8:00 – 8:30AM



Welcome!

Please scan the QR code to sign in and enjoy some breakfast!

Scan Me

The summit will begin promptly at 8:30 AM.

Host Committee

Dolores Woods, MA, RDN - UTHealth Houston, Nourish Program
Maria de la Cruz - Harris Health, co-chair Health Equity Collective Food Security workgroup
Melanie McGuire – Houston Food Bank, co-chair Health Equity Collective Food Security workgroup
Melisa Danho, MPH, RDN, LD – UTHealth Houston
Shreela Sharma, PhD, RDN, LD – UTHealth Houston, Center for Health Equity; co-lead Health Equity collective
Naomi Tice, MPH - UTHealth Houston, Center for Health Equity
Heidi McPherson, MPH - UTHealth Houston, Center for Health Equity; co-lead Health Equity collective
Jayna Dave, PhD - Baylor College of Medicine, Children's Nutrition Research Center
Rupa Mahadevan, MD - UTHealth Houston, McGovern Medical School & Nourish Program
Jackie Wheeler, MPH – UTHealth Houston, School of Public Health, & Nourish Program

Sponsors:

UTHealth Houston

UTHealth Houston
School of Public Health
Center for Health Equity

MICHAEL & SUSAN DELL CENTER for HEALTHY LIVING

Agenda

8:00 – 8:30 AM: Check-In & Breakfast

8:30 – 8:40 AM: Summit Kickoff & Overview

8:40 – 8:50 AM: Nourish Program & Culinary Medicine Insights

8:50 – 9:00 AM: Data Visualization for FIM Success

9:00 – 9:50 AM: FIM Program Presentations

9:50 – 10:00 AM: Break

10:00 – 11:10 AM: FIM Program Presentations

11:10 – 11:20AM: FIM Landscape Scan

11:20 – 11:30AM: HEC Food Security Workgroup

11:30 – 12:00PM: Lunch & Networking

8:30 – 8:40 AM

Summit Kickoff & Overview



Speaker: Shreela Sharma, PhD, RDN, LD



Speaker: Melanie McGuire

The Center for Health Equity

OUR VISION We see a world populated by healthy people across flourishing communities.

"Health Equity means that everyone has a fair and just opportunity to be as healthy as possible."
– Robert Wood Johnson Foundation

PURPOSE

HOW WE WILL CREATE SHARED VALUE

3 Layers of Activity



- Community Voice
- Evidence-based Programs and Interventions
- Innovative Data Analysis
- Dynamic Insights
- Customizable Actions
- Collective Impact Efforts
- Systems Design
- Capacity Building Focus

OUR VALUES

Human-Centered Design
Innovation through Collaboration
Transparency
Courage
Impact

Policy and Systems ⟷	Data and analytics ⟷	Interventions (Design, Implementation, Evaluation)
Backbone - Health Equity Collective systems coalition for NMDOH	Spatial epidemiology – mapping and advocacy	Food Is Medicine – diabetes, maternal health, children
Community and Stakeholder Engagement Studio	Food security Nutritional Epidemiology	School-based research- Child Health, Oral health
Policy partnerships	Water security	Physical Activity
Community Health Workers		Medical Legal Partnership
		Financial security
		Maternal health

UTHealth Houston
School of Public Health
Center for Health Equity

HEALTH EQUITY
COLLECTIVE
Driving Better Health Together

- Multi-sector action-oriented, collective impact effort to improve care coordination for NMDOH.
- Established in Dec 2018
- Membership is currently >1,300 members representing, >325 organizations, including >50 coalitions in the Greater Houston region
- Steering committee and 8 workgroups and guiding work of Coalition
- UTHealth Houston Center for Health Equity serving as the backbone organization (co-leads: Heidi McPherson and Shreela Sharma).

Structure of the Health Equity Collective

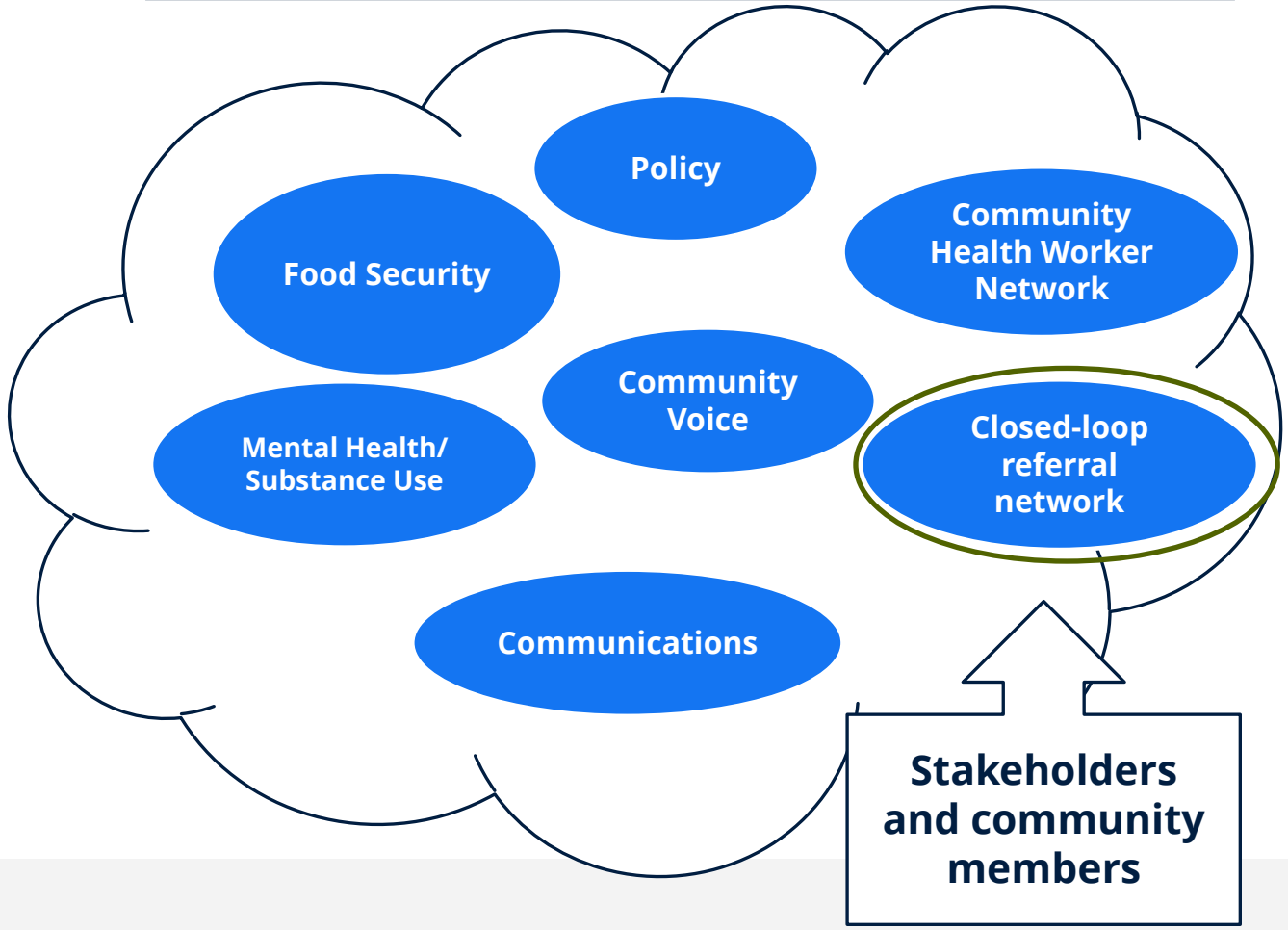
Common Agenda and Shared Metrics

Strategic guidance

Steering Committee
Workgroup co-chairs + backbone

Backbone Team
UTHealth Houston
Center for Health Equity

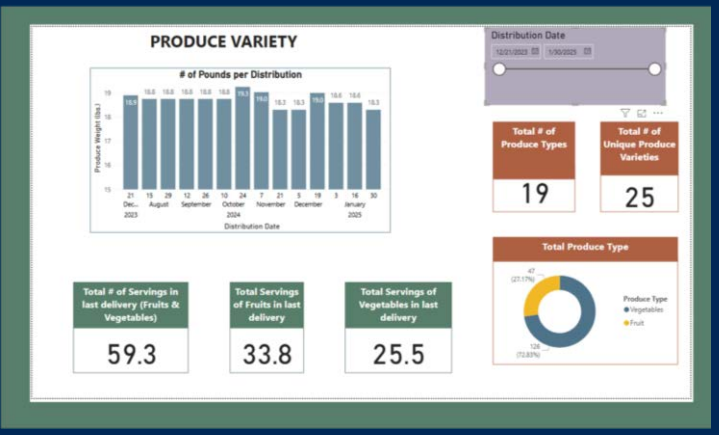
Workgroups & Taskforces



Health Equity Collective Steering Committee Member Organizations, 2023-2025

- UTHealth Houston
- Kaiser Permanente
- Legacy Community Health
- Memorial Hermann Health
- Harris Health System
- Harris Center for Mental Health/IDD
- Harris County Public Health
- Houston Food Bank
- City of Houston Health Department
- MD Anderson Cancer Center
- Texas Children's Hospital
- Network of Behavioral Health Providers
- San Jose Clinic

Food Is Medicine at the Center for Health Equity Design, Implementation, Measurement & Evaluation



Data visualization studio

1. Assessment & Design (Human-centered design)
2. Build partnerships
3. Capacity building & Technical Assistance for partners
4. Implementation toolkit
5. Implementation outcomes and impact evaluation
6. Sustainability, scalability

FIM Core Team







Thank you

Website: https://sph.uth.edu/research/centers/che/

Want to learn more? Click on the QR code below!

8:30 – 8:40 AM

Food Rx Video

8:40 – 8:50 AM

UTHealth Houston Nourish Program



Melisa Danho, MPH, RD, LD
Dietetic Internship Director



Rupa Mahadevan
Assistant Professor, Community and General Pediatrics



Dolores Woods, MA, RD, LD
Nutritionist Supervisor

UTHealth Houston School of Public Health | Michael & Susan Dell Center for Healthy Living

nourish

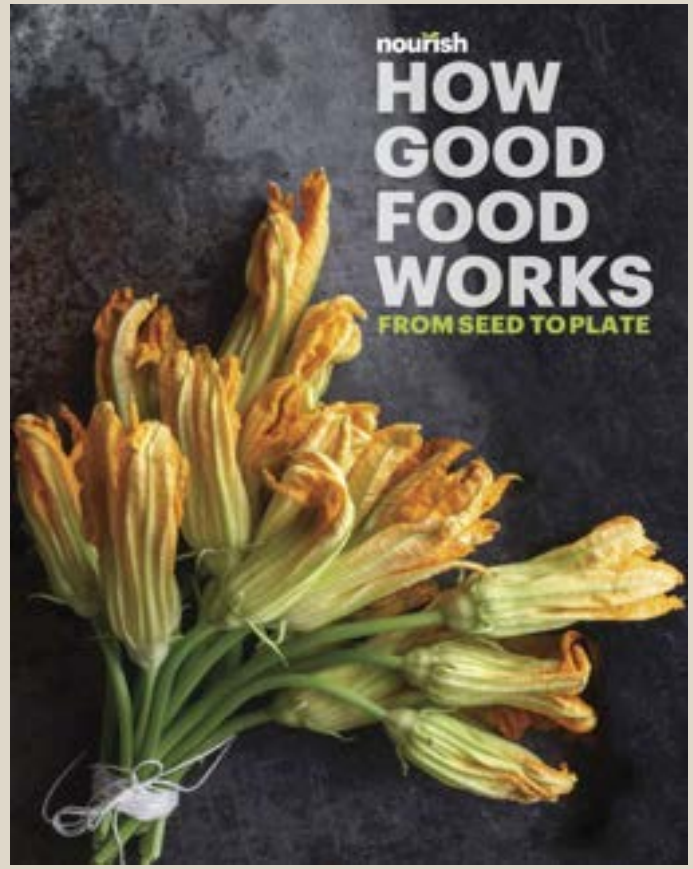
Objectives

- Nourish Program overview
- Describe Nourish research activities
- Discuss Nourish educational initiatives
- Establish additional clinical collaborations
- Identify ways to collaborate with Nourish

Seed to plate to prevention

nourish

We believe the food at our fingertips is the most powerful tool for reclaiming and sustaining our health. Real, beautiful, fresh, honest food contains nearly everything we need to be happy and healthy. This is no revelation. We all know we should eat better. What most of us don't know is how to do it.



Vision & Mission

Holistic Garden

nourish

The Holistic Garden at the School of Public Health teaches how to use the garden as a tool to improve physical and mental health through better nutrition, regular exercise, and contemplation in a natural setting.









