Community Food-Pantry Partnerships to Improve Nutrition and Chronic-Disease Management

Ascension Columbia St. Mary’s
Ascension Ebenezer Diabetic Friendly Food Pantry Key Programs and Services

• Cancer
  - Education and outreach
  - Screening and referrals

• Diabetes
  - DI(ne)BETES
  - Under 8 Program
  - Prevention and control education/activities
  - Glucose screening and education

• Heart Health
  - Hypertension/Blood pressure screening training and education
  - Lunch & Learn
Most food pantries have to rely on canned foods high in sodium and sugar - ingredients that are harmful for diabetics.

The Ascension Ebenezer Diabetic Friendly Food Pantry features low-sodium, low-carb, and less-processed foods. It also offers more fresh fruit and vegetables as well as regular cooking classes to show people how to prepare healthy meals.
Ascension Ebenezer Diabetes Friendly Food Pantry

• 1,000 people receive healthy and nutritious food from the diabetic-friendly food pantry each month.

• 31% of client households have a member with diabetes.

• 55% of client households have a member with high blood pressure.

• 67% of households choose between paying for food and paying for medicine/medical care.
Ascension Ebenezer Health Resource Center

DI(ne)ABETES

The DI(ne)ABETES events targeted audiences were people with diabetes, pre-diabetes or people with a family history of diabetes.

Attendees have the opportunity to dine with Ascension Columbia St. Mary’s staff and others to learn about nutrition and diabetes by Registered Nutritionist Dietitian and Certified Diabetes Educator.

Since the inception of the program in February 2014, 853 people have been positively impacted by the program!
Past and Current Programs

- Community-based Chronic Disease Management (CCDM)

- Under 8 Healthy Food Box Program (at Ascension Ebenezer Health Resource Center)

- Under 8 Healthy Food Box Pilot Program (at Prospect Medical Commons Clinic)

- Ascension Columbia-St. Mary’s Family Health Center Referrals
Community-based Chronic Disease Management (CCDM)

• Established to address the number of untreated cases of hypertension and diabetes in the uninsured pantry clients.

• Partially funded by the Healthier Wisconsin Partnership Program through the Medical College of Wisconsin.

• CCDM opted to treat hypertension and diabetes without attempting to provide a full range of primary care.
Community-based Chronic Disease Management (CCDM): Cont.

- Laboratory testing, medical assessment, medication prescription and adjustment provided along with health screening and education and social services.

- CCDM’s approach achieved remarkable results with significant decrease in blood pressures results for 70% of enrolled clients and improved laboratory tested results in patients with diabetes.
**Program Goal**
Having access to healthy foods on a weekly basis improves overall health. Participants are provided a food box and health education each week.

**Program Structure**
- Boxes consist of dry goods/fresh produce and were distributed each week for 15-weeks.
- Education was offered to clients.
- Appointment lasted 15-30 minutes.

**Health Topics**
As participants picked up their boxes, nurses and community health workers offered the following educational topics such as:

- Living with Diabetes
- Healthy A1C ranges
- Nutrition
- Label Reading
- Processed Foods
- 7 Veggies
- Sugars/Sodium Control
- Cholesterol
# Program Results

## Participant Measures – Healthy Improvement

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Columbia St. Mary’s
A Passion for Patient Care
Under 8 Pilot Food Box Program at Prospect Medical Clinic

• Primary goal was to identify patients with elevated A1C in the 9.0 - 11.0 range. Pts identified through quality measures and referred by physicians at the clinic.

• 10 patients were enlisted and followed from February, 2016 to May, 2017.

• Attempted to meet with patients monthly and provided routine follow up phone calls.
Under 8 Pilot Food Box Program at Prospect Medical Clinic: Cont.

• Patients were provided a food box, medication management, blood glucose supplies as needed, lifestyle and dietary modifications and referrals to Ebenezer Resource Center.

• 8 out of the 10 patients followed had lower A1C at the end then at the onset of the pilot program. Of those 8 patients with lower A1c, 5 of those were below 8.0.

• Barriers included patients not keeping appointments, not routinely monitoring blood glucose levels and inconsistently taking their medications as prescribed.
Clinic patients referred to Nurse Practitioner (NP) for diabetes education and lifestyle modifications.

NP role is to establish relationship with the patients and identify needs and potential barriers to successful diabetes management.

Assessment may identify medication teaching, lifestyle modifications, psychosocial needs, financial needs and food scarcity issues.

Food Voucher program available to any client who needs access to food and has need for further support at the Ascension Ebenezer Health Resource Center.
Additional Programs

Gardening

• 4 raised bed gardens were added to the pantry

• Encourages the tasting of fresh picked vegetables

• Demonstrate how easy it is to grow their own food

Shopping Assistance

• Education on health issues and dietary requirements and /or restrictions

• Label reading and Healthier food options based on health conditions

• Assistance with cooking tips and new recipes
Additional Programs

Lunch and Learn:

• Free nutritious lunch

• Community education program for pantry participants

• Educational sessions on health and nutrition