

ALASKA

Nutrition Incentive and Produce Prescription Food is Medicine: Statewide Landscape Assessment

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FOOD BANK
of ALASKA



Prepared For
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is Medicine Coalition

Prepared By
Melissa Heuer
Spork Consulting

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Alaska Nutrition Incentive and Produce Prescription
Food is Medicine
Statewide Landscape Assessment
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The Alaska Nutrition Incentive and Produce Prescription Food is Medicine Statewide Landscape Assessment was produced for the Food Bank of Alaska by Melissa Heuer at Spork Consulting.

Primary authors:

Melissa Heuer, MBA, Principal, Spork Consulting
Karol Fink MS RDN, State of Alaska Department of Health, Division of Public Health, Dietitian
Grace Heglund-Lohman, JD MPH, Advocacy Manager, Food Bank of Alaska
Rachael Miller, MBA, Chief Advocacy Officer, Food Bank of Alaska

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Opportunities to participate:
Join the Alaska Food is Medicine Coalition
Email fim@foodbankofalaska.org

Join the Alaska Food is Medicine listserv:
<https://list.state.ak.us/mailman/listinfo/akfoodismedicine>
or scan the QR code



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This assessment provides the first coordinated, statewide view of Alaska's nutrition incentive and medically prescribed Food is Medicine ecosystem: documenting existing programs, gaps, and opportunities for growth. It focuses on nutrition incentive, produce prescription, and other medically supportive food interventions that link nutrition access with healthcare as well as public health strategies to prevent and manage diet-related chronic disease and increase food security. The report is intended to guide policymakers, Tribal and community leaders, healthcare systems, and funders in planning, financing, and implementing scalable nutrition incentive and medically prescribed Food is Medicine program approaches that advance nutrition security and health equity across Alaska.

Alaska's Food is Medicine ecosystem is in an early but active stage of development. Programs operate across multiple regions and sectors, and demand frequently exceeds capacity. Many key public, Tribal, nonprofit, and food system partners are already engaged. At the same time, the system is fragile. Funding is short-term, staffing is thin, and logistics are complex. Common evaluation and coordination infrastructure is still emerging. These conditions underscore the importance of a statewide strategy that combines durable financing, most likely through Medicaid and aligned public funding, with shared tools and workflows, targeted capacity building, and grounded coalition governance.

Access to Food is Medicine services remains uneven, especially in rural and off-road communities where transportation and supply chain barriers are most severe. Capacity is constrained by limited staffing, complex logistics, and inconsistent data systems. Short-term, braided grants and the absence of stable healthcare financing limit long-term sustainability and scale.

Looking ahead, the report suggests a phased strategy that builds from what is already working in Alaska, particularly produce prescription and nutrition incentive programs, established cross-sector partnerships, and early evaluation efforts, toward more integrated and sustainably financed Food is Medicine systems. Emerging Medicaid authorities, including Section 1115 waivers and other health related social needs tools, offer the most promising pathway for long-term financing if developed over multiple years in alignment with Tribal leadership, Indigenous food systems, and Alaska Department of Health priorities.

Summary of Key Findings

System Conditions (Capacity, Funding, Logistics, Data)

1. Demand for nutrition incentive and medically prescribed Food is Medicine services consistently exceeds program capacity; programs report enrollment caps and waitlists driven by staffing, funding, storage, and transportation constraints rather than lack of interest or clinical relevance.
2. Most initiatives rely on short-term, braided funding (e.g., United States Department of Agriculture (USDA) Gus Schumacher Nutrition Incentive Program (GusNIP), Centers for Disease Control and Prevention (CDC) grants, Tribal subawards, Municipality of Anchorage alcohol tax funding, food bank resources, with few organizations having more than two to three years of secured support, limiting workforce stability, planning, and infrastructure investment.
3. Staffing is lean, often around one full-time equivalent or less; programs face recurring logistical challenges including high transportation costs, seasonal variability in produce availability, barge delays, and limited cold storage, particularly in rural and off-road communities.
4. Data and evaluation systems exist but are fragmented; programs track different combinations of enrollment, utilization, food security, and health outcomes using varied platforms, resulting in inconsistent metrics and limited analytic capacity.

Organizational and Community Assets

1. Cross-sector partnerships are a significant strength, linking Tribal health organizations, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Supplemental Nutrition Assistance Program (SNAP, often referred to as food stamps), programs for seniors and older adults, and other public nutrition programs, food banks, farmers' market networks, producers, and state agencies in collaborative Food is Medicine efforts.
2. Nutrition incentive and produce prescription programs currently anchor Alaska's Food is Medicine landscape and represent the most operationally feasible model, reflecting strong clinic–community linkages and alignment with chronic disease prevention and food security goals.
3. Many programs already collect meaningful data and express a strong interest in shared evaluation frameworks and standard measures, indicating readiness for coordinated learning, quality improvement, and policy development.

Equity and Phased Advancement

1. Equity and cultural relevance are emerging priorities: programs emphasize participant dignity, choice, language access, and navigation support, yet integration of traditional and subsistence foods is limited by cost, sourcing, and seasonality. Formal roles for participant or community governance remain uncommon.
2. Medicaid offers the most promising long-term financing pathway, but timelines are multi-year. National experiences show that Medicaid supports, including Section 1115 waiver demonstration projects, can sustain medically prescribed Food is Medicine benefits when paired with strong implementation infrastructure. In Alaska, a phased, multi-year planning approach is more realistic than immediate adoption.
3. Given the current capacity and financing realities, this assessment recommends a phased approach to advancement. In the near term, this means strengthening shared governance, standardizing core program models and referral workflows, and investing in workforce, logistics, and evaluation systems. Pursuing multi-year Medicaid funding and other policy pathways are longer-term strategies for realizing resilient, integrated Food is Medicine benefits.

Glossary of Terms and Abbreviations

Abbreviations and Acronyms

AFMA	Alaska Farmers Market Association
CAMP	Chronic Care, Active Management and Prevention
CDC	Centers for Disease Control and Prevention
CHLPI	Center for Health Law & Policy Innovation
CMS	Centers for Medicare & Medicaid Services
DOH	Alaska Department of Health
FBA	Food Bank of Alaska
FIM	Food is Medicine
FMNP	Farmers' Market Nutrition Program
GusNIP	Gus Schumacher Nutrition Incentive Program, United States Department of Agriculture
IHS	Indian Health Service
ISER	Institute of Social and Economic Research, University of Alaska Anchorage
MTG	Medically Tailored Groceries
MTM	Medically Tailored Meals
NI	Nutrition Incentive
PHHS	Public Health and Health Services
PPR	Produce Prescription
REACH	Racial and Ethnic Approaches to Community Health
RHTP	Rural Health Transformation Program
SNAP	Supplemental Nutrition Assistance Program
SFMNP	Senior Farmers' Market Nutrition Program

USDA	United States Department of Agriculture
WIC	Special Supplemental Nutrition Program for Women, Infants, and Children

Key Terms

Food is Medicine (FIM)

While the term Food is Medicine has gained popularity in modern healthcare and policy circles, it is essential to acknowledge that many cultures have long understood and practiced the use of food as a source of healing, wellness, and cultural identity. These traditions, rooted in historical knowledge and relationship with the land, predate contemporary frameworks and should be recognized as foundational to the concept.

For this landscape assessment, we thought of Food is Medicine as an umbrella term for a range of programs that recognize the role of nutrition in preventing, managing, and treating chronic disease. We reviewed interventions that integrate food and nutrition support services; however, we focused only on nutrition incentive, produce prescription and medically prescribed groceries and meals.

Nutrition Incentive Programs

Nutrition incentive projects increase the purchase of fruits and vegetables by low-income consumers participating in benefit programs by providing incentives at the point of purchase. Some programs that increase the purchasing power of participants, include SNAP, WIC, or Senior Farmers' Market Nutrition Program recipients, for fruits, vegetables, and other healthy foods, typically through market matching funds, vouchers, or discounts at farmers' markets, farm stands, or other retailers (e.g., Alaska Farmers' Market Association Market Match program).

Medically Prescribed Produce, Groceries and Meals

Produce Prescription Programs

Interventions in which health care providers or community partners prescribe fruits and vegetables or provide vouchers/benefits for produce to food insecure patients with diet--related health risks, usually paired with nutrition education or care coordination. Produce prescriptions generally include fresh, frozen, or canned produce with no added salt, sugar, or fat. Individuals with specific nutritional needs and food access challenges can get produce prescriptions from their health care provider.

Medically Tailored Groceries

Unprepared food items are prepackaged in a box or bag, designed by nutrition professionals to meet the specific medical and dietary needs of individuals who can prepare meals themselves. Health care providers, health insurance plans, and community-based organizations can screen patients to determine whether they are eligible to receive medically tailored groceries.

Medically Tailored Meals

Fully prepared, home-delivered meals designed and overseen by registered dietitian nutritionists to meet the medical and nutritional needs of people with complex or severe health conditions who are unable to shop and prepare meals on their own. Meals are provided to patients through a referral from a medical

professional or health care plan and are part of a treatment plan for certain diet-related health diseases or conditions.

Medically Supportive Meals

Medically supportive meals are prepared meals (e.g., heart-healthy or diabetes-friendly meals) provided to an individual to manage chronic diseases or prevent disease in individuals at higher risk for illness. Unlike medically tailored meals, medically supportive meals are medically supportive meals include healthy foods that can be used by a broad patient population to improve dietary habits and overall health.

Health Equity

When everyone has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance. These social circumstances are what have become known in public health as the social determinants of health.^{1,2}

Social Determinants of Health

A person's exposure to conditions that negatively impact their health is influenced by their income, how many years of education they've completed, where they live, and their surroundings.³ Additional characteristics such as a person's age, race, gender, and possible disabilities also play important roles in contributing to differences in their lived experience, access to resources, and to health inequities. These non-medical social risk factors are often referred to more broadly as social determinants of health^{2,3} and can be measured at the individual level by assessing health-related social needs.

Health-Related Social Needs

Social and economic needs that individuals experience that affect their ability to maintain their health and well-being. They put individuals at risk for worse health outcomes and increased health care use. HRSN refers to individual-level factors such as financial instability, lack of access to healthy food, lack of access to affordable and stable housing and utilities, lack of access to health care, and lack of access to transportation.³

¹ Chelak, K., & Chakole, S. (2023). The Role of Social Determinants of Health in Promoting Health Equality: A Narrative Review. *Cureus*, 15(1), e33425. <https://doi.org/10.7759/cureus.33425>

² Solar O, Irwin A. A conceptual framework for action on the social determinants of health. Social determinants of health discussion paper Geneva, Switzerland: WHO; 2010. https://iris.who.int/bitstream/handle/10665/44489/9789241500852_eng.pdf

³ Centers for Medicare & Medicaid Services, "Understanding Social Drivers of Health and Health-Related Social Needs," *CMS Innovation Center*, August 21, 2024, revised February 27, 2025, <https://www.cms.gov/priorities/innovation/key-concepts/social-drivers-health-and-health-related-social-needs>

Food Sovereignty

The right of peoples and communities to define their own food systems, including production, distribution, and consumption, in ways that are culturally appropriate and ecologically sound, and that uphold Indigenous governance and self-determination.

Traditional and Subsistence Foods

Culturally important foods obtained through hunting, fishing, gathering, and local production that have nourished Alaska Native communities for generations and remain central to nutrition, identity, and well-being.

Nutrition Security

Reliable access to foods and beverages that promote well-being and prevent or treat disease, not just sufficient calories.

Rural Health Transformation Program

A federal initiative administered by Centers for Medicare & Medicaid Services (CMS) that provides time-limited funding to states, including Alaska, to strengthen rural and frontier health systems through flexible, community-driven strategies.

The Food Bank of Alaska, with support from Spork Consulting and in partnership with the Alaska Department of Health, is leading a statewide Alaska Food is Medicine initiative focused on strengthening nutrition incentive, produce prescription, and other medically prescribed Food is Medicine programs. This ten-year effort (2025–2035) aims to improve coordination, create enduring capacity, and align policy for food-based health interventions across Alaska. The Food Bank of Alaska has contracted Spork Consulting to conduct an Alaska Food is Medicine Landscape Assessment to document existing programs, identify gaps and opportunities, and inform future strategy.

Project Partners

This assessment reflects collaboration among statewide public health, food access, and research partners who bring complementary expertise in nutrition, chronic disease prevention, food systems, and community-based implementation. Together, these partners support a coordinated, evidence-informed approach to advancing Food is Medicine efforts across Alaska.

The Physical Activity and Nutrition unit within the section of Chronic Disease Prevention and Health Promotion within the Alaska Department of Health entered into a cooperative agreement with the Centers for Disease Control and Prevention Division of Nutrition, Physical Activity and Obesity. One deliverable of the agreement is that the state implement activities that coordinate the development, uptake and expansion of Produce Incentive and Food is Medicine programs with an initial focus on Fruit and Vegetable Voucher Incentives and Produce Prescription Programs. These activities should lead to increased availability of resources; increased access to healthier foods, and increased consumption of produce and healthier foods. The long-term outcomes of this agreement are increased availability and access to produce and healthy foods for low-income families or those at nutritional risk leading to more food and nutrition secure Alaskans, living at a healthy weight and better able to manage their chronic conditions.

