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Produce Prescription Fulfillment Through Community Food Access

A feasibility proposal

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1. Definition and Premise

Food justice, as this proposal uses the term, is the effective ability of people to choose healthy food. The definition is deliberate. What matters is not the availability of nutritious food in the abstract, but each person's real capability to select it. That capability has two conditions, and they fail independently.

The first condition is preference. People cannot choose what they are not aware of wanting or needing. Preference for fresh, healthy food is formed rather than assumed, and it is formed in trusted settings: at events, through relationships, through education and repeated exposure. This is Food Strong's function in the region. Its venues and programs, from the Care-A-Van to the Coit Road Farmers Market to school and church partners, exist to build the awareness and relationships through which people come to want what serves them.

The second condition is access. Preference without means changes nothing. Even where demand exists and is felt, financial and logistical barriers limit the ability to act on it: price, transportation, and availability at the times and places people actually are. A person can know exactly what they want and remain unable to choose it.

2. The Argument

The proposal's logic proceeds in five premises and a hypothesis.

Premise 1. Preference is formed in trusted community settings, and an implementing organization with community trust is the mechanism of its formation.

Premise 2. Preference alone does not produce choice. Financial and logistical barriers bind independently of demand, so a program that builds preference without removing barriers changes awareness but not outcomes.

Premise 3. Subsidy instruments relieve both conditions at once. Produce prescriptions, pantry distribution, SNAP, and incentive matching each place healthy food within reach at the moment of choice. But their effect is momentary by construction: the dollar is spent, the food is distributed, and the next funding cycle must purchase the same impact again. Nothing in the instrument itself causes supply to reorganize around the demand it reveals.

Premise 4. For the effect to become durable, the demand these programs create and reveal must induce a supply response, with production planned against it and capacity built to serve it, so that need is met dynamically rather than re-purchased each cycle.

Premise 5. Both sides of that exchange already exist. Farms in the region grow produce to sell, and program participants demand the produce those farms supply. What is missing between them is legibility. Neither side can see the other in structured form, and both adapt to the resulting uncertainty. Producers limit planting, diversification, and harvest scaling when sell-through is uncertain. Buyers avoid reliance on local supply when volumes and service are inconsistent. Handling and storage infrastructure stays underbuilt when throughput is irregular. The result is a stable but suboptimal equilibrium in which local supply remains underutilized while the demand for it goes unmet.

Hypothesis. If supply and demand are made transparent to one another, certainty of sales rises, and certainty initiates a reinforcing cycle. Lower downside risk makes producing near capacity rational. Lower risk supports reinvestment in capacity and reliability. Improved reliability improves delivered economics. Better economics and reliability sustain more consistent purchasing, which returns as higher certainty.

The observable signature of this cycle is a growth trend of use, alongside improving farm margins and stable or improving delivered costs. The pilot exists to detect that signature or to establish its absence.

Transparency is provided through the MiCyte network: hosted nodes recording choice-based selection and prescription redemption on the demand side, and farm records, planning, and expected-harvest representation on the supply side.

3. The Assumption This Rests On

The argument depends on one assumption that should be stated openly rather than buried, because the pilot is partly designed to test it.

The assumption is that regional farms are an underutilized asset rather than a fully utilized one. If farms are already producing at their practical ceiling, then better demand information improves allocation without expanding supply, and the reinforcing cycle has nothing to reinforce.

Two consequences follow if the assumption holds. The first is realization through certainty. Underutilization driven by planning risk is recoverable, because the constraint is a decision made under uncertainty rather than a physical limit. When sell-through becomes predictable, capacity that already exists gets used, and the reinvestment it funds raises the ceiling further. The second is channel advantage through proximity. Delivered cost for perishable goods is dominated by components that scale with distance and time: transport, refrigeration dependence, spoilage exposure, and handoff complexity. Proximity compresses those components, which is where a local channel can compete on cost rather than on preference.

The assumption has bounds, and they are real. The reinforcing cycle plateaus against land and agronomic limits, labor availability, the adjacency radius beyond which delivered overhead erases the local advantage, seasonal alignment between what a region grows and when demand occurs, and handling capacity. The pilot's supply analysis is designed to locate those bounds for this region rather than to assume they are distant.

4. Method and Data

The pilot instruments both sides of the exchange and analyzes the gap between them.

Demand. Every participant selection and prescription redemption at every program event is recorded as structured data: item, quantity, transaction

value, site, date, and mechanism. Prescription redemptions and free selections feed one demand record, which makes a further measure available: the overlap between what participants choose and what clinicians recommend, measured at the category level. Year one uses published Community Health Needs Assessment data for any population-level clinical context. No patient-level Clinic data is requested, which keeps the pilot outside data use agreements and IRB review.

Supply. A farm operational baseline is constructed for the surrounding region: what each farm grows, at what prices it sells, on what acreage, with what infrastructure, and at what current output. Farms already maintaining records on the network are represented through their own records. Farms that are not are represented through structured interviews against their farm plans, captured as static accounts, so that the supply picture reflects the region's actual capacity rather than its early adopters.

Analysis. Five steps, performed in the pilot's final quarter.

1. **Realized-capacity estimation.** From the baseline, an estimate of what each farm could output if fully realized, given its size, crops, and the infrastructure gap between its current and attainable operation.
2. **Gap analysis.** Recorded demand set against current and realizable supply, by item and by season, identifying where the region can meet its own demand and where it cannot.
3. **Delivered-cost comparison.** Local coordinated sourcing against current sourcing on transport, handling, storage, and shrink, identifying which cost components proximity and coordination actually compress.
4. **Density simulation.** The participation level at which ordinary transactions, through SNAP redemption, incentive matching, and market sales, would carry the exchange without grant support.
5. **Subsidy horizon estimation.** From prices and quantities on both sides, the finite period over which funded or supplemented pricing must be sustained while farm planning adjusts to legible demand, at the end of which margins improve for buyer and seller without further subsidy.

