# FOOD IS MEDICINE REPLICATION GUIDE

## For Health Centers

MIGRANT HEALTH
NCFH
National Center for Farmworker Health, Inc.

The National Center for Farmworker Health (NCFH) is a national nonprofit organization located in Buda, Texas. Our mission is to improve the health of farmworker families. NCFH contributes to this mission through community-specific resources and technical assistance, governance development and training, program management, staff development and training, and health education resources and programs. Learn more about the work of NCFH at our website: ncfh.org, which includes our Chronic Disease Resource Hub and Health-Related Needs Hub.

In addition to the sources cited throughout the document, we appreciate the input of countless organizations and individuals who shared their expertise in the field of Food is Medicine programs and health centers.

If you have questions, comments, or additions to this guide, please email info@ncfh.org.

# TABLE OF CONTENTS

# *INTRODUCTION*

A Food is Medicine program offers a promising solution to the compounding issues of food insecurity, nutrition, rising health care costs, and poor health. These programs facilitate the distribution of produce and other healthy food staples that can help to manage, treat, and prevent chronic conditions, such as prediabetes, diabetes, and hypertension, as part of a health care system intervention. Key types include medically tailored meals, medically tailored groceries, and produce prescriptions.

There are many health conditions that can be directly associated with food insecurity.

## HEALTH CONDITIONS ASSOCIATED WITH FOOD INSECURITY

| Children | Non-Older Adults | Older Adults |
|---|---|---|
| Risks of some congenital disorders | Decreased nutrient intake | Decreased nutrient intake |
| Risk of hospitalization | Depression | Being in fair or poor health |
| Anemia | Diabetes | Depression |
| Lower nutrient intakes | Hyperlipidemia | Having limitation in activities of daily living |
| Cognitive problems | Hypertension | |
| Aggression | Poor sleep | |
| Anxiety | Being in fair or poor health | |
| Asthma | Worse oral health | |
| Poor oral health | | |
| Depression | | |
| Suicidal ideation | | |
| Behavioral problems | | |
| Being in fair or poor health | | |

Source: https://chlpi.org/wp-content/uploads/2013/12/Produce-RX-March-2021.pdf

The good news is that food insecurity is a modifiable risk for poor health conditions and can be addressed in several ways. Food is Medicine programs are one of them, going beyond food insecurity to provide adequate nutrition as well.

Migratory and Seasonal Agricultural Workers (MSAWs) living with chronic health conditions often face challenges in maintaining a healthy diet. One of the many significant barriers to health for MSAWs is indeed food insecurity, due to the connection between poor diet, stress, and chronic disease incidence[1]. MSAWs may be particularly vulnerable to food insecurity and the chronic conditions associated with it; according to a 2004 study out of North Carolina, 47% of the MSAWs surveyed were classified as experiencing food insecurity, with 5% experiencing severe food insecurity[2]. Many MSAWs live far from sources of fresh, unprocessed food and have limited access to health care, have no way to seek them out, and live in conditions that make disease management behaviors much more difficult.

To support the Special Medically Underserved Population (SMUP), including MSAWs, we need to think beyond the health care system. Food is Medicine programs offer a promising model that links the community, food sources, and the health care system, working together to promote behavior change, provide nutrition education and increase food literacy, connect patients to local resources, and, in some cases, provide financial incentives. Food is Medicine programs show promise as a model for integrating community and health care resources to support the health of MSAW and other SMUP patients.

NCFH recently detailed in "Making a Case: Food is Medicine in Primary Care Settings" that for health centers, the mission and effectiveness of Food is Medicine can also be aligned with margins. We can identify the following benefits for health centers: reduced care costs for high-risk patients, improved quality metrics, enhanced patient engagement and satisfaction, staff enthusiasm and workflow improvements, payer support, and, beyond health, the ripple effect created on local economies.

As previously explained, there is a documented relationship between food insecurity and chronic disease incidence. The growing body of studies demonstrates the effectiveness of Food is Medicine programs in managing these diseases. The Food is Medicine Research Action Plan from the Aspen Institute celebrates and compiles all analyses to date as this field continues to expand rapidly. Early findings have shown improvements in blood pressure, reductions in body mass index (BMI), reduced A1C levels in those with diabetes, decreased food insecurity, decreased symptoms of depression, support adherence to care plans, and improved relationships between patients and providers[3].

In interviews conducted with staff at Pasadena Health Center, located in Houston, TX, one of the greatest improvements they noted was the increase in trust between the patient and provider. We obtained similar feedback from a health center in Tennessee, which highlighted increased patient engagement and improved health outcomes since adding the food pantry, a win for both patients and staff. Patients were motivated by seeing improvements in their health, and staff were motivated by seeing those improvements. Additionally, with improved health outcomes come more opportunities - incentive payments and expanded partnership opportunities, also resulting in national recognition of quality services by the Health Resource and Service Administration (HRSA). Food is Medicine programs can allow patients to see a health center as a trusted partner in improving their health and providing support.

As more health care systems move to a value-based model, health centers have an increased sense of urgency to improve overall health and reduce costs. Food is Medicine programs provide a cost-effective way to address health-related needs and the diseases they aggravate. One study modeled that giving Medicare and Medicaid participants a 30% subsidy to reduce the cost of produce nationally over a lifetime would result in $39.7 billion in savings in health care costs[4]. In another recent study, a preliminary analysis showed that each additional quality-adjusted life year (QALY) gained with Food is Medicine costs about $1,300. This is highly cost-effective, given that a typical willingness to-pay threshold per QALY is assumed to be $50,000 to $100,000[5].

Another good example is the San Diego Farmer's Food as Medicine Services, a partnership between UC San Diego Center for Community Health under UC San Diego Altman Clinical and Translational Research Institute (ACTRI), San Diego County Health and Human Services Agency, San Diego farmers, grocery stores, and community-based organizations across San Diego County. San Diego farmers provided 33,000 farm-fresh produce boxes to more than 2,250 households across the county as part of the ¡Más Fresco! Plus program. They estimate the program's cost per beneficiary for locally sourced produce at $36 per home-delivered produce box, totaling $864 over 6 months if one box is delivered per week (cost estimates will vary by provider). This cost is less than 1/5 of that of a 1-day hospital stay.[6] What is the cost of the health center to treat chronic disease patients?

As a health center, you can collaborate with programs such as the ¡Más Fresco! Plus program or start your own! The National Center for Farmworker Health has developed this Food is Medicine Replication Guide to help you implement your own Food is Medicine program and determine which intervention model best fits your health center, community, and patients.

# STEP 1: HEALTH CENTER READINESS ASSESSMENT

**Are you prepared to implement a Food is Medicine program at your health center?**

To find out how ready your health center is, fill out the Health Center Food is Medicine Readiness Assessment (Appendix A). This tool provides concrete examples of the values and practices that can develop a successful program like Food is Medicine. After filling it out and scoring it, the results will show which elements your health center is well prepared to handle, and which still need improvement before initiating your program.

How you answer the assessment will guide the next steps you take towards developing your Food is Medicine program. If you answered "yes" to most of the assessment questions, your health center is likely in a good position to start a Food is Medicine program. As you begin to gather your team and develop an action plan, notice which questions you may have answered with "somewhat" or "no." The questions you answered as "no" should be resolved before beginning your program. For the questions you answered "somewhat," make these the top priority areas to improve before beginning the program, or address in the early days of your program implementation.

If you answered mostly "somewhat", your health center may have many of the elements necessary to start a Food is Medicine program but still needs to address a few priority areas. With some effort, you can increase the frequency and effectiveness of these practices in your health center procedures. Address the questions you answered "no" to, then take the assessment again to see where you are.

If you answered mostly "no", your health center may not be ready to start a Food is Medicine program, but you have identified the key areas to work on first to work towards this goal.

