Food Pharmacy:

Partnership between local food bank and medical clinic

Jeff Domingus, DO

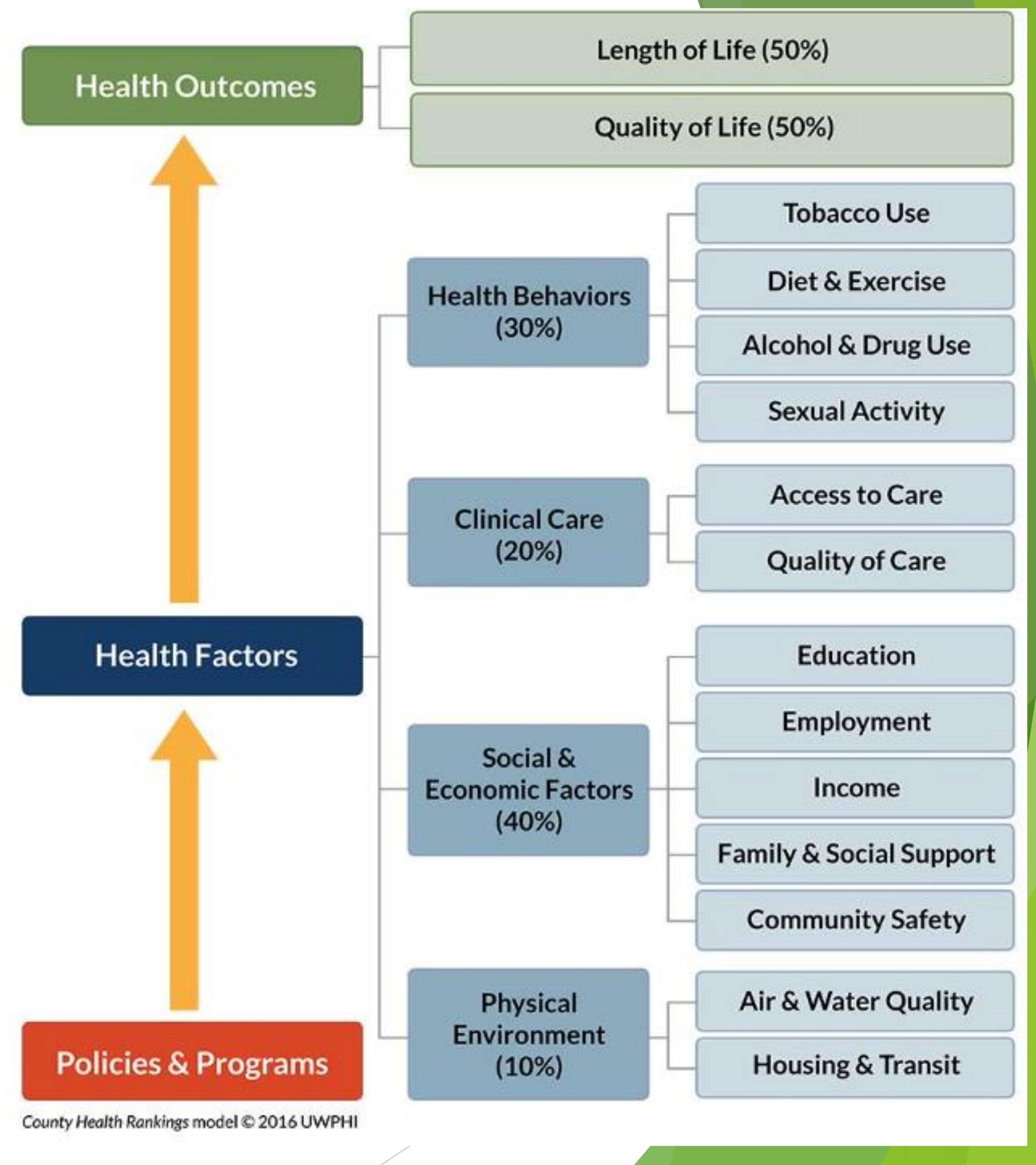
3/20/2024

To find health should be the object of the doctor. Any one can find disease.

~ Andrew Taylor Still

AZ QUOTES

- Medical care is estimated to account for only 10-20 percent of the modifiable contributors to healthy outcomes for a population
  - Hood, C. M., K. P. Gennuso, G. R. Swain, and B. B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventive Medicine* 50(2):129-135. https://doi.org/10.1016/j.amepre.2015.08.024



HCHC Pharmacy opens in October 2020 with great success by providing access to quality medications at affordable prices…

- 340B formulary patient example
  - Invokamet 150/1000mg
    - $588 cash; $16 340b
  - Victoza 1.2mg
    - $535 cash; $16 340b
  - Lantus vial
    - $77 cash; $15 340b
  - Lipitor 40mg
    - $19 cash; $15 340B

Mixed messaging…

DOH!

Put your money where your mouth is…

- Online subscription with fresh produce delivered weekly and placed in pharmacy

FREE, ENJOY!

¡GRATIS, DISFRUTA!

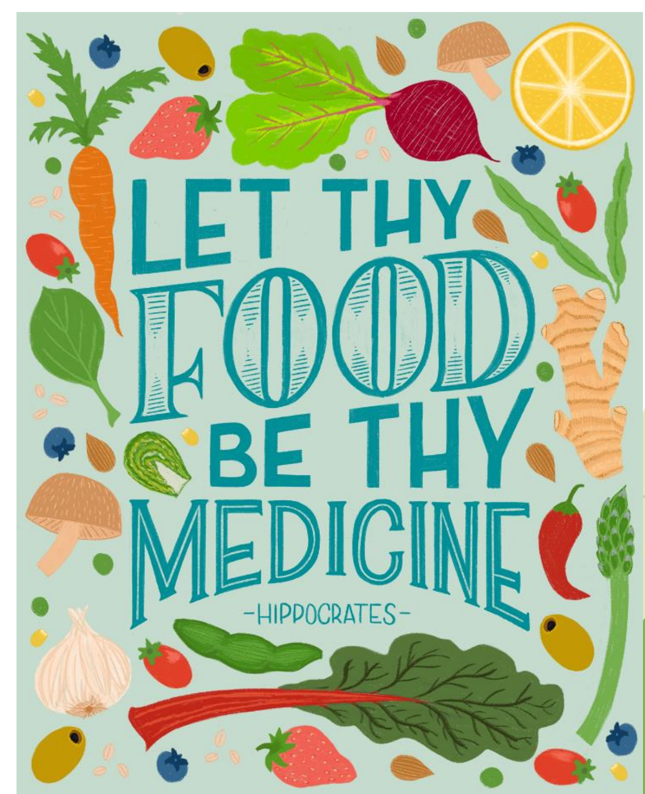
مجانا ، استمتع!

BELAş, KÊFÊ!

BURE, KUFURAHIA!

ናጻ ተሓጎስ!

Бесплатно, наслаждайтесь!



Food Pharmacy

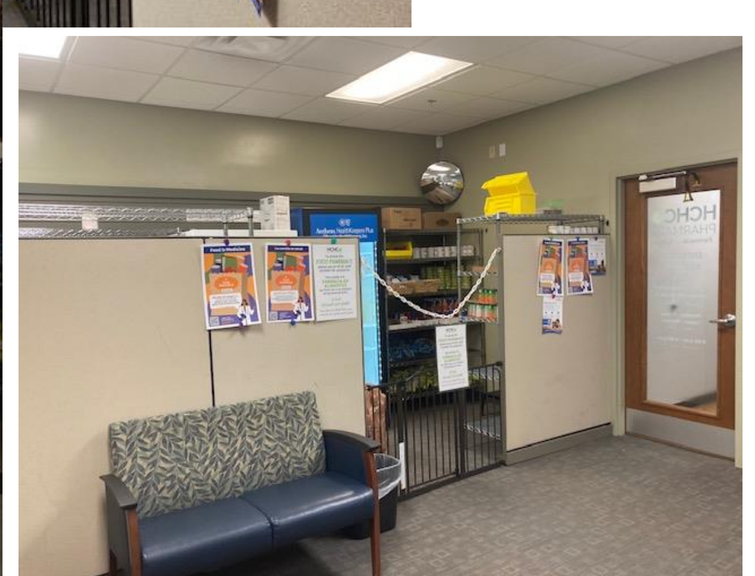
- "Low barrier" food pantry access
  - Any patient can access Food Pharmacy during a routine scheduled appointment
  - Staff members are trained in assisting with patients
  - Providers can incorporate Food Pharmacy into the appointment
    - Real-time education (eg interpreting nutrition labels)
    - Compare/Contrast unhealthy vs healthy food options
    - Access to fresh produce
- Culturally sensitive staple items that are appropriate for all chronic disease states
- Resources to access BRAFB services in the community if patient has food insecurity
- Sends a message that we value "health" at HCHC

HCHC
HEALTHY COMMUNITY HEALTH CENTERS

To access the
FOOD PHARMACY
please see an HCHC staff member for assistance

Para acceder a la
FARMACIA DE ALIMENTOS
por favor vea a un miembro del personal de HCHC.

للوصول الى
الطعام لدى الصيدليه
يرجى مراجعة الموظف لدى مراكز صحة المجتمع الصحى للحصول على المساعده.



