Kristin Gecan: 
Welcome to With Intent, a podcast from IIT Institute of Design about how design permeates our world, whether we call it design or not. I'm Kristin Gecan.

Today you can fill a prescription for food. Walk into a pharmacy in San Francisco to pick it up. This episode I talk to Dr. Rita Nguyen, the person who's made this possible. Rita believes that doctors should be able to prescribe food and that the healthcare system should pay for it. Trained as a physician and currently assistant health officer at the San Francisco Department of Public Health, she's also founder of the Food as Medicine Collaborative. Rita talks about how she's scaling the collaborative, and how she got interested in design as a way of achieving her goals.

Coming from a healthcare background, coming from the field of medicine, how did you get interested in design?

Rita Nguyen:
That's a fascinating question. I had no idea what design was until a friend of mine put the Stanford d.school fellowship in front of me and said, "You should apply." And because I didn't know what design was, I didn't even understand how it fit within what I was doing, but she did because she understood design could do for I was trying to accomplish. And I ended up applying and getting the Civic Innovation fellowship out of the Stanford d.school. And that's where I really picked up my design chops and even understood what it was, how to apply it. And honestly, coming from a medical background and training, it was just incredibly eye opening because it's a totally different way of thinking.

Kristin Gecan:
So then maybe we should back up a little bit further too and find out how you got into healthcare. What fed your interest there?

Rita Nguyen:
I think I've always been committed to social justice and recognizing the inequities around me. I don't know. I just remember growing up that, I think I was always acutely aware of my privilege. So even though I'm, I don't know how folks call it, first or second generation immigrant, but my parents came over. So I was born here. And they literally came over with nothing because they were escaping a war in Vietnam. But I do acknowledge that the privilege they had was that they were educated. So even though they didn't have any money or belongings when they came as refugees, the fact that they were educated was already a place of privilege that others didn't have. And so I was lucky enough that because of their education they were able to get jobs. They had to get retrained in the US and all that, but then I grew up in a household where I had two college graduate working parents.

And I recognized that my life was comfortable. I didn't have trauma. I didn't lack resources. But growing up on the east side of San Jose, a lot of my friends did. And I think I always just immediately recognized the inequities that were surrounding me. And I don't know. It just always got to me. It was like, well, I just happened to be born in this family. I just happened to get these resources. And so I think a lot of what drive my work is social justice.

And then there was something about health that seemed very concrete to me, that was like, obviously I want people to be healthy. So medicine wasn't always the path I knew I wanted to go on. I think I was always interested in the concept of public health and community health, and how do we uplift the health of entire societies? I could see a path with clinical medicine. It didn't take me long after getting all my training done to then find my way back to public health. So right
now I only see patients maybe 10% of the time, and the rest of my time is committed to public health, community health, how do we fix societies to be better and healthier?

Kristin Gecan:
So if we think about what you mentioned earlier, this friend kind of came to you and knew that this design tool set would be of service to you in some way. And you are already coming with this social justice mindset. How did you start to see that there were underlying systemic issues that needed to be addressed? Do you have a moment or a story in which you sort of realized, oh, I need a different way to confront this.

Rita Nguyen:
I think I recognized relatively early on that's systems issues was what I needed to address, that it wasn't enough to treat patients one on one. I mean, a lot of what brought me to clinical medicine was the experience I had in college around a free clinic. And so it was very satisfying, gratifying to have someone in front of you and give them something, and be able to hear their ailments and literally just give them medicine because we were a free clinic.

But then very quickly I was like, who's keeping an eye on you after you leave here? The 20 minute encounter I had with you, and now you have to navigate a system because you have Parkinson's and you don't speak English and you need to go see a neurologist. I was working on the back end of the clinic, trying to connect people to all those other things they needed beyond the 20 minute encounter with me.

I think I just became very frustrated with the system that we work in and the constraints and how difficult it made for people to access healthcare, or honestly when it comes to social determinants of health, just the basics of living with dignity. I think I've always had the framing of, it's gratifying to see the impact one on one, but I need to do something about the system that underlies it because these feel like band aids.

Part of my frustration was that I felt like we were working within a disease care system rather than a healthcare system. That we've set up systems to just tackle specific diseases, but not looking at a whole person or thinking about, how do I actually get to the outcome I want? Which is healthy, thriving communities. And so with that lens, and thinking about food security is a major social determinant of health, that's where the concept of the Food as Medicine Collaborative came out of. It's like, how do we really start to reimagine what the healthcare system could be doing differently to actually get to this goal of healthy thriving communities, rather than just, let's deliver disease care. And the concept there was really to get healthcare systems to own food security as a health issue, not just this moral issue that nonprofits and public health departments had to worry about. But if you actually want to make your patients healthy, you have to address the fact that they don't have access to healthy food, nor do they sometimes know what to do with it.

