FOOD IS MEDICINE™ COALITION

Medically Tailored Meal Intervention Accreditation Criteria and Requirements

Version 1.1

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Terms and Definitions

Agency: An agency is a legal entity that provides a medically tailored meal (MTM) intervention which meets the requirements of this standard and is accredited by the Food Is Medicine Coalition (FIMC).

FIMC Clinical Committee: The FIMC Clinical Committee is comprised of Registered Dietitian Nutritionists (RDNs) from FIMC agencies and provides professional guidance on the nutritional aspects of services provided by FIMC agencies. The Committee develops and maintains relevant and up-to-date Nutrition Standards for medically tailored meals and groceries, informed by evidence-based nutrition guidelines. The Committee is instrumental in providing input regarding the definitions and applications of medically tailored meals, medically tailored groceries, medical nutrition therapy, and industry-standard nutrition practices.

Culinary Team: A culinary team includes at least one person experienced in culinary leadership (e.g., has experience running a professional kitchen) and volume food production (e.g., has worked in a hospital or school restaurant).

Food Is Medicine Coalition (FIMC): The Food Is Medicine Coalition (FIMC) is a national coalition of nonprofit organizations that provide medically tailored meals (MTMs) and groceries, medical nutrition therapy and nutrition counseling and education to people in communities across the country living with severe, chronic or complex illnesses. FIMC's purpose is to advance equitable access to these life-saving interventions through policy change, research and evaluation, and best practices. FIMC agencies created the medically tailored meal intervention and FIMC is the owner of the MTM Intervention Accreditation Criteria and Requirements (i.e., this document).

Medically Tailored Meal (MTMs): An MTM is a component of the MTM Intervention. MTMs are meals delivered to individuals of all ages who live with severe, chronic or complex illness(es) and/or experience activities of daily living limitations, as deemed necessary by a healthcare professional and defined in this standard. A Registered Dietitian Nutritionist (RDN) tailors meal plans to meet the medical needs of the client according to the FIMC MTM Nutrition Standards. MTMs are designed to improve health outcomes, lower cost of care and increase client satisfaction.

Client: A client is a person who receives the medically tailored meal intervention from an agency. Clients live with severe, chronic or complex illness(es) and/or experience activities of daily living limitations. Clients receiving MTMs often require the assistance of family or caregivers and have complex dietary restrictions. As a result, many cannot take advantage of traditional emergency food support systems that may not meet their nutrition needs and/or require participants to leave their homes or shop in stores.

NOTE: An emerging body of research points to MTMs being efficacious alongside treatment for a variety of conditions and situations besides those listed above, such as for those recently exiting the hospital and needing to stabilize at home, for pregnant and post-partum persons, or for those living with mental or behavioral health issues.

Medically Tailored Meal (MTM) Intervention: (See Annex 4) The MTM intervention is the comprehensive process of delivering medically tailored meals where:

- the client is **referred** to the agency with the involvement of healthcare personnel and their eligibility for MTMs is confirmed,
- an **intake and eligibility assessment** is conducted by the agency and a **nutrition risk assessment** is conducted if appropriate,
- the client goes through a **nutrition assessment** with a Registered Dietitian Nutritionist (RDN),
- a **meal and care plan** is tailored for the specific medical circumstances of the client by the RDN,
- **meals** are prepared by the agency and home-delivered, shipped or available for pick-up for the client,
- the client is **reassessed** for eligibility and nutrition need at regular intervals, and
- the client experiences the **ongoing Nutrition Care Process (NCP)**, including nutrition education, support, and reassessment of their needs throughout the course of their intervention.

Terms and Definitions

Medical Nutrition Therapy (MNT): MNT is an evidence-based application of the Nutrition Care Process provided by an RDN. The provision of MNT to a client includes: nutrition assessment/reassessment, nutrition diagnosis, nutrition intervention and monitoring and evaluation that typically results in the prevention, delay or management of diseases and/or conditions. [1]

Nutrition Care Process (NCP): The Nutrition Care Process (NCP) is a systematic approach to providing high quality nutrition care. The NCP was conceived of and is managed by the Academy of Nutrition and Dietetics which credentials Registered Dietitian Nutritionists (RDNs). The NCP consists of four distinct, interrelated steps:

- Nutrition Assessment: The RDN collects and documents information such as food or nutrition-related history; biochemical data, medical tests and procedures; anthropometric measurements, nutrition-focused physical findings and client history.
- Nutrition Diagnoses: Data collected during the nutrition assessment guides the RDN in selection of the appropriate nutrition diagnosis (i.e., naming the specific problems).
- Nutrition Intervention: The RDN then selects the nutrition intervention that will be directed to the root cause (or etiology) of the nutrition problem and aimed at alleviating the signs and symptoms of the diagnosis.
- Nutrition Monitoring and Evaluation: The final step of the process is monitoring and evaluation, which the RDN uses to determine if the client has achieved, or is making progress toward, the planned goals. [2]

Nutrition Counseling: Nutrition counseling is a supportive process to establish food, nutrition and physical activity priorities, goals, and action plans that acknowledge and foster responsibility for self-care to treat an existing condition and promote health. [3]

Nutrition Education: Nutrition education is the reinforcement of basic or essential nutrition-related knowledge. Nutrition education may be a component of MNT but can also occur independently of MNT, may be targeted at the individual level and/or population level and include interventions for supportive individuals or structures. [4]

FIMC Medically Tailored Meal (MTM) Nutrition Standards: The FIMC MTM Nutrition Standards are developed using evidence-based guidelines and/or joint consensus nutrition guidelines. The FIMC MTM Nutrition Standards include the table contained in Annex 1 this document.

Registered Dietitian Nutritionist (RDN) In Training: An RDN in training is a dietetic intern or an individual who is eligible for dietetic registration.

Referral: Any written, verbal or electronic request to an agency for medically tailored meals. Referrals may require verification, documentation of health condition(s) or other relevant data to assess an individual's eligibility to receive MTM services. Referrals may come from a variety of community, healthcare, and private sources.

Referrer: A referrer is the person or entity referring a potential client to an FIMC agency.

[1] Academy of Nutrition and Dietetics, "Definition of Terms List," Eat Right, February 2021, p. 49, www.eatrightpro.org/-/media/files/eatrightpro/practice/academy-definition-of-terms-list-feb-2021.pdf.

[2] Mary G. Roseman &; Sandra N. Miller, "Academy of Nutrition and Dietetics: Revised 2021 Standards of Professional Performance for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Management of Food and Nutrition Systems," Journal of the Academy of Nutrition and Dietetics 121, no. 6 (2021): page #, https://www.jandonline.org/action/showPdf?pii=S2212-2672%2821%2900100-3.

[3] Academy of Nutrition and Dietetics, "Nutrition Intervention Snapshot," Eat Right, 2020, https://www.ncpro.org/nutrition-intervention-snapshot.

[4] Academy of Nutrition and Dietetics, "Definition of Terms List," Eat Right, February 2021, p. 34, www.eatrightpro.org/-/media/files/eatrightpro/practice /academy-definition-of-terms-list-feb-2021.pdf.

Terms and Definitions

Subcontractor: A subcontractor is a separate legal entity with whom a FIMC agency has a contractual agreement allowing the subcontractor to conduct activities that are within the scope of their FIMC accreditation on their behalf. Examples of activities that may be subcontracted include delivery services or subcontracting with Registered Dietitian Nutritionists (RDNs). The agency shall maintain oversight and control over the activities conducted by its subcontractor(s) at all times.

