FIMMA
FOOD IS MEDICINE MASSACHUSETTS

MAY 2021

Food is Medicine Program Definitions and Standards

CONTENTS

Introduction: Methodology

The Food is Medicine program definitions and standards were created by the Community Based Organization (CBO) Task Force within the Food is Medicine Massachusetts (FIMMA) coalition from February 2019 through October 2020. The definitions and standards were created as a response to the Massachusetts Food is Medicine State Plan's findings that there were no clear definitions or standards for these services across the state, and that this lack of clarity was a barrier to healthcare organizations making referrals to these services.

The CBO Task Force consists of 76 organizations representing healthcare systems, governmental agencies, nutrition services providers, and community based organizations that provide a range of Food is Medicine (FIM) services. Members elect to participate in the Task Force as part of their FIMMA membership application. The primary goal for the Task Force was to reach consensus on broad intervention definitions and intervention standards. These definitions and standards will provide guidance to CBOs, healthcare payers, healthcare providers, and consumers for the purpose of:

- Expanding access to Food is Medicine interventions to individuals at risk for or coping with diet-related chronic illness;
- Investing in and scaling Food is Medicine interventions;
- Expanding health insurance reimbursement of Food is Medicine interventions;
- Referring consumers in the healthcare setting to the appropriate nutrition resource in the community.

Process for creating definitions

1. An initial discussion with CBO Task Force created a set of guidelines for the definitions, including:
   a. Definitions should be as broad as possible, so as not to exclude FIM programs by their program designs.
   b. Where certain specificity is needed, consider where it could be included as part of Program Standards, as opposed to the definition itself.
   c. Ensure that definitions promote health equity.
4. Existing definitions, as found in the State Plan survey and report, a literature review, and environmental scan of usage, were compiled and compared for commonalities.
5. Based on this information, the CBO Task Force leaders (Community Servings and the Greater Boston Food Bank) developed recommendations for discussion with the Task Force.
6. Following the discussion, the Task Force members provided final feedback and agreed upon those definitions.
7. The definitions were presented to the FIMMA Steering Committee for edits and feedback.
8. The CBO Task Force incorporated the Steering Committee's edits into a final draft that the Steering Committee voted to approve in October 2020.

Process for creating standards

1. Using the categories of standards (e.g. standards for eligibility, staffing, etc.) set by the Food is Medicine Coalition's medically tailored meal standards as a guide, data was collected on key program elements from:
   a. An environmental scan of FIM organizations throughout MA and nationally
   b. A literature review of peer-reviewed research on FIM programs
   c. Informational interviews of FIMMA member organizations representing each FIM program type

2. A draft set of standards was created using this data; this draft was reviewed, edited, and approved by a working group consisting of representatives from the organizations who were interviewed (#1c) and other members of the CBO Task Force.
3. The standards were presented to the CBO Task Force during monthly meetings, where members had the opportunity to provide feedback then or subsequently through email.

Following the development of all four sets of standards, all standards were presented to the FIMMA Steering Committee for edits and feedback.

Members of the standards working group incorporated the Steering Committee's edits into a final draft that the Steering Committee voted to approve in October 2020.

Definitions for Food is Medicine Intervention Types

MEDICALLY TAILORED MEALS:

Medically tailored meals are developed to address the dietary needs of an individual's medical condition by a Registered Dietitian Nutritionist. Individuals are referred by a healthcare provider or plan.

MEDICALLY TAILORED FOOD PACKAGES:

Medically tailored food packages include a selection of minimally prepared grocery items selected by a Registered Dietitian Nutritionist or other qualified nutrition professional as part of a treatment plan for an individual with a defined medical diagnosis. The recipient of a medically tailored food package is typically capable of shopping for and picking up the food and preparing it at home, and is referred by a healthcare provider or plan.

NUTRITIOUS FOOD REFERRALS:

Nutritious food referrals provide funds for free or discounted nutritious foods. Individuals must receive referrals from healthcare providers or plans after being identified as having or being at risk for diet-related diseases.

