed for scale.

STRENGTHEN DATA AND EVALUATION

With uneven capacity to track outcomes, standardized reporting systems and shared evaluation tools are needed to demonstrate value and guide improvement.

INTEGRATE WITH EXISTING SYSTEMS

Embedding PRx into SNAP, WIC, and clinical workflows will reduce barriers for patients and ensure programs are easier to sustain.

Roles for HPCA and Partners

Drawing on the insights shared by survey respondents, HPCA identified opportunities to support FQHCs in scaling and sustaining PRx programs.

- **HPCA:** Develop a Hawai‘i PRx toolkit to increase spread of best practices from longstanding PRx programs, lead training and peer learning, and standardize data collection.
- **State agencies:** Streamline SNAP/WIC processes and align Medicaid policy with PRx.
- **Food system partners:** Ensure reliable produce supply chains and prioritize culturally appropriate foods.
- **Community organizations:** Support outreach, reduce stigma, and expand accessible distribution sites.

Together, these actions form the roadmap for moving PRx from small pilots to a durable, equity-driven strategy that links healthcare, food security, and local agriculture.

Conclusion

The current landscape of PRx in Hawai‘i is modest but full of potential. Patients benefit from healthier diets, greater food security, and better disease management. Health centers see alignment with clinical care and opportunities to support local producers. Yet programs remain fragile, constrained by unstable funding, staffing shortages, infrastructure gaps, and uneven data capacity.

The future of PRx in Hawai‘i hinges on whether these barriers are addressed. With Medicaid’s Nutrition Supports benefit set to launch in 2026, there is a window of opportunity to build lasting infrastructure for PRx. The priorities identified by FQHCs, such as sustainable funding, workforce support, evaluation tools, and systems integration, show what is needed.

If HPCA, state agencies, food system partners, and community organizations act on these priorities, PRx can move beyond pilot projects to become a permanent feature of primary care in Hawai‘i.

Beyond the Clinic: Addressing Food Insecurity in Hawai‘i’s Federally Qualified Health Centers

Hawai‘i Primary Care Association

Food Insecurity

2025

The Urgency of Food Insecurity in Hawai‘i

In Hawai‘i, food insecurity is a daily reality for far too many families. Nearly one in three households report struggling with reliable access to food, and almost the same proportion of households with children report at least one keiki going without food.[i,ii] The cost of food is among the highest in the nation, averaging more than $4 per meal compared to under $3.50 on the continent.[iii] Even families who are employed often fall into the ALICE category (Asset Limited, Income Constrained, Employed) working hard but still unable to cover the cost of basics like food, housing, and healthcare. [iv] Nearly half (46%) of ALICE households report not having consistent access to food.[iv]

For patients at Federally Qualified Health Centers (FQHC) managing chronic conditions such as diabetes or hypertension, the struggle to provide healthy meals is not only stressful but also has a direct negative impact on their health.

Populations Most Impacted

The survey findings highlight who is most affected by food insecurity across Hawai‘i’s FQHCs. Every health center identified low-income households and individuals experiencing homelessness or housing instability as the populations most at risk. These groups consistently face the most severe barriers to stable access to food.

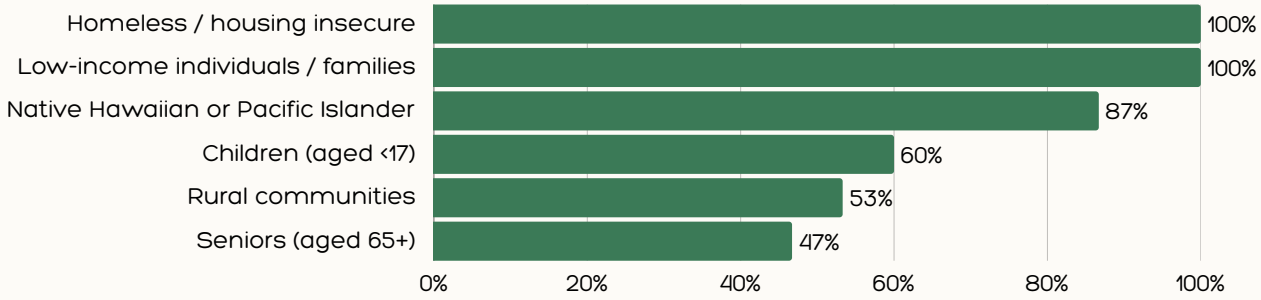
A large majority of FQHCs also pointed to Native Hawaiian and Pacific Islander communities (87%), reflecting persistent inequities tied to income, housing, and health outcomes. Children and families with young children (60%) were also frequently cited, underscoring the importance of interventions like WIC and school-based supports.

Rural residents (53%) and seniors (47%) were named less often but still represent significant proportions of those struggling to secure food. For seniors, living on fixed incomes combined with high food costs creates daily trade-offs between essentials like rent, medications, and groceries.

Together, the results make clear that food insecurity is not spread evenly. It concentrates among those already navigating structural inequities, which is why FQHCs see addressing food insecurity as inseparable from their mission to provide comprehensive, community-centered care.

i https://hawaiifoodbank.org/wp-content/uploads/2024/05/HawaiiFoodbank_TheStateOfFoodInsecurityInHawaii_2023_ExecutiveSummary.pdf
ii https://hawaiifoodbank.org/food-insecurity/
iii https://map.feedingamerica.org/county/2023/overall/hawaii
iv https://www.auw.org/auw-alice-report-2024/

Figure 1. Populations Impacted by Food Insecurity at FQHCs (N = 15 respondents from 6 FQHCs)



Screening and Tracking

FQHCs have long recognized that food insecurity and other health-related social needs significantly influence patient outcomes. This issue gained greater visibility in 2020 when the Uniform Data System (UDS) began requiring FQHCs to document and report the number of patients screening positive for food insecurity. While health centers had been addressing these needs for years, the new reporting requirement highlighted the necessity of bringing this often-overlooked work to the forefront at a national level.

Integrating Food Insecurity Screening into Routine Care

Screening for food insecurity has become a routine part of care, and many FQHCs report that it is increasingly integrated into clinic workflows. Medical assistants, nurses, and care coordinators typically ask the questions during intake or review patient responses; in some settings, CHWs or behavioral health staff also take part in screening. Staff noted that embedding food insecurity into regular workflows helps normalize the process and positions it as a standard component of patient care.

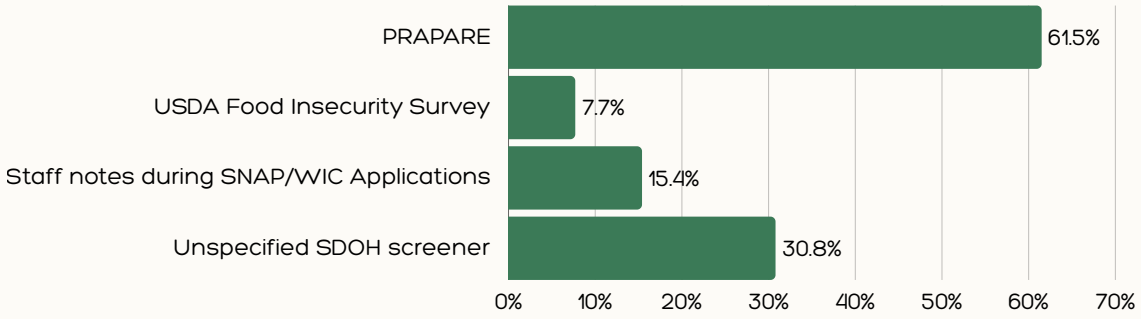
Most centers use standardized tools like Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE), with one FQHC using the USDA food insecurity screener. About two-thirds report that their EHRs can capture results, but fewer can track whether referrals were completed or if the patient ultimately received support.

Understanding the Scale of Food Insecurity Needs

When asked about the scale of need, responses showed significant variation and, in many cases, uncertainty. Out of 15 responses from 7 FQHCs:

- Two centers reported serving more than 1,000 food-insecure patients annually.
- One health center estimated serving between 100 and 500 food-insecure patients annually, though they also noted some patients exceeded 1,000.
- Nearly half of the responses (46.7%) indicated staff were unsure about the number served.
- About a quarter (26.7%) said they don't have access to this information.