Anthem. HealthKeepers Plus
Offered by HealthKeepers, Inc.

2023

Month	Total patients	Patients screened positive for food insecurity	Referred to external community food resources	Households receiving food in-clinic	Total bags/boxes distributed	Participants with diet-related chronic illness
July	789	73	73	14	88	6
August	1978	261	261	45	329	40
Sept		400	400	102	437	42
October	2072	404	404	106	446	39
Nov	2263	472	459	114	287	60
Dec	2082	380	371	92	260	

2024

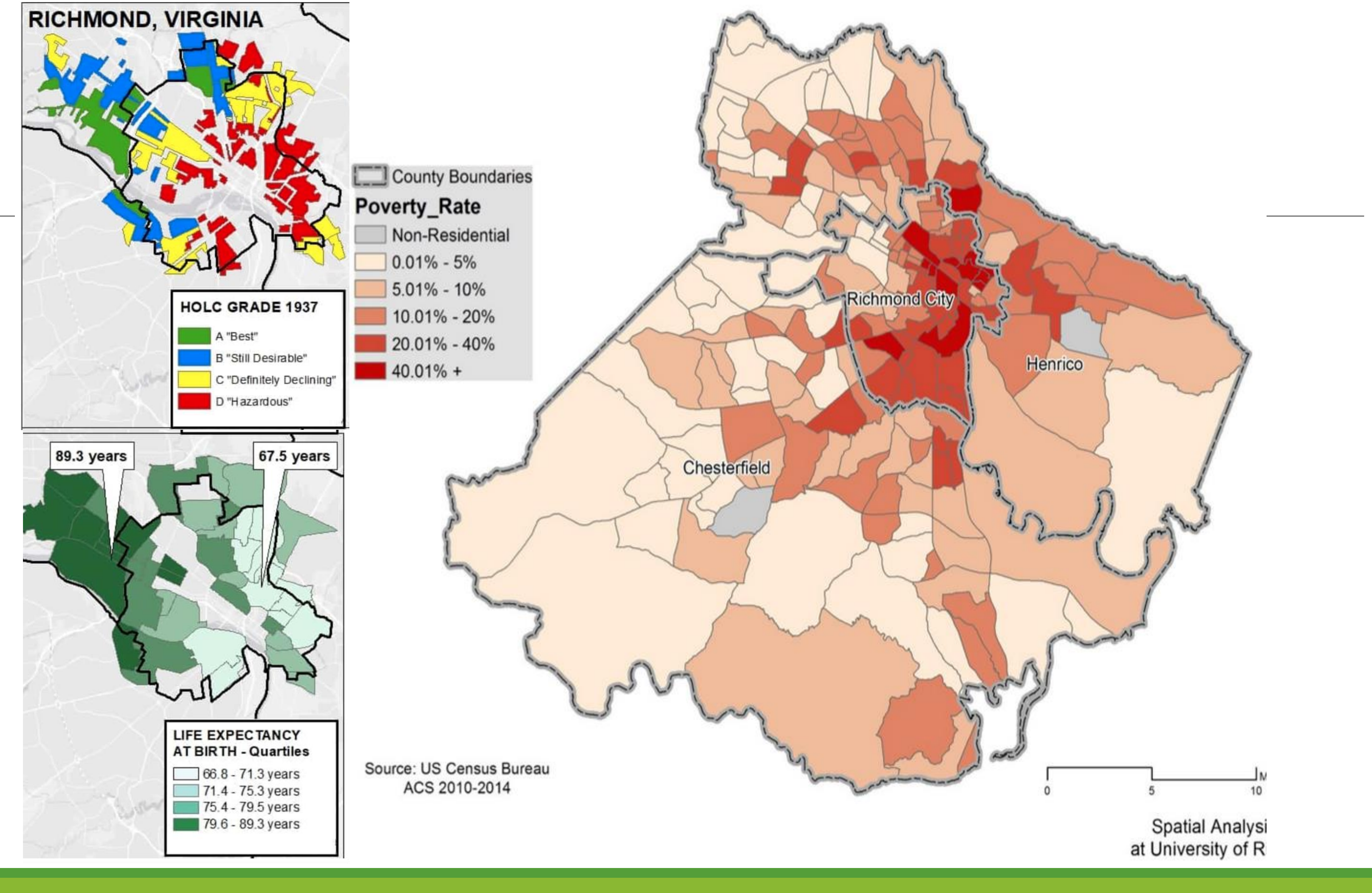
Month	Patients receiving food age 0-18	Patients receiving food age 19-59	Patients receiving food age 60+	Total patients receiving food in clinic	Households receiving food in-clinic
January	188	265	62	515	**120**
February	158	197	66	421	109

In the News…

BRAFB and Healthy Community Health Centers establish 'Food Pharmacy'

- BRAFB and Healthy Community Health Centers establish 'Food Pharmacy' (whsv.com)

Our vision is a healthier community where everyone has equitable access to nourishing food and meaningful opportunities to grow, choose, cook, and enjoy fresh produce.



RICHMOND, VIRGINIA
HOLC GRADE 1937
A "Best"
B "Still Desirable"
C "Definitely Declining"
D "Hazardous"
89.3 years
67.5 years
LIFE EXPECTANCY AT BIRTH - Quartiles
66.8 - 71.3 years
71.4 - 75.3 years
75.4 - 79.5 years
79.6 - 89.3 years
County Boundaries
Poverty_Rate
Non-Residential
0.01% - 5%
5.01% - 10%
10.01% - 20%
20.01% - 40%
40.01% +
Richmond City
Henrico
Chesterfield
Source: US Census Bureau ACS 2010-2014
0
5
10
Spatial Analysi
at University of R

SHALOM
FARMS

FRESH · LOCAL · AFFORDABLE
SHALOM FARMS
A FIRST GRADE
B SECOND GRADE
C THIRD GRADE
D FOURTH GRADE
SPARSELY SETTLED (COLOR INDICATES GRADE)
INDUSTRIAL & COMMERCIAL
PREPARED BY
DIVISION OF RESEARCH & STATISTICS
HOME OWNERS' LOAN CORPORATION. APR. 3, 1937
CITY OF
RICHMOND
VIRGINIA
AND ENVIRONS
DEPARTMENT OF PUBLIC WORKS
1923
JAMES RIVER
SHALOM
FARMS

Produce Rx

Our clinical produce program provides weekly produce and cooking classes to participants enrolled in chronic disease prevention and management programs.

We work primarily with health care providers to help individuals and their families overcome barriers to healthy eating.

- weekly prescriptions of produce
- health screenings
- health coaching & goal setting
- free kitchen supplies
- hands-on cooking classes

MHWP
Mobile Health & Wellness Program
VCU

Cooking and food skills

Food access is about more than physical and financial access to food – it includes knowledge, confidence, and trust. We take our food skills on the road so every produce purchase includes an idea, hands-on experience, or recipe.

- 140 hours of cooking education
- 2400 participants of all ages
- Mobile Market demos
- food pantry demos

Mobile Market

Location and income should not determine access to healthy food. The Mobile Market visits neighborhoods across the city, connecting communities to fresh, local, and sustainably grown produce.

Each season, we…

- host almost 400 markets
- process more than 4,000 transactions
- reach more than 1500 unique customers
- distribute more than 170,000 servings of produce

1611

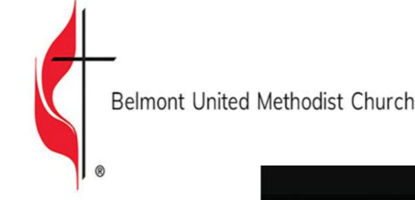
GROWN TO GO
FRESH | AFFORDABLE | QUICK | LOCAL | HEALTHY
SNAP
GROWN TO GO

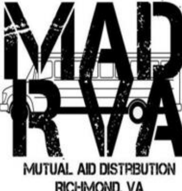
SHALOM FARMS
FRESH · LOCAL · AFFORDABLE · SNAP/EBT ACCEPTED
FRESH | AFFORDABLE

Nutrition Distribution

We partner with community food pantries, meal programs, and mutual aid organizations, providing weekly distributions of our produce to those most in need

- more than 80,000 pounds donated each year
- over a dozen partners – in addition to Feed More's network of agencies





Sustainable Agriculture & Community Engagement

We partner with community food pantries, meal programs, and mutual aid organizations, providing weekly distributions of our produce to those most in need

- <200,000 pounds grown each year
- 7,000 volunteer visits
- Certified Naturally Grown
- 2 sites – 8 acres

COLLEGIATE

Questions?

