Goal 3

WHAT WE ENVISION FOR OUR COMMUNITY

Everyone in the region has access to healthy, affordable food and quality, affordable housing

Community Outcomes How we will know if we have made a difference

SHORT-TERM

- Increase the percent of patients screened for health-related social needs (e.g. food and housing insecurity)
- Increase referrals to community resources for patients with health-related social needs
- Increase support for existing food and housing efforts to meet the full scope of community needs
- Increase legal representation for tenants facing eviction

INTERMEDIATE

- Reduce unnecessary emergency department use stemming from patients' health-related social needs
- Decrease requests for emergency shelter
- Decrease the eviction filing rate
- Decrease mortgage and tax foreclosures
- Improve housing conditions and quality
- Increase enrollment in food assistance safety net programs (e.g. SNAP, Produce Perks)
- Increase the availability of healthy foods (e.g. fruits, vegetables)

LONG-TERM

- Decrease severe housing cost burden
- Increase available quality, affordable housing units
- Decreasing percentage of housing vacancies
- Decrease food desert areas
- Decrease household food insecurity
- Increase the consumption of healthy food (e.g. fruits, vegetables)

Priority Populations The people and places experiencing significant health disparities

Black persons, veterans and active-duty military, people with disabilities, people who are uninsured or underinsured, and foreign-born persons and those who speak English as a second language.

Goal 3

Priorities and Strategies

Evidence-informed actions to help achieve our goal

Cross-Cutting Strategies

3.0.1 Improve coordination between health care systems and social service agencies by establishing a shared mechanism to screen, refer, and follow up on patients' health-related social needs (e.g. housing, legal issues, food insecurity).

Organizing patient care activities and sharing information among all of the participants concerned with a patient's care is essential to achieve safer and more effective care.

LEAD	Coordinated care organization, Hospitals, Federally qualified health centers
PARTNERS	Social service agency, Community based organizations
SAMPLE PILOT DESCRIPTION	Health care providers screen for health-related social needs during routine health care activities. Upon identifying a patient with a health-related social need (e.g. a volatile housing situation), the provider refers this patient to a local social service agency which is equipped to follow up with this need and identify any additional areas of assistance the patient may need.
REAL WORLD EXAMPLE	Health care Access Now Adult Health Care Coordination connects community health workers (CHWs) with patients from primary care practices and Medicaid health plans. The CHWs complete a social and medical access assessment to identify the needs of the patient. Together they craft a plan to meet chronic disease self-management goals, which includes finding resources to eliminate barriers to regular and timely medical care.
POTENTIAL IMPACT	Reduced hospital admissions, improved quality of chronic disease management, improved patient satisfaction, and better access to specialty care.
TIMELINE FOR IMPLEMENTATION	3-6 months

Cross-Cutting Strategies

3.0.2 Increase the number of Community Health Workers to connect individuals to resources and programs addressing food and housing needs.

Increase the number of community health workers who play a critical role in connecting people to care, including COVID-19 care; mental health and substance use disorder prevention, treatment and recovery services; chronic disease care; and other important health services.

LEAD	Community based health care organizations
PARTNERS	Hospitals, Federally qualified health centers
SAMPLE PILOT DESCRIPTION	Community Health Workers (CHWs) are equipped with the skill sets needed to provide effective community outreach, build trust with communities, support connections to and retention in care and support services, and other strategies to increase access to care and to assist individuals in prevention services. Additionally, they can serve to assist in holistic recovery from the effects of the COVID-19 pandemic and other public health emergencies in underserved communities. These combined efforts are intended to advance public health, strengthen the public health workforce, reduce health disparities, and help underserved populations achieve health equity.
REAL WORLD EXAMPLE	Health care Access Now (HCAN) collaborates with Mercy Health as a Pathways Community Hub partner. HCAN is the Hub for the Cincinnati regional area. This partnership means an expansion of services for those members of vulnerable populations who face obstacles to good health in the Cincinnati area. The Hub provides a framework for Community Health Workers to identify and help remove barriers to health care access for underserved populations. The Hub's "pathway" model presents a structure that clarifies the different obstructions to health care that may exist for clients, including transportation, education, safety, and housing. Hub partnerships benefit health care organizations because their CHWs can access additional education. The metrics provided by all Hub members allow organizations to demonstrate the effectiveness of methods and resources.
POTENTIAL IMPACT	Extending care beyond the hospital or clinic walls to help bridge gaps in care, expand access to care and, ultimately, improve health outcomes for high-risk patients.
TIMELINE FOR IMPLEMENTATION	3-6 months