Figure 2. Food Insecurity Screening and Reach (n=15 responses, 7 FQHCs)



This wide range highlights the urgent need for consistent data collection and tracking across health centers. This reflects not only gaps in documentation but also the need for clearer communication and training on how food insecurity interventions are recorded in the EHR. The fact that many centers cannot confidently estimate how many food-insecure patients they serve each year points to a system-level gap that must be addressed before interventions can be fully scaled and evaluated.

> "We can identify the need, but the challenge is making sure families actually receive food or benefits after the screen." — FQHC staff

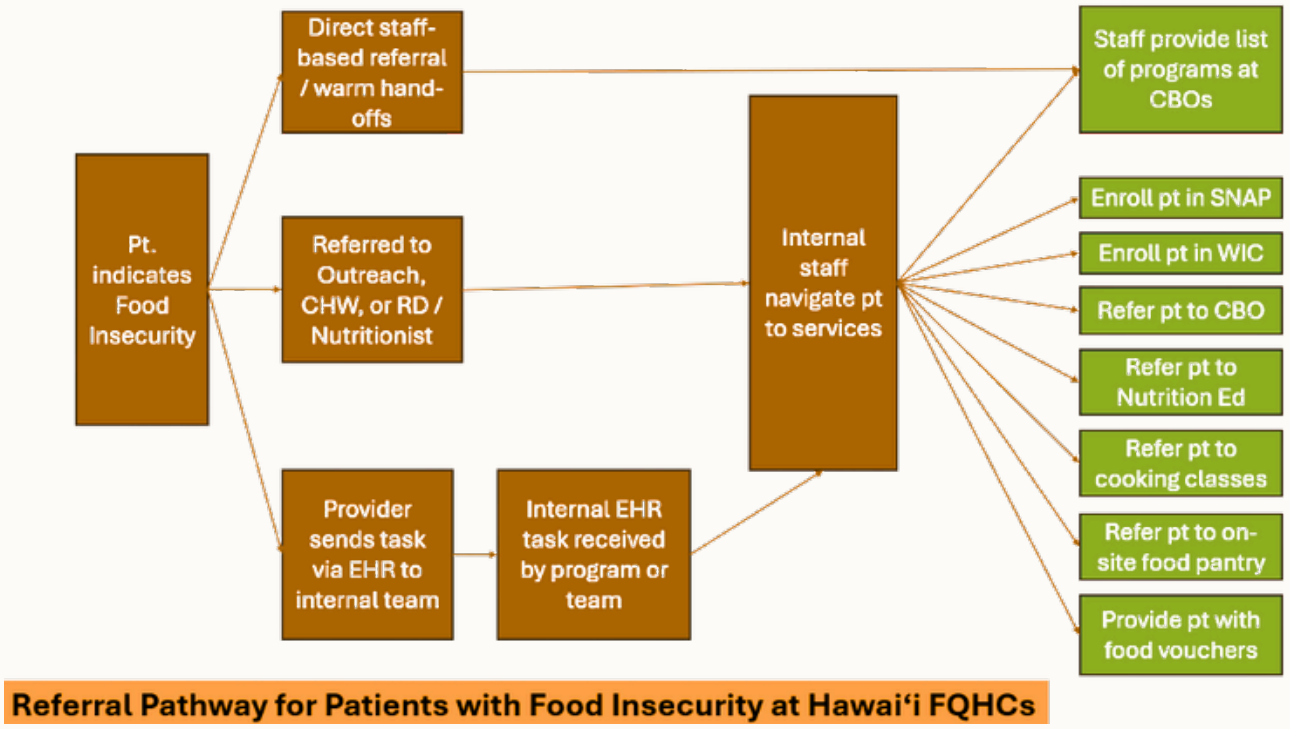
Referral and Enrollment

Once a patient screens positive, FQHCs use a range of referral pathways to connect them with services:

- **Staff-based referrals:** Verbal referrals, warm handoffs, and in-person application assistance are the most common methods.
- **Outreach workers and CHWs:** Many centers rely on outreach departments, coordinators, and navigators to ensure patients complete applications and follow through on referrals.
- **EHR-based workflows:** Some centers use EMR tasks or provider orders to generate referrals and track patient connections.
- **External partnerships:** Centers often share program contact information, distribute resource lists, or partner directly with CBOs for pantry and voucher access.

> "Eligibility workers guide SNAP applications; CHWs interpret, stay with families through the process so they don't get lost." — FQHC staff

Figure 3. Referral Pathway for Food Insecure Individuals at FQHCs (N= 13 respondents from 6 FQHCs)



Referral Pathway for Patients with Food Insecurity at Hawai'i FQHCs

This diversity in referral pathways reflects adaptability but also points to inconsistency. Some FQHCs have embedded food insecurity directly into their provider and EHR workflows, while others depend heavily on individual staff or ad hoc systems.

Interventions Provided

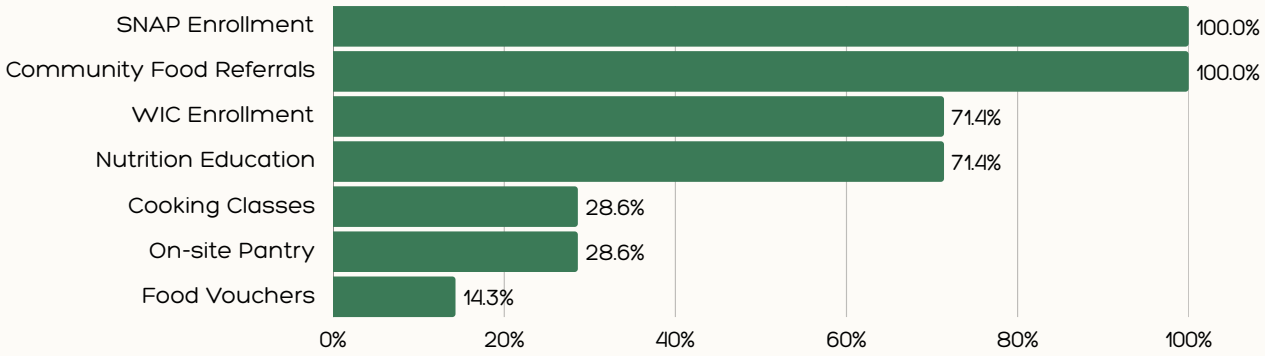
The survey revealed that Hawai'i's FQHCs are implementing a wide array of food insecurity interventions. Every health center provides SNAP enrollment assistance, and nearly all support WIC enrollment as well. Community food referrals are a staple service across sites, ensuring families are connected to food banks, pantries, or Community-based Organization (CBO)-run programs.

Beyond enrollment and referrals, centers are layering in direct supports:

- **Nutrition education and cooking classes** at several sites to strengthen capacity to prepare produce and healthy meals.

- **On-site food pantries or in-clinic food boxes** at health centers.
- **Food vouchers** for patients at select centers.
- **Produce prescription programs and other innovative models** at health centers, including pre-made meals and school- or kūpuna-based pantries.

Figure 4. Interventions to Address Food Insecurity (N = 16 responses, 7 FQHCs)



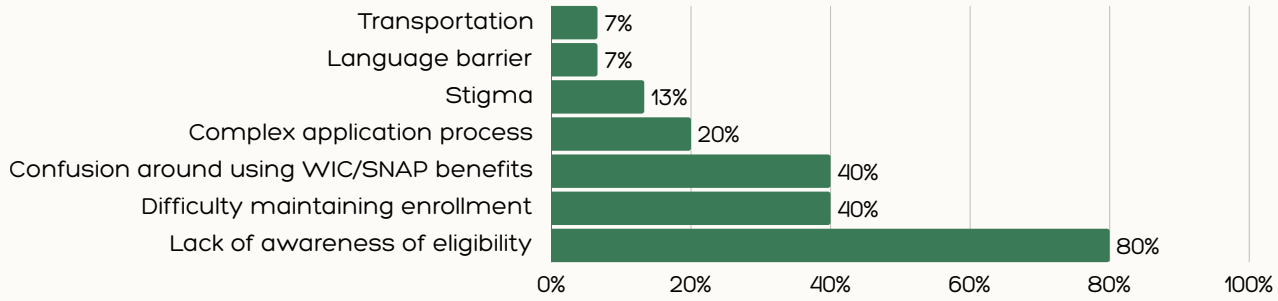
These interventions show the breadth of strategies being deployed, from traditional benefits enrollment to direct, clinic-based food access. However, their availability is uneven across the network, with some centers providing comprehensive supports while others focus primarily on referrals.