Erin Lingo
erin@shalomfarms.org

shalomfarms.org

Sentara Community Care

Overcoming challenges & removing barriers

March 2024

Sentara Health

130+ year not-for-profit mission

12
Hospitals

9
Magnet Nursing Hospitals

1
Sentara College of Health Sciences

300+
Sites of Care

1,300
Sentara Medical Group Providers

1,200,000+
Member Health Plan

900+
Physicians

470+
Advanced Practice Providers

700,000+
Medicaid Covered Lives

Sentara Health

20+ years Best Hospitals

U.S. News & World Report

3
States Served
(VA, NC, FL)

Nearly
30,000
Team Members

Aa2/AA
Ratings

2nd
Largest Private
Employer in
Virginia

$260+M
2022 Investment
in Our Communities

$11.2B
Total Operating
Revenue

$54M
Investment in
Community Benefit
Programs

$185+M
Investment in
Employee
Compensation

Service Areas

- Northern Virginia
- Halifax
- Hampton Roads
- Northeast NC
- Blue Ridge

- Sentara Hospitals
- Sentara Health Plans
  - Optima Health
  - Virginia Premier
- AvMed

Winchester
Front Royal
Washington
Fairfax
Woodbridge
Harrisonburg
Culpeper
Fredericksburg
Staunton
Charlottesville
Richmond
Lynchburg
Farmville
Williamsburg
Petersburg
Hampton
Blackstone
Suffolk
Norfolk
Virginia Beach
Halifax
Emporia
Danville

Who We Are

We are an organization driven to **improve health** every day. While we meet that mission through the healthcare services we provide to our patients and the coverage we provide to our health plan members, we know that genuinely improving health every day requires a much **deeper commitment** within our communities.

We Are Committed

For more than 130 years, Sentara's presence in our communities has never been defined solely by our hospitals and clinics. By listening and striving to be a **trusted partner** to residents, fellow nonprofits, educators, health and human services providers, and faith-based organizations who share our mission, we work daily to be an **anchor** upon which all can rely.

Sentara Strategic Imperatives

Consumers

Awareness & Preference

Experience

Top-tier Quality and Safety

Share of Care

Service Growth

Community

Health Equity

Social Determinants

Fiscal Stewardship

Access & Affordability

Colleagues

Engaged Culture

Focused on DE&I

Attract & Retain Top Talent

Capabilities

Digital Optimization

Technology Infrastructure

Investments to Enable Growth

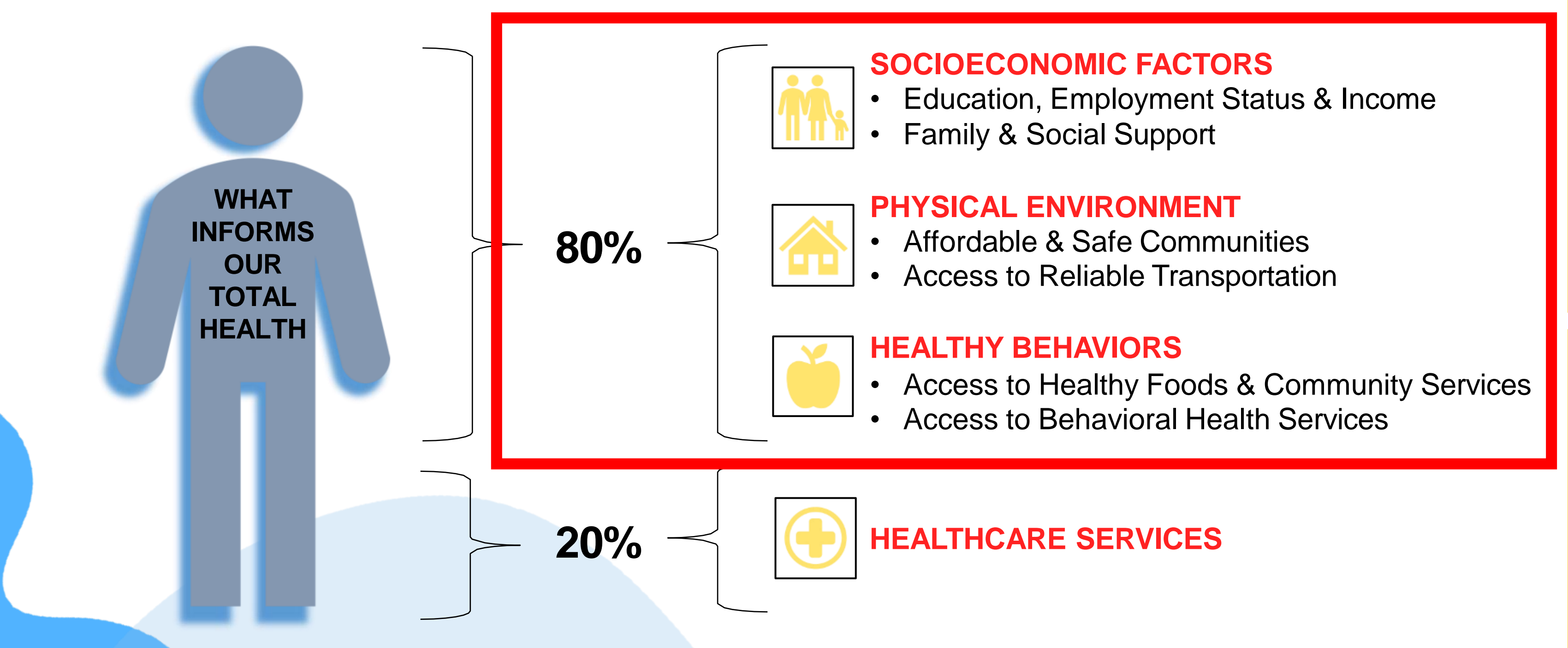
Proprietary and Confidential

Equitable Access to Care & Services

Advancing Health Equity

by aligning Sentara's resources with needs identified by the community, investing in innovative initiatives, and catalyzing local partnerships.

Partnering on the Path to Total Health and Well-being

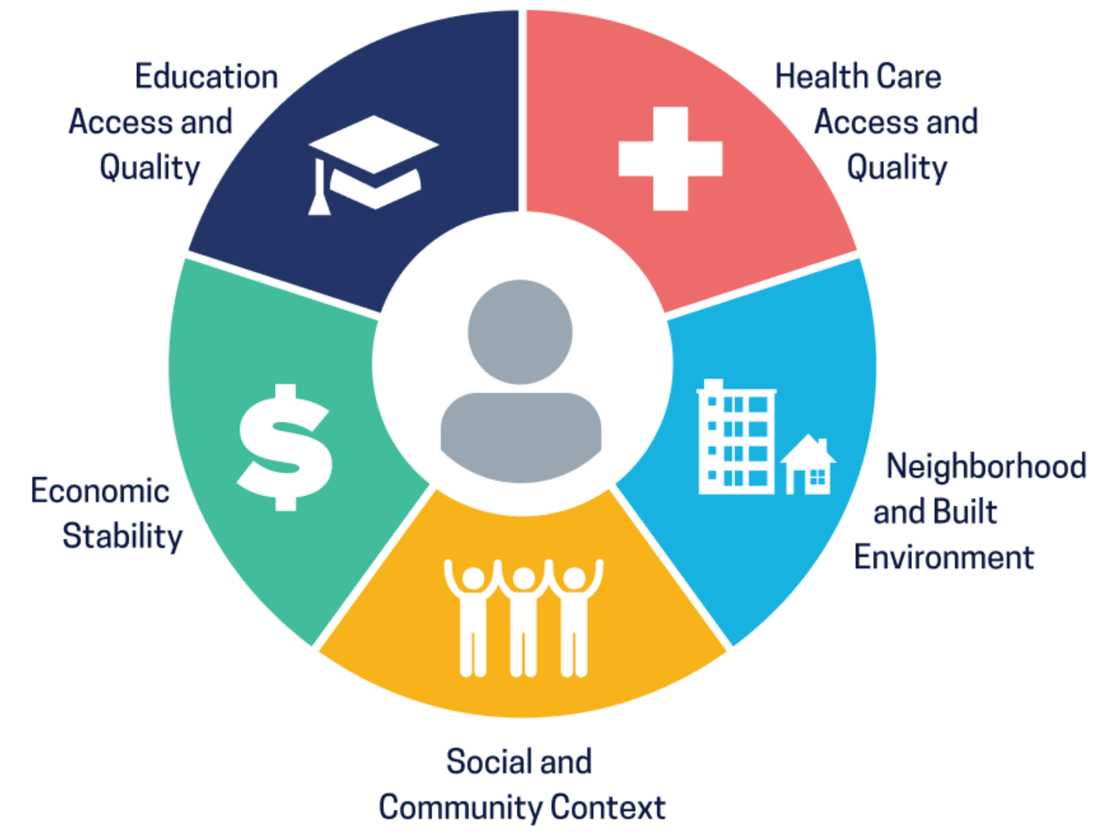


Sentara Community Care addresses each of the core factors contributing to an individual's total health — regardless of where they are on their path to well-being

Addressing Root Causes

In order to live our mission to improve health every day, we have to go beyond our walls and help the community address the factors affecting our community most. Eighty percent of what determines an individual's health occurs outside of the hospital.