# STEP 2: CONDUCT ASSET MAPPING

If you have determined that your health center is ready for a Food is Medicine program, you can move on to working on an asset map

### What is Community Asset Mapping?

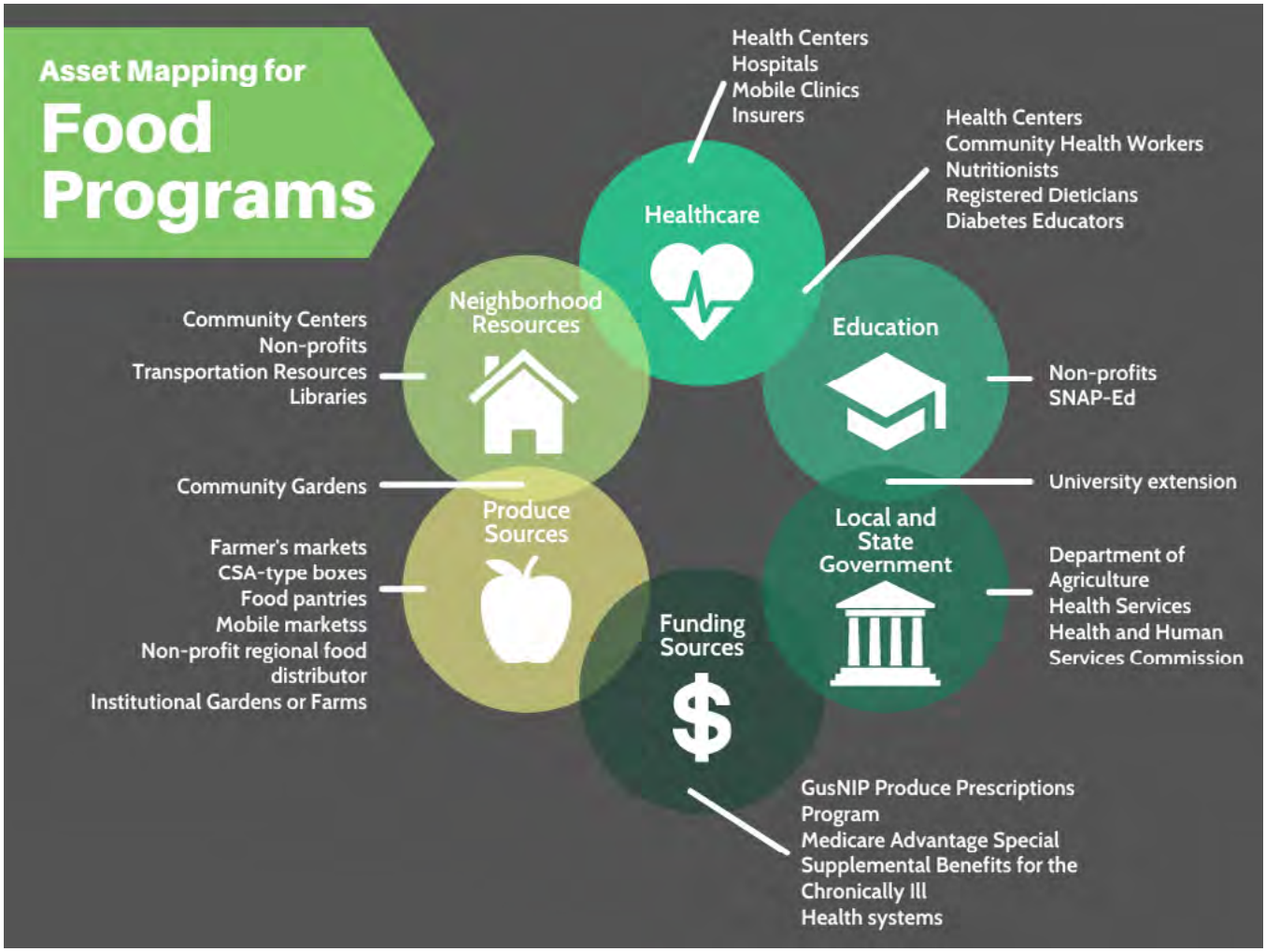
As with any program, it is important to determine what resources are available in your community and within your health center setting, and how you can connect with them to achieve your program goals. The following categories should be considered when creating a community asset map:

- **Healthcare:** Consider potential partnerships with organizations in the health care industry, such as rural hospitals, mobile clinic sites, general and specialty providers, insurers, and pharmacies. Working together can reduce health care utilization among uncontrolled chronic disease patients.
- **Education:** Is your health center providing patient education for nutrition and chronic diseases, or are there other organizations doing the same in your community? Consider reaching out to local universities or colleges, extension programs, non-profit organizations, Supplemental Nutrition Assistance Program (SNAP)-Ed services, Area Agencies on Aging (AAAs), Area Health Education Centers (AHECs), Community Health Worker groups, and faith-based organizations. Also, make sure that you are using community-tailored educational approaches that may further strengthen Food is Medicine programs and help address persistent health-related needs in nutrition knowledge and food-related skills among Special Medically Underserved Population (SMUP).
- **Local and State Government:** The U.S. Department of Agriculture (USDA) has a nutrition division that works closely with food banks and other food programs. Also, on the state level, they have area representatives who can help you find some resources and make local connections. At the local level, work with your city council, as there is a growing focus on developing sustainable, fair, and healthy food systems that need to be connected to communities, and health centers can serve as the connector.
- **Funding Sources:** There are multiple sources of funds available at the local and federal levels, as well as private philanthropic sources, for programs that are innovative and apply evidence-based and collaborative patient interventions. Talk to your liaisons and counterparts to discuss potential funding opportunities. The growing recognition of Food is Medicine programs as an effective intervention is also reflected in the amount of available funding, making it easier to find support for them.

# STEP 2: CONDUCT ASSET MAPPING (CONTINUED)

- **Produce Sources:** Go directly to the source. If you are in a rural area and serve MSAWs, look for local agricultural growers, grower associations, and employers that could directly support you with in-kind donations of produce/food. Also, reach out to your area food banks, food pantries, farmers' markets/stands, and mobile food options. For example, studies have shown that including regenerative small-scale local farmers in your food procurement can increase high-quality nutrient intake and stimulate the local economy.
- **Neighborhood Resources:** Need a place to hold the distribution? Identify places in your community where MSAWs already gather, such as churches, community recreation centers, libraries, flea markets, etc. Also, seek support from partners who can address access challenges for your participants, such as transportation resources and volunteer nonprofits.
- **Technology Resources:** Could new technology, such as artificial intelligence (AI), digital platforms, and software applications, be assets used to leverage the needs of the community that are not being served, or fill the gaps necessary for the program to run more efficiently? Key technology applications in Food is Medicine programs include virtual food pharmacies and digital ordering, electronic health record (EHR) integration and tracking, shop-by-diet technologies, and precision nutrition. These tools can precisely identify foods that align with special diets, multiple chronic conditions, community-specific needs, and lifestyle preferences. For rural areas, where resources are limited, this can be a good way to bridge the gap between fresh food and its health outcomes and to modernize Food is Medicine programs.

Below is an example of asset mapping done for Food is Medicine programs. Notice that some community assets and organizations will fall between sectors.




You can find an Asset Mapping Template (Appendix B) for you to complete at the end of this guide.

