FOOD Rx REPLICATION GUIDE

For Health Centers

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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 population-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 Diabetes Resource Hub and Social Determinants of Health 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 produce prescription programs and Community and Migrant Health Centers.

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

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INTRODUCTION

Food Rx programs, also referred to as fruit and vegetable or produce prescription programs, offer a promising solution to the compounding issues of food insecurity, rising healthcare costs, and ill health. These programs facilitate the distribution of produce and other healthy food staples to patients who suffer from diet-related diseases such as prediabetes, diabetes, and hypertension.

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

HEALTH CONDITIONS ASSOCIATED WITH FOOD INSECURITY

Children	Non-Older Adults	Older Adults
Risks of some birth defects	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 Rx programs is one of them.

Participation in Food Rx Programs have also been shown to:

- Reduce blood pressure
- Improve body mass index (BMI) scores
- Improve A1c levels in individuals with diabetes
- Relieve food insecurity
- Decrease symptoms of depression and improve overall health management
- Improve relationships between patients and providers[3]

Migratory and Seasonal Agricultural Workers (MSAWs) living with chronic health conditions in underserved communities face challenges to healthy eating. One of the many significant barriers to health for MSAW populations 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 healthy produce and access to healthcare, have very limited time to seek out these services, and live in conditions that make disease management behaviors much more difficult.

In order to support special and vulnerable populations (SVP) including MSAWs, we need to think outside the box and link community resources outside the health care setting through innovative programs. Food prescription programs, such as Food Rx, offer a promising formula that link the community and the health care system, working together to promote behavior change, provide nutrition education, connect patients to local resources, and in some cases, provide financial incentives. Food Rx programs show promise as a model for integrating community and health care resources to support the health of MSAW and SVP patients.

As explained above, there is a documented relationship between food insecurity and chronic disease incidence. There is a growing collection of research to demonstrate the effectiveness of these programs in managing these diseases, but 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, and improvements in the relationship between patient and provider[3].

Food Rx programs can provide three main benefits to Health Centers: improved social determinants of health (SDOH) for patients, lowered healthcare costs, and an increased sense of trust between the patient and health center (HC). 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. Food Rx programs can allow patients to see a HC as a trusted partner in improving their health and providing support.

As more health care systems move to a value-based model, HCs have an increased sense of urgency to improve SDOH, improve overall health, and keep costs down. Food Rx programs also provide a cost-effective way of addressing SDOH 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 a $39.7 billion savings in health care costs[4]. In another recent study, preliminary analysis showed that each additional quality adjusted life years (QALY) gained with Food Rx 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].

NCFH has developed this Food Rx replication guide with the purpose of helping HCs to be able to implement their own Food Rx programs.

STEP 1: HEALTH CENTER READINESS ASSESSMENT

Are you prepared to implement a Food Rx program at your HC?

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

How you answer the assessment will guide the next steps you take towards developing your Food Rx program. If you answered Yes to most of the assessment questions, your HC is likely in a good position to start a Food Rx 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 HC may have many of the elements necessary to start a Food Rx 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 HC procedures. Address the questions you answered "no" to, then take the assessment again to see where you are.

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

STEP 2: CONDUCT ASSET MAPPING

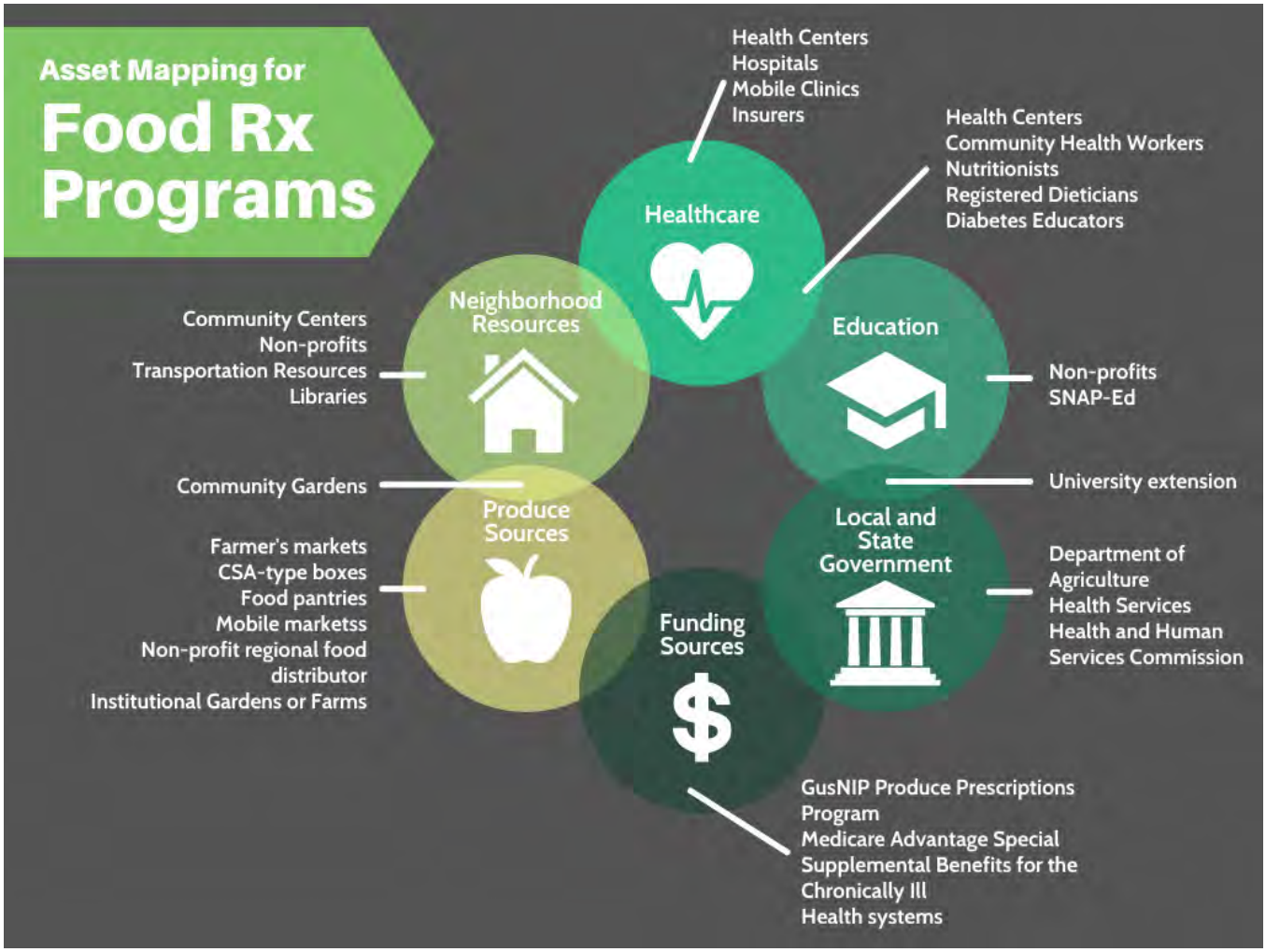
If you have determined that your HC is ready for a Food Rx program, you can move to working on an asset map.