Barriers to Accessing Support

Despite their best efforts, health centers identified significant barriers standing between patients and food security:

- **Awareness:** Most patients don't realize they qualify for SNAP or WIC. Even if they do, they may not know how to use benefits at markets or stores.
- **Enrollment challenges:** Applications can feel daunting, and maintaining enrollment is difficult because of frequent recertification requirements.
- **Transportation:** Families with unreliable transportation may struggle to get to pantries, markets, or redemption sites.
- **Stigma:** In some communities, patients may feel embarrassed or ashamed to seek help.
- **Capacity:** Staffing shortages and infrastructure gaps (like refrigeration or storage) prevent some centers from offering more robust programs.

Figure 5. Barriers to Accessing Food Assistance Programs (N = 15 respondents from 6 FQHCs)



"When SNAP benefits go up, WIC services go down because patients/clients don't need the supplemental food benefits of WIC when they have so much SNAP dollars. This is very concerning to our WIC staff because we want to monitor moms & babies. We want to make sure everyone is eating healthy foods, being successful with breastfeeding, being emotionally supported, meeting growth benchmarks, etc. but with increased SNAP benefits families don't come in as often or at all." **– FQHC staff**

Key Gaps in Addressing Food Insecurity

Even when FQHCs link patients to support services, they often lack visibility into subsequent outcomes. Very few have established systems for closed-loop referrals that verify whether patients actually accessed food or benefits. Additionally, food insecurity is not consistently integrated into chronic disease management or wider screening processes, complicating the assessment of these interventions' overall effectiveness.

Survey feedback has also highlighted significant perceived gaps in tackling food insecurity. From 11 responses across six health centers, several common themes have surfaced:

Funding	Many noted unstable or unreliable funding streams as the most significant barrier. Without sustainable reimbursement models, programs remain fragile and short-term.
Access	High food costs, limited transportation, and lack of refrigeration for unsheltered patients were frequently cited challenges. Rural areas in particular face limited food variety and availability.

Vulnerable populations	Homeless individuals and children were identified as groups with especially limited access to healthy foods.
Workforce and infrastructure	Some centers lack CHWs to assist with enrollment and noted few grocery stores or farmers' markets in their communities.
Equity	Persistent disparities between racial/ethnic and lower socioeconomic groups were flagged.
Process and systems	Gaps were noted in intake processes and referral pathways, where patients can be identified but not consistently connected to food resources.

Together, these findings underscore that while screening and referrals are happening, structural gaps in funding, infrastructure, and equity limit the ability of health centers to fully address food insecurity for their patients.

Recommendations

Based on the insights gathered from survey respondents, HPCA has identified opportunities to assist FQHCs in tackling food insecurity.

For HPCA	For System Partners
Standardize screening and referral workflows: Use consistent screening tools, EHR fields, and referral processes so FQHCs know how many patients are affected and what support they actually receive.	**Simplify enrollment:** Streamline SNAP/WIC applications, digitize recertification, expand interpreter access, and support EBT at FQHC-linked markets.
Build closed-loop referrals: Ensure referrals do not stop at identification by tracking whether patients access food or benefits.	**Provide culturally relevant, reliable food:** Provide consistent, culturally relevant produce; align delivery schedules with clinic hours.
HPCA + System Partners	
Invest in workforce: Fund and sustain CHWs, outreach staff, and eligibility workers who are essential for enrollment and reducing stigma.	
Expand food access programs at FQHCs: Support the growth of on-site markets, pantries, and partnerships that accept SNAP/EBT and DA BUX.	

Conclusion

FQHCs in Hawai‘i are actively making a difference every day. They engage with patients about their access to food, connect them to vital resources, and foster collaborations to bridge the gap. However, many patients currently face food insecurity without a clear or reliable means of support. Obstacles such as a lack of awareness, complex enrollment processes, transportation issues, and stigma hinder families from receiving the assistance they require.

With the upcoming Medicaid Nutrition Supports benefit, the Hawai‘i Primary Care Association (HPCA) and its partners have a unique opportunity. By standardizing workflows, investing in staff and infrastructure, and incorporating culturally relevant practices, Hawai‘i can transition from merely identifying food insecurity to effectively addressing it. This ensures that every family screened for food insecurity leaves with not just an acknowledgment of their situation, but a concrete solution.

SNAP and WIC Integration in Hawai‘i’s Federally Qualified Health Centers Produce Access Programs

Hawai‘i Primary Care Association

SNAP/WIC

2025

Introduction

Federal nutrition programs such as the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) are vital supports for families in Hawai'i experiencing food insecurity. SNAP, the nation's largest food assistance program, provides monthly benefits to low-income households to help purchase groceries and maintain healthier diets.[i] Research shows SNAP improves access to food, reduces food insecurity by 5–20%, and is associated with better health outcomes and lower healthcare costs. [ii,iii,iv]

WIC complements SNAP by providing targeted food packages, breastfeeding support, and nutrition education—both in-person and virtual. These services are linked to positive changes in participant knowledge, attitudes, and behaviors, and are especially critical during pregnancy and early childhood development.[v] Together, SNAP and WIC not only provide immediate resources to access nutritious foods, but also strengthen preventive health by improving diet quality and reducing risks of chronic disease. [vi]

Federally Qualified Health Centers (FQHCs) are central to connecting patients with these benefits. Through enrollment assistance, referrals, co-location of services, and partnerships with WIC and SNAP agencies, health centers serve as key access points for vulnerable populations. In doing so, they help ensure that nutrition security becomes part of comprehensive primary care.

Within the broader Food Is Medicine framework, WIC and SNAP function as foundational programs. They provide the baseline supports upon which interventions such as produce prescriptions, medically tailored meals, and nutrition incentive programs can build.[vii] Their integration into FQHC workflows is essential to strengthening their response to food insecurity.

This section of the survey summarizes how FQHCs are currently integrating WIC and SNAP into patient care, identifies barriers that families encounter, and highlights opportunities to improve coordination in support of a more cohesive Food Is Medicine approach statewide.

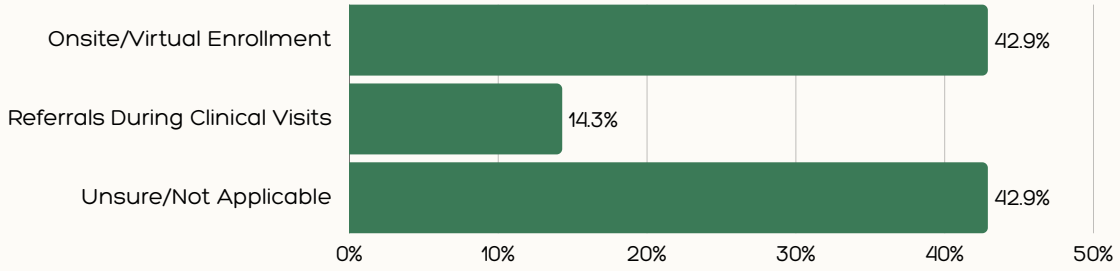
SNAP Enrollment and Support

All participating FQHCs (N=7) reported that they assist patients with SNAP enrollment, though the level of support varies. Some health centers provide onsite or virtual enrollment sessions, others focus on referrals during clinical visits, and a few participants reported being

[i] https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program
[ii] https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2023.307489
[iii] https://www.cbpp.org/research/food-assistance/snap-is-linked-with-improved-health-outcomes-and-lower-health-care-costs
[iv] https://www.fns.usda.gov/research/snap-indicators-diet-quality-nutrition-and-health-americans-program-participation-status-2011
[v] https://fns-prod.azureedge.us/sites/default/files/resource-files/wic-ppc-2022-report.pdf
[vi] https://www.fns.usda.gov/research/snap-indicators-diet-quality-nutrition-and-health-americans-program-participation-status-2011
[vii] https://tuftsfoodismedicine.org/

All participating FQHCs (N=7) reported that they assist patients with SNAP enrollment, though the level of support varies. Some health centers provide onsite or virtual enrollment sessions, others focus on referrals during clinical visits, and a few participants reported being unsure of their center's activities. This inconsistency highlights the need for clearer internal communication about SNAP services.

