MEDICALLY TAILORED MEALS FOR VERMONT

NEEDS, OPPORTUNITIES AND CHALLENGES

REPORT TO STAKEHOLDERS
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AGENDA– Medically Tailored Meals (“MTM”)

2:00–2:15 pm	Introduction	Helen Labun
2:15–2:20	Background on MTM	Marydale DeBor
2:20-2:35	Framework for Evaluating Vermont Options	Marydale
2:35-2:40	*Clarifying questions*	Group
2:40-2:50	Options	Marydale
2:50-3:10	FIMC Accelerator Program *Q & A*	Eileen Liponis, E.D. New Hampshire Food Bank
3:10-3:15	Conclusion	Helen
3:15-3:30	Discussion	Group

Housekeeping Items

For time considerations, we won't do person-by-person introductions – please introduce your affiliation at the start of questions / comments.

During the presentations, please put clarifying questions into the chat – Helen will either answer in chat or feed to Marydale to answer.

We have two open Q&A opportunities – questions for Eileen about her experience in the MTM accelerator and discussion at end.

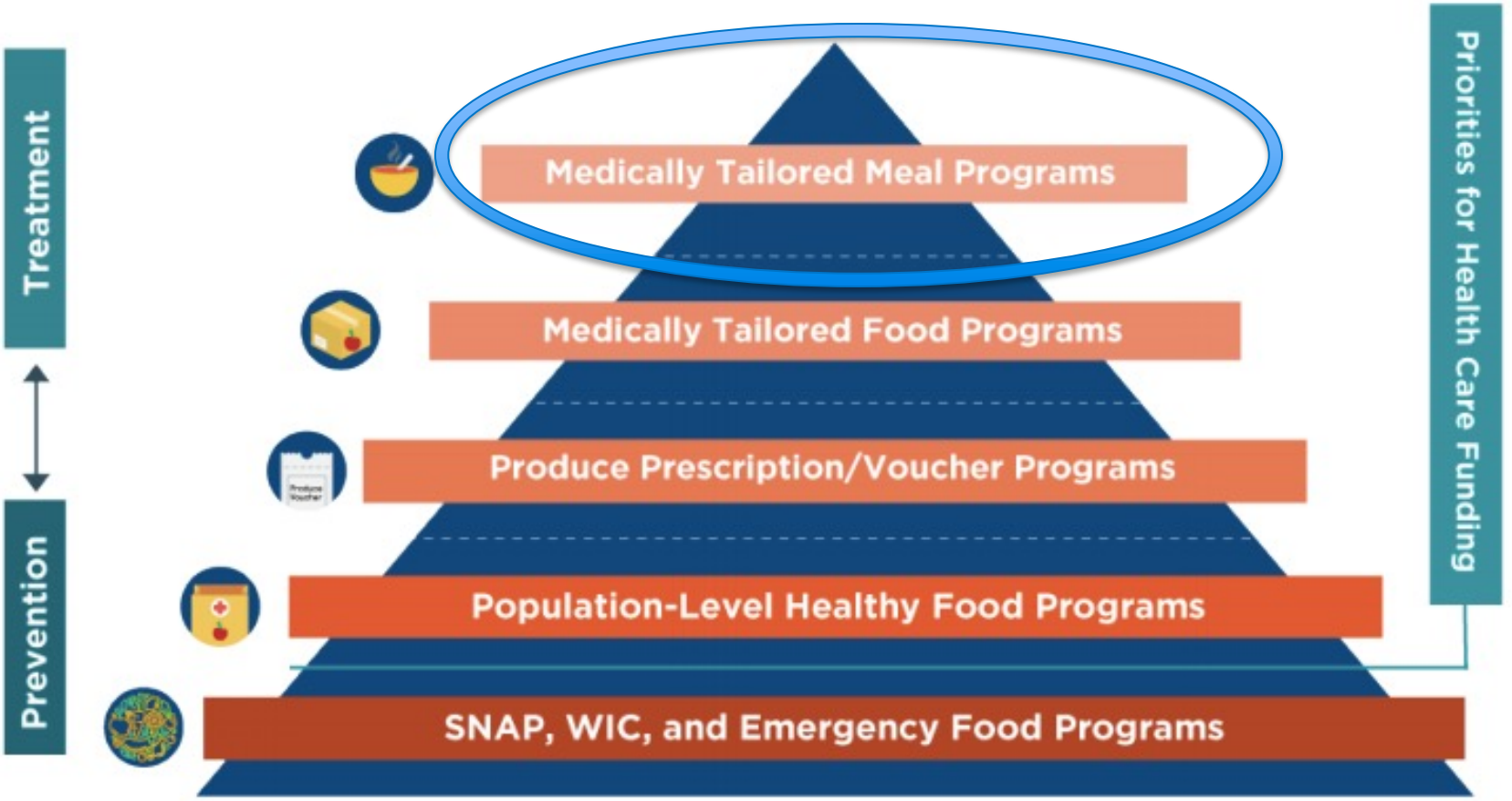
Everyone is welcome to follow up after with additional questions, ideas, resources, etc. – hlabun@bistatepca.org

This slide deck is available linked in the calendar invitation, we will also put it into the chat and circulate after for reference.