Priority 3.1

Eliminate residential evictions due to inability to pay rent

Featured Strategies

3.1.1 Expand partnerships for addressing food needs by increasing the number of care coordination agencies within the Pathways Community Hub model.

The expansion of care coordination agencies will ensure patients' needs and preferences are known and communicated at the right time to the right people, resulting in high-quality, high-value health care. This information sharing guides safe, appropriate, and effective care delivery.

LEAD	Care Coordination Agencies
PARTNERS	Hospitals, Federally Qualified Health Centers, Community-based organizations, Insurance providers
SAMPLE PILOT DESCRIPTION	Community health workers (CHWs) engage at-risk individuals they meet through canvassing, referrals from Managed Care Organizations, and community partners. The CHWs then complete a comprehensive needs and risk assessment. CHWs enroll clients in Hub based on evaluation, opening standardized Pathways or connections to care and services. CHWs check in with clients regularly, provide continued support, link them to care and resources and educate the client on the goal of self-sufficiency. CHWs work with clients to complete Pathways by helping to work toward goals and maintain successful care and service connections. As the Pathways are completed, they are sent to Medicaid Managed Care for reimbursement and back to community agencies.
REAL WORLD EXAMPLE	The Dayton Regional Pathways Hub coordinates and operates a network of partnering care coordination agencies. Each partner employs community health workers to ensure that the necessary resources and services are in place to support clients in overcoming barriers to accessing health care. The Greater Dayton Area Hospital Association (GDAHA) delivers the Pathways Community Hub model, an evidence-based approach to Health Care Coordination, in communities throughout the greater Dayton area.
TIMELINE	6-12 months

Featured Strategies

3.1.2 Increase funding to support ongoing efforts to provide residents access to legal defense, emergency rent, tenant advocacy, and other housing and eviction services.

Legal help, emergency rental assistance funds, and landlord-tenant mediation services are key mechanisms for homelessness prevention. Health systems should partner with, refer to, and fund entities such as HOME, Legal Aid Society of Greater Cincinnati, Society of St. Vincent de Paul, and Community Action Agency that provide these services, in order to increase their capacity to provide needed help to the surrounding community.

LEAD	Hospitals, community-based organizations, legal aid societies
PARTNERS	Insurance providers
SAMPLE PILOT DESCRIPTION	A health system dedicates a funding stream to a partnership with its local Legal Aid society to create an avenue for medical providers to refer patients with legal needs related to social determinants of health.
REAL WORLD EXAMPLE	Cincinnati Children's Hospital Medical Center (CCHMC) has a medical-legal partnership called Child HeLP with the Legal Aid Society of Greater Cincinnati. This partnership has made it possible for health care providers to immediately connect a patient to legal services upon disclosing a need. In one example, CCHMC referred numerous patients to Legal Aid due to unsafe, unhealthy living conditions in their rental housing, including asthma triggers such as mold and dust. Child HeLP discovered that 16 referred families were living in housing owned by the same landlord, who had ignored previous orders to amend code violations. Child HeLP's intervention and subsequent advocacy resulted in substantial improvements to most of these units, resulting in improved housing conditions for families.
POTENTIAL IMPACT	Increased housing stability, fewer hospital admissions for patients with chronic illnesses due to improved housing quality and stability, lower health care costs over time
TIMELINE FOR IMPLEMENTATION	6-12 months

Featured Strategies

3.1.3 Invest in eviction diversion programs that offer rental assistance, mediation, legal representation, and other social and housing services to tenants and landlords.

