Evolving food as medicine programs to advance health equity: insights from two decades of practice

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Purpose of review
The Food as Medicine (FAM) movement has gained momentum as a strategy to address food insecurity and manage diet-related chronic conditions by integrating food prescriptions, medically tailored meals, and culinary and nutrition education into clinical care. However, few FAM programs have evaluated long-term sustainability, equity outcomes, or structural impact on systems-level change beyond food insecurity in the hospital setting alone. This case study reviews feasible, equity-centered evaluation strategies leveraged by the Nourishing Our Community Program (NoC) at Boston Medical Center (BMC), one of the country's oldest and most comprehensive health system-based FAM initiatives.

Recent findings
We trace the historical development of NoC, highlighting key adaptations in evaluation strategy and outlining embedded data collection methods across clinical and community settings. The evaluation approach captures both traditional metrics (e.g., food insecurity screening outcomes) and broader measures, including patient experience, cultural relevance, and local economic impact.

Summary
By embedding equity into every stage of program design and assessment, this case study provides a replicable framework for health systems aiming to sustain and scale food-based interventions. It also contributes to the limited but growing body of literature on systems-level implementation of FAM programs that address both individual health outcomes and structural drivers of inequity.

Keywords
Food as Medicine, food insecurity, food is medicine, health equity, nutrition

INTRODUCTION

Food as Medicine interventions to address diet-related disparities

Food insecurity disproportionately affects individuals with lower socioeconomic status and members of racial and ethnic minority groups, who are more likely to live in communities with limited food resources [1]. National estimates suggest that approximately 13.5 million Americans live in areas without adequate access to supermarkets or large grocery stores, restricting their ability to obtain foods optimal for health [2]. Limited access to affordable, nutritious foods is closely linked to poor diet quality and a higher risk of developing chronic, diet-related conditions such as cardiovascular disease, diabetes, and certain cancers [3].

For decades, federal nutrition assistance programs such as the Supplemental Nutrition Assistance Program (SNAP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) have played a vital role in supporting healthful nutrition outcomes among low-income individuals and families. Participation in these programs is consistently linked to improved food security during the period that benefits are received [4,5]. Yet, national rates of food insecurity in the United States (US) remain high and have even increased in recent years [6]. Research indicates that benefit levels are

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KEY POINTS

- Boston Medical Center's Nourishing Our Community program, one of the nation's first Food as Medicine (FAM) initiatives, demonstrates how efforts can evolve from food access to equity-oriented, system-level strategies.
- This case study identifies key sustainability drivers and introduces a replicable, equity-focused evaluation approach grounded in implementation frameworks.
- Embedding equity-focused implementation within FAM initiatives is critical for addressing structural determinants of health beyond food access.
- Community partnerships strengthen equity goals by supporting culturally responsive services, reinvesting in local economies, and advancing community leadership.

often inadequate to fully meet household nutritional needs [7]. Moreover, eligibility restrictions and administrative hurdles continue to limit access [8], particularly for working families and for populations facing barriers such as language or transportation challenges [9].

To augment existing federal nutrition assistance programs and more directly address diet-related health disparities, the Food as Medicine (FAM) movement, also referred to as Food is Medicine, has emerged as a growing national initiative in the United States. FAM aims to reduce food and nutrition insecurity by providing a range of food-based services, including medically tailored meals, produce prescriptions, grocery support, nutrition education, and culinary skills training, all designed to improve dietary patterns and promote overall health [10].

FAM programs augment traditional federal nutrition assistance by embedding food support directly within healthcare delivery systems. Unlike broad federal-based assistance programs, FAM initiatives are medically tailored to patients' specific needs, with the explicit goal of improving health outcomes [11]. Participation often requires a medical diagnosis and referral, and in some cases, services may be reimbursed through public or private insurance. Numerous studies demonstrate that FAM interventions can improve dietary behaviors [12,13], and that FAM may serve as an effective disease prevention strategy [14].

One of the earliest examples of a FAM program was launched at Boston Medical Center (BMC), which established one of the nation's first hospital-based therapeutic food pantries in 2001 [15]. Since then, BMC's FAM initiatives have expanded to include a teaching kitchen, rooftop farms, home-delivered food prescription services, and advocacy and policy initiatives.

