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WEST VIRGINIA ENVIRONMENTAL SCAN | 2024

Revised September 2025

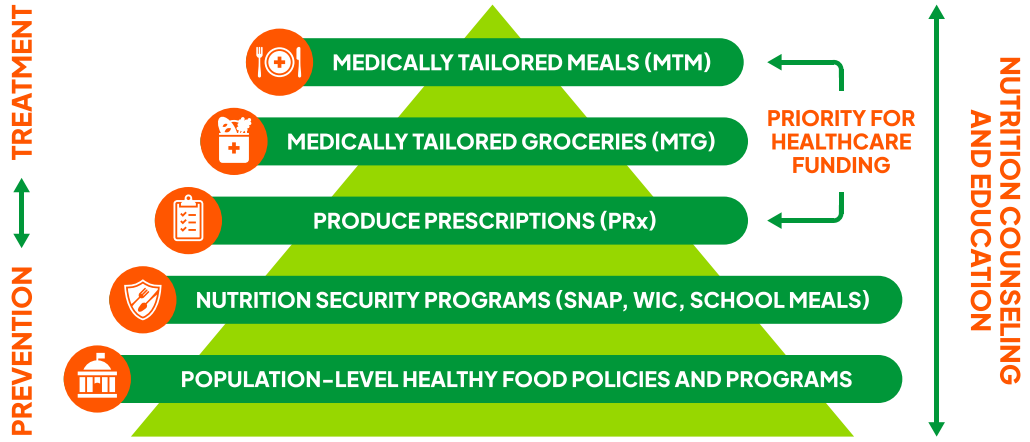
Introduction

This report provides an overview of the Food is Medicine landscape across West Virginia for the 2024 calendar year. The information was gathered to facilitate information-sharing among key stakeholders, funders, and those working in (or interested in working in) the Food is Medicine space. While lacking a universal definition, Food is Medicine interventions are often thought of as "a spectrum of programs and services that respond to the critical link between nutrition and health" and have shown promise in reducing the burdens associated with diet-sensitive chronic conditions and nutrition insecurity among vulnerable populations.[1]

Methods

In mid-August 2024, a "Request for Information" survey was emailed to the lead contacts of 14 agencies known to directly oversee implementation of Food is Medicine programs. The survey was open for three weeks and weekly reminders were sent. Respondents were asked to report on their implementation of FIM programs during the 2024 calendar year. Questions were primarily closed-ended and included identification of the physical locations of existing (or planned) programs and/or referring agencies, the number of people anticipated to be served, and range of current funding levels. Respondents were also asked to identify their priority populations, expectations for the future of their programs in terms of sustainability or expansion in the upcoming year (2025) and identify barriers to program implementation. To facilitate shared understanding of terminology and to promote consistency between responses, the following figure[2] and definitions[3] of Food is Medicine interventions were included in the survey:

Figure 1. Food is Medicine Pyramid



1. **Medically tailored meals:** home-delivered, nutritious meals customized for patients with severe chronic conditions and limitations in activities of daily living who are identified and referred by a medical provider or health care plan. Meals are designed by a Registered Dietitian Nutritionist (RDN), tailored to the patient's nutritional and medical needs.

2. **Medically tailored groceries:** Healthy, curated food products that aim to treat specific, diet-sensitive conditions and support health.

3. **Produce prescriptions:** free or discounted produce – fruits, vegetables and sometimes other healthy foods –provided to ambulatory patients based on a range of eligibility criteria.

4. **Nutrition Security Programs:** include federal, state, and charitable programs that aim to help individuals with food and nutrition security eat a better diet – e.g. SNAP, WIC and school meals.

5. **Population-level Healthy Food Policies and Programs:** Interventions to address systems and environmental barriers to healthy eating. Examples include employer-based wellness programs incentivizing healthy eating; nutrition standards for food procured by an institution (e.g. school meals, worksite cafeterias); and FDA efforts around labeling and additives.