## How to Identify Potential Partners:

The best partnerships are the ones you already have with organizations in your community. However, many health centers do not yet have established relationships with organizations that can provide the produce needed for a Food is Medicine program. You may need to conduct an analysis to find organizations that can fulfill this role. At the base of any Food is Medicine program is the relationship between the health care organization and an organization that supplies the produce. Additional collaborations will increase the program's efficacy and opportunities and can be added as the program grows. The following are descriptions of the types of partnerships you may want to consider and develop as part of your program implementation:

*Voucher-based programs:* These programs are a partnership between a health center and a produce partner. The health center identifies the patients who need food assistance, provides a voucher or coupon, and refers them to the produce partner who distributes the food at their site. Patients attend the produce distribution and "cash in" their vouchers or coupons for medically tailored groceries/food packages, which include fresh produce and other healthy staples. Benefits of this program may include increased participant choice and autonomy over food selection, as well as more sites for redeeming vouchers. On the other hand, participants may encounter challenges traveling to the site locations, and vendors may require more training and technical assistance. Examples of produce partners include:

- Farmer's markets
- Grocery stores
- Small farmers
- Farmstands
- Food hubs
- Native trading posts

*Food delivery programs:* These programs are partnerships between a health center and a produce partner that directly deliver produce to an identified location. The health center identifies the patients and refers them to the produce partner. The partner delivers produce to a residence or centralized location, which could include the health center itself. The patients receive their produce or other healthy food staples at that specified location. This may take the form of medically tailored meals, medically tailored groceries, or produce prescription formats. Benefits of this program may include increased patient participation, since no transportation is required, especially if deliveries are made to participants' homes or places they frequent. A potential downside of this type of program is less participant choice in their food delivery.

Examples of food delivery produce partners include:

- CSA (community supported agriculture) or produce box distribution
- Food prep delivery companies
- Mobile markets
- Mobile pantries

*Referral programs:* These programs are a good option for health centers and organizations with limited resources. The health center identifies patients, connects them to an existing source of free produce, and integrates the referral process into its workflow to the greatest extent possible. The health center may refer to a local or national service/program that serves its area. The main benefits of this program are reduced funding and coordination needs for the health center. However, this type of program may not expand community resources to alleviate health-related needs, and may be limited in scope, duration, or patient eligibility.

Examples of referral programs include:

- Food Pantries
- Double up SNAP
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Cash Value Benefit (CVB)

**Create Your Own Asset Mapping:**

You can use the Asset Mapping Template (Appendix B) to identify organizations or programs like the ones listed above that your health center could collaborate with. Start with organizations you are already connected with. If you need ideas, brainstorm with your team and do a quick online search of your community resources. When you complete the Asset Map, you will see the potential connections in your community that can make your Food is Medicine program a reality and gain a clear picture of all the resources available to support its implementation.

# *STEP 3: ASSESS PARTNER READINESS*

Now that you have identified potential partners, you will need to determine if these organizations or programs have the capacity to build a solid program with your health center. It is important to meet with your partners and evaluate the readiness of their organization to set clear expectations and identify the areas that need the most attention to getting the program off the ground. There are three Readiness Assessments based on the type of program partner you plan to work with. If you have multiple program models at your disposal, assess the readiness of each potential partner.

- If you would like to initiate a Voucher-Based program, or have identified an organization to partner with that already hosts this type of program, use the **Voucher Programs Readiness Assessment** (Appendix C).
- If you would like to host a food distribution program or have identified an existing food distribution program to integrate with, use the **Food Delivery Programs Readiness Assessment** (Appendix D).
- If you would like to refer patients to an already-existing program, such as SNAP, WIC, or a food bank, use the **Referral Programs Readiness Assessment** (Appendix E).

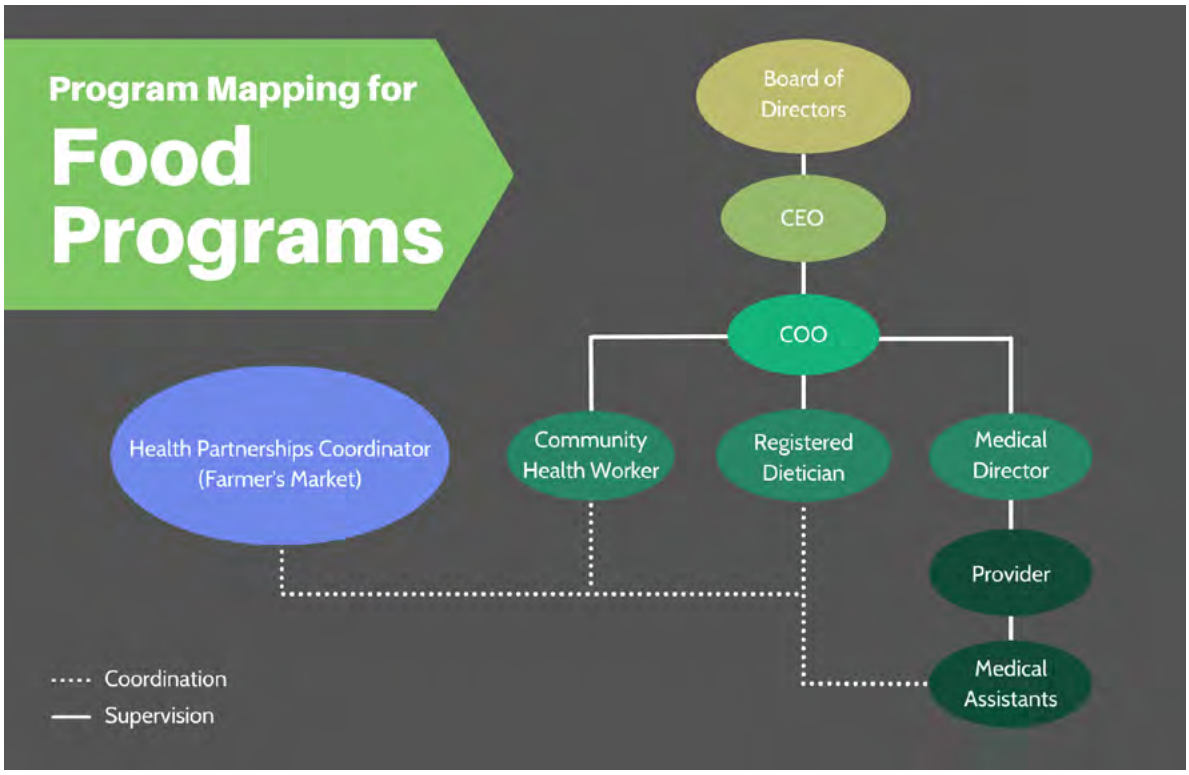
Once you have completed one or more of these assessments, you should have a clearer picture of your partner organization's readiness to meet the challenges of establishing a Food is Medicine program. If you evaluated multiple partners, perhaps choose the partner organization that answered mostly "yes." If you have multiple program types (*Voucher, Food Delivery, or Referral*) available, this assessment may help you select a program type based on the organization's readiness.

If the partner organization answered mostly yes, continue reading to develop your collaborative relationship. If your partner organization answered mostly no, continue reading to learn more about how to prepare for this type of program implementation. You may not be ready to start a Food is Medicine program just yet, but you can begin gathering the tools necessary to move these "no" answers to "yes" and reevaluate your readiness at a later date.

# STEP 4: DEVELOP PARTNERSHIPS

Once you select your partner organization to supply the food produce, you can begin to build your collaboration and invite other organizations to complement your program with more resources, such as nutrition education, transportation, additional food staples, and household necessities, or social support networks.

**Program Mapping**




As you build your team, creating a program map can be a useful tool in determining your team's roles. You can start with your own organization's map, then add members of partner organizations. In this example, we mapped areas where partners may need supervision and coordination.

As you may notice, leadership roles are included in this organization program diagram. Leadership support is essential to the sustainability of any health center program. Programs should align with the organization's mission and vision, and should have leadership buy-in. Once that is defined and formally obtained through a letter of support, Memorandum of Understanding (MOU), or similar agreement, you can move on to determining who will coordinate the actual program delivery.

We suggest both organizations, the health center and the partner, complete a program map to get a full picture of all the players that need to be involved to get the program off the ground. Come together as a team to create your complementary program maps, and delegate responsibilities to each partner as you go. Consider listing the tasks in the Action Planning section (found on step 6) under the role of each person in your Program Map.