Food Bank of Alaska is a statewide nonprofit organization that leads hunger relief and food access efforts across Alaska. In addition to its core role in food distribution, the Food Bank supports community partners through coordination, technical assistance, and systems-level initiatives that strengthen food security, improve nutrition access, and advance policy and health aligned food programs statewide.

Spork Consulting is an Anchorage-based firm that specializes in food systems research, applied research, and program development projects. The firm brings expertise in stakeholder engagement and applied analysis to support community driven and policy relevant decision making across Alaska.

The Alaska Food is Medicine Coalition is a statewide, multisector collaborative convened by the Food Bank of Alaska to support coordination, shared learning, and strategic alignment among organizations engaged in Food is Medicine work. The coalition brings together Tribal health organizations, healthcare providers, food banks, state agencies, community-based organizations, and research partners to inform the landscape assessment, elevate on-the-ground experience, and help guide future program development, funding alignment, and policy strategy.

Nutrition Security Evidence-based Solutions

Nutrition security means all Americans and Alaskans have consistent and equitable access to healthy, safe, affordable foods essential to optimal health and well-being. Poor nutrition is a leading cause of illness in the United States, associated with more than half a million deaths per year. It is linked with increased risk of obesity, diabetes, and heart disease as well as broader impacts including higher health care costs and decreased productivity.⁴

Healthy food, especially fruit and vegetable intake, has been linked to improved health and well-being including maintaining a healthy weight and reduced risks of type 2 diabetes, stroke, cardiovascular disease, cancer, and early death.⁵ Despite the benefits of fruits and vegetables, only 8% of Alaska children and 8% of Alaska adults meet the recommended daily intake of fruits and vegetables, respectively.⁶

Improving nutritional status of the population and individuals requires a spectrum of programs and services that include federal level policies, population-based initiatives, individual clinical-based services and personal responsibility. Population-level healthy food policies and programs such as the Farm Bill and the Dietary Guidelines for Americans impact the food available and its prices. Proper implementation of these population-level policies serves as the basis for society-wide access to healthy affordable foods.

Programs specifically addressing food and nutrition security such as the Supplemental Nutrition Assistance Program (SNAP); Women Infant and Children (WIC); school meal programs [such as National School Lunch Program, School Breakfast Program, Special Milk Program, and After School Snack Program, Summer Food Service Program]; Child and Adult Care Food Program; and senior meals or senior meal delivery programs such as Meals on Wheels play an important role in food security and providing healthy food to individuals.

In 2023, the Community Preventive Services Task Force recommended fruit and vegetable incentive and produce prescription programs for households with lower

⁴ U.S. Department of Agriculture. (n.d.). *Nutrition security*. <https://www.usda.gov/nutrition-security>

⁵ U.S. Department of Agriculture & U.S. Department of Health and Human Services. (2020). *Dietary Guidelines for Americans, 2020–2025* (9th ed.). December 2020. Available at <https://www.dietaryguidelines.gov>

⁶ Alaska Department of Health. (2025). *Alaska physical activity, nutrition and obesity facts report*. Section of Chronic Disease Prevention and Health Promotion, Division of Public Health. https://health.alaska.gov/media/njuccksa/ak_2025_panandobesityfactsreport.pdf

incomes based on strong evidence of effectiveness in reducing household food insecurity and increasing household fruit and vegetable consumption. The task force systematically reviewed 30 studies available at that time. The studies showed improvement in diet-related health conditions such as blood glucose levels when nutrition incentives or produce prescriptions were provided.⁷

One multisite evaluation found that produce prescriptions were associated with significant improvements in fruit and vegetable intake, food security, and clinically relevant improvements in long-term blood glucose, blood pressure, and weight for adults with poor cardiometabolic health.⁸ Losing weight typically takes an extended period of time and requires numerous life-style change along with changes to diet. However, eating a healthy diet, particularly one that includes plenty of fruits and vegetables, is associated with a lower rate of almost every chronic disease, including diabetes, heart disease, cancer, and weight.

A microsimulation model estimated that produce prescription programs implemented nationally for American adults aged 40 to 79 years with diabetes and food insecurity could prevent 292,000 cardiovascular disease events, gain 260,000 quality-adjusted life-years, and save \$39.6 billion in health care costs and \$4.8 billion in productivity costs over a lifetime.⁹

Additionally, more evidence continues to emerge that these interventions have the potential to improve disease management (e.g., diabetes control) and avert long-term negative health outcomes, such as cardiovascular events. With national attention to “Food is Medicine” and the connection between food, health, and social determinants of health, opportunities to expand these programs are growing.¹⁰ With the proper investment of resources there is ample opportunity to expand the reach of nutrition incentive and produce prescription programs in Alaska and serve people in their communities to improve nutrition security and improve health.

⁷ Community Preventive Services Task Force. (2023). *Fruit and vegetable incentive programs*. The Community Guide. <https://www.thecommunityguide.org/news/cpstf-recommends-fruit-vegetable-incentive-programs.html>

⁸ Hager, K., Cuite, C. L., Hardin-Fanning, F., Hecht, A. A., Lagisetty, P., McCormack, L. A., Moran, A., & Mozaffarian, D. (2023). Impact of produce prescriptions on diet, food security, and cardiometabolic health outcomes: A multisite evaluation of 9 produce prescription programs in the United States. *Circulation: Cardiovascular Quality and Outcomes*, 16(9), e009520. <https://doi.org/10.1161/CIRCOUTCOMES.122.009520>

⁹ Wang, L., Schoueri-Mychasiw, N., Mattes, M. D., Liu, J., Wilde, P., Mozaffarian, D., & Du, M. (2023). Health and economic impacts of implementing produce prescription programs for diabetes in the United States: A microsimulation study. *Journal of the American Heart Association*, 12(15), e029215. <https://doi.org/10.1161/JAHA.122.029215>

¹⁰ Food is Medicine Coalition. (n.d.). *Emerging research*. <https://fimcoalition.org/research/emergingresearch/> (last visited June 17, 2024)

Study Purpose and Scope of Work

Food is Medicine initiatives, including nutrition incentive programs, produce prescriptions, and other medically prescribed food interventions, have been expanding across Alaska in response to growing recognition of the role of nutrition in chronic disease prevention and management. While a range of programs are currently operating across the state, there has been no comprehensive statewide assessment to document existing efforts, understand how programs are structured and delivered, or identify shared challenges and opportunities for coordination and growth.

This report documents a clear, statewide understanding of current Food is Medicine activity, including where programs are operating, the populations they serve, how services are delivered, and what resources, infrastructure, or policy supports are needed to sustain or expand these efforts. Drawing on survey data, policy document review, and coalition input, the assessment compiles information across clinical, community, and Tribal settings to create a shared evidence base for future planning.

Through this report, the project team seeks to describe the existing nutrition incentive and medically prescribed Food is Medicine ecosystem; identify gaps in access, capacity, financing, and geographic coverage; and elevate lessons learned directly from practitioners through a statewide survey and coalition engagement. The findings are intended to support coordinated planning, inform technical assistance and resource development, and provide an evidence-informed foundation for future program and policy decisions at the state, Tribal, and local levels.

The Landscape Assessment aligns with the Food Bank of Alaska's long-term, statewide Food is Medicine initiative and complements the Alaska health department's efforts related to chronic disease prevention, and health-related social needs.¹¹ Over time, the results of this assessment are expected to support more effective collaboration among partners, strengthen Food is Medicine program delivery, and contribute to improved nutrition access and health outcomes for Alaskans.

How to Use This Report

Food is Medicine initiatives in Alaska connect nutritious food with healthcare to improve chronic disease prevention, health equity, and local food systems, building on a growing set of nutrition incentive, produce prescription, and medically prescribed food programs. This Landscape Assessment offers the first coordinated, statewide view of these efforts, identifying current programs, gaps, and opportunities to guide long-term- strategy, financing, and implementation.

¹¹ Alaska Department of Health. (2024, September). *AK Behavioral Risk Factor Surveillance System (BRFSS) brief report: Social risk factors and health inequities among Alaska adults* [PDF]. Alaska Division of Public Health, Chronic Disease Prevention and Health Promotion. https://health.alaska.gov/media/drhegv4/akbrfss_briefreport_aksdoh.pdf

This report is designed as a practical tool for multiple audiences engaged in planning, implementing, and financing nutrition incentive and medically prescribed Food is Medicine initiatives in Alaska. Different sections are intended to be used in complementary ways, depending on audience roles.

State agency staff, policymakers, and funders may find the Alaska food system context, policy alignment, and strategic implications sections most useful for statewide planning, priority-setting, and financing decisions. Healthcare systems, Tribal health organizations, and community-based partners may wish to focus on sections describing current program models, implementation feasibility, and survey findings to inform program design, partnerships, and operational planning.

The Alaska specific context and alignment sections are intended to support shared understanding across sectors and to facilitate coordination between Food Bank of Alaska, the Alaska Department of Health, and coalition partners. Taken together, the report is intended to support both near-term planning, by clearly identifying existing capacity, gaps, and constraints, and longer-term implementation, by offering a framework that can be updated as programs, data systems, and financing pathways evolve over time.

Methodology

The information in this assessment is derived from the best available programmatic, policy, and practice-based data related to nutrition incentive and produce prescription Food is Medicine activity in Alaska at the time of writing. Data sources include a review of existing draft landscape documents, internal outlines, and background materials developed by Spork Consulting in collaboration with the Food Bank of Alaska and project partners, as well as reference to national models and comparable Nutrition Incentive and Produce Prescription landscape assessments conducted in other states. The Special Supplemental Nutrition Program for Women, Infants, and Children and Food Distribution Program on Indian Reservations are outside the scope of this assessment as medically prescribed groceries programs as both are described extensively in numerous state and federal resources.

A statewide Alaska Food is Medicine Landscape Survey was conducted in October and November 2025. The survey was designed to gather information from organizations involved in or supporting Food is Medicine programs, including nutrition incentives, produce prescriptions, and related interventions, and was administered primarily online, with an option to complete the survey by phone. Outreach to identify and invite participants was conducted through coalition partners, direct email outreach, and distribution through Tribal, state, and nonprofit listservs to reach as many known and emerging programs as possible.

The Landscape Survey received nine voluntary responses representing a cross-section of organizations, including Tribal health organizations, state and municipal WIC agencies, regional food banks, and statewide farmers' market leadership. Survey responses were supplemented by following up emails, phone calls and review of publicly accessible

documents and websites. While participation was voluntary, the responses provide valuable qualitative and quantitative insight into current program operations, service models, capacity, and constraints. As with many systems-mapping efforts, participation bias may exist, as organizations already engaged in or interested in expanding Food is Medicine programs may have been more likely to respond.

Indigenous Food is Medicine Frameworks and Practice-Based Context

This assessment is informed by Indigenous-led Food is Medicine frameworks that center food sovereignty, cultural relevance, and community governance as foundational to health and healing. National and regional guidance developed by Indigenous organizations describe how Food is Medicine models, such as produce prescriptions, medically prescribed groceries, and nutrition support programs, can be structured to uphold Tribal sovereignty, respect data governance, and reflect culturally appropriate definitions of wellness.

While this report does not evaluate individual program outcomes or prescribe specific models for any Alaska Native community, these Indigenous-led frameworks provide important practice-based context for implementation design, partnership structures, and values-based approaches. Integrating this perspective reinforces the need to align Food is Medicine strategies with Indigenous leadership, subsistence and traditional food systems, and community-defined priorities alongside state and healthcare system planning efforts.^{3,12}

In addition to survey data, the assessment draws on ongoing Food Bank of Alaska internal mapping and coalition-building efforts. Limitations of this assessment include variability in data availability across programs, differences in how Food is Medicine activities are defined and tracked, and the absence of a comprehensive statewide inventory of programs at the outset of this work.

¹² Center for Health Law and Policy Innovation. (2024). *Food is medicine: A state Medicaid policy toolkit*. Harvard Law School. https://fimcoalition.org/wp-content/uploads/2024/07/Food-is-Medicine-A-State-Medicaid-Policy-Toolkit_Final-July-2024-1.pdf

Food is Medicine refers to a spectrum of interventions that integrate access to nutritious food into health care delivery as a preventive and therapeutic tool. Nationally, this continuum ranges from population-level nutrition security programs to medically prescribed food interventions, with growing evidence linking food access interventions to improvements in food security, diet quality, and selected health outcomes.⁴

Fundamental to Food is Medicine practices are population-level nutrition security programs, including SNAP, WIC, school meals, senior nutrition programs, and related federal food assistance. These programs provide food access for many Alaskans and are central to both Food Bank of Alaska and Alaska Department of Health strategies to reduce food insecurity and mitigate diet-related disease risk. Nutrition incentive programs, such as SNAP matching at farmers' markets, increase purchasing power for fruits, vegetables, and other healthy foods. The evidence for Nutrition Incentive programs from multiple evaluations indicate improvements in fruit and vegetable intake and food security¹³ while supporting local and regional food systems.

