Better Food, Better Health Pilot

Long-Term Services and Supports (LTSS) Subcommittee Meeting

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What We Want to Share about the Better Food, Better Health Pilot

In this presentation, we will:

Describe the collaborating organizations facilitating the Better Food, Better Health (BFBH) pilot program and the individuals and communities they serve

Describe how the collaborators eliminated barriers to managing chronic illnesses like diabetes, hypertension, and heart failure

Share insights into what they learned along the way and the aspects of this work that surprised them

Discuss the impact of this work on the individuals and communities served as well as how this work impacted the collaborating organizations

Background for Better Food, Better Health Pilot

‘Decades of research confirm that our eating habits can play a major role in how cardiovascular disease, diabetes, and cancer develop…and in how we prevent, treat, and heal these diseases and many others like them. Just as important are the foods you should avoid when you live with conditions such as heart disease, gastrointestinal (GI) issues, osteoporosis, kidney and liver disease, dementia, and many others”.

In collaboration with community-based organizations Philabundance and Manna, the **Better Food, Better Health pilot program** served UPMC Community HealthChoices (CHC) members living in Southeastern Pennsylvania who are diagnosed with hypertension, diabetes, and heart failure. Participants received medically tailored meals and biweekly fresh produce along with nutrition education and counseling.

Reference
1) Harvard Medical School Food-Is-Medicine - Harvard Health

Collaborators:

The Individuals and Communities Served by this Pilot Program

Who are the participating individuals and where is their community?

UPMC CHC members living in Southeastern Pennsylvania who are diagnosed with hypertension, diabetes, and heart failure are eligible to participate in the Better Food, Better Health pilot.

Better Food, Better Health Participants

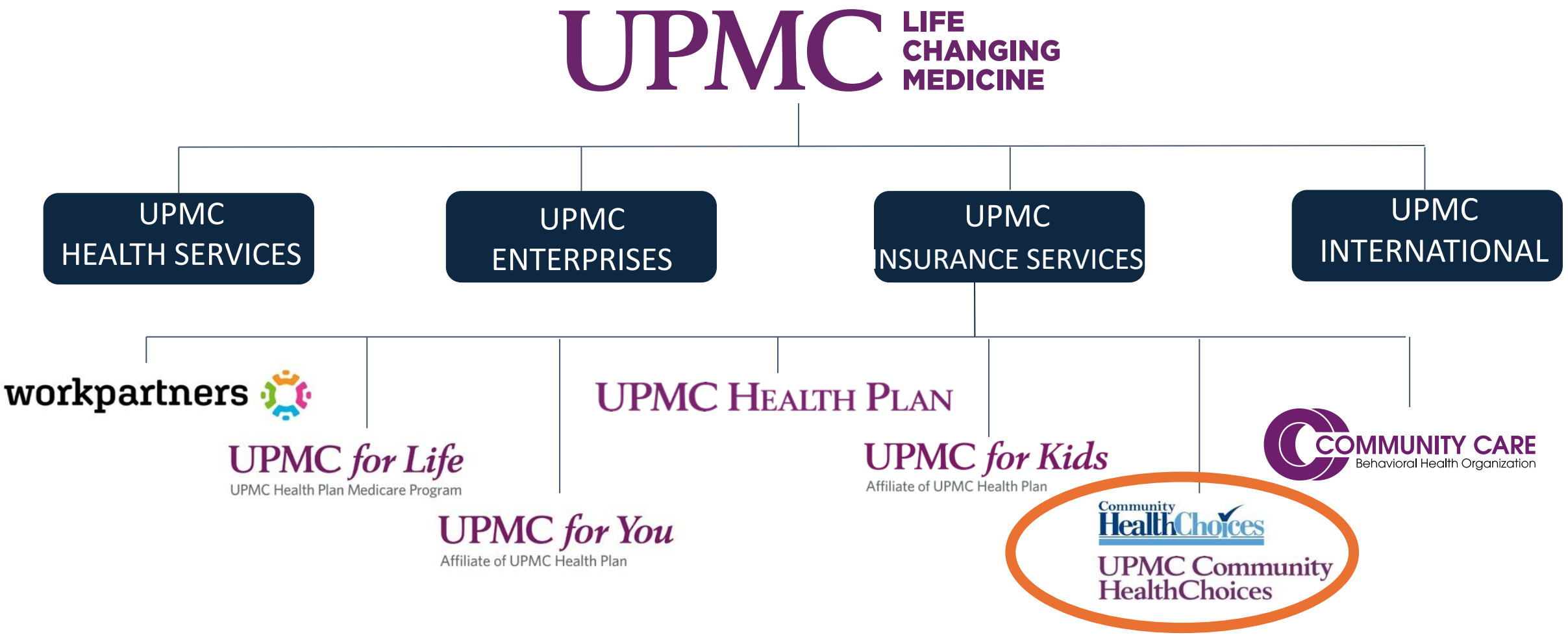
Participant Demographics	Measure
Total participants completed	167
Males/females	62 males/105 females
Age of participants	Range 27-92 years-old; mean age of 57
Baseline Diabetes Diagnosis	100% (eligibility criteria)
Baseline Hypertension Diagnosis	93%
Baseline Congestive Heart Failure Diagnosis	29%