Telehealth: Telehealth includes certain medical or health services provided by a doctor or other health care provider who is located elsewhere using audio and video communications technology (or audio-only telehealth services in some cases), like a phone or a computer. Many of the same services that usually occur in-person may be provided as telehealth services, like psychotherapy and office visits. [5]

NOTE: When MNT is provided via telehealth, the agency and RDNs shall comply with all applicable federal and state telehealth laws, HIPAA requirements, and (health insurance) payer policies. [6]

Volunteer: A volunteer is an individual who donates their time, skill(s), or service(s) to an agency without obligations and without receiving direct financial compensations for their work.

501(c)(3) Organization: A 501(c)(3) organization is a corporation, trust, unincorporated association, or other type of organization exempt from federal income tax under section 501(c)(3) of Title 26 of the United States Code.

[5] Medicare, Telehealth, https://www.medicare.gov/coverage/telehealth

[6] CCHP, State Telehealth Laws & Medicaid Program Policies, www.cchpca.org/all-telehealth-policies

FIMC MTM ACR Standard

The Food Is Medicine Coalition (FIMC) Medically Tailored Meal (MTM) Intervention Accreditation Criteria and Requirements (ACR) ensures that all FIMC MTM Accredited agencies provide the same level of service. This means that regardless of location, size, or clients and meal plans catered for, all FIMC MTM Accredited agencies prepare and provide a high quality medically tailored meal intervention suitable for diagnosis as codified and defined by the FIMC Clinical Committee. Throughout this document the terms “ACR” and “standard” are used interchangeably.

All FIMC MTM Accredited agencies shall maintain conformity with the requirements of the FIMC ACR.

This standard is divided in eight pillars:

1. General Requirements
2. Fully Integrated Registered Dietitian Nutritionist(s) (RDN)
3. Client Referrals, Eligibility, Intake and Disenrollment for MTM
4. Nutrition Care Process Intervention: Medical Nutrition Therapy, Nutrition Counseling and Nutrition Education
5. Medical Tailoring Following the FIMC Clinical Committee Guidelines
6. Food Safety
7. Community-based Volunteer-supported Services
8. HIPAA Compliance

PILLAR 1:
General Requirements

1.1 Agencies shall meet the requirements of this standard to maintain its accreditation as a FIMC MTM agency. The FIMC MTM Accredited agency is responsible for the compliance of any subcontracted entity to this standard (see Section 1.D).

1.2 Agencies shall undergo audits every three (3) years and conduct annual self-evaluations. [7]

1.3 Agencies shall provide an affidavit [8] confirming they are in compliance with all applicable federal, state and local laws.

- **1.3.1** When a legal requirement is more stringent than the requirements of this standard, the law shall prevail.

A. Training

1.4 Agencies shall have established training plans for the personnel involved in delivering the MTM intervention.

- **1.4.1** Agencies shall ensure their personnel are trained in internal procedures and policies (as defined in this standard) relevant to their role prior to conducting work independently.

B. Regulation and 501(c)(3) Status

1.5 Each agency shall be registered as a 501(c)(3) nonprofit organization.

1.6 Agencies' mission shall be aligned with the mission of FIMC.

C. Quality Improvement Program

1.7 Agencies shall develop, maintain, and implement a Quality Improvement Program (QIP), which is the mechanism to monitor quality assurance, promote continuous improvement and support the agency's adherence to the requirements of this standard. ***NOTE****: See also sections 4.7, 5.9 and 6.6*

1.8 Agencies shall report on client and volunteer satisfaction measures annually to their Board of Directors.

1.9 At a minimum, agencies shall conduct an annual audit to ensure conformity and/or progress toward their QIP goals and measures.

1.10 1.1Agencies shall establish a Quality Improvement Committee (or equivalent) that meets at least quarterly to evaluate progress toward QIP goals and address issues raised by clients, staff, and/or volunteers.

- **1.10.1** The Quality Improvement Committee shall include representatives of different departments (e.g., key members of program and operations teams).

1.11 Agencies may establish additional committees that provide technical expertise or guidance, such as technical committees or medical committees. Such additional committees shall meet at least annually.

[7] See FIMC ACR Program Manual for breakdown of surveillance and re-accreditation activities based on category of Agency.

[8] A FIMC affidavit template is available for use.

1.12 Agencies shall develop, implement, and maintain a documented policy on addressing complaints from clients, volunteers and stakeholders. The policy shall be readily available (e.g., publicly available on the agency's website, on display in the agency).

D. Subcontracting

1.13 FIMC MTM Accredited agencies must operate their own kitchens, which prepare their medically tailored meals.

Exceptions:

- **1.13.1** FIMC MTM Accredited agencies lacking the capacity to independently supply an unserved population may purchase some meals on a temporary basis from other FIMC MTM Accredited agencies to service the previously unserved population, e.g., new geographies or diagnoses. In such cases, the FIMC MTM Accredited agency shall take reasonable efforts to develop the independent capacity to supply the unserved population during the pendency of the purchase agreement. Once the FIMC MTM Accredited agency develops independent capacity to supply the unserved population, the FIMC MTM Accredited agency shall cease purchasing meals from other FIMC MTM Accredited agencies. Any purchases under this exception shall be negotiated at arms' length and shall not involve the exchange of any unnecessary, competitively sensitive information. The agencies' agreement shall not contain any prohibition on competition to serve the unserved population.
- **1.13.2** In the event of disaster, emergency, renovation or other temporary situation where the agency's kitchen becomes unusable for a time, FIMC MTM Accredited agencies may subcontract portions of meal preparation to other entities.

1.14 Agencies may use subcontracted entities to conduct other activities on their behalf (such as delivery), that fall under the scope of their FIMC accreditation. In those instances:

- **1.14.1** The agency shall retain full responsibility for meeting accreditation requirements.
- **1.14.2** The agency and the subcontracted entity shall have a contractual relationship for service that also covers confidentiality and intellectual property.
- **1.14.3** The agency shall maintain oversight of the subcontracted entity.
- **1.14.4** The agency shall develop, implement, and maintain a procedure to ensure the subcontracted entity conforms with all applicable FIMC accreditation requirements. This procedure shall include a minimum of quarterly audits of the subcontracted entity's operations.

E. Client Experience

1.15 Agencies shall establish a policy against discrimination on the basis of race, color, national origin, age, sex, sexual orientation, gender identity, and disability.

1.16 Agencies shall treat all client-related information as confidential, unless otherwise stated. Examples of client-related confidential information include: diagnosis, treatment plan, insurance and social security information, address and phone number, etc.

PILLAR 1:
General Requirements

1.17 To ensure high quality of services, agencies shall:

- **1.17.1** Give instructions to all clients on preparing/reheating meals.
- **1.17.2** Use translation and auxiliary aids free of charge when clients need language assistance in person or virtually/by phone to access services.
- **1.17.3** Ensure all written or online information for clients is available in languages most commonly understood by clients and accessible to diverse comprehension levels.
- **1.17.4** Provide clients with information and referrals to other services to improve their overall health and well-being, as needed or requested.
- **1.17.5** Implement a process to notify clients who have missed meal deliveries without forewarning.
- **1.17.6** Review at least annually materials sent to clients to confirm relevance and applicability (e.g., best practices, availability of information in relevant languages).
- **1.17.7** Implement a mechanism for clients to provide feedback on meals, nutrition services, volunteer services, client services and delivery services. This process shall include at least an annual survey that is in line with the requirements set forth by the FIMC Research Committee. [9]
- **1.17.8** Use at least one method of collecting real-time client feedback (e.g., voicemail, email, text, documentation during client calls, one-off surveys) and reassess outreach approach(es) for accessibility on an as-needed basis to ensure responsiveness.

