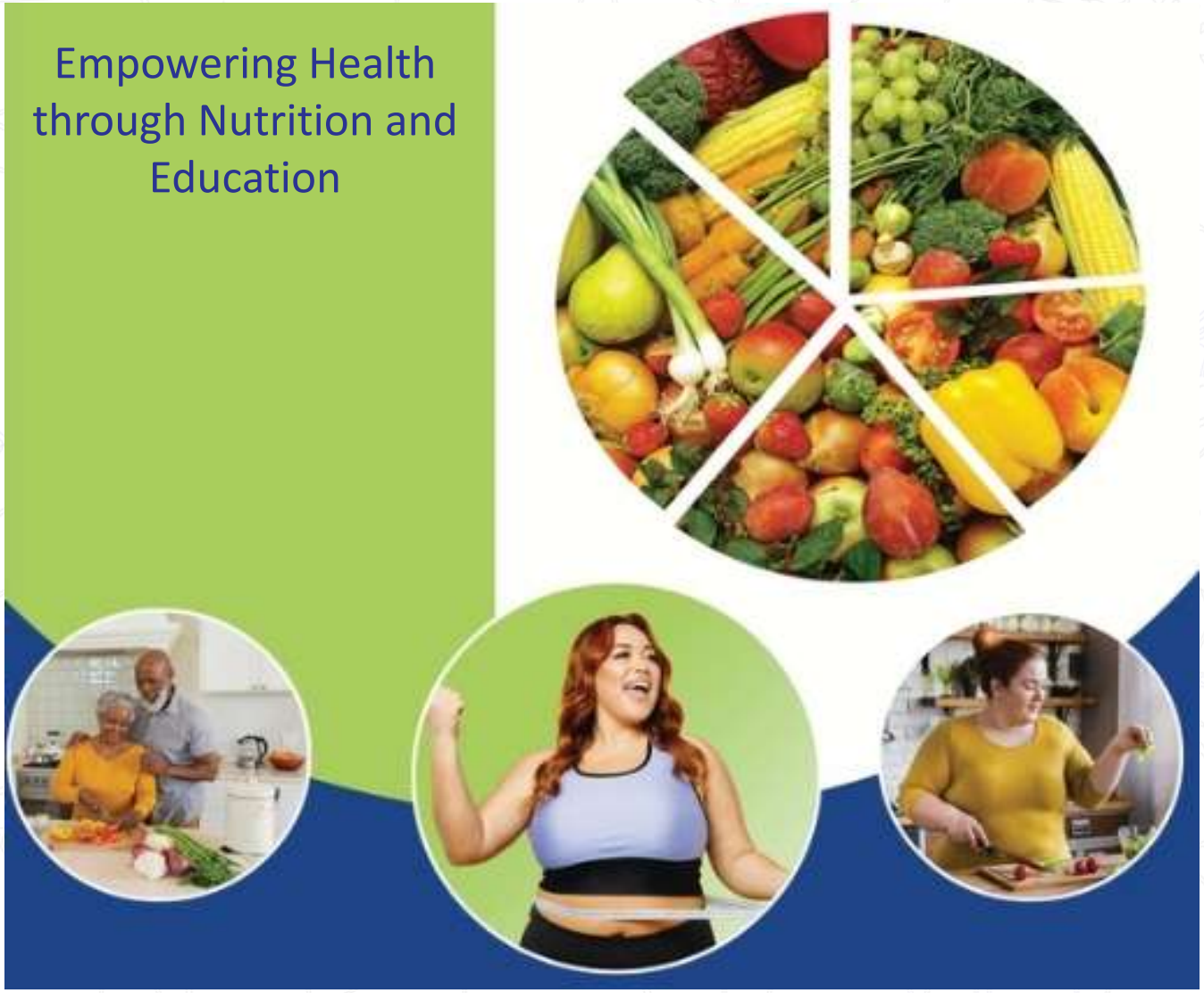
Food Prescription Program

SUSSEX COUNTY is Our Specialty

Empowering Health through Nutrition and Education



Kim Blanch, BSN, RN
Director of Community & Mobile Outreach

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The history

2016, Beebe launches a monthly food program in partnership with the Food Bank of DE