What is Community Asset Mapping?

As any program, it is important to determine what resources are available in your community and within your HC setting, and how you can connect with those resources in order 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.
- **Education:** Is your HC providing patient education for 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, SNAP-Ed services, Area Agency on Aging (AAA), Area Health Education Centers (AHECS), Community Health Worker groups, and faith-based organizations.
- **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. Reach out to your local representative. Also, on the state level, they have area representatives that can help you find some resources and make local connections.
- **Funding Sources:** There are multiple sources of funds available at a local and federal level for programs that are innovative and apply evidence based and collaborative patient interventions. Talk to your liaisons and counter parts to discuss potential funding opportunities.
- **Produce Sources:** Go directly to the source. If you are located 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, farmer's markets/stands, and mobile food options.
- **Neighborhood Resources:** Need a place to hold the distribution? Identify places or locations in your community where the MSAW population already gathers at, such as churches, community recreation centers, libraries, etc. Also, seek support from partners that could solve barriers to access for your participants, such as transportation resources and volunteer nonprofits.

Below is an example of asset mapping done for Food Rx 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 HCs do not yet have established relationships with organizations that can provide the produce needed for a fruit and vegetable Food Rx program. You may need to do some research to find organizations that can fulfill this role. At the base of any Food Rx program is the relationship between the healthcare organization and an organization that supplies the produce. Additional collaborations will increase the efficacy and equity of the program but 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 HC and a produce partner. The HC identifies the patient needing 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 fresh produce and other healthy food staples. Benefits of this program may include increased participant choice and autonomy over food selection and more site options to redeem 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
- Farmstands
- Grocery stores
- Native trading posts

Food delivery programs: These programs are a partnership between a HC and a produce partner who directly delivers produce to an identified location. The HC identifies the patient and refers them to the produce partner. The partner delivers produce to a residence or centralized location, which could include the HC itself. The patients receive their produce or other healthy food staples at that specified location. Benefits of this program may include more participation from patients 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
- Mobile markets
- Mobile pantries

Referral programs: These programs are a good option for HCs and organizations with limited resources. The HC identifies the patient, connects them to an already-existing source of free produce, and integrates the referral process into their workflow to the greatest degree possible. The main benefits of this program are less need for funding and coordination on the part of the HC. However, this type of program may not expand community resources to alleviate social determinants of health, and may be limited in scope, length, or patient eligibility.

Examples of referral programs include:

- Food Pantries
- Double up SNAP
- 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 HC 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 to make your Food Rx program a reality and have a clear picture of all the resources available that can support the implementation of a Food Rx program.

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 HC. It is important to meet with your partners and evaluate the readiness of their organization to set clear expectations and find areas that need the most attention in order to get 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, use the **Referral Programs Readiness Assessment** (Appendix E).

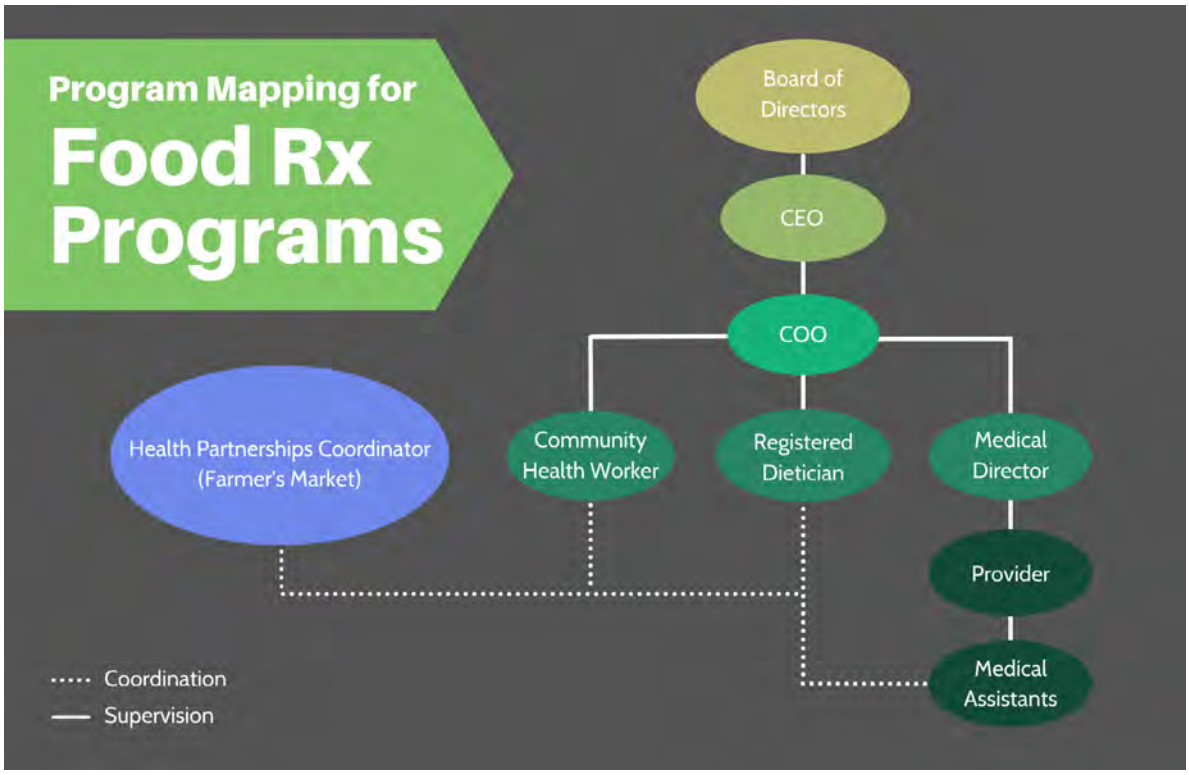
Once you have completed one or more of these assessments, you should have a clearer picture of the readiness of your partner organization to meet the challenges that come with establishing a Food Rx program. If you evaluated multiple partners, perhaps choose the partner organization that answered mostly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

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 Rx program just yet, but you begin to gather 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 HC 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 contract, you can move on to who is coordinating the actual program delivery.

We suggest both organizations, the HC 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 tasks are delegated. For example, the nutrition education part can be done by care coordinators, Community Health Workers (CHWs), patient navigators, etc., who are already delivering direct education to patients. Reach out to physicians and include them in your plan for implementation and consider training them to support your program. They can become your biggest champions by referring patients that fit the Food Rx program criteria.