¹³ Community Preventive Services Task Force. (2023). *Social determinants of health: Fruit and vegetable incentive programs. The Community Guide*. <https://doi.org/10.15620/cdc/168585>

Figure 1: Nation Food is Medicine Intervention and Enabling Systems

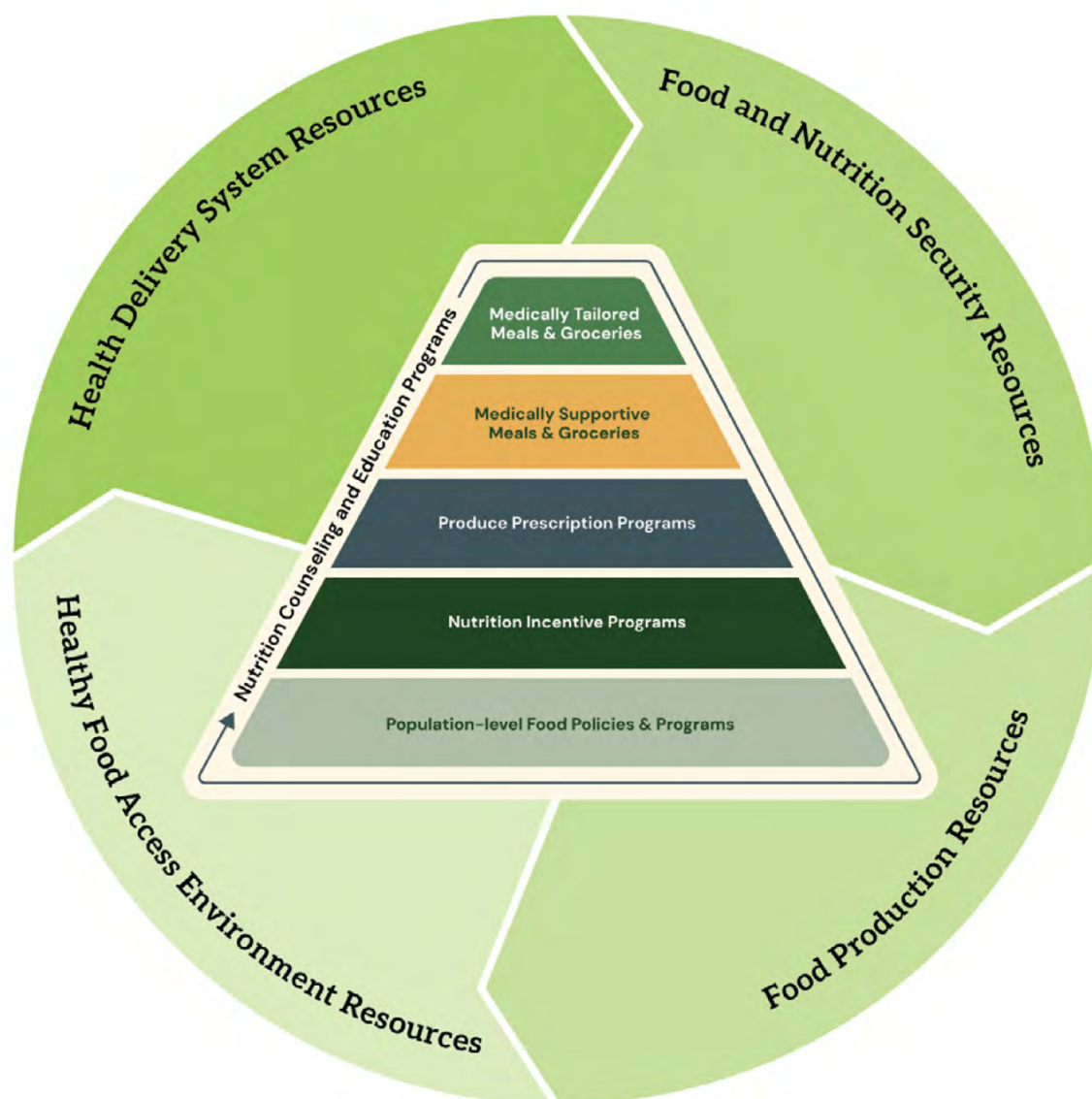


Figure 1, above, illustrates a range of food-based interventions and the systems that support them, conceptualized in a tiered framework to reflect differences in clinical intensity, target population needs, and enabling resources.¹⁴

This graphic created by the U.S. Department of Health and Human Services as a national resource is used as a reference but may not mirror exactly the language we are working to co-create to describe Food is Medicine in the Alaska context. While it offers a

¹⁴ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2024). *Food Is Medicine landscape summary* [PDF]. U.S. Department of Health and Human Services. <https://odphp.health.gov/sites/default/files/2024-09/Food%20Is%20Medicine%20Landscape%20Summary%20FINAL%20508.pdf>

useful visual for conceptualizing FIM as a continuum, from broader, preventive and community-level activities at the base of the pyramid to more medically intensive, individualized interventions at the peak, it does not yet fully reflect the language, cultural priorities, community roles, or region-specific considerations that are central to the Alaska Food Is Medicine landscape.

In Figure 1:

- The base of the pyramid includes interventions with broad reach that support healthy eating patterns and food access for many people (e.g., population-level policies, incentives, produce prescription models).
- The middle and upper tiers include interventions more closely linked to clinical care (such as medically tailored meals and groceries) typically offered to individuals with complex diet-sensitive conditions or chronic illnesses, often in coordination with health-care teams.
- The outer enabling systems (e.g., food and nutrition security resources, healthy food access environments, health delivery system resources, food production resources) represent the broader ecosystem that strengthens FIM's effectiveness and sustainability.

In the Alaska Food Is Medicine framework, we are co-creating language that better describes how community sovereignty, subsistence and local food systems, Tribal health models, traditional foods, and multisector partnerships shape what Food Is Medicine means here. This Alaska-specific language emphasizes the relational, cultural, and place-based nature that underscores effective FIM work should be grounded in local definitions of health, food security, and well-being.

While used as a reference to situate our work within broader definitions of Food Is Medicine, we also recognize that our community-driven language and priorities may differ from the national graphic's wording and structure, and we invite readers to interpret the figure through the lens of Alaska's values, context, and chosen terminology.

Produce prescription programs represent a more direct integration of food and health care, in which individuals with diet-related health risks are referred by health providers or community partners to receive produce at no or low cost, often accompanied by nutrition education or navigation support. Medically tailored groceries and meals occupy the most intensive end of the continuum and are typically reserved for individuals with complex medical needs, most often in states where Medicaid or managed care entities help finance Food is Medicine models.⁴

In Alaska, Food Is Medicine encompasses traditional and subsistence foods, Tribal food sovereignty, and community-led wellness practices. Alaska Native communities and Tribal health organizations have long recognized food as medicine; accordingly, any statewide strategy must center Indigenous leadership, respect Tribal authority over food and health systems, and align with principles of data sovereignty and self-

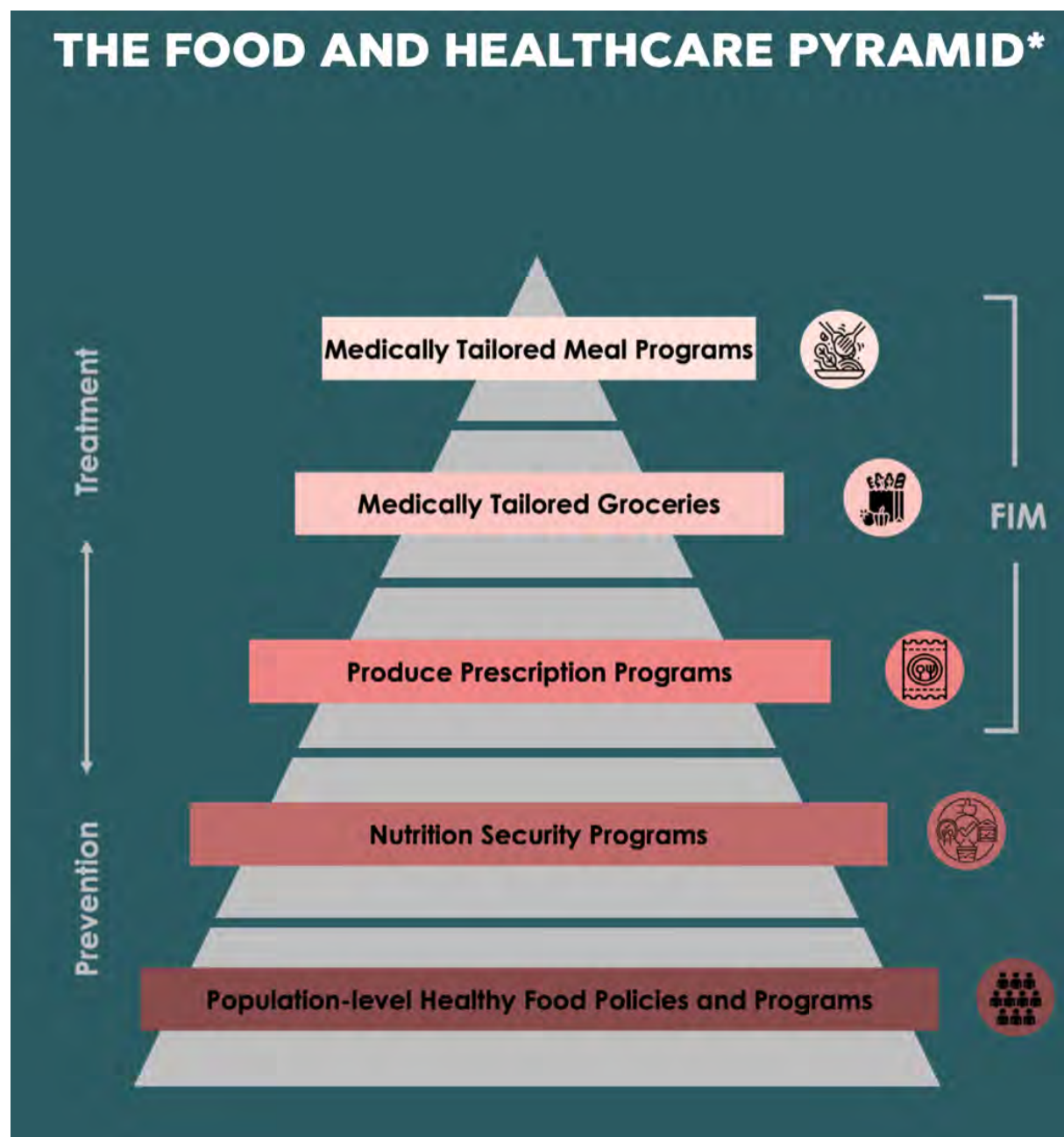
determination.¹⁵ This assessment focused on nutrition incentive and medically prescribed Food Is Medicine programs within the defined project scope. While traditional and subsistence food systems are integral to Food Is Medicine in Alaska and to community health more broadly, they were not examined in detail in this analysis.

Alaska Food System and Health Context

This pyramid in Figure 2, below, was developed by the Alaska Department of Health in partnership with the Center for Health Law and Policy Innovation and is included here as an Alaska-specific reference framework.¹² While the graphic reflects current Food Is Medicine concepts and program models in Alaska, the terminology and structure do not fully mirror the working definitions, language, and visuals being developed through the Food Is Medicine Coalition. As programs continue to evolve and expand across the state, coalition partners are adapting terms and frameworks to more clearly align with Alaska's emerging program landscape and implementation realities.

¹⁵ Wark, K., Volkeimer, J., Mortenson, R., Trainor, J., Presley, J., Jauregui-Dusseau, A., Clyma, K. R., & Jernigan, V. B. B. (2023). The development of a community-led Alaska Native traditional foods gathering. *Health Promotion Practice*, 24(6), 1091–1095. <https://doi.org/10.1177/15248399231190363>

Figure 2: The Alaska Food and Healthcare Pyramid



Source: Adapted from Center for Health Law and Policy Innovation & State of Alaska, *What is Food is Medicine? Alaska factsheet* (June 2024).

Food already plays a central role in Alaska's health and well-being systems, and the pyramid in Figure 2 illustrates how foundational nutrition programs and community-based food strategies connect to emerging Food is Medicine efforts within healthcare. At the base are programs such as SNAP and WIC, which provide essential support for food access and nutrition across the state and are strengthened in Alaska through targeted

investments and partnerships, while Food is Medicine programs build on this foundation by intentionally linking food access to patient care so that healthcare providers and community partners can respond to diet-related needs as part of broader prevention and treatment strategies.

Alaska's food system operates within structural conditions that shape both food access and health outcomes, including vast geography, limited road connectivity, high transportation costs, and pronounced seasonal variation that affect how food moves into and within communities, particularly in rural and offroad regions.¹⁶ These dynamics influence food affordability and availability, diet quality, and the feasibility of nutrition-focused health interventions in ways that differ markedly within the state.

Transportation systems play a critical role in food availability and quality. Analysis of bypass mail supply chains by the Institute of Social and Economic Research indicates that in 2022 alone, approximately 360,000 USDA servings of fruits and vegetables spoiled during transit to rural Alaska, representing a significant loss of nutritional value.¹⁷ This work underscores how transportation and logistics challenges directly affect diet quality, food access, and the feasibility of nutrition-focused interventions in rural and remote regions.