In the process of mapping your program, you may find the need for new collaborations across teams and organizations. We encourage you to think outside the box and be creative about how you delegate tasks. For example, the nutrition education component can be delivered by nutritionists, care coordinators, Community Health Workers (CHWs), patient navigators, and others who already provide direct education to patients. Reach out to physicians, include them in your implementation plan, and consider training them to support your program. Health centers have a natural inclination toward team-based approaches, support patients with a whole-body approach, and are therefore well-equipped to create a strong program. Health center staff are your biggest champions, as they refer patients who meet the Food is Medicine program criteria. Also, look for collaborations with organizations that have expertise in working with your community characteristics and profile. An example is NCFH, which has worked with health center outreach staff, CHWs, and patient support services to deliver community-focused and appropriate health education to MSAWs' communities.

### Successful Partner Relationships

Clearly designating program roles and responsibilities is a good first step in establishing a successful partnership.

Another important step is ensuring quality communication between program partners. Consider holding consistent meetings between partners to share successes and challenges for both the program and patients, and to set mutual goals. Some health centers have found success with more frequent meetings at the beginning of their program (for example, biweekly) and then moving to a less frequent interval (such as monthly).

Build trust in your partnership by getting to know your program partners, their organizations, and communication styles. The most successful partnerships are those in which both partners are receiving a mutual benefit.

# STEP 5: EXPLORE ADDITIONAL FUNDING

Now that you have decided to initiate a Food is Medicine program, assessed your strengths, and developed partnerships, the next step is to ensure your program is financially sustainable. Funding can pose one of the greatest challenges to initiating a Food is Medicine program. Many health centers do not have the funds to create one themselves and think that the program is out of reach. However, we highlight below some of the many options health centers have for funding a Food is Medicine program. Fill in funding examples from your asset map or consider the examples below. Consider reaching out to these potential funding partners, as a well-funded program can last longer and have a much greater impact than a simple referral program.

| *Healthcare Funding* | *Grant Funding* | *Private Funding* | *State and Local Funding* |
|---|---|---|---|
| Medicare Advantage Special Supplemental Benefits for the Chronically Ill | Gus Schumacher Nutrition Incentive Program | Insurance companies such as Elevance Health | Community Development Block Grant |
| Medicaid Managed Care | Feeding America to Grant Funding | National foundations or civic groups (like Rotary, etc.) operating locally | SNAP-ED Policy, Systems, and Environmental Work |
| Section 1115 Demonstration Waivers | | Faith based charity organizations such as Episcopal Health Foundation | Double-Up SNAP |
| | | Companies with philanthropic arms such as Shipt | |

Even for health centers that do not secure funding, a Food is Medicine program can still have potential. Health centers may elect to refer patients to a program or series of programs that already have the capacity to provide free, healthy food to participants. Or self-fund a pilot program in which the health center can provide data and results demonstrating that Food is Medicine programs are cost-saving interventions for at-risk patients.

Optimally, health centers should strive to make their Food is Medicine programs sustainable. As you start, you will need financial support from any source you can secure. Think creatively and seek opportunities within the Food is Medicine movement. Many new ventures and funding partners are entering the arena as this topic gains popularity for its cost-saving potential, making it a worthwhile investment.

# *STEP 6: ACTION PLANNING*

Now is the time to meet with your program partner and work out the details of your program.

We have outlined the essential functions of a Food is Medicine program that must be addressed before launching. In the following pages, you will find an action planning checklist for each of the three main program types: *Voucher Programs*, *Food Delivery Programs*, and *Referral Programs*. Each table lists tasks each program partner may be responsible for, as well as activities that need to be done together. Decide which staff will be responsible for each item at the respective organization and write out how each item should operate in your program. This will become your program policy and can be used to train new staff on how your program operates.

## *Action Plan: Voucher Program*

| Health Center | Produce Partner |
|---|---|
| ☐ Decide on a referral system based on patient responses to screener questions and team members involved.<br>☐ Document and track your referrals.<br>☐ Establish a system for distributing vouchers to patients.<br>☐ Distribute a calendar of places and times where patients can redeem their vouchers.<br>☐ Follow up with patients at their next appointment to see how they are finding the program and to gather disease measures that may show if health outcomes have improved.<br>☐ Track and communicate patient outcomes. | ☐ Provide health center a calendar of places and times where patients can redeem their vouchers.<br>☐ Provide patients a variety of fresh, seasonal produce.<br>☐ Provide patients with a variety produce that represents their preferences.<br>☐ Train staff to accept and process produce prescription vouchers. |

**Done in Coordination**

- ☐ Create a nutrition policy to outline the items that can be redeemed through the Voucher Program.
- ☐ Decide the value of your voucher and how many vouchers each patient or household will receive.
- ☐ Decide on how you will receive, track, and document the circulation of fruit and vegetable prescription vouchers, or decide on an electronic voucher system.
- ☐ Provide nutrition education to patients.
- ☐ Decide on when patients "graduate" from the program (based on health outcomes, food insecurity, etc.).
- ☐ Develop baseline and post-intervention participant surveys to measure program effectiveness.
- ☐ Complete any funding requirements or documentation.
- ☐ Consider gathering participant feedback on the program: ease of following the program, room for improvements, quality of produce, quality of nutrition education.

## *Action Plan: Food Delivery Program*

| Health Center | Produce Partner |
|---|---|
| ☐ Decide on a referral system based on patient responses to screener questions and team members involved.<br>☐ Document and track your referrals.<br>☐ Distribute a calendar of times where patients can pick up their food prescription.<br>☐ If delivering to patients' homes, confirm home address during enrollment.<br>☐ Follow up with patients at their next appointment to see how they are finding the program and to gather disease measures that may show if health outcomes have improved.<br>☐ Track and communicate patient outcomes. | ☐ Provide the health center with a calendar of places and times where patients can pick up their food prescription or provide schedule for patient home deliveries.<br>☐ Deliver food prescriptions regularly.<br>☐ Provide patients a variety of fresh, seasonal produce.<br>☐ Provide patients a variety of produce that represent their preferences. |

**Done in Coordination**

- ☐ Create a nutrition policy to outline the items that can be distributed at the Delivery Program.
- ☐ Decide on the quantity of food each patient or household will receive in their food delivery.
- ☐ Collect patient feedback on delivery site options available, including at home or a centralized location.
- ☐ Receive, track, and document the pounds of food or produce distributed.
- ☐ Provide nutrition education to patients.
- ☐ Decide on when patients "graduate" from the program (based on health outcomes, food insecurity, etc.).
- ☐ Develop baseline and post-intervention participant surveys to measure program effectiveness.
- ☐ Complete any funding requirements or documentation.
- ☐ Consider gathering participant feedback on the program: ease of following the program, room for improvements, quality of produce, quality of nutrition education.

## *Action Plan: Referral Program*

| Health Center | Produce Partner |
|---|---|
| ☐ Decide on a referral system based on patient responses to screener questions and team members involved.<br>☐ Document and track your referrals.<br>☐ Follow up with patients at their next appointment to see how they are finding the program and to gather disease measures that may show if health outcomes have improved.<br>☐ Track and communicate patient outcomes.<br>☐ Decide on when patients "graduate" from the program (based on health outcomes, food insecurity, etc.). | ☐ Provide the health center with a calendar of places and times where patients can pick up their food prescription.<br>☐ Provide patients a variety of fresh, seasonal produce.<br>☐ Provide patients a variety of culturally relevant produce. |

**Done in Coordination**

- ☐ Communicate program outcomes such as pounds of food distributed and patient outcomes.
- ☐ Provide nutrition education to patients.
- ☐ Develop baseline and post-intervention participant surveys to measure program effectiveness.
- ☐ Consider gathering participant feedback on the program: ease of following the program, room for improvements, quality of produce, quality of nutrition education.