COMMUNITY-LEVEL HEALTHY FOOD PROGRAMS:

Community-level healthy food programs provide nutritious foods for a population that currently has or is at increased risk for chronic disease associated with food insecurity. These programs are done in partnership or consultation with a healthcare payer, provider or nutrition professional, for screening or referrals, and/or in program design, management, or evaluation.

Introduction to Standards

ON FOOD QUALITY AND SOURCING IN FOOD IS MEDICINE (FIM) INTERVENTIONS:

The purpose of FIM providers is to increase consumption of nutritious foods for individuals with food insecurity who experience or are at risk of experiencing diet-related disease. As partnerships with healthcare providers develop and scale, FIM interventions present a unique opportunity to purchase from local food producers, thereby optimizing health through freshly harvested food, supporting our environment through sourcing from farms practicing sustainable agriculture, and bolstering our regional economies through the economic multiplier effect of buying locally. **To maximize the interventions' impact, FIM programs should make every effort to source food locally to enable a resilient and sustainable regional food system.** Robust evidence reveals rampant health disparities and inequities in communities of color**. FIM providers should make every effort to offer culturally familiar food options in consideration of the population they serve.**

ON PILOTING, DEVELOPING AND/OR SCALING FIM INTERVENTIONS:

In recognition of the diversity of regional CBOs that can provide valuable support to individuals with complex needs, a central FIM goal is to nurture, build and strengthen partnerships between local CBOs and the healthcare system, so that both sectors can provide high-quality, comprehensive support to those with complex needs. By building a responsive infrastructure that utilizes existing local/regional FIM and/or healthy, local food-based programs and leverages local knowledge such as the cultural needs of a target population, a nimble and responsive community-based solution is advanced. In supporting community-based solutions, FIM can also lead to widening job creation, worker education and skills, as well as diversity and equity policies to foster greater inclusion of vulnerable groups into the labor market. When the resiliency and diversity of regional CBOs and their local economies are strengthened through FIM programs, the benefits span far beyond Food is Medicine.

MEDICALLY TAILORED MEALS

Definition: Medically tailored meals (MTM) are developed to address the dietary needs of an individual's medical condition by a Registered Dietitian Nutritionist. Individuals are referred by a healthcare provider or plan.

Medically Tailored Meals Program Standards

1. ROLE OF NUTRITION PROFESSIONALS

The goal of this section is to ensure that individuals receiving MTM services have access to an appropriate level of engagement from a nutrition professional to ensure that they receive MTM that address their medical and nutritional needs, and their needs for related nutrition counseling and education. "Nutrition Professionals" may include Registered Dietitian Nutritionists (RDNs), credentialed Nutrition and Dietetics Technicians, Registered (NDTRs), and Licensed Dietitian Nutritionists (LDNs), whose recommended scope of work in the provision of MTM is delineated below.

- An initial in-depth assessment of the client's medical and nutritional needs in order to ensure that the client receives an appropriate meal program/plan should be conducted by an RDN or LDN.
- RDNs or NDTRs must be engaged with kitchen staff in the development of the meals to ensure adherence to clinical standards.
- RDNs must be integrated into the entire intervention process, from menu design to intake, assessment and ongoing Medical Nutrition Therapy (MNT), nutrition counseling and nutrition education.

2A. REFERRAL

- Clients are referred by a healthcare professional as part of a treatment plan.
  - The term "healthcare professional" is broad, and includes, without limitation, physicians, nurse practitioners, nurses, physician assistants, social workers, case managers, care coordinators, patient navigators, health outreach workers, community health workers, RDNs, diabetes educators, oral health providers, substance use disorder treatment professionals, and mental health professionals.
- Each referral must include a client's diagnosis and the rationale for the MTM program.
- Program access must not be prioritized by categorical restrictions like immigration status, race, sexual orientation, etc.

