RESEARCH ARTICLES

Promoting Meal Planning and a Nutritious Weight-Loss Diet: A Qualitative Study of Hispanic Households Participating in a Food is Medicine Program

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ABSTRACT

Background

Diet-related chronic diseases disproportionately affect Hispanic populations in the U.S.

Objective

To explore experiences and perceptions of Hispanic households participating in FoodRx, a program delivering 26 weeks of meal plans along with grocery delivery to support adoption of healthy meals as well as weight loss for at least two adults in each household.

Design/Setting/Participants

We used purposeful sampling, recruiting 22 individuals among those currently enrolled in the study. Each household participated in semi-structured interviews in their homes. The interviews were audio recorded, transcribed verbatim, and analyzed using thematic analysis. Household eligibility included: at least two individuals aged 18 or older with a BMI ≥ 27 interested in losing weight; at least one child aged 3-17 years old; and identified as Hispanic.

Findings

Five themes emerged from the data analysis. The realization that healthy foods could be tasty, seeing health improvements, cost savings, and time efficiency were the most identified benefits, and these were influenced by family support. Challenges in successfully adopting and maintaining a weight-loss diet were also identified, such as children disliking vegetables.

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Conclusion

FoodRx facilitated positive dietary changes, improved health, and strengthened family bonds, though adherence was influenced by family support and contextual barriers.

Introduction

Diet-related chronic diseases are public health burdens that affect children and adults globally.[1] The prevalence of people with obesity across all age and racial/ethnic groups in the United States remains historically high.[2] Over the last two decades, the proportion of people with obesity in the U.S. increased by nearly 40% among adults and children aged 2 to 19 years.[3] Obesity rates are higher among Hispanics,[4] with the prevalence among adults being 45.6%[5] and among children 26.2%.[6] Obesity is linked to multiple chronic diseases, like heart disease, type 2 diabetes, high blood pressure (hypertension), stroke, sleep apnea, and several types of cancer.[7-9] Obesity is the direct consequence of a suboptimal diet quality and excessive caloric intake.[10,11] This study was intended to address diet quality and quantity by making it much easier for participants to adhere to meal plans that would improve their health.

While many believe that a poor diet is solely due to individual responsibility, the major barriers to a healthy diet are the placement and promotion of ultra-processed foods by the media, the marketing and convenience of ultra-processed foods in supermarkets (which are highlighted on the ends of aisles and at cash registers), and the excessive portions served by restaurants.[12, 13] Market research shows that when supermarkets highlight ultra-processed foods and place them in multiple settings, sales increase significantly.[14-16] Overcoming these contextual barriers to optimal weight and nutritious diets is critical to prevent excessive food consumption, prevent diabetes, and achieve weight loss.

Food is Medicine, integrated health system food-based programs, and interventions aimed to promote health and equity have proven effective in diabetes management, weight loss, health care utilization, and addressing food insecurity.[17,18] Food is Medicine programs offer individuals medically tailored meals, groceries, and produce.[19,20]

To address low-nutrient diets, we developed FoodRx, a Food is Medicine program for families who belong to a Hispanic ethnic group to meet >90% of the recommended dietary allowances (RDAs) per week for 23 micro and macronutrients, as well as meet the EAT-Lancet sustainability guidelines, limiting servings of poultry, fish, and eggs to twice per week (3-4 oz. of meat/fish per serving), and red meat not more than an average of once per week. The meal plans included breakfast, lunch, dinner, and snack every day for 26 weeks. The recipes were tailored to each household member's caloric needs, so they received the quantities needed to serve all the household

members reaching their needed calories, based on age, gender, and activity level and weight goals. Adults who wanted to lose weight were provided with 1500 calories per day and children were provided with anywhere between 1200-4000 calories as needed to continue their growth and physical activity.

Additionally, FoodRx was designed to benefit everyone regardless of income level. Our pilot studies showed that the costs of healthy foods were affordable and fell within the maximum allotments of the Supplemental Nutrition Assistance Program (SNAP) when average calories were < 2000 per person.[21] In contrast to most Food is Medicine programs, income was not an eligibility criteria and participants only had to agree to pay for the groceries. Families with three household members paid $110/week, four members paid $150/week, and five paid $190/week. (SNAP allotments are more than $60/week higher, and higher costs were covered by the study.)

This study aimed to understand the experiences of Hispanic households who participated in FoodRx and to identify factors that influenced their adherence or lack of adherence to the program and whether they achieved desired health outcomes.