Figure 1. SNAP Enrollment and Acceptance by FQHC (N = 7 FQHCs)



WIC Partnerships

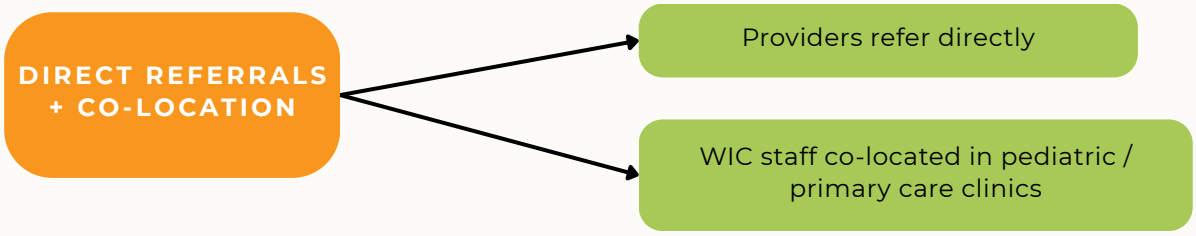
Formal partnerships with WIC are less common. Only three FQHCs (43%) reported formal partnerships, which typically include built-in referral processes, dedicated staff, or onsite WIC operations. The majority of health centers either do not have a WIC partnership or have inconsistent awareness of existing relationships.

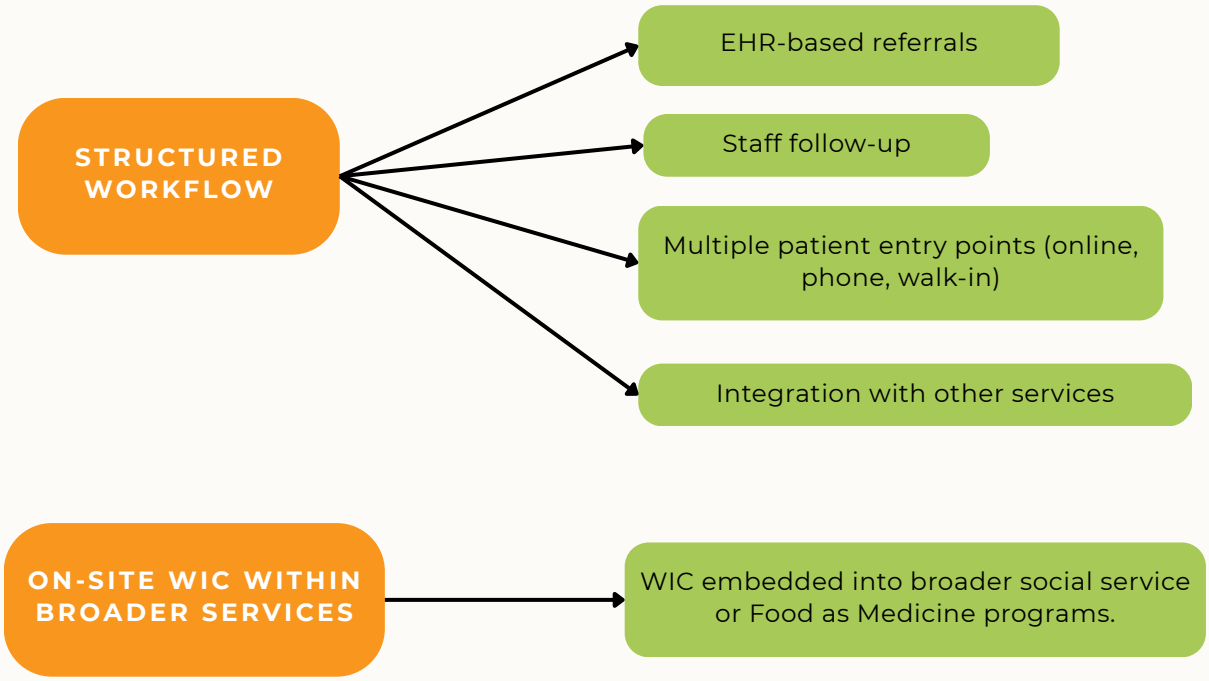
Key partnership elements include:

- Referrals to WIC built into clinic workflows
- Coordinating WIC services with other programs
- Dedicated support staff
- Onsite WIC operations

This variability suggests that WIC integration depends heavily on local circumstances rather than a standardized statewide approach.

Figure 2. WIC Partnership Models (N = 6 respondents, 3 FQHCs)





Integration with Produce Programming

Survey responses confirm that SNAP and WIC enhance participation in produce programs. At one health center, 51–75% of produce program participants were enrolled in one or both benefits, while two others estimated more than 75% participation.

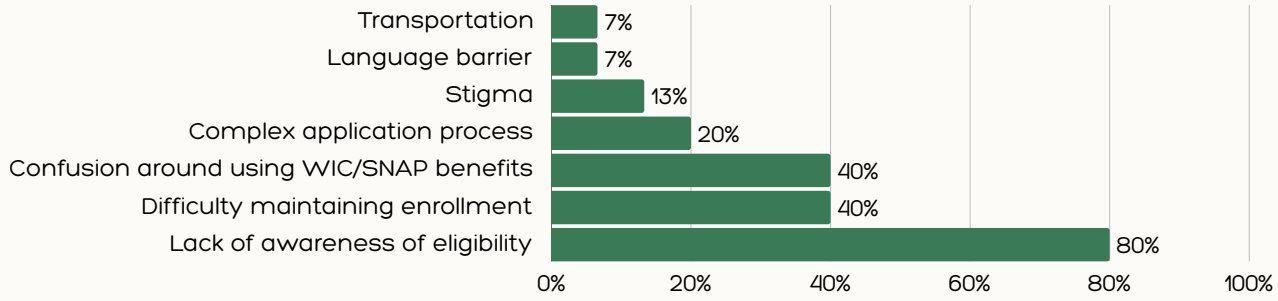
Health centers noted that SNAP and WIC connect to produce programs in three main ways:

1. **Joint education and outreach efforts** (67% of responses)
2. **Referrals to produce programs** (33%)
3. **Providing financial support, such as vouchers** (33%)

Barriers to Access

While SNAP and WIC are widely used, patients continue to face major barriers to access. Every participant reported that **lack of awareness of eligibility** is a barrier. Other challenges included confusion about how benefits can be used (83%), difficulty with the application process (67%), and maintaining enrollment (67%). Stigma was reported by one-third of participants.