These food system dynamics intersect with broader health patterns, including elevated rates of diet-related chronic disease and persistent health inequities, particularly in rural and Alaska Native communities.^{18,19} Outcomes are closely linked to structural factors, such as food affordability, reliability of supply, transportation infrastructure, and access to preventive services, rather than individual behavior alone, prompting Alaska's public health and nutrition strategies to emphasize systems-level approaches that address upstream conditions alongside clinical care.⁸

At the population level, foundational nutrition access programs, including the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), play a critical role in supporting food security and nutrition education statewide.^{11,20} In Alaska, these programs are strengthened through focused initiatives such as farmers' market and

¹⁶ Alaska Food Strategy Task Force. (2024). *Alaska Food Strategy Task Force report* [Report]. State of Alaska. <https://www.akfoodpolicycouncil.org/wp-content/uploads/2024/09/AFSTF-Report-2024-FINAL-WEB.pdf>

¹⁷ Jones, A. (2025). *Bypass mail supply chains and produce spoilage in rural Alaska: Unpublished analysis of USDA fruit and vegetable servings lost in transit, 2022* [Unpublished manuscript]. Institute of Social and Economic Research, University of Alaska Anchorage.

¹⁸ Alaska Department of Health. (2023). *Alaska chronic disease facts: 2023 brief report* [PDF]. Alaska Division of Public Health, Chronic Disease Prevention and Health Promotion. <https://health.alaska.gov/media/hppatozl/2023-chronic-disease-brief-report.pdf>

¹⁹ Alaska Department of Health. (2025). *Alaska chronic disease facts: 2025 brief report* [PDF]. Alaska Division of Public Health, Chronic Disease Prevention and Health Promotion. https://health.alaska.gov/media/yzdjotwh/2025_ak-chronic-disease-brief-report.pdf

²⁰ Center for Health Law and Policy Innovation & State of Alaska. (2024, June). *What is Food is Medicine? Alaska factsheet* [PDF]. Harvard Law School. <https://chlp.org/wp-content/uploads/2024/06/Alaska-What-is-Food-is-Medicine-Factsheet.pdf>

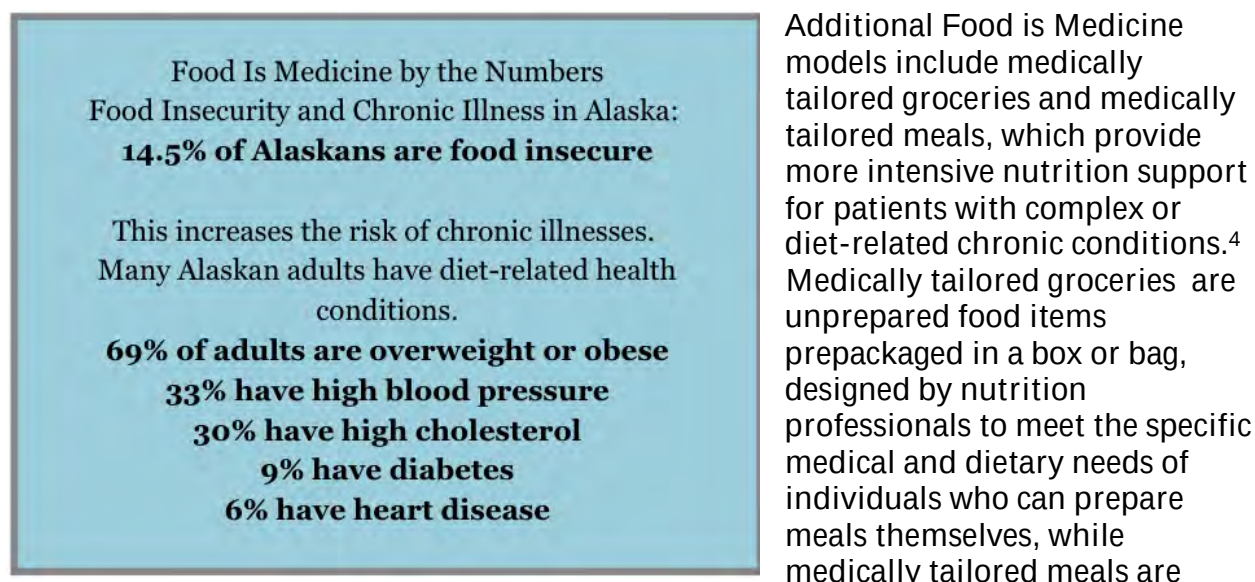
retail produce incentives that provide dollar-for-dollar matches on qualifying fruit and vegetable purchases for SNAP, WIC, and senior participants, increasing purchasing power for healthy foods and helping to offset cost barriers.¹²

Medically prescribed Food is Medicine approaches build on this foundation by integrating food and nutrition into healthcare delivery rather than functioning as standalone programs, connecting clinical screening and care with food access strategies so that diet-related conditions and food insecurity are addressed as part of a patient's treatment plan. Providers identify nutrition-related needs and use prescriptions or referrals to link patients to appropriate food supports, often in partnership with community-based organizations.

Produce prescription programs are among the most established Food is Medicine models in Alaska, providing free or discounted fruits and vegetables to patients with diet-related health risks, such as diabetes, prediabetes, gestational diabetes, hypertension, or obesity, who face barriers to accessing healthy food.¹²

Evidence summarized in the Alaska Food Is Medicine factsheet and related systematic reviews indicates that these programs are associated with improvements in food security, fruit and vegetable intake, blood pressure, body mass index, and blood sugar levels.^{12,21,22} The Yukon–Kuskokwim Health Corporation's produce prescription program, launched in 2019, demonstrates the feasibility of clinically integrated nutrition support within a Tribal health system.¹²

Figure 3: Food Insecurity and Chronic Conditions in Alaska



²¹ Community Preventive Services Task Force. (2023). *Social determinants of health: Fruit and vegetable incentive programs*. *The Community Guide*. <https://doi.org/10.15620/cdc/168585>

²² Hager, E. R., et al. (2023). Impact of produce prescriptions on diet, food security, and cardiometabolic health: Results from a multisite evaluation. *Circulation: Cardiovascular Quality and Outcomes*, 16(9), e009520. <https://doi.org/10.1161/CIRCOUTCOMES.122.009520>

prepared, home--delivered meals designed for patients whose medical conditions limit their ability to shop for or prepare food.

These nutrition-related interventions are especially relevant given Alaska's burden of diet-related chronic disease, with recent state data showing that approximately 69 percent of adults have overweight or obesity, 33 percent have high blood pressure, 30 percent have high cholesterol, 9 percent have diabetes, and 6 percent have heart disease.¹¹ Food insecurity affects an estimated 14.5 percent of Alaskans and increases the risk of chronic illness and poor health outcomes, while emerging national evidence indicates that well-targeted Food Is Medicine programs can generate healthcare cost savings when directed to food-insecure patients with diet-related conditions.²³

Food is Medicine efforts in Alaska exist alongside enduring Indigenous food systems and subsistence practices that play a central role in nutrition, cultural identity, and community well-being for many Alaska Native communities. Recent state data on social risk factors and health inequities underscore the importance of addressing these structural conditions in partnership with Indigenous-led food and health systems.³ As the state explores opportunities to strengthen Food is Medicine strategies, including potential Medicaid Section 1115 waivers and other financing pathways, aligning clinical nutrition interventions with robust population-level programs, community-based organizations, and culturally grounded food systems remains essential.^{11,12}

Current Food is Medicine Landscape

Nutrition incentive and medically prescribed Food is Medicine activity in Alaska is taking shape through a growing but still fragmented set of efforts led by food banks, Tribal health organizations, WIC programs, hospitals and clinics, and farmers' market partners. Produce prescription initiatives currently anchor much of this work, typically linking healthcare providers with food banks, Tribal partners, or retailers.²⁴ Nutrition incentive programs expand purchasing power for fruits and vegetables and channel resources toward local producers, including through Alaska's SNAP market match efforts.²⁵

These initiatives differ in size, structure, and geography, some serve entire regions or the state year-round, while others are seasonal or limited by staffing and transportation. They share a focus on improving access to healthy foods, supporting chronic disease

²³ Feeding America. (2023). *Map the Meal Gap: Food insecurity in Alaska* [Data set]. Feeding America. <https://map.feedingamerica.org/county/2023/overall/alaska>

²⁴ U.S. Department of Agriculture, Food and Nutrition Service. (2023). *The evaluation of Food Insecurity Nutrition Incentives (FINI): Interim report* [Report]. https://fns-prod.azureedge.us/sites/default/files/resource-files/FINI-InterimReport_1.pdf

²⁵ Alaska Farmers Market Association. (2024). *Food access and food assistance programs at Alaska farmers markets* [Webpage]. <https://alaskafarmersmarkets.org/food-access-and-food-assistance-programs/>

management, and reducing food insecurity in ways that align with Alaska Department of Health prevention priorities and Food Bank of Alaska's Food is Medicine framework.²⁶

To better understand this emerging ecosystem, a statewide Food is Medicine landscape survey was conducted with program leaders across sectors; the next section summarizes key findings from that survey and how they inform this assessment.

The survey was designed to anchor this assessment in the day-to-day experience of current Food is Medicine operators. In the absence of comprehensive administrative data, this type of survey is a common early-stage tool for understanding how programs function on the ground, where capacity is constrained, and how ready systems are for growth.²⁷ For this report, the survey provides a primary source of empirical information about how nutrition incentive and medically prescribed Food is Medicine programs are currently operating in Alaska and where partners see the most immediate opportunities for action.

The landscape survey highlighted several consistent service gaps across programs.

Key Gaps

- Regional gaps, with limited or no nutrition incentive and medically prescribed Food is Medicine services in many rural, offroad, and smaller communities despite high need.
- Thin staffing and operational capacity at both healthcare and food partner organizations, especially for data, care coordination, and logistics.
- Fragmented program models and referrals, with few standardized workflows or shared screening tools linking clinics to food resources.
- Limited and inconsistent data systems for tracking enrollment, utilization, outcomes, and equity metrics across programs.
- Heavy reliance on short-term grant funding and minimal access to durable payment mechanisms such as Medicaid based coverage or value-based contracts.

Respondents

Representatives from nine organizations completed the survey: State of Alaska WIC and Municipality of Anchorage WIC; Alaska Native Tribal Health Consortium; Yukon-Kuskokwim Health Corporation; Copper River Native Association; Norton Sound Health Corporation; Food Bank of Alaska; Fairbanks Community Food Bank; and the Alaska Farmers Market Association. Collectively, these respondents represent the core sectors needed for a functioning nutrition incentive and medically prescribed Food is Medicine system in Alaska, including public nutrition programs and vendor networks, the Tribal health system, emergency food distribution and logistics, and the statewide

²⁶ Alaska Department of Health. (2024). *Alaska Health Systems Collaboration Unit FY24 Annual Report*. https://health.alaska.gov/media/zyfhyhce/ak_hsc_arfy24.pdf

²⁷ Centers for Disease Control and Prevention. (2022). *CDC Approach to Program Evaluation in Public Health*. <https://www.cdc.gov/evaluation/php/about/index.html>

nutrition incentive infrastructure administered through the Alaska Farmers Market Association Market Match program.

Survey respondents reflect a meaningful cross-section of organizations that are already investing staff, funds, and infrastructure in nutrition incentive and medically prescribed food related work. Because these sectors anchor food access, clinical referral pathways, and benefit redemption, their responses offer a credible baseline for understanding how nutrition incentive and medically prescribed food is currently configured and where system constraints are most pronounced.

Current Programs

Produce prescription and nutrition incentive programs are emerging as important strategies to address food insecurity and diet-related disease in Alaska by connecting patients and low-income residents with consistent access to fruits and vegetables through health care and public benefit systems. Together, the programs described in this section illustrate a diverse but relatively small field, with initiatives led by Tribal health organizations, state and local agencies, and food banks operating across urban centers and rural regions. The summaries that follow highlight considerable variation in benefit design, eligibility criteria, staffing, and funding stability, reflecting both innovation and fragmentation in how these models are currently implemented.

At the same time, the available data underscore significant gaps in standardized reporting, capacity, and long-term sustainability that constrain the ability to compare programs, estimate the number of Alaskans served, or assess health outcomes. Organizations reported using different time frames, units of measurement, and tracking systems, and many are operating with minimal staff and short-term or braided funding that requires ongoing administrative effort to maintain. This section synthesizes what is known about benefit structure, eligibility, reach, resources, duration, and self-reported capacity and challenges, while being explicit about the limitations of the underlying data and the need for shared metrics and evaluation support in future work.