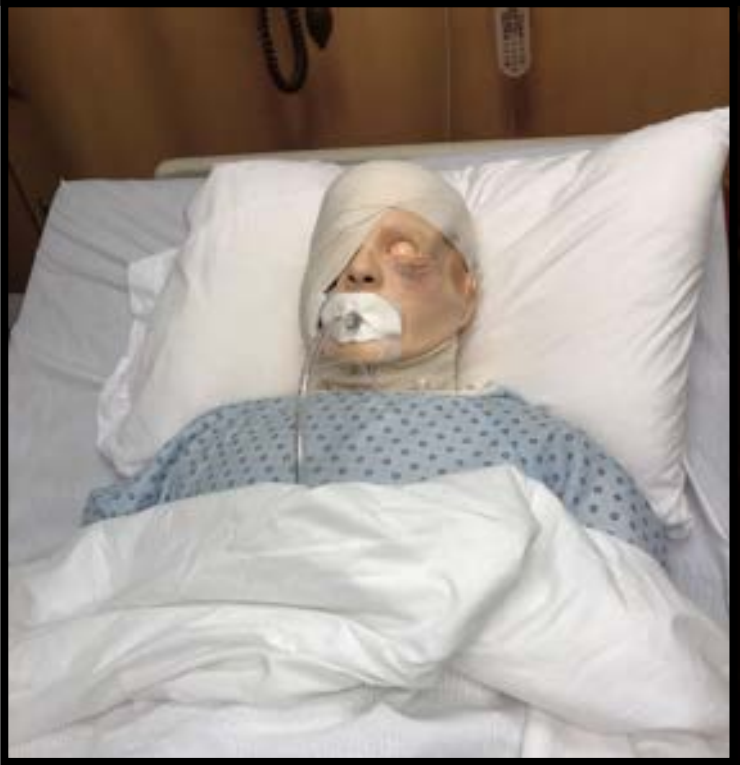

Simulation Lab

Meet Andy Sims! The Simulation and Clinical Assessment lab provides students the opportunity to learn and practice skills needed in the clinical setting of dietetics.



nourish







Nutrition Research and Demonstration Kitchen

nourish

A state-of-the-art facility that provides experiential learning opportunities for

- Students
- Professionals
- Community members

In the Nourish Kitchen we focus on:

- Healthy cooking techniques
- Population-based Nutrition Needs
- Flavors













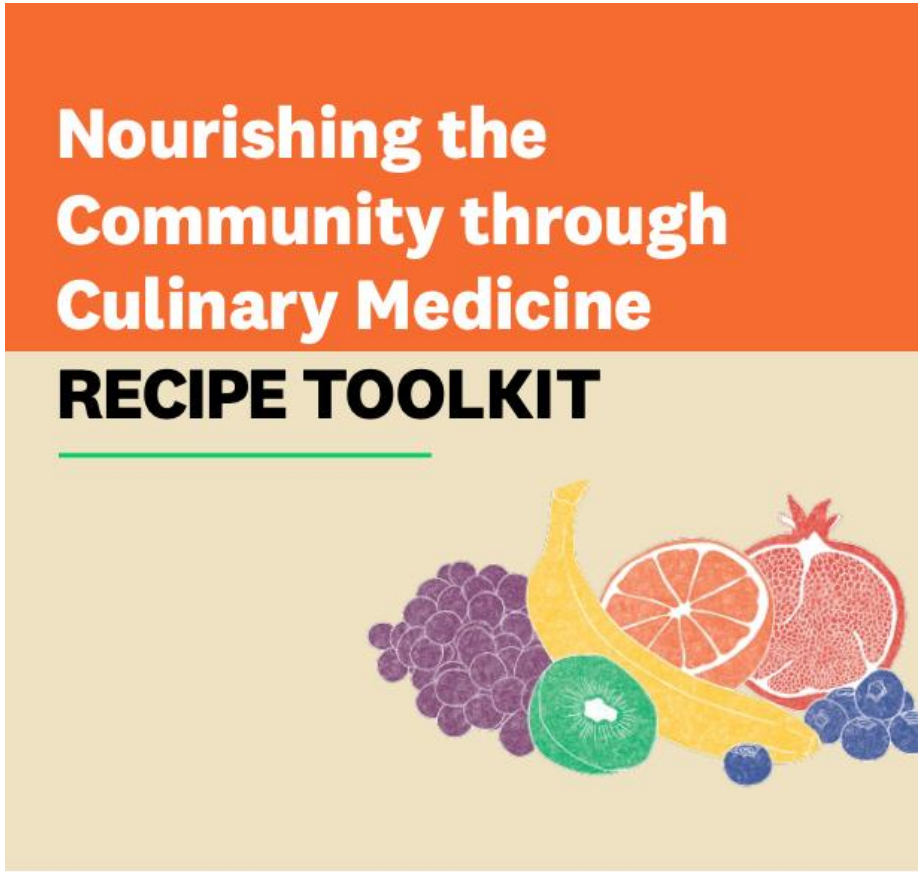


Research Activities

nourish

Disease Specific:

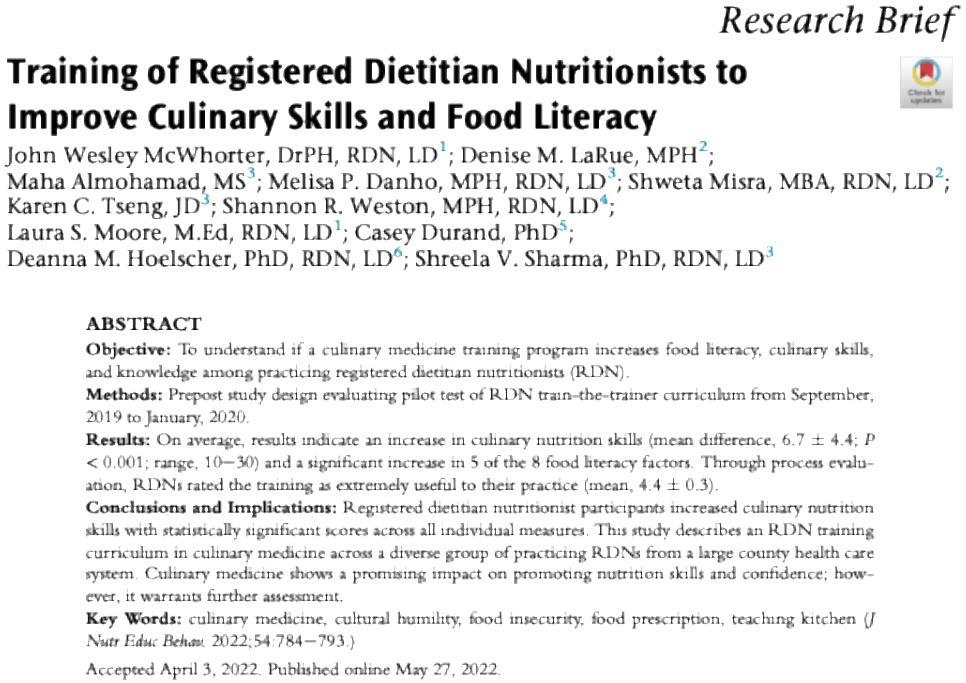
- Teaching Kitchen Multisite Trial
  - Year-long teaching kitchen-based curriculum for adults with overweight/obesity and metabolic abnormality in collaboration with Harvard SPH, Dartmouth Health, UCI, UCLA
- Harris Health
  - A Prescription for Healthy Living
  - My Kitchen / Mi Cocina
- Nourishing the Community Through Culinary Medicine
    - Blue Cross Blue Shield funded project to develop 5 sessions of virtual CM for adults living with diabetes



nourish UTHealth BlueCross BlueShield of Texas

Clinical Activities

- Train the Trainer Series
  - RD/CHW (Harris Health)
  - MD/RD (Texas Children's Renal)
  - MD/Chef (Hope Clinic – SCAN)
  - Joint Physician/RD Training in MedEd
- ICARE Interprofessional Learning
  - (Improving Care Access and Realizing Equity)
- Virtual Patient Centered Culinary Classes
  - Diabetes Classes
  - Hypertension Classes
  - Specialty classes



Research Brief

Training of Registered Dietitian Nutritionists to Improve Culinary Skills and Food Literacy

John Wesley McWhorter, DrPH, RDN, LD[1]; Denise M. LaRue, MPH[2]; Maha Almohamad, MS[3]; Melisa P. Danho, MPH, RDN, LD[3]; Shweta Misra, MBA, RDN, LD[2]; Karen C. Tseng, JD[3]; Shannon R. Weston, MPH, RDN, LD[4]; Laura S. Moore, M.Ed, RDN, LD[1]; Casey Durand, PhD[5]; Deanna M. Hoelscher, PhD, RDN, LD[6]; Shreela V. Sharma, PhD, RDN, LD[3]

ABSTRACT

Objective: To understand if a culinary medicine training program increases food literacy, culinary skills, and knowledge among practicing registered dietitian nutritionists (RDN).

Methods: Prepost study design evaluating pilot test of RDN train-the-trainer curriculum from September, 2019 to January, 2020.

Results: On average, results indicate an increase in culinary nutrition skills (mean difference, 6.7 ± 4.4; $P < 0.001$; range, 10−30) and a significant increase in 5 of the 8 food literacy factors. Through process evaluation, RDNs rated the training as extremely useful to their practice (mean, 4.4 ± 0.3).

Conclusions and Implications: Registered dietitian nutritionist participants increased culinary nutrition skills with statistically significant scores across all individual measures. This study describes an RDN training curriculum in culinary medicine across a diverse group of practicing RDNs from a large county health care system. Culinary medicine shows a promising impact on promoting nutrition skills and confidence; however, it warrants further assessment.

Key Words: culinary medicine, cultural humility, food insecurity, food prescription, teaching kitchen (*J Nutr Educ Behav.* 2022;54:784−793.)

Accepted April 3, 2022. Published online May 27, 2022.

Programs, Classes & Catalog



Nourish Community Programs

With an emphasis on hands-on techniques rooted in the belief that we learn best by doing, Nourish community wellness classes are tailored to your team and taught by our registered dietitian nutritionists, chefs, and behavioral scientists.

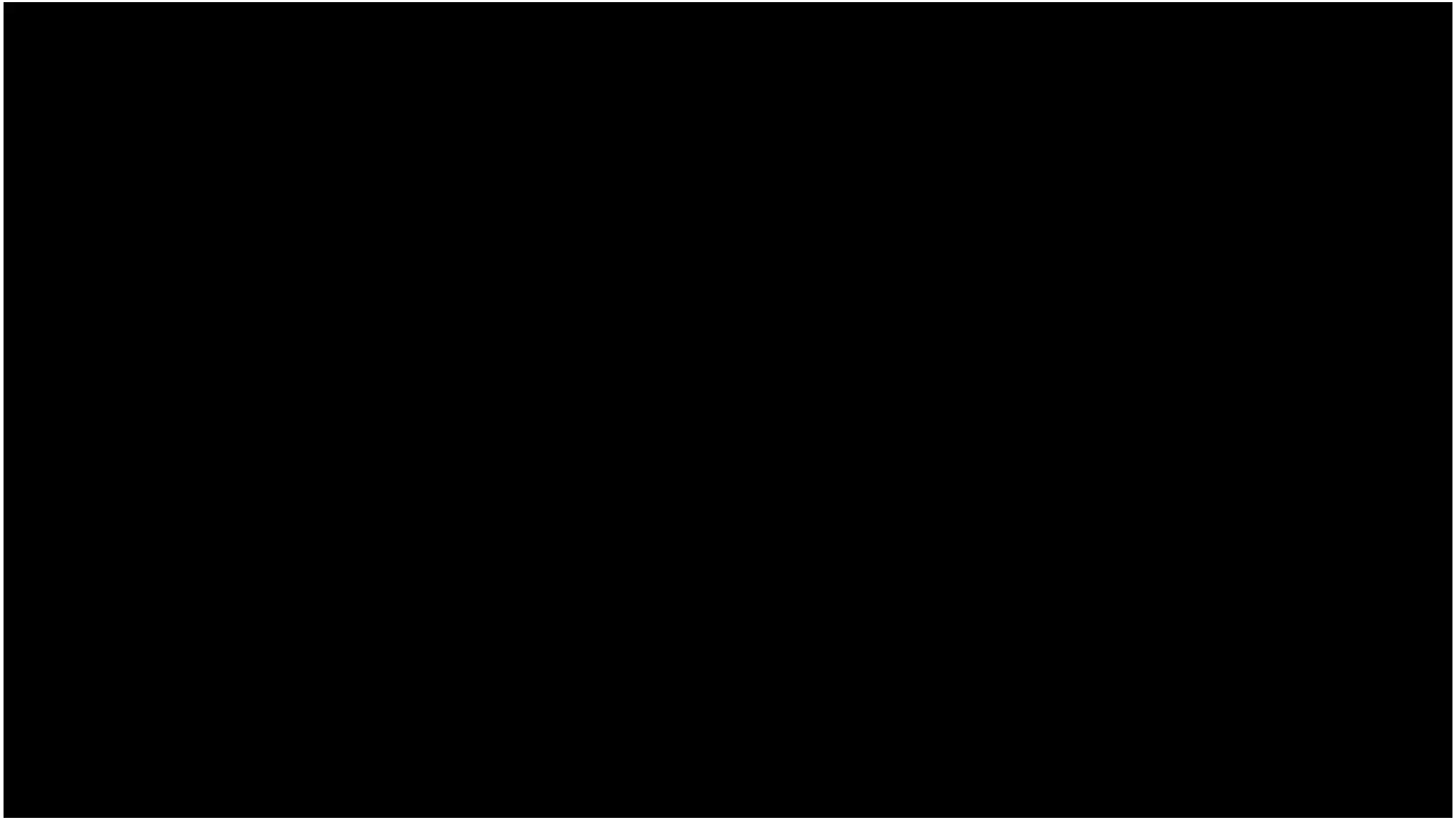
Nourish Healthcare Professionals Programs

The Nourish Program's "seed-to-plate" prevention curricula enhances the learning of strategies associated with successful behavior change as it relates to chronic disease.

Nourish Worksite Wellness Programs

Nourish teaches your team how to unlock the remarkable potential of what we eat, celebrating both the emotional and functional role food plays in our lives.

Dietetic Internship & Nourish



Contact Information

nourish

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Rupa Mahadevan
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Melisa Danho
Melisa.Danho@uth.tmc.edu

Catalogue of Services

Website

8:50 – 9:00 AM

Data Visualization Studio



Speaker: Ryan Ramphul, PhD



Speaker: Wes Gibson, MPH

UTHealth Houston
School of Public Health
Center for Health Equity

Data Visualization Studio:
Real-Time Monitoring. Geographic Insight. Measurable Impact



go.uth.edu/CHE

Why?



Image credit: University of Victoria (2023), https://www.linkedin.com/pulse/pressure-can-either-refine-you-confine-harry-smith/

UTHealth Houston
School of Public Health
Center for Health Equity











Real-time monitoring to keep initiatives on track



Data scientists, cartographers, and statisticians transform complex data into actionable insights

Data Visualization Studio

ArcGIS Pro



Power BI



The Team



Shreela Sharma, PhD, RDN, LD, Professor & Vice-Chair of Epidemiology, Director of CHE



Ryan Ramphul, PhD, MS, Assistant Professor of Epidemiology, Spatial Epidemiologist



Wes Gibson, MPH, Sr. Program Manager

Houston Food Bank Culture Initiative



Image credit: Houston Food Bank (2025), https://www.houstonfoodbank.org/find-help/

Houston Food Bank Cultural Initiative

San Antonio Food Insecurity Data Portal



Image credit: Alamy Stock Photo (2025), https://www.lonelyplanet.com/destinations/usa/texas/san-antonio

San Antonio Food Insecurity Data Portal

Power BI Dashboards

Provision of healthy food to prevent, manage, or treat specific health conditions, integrated with the doctor's clinic and hospital system







Volpp, K. G., Berkowitz, S. A., Sharma, S. V., Anderson, C. A. M., Brewer, L. C., Elkind, M. S. V., Gardner, C. D., Gervis, J. E., Harrington, R. A., Herrero, M., Lichtenstein, A. H., McClellan, M., Muse, J., Roberto, C. A., Zachariah, J. P. V., & American Heart Association (2023). Food Is Medicine: A Presidential Advisory From the American Heart Association. Circulation, 148(18), 1417–1439. https://doi.org/10.1161/CIR.0000000000001182

Contact Information



Wes Gibson, MPH, Sr. Program Manager

Wesley.R.Gibson@uth.tmc.edu

9:00 – 9:50 AM

Presentations
Round 1

9:00 – 9:07 AM

AccessHealth

Coming Up Next: Casa El Buen Samaritano

Darci Moore
Population Health Programs Manager
dmoore@myaccesshealth.org

Rumaysah Popalzai
Clinical Dietitian
rpopalzai@myaccesshealth.org



AccessHealth's Food Is Medicine Team
(Population Health Department)

Food RX at AccessHealth:

- Through partnership with Houston Food Bank, AccessHealth patients can be prescribed healthy foods to improve their health
  - Eligibility: food insecure & diagnosis of chronic condition or pregnant
  - All patients screened for food insecurity every 90 days
  - Patients visit a Community Health Worker to enroll in program
- Began through a partnership with Catholic Charities' Mamie George Community Center's food pantry in Richmond
  - patient visits food pantry to pick up healthy foods
- Expanded to all 6 clinics in 2024





Maternal Health Focus:

The OB Department's maternal health program, **PRECARE**, supports moms through their pregnancy by connecting them with a Community Health Worker to make sure their non-medical needs are also met throughout their pregnancy.