Building on this early example, FAM has grown over the past two decades into a nationally recognized strategy for addressing diet-related chronic disease and food insecurity [10]. This momentum culminated in the 2022 White House National Strategy on Hunger, Nutrition, and Health, which identified FAM as a policy priority and emphasized the integration of nutrition services into healthcare [16]. However, despite this progress, the healthcare landscape has undergone significant shifts. The current 2025 administration has rolled back several supportive policies, and key financial mechanisms have been rescinded [17,18].

In this uncertain time, it is more crucial than ever to build on the momentum of the past several years and learn from existing models. Nonprofit and community organizations, operating independently of federal agencies and policies, as well as health systems with sustainable internal operations, provide valuable FAM examples to study and replicate.

Misalignment of Food as Medicine and healthy equity

As historic cuts to FAM and federal nutrition programs emerge in this evolving political climate, it is critical not only to identify strategies to expand FAM initiatives but also to embed a deliberate commitment to health equity and protect vulnerable populations. Such a commitment is essential for strengthening the effectiveness of FAM interventions and advancing population health efforts to reduce future rates of food insecurity. Researchers and healthcare systems are uniquely positioned to lead this work given their ability to [1] systematically identify populations most affected by longstanding structural disinvestment and [2] develop and test strategies that bridge service delivery gaps while dismantling the inequitable structures that sustain them.

Effectively advancing health equity through FAM requires rigorous evaluation. While FAM conceptually seeks to enhance individuals' access to and capacity for nourishing themselves in ways that support health [10], most evaluations focus on outcomes such as dietary quality, food insecurity status, and health indicators [19,20]. A smaller body of research has explored patient experiences, assessing factors such as program appropriateness, cultural acceptability, and taste preferences [21,22]. Yet, relatively few studies have measured equity as an outcome, despite national calls to do so [23–25].

Specific aim

Thus, we present a case study of one of the nation's earliest FAM initiatives, highlighting the drivers

underlying its long-term sustainability, growth, and adaptability despite changes in political support [26–28]. We also describe a replicable evaluation strategy, developed over the course of two decades, to assess progress toward equity goals through implementation. Together, these contributions aim to inform the design of new FAM programs and the reform of existing ones, fostering sustainable models that more intentionally address and measure health equity outcomes.

Boston Medical Center

BMC is an integrated health system that includes an academic safety-net medical center, and a network of community health centers. It also operates WellSense Health Plan, a nonprofit insurer that provides Medicaid and Medicare coverage to more than 500 000 members in Massachusetts and New Hampshire. BMC serves a patient population in which 85% of patients have public insurance or are uninsured. Approximately 70% of BMC's patients identify as racial or ethnic minorities, and more than 30% speak a primary language other than English [29].

To address patients' nutritional needs, BMC launched its FAM program, Nourishing Our Community (NoC). Over time, this program expanded beyond food distribution to more directly address the underlying causes of food insecurity while advancing the hospital's broader health equity objectives (see Table 1 for an overview of activities and Fig. 1 for a timeline). The evolution of NoC can be understood through the Getting to Equity Framework [30], which highlights system-level strategies to promote across four domains: increasing access to healthy options, enhancing social and economic resources, removing barriers to healthy behaviors, and strengthening community capacity.

Nourishing Our Community

The origins of NoC date back to the establishment of BMC's hospital-based Therapeutic Food Pantry in 2001 [15]. Led by pediatrician Dr Deborah Frank, the initiative was founded in recognition of the profound impact of food insecurity on child health and development [15]. Patients are referred to the Therapeutic Food Pantry by a clinician or staff member and can visit the pantry every two weeks and receive approximately a three-day supply of food for their household, tailored to their medical conditions. Developed through philanthropy, the Therapeutic Food Pantry laid the foundation for broader, system-wide efforts to increase access to healthy food. To ensure long-term sustainability, the hospital launched a fundraising campaign in 2000 to secure endowed funding. These endowments, together with ongoing support from individual donors and state and federal grants, have enabled the continued growth of NoC.

In 2008, BMC expanded its FAM efforts by establishing its Teaching Kitchen, designed to provide cooking and nutrition education to a wide range of audiences, including patients, staff, trainees, and members of the broader Boston community. Two culinary-trained registered dietitian nutritionists lead classes that are frequently co-facilitated by community members, clinical partners, and volunteers. To promote accessibility, sessions can be delivered in-person or virtually in multiple languages. The Teaching Kitchen aims to build individual capacity by fostering knowledge of food and nutrition, enhancing food preparation skills, and supporting community building, ultimately promoting greater self-sufficiency in managing one's health.

