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Nourishing Patients with Food-Based Interventions at FQHCs

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Treating Families Well Since 1988

- Federally Qualified Health Center
- Accredited by The Joint Commission
- Westside's vision is to **achieve health equity for all**.
- Our mission is to improve the health of our communities by **providing equal access to quality healthcare, regardless of ability to pay**.

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Patient Services & Sites

- Services we offer:
  - Primary Medical Care
  - Dental Care
  - Behavioral Health Care
  - Social Support Services
  - Mobile Health Services

- Where we are located:
  - 5 health center sites
  - 4 dental sites
  - 1 mobile health unit

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Who We Serve

- **23,463** patients served
- **122,446** patient visits
- **51%** of our patients are Hispanic/Latino
- **4 in 10** patients are best served in a language other than English
- **83%** of our patients live at 200% below the Federal Poverty Level
- **30%** of our patients are uninsured
- **47%** of our patients receive insurance through Medicaid
- **5%** of our patients receive insurance through Medicare

*Data from 2024

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Feeding Families: Our Food Is Medicine Program

Roots of FIM in Community Health Centers

"In the 1960s, Dr. Jack Geiger and a group of health professionals started a community health center in the Mississippi Delta, where children were dying from infectious diarrhea and malnutrition. Geiger and company began writing prescriptions for healthy food — patients would buy the prescribed food at a grocery store that would charge the clinic for the cost.

When Geiger caught flack for prescribing food instead of drugs, he replied, "The last time I looked at my textbooks, the most specific therapy for malnutrition was food."

Source: https://nppc.health/food-is-medicine-the-inextricable-link-between-food-and-health/

Dr. Geiger and Dr. John Hatch during construction of the Delta Health Center, 1968. (Photo by Daniel Bernstein)

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Feeding Families Program

Feeding Families was developed by a multi-disciplinary team at Westside Family Healthcare.

It is a **52-week program delivering fresh foods** to the door of patients living with uncontrolled chronic diseases. Westside provides monthly nutrition counseling and weekly support by a community health worker team.

Patients receive fresh produce, eggs, and bread delivered to their door each week – enough to feed the **entire household**. They also receive countertop appliances throughout the year to help prepare healthy meals for their family.

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Program Basics

- Launched in 2020
- Funded by Highmark Blueprints - $330,000 investment over two grant cycles
- Completed 2 cohorts
- Maximum of 50 patients in each group
- Engaged a multidisciplinary team to support the program
- Partnered with Hungry Harvest to deliver produce every week for 52 weeks
- Program evaluation completed by Dr. Allison Karpyn and the UD CRESP team

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Eligibility Criteria

- Current patient of Westside
- Uncontrolled Diabetes, hypertension and/or obese
- Positive screen for food insecurity
- Reside in New Castle County
- Reside in a location that can receive weekly produce deliveries
- Ability to participate in frequent check ins
- Ability to participate monthly nutrition counseling appointments
- Willingness to complete surveys and share personal impact for the research study

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Cohort 2 Participant Characteristics

Table 1. Participant Characteristics

	n	%
Age		
20-29	1	2.3%
30-39	0	0.0%
40-49	11	25.6%
50-59	12	27.9%
60-69	11	25.6%
70-79	4	9.3%
80-89	3	7.0%
90-99	1	2.3%
Gender		
Women	29	67.4%
Men	14	32.6%
Race		
American Indian or Alaskan Native	1	2.3%
Black or African American	18	41.9%
White	20	46.5%
Not Reported	4	9.3%
Ethnicity		
Hispanic or Latino	14	32.6%
Not Hispanic or Latino	26	60.5%
Not reported	3	7.0%
Health Conditions of Participants		
Obesity	21	48.84%
Diabetes	24	55.81%
Hypertension	26	60.47%
Comorbidity	21	48.84%

Cohort 2 Primary & Secondary Outcomes

	Baseline		Midpoint		Endpoint	
	n	Mean (std. dev)	n	Mean (std. dev)	n	Mean (std. dev)
Daily Servings FV Consumption	41	4.39 (1.84)	34	3.97 (1.41)	37	4.29 (1.69)
BMI	44	35.95 (9.87)	41	35.79 (9.67)	34	35.14 (8.3)
A1C	24	7.87 (2.15)	20	7.44 (1.53)	19	7.91 (2.23)
Participants using All Food Box Items (%)	**22**	**45.45%**	**22**	**86.46%**	**22**	**95.45%**

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Cohort 2 Primary & Secondary Outcomes

	Baseline		Midpoint		Endpoint	
Behavioral Change: *Percent of Participants Self-Reporting a Reduction in Consumption of:*						
Sodium	39	58.97%	33	87.88%	34	88.24%
Sugar	40	65.00%	33	90.91%	34	91.18%
Fat	39	66.67%	33	87.88%	34	88.24%
Food Insecurity Screener:						
Percentage of participants reporting 'never true' to worrying about food running out before they got money to buy more within the past six months.	51	39%	38	47%	41	56%
Percentage of participants reporting 'never true' to the statement: 'Within the past six months, the food I bought just didn't last, and I didn't have money to get more	51	37%	38	42%	41	58%

Cohort 2 Primary & Secondary Outcomes

	Baseline		Midpoint		Endpoint	
Commitment to Health Goals:						
Percentage working towards health goal	38	90%	35	96%	20	97%
Percentage Reporting Progress Due to the Program	38	97%	35	100%	20	97%