The subsidy horizon is the analysis's central product. It converts the question every food-access funder faces, whether this must be funded again, into a better one: how long must it be funded, and toward what end state. A program with a measured horizon is an investment with a completion condition rather than a recurring expense.

5. Program Structure

The pilot has three roles, kept deliberately clean.

Cleveland Clinic is the clinical anchor: the source of prescriptions and clinician participation, the applicant or sponsor for the funding avenues that require Clinic initiation, and the recipient of quarterly reporting and the final feasibility report.

Food Strong is the implementation setting. Through the Care-A-Van and its established venues, including the Coit Road Farmers Market and school and church partners, Food Strong is where fulfillment physically happens and where community trust already exists. Food Strong operates distribution, holds the participant relationships, and is the party the Clinic funds or hires.

Fruitful Network Development is Food Strong's technology services provider under a standing agreement, operating the live inventory, point of sale, and payment systems Food Strong runs on today. For the pilot, Food Strong contracts FND for the program's defined data responsibilities: collection, farm interviews, evaluation, simulation, and the month-twelve assessment. FND is engaged by Food Strong as a vendor line within the program budget, not funded directly by the Clinic.

The sentence that summarizes the structure: the Clinic engages Food Strong, in a state of capability provided by FND.

One commitment is fixed across every version of this program. Food access never depends on any data system. Events proceed and participants are served regardless of the state of any evaluation infrastructure, and no participant's access is conditioned on data participation beyond what the funder requires. The evaluation is the part of this program that is unproven, and nothing unproven should stand between a person and food.

6. Implementation: Two Configurations, Run as Pilot Arms

How prescription and fulfillment come together is the pilot's central design question, and we propose answering it by measurement rather than assumption.

Configuration A: fulfillment travels to prescribing. Food Strong is engaged to appear at clinical settings or Clinic-side events and fulfill produce prescriptions on site. The prescribing context is fixed and the food comes to it. This arm tests whether redemption improves when fulfillment is immediate, at the moment and place of clinical contact. Its requirements are scheduling against clinical settings, transport and cold chain, and a defined prescription instrument that the point of sale can record redemption against.

Configuration B: prescribing travels to fulfillment. Clinicians or prescribers are hosted at Care-A-Van events, where Food Strong already distributes and where health screenings are already integrated. The community setting is fixed and the clinical function comes to it. This arm tests whether clinical engagement improves inside a trusted community setting rather than a clinical one.

Running a portion of events in each configuration lets redemption rates, participation, and cost per fulfilled prescription determine which model a phase-two program should scale. The pilot's largest unknown becomes its study design.

7. Outcomes and Deliverables

Reported quarterly, with a final report at month twelve.

Participation and redemption. Unique participants, repeat rate, and prescription redemption rate by configuration and mechanism.

Demand. Selection volume and transaction value by item, site, and season, with unmet demand recorded as the planting signal for the following season.

Overlap. Correspondence between participant selections and clinician dietary recommendations, with divergence identified as the target for education rather than treated as noncompliance.

Supply. Farms onboarded and represented, current and realizable capacity by item and season, and the capacity gap between them.

Cost. Cost per fulfilled prescription, per distributed pound, and per participant over time, including the share of each program dollar recovered through participant transactions.

Final deliverable. A month-twelve feasibility report stating whether the two-sided window exists, the participation density at which the exchange self-sustains, the estimated subsidy horizon, and a recommendation on which configuration and funding structure phase two should carry forward.

8. Funding Avenues and Sequencing

The avenues are complementary, and the proposed sequence lets each step de-risk the next. The pilot also extends a direction the Clinic has already set: its Nourish food pharmacies established food prescribing within the Clinic's

own walls, and this program carries that model into the community settings where preference is formed.

Now. A Community Sponsorship of an upcoming Care-A-Van event puts the partnership into practice at low stakes, with four to six weeks of lead time.

August to October. The community commitment application funds the program's operations through Food Strong, including the engagement of the Care-A-Van and the staffing both configurations require, establishing the operating relationship every later step builds on.

Fall cycle. A Caregiver Catalyst application from your team, targeting the January 2027 round, funds the evaluation scope: the choice-based access mechanisms, the data responsibilities, and the feasibility deliverable. Drafts of the application and budget exist.

Next window. A Community Partnership application, sponsored from your side, establishes the enduring relationship independent of any single program year.

As the record accrues. With a funded pilot reporting inside the Clinic's own systems, Food Strong becomes a demonstrated fit for the hunger commitment's stated purpose of expanding proven programs and building lasting capacity.

9. Questions for Your Guidance

Four points would let us finalize drafts against the October deadline.

1. For the August application: the program's formal name and portal, whether it must be initiated or sponsored from the Clinic side, and whether awards can fund contracted services within a community partner's budget.
 2. Whether prescribers or clinicians can participate at community events in year one, or whether Configuration B belongs to a later phase.
 3. How a produce prescription should be defined administratively for this pilot, meaning who issues it, what it specifies, and how redemption is evidenced, so that recording can be configured to your team's standard from the first event.
 4. Whether an August award and a Catalyst award can operate within the same program year.
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10. Next Steps

With your answers to the questions above, we will finalize the community commitment application against the October deadline, finalize the Catalyst application and budget for the fall cycle, and send the sponsorship invitation for the next available Care-A-Van event.

Food Strong's operating systems are in place today, so the pilot can begin recording from its first funded event.

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