As One Sentara, we have a responsibility to strengthen our communities – and every individual who calls those communities home – by swimming farther 'upstream' to address root causes of inequitable health outcomes and community conditions. We do this through a holistic approach to first listening to our communities, learning how we can act as a 'force multiplier' for community partners, and acting with greater intentionality across our operations to improve the conditions in which we all live, work, learn, play, and worship



Building the Capacity of Virginia's Hunger Relief Network

2019

$1M investment from Sentara to jumpstart Federation's health equity plan

2020

"We Care" initiative: $500K catalytic investment to deliver 224,500 food boxes (3.4M meals) to 540,000 people at the peak of the COVID pandemic

2021

$~1.3M in grants to grassroots hunger relief organizations; $475,000 in employee-directed funds to 9 food banks

2022

Prime Sponsor: Nutrition Security and Health Summit

2022

$~1.2M in grants to grassroots hunger relief organizations

2022-23

$500K investment to support Federation's Health Equity Plan implementation

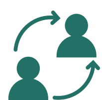
2022-23

Active participation in Healthy Pantry model/best practices development and connecting food resources to Sentara Community Care sites

As a result of Sentara's FY '23 investments alone, Virginia's food banks have:

Documented nutrition policies, solidifying commitment to source healthier and more culturally responsive food

Expanded the food pharmacy program to a total of 50 food pharmacy locations, reaching over 29,000 patients annually



Assisted 1,956 new people with SNAP applications

Completed a statewide assessment of how to better serve neighbors facing nutrition insecurity

Scaled the implementation and use of the inventory nutrition ranking tool, Nourish

Launched a campaign to establish recurring Medicaid funding for nutrition

Created the statewide Healthy Pantry Initiative, a neighbor-centered transformation of Virginia's pantry network, to better connect neighbors facing hunger with the food and resources they need to lead healthy, thriving lives

Systemwide Alignment: Sentara Community Care

Consumers

Awareness & Preference
Experience
Top-tier Quality and Safety
Share of Care
Service Growth

Community

Health Equity
Social Determinants
Fiscal Stewardship
Access & Affordability

Capabilities

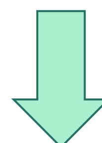
Digital Optimization
Technology Infrastructure
Investments to Enable Growth

Colleagues

Engaged Culture
Focused on DE&I
Attract & Retain Top Talent

Health Equity → To provide care for all in our communities by opening Community Care Centers in markets identified with the greatest needs

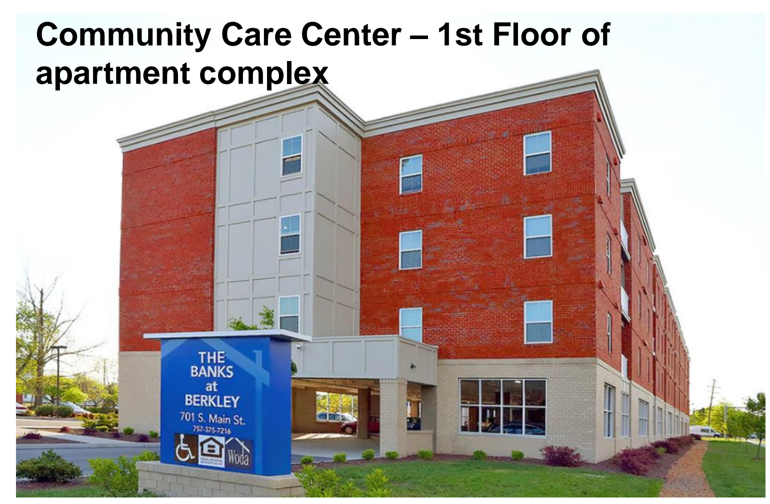
Access & Affordability → To actively promote access, transparency, and affordability



KEY PERFORMANCE INDICATORS

- Reduce cost of care
- Reduce unnecessary ED utilization
- Improve re-admission rates
- Close key HEDIS gaps in care
- Convert uninsured to insured
- Increase lives under management

Sentara Community Care: Care Model Mission

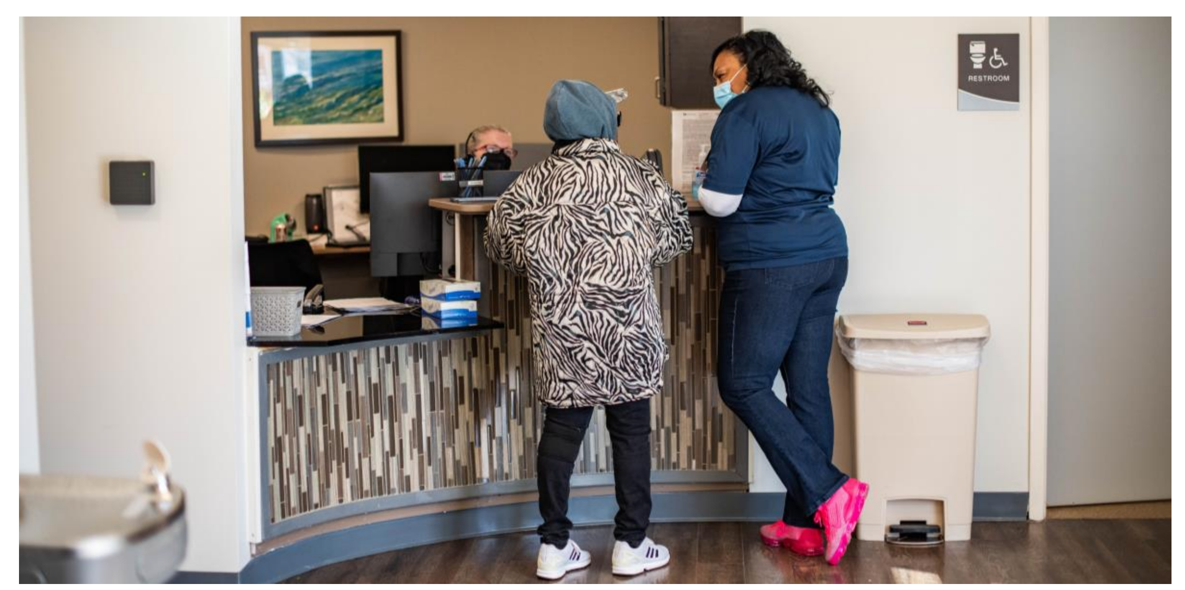


- Bring neighborhood-level health and wellness services to historically marginalized and under-resourced communities to improve total health focused on the social drivers of health.

- Advance health equity and improve disparity gaps
- Dismantle barriers to care by **bringing care to where the community lives, works, plays, learns, and worships**.

- Develop programs with community partners to support the community.
- Deliver full service primary care, maternal health, mental health, and social support services

Sentara Community Care: Care Model Mission



Community Care Centers
Our Community Care Centers are designed to make accessing healthcare services easy and convenient, delivering comprehensive medical, behavioral health, and social support services all under one roof, right within your neighborhood.

Sentara Mobile Care
Recognizing that transportation and time constraints often hinder access to healthcare, Sentara Mobile Care takes healthcare to the streets, quite literally. Our Mobile Care units travel directly to the communities with the greatest needs and largest gaps in healthcare, ensuring that healthcare isn't a burden but a readily available resource.

Sentara Community Care: Care Modes

Care Centers

- 6 Days per week
- Typical practice clinic with additional services to support the community
- Direct provider services: PC (Child-Adult), BH, Prenatal Care
- Evening and weekend hours
- Food Pantries at some locations

Mobile Care

- 5 Days per week, evening and weekend hours
- Direct provider services: PC (Child-Adult), Prenatal Care, BH
- 15-20 neighborhoods served monthly per vehicle
- Reduces traditional barriers, transportation challenges and inconvenient times
- Locations chosen to maximize convenience and proximity to other essential community organizations and services

School Care

- Operate during school hours within title I schools
- Direct provider services: PC services for acute issues
- 1 medical assistant on-site at school during school hours
- Virtual technology that connects student and faculty to NP
- Goals to reduce absenteeism and improve child wellness care

Neighborhood Community Health Workers

- 6 Days per week
- Support patients 1:1 with their SDOH needs
- In the community/neighborhoods
- At community events

Community Health Activities

- Large group events in underserved communities
- Provide health and wellness services outside the typical clinics at events in the community (health checks, immunizations, sports physicals)
- Classes/Activities on-site at centers and at partner organizations in the neighborhoods that will improve the lives in the areas we serve

Sentara Community Care

Uniquely Designed Care Services

1. Primary Care & Behavioral Health Services

- Comprehensive & preventative primary care services for children to adults
- Mental health providers and counseling
- Addiction medicine programs
- Onsite lab draws
- Walk-ins welcome
- Virtual options
- Non-traditional clinic hours

2. Wraparound Services

- Frequent check-ins
- Increased health education
- Nutrition and wellness classes
- Social drivers of health support and connections
- Insurance enrollment
- Transportation assistance
- Food and nutrition assistance
- And more…

3. Community Partner Support

- Neighborhood community support system
- Faith-based leaders
- Food bank & food pantry organizations
- School divisions
- And more…

Sentara Community Care

Uniquely Designed Care Team

Connecting to Community Services & Partners

- Neighborhood leaders
- Community organizations
- Faith-based leaders
- CSBs
- FQHCs & Free Clinics
- Homeless shelters
- State/City/County services
- Foodbank
- And many more…

Nurse Practitioners (FNPs, Maternal Health NPs)