Eviction prevention programs do more than prevent displacement: they have the potential to improve health outcomes, save future costs, and help stabilize a family's housing situation long term. Health systems have an opportunity to build partnerships with organizations that provide these services and provide them with increased funding to reduce evictions in the local community.

LEAD	Hospitals
PARTNERS	Local housing community-based organizations, Insurance providers
SAMPLE PILOT DESCRIPTION	A health system identifies a local provider of emergency housing assistance, including rental assistance, landlord/tenant mediation, and long-term stability coaching. The health system dedicates a funding stream to this partner for use in relevant high-need communities based on internal data. Health systems can refer patients in need of assistance to the organization and assist the organization in advertising its eviction prevention services to ensure tenants in need receive assistance.
REAL WORLD EXAMPLE	Bons Secours Mercy Health partnered with Housing Opportunities Made Equal Cincinnati (HOME) and Working in Neighborhoods (WIN) to administer funding for eviction and foreclosure prevention in the Bond Hill and Roselawn neighborhoods. Over 200 households participated in the program, and 90% remained in their homes for at least seven months after receiving this assistance, indicating increased housing stability. It is estimated that eviction rates could have been as much as 40% higher without this assistance.
POTENTIAL IMPACT	Reduced residential evictions, greater appointment and medication adherence due to reduction in additional stressors, improved mental and overall health in affected communities
TIMELINE	6-12 months

Featured Strategies

3.1.4 Establish nonprofit affordable housing development collaboratives with existing local community-based organizations.

Health systems can impact their surrounding communities through partnerships with existing nonprofit development entities that have the expertise necessary to administer programs to create and rehabilitate quality affordable housing.

LEAD	Community-based organizations and local housing authorities
PARTNERS	Hospitals, City and county government entities
SAMPLE PILOT DESCRIPTION	A health system wants to invest in affordable housing in its surrounding community and, as a result, establishes a partnership with a local nonprofit. The health system purchases properties to rehabilitate and rent or resell at affordable prices, focusing on improving housing quality and availability. Additional services to existing neighborhood residents can also be provided through this partnership.
REAL WORLD EXAMPLE	The Healthy Homes initiative is a partnership between Nationwide Children's Hospital and Community Development for All People in Columbus. Since 2008, this partnership has impacted over 450 homes on Columbus's South Side. Healthy Homes has developed new builds and rehabilitated existing homes in disrepair to rent at affordable rates and made exterior home repair grants to neighborhood residents.
POTENTIAL IMPACT	Increase quantity of housing stock by utilizing vacant lot space and rehabilitating vacant properties, expand the availability of quality affordable housing, and help existing homeowners remain in their homes
TIMELINE	1-3 years

Featured Strategies

3.1.5 Ensure all subsidized and naturally-occurring affordable housing is safe and up to code through collaboration with local fair housing organizations and relevant municipal departments.

Ensuring that affordable housing is well-maintained, secure, and healthy is a critical component of improving health outcomes related to housing.

LEAD	Hospitals
PARTNERS	Local housing organizations, City and county code enforcement entities
SAMPLE PILOT DESCRIPTION	Health systems, public servants, and local fair housing organizations convene a series of working sessions to identify ways they can collaborate to improve proactive municipal code enforcement, educate the public about their housing quality rights, identify problem landlords and neighborhoods of critical concern, and bring these action items to the attention of local governments.
REAL WORLD EXAMPLE	The Strategic Code Enforcement Management Academy (SCEMA) program brings together government entities, housing nonprofits, health nonprofits, and other interested community partners, including health systems, to learn about proactive code enforcement mechanisms and how stakeholders of different kinds can advocate for and improve code enforcement.
POTENTIAL IMPACT	Reduction in admissions for chronic illnesses impacted by environmental issues, greater housing stability due to decreased turnover
TIMELINE	3-9 months

Additional Strategies

For further details on additional strategies, including real world examples, see Appendix I.

3.1.6 Partner with small landlords to subsidize property improvements for long-term commitments to affordable rentals.

Small landlords tend to have less capital, making updating and maintaining their properties more challenging, especially if they charge moderate rents. They can be incentivized to keep properties affordable while improving housing quality through low-cost loans and grants for home repairs.