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 HCs 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 Rx program, assessed your strengths, and developed partnerships, ensuring your program is financially sustainable is the next step. Funding can pose one of the greatest challenges to initiating a Food Rx program. Many HCs 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 HCs have for funding a Food Rx 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	Double-Up SNAP
		Companies with philanthropic arms such as Shipt	

Even for HCs that do not secure funding, a Food Rx program can still have potential. HCs may elect to refer patients to a program or series of programs that already have the capacity to provide free and healthy foods to participants.

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 Rx program that need to 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 on 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. ☐ Document and track your referrals. ☐ Establish a system for distributing vouchers to patients. ☐ Distribute a calendar of places and times where patients can redeem their vouchers. ☐ 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. ☐ Track and communicate patient outcomes.	☐ Provide HC a calendar of places and times where patients can redeem their vouchers. ☐ Provide patients a variety of fresh, seasonal produce. ☐ Provide patients a variety of culturally relevant produce. ☐ Train staff on accepting 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. ☐ Document and track your referrals. ☐ Distribute a calendar of times where patients can pick up their food prescription. ☐ If delivering to patients' homes, confirm home address during enrollment. ☐ 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. ☐ Track and communicate patient outcomes.	☐ Provide HC a calendar of places and times where patients can pick up their food prescription or provide schedule for patient home deliveries. ☐ Deliver food prescriptions regularly. ☐ Provide patients a variety of fresh, seasonal produce. ☐ Provide patients a variety of culturally relevant produce.

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. ☐ Document and track your referrals. ☐ 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. ☐ Track and communicate patient outcomes. ☐ Decide on when patients "graduate" from the program (based on health outcomes, food insecurity, etc.).	☐ Provide HC a calendar of places and times where patients can pick up their food prescription. ☐ Provide patients a variety of fresh, seasonal produce. ☐ 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.

PATIENT SELECTION

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

- Food insecurity
- Diagnosis of chronic disease

Food Insecurity Screening

In order to identify patients experiencing food insecurity, a screening process is necessary. HCs should already be screening for SDOH, and food insecurity is just one of many that may impact patient populations.

Here are three SDOH Screening Tools your HC may already be familiar with and using to screen patients:

- The PRAPARE Tool (Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences) allows HCs and their community partners to learn about their patients, leverage data, and improve health equity outcomes.
    - As a 21-question comprehensive SDOH 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 HCs' 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 this screener become a regular part of your patient intake to capture as many food insecure patients as possible.

Diagnosis of Chronic Disease

Many Food Rx programs require the diagnosis of a chronic disease to receive a produce prescription. Some 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 poses for developing a chronic illness and choose to take a more preventative approach. You may choose to offer the produce prescription as an incentive for participation in a chronic disease management or other prevention program. This model offers a solution to the systemic barriers faced by program participants and complements the information they will receive in a prevention program.

Choose the criteria for referral 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. Whoever 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's 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 simply identified an external organization to refer to, provide the patient 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 existing food resources and habits (Sample from GusNIP NTAE Nutrition Incentive Hub in Appendix F), as well as become familiar with the structure of the program. Consider developing written resources or a handout that describes the important 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 HC.

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, 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. Next you will find more information on program evaluation and surveys.

Evaluation

While some benefits of a Food Rx 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 Rx program benefits and effectiveness could include:

Source	Outcome	Unit of measure
EHR	Disease measures and health outcomes	• Blood pressure readings • BMI • A1C
EHR	Healthcare utilization	• Preventative visits • Nutrition education attendance • Disease prevention / management class attendance • Missed appointments • Emergency department usage • Missed appointments • 30-day readmissions
Food Insecurity Screener	Food insecurity and related SDOH	• Food security status • Income • Transportation
Baseline and Post Surveys	Nutrition quality and fruit / vegetable intake	• Frequency of fruit / vegetable intake • Healthy Eating Index • Weight of produce prescription • Dollar value of produce prescription

Baseline and Post Surveys	Participant satisfaction and wellbeing	• Quality of life measurements
		• Post-intervention only:
		  • Open-ended space on survey for suggestions
		  • Satisfaction rating on program quality
		  • Satisfaction rating on program accessibility

In order to maximize the quality of the data you would like to collect and reduce participant and staff burden, we recommend conducting 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 into the program.

In general, more detailed screenings and surveys result in higher quality data but higher participant and staff burden. Shorter, more simple screenings and surveys tend to result in lower quality data and low 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 produce prescription process of referring, tracking, and following 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 HCs also choose to integrate a SDOH data management software such as i2i Population Health with their EHR to measure the quality improvement of their program and continue to meet their SDOH 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 a manner that complies with HIPAA, make sure that you deidentify 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: 0	Somewhat total: 0
No total: 0	No total: 0

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 to improve your program's 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 Rx program, here are a couple 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 researchers that your program is working and is worthy of receiving 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 HCs and organizations across the country who are considering a Food Rx program and/or who also have implemented one would also appreciate this information to learn alongside you. By sharing your experiences, you can help others improve and facilitate their own programs.

Continual Improvement: Every quarter, we recommend 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 implementation to this point, return to the Readiness Assessment on page 24. 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 Rx projects have the potential to improve disease measures, lower healthcare costs, and build trust across all populations, 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 so that your program can have the greatest impact possible.

RESOURCES

NCFH's Food Rx Partnerships for Health Equity Webinar
https://www.youtube.com/watch?v=fqs3R3rV8gw

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: www.ncfh.org

More info on farmworkers and chronic disease / food insecurity:
http://www.ncfh.org/uploads/3/8/6/8/38685499/msaw_diabetes_fact_sheet_april_2021.pdf

References to connections between food insecurity and chronic disease:
https://foodcommunitybenefit.noharm.org/resources/implementation-strategy/food-insecurity-screening
https://www.chlpi.org/wp-content/uploads/2013/12/Produce-RX-March-2021.pdf

Nutrition Incentive Hub Reporting and Evaluation Metrics
https://www.nutritionincentivehub.org/resources/resources/reporting-evaluation

Additional state and local funding opportunities:

Rural Community Development Block Grants (CBDG)
https://www.texasagriculture.gov/Grants-Services/Rural-Economic-Development/Rural-Community-Development-Block-Grant-CDBG#:~:text=Community%20Development%20Block%20Grant%20(TxCDBG,of%20low%2D%20to%20moderate%2Dincome

Certified Farmer Market Texas
https://texasagriculture.gov/GrantsServices/CertifiedFarmersMarkets.aspx

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

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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.