Table 1: Produce Prescription Programs Identified in Alaska

Organization	Program Name	Region(s) served	Eligible population(s)	What is provided	Funding Source(s)	How long has program been operating	Amount of time funding continues
Alaska Native Tribal Health Consortium	Produce Distribution Program	Anchorage	Alaska Native adults in cancer treatment	Weekly box of produce picked-up by patient at central location.	CDC Comprehensive Cancer Program	Less than year	Not reported
Copper River Native Association	CRNA Prescription Produce	Copper River Basin, Ahtna region	Tribal members, low income individuals, individuals with diet related conditions, food insecure individuals, SNAP and/or WIC beneficiaries	Monthly allotment of produce picked-up by patient at central location. If they are a tribal member, they can receive available traditional meats.	Not reported	1 year	24-36 months, more than 3 years.
Fairbanks Community Food Bank	Food is Medicine Program	Fairbanks North Star Borough	Patients referred by health care providers	Patients can pick-up up to 6 pounds fresh produce of their choice five days a week from a central location.	Direct donations of produce and financial donations	6 years	Not reported
Food Bank of Alaska, State of Alaska, Department of Health	Growing Hope	Anchorage	Food insecure patients in cancer care	Weekly box of produce picked-up by patient at central location.	CDC PHHS Block Grant and Comprehensive Cancer Program; Foundation funding	Less than year	Less than a year
Norton Sound Health Corporation	Produce Rx. Prescriptions for Health	Nome and 15 surrounding villages	SNAP or Medicaid beneficiaries with at least one of the following medical conditions: heart disease, high blood pressure, diabetes, pre-diabetes, gestational diabetes, overweight, or obesity	Monthly box of produce delivered to the participant's home. The amount of produce received is based on household size.	USDA GusNIP	Less than year	Less than a year
					CDC REACH		Opportunities for continued funding
Yukon-Kuskokwim Health Corporation	Prescription Produce Program	Bethel and villages in the Yukon-Kuskokwim Delta Tribal Health region	Criteria changes due to funding source. Has been patients with diabetes, with diet-related conditions, Medicaid beneficiaries, low-income adults and/or food insecure adults.	Between \$45-\$90 depending on which program the participant is enrolled in and household size. Vouchers or boxes are available on a per month basis.	Special Diabetes Program for Indians funding (through HIS), USDA GusNIP, Food Security Grant	8 years	Less than a year

Produce Prescription Programs

Produce prescription programs were identified at six organizations. Four programs are managed by Tribal health organizations and two programs are managed by food banks. The programs serve various regions including Anchorage (2 programs), Cooper River Native Association service area, Fairbanks North Star Borough, Norton Sound Health Corporation service area and the Yukon–Kuskokwim Health Corporation service area.

Frequency and Type of Benefit

Four programs offered a weekly benefit, one program offered the benefit three times a month and another program offered the benefit five days a week. Five programs operated year-round and one program operated only during the summer months.

Four programs provided patients with a pre-packaged boxes of produce; one provided patients choice by offering a shopping experience at a central location; and one program offered patients a choice of either produce box delivery or paper vouchers for approved fresh, frozen or canned fruits and vegetables at their local store.

Program Eligibility

All produce prescription programs required a health care provider involvement. Two programs were specifically for patients undergoing cancer treatment, one program for patients with diet-related conditions, one program mentioned “certain health problems.” The criteria for three programs included reference to low income (as documented by SNAP or Medicaid enrollment) and/or food insecurity. One program adjusted eligibility through the year based on changes in funding sources; the program started by serving patients with diabetes but has now serves adults with food insecurity.

Number of Alaskans Served

While we wanted to estimate the number of unique Alaskans served by produce prescription programs annually, there is no standard reporting format used by these organizations. Each organization reported counts in a different format and time frame. Some programs tracked the number of unique individuals served while other programs did not. Some programs tracked the amount of participation per individual (e.g. number of weeks individual participated) and others did not. To minimize survey burden, we relied on information as reported by respondents, recognizing that standardized metrics do not currently exist across produce prescription programs. As a result, we were unable to estimate the annual number of unique Alaskans served. This approach reflects a deliberate effort to avoid imposing new reporting requirements on programs that operate across different funding sources and cycles and already face significant administrative demands.

Funding and Staff Resources

Funding for the programs came from a variety of sources. One program was funded exclusively on donations, four programs used various combinations of federal funds and two did not report their funding source. Four programs were operating with one or less FTE while two programs operate with 2-3 FTE. We were unable to summarize program costs due to variation on how survey respondents provide the information.

Duration

Two programs had been operating for about six years however both programs reported having less than one year of funding available. The remaining four programs had been operating for one year or less; of these, only one program has more than one year of funding available.

Capacity

One program reported strong capacity described as well-resourced, able to grow or improve services. Two programs reported adequate capacity described as can meet current demand but have limited room to expand. Two programs reported limited capacity (some resources in place, but significant constraints) and one reported very limited capacity described as major gaps in staff and resources: they cannot meet demand.

Key Challenges and Requested Resources

All six programs mentioned funding as a key challenge or requested resource. Staff capacity and training was mentioned by three programs. The most requested resources after funding were example evaluation plans (5 programs); model policies and procedures (3 programs); and one request for webinars with other agencies operating similar programs. One program mentioned the challenging of delivery and transportation of fresh fruits and vegetables in Alaska.

We did not request any health or social outcomes as it was not within the scope of this assessment and could be considered protected health information.

Table 2: Nutrition Incentive Programs Identified in Alaska

Organization	Program Name	Region(s) served	Eligible population(s)	What is provided	How long has program been operating	How many months of funding remain	Funding Source(s)
Alaska Farmers Market Association	SNAP Market Match and Local Food Purchase Program	Iliamna, Anchorage, Kenai, Mat-Su, Fairbanks, Southeast, other market regions	SNAP Beneficiaries	\$1 for \$1 match up to \$40 at Farmers Markets every week	4 years in current format. Initial program fielded in 2011 - 2015	1-2 years	State of Alaska Legislative Appropriation
Municipality of Anchorage, Anchorage Health Department	Fresh Bucks	Anchorage	WIC beneficiaries, SNAP beneficiaries	\$30 in paper vouchers per week to use at Grown North Farm and Muldoon Farmers Markets	4 years - Started in summer of 2022	1 more year	Municipality of Anchorage Alcoholic Beverages Retail Sales Tax
State of Alaska, Department of Health, Division of Public Assistance	Senior's Farmers Market Program	2025 authorized farmer-vendors were: Anchorage, Eagle River, Fairbanks, Delta Junction, Homer, Kenai, Palmer, Wasilla, Willow, Soldotna, Kodiak, Juneau and Sitka.	Alaska age 60 or older with income less than 185% of federal poverty level	\$40 per year of electronic food benefits for fresh Alaska-grown fruits and vegetables at farmers markets	5 years - started in 2001	Not reported	USDA Senior Farmers Market Nutrition Program, Alaska General Fund
State of Alaska, Department of Health, Division of Public Assistance	WIC Farmers Market Nutrition Program	2025 authorized farmer-vendors were: Anchorage, Eagle River, Fairbanks, Delta Junction, Homer, Kenai, Palmer, Wasilla, Willow, Soldotna, Kodiak, Juneau and Sitka.	WIC beneficiaries	\$45 per year of electronic food benefits for fresh Alaska-grown fruits and vegetables at farmers markets *(\$30 from USDA with a bonus boost from AFMA of \$15)	8 years - Piloted in 1998	Not reported	USDA WIC Farmers Market Nutrition Program, Alaska Farmers Market Association

Nutrition Incentive Programs Summary

Four nutrition incentive programs were identified at three organizations. Two programs are managed by the State of Alaska Division of Public Assistance, one program is managed by the Municipality of Anchorage Department of Health, and one by the Alaska Farmers Market Association. The programs serve a wide variety of geographic regions and communities in the state.

Frequency and Type of Benefit

All four programs provide cash-equivalent benefits - such as paper vouchers, tokens or electronic - that can only be redeemed at authorized farmers' markets or with farmers. One program provided SNAP beneficiaries a \$1 for \$1 match up to \$40 at authorized Farmers Markets every week. Beneficiaries check-in at the market manager table with their SNAP Quest card (electronic benefit card) to get tokens or paper vouchers that match their SNAP spending can be spent at the market. Another program provides SNAP or WIC beneficiaries \$30 in paper vouchers each week at two different farmers market locations. Beneficiaries check-in at the market manager table with their identification and WIC or SNAP cards and are given paper vouchers to spend at the market.

Two of the programs use the same electronic App called Healthy Together but have different funding sources and eligibility criteria. WIC beneficiaries enroll with their local WIC agency. The local WIC agency approves and loads the annual electronic benefits allocation of \$45 into the Healthy Together app that can be spent with authorized farmers. Low-income seniors can choose to register with their local Senior Agency or fill out a Senior Farmers' Market Nutrition Program application using the Healthy Together app. Once the annual electronic benefits allocation of \$40 is approved, it becomes immediately accessible in the Healthy Together app, allowing seniors to start spending with authorized farmers that day.

Program Eligibility

One program served both WIC and SNAP beneficiaries, one program served SNAP beneficiaries, one served WIC beneficiaries and one served Alaskans age 60 or older with income levels less than 185% of the federal poverty level.

Number of Alaskans Served

While we wanted to estimate the number of unique Alaskans served by nutrition incentives annually, there is no standard reporting format used by these organizations. To reduce survey burden of the respondent, we accepted what was reported and did not request additional information. Therefore, we were unable to estimate the annual number of unique Alaskans served by these nutrition incentive programs.

Funding and Staff Resources

One nutrition incentive program operated using funding from Alaska legislative appropriation, one program operated using alcoholic beverage retail sales tax. Two of the programs braided funding. For this program, most of the funds came from the United State Department of Agriculture Senior Farmers Market Nutrition Program or the WIC Farmers Market Nutrition Program the program was supplemented with Alaska Farmers Market Association funds.

Duration

One nutrition incentive program was first piloted in 1998 and became permanent a few years later and has been operating continuously since. Another program started in 2001. Another program launched in 2011 and ended in 2015 due to loss of funding. The program was reestablished in 2021 when funding was secured and has been operating for five years. One nutrition incentive program began in 2022 and has secured funding for calendar year 2026.

Capacity, Key Challenges and Requested Resources

Due to a design flaw in our survey we did not capture useful information about program capacity, key challenges and requested resources from four of the five nutrition incentive programs. To reduce survey participate burden, we did not follow up with additional requests.

Program Mix and Structural Constraints

Six of the programs report operating a produce prescription program, four programs report nutrition incentive programs, one program mentioned medically prescribed traditional meats if a tribal member, and none report medically prescribed meals.

Alaska's distribution of produce prescription and nutrition incentive programs is consistent with national experience, in which produce prescriptions frequently serve as a key linkage between clinical care and food access, with some systems also incorporating higher-intensity medically prescribed nutrition interventions such as medically tailored meals.^{28,29}

In Alaska, the concentration of activity around nutrition incentive and produce prescriptions programs reflects both strong clinic–community partnerships and the strong evidence that these programs reduce household food insecurity and increase

²⁸ Centers for Medicare & Medicaid Services. (2023). *Social Drivers of Health and Health-Related Social Needs*. <https://www.cms.gov/priorities/innovation/key-concepts/social-drivers-health-and-health-related-social-needs>

²⁹ Hager, E. R., Quigg, A. M., Black, M. M., et al. (2023). Community-based fruit and vegetable prescription programs: A scoping review. *Maternal and Child Health Journal*, 27, 1912–1928. <https://pmc.ncbi.nlm.nih.gov/articles/PMC10511821/>

household fruit and vegetable consumption.³⁰ The limited availability of medically prescribed groceries and meals likely reflects how resource-intensive these programs are to run in practice. For example, they require reliable systems for preparing, safely storing, and transporting food to patients, alongside the absence of stable, long-term financing pathways to support more intensive services at scale.⁴

Other Survey Findings

Most (eight of ten) surveyed programs operate year-round when supply chains and staffing allow, with several noting seasonal limits related to farm production and transportation. Half of the programs operate at a single site and half across multiple locations, reflecting a mix of regional hub-and-spoke models and smaller, place-based programs in rural communities. Narrative responses underscore how Alaska's environment shapes implementation decisions. Respondents describe recurring challenges related to seasonal gaps in produce availability, barge delays, limited cold storage, and the logistics of moving food to villages—factors that are especially consequential for rural and oncology-linked pilots, where timing and consistency are central to clinical impact.

Participants Served, Demand Pressure, and Capacity Constraints

Programs are reaching Alaskans but remain far from meeting the level of need described by survey respondents. Most respondents report serving between 101 and 500 unique participants annually, with some programs serving more than 500 people each year, and weekly and monthly contact figures indicate that many participants interact with programs multiple times rather than receiving onetime support.

Respondents consistently noted that more patients and community members could benefit from services than current enrollment numbers reflect, even though differences in counting methods, reporting periods, and program models prevent generating a precise estimate of total need. Several organizations report that demand has already outpaced their operational capacity: one program that initially anticipated serving 5–10 patients per day now caps enrollment at 1,000 participants and serves up to 150 people daily. Others described informal caps or waitlists driven by staffing, storage, and funding limitations. In this context, observed enrollment levels should be interpreted as reflections of program capacity and reporting differences rather than indicators of limited interest or clinical relevance, underscoring the importance of consistent and reliable financing and workforce supports.