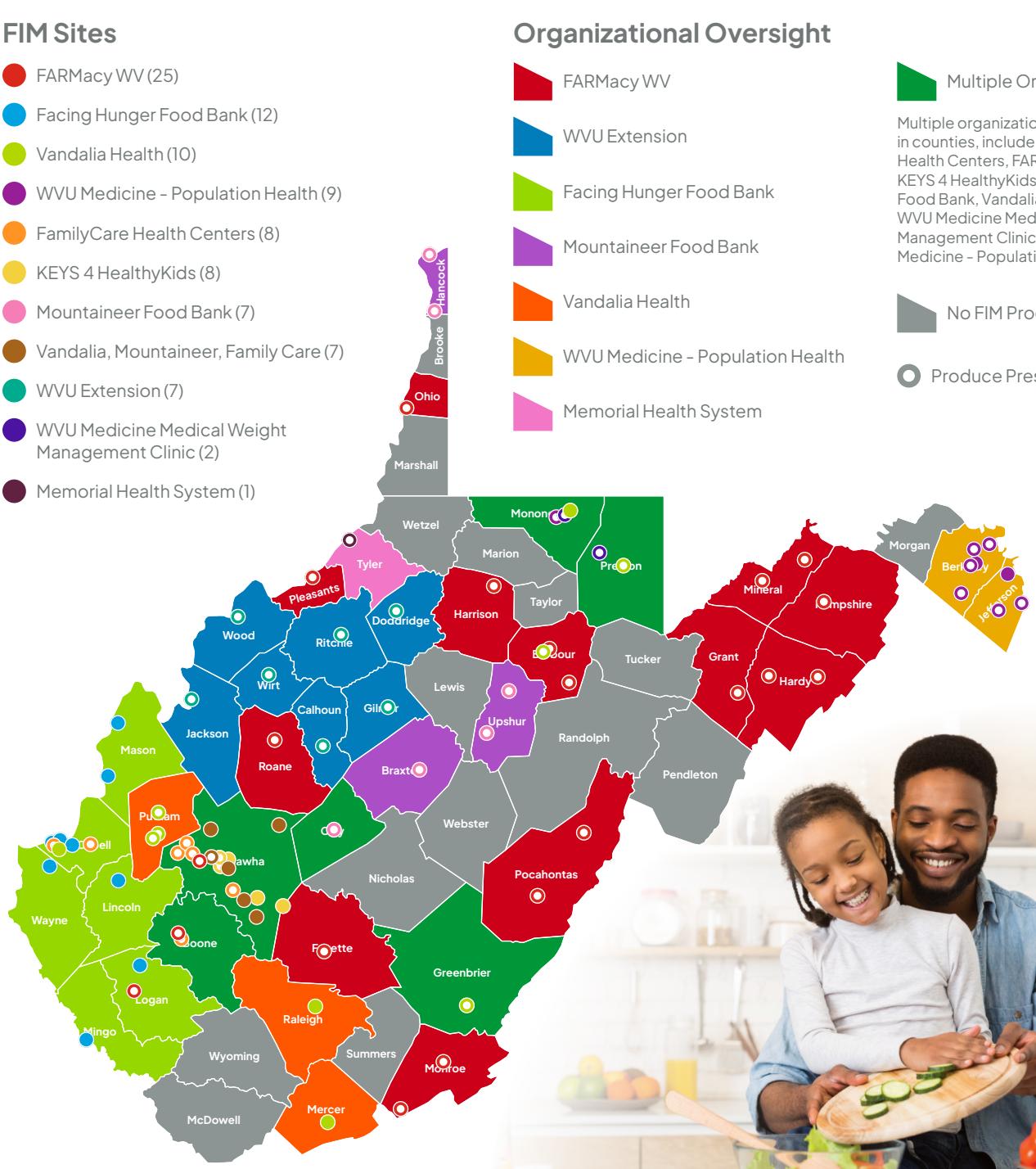
Results

The response rate was 12/14 (85.7%) and was representative of a variety of non-profit organizations, large healthcare systems, food banks, Federally Qualified Health Centers, and Extension which are identified in Figure 2.

Geographic Coverage

Forty of WV's 55 counties (76.4%) were involved in FIM programming, where involvement is defined as offering programs at physical locations or recruiting or referring patients to programs. Counties not served in 2024 were Hancock, Lewis, Marion, Marshall, McDowell, Morgan, Nicholas, Pendleton, Randolph, Summers, Taylor, Tucker, Webster, Wetzel, and Wyoming.

