FOOD-FIRST CARE FOR CARDIOMETABOLIC DISEASE

We put the food behind the *recommendation.*

Clinical nutrition care, medically tailored groceries, and human support in one continuous patient experience.

120,000+ DELIVERIES

CLINICAL PROVIDER + NPI

PHILADELPHIA TEACHING KITCHEN

HEALTH PLAN INFRASTRUCTURE

Built in Philadelphia. ***Ready for New Jersey.***

TRACTION AND VALIDATION

Built in the real world, *not in a pitch deck.*

120,000+

MEDICALLY TAILORED GROCERY DELIVERIES

Independence Blue Cross	Penn Nursing
City of Philadelphia	AARP AgeTech Collaborative

"When food is medicine and community is the foundation, real change happens."

Sheila Jones · Community Health Worker Supervisor · City of Philadelphia

FOOD IS MEDICINE LEADERSHIP

Part of the movement shaping *Food is Medicine.*

The Aspen Institute

Featured in the Food is Medicine Community Action Plan

National Produce Prescription Collaborative

Member organization

New York State Food Summit

2026 speaker

IN THE FIELD

Contributing to the national Food is Medicine conversation.

THE PROBLEM

Most nutrition care stops at the *recommendation.*

> *"Eat differently."*
> *"Lose weight."*
> *"Control your A1c."*

Then the patient goes home.

FARERX CONTINUES THE CARE JOURNEY

01 Recommendation →

02 Education →

03 *Food* →

04 Practice →

05 *Human support* →

06 Measurement

— THE FARERX SOLUTION

The lesson doesn't end when the appointment does. *The food goes home.*

01

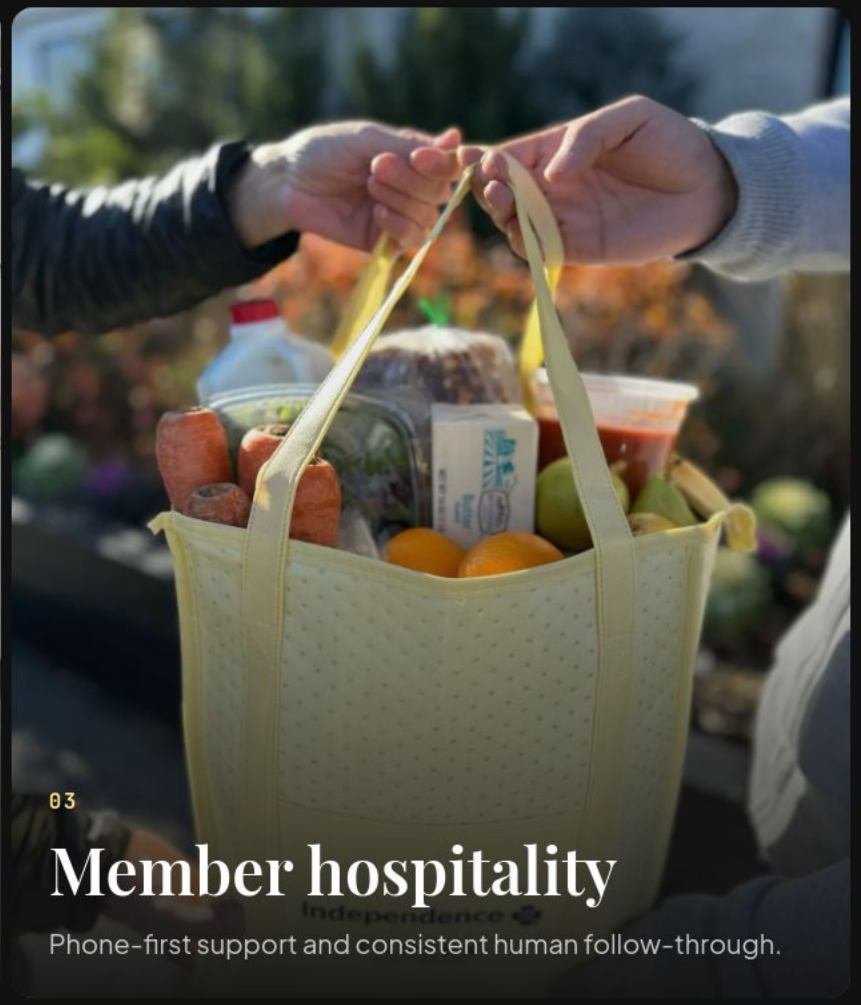
Clinical nutrition care

RD-led assessment, care, and education.

02

Medically tailored groceries

Food personalized around the patient and care plan.



03

Member hospitality

Phone-first support and consistent human follow-through.

HOW FARERX WORKS

One referral. *FareRx handles the rest.*

01
Provider identifies the patient

02
FareRx enrolls and establishes baseline

03
RD delivers clinical nutrition care

04
FareRx personalizes weekly groceries

05
Team maintains patient engagement

06
Outcomes return to the partner

FareRx works through existing referral, claims, and EHR workflows.

PERSONALIZED CARE

Food is personal. *Care should be too.*

FareRx designs each program around the people it serves, including the food they eat, the languages they speak, and the realities that shape their health.

Culture + food preferences
Food and recipes based on what patients actually eat.

Language
Education and support adapted to the population.

Health literacy
Practical guidance that works outside the clinic.

Local context
Programs shaped around community needs and barriers.

We don’t ask patients to adapt to the program. *We adapt the program to the patient.*

— TECHNOLOGY-ENABLED, HUMAN-DELIVERED

Healthcare doesn't need another *login.*

TECHNOLOGY COORDINATES

- Enrollment and eligibility
- Care-plan personalization
- Grocery fulfillment
- Engagement tracking
- Partner reporting

→

PEOPLE DELIVER

- Phone-first support
- Clinical nutrition care
- Weekly human connection
- Real follow-through

FareRx uses technology to make every patient interaction more valuable and human.