The first step in the Food is Medicine program is selecting which patients will be eligible to receive this valuable benefit. Qualifications for referral to a Food is Medicine program usually include a combination of:

- Food & Nutrition Security
- Diagnosis of chronic disease

### Food Insecurity Screening

In order to identify patients experiencing food insecurity, a screening process is necessary. Health centers should already be screening for health-related needs, and food insecurity is just one of many issues that may impact patients.

Here are three health-related needs screening tools your health center may already be familiar with and using to screen patients:

- *The PRAPARE Tool* (Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences) allows health centers and their community partners to learn about their patients, leverage data, and improve health equity outcomes.
    - As a 21-question comprehensive health-related needs screener, this tool is certainly longer than a simple 2-question food insecurity screener but will give a much more holistic view into patients' strengths and challenges, as well as present a clearer story told through data.
    - Endorsed by the National Association for Community Health Centers (NACHC)
    - Available in 25 languages plus an adapted version for Native American populations.
- *USDA Food Security Survey Tools* offer a variety of survey lengths to choose from, including a 6-Item Short Form Survey, a 10-question US Adult Food Security Survey, and an 18-question US Household Food Security Survey, with advantages and limitations to each.
    - The 6-question Short Form Survey provides the least possible participant burden, and evidence shows it can identify households that are food-insecure and experiencing very low food security. However, it is somewhat less reliable than the 18-item survey and does not identify the conditions of children in the household.
    - The 10-question US Adult Food Security Survey provides less participant burden than the 18-question form and makes food security statistics between households of different compositions more easily comparable.
    - The 18-question US Household Food Security Survey offers the most reliable data of the USDA tools, and most participants in the general population only need to answer 3 questions. Additional questions are included if there are children in the household. Available in English, Spanish, and Chinese.

- The *Hunger Vital Sign™* is a simple two-question, validated screener and is endorsed by the American Hospital Association, the American Academy of Pediatrics, and Feeding America.

  This screener consists of the following two questions:

  1. Within the past 12 months, we worried whether our food would run out before we had money to buy more.
  2. Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.

  Patients may respond with often true, sometimes true, or never true. Patients who answer either question with often true or sometimes true are considered food insecure.

  We find that this screener is both reliable and brief enough to meet most health centers' needs, although partners have identified room for elaboration, especially when it comes to rural settings, where patients may have the money to buy more food but lack transportation or other forms of access.

  The screener may be conducted by physicians, medical assistants, or nurses. We suggest the Hunger Vital Sign™ screener becomes a regular part of your patient intake to capture as many food insecure patients as possible.

  In addition to these health-related needs screening tools, health centers can also go deeper by adding questions to further explore nutrition security. Often, patients have access to food, but the options available to them are not the healthiest. A good follow-up question to ask to assess nutrition security might be: "I worried that the food I ate would not support my health and well-being."

### Diagnosis of Chronic Disease

Most Food is Medicine programs require a diagnosis of a chronic disease, since these interventions are specifically designed to relieve and improve diet-related diseases. Some of the chronic diseases you may choose to trigger a referral may include:

- Diabetes or prediabetes
- Hypertension
- Heart disease

Other programs recognize the risk that food insecurity and poor nutrition pose for developing a chronic illness and choose to take a more preventive approach. You may choose to offer the Food is Medicine program as an incentive for participation in a chronic disease prevention program. This model addresses the systematic challenges faced by program participants and complements the information they will receive through a prevention program.

Choose the criteria for referrals that fit your program's goals best and be sure to integrate these screenings into each visit. Integrating this process into your Electronic Health Record (EHR) will also help to streamline the process and measure program outcomes.

After a patient receives their screening and a referral is triggered, you will need to let them know that they qualify for your program. This can be done by either the physician or a member of the care team, such as a physician's assistant, care coordinator, Community Health Worker (CHW), or nutritionist. Whomever you choose, make sure this person is well-trained on explaining the details of the program and what the patient can expect.

## Referral

- Once you have determined your screening tool and patient criteria for participating and graduating from the program, it is time to refer your patients.
- If you have an integrated program with a partner, choose a team member to receive the referral, explain the program, conduct baseline surveys, give the patient any vouchers or distribution times, and document the encounter in the EHR.
- If you have identified an external organization to refer to, provide the patient with their program information.
- Be sure these roles and responsibilities are reflected in your program map.

## Enrollment

Upon enrollment, patients will complete baseline surveys to measure their current food resources and habits and become familiar with the structure of the program. Sample participant-level surveys are available in the GusNIP NTAE Nutrition Incentive Hub for two program types: Nutrition Incentives (NI) Baseline and Produce Prescription Baseline and post-surveys. You can also find other program patient enrollment guides, such as the County of Los Angeles Dept of Public Health program (Fresco y Saludable / Fresh and Healthy). Consider developing written resources, such as a handout, that outlines the key details patients need to know to participate in the program. These may include:

- Overview of the program
- Distribution times or retail hours
- Pickup or retail addresses
- Important instructions, including eligible retail items, or individuals who may pick up a produce delivery
- Lifestyle or disease prevention programming place and times
- Date and time of their next appointment at the health center

Develop your surveying and enrollment materials with patient literacy in mind. Testing these materials with patients ahead of time can reveal difficult or confusing content. If possible, have a staff member available to help patients with surveys or explain program details.

Consider gathering participant feedback on the program. You might consider gathering their input on the ease of following the program, the quality of the produce, and the quality of nutrition education. Leaving space for patients to share open-ended feedback may lead to modifications you can address in your continuous improvement process. More information on program evaluation and surveys can be found below.

Follow up with all enrolled patients. If you had patients who did not show to pick up their food or redeem their vouchers, follow up with them too to find out more about why they did not utilize the program. This can help you identify and remove any barriers to accessing the program you may not have considered.

## Evaluation

While some benefits of a Food is Medicine program are difficult to quantify, such as improvements in quality of life, stress, and patient-provider relationships, others can be tracked and evaluated to measure the effectiveness of your program.

Measures of Food is Medicine program benefits and effectiveness could include:

| *Source* | *Outcome* | *Unit of measure* |
|---|---|---|
| EHR | Disease measures and health outcomes | • Blood pressure readings<br>• BMI<br>• A1C |
| EHR | Healthcare utilization | • Preventative visits<br>• Nutrition education attendance<br>• Disease prevention / management class attendance<br>• Missed appointments<br>• Emergency department usage<br>• Missed appointments<br>• 30-day readmissions |
| Food Insecurity Screener | Food insecurity and health related needs | • Food security status<br>• Income<br>• Transportation |
| Baseline and Post Surveys | Nutrition quality and fruit / vegetable intake | • Frequency of fruit / vegetable intake<br>• Healthy Eating Index<br>• Weight of produce prescription<br>• Dollar value of produce prescription |
| Baseline and Post Surveys | Participant satisfaction and wellbeing | • Quality of life measurements<br>• Post-intervention only:<br>  • Open-ended space on survey for suggestions<br>  • Satisfaction rating on program quality<br>  • Satisfaction rating on program accessibility |

In order to maximize the quality of the data you would like to collect and reduce participant and staff urden, we recommend conducting the evaluation in three phases: screening, baseline surveying, and post-intervention surveying. Post-intervention surveying may be conducted once patients have graduated from the program, or at regular intervals, such as at follow-up visits or at nutrition education classes. Post-intervention surveying should also include the same food insecurity screening you originally conducted to determine eligibility for the program.

In general, more detailed screenings and surveys result in higher-quality data but impose a greater burden on participants and staff. Shorter, simpler screenings and surveys tend to yield lower-quality data and lower participant and staff burden. Choosing the right balance for you will depend on what you and your partners want to measure.