Best Practice:

- ✓ In addition to the annual client survey, agencies may establish a Client Advisory Board (or equivalent), hold client focus groups, conduct targeted surveys, etc. to provide insight, input, feedback, guidance, oversight and/or expertise on programs and services.
- ✓ Agencies may post their non-discrimination policy on their website and/or include a statement in materials provided to clients engaging with the agency for the first time.
- ✓ Surveys (clients, volunteers) should be made available to clients based on accessibility: email, phone, paper, etc. and in a language that is widely spoken by clients.

[9] Requirements are currently under development. Until formalized, each agency shall develop their own annual survey.

PILLAR 2:
Fully Integrated Registered Dietitian Nutritionist(s) (RDN)

- **2.1** Each agency shall employ (staff or contractor) at least one Full Time Equivalent (FTE) Registered Dietitian Nutritionist (RDN).
- **2.2** The agency's RDN shall be credentialed by the Commission on Dietetic Registration[1] and hold valid licenses as applicable by the relevant state.
- **2.3** There shall be at least one FTE RDN for every 1,000 active medically tailored meal (MTM) intervention clients.
- **2.4** The RDN shall collaborate with kitchen staff or subcontracted meal preparers to ensure meals adhere to the FIMC Medically Tailored Meal (MTM) Nutrition Standards.
- **2.5** The RDN shall be integrated into the MTM intervention process from assessment of a new client to menu design and ongoing medical nutrition therapy, nutrition counseling and nutrition education, reassessment and evaluation.

Best Practice:

- ✓ Agencies may connect with local dietetic internships to precept dietetic interns who are completing their practicums.
- ✓ Agencies should ensure RDNs can communicate in the language(s) that are widely spoken amongst clients by being fluent or using a translation service.

[10] Commission on Dietetic Registration, "CDR's Roles and Governance," CDR, https://www.cdrnet.org/cdrs-roles.

PILLAR 3:
Client Referrals, Eligibility, Intake and Disenrollment for MTM

A. Referrals

3.1 Referrals should be accepted for review from a variety of community, healthcare and private sources ("referrers"), including clients who refer themselves.

B. Intake

3.2 At intake, agencies shall collect relevant data, including demographics (unless precluded by an agreement with a referral partner).

C. Assessment and Reassessment of Eligibility

3.3 Agencies shall develop, implement, and maintain written procedures to determine eligibility criteria and conduct assessment and reassessment of eligibility for a meal plan.

3.4 Eligibility criteria shall include:

- **3.4.1** Medical diagnoses by the most current International Code for Diagnosis (ICD) or medical necessity as determined by healthcare authorization (e.g., health plan provides an authorization for meals; healthcare provider provides agency a problem list; a clinician provides a medical note or signs the referral, etc.).
- **3.4.2** Activities of Daily Living (ADL) limitations, if any.

3.5 The assessment and reassessment of eligibility shall include:

- **3.5.1** Provisions to contact the client or referrer in case of an incomplete application.
- **3.5.2** Timelines for initiating the intake once the client's eligibility has been confirmed.
- **3.5.3** Frequency of eligibility reassessment, which should occur every six months and must occur at least annually (every twelve months).
- **3.5.4** Exceptions to eligibility reassessment requirements (e.g., long-term or terminal illnesses).

3.6 To facilitate enrollment and disenrollment, agency shall establish best practices for how to contact clients (e.g., minimum number of attempts, contact at different times of day, different days of the week, by email/phone/text).

- **3.6.1** The agency shall inform the client and/or referrer on enrollment status including enrollment start date, inability to enroll, and/or completion of service or disenrollment.

D. Disenrollment

3.7 Agencies shall implement a protocol for disenrollment. Disenrollment factors may include but are not limited to lack of ongoing need, disengagement, non-adherence, and geographical relocation.

3.8 Upon disenrollment, agencies shall refer clients to appropriate step-down nutrition resources at their agency or within the community, when appropriate, feasible and necessary.

Best Practice:

- ✓ Agencies may develop an online questionnaire for potential clients to determine whether they may be eligible to receive MTM.
- ✓ To preserve resources, an agency may automatically pause meal deliveries to clients who skip/decline a delivery. In those instances, clients should be able to restart delivery services very easily.

PILLAR 4:
Nutrition Care Process Interventions: Medical Nutrition Therapy, Nutrition Counseling and Nutrition Education

4.1 The client's disease and symptom-related nutrition needs shall be assessed, reassessed and addressed using the established steps of the Nutrition Care Process (NCP) by an RDN or by another qualified practitioner (e.g., Nutrition and Dietetics Technician, Registered, or NDTR) under the supervision of a credentialed RDN.

4.2 Agencies shall implement policies and procedures regarding nutrition risk screening once a client is deemed eligible.

4.3 Agencies shall implement a system for prioritization of client nutrition assessment and reassessment based on nutrition risk.

4.4 An RDN or another trained staff (if the screening tool(s) used to identify appropriate nutrition interventions was developed or approved by an RDN) shall identify the need for medical nutrition therapy, nutrition counseling and nutrition education.

- **4.4.1** RDNs shall utilize Academy of Nutrition & Dietetics' Evidence-Based Nutrition Practice Guidelines [11] and other medical standards of practice and adopt evidence-based practices into their MNT as needed.
- **4.4.2** Client nutrition education materials shall be developed from evidence-based sources and under the supervision of an RDN.

4.5 An RDN shall provide clients with ongoing access to medical nutrition therapy, nutrition counseling and nutrition education, following the Standards of Practice in Nutrition Care and Standards of Professional Performance for RDNs. [12]

- **4.5.1** Where appropriate, medical nutrition therapy can be provided by an RDN in training under the supervision of a credentialed RDN.
- **4.5.2** Where appropriate, nutrition counseling or education can be provided by another qualified practitioner (e.g., Nutrition and Dietetics Technician, Registered, or NDTR) under the supervision of a credentialed RDN.

4.6 When clients receive medical nutrition therapy, the client should have a clear, detailed, evidence-based care plan to ensure:

- achievement of guideline determined by medical therapy goals,
- effective management of co-morbid conditions, and
- follow-up with healthcare team, as appropriate.

- **4.6.1** The care plan shall be documented by an RDN (or RDN in training, per 4.5.1) following the standards set forth by the Academy of Nutrition and Dietetics' Nutrition Care Process. [13]

[11] Academy of Nutrition and Dietetics, "Evidence-Based Nutrition Practice Guidelines," Eat Right, year published, https://www.eatrightpro.org/practice/guidelines-and-positions/evidence-based-nutrition-practice-guidelines.

[12] Academy Quality Management Committee, "Academy of Nutrition and Dietetics: Revised 2017 Standards of Practice in Nutrition Care and Standards of Professional Performance for Registered Dietitian Nutritionists," Journal of the Academy of Nutrition and Dietetics 118, no. 1 (2018): 138, https://www.jandonline.org/action/showPdf?pii=S2212-2672%2817%2931625-8.