MARKET AND BUSINESS MODEL

Multiple buyers. Multiple paths to *scale.*

Approximately 774,000 New Jersey adults have diagnosed diabetes.

SOURCE: AMERICAN DIABETES ASSOCIATION, THE BURDEN OF DIABETES IN NEW JERSEY, 2025.

WHO FARERX SERVES

- People with diabetes and cardiometabolic conditions
- Medicare and Medicaid populations
- Patients needing support between visits
- Employees and families in self-funded plans

WHO BUYS

- Health plans
- Health systems
- Self-funded employers
- Public and community health programs
- Value-based care organizations

HOW FARERX EARNS REVENUE

- Reimbursed clinical services
- Contracted program fees
- Funded grocery benefits
- Value-based arrangements

STAKEHOLDER VALUE

Value flows across the *care system.*

01	02	03	04	05
Patient	**Provider**	**Health system**	**Health plan**	**Public sector**
Food, care, and a trusted relationship	Care continues beyond the appointment	Capacity, quality, and limited operational lift	Outcomes, utilization, and potential savings	Scalable programs with accountable funding

Each stakeholder receives a different form of value.

MEASUREMENT

Measure the value that matters to each *partner.*

CLINICAL OUTCOMES	UTILIZATION + ECONOMICS	PATIENT EXPERIENCE
A1c	ED visits	Enrollment
Blood pressure	Avoidable admissions	Retention
Weight / BMI	Total cost of care	Completion
Population-specific measures	Cost savings or ROI	Patient satisfaction

✓ Final measures reflect the target population, partner priorities, and available clinical and claims data.

PAYMENT PATHWAYS

A practical path to payment and *scale.*

01

Clinical services

Eligible MNT, DSME, and related clinical services reimbursed through existing claims pathways where applicable.

02

Food + program services

Funded through health-plan benefits, partner contracts, public programs, pilots, or value-based arrangements.

03

Health-system role

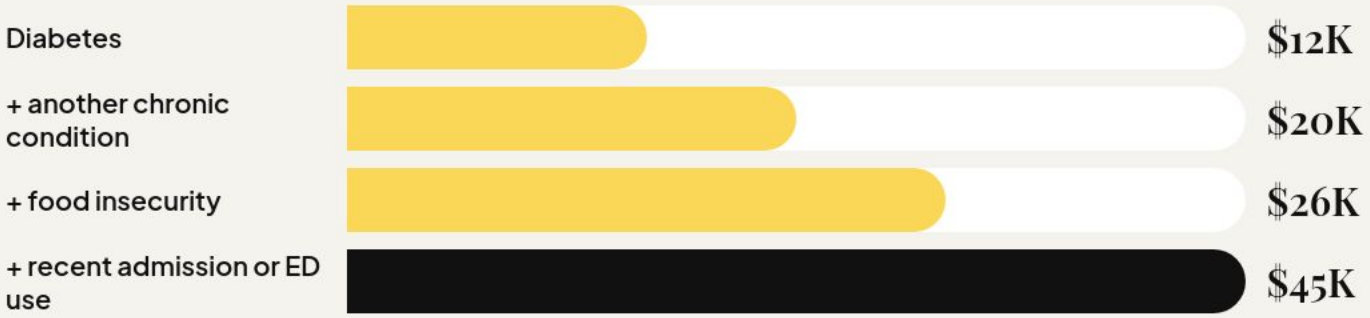
Identify and refer appropriate patients with limited financial or operational burden.

Pilot → evidence → sustainable reimbursement

TARGETING AND ROI

Targeting drives the *return.*

ILLUSTRATIVE BASELINE ANNUAL COST



ILLUSTRATIVE NATIONAL BENCHMARKS. NOT FARERX OUTCOMES OR CUSTOMER CLAIMS EXPERIENCE.

2×–4×

Modeled return can land in this range at targeted risk tiers.

$139 PMPM lower medical cost

Among completers in a six-month Blue Cross NC food-delivery and health-coaching program.

EXTERNAL REFERENCE. TYPE 2 DIABETES AND FOOD INSECURITY. NEJM CATALYST, CAT.22.0351.

Program cost remains relatively stable. Potential return rises with baseline risk and cost. Actual economics depend on population, duration, enrollment, retention, and available claims data.

HEALTHCARE-READY INFRASTRUCTURE

Ready to operate inside *healthcare.*

CLINICAL

- Licensed clinical entity
- NPI

PAYMENT

- Credentialed payer relationships
- Claims-based clinical services

SECURITY

- HIPAA-compliant program
- SOC 2 Type II
- Third-party security reviews

IMPLEMENTATION

- 30–60 day implementation
- Works through existing EHR workflows

LEADERSHIP TEAM

Built by operators. Delivered by clinicians.

Mike Cangi

FOUNDER & CEO

Food is Medicine, healthcare innovation, and program leadership

Kenneth Rice, MD

MEDICAL ADVISOR

Clinical oversight and physician leadership

Kathryn Oakes, RDN, LDN

CLINICAL NUTRITION LEAD

Nutrition program design and delivery

Jean Fox

GENERAL MANAGER, PHILADELPHIA HUB

Operations, food, and patient experience

— NEW JERSEY OPPORTUNITY

Let's build the New Jersey model for *food-first care.*

HEALTH SYSTEM

Referral-based cardiometabolic care

HEALTH PLAN

Claims-based benefit integration

PUBLIC SECTOR

NJ FamilyCare + population-health pathways

Start with the right population. Prove what works. Build the path to scale.