In 2017, NoC expanded to include BMC's first Rooftop Farm. The farm supplies fresh produce to BMC's Therapeutic Food Pantry, Teaching Kitchen, on-site farmer's market, and food services operations, including inpatient meals and cafeteria offerings. They also support community food access through regular donations to local food assistance programs. To better reflect the cultural diversity of patients and neighborhood residents, the Rooftop Farms began cultivating crops recommended by patients and community members. The farm is run by two full-time staff members and is supported through an extensive network of individual employees and corporate volunteers. The addition of the Rooftop Farm not only strengthened institutional food procurement practices but also demonstrated the potential for urban agriculture to increase access to fresh food within the surrounding community. Building on this success, BMC launched a second farm in 2024.

During the COVID-19 pandemic, NoC program rapidly adapted its operations by transitioning the Teaching Kitchen to virtual instruction and initiating home delivery of items from the Therapeutic Food Pantry [31]. Building on the demonstrated value of these strategies in addressing both pandemic-related and longstanding barriers to FAM, BMC launched a new nutritionally appropriate food box delivery initiative in 2025 to support patients with food insecurity and qualifying medical conditions, implemented through two primary mechanisms. The first mechanism provides free food from the Greater Boston Food Bank to patients who belong to select populations and meet clinical criteria, such as being diagnosed with or at risk for malnutrition. These boxes are delivered directly to patients' homes at no cost, with delivery expenses covered by BMC. The second mechanism operates

Table 1. Activities toward equity through Boston Medical Center's Food as Medicine program

Program component	Function and intended purpose	Activities towards equity	Getting to Equity constructs
Nourishing our community program			
Therapeutic Food Pantry	Provides nutritionally appropriate food for all patients who express a need for food assistance.	Expand services to provide food delivery for patients who screen positive for food insecurity and meet clinical eligibility criteria. Actively engaging both users and nonusers to better understand acceptance, needs, and barriers to access.	Increasing healthy options
Nutritionally appropriate food box delivery program	Through a partnership with the BMC Department of Pediatrics, families with young children who meet eligibility criteria receive food boxes that include meals and ingredients sourced from a locally owned grocery store.	Partner with a community grocer to facilitate all aspects of the project, creating revenue opportunities while engaging families in shaping the contents of the boxes.	Increasing healthy options; Improve social and economic resources; Building on community capacity
Rooftop Farm	Grows food for the Therapeutic Food Pantry, Teaching Kitchen, and BMC staff (via weekly farmers market).	Distribute fresh food to local community partners and engage patients and community members in guiding crop selection.	Increasing healthy options
Teaching Kitchen	Offers culinary and nutrition education in a group format.	Engage patients through paid opportunities to co-facilitate and co-design programs, while also seeking their feedback on educational resources and class topics in both print and digital formats.	Reducing deterrents to healthy behaviors
Value-based Procurement Efforts			
Value-based procurement advisory counsel	An internal task force guiding hospital food purchasing to align cafeterias, cafés, and inpatient meals with local sourcing, patient health, and planetary health goals.	Establish the organizational goal to commit to sourcing 5% of food from local producers.	Building community capacity
Children's HealthWatch			
Policy and advocacy	A nonpartisan expert network that collects data from urban hospitals on babies and children in families facing economic hardship, and shares findings to guide evidence-based policy.	Advocate for approaching food insecurity from a broader perspective by addressing employment opportunities, equitable salaries, and the financial literacy of families.	Improving social and economic resources
Assessment and research	Design and validate food-insecurity screening tools to evaluate the nutritional status of patients at BMC and across partnering health systems.	Integrate screening tools into clinical workflows to actively identify patients who would benefit from social needs resources, including food, housing, and financial support.	Improving social and economic resources

through the Massachusetts Health-Related Social Needs reimbursement model, in which BMC's affiliated insurer, WellSense Health Plan, covers the cost of food boxes prepared by a local market and the delivery to patients from the Pediatric Primary Care Clinic, supporting families with young children at risk of food insecurity. For patients who do not qualify for these services but still express interest or need, referrals can be made to the in-person Therapeutic Food Pantry, which serves as a safety net to ensure resources are available to all patients regardless of screening status or clinical eligibility.