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APPENDIX A:
Health Center Food Rx 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 HC 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. Does your HC 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? *Note: If you are not sure, read the full Food Rx 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 HC 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 HC 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 HC have a Food Rx policy?	☐	☐	☐
10. Has your HC identified food insecurity as a key issue to improve the quality of health amongst their patient population?	☐	☐	☐
TOTALS	0	0	0

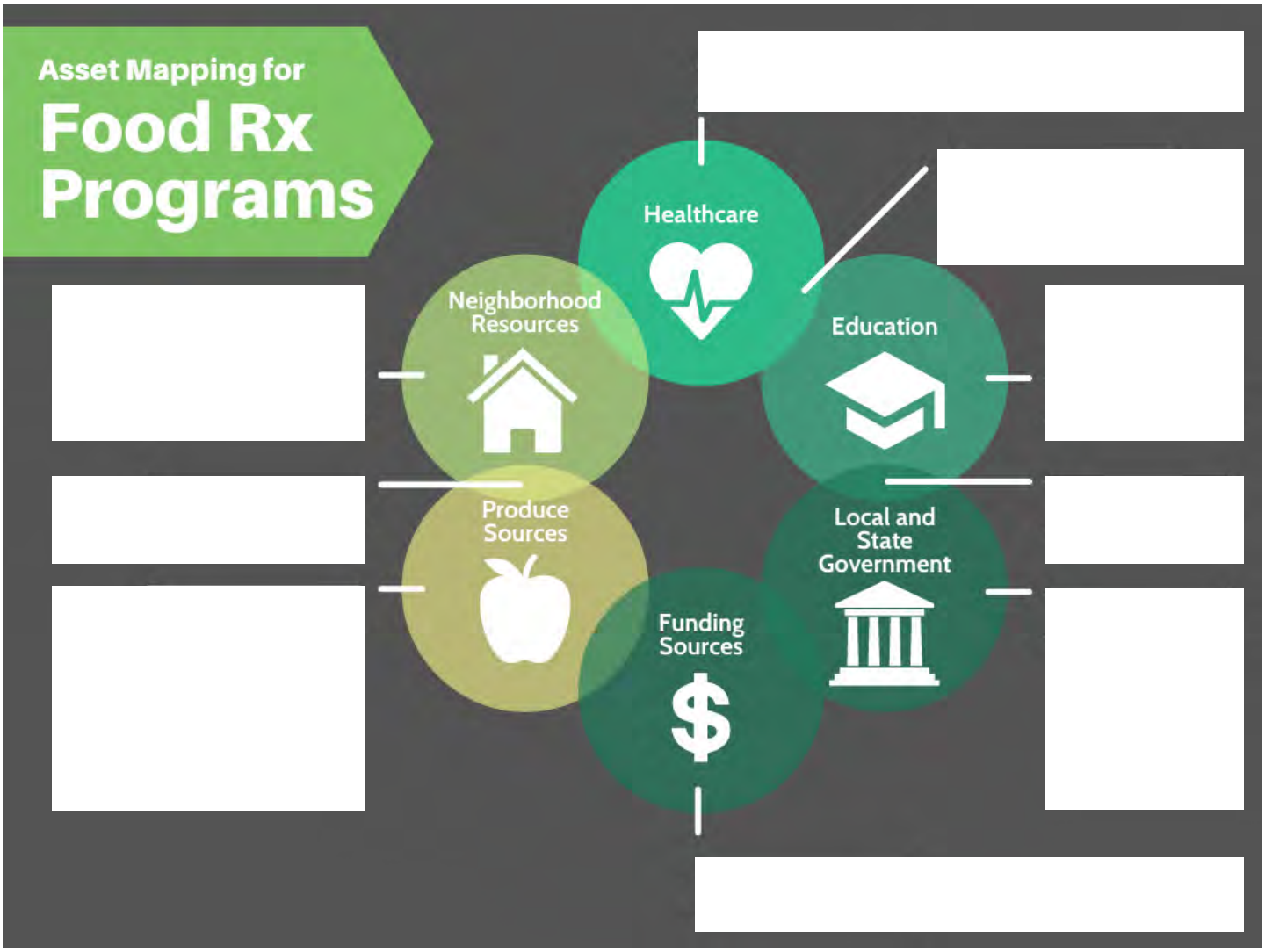
If you answered mostly Yes to most of the assessment questions, your HC is likely in a good position to start a Food Rx program. As you begin to gather your team and develop an action plan, notice which questions you may have answered with "somewhat" or "no." The questions you answered with a "no," should 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 HC may have many of the elements necessary to start a Food Rx 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 HC procedures. Address the questions you answered "no" to, then take the assessment again to see where you are.

If you answered mostly No, your HC may not be ready to start a Food Rx 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 the ones listed above that your HC 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 Rx 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 Rx 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 HC 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	0	0	0

If you answered mostly Yes, chances are your partner organization is well-positioned to start a Food Rx 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 Rx 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 Rx 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 HC 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	0	0	0

If you answered mostly Yes, chances are your partner organization is well-positioned to start a Food Rx 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 Rx 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 Rx 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 HC 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

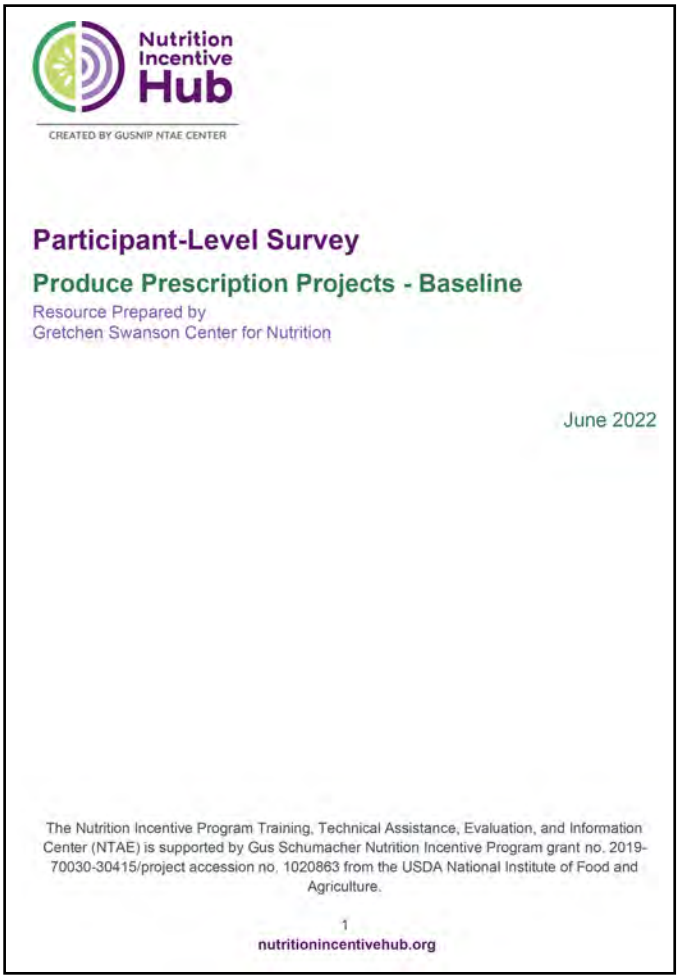
	Yes	Somewhat	No
1. Is the location to the existing program accessible for your patients?	☐	☐	☐
2. Do the hours of operation work for your patient population?	☐	☐	☐
3.Does the referral program have a nutrition policy to determine which foods are appropriate for your patients, or are they willing to implement 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	0	0	0