LEAD	Local housing organizations, City and county government entities
PARTNERS	Community-based housing organizations

3.1.7 Offer incentives for the development and/or preservation of affordable and mixed-income housing in areas with high concentrations of poverty.

It is crucial to locate affordable housing in locations with high concentrations of poverty to provide low-income families with access to high-quality public schools and services and greater potential for economic mobility. Incentivizing developers to locate affordable housing in these neighborhoods through grants, low-cost loans, and other means could help increase the availability of such housing opportunities.

LEAD	Housing trust fund, Government entities, Insurance providers
PARTNERS	Health systems, developers, community development corporations, Insurance providers

Policy/Advocacy

Incentivize developers who receive public investment in publicly-owned land, public funds, or tax exemptions to provide affordable housing.

As governments collaborate with developers to encourage investment in our communities, they often provide low-cost purchases of public land, government funding assistance, or tax breaks. Ensure that these public investments benefit the community, not just the developer, by requiring or incentivizing developers to make affordable housing investments that match the value of governmental support they receive.

LEAD	Government entities
PARTNERS	Developers, Health systems
SAMPLE PILOT DESCRIPTION	A municipality offers a tax credit for developing properties in a neighborhood with a large concentration of vacant buildings and empty lots. Health systems' government relations personnel collaborate to advocate for the passage of a policy that would require developers to provide affordable housing proportionate to the value of the tax credit they receive for developing in this neighborhood.
REAL WORLD EXAMPLES	The Health care Anchor Network (HAN), a collaborative of health systems across the nation, gathered on Capitol Hill to advocate for a statement regarding the necessity of universally available affordable housing and a briefing detailing key strategies for increasing the availability of affordable housing, including the reimagining of public investment in development to include affordable housing as a key priority at the local, state, and federal levels.
POTENTIAL IMPACT	Increased availability of affordable housing, reduction of displacement as distressed communities experience reinvestment, expansion of available housing stock overall
TIMELINE	3-6 months

Policy/Advocacy

Advocate to expand Housing Choice Vouchers (HCV) and/or the creation of a targeted renters' tax credit to assist families, while also incentivizing landlords to accept HCV.

An expansion of the Housing Choice Voucher program would extend much-needed assistance to households that currently struggle under the burden of high rental costs. Additionally, renters' tax credits could increase the availability of affordable housing by decreasing the number of rent landlords need to collect from their tenants.

LEAD	Local housing organization (e.g. LISC, HOME)
PARTNERS	Government entities, Health systems
SAMPLE PILOT DESCRIPTION	A health system's government and accountability personnel advocate for the expansion of the HCV program and the establishment of renters' tax credits, as well as incentives for landlords to accept HCV. Health systems partner with local housing advocacy groups to expand their efforts to educate landlords regarding the benefits of accepting HCV and incentives that may be available to them locally for accepting HCV.
REAL WORLD EXAMPLES	Health clinics and health-based nonprofits are members of the National Low Income Housing Coalition, which advocated for and endorsed a bill to expand the HCV program. The bill has been introduced to Congress with bipartisan support.
POTENTIAL IMPACT	Greater mobility for users of HCV, increased housing stability, decreased homelessness
TIMELINE	3-6 months

Policy/Advocacy

Support or expand rental registration programs that require or incentivize landlords to register their properties.

Most code enforcement strategies are reactionary, meaning that a resident or concerned citizen must report property for a code violation to trigger municipal code enforcement actions. An alternative model is to create a rental registration system that requires proactive inspection of units and allows governments to identify problem landlords more easily.