And so what the Food as Medicine Collaborative does is, we are a multi-sector collaboration comprised of nonprofits, government, food businesses, researchers, academia, who are trying to bring together the food system and health systems to promote greater health equity by addressing food insecurity. And so we wanted to tangibly provide an intervention for healthcare to recognize how they could actually do this work. And so programmatically, it manifested as what we called food pharmacies, where just an onsite entity that allowed doctors to prescribe healthy foods to their patients and the patients could actually fill it onsite like you would at a pharmacy.

And we didn't want food pharmacies to merely be a food dispensary, because I think the goal here isn't to turn clinics and healthcare into grocery stores and food pantries. I think that doesn't
quite leverage the full potential of healthcare and what we could be doing for patients. But it was really about, how do you really marry this idea that food and nutrition is critical to your health? We're not just paying lip service to it. We're making it possible. We're enabling it. But pairing it with other skills and tool sets so that you can actually use the food. **So it's not just a handout, but it's paired with nutrition education.** We have cooking demonstrations with our nutritionist there. We also give out tools to patients, because a lot of our patients don't have kitchens even, and so they need things like crock pot or cutting boards or knives, even to just get started. And then the final key piece to it is connecting them to the food safety net. Because I'm not saying that healthcare needs to own food security. I'm saying healthcare needs to have a role in it. We can't pretend that this doesn't affect our patients. And we occupy about a fifth of the GDP for the country. If you could get healthcare to care about these things and invest in it, then you could really have an impact on healthy communities.

And so it started with the programmatic element, but we always had systems and policy change in mind. So we first started off with the pilot that the d.school helped us get off the ground. And then **within a year we had three food pharmacies at clinics. In the next five years we now have 16 food pharmacies across five health systems in San Francisco.**

So we were really scaling a programmatic intervention, but seeing the systems change. All these clinics and health systems were starting to really buy in, that this is work we should be doing. We should be investing in this. And we leveraged that to get them to organize around a statewide policy ask so that Medicaid, which is the health insurance for low income and pregnant women and kids and so forth, to actually pay for food as a covered medical benefit, so that in the same way that insurance pays for your diabetes or your hypertension pills, they should be paying for your food because that will also make you well.

And so after about a year and a half of work, Medicaid in California actually included it in our next waiver. And so that was a huge win for this body of work, is that we started from these programs that were helping one-on-one people, changing a system in healthcare, but then having statewide policy change to actually funnel healthcare dollars to support food security and what was underlying health disparities.

**Kristin Gecan:**

So, can you walk me through how this actually works for an individual? How do they get connected to it and what happens when they do?

**Rita Nguyen:**

A key piece to how we approach this work was through a health equity lens, and so we were very purposeful about who would get access to food pharmacies. It's referral based. It's just kind of like a prescription. You can't just show up at a pharmacy and say, I want morphine. It has to be prescribed to you. So we would message to providers that they could prescribe food pharmacy as an intervention to certain patients.

And also much of this work was designed with a race equity lens. And so we looked in San Francisco and who was having the most disproportionate health disparities in the city, and it was Black African Americans in San Francisco. And so we really wanted to prioritize those patients, because as you can imagine, demand was much greater than supply, so we had to really focus, what's the population?

And so, providers could write prescriptions to a food pharmacy. So you would show up and you would say, hi, I'm Kristin. And it's very much so a farmer's market style in a lot of our clinics. And that was intentional. We didn't want this sterile, uninspiring environment that
healthcare sometimes has. And sometimes people associate healthcare and food with a message of restriction and no, like, don't eat this, don't eat that. You can't do this. You can't do that. And it's not really a message of inspiration or hope or enabling patients to feel self-empowered. So these are some of the concepts that I got out of my experience with design. How do we create experiences that empower patients to be active advocates of their own health rather than these passive recipients of healthcare? And so the experience is informed by design and being intentional about how you want people to feel when they're there.

But anyway, you show up and all the foods have been selected by our registered dieticians. And there are stations throughout where folks are giving people as much produce as they can pretty much carry home. And then registered dieticians are there, volunteers are there providing nutrition, education, and recipe cards. And then there's various stations to also ... For example, there's like a cooking demonstration station with a registered dietician. And then we also have a referrals table that helps connect people to local resources.