[13] Electronic Nutrition Care Process Terminology (eNCPT), "The Nutrition Care Process", https://www.ncpro.org/nutrition-care-process

PILLAR 4:
Nutrition Care Process Interventions: Medical Nutrition Therapy, Nutrition Counseling and Nutrition Education

4.7 Agencies shall aim to offer nutrition services based on clients' needs. Agencies shall offer medical nutrition therapy in-person, via telehealth and/or via telephonic intervention.[14] Agencies may offer in-home visits per policy and protocol. Other nutrition counseling and/or education may be provided through multiple modalities.

4.8 Nutrition reassessments should occur every six months and shall occur, at minimum, annually (every twelve months).

- **4.8.1** If a nutrition reassessment is required based on the NCP or follow-up is requested by the client, the nutrition reassessment and/or education shall be initiated within a maximum of two weeks of the request being accepted.
- **4.8.2** If a request is denied, the agency shall document the justification for denying nutrition reassessment and/or education.
- **4.8.3** An agency may implement (and document) exceptions to nutrition reassessment requirements (e.g., clients with external dietitians, long-term or terminal illnesses).

4.9 Clients should receive their first meal delivery as soon as possible, no later than two weeks after completion of their nutrition assessment, if one is successfully completed.

4.10 The agency's Quality Improvement Program (QIP) (Section 1.C) shall include randomized Quality Assurance chart reviews to ensure compliance with the Nutrition Care Process and completeness of client nutrition assessment and care plan (if applicable). Each agency shall determine:

- Frequency of randomized chart reviews, which shall be no less than twice a year.
- Sampling rate and methodology.
- Measures to ensure the reviewer is not reviewing their own work.

Best Practice:

- ✓ If an agency identifies a nutritional need they cannot provide, the agency should recommend alternative routes to seek necessary care.
- ✓ In order to provide meals to clients as soon as possible, the first meal delivery may precede the full nutrition assessment, i.e., based on the referral, intake and nutrition risk assessment.
- ✓ Where possible, nutrition and eligibility re-assessments should be combined and conducted simultaneously twice every year (every 6 months).

[14] Note that telephonic interventions may not be a reimbursable service.

PILLAR 5:
Medical Tailoring following the FIMC Clinical Committee Guidelines

A. Variety and Number of Meal Plans Provided

5.1 All meal plans shall be appropriate for persons with diabetes and heart disease.

5.2 Agencies shall tailor meal plans for at least two of the following additional conditions:

- HIV
- Renal disease
- Chronic Obstructive Pulmonary Disorder (COPD)
- Cancers
- Inability to chew or swallow/Dysphagia
- Gastrointestinal issues
- Gestational diabetes and/or high-risk pregnancy

5.3 An agency may provide additional medically tailored meal plans to clients living with conditions other than those specified in Annex 1 and indicator 5.2 of this document.

5.4 An agency shall develop their own Agency-specific MTM guidelines to inform the development of meal plans per diet type in accordance with Annexes 1 and 2.

B. Density and Duration of Nutrition Delivered

5.5 The number of meals in each client's specific meal program and the duration of the intervention shall be in line with the plan developed by the RDN at the time of their nutrition (re)assessment.

5.6 Agencies should provide clients no less than 10 meals per week for a minimum of six months, unless requested otherwise by the client or healthcare partner. [15]

C. Quality of Prepared Meals

5.7 Meals shall be prepared in a facility under the control of the agency.

5.8 Meals shall be prepared using as many fresh ingredients as possible and in a way that preserves the nutrient value of the food, e.g., baking, braising, and sautéing rather than frying. The use of some processed or packaged ingredients is allowed in the preparation of meals. [16] See table below for prohibited categories of foods and ingredients.

[15] The 10 meals a week threshold best practice is based on research conducted by Community Servings and Commonwealth Care Alliance. See Berkowitz SA, Terranova J, Hill C, Ajay T, Linsky T, Tishler LW, et al. Meal Delivery Programs Reduce the Use of Costly Health Care in Dually Eligible Medicare And Medicaid Beneficiaries. Health Aff. 2018;37(4):535-542. Note that this is an ongoing area of research and the requirements of the ACR will be updated accordingly.

[16] Agencies may develop their sourcing policies using existing guidelines such as the NOVA Classification Reference System. See Center for Epidemiological Studies in Health and Nutrition, "The NOVA Food Classification System," EduChange, 2018, https://educhange.com/wp-content/uploads/2018/09/NOVA-Classification-Reference-Sheet.pdf

Table 5C : Prohibited Categories of Foods and Ingredients
This list is updated continuously by the FIMC Clinical Committee:

Prohibited Meal Ingredients	Exception(s)
Artificial food coloring	Natural food coloring
Artificial sweeteners (i.e., acesulfame-K, aspartame, neotame, saccharin, and sucralose)	
High fructose corn syrup (HFCS)	
Preservatives	Natural preservatives (e.g., sodium chloride, ascorbic acid (vitamin C), sugar, vinegar). Very limited amounts of phosphate additives and potassium additives.
Trans Fats	
Ultra processed foods (e.g., fried foods, sugar-sweetened beverages, desserts)	Processed foods such as canned or frozen vegetables or meats with no additives are acceptable. Bread, flour and other staples are also acceptable. Desserts specially prepared according to the MTM Nutrition Standards are also acceptable.

NOTE: *The prepared meals section does not apply to bags or boxes of non-perishable foods provided to clients in the event of an emergency.*

5.9 The agency's Quality Improvement Plan (QIP) (see Section 1.C.) shall include tastings of the agencies' meal offerings, at least monthly.

- **5.9.1** The food shall be reheated the same way clients would experience the food (e.g., reheated in a microwave).
- **5.9.2** The tasting shall assess the presentation, appearance, texture, flavor, correct labeling, proper portioning, packaging, sealing, and adherence to recipes.
- **5.9.3** If the result of the testing was not satisfactory, the agency shall take steps to improve the quality of their meal offerings.

[15] The 10 meals a week threshold best practice is based on research conducted by Community Servings and Commonwealth Care Alliance. See Berkowitz SA, Terranova J, Hill C, Ajay T, Linsky T, Tishler LW, et al. Meal Delivery Programs Reduce the Use of Costly Health Care in Dually Eligible Medicare And Medicaid Beneficiaries. Health Aff. 2018;37(4):535-542. Note that this is an ongoing area of research and the requirements of the ACR will be updated accordingly.

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PILLAR 5:
Medical Tailoring following the FIMC Clinical Committee Guidelines

D. Menu and Recipe Development and Adherence

5.10 Agencies shall establish a process for menu and recipe development that includes contributions of the culinary team and RDNs. The process shall specify that:

- **5.10.1** Agencies shall change their menu offerings as often as necessary based on client feedback, seasonality, and procurement options.
- **5.10.2** RDNs shall analyze recipes utilizing the FIMC Clinical Committee MTM Nutrition Standards (see Annexes 1 and 2) and other established guidelines.
- **5.10.3** Agencies shall offer foods that meet the cultural needs of the clients being served.
- **5.10.4** The culinary team shall strictly adhere to RDN-approved recipes and seek RDN approval for ingredient substitution.