Figure 3. Main Barriers to Accessing SNAP and WIC Services (N = 15 respondents from 6 FQHCs)



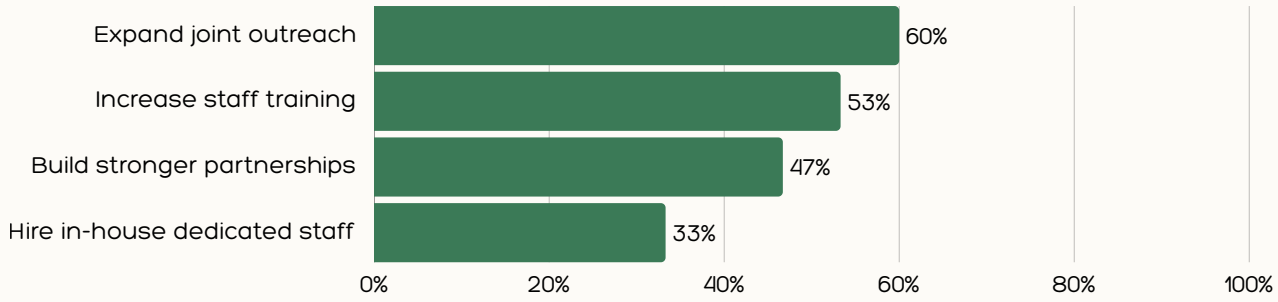
Additional barriers noted included language access, transportation, and reduced WIC engagement when SNAP benefits increase. One participant emphasized that increased SNAP allotments sometimes discourage families from accessing WIC, limiting opportunities for monitoring maternal and child health.

Opportunities for Stronger Integration

FQHCs identified several strategies to strengthen the integration of SNAP and WIC into patient care:

- Expand joint outreach efforts (60%).
- Increase staff training on referral processes (53%).
- Build stronger partnerships with local WIC/SNAP agencies (47%).
- Hire dedicated staff to manage enrollment and follow-up (33%).

Figure 4. Recommendations to Strengthen SNAP and WIC Integration (N = 15 respondents from 6 FQHCs)



Conclusion

SNAP and WIC are lifelines for patients served by Hawai'i's FQHCs. The majority of produce program participants are already enrolled in these benefits, yet integration remains uneven. While some health centers have built formalized partnerships, others rely on ad hoc referrals or lack clarity about existing services.

The survey reinforces three key findings:

1. Patients struggle to navigate WIC and SNAP due to lack of awareness, confusion, and administrative barriers.
2. Internal communication gaps within FQHCs create inconsistent messaging about available supports.
3. Stronger integration of WIC and SNAP, through training, workflows, and agency partnerships, presents a powerful opportunity to reinforce produce prescriptions and other Food Is Medicine programs.

Investing in these improvements will allow Hawai‘i’s health centers to fully leverage federal nutrition programs as part of a comprehensive response to food insecurity, improving health and advancing equity across the state.

Recommendations

Building for Tomorrow: Strategies to Sustain and Scale Nutrition Supports in Hawai‘i

Introduction

This series started by exploring how Hawai‘i’s Federally Qualified Health Centers (FQHCs) are enhancing access to fresh produce and integrating nutrition into healthcare delivery. What we discovered is both inspiring and urgent. Throughout the state, health centers are:

- Piloting produce distribution initiatives
- Incorporating WIC and SNAP into their workflows
- Screening for food insecurity
- Prescribing fruits and vegetables as part of patient care

Both patients and staff recognize the significance of these efforts. As one participant noted, ***“Food as medicine has always been one of our highest aspirations for patients and communities.”*** Another highlighted the tangible benefits, stating, ***“Patients utilize the benefit, eat better, and it also helps the local economy.”*** These testimonials emphasize that produce programs are not mere additions; they are crucial for patient health and community resilience.

However, the findings indicate that Hawai‘i is at a pivotal moment. Many programs rely on short-term grants, and while staff are dedicated, they are stretched thin. Clinics face infrastructure challenges, and data systems often fail to consistently capture outcomes. The vision is robust, but the foundation remains precarious.

Lessons Learned

1	**Food Is Medicine is No Longer a Fringe Idea**	Across FQHCs, staff voiced a shared conviction that access to healthy food belongs inside primary care. What once may have been viewed as an add-on is now seen as central to chronic disease management, maternal and child health, and the well-being of kūpuna.
2	**Funding Models Dictate Program Lifespans**	Health centers repeatedly stressed that programs close when the money runs out. A single grant can launch an initiative, but without sustainable reimbursement, momentum fades. Staff were clear: the greatest barrier to long-term impact is not interest or patient demand - it is unstable funding.
3	**Workforce is the Lifeblood, and It is Stretched Thin**	CHWs, navigators, nutritionists, and outreach staff are holding these programs together, often on top of their regular duties. Respondents called for dedicated roles and training. As one staff member put it, ***"We need champions from within our communities to sustain this work."***
4	**Infrastructure is Essential for Access**	Storage, refrigeration, and transportation are not glamorous, but they are critical. Without the physical means to handle produce, even well-designed programs can stall. Several centers noted that scaling would not be possible without investments in these basics.
5	**Patient Trust and Community Connections Drive Participation**	The most effective outreach doesn't come from flyers or websites — it comes from trusted referrals, CHWs, and word of mouth. Patients engage because they trust their providers and neighbors. This trust is an asset Hawai'i must build upon.
6	**Data Capacity Remains Uneven**	Some centers track participation and outcomes, others rely on anecdotal evidence. Staff often described uncertainty about whether their systems could capture food insecurity referrals or PRx results. Without consistent data, programs remain harder to defend, scale, or evaluate.

Themes for the Future

Taken together, the responses show Hawai'i's FQHCs are aligned on the path forward. The themes that cut across centers and programs are clear:

- **Stability matters most.** Programs cannot survive on short-term funding alone.
- **People power drives change.** Dedicated staff and community champions are essential to connect patients with services.
- **The basics are not optional.** Refrigeration, storage, and transportation are foundational to scale.
- **Equity must be centered.** Native Hawaiian, Pacific Islander, kūpuna, and families with young children consistently emerge as priority populations, and programs must reflect their cultural and nutritional needs.
- **Data is the bridge to policy.** To secure lasting reimbursement and system alignment, FQHCs need to demonstrate outcomes with consistent, standardized measures.

Recommendations

For HPCA	For System Partners
• Co-develop a **statewide PRx and nutrition supports framework** with common workflows, data standards, and evaluation tools. • Provide **training and technical assistance** in Medicaid billing, GusNIP applications, and braided funding models. • Convene **peer learning collaboratives** for FQHCs to share strategies, troubleshoot barriers, and scale successful models. • Standardize **EHR integration** for screening, referrals, and program tracking across health centers.	• Ensure **Medicaid Nutrition Supports** implementation in 2026 is accessible, adequately reimbursed, and culturally relevant. • Expand **SNAP and WIC co-location pilots**, streamline applications, and digitize processes to reduce patient burden. • Invest in **infrastructure upgrades** (refrigeration, storage, transportation) to enable clinics to manage produce at scale. • Fund and sustain **CHW and navigator positions** dedicated to food insecurity and nutrition supports. • Strengthen **food system partnerships** so local farms and food hubs remain at the center of supply chains.

Conclusion

The collective responses from Hawai'i's FQHCs show that food is already being treated as part of patient care. Staff are committed, patients are engaged, and communities are ready. What remains uncertain is whether these efforts can take root and flourish beyond the short-term support that currently sustains them.

As one staff member reflected, ***"We were able to help feed the community during some of the hardest times (pandemic) and have continued to do so in the years after."*** That resilience is a strength to build on, but resilience alone is not enough. Programs need steady resources, strong infrastructure, and clear systems to become a lasting part of health care.

Moving forward will require shared effort. If HPCA, state agencies, health plans, and community partners align on funding, invest in workforce and infrastructure, and strengthen data systems, the foundation will be in place for long-term growth. Doing so will not only improve patient health and reduce food insecurity, but also strengthen Hawai'i's local economy by supporting farmers, food hubs, and community food providers, while honoring cultural traditions that have long connected food, health, and community.

The Harvesting Insights series closes with this perspective:

> Hawai'i has planted the seeds of food-as-medicine. The challenge now is to create fertile ground for those seeds to grow into enduring programs. With the right conditions, the harvest will be healthier patients, stronger communities, and a food system rooted in both health and culture.

Appendix

About the Produce Program Survey

The Produce Program Survey was developed by the Hawai'i Primary Care Association (HPCA) to better understand the current landscape of produce programs and food insecurity interventions across Hawai'i's Federally Qualified Health Centers (FQHCs).