PRECARE & Food RX

PRECARE program focus:

June 2023-Nov 2024:

73 moms enrolled in Food RX



Outcomes:

83% of patients reported improvement in food insecurity

(via survey completed at program intake and exit)

Lessons Learned:

Patients may face additional barriers accessing healthy foods

- Lack of transportation - must connect them to resources
- Nutrition education and appointments with Dietician also necessary

9:07 – 9:14 AM

Casa El Buen Samaritano

Coming Up Next: HOPE Clinic

Casa el Buen Samaritano

Emily Fleisher, MSN, RN

Clinic Manager

e.fleisher@casaelbuen.org

Nicole Ellis, FNP

n.ellis@casaelbuen.org



Goals of FoodRx at Casa el Buen Samaritano:

To provide healthily food options free of cost for patients with a diagnosis of diabetes, hypertension, and/or obesity.

Patients that screen positive for food insecurity and meet one of the following criteria are eligible to sign up for FoodRx resources:

Hemoglobin A1C > 5.7

BMI > 25

Blood Pressure > 120/80

Population served: adult primary care patients, less than 200% below the poverty line, have no insurance/access to care, and 95% Spanish speaking.



Evaluation

- Monthly chart review of all registered patients to notate trends of hemoglobin A1C, BMI, and/or blood pressure.
- Being proactive not just in enrolling patients into the program but also establish a follow up process.

9:14 – 9:21 AM

HOPE Clinic

Coming Up Next: Memorial Hermann

Andrea Caracostis, MD, MPH
Chief Executive Officer
HOPE Clinic
acaracostis@hopechc.org

HOPE CLINIC
a community health center

Bite of HOPE
A HOPE CLINIC INITIATIVE



The Four Pillars

CULINARY MEDICINE









FoodRx + Bite of HOPE

Fresh, healthy food helps patients lower A1C and prevent diabetes

Culturally-inspired recipes by Bite of HOPE chefs make healthy eating easy and enjoyable

📈 164 patients enrolled (July 2024 – March 2025)

✅ 42% of participants (69 patients) achieved an A1C under 7

After-School Program

More Adventurous Eaters: Reported increased willingness to try new vegetables

Smarter Choices: Demonstrated stronger understanding of how food impacts health

Empowered Voices: Shared stories of cooking at home and teaching family members

Long-Term Impact: Built confidence in making healthier, informed decisions









✅ In 2024, Bite of HOPE reached over **450 families** through engaging virtual and in-person sessions.

Small Food Business Program

- Technical assistance provided by certified chefs
- Financial literacy training provided by BakerRipley Entrepreneurship Program
- Helps develop nutritious menus for improved community health
- Empowers local businesses to promote healthier eating options

Number of graduates: 63

✅ Every participating business successfully created and presented at least one new healthy dish by the end of the program, demonstrating a tangible shift toward healthier menu offerings.





"This program gave me the skills to chase my dream of owning a food business and hope for a healthier future for my family"
Gladys

CULINARY INSTITUTE

Number of graduates: 43
Currently enrolled: 14

✅ **Outcomes:**

44% Catering business
7% Bakery
7% Working with communities
5% Employed in restaurant
37% Unreported

The program saw 10% attrition rate

9:21 – 9:28 AM

Memorial Hermann Health System

Coming Up Next: Christus St. Mary's/Small Places

Memorial Hermann Health System: Community Benefit Corporation

Jorge Sanchez
Program Manager, Food as Health Initiatives
Jorge.Sanchez@MemorialHermann.org

Monica King
Director, Community Benefit Initiatives
Monica.King@MemorialHermann.org

Our Mission:

We are a non-profit, values-driven, community owned health system dedicated to improving health.

Community Benefit Corporation:

To advance Memorial Hermann's vision of creating healthier communities, the Memorial Hermann CBC implements initiatives that are centered at the core of four intersecting pillars:

Access to Health Care, Emotional Well-being, **Food as Health**, and Exercise is Medicine.

Food as Health:

Patients are screened for food insecurity and have access to several resources providing support and assistance in getting healthy nutritious foods. Programs include: SNAP application assistance, Healthy Pantry sites at our Community Resource Centers, Nutrition Hubs at 3 local parks, mobile farmers market, and the newly opened Food and More Market

Food and More Market

This onsite grocery store offers a way for patients to obtain fresh foods, education, and care management services close to home.

Currently, Navigators screen patients that meet the following criteria:
Positive for food insecurity **(+)** existing and or emerging chronic condition.
Identified patients are then enrolled into the Food and More Market program which includes nutrition education, food access every 2 weeks, and consultations with registered dietitian.

Additionally, the Food and More Market serves our Memorial Hermann community at MHSW with temporary food assistance. This is in direct efforts with our Community Resource Center at MHSW.

456
YTD Unique Patients

288
Quarterly Unique Patients

10,187
Quarterly Lbs. of Food Donated

66
Quarterly Program Participants



9:28 – 9:35 AM

CHRISTUS St. Mary's/Small Places

Coming Up Next: Community Health Choice

CHRISTUS St. Mary's Clinic

Nancy Kwan, Physician

Jocelyn Cox, Practice Manager

nancy.kwan@christushealth.org

jocelyn.cox@christushealth.org



Background/Mission – Describe the FIM program goals and implementation

Partnership with the Houston Food Bank

Food for Change FoodRx Program

Patient population: Prediabetic, Diabetic patients who screen positive for food insecurity

Identified by clinicians, enrolled by nutritionist

Biweekly distributions on site every 2nd and 4th Friday of the month

Patients receive 30 lbs of fresh produce and some shelf stable foods at each distribution

Goals:

- *Address food insecurity*
  - *Increase access to fresh produce*
  - *Alleviate financial burden of increase food costs*
- *Decrease barriers*
  - *on-site distribution*
- *Increase nutrition education*
- *Improve health outcomes*

6/2019: Food for Change Partnership

2020: Moved into St. Austin Center

2020: Pilot & started market trailer distributions on site



Describe the FIM program evaluation approach (if applicable) and/or lessons learned

Limited Evaluation:

- Houston Food Bank tracks utilization and provides data after each distribution.
- A1c reported quarterly through data sharing.

Lessons Learned:

- Higher patient participation in the program when the market trailer came on site vs. patients accessing Food for Change markets
  - consistent distribution times
  - familiar location
- EMR text communication
  - reminders increased engagement
  - quick way to notify patients for distribution changes (weather cancellations, etc)
- Balancing patient needs vs. community needs

Background/Mission – Describe the FIM program goals and implementation

Partnership with Finca Tres Robles

Evaluation partner: UTHealth Houston Center for Health Equity

Community work at St. Austin Center

Patient population: 15 prediabetic patients with food insecurity, living within East End zip codes

Identified by clinicians, enrolled by nutritionist

Program: $200 monthly credit to shop at the Farm store

Duration: 1 year

Goals:

- *Address food insecurity*
  - *Increase access to fresh produce*
  - *Alleviate financial burden of increase food costs*
- *Build community*
- *Increase nutrition education*
- *Improve health outcomes*



UTHealth Houston
School of Public Health
Center for Health Equity

Finca Tres Robles

Finca Tres Robles is a non-profit urban farm in the heart of historic Segundo Barrio.

The farm has distributes free, fresh produce in the neighborhood every other week via the Neighborhood Food Access (NFA) and Pre-K Produce Programs.

The newly reopened Finca is now equipped with a farm grocery store, an event pavilion, and a education center for classes and workshops.

Every project the farm undertakes is to continue the mission of reconnecting the bonds between people, place, and food, and to ensure fresh, nutritious food is accessible to the East End community.







9:35 – 9:42 AM

Community Health Choice

Coming Up Next: San Jose Clinic

Community Health Choice

Mayela Botello CHWI,
Wellness Advocate Manager
Mayela.Botello@communityhealthchoice.org



Background/Mission – Describe the FIM program goals and implementation

Population Served -

A cross-sector partnership between the Houston Food Bank and Community Health Choice to provide high-risk pregnant STAR Medicaid members with up to 30 pounds of fresh fruits, vegetables and additional healthy food options twice a month for up to 12 months.

Program Goals –

- To reduce adverse health outcomes and food insecurity.
- To improve adherence to health services and timely checkups.

Key Implementation Considerations –

- Program launch: June 28th, 2023
- Members can either receive home delivery or pantry pick-up from the closest Food for Change Market based on individual needs and preferences.
- Members are assigned a CHW to conduct ongoing outreach and follow-up to remove any barriers to redemption of the produce prescription.
- Members experiencing transportation issues can receive free rides to and from the nearest market location to redeem their prescription.

Describe the FIM program evaluation approach (if applicable) and/or lessons learned

Lessons Learned -

- **Awareness Building & Support:** Members often had to be re-engaged after initial enrollment into the program. This demonstrated that there is significant value in having a CHW provide ongoing engagement and support to reduce hesitancy to use the benefit due and sensitivity to those who are experiencing food insecurity.
- **Creating a Personalized Journey:** CHC instituted several rounds of follow-up with the member to ensure use of the benefit. Reminders about the service were also layered in to the case management program to create multiple layers of engagement. Over time, the reporting between the HFB and CHC has matured to create real-time opportunities in closing redemption gaps and ensuring that the follow-up assistance is tailored to those who need it most.
- **Cross-Sector Collaboration:** The importance of conducting advisory group meetings to gather ongoing feedback and involving cross-sector stakeholders in this process ensures that findings are relevant and actionable. By combining the quantitative data with qualitative insights, CHC has a more comprehensive understanding of program impact and experiences, which allows for refinement and adjustment of program based on participant needs and outcomes.

9:42 – 9:49 AM

San Jose Clinic

Coming Up Next: Break!

SAN JOSÉ CLINIC

Sandra “Sandy” Martinez
Community Relations and Outreach Coordinator
Sandrapmartinez@sanjoseclinic.org





Our Mission

To provide healing through **quality healthcare and education** with respect and compassion for those with limited access to care.

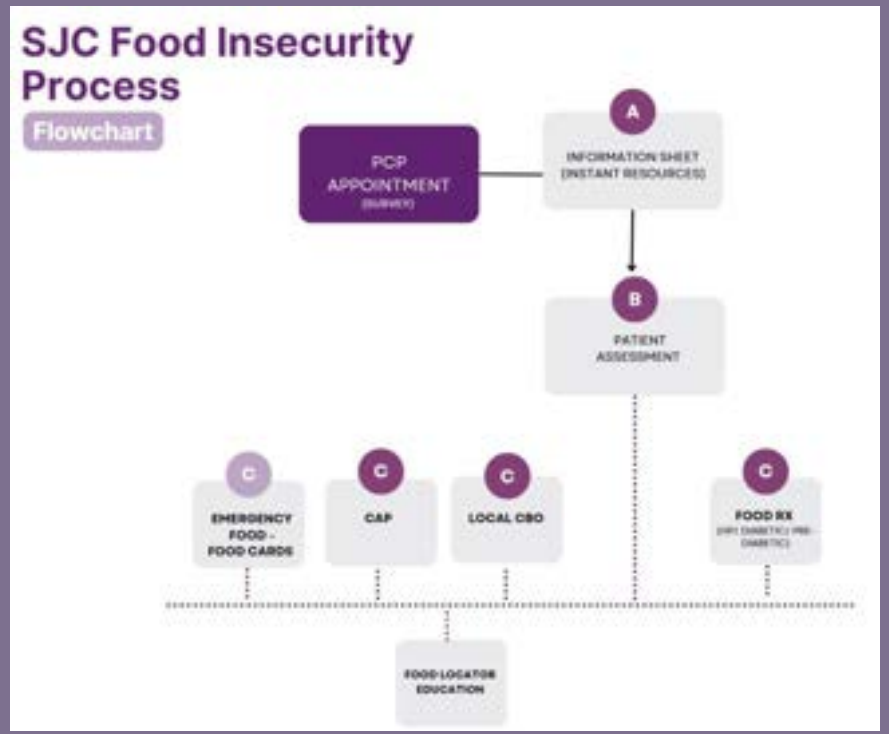
250% FPL

Level A 45%
Level B 21%
Level C 2%
Level D 13%
Level E 19%

Gender
64% Female
36% Male

Demographic
45-64 49%
26-44 30 %
65+ 9%
18-25 7%
0-17 5%

Houston,
Rosenberg
Richmond
Katy
Missouri City
Humble
New Caney
Spring Cleveland
Porter



Food RX Requirements

Positive for Food Insecurity

1. Did you worry that food at home would runout before your family for money to buy more.
2. Did the food that your family purchased run out, and you didn't have money to get more.
3. Do your meals only include a few kinds of cheap food because your family was running out of money to buy food.
4. Did you have to eat less because your family didn't have enough food to buy.