2B. ASSESSMENT AND REASSESSMENT

- Clients' nutrition needs related to their disease, medication, and symptoms are assessed upon intake and at least annually thereafter.
- Assessment and reassessment are overseen or approved by an RDN or LDN.

3. MEDICAL NUTRITION THERAPY (MNT), NUTRITION COUNSELING, AND NUTRITION EDUCATION

- MTM providers must offer MNT, nutrition counseling, and nutrition education, as defined by the Academy of Nutrition and Dietetics.
- MNT practices/standards must adhere to those established by the Academy of Nutrition and Dietetics.
  - Nutrition counseling may include nutrition workshops and peer support groups.
  - Nutrition counseling may take place telephonically, via a secure online platform, or in person.

4. MEDICAL TAILORING

- MTM providers must offer medical diets to at least one of the following illness groups (and/or illness groups currently studied and shown to respond to diet related intervention):
  - HIV, cardiovascular disease, diabetes, renal disease, lung disease, and cancer
- For clients with multiple conditions, meals must be tailored to address the primary diagnosis and any co-morbid conditions whose nutritional needs conflict with the primary diagnosis.

4A. QUANTITY OF NUTRITION & DURATION OF SERVICE PROVIDED

- MTM providers must provide a minimum of 50% of clients' daily nutritional needs, or two meals a day, including caloric intake, macronutrients, vitamins, and minerals.
- Service must be offered for a minimum of 12 weeks.

4B. FOOD QUALITY

- When possible, meals should be made from scratch, using minimally processed ingredients. When pre-prepared foods are used, they must meet nutritional standards approved by an RDN.
- Regular quality testing, via client feedback and nutrition audits by RDNs/NDTRs, must be used as part of assessment of meal quality.
- MTM providers should offer culturally familiar food.
- MTM providers should source as much food as possible via local producers, including, without limitation, farms, fisheries, and dairy producers.

4C. CLINICAL STANDARDS

- Meals must meet the clinical nutrition standards for medically tailored meals as developed by the Food is Medicine Coalition (FIMC).
- On an annual basis, the CBO Task Force will review the standards developed by FIMC and the Academy of Nutrition and Dietetics, and update these standards as warranted.

5. FOOD SAFETY & EMERGENCY PREPAREDNESS

- MTM providers:
  - Must have a food safety policy, a certified food handler on each kitchen shift, and maintain clean kitchen and facilities.
  - Must meet State and local Board of Health standards and pass inspections.
  - Must have an emergency response plan outlining strategies for equitable distribution of food during emergencies (e.g., natural disasters and pandemics) to clients.
- Lead kitchen staff must be ServSafe Food Protection Manager certified.

6. PROGRAM ASSESSMENT & QUALITY IMPROVEMENT

- MTM providers:
  - Must maintain a Quality Improvement Program with client satisfaction measures that are reported on annually, including:
    - Client satisfaction surveys, or other opportunities for clients to provide feedback
    - Policy on addressing client complaints
    - Quality Improvement Committee to evaluate quality goals and address issues
    - Process to reach clients who have fallen out of care and have not notified the agency
    - Provide information and referral services to clients, as need or requested
  - Should work towards tracking clinical and cost outcomes.
  - Should assess status of culturally familiar food, and quantity of food used in the program that is locally sourced.
- Program assessment should work towards tracking demographic data that aligns with the goal of achieving health equity, including but not limited to race, gender, income, etc.
- When advancements in technology alter program design and implementation, programs should assess if there is an appropriate level of human oversight for these processes and decisions.

7. LEGAL ENTITY

- MTM providers must operate as a 501(c)(3) corporation.

8. HIPAA COMPLIANCE

- If MTM providers receive Protected Health Information, they must be knowledgeable of HIPAA requirements regardless of their contracting status.
- If MTM providers are currently or plan to become contracting partners, they must

manage Protected Health Information received from contracting partners in accordance with all applicable federal and state laws governing such information. Therefore, MTM providers must maintain privacy policies and procedures in compliance with applicable law.