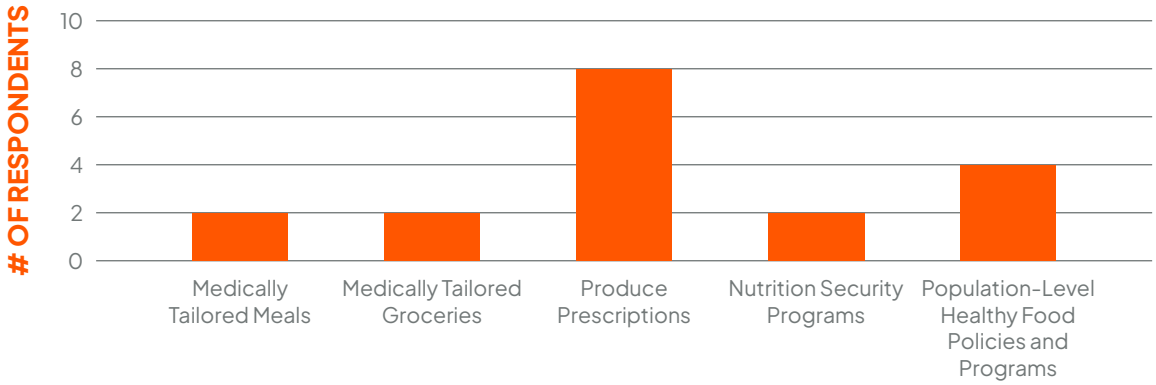
Figure 2. Food is Medicine Programs in West Virginia



Program Variety

In terms of the types of FIM programs implemented, 8/12 respondents (75%) said they offered produce prescription programs which constituted 44.4% of all responses. More than one-third (4/11) were involved in population-level healthy food programs and policies. Four respondents (36.4%) indicated they oversaw more than one type of program.

Figure 3. Frequency of Program Type Implemented

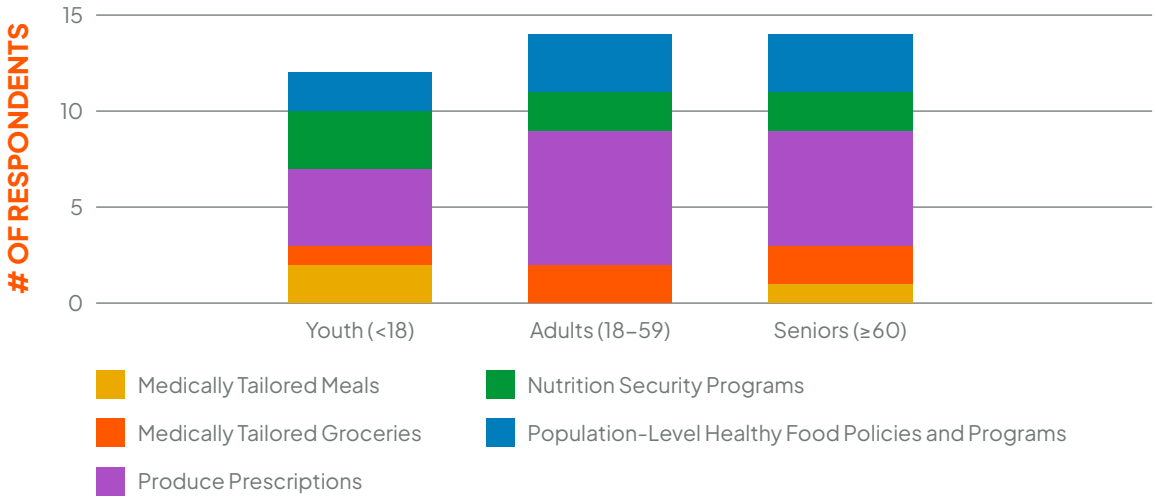


Priority Populations

Age

A mix of age groups are served by each type of program; however, no adults aged 18–59 were included in any medically tailored meal programs. Medically tailored meal and nutrition security programs appeared to target youth more often than adult populations, while adults (including older adults) were more often served by produce prescriptions and population-level healthy food program and policies.

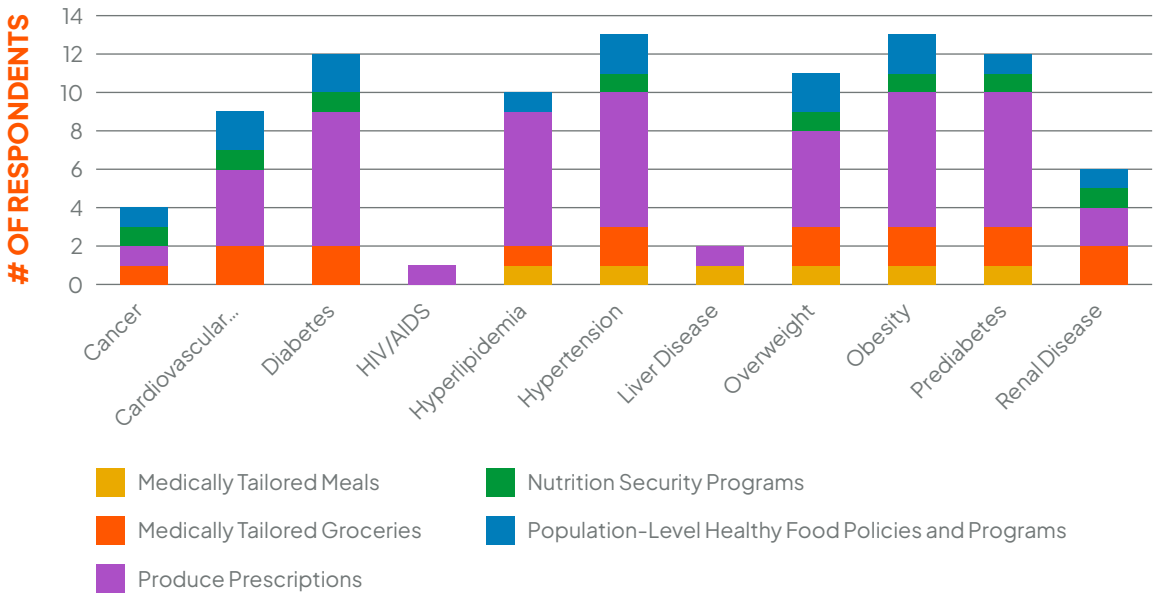
Figure 4. Frequency of Program Type by Age Group Served