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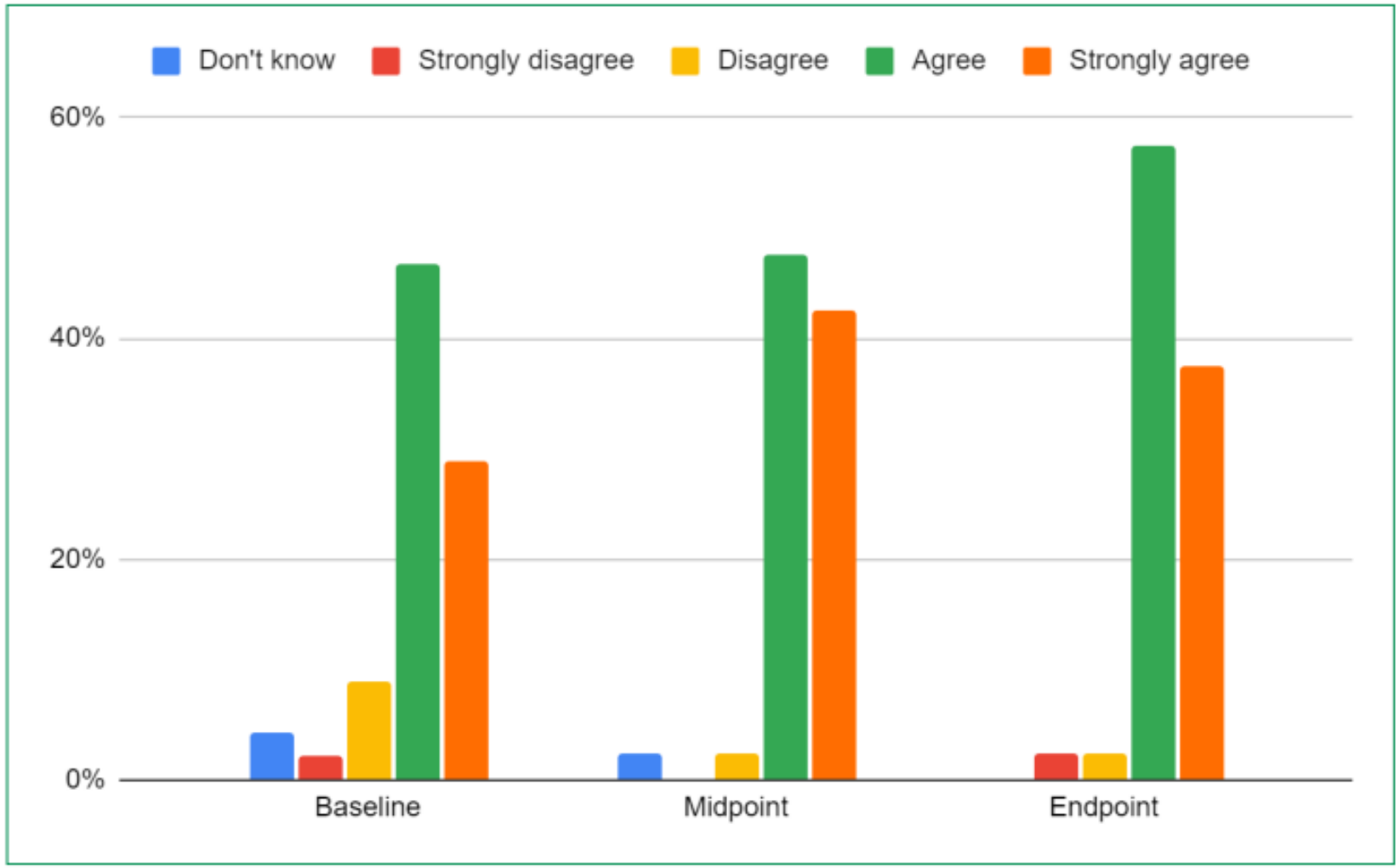
Cohort 2 Knowledge & Skills to Prepare Healthy Meals

Figure 1. Knowledge and Skills to Prepare Healthy Meals



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Research Conclusions

- Participants demonstrated significant reductions in BMI and improved dietary behaviors, including decreased consumption of sodium, sugar, and fats.
- While changes in A1C levels were not statistically significant, the overall trend indicated improvement.
- The program also led to modest enhancements in food security.

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Research Limitations

- Small sample size (n=43) limited statistical power
- Quasi-experimental design without a control group makes it difficult to attribute changes solely to the intervention
- Self-reported dietary behavior changes (sodium, sugar, and fat consumption) may be subject to social desirability bias, where participants report behaviors they believe are expected rather than actual practices.
- 12-month intervention period may be insufficient to observe significant changes in certain clinical markers like A1C
- Participant attrition was notable for some measures
- Population was predominantly older adults (average age 58.7 years) with established chronic conditions, potentially limiting generalizability to younger populations or those at earlier stages of disease development.
- Study did not include comprehensive cost-effectiveness analyses, which would be valuable for policy decisions regarding scaling and sustaining such FIM interventions.

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Next Steps

- Seek funding to launch Cohort 3 ($180,000 to $200,000)
- Incorporate learnings with consideration on expanding the number of participants, age range & consider a control group to assess the intervention
- Continued involvement in expanding FIM program
- Support Medicaid waivers to incorporate long-term FIM programs for patients with chronic illnesses

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Questions?

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