METHODS

In brief, the FoodRx study was conducted in Southern California among Hispanic households and is a crossover randomized control trial aimed to evaluate the effectiveness of 26 weeks of customized healthy meal plans that were developed by registered dietitian nutritionists with the delivery of most ingredients to promote weight loss among adults. Over a six-month period, enrolled households received weekly grocery deliveries, recipes, preparation instructions and tips, tailored to the caloric needs of each household member. Details on FoodRx were published elsewhere.[21] Semi-structured interviews were conducted in person in their homes and participants were asked about their experience, challenges, and the benefits of FoodRx.

Eligible households had at least two adults with a body mass index (BMI) of 27 or higher. Participants were invited to participate in the winter and spring of 2024 to provide more detailed feedback on their experience. Children who were at least five years old (n=8) and adults (n=14) participated in semi-structured interviews. Each household member received a $50 gift card incentive for completing the interview. The study was approved by the Kaiser Permanente Institutional Review Board.

Data analysis

Interviews were audio-recorded and transcribed verbatim. NVivo transcription software version 14 was used for transcription and data analysis. Research team members reviewed the transcripts for accuracy and separately analyzed the data using open coding and thematic analysis. The process involved identifying codes, reviewing the codes to categorize them, and

Table 1. Characteristics of household members enrolled in FoodRx and the selected sample that participated in the qualitative interviews

Characteristics	Intervention household (n= 64)*	Interviewed households (n= 7)**
Average household size	3.0	3.0
Gender		
Female	54.0%	50.0%
Male	46.0%	50.0%
Age		
Below18 years	39.8%	36.4%
18 to 30 years	7.1%	13.6%
31 to 40 years	26.5%	22.7%
41 to 50 years	20.4%	22.7%
Older than 50 years	6.2%	4.5%

*Total number of individuals within the household = 193

**Total number of individuals interviewed from the seven households = 22

developing themes that emerged from the categories.[22] The qualitative researchers met to review the codes and themes and achieved a 100% consensus on the qualitative findings.

RESULTS

Twenty-two individuals participated in semi-structured one-on-one interviews consisting of 14 adults and 8 children. The average age of the adults was 38.5 years (range 24 to 61), and of the children 9.6 years (range 5 to 15). Household members enrolled in FoodRx and those interviewed did not differ by baseline characteristics (Table 1).

Five main themes emerged from the thematic data analysis:

Theme 1: Exposure and access to healthy meal plans influenced perceptions of nutritious foods and dietary choices

The participants described their perception of nutritious foods prior to the program, changes in their perceptions, and dietary choices. Most participants reported a shift in what they perceived as healthy foods and diet. They described their perception of healthy foods as something bland or not tasty. To their surprise, however, they reported that the dishes prepared using the program recipes exceeded their expectations.

> *"It is the fact that [previously] we did not particularly eat very healthy. So, [now] it is trying new foods, trying new healthy foods. You know, historically, they [healthy foods] get a bad rep, like, healthy foods are not the best tasty food. I think that's where we had that hesitation.... And then you try it, and it is like, oh, this is really good."*

Other participants commented on how the program changed their lifestyle.

> *"I dig it. I mean, and it's one of the things that we kind of keep talking about is that it's been a lifestyle change. (Previously), we (were) spending a lot of money on eating out. We knew that, you know, it wasn't the healthiest foods ... we feel better ... the energy is there. ... I also stopped drinking coffee as much and I don't drink soda as much."*

The shift in this perception also influenced participants' awareness of the type of foods they consumed.

> *"I am more open to like more greens or more on the healthy stuff. Before, if you ask me, veggie burrito or veggie tacos, I am like, no, that makes no sense, you know? But we have had one that's been my favorite meal, and it was like chickpea tacos, you know, zero protein or at least meat-wise. But it was one of my favorites. So, now I am like, okay, now I can see that other healthy options are still tasty."*

One participant said her body started "rejecting" too much meat. At the same time, a few others mentioned changing their shopping habits by reducing their purchase and consumption of soda. Interestingly, some of the children we interviewed also reported being more self-aware of healthy eating. This was mostly seen among children who were involved in the meal preparations. For instance, a 6-year-old said his parents got him a set of kids cooking utensils that he uses in the kitchen. A 13-year-old said she stopped visiting fast food restaurants with her friends when she started the program and told her friends about FoodRx.

Theme 2: Motivators and drivers for adopting meal planning and dietary lifestyle changes

The participants identified several motivators and drivers for dietary lifestyle changes and program participation: 1) personal motivation and visible results; 2) learning new cooking skills; 3) reduced trips to the grocery store; and 4) ability to plan effectively and manage resources such as leftovers. The desire to be healthy was the main motivator. Some of the participants reported that they had previously tried other paid mobile app weight loss programs or restrictive diets such as keto and intermittent fasting, but they were either too expensive or too restrictive.