Patients identified as food insecure through the hunger vital signs

Epworth Church volunteers began delivering to our homebound participants; Jewish Seaside volunteers later joined

Food Prescription Program Overview

- Planning began pre-pandemic; space secured
- Condition-specific pathways (CVD, DM, MH, Onco, etc.)
- Food market for dignified shopping with color-coded food displays based on nutritional considerations for health conditions
- Health Coach model with CHW intervention for social need/resource connection
- Platform for data collection/participant monitoring/food inventory

- **Focus groups for programmatic development**

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Food Rx Program Funding

- Grant-funded through MERCK's philanthropic division
  - Solutions for Healthy Communities
- Supports:
  - Food provision
  - Culinary education
  - Nutritional education
  - Self-management education

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Program Objectives

1

Serve populations within our communities where data demonstrates need

2

Provide individuals experiencing food insecurity equitable access to nutritious foods & related education

3

Improve the overall health, wellbeing, and self-management capacity of individuals who have been diagnosed with a chronic health condition

4

Provide educational experiences in a meaningful way - empowering participants to integrate new skills & knowledge as they pursue their personal health goals

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Patient Population & Eligibility Criteria

Who We Serve

- Individuals who struggle with a chronic condition such as high blood pressure, high cholesterol, diabetes, and/or obesity
- Individuals who are experiencing food insecurity
- Individuals who demonstrate a readiness to change
- Individuals who reside in Georgetown and Millsboro, DE

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How Participants Join

- Referrals from:
  - Healthcare providers
  - EMR reports
  - Community organizations/partners
  - Community Health Workers
  - Outreach Events
  - Cold Calls
  - Self-Referral (with eligibility screening)
    - Word of Mouth
    - Flyers
- Intake includes:
  - Eligibility screening (including initial biometrics)
  - Consent and onboarding

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Food Access & Partnerships

- Food Bank of DE
  - Provides us with the nutritious foods we serve our participants such as fresh produce, lean proteins, and heart healthy, diabetes-friendly dry goods
- Georgetown Public Library
  - Provides us space to host educational sessions and collect biometrics
- Grace United Methodist Church (Millsboro)
  - Provides us with a space to host our educational sessions and collect biometrics of participants; we supply them with any extra food donations/support they may need

Food Bank OF DELAWARE

DelawareLibraries

Grace United Methodist Church

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Food Distribution Methods

- Delivery for homebound or transportation-limited participants
- Easily accessible food pick-up locations within Georgetown and Millsboro

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FIM Intervention Approach

- Twelve weeks of education within a six-month cohort
  - 3 weeks of Culinary Classes
  - 3 weeks of Nutrition Classes (with a Registered Dietician)
  - 6 weeks of Healthy Living with Chronic Conditions Classes
- SDOH assessment and connection to resources
- Connection to primary and specialty care
- Ongoing food provision and coaching

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Removing Barriers to Participation

Access Accommodations:

- Online, recorded, and telephonic class options
- Transportation support & home visits
- Step-by-Step tech access guide

Incentives

- Graduation ceremony for participants who meet attendance requirements

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Measuring Impact: Clinical and Behavioral Outcomes

Clinical Data Tracked:

- Blood Pressure, A1C, Total Cholesterol, HDL, Triglycerides, BMI, etc.