If you answered mostly Yes, chances are your partner organization is well-positioned to start a Food Rx 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 Rx 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 Rx 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 F:
Enrollment Form/ Survey Sample



Nutrition Incentive Hub

CREATED BY GUSNIP NTAE CENTER

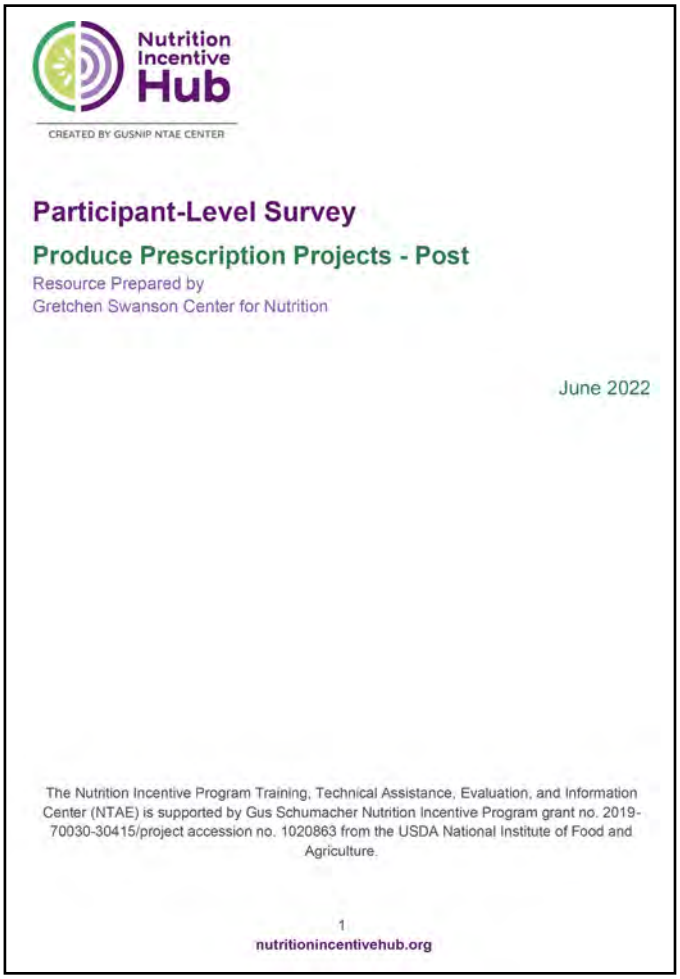
Participant-Level Survey

Produce Prescription Projects - Baseline

Resource Prepared by
Gretchen Swanson Center for Nutrition

June 2022

The Nutrition Incentive Program Training, Technical Assistance, Evaluation, and Information Center (NTAE) is supported by Gus Schumacher Nutrition Incentive Program grant no. 2019-70030-30415/project accession no. 1020863 from the USDA National Institute of Food and Agriculture.



Nutrition Incentive Hub

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Participant-Level Survey

Produce Prescription Projects - Post

Resource Prepared by
Gretchen Swanson Center for Nutrition

June 2022

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Participant-Level Survey

Produce Prescription Projects - Baseline

Resource Prepared by
Gretchen Swanson Center for Nutrition

June 2022

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PID

Consent Statement ***Note: You may use your own consent statement or tailor the one provided below.***

Thank you for your willingness to participate in this survey. If you are an adult (at least 18 years of age) and currently participating in *[name of nutrition incentive program]*, you are eligible for this survey. If you complete this survey, it will be included in a research study evaluating the program. Participation in this study is voluntary and anonymous. Your name and contact information will not be linked with your responses. You can choose to not answer any questions you do not want to answer and/or you can stop at any time. We will protect the information that you provide by not attaching your name to your responses and safely storing this information. The information provided will be combined with responses from other individuals. You may contact our program manager at *[e-mail]* if you have any questions about this research. You may also contact a representative at *[name of IRB]* with any questions about your involvement in this study at *[e-mail].* By participating in this survey, I agree to my survey responses being part of a research study.

1. How are you taking this survey today? *Note: The answers for this question should be tailored to the survey distribution methods your program will use.*
   - ☐ Someone read me the questions in person
   - ☐ Someone read me the questions over the phone/zoom
   - ☐ I took the survey in-person, but I read the questions to myself
   - ☐ I took the survey at home using an electronic link
   - ☐ Prefer not to answer

2. Please write the name of the clinic where you are currently receiving and/or enrolled in [insert incentive program (e.g., Double Up Food Bucks)].

The first set of questions is about your participation in the Supplemental Nutrition Assistance Program, or SNAP, and about your participation in the [insert name of PPR program].

3. In the last 30 days, have you or anyone in your household received EBT, food stamps or SNAP benefits?
   - ☐ Yes
   - ☐ No → ***Go to Question 5***
   - ☐ Don't know/Prefer not to answer → ***Go to Question 5***

4. How long have you been receiving EBT, food stamps, or SNAP benefits?
   - ☐ I just started
   - ☐ Less than a year
   - ☐ More than a year
   - ☐ Don't know/Prefer not to answer

5. How many times have you used your [insert PPR redemption type (e.g., *Food Bucks Rx vouchers*)] to get fruits and vegetables?
   - ☐ I have never used it/them
   - ☐ 1-2 times
   - ☐ 3-10 times
   - ☐ More than 10 times
   - ☐ Don't know/Prefer not to answer

PID

The next set of questions is about the different kinds of foods you ate or drank during the past month, that is, the past 30 days. When answering, please include meals and snacks eaten at home, at work or school, in restaurants, and anyplace else.