The agency must:

- Assess the applicability of federal and state laws governing the privacy and confidentiality of client information, including the federal Health Information Portability and Accountability Act ("HIPAA")
- Implement policies and procedures to safeguard client information in compliance with applicable law.

9. CLIENT-CENTEREDNESS

- MTM programs must strive to meet the individual needs of their clients. This client-centered approach includes addressing individual dietary needs, as well as other elements of program implementation, such as delivery of meals, household capacity for storing and heating meals, client communication, and cultural appropriateness of meals.
- Clients must be provided with easy to understand and accurate information about how to use and enroll in the program. Translation services should be provided when needed.

MEDICALLY TAILORED FOOD PACKAGES

Definition: Medically tailored food packages (MTFP) include a selection of minimally prepared grocery items selected by a Registered Dietitian Nutritionist or other qualified nutrition professional as part of a treatment plan for an individual with a defined medical diagnosis. The recipient of a medically tailored food package is typically capable of shopping for and picking up the food and preparing it at home, and is referred by a healthcare provider or plan.

Medically Tailored Food Package Program Standards

1. ROLE OF NUTRITION PROFESSIONALS

The goal of this section is to ensure that individuals receiving MTFP services have access to an appropriate level of engagement from a nutrition professional to ensure that they receive MTFP that address their medical and nutritional needs, and their needs for related nutrition counseling and education. "Nutrition Professionals" may include Registered Dietitian Nutritionists (RDNs), credentialed Nutrition and Dietetics Technicians, Registered (NDTRs), and Licensed Dietitian Nutritionists (LDNs), whose recommended scope of work in the provision of MTFP is delineated below.

- An initial in-depth assessment of the client's medical and nutritional needs and food preparation skills, in order to ensure that the client receives an appropriate groceries program/plan, should be conducted by an RDN or LDN.
- RDNs or NDTRs must be engaged with program staff when curating foods for MTFP to ensure adherence to clinical standards.
- RDNs must be integrated into the entire intervention process, from MTFP design to intake, assessment and ongoing MNT, nutrition counseling and nutrition education.

2A. REFERRAL

- Clients are referred by a healthcare professional as part of a treatment plan.
  - The term "healthcare professional" is broad, and includes, without limitation, physicians, nurse practitioners, nurses, physician assistants, social workers, case managers, care coordinators, patient navigators, health outreach workers, community health workers, RDNs, diabetes educators, oral health providers, substance use disorder treatment professionals, and mental health professionals.
- Each referral must include a client's diagnosis and the rationale for the MTFP program.
- Program access must not be prioritized by categorical restrictions like immigration status, race, sexual orientation, etc.

2B. ASSESSMENT AND REASSESSMENT

- Client's disease, medication, symptom-related nutrition needs, nutrition literacy, and cooking skills are assessed upon intake. Reassessments should be conducted annually or at least once during program duration.
- Assessment and reassessment are overseen or approved by an RDN or LDN.

3. MEDICAL NUTRITION THERAPY, NUTRITION COUNSELING, AND NUTRITION EDUCATION

- MTFP providers must offer MNT, nutrition counseling, and nutrition education, as defined by the Academy of Nutrition and Dietetics.
- MNT practices/standards must adhere to those established by the Academy of Nutrition and Dietetics.
  - Nutrition Counseling may include nutrition workshops and peer support groups.
  - Nutrition Counseling may take place telephonically, via a secure online platform, or in person.

4. MEDICAL TAILORING

- MTFP providers must offer medical diets to any of the following illness groups (and/or illness groups currently studied and shown to respond to diet related intervention):
  - HIV, cardiovascular disease, diabetes, prediabetes, renal disease, lung disease, hypertension, high cholesterol, obesity/

overweight, and cancer.

- For clients with multiple conditions, food packages must be tailored to address the primary diagnosis and any co-morbid conditions whose nutritional needs conflict with the primary diagnosis.