One Sentara Care Support

Psychiatrists/Mental Health NPs

Community Health Workers

Individual

Medical Assistants

LPC/LCSWs

RN Care Managers

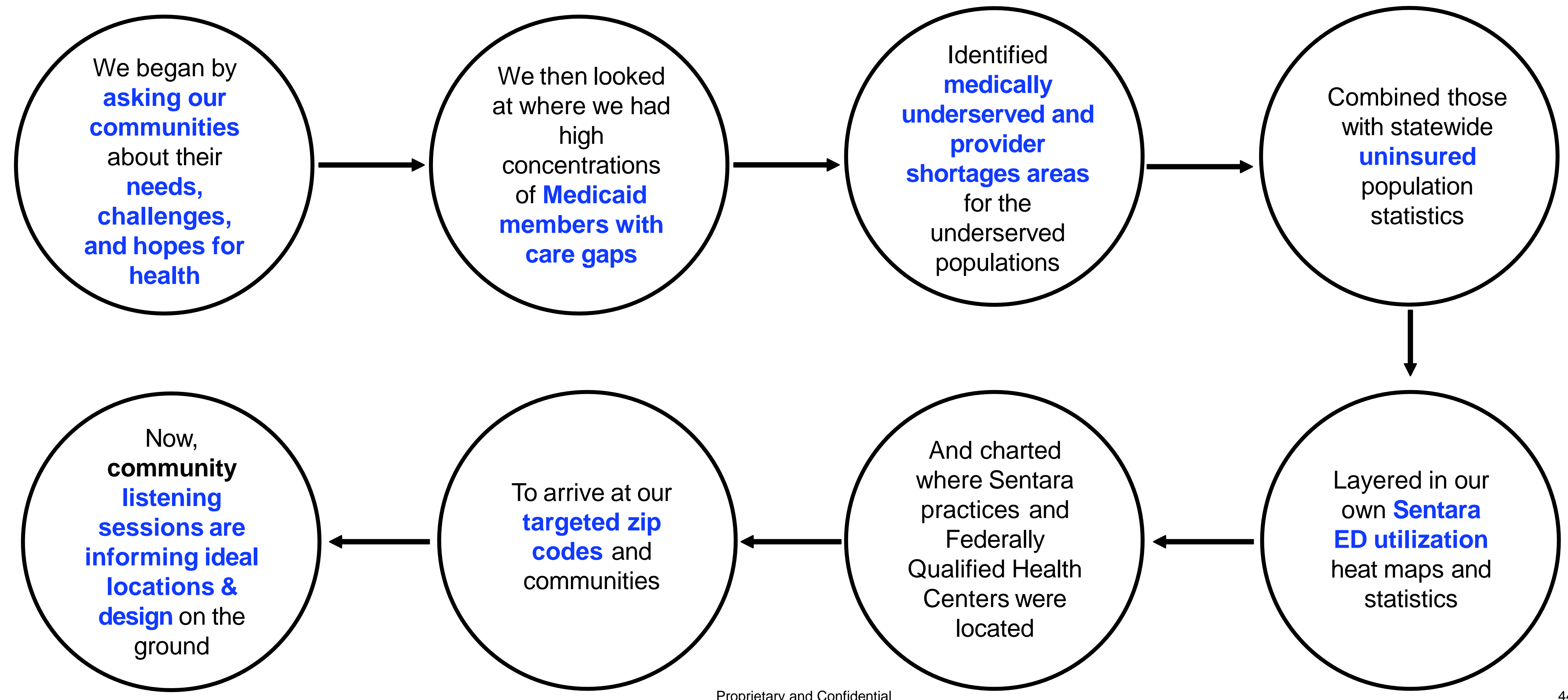
Social Drivers of Health Model: Link to Community Services

In partnership with community and faith-based organizations, we help ensure that Community Care locations provide access to the following services:

Financial literacy	**Food and nutrition security assistance**	**Cooking and health education services**	**Healthcare navigation**	**Education and career training**
Substance use resources	**Naturalization service support**	**Transportation assistance**	**Housing assistance**	**Domestic and community violence assistance**

Note: This list is representative of the types of services to be offered. Specific services will vary to meet each community's most pressing needs.

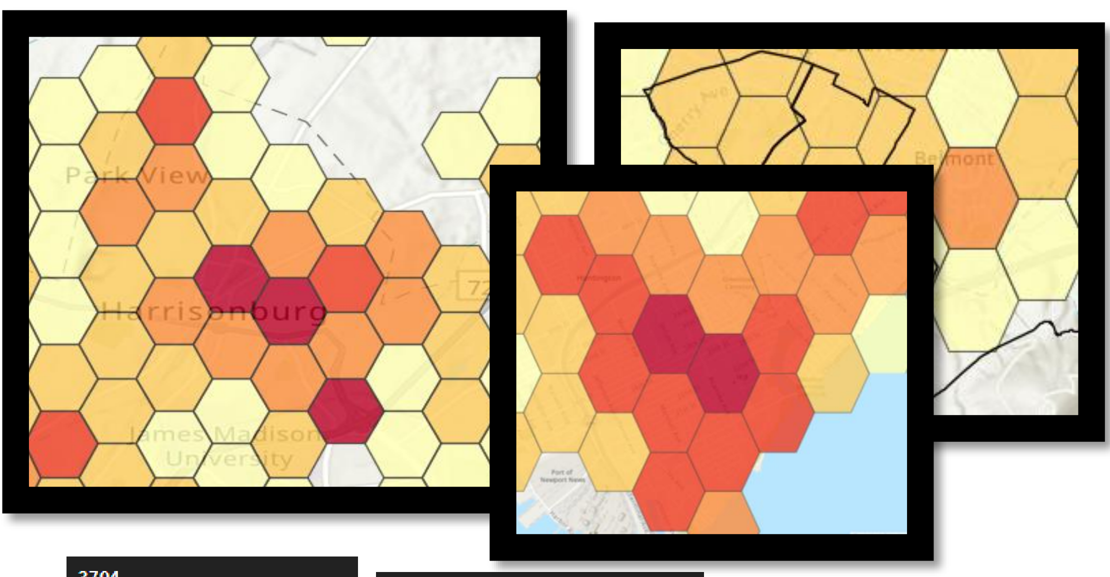
We go where our data leads – and where our communities tell us.



Heat Maps for Prioritizing Areas

(Care Gaps: Well Visits, Uncontrolled Diabetes, Hypertension, Immunizations, Substance Use Initiations & Engagement, Prenatal Care)

Hospital High ER Utilizers



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Average Age: 50

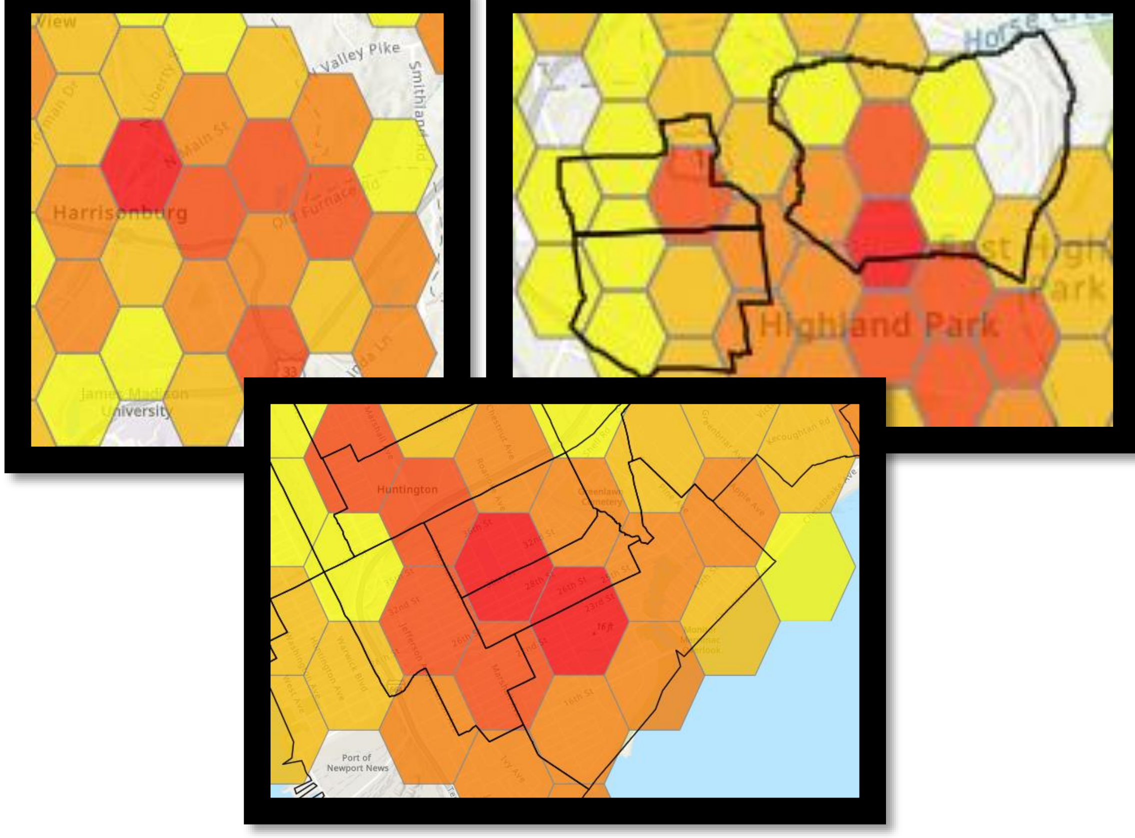
ED Visits by Condition:
Hypertension: 1650
Diabetes: 872
Asthma: 273
Behavioral Health: 2064
Unsheltered: 131

ED Visits by Gender:
Male: 1777
Female: 1927

ED Visits by Race:
White: 2895
Black: 468
Asian and Pacific Islander: 62
Native American:
Other/Patient Refused: 279

ED Visits by Payor:
Commercial: 662
Medicare: 1466
Medicaid: 885
Military: 4
Self Pay/Charity/Welfare/Other: 687

Medicaid Members w/Care Gaps



Intersection between health care & food: Access to Nutritious Food

Intersection between health care & food: Food Hub

Sentara Community Care: Key Learnings

- ✓ Models of care need to be flexible and adoptive to deliver effective care.
- ✓ Community and consumer trust is vital.
- ✓ Partnerships with community-based organizations are essential.
- ✓ Access to nutritious food isn't just a matter of convenience or preference; it's a critical element in ensuring the total health of an individual.