Chronic Conditions

Hypertension, obesity, prediabetes, diabetes and overweight were the conditions most often prioritized by Food is Medicine programs. People with hypertension, overweight, obesity or prediabetes were served by the entire spectrum of programs within the Food is Medicine pyramid. Conditions least targeted were cancer, HIV/AIDS, liver and renal disease.

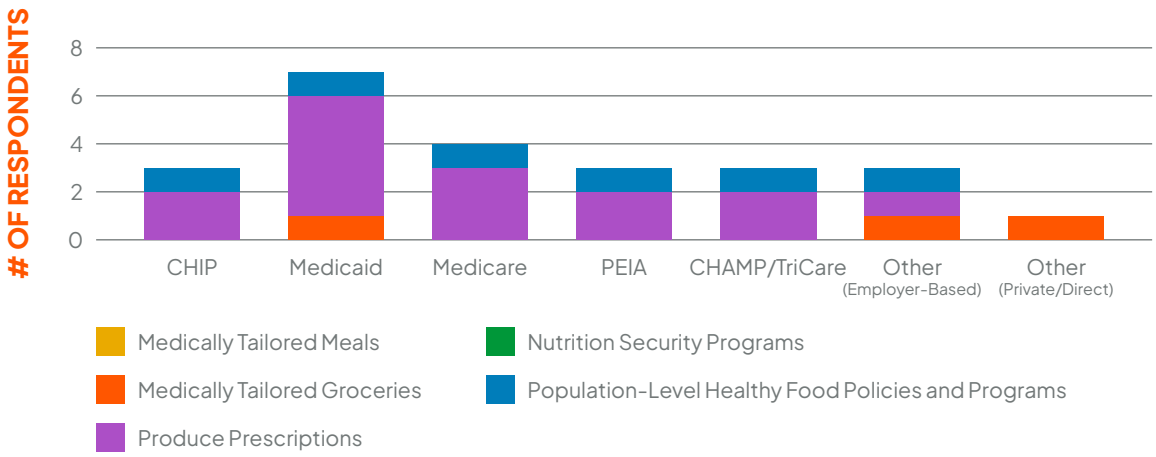
Figure 5. Frequency of Program Type by Chronic Condition



Insurance Status

People with most major insurance types were served by produce prescriptions, and population-level healthy food programs and policies. In addition to produce prescriptions and population-level programs, those with Medicaid and other employer-based or direct pay insurance were served by medically tailored grocery programs. *Note: It is possible that information regarding insurance status is not routinely asked or included as part of eligibility criteria for enrollment in FIM programs, which was noted in a comment by one respondent.*