Value-based procurement

In addition to patient programs, BMC has embraced value-based procurement strategies that prioritize local, sustainable, and culturally relevant food

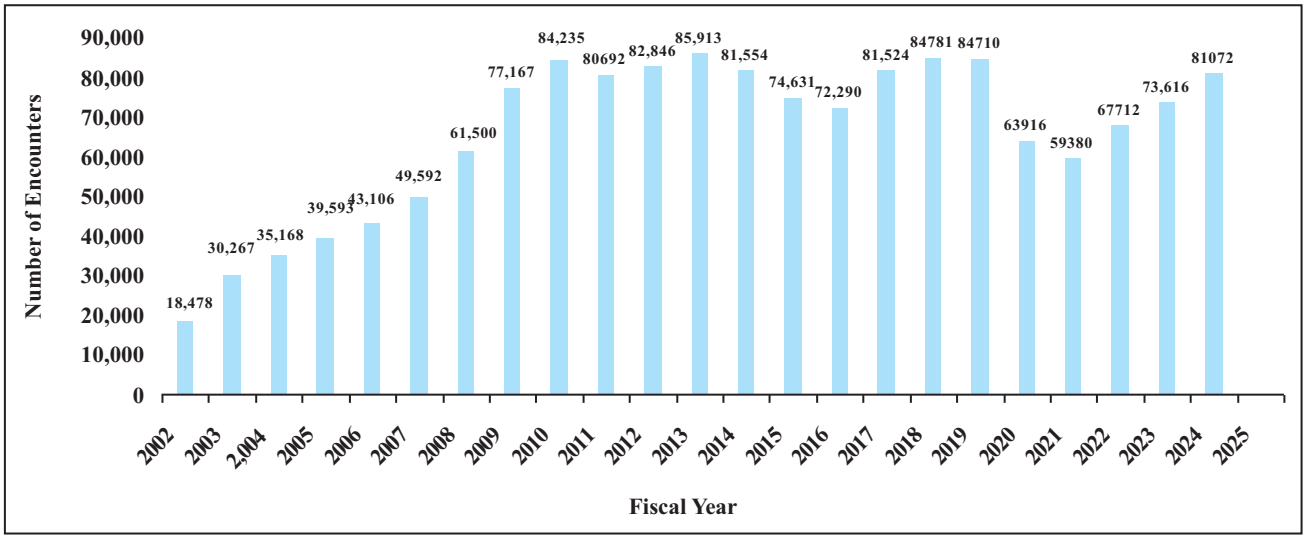

FIGURE 1. Therapeutic food pantry encounters by fiscal year.

sources as part of its broader commitment to health equity. These strategies aim to invest in local food systems by increasing patient access to healthy options and building community capacity through local purchasing, aimed at supporting economic mobility. BMC sources items for its retail food operations from local growers and food makers. In addition, BMC has invested in partnerships, such as Nubian Markets, a local café and halal butcher that celebrates the culinary traditions of the African diaspora. As part of the partnership, Nubian Markets sells prepared meals in BMC cafeterias and serves as the primary vendor for the nutritionally appropriate food box delivery programs. This collaboration ensures that patients and staff have access to culturally responsive, locally sourced foods, while directing dollars into the local food system and aiming to shift power and control of the campus food environment toward community ownership.

Children's HealthWatch

Children's HealthWatch, a nonpartisan network of pediatricians, public health researchers, and experts in children's health and policy, committed to improving the health of children in the United States is based out of BMC. The organization collects data in urban hospitals nationwide, focusing on infants and toddlers from families experiencing economic hardship. The findings are analyzed and shared with academics, policymakers, and the public to inform evidence-based policy and decision-making and help improve social and financial resources for patients.

Children's HealthWatch developed the Hunger Vital Sign™, a validated two-question food insecurity screening tool based on the U.S. Household Food Security Survey Module, designed to identify households at risk of food insecurity [32]. The Hunger Vital Sign was subsequently incorporated into BMC's electronic health record-based screening and referral model for social determinants of health [33]. Clinical settings across the health system systematically screen patients to identify those who may benefit from food-based services offered through NOCP, as well as support addressing other social determinants of health.