So when you walk into it, it's a lively environment. There's food, but there's also healthcare professionals there. There's also referrals. Most of our sites we actually have either a physician or a pharmacist who's actually talking to patients about their health issue, whether it be hypertension or diabetes, and also making adjustments to their medications. And so there's really this marrying of the concept that, food actually is really core to my health and healthcare is delivering this to me. We've heard patients say through our focus groups that they really see that concept when it gets tied to healthcare, and they pay more attention to their numbers. They're excited to get their blood pressure checked on site because they're thinking about, what did I eat this last week? It's going to show in my numbers. Which I think is great. It's like, yes, you are empowered to make an impact on your health. You don't just have to receive our pills and take it.

Kristin Gecan:

You mentioned that you identified this particular population that was prioritized, and that you had to talk a lot about race as you were, I think, maybe putting the collaborative together and figuring out how you were going to deliver these services. So could you just give me a little bit of a flavor for what those conversations looked like? I'm sure there were uncomfortable moments and then there were some rays of light. And how this came together for you.

Rita Nguyen:

I would say that race equity, in many ways, laid the foundations for this work to scale. And what I mean by that is that the San Francisco Department of Public Health had already committed in 2014 to really focusing on health disparities in Black African American communities in San Francisco. So the whole department was really trying to walk the walk of saying, we do tackle health disparities and what are we doing for this community in San Francisco that has the worst health outcomes. That and Pacific Islanders. And the system had bought into the idea that we need to start being intentional about our interventions and who gets access to our interventions.

I think what's important to recognize is when you're trying to design an intervention that is very intentionally tackling race equity issues, that you have to recognize that you can't just off the bat do that. It requires a lot of culture change underneath it for a system to buy into why we need to be an anti-racist organization that is specifically calling out race and anti-Black racism. I can't take credit for all that background work, but we were certainly part of it.

To be concrete, if you were to first start asking clinics, we want you to prioritize Black African American patients for this intervention. So we want you to call them up and invite them personally. And for the other patients, they don't get such high touch support. You can imagine

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there's resistance at first where it's like, well, what about my ethnic group? Why are they getting special treatment? Why are they getting more? So a lot of the work actually has to start with confronting racism and anti-Black racism and how it manifests and the repercussions it has for that community.

And so it took literally took years, and we're still on the journey of having even just our staff recognize that anti-Black racism is so prevalent. And in order to do something about it, you actually have to really embrace and pursue equity and thinking about disproportionately investing resources and efforts into communities that have been historically disinvested in and structurally oppressed. A lot of that work was culture change. A lot of that was messaging around why we were even doing this and getting folks to buy in. That then allowed us to actually prioritize patients for the program itself.

What I've heard from other colleagues and efforts to address racism is that if you don't approach it with nuance and purposefulness and just a lot of thought, you could actually do more harm than good. So if you bring your staff in at too late of a stage to address anti-Black racism, it could actually worsen race relations. So I think figuring out where to start from and engaging that conversation is important. And we benefited from the expertise of many leaders and experts who talk about race relations. So I think you got to do it right.

Kristin Gecan:
So we talked a little bit earlier about the difference between treating a patient individually, being able to have that satisfaction of seeing that impact being made there, and then moving to the systems level. There, you run the risk of being a bit more removed, not maybe being able to sort of that human aspect of it quite as much. And also not being able to sort of bear witness to what's working, what's not working. Have you experienced that or noticed that? Or are there ways that you've tried to make sure that you're able to iterate and improve?

Rita Nguyen:
I think that is one of the greatest challenges of applying human centered design to systems change. Because I by no means think of myself as an actual designer or an expert in design. I was lucky enough to be exposed to it and trained in some of the skills. I felt like design was particularly good for creating user-centered products and experiences. So, very much so focused on the individual. I think it was harder for me to recognize how to apply some of those frameworks and tools to large scale systems change. And I think the way I'm reconciling it is that design is one of many tools that a change agent can employ to impact large scale change. So depending on what your goal is, you would use design, or sometimes you would use research, or sometimes you would use Lean process improvement methodology.

So I've seen design as one of my tools in my toolkit of how I want to affect change in my community. And I do think it's particularly good for the programmatic elements of what I'm to get done. There are mindsets within design that I think are applicable across the board, like showing more than telling, for example, or radical collaboration. Those design mindsets I think apply more across the spectrum in terms of what you're trying to get done.