Health Metric

Prediabetes | Diabetic
Hemoglobin A1C >5.7

High Blood Pressure
BP > 120/80

38.3 %
Screened Positive

76%
Eligible for Food RX



FOREVER HEALING
SAN JOSÉ CLINIC

Learning and Next Steps

- **Screening Process: Reflects population and Culture.**
  - Do your meals only include a few kinds of cheap food because your family was running out of money to buy food. (We eat what we have)
  - Did you have to eat less because your family didn't have enough food to buy. (Women, were stating no, but yes to this question.
- **Utilization:**
  - Action Plan: Identify Barriers
    - Reduce the ASK.
    - What is your Schedule? / Do you have someone who can take you?
    - Let's map it out? (Clear Road Map)
- **Creating Experts:**
  - Map it out: Patient Informed Experience.
  - Troubleshooting (if this, than this). Example: Order Ahead
  - Building Support (Using Voicemails, Recording Vid)
- **Next Steps:**
  - Emergency Meals
  - Increase Utilization
  - Increase Partnerships and collaborations with local CBO.
  - Supply the meals (During Education / Workshops).
  - Increase support for Malnourishment. (Younger Population)



9:50 – 10:00 AM

Break



Veg Out (Wasting Thyme) - Masego

10:00 – 11:10 AM

Presentations
Round 2

10:00 – 10:07 AM

Suvida

Coming Up Next: Harris Health

(Contact info)
Monica Sanchez, MPH, RD, LD
Food RX Lead, Clinical Dietitian
Msanchez@suvidahealthcare.com

Wesley McWhorter, DrPH, MS,RDN, LD, CSCS
Vice President, Lifestyle Medicine
WMcWhorter@suvidahealthcare.com







Road to FoodRX 2.0

2023

March 2023

Pilot food distribution at Aldine open house

~150 distributions

August 2023

FoodRX kickoff at Aldine

3600+ lbs food

~150 distributions

2024

March 2024

FoodRX launches in Spring Branch

~150 distributions

February 2025**2025**

Food RX 2.0: February to July Pilot in Spring Branch, Aldine, Pasadena

Prepackaged produce, healthy staples, and lean proteins for eligible patients

Urban Harvest

houston foodbank

Formal agreement made with Houston Food Bank

July 2023

~150 distributions

FoodRX launches in Pasadena

September 2023

Food RX 2.0 Updated: Target population:

- Food Insecurity + Uncontrolled DM and/ or HTN

October 2024

Food RX 2.0 analysis of results

July 2025

Food RX 2.0: February 2025 to July 2025

Target population:

- Adults experiencing food insecurity + uncontrolled diabetes (A1c ≥8.5%) or uncontrolled hypertension (BP ≥140/90)

Program goals:

- Increase access to nutritious foods to support improved glycemic and/ or blood pressure control
- Deliver hands-on education through culturally relevant culinary medicine demonstrations
- Reinforce evidence-based lifestyle medicine principles in a supportive, group-based format

Implementation approach:

- Delivered twice monthly at select clinics
- Includes culinary medicine demonstrations led by a culinary trained Registered Dietitian
- Patients receive nutrient-dense food boxes (produce box, dry goods and lean protein)











Suvida's Food RX 2.0 Evaluation & Lessons Learned



Evaluation approach:

- **Comparison group design** across markets:
  - *No intervention* (clinics not participating)
  - *Lifestyle medicine only* (SuBienestar + Viva el Bienestar)
  - *Lifestyle medicine + Food RX 2.0*
- **Data sources:**
  - EMR data (A1c, BP, BMI)
  - Food security screening
  - Patient-reported data (behavior change, confidence, satisfaction)
- **Timepoints:**
  - Baseline
  - 3 months post-program
  - End of year

Outcomes:

- Clinical improvements (A1c, BP)
- Change in food security
- Patient satisfaction
- Patient engagement
- Self-reported behavior change

Lessons learned and next steps:

- **Food RX 1.0** was not sustainable due to clinic staff burden and limited volunteer support
- **Food RX 2.0** is a more targeted and operationally feasible model
- Allows for clearer demonstration of patient improvements and **ROI** and value
- Preliminary results will be shared in **Summer 2025**

10:07 – 10:14 AM

Harris Health

Coming Up Next: Legacy Community Health – FQHC

Harris Health





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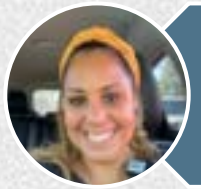

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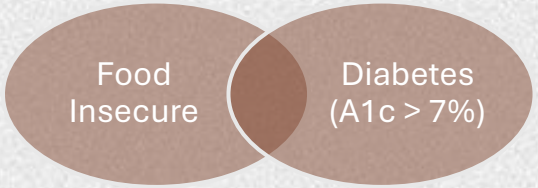
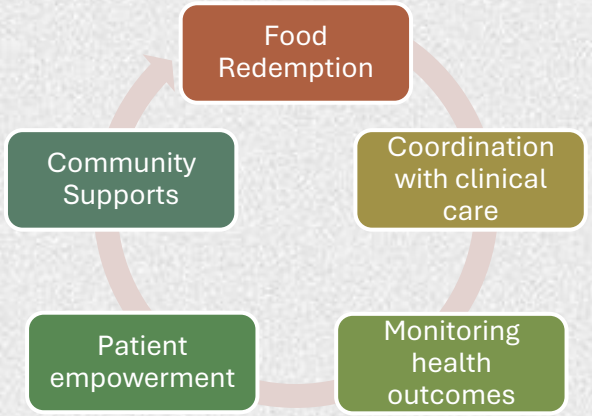
Food Rx at Harris Health







Food Farmacy

- Healthy food pantry co-located within clinic site
- Up to 30 lbs. of produce per visit
- Care coordination with dietitian and patient educator for pts with A1c ≥ 9%
- Basic nutrition education by CHW and culinary medicine offerings
- Connection to food bank navigator for benefits enrollment
- Connection to community supports with ongoing follow-up



Community Redemption

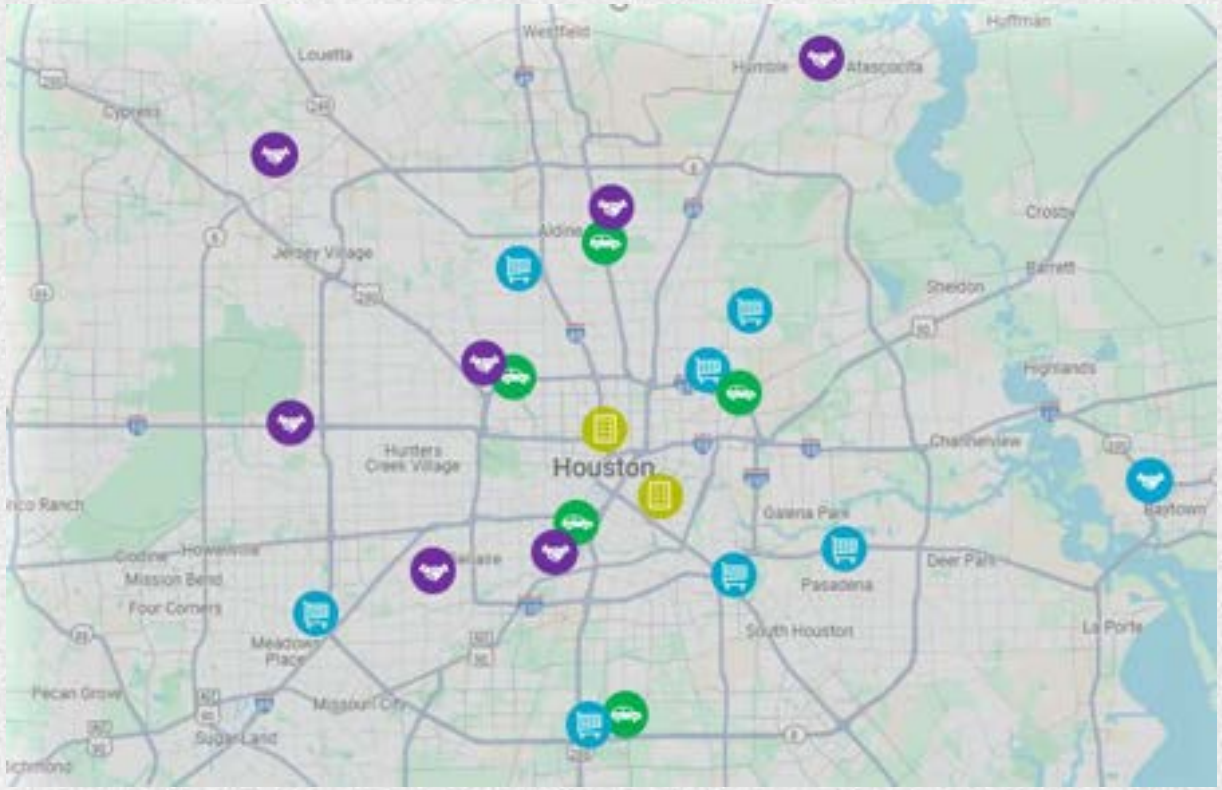
- CHW co-located at specialized community pantry
- Up to 30 lbs. of produce per visit
- Care coordination with dietitian and patient educator for pts with A1c ≥ 9%
- Basic nutrition education by CHW and culinary medicine offerings
- Connection to food bank navigator for benefits enrollment
- Connection to community supports with ongoing follow-up



Food Lockers

- Climate-controlled lockers with self-serve capabilities
- Up to 30 lbs. of produce per pickup
- Care coordination with dietitian and patient educator for pts with A1c ≥ 9%
- Basic nutrition education by CHW and culinary medicine offerings
- Connection to food bank navigator for benefits enrollment
- Connection to community supports with ongoing follow-up

Food Rx across Harris Health



Legend

- Food Farmacy
- Food Lockers
- Community Redemption
- Home delivery

Existing Food Rx Locations	Launch Dates
Strawberry Food Farmacy	May 2019
Acres Home Health Food Farmacy	August 2020
LBJ Campus Food Farmacy	May 2021
Baytown/Baytown Hearts & Hands	April 2023
El Franco Food Farmacy	December 13, 2024
Gulfgate Food Farmacy	December 4, 2024
Settegast Food Farmacy	December 11, 2024
MLK Food Farmacy	April 2, 2025

Existing Food Rx Research Projects	Launch Date
LBJ/MLK/Smith - Chronic Kidney Disease *Research Partnership testing home delivery*	October 2023 – through 2027
Ben Taub/LBJ/Aldine/Northwest - Obstetrics *Research Partnership testing home delivery*	December 2023 – through 2026

Food Rx Expansion – Cigna Food Lockers	Timeline
Casa de Amigos	Summer 2025
Thomas Street at Quentin Mease	Summer 2025

Food Rx Expansion – Community Redemption	Timeline
Cypress	Summer 2025
Squatty-Lyons	Summer 2025
Aldine	2026 – 2027
Danny Jackson	2026 – 2027
Northwest	2026 – 2027
Smith Clinic	2026 – 2027
Vallbona	2026 - 2027

Food Rx Evaluation & Lessons Learned

Food Rx Scorecard

Outcome	Source(s)	Data timepoint(s)
Vegetable consumption (self-report)	EPIC	Baseline, midpoint (visit 6), endpoint (visit 12)
Nutrition knowledge (how food impacts health)	EPIC	Baseline, midpoint (visit 6), endpoint (visit 12)
A1c control	EPIC	Collected as recommended clinically (usual care) Pre (~visit 1) & Post (~visit 12)
Process		
% Screened for FI (screened/eligible)	EPIC	Tracked monthly
% Prescribed Food Rx (screens +)	EPIC	Monthly
% Food Rx redemption	Link2Feed/ EPIC	Monthly
% Food for Change program retention	Link2Feed/ EPIC	Monthly
Satisfaction		
Patient	Epic	Midpoint (visit 6), endpoint (visit 12)
Provider	Qualtrics Survey	Annually

Lessons Learned

- Integrate food insecurity screening into clinical workflow
- Streamline referrals connecting eligible patients to resources
- Train staff on best approaches to address food insecurity stigma
- Consider patient barriers, e.g., transportation and access
- Define team roles and responsibilities, including within the larger care team
- Research and implement food safety and infection control requirements
- Set operational hours and capacity limits that align with patient needs
- Continually adjust model to meet the dynamic needs of both patients and clinic
- It takes a village – aligned partnerships with key organizations are critical to support outcomes

FoodRx In partnership with houston foodbank

UTHealth Houston School of Public Health

FIM Research: OB Food Rx

HARRISHEALTH

- Assess the feasibility and preliminary effects of a home delivery produce prescription program on a wide range of clinical and non-clinical outcomes among low-income, ethnically diverse pregnant mothers

UTHealth Houston
School of Public Health
Center for Health Equity

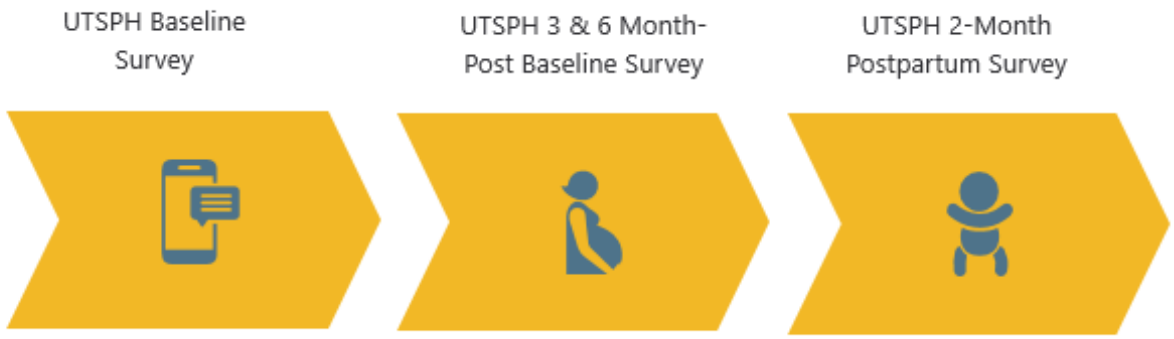
- Medically-confirmed pregnancy, ≤ 20 weeks gestational age
- Receiving prenatal care at designated Harris Health clinics
- Between 18 and 44 years of age
- Designated as high risk (≥35 years old *or* obese or overweight (BMI≥25.0) *or* prior history of pregnancy hypertension or gestational diabetes

Planet Harvest

- Home-delivery of fresh produce and nutrition education via Door Dash
- Tailored nutrition education and support through Chatbot Flora
- Participant experience: through 2 months post-partum (up to 11 months total)

brighterbites®

OB Food Rx Evaluation & Lessons Learned



Comparative Effectiveness Randomized Control study with active control group stratified by gestational age and BMI to assess preliminary impact of produce Rx.

Primary Outcome

- Weight gain during pregnancy.

Secondary Outcomes-

- Pregnancy & Birth Outcomes
- Food & Nutrition Security & Diet Quality
- Implementation outcomes- utilization of food & program satisfaction

01. In-Depth Workflow

The mapping out of each component of the project, along with the timeline for each piece, helped identify wedge points in recruitment

02. Additional Participant Touchpoints

Community Health Worker engagement with participants and research team key to successful implementation

03. Continuous Review of KPIs

Creating space to review and revisit KPIs to ensure the full, cross-sector team is away of project progress, and voices additional data tracking necessary

10:14 – 10:21 AM

Legacy Community Health – FQHC

Coming Up Next: Legacy Community Health x Brighter Bites– School Based

Food Rx

Jamie Rose

Data Analyst – Health Connect Team

AmeriCorps program

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William Lyons, LCSW-S

Senior Manager of Programs SDOH

WLyons@legacycommunityhealth.org



2020 Program Began → October 2023 Switch to Epic → Fall 2023 Program Expansion → Fall 2024 Program Evaluation

Program Goal:

See a stabilization or reduction in certain health metrics over the course of 12 months

Target Population

Patients who are food insecure according to the PRAPRE Screening & who meet the following eligibility criteria:

- Pediatric Patients
  - BMI Percentile ≥ 85
- Adult Patients
  - A1c ≥ 5.7
  - BP ≥ 140/90
- Pregnant Patients
  - BMI ≥ 30
  - Current diagnosis of hypertension
  - Current diagnosis of pre-gestational diabetes
  - Current diagnosis of diabetes
  - History of preeclampsia

Enrollment

1. Patient gets screened for food insecurity
2. Patients are referred by their provider
3. Health Connect staff enrolls the patient
4. Health Connect staff mails the patient's FoodRx ID, and FoodRx Welcome Packet to them

Participation

- Patient can visit a Food For Change Market two times each month to receive 30 pounds of fresh food
- Patients without transportation are eligible for the LCH Non-Emergency Transportation program

Program Evaluation:

Reviewed eligibility, enrollment, and utilization of FoodRx patients who were enrolled from January - June 2024

Table 1.