Evaluating health equity

For the past 20 years, the Therapeutic Food Pantry has primarily measured its success by tracking the number of individuals served and the total pounds of food distributed. These metrics rose substantially in the program's early years, remained relatively stable between 2009 and 2019, and have increased again since 2021 (see Fig. 2). While the program tracked total visits, it did not previously differentiate between new and repeat visitors, patients who were referred but never used the pantry, or the demographic characteristics of these groups. As a result, the program lacked critical insight into which populations were being underserved and how to better support them. This gap in evaluation contributed to the underutilization of the Therapeutic Food Pantry among certain populations [33,34]

Other components of NoC have historically used similar evaluation strategies, primarily tracking output-focused metrics such as the number of attendees for educational classes and the pounds of produce harvested from the Rooftop Farms. However, these measures offered limited insight into program reach, specifically, who is being served, appropriateness of

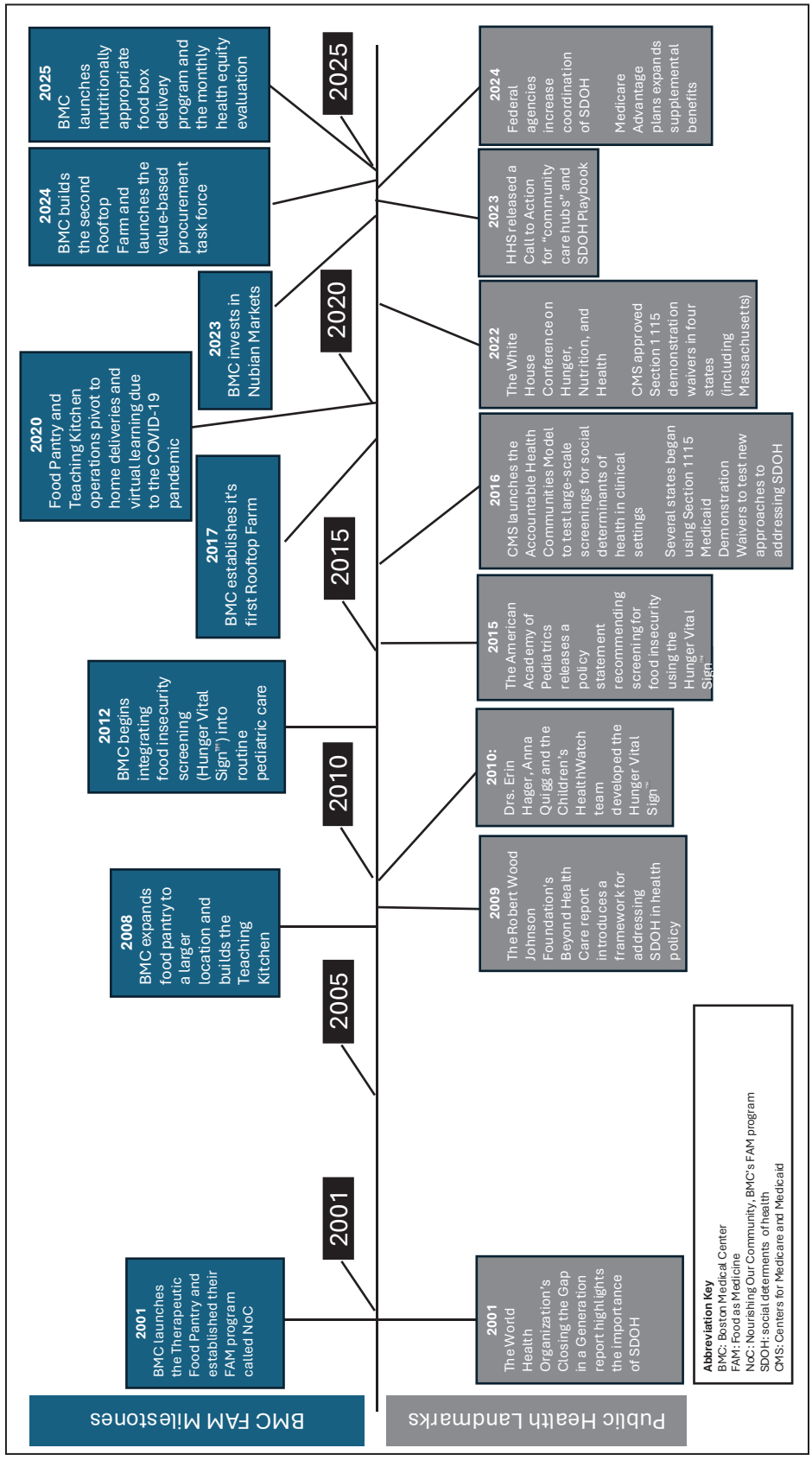

FIGURE 2. Timeline.

the service, which populations may be underserved or excluded, and how practical the interventions are in advancing not only health, but larger systemic equity outcomes.