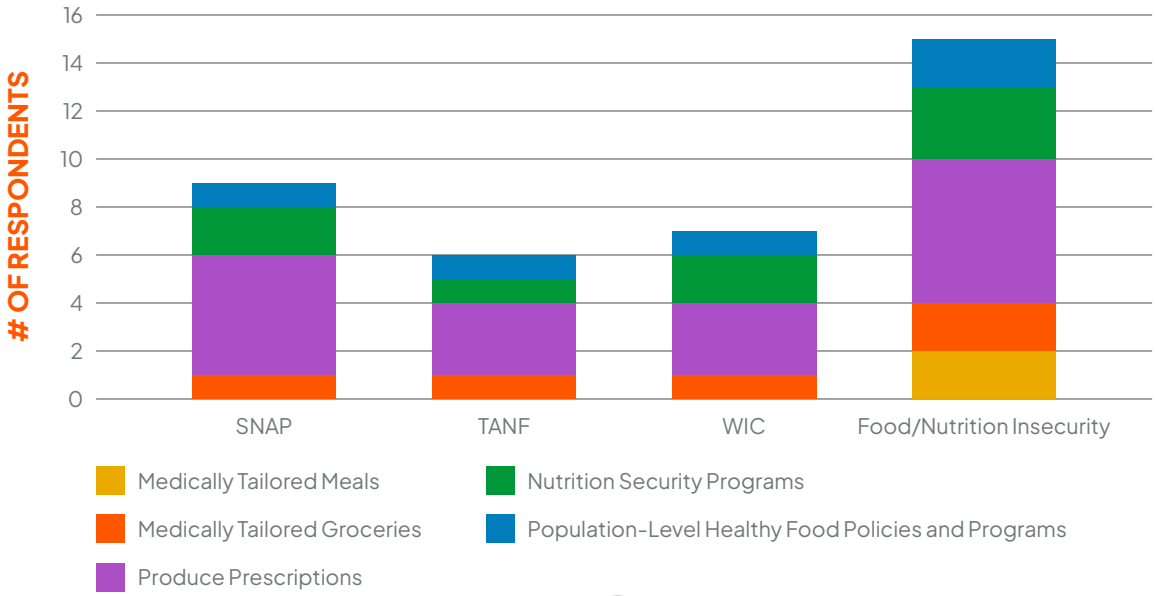
Figure 6. Frequency of Program Type by Insurance Status



Public Assistance Programs and Food/Nutrition Insecurity

All program types prioritized those with or at high risk for food/nutrition insecurity, and all programs except medically tailored meals included those who participated in the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) or the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). *Note: 4/11 respondents (36.3%) said that their programs were open to everyone, therefore specific populations or demographics were not prioritized for recruitment/enrollment.*

Figure 7. Frequency of Program Type by Assistance Programs and Food/Nutrition Insecurity



Reach and Estimated Cost

Respondents estimated serving a range of 3,200 to more than 4,000 participants through FIM interventions in 2024. Over one-third (4/11) of respondents estimated being able to serve more than 500 participants each. The estimated total budget for all programs ranged from $2,325,000 to more than$3,175,000. This yields a per participant cost range of $581–$1,161 (average $764). Most respondents (91.7%) included locally grown produce as part of their FIM interventions.

Barriers and Sustainability

When asked whether current level of programming could be sustained into 2025, most respondents said "yes" (7), while fewer said "probably yes" (4) and "probably not" (1); however when asked if they anticipated being able to expand their programs in 2025, there was less certainty; two respondents said "probably not" and five were "unsure".

In terms of barriers to program implementation the most frequently reported barrier was lack of sustainable funding, followed by challenges with participant recruitment/enrollment and participant retention. Lack of access to local produce and lack of access to administrative/organizational support were also identified as barriers. Lack of support for program implementation/coordination and lack of support for program evaluation were identified as barriers by fewer respondents.

Figure 8. Perceived Barriers to Program Implementation

References:

1.Hager K, Kummer C, Lewin-Zwerdling A, Zhongyu L. 2024 Food is Medicine Research Action Plan. Published April 2024. Accessed Sept 16, 2024 from: https://aspenfood.org/wp-content/uploads/2024/04/Food-is-Medicine- Action-Plan-2024–Final.pdf

2.Mozaffarian D, Blanck HM, Garfield KM, Wassung A, Petersen R. A Food is Medicine approach to achieve nutrition security and improve health. Nat Med. 2022;28(11):2238–2240. doi:10.1038/s41591–022–02027–3

3.Tufts University (2024). Food is Medicine Advocacy Day Flyer. Accessed September 16, 2024 from: https:// tuftsfoodismedicine.org/wp-content/uploads/2024/04/Food-is-Medicine-Flyer-v2.pdf

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Future Implications

We recognize that entities vary in their understanding and interpretation of the FIM concept, and the definitions provided to guide this survey may not be universally accepted. We see this report as the first step in laying the foundation for a comprehensive, statewide approach to FIM that will meet the unique needs of individuals and facilitate access to programs and services in our most rural and vulnerable communities. We look forward to increased engagement and involvement with a broader group of stakeholders who can inform and advance these efforts, leading to greater inclusivity, scalability and sustainability.

Special Thanks

Sincere gratitude is extended to those who responded to this request for information. We would also like to express our appreciation to Josh Lohnes from the Center for Resilient Communities, Food Justice Lab at West Virginia University for his initial creation of Figure 2 (now revised).

Go to wvfim.org to learn more.