Questions?

Thank You

Food Insecurity & Health Disparity in Southwest Virginia

Food is Medicine - Homecare Food Delivery Program

Governor's Roadmap to End Hunger

Food is Medicine is an integral part of the plan.

Federation of Virginia Food Banks

Leading statewide Food Farmacy and Healthy Pantry expansion efforts.

Strategic National Partnerships

U.S. Department of Health and Human Serivces , Elevance Foundation, etc.

Finding Our Way

Food Insecurity

Food insecurity impacts overall nutritional health, affecting the body's ability to heal and recover from injury or illness and restricting activities of daily living, which may lead to the onset or worsening of chronic diseases.

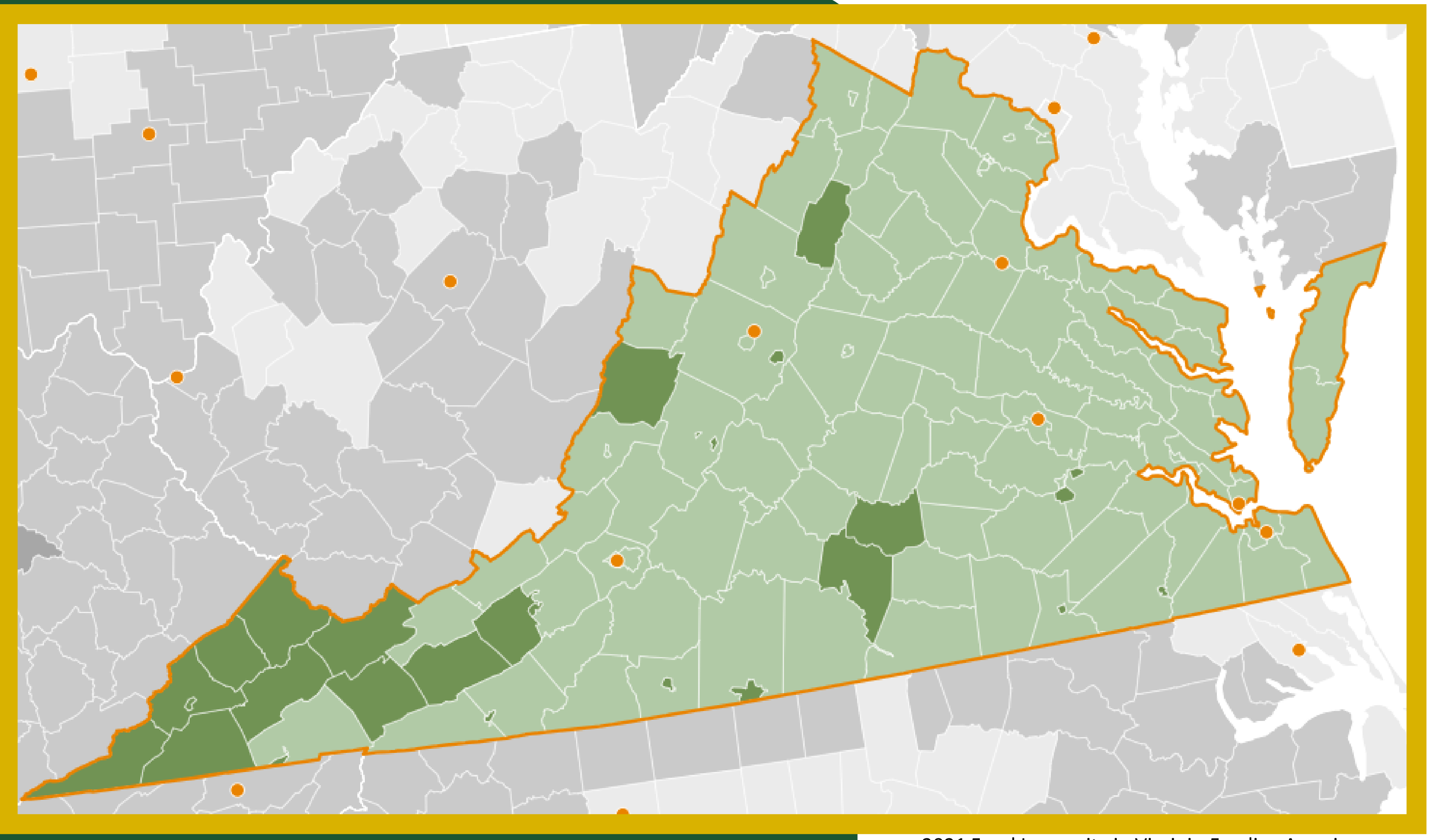
Food Insecurity Rates
(all ages)

11.9-23.6%

0-11.8%

Age 50+ Across Virginia

0-11.8%



2021 Food Insecurity in Virginia-Feeding America

Virginia is 8.1%

Food Insecurity by County

Locality	Overall	Child
Buchanan	18.80%	24.80%
Norton City	18.70%	19.80%
Lee	17.90%	20%
Dickenson	17.70%	19.80%
Wise	15.60%	17%
Russell	15.50%	13.80%
Martinsville City	14.80%	27.90%
Smyth	14.60%	15.60%
Bristol City	14.30%	17%
Danville City	13.70%	27%
Scott	13.70%	13.30%
Tazewell	13.70%	15.50%
Radford City	13.60%	10.40%
Galax City	12.80%	12.80%
Pulaski	11.90%	11.90%
Wythe	11.90%	12.40%
Grayson	11.80%	13.50%
Washington	11.70%	11%

Locality	Overall	Child
Carroll	11.40%	10.20%
Henry	11.10%	16.30%
Roanoke City	11%	16.30%
Alleghany	10.90%	11.30%
Pittsylvania	10.60%	14.60%
Montgomery	10.60%	6.70%
Craig	10.50%	9.90%
Covington City	10.50%	14.50%
Patrick	10.40%	9%
Bland	9.80%	10.90%
Franklin	9.40%	10%
Giles	8.90%	7.40%
Salem City	8.70%	7.30%
Bedford	7.40%	7.10%
Floyd	7.40%	5.30%
Roanoke	7.10%	4.40%
Botetourt	6.40%	3%

Virginia has significant inequities in food access attributable to both geographic location and racial distribution. For example, the Southwest region has 30% higher food insecurity than the state median. Racial disparities are evidenced in higher rates of food insecurity among Black and Latino households.

Disparities by Race

Compared to white Virginians...

3.4X — **Black households in Virginia** are 3.4 times as likely to experience food insecurity[7]

2.4X — **Hispanic households in Virginia** are 2.4 times as likely to experience food insecurity[7]

Rural Virginia

Higher Rates of Food Insecurity and Chronic Disease

Lower Distribution of Pantry Resources

Above Average FI Rate

38%

33%

27%

22%

16%

11%

Very High Chronic Disease

TEFAP Pantry

Non-TEFAP Pantry

Blue Ridge Area FOOD BANK

CAPITAL AREA FOOD BANK

FREDERICKSBURG REGIONAL FOOD BANK

FEEDING SOUTHWEST VIRGINIA

VIRGINIA PENINSULA Foodbank

FEED MORE

Foodbank of Southeastern Virginia and the Eastern Shore

[7] Data from Map the Meal Gap Data specific to Virginia, 2021 data

[8] Site study commissioned by Federation of Virginia Food Banks, delivered May 8, 2023, by Phillip Reese