LEAD	Government entities
PARTNERS	Health systems, housing nonprofits, health nonprofits
SAMPLE PILOT DESCRIPTION	Local health systems' housing and government relations personnel collaborate with nonprofits to present evidence-based recommendations to governments, demonstrating the need for a rental registration program.
REAL WORLD EXAMPLES	The Lead-Safe Cleveland Coalition, made up of health systems, nonprofits, public health officials, and government officials, successfully advocated strengthening Cleveland's existing rental registration program, which will require all Cleveland rental units to be inspected for lead safety by 2023.
POTENTIAL IMPACT	Better housing quality, improved outcomes for environmentally-impacted chronic conditions (e.g., asthma), reduced hospital admissions
TIMELINE	3-6 months

Policy/Advocacy

Support existing legislation to ban housing discrimination based on the source of income, and advocate to improve the enforcement of existing fair housing laws, including federal protections related to race, disability, national origin, sexual orientation, and gender.

Legislation that protects renters from various forms of discrimination substantially impacts marginalized groups' abilities to find quality affordable housing. Enforcing existing fair housing laws is key to ensuring they are effective. Advocating for new protections against things like the source of income discrimination in localities where they do not currently exist is also a key component of fair housing strategy.

LEAD	Local housing community-based organizations nonprofits
PARTNERS	Hospitals, Health focused nonprofits, Government entities
SAMPLE PILOT DESCRIPTION	Health systems' government relations personnel advocate for new renter protections and the strengthening and enforcement of existing protections. Health systems partner with local fair housing agencies to assist in their advocacy work through funding and platforming those efforts.
REAL WORLD EXAMPLES	Beth Israel Deaconess Medical Center (BIDMC) in Boston provided funds to the Boston Tenant Coalition to advocate for, among other things, discrimination protections in the City of Boston, which go beyond traditional discrimination protections to require that landlords proactively address the impacts of historical housing discrimination.
POTENTIAL IMPACT	Expansion of options for housing among low-income and minority renters resulting in greater social mobility, decreased likelihood of homelessness
TIMELINE	3-6 months

Policy/Advocacy

Establish and help contribute to consistent, dedicated funding streams for affordable housing investment region-wide (e.g., a regional housing trust fund).

Affordable housing trust funds and other dedicated funding sources are cornerstones of an affordable housing strategy. Establishing a regional fund would expand the reach of existing affordable housing resources to more communities in need.

LEAD	City or county government entities
PARTNERS	Health systems, Nonprofits
SAMPLE PILOT DESCRIPTION	A health system's government relations personnel coordinate with local health and housing advocacy organizations to synthesize evidence for the benefits of a region-wide housing trust fund with a dedicated funding stream and present this evidence to governmental decision-makers.
REAL WORLD EXAMPLES	The Housing Development Consortium is an ongoing advocate for the expansion of the Washington State Housing Trust Fund. Its members include a clinic and community health services provider.
POTENTIAL IMPACT	Greater availability of affordable housing, improved conditions in existing affordable housing, long-term stabilization of the housing market, improved health outcomes for those with health conditions impacted by their living environment, reduced hospital admissions
TIMELINE	3-6 months

Priority 3.2

Ensure healthy food access within 10 minutes by foot or public transit in urban communities or by car in rural communities

Featured Strategies

3.2.1 Expand the availability of nutritious food through clinical care for high-priority populations.

Food as medicine interventions include medically tailored meals (also called therapeutic meals), medically tailored groceries (sometimes known as food "farmacies" or healthy food prescriptions), and produce prescriptions. They are typically directed by clinicians through the health care system, provided at no cost or meager cost to the patient, and funded by health care, government, or philanthropy.

LEAD	Local hospitals, Federally Qualified Health Centers, and Community-based clinics
PARTNERS	Local food policy council, Local agriculture
SAMPLE PILOT DESCRIPTION	Screen all patients for food insecurity, especially in practices that serve at-risk populations, and document findings in the electronic health record. Educate patients at risk of food insecurity about appropriate coping strategies. Physicians can help patients avoid unhealthy coping strategies like prioritizing food quantity over quality, stretching, avoiding medical care or filling prescriptions, choosing a small variety of low-cost or fast foods, fasting or skipping meals, and overeating when food is available. Patients should be screened at each visit to ensure appropriate evaluation and management of intermittent or recurrent food insecurity. Connect patients with assistance programs and encourage patients with food insecurity to utilize local food assistance programming.
REAL WORLD EXAMPLE	Kroger Health and University of Cincinnati partnered to conduct, Supermarket and Web-based Intervention targeting Nutrition or SuperWIN, a groundbreaking, randomized, controlled trial aimed at increasing diet quality and decreasing cardiovascular risk by promoting a heart-healthy diet through nutrition counseling provided by a registered dietitian. The in-aisle teaching with a Kroger Health registered dietitian significantly increased adherence to a heart healthy dietary pattern compared to traditional nutrition counseling alone. Adherence was further improved when in-aisle teaching was paired with education on how to use online shopping technologies, including grocery delivery service, the Kroger app and website, and OptUP, Kroger Health's industry-leading nutrition rating system to simplify and track healthier shopping.