6. During the past month, how often did you drink 100% PURE FRUIT JUICES such as orange, apple, grape, etc.?

   DO NOT INCLUDE fruit-flavored drinks with added sugar like Capri-Sun, Sunny D, or other fruit-flavored drinks.
   - ☐ Never
   - ☐ 1 time last month
   - ☐ 2-3 times last month
   - ☐ 1 time per week
   - ☐ 2 times per week
   - ☐ 3-4 times per week
   - ☐ 5-6 times per week
   - ☐ 1 time per day
   - ☐ 2-3 times per day
   - ☐ 4-5 times per day
   - ☐ 6 or more times per day
   - ☐ Don't know/Prefer not to answer

7. During the past month, how often did you eat FRUIT like apples, bananas, oranges, melon, or any other fruit?

   INCLUDE fresh, frozen, canned, or dried fruit.
   DO NOT INCLUDE juices.
   - ☐ Never
   - ☐ 1 time last month
   - ☐ 2-3 times last month
   - ☐ 1 time per week
   - ☐ 2 times per week
   - ☐ 3-4 times per week
   - ☐ 5-6 times per week
   - ☐ 1 time per day
   - ☐ 2 or more times per day
   - ☐ Don't know/Prefer not to answer

8. During the past month, how often did you eat a GREEN LEAFY OR LETTUCE SALAD, with or without other vegetables?
   - ☐ Never
   - ☐ 1 time last month
   - ☐ 2-3 times last month
   - ☐ 1 time per week
   - ☐ 2 times per week
   - ☐ 3-4 times per week
   - ☐ 5-6 times per week
   - ☐ 1 time per day
   - ☐ 2 or more times per day
   - ☐ Don't know/Prefer not to answer

9. During the past month, how often did you eat any kind of FRIED POTATOES like French fries, tater tots, hash brown potatoes, or other fried potatoes?
   - ☐ Never
   - ☐ 1 time last month
   - ☐ 2-3 times last month
   - ☐ 1 time per week
   - ☐ 2 times per week
   - ☐ 3-4 times per week
   - ☐ 5-6 times per week
   - ☐ 1 time per day
   - ☐ 2 or more times per day
   - ☐ Don't know/Prefer not to answer

10. During the past month, how often did you eat any OTHER KIND OF POTATOES that aren't fried, like baked, boiled, mashed, or potatoes used in soups and stews?
    - ☐ Never
    - ☐ 1 time last month
    - ☐ 2-3 times last month
    - ☐ 1 time per week
    - ☐ 2 times per week
    - ☐ 3-4 times per week
    - ☐ 5-6 times per week
    - ☐ 1 time per day
    - ☐ 2 or more times per day
    - ☐ Don't know/Prefer not to answer

PID

11. During the past month, how often did you eat refried beans, baked beans, pinto beans, black beans, beans in soup, or any other type of COOKED BEANS?

    INCLUDE canned or dry beans.
    DO NOT INCLUDE green beans or string beans.
    - ☐ Never
    - ☐ 1 time last month
    - ☐ 2-3 times last month
    - ☐ 1 time per week
    - ☐ 2 times per week
    - ☐ 3-4 times per week
    - ☐ 5-6 times per week
    - ☐ 1 time per day
    - ☐ 2 or more times per day
    - ☐ Don't know/Prefer not to answer

12. During the past month, how often did you eat other VEGETABLES that were not deep-fried? These are vegetables like carrots, broccoli, collards, green beans, corn, or other vegetables that are not deep-fried.

    INCLUDE canned, frozen, or fresh vegetables. ALSO INCLUDE vegetables that are raw, boiled, broiled, baked, grilled, stir-fried, or microwaved.
    - ☐ Never
    - ☐ 1 time last month
    - ☐ 2-3 times last month
    - ☐ 1 time per week
    - ☐ 2 times per week
    - ☐ 3-4 times per week
    - ☐ 5-6 times per week
    - ☐ 1 time per day
    - ☐ 2 or more times per day
    - ☐ Don't know/Prefer not to answer

13. During the past month, how often did you eat packaged or homemade SALSA made with tomato?
    - ☐ Never
    - ☐ 1 time last month
    - ☐ 2-3 times last month
    - ☐ 1 time per week
    - ☐ 2 times per week
    - ☐ 3-4 times per week
    - ☐ 5-6 times per week
    - ☐ 1 time per day
    - ☐ 2 or more times per day
    - ☐ Don't know/Prefer not to answer

14. During the past month, how often did you eat PIZZA?

    INCLUDE frozen pizza, fast food pizza, and homemade pizza.
    - ☐ Never
    - ☐ 1 time last month
    - ☐ 2-3 times last month
    - ☐ 1 time per week
    - ☐ 2 times per week
    - ☐ 3-4 times per week
    - ☐ 5-6 times per week
    - ☐ 1 time per day
    - ☐ 2 or more times per day
    - ☐ Don't know/Prefer not to answer

15. During the past month, how often did you eat TOMATO SAUCE in recipes such as spaghetti, lasagna, or other dishes?

    DO NOT INCLUDE tomato sauce on pizza.
    - ☐ Never
    - ☐ 1 time last month
    - ☐ 2-3 times last month
    - ☐ 1 time per week
    - ☐ 2 times per week
    - ☐ 3-4 times per week
    - ☐ 5-6 times per week
    - ☐ 1 time per day
    - ☐ 2 or more times per day
    - ☐ Don't know/Prefer not to answer

PID

The next set of questions is about the food eaten in your household in the last 30 days, and whether you were able to afford the food you need.

16. The food that we bought just didn't last, and we didn't have money to get more. Was that often, sometimes, or never true for your household in the last 30 days?
    - ☐ Often true
    - ☐ Sometimes true
    - ☐ Never true
    - ☐ Don't know/Prefer not to answer

17. We couldn't afford to eat balanced meals. Was that often, sometimes, or never true for your household in the last 30 days?
    - ☐ Often true
    - ☐ Sometimes true
    - ☐ Never true
    - ☐ Don't know/Prefer not to answer

18. In the last 30 days, did you or other adults in your household ever cut the size of your meals or skip meals because there wasn't enough money for food?
    - ☐ Yes
    - ☐ No → ***Go to Question 20***
    - ☐ Don't know/Prefer not to answer → ***Go to Question 20***

19. In the last 30 days, how many days did this happen?

    _____days

20. In the last 30 days, did you ever eat less than you felt you should because there wasn't enough money for food?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/Prefer not to answer

21. In the last 30 days, were you ever hungry but didn't eat because there wasn't enough money for food?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/Prefer not to answer

The next items ask about how the coronavirus (COVID-19) pandemic has affected you and your household. Please select how much you personally disagree or agree with each of the statements.

22. The coronavirus (COVID-19) has made it hard for me and others in my household to make ends meet.
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither disagree nor agree
    - ☐ Agree
    - ☐ Strongly agree
    - ☐ Don't know/Prefer not to answer

23. The coronavirus (COVID-19) has made it hard for me and others in my household to get fresh fruits and vegetables.
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither disagree nor agree
    - ☐ Agree
    - ☐ Strongly agree
    - ☐ Don't know/Prefer not to answer

24. Since the coronavirus (COVID-19) outbreak, have you or anyone in your household gotten free groceries from a food pantry, food bank, church, or other place that helps with free food?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/Prefer not to answer

The last section is about you.