### EHR Integration

Integrate the Food is Medicine program referral process, tracking, and follow-up into your EHR. You may even set your EHR to streamline program processes, such as:

- Integrating food insecurity screening into intake forms and patient chart.
- Alerting pertinent staff when patients meet eligibility criteria.
- Triggering workflows when chronic disease diagnoses are made.
- Documenting when patients follow through with redeeming their subscription.

If your EHR does not offer the capabilities outlined above, see our Tracking Spreadsheet for Program Documentation (included in the Resources section) as a starting point.

Some health centers also choose to integrate health-related needs data management software, such as i2i Population Health, with their EHR to measure the quality improvement of their program and continue to meet their health-related needs goals.

Establish a predetermined schedule and have a timeline for when to share data with your program partners. If your program partners are not equipped to handle protected health information in compliance with HIPAA, make sure you de-identify any program data that will be shared.

## *GOAL SETTING*

Refer back to the readiness assessment questions (Appendix A) you answered “no” or “somewhat” and use this section to develop goals to address those areas.

Fill in the numbers of the questions from the readiness assessment to which you gave “no” or “somewhat” answer to below.

| Health Center Assessment | Partner Assessment |
|---|---|
| "Somewhat" total: | "Somewhat" total: |
| "No" total: | "No" total: |

Now, determine how you might be able to change your answer to "yes" if you were to take the assessment again. What actions would you need to take? Who will be responsible for taking these steps? Document your goals below.

You can repeat this process as many times as you need until all areas for improvement are addressed. We suggest you return to this goal-setting chart with your produce partner, even after you have initiated your program, to continue improving its quality and effectiveness.

| Goal | Action Step Descriptions | Party Responsible | Begin Date | Due Date |
|---|---|---|---|---|
| | | | | |

# *STEP 7: IMPLEMENT YOUR PROGRAM*

When you are ready to implement your Food is Medicine program, here are a couple of recommendations to be mindful of as you distribute your first vouchers, make your first deliveries, or provide your initial referrals.

**Monitor:** We cannot stress enough how important it is to keep up with documenting the successes and challenges you face as you implement your program. With this information, you can monitor the effectiveness of your program and make changes as needed through a continual improvement process. This will help you demonstrate the effectiveness of your program and help inform and educate those who may want to replicate it. Documenting the program's success can also demonstrate to funders or institutions that it is working and worthy of additional funding and recognition.

**Share:** Communicate those successes and challenges! We would love to hear about what is going well and what has been a struggle for you in implementation. Many other health centers and organizations across the country that are considering a Food is Medicine program and/or who have also implemented one would also appreciate this information to learn alongside you. By sharing your experiences, you can help others improve their programs and facilitate their own.

**Continual Improvement:** Every quarter, we recommend that you reflect on how your program is proceeding. This is an excellent time to review and organize the data you have collected thus far. How are patient measures such as blood pressure, body mass index (BMI), A1C changing? Is your program having the desired impact of the organization? Is it meeting the goals you had initially outlined?

- If "yes", congratulations! This is why you started the program in the first place. Share your successes with your partner organizations and be sure to give yourself and your team some recognition for this accomplishment. As you look towards your next quarter, what would you like to improve?
- If "no", why do you think that is? Are there any clues as to why you have not accomplished your desired goals or patient measures? Are there any barriers to the effectiveness of the program?

Once you have evaluated the implementation to this point, return to the Readiness Assessment on page 9. Are there any items on your readiness assessment that you answered "Somewhat" to? Perhaps these can be improved. No program will remain static through time, and returning to a consistent strategic planning phase will keep your program growing and improving in the long run.

# CONCLUSION

With this guide, we hope that your health center takes these steps to address food insecurity as the very important determinant of health that it is. Food is Medicine programs have the potential to improve disease measures, lower health care costs, and build trust across all communities, but can be especially powerful in eliminating the many systemic challenges faced by Migratory and Seasonal Agricultural Workers and their families. Below you will find additional resources, reading materials, and information on funding opportunities to help your program have the greatest impact possible.

# RESOURCES

Tracking Spreadsheet for Program Documentation:
https://ncfh.box.com/s/rv02uw0bbc3dv3vbt8glv6uksrsc7iyg

*PRAPARE Tool:*

Download the tool in 25 languages:
https://prapare.org/the-prapare-screening-tool/

PRAPARE Implementation Tool:
https://prapare.org/prapare-toolkit/

USDA Food Security Survey Tools:
https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/survey-tools/#six

Hunger Vital Sign:
https://childrenshealthwatch.org/public-policy/hunger-vital-sign/

i2i Population Health Data Management Solutions
https://www.i2ipophealth.com/services/#data-solutions

**Further Reading**

- More information on NCFH: ncfh.org
- More information on agricultural workers and chronic disease / food insecurity:
  - o https://www.ncfh.org/digital-library/diabetes-and-us-agricultural-workers-fact-sheet/
- References to connections between food insecurity and chronic disease:
  - o https://www.chlpi.org/wp-content/uploads/2013/12/Produce-RX-March-2021.pdf
- Leading Food is Medicine academic programs:
  - o Tufts Food is Medicine Institute https://tuftsfoodismedicine.org/
  - o Harvard Center for Health Law and Policy Innovation https://chlpi.org/
- Fresh Food As Medicine for the Heartburn of High Prices, Deloitte Insights, September 2022
  - o https://www.deloitte.com/us/en/insights/industry/retail-distribution/future-of-fresh-food-sales/fresh-food-as-medicine-for-the-heartburn-of-high-prices.html
- Food is Medicine effect on local communities:
  - o Maximizing the Impact of Nutrition Interventions with Local Food Procurement https://chlpi.org/wp-content/uploads/2025/07/Maximizing-the-Impact-of-Nutrition-Interventions-with-Local-Food-Procurement_FINAL_.pdf
  - o From Farm to FIM: The economic Impact of Local Food is Medicine https://www.rockefellerfoundation.org/wp-content/uploads/2026/03/From-Farm-to-Food is Medicine-The-Economic-Impact-of-Local-Food-is-Medicine-Report-Final.pdf
- Nutrition Incentive Hub Reporting and Evaluation Metrics:
  - o https://www.nutritionincentivehub.org/resources/resources/reporting-evaluation

**Additional examples of state and local funding opportunities:**

- Pathways to Enable Food is Medicine Interventions through Select Federal Health Policies, July 2024
    - https://odphp.health.gov/sites/default/files/2025-02/Food-Is-Medicine_Pathways-Brief-508.pdf
- Food is Medicine: A State Medicaid Policy Toolkit, July 2024
    - https://fimcoalition.org/wp-content/uploads/2024/07/Food-is-Medicine-A-State-Medicaid-Policy-Toolkit_Final-July-2024-1.pdf
- Rural Community Development Block Grants (CBDG)
    - https://www.hudexchange.info/programs/cdbg/
- USDA Local Food Directories
    - https://www.usdalocalfoodportal.com/

*For questions, comments, or additions to this guide, please email: Info@ncfh.org.*

# REFERENCES


1. Seligman, H. K. and Shillinger, D. 2010. Hunger and Socioeconomic Disparities in Chronic Disease. The New England Journal of Medicine, 363:6-9. doi:10.1056/NEJMp1000072

2. Sara A. Quandt, S, PhDa Thomas A. Arcury, PhDb Julie Early, MSb Janeth Tapiac Jessie D. Davisa Household Food Security Among Migrant and Seasonal Latino Farmworkers in North Carolina. Public Health Reports,

3. Garfield K, Scott E, Sukys K, et al. Mainstreaming Produce Prescriptions: A Policy Strategy Report. https://chlpi.org/wp-content/uploads/2013/12/Produce-RX-March-2021.pdf. Published March 2021. Accessed March 2021.