Participants began by sharing background information, such as the FQHC they represented and their role within the organization. The survey itself was structured into five thematic sections:

1. Current produce program offerings
2. Previously implemented produce programs
3. Food insecurity interventions
4. Capacity for program expansion
5. Technical assistance and funding needs

Survey questions are included with domain subcategories summarized in the following Table.

	Background Info	FQHC Represented, Participant Role
Five Domain Areas	**Current Produce Program Offerings**	Program type and purpose, populations served, patient reach, delivery methods, duration, workflow integration, referral and recruitment, staffing, funding sources, successes, challenges, capacity for growth, SNAP/WIC connections
	Previously Implemented Produce Programs	Program type, patient reach, duration, funding, reason for discontinuation
	Food Insecurity Interventions	Populations affected, annual patients served, screening and workflow, intervention types, referral and enrollment, EHR tracking, SNAP/WIC integration, gaps and barriers
	Capacity for Program Expansion	Readiness, prospective partners, leadership support, staff training, data systems and privacy, use of SNAP/WIC, resource needs
	Identified Needs for Technical Assistance and Funding	Types of TA, resource needs, funding gaps, awareness of opportunities, program cost estimates
	Additional Feedback	General comments, interest in future interviews

The survey used skip patterns to tailor questions based on responses. Participants involved in current or past produce programs answered detailed questions about program type, populations served, workflows, funding, and (if applicable) reasons for discontinuation. Those without produce programs skipped these sections.

All respondents were asked about food insecurity interventions, including screening practices, data tracking, services offered, and SNAP/WIC integration. They were also asked to assess their FQHC's readiness to expand produce programming, with questions on partnerships, staffing, infrastructure, leadership support, and workflows.

The survey concluded with an open-ended prompt for additional comments, allowing respondents to share reflections and identify unmet needs.

Survey Methodology

The Hawai‘i Primary Care Association (HPCA) conducted an online survey using Microsoft Forms from February 4–25, 2025. The survey was shared during HPCA’s Nutrition Supports Workgroup and emailed to representatives from each of Hawai‘i’s 14 Federally Qualified Health Centers (FQHCs).

The responses provided insights into the resources, challenges, and opportunities in communities such as Nānākuli/Waiʻanae, Hilo, Molokaʻi, North Hawaiʻi, Līhuʻe/Waimea, and Kahului, and guided future technical assistance and resource development to support sustainable produce programs.

Survey Limitations

While this survey offers valuable, context-specific insight, several limitations should be noted. Response bias and varying levels of involvement in program operations likely affected the quality and consistency of answers. Some participants were not directly engaged with their FQHC’s food access programs, leading to gaps in knowledge or reliance on general impressions rather than firsthand experience. In some cases, participants from the same FQHC gave conflicting responses to identical questions, highlighting differences in program awareness and internal communication. These discrepancies make it difficult to draw precise organizational-level conclusions and underscore the need for stronger communication around food-related initiatives.

Survey design also presented challenges. Although it included both closed- and open-ended questions, the lack of real-time clarification meant key terms, such as local farm partnership or produce prescription, may have been interpreted differently across participants. Without shared definitions, responses are not always directly comparable across sites. This points to the need for engagement methods beyond surveys. While the self-paced format allowed thoughtful reflection, follow-up approaches like structured focus groups or interviews could offer greater clarity, encourage team discussion, and give facilitators the chance to resolve confusion in real time. Conducting these sessions at each FQHC would help validate findings, reconcile discrepancies, and create a more accurate picture of program implementation and readiness.

FQHC Produce Program Survey Questions

Purpose:
The Hawaii Primary Care Association (HPCA) is conducting this survey to gather insights into the current produce programs, food insecurity interventions, and the capacity for expanding access to fresh produce within Federally Qualified Health Centers (FQHCs) across Hawaiʻi. Your responses will help us better understand the resources, challenges, and opportunities specific to Hawaiʻi's communities - such as Nānākuli/Waiʻanae, Hilo, Molokaʻi, North Hawaiʻi, Līhuʻe/Waimea, and Kahului. This information will guide future technical assistance and resource development to strengthen efforts to address food insecurity and support sustainable produce programs for FQHC patients.

Why Your Participation Matters:
As a key healthcare provider in your community, your input is invaluable. It will inform strategies and collaborations that can improve access to healthy, local food, support patient health outcomes, and contribute to long-term community well-being. This survey should take approximately 15-20 minutes to complete. Your responses will be kept confidential and will only be used to inform the collective assessment of FQHCs across Hawaii.

Mahalo nunui, The HPCA Team

When you submit this form, it will not automatically collect your details like name and email address unless you provide it yourself.
*Required

General Information

1. Which FQHC do you work for?*
◯ Hāmākua-Kohala Health
◯ Hāna Health
◯ Hawaiʻi Island Community Health Center
◯ Kalihi-Palama Health Center
◯ Hoʻōla Lāhui Hawaiʻi/Kauaʻi Community Health Center
◯ Kōkua Kalihi Valley Comprehensive Family Services
◯ Koʻolauloa Health Center
◯ Lānaʻi Community Health Center
◯ Mālama I Ke Ola Health Center
◯ Molokaʻi Community Health Center
◯ Wahiawā Health
◯ Waiʻanae Coast Comprehensive Health Center

2. What is your role or title at your FQHC?*
◯ Clinical Staff (Physician, Nurse, etc.)
◯ Administrative/Leadership (CEO, COO, Director, etc.)
◯ Program/Project Manager
◯ Dietitian/Nutritionist
◯ Public Health Worker (Community Health Worker, Community Health Educator, social worker, etc.)
◯ Other: ____

3. Does your FQHC currently have any produce programs (e.g., produce prescriptions, partnerships with local farms, community gardens, produce vouchers, etc.)?*
◯ Yes, active program(s)
◯ No, but one is in development
◯ No, no plans at this time
◯ Unsure

Current Produce Programs

4. Which type(s) of produce programs are currently implemented?
Check all that apply
▫ Produce Prescription (PRx) Program
▫ Community-Supported Agriculture (CSA)
▫ Farmers' Market Vouchers
▫ Grocery Store Vouchers
▫ On-site Community Garden
▫ Local Farm Partnership
▫ Food Distribution
▫ Referrals to another program (please describe in "Other")
▫ None (to my knowledge - please skip to the next section)

5.What (is/are) the primary goal(s) of your produce programs?
Check all that apply
▫ Improve patient nutrition
▫ Reduce food insecurity
▫ Support local agriculture
▫ Improve chronic disease management
▫ Support Indigenous/local culture(s)

6. Which populations are prioritized for your PRx program?
Check all that apply
▫ Patients with or at risk for chronic conditions (e.g., diabetes, hypertension)
▫ Patients screening positive for food insecurity
▫ Pediatric patients and families
▫ Pregnant and/or postpartum patients
▫ Elderly patients/kūpuna

. How many patients participate in your produce programs annually?
◯ Less than 100
◯ 100-500
◯ 501-1,000
◯ More than 1,000
◯ I don't have access to this information
◯ We don't track this information
◯ Unsure

8. What are the main ways patients find out about your produce programs?
Please select at most 3 options.
▫ Referrals within your organization
▫ Referrals from other organizations
▫ Word of mouth (coconut wireless)
▫ Flyers posted in clinic
▫ Mailed flyers
▫ Website
▫ E-mail
▫ Phone call
▫ Text
▫ Social media

9. How is the PRx benefit provided to patients?
Check all that apply
▫ Paper vouchers or coupons for produce that can be redeemed in-person
▫ Electronic credit or “food prescription” that can be redeemed at partner stores/farmers’ markets
▫ On-site distribution of produce boxes/bags at the health center
▫ Delivery of produce boxes/bags to participants
▫ Other

10. How long have your produce programs been in place?
If it varies based on the program, please describe in "Other"
◯ Less than 1 year
◯ 1-2 years
◯ 3-5 years
◯ More than 5 years
◯ Unsure
◯ Other

11. How are your programs funded?
Check all that apply
▫ Short-term grants (2 years or less)
▫ Long-term grants (more than 2 years)
▫ Private donations
▫ State funding
▫ Partnerships with local organizations
▫ Unsure
▫ Other