Best Practice:

- ✓ Agencies should develop a medium- and long-term plan toward increasing their meal production in the goal of providing more meals to existing clients (e.g., 3 meals a day where appropriate) and reaching more clients.
- ✓ In the event staff and/or volunteers eat agency-prepared meals (e.g., leftovers), the agency may request they provide feedback on the quality of meals as part of its QIP.
- ✓ Clients should have the option to request less food if they are unable to consume or store all the meals provided, to avoid food waste or disenrollment.

PILLAR 6:
Food Safety

6.1 Agencies shall be licensed and inspected by the appropriate regulatory agency.

6.2 Agencies shall be in good standing with the appropriate regulatory authority.

6.3 Agencies shall develop and implement a written food safety policy(ies) that addresses the full production cycle, from receipt of ingredients at the facility to delivery to clients. At a minimum the food safety plan shall address:

- **6.3.1** Food handler health [17] and hygiene
- **6.3.2** Food safety training for staff and volunteers
- **6.3.3** Procedures for safely cooking, cooling, and packaging food
- **6.3.4** Steps to respond to food manufacturer recalls
- **6.3.5** Contingency(ies) to ensure continued food safety during emergencies such as weather-related conditions, natural disasters, or kitchen malfunctions

6.4 Agencies shall ensure that a certified food handler is present and on duty at any time the kitchen is open for client meal production and/or packaging.

A. Packaging and Labeling

6.5 Labeling of agency-prepared products shall contain, at a minimum:

- **6.5.1** Food identifier (e.g., name of recipe, component, etc.)
- **6.5.2** Dietary designation, or restriction (e.g., diabetic friendly, heart healthy, kidney kind, etc.), if appropriate
- **6.5.3** Allergens (i.e., the nine major allergens) [18]
- **6.5.4** Date by which product should be consumed (e.g., best by, use by, freeze by date).
- **6.5.5** Food safety/reheating instructions. Where food safety/reheating instructions are not on-label, they shall be communicated to clients off- label via email, via mail, at intake, on the agency website, on a magnet and/or in a menu packet.

[17] For example, an accredited and/or state-recognized food handler certification program

[18] The "Big Nine": milk, eggs, tree nuts, peanuts, fish, crustacean shellfish, wheat, soybeans, sesame. See www.fda.gov/food/food-labeling-nutrition/food-allergies

PILLAR 6:
Food Safety

B. Meal Delivery

6.6 Agencies shall develop and implement written procedures to ensure that clients are receiving the correct items for their dietary needs and that they arrive in a food safe condition, regardless of delivery mechanism (pick-up service, hand or driver delivered by staff, volunteer or third-party, shipping, etc.). Procedures shall include steps to ensure:

- **6.6.1** Meal packaging is properly sealed and intact.
- **6.6.2** Compliant labels are legible and secured (see 6.5).
- **6.6.3** The correct items are delivered to each client.
- **6.6.4** Food safety, including maintenance of appropriate temperatures and prevention of contamination are prioritized during the delivery period.
- **6.6.5** Deliveries arrive during the specified time period.
- **6.6.6** Delivery errors are documented and corrected.
- **6.6.7** Missed deliveries are documented and clients receive appropriate follow- up communication from agency staff.
- **6.6.8** Client feedback on delivery is incorporated into quality improvement processes.

Best Practice:

✓ Agencies could publish their menu offerings on their website for client visibility.

PILLAR 7:
Community-based Volunteer-supported Services

7.1 Volunteers shall not receive direct financial compensation for their work.

- **7.1.1** Agencies may develop and implement a policy to provide incentives or indirect compensation to volunteers, such as branded swag or MTMs deemed safe to eat but unfit for distribution.

7.2 Prior to conducting work, volunteers shall:

- **7.2.1** Sign a confidentiality agreement.
- **7.2.2** Receive general orientation and training in appropriate service/volunteer area.
- **7.2.3** Receive training on relevant HIPAA requirements, for any volunteer who has access to client information.
- **7.2.4** Receive basic training in food safety, for applicable volunteers.
- **7.2.5** Undergo a background check, if deemed necessary by the agency, e.g., for any volunteer who is in contact with clients, such as meals delivery volunteers, client services or nutrition volunteers.
  - **7.2.5.1** Agencies requiring background checks shall determine exclusion criteria to ensure client safety.

- **7.2.6** Provide valid driver's license and driving record, for any volunteer who drives agency-owned or leased vehicles.
- **7.2.7** Receive any other training or background checks required by local municipalities or state.

7.3 Volunteers shall be given the opportunity to provide feedback, at least annually, on the volunteer experience.

- **7.3.1** The volunteer feedback mechanism shall include an annual survey that is in line with requirements set forth by the FIMC Volunteer Services Subcommittee. [19]
- **7.3.2** Agencies shall create a procedure to manage and/or exit unfit volunteers, unruly volunteers, or those who pose an existential threat to the organization or other volunteers. For example, agencies may develop a code of conduct, implement a warning or strike system, or offer de-escalation training.

Best Practice:

- ✓ Agencies could publish their menu offerings on their website for client visibility.
- ✓ Agencies may provide volunteers with agency-branded clothes or accessories (e.g., t-shirt, hat, pin) to make volunteers easily identifiable; agencies should ensure those are used in the appropriate setting to protect client confidentiality.
- ✓ Agencies may promote volunteer opportunities for youth; agencies should ensure there are additional safeguards in place to account for youth carrying out agency services.
- ✓ Agencies may provide volunteer opportunities for individuals needing to complete court-mandated or school requirements; agencies should clearly state expectation on their website and provide social equity statement.

[19] Requirements are currently under development. Until formalized, each agency shall develop their own annual survey.

PILLAR 8:
HIPAA Compliance

Depending on the status of an agency under HIPAA, sections B and E of this pillar may not be applicable to all agencies.

8.1 Agencies shall be HIPAA compliant, as required per the law.

- **8.1.1** This applies, but is not limited to, the protection of personal health information of clients, data security, and data sharing requirements.

A. Compliance Oversight

8.2 Agencies shall have an appointed Privacy Officer to oversee their compliance with HIPAA privacy requirements.[20]

8.3 Agencies shall have an appointed Chief Security Officer to oversee their compliance with HIPAA security requirements. [21]

*NOTE: The positions in **8.2** and **8.3** can be held by the same person (using a different title), a contractor or employee, on a full-time basis or part-time as part of a broader position. For example, the same person can serve as the Privacy Officer and the Medicaid compliance officer.*

8.4 Agencies that do not have a HIPAA compliance committee that meets at least annually and oversees their compliance with HIPAA requirements (or with a broader range of regulatory requirements that includes HIPAA) should document HIPAA compliance activities in a report at least annually to ensure continuity in HIPAA compliance activities within the agency over time.

B. Notice of Privacy Practices (applicable only to organizations that are HIPAA covered entities)

8.5 Agencies shall adopt a Notice of Privacy Practices that describes how the agency uses and discloses clients' protected health information. [22]

8.6 Agencies shall post the Notice of Privacy Practices on their public-facing website. [23]

8.7 Agencies shall offer the Notice of Privacy Practices to all new clients when they begin providing services to them (e.g., at the time of initial intake). [24]

[20] HIPAA Regulation, 45 C.F.R. 164.530(a)(1)(i)

[21] HIPAA Regulation, 45 C.F.R. 164.308(a)(2)

[22] HIPAA Regulation, 45 C.F.R. 164.520(c)(3)(i)

[23] HIPAA Regulation, 45 C.F.R. 164.520(c)(3)(i)

[24] HIPAA Regulation, 45 C.F.R. 164.520(c)(2)(1)(A)

C. Privacy and Security Training

8.8 Agencies shall develop, maintain, and implement privacy and security awareness training to: [25]

- **8.8.1** All employees who have access to client information within 30 days of the date of hire and annually thereafter. [26]
- **8.8.2** All volunteers who have access to client information prior to the commencement of volunteer activity and annually thereafter. [27]

NOTE: Trainings may be held in person, remotely or virtually.