4. Lee Y, Mozaffarian D, Sy S, et al. Cost-effectiveness of financial incentives for improving diet and health through Medicare and Medicaid: A microsimulation study. PLoS medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6424388/. Published March 19, 2019. Accessed March 2021.

5. Sanders D, Sharma S, Ranjit N. Food Prescription Programs: The Houston Food Bank Experience and Outcomes: A Multidimensional Evaluation of the Houston Food Bank Food Rx Program; September 13, 2022. https://sph.uth.edu/research/centers/dell/webinars/webinar.htm?id=53f2a4af-beaf-4477-94fa-9f24dc9a9242.

6. Public Health Alliance of Southern California FFAM Impact. (https://uploads-ssl.webflow.com/6037d-24d0cb4843f93fb3985/65b7ffd52422139Oa4bd8f82_Farmer%27s%20Food%20as%20Medicine_Public%20Health%20Alliance_Jan2024.pdf)



This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,742,242 with 0 % financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

# APPENDIX A:
# Health Center Food is Medicine Readiness Assessment Questionnaire

*Directions:* Select Yes, Somewhat, or No for each statement below, depending on how often or how well each statement describes your current health center practices and values.

| | |
|---|---|
| **Yes** | Things our health center does frequently, or statement applies to partner to a great degree |
| **Somewhat** | Things our health center does occasionally, or statement applies to partner to a moderate degree |
| **No** | Things our health center rarely or never does, or statement applies to partner to minimal degree or not at all |

| | Yes | Somewhat | No |
|---|---|---|---|
| 1. Does your health center currently screen for food insecurity? | ☐ | ☐ | ☐ |
| 2. Is addressing food insecurity a priority for the leadership of your organization? | ☐ | ☐ | ☐ |
| 3. Do staff have the capacity to coordinate a produce prescription program, including tracking program data?<br>*Note: If you are not sure, read the full Food is Medicine Replication Guide to get a sense of what a program entails, then return to this question.* | ☐ | ☐ | ☐ |
| 4. Do staff understand the relationship between food insecurity and chronic diet-related diseases? | ☐ | ☐ | ☐ |
| 5. Does your health center have a referral system in place for food insecure patients? | ☐ | ☐ | ☐ |
| • *If you answered yes or somewhat, where are patients referred to for food insecurity?* | | | |
| • *What staff are involved in this referral system?* | | | |
| 6. Are food insecurity and any subsequent referrals integrated into your Electronic Health Record (EHR)? | ☐ | ☐ | ☐ |
| 7. Does your health center currently offer any diabetes, hypertension, or heart disease education programs? | ☐ | ☐ | ☐ |
| • *If you answered yes or somewhat, who are the staff responsible for implementing these programs?* | | | |
| 8. Do any of your community partners offer any diabetes, hypertension, or heart disease education programs? | ☐ | ☐ | ☐ |
| 9. Does your health center have a Food is Medicine policy? | ☐ | ☐ | ☐ |
| 10. Has your health center identified food insecurity as a key issue to improve the quality of health amongst their patient population? | ☐ | ☐ | ☐ |
| *TOTALS* | | | |

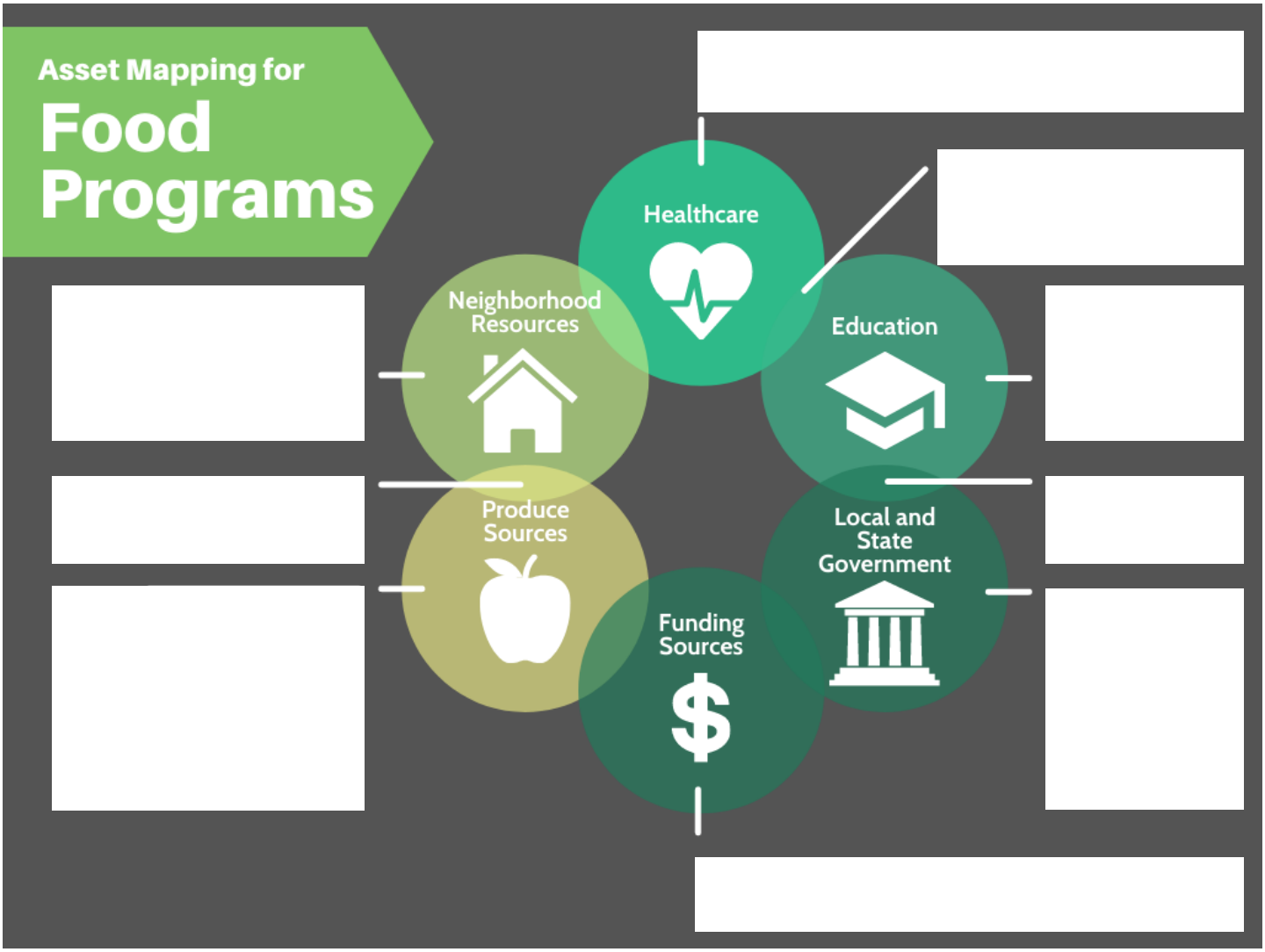
*If you answered mostly Yes* to most of the assessment questions, your health center is likely in a good position to start a Food is Medicine program. As you begin to gather your team and develop an action plan, notice which questions you may have answered with "somewhat" or "no." The questions you answered with a "no," should be resolved before beginning your program. For the questions you answered "somewhat," make these the top priority areas to improve before beginning the program, or address in the early days of your program implementation.

*If you answered mostly Somewhat*, your health center may have many of the elements necessary to start a Food is Medicine program, but still needs to address a few priority areas. With some effort, you can increase how often and how well these practices are integrated into your health center procedures. Address the questions you answered "no" to, then take the assessment again to see where you are.

*If you answered mostly No*, your health center may not be ready to start a Food is Medicine program, but you have identified the key areas to work on first to work towards this goal.