4A. QUANTITY OF NUTRITION & DURATION OF SERVICE PROVIDED

- MTFP providers must provide enough food to make up at least one meal, or 30% of clients daily nutritional needs, including caloric intake, macronutrients, vitamins, and minerals, throughout the duration of the service.
- Service must be offered for a minimum of 12 weeks.

4B. FOOD QUALITY

- MTFP should include a selection of unprepared foods or minimally prepared ingredients (e.g. pre-cut vegetables, cooked chicken breast, cooked grains). The prepared ingredients must meet nutritional standards approved by an RDN.
- MTFP providers should offer culturally familiar food.
- MTFP providers should source as much food as possible via local producers, including, without limitation, farms, fisheries, and dairy producers.

4C. CLINICAL STANDARDS

- Clinical standards for MTFP food should be adapted from FIMC MTM standards.
- On an annual basis, the CBO Task Force will review the standards developed by FIMC and the Academy of Nutrition and Dietetics, and update these standards as warranted.

5. FOOD SAFETY & EMERGENCY PREPAREDNESS

- MTFP providers:
  - Must have a food safety policy, a certified food handler on each kitchen shift, and maintain clean kitchen and facilities if some foods in the MTFP are partially prepared.
  - Must meet State and local Board of Health standards and pass inspections.
  - Must have an emergency response plan outlining strategies for equitable distribution of food during emergencies (e.g., natural disasters and pandemics) to clients.
- Lead kitchen staff must be ServSafe Food Protection Manager certified if some foods in the MTFP are partially prepared.

6. PROGRAM ASSESSMENT & QUALITY IMPROVEMENT

- MTFP providers:
  - Must maintain a Quality Improvement Program with client satisfaction measures that are reported on annually, including:
    - Client satisfaction surveys, or other opportunities for clients to provide feedback
    - Policy on addressing client complaints
    - Quality Improvement Committee to evaluate quality goals and address issues
    - Process to reach clients who have fallen out of care and have not notified the agency
    - Provide information and referral services to clients, as needed or requested
  - Should work towards tracking clinical and cost outcomes.
  - Should assess status of culturally familiar food, and quantity of food used in the program that is locally sourced.
- Program assessment should work towards tracking demographic data that aligns with the goal of achieving health equity, including but not limited to race, gender, income, etc.

7. LEGAL ENTITY

- MTFP providers must operate as a 501(c)(3) corporation.

8. HIPAA COMPLIANCE

- If MTFP providers receive Protected Health information, they must be knowledgeable of HIPAA requirements regardless of their contracting status.
- If MTFP providers are currently or plan to become contracting partners, they must

manage Protected Health Information received from contracting partners in accordance with all applicable federal and state laws governing such information. Therefore, MTFP providers must maintain privacy policies and procedures in compliance with applicable law.

The agency must:

- Assess the applicability of federal and state laws governing the privacy and confidentiality of client information, including the federal Health Information Portability and Accountability Act ("HIPAA")
- Implement policies and procedures to safeguard client information in compliance with applicable law"

9. CLIENT-CENTEREDNESS

- MTFP programs must strive to meet the individual needs of their clients. This client-centered approach includes addressing individual dietary needs, as well as other elements of program implementation, such as delivery of food packages, household resources for storing and cooking foods (including availability of appliances and cooking implements), client communication, and cultural familiarity of foods.
- Clients must be provided with easy to understand and accurate information about how to use and enroll in the program, its hours and locations, and how often they can utilize it. Translation services should be provided when needed.

NUTRITIOUS FOOD REFERRALS

Definition: Nutritious food referrals (NFR) provide funds for free or discounted nutritious foods. Individuals must receive referrals from healthcare providers or plans after being identified as having or being at risk for diet-related diseases.

Nutritious Food Referrals Program Standards

1. STRUCTURE

- The NFR program is a partnership between the NFR food program, the healthcare organization or professional referring patients into the program, and a vendor of nutritious foods. Types of partnering agencies and delineation of roles may vary but typically include a non-profit agency operating the NFR program, a healthcare agency screening patients and making program referrals, and a local food provider that accepts NFR food vouchers.
- At least one of the partners must be a nonprofit, public entity, or a locally owned or operated food provider.