“We expected to serve 5-10 patients a day when we started. We now have had to cap the patients we can enrolled to 1,000. We serve up to 150 patients each day.”
– Food Is Medicine Landscape Survey Respondent

³⁰ Community Preventive Services Task Force. Social Determinants of Health: Fruit and Vegetable Incentive Programs. In: *The Community Guide* [Internet]. Atlanta (GA): Community Preventive Services Task Force; 2023. <https://www.thecommunityguide.org/findings/social-determinants-health-fruit-vegetable-incentive-programs.html>

Partnerships

Survey responses describe partnership networks that already involve many of the actors required for a statewide Food is Medicine strategy, including Tribal health organizations and Alaska Native Tribal Health Consortium (ANTHC), state and municipal WIC programs, regional food banks, Alaska Farmers Market Association, agricultural producers, oncology programs, public health agencies, community foundations, and disease-specific nonprofits. This breadth of collaboration aligns with national guidance emphasizing cross-sector partnership as a cornerstone of effective Food is Medicine implementation and supports Food Bank of Alaska priorities around coalition-based models. Together, the findings suggest that many organizations are ready for more formalized coordination, provided that governance, roles, and data-sharing expectations are clearly defined.

Funding Profile

The survey documents consistent reliance on braided, time-limited funding. Respondents report using USDA funds, CDC cancer and public health grants administered through the State of Alaska, Alaska Native Tribal Health Consortium subawards, time-bound legislative appropriations,³¹ donations and internal food bank resources to sustain their programs. Only one produce prescription program affirmatively noted 2-3 years of secured future funding. This lack of sustainability constrains long-term planning, staffing, and investments in logistics and storage. It is difficult for these organizations to commit to sustained program models, conditions that mirror national concerns about Food is Medicine sustainability.^{27,29} These findings reinforce Food Bank of Alaska priorities to shift from grant-funded programs toward more durable financing strategies, including potential use of Medicaid authorities such as Section 1115 waivers.⁴

When asked “what key challenges do you face in operating or expanding the program,” funding was a top response for the produce prescription programs.

*“Funding to support both staff and the produce”
“Consistency, training, funding for the foods”,
“Staff capacity specifically for customer engagement and outreach.”
“Staffing, funding, logistics”*

– Food Is Medicine Landscape Survey Respondents

³¹ Alaska Office of Management and Budget, *Capital Appropriation Status Report (1634)*, released February 4, 2025, https://omb.alaska.gov/ombfiles/26_budget/PDFs/casr_Capital_Appropriation_Status_Report_1634_2-4-25.pdf

Implementation Bottlenecks

Five of the six produce prescription programs reported dedicating roughly one or more FTE staff member to program activities. When prescription program operators were asked to assess their overall capacity, responses reflected a wide range of operating conditions. Approximately half of respondents reported having adequate resources to meet current demand but limited ability to expand, while the remaining operators described notable constraints. One operator reported strong capacity, indicating it was well resourced and able to grow or improve services. Two reported adequate capacity, noting they could meet current demand but had limited room to expand. Two reported limited capacity, with some resources in place but significant constraints, and one reported very limited capacity, citing major gaps in staffing and resources that prevent them from meeting demand.

Across responses, staffing limitations, funding for personnel and food, logistical complexity in remote areas, training needs, and limited outreach and participant-engagement capacity emerge as common implementation bottlenecks. This pattern is consistent with national literature that identifies workforce and operational infrastructure as core determinants of Food is Medicine success alongside direct food funding.^{6, 32} For Alaska, the findings point to the need for financing models that support the full continuum of activities: screening, referral, navigation, procurement, food storage, distribution, redemption, general administration and data reporting - not only the food benefit itself.

Evaluation Practices

Despite lean staffing, most respondents report using meaningful data systems and measures. All programs who answered the questions track enrollment, and about half track incentives issued or redeemed, food security, food literacy or skills, and selected health outcomes. The produce prescriptions operating within the health care setting capture data through the electronic health records (EHR). The nutrition incentive programs capture information using a enrollment systems, purchase and redemption tracking, and participant surveys or interviews; one program combines electronic health record data with Qualtrics surveys and vendor receipts, and oncology-linked pilots rely on follow-up navigator interviews.

Respondents also describe clear gaps, including limited analytic capacity, absence of standardized metrics, and a need for example evaluation plans and technical assistance. Many indicate that they could share at least some aggregated data with a broader group if appropriate privacy protections and data-governance frameworks, especially those reflecting Tribal data sovereignty, are in place. Taken together, these findings suggest strong readiness for a shared evaluation framework and common metrics that can support learning, quality improvement, and policy development.

³² Nagata, J. M., Kriyantono, Y., Palar, K., et al. (2024). Implementation of Food is Medicine programs in healthcare settings. *Nutrients*, 16(9), 2074. <https://pmc.ncbi.nlm.nih.gov/articles/PMC11535093/>

Participant Voice

Survey responses highlight both strengths and challenges related to cultural relevance and equity. One Tribal program reported aligning eligibility with Indian Health Service beneficiary status, allowing traditional meats to be included in program offerings. Other programs described structuring benefits to allow purchases of all SNAP-authorized foods, giving participants flexibility to select culturally important items where available.

At the same time, several program operators noted that traditional and subsistence foods are not yet consistently incorporated due to practical constraints, including cost, limited sourcing, seasonal availability, and storage and distribution challenges.

The feedback we received from patients was positive. We would like to explore increased variety of produce and continue growing this project.
– Food Is Medicine Landscape Survey Respondent

Equity practices described by respondents include language access, low-literacy materials, transportation support, and the use of navigators or social workers to help participants overcome barriers. Most programs collect community input through informal mechanisms, surveys, comment cards, conversations, and staff observations, but few report formal advisory councils or governance roles for people with lived experience. These findings align with Food Bank of Alaska priorities around equity, dignity, and participant choice and point to an opportunity to strengthen community and Tribal leadership within Food is Medicine planning, implementation, and evaluation structures.

Implications for Alaska's Food is Medicine System

Overall, survey findings suggest that Alaska's nutrition incentive and produce prescription Food is Medicine ecosystem is in an early but active stage of development. Programs operate across multiple regions, demand frequently exceeds capacity, and many key public, Tribal, nonprofit, and food system partners are already engaged. At the same time, the system is fragile: funding is short-term, staffing is thin, logistics are complex, and common evaluation and coordination infrastructure are still emerging. These conditions underscore the importance of a statewide strategy that combines durable financing, most likely through Medicaid and aligned public funding, with shared tools and workflows, targeted capacity-building, and grounded coalition governance.

Alignment with Food Bank of Alaska and Alaska Department of Health

The Landscape Assessment is intentionally aligned with existing Food Bank of Alaska frameworks to support coherent statewide planning, consistent messaging, and efficient use of limited capacity. In an early-stage Food is Medicine environment, where programs are grant-funded and infrastructures are still emerging, cross-organizational alignment on vision, terminology, and core priorities is a critical enabling condition for scale. While nutrition incentive programs are designed to improve food security and

increase fruit and vegetable intake, produce prescription programs are prescribed as part of disease management. Accordingly, policy and financing strategies for produce prescription programs emphasize the central role of Medicaid and health systems in providing reliable coverage. They also highlight the importance of elevating Tribal leadership and community-based organizations as co-designers and implementers, and the need for data-informed policy advocacy and shared evaluation infrastructure.⁴

The Landscape Assessment is intentionally aligned with existing Food Bank of Alaska frameworks to support coherent statewide planning, consistent messaging, and efficient use of limited capacity. In an early-stage Food is Medicine environment, where many programs are grant funded and infrastructures are still emerging, cross-organizational alignment on vision, terminology, and core priorities helps create the conditions needed for sustainable growth and eventual scale.^{33,34}

Future Opportunities

Survey findings highlight both the momentum and the structural constraints shaping nutrition incentive and produce prescription Food is Medicine implementation in Alaska. While respondents primarily described current funding sources, delivery challenges, and gaps in reach, these patterns point to a need for more durable financing, stronger integration with health systems, and investments that bolster community-based delivery in rural communities.

To situate these survey results within the broader policy environment, the following sections examine two complementary state and federal frameworks that have the potential to shape near- and long-term opportunities for Food is Medicine in Alaska: Medicaid Section 1115 demonstration waivers, which represent a primary mechanism for sustainable reimbursement of nutrition services, and Alaska's Rural Health Transformation Program, which offers a parallel pathway for building the community infrastructure, workforce capacity, and data systems needed to support prevention-focused, locally-led Food is Medicine models.

³³ U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2022). *Current Federal Programming and Coordination Efforts Related to Food Is Medicine*. <https://health.gov/sites/default/files/2022-09/Current%20Federal%20Programming%20and%20Coordination%20Efforts%20Related%20to%20Food%20is%20Medicine.pdf>

³⁴ Centers for Medicare & Medicaid Services. (2022). *CMS Framework for Health Equity 2022–2032*. <https://www.cms.gov/files/document/cms-framework-health-equity.pdf>

Medicaid Section 1115 Waivers and Food is Medicine: National Models and Implications for Alaska

Section 1115 of the Social Security Act allows states to test new approaches in Medicaid that differ from federal program rules, as long as demonstrations further Medicaid objectives and remain budget neutral to the federal government.³⁵ In the past decade, and especially since 2021, states have increasingly used Section 1115 waivers to address health-related social needs, including nutrition supports such as produce prescriptions and medically prescribed groceries and meals.³⁶

Within the Food is Medicine field, Section 1115 waivers have emerged as one of the most promising pathways for sustainable financing because they allow states to reimburse non-traditional services delivered by community-based organizations when those services are targeted, time-limited, and linked to improved health outcomes.³⁷ National policy toolkits and peer-reviewed literature consistently identify section 1115 demonstrations as a primary mechanism through which Food is Medicine has moved from short-term pilots to scalable systems in multiple states.⁴

National Landscape

A growing number of states have approved or pending Section 1115 waivers that explicitly include nutrition supports. States further along in implementation include Massachusetts, Oregon, North Carolina, California, Washington, New Jersey, Maine, Delaware, and Arkansas, among others.^{38,39} These waivers vary in scope but commonly cover medically prescribed groceries and meals, pantry-stocking supports, and produce prescription benefits for defined high-risk populations.^{4,29}

³⁵ Centers for Medicare & Medicaid Services. (2023). *About Section 1115 Demonstrations*. Baltimore, MD: U.S. Department of Health and Human Services. <https://www.medicaid.gov/medicaid/section-1115-demonstrations/index.html>

³⁶ Hager, K., et al. (2024). *The evolution and scope of Medicaid Section 1115 demonstrations to address health-related social needs*. *Health Affairs Scholar*, 2(2), qxae013. <https://academic.oup.com/healthaffairsscholar/article/2/2/qxae013/7595880>

³⁷ Centers for Medicare & Medicaid Services. (2023). *Medicaid and Children's Health Insurance Program (CHIP) health-related social needs (HRSN) "in lieu of services and settings" (ILOS) guidance*. Center for Medicaid and CHIP Services. <https://www.medicaid.gov>

³⁸ Centers for Medicare & Medicaid Services. (2023). *Coverage of services and supports to address health-related social needs in Medicaid and the Children's Health Insurance Program (CIB)*: November 16, 2023). Center for Medicaid and CHIP Services. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib11162023.pdf>

³⁹ Kaiser Family Foundation. (2024). *Section 1115 Medicaid waiver watch: A closer look at recent approvals to address health-related social needs (HRSN)*. KFF. <https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-waiver-watch-a-closer-look-at-recent-approvals-to-address-health-related-social-needs-hrsn/>

Analyses of these states suggest a relatively consistent trajectory: approximately 6–12 months of concept development, stakeholder engagement, and actuarial and budget-neutrality analysis; up to 12–15 months of review and negotiation with the Centers for Medicare & Medicaid Services following submission; and an initial five-year demonstration period once approved.^{4,29} In practice, the full arc from early planning to services reaching Medicaid members often spans two to four years, underscoring the importance of early planning and realistic expectations. Lessons from these implementations emphasize starting with clearly defined target populations and a focused benefit set, investing early in data and evaluation infrastructure, and building formal contracting relationships between Medicaid agencies, managed care entities, and community-based food providers.⁴

Several states, including Hawaii, Oklahoma, and Massachusetts, are also beginning to integrate local food system priorities into 1115 Food is Medicine designs. For example, some approved or pending waivers highlight local sourcing and support for regional producers as explicit aims of Medicaid-financed nutrition benefits, while others embed local procurement expectations into program standards or in-lieu-of-services guidance rather than hard mandates.⁴ These approaches illustrate how Medicaid policy can be used to advance both health and food system resilience when designed intentionally.