Furthermore, the delivery component of the program and the provision of recipes were considered motivators as they reduced existing barriers such as time to shop, prepare, and cook meals.

> *"I really like the convenience of it. I like having fruits and veggies in my fridge at all times and just having something that I could kind of quickly make."*

One family reported that they never cooked before the program and now enjoyed cooking. The program not only motivated them to cook healthy meals but also to plan their meals effectively and manage leftovers efficiently. Many families followed the instructions for saving leftovers and took them to eat at work the following day.

> *"This has been a great program. I love the fact that I don't have to go to the grocery store as often. It has saved me money. And I like the fact that I don't have to think what I need to do for dinner when I get here [home]. So it's [groceries] all here already. It has helped me to organize my meal prep, instead of just having to go and buy things[ingredients] at the last minute."*

When asked how the program impacted their overall health:

> *"I always thought it was just how my life would say to me, like, I'm always going to live with this bothersome stomachache. And it's not. ..., I haven't had that stomachache!"*

One father said:

> "(*This) is what my body needs – healthy, especially I want to eat it all my life. I am from Mexico. Before, I used to eat fatty foods. I don't like that. I like being thinner and healthier."*

Theme 3: Perceived barriers to sustainable meal planning and healthy diets

Multi-level factors, including individual and interpersonal relationships, contributed to the adoption of dietary lifestyle changes and adherence to the program. Many families said it took a while for them to adjust to the meals but they were able to do so.

> *"At the beginning, we were we were always so hungry. But once our body adjusted to what we were eating, it was a lot easier."*

A major barrier identified was the lack of time and support from family members.

> *"There's a lot more cooking. I was a little resentful of the beginning because I did not cook on Fridays as it was not my thing. I was looking forward to eating out, and I was like, It's Friday, (now) I have to cook. And it does take a lot longer than what we're used to ... but I don't necessarily think that's a bad thing."*

For example, working parents reported a lack of time due to work, or also having to adjust the meals to satisfy their children.

> *"[Before the program] I think it is like a combination of things, like not being prepared to cook. So, it is not that I mind making the meal. It is just that we do not always know what we are going to make and what we are going to eat. And it is kind of like, well, what do you want to eat? And ... eventually we figured that out. It is like we do not want to go to the grocery store, buy all that stuff, and then come back and make it when we are already hungry. Our daughter is already complaining that she is hungry. So, then we will just go get something (from a restaurant).*
>
> *[Now with the program] we have stuff here that makes things a lot easier to do. ..., I already have an idea of what I can make for it to be still healthy, and we have to tailor it to look like something my daughter would eat."*

In addition, children's dietary needs contributed to the program adherence. For instance, some participants reported choosing alternative menus on some days to please their children or have a family treat. Not all children liked eating more fruits and vegetables.

> *"I am just kind of nervous to try how it [new food] tastes, and I do not really like how certain things taste. But I am happy to try them."*

Pressure from peers and social networks was another barrier. Some participants reported developing strategies such as taking their homemade foods to social gatherings to overcome these barriers. Lastly, a few participants reported difficulty in changing their dietary habits as barriers to the adoption of dietary lifestyle changes and adherence to FoodRx. For example, one admitted to still consuming unhealthy snacks such as fried chips and candy because "they taste good," and it was difficult for them to resist on some occasions.

Nearly all the children interviewed reported eating at school on some days when their favorite foods were served, but they did not mind eating something different from their friends.

Theme 4: Perceived impact of FoodRx expands beyond health outcomes—saving costs and strengthening family bonds

All the interviewed adult participants reported some type of benefit from participating in FoodRx. The main benefit identified was health, which was not limited to weight loss or diet-related diseases. In fact, most of the health benefits included improvements in mood, energy levels, and sleep.

> *"I think when I started [FoodRx at baseline], I was around 350 lbs, and I think we just weighed in at 330 lbs. So [lost] about 20 lbs.... But I have always been big my entire life, so the weight did not necessarily bother me. The bigger benefits for me [during the program] were the energy levels and just kind of feeling better."*

One participant reported a reduction in sweats and many reported feeling more energetic.

> *"Just I used to sweat a lot ... not so much now, you know, that's one of the things I noticed. Again, the energy level–coming home from work, not feeling so tired... Just overall feeling more energized."*

Another family reported even more energy among their children as well.

> *"We're not eating out as much. It's the fact that we're more and more energetic. We've also noticed (my son) kind of lost weight. You see that he's running faster, he's more energetic. So I do see those as benefits."*

Other reported health benefits included improvement in blood sugar levels, dietary quality, body weight, blood pressure, and cholesterol.