Eligibility Group	# of Patients Enrolled	% Eligible Patients Enrolled
Adults	329	65%
Pregnant	104	63%
Pediatrics	45	26%
Total	**478**	**56%**

Figure 1.

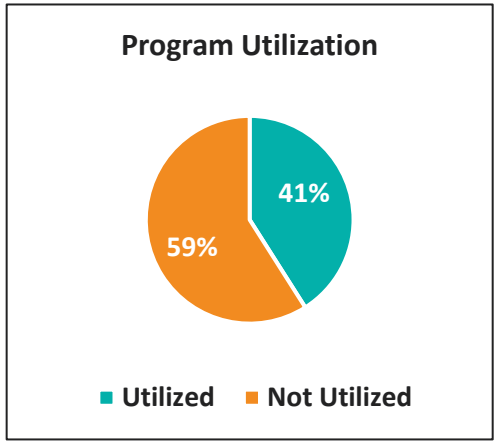


Figure 2.

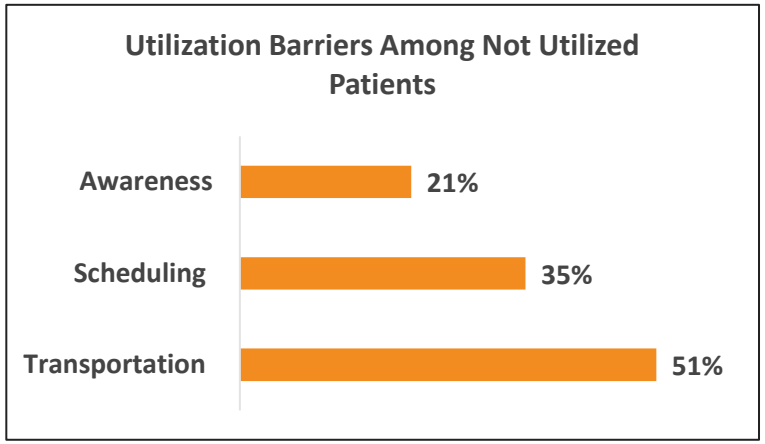
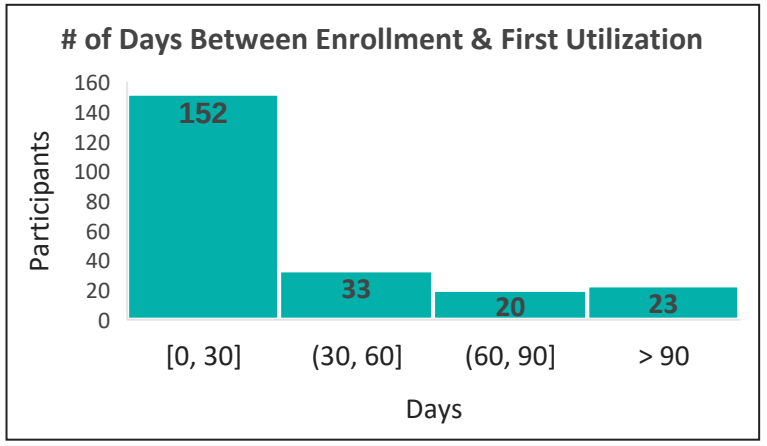


Figure 3.



Evaluation Takeaways

1. Evaluate the program at least once a year
2. Increase recruitment efforts for pediatric patients
3. Advertise our non-emergency transportation program
4. Host another Food For Change market at a Legacy Clinic on Saturdays
5. Confirm that patients want to be enrolled in the program and that they are aware of what the program is
6. Follow up with patients who have not utilized their benefits within 3 months

10:21 – 10:28 AM

Brighter Bites x Legacy Community Health for school-based health clinics

Coming Up Next: UT Physicians – Brighter Bites FIM

Home Delivery Produce Prescription Program in School-Based Health Centers - Galena Park, TX

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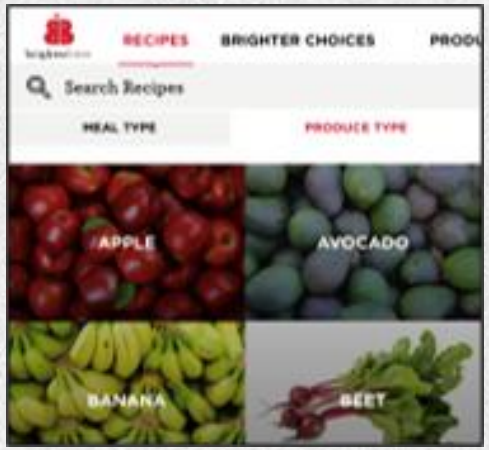
Program Background

- Funding: USDA GusNIP
- Eligibility:
  - Youth 12-17yo at risk for obesity receiving care at Legacy School-based Health Center in Galena Park ISD
  - Medicaid or CHIP eligible
- Intervention:
  - Home delivery produce prescriptions + nutrition education materials and 5 virtual cooking classes
  - 16 home deliveries (bi-weekly for 32 weeks)







Program Partners and Roles

- **Screen** eligible patients
- **Recruit** patients
- **Obtain** biometrics (height, weight, labs)
- Patient **follow-up**
- **Schedule** well-child appointments
- **Extract** participant information from health record system

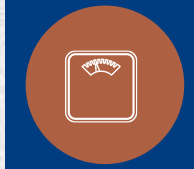
- **Schedule** produce deliveries
- **Partner** with DoorDash for produce delivery
- **Track** delivery and following up with participants
- **Deliver** nutrition education through Brighter Bites materials & virtual nutrition classes (partnering with Nourish)

- **Facilitate** collaboration with Legacy Community Health & Brighter Bites
- Study **development and design**
- **Develop** process & recruitment workflow
- Database **development**
- **Develop** study materials
- Quality assurance
- Analysis

Evaluation Approach

- Non-randomized controlled trial design
  - Control group from 1-to-1 match using EMR data
- Data collected from well child visits:
  - Biometrics, food insecurity, PHQ-A
- Digital self-reported surveys:
  - Parent and Youth pre- & post-survey:
    - Dietary intake, diet-related home environment and practices, household nutrition security
  - Produce utilization survey
- Process evaluation

Outcomes of Interest



Weight change over time



Adolescent biometrics



Food & nutrition security



Dietary behaviors



Depressive symptoms (PHQ-A)

Lessons Learned



- Be patient with the process
- Open communication among the study team
- Be flexible and ready to adapt quickly

10:28 – 10:35 AM

UT Physicians- Brighter Bites FIM for children

Coming Up Next: UT Physicians- STEP Clinic

UT Physicians x Brighter Bites Produce Rx program

Presenters:

Vinay Prabhu, MD

Pediatrician at UT Physicians and assistant professor at UTHealth Houston McGovern Medical School

Interest in child nutrition and improving obesity-related health outcomes

Ru-Jye (Lindi) Chuang, DrPH, MS

Assistant Professor
Department of Health Promotion & Behavioral Sciences
Center for Health Equity
UTHealth Houston School of Public Health

UTHealth Houston | UT Physicians

brighterbites

UTHealth Houston School of Public Health
Center for Health Equity

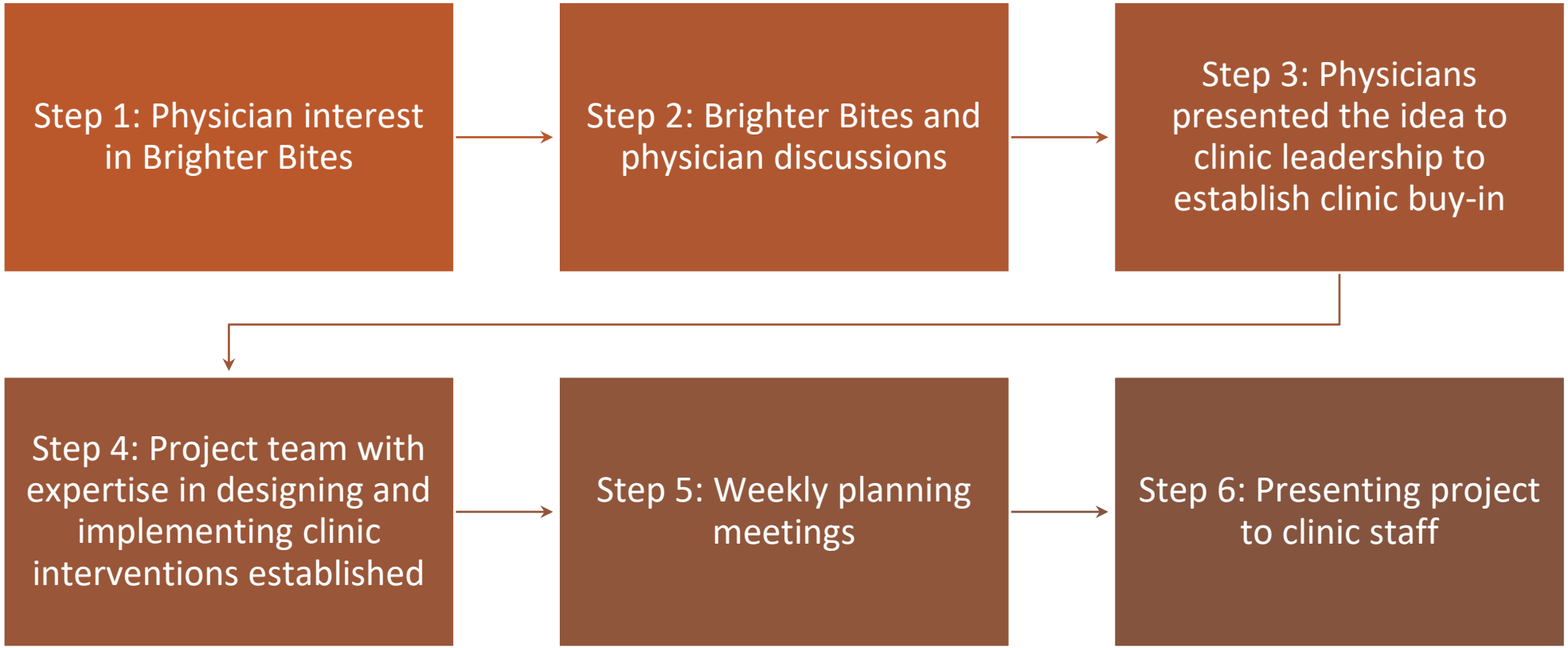
OVERVIEW

Two clinics at UT Physicians partnered with Brighter Bites to pilot test the impacts of a produce prescription program and Brighter Bites nutrition education among Medicaid-eligible overweight/obese patients, aged 5-12 years.

OBJECTIVE

Clinically evaluate the feasibility and effectiveness of two different produce prescription strategies in improving obesity-related outcomes and dietary behaviors among a cohort of Medicaid-eligible children aged 5-12 years old.

HOW DID IT HAPPEN?



UTHealth Houston | UT Physicians

UTHealth Houston School of Public Health
Center for Health Equity

brighterbites

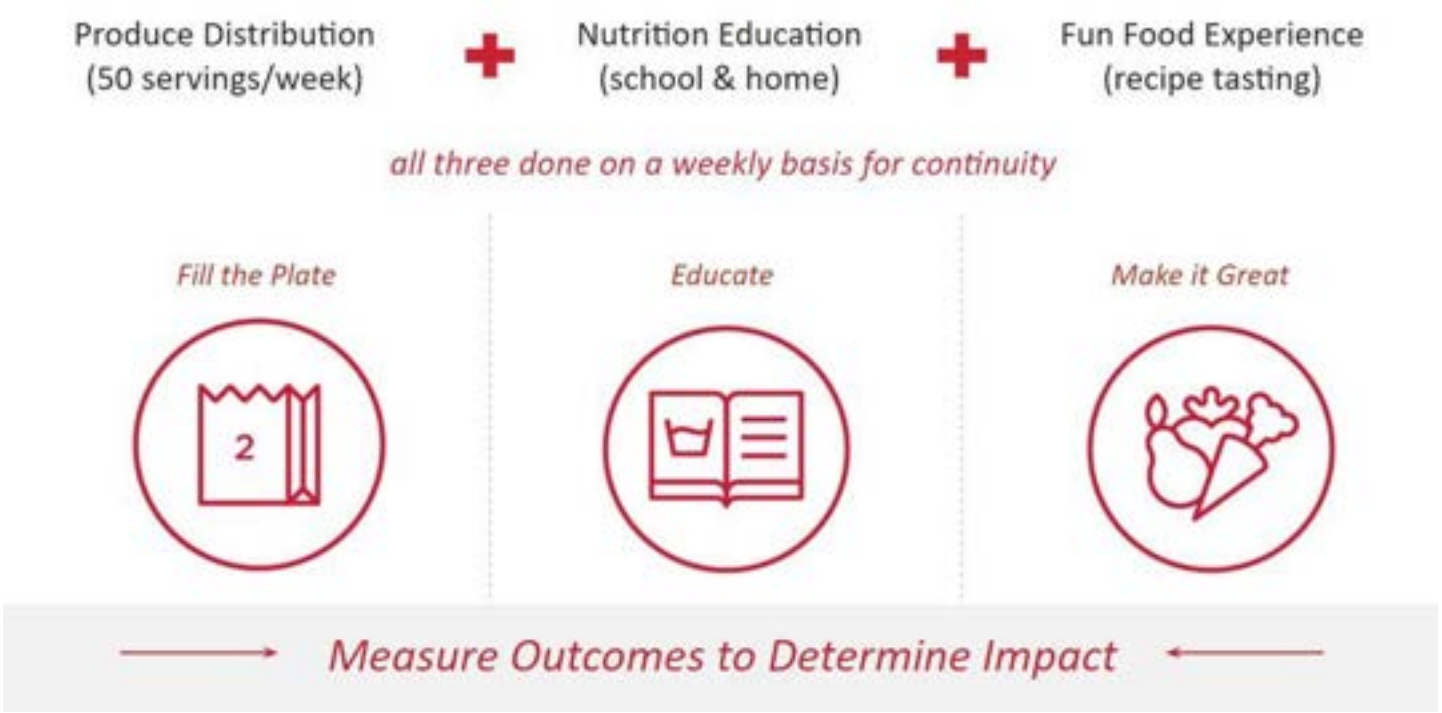
- **Identify and prescribe program** to eligible patients
- **Obtain** vitals and blood work
- Patient **follow-up**
- **Schedule** well-check up appointments
- **Extract** participant information from health record system

- **Facilitate** collaboration UT Physicians and Brighter Bites
- Study **development and design**
- **Develop** process & recruitment workflow
- Database **development**
- **Develop** assessment tools (survey, process tracking)
- Quality assurance
- Analysis

- **Partner** with organizations for produce & voucher delivery
- **Schedule** produce and voucher deliveries
- Produce and voucher **delivery**
- **Tracking** delivery and following up with participants
- **Deliver** nutrition education of Brighter Bites materials through text and app

BRIGHTER BITES

- National, evidence-based program rooted in behavioral theory consisting of 16 weeks of school-based nutrition programming targeting under-resourced families.
- Certified by the National Cancer Institute (NCI) as an Evidence-Based Cancer Prevention and Control Program.