This meeting is being recorded and will be available to those who can't attend (or those who can attend and want a replay).

Introduction to Report:

Disclaimer: This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $99,960 with 0 percentage financed with non governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.



Paradigm developed by National Food is Medicine Coalition

MTMs give insight into broader range of programs

The MTM format is in some ways an extreme example of a food is medicine program in its treatment applications, clinical evidence, cost evidence, and stable funding streams. One benefit of looking at a model so far down the road in its evolution is that it can provide insights into other projects as well:

- Understanding structures used to cover food as a benefit in insurance plans.
- Measuring the “dose” for food as medicine interventions – volume of daily diet / frequency of interaction with the program needed to move the needle on clinical measures.
- Setting expectations for results at different timeframes – you *can* expect the right intervention to show results on a short timeframe.
- Setting specific goals for clinical outcomes and measuring progress.
- Building a framework for collaborating beyond Vermont & utilizing research from beyond our state.

Questions Posed in Consulting Contract

Based on stakeholder feedback, we contracted with an experienced MTM consultant to explore key questions:

- Priority populations to serve in early phase MTM programs – system for understanding client characteristics that fit well with MTM pilot.
- Options for bringing smaller projects to scale.
- Delivery systems for rural areas – national models are built on urban setting.
- Systems for measuring impact of early-stage programs – note this is also related to admin / IT capacity to implement national systems.
- Path (or paths) forward for funding.

An underlying theme is understanding the degree to which we can replicate elements of national MTM model in Vermont and where we will need to build our own approach that maintains key principles but adjusts implementation details.

Background On Medically Tailored Meals

What is a Medically Tailored Meal?

*"Medically tailored meals are delivered to individuals living with severe illness through a **referral from a medical professional or healthcare plan.** Meal plans are tailored to the medical needs of the recipient by a Registered Dietitian Nutritionist (RDN), and are designed to improve health outcomes, lower cost of care and increase patient satisfaction."* National Food is Medicine Coalition.

Distinguishing Attributes Include:

- Level of tailoring to patient needs – able to comply with multiple medical constraints and also be enjoyed by patient.
- Close tracking of treatment and clinical results – includes anticipating many patients will see improvement and be able to move off the plan.
- Large percentage of daily food needs met by these meals - Range: 2-3 meals a day; 5-7 days /week, often for the entire household.
- Transportation barriers removed by home delivery – this has an additional benefit of someone checking in on patient regularly. However, delivery via post is also possible, as are blended models where some patients pick up.

Treatment-focused intervention, but prevention is often an indirect benefit

Different Starting Points for MTMs

Vermont can benefit from lessons learned in other states, but other programs have had decades of investment & development so may not offer a *starting* point.

History and Evolution of MTM programs

Existing programs originated during HIV/AIDs epidemic, 30 years ago; response to wasting syndrome; Now ~ 12 non-profit organizations in major metropolitan areas.

All aspects of food production, delivery, client/patient services; evaluation housed in a single organization dedicated only to MTMs

- Strong Advocacy: local, state and federal
- Ryan White Act (federal) reimbursement,
- Built strong philanthropic base
- Past ~ 5 years expanded to serve food insecure patients with complex multiple chronic diseases and social needs: 5-7 days per week; 2-3 meals a day. Meeting all nutrition needs.
- Built strong research base, collaboration with academic researchers
- Past 2-3 years: Medicaid contracts (under waivers); Medicare Advantage; MCOs = the future
- Strong management, administration, IT systems; volunteer base
- Formed national coalition: FIMC, fimcoaliton.org; **Created Accelerator program:**
    - Training and Mentorship; 3 Food banks and 1 MOW programs first cohort: 2020-2021
- Massachusetts has statewide food is medicine plan covering MTMs and other elements of food-based health interventions.

Framework for Evaluating Vermont Options

Mapping starting assets

Based on interviews of organizations currently interested in pursuing MTMs, we can identify components in place – even if they aren't all in the same organization or same region of the state. **The following elements are based on national research and frameworks for replicating Medically Tailored Meals.**

- **Food Production** with trained chef & registered dietitian
- **Food Storage** infrastructure
- **Meal Delivery** systems and options to reach patients at home
- **Nutrition Education** and counseling capacity
- **Administrative Capacity**: reliable IT and HIPAA compliance; assessment and reporting per metrics
- **Health Care Experience** including ability to manage patient referrals
- Geography
- Client Characteristics
- Funding Options

These categories reappear in **appendix slides**, showing different options for trialing a Vermont Medically Tailored Meals approach.

