



CREATED BY GUSNIP NTAE CENTER

Survey for Health Care Providers

Produce Prescription Projects

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

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

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

2. Please write the name of the clinic where you are currently working as it relates to *[insert incentive program (e.g., Double Up Food Bucks)]*.

Demographic Information

3. What is your age?
 - _____
 - Prefer not to answer
4. How do you describe yourself?
 - Woman
 - Man
 - Non-binary
 - Third gender
 - Prefer to describe myself: _____
 - Prefer not to answer
5. Are you of Hispanic, Latino/a, or Spanish origin?
 - Yes
 - No
 - Prefer not to answer
6. How would you describe your racial or ethnic background? *Check all that apply.*
 - Asian
 - Black or African American
 - American Indian or Alaska Native
 - Middle Eastern or North African
 - Native Hawaiian
 - Pacific Islander
 - White or European American
 - Any other race:
 - Don't know/not sure
 - Prefer not to answer

Clinical Experience

7. What is your primary clinical / training profession?
- MD, DO
 - Nurse practitioner / Physician assistant
 - Registered dietitian nutritionist (RDN)
 - Pharmacist
 - Physical therapist / Occupational therapist / Speech language pathologist
 - Social worker / case manager
 - Other (please specify) _____
8. What is your clinic's specialty (e.g., internal medicine, endocrinology, family medicine, etc.)? _____
9. How many years have you been practicing since completing your degree? (If you are a MD, since completing your residency)?
- Less than 5 years
 - 5-10 years
 - More than 10 years

Program Related Questions

Please select how much you personally disagree or agree with the following statements.

10. My clinical training prepared me to educate patients on healthy eating.
- Strongly Disagree
 - Disagree
 - Neither disagree nor agree
 - Agree
 - Strongly Agree
 - Does not apply to me

11. My clinical training prepared me to address social determinants of health, including those related to food insecurity with my patients.
- Strongly Disagree
 - Disagree
 - Neither disagree nor agree
 - Agree
 - Strongly Agree
 - Does not apply to me

The next set of items refer to the produce prescription program being implemented in your clinic. Throughout the document produce prescription programs will be abbreviated as PPR. Please select how much you disagree or agree with the following statements.

12. The program has changed how I talk with my patients about healthy eating or whether I talk to my patients about healthy eating.
- Strongly Disagree
 - Disagree
 - Neither disagree nor agree
 - Agree
 - Strongly Agree
 - Does not apply to me
13. The program has changed my opinion on the importance of healthy eating in improving my patients' health.
- Strongly Disagree
 - Disagree
 - Neither disagree nor agree
 - Agree
 - Strongly Agree
14. There were/are significant barriers to program implementation at our site.
- Strongly Disagree
 - Disagree
 - Neither disagree nor agree
 - Agree
 - Strongly Agree

15. PPR negatively impacted the clinical workflow.

- Strongly Disagree
- Disagree
- Neither disagree nor agree
- Agree
- Strongly Agree

16. The project has been beneficial for patients, and I would recommend this program to be used at similar clinics.

- Strongly Disagree
- Disagree
- Neither disagree nor agree
- Agree
- Strongly Agree

Workflow/Other Clinical Factors

17. Which of the following did you add in response to your PPR? Select all changes that apply:

- Implemented new screening tools, survey measures, or questions in clinical visit (e.g., 2-item food insecurity screener, dietary intake items, others)
- Integrated new screeners or survey in electronic health record (e.g., food insecurity)
- Added a patient follow-up visit or increased the duration or timing of a patient follow-up visit
- Added nutrition education components to clinical visits
- Added auxiliary services to accommodate patients (e.g., free transportation to clinic)
- Added or expanded clinical/administrative personnel
- Other: _____
- Did not change

18. Did your clinic experience any of the following challenges in implementing your PPR? *Select all that apply.*

- Inadequate staffing
- Limited training for providers
- Limited time for patient encounters
- Insufficient resources for nutrition education
- Insufficient resources for electronic health record abstraction
- Insufficient resources for survey administration
- Other (Please specify):

19. On average, how many additional hours per week would you estimate you've added to engage in direct patient-facing encounters for your clinic's PPR? *Please include additional time spent in clinic encounters, enrollment, recruitment, and direct patient communication.*

- None
- 1-3 hours
- 4-6 hours
- 7-10 hours
- More than 10 hours

20. On average, how many additional working hours per week would you estimate you've added to administer your clinic's PPR? *Please include additional time spent in charting and administrative tasks.*

- None
- 1-3 hours
- 4-6 hours
- 7-10 hours
- More than 10 hours

21. What conditions are included as eligible for patients to participate in your PPR? *Select all that apply.*

- Food insecurity
- Hypertension
- Hyperlipidemia
- Type 2 diabetes / pre-diabetes
- Cardiovascular disease
- Obesity
- Other: _____
- No health condition is required

22. What support staff do providers think are the most essential for feasible program implementation? *Select all that apply.*

- Registered dietitian nutritionist
- Pharmacist
- Physical therapist / occupational therapist / speech language pathologist
- Social worker / case manager
- Front desk
- Nursing / healthcare tech / assistant
- Clinic coordinator
- Scheduler
- Other (please specify) _____

Experience

23. Overall, how would you rate your experience offering [insert name of PPR]?

- Very negative
- Negative
- Neutral
- Positive
- Very positive

24. If available, would you participate again in [insert name of PPR]?

- Yes
- No
- Don't know

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