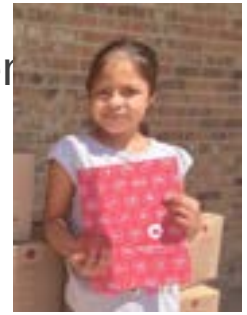
PROGRAM COMPONENTS

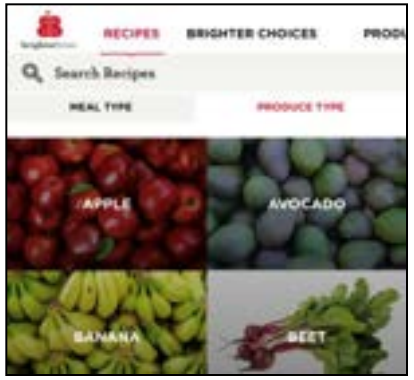
Produce Boxes or Bags
- Home delivery via DoorDash
- 16 deliveries, every 2 weeks





Fresh Produce Card
- Plastic voucher cards
- $25 for fresh produce
- 16 reloads, every 2 weeks
- 6 Retailers: - Kroger - Randall's - CVS
  - Walmart - Walgreens - Dollar Ge





Nutrition Education
- Materials delivered through text message
- Brighter Bites app

OUTCOMES	DATA SOURCE	MEASURES
Primary	Health record system	Body Mass index (BMI) z-scores
		Hemoglobin A1C
		Aspartate aminotransferase (AST)
		Alanine transaminase (ALT)
		Lipid panel (LDL, HDL, triglycerides, and total cholesterol)
Secondary	Baseline & Post survey	Child FV intake
		Parent dietary intake
		Home feeding behaviors
		Food insecurity
		Nutrition insecurity
		Program utilization
	Parent interviews	Program satisfaction
		Participant acceptability
		Program improvement

RESULTS: DATA FROM PARENT SURVEY

Post process metrics (40 Voucher and 28 home delivery participants):

- **71%** reported **home deliveries were helpful**
- **87%** reported the **vouchers were helpful**
- Home delivery: ~70% consumed all fruits, ~60% consumed all vegetables
  - ~ 40% reported receiving spoiled produce at least once
  - ~ 10% reported not knowing how to use the F&V
- Vouchers: ~70% used all the money
  - ~12% reported problems using the vouchers
- **85.3%** reported program **helped save money** on weekly shopping bill
- 73% reported Brighter Bites nutrition tips were helpful



Source: Brighter Bites

PRELIMINARY POST RESULTS: FEEDBACK ON PROGRAM

Feedback from parents (N=12 voucher and home delivery participants):

- Overall, program was helpful & helped introduce children to new F&V
  - *"I think **everything really helped**. He **enjoyed** everything. There was a lot of fruit, vegetables. … vegetables and fruits."*
  - *"[Vouchers] helped me buy fruits and vegetables I wouldn't usually buy, which was nice."*
  - *"Well one change was that I was able to **use more of the vegetables** and **introduce it to him because he didn't really enjoy vegetables.** And well i saw many new recipes and tried them for him."*

- Additional parent reported limitations
  - **Home location**: *"Well, there were many times when I didn't receive it because I live in a mobile home."*
  - **Limited grocery stores for vouchers:** *"You know you have to go to 2 different stores and that's it."*



Source: Brighter Bites

10:35 – 10:42 AM

UT Physicians- STEP Clinic

Coming Up Next: UT Physicians- Cigna

Integrating Food is Medicine into Brain Health: Use of the Mediterranean Diet in the Stroke Transitions, Education and Prevention (STEP) Clinic

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UTHealth® Houston
McGovern Medical School
Neurology

Background/Mission – Describe the FIM program goals and implementation

*Our **mission** is to enhance brain health and reduce the risk of cognitive decline by adopting Mediterranean-Style Dietary Approach as a medically tailored nutritional strategy.*

Goals

- **Advance a Food is Medicine model for brain health** through clinical and community-based implementation of the Mediterranean Style Diets (including MIND diet)
- **Promote dietary patterns to optimize brain health** to reduce the risk of stroke and post-stroke cognitive decline and dementia.
- **Raise awareness** about the role of nutrition in secondary prevention, cognitive function, neurologic recovery, and mental health
- **Support individuals** in adopting sustainable, culturally relevant, and evidence-based eating habits to improve long-term wellness

Implementation Approach

- Provide educational tools for patients – *Diet Pyramid and educational tools in English and Spanish*
- Partner with healthcare providers to incorporate dietary education into preventative strategies – *Stroke Provider Manual*
- Monitor impact through clinical measures, and behavior change tracking.

Population served

- Individuals with stroke and TIA

Background/Mission – Describe the FIM program goals and implementation

Implementation Approach

- Provide multilingual, culturally tailored Med. Diet education tools
- Partner with healthcare providers to incorporate diet into preventative strategies
- Collaborate with community organizations to ensure **access to brain health promoting foods**
- Offer accessible resources, caregiver guidance, and community support groups
- Monitor impact through cognitive and mood assessments, clinical measures, and behavior change tracking.

Population served

- Individuals with stroke and/or vascular cognitive impairment - stroke survivors, caregivers, families, general public, and healthcare providers — particularly those in historically underserved or food-insecure communities.

Describe the FIM program evaluation approach

Short term evaluation

- Pre- and Post-Program Assessments
- Dietary adherence tracking (MIND Diet scoring tools)
- Cognitive Assessments (Montreal Cognitive Assessment - MOCA) and Depression screen (PHQ-9)
- Participant surveys on knowledge, attitudes, and beliefs about healthy eating

Long term evaluation

- Follow-up surveys at 6 months and 1 year after program completion to assess the sustainability of diet changes and impact on cognitive function.
- Clinical tracking of health indicators (e.g., blood pressure, weight, stroke risk markers)
- Behavioral tracking through digital food logs, apps, or food frequency questionnaires
- Focus groups and caregiver interviews to assess barriers, preferences, and cultural considerations
- Healthcare provider feedback on workflow integration and clinical relevance
- Program participation and referral data across diverse population groups

Describe the FIM program evaluation approach and/or lessons learned

Things to consider

- Socioeconomic status, food access, and cultural food preferences will be tracked to ensure equitable implementation.
- A culturally tailored Food is Medicine framework will be developed to reduce barriers to dietary change and address disparities in access to brain-supportive foods.
- Barriers to dietary change will be explored through qualitative interviews, focus groups, and provider reflections.

10:42 – 10:49 AM

UT Physicians- Cigna

Coming Up Next: Harris Center for Mental Health

UTHealth Houston School of Public Health, Center for Health Equity; UTHealth Houston- UT Physicians; Brighter Bites

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Produce Rx for Hispanic Adults with Type 2 Diabetes

Goal: To address disproportionate rates of Type 2 diabetes and food insecurity among Hispanic adults in Houston by coupling access to food and vegetables (F&V) with nutrition education.

Intervention: Enroll 100 Hispanic adults with type 2 diabetes from 3 UT Physicians clinic locations

- Participants will receive
    - Home delivery of F&V boxes from Brighter Bites
    - 1:1 and group nutrition education by UTP Registered Dietitians
    - Access to virtual cooking demonstrations

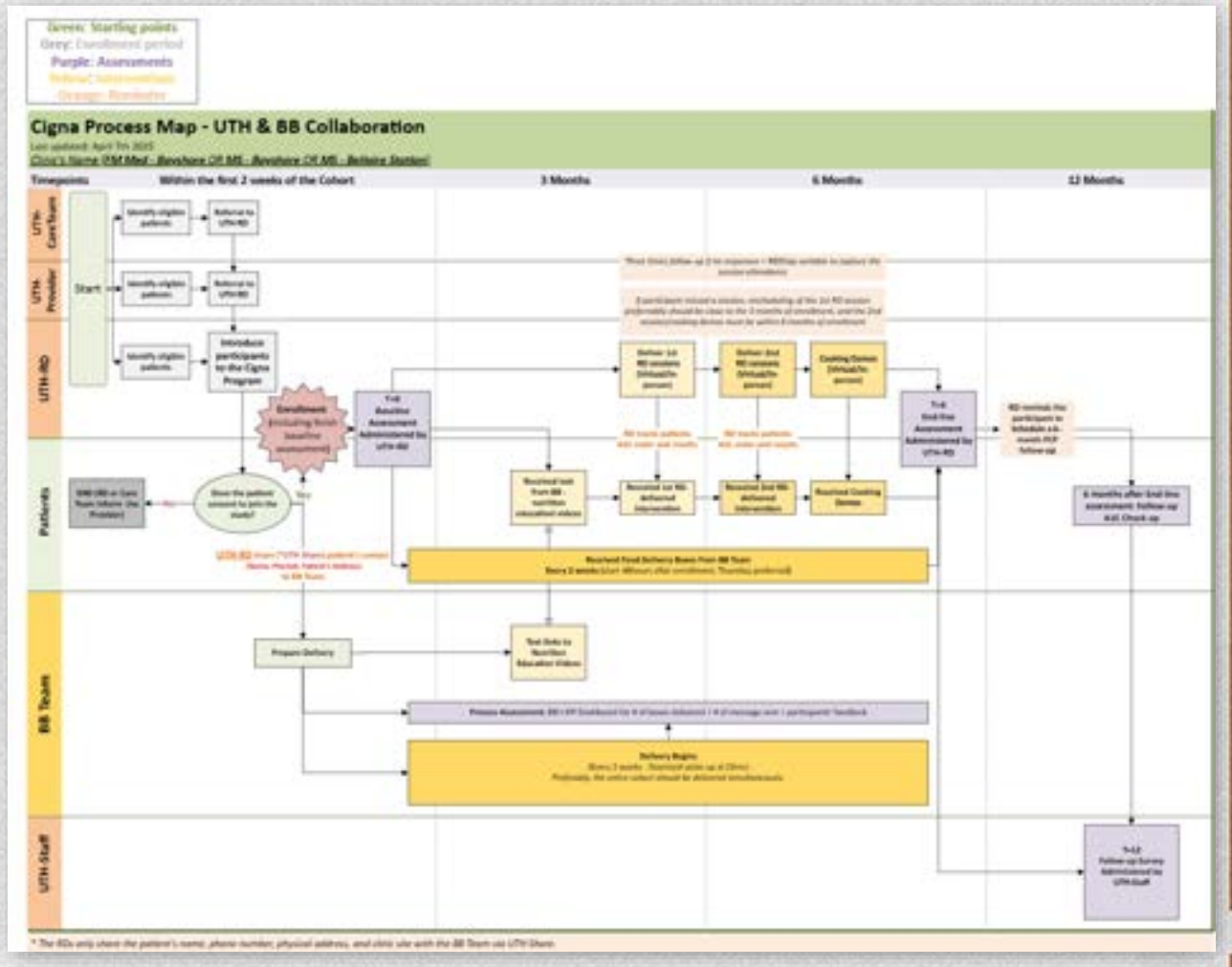
Objectives: We anticipate that participants will:

- Report improved access to F&V
- Increase knowledge about nutrition and meal planning for diabetes management
- Increase self-reported F&V consumption
- Reduce A1C/GMI by .3 percentage points or more

Describe the FIM program evaluation approach and/or lessons learned

Program Evaluation:

- Pre- and post-intervention assessments of patients' food insecurity (Hunger Vital Signs, EHR), nutrition security (Tufts screener), nutrition knowledge for diabetes management (survey), fruit and vegetable consumption (survey), and A1c/GMI levels (EHR).
  - Baseline, discharge, and 6 month follow-up
- Process evaluation will measure program dosage, reach, fidelity of Produce Rx. A real-time monitoring dashboard will measure key performance indicators.



10:49 – 10:56 AM

Harris Center for Mental Health

Coming Up Next: United Healthcare

The Harris Center for Mental Health and IDD - Partnership

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Program Goals

Addressing Food Insecurity:

- **Increase access to nutritious food:**
- Provide access to a variety of healthy, culturally appropriate foods.
- Partner with local food banks and pantries to expand reach.
- **Improve food security:**
- Explore the root causes and trends of food insecurity with mental health population
- Offer resources and support for accessing food assistance programs.

Improve Health Outcomes:

- **Target individuals with serious mental health conditions** and co-occurring diabetes, hypertension, heart disease, and obesity to improve health outcomes

Promote healthy eating habits:

- Encourage the consumption of fruits, vegetables, and whole grains.

Evaluate program effectiveness:

•Use data to improve program design, implementation, identify analytics and outcomes that demonstrate and show the value of the program to stakeholders.

Harris Center Survey – Determinants of Health Findings

"Social determinants of health (SDOH) are known to influence mental health outcomes, which are independent risk factors for poor health status, emotional wellness and physical illness."

Journal of the American Medical Informatics Association, 26(8-9), 2019, 895–899

Eight key DOH related findings from the Harris Center survey revealed the following:

The Harris Center, anticipating the potential of the significant and devastating impact of COVID-19 on direct behavioral health patient care developed and administered a survey entitled *Harris Center COVID-19 & Impact Social Determinants of Health.*[18] This survey was administered to patients by care managers through telephonic, socially distanced in person contact, and telehealth between April 2020 and April 2021. The survey was administered to 7,560 individual clients using a random number recruitment of active outpatient adult (81% adults) and children (19%) with SMI and or SED conditions.