25. Would you say that in general your health is poor, fair, good, very good, or excellent?
    - ☐ Poor
    - ☐ Fair
    - ☐ Good
    - ☐ Very good
    - ☐ Excellent
    - ☐ Don't know/Prefer not to answer

PID

26. What is your age?
    - ☐ Age: _____
    - ☐ Don't know/Prefer not to answer

27. How do you describe yourself?
    - ☐ Man
    - ☐ Non-binary/third gender
    - ☐ Woman
    - ☐ Prefer to self-describe: _____
    - ☐ Prefer not to answer

28. Are you of Hispanic, Latino/a, or Spanish origin?
    - ☐ Yes
    - ☐ No
    - ☐ Prefer not to answer

29. How would you describe your racial or ethnic background? *Check all that apply.*
    - ☐ American Indian or Alaska Native
    - ☐ Asian
    - ☐ Black or African American
    - ☐ Native Hawaiian
    - ☐ Other Pacific Islander
    - ☐ White
    - ☐ Other race: _____
    - ☐ Don't know/not sure
    - ☐ Prefer not to answer

30. What is the zip code where you currently live?
    - ☐ Enter 5-digit zip code:____
    - ☐ Don't know/Prefer not to answer

You have completed the survey. Please return your survey to the program staff. Thank you for your participation!

Participant-Level Survey

Produce Prescription Projects - Post

Resource Prepared by
Gretchen Swanson Center for Nutrition

June 2022

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Consent Statement *Note: You may use your own consent statement or tailor the one provided below.*

Thank you for your willingness to participate in this survey. If you are an adult (at least 18 years of age) and currently participating in *[name of nutrition incentive program]*, you are eligible for this survey. If you complete this survey, it will be included in a research study evaluating the program. Participation in this study is voluntary and anonymous. Your name and contact information will not be linked with your responses. You can choose to not answer any questions you do not want to answer and/or you can stop at any time. We will protect the information that you provide by not attaching your name to your responses and safely storing this information. The information provided will be combined with responses from other individuals. You may contact our program manager at *[e-mail]* if you have any questions about this research. You may also contact a representative at *[name of IRB]* with any questions about your involvement in this study at *[e-mail].* By participating in this survey, I agree to my survey responses being part of a research study.

1. How are you taking this survey today? *Note: The answers for this question should be tailored to the survey distribution methods your program will use.*
   - ☐ Someone read me the questions in person
   - ☐ Someone read me the questions over the phone/zoom
   - ☐ I took the survey in-person, but I read the questions to myself
   - ☐ I took the survey at home using an electronic link
   - ☐ Prefer not to answer

2. Please write the name of the clinic where you are currently receiving and/or enrolled in [insert incentive program (e.g., Double Up Food Bucks)].

The first set of questions is about your participation in the Supplemental Nutrition Assistance Program, or SNAP, and about your participation in the [insert name of PPR program].

3. In the last 30 days, have you or anyone in your household received EBT, food stamps or SNAP benefits?
   - ☐ Yes
   - ☐ No → ***Go to Question 5***
   - ☐ Don't know/Prefer not to answer → ***Go to Question 5***

4. How long have you been receiving EBT, food stamps, or SNAP benefits?
   - ☐ I just started
   - ☐ Less than a year
   - ☐ More than a year
   - ☐ Don't know/Prefer not to answer

5. Have you used [insert PPR redemption type (e.g., *Food Bucks Rx vouchers*)] to get fruits and vegetables at any of the following places? *Check all that apply. Note: The answers for this question should be tailored to the redemption sites offered with your program. In the case that your program has only one firm type, this question can be omitted.*
   - ☐ Grocery store
   - ☐ Small food store (e.g., corner store, bodega, etc.)
   - ☐ Farmers market
   - ☐ Mobile farm truck
   - ☐ CSA or produce box
   - ☐ On-site clinic 'farmacy'
   - ☐ Other: _____
   - ☐ Don't know/Prefer not to answer

PID

6. How many times have you used your [insert PPR redemption type (e.g., *Food Bucks Rx vouchers*)] to get fruits and vegetables?
   - ☐ I have never used it/them
   - ☐ 1-2 times
   - ☐ 3-10 times
   - ☐ More than 10 times
   - ☐ Don't know/Prefer not to answer

7. Did you participate in any nutrition or food education activities as part of [PPR program name], such as [*insert nutrition education activities offered by your program – e.g., a healthy food table, cooking class, consultation with a registered dietitian, diabetes education class, grocery store tour, etc.*]?
   - ☐ No, I did not participate in any activities
   - ☐ Yes, I participated in 1 activity
   - ☐ Yes, I participated in 2 or more activities
   - ☐ Don't know/Prefer not to answer

8. Overall, how would you rate your experience with *[insert name of PPR program]*?
   - ☐ Very negative
   - ☐ Negative
   - ☐ Neutral
   - ☐ Positive
   - ☐ Very positive
   - ☐ Don't know/Prefer not to answer

The next set of questions is about the different kinds of foods you ate or drank during the past month, that is, the past 30 days. When answering, please include meals and snacks eaten at home, at work or school, in restaurants, and anyplace else.

9. During the past month, how often did you drink 100% PURE FRUIT JUICES such as orange, apple, grape, etc.?

   DO NOT INCLUDE fruit-flavored drinks with added sugar like Capri-Sun, Sunny D, or other fruit-flavored drinks.
   - ☐ Never
   - ☐ 1 time last month
   - ☐ 2-3 times last month
   - ☐ 1 time per week
   - ☐ 2 times per week
   - ☐ 3-4 times per week
   - ☐ 5-6 times per week
   - ☐ 1 time per day
   - ☐ 2-3 times per day
   - ☐ 4-5 times per day
   - ☐ 6 or more times per day
   - ☐ Don't know/Prefer not to answer

10. During the past month, how often did you eat FRUIT like apples, bananas, oranges, melon, or any other fruit?

    INCLUDE fresh, frozen, canned, or dried fruit.
    DO NOT INCLUDE juices.
    - ☐ Never
    - ☐ 1 time last month
    - ☐ 2-3 times last month
    - ☐ 1 time per week
    - ☐ 2 times per week
    - ☐ 3-4 times per week
    - ☐ 5-6 times per week
    - ☐ 1 time per day
    - ☐ 2-3 times per day
    - ☐ 4-5 times per day
    - ☐ 6 or more times per day
    - ☐ Don't know/Prefer not to answer

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11. During the past month, how often did you eat a GREEN LEAFY OR LETTUCE SALAD, with or without other vegetables?
    - ☐ Never
    - ☐ 1 time last month
    - ☐ 2-3 times last month
    - ☐ 1 time per week
    - ☐ 2 times per week
    - ☐ 3-4 times per week
    - ☐ 5-6 times per week
    - ☐ 1 time per day
    - ☐ 2 or more times per day
    - ☐ Don't know/Prefer not to answer