2. ADMINISTRATION

- NFR partnering agencies should develop policies and procedures that clearly delineate the roles and responsibilities of each organization, including but not limited to: client eligibility and screening processes, referral mechanisms, client assessments, tracking NFR voucher redemption and client clinical outcomes, and communication methods across agencies.
- To preserve the dignity and privacy of NFR clients, NFR program staff or volunteers should be on-site at markets where patients redeem NFR vouchers to provide assistance with NFR voucher redemption, whenever feasible. If program staff or volunteers cannot be on-site at all markets:
  - Market vendors/staff should be trained on NFR redemption procedures and HIPAA compliance for gathering NFR voucher redemption data.
  - Market vendors/staff should have a mechanism for communicating with NFR program staff if they need NFR program technical assistance.

3. ELIGIBILITY

- NFR programs must offer NFRs to selected individuals experiencing or at risk for a chronic disease and/or to individuals experiencing food insecurity whose health outcome might be improved by better access to a variety of nutritious foods. Qualifying diseases include, but are not limited to: HIV/AIDS, heart disease, diabetes, renal disease, lung disease, gastrointestinal diseases, and auto-immune disease or immune deficiencies.
- Program access must not be prioritized by categorical restrictions like immigration status, race, sexual orientation, etc.

4. REFERRAL

- Clients are referred by a healthcare professional as part of a treatment or prevention plan.
- The term “healthcare professional” is broad, and includes, without limitation, physicians, nurse practitioners, nurses, physician assistants, social workers, case managers, care coordinators, patient navigators, health outreach workers, community health workers, registered dietitian nutritionists, diabetes educators, oral health providers, substance use disorder treatment professionals, and mental health professionals.

5. NUTRITION/FOOD PROVIDED

- Eligible NFR foods are minimally or un-processed whole foods without additives (vitamin fortification is acceptable). This includes but is not limited to the following foods: milk and unsweetened yogurt, unsweetened dairy substitutes, fruits, vegetables, whole grains, legumes, seeds, nuts, lean meat, poultry, fish, and eggs. NFR foods can include canned or frozen whole foods (no additives).
- NFR offerings must include fresh fruits and vegetables.
- NFR providers must offer a variety of NFR-eligible foods for patients, whenever feasible.
- NFR providers should source as much food as

possible via local producers, including, without limitation, farms, fisheries, and dairy producers.

- NFR providers should offer culturally familiar food.
- NFR programs should last for a minimum of 12 weeks.

6. CLIENT ACCESS

- Clients must be provided with easy to understand and accurate information about how to use the program, including the hours and locations of markets that accept NFR vouchers, types of eligible NFR foods, and the deadlines for redeeming NFR vouchers. Translation services should be provided when needed.
- Voucher redemption deadlines must account for client needs and schedules.
- Eligible foods must be free, subsidized, or discounted to the client in order to incentivize the completion of the referral. NFR programs that provide vouchers for food should consider the minimum amount of funds that will incentivize clients to purchase NFR-eligible foods. NFR programs that provide NFR food discounts should subsidize a minimum of 30% of the NFR-eligible food purchase.
- Services or funds for transportation to NFR-eligible food providers should be provided for clients with transportation barriers, whenever feasible.

7. NUTRITION EDUCATION

- NFR programs must offer nutrition education and/or NFR program education to maximize the impact of the NFR program. Education may include but is not limited to information on food storage and preparation, tips for shopping at the market, and recipes for offered foods.
- NFR programs should offer hands-on education such as cooking classes and demonstrations to build community and enhance behavioral change, whenever feasible.
- When the NFR program does not allow for clients to choose the foods that they redeem, recipes for cooking with the available foods should be provided.