8.9 Agencies shall maintain evidence that trainings have been provided and received such as: signed acknowledgement forms, signed attendance sheets, virtual attendance sheets or any other form of paper or electronic documentation. [28]

8.10 Agencies shall issue security reminders and alerts to employees and volunteers who have access to client information, at least annually and as often as needed. [29]

D. Written Privacy Policies and Forms

8.11 Agencies shall develop, maintain and implement a policy:

- **8.11.1** Governing the purposes for which client information may be used or disclosed. [30]
- **8.11.2** Requiring the use and disclosure of the minimum necessary amount of client information for the intended purpose. [31]
- **8.11.3** Setting forth the steps employees and volunteers must take to verify the identity of individuals with whom they are sharing client information. [32]
- **8.11.4** Describing the circumstances under which employees and volunteers may share client information with a client's family members, friends, or guardian/caretakers. For example, implicit consent, verbal authorization, or the determination of a healthcare professional, may be sufficient in some instances. [33]
- **8.11.5** Governing the investigation of and response to any actual or suspected breach of client information, such as an Incident Response Plan. [34]

8.12 Agencies shall implement a standard authorization form that clients must sign when the use or disclosure of their information requires authorization under the organization's policies or applicable law. [35]

[25] HIPAA Regulation, 45 C.F.R. 164.530(b)

[26] HIPAA Regulation, 45 C.F.R. 164.308(a)(5)

[27] HIPAA Regulation, 45 C.F.R. 164.308(a)(5)

[28] HIPAA Regulation, 45 C.F.R. 164.308(a)(5)

[29] HIPAA Regulation, 45 C.F.R. 164.308(a)(5)

[30] HIPAA Regulation, 45 C.F.R. 164.530(i)

[31] HIPAA Regulation, 45 C.F.R. 164.502(b) and 514(d)

[32] HIPAA Regulation, 45 C.F.R. 164.514(h)

[33] HIPAA Regulation, 45 C.F.R. 164.510(b)

[34] HIPAA Regulation, 45 C.F.R. 164.308(a)(6)

[35] HIPAA Regulation, 45 C.F.R. 164.508

PILLAR 8:
HIPAA Compliance

8.13 Agencies shall implement a standard business associate agreement (if the organization is a covered entity or business associate) or confidentiality agreement (if the organization is neither a covered entity nor business associate) that must be signed by subcontractors that have access to the organization's client information. [36]

E. Written Client Rights Policies (applicable only to organizations that are HIPAA covered entities or business associates.

See **Annex 3** to determine if an HIPAA covered entity.)

8.14 Agencies shall develop, maintain and implement a policy governing:

- **8.14.1** Client requests to access to their records. [37]
- **8.14.2** Client requests to amend their records. [38]
- **8.14.3** Client requests for an accounting of disclosures. [39]
- **8.14.4** Client requests for restrictions on otherwise permissible uses and disclosures of their information. [40]
- **8.14.5** Client requests for confidential communications. [41]

F. Written Security Policies

8.15 Agencies shall develop, maintain and implement a policy governing:

- **8.15.1** User authentication (e.g., unique user ID, no group passwords, minimum password strength, password management, termination of user rights). [42]
- **8.15.2** Secure workstation use (e.g., access control such as automatic log-off, acceptable use, virus protection). [43]
- **8.15.3** Data backup and recovery. [44]
- **8.15.4** Role-based access (e.g., different classes of users, administrative rights). [45]
- **8.15.5** The encryption of client information transmitted over open networks or maintained on mobile devices and media. [46]
- **8.15.6** The physical security of offices or facilities where client information is maintained. [47]
- **8.15.7** Hardware and software inventory and change management.
- **8.15.8** Remote access to client information by employees and volunteers.
- **8.15.9** Contingency planning, business continuity and disaster recovery. [48]

[36] HIPAA Regulation, 45 C.F.R. 164.502(e) and 504(e); 45 C.F.R. 164.308(b)

[37] HIPAA Regulation, 45 C.F.R. 164.524

[38] HIPAA Regulation, 45 C.F.R. 164.526

[39] HIPAA Regulation, 45 C.F.R. 164.528

[40] HIPAA Regulation, 45 C.F.R. 164.522(a)

[41] HIPAA Regulation, 45 C.F.R. 164.522(b)

[42] HIPAA Regulation, 45 C.F.R. 164.308(a)(4) and 312(a)(2)

[43] HIPAA Regulation, 45 C.F.R. 164.310(b) and (c)

[44] HIPAA Regulation, 45 C.F.R. 164.308(a)(7)

[45] HIPAA Regulation, 45 C.F.R. 164.308(a)(3)

[46] HIPAA Regulation, 45 C.F.R. 164.312(a)(iv)

[47]HIPAA Regulation, 45 C.F.R. 164.310(a)

[48] HIPAA Regulation, 45 C.F.R. 164.308(a)(7)

8.15 Agencies shall develop, maintain and implement a policy governing *(continued)*

- **8.15.10** The screening of employees and volunteers who have access to client information. [49]
- **8.15.11** The steps that are taken when an employee or volunteer violates any of the organization's privacy or security policies (e.g., sanctions, mitigation of risks, breach notification, other required reporting). [50]
- **8.15.12** The steps that are taken when there are any compliance issues and breaches with HIPAA or healthcare provider requirements. [51]

G. Security Risk Analysis

8.16 Agencies shall conduct a security risk analysis at a minimum every two years. [52]

8.17 Agencies shall develop a corrective action plan to address any risks identified by the security risk analysis. [53]

[49] HIPAA Regulation, 45 C.F.R. 164.308(a)(3)(ii)(B)

[50] HIPAA Regulation, 45 C.F.R. 164.530(e) and 308(a)(c)

[51] HIPAA Regulation, 45 C.F.R. 164.400-414

[52] HIPAA Regulation, 45 C.F.R. 164.308(a)(1)(ii)(A)

[53] HIPAA Regulation, 45 C.F.R. 164.308(a)(1)(ii)(B)