UPMC's Five Zones Throughout Pennsylvania

***Collaborator*:**

UPMC CHC

UPMC Organizational Chart



Collaborator:

MANNA

MANNA uses nutrition to improve health for people with serious illnesses who need to heal. By providing medically tailored meals and nutrition education, we empower people to improve their health and quality of life.

Delivering Nourishment. Improving Health.

MANNA's Mission

History of MANNA

- Metropolitan Area Neighborhood Nutrition Alliance
- Non-profit organization
  - Part of National Food is Medicine Coalition (FIMC)
    - https://www.fimcoalition.org/
- Started in 1990 serving persons living with human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS)
- 2006 expanded mission to help all individuals suffering from serious illnesses
- Services Provided: Medical Nutrition Therapy
  - Home Delivered Meals
  - Nutrition Counseling

MANNA By the Numbers

Since 1990:

- Delivered over 23 Million meals to over 50,000 individuals
- 1,339,590 meals delivered in Fiscal Year 2024
- 5,473 clients and 597 dependents served in Fiscal Year 2024
- Community-based volunteer organization
  - Volunteers are critical to MANNA's mission, ,comprise 97% of our workforce
  - 8,128 volunteers contributed more than 56,000 hours of service

PREVENTION → **TREATMENT**

SNAP/WIC/School Lunch

Congregate Meals

Food Pantries/Grocery Bag Programs

Senior Home-delivered Meals

Prescription Fruit and Vegetable Programs

Home-Delivered Grocery Bags

MANNA → Medically Tailored Home-delivered Meals

INTENSITY OF ILLNESS AND SYMPTOMS →

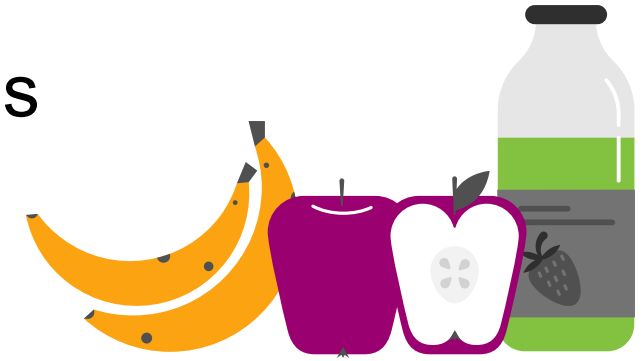
Collaborator:

Philabundance

For 40 years, Philabundance has focused on providing emergency food in order to relieve hunger.

This is important work. But it doesn't ensure that the same people aren't hungry again tomorrow or in the future. So, we are expanding our work by pursuing a bold new strategy to **End Hunger For Good.**

Mission: To drive out hunger in our communities today and end hunger for good.



PHILABUNDANCE

Who is Philabundance?

- Food bank in Philadelphia, founded in 1984
  - More than 130,000 individuals per week (during the COVID-19 pandemic)
    - 30% are children
    - 15% are seniors
  - Distributed over 52 million pounds of food last fiscal year
  - Partner with approximately 350 agencies & direct service programs to distribute food

- Newly formed Healthcare Partnerships (formerly Ending Hunger for Good) department

PHILABUNDANCE

How Philabundance Impacts the Community

- **Food Distribution to Partner Agencies**
- **Philabundance Community Kitchen**
- **Special Initiatives: Good Pizza and Let's Eat**
- **Ending Hunger for Good**