Featured Strategies

POTENTIAL IMPACT	Improve patients' ability to follow dietary recommendations and access to recommended foods, alleviate food-related budget constraints that prevent patients from affording medications and paying bills, increase likelihood that patients will continue to eat healthily long-term, better disease management, fewer hospital admissions
TIMELINE	6-12 months

3.2.2 Provide Produce Prescriptions (PRx/Food As Medicine) at school-based health centers, community health centers, and health systems.

Produce prescription programs that use monetary incentives to promote fruit and vegetable consumption among under-resourced patients through physician identification and referral. Most programs target low-income patients with diet-related illnesses such as diabetes, obesity, heart disease, etc.

LEAD	Local food organizations
PARTNERS	Community-based clinics, Federally Qualified Health Centers, School-based health centers
SAMPLE PILOT DESCRIPTION	Physicians screen for and identify appropriate patients and write prescriptions for nutrient-rich foods. These prescriptions can obtain subsidized produce/food items through various community partners (local farmers' markets, grocery stores, and community-supported agriculture initiatives). PRx participants receive vouchers for use at local farmers' markets to choose fresh vegetables or fruits as economically feasible. Fresh produce mobile vans can make weekly stops at various locations, making it easier for PRx participants to use those vouchers.
REAL WORLD EXAMPLE	The Ohio Department of Health Bureau of Maternal, Child and Family Health and Produce Perks Midwest created the Infant Vitality Produce Prescription Program as a mechanism for responding to infant and maternal health needs among low-income pregnant women and mothers in counties with high infant mortality rates in the Black community relative to other Ohio counties. The Infant Vitality Produce Prescription Program improves food security for pregnant women and mothers in eligible counties all the way through an infant's first year.
POTENTIAL IMPACT	Healthier eating habits among community members in low-resource neighborhoods, better patient understanding of the role of nutrition in health management
TIMELINE	6-12 months

Featured Strategies

3.2.3 Support and fund the capacity and implementation of healthy food access points (e.g., food co-ops, nonprofits, farmers' markets, healthy food pantries, and supermarkets) and food equity plans.

Many rural and urban areas have limited access to healthy, affordable foods. Food deserts are found in rural and urban areas where supermarkets or grocery stores are scarce, directly contributing to food insecurity. Instead, these areas may have more convenience stores that are more likely to sell processed, shelf-stable goods rather than fresh produce. As a result, residents may have to travel to find healthy food, which can be more challenging for those without reliable access to transportation. Initiatives to increase access to healthier foods and beverages in retail venues can improve existing stores, encourage the placement of new stores, improve transportation access to healthier food retailers, and/or implement comprehensive in-store markets and promotion.

LEAD	Local Food Policy Council
PARTNERS	Hospitals, City and County governments, Foundations, Neighborhood associations, health care systems, local businesses
SAMPLE PILOT DESCRIPTION	Sell food at various retail venues in a community to increase fruit and vegetable consumption by community members. It's important to improve access to these venues and increase the availability of high-quality, affordable fruits and vegetables sold at these locations.
REAL WORLD EXAMPLE	Healthier food retail (HFR) initiatives were created by the Centers for Disease Control and Prevention to help increase people's access to places that sell healthier foods and beverages in underserved areas, including grocery stores, small stores, farmers' markets, bodegas, or mobile food retail. Initiatives can involve creating new food retail outlets that sell healthier foods, improving the quality, variety, and amount of healthier foods and beverages at existing stores, or promoting and marketing healthier foods and beverages to the individual.
POTENTIAL IMPACT	Better access to healthy food in urban areas with low public transportation service as well as rural areas
TIMELINE	9-12 months

Goal 3

Additional Strategies

For further details on additional strategies, including real world examples, see Appendix I.