ANNEX 1:
Guidance for the Development of Medically Tailored Meal Plans (based on a 180-pound male)

last updated: June 2023

Nutrient	HIV/AIDS	HIV/AIDS +HLD (hyperlipidemia)	Elderly	Kidney Chronic Stages 3-5(non-dialysis)	Kidney/Dialysis	Diabetes Pre-diabetes	Heart Failure	DASH TLC Heart Healthy
Calories	Needs vary similar to healthy individuals	Needs vary	Needs vary	23-35 kcal/kg	25-35 kcal/kg	Needs vary	Higher if catabolic	As per individual needs
Protein% of total daily calories	*10-35% of daily caloriesIndividualized (RDA*)	10-35% of daily calories individualized	N/A	0.55-0.6 g/kgW/ diabetes:0.6-0.8 g/kg	10-1.2g/kgWith or without diabetes		N/A	18% Daily caloriesLean meats/plant- based sources
Proteing/kg body weight	N/A	N/A	1-1.25g/kg(NCM)	< 64 g /day	HD 1.2 g/kgPD 1.2-1.3 g/kg	Individualized macronutrient composition * See MTM Meal Guidelines for nutrient target values	1.1g/kg is stable1.3 g/kg if depleted for CHF	N/A
Carbohydrate % total daily calories	45-65% (RDA*)Added sugar <10%	N/A	45-65% daily calories	N/A	N/A		N/A	55% daily calories Emphasize whole grains + vegetables
Total Fat% total daily calories	20-35% (AMDR)	25-35% of total daily calories	20-35% of daily calories	N/A	N/A		N/A	25-35% daily calories
Saturated Fat% total daily calories	<10% of kcal (DGA)	<7% total daily calories	<10% daily calories (DGA)	N/A	N/A	<7%	<7%	6-7% daily calories
Sodium (mg)	DGACDDR: 2300 mg	DGA	</= 2300 mg/day CDDR	</= 2100 mg	<2100 mg/day	<2300 mg/day	CHF: 2000-3000 mg/day	</= 2300 mg for standard</=1500 mg for lower NA DASH
Cholesterol	DGA	<200 mg/day	<300 mg/day	N/A	N/A	N/A	<200mg/day	150
Fiber (g)	14g/1000 (DGA)	14g/1000 (DGA)	30g/day Male21g/day Female14g/1000 kcal	N/A	N/A	N/A	Female: 21-25 gMale: 25-28 gSoluble fiber 7-13 g	25-31 g
Vitamin D (IU)	600 IU (RDA)	600 IU (RDA)	800 IU (RDA)	N/A	N/A	N/A	600 IU	N/A
Calcium (mg)	1000 mg (RDA)	1000 mg (RDA)	1200 mg (RDA)	Stages 3-5 not to exceed 2000 mg/day	N/A	RDA	1000 mg	1000-1200 mg
Potassium	Male: 3400 mgFemale: 2600 mg(Adequate Intake)	DGA	3400 mg/day	</= 3500 mg/day	2400-2700 mg/day	DGA	N/A	4700 mg
Phosphorus	700 mg (RDA)	N/A	700 mg (RDA)	No limit, but pay attention to sources due to bio-availability.Limit to 2 dairy exchanges/day (4 oz fluid milk or 1 oz cheese).Avoid foods with phosphoric additives.	Limit to <1200 mg/day	RDA	N/A	N/A
Reference for Evidence Based Guidelines	EALDGA (link)Dietary patterns for adults should be incorporated	EAL	NCM	NKF-KDOQIEALAND Nutrition Care Manual	NKF-KDOQIEALAND Nutrition care Manual	ADA EAL	EAL	DASHTLCDietary patterns for adults should be incorporated.

N/A: not applicable because guidelines do not exist for this value, is not relevant for condition or listed elsewhere on chart
NCM: Academy of Nutrition and Dietetics Nutrition Care Manual (member only site)
AI: Adequate Intake
CDDR: Chronic Disease Risk Reduction Level
AMDR: Acceptable Macronutrient Ranges and Recommendations – https://www.nutritioncaremanual.org
DGA: Dietary Guidelines for Americans – https://www.dietaryguidelines.gov/
NKF KDOQI: National Kidney Foundation Kidney Disease Quality Initiative – https://www.kidney.org/professionals/guidelines
RDA/DRI Reports: https://www.nal.usda.gov/fnic/dri-nutrient-reports
DRI's Interactive: https://www.nal.usda.gov/fnic/interactiveDRI/
EAL: Evidence Analysis Library form and the Evidence-based Nutrition Practice Guideline –https://www.andeal.org (member only access)
ADA Standards of Medical Care for Diabetes: Volume 46 Issue Supplement 1 | Diabetes Care | American Diabetes Association (diabetesjournals.org)
TLC: Therapeutic Lifestyle Changes (NIH/NHLBI)- Therapeutic Lifestyle Changes (TLC) To Lower Cholesterol | NHLBI, NIH
DASH Eating Plan: DASH Eating Plan | NHLBI, NIH

ANNEX 2:
Medically Tailored Meal Guidelines and Plans

As per **5.4**, an agency shall develop its own MTM guidelines for each meal plan to be appropriate for the average population served, for example considering age and level of activity.

An agency's MTM guidelines shall establish the nutritional needs (quantities or ranges) of clients by diet type and shall include, at a minimum:

- Kilocalories (kcal)
- Carbohydrates (where relevant)
- Protein
- Total fat
- Saturated fat
- Sodium
- Dietary fiber
- Potassium (where relevant)
- Phosphates (where relevant)

Agencies may develop their MTM guidelines using any of the templates provided in this annex and shall provide information by diet type and:

- Per meal type (see Template 1)
- Per meal and day (see Template 2), and/or
- Per week (see Template 3).

A completed table is provided as an *example* below.

Template 1 – MTM Plan by diet type and per meal type

Diet Type	Breakfast (if applicable)	Lunch (if applicable)	Dinner (if applicable)	Conditions / Disease:
Regular: Heart Healthy				
Diabetic Friendly:				

ANNEX 2:
Medically Tailored Meal Guidelines and Plans

Template 2 – MTM Plan by diet type per meal and per day

Diet Type	Per Meal	Per Day	Conditions / Disease:
Regular: Heart Healthy			
Diabetic Friendly			

Template 3 – MTM Plan by diet type per week

Diet Type	Per week based on 10 meals per week	Per week based on 14 meals per week	Per week based on 21 meals per week	Conditions / Disease:
Regular: Heart Healthy				
Diabetic Friendly				

Example of MTM Guidelines per diet type:

Below is an *example* of MTM guidelines by diet type per meal (assuming the nutritional value of breakfast, lunch and dinner meals is the same) and per day. Individual MTM agencies should use Annex 1 to develop their own guidelines for meal plans for their unique populations.