To guide equity-centered implementation evaluation efforts, NoC leveraged Shelton's (2020) extension of the RE-AIM (reach, effectiveness, adoption, implementation, and maintenance) framework for enhancing sustainability and centering equity [28]. Below, we describe how strategies to collect data informed by this framework were integrated into existing health system workflows to enable continuous, real-time data capture among program participants, employees, and community partners.

Participant-level data on reach (e.g., the number, proportion, and representativeness of FAM participants, as well as reasons why participation is possible or not) and effectiveness (i.e., impact on health-related social needs) are collected across programs. For patients who screen positive but do not utilize the pantry, student volunteers conduct follow-up calls to identify barriers and clarify needs. These data inform the identification of health disparities and guide the development of targeted outreach strategies to engage underserved populations more effectively.

Educational programming in the Teaching Kitchen and Rooftop Farm administers surveys after classes to assess participants' experience, perceived value, and overall satisfaction. These surveys also collect feedback on class content, cultural relevance, and access logistics. Additionally, patients who register but do not attend are contacted as part of a routine quality improvement effort to identify participation barriers and inform future scheduling and outreach strategies for diverse populations.

To ground the program in patient voice and lived experience, a patient advisory committee meets quarterly to provide structured feedback on program design, delivery, and accessibility. Their insights help ensure that NoC FAM services remain relevant, respectful, and responsive to community needs, with patient experiences and preferences previously documented in published work [35].

Beyond reach alone, quantitative effectiveness data are collected within the electronic health record. Because the programs are clinically integrated, individual patients' utilization across services is tracked, and health outcomes can be extracted to address specific research questions. While health outcomes are assessed in selected projects, they are not routinely collected across all programs.

For program-level outcomes around program adoption (i.e., number, proportion, and representativeness of implementation settings), implementation (i.e., fidelity and consistency of intervention delivery), and maintenance (i.e., extent to which intervention is sustained over time at individual and organization levels), monthly surveys are distributed to NoC program managers via REDCap. Data are stored in a centralized database, allowing evaluation at the program level and subsequent aggregation for system-level analysis.

Sustainability drivers

BMC has had the opportunity and privilege to evolve and strengthen its FAM program through strong leadership support, a large volunteer network, strategic fundraising efforts, and past policy changes (see public health landmarks in Fig. 1). With a consistent organizational commitment, BMC has been able to adapt programming and operations in real-time, guided by feedback and an increasing institutional priority to address not only patient health needs but also broader goals of advancing health equity.

Partnerships with community-based organizations, such as Nubian Markets, have played a critical role in advancing system-level goals related to community engagement and food justice [36▪▪]. These collaborations facilitate access to culturally responsive, locally sourced foods for patients, while simultaneously reinvesting resources into the local food economy. Moreover, such partnerships represent a shift in power from institutionally driven food initiatives to models centered on community leadership and ownership. Through this process, community partners have established best practices and a strategic vision that increasingly guides institutional priorities [36▪▪].

BMC's diverse funding base, comprising public and private philanthropy, subsidized food sourcing from food banks, and newer reimbursement models have enabled its FAM program to remain resilient in the face of shifting political and policy landscapes. Even in the more recent political climate, as public funding for food and nutrition programs has fluctuated, philanthropic support has provided a consistent foundation, allowing the BMC FAM to continue to operate.

CONCLUSION

In recognition of its broad FAM services and institutional initiatives to advance health equity, BMC received Health Equity Accreditation from The Joint Commission in 2023 [37]. This designation affirms BMC's commitment to identifying and addressing disparities in care and outcomes, while also highlighting the institution's broader focus on integrating social care into healthcare delivery to address the root causes of health inequities. Despite this progress,

equity-focused efforts at BMC have only taken shape in the past several years, and additional data are needed to evaluate their impact. Assessing implementation outcomes through an equity lens is a crucial step in advancing FAM programs beyond single-purpose food access initiatives toward more comprehensive, disease-prevention approaches.

Health systems should continue testing and refining FAM approaches to identify best practices that move beyond improving food access to addressing the structural drivers of food insecurity (e.g., wage stagnation and income inequity, rising housing costs, food apartheid, legacy of discriminatory zoning and redlining). This case study illustrates one example of a long-standing program seeking to expand its reach and impact, serving as a model for other health systems to build upon. In doing so, we call for large health systems implementing FAM initiatives to align their operations more intentionally with equity goals, thereby strengthening program sustainability and maximizing public health benefit.

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- ■■ of outstanding interest

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