12. During the past month, how often did you eat any kind of FRIED POTATOES like French fries, tater tots, hash brown potatoes, or other fried potatoes?
    - ☐ Never
    - ☐ 1 time last month
    - ☐ 2-3 times last month
    - ☐ 1 time per week
    - ☐ 2 times per week
    - ☐ 3-4 times per week
    - ☐ 5-6 times per week
    - ☐ 1 time per day
    - ☐ 2 or more times per day
    - ☐ Don't know/Prefer not to answer

13. During the past month, how often did you eat any OTHER KIND OF POTATOES that aren't fried, like baked, boiled, mashed, or potatoes used in soups and stews?
    - ☐ Never
    - ☐ 1 time last month
    - ☐ 2-3 times last month
    - ☐ 1 time per week
    - ☐ 2 times per week
    - ☐ 3-4 times per week
    - ☐ 5-6 times per week
    - ☐ 1 time per day
    - ☐ 2 or more times per day
    - ☐ Don't know/Prefer not to answer

14. During the past month, how often did you eat refried beans, baked beans, pinto beans, black beans, beans in soup, or any other type of COOKED BEANS?

    INCLUDE canned or dry beans.
    DO NOT INCLUDE green beans or string beans.
    - ☐ Never
    - ☐ 1 time last month
    - ☐ 2-3 times last month
    - ☐ 1 time per week
    - ☐ 2 times per week
    - ☐ 3-4 times per week
    - ☐ 5-6 times per week
    - ☐ 1 time per day
    - ☐ 2 or more times per day
    - ☐ Don't know/Prefer not to answer

15. During the past month, how often did you eat other VEGETABLES that were not deep-fried? These are vegetables like carrots, broccoli, collards, green beans, corn, or other vegetables that are not deep-fried.

    INCLUDE canned, frozen, or fresh vegetables. ALSO INCLUDE vegetables that are raw, boiled, broiled, baked, grilled, stir-fried, or microwaved.
    - ☐ Never
    - ☐ 1 time last month
    - ☐ 2-3 times last month
    - ☐ 1 time per week
    - ☐ 2 times per week
    - ☐ 3-4 times per week
    - ☐ 5-6 times per week
    - ☐ 1 time per day
    - ☐ 2 or more times per day
    - ☐ Don't know/Prefer not to answer

PID

16. During the past month, how often did you eat packaged or homemade SALSA made with tomato?
    - ☐ Never
    - ☐ 1 time last month
    - ☐ 2-3 times last month
    - ☐ 1 time per week
    - ☐ 2 times per week
    - ☐ 3-4 times per week
    - ☐ 5-6 times per week
    - ☐ 1 time per day
    - ☐ 2 or more times per day
    - ☐ Don't know/Prefer not to answer

17. During the past month, how often did you eat PIZZA?

    INCLUDE frozen pizza, fast food pizza, and homemade pizza.
    - ☐ Never
    - ☐ 1 time last month
    - ☐ 2-3 times last month
    - ☐ 1 time per week
    - ☐ 2 times per week
    - ☐ 3-4 times per week
    - ☐ 5-6 times per week
    - ☐ 1 time per day
    - ☐ 2 or more times per day
    - ☐ Don't know/Prefer not to answer

18. During the past month, how often did you eat TOMATO SAUCE in recipes such as spaghetti, lasagna, or other dishes?

    DO NOT INCLUDE tomato sauce on pizza.
    - ☐ Never
    - ☐ 1 time last month
    - ☐ 2-3 times last month
    - ☐ 1 time per week
    - ☐ 2 times per week
    - ☐ 3-4 times per week
    - ☐ 5-6 times per week
    - ☐ 1 time per day
    - ☐ 2 or more times per day
    - ☐ Don't know/Prefer not to answer

The next set of questions is about the food eaten in your household in the last 30 days, and whether you were able to afford the food you need.

19. The food that we bought just didn't last, and we didn't have money to get more. Was that often, sometimes, or never true for your household in the last 30 days?
    - ☐ Often true
    - ☐ Sometimes true
    - ☐ Never true
    - ☐ Don't know/Prefer not to answer

20. We couldn't afford to eat balanced meals. Was that often, sometimes, or never true for your household in the last 30 days?
    - ☐ Often true
    - ☐ Sometimes true
    - ☐ Never true
    - ☐ Don't know/Prefer not to answer

21. In the last 30 days, did you or other adults in your household ever cut the size of your meals or skip meals because there wasn't enough money for food?
    - ☐ Yes
    - ☐ No → ***Go to Question 23***
    - ☐ Don't know/Prefer not to answer → ***Go to Question 23***

22. In the last 30 days, how many days did this happen?

    _____days

23. In the last 30 days, did you ever eat less than you felt you should because there wasn't enough money for food?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/Prefer not to answer

24. In the last 30 days, were you ever hungry but didn't eat because there wasn't enough money for food?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know/Prefer not to answer

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The next items ask about how the coronavirus (COVID-19) pandemic has affected you and your household. Please select how much you personally disagree or agree with each of the statements.

25. The coronavirus (COVID-19) has made it hard for me and others in my household to make ends meet.
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither disagree nor agree
    - ☐ Agree
    - ☐ Strongly agree
    - ☐ Don't know/Prefer not to answer

26. The coronavirus (COVID-19) has made it hard for me and others in my household to buy fruits and vegetables.
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neither disagree nor agree
    - ☐ Agree
    - ☐ Strongly agree
    - ☐ Don't know/Prefer not to answer

27. Since the coronavirus (COVID-19) outbreak have you or anyone in your household gotten free groceries from a food pantry, food bank, church, or other place that helps with free food?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know

The last section is about you.

28. Would you say that in general your health is poor, fair, good, very good, or excellent?
    - ☐ Poor
    - ☐ Fair
    - ☐ Good
    - ☐ Very good
    - ☐ Excellent
    - ☐ Don't know/Prefer not to answer

29. What is your age?
    - ☐ Age:_____
    - ☐ Prefer not to answer

30. How do you describe yourself?
    - ☐ Man
    - ☐ Non-binary/third gender
    - ☐ Woman
    - ☐ Prefer to self-describe: _____
    - ☐ Prefer not to answer

31. Are you of Hispanic, Latino/a, or Spanish origin?
    - ☐ Yes
    - ☐ No
    - ☐ Prefer not to answer

32. How would you describe your racial or ethnic background? *Check all that apply.*
    - ☐ American Indian or Alaska Native
    - ☐ Asian
    - ☐ Black or African American
    - ☐ Native Hawaiian
    - ☐ Other Pacific Islander
    - ☐ White
    - ☐ Other race: _____
    - ☐ Don't know/not sure
    - ☐ Prefer not to answer

33. What is the zip code where you currently live?
    - ☐ Enter 5-digit zip code:_____
    - ☐ Don't know

You have completed the survey. Please return your survey to the program staff. Thank you for your participation!