In our work at the Food as Medicine Collaborative, we are so intentional that our goal is systems change, but at the same time we can't lose sight of the whole point of all this was to actually impact people's lives. And I think it's reflected in our work. We started out with a program that patients love, that they kept coming back to. If we hadn't designed a good program, then it wouldn't have scaled. If it didn't scale, health systems wouldn't have bought into it. And then I couldn't have done all the policy work we did on the other end.

Rita Nguyen (19:17):
So I think there's a balance to be struck and different skill sets to be used depending on what you're trying to get done. I think it also falls down on values, if you stick close to your values. I don't think we would ever tolerate a program that was disrespectful or uninviting. We, I think, naturally have designed something that will meet people's needs, but also be a positive experience, while also balancing the other goals that we're trying to accomplish beyond a killer program.

Kristin Gecan:
So, what is your dream for it? Ultimately, it has scaled. It is scaling. What's sort of the big goal that you're alluding to? What are you after?

Rita Nguyen:
So one of our biggest goals is having healthcare pay for food, and we're getting there. **There's a mechanism for Medicaid in California to pay for food now, but our next goal is Medicare.** So between Medicare and Medicaid, they are the largest payers of healthcare, especially for vulnerable people in the country. So Medicare is more for disabled and older adults, and those on dialysis and so forth. We want private health insurers to also pay for food. So we want it to become the norm. Food is just part of medical care and that you should be able to have access to it, to manage your chronic diseases like hypertension and diabetes.

And the Food as Medicine Collaborative, even though in San Francisco we're most tangibly known for our food pharmacy intervention, whenever we interface with another healthcare system, we say that we are agnostic to the intervention. You don't have to have a food pharmacy. Maybe you want grocery bags to be delivered, or maybe you want food vouchers so that your patients can go buy these foods at the grocery store. The reason why we coined it the Food as Medicine Collaborative and not the Food Pharmacy Collaborative is that we are not wedded to this one intervention. We just want food and healthcare to work together, whatever form that takes and makes sense for patients in the healthcare system they're in. It's more buying into this concept that healthcare needs to pay attention to food security and do something about it and not wait for nonprofit and healthcare to just tackle this problem on their own.

Kristin Gecan:
You mentioned hypertension, diabetes. People with these particular conditions are able to access the Food as Medicine Collaborative. Is there a longer list of conditions?

Rita Nguyen:
I mean, as you can imagine, the list is essentially limitless. The true prevention would be like how do you intervene with somebody before they got diabetes or before they became obese or had kidney disease. A huge number of health conditions are diet sensitive or diet related. And so our group has thought about that comprehensive list. And just trying to think realistically, we can't ask healthcare for all of that all at once. So we have to prioritize certain diagnoses that seem more obviously tied to diet than others. But honestly, depression and anxiety, the outcomes there related to how people eat as well. Right now we phrase it as medically supportive food and nutrition to really hone in on the fact that this is to support medically your health. And again, this is being strategic with healthcare. They want us to speak their lingo. I get it. They don't want to become food pantries, nor should they. And so they need to think strategically about, how do we invest in medically supportive food to advance medical outcomes.
Kristin Gecan:
And by starting with these, sort of the short list, then you're able to provide the evidence that it works and then move on to other conditions.

Rita Nguyen:
Exactly.

Kristin Gecan:
We talked about how you were introduced to design. How would you define design?

Rita Nguyen:
I would say **human-centered design is an approach to tackling a problem that is rooted in empathy for the user.** I think it is an approach to innovation and thinking differently and creating differently, that really is based in empathy for who you're designing for. And under that premise, if you base what you're trying to do in an understanding and empathy for your user, it leads to better products that are more informed by what people actually want and can use and love.

Kristin Gecan:
And so along the same lines, the title of our panel a couple weeks ago was, For Whom Am I Making This? And that is part of this Latham series where we're thinking about these fundamental questions. Why am I making this? For whom am I making this? Do you ask yourself those types of questions from time to time as you're thinking about the important work that you're doing, and just kind of grounding it and kind of coming back to purpose?

