

Food Is Medicine: Four Lessons From Incorporating Cooking Classes Into Practice

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This unconventional intervention can improve patients' quality of life.

Helping high-risk patients improve their health sometimes requires unconventional interventions that allow us to tap into our creativity and passions.

This was the case when I began treating a patient who had congestive heart failure (CHF) and end-stage renal disease requiring dialysis. She received medically tailored meals delivered to her home. As long as she ate them, she did not experience complications. But she loved to travel and did not have access to pre-made meals on her trips. During one trip, she received emergency dialysis after eating too many bratwursts at an Oktoberfest celebration. After that, I wondered about the possibility of teaching her how to prepare food appropriately for her chronic conditions. She and her family could enjoy the meals together, and she could apply the knowledge to select appropriate foods when not at home.

This idea turned into bi-weekly cooking classes involving 10 patients with CHF. A registered dietitian and I conducted the classes, demon-

strating how to prepare meals from weekly meal kits we provided and offering CHF-specific nutrition education. The classes were held in person initially, until COVID forced us to transition to live, virtual classes. Boston Medical Center (BMC) loaned us iPads and hotspots for patients, most of whom did not have the technology they needed at home. We also partnered with staff from the BMC Teaching Kitchen to make our recipes and short demonstration videos available online to patients. The website that hosted this content has since evolved into a mobile app, The Pursuit By You, which is in the pilot stage.

Two dietetic students helped develop recipes, and two project coordinators (who work as scribes in the clinic) translated our content into Spanish and helped purchase, assemble, and deliver meal-kit ingredients. In total, our team prepared 1,680 meal kits for 10 patients over 12 weeks. Meal kit costs totaled \$9,600, paid through a grant from the Family Medicine Discovers Rapid Cycle Scientific Discover and Innovation (FMD RapSDI) program. We were able to bill for group virtual nutrition visits, which covered part of my time.

WHAT WE LEARNED

Our takeaway lessons from this project include the following:


1. Supplying high-risk patients with cooking instruction and fresh, healthy food increases the likelihood that they will eat fresh, healthy food, and it improves their quality of life. Over the course of the project, we saw participants' skills, knowledge, and enthusiasm

for cooking progressively increase. Their self-reported quality-of-life scores increased, and they reported less pain/discomfort, less depression/anxiety, and fewer barriers to completing usual activities at the end of the project than at baseline.

2. Patients want to participate in programs like this. Patients were active and engaged in the cooking classes. We know they were making the recipes at home because they often texted photos to show off their meals. When our 12-week session ended, we had multiple requests to continue the classes, which we are considering.

3. Purchasing, assembling, and delivering meal kits yourself is not sustainable. While we successfully provided meal kits for 12 weeks, it was taxing and required an extra 12 hours of work per class. A better option would be to partner with a company or organization that can provide the logistical support for preparing and delivering meal kits while adhering to specified recipes and nutritional standards.

4. Things won't go as planned, but don't give up. When COVID-19 made us pivot from in-person to virtual classes, we kept moving ahead and found help at every turn, whether it was a word of encouragement, a PhD in statistics, or 10 iPads.

This was a small experiment, but I hope it encourages other physicians to look for creative ways to leverage their passions to help patients. 

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