PHILABUNDANCE

UPMC Welcome Kit

Better Food, Better Health Collaboration Model

UPMC	MANNA	PHILABUNDANCE
Identify eligible participant volunteers based on clinical diagnoses	Outreach to consented participants to enroll them with MANNA for nutritional counseling and medically tailored meal delivery AND Philabundance Produce Delivery Program to streamline the number of enrollments required by our participants	Receive list of new Better Food, Better Health enrollee participants from MANNA weekly
Outreach to participant by Nurse Care Manager and enroll interested participants		Outreach to confirmed enrollees with delivery dates, times, and instructions
Send Participant's Information to MANNA	Begin weekly meal delivery of 3 meals per day for 7 days per week	Biweekly fruit and vegetable box delivered to participants' homes
Better Food, Better Health Welcome Kit sent to participant's home	Conduct Monthly Nutritional Counseling Sessions with Participant	Send list of participant enrollees and completed delivery dates and times to UPMC weekly
Participant attends Welcome Aboard telephone session with new enrollees' group	Meet with UPMC monthly to review data and progress with the program	

Step 1: UPMC Meeting People Where They Are

- Early on, we learned that text messaging yielded more compliance
- We reached out to people by phone, not letter initially. Once we identified an eligible member, we connected with their service coordinator provided the phone number we would be calling from. The coordinated “warm hand-off” and 1:1 connection helped a lot.
- We had to be prepared to solve problems that eligible members brought up before we could get their attention/agreement to participate in the program. Audrey, our Nurse Care Manager, was instrumental in first connecting members with resources to address their immediate concerns before engaging them in the program.

Step 2: MANNA

- First Nutritional Assessment Session with Registered Dietician
- Medically Tailored Meals Planning
- Monthly Nutritional Counseling Sessions

Step 3: Philabundance: Biweekly Produce Delivery

Food and Nutrition Education

Each household will receive **one or two produce boxes (12 pounds. each)** on a **biweekly basis**

- Household size: 1-2 people = 1 box; 3+ people = 2 boxes
- Sample box: 1 Pack of Salad Greens, 1 Bunch of Organic Celery, 2 Crowns of Broccoli, 1 Bunch of Asparagus, 3 Apples, 4 Blood Oranges

Mailed **recipe cards** with nutrition and produce storage information

Digital nutrition education with 24-hr access to Registered Dietitians

Contacting Participants

Enrollment

Biweekly calls/texts with delivery reminders and opportunities to gather qualitative feedback

Phone calls from our transportation team when they are on their way with delivery

Troubleshooting, ad hoc

PHILABUNDANCE

What the did the UPMC team learn?

Biometric Data Collection		
Identified Barriers	**Implemented Changes**	**Evaluate Changes**
• Many participants were not consistent with checking their biometric data which includes body weight, blood pressure, and blood sugars during the program. • Nutritional counselors did not have the make and model information on the blood pressure, blood sugar, and scales provided to the participants	• UPMC CHC sent the MANNA Nutritional Counselors a "Welcome Box" so they were familiar with all the devices the participants were using	• The Nutritional Counselors could review the correct use for the blood pressure cuffs, blood sugar monitors, and body weight scales • **Impact**: There was improved reporting of biometric data by the participants to the Nutritional Counselors during their monthly check in with the participants.
Future Application		
In person education and demonstration of the monitoring and self-management tools are planned at the start of the next phase of this project.		

What did the MANNA team learn?

Food Storage		
Identified Barriers	**Implemented Changes**	**Evaluate Changes**
• Limited storage space for prepared meals • Some participants gave their meals to friends/family members to prevent waste and spoilage	• MANNA reduced portion sizes and thus the size of packaging	• Portion sizes reduced • ***Impact***: Reduced food waste
Future Application		
• Reduce number of meals from 3 meals per day for 7 days per week to 2 meals per day for 5 days per week. • Fruit and vegetable deliveries that were also delivered with the prepared meals will be optional rather than mandatory.		

What did the MANNA team learn?

Delivery Issues		
Identified Barriers	**Implemented Changes**	**Evaluate Changes**
• Missed produce and meal deliveries which impact a participant's ability to stay enrolled in the program	• MANNA and Philabundance standardized their food delivery process that includes a point person that oversees all drivers doing deliveries • Special delivery instructions were reviewed and followed closely	• MANNA and Philabundance reported a reduction in missed deliveries • ***Impact***: Fewer enrollment status changes
Future Application		
Current food delivery process will continue in the next version of this program and will be monitored for any new changes.		

What did the Philabundance team learn?