Behavioral Outcomes:

- Improved health literacy
- Goal setting & adherence
- Reduced food insecurity

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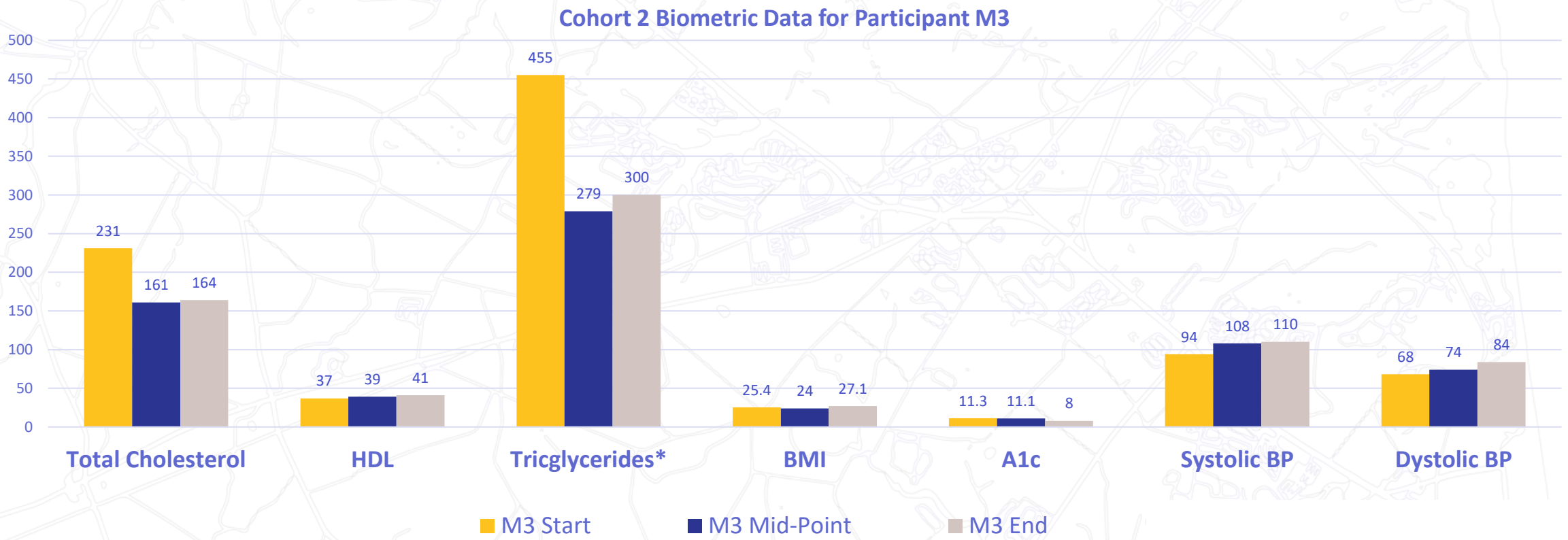
Case Study #1

Biometric Data for M3



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Case Study #1

Connection to Care

This participant did not have a connection to care until they were enrolled into the program. After initial biometrics were taken, it was discovered they were diabetic. They were connected to primary care. Data show a significant decrease in their A1C levels during participation.

Along with the improvement of biometric data, changes in mood, energy, and an increase in social interactions were observed by fellow participants and our staff.