Rural Virginia Health Disparities and Resources

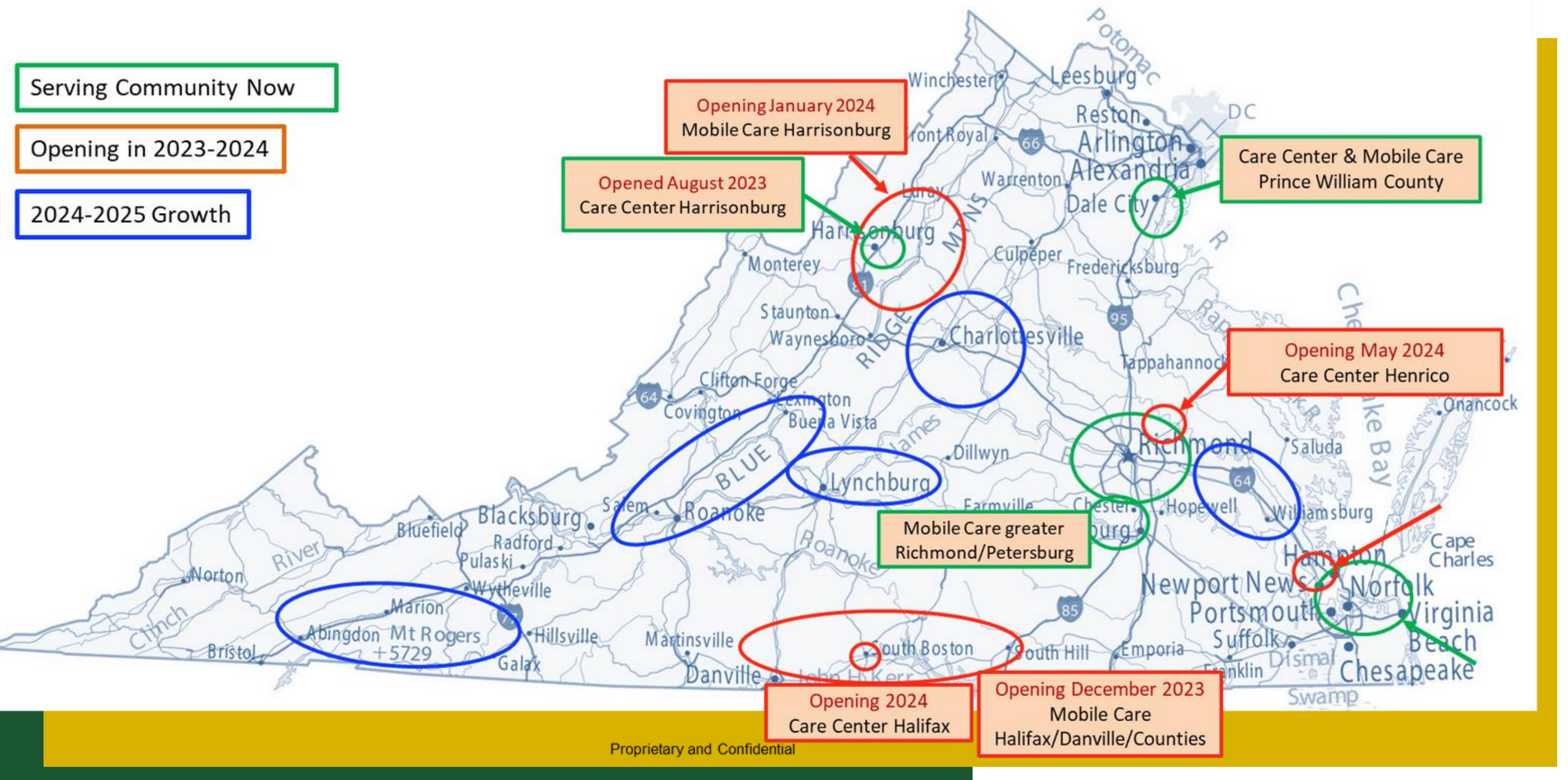
Sentara Community Care

Map of Virginia Regional Plan

Prioritization Method:

- ✓ % of Medicaid members w/gaps in care using 2022 data
- ✓ Health prof. shortage area/Medically underserved
- ✓ % of SHP Medicaid members marketshare
- ✓ % of uninsured community members

Sentara Community Care Virginia Regional Plan



VDH Cardiovascular Snapshot in SWVA

Unveiling the Hidden Crisis: Food Insecurity's Impact on Health

700,000

food-insecure Virginians

Food insecurity increases the risk of developing **chronic disease:**

Adults facing food insecurity are 2-3 times more likely to suffer from **diabetes** than food-secure individuals.[2]

The prevalence of **cardiovascular disease** is estimated to be 6 times higher in households with very low food security compared to food-secure households.[3]

Food insecurity is associated with a 257% higher risk of **anxiety** and a 253% higher risk of **depression.**[4]

$1,539

On average, food-insecure individuals spend $1,539 ***more*** on **healthcare** per year in Virginia.[5]

Challenges

Tackling the health crisis in Southwest Virginia by reducing food insecurity for neighbors who don't have access to our other programs.

Funding

Capacity & Expansion

Access

Innovative Solutions

Delivering heathy food to neighbors who can't access our traditional programs by utilizing community home health agencies already providing medical services.

2023
5,000 Neighbors served
7 Partners
3,000 Boxes Distributed

Partnerships

The agency screens its patients for food insecurity, and the Food Bank provides non-perishable healthy choice food boxes to leave with the patient.

Delivery

Non-perishable food boxes are delivered during routine visits or appointments.

Success Isn’t Measured in Numbers

“Thank you for these food boxes. Fills many gaps in my food needs!”

“It’s almost like getting a present. I’m shut in, but I don’t feel as shut out now!”

Replicable Model

Feeding Southwest Virginia's Homecare Food Delivery Program is a sustainable model already replicated across the state.

Questions:

Feeding Southwest Virginia

Allison McGee

amcgee@feedingswva.org

Delivering Health & Hope through a Cross-Sector Collaboration

Walnut Hill Pharmacy History

Walnut Hill Pharmacy, a community pharmacy located in Petersburg, Virginia, has been serving the Tri-Cities for more than 60 years.

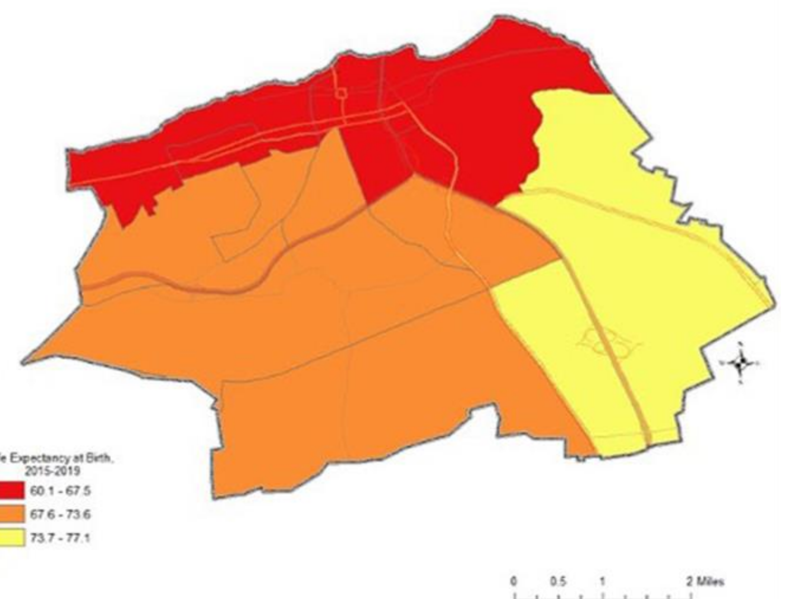
In 2010, owners and pharmacists Jarrett Rockwell and Heather Scott purchased the pharmacy and have continued to evolve and innovate this beloved community destination. Under their leadership, Walnut Hill Pharmacy added a transportation fleet, providing over 200 deliveries daily.

In 2023, Jarrett and Heather bought the adjoining building to the pharmacy with a vision to offer whole person health solutions that can address health related factors and behaviors that so often contribute to chronic disease and an overreliance on medications and costly medical interventions.

City of Petersburg Health Snapshot

Ranked lowest overall in both health outcomes and health factors, ranked **133rd** out of **133** localities across Virginia

Average life expectancy of **66.2 years** vs. state average of **77.6 years**



- **11.4 %** of adults aged 20 years or older diagnosed with diabetes; state average of **8.7%**
- **38.5%** of Medicare population diagnosed with diabetes; state average of **27.4%**
- **42.2%** of adults have high blood pressure; state average of **33.2%**
- **68%** of Medicare population have high blood pressure, state average of **59.3%**
- Highest rates of **cancer** diagnosis and deaths, **heart disease** and **stroke** in the Tri-Cities
- Highest rates of **uninsured** adults in the Tri-Cities
- **16%** food insecurity rate; state average of **8.1%**
- Food desert with **27%** of people having limited access to healthy foods

2023 Community Health Needs Assessment **(2023)** ***The Cameron Foundation*****. Available at: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://camfound.org/wp-content/uploads/2023/06/CHNA-5.9.pdf (Accessed: 2024).**

Collaborative Beginnings

In 2023, United Healthcare, Walnut Hill Pharmacy and Feed More came together to brainstorm how to use the pharmacy's new adjoining space to improve health outcomes for the Walnut Hill Pharmacy patients and their community using Food as Medicine interventions

From the conversations came the idea to launch the **Walnut Hill Food Pharmacy Pilot** with initial funding and collaborative support from United Healthcare and operate the pilot out of the **Walnut Hill Wellness Hub** with support from CHW Strength and other community partners

Food Pharmacy Pilot Details

Pilot Participant Eligibility Criteria

- Current pharmacy patient
- Diabetes diagnosis
- Prescribed 2+ diabetes related medications
- Screen positive for food insecurity