8. ROLE OF NUTRITION PROFESSIONALS

- "Nutrition Professionals" may include Registered Dietitian Nutritionists (RDNs), credentialed Nutrition and Dietetics Technicians, Registered (NDTRs), Licensed Dietitian Nutritionists (LDNs), and Dietetic Interns. Nutrition professionals should be involved in at least one of the activities, for which they are credentialed to perform, delineated below.
  - Interacting with clients, providing support in making food purchasing decisions, and providing nutrition education at markets where clients pick up/purchase their NFR foods.
  - Developing nutrition education materials or delivering nutrition education.
  - Incorporating discussions about how clients are utilizing their NFRs into ongoing nutrition counseling sessions they have with individual patients.
  - Referring clients to the NFR program and assessing their NFR usage and needs throughout the duration of the program.
  - Providing training to healthcare partner staff about how the NFR program works and why Food is Medicine interventions are important to client health.

9. PROGRAM ASSESSMENT

- NFR programs must maintain a Quality Improvement Program that includes patient satisfaction surveys (or other opportunities for clients to provide feedback), policy on addressing patient complaints, and program staff to evaluate quality goals and address issues. Findings from the Quality Improvement Program should be reported at least annually.
- The redemption of NFR vouchers must be tracked for each NFR patient. This may be tracked manually by program staff/volunteers/associates or by data systems linked to electronic benefit cards for the NFR program. The healthcare partner should work towards tracking clinical and cost outcomes.
- NFR programs should assess status of

culturally familiar food, and quantity of food used in the program that is locally sourced.

10. FOOD SAFETY & EMERGENCY PREPAREDNESS

- NFR programs must have a food safety policy that all staff are trained on, as appropriate for the entity.
- NFR programs must meet their respective State and local Board of Health standards and pass inspections.
- NFR programs must have an emergency response plan outlining strategies for equitable distribution of food during emergencies (e.g., natural disasters and pandemics) to clients.

COMMUNITY-LEVEL HEALTHY FOOD PROGRAMS

Definition: Community-level healthy food programs (CLHFP) provide nutritious foods for a population that currently has or is at increased risk for chronic disease associated with food insecurity. These programs are done in partnership or consultation with a healthcare payer, provider or nutrition professional, for screening or referrals, and/or in program design, management, or evaluation.

Background: Because CLHFP vary greatly in program design, this section provides additional context to the standards.

Examples of population level healthy food programs (excluding generalized federal nutrition programs such as SNAP and WIC)**.** *These programs qualify as CLHFP when done in partnership or consultation with a healthcare payer, provider or nutrition professional for screening or referrals, and/or in program design, management, or evaluation:*

- Grocery store and farmers market nutrition incentives (NIs)
- Community supported agriculture
- Food bank/pantry and produce/food boxes
- Discounted/free food markets (mobile and immobile)
- Delivered or congregate meals
- Community garden/home gardens

Community-Level Healthy Food Program Standards

1. ELIGIBILITY

- Programs must offer nutritious foods to a population that currently has or is at increased risk for chronic disease including chronic illnesses that might be associated with food insecurity, including but not limited to: HIV/AIDS, heart disease, diabetes, renal disease, lung disease, gastrointestinal diseases, overweight and obesity, and auto-immune deficiencies.
- Any member of that population is eligible for the program.
  - Program access must not be prioritized by categorical restrictions like immigration status, race, sexual orientation, etc.

2. ADMINISTRATION

- Programs are done in partnership or consultation with a healthcare payer, provider or nutrition professional.
  - The term "healthcare professional" is broad, and includes, without limitation, physicians, nurse practitioners, nurses, physician assistants, social workers, case managers, care coordinators, patient navigators, health outreach workers, community health workers, oral health providers, substance use disorder treatment professionals, and mental health professionals.
  - "Nutrition professionals" may include Registered Dietitian Nutritionists (RDNs), credentialed Nutrition and Dietetics Technicians, Registered (NDTRs), Licensed Dietitian Nutritionists (LDNs), and diabetes educators.

