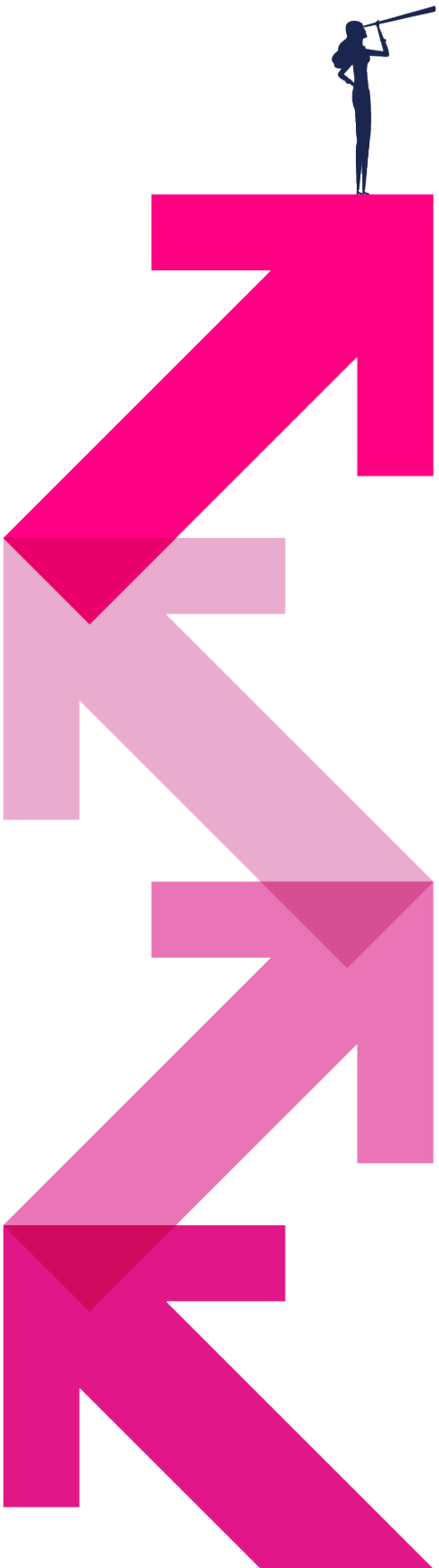


Going Beyond Food as Medicine:

How Food-Enabled Engagement Can Accelerate Clinical Improvement

Evidence from a six-month cardiometabolic health program conducted by Bento Health and La Clínica De La Raza, and supported by a grant from Kaiser Permanente

Executive Summary

Improving health outcomes among high-risk populations remains one of healthcare's greatest challenges. Even when effective interventions are available, engaging patients consistently enough to achieve meaningful, lasting improvements is difficult.

A six-month program conducted by Bento Health in partnership with La Clínica (an Oakland, CA based FQHC) provides compelling evidence for a different approach: **using healthy groceries not only as a nutritional intervention, but as a catalyst for sustained healthcare engagement.**

The Bento Health and La Clínica program has enrolled 250 patients with uncontrolled Type 2 diabetes, hypertension, or both, all of whom were on Medicaid or Medicaid-eligible. The average age was 56.6 years, and nearly half (47.6%) were managing both diabetes and hypertension.

A retrospective longitudinal analysis evaluated clinical outcomes at baseline, three months, and six months, adjusting for measured patient characteristics and program engagement. **The Bento Health program demonstrated substantial improvements in patient engagement, healthcare participation, and clinical outcomes:**



Rapid, meaningful improvement in glycemic control

Average HbA1c declined by 0.9 percentage points within the first three months (8.9% to 8.0%), reaching a 1.3-percentage-point reduction by six months (7.6%; $p<0.001$).



Even greater improvement among a smaller group of the highest-risk patients

A subgroup with severely elevated baseline HbA1c and systolic blood pressure experienced an average 2.25-percentage-point reduction HbA1c (11.2% to 8.95%) and a 9.0 mmHg reduction (143.0 mmHg to 134 mmHg) in systolic blood pressure over six months.



Turning engagement into healthcare action

Following baseline clinical assessments, Bento Health coordinated additional primary care visits and laboratory testing at three and six months, achieving reported completion rates exceeding 80% at both milestones. Patients also completed an average of 8 coaching calls each.



Sustained patient engagement

Six-month program retention reached up to 93.3%.