Diet Type	Per Meal	Per Day	Conditions/ Diseases
Regular: Heart Healthy Based on DGA for micronutrients Macronutrients based on EAL for HIV/AIDS	500-700 kcal (25-30 kcal/kg) 25 g protein (1g /kg) 23-31 g total fat (35% kcal) 6-9 g saturated fat (10% kcal) < 800 mg sodium 8-9 g dietary fiber (14g/1000kcal)	1500-2100 kcal 70-80 g protein 70-74 g total fat 21 g saturated fat 1500-2000 mg sodium 25-28 g dietary fiber (14g/ 1000 kcal)	HIV/AIDS Hepatitis C Breast Cancer CVD Overweight/obesity Heart failure End stage liver failure Ascites
Diabetic Friendly: 2019 update: fat 20=35% Fiber 14 g/1000 kcal CHO- individualized	500-700 kcal (25-30 kcal/kg) 55-60 g carbohydrate 25g protein (15-20%) 23-31 g total fat 4-5 g saturated fat < 800 mg sodium 8-9 g dietary fiber (14g/1000 kcal)	1500-2100 kcal 165-180 g carbohydrate 75 g protein 69-93 g total fat 12-15 g saturated fat 2300 mg sodium 25-28 g dietary fiber (14g/1000 kcal)	Pre-diabetes Diabetes Heart disease Weight loss CKD GFR<30
Dialysis – ESKD	500-700 kcal (25-30 kcal/kg) 35 g protein 23-31 g total fat (35% kcal) 6-9 g saturated fat (10% kcal) 8-9 g dietary fiber (14g/1000kcal) 700 gm sodium **No Phosphorus Parameters rec: limit dairy to one 4 oz serving/ day and not Phosphate additives. Whole grains may be used as long as potassium remains at or below the limit.** 900 mg potassium	1500-2100 kcal 70-80 g protein 70-74 g total fat 21 g saturated fat 2100 mg /day sodium 25-28 g dietary fiber (14g/1000 kcal) <1200 mg/day phosphorus 2730 mg/day potassium	CKD stages 4-5 or on dialysis
Chronic Kidney Disease 500-700 kcal (25-30 kcal/kg)	500-700 kcal (25-30 kcal/kg) < or = 20 g protein 23-31 g total fat (35% kcal) 6-9 g saturated fat (10% kcal) 700 mg sodium 8-9 g dietary fiber (14g/1000 kcal) 1200 mg potassium No phosphorus parameters, limit foods with phosphorus additives	1500-2100 kcal < 64 g protein 70-74 g total fat 21 g saturated fat 2100 mg per day sodium 25-28 g dietary fiber (14g/1000 kcal) 3500 mg/day potassium 2 dairy exchanges /day (i.e., 4 fl oz dairy or 1 oz cheese)	CKD stages 3-4
GI-Friendly Lower fiber without strong odors or acidic foods.	500-700 kcal 25 g protein 23-31 g total fat (35% kcal) 6-9 g saturated fat (10% kcal) < 800 mg sodium 4-6.5 g dietary fiber	1500-2100 kcal 75 g protein 70-74 g total fat 21 g saturated fat 2300 mg sodium 13-20g fiber	Nausea/vomiting Diarrhea Cancer treatment side effects Post GI surgery IBD/IBS
Texture Modified **Soft – IDDSI level 6** **Minced – IDDSI level 5** **Pureed – IDDSI level 4**	Same as other diet types but texture modified, i.e. minced or pureed.	Same as assigned MTM	Dysphagia due to: Alzheimer's Disease Parkinson's Post CVA/Stroke Poor dentition/edentulous

ANNEX 3:
Guidance to Determine an Agency's HIPAA Status

Each agency must determine its status under HIPAA in consultation with its legal counsel.

The below guidance is not intended to serve as and cannot be relied upon as legal advice.

Agencies not subject to HIPAA may still be covered by state confidentiality laws.

1. Is the agency a "health care provider"?

A health care provider is any individual or entity who furnishes, bills, or is paid for health care in the normal course of business. While the delivery of meals, on its own, is generally not considered health care, the provision of services by registered dieticians or other licensed health care professionals to medically tailor meals may be considered health care.

✓ If "yes," go to Question **2**.
✓ If "no," the agency is not a covered entity; go to Question **3**.

2. Does the agency submit electronic claims for health care to any health plans?

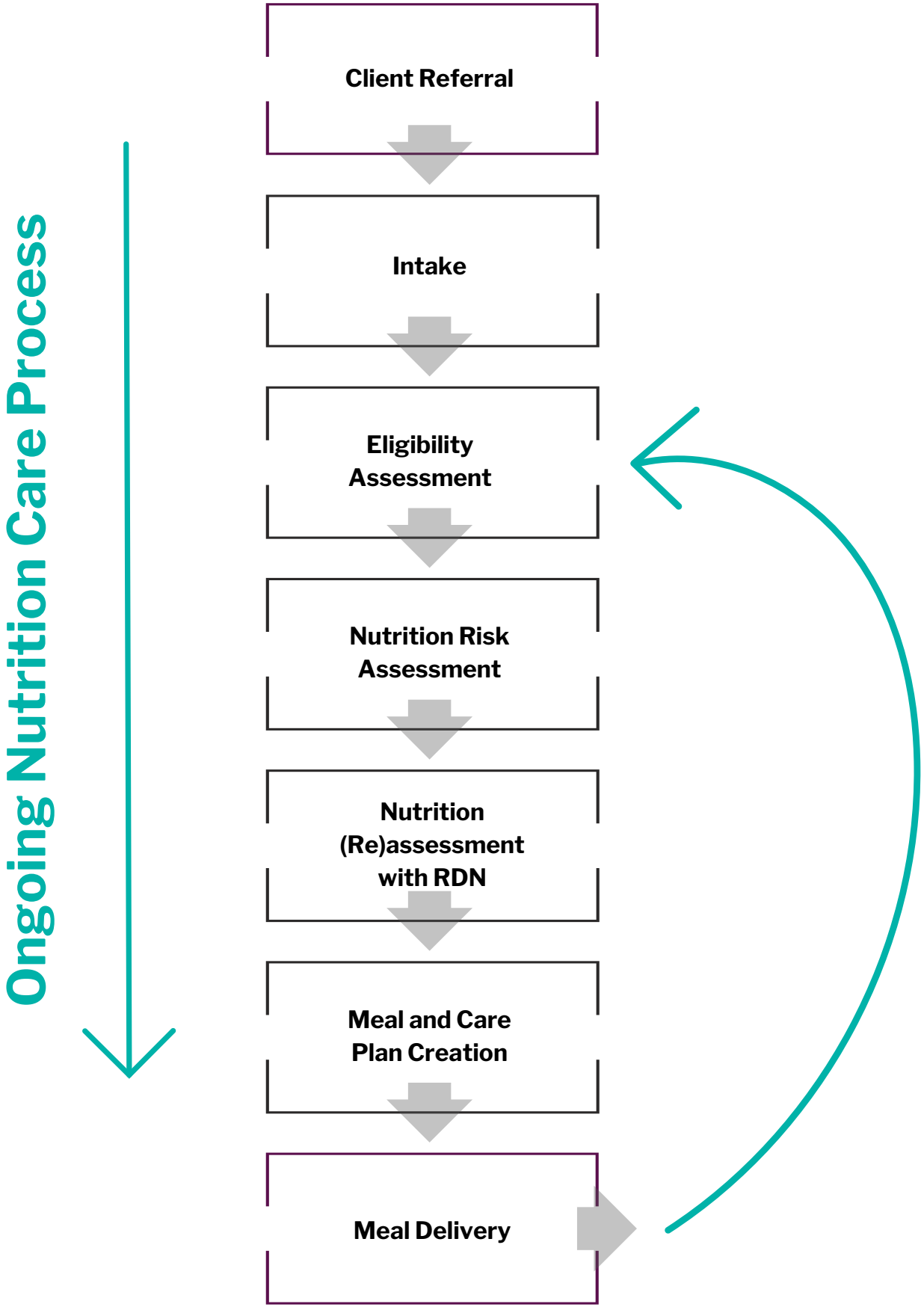
A health plan includes a private health insurer or HMO, a self-insured employee health benefit plan, a government health insurance program such as Medicare or Medicaid, and other types of third-party payors.

✓ If "yes," the agency is a covered entity.
✓ If "no," the agency is not a covered entity; go to Question **3**.

3. Does the agency receive, create or maintain client-identifying information in connection with providing services to another covered entity (either a health care provider or a health plan)?

✓ If "yes," the agency is a business associate.
✓ If "no," the agency is not a business associate and is not subject to HIPAA.

ANNEX 4:
Flowchart of Experience



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info@fimcoalition.org