12. Please describe your funding sources.
Open-ended

13. Please indicate your level of agreement with the following statements.

	Strongly Agree	Disagree	Neutral	Agree	Strongly Agree
Our Prx program is well-integrated into clinic workflows.	◯	◯	◯	◯	◯
We have adequate funding to sustain our Prx program.	◯	◯	◯	◯	◯
We have adequate staffing to sustain our PRx program.	◯	◯	◯	◯	◯
Patients generally have positive experiences with our PRx program.	◯	◯	◯	◯	◯
We track patient participation and outcomes effectively.	◯	◯	◯	◯	◯

14. What are the top 2–3 successes you've seen from your PRx program?
Open-ended

15. What are the main challenges or barriers to sustain or expand your produce programs?
Please select at most 3 options.
▫ Limited funding or short-term grants
▫ Staffing constraints
▫ Difficulty in patient referral or enrollment processes
(continued)

▫ Lack of existing community partnerships with distributors or local food sources (farmers, food hubs, etc.)
▫ Low patient engagement or awareness
▫ Limited patient access due to transportation or timing
▫ Geographic/logistical barriers (e.g., rural access to fresh produce)
▫ Limited space to maintain programs
▫ Data tracking or EHR integration challenges
▫ Inadequate support from leadership/administration
▫ Other

16. Please rate your FQHC's capacity to continue or grow the PRx program.
◯ 1 = Very Low (We struggle to maintain the current program)
◯ 2 = Low
◯ 3 = Moderate (We are able to maintain our program, but would have difficulty expanding)
◯ 4 = High
◯ 5 = Very High (We have ample resources to expand significantly)

17. Does your FQHC partner with WIC and/or SNAP programs to support your produce programs?
◯ Yes, with WIC
◯ Yes, with SNAP
◯ Yes, with both
◯ No, but we refer patients to these programs
◯ No, not at all
◯ Unsure
◯ Other

18.If you do partner with WIC and/or SNAP, how do these partnerships enhance your produce programs?
Check all that apply
▫ Providing financial support (e.g., vouchers) for produce
▫ Referring patients to produce programs
▫ Joint education and/or outreach efforts
▫ Other

19. What percentage of your patients participating in produce programs are enrolled in WIC or SNAP?
◯ Less than 25%
◯ 25-50%
◯ 51-75%
◯ More than 75%
◯ I don't have access to this information
◯ We don't track this information
◯ Unsure
◯ Other

Previous Produce Programs

20. Did your FQHC previously have any produce programs (e.g., produce prescriptions, partnerships with local farms, community gardens, produce vouchers, etc.) that are no longer available?*

◯ Yes
◯ No
◯ Unsure

21.Which type(s) of produce programs were previously implemented?
Check all that apply

▫ Produce Prescription (PRx) Program
▫ Community-Supported Agriculture (CSA)
▫ Farmers' Market Vouchers
▫ Grocery Store Vouchers
▫ On-site Community Garden
▫ Local Farm Partnership
▫ Food Distribution
▫ Referrals to another program (please describe in "Other")
▫ None (to my knowledge - please skip to the next section)
▫ Other

22. How many patients participated in the previous produce program(s) annually?

◯ Less than 100
◯ 100-500
◯ 501-1,000
◯ More than 1,000
◯ I don't have access to this information
◯ We don't track this information
◯ Unsure

23. How long was/were the pervious produce program(s) in place?
If it varied based on the program, please describe in "Other"

◯ Less than 1 year
◯ 1-2 years
◯ 3-5 years
◯ More than 5 years
◯ Unsure
◯ Other

24. How was/were the previous produce program(s) funded?
Check all that apply
▫ Short-term grants (2 years or less)
▫ Long-term grants (more than 2 years)
▫ Private donations
▫ State funding
▫ Partnerships with local organizations
▫ Unsure

25. What were the main reasons the previous produce program(s) ended?
Check all that apply
▫ Funding
▫ Staffing
▫ Partnerships
▫ Space/location
▫ Patient participation
▫ Patient access – transportation
▫ Patient access – timing
▫ Inadequate support from leadership/administration
▫ Created a new program that better fit patient needs
▫ Unsure
▫ Other

Food Insecurity Questions

26. Does your clinic screen patients for food insecurity (e.g., using PRAPARE or other SDoH tools)?*
◯ Yes, routinely (for all or most patients)
◯ Yes, occasionally (only for some patients or certain programs)
◯ No, we do not screen at this time
◯ Unsure

27. If yes, what tool do you use to screen for food insecurity?
If you use a custom tool, please describe it in "Other"
◯ PRAPARE
◯ Hunger Vital Sign
◯ USDA Food Insecurity Survey
◯ Staff notes during SNAP/WIC applications
◯ Other

28. Does your electronic health record (EHR) system track patient screenings, prescriptions, and outcomes related to food insecurity and nutrition?

◯ Yes
◯ No
◯ In progress
◯ Unsure
◯ Other

29. How many food-insecure patients does your FQHC serve annually?

◯ Less than 100
◯ 100-500
◯ 501-1,000
◯ More than 1,000
◯ I don't have access to this information
◯ We do not track this information
◯ Unsure

30. What types of food insecurity interventions does your FQHC provide?

Check all that apply

▫ Referral to community food resources (e.g., food banks, pantries)
▫ Enrollment assistance for SNAP
▫ Enrollment assistance for WIC
▫ Food voucher programs
▫ Produce prescriptions (PRx)
▫ On-site food pantry
▫ Distribution of in-clinic food boxes (not tied to a PRx program)
▫ Nutrition education classes and/or workshops
▫ Partnerships with local farms for produce distribution
▫ Cooking/nutrition classes
▫ Medically Tailored Meals (MTM)
▫ Pre-made meals (non-medically tailored)
▫ Unsure
▫ Other

31. How are food-insecure patients referred to food programs (e.g., PRx, food banks, CSA)?

Open-ended

32. Does your FQHC integrate or coordinate WIC services into any existing produce or nutrition programs?

◯ Yes, we have a formal partnership with WIC
◯ Yes, but on a limited or informal basis
◯ No, not currently
◯ Unsure / Not applicable
◯ Other

33. If you do integrate or coordinate WIC services, please briefly describe how this is done at your FQHC.
Open-ended

34. Does your FQHC accept SNAP/EBT for any produce purchases or coordinate SNAP enrollment for patients?
◯ Yes, we accept SNAP/EBT on site (e.g., at a market stand, farm box pickup)
◯ Yes, but limited to specific sites or events
◯ We assist with SNAP enrollment only (do not accept SNAP/EBT onsite)
◯ No, not at this time
◯ Unsure / Not applicable
◯ Other

35. If you do integrate and/or accept SNAP/EBT, please briefly describe how this is done at your FQHC.
Open-ended

36. If you offer WIC and/or SNAP enrollment assistance, how do you connect these benefits to your produce or food insecurity programs?
◯ We provide referrals during clinical visits
◯ We have onsite or virtual enrollment sessions for WIC/SNAP
◯ We offer joint patient education sessions on using WIC/SNAP benefits for produce
◯ Unsure/not applicable
◯ Other

37. What specific barriers do patients face in accessing WIC or SNAP at your FQHC?
Check all that apply
▫ Lack of awareness about program eligibility
▫ Complex application process
▫ Stigma associated with using these programs
▫ Difficulty in maintaining program enrollment
▫ Confusion around how WIC/SNAP can be utilized
▫ Other

38. Please select the populations most impacted by food insecurity in your service area.
Check all that apply
▫ Native Hawaiian or Pacific Islander communities
▫ Low-income individuals/families (general)
▫ Rural or geographically isolated residents
▫ Homeless or housing-insecure individuals
▫ Children (17 & under)
▫ Seniors (65+)
▫ Other

39. Where do you see the largest gaps in addressing food insecurity among your patients?
Open-ended

Capacity to Expand Produce Programs

40. Does your FQHC have plans to start or expand produce programs in the next 12 months?*
If there are tentative plans/interest, please describe in "Other"
◯ Yes
◯ No
◯ Unsure
◯ Other