Improvement across additional cardiometabolic measures

Average triglycerides declined by 49.6 mg/dL, total cholesterol by 10.1 mg/dL, and BMI by 0.4, with statistically significant changes in adjusted longitudinal analyses.



Importantly, the analysis also found that patients with greater engagement in Bento Health Care Navigation touchpoints had significantly lower HbA1c levels than those with fewer interactions, even after adjustment for measured covariates ($p<0.01$).

These findings demonstrate more than improvements in clinical biomarkers. They show how an integrated model combining food access and personalized Care Navigation can sustain patient participation, support completion of important healthcare activities, and accompany substantial clinical improvements within a relatively short period.

Food as an Engagement Catalyst

Traditional healthcare programs often begin by asking patients to take action before establishing trust. For high-risk patients facing complex health and social challenges, this creates barriers to engagement. Bento Health takes a different approach by beginning with something of immediate, tangible value: healthy, personalized groceries that patients select themselves. Once Bento Health becomes a trusted weekly resource, the Care Navigation team can begin to nudge members toward deeper engagement with other healthcare resources such as lab work, PCP visits, and cancer screenings.

Combined with ongoing Care Navigation, groceries create recurring opportunities to build trust, address barriers, and support healthier behaviors. The goal extends beyond improving nutrition. Food becomes the catalyst for sustained engagement in the healthcare activities that improve health outcomes.

Substantial Clinical Improvements in Just Six Months

Rapid Improvement in Glycemic Control

One of the program's most compelling findings was the speed and magnitude of improvement in blood sugar control.

Among patients with Type 2 diabetes, mean HbA1c declined from 8.9% at baseline to 8.0% after just three months—a 0.9-percentage-point improvement. By six months, average HbA1c had declined further to 7.6%, representing a 1.3-percentage-point improvement in just six months ($p<0.001$).

Nearly a full percentage point of improvement was evident within the first three months, with further gains by month six. These results demonstrate substantial improvement in glycemic control over a relatively short period for patients managing chronic cardiometabolic conditions.



Improvements Beyond Blood Sugar

The analysis also identified statistically significant improvements in other cardiometabolic risk factors:

Clinical Measure	Baseline	6 Months	Change
HbA1c (diabetes cohort)	8.9%	7.6%	**–1.3%**
Triglycerides	222.3 mg/dL	172.7 mg/dL	**–49.6 mg/dL**
Total cholesterol	179.5 mg/dL	169.4 mg/dL	**–10.1 mg/dL**
BMI	32.1	31.7	**–0.4**

Together, these results demonstrate substantial, statistically significant improvements across multiple cardiometabolic risk factors in just six months—not just blood sugar control.

Greater Improvements Among Patients With Multiple Chronic Conditions

The program also demonstrated substantial improvements among patients managing both Type 2 diabetes and hypertension—a population facing elevated clinical complexity.

Of the 250 patients, 119 (47.6%) had both conditions. **Within this group, the reported average six-month improvements were:**

- 1.34-percentage-point reduction in HbA1c
- 4.85 mmHg reduction in systolic blood pressure

The most pronounced improvements were observed among a smaller subgroup with particularly elevated baseline risk, defined by HbA1c of at least 10.0% and systolic blood pressure of at least 145 mmHg. **Over six months, this subgroup experienced:**

- 2.25-percentage-point average reduction in HbA1c
- 9.0 mmHg average reduction in systolic blood pressure

These findings are particularly relevant for health plans managing patients with multiple uncontrolled chronic conditions. They demonstrate that substantial clinical improvements were observed even among patients entering the program with some of the highest levels of cardiometabolic risk.

Turning Engagement Into Healthcare Participation

For health plans, engaging high-risk patients is only the beginning. The greater challenge is converting that engagement into meaningful healthcare participation, particularly consistent primary care visits, laboratory testing, and chronic disease management.

Bento Health's Care Navigation model was designed to do exactly that.

Following patients' initial primary care visits and baseline laboratory testing, Bento Health care navigators worked with patients and their primary care providers to coordinate two additional rounds of primary care checkups and laboratory testing at three and six months. This structured approach created recurring opportunities to monitor clinical progress, address barriers to care, and support patients in following through with recommended healthcare activities.