Alaska's Current 1115 Status and Food is Medicine

Alaska's existing Section 1115 authority, the Behavioral Health Reform 1115 demonstration, focuses on substance use disorder and broader behavioral health system transformation, not on nutrition services. The waiver was initially approved in 2018, implemented in 2019, and is authorized through December 31, 2028.^{40,41} While current waiver documents do not include a dedicated Food is Medicine benefit, state materials reference broader exploration of health-related social needs interventions, including food-related supports, as part of ongoing reform.³²

Public notices and planning documents from 2025 indicate that Alaska is currently focused on reviewing and refining its existing behavioral health waiver rather than advancing a Food is Medicine specific 1115 demonstration. In parallel, statewide partners, including Food Bank of Alaska and the Department of Health, are investing in landscape analysis, coalition building, and technical assistance to position the state for future Medicaid pathways that could include food-related supports.⁴²

⁴⁰ Centers for Medicare & Medicaid Services. (2024). *Alaska Behavioral Health Reform section 1115 demonstration* (Project No. 11-W-00318/0). Medicaid.gov. <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/80966>

⁴¹ Alaska Department of Health. (2023). *1115 Behavioral Health Medicaid Services*. State of Alaska. <https://health.alaska.gov/en/services/1115-behavioral-health-medicaid/>

⁴² Food Bank of Alaska. (2024, May). *Food Bank of Alaska launches statewide initiative to improve nutrition access and public health through produce incentives and Food is Medicine programs* [Press release]. Food Bank of Alaska. https://foodbankofalaska.org/hubfs/Website/Resource%20Library/Press%20Releases/FBA_Press%20Release%20Food%20is%20Medicine%20May%202024.pdf

Planning Implications and Timelines for Alaska

Drawing on national experience, Alaska should expect a phased, multiyear pathway if Section 1115 is pursued as a financing mechanism for Food is Medicine. In the near term (approximately 2026–2029), progress is most likely to come from grant-funded pilots, alignment with existing behavioral health and chronic disease programs, and structured planning for Medicaid integration.^{43,44} Alaska does have statutory authority in AS.47.07.036 to apply for a section 1115 waiver to establish one or more demonstration projects focused on health-related needs that may include nutrition and food security. A realistic 1115 timeline would include one to two years of concept development, stakeholder engagement, and policy design, followed by two years of Centers for Medicare & Medicaid Services review and negotiation for an amendment or new demonstration and a year for Alaska to begin implementation.²⁸ If Alaska pursues an 1115 waiver for food related supports, it will likely take four years before programs are fully operating (see Figure 4).⁴⁵

National lessons suggest that Alaska will benefit from clearly defining populations of focus (for example, adults with diabetes); selecting a limited initial benefit set (such as produce prescriptions and/or medically supportive groceries); and addressing provider readiness, contracting, data systems, and local sourcing capacity early in the design process.^{27,28} States that underestimated community-based provider capacity, contractual complexity, or data requirements have experienced slower implementation, uneven uptake, and challenges demonstrating impact, underscoring the importance of phased rollout and technical assistance.^{27,46}

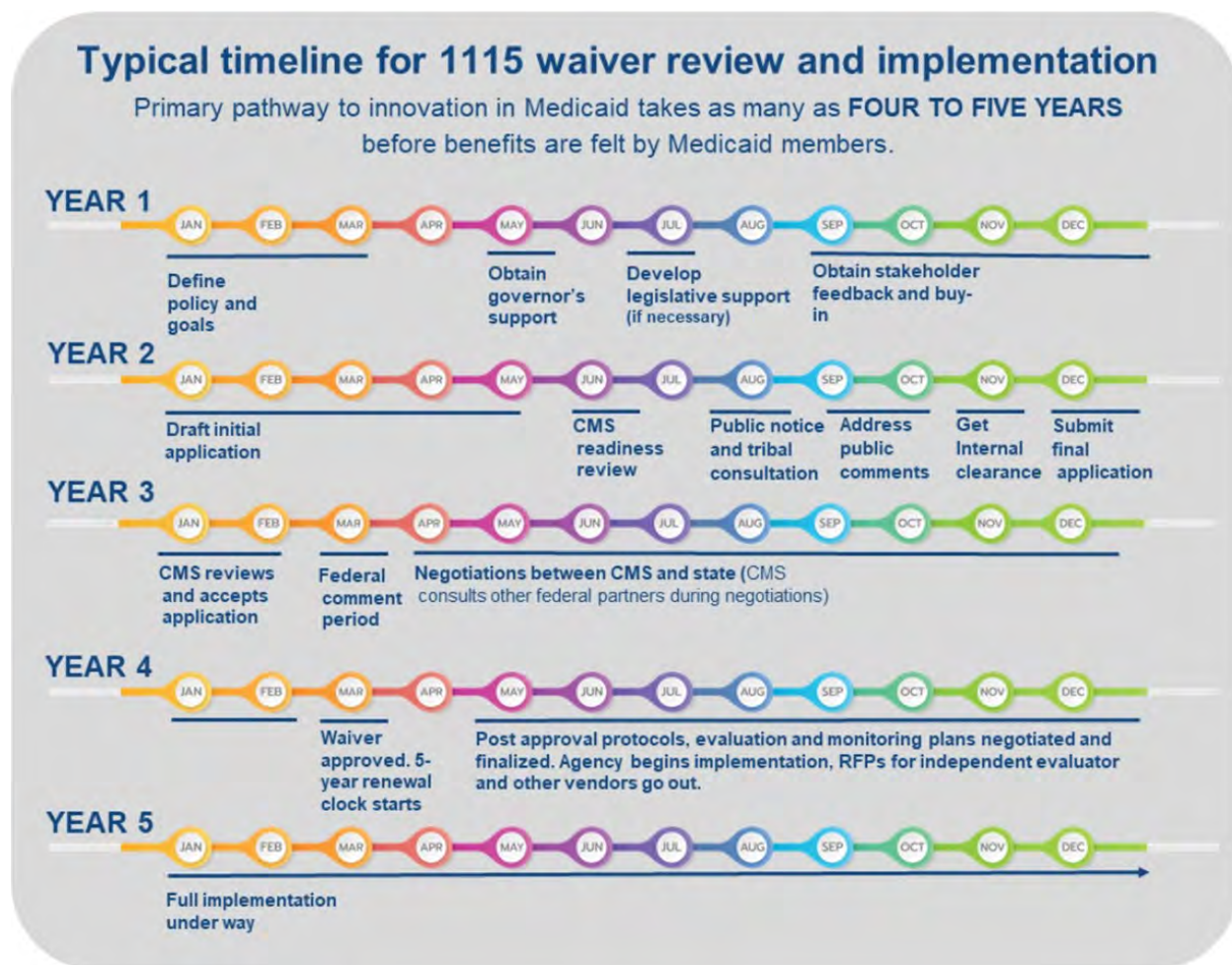
⁴³ Alaska Department of Health. (2024). *Alaska Medicaid reform annual report, FY2024*. State of Alaska. <https://health.alaska.gov/media/alpdbqal/2024-annual-medicaid-reform-report.pdf>

⁴⁴ Alaska Department of Health. (2025). *Food is Medicine and produce incentives coordination* (Request for Proposals No. 2525H036). State of Alaska. <https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=152374>

⁴⁵ National Association of Medicaid Directors. (2024). *Medicaid innovation pathway: How 1115 waivers work*. <https://medicaiddirectors.org/resource/how-1115-waivers-work/>

⁴⁶ Centers for Disease Control and Prevention. (2024). *A Food is Medicine approach to achieve nutrition security and health equity*. U.S. Department of Health & Human Services. https://stacks.cdc.gov/view/cdc/148997/cdc_148997_DS1.pdf

Figure 4 . Medicaid Innovation Pathway: How 1115 Waivers Work, National Association of Medicaid Directors



Strategic Relevance

For Alaska's Food is Medicine coalition, Section 1115 should be viewed as a long-term strategic tool that can guide, but should not delay, near-term program development. Building standardized program models, common screening and referral workflows, shared evaluation metrics, and strong partnerships with Tribal health organizations and community-based food providers will be essential regardless of which Medicaid pathway the state ultimately chooses.⁴ Survey findings in this assessment indicate that many foundational elements of a successful 1115 demonstration are already in place: cross-sector partnerships, documented demand, emerging evaluation capacity, and early experience with produce prescriptions and nutrition incentives. Framing Food is Medicine within Alaska's broader Medicaid and health equity strategy, rather than as a standalone benefit, aligns with national best practices and increases the likelihood that any future 1115 efforts will be both approvable by Centers for Medicare & Medicaid Services and meaningful for Alaska communities.⁴

Alaska's Rural Health Transformation Program: Healthy Communities Initiative

Alaska's Rural Health Transformation Program (RHTP) is a new federal to state initiative that would direct a share of a national \$50 billion investment toward strengthening rural health systems over five years.⁴⁷ Alaska's proposal organizes this work into six initiatives intended to support community-led, regionally designed systems that improve access to a full continuum of care as close to home as possible. Initiative 3, Healthy Communities, is especially relevant to Food is Medicine because it focuses on prevention, chronic disease risk reduction, and community-level determinants of health in rural and offroad regions.

Alignment with Food is Medicine

The RHTP Healthy Communities initiative emphasizes prevention and promotion of healthy lifestyles, supports community-level efforts to reduce chronic disease risk, and complements clinical care rather than focusing on clinical encounters alone.⁴⁸ Potential uses of funds include nutrition and health education, cooking and food skills programs, community wellness infrastructure, and culturally appropriate health promotion efforts, activities that align closely with Food is Medicine goals of improving diet quality, food security, and self-management of diet-related conditions.^{4,37} Although the Rural Health Transformation Program does not label Food is Medicine as a specific program category, Healthy Communities is designed to create an enabling environment for Food is Medicine interventions. For example, investments in wellness centers, multiuse community spaces, and mobile or itinerant service models can host nutrition education, cooking demonstrations, and community-based produce distribution that complement produce prescription and nutrition incentive programs.³⁷

The initiative also emphasizes that effective prevention in rural Alaska must be culturally grounded and locally led, calling for approaches that reflect community priorities.³⁷ This orientation is consistent with Alaska-specific Food is Medicine frameworks that center traditional foods, subsistence practices, and community-defined concepts of wellness. It provides a potential vehicle for integrating these elements into funded prevention and wellness activities, including Food is Medicine interventions.

Digital Tools, Data Infrastructure, and Community Capacity

A core feature of the Healthy Communities initiative is investment in consumer-facing digital tools and population health infrastructure to support chronic disease self-management, health literacy, and care coordination, particularly where geography and weather limit in-person services.³⁷ For Food is Medicine programs, these investments could strengthen referral pathways from clinics to community food resources, enable shared tracking of participation and outcomes, and support evaluation across regions. Interoperable data systems and population health analytics envisioned under the program would make it easier to identify individuals at elevated nutrition-related risk,

coordinate care between health providers and community-based food organizations and monitor the impact of Food is Medicine interventions over time.³⁷ At the same time, the Rural Health Transformation Program framework explicitly recognizes variation in community capacity and prioritizes flexible, locally governed data approaches, aligning with nutrition incentive and medically prescribed Food is Medicine best practices in Alaska that emphasize proportional reporting expectations, privacy protections, and Tribal data sovereignty.^{27,32}

Community Infrastructure

Healthy Communities also allows Rural Health Transformation Program resources to be used for physical infrastructure that can host prevention and wellness activities, including community wellness centers, shared multiuse spaces, and facilities suitable for nutrition education, cooking classes, and healthy food access efforts.³⁷ It is notable that use of funds is restricted when purchasing meals or investing in building construction or expansion, among other limitations.^{47,48} Such investments will require public-private partnerships and are particularly important in rural and offroad communities, where existing facilities are limited, and single spaces often serve multiple functions, from health promotion to community gatherings. By supporting locally driven planning and regional health-delivery strategies, the initiative creates space for Food is Medicine activities to be embedded within broader prevention ecosystems rather than operating as isolated pilots, increasing the likelihood that nutrition-focused interventions will be sustained over time, are aligned with other chronic disease and wellness efforts, and will be accountable to local leadership and priorities.³⁷

Rural Health Transformation Program Implications

The Rural Health Transformation Program Healthy Communities initiative provides a complementary policy and funding context for Alaska's Food is Medicine work. While the program dollars are not intended to replace Medicaid-financed services or duplicate existing programs, they can support development of infrastructure, workforce capacity, digital tools, and community readiness that Food is Medicine interventions require to be successful.³⁷ In particular, Healthy Communities investments can support community-based nutrition education and food-skills development; culturally responsive wellness programming aligned with Indigenous Food is Medicine principles; data systems and digital tools that strengthen referral, coordination, and evaluation; and physical spaces that enable nutrition and wellness activities in rural communities.³⁷

As Alaska explores Medicaid-aligned Food is Medicine strategies, including potential Section 1115 demonstration pathways, deliberate alignment with Healthy Communities will be important. Healthy Communities can help braid prevention-focused, community-level investments with clinically integrated nutrition benefits. Through

⁴⁷ Rural Health Transformation (RHT) Program. Grants.gov, opportunity no. 360442, accessed January 21, 2026, <https://grants.gov/search-results-detail/360442>

⁴⁸ State of Alaska Department of Health. "CMS Rural Health Transformation Program (CMS-RHT-26-001) Project Narrative and Supporting Documents," November 4, 2025, accessed January 21, 2026, <https://health.alaska.gov/media/bxangqdz/alaska-rhtp-project-narrative-and-supporting-documents.pdf>

coordinated planning, this alignment can reduce fragmentation, support local autonomy, and advance shared goals of improved nutrition security, chronic disease prevention, and health equity across rural communities.³⁷

Conclusions and Strategic Implications

The nutrition incentive and medically prescribed Food is Medicine programs reviewed in this assessment have strong momentum but operate in a fragile system dependent on short-term grants, thin staffing, complex logistics, and limited durable healthcare financing. Programs led by Tribal health organizations, food banks, public nutrition partners, and healthcare systems are meeting some of the need and advancing prevention, yet overall reach is constrained more by capacity, infrastructure, funding and geography than by demand or clinical relevance.