Food as Medicine Interventions

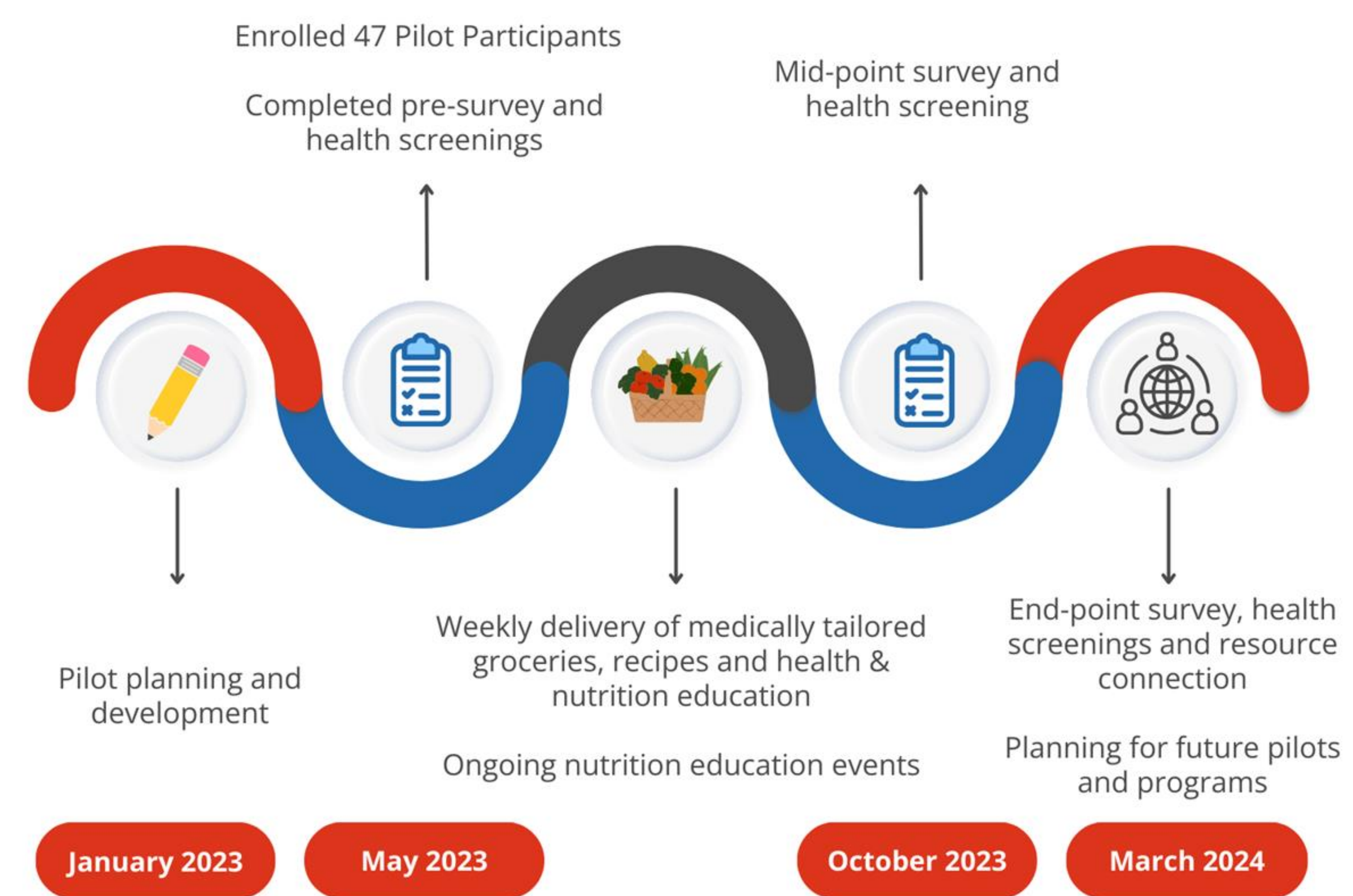
- Delivery of medically tailored groceries (produce & shelf stable)
- Grocery menus developed in partnership with Feed More Registered Dietician
- Recipes and ongoing health and nutrition education
- Educational events
- CHW ongoing support to provide SDoH resource connection

Outcome Measures

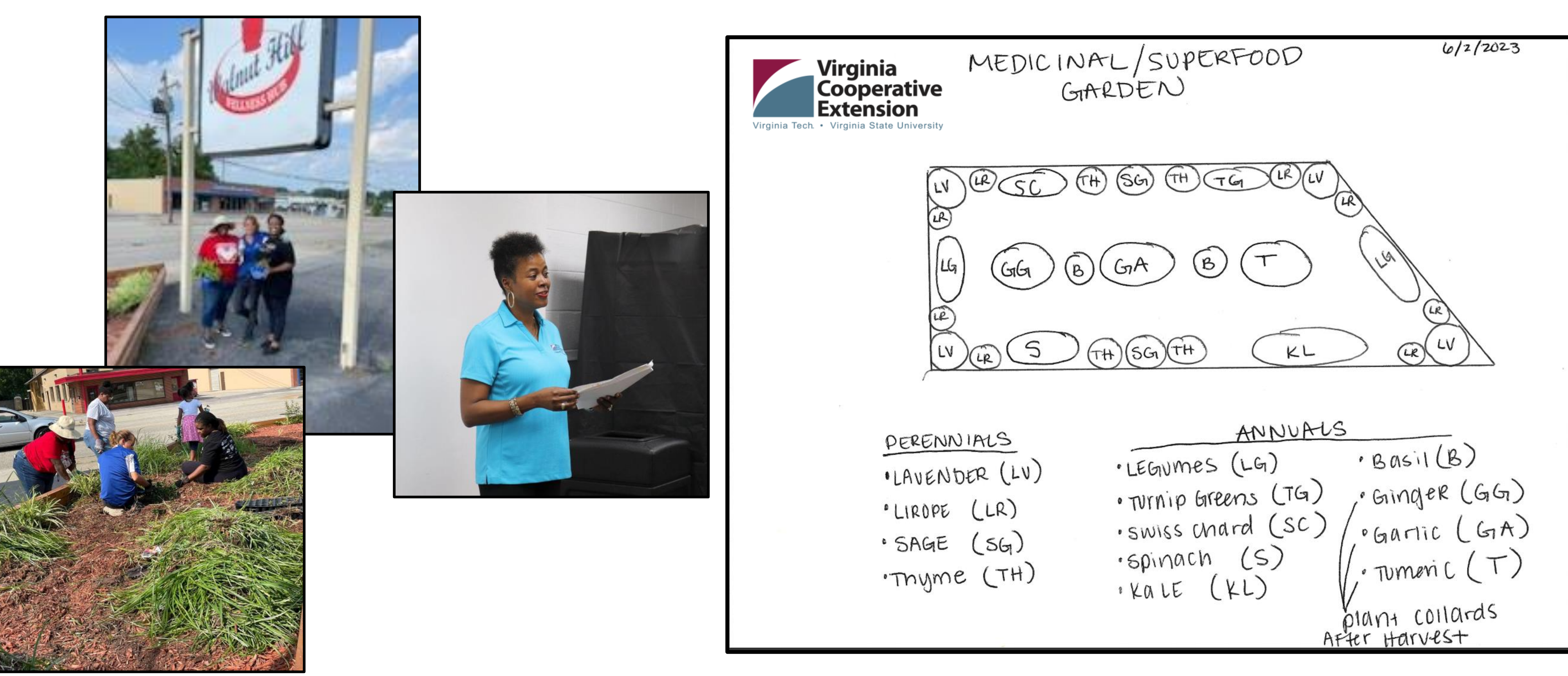
Collected at start, mid-point and end of pilot

- Self-reported health survey
- A1C (hemoglobin A1C) testing
- Blood pressure screening

Food Pharmacy Pilot Model and Timeline



Community Collaborations



Nutrition Education & Community Garden

Early Pilot Successes

“Overall I am seeing lower blood sugar and I am getting access to healthy foods”

“I really appreciate the program and have been less worried about food since the deliveries have started”

As we collect end-point data, we can share that the midpoint survey data is promising. Participants have reported:

- A meaningful increase in healthy food access (nutrition security)
- An increase in health and well-being scores
- A modest improvement in isolation and depression scores
- A decrease in diabetes-related hospitalizations
- Increased knowledge of how to manage their diabetes

“You all do what my Dr.s don't do. I love the pamphlets you include in my deliveries”

“A1C went down, had fruits delivered that I knew nothing about. Opened my eyes to new stuff”

Lessons Learned for Future Programming

As the Wellness Hub partners plan for the future, we are using participant survey feedback, interviews and program learnings to inform program and pilot development.

- Delivery is a critical component to increasing access to healthy foods
- Transportation barriers impacted participation in in-person activities
- Recipes and food education are valuable to participants
- Interest in increased variety of food including prepared meals and more protein options

"I don't always have transportation to go get food. [Delivery] was very important to me."

"They introduced [me to] things I've never seen, the recipes taught me how to make things I wouldn't ordinarily make."

"Maybe have an education program set up using zoom."

"There is a lot of repetition in canned food, want to see...more variety"

Community Impact

Once a fast food restaurant, the Walnut Hill Wellness Hub has been transformed into a purpose driven space where the community unites in a shared mission to deliver health and hope across the Tri-Cities.

Want to Learn More?

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Heather Scott, Owner

We would LOVE to collaborate with YOU

Contact us at Visionary@CHWStrength.com