***Food Insecurity**	34.69% Believed that they would run out of food
***Percent Uninsured:**	39.26 % Uninsured
Economic Insecurity	56.86% Found it difficult to pay for basic needs (i.e., food)
Feeling lonely & isolated:	54.16% Frequently felt lonely and isolated
***Fearful about the future:**	52.46%
***Can't keep up with medications:**	44.49%
***Lost access to health appointments:**	24.75%
***Have not seen a healthcare provider**	31.43% in last year

Reasons Why we Worked with Houston Food Bank for Food As Medicine Program:

A High Numbers of Harris Center Patients with Abnormal BMI and HB1C

The Harris Center Population Health: BMI

Health Analytics & Research Department The Harris Center for Mental Health & IDD

The Most Recent BMI scores for Harris Center Clients served during FY23



Medical Complications of Obesity



*Race Ethnicity * Most Recent_BMI_Category Crosstabulation*

			MostRecent_BMI_Category				
			Underweight	Normal weight	Overweight	Obesity	Total
Race Ethnicity	American Indian or Alaska Native	Count	0	8	11	18	37
		% within Race_Ethnicity	0.0%	21.6%	29.7%	48.6%	100.0%
	Asian	Count	19	169	133	122	443
		% within Race_Ethnicity	4.3%	38.1%	30.0%	27.5%	100.0%
	Black or African American	Count	177	2175	2228	4244	8824
		% within Race_Ethnicity	2.0%	24.6%	25.2%	48.1%	100.0%
	Native Hawaiian or other Pacific Islander	Count	0	5	2	9	16
		% within Race_Ethnicity	0.0%	31.3%	12.5%	56.3%	100.0%
	Hispanic/Latino	Count	78	1066	1544	2999	5686
		% within Race_Ethnicity	1.4%	18.8%	27.2%	52.7%	100.0%
	White/Caucasian	Count	102	1017	1208	1810	4137
		% within Race_Ethnicity	2.5%	24.6%	29.2%	43.8%	100.0%
	Unknown or not collected	Count	12	107	142	245	506
		% within Race_Ethnicity	2.4%	21.1%	28.1%	48.4%	100.0%
Total		Count	388	4549	5268	9444	19649
		% within Race_Ethnicity	2.0%	23.2%	26.8%	48.1%	100.0%

The Harris Center Population Health: HB1C FY 23

Health Analytics & Research Department The Harris Center for Mental Health & IDD





Race Ethnicity * MostRecent_HBA1C_Category Crosstabulation

			MostRecent_HBA1C_Category			
			Normal_HBA1C	Prediabetes	Diabetes	Total
Race Ethnicity	American Indian or Alaska Native	Count	9	9	4	22
		% within Race_Ethnicity	40.9%	40.9%	18.2%	100.0%
	Asian	Count	112	83	39	234
		% within Race_Ethnicity	47.9%	35.5%	16.7%	100.0%
	Black or African American	Count	2358	1669	489	4516
		% within Race_Ethnicity	52.2%	37.0%	10.8%	100.0%
	Native Hawaiian or other Pacific Islander	Count	6	4	1	11
		% within Race_Ethnicity	54.5%	36.4%	9.1%	100.0%
	Hispanic/Latino	Count	1848	871	333	3052
		% within Race_Ethnicity	60.6%	28.5%	10.9%	100.0%
	White/Caucasian	Count	1417	505	165	2087
		% within Race_Ethnicity	67.9%	24.2%	7.9%	100.0%
	Unknown or not collected	Count	120	75	39	234
		% within Race_Ethnicity	51.3%	32.1%	16.7%	100.0%
Total		Count	5870	3216	1070	10156
		% within Race_Ethnicity	57.8%	31.7%	10.5%	100.0%



In studies of adults with severe mental illness in the USA, those with food insecurity were more likely to report less mental health service utilization. On the other hand, food insecurity has been associated with increased medical and psychiatric emergency service utilization

(HHS Peer Reviewed; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4103585)

We believe partnerships to provide Specialized onsite Food Trailers are crucial – because many of our patients are uncomfortable and will not seek Healthcare or Food Bank Services in the community







People with severe mental health issues often avoid food banks and health facilities due to a lack of trust, stemming from potential stigma, negative past experiences, and anxieties about being judged or treated poorly (By family & friends) when seeking help, which can further exacerbate their mental health struggles.

Nourishing the Mind: How Food Security Influences Mental Wellbeing: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10893396/#:~:text=Nourishing%20the%20Mind%3A%20How%20Food%20Security%20ences%20Mental%20Wellbeing

The Connection: Hunger & Mental Health are Intrinsically Linked: https://oleanfoodpantry.org/food-insecurity-mental-health-breaking-the-stigma/#:~:text=The%20stigma%20attached%20to%20food,of%20being%20labeled%20%E2%80%9Ccrazy.%E2%80%9D

The devastating mental health impact of needing to use food banks: https://www.moneyandmentalhealth.org/mental-health-impact-food-banks/



Implementation: Food Rx Enrollment & Evaluation Process

Screen for Eligibility

- All patients are screened for Food insecurity using 2 item-Hunger vital signs –Patients that screen positive and/or meet qualifying criteria Food Insecurity-NMDOH, poverty level- 200%, depression screen, Quality of life screen, BP, BMI – health conditions, contacts clients with opportunity - gets them to opt in – tell them there are enrollment form, quality of life survey, once dates of food truck delivery – let them know dates, make sure they have means to take

Enroll into Food Truck

- Clients assigned unique Food ID number
- Client completes enrollment form (Forms Assembly)
- Patient completes Quality of Life survey
- FIRST Link refer to HFB for SNAP application assistance

Redeem Food

- Identified Patients will get 35 lbs of fresh produce, protien and additional items twice a month at our sites



Describe the FIM program evaluation approach:

In addition to the Food Bank custom post-test survey, we will capitalize on routinely gathered metrics, comparing pre- to post-intervention scores:

Metabolic Indicators

- BMI
- HGA1c
- BP

Mental Health Indicator

- PHQ-9 Depression Screener

NMDOH Screener

- American Association of Family Physicians – Food Insecurity Items

Although sample is very small, preliminary results suggest a bump in BMI for underweight patients

Among Harris Center Patients (n=10,000) Food Insecurity was associated with:

Medical Uninsurance

Poverty (28% of FPL or $4,600/year)

Psychiatric Hospitalizations

Working Age (18-64 y/o)

Jail Bookings

Jail Diversion visits

Homelessness (58%)

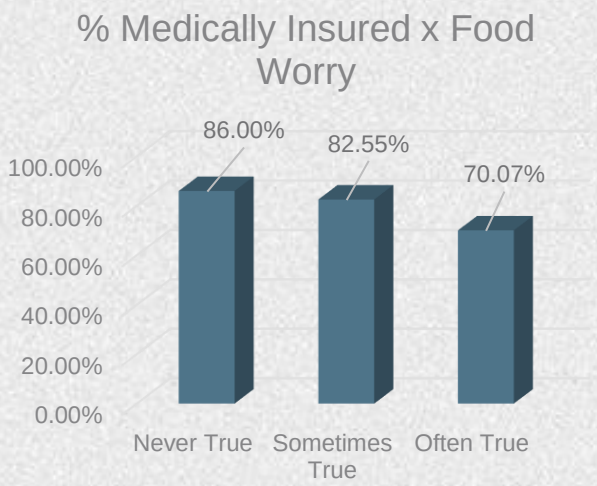
Substance Abuse Dx (38%)

People of Color (79%)

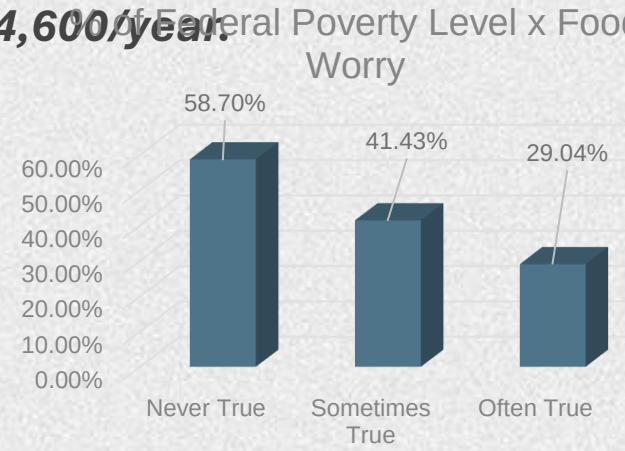
Obesity (51%)

Prediabetes (30%) and Diabetes (13%)

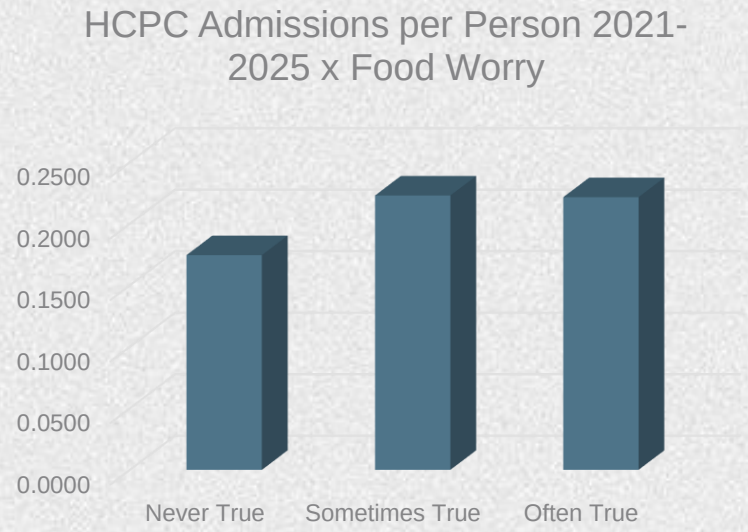
Medical Insurance: ***Medical insurance rates are linked to food insecurity.***



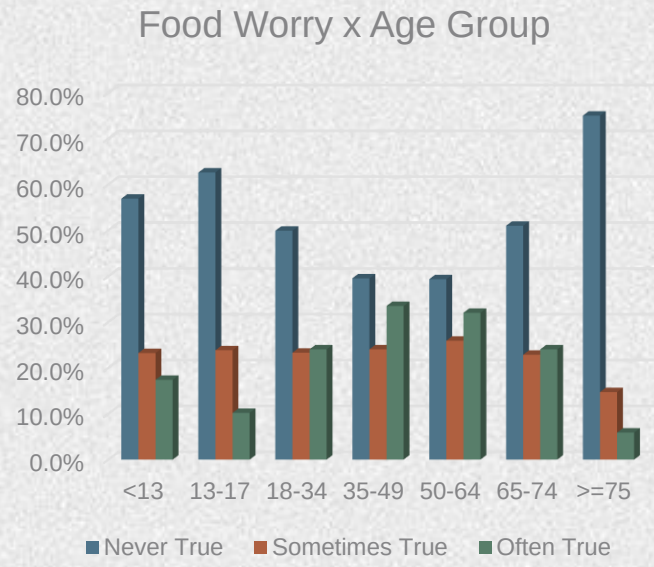
Poverty FPL: The average patient who was "often worried" had an income under $4,600/year.



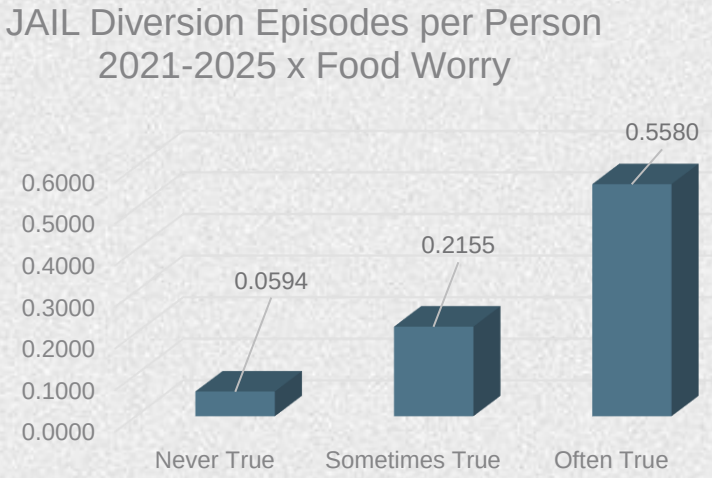
Psychiatric Hospitalizations



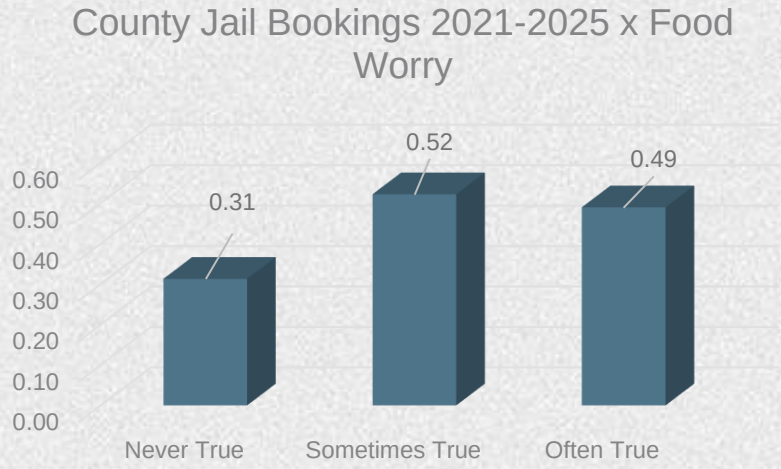
Working Age (18-64 y/o): ***The distribution is significantly different than expected. Food security seems to falter in mid-life.***



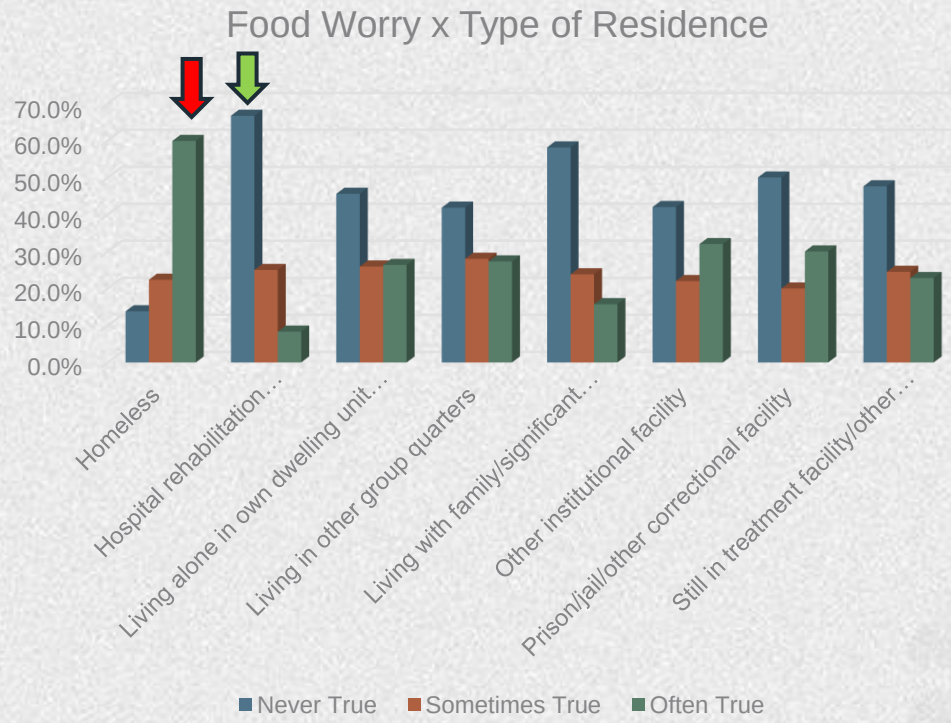
Jail Booking: ***People who are taken to the Jail Diversion Center are also Food Insecure. More than half of those who were "Often Worried" had been to the Diversion Center (sample=all people treated in in-patient care 2021-2025). Food insecurity is linked to criminal justice involvement.***