The program achieved six-month retention rates of up to 93.3%, alongside consistently high completion rates for follow-up healthcare activities:

Follow-Up Milestone	Laboratory Completion	PCP Visit Completion
3 Months	88.0%	87.6%
6 Months	85.3%	84.5%

Reported completion rates exceeded 80% for both laboratory testing and primary care visits at each follow-up milestone, demonstrating the program's ability to translate ongoing engagement into meaningful healthcare participation.

For health plans struggling to engage members in recommended care, this represents a valuable capability: helping patients remain connected to their healthcare providers and complete the activities necessary for effective chronic disease management.



The Engagement Connection: Why Care Navigation Matters

One of the study's most important findings was the relationship between sustained patient engagement and improved clinical outcomes.

Patients with more frequent Care Navigation interactions demonstrated significantly better glycemic control. Among patients with diabetes, those receiving the most coaching calls had significantly lower HbA1c levels than those receiving the fewest, even after adjusting for measured patient characteristics ($p<0.01$).

Notably, the number of grocery orders was not significantly associated with HbA1c in the same analysis.

This finding provides evidence consistent with a central premise of Bento Health's Food as Engagement model:



Groceries provide immediate value and help create opportunities for ongoing engagement...

+



...while personalized Care Navigation supports healthier behaviors and meaningful healthcare action.

The high rates of follow-up PCP visits and laboratory completion provide additional evidence of the healthcare participation that Bento Health's model is designed to encourage.

Food creates the opportunity to engage. Care Navigation helps turn that engagement into meaningful healthcare action.

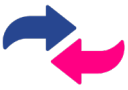
Implications for Health Plans

For health plans and risk bearing providers, these findings make a compelling case for rethinking Food as Medicine as more than a standalone nutritional benefit.

When integrated with personalized Care Navigation, food access can serve as part of a broader engagement strategy aligned with several health plan priorities:



Clinical quality (HEDIS & Star Ratings):
Supporting improvements in glycemic control and other cardiometabolic measures relevant to chronic disease management.



Care-gap closure:
Helping patients participate in follow-up primary care and complete laboratory testing, with reported completion rates exceeding 80% at three and six months.



Sustained member engagement:
Using recurring grocery access and personalized support to maintain ongoing relationships, with program retention reaching up to 93.3% at six months.



High-risk population management:
Demonstrating substantial observed improvements among patients managing multiple chronic conditions, including those with severely elevated baseline risk.



Economic value:
Addressing risk factors associated with costly complications, while creating opportunities for future evaluation of utilization and total cost of care.

The opportunity for health plans extends beyond purchasing a nutritional benefit. It is the potential to invest in an engagement model that helps members connect with existing healthcare resources, participate in recommended care, and achieve better clinical outcomes.

Conclusion: Beyond Food as Medicine

The future of Food as Medicine may depend not only on what food does for patients, but on what food inspires patients to do.

The Bento Health and La Clínica program demonstrated substantial clinical improvements in a relatively short period. Average HbA1c improved by 0.9 percentage points within three months and 1.3 points by six months, alongside statistically significant improvements in triglycerides, cholesterol, and BMI. Among a small subgroup of patients with severely elevated baseline HbA1c

and blood pressure, average improvements were even greater, including a 2.25-percentage-point reduction in HbA1c over six months.

Equally important, following baseline clinical assessments, Bento Health coordinated additional primary care visits and laboratory testing at three and six months, achieving reported completion rates exceeding 80% at both follow-up milestones. Six-month program retention reached up to 93.3%, and greater engagement with Care Navigation was significantly associated with better glycemic outcomes.

Together, these findings present a compelling picture of what an integrated Food as Medicine + Care Navigation model can accomplish: sustained engagement, meaningful healthcare participation, and substantial improvements in clinical outcomes.

For health plans seeking to improve outcomes among high-risk populations, the message is clear: use food not only to nourish members, but to engage them in the healthcare activities that can improve their lives.

About Bento Health

Bento Health is a patient engagement company that improves health outcomes for our nation's highest-risk and hardest-to-reach individuals through our best-in-class medically tailored groceries, Care Navigation and coaching.

Learn more: gobento.com

>> Click here to schedule a demo

About La Clínica De La Raza

La Clínica was founded in 1971 to address health barriers and create better lives for the underserved. Today, La Clínica is the first choice for providing multi-lingual, accessible full-scope health care services in the East Bay, no matter a patient's income level or insurance status.

Learn more: laclinica.org