3.2.4 Promote farm-to-school programming within school districts and health systems.

Farm to school programs connects schools with nearby farms to incorporate locally grown foods into school breakfasts, lunches, and snacks. Local food is delivered via salad bars, fruit and vegetable bars, breakfast or lunch entrees, or taste-testing or snack programs.

LEAD	Farmers, Local food organizations
PARTNERS	Local public school systems

3.2.5 Increase access to healthy food during non-school hours for zip codes with high disparities within priority populations (including evenings, weekends, and summer).

During the pandemic, local schools and childcare centers have provided a nutrition lifeline for children, many of whom depend on USDA's child nutrition programs for the nourishment they need to grow and thrive. Ensure these resources are expanded and continue to be made available.

LEAD	Local public school systems
PARTNERS	Local food organizations

Policy/Advocacy

3.2.6 Invest in local farmers' markets' technological and human capacity to accept federal food assistance program benefits and promote these markets to program participants.

The United States Department of Agriculture's Food and Nutrition Service (FNS) operates an EBT machine that requires an FNS license. FNS allows markets to obtain a single FNS license for all eligible vendors at the market.

LEAD	Community-based food organizations, Local and federal government entities
PARTNERS	Local food organizations
SAMPLE PILOT DESCRIPTION	SNAP benefits are redeemed using one centrally located point-of-sale (POS) terminal; transactions are processed throughout the farmer's markets using script (digital coupons, certificates, tokens, or receipts).
REAL WORLD EXAMPLES	The Produce Perks program provides a $25 match on SNAP/EBT and P-EBT purchases. This means any amount spent with SNAP/EBT or P-EBT, up to $25, will be matched $1-for-$1. Produce Perks matching dollars can be spent on fruits and vegetables.
POTENTIAL IMPACT	Adopting EBT technology to accept SNAP benefits can help markets tap into a more extensive customer base by providing an easy and convenient way for individuals to redeem SNAP benefits on eligible food items. For vendors selling eligible food items, the potential for increased sales from SNAP redemptions can be substantial.
TIMELINE	12- 24 months

Policy/Advocacy

3.2.7 Maintain and/or increase enrollment in federal food assistance and education programming and policies by removing barriers to participation for qualifying families and individuals.

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides nutritious foods, nutrition education, breastfeeding support, and referrals to health care and social services to pregnant and postpartum people with low incomes with infants and children under age 5.

LEAD	Job and Family Services
PARTNERS	Local food organization, local health advocacy organizations
SAMPLE PILOT DESCRIPTION	Determining income and/or residence eligibility in advance to reduce the duration of the certification appointment and decrease the number of documents that applicants must bring; using presumptive eligibility to begin providing food benefits as soon as pregnant applicants are determined to be income-eligible; allowing temporary 30-day certifications to give applicants more time to provide eligibility documents without delaying food benefits; and eliminating the requirement that households without any income provide a third-party statement, which can prevent or delay vulnerable families from accessing nutrition assistance during periods of prenatal, infant, and child development.
REAL WORLD EXAMPLE	The Supplemental Nutrition Assistance Program, or SNAP, is a federally funded program that provides food vouchers to low-income households. States can adjust aspects of program administration, including policies that affect the administrative burden associated with program participation. The administrative burden includes barriers that increase the costs (time, money, and psychological distress) of applying for and maintaining enrollment in SNAP. These barriers may reduce participation among households eligible for the program. SNAP receipt is associated with improved birth outcomes, reduced childhood food insecurity, and improved child health, so eligible families must have access to the program.
POTENTIAL IMPACT	Families and children unable to participate in SNAP due to procedural barriers and other difficulties in applying are more likely to be hungry and underweight. These families are also more likely to be food insecure and housing insecure.
TIMELINE	12-24 months