Rita Nguyen:
I would say I don't in terms of the people I'm trying to serve, but I do when I'm trying to ask myself, **am I designing this for people or am I designing this for systems?** That's the contradiction I feel internally. It's quite obvious to me, my commitment to mission and my commitment to equity. That's not hard for me to remind myself that this is for the communities that are most depressed and disenfranchised, and in our society it's often Black African Americans. Pacific Islanders is quite comparable in terms of their health outcomes. I think what I struggle with more, and I think it's just a process for me of just acknowledging that I'm also really targeting healthcare as a target. I want healthcare to change. I want them to evolve. And so a lot of what I do focuses on, how do I get them to change? I'm designing for them in many respects. I think part of where my struggle with this comes from is that framing that I introduced around the health impact partners. They have a framework where they think about ... Most people think about the health inequities. People of color are dying from heart attacks more than others. You go deeper then you're looking at social determinants of health around food, housing, education, so forth. And then you go deeper than that and then you're looking at power imbalances and structural oppression and racism.

And so where I struggle is that the intervention at that deepest level is to put power in the hands of those that have been disenfranchised. And sometimes I struggle with whether or not that's what I'm doing if I'm rectifying the healthcare system. Again, I recognize that our interventions are giving more resources to those that are disenfranchised, which in some levels may be power, but somehow it feels like a more removed version of power than just giving power to the people directly.
Honestly, if you just gave people money. Poverty is a lot of this, right? If people just had more money, a lot of these issues wouldn't exist. And I think where I've landed is, I think it's a yes, and. I think you can't have either. I think you can't just have either in isolation. I think it's yes, and. We need to think about how do we give more actual power and resources to people. People need to be able to make their own decisions, not just these healthcare executives that decide how to spend taxpayer dollars. I agree with that. They do need power. But at the same time, we also need the system to become more equitable. We need the system to transform. So I think that's where I've landed, is that I do believe in restructuring our societies so that power is more equitably spread, and I think we need to change our systems to reflect that as well.

Kristin Gecan:
How do you give yourself room to resurface these questions over time? And the answer today may be different than the answer tomorrow. And not just you individually, but as a collaborative, as an organization, do you have space, time, room set aside to entertain these questions?

Rita Nguyen:
I don't have dedicated time, but I acknowledge that it is a process and it's a journey. I think it would be a real disservice to assume that the solutions we thought of today should always be the solutions. And I think that's where the iterative mindset comes in. And I personally think that I'm still in a growth journey around race equity and how to make that manifest, and how do you balance people power and system power. And so I'm very open to those conversations and that dialogue to continue. I actively feel like I'm in evolution and in growth, which I think honestly, everybody should be, because otherwise we'd be a very stagnant society. And so the short answer is I don't have dedicated time to think about it. I think it just sort of surfaces as we evolve the work, and as I hear from others and they plant seeds in my mind of how I approach my own work.

Kristin Gecan:
This is sort of an outlier question. There's not a great segue here, but I need to ask about it. If there was anything as the Food as Medicine Collaborative continued work through the pandemic, what special challenges that might have presented to you, and if any of those became opportunities or presented new ideas.

Rita Nguyen:
I mean, the pandemic, just unprecedented on so many levels. So we did pivot quite quickly to different interventions like home delivered groceries or giving people more vouchers so they could go purchase groceries. And we also just had more mobile food that was being passed out and less of a whole experience.

What I was so grateful for, and what I think was a manifestation of that systems change, is I thought healthcare was going to pull the plug. I thought they were going to say our hair's on fire. We got to deal with COVID. We can't do anything else. But we grew in 2020. More clinics got on board.

And I think that speaks to the inequities that COVID laid bare. It was no surprise that the communities hardest hit by COVID were those who were low income or communities of color who lived in disenfranchised communities that were disinvested in. There was just more of a recognition of how on the edge people live. And so healthcare saw that too. Healthcare providers felt like it was really in their face. They really couldn't ignore the fact that so many of
their patients didn’t have enough money to buy food anymore. So nationwide, I think food security became more visible as a result of COVID. And it was wonderful to see our healthcare partners continue to invest in it and grow the work because they really saw how stark the need was for their patients.

And so we had more clinics jump on in 2020. We also had our partners raise something like 1.7 million dollars in 2020, just for food. There was just more visibility around how important food security was as an issue.

Kristin Gecan:
A big thanks to Rita for giving us a window into a compelling new way of confronting and preventing disease. Rita is one of ID’s 2021 Latham Fellows at the Institute of Design. For more about our Latham Fellows, visit our website and YouTube channel.
You can find show notes and a full transcript of this conversation on the IIT Institute of Design website, id.iit.edu. Please subscribe, rate, and review With Intent on your favorite service. This is a new show and we’d love your support. Our theme music comes from ID alum Adithya Ravi. Until next time.