Evidence from Alaska and nationally shows that nutrition incentive and medically prescribed Food is Medicine programs achieves the greatest and most equitable impact when supported by stable financing, strong cross-sector partnerships, shared evaluation frameworks, and explicit commitments to equity and participant choice. In Alaska, many of these enabling conditions are emerging but not fully institutionalized, leaving promising efforts vulnerable to funding and staffing disruptions.^{33,49} Without renewal or identification of additional funding sources, most programs have less than one to three years of support remaining, and many face the prospect of winding down or sunseting despite strong demand and positive outcomes.

These findings point to the need for a coordinated statewide strategy that centers Tribal leadership and Indigenous food systems, aligns with Alaska Department of Health priorities on chronic disease prevention, and coordinates with Food Bank of Alaska's statewide Food is Medicine coalition. Long-term financing pathways, especially Medicaid authorities such as Section 1115 waivers and related options, will be critical to move medically prescribed Food is Medicine programs from grant-funded pilots to integrated components of care. Additional funding opportunities exist in the Rural Health Transformation Program Healthy Communities initiative. Given the short application period and speed at which these funds are to be dispersed, existing Food is Medicine programs are best positioned to take advantage of this opportunity.

In the near term, Alaska is best positioned for phased advancement: strengthening shared governance and coalition structures; standardizing core program models, screening and referral workflows, and common metrics; and investing in workforce, logistics, and data systems that can support implementation across rural, hub, and urban communities. Parallel planning for Medicaid pathways, grounded in real program data and community readiness, can help ensure that future financing is both operationally feasible and responsive to local priorities. Alignment of Food is Medicine policy goals with Rural Health Transformation Program objectives offers another avenue for programs to demonstrate improved health outcomes and successful innovation.

⁴⁹ National Institute of Food and Agriculture. (2024). *GusNIP Nutrition Incentive Program: Year 4 impact findings report*. Retrieved from <https://nutritionincentivehub.org/media/ev5aet4n/year-4-gusnip-impact-findings-report-2024.pdf>

Ultimately, the key question is how policy, financing, and infrastructure can be aligned to sustain nutrition incentive and medically prescribed Food is Medicine programs for the long-term, not whether programs work or whether demand exists. By building on existing partnerships, centering equity and Indigenous leadership, and braiding prevention-focused community investments with clinically integrated nutrition benefits, Alaska can position Food is Medicine as a core pillar of its health equity and chronic disease prevention agenda.

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Norton Sound Health Corporation Produce Prescription Program:
Program information flyer.



The flyer is titled "Produce Rx" in large, bold, black letters, with "PRESCRIPTIONS FOR HEALTH" in smaller text to the right. Above the title is an illustration of a wooden basket filled with various fresh vegetables like tomatoes, peppers, and leafy greens. Below the title, a purple banner contains the text: "PEOPLE WITH SNAP OR MEDICAID AND CERTAIN HEALTH PROBLEMS COULD GET A PRODUCE PRESCRIPTION!". To the left of a list of benefits is a green circle with the text: "WONDERING IF YOU'RE ELIGIBLE? SCAN THE QR CODE OR TALK TO YOUR DOCTOR". The list of benefits includes: "✓ DETERMINE ELIGIBILITY", "✓ TAKE SHORT SURVEYS", and "✓ RECEIVE PRODUCE & NUTRITION EDUCATION". Below the circle is a QR code with a green border. To the right of the QR code is the text "Questions? 443-3365". At the bottom left is the Norton Sound Health Corporation logo, which includes a circular seal with "NORTH STAR" and "NSHC" and the text "NORTON SOUND HEALTH CORPORATION". At the bottom right is a stylized logo for "GAMP" featuring a bear and a person.

Produce Rx PRESCRIPTIONS FOR HEALTH

PEOPLE WITH SNAP OR MEDICAID AND CERTAIN HEALTH PROBLEMS COULD GET A PRODUCE PRESCRIPTION!

WONDERING IF YOU'RE ELIGIBLE? SCAN THE QR CODE OR TALK TO YOUR DOCTOR

- ✓ DETERMINE ELIGIBILITY
- ✓ TAKE SHORT SURVEYS
- ✓ RECEIVE PRODUCE & NUTRITION EDUCATION

Questions?
443-3365

 NORTON SOUND HEALTH CORPORATION



Yukon-Kuskokwim Prescription Produce Program
Example program offering.

Example of Produce Prescription Program



AC Bethel
2.4K followers • 22 following

Qualifying diagnosis:
Food insecurity, older than 18

Patient can select either:
\$45 voucher or
produce box delivery

USDA Nutrition Incentive Grant



**Yukon-Kuskokwim
HEALTH CORPORATION**
Diabetes Prevention & Control

Prescription Produce Program

Valid Dates from: to: Amount used

\$45

for the purchase of WIC approved fresh, frozen or canned fruits and vegetables.

Participant ID:
Voucher:

This purchase is tax-exempt. No refunds given.

**CHRONIC DISEASE PREVENTION
HEALTH PROMOTION**



Alaska Farmers Market Association Market Match Program for Supplemental Nutrition Assistance Program (SNAP) Beneficiaries
Program informational flyer.

Shopping with a Quest Card?

Get **DOUBLE** the veggies with SNAP
Market Match

ALASKA QUEST

Buy \$1 of veggies with Quest Card

Get \$1 FREE

SNAP Supplemental Nutrition Assistance Program

Spend up to \$40 get up to \$40 FREE every week

Visit the market manager or info booth

Start Shopping!

Alaska Farmers Markets

GET AN EXTRA \$30 FOR BUYING FRUITS & VEGGIES

We're offering an extra \$30 in Fresh Bucks for the Municipality of Anchorage WIC and SNAP families to buy fruits and vegetables at authorized farmer's markets! Just stop by our booth with your SNAP or WIC card to collect your Fresh Bucks coupons once a week. This offer is available until funds run out, so don't miss out!



GROW NORTH FARM
3601 Mountain View Dr,
July 17, 24, 31
August 7, 14, 21, 28
4:00 p.m. to 7:00 p.m.



MULDOON FARMERS MARKET
1301 Muldoon Rd,
July 19 & 26
August 02, 09, 16, 23, 30
9:30 a.m. to 2:30 p.m.



This institution is an equal opportunity provider

Fairbanks Community Food Bank - Food is Medicine Program
Program informational flyer.



**Doctor said you must change your diet
but you can't afford it?**

Ask for a medical referral to the
Fairbanks Community Food Bank

FOOD IS MEDICINE program

**Monday - Friday
11 am to 3 pm
2582 Rickert Street**

**This is what you can expect
Monday through Friday
between the hours of
11 am and 3 pm**

Up to 6 pounds of fresh
produce each day for each
medically referred patient

Customer choice when
possible

There is no charge for this
program

- Our local Fairbanks Community Food Bank's mission is to collect local surplus food and give it to local people who need food assistance. Each day we collect 2-5 tons of local food. The Fairbanks Community Food Bank keeps our doors open primarily with regular small donations. 75% of all we need to operate daily is donated volunteer time, donated food, and donated buildings and equipment. THANK YOU to all who have been part of this amazing mission for 40 years.
- We have collected 70 million pounds of food
- Done the work with one million volunteer hours
- 4,000 local food and dollar donors help us pay the costs to get the food bank work done each year.

Fairbanks Community Food Bank
725 26th Avenue
Fairbanks, Alaska 99701
907-457-4273 (45-SHARE)
www.fairbanksfoodbank.org



Senior Farmers Market Electronic Food Benefits

Program website information about how to access electronic benefits.



State of Alaska
Department of Health

[Home](#) / [Services](#) / [Seniors Farmers' Market Nutrition Program \(SFMNP\)](#)

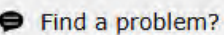
Seniors Farmers' Market Nutrition Program

Provides low-income Seniors residing in participating communities with electronic food benefits for fresh Alaska-grown fruits and vegetables at farmers markets

[Overview](#) [Eligibility](#) [How to Sign Up](#) [Resources](#) [Contacts](#)

Overview

The Alaska Senior Farmers' Market Nutrition Program (SFMNP) provides \$40 in electronic benefits to seniors and helps expand the awareness of farmers' markets in the state. The program provides low-income seniors with electronic benefits that can be exchanged for fresh Alaska-grown fruits, vegetables, fresh-cut herbs and honey at participating farmers' markets, autism resource fairs, and roadside stands within Alaska.





Senior Farmers' Market Nutrition Program (SFMNP)

2025 Application for Eligibility

Instructions: To receive benefits for fresh, Alaska grown fruits, vegetables, herbs, and Alaska sourced honey, submit this completed application to your nearest participating agency found listed online at:

<http://health.alaska.gov/dpa/Pages/nutri/fmnp/fmnpseior.aspx> or by calling the State of Alaska at (907) 465-3100.

Applications received by the State of Alaska will not be processed.

Name: _____ Date of Birth: _____

Physical Address: _____

Mailing Address (if different): _____

City: _____ Zip code: _____ Phone Number: _____ Email: _____

How did you hear about the program? Check the one you have currently used.

☐ Word of Mouth

☐ Tablet

☐ Smart Phone

☐ Other, please describe _____

☐ Newsletter

Please Check all that apply to determine eligibility:

☐ I am 60 years old or older as of September 30, 2025

☐ I currently live in Alaska

The following are true (check all that apply):

☐ I am actively receiving benefits from the Commodity Supplemental Food Program

☐ My income is below 185% of the federal poverty level (more information on next page)

Do you consider yourself Hispanic/Latino? (circle one):

☐ Yes, I consider myself Hispanic/Latino

☐ No, I do not consider myself Hispanic/Latino

Please check all that apply to you:

☐ Asian

☐ White/Caucasian

☐ American Indian or Alaska Native

☐ Native Hawaiian or Other Pacific Islander

☐ Black or African American

This information may be shared with the USDA and is used to learn about who our program serves. It does not affect your SFMNP eligibility. If you choose not to answer the following two questions, staff will be required to make a visual determination on your behalf.

By signing this form, you certify that the information you provided on this form is complete and accurate to the best of your knowledge, you will not apply for or receive more than the individual maximum benefit of \$40 during the current year, and that you have read and agree to the following: I have been advised of my rights and obligations under the SFMNP. This certification form is being submitted in connection with the receipt of Federal assistance. Program officials may verify information on this form. I understand that intentionally making a false or misleading statement or intentionally misrepresenting, concealing, or withholding facts may result in paying the State agency, in cash, the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law. Standards for eligibility and participation in the SFMNP are the same for everyone. I understand that I may appeal any decision made by the local agency regarding my eligibility for the SFMNP. I may be added to a waitlist as benefits are issued on a first come, first serve basis.

Participant Signature _____

Date _____

Agency Use Only:

☐ Proxy form received

Benefits Issued: _____

Representative Initials: _____

Steps to access your electronic Senior Farmers' Market electronic food benefits:

Download the Healthy Together app



Scan with your phone

1. Scan the QR code or go to: <https://app.healthytogether.co>
2. Sign up for a Healthy Together account using your phone number or email.
3. Select "Alaska" from the list of regions.
4. From the list of available programs, select "AK Senior FMNP" to connect to the appropriate program.
5. Follow the instructions to verify your Senior account, be sure to use the email/phone number that you provided on your Senior FMNP application.
6. Once verified you'll have access to the AK Senior FMNP program to access your benefit, transaction history, view resources, and find farmers' markets and farm stands to visit.

WIC Farmers Market Electronic Food Benefits

Program information about how to access the electronic benefit.



State of Alaska
Department of Health



[Home](#) / [Services](#) / [WIC Farmers' Market Nutrition Program \(FMNP\)](#)

WIC Farmers' Market Nutrition Program

Provides WIC participants in participating communities with electronic food benefits for fresh Alaska-grown fruits and vegetables at farmers markets

[Overview](#) [Eligibility](#) [Resources](#) [Contacts](#)

Overview

The WIC Farmers' Market Nutrition Program (FMNP) provides \$45.00 of FMNP electronic food benefits for each eligible family member that can be exchanged for fresh Alaska-grown fruits, vegetables and fresh-cut herbs at participating farmers' markets, authorized farms, and roadside stands within Alaska.



Who qualifies?

This program is open to WIC participants in Anchorage, Eagle River, Fairbanks, Delta Junction, Homer, Kenai, Palmer, Wasilla, Kodiak, Juneau and Sitka.

 [Find a problem?](#)

Tips and Reminders

Talk to the farmers. They love talking about what they've grown and may have some great recipes to share with you.

Steps to access your Farmers' Market electronic food benefits:

Download the Healthy Together app



Scan with your phone

1. Scan the QR code or go to: <https://app.healthytogether.co>
2. Sign up for a Healthy Together account using your phone number or email.
3. Select "Alaska" from the list of regions.
4. From the list of available programs, select "AK Senior FMNP" or "AK WIC FMNP" to connect to the appropriate program.
5. Follow the instructions to verify your account, be sure to use the email/phone number that you provided on your FMNP application.
6. Once verified you'll have access to the AK FMNP program to access your benefit, transaction history, view resources, and find farmers' markets and farm stands to visit.