3. NUTRITION/FOOD PROVIDED

- Types of food provided[1]
  - Eligible CLHFP foods can include:
    - Single ingredient food items including fresh fruits, vegetables, whole grains, legumes, seeds, nuts, lean meat, poultry, fish and eggs.
    - Items from 1) that have been minimally processed for storage or easier preparation. This includes canned or frozen fruit, vegetables, beans, and animal proteins.
      - » Vegetables should have no more than 140mg of added sodium per serving; Fruit should have no added sugar;

1. Programs may also offer resources to grow one's own food.

Beans and animal proteins should have less than 200mg of added sodium per serving.

- Dairy items such as milk and yogurt or non-dairy beverage and yogurt alternatives. Items should have no added sugar.
- Prepared meals should contain no more than 6.5 grams of saturated fat, 600 milligrams of added sodium, and 10 grams of added sugar.[2]

- CLHFP providers must offer a variety of CLHFP-eligible foods for participants, whenever feasible.
- CLHFP providers should source as much food as possible via local producers, including, without limitation, farms, fisheries, and dairy producers.
- CLHFP providers should offer culturally familiar food.

- Amount of food provided
  - The program should offer healthful food choices or the ability to grow healthy foods that result in a regular increase of nutritious food consumption and improved food access for a sustained period of time in order to encourage beneficial habits for a participant's long-term health.

4. PARTICIPANT ACCESS

- CLHLP programs must remove barriers to a population's ability to access healthy food. These may be, but are not limited to, financial barriers (e.g. foods that are free, subsidized or discounted to the client), location barriers (e.g., mobile markets that serve areas without brick-and-mortar markets), or time barriers (e.g., prepared meals for working parents).
- Participants must be provided with easy to understand and accurate information about how to use and enroll in the program, its hours and locations, and how often they can utilize it. Translation services should be provided when needed.
- Services or funds for transportation to pick up or deliver foods should be provided for participants with transportation barriers, whenever feasible.

5. NUTRITION EDUCATION

- If feasible, the program should offer nutrition education or a nutrition education strategy to maximize the impact of the program. Education may include information on food storage and preparation, tips for shopping for nutritious foods, education for beginner gardeners, and food demonstrations and recipes for offered foods.

6. PARTICIPANT SATISFACTION AND IMPACT ASSESSMENT

- CLHFPs:
  - Must maintain a Quality Improvement Program that includes relevant metrics. It is suggested that the program maintains participant satisfaction surveys (or other opportunities for clients to provide feedback) and resources on addressing participant complaints. Findings from the Quality Improvement Program should be reviewed at least annually.
    - For programs operating with a nutrition incentive partnership that already requires the program to evaluate and report on specific metrics, those metrics are an adequate stand-in for the Quality Improvement Plan outlined above.
  - Should assess status of culturally familiar food, and quantity of food used in the program that is locally sourced.
  - Should be held accountable for identifying the food needs of the population.
  - Should assess community language

2. This guideline is informed by Supporting Wellness at Pantries (SWAP). SWAP was developed by researchers at the University of Saint Joseph (USJ) Department of Nutrition and Public Health and SNAP-Ed program, and was a collaboration between USJ, the UConn Rudd Center for Food Policy & Obesity, and the Council of Churches of Greater Bridgeport.

needs and provide translated outreach, communication, and programmatic materials when needed.

- For CLHFPs that were designed in consultation (that is, not an ongoing partnership) with a healthcare payer, provider, or nutrition professional, programs must conduct an annual internal review to ensure fidelity to the original recommendations.

7. FOOD SAFETY & EMERGENCY PREPAREDNESS

- Programs must have a food safety policy that all staff and volunteers are trained on, as appropriate for the entity.
- When necessary, programs must have permissions from the boards of health in the towns in which the food is distributed.
- Programs must have an emergency response plan outlining their strategies for equitable continuation of services during emergencies (e.g., natural disasters and pandemics) for their participants.