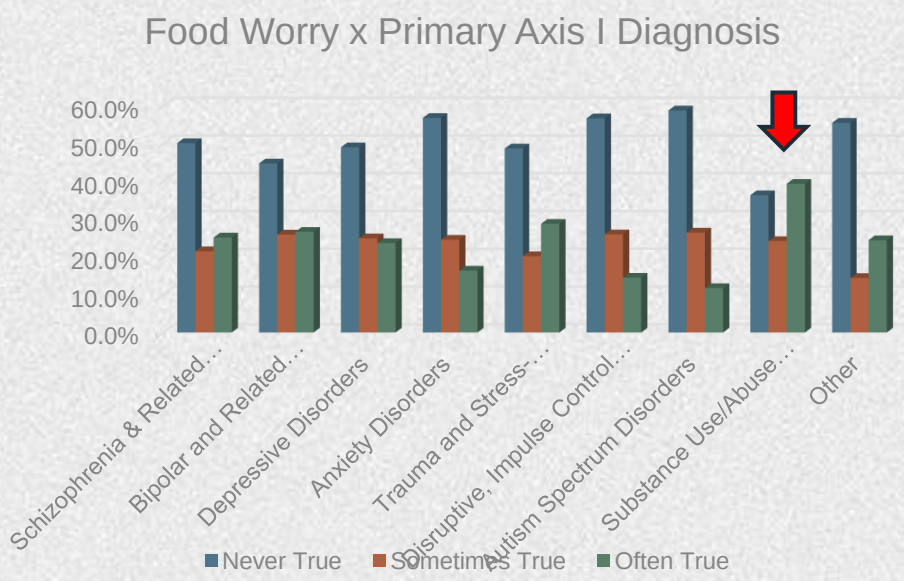
Jail Diversion visit



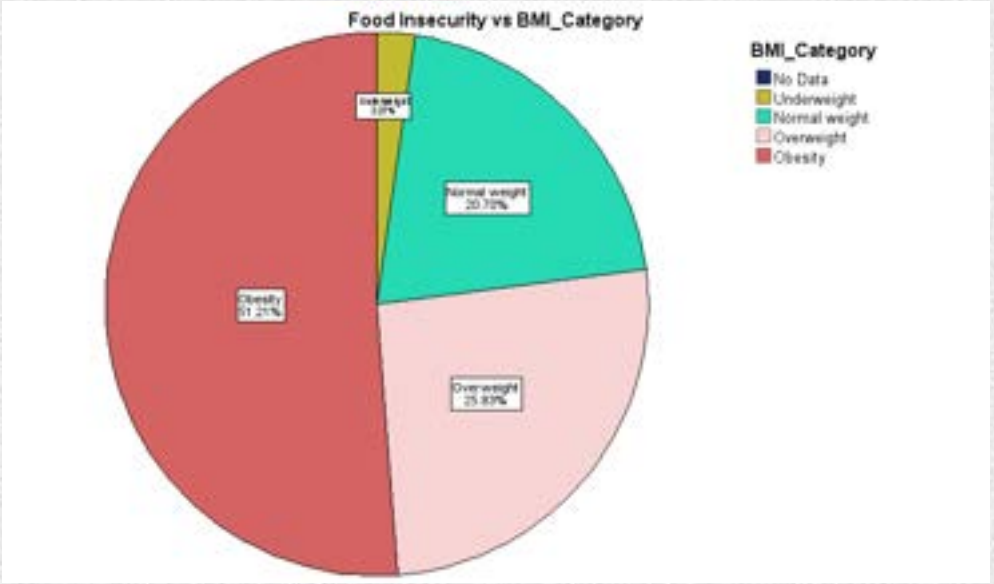
Homelessness (58%): ***As might be expected, best, homeless people are "Often Worried". Hospital food may not be the best, but it is apparently very reliable.***



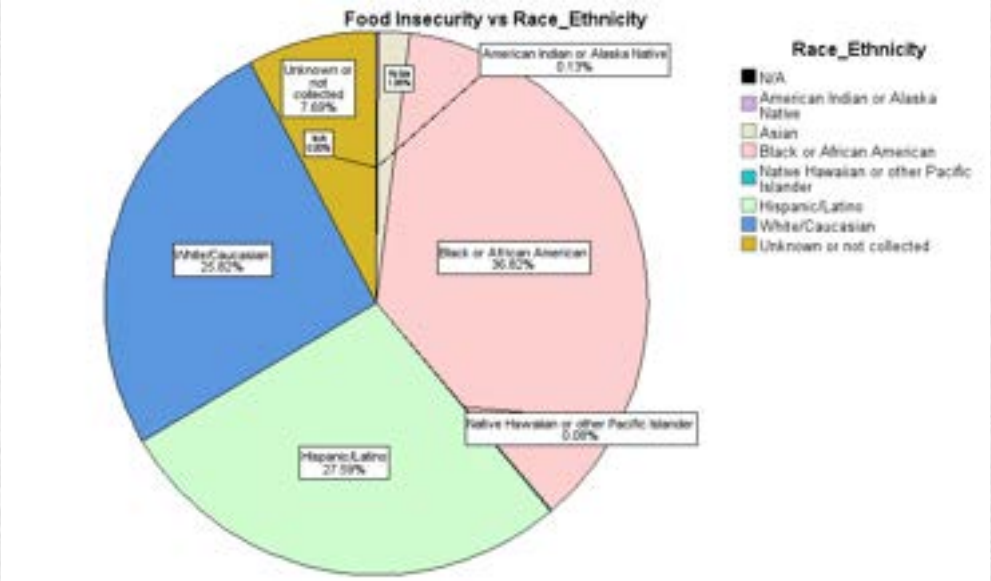
Substance Abuse Dx (38%)



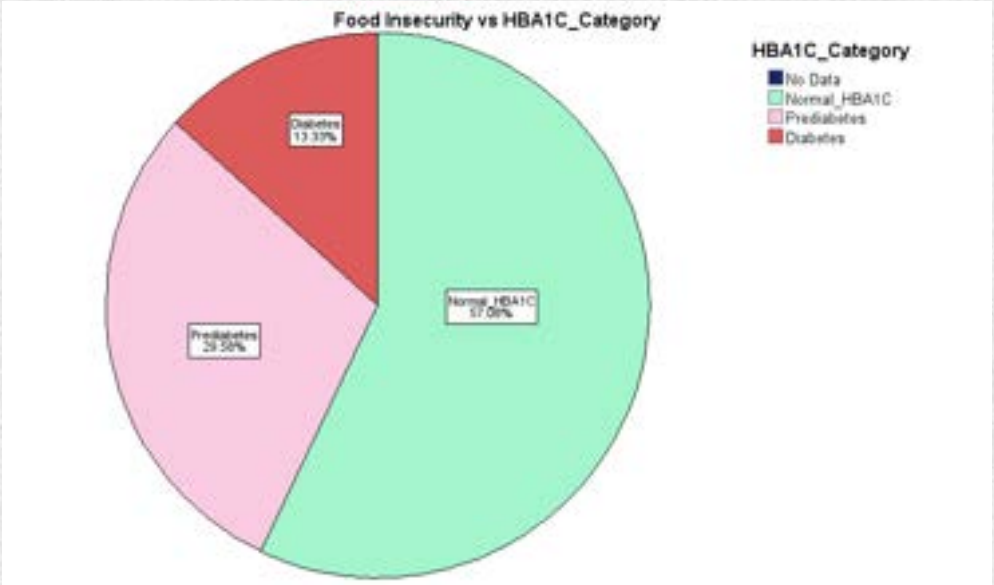
Obesity (51%)



People of Color (79%)



Prediabetes (30%) & Diabetes (13%)











Since April 2024 Four Clinics Have Enrolled: _____Clients

10:56 – 11:03 AM

United Healthcare

Coming Up Next: VA FIM Video

UnitedHealthcare

Arnita Burton
Associate Director of Clinical Innovations, Analytics & SDOH
Arnita_burton@uhc.com



Background/Mission – Describe the FIM program goals and implementation

- **Pilot collaboration:** UHC and Houston Food Bank
- **Intervention:** Address food insecurity through screening and identification of UHC STAR Kids children at risk for morbid obesity. Home delivered fresh meals, nutrition education
- I**mplementation:** 11/1/2023 – 11/30/2024
- **Target:** 100 STAR Kids Population ages 3-17 elevated BMI ≥ 85th percentile
- **HEDIS Quality Measure**: Weight Assessment and Counseling for Nutritious and Physical Activity for Children/Adolescents (WCC)
- **Outcomes:** Patient engagement through education and counseling, reduction in BMI

Describe the FIM program evaluation approach (if applicable) and/or lessons learned

Outcomes (pending analysis):

- Patient engagement through education and counseling
- Reduction in BMI
- # of members enrolled to SNAP via Houston Food Bank

11:03-11:07 AM

VA FIM Video



11:10 – 11:20 AM

FIM Landscape Scan



Speaker: Naomi Tice, MPH

UTHealth Houston
School of Public Health
Center for Health Equity

Statewide Food is Medicine Landscape Scan

Naomi Tice & Wes Gibson

Friday, April 25



go.uth.edu/CHE

Acknowledgements

- To the amazing group of students who have supported the implementation of this landscape scan:
  - Angelina Johnson
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- To Dr. Sharma and the Center for Health Equity for their full-hearted support of this work!
- To Cassidy Penn, my co-lead for the Health Equity Collective FIM Lanscape Scan subgroup
- To the Health Equity Collective Food Security Workgroup for all their input and support
- To everyone here today, whose amazing work made this landscape scan necessary, and for so many of y'alls input into the landscape scan design and implementation.

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The Idea

Who is doing FIM in Texas and how are we connected?

How can we build collaboration and information sharing?

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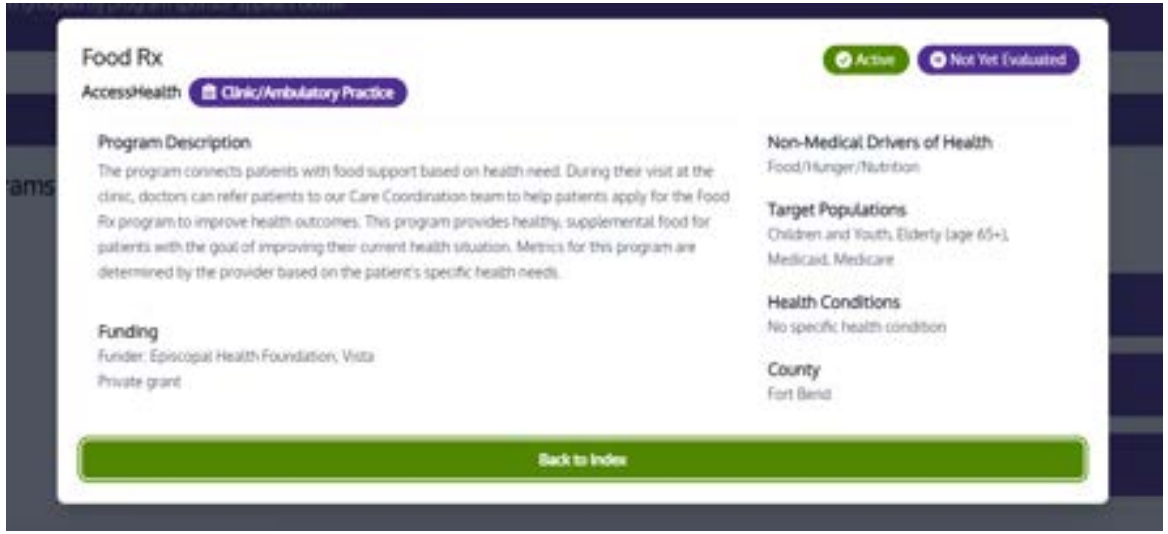
What work is already happening?

Texas Consortium

- Food Affinity Group
- Program Index

Health Equity Collective

- Food Security Workgroup



And how can we build on it?

FIM Landscape Scan

- Data Visualization
- Program Mapping

FIM Collaborative

- Houston's FIM Mini Summit

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Food is Medicine Programs-

1.Provide healthy food specifically for the purpose of preventing, managing, or treating a specific clinical condition and/or nutrition or food insecurity

2. Are directly integrated with the health care sector

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3. Recruit participants through direct engagement with the health care sector

Types of FIM Interventions

Definition of FIM Intervention Types for the Purpose of the Landscape Scan:

1.) ***Medically Tailored Meals-*** provision of fully prepared meals designed by a registered dietitian to meet the specific dietary needs of an individual living with one or more health conditions.
2.) ***Medically Tailored Groceries-*** a selection of groceries, such as vegetables, fruits, grains, beans, lean proteins and/or dairy prescribed by a registered dietitian nutritionist for patients with a broader range of diet-related acute and chronic conditions.
3.) ***Produce Prescription Programs-*** clinicians "prescribe" fruits and vegetables, or other healthy foods, to at-risk patients in the form of coupons or vouchers for local farmers' markets, grocery stores or mobile markets.

FIM Landscape Scan Questionnaire

Program Information

- Details of the FIM Program

Partnerships & Collaborations

- Partnerships and cross-sector collaboration

History and Rationale for FIM Programming

- Prior experience or research related to food is medicine and organizational capacity

Funding

- Funding used to finance FIM programs

Initial Data Analysis

Data analysis is still under way, these are initial results

Power Bi Dashboard Link

Key Takeaways so Far

Data analysis is still under way- further reporting will include further breakdowns of how program type and design relate to health outcomes, geographic regions, and more

- Food is Medicine is thriving in Texas
- There are areas in Texas that need greater access to FIM programs
- Clarification around FIM program definitions is needed
- FIM as a covered benefit

Next Steps

- Share the landscape scan! This will stay open and data collection is ongoing
- Health Equity Collective Virtual Networking Session in May
- FIM Collaborative

11:20 – 11:30 AM

HEC Food Security Workgroup



Speaker: Maria De La Cruz, MPA



Speaker: Melanie McGuire

Food Is Medicine Doesn’t Stop Here!

- Thank you for joining us today
- We hope the sessions sparked ideas, questions, and inspiration
- Let’s continue driving FIM initiatives in our communities
- Next Food Security Workgroup Meeting – May 23

11:30 AM – 12:00 PM

Sign Out + Stay in Touch!



Lunch and networking will be available for the next 30 minutes. Please connect with fellow attendees and share ideas and reflections!