41. How would your rate your FQHC's capacity to expand community food programs (e.g., additional PRx or food insecurity programs)?*
◯ 1 = Very Low (We are stretched thin)
◯ 2 = Low
◯ 3 = Moderate
◯ 4 = High
◯ 5 = Very High (We already have plans in action to expand)

42. Which local or regional partners are you already working with on produce or food insecurity programs?
Check all that apply.
▫ Local farmers or farmers' cooperatives
▫ Food hubs or distribution centers
▫ Community-based organizations (CBOs) providing social services
▫ State or county government agencies
▫ Other FQHCs or clinics
▫ Local volunteers
▫ Community educators and other gatekeepers
▫ None at this time
▫ Other

43. Are there any other resources (e.g., certified kitchens) or partnerships (e.g., schools, farms, organizations) in your community you would be interested in accessing?
Open-ended

44. Is there leadership support for cross-sector partnerships with food growers, distributors, and community organizations?
◯ Yes
◯ No
◯ Unsure
◯ Other

45. Do you have dedicated staff trained in screening for food insecurity and determining patient eligibility for food prescriptions?
◯ Yes
◯ No
◯ In progress
◯ Unsure
◯ Other

46. Are your data systems capable of tracking patient engagement and health outcomes as part of produce prescription interventions?
◯ Yes
◯ No
◯ In progress
◯ Unsure
◯ Other

47. Do you have processes in place to protect patient data related to participation in produce prescription programs?
◯ Yes
◯ No
◯ In progress
◯ Unsure
◯ Other

48. How can your FQHC better leverage WIC and SNAP to expand produce programs and address food insecurity?
Check all that apply
▫ Hire in-house dedicated staff for WIC/SNAP
▫ Expand joint outreach efforts
▫ Increase staff training on WIC and SNAP referral processes
▫ Build stronger partnerships with local WIC/SNAP offices
▫ Other

Technical Assistance (TA) & Funding Needs

49. What additional resources would be most helpful in expanding access to fresh produce for your patients?
Check all that apply
▫ Additional funding
▫ Long-term funding
▫ Community partnerships
▫ Infrastructure (e.g., refrigeration, storage, space)
▫ Staff training
▫ Other technical assistance (TA)
▫ Other

50. Are you aware of any existing grant or funding opportunities to support produce or food insecurity programs?
◯ Yes, and we have applied/are applying
◯ Yes, but we haven't applied
◯ No, not aware
◯ Unsure
◯ Other

51. Besides paying for the produce and direct staff, what are specific ways you would use funding for future produce prescriptions and other nutrition supports services?
(For example, this may include needs assessments, training materials for nutrition education, creating or expanding data tracking software, reimbursing time spent building and maintaining community partnerships, renting or building a space for storage and/or programming, and/or purchasing a vehicle to help with deliveries.)
Open-ended

52. What types of technical assistance (TA) would be most beneficial your FQHC to expand access to food in your community?
◯ Grant writing and/or application support
◯ Training staff on SDOH/PRAPARE screening
◯ Training on funding definitions
◯ Workflow development for screening/referrals
◯ Best practices for integrating WIC/SNAP into produce programs
◯ Overall workflow and/or best practices
◯ Data collection and/or evaluation (e.g., tracking patient outcomes, ROI)
◯ Community partnership building (e.g., with farmers, food banks)
◯ Policy advocacy and/or identifying legislative support
◯ Other

53. Please describe any specific training or support you would like to receive to enhance your FQHC's capacity to implement or sustain a PRx program (including SNAP/WIC coordination).
Open-ended

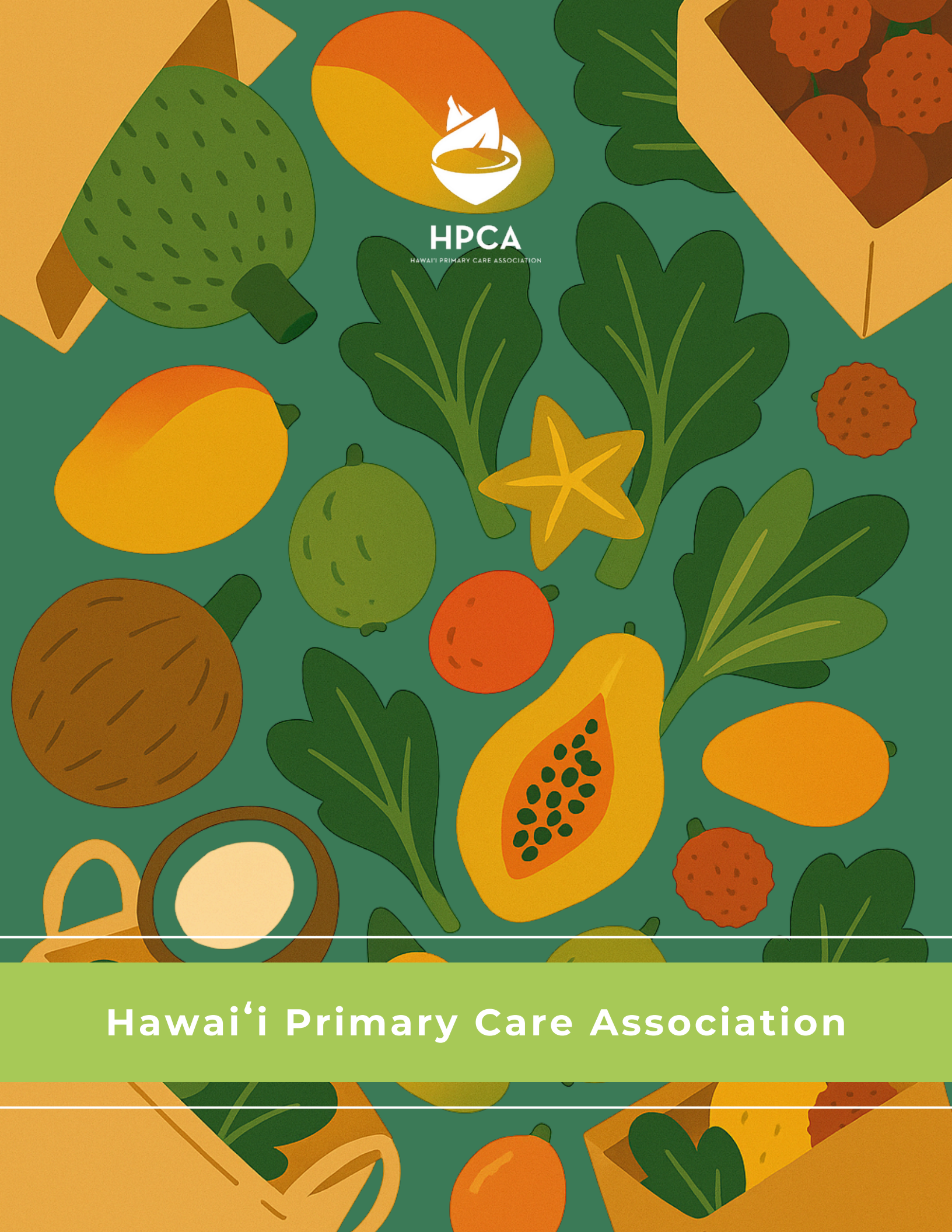
Final Thoughts

Thank you so much for your participation! We appreciate your time and all the work you do. If you're interested in entering our raffle for a Feel Good prize, please provide your email address in Question 56.

54. Feel free to share any other feedback or thoughts on produce programs you have here. Please share any additional comments, stories, or insights about your FQHC's experience (or interest) in produce prescription programs, SNAP/WIC integration, or other food insecurity interventions.
Open-ended

55. If you are willing to participate in a follow-up interview or focus group, please provide your contact information (name and email/phone).
Open-ended

56.Thank you again for taking the time to share your response. If you're interested in entering a raffle to win a Feel Good prize, please enter your email address below. Winners will be selected randomly and notified by the email listed below.
Open-ended



Hawai‘i Primary Care Association