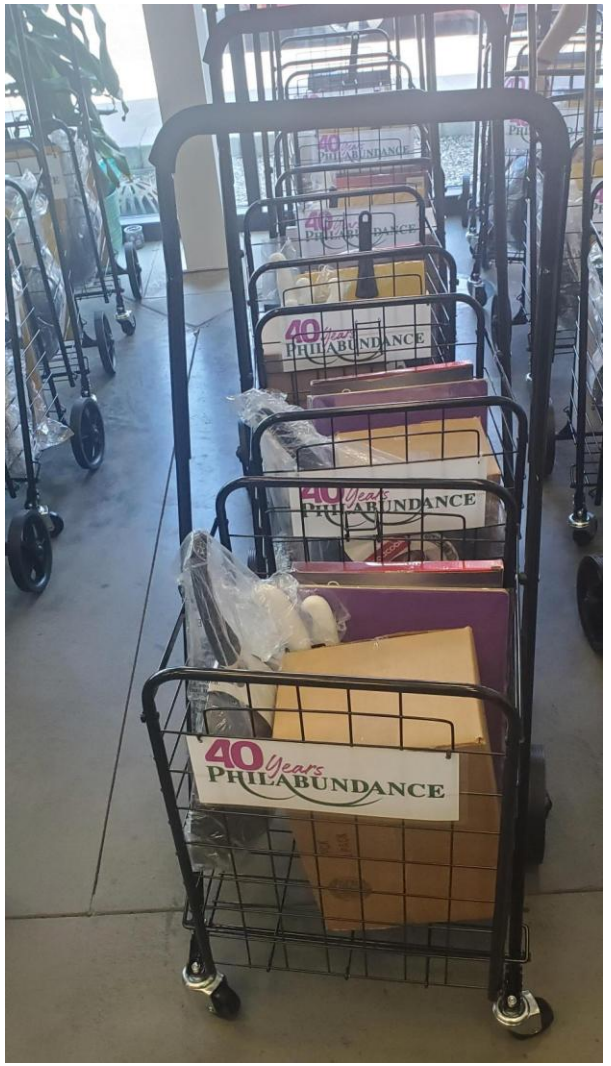
Unfamiliar Fruits and Vegetables		
Identified Barriers	**Implemented Changes**	**Evaluate Changes**
• Participants were unfamiliar with some of the fruits and vegetables they received. • Unsure how to prepare or cook some of the vegetables resulting in wasted food	• Philabundance developed recipe cards and dictionary of cooking terms for the participants	• Participants reported the recipe cards were helpful • **Impact**: Decreased food and vegetables wasted
Future Application		
Recipe cards and educational materials on all fruits and vegetables will be provided from at the start of the next version of this program		

Capstone Project: Community Cook-In

UPMC and Philabundance hosted a Community Cook-In at the Philabundance Community Kitchen (PCK) on August 21, 2024.

- 80 participants/caregivers attended.
- Participants received a cooking demonstration, lunch, and a take-home kit with a prepared meal and meal kit essentials.
- UPMC CHC and the Community Engagement Team collaborated with various organizations, including Philadelphia Corporation for Aging, Community Behavioral Health, PA Career Link, Senior Law Center, Pennsylvania Assistive Technology Foundation, Acme, MANNA, Impact Services, and Congresso Latino.

Philabundance Cook-In – *Participant Experience*



How did the Better Food Better Health, pilot impact the members?

Throughout the program,

- MANNA delivered 168,588 medically tailored meals.
- Philabundance delivered 5,983 produce boxes and sent 155 recipe cards.
- **15%** of participants achieved a 5% or greater decrease in Body Mass Index (BMI).
- Participants experienced an average reduction of 1.29 BMI points.
- **5%** of participants moved from a high glucose category to a normal glucose category.

Our Conclusions from this Pilot

1. These results highlight that participants are successfully **preventing further health decline** through the program.
2. *Food is Medicine* can support complication free survival in those individuals with diabetes.

Thank You

Thank you for joining our presentation on Better Food, Better Health!

A huge thank you to our participants, our staff, our collaborators, and the Office of Long-Term Living for making this a very successful pilot.

Through the Better Food, Better Health pilot, we delivered 168,588 medically tailored meals and 5,983 produce boxes to participants with chronic illnesses in Southeastern Pennsylvania.

Nutrition education included 155 recipe cards and daily access to registered dietitians.

As a result, 15% of participants achieved a 5% or greater decrease in BMI, and 5% moved from high to normal glucose levels.

These outcomes show by working together, we can make a real difference through food.

Food truly can be medicine.

Questions