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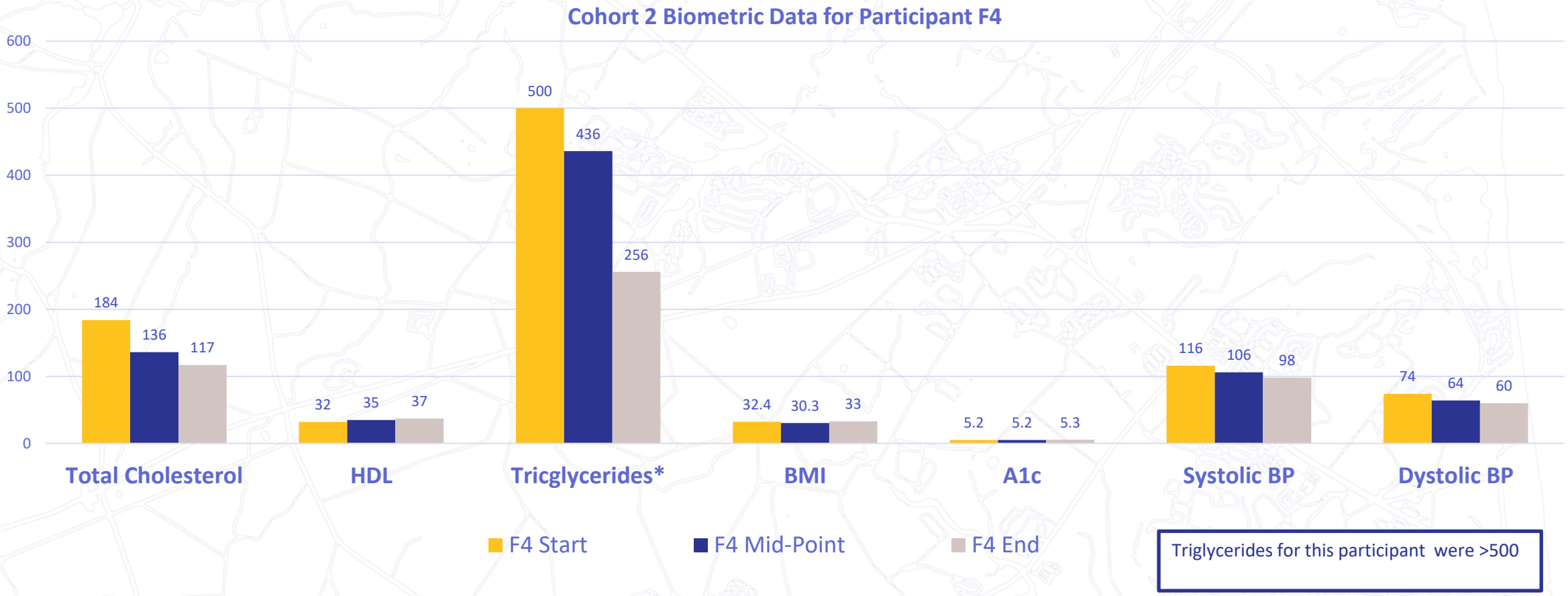
Case Study #2

Biometric Data for F4



Triglycerides for this participant were >500

Case Study #2

Participation & Gratitude

This participant attended 4 of 6 nutrition and culinary classes, along with all sessions of the Healthy Living with Chronic Conditions program. Their biometric data suggests successful implementation of the new knowledge into their daily routine, demonstrating noticeable improvement.

“I did not think about counting calories or reading food labels until I joined this program; I am very thankful and happy that I was approached by Beebe and informed about this program.”

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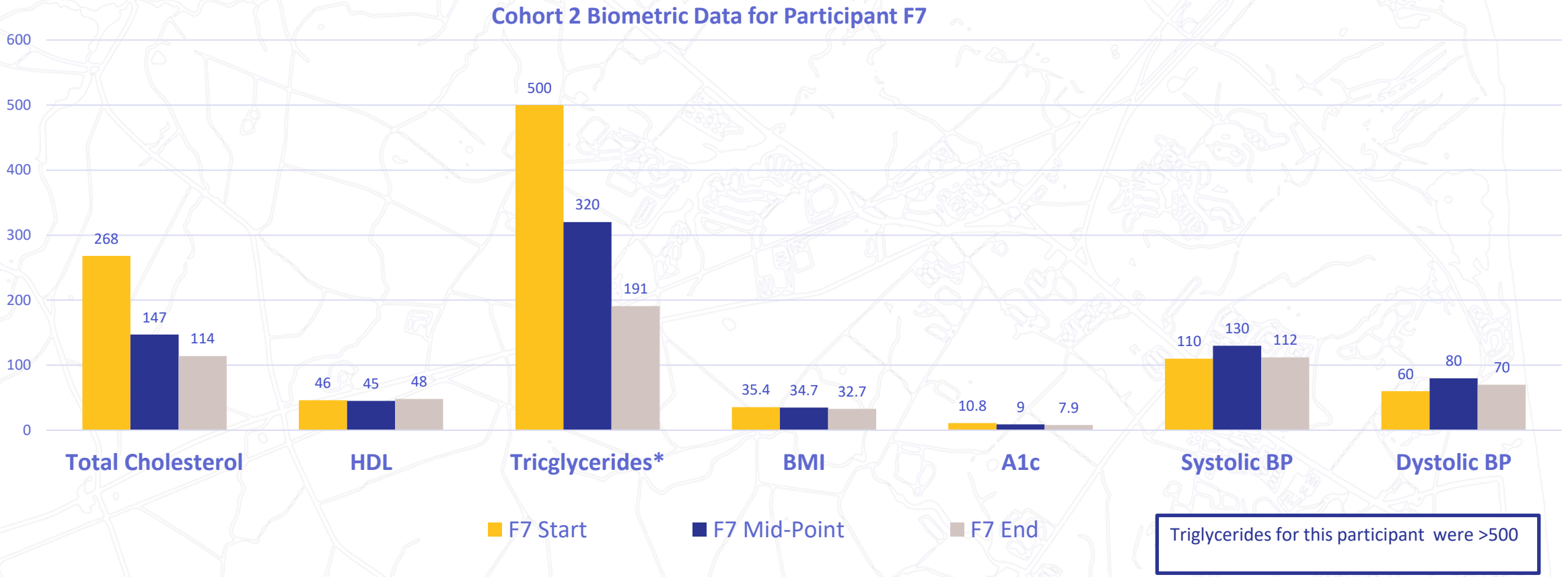
Case Study #3