While the program's primary goal was to support weight loss and improve dietary quality, participants described financial savings on food-related costs as a huge benefit of the program. They also compared the cost savings to other dietary plans or programs they have tried. For instance, one family said they never realized how much they spent on eating out before they joined the program.

> *"A little bit before we started the program, we talked about how much we were spending a month on food and takeout, and we were astonished because we were spending around $1,000 on takeout and food. Now [spending on food] has dropped a lot for us."*

Another perceived benefit of the program that stood out was family bonding. Some households reported having multiple members contributing to preparing and cooking the meals, which allowed them to spend more time together. For others, mealtimes were bonding times as everyone was at the table. For one single mom, it was an opportunity to spend more time with her children. Another family said they only had dinner when everyone was at the table, which was something they rarely did before the program.

Theme 5: Change in dietary lifestyle is a gradual process, and support from household members is crucial for success

The interviews with families suggest that participation in FoodRx was a little overwhelming at the initial stage of the program.

> *"I think I broke down twice at the beginning, and he [husband] was like, just do what you can. Do not let it stress you out. This is supposed to be a good thing. He would talk to me. But it was like the first 2 to 3 deliveries were just extremely overwhelming. How am I supposed to do with so much food? I am supposed to make all these meals. It was like jumping into a cold pool. After that, it became easier. But the first week, I definitely cried on the first week."*
>
> *"I feel like we've become a lot more adventurous on the stuff we eat and the child [had] the biggest impact. ... At the beginning he was hesitant, and now ... he's just been eating whatever it is that we're serving and we're making."*

Within a couple of weeks of joining the program, many participants felt even more confident in their cooking skills and found the process to be easier than they thought. Our interviews with participants also revealed that household members who supported one another with meal preparation and cooking were less likely to report being overwhelmed.

DISCUSSION

In this qualitative analysis of FoodRx, we found that the program was mostly beneficial to participants. Participants consistently reported improved overall health beyond diet-related conditions, adoption of healthier diets and cooking habits, cost savings, and increased knowledge of dietary choices as top perceived benefits of the program. Participants also reported multi-level barriers and facilitators to successful program benefits.

Time constraints have been well-established as a major challenge to weight loss due to the inability to plan healthy meals and incorporate them into daily diets effectively.[23] While our data supports this evidence, we found that participants lacking ideas about what to eat before mealtime and not having needed ingredients to be more obvious barriers. Participants reported that before joining the program, they opted for convenient and readily available foods because they never planned their meals. As such, participants highlighted the weekly menu and instructions for preparation and grocery deliveries as it helped them use their time more efficiently to plan meals ahead and limited their trips to grocery stores while reducing costs.

Participants with limited cooking experiences and households that primarily ate out before the program described the process as initially overwhelming. Interestingly, they said these feelings did not last beyond two weeks. The feeling of being overwhelmed was less expressed among households with shared cooking roles, highlighting the importance of family support in the adoption of healthy lifestyles or lifestyle changes.[24]

Limitations

There are limitations in this study. The selection of participants was based on their availability, but participants who were more satisfied might have been more willing to participate. However, we ensured that the households interviewed reflected the overall sample in FoodRx. The limitations of meal planning were that it was not customized to meet individual preferences, which led to lower adherence. It also covered 7 days per week, which was a problem if families were not eating at home every day, so some food was wasted.

Implications for Research, Practice, and Policy

While most recommendations for people to improve their diet start with small changes, this study was the opposite and nudged people to make a dramatic change immediately as they received both meal plans and grocery delivery covering all meals for 7 days each week. It was overwhelming for many families, but the ones in this study were able to adjust after two weeks, and it did change their lives dramatically. Few families ever prepared all their meals at home, and most did not usually prepare so many vegetables or consume as much fruit. Future interventions could compare the standard recommended small changes over time, with dramatic changes at the onset.

Also, the component of grocery delivery was a strong determinant that led to dining out less frequently. There is strong evidence in other Food is Medicine studies that food delivery does change one's diet.[17,25] This is likely due to the convenience of having the food right in front of them at home, the hesitancy of people to waste food, and the fact that having to go to a supermarket to purchase food exposes shoppers to a wide variety of unhealthy foods that they should avoid.[16]

Conclusion

The findings of this study identified fundamental factors that may influence the adoption and success of meal planning and changes in dietary behavior within Hispanic households. However, program adherence and health outcomes were influenced by family support and makeup, such as age and size. Future studies exploring the intensity of food delivery (a few meals and ingredients vs. everything that is needed per week) social and health impact, sustainability, and scalability of Food is Medicine programs, particularly among racial/ethnic minority groups, are recommended.

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