# APPENDIX B:
# Asset Mapping Template

Use the blank asset map below to identify organizations or programs like those listed on page 7 that your health center could collaborate with. Start with organizations you are already connected with. If you need ideas, brainstorm with your staff and do a quick online search of your community resources. As you fill it in, you will begin to see the potential connections in your community to make your Food is Medicine program a reality. When you are done filling in the map, you will have a clear picture of all the resources available that can support the implementation of a Food is Medicine program.




*Notes*

# APPENDIX C:
# Voucher Programs Readiness Assessment

*Directions:* Select Yes, Somewhat, or No for each statement below, depending on how often or how well each statement describes your current health center practices and values.

| | |
|---|---|
| **Yes** | Things partner does frequently, or statement applies to partner to a great degree |
| **Somewhat** | Things partner does occasionally, or statement applies to partner to a moderate degree |
| **No** | Things partner rarely or never does, or statement applies to partner to minimal degree or not at all |

| | Yes | Somewhat | No |
|---|---|---|---|
| 1. Is addressing food insecurity a priority for the leadership of your organization? | ☐ | ☐ | ☐ |
| 2. Does your staff understand the relationship between food insecurity and chronic diet-related diseases? | ☐ | ☐ | ☐ |
| 3. Do staff have the capacity to coordinate a produce prescription program, including tracking program data? | ☐ | ☐ | ☐ |
| 4. Is there a variety of fresh, seasonal produce available at the redemption site? | ☐ | ☐ | ☐ |
| 5. Is there a nutrition policy to outline the items that can be redeemed through the voucher program? | ☐ | ☐ | ☐ |
| 6. Is there a variety of culturally relevant produce available at the redemption site? | ☐ | ☐ | ☐ |
| 7. Does your organization have a system for receiving, tracking, and documenting the circulation of fruit and vegetable prescription vouchers? | ☐ | ☐ | ☐ |
| 8. Are there multiple times and locations at which patients can redeem their vouchers? | ☐ | ☐ | ☐ |
| 9. Is there nutrition education available at the redemption site? | ☐ | ☐ | ☐ |
| 10. Does the voucher program receive consistent funding? | ☐ | ☐ | ☐ |
| *TOTALS* | | | |

*If you answered mostly Yes*, chances are your partner organization is well-positioned to start a Food is Medicine program in coordination with your HC. As you assemble your team and action plan, notice which questions you may have answered with "somewhat" or "no." Make these your first priorities as you plan your program.

*If you answered mostly Somewhat*, your partner organization has many of the elements necessary to start a Food is Medicine program. With some effort and collaboration between the two, you can increase how often and how well these practices are integrated into the program procedures. Make a concrete plan with a policy that addresses these areas of improvement, and you may soon be ready to initiate your program.

*If you answered mostly No*, your partner organization may not be ready to start a Food is Medicine program, but they have identified the key areas to work on first. It may be that some of these areas, fall outside of their mission, and you may need additional partners from your asset map to fulfill these roles. If questions 1-3 were answered "no," consider other partner options instead.

# APPENDIX D:
# Food Delivery Programs Readiness Assessment

*Directions:* Select Yes, Somewhat, or No for each statement below, depending on how often or how well each statement describes your current health center practices and values.

| | |
|---|---|
| **Yes** | Things partner does frequently, or statement applies to partner to a great degree |
| **Somewhat** | Things partner does occasionally, or statement applies to partner to a moderate degree |
| **No** | Things partner rarely or never does, or statement applies to partner to minimal degree or not at all |

| | Yes | Somewhat | No |
|---|---|---|---|
| 1. Is addressing food insecurity a priority for the leadership of your organization? | ☐ | ☐ | ☐ |
| 2. Does your staff understand the relationship between food insecurity and chronic diet-related diseases? | ☐ | ☐ | ☐ |
| 3. Is there a variety of fresh, seasonal produce available at the redemption site? | ☐ | ☐ | ☐ |
| 4. Is there a nutrition policy to outline the items that meet the nutritional quality needed for the delivery program? | ☐ | ☐ | ☐ |
| 5. Is there a variety of culturally relevant produce available at the redemption site? | ☐ | ☐ | ☐ |
| 6. Are there multiple times and locations at which patients can pick up their food distribution/ produce, or can they be delivered to their homes? | ☐ | ☐ | ☐ |
| 7. Is there nutrition education available at the redemption site? | ☐ | ☐ | ☐ |
| 8. Does the program provide a reliable way of transporting produce to the distribution site? | ☐ | ☐ | ☐ |
| 9. Does the distribution program have a policy to determine eligibility (for example, will you accept program referrals only or walk-ins)? | ☐ | ☐ | ☐ |
| 10. Do you have a system for tracking patient utilization of program, pounds of produce distributed? | ☐ | ☐ | ☐ |
| 11. Does the food delivery program receive consistent funding? | ☐ | ☐ | ☐ |
| *TOTALS* | | | |

*If you answered mostly Yes*, chances are your partner organization is well-positioned to start a Food is Medicine program in coordination with your HC. As you assemble your team and action plan, notice which questions you may have answered with "somewhat" or "no." Make these your first priorities as you plan your program.

*If you answered mostly Somewhat*, your partner organization has many of the elements necessary to start a Food is Medicine program. With some effort and collaboration between the two, you can increase how often and how well these practices are integrated into the program procedures. Make a concrete plan with a policy that addresses these areas of improvement, and you may soon be ready to initiate your program.

*If you answered mostly No*, your partner organization may not be ready to start a Food is Medicine program, but they have identified the key areas to work on first. It may be that some of these areas fall outside of their mission, and you may need additional partners from your asset map to fulfill these roles. If questions 1-3 were answered "no," consider other partner options instead.

# APPENDIX E:
# Referral Programs Readiness Assessment

*Directions:* Select Yes, Somewhat, or No for each statement below, depending on how often or how well each statement describes your current health center practices and values.

| | |
|---|---|
| **Yes** | Things partner does frequently, or statement applies to partner to a great degree |
| **Somewhat** | Things partner does occasionally, or statement applies to partner to a moderate degree |
| **No** | Things partner rarely or never does, or statement applies to partner to minimal degree or not at all |

| | Yes | Somewhat | No |
|---|---|---|---|
| 1. Is the location to the existing program accessible for your patients? | ☐ | ☐ | ☐ |
| 2. Do the hours of operation work for your patient population? | ☐ | ☐ | ☐ |
| 3.Does the referral program have a nutrition policy to determine which foods are appropriate for your patients, or are they willing to implement one? | ☐ | ☐ | ☐ |
| 4. Does the referral program have a documentation system for tracking patient use of the program or are they willing to implement one? | ☐ | ☐ | ☐ |
| 5. Are you able to meet any documentation requirements of the produce partner? | ☐ | ☐ | ☐ |
| 6.Have you reached out to the existing program and evaluated their capacity to accept new program participants? | ☐ | ☐ | ☐ |
| 7. Have you discussed a referral plan that works for this existing program? | ☐ | ☐ | ☐ |
| *TOTALS* | | | |

*If you answered mostly Yes*, chances are your partner organization is well-positioned to start a Food is Medicine program in coordination with your HC. As you assemble your team and action plan, notice which questions you may have answered with "somewhat" or "no." Make these your first priorities as you plan your program.

*If you answered mostly Somewhat*, your partner organization has many of the elements necessary to start a Food is Medicine program. With some effort and collaboration between the two, you can increase how often and how well these practices are integrated into the program procedures. Make a concrete plan with a policy that addresses these areas of improvement, and you may soon be ready to initiate your program.

*If you answered mostly No*, your partner organization may not be ready to start a Food is Medicine program, but they have identified the key areas to work on first. It may be that some of these areas fall outside of their mission, and you may need additional partners from your asset map to fulfill these roles. If questions 1-3 were answered "no," consider other partner options instead.