Biometric Data for F7



Triglycerides for this participant were >500

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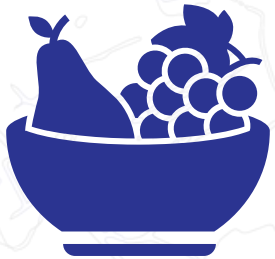
Case Study #3

Participation & Connection to Care

This participant attended 2 of 6 nutrition and culinary classes, plus all 6 sessions of the Healthy Living with Chronic Conditions program. Biometric data and participant testimonial indicate education has been incorporated into their lifestyle, in combination with connection to medical care.

This participant was successfully reconnected to a primary care provider (PCP) to support medical management of their chronic conditions.



This case further demonstrates that connection to care, nutritious food, and education on how to prepare healthy meals, enables participants to improve their lifestyles and become healthier versions of themselves.

Positive Feedback

We asked the participants to give us some feedback about the program and what they liked best. Here are a few of their responses:

“It was well-paced and very informative. They also checked our vitals in the beginning, middle, and end; I hope a lot of other people know about the program.” MG

“They provided us with a very trusting environment to be vulnerable and share things we have been going through and talk about how we plan to get through those things; setting goals for ourselves” MG

"This program is fun, I'm enjoying myself. The class (SMP) and instructors are making me think more about my health and how I am responsible for it." KB

"I liked getting my lab work and seeing my progress. It's nice to see how hard I've worked to get my blood work to a normal level" - MM

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Lessons Learned

- Accessibility was essential for participants with transportation barriers, those who are homebound, those who are native Spanish-speakers, and/or those who work during the day.
- Participants would have liked more structure to the nutrition classes with an agenda, so the discussion topic was determined in advance rather than based on real-time participant input.
- Participants voiced interest in greater variety of heart healthy dry goods; we worked with the FBD to provide those extra options.
- Some participants shared that it was too much produce, so we created a rotation between 10lb and 20lb boxes of produce each week.

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Cohort 2

High-level summary

Cohort 2 - Participants' Biometric Summary	
Total participants with a Biometric decrease from	**Rate of total participants with a Biometric decrease**
17 out of 25 participants had a decrease in their Total Cholesterol	68%
17 out of 25 participants had an increase in their HDL	68%
13 out of 25 participants had a decrease in their Triglycerides	52%
9 out of 25 participants had a decrease in their BMI	36%
13 out of 25 participants had a decrease in their A1c	52%
17 out of 25 participants had a decrease in their Systolic Blood Pressure(BP)	68%
11 out of 25 had a decrease in their Diastolic Blood Pressure (BP)	44%

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Questions?

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