Key challenges for Vermont

While other states' experiences provide us with guideposts and a broad clinical evidence base, we will need to adjust to match our starting point.

- Rural distribution systems
  - Can blend pick up & delivery
  - Can blend paid & volunteer delivery
  - Mail delivery is a 'last mile' solution where necessary, has been successful elsewhere
- Production capacity
  - This can't be done with dozens of volunteer kitchens, need some centralization for volume, consistency, sourcing, clinical guidance & quality
  - Note the MTM Accelerator program assumes the production capacity exists before joining
- IT / data management systems
  - Info management for MTM production facility is a heavy lift – tracking meal plans, patient customization, delivery routes, etc.
  - Systems to handle patient referrals between health care practice and community-based organization, data for evaluation
- Funding options
  - Not a strong local philanthropic base for investing in health care innovation or systems
  - No MCOs limits payment options for Medicaid
  - Medicare Advantage plans are new in this market, don't yet include MTM as member benefit, will hopefully expand
- Other issues related to scale
  - Identifying patient groups to target in pilot – need critical mass of patients with common dietary needs
  - Any program will need to have a pathway to bringing in all payer types to reach enough eligible patients
  - Separating what should be supported by a statewide program and what can be tailored / controlled at a local level – having one single, dedicated MTM organization seems unlikely.

Funding Challenge – a few more details

Outside of Vermont: Medically Tailored Meals programs began with a *very* strong philanthropic base. They built from that starting point, over decades, to sophisticated data collection & patient management programs that can tap into more traditional health care payment models.

Other MTMs also have an urban patient core, with enough volume that even if they are splitting by payer type they still have critical mass.

Inside of Vermont: We are looking at the two-part problem of funding for start up costs and sustainable funding streams.

For sustainable funding streams, we currently lack the most common mechanisms: MCO structure for Medicaid ILS waivers (or clear path for ACO to serve that function), Medicare Advantage (although this is expanding), health care focused foundations.

Mapping path forward to build on starting assets

From our research and stakeholder interviews we believe we need the following things to happen next:

- Identifying Actual Data / IT Restrictions: We know that there is a high burden on shared data and information management for successful MTM programs. It is difficult to know how close we are to being able to handle those demands until there are more pilot programs launched with attention to both operational and clinical data needs. Until then we're just guessing at the gap. Details on this bottleneck are beyond the scope of this presentation.

- Proof of Concept Programs: Sustainable funding will require proof of concept. Scaling up to be able to address multiple medical conditions will require demonstrating an ability to tailor to one or two at the outset. We can design theoretical solutions to delivery, but need to pilot options to know if they'll work. This presentation will outline three possible starting points.

- Clearing the Path to Statewide Scale: See next slide. Some elements of MTMs will only be sustainable if centralized, others can be more localized.

Managing scale

Examples of how we can divide functions to balance scalability & local connection; Consolidation of all essential functions in one organization in VT is unlikely

Statewide

- Coordination with national Food is Medicine coalition, best practices
- Recipe development
- Baseline meal production, ingredient sourcing, food safety
- Training (culinary, specific to MTMs)
- General clinical guidance
- Data support & coordination
- Development, fundraising, linking to health care payment reform
- Outreach materials, explaining "Medically Tailored Meals" concept, referral process
- *Statewide Guidance and Systems Promote Uniformity, Consistency*

Local

- Patient referral and direct outreach
- Patient monitoring and adjusting appropriate diet
- Nutrition counseling and education
- Meal delivery to patients
- Provider outreach and recruitment
- Coordination across local community-based organizations
- Meal tailoring and some elements of production
- Data collection, impact measurements – coordinated

Clarifying Questions on Framework for Evaluating Options?

Examples of ‘Proof of Concept’ Options

Quick Recap Before Examples of Next Steps

Basic elements to evaluate for Medically Tailored Meals programs:

- Food Production with trained chef & registered dietitian
- Food storage infrastructure
- Meal delivery systems and options to reach patients at home
- Nutrition education and counseling capacity
- Administrative Capacity including reliable IT and HIPAA compliance
- Health Care Experience including ability to manage patient referrals
- Geography
- Client Characteristics; Eligibility
- Funding Options

Challenges that may require a different solution in Vermont compared to existing MTM programs in other states

- Rural distribution systems
- Production capacity
- IT / data management systems
- Funding options
- Other Scale Issues
  - Enough patients with common condition
  - Ability to bring in multiple payers
  - Statewide v. local components

Proof of Concept – Option A

Replicate the elements of a full MTM program for a small region and discrete set of condition(s), working with patients in a single health care practice network. Work out the operational details, then scale to cover larger regions and more points of referral.

Advantages

- Can test out all elements of an MTM system before trying to scale a program.
- Can match initial patient focus to specific funding source (for example, by payer or by diagnosis treated).
- Focusing on a small region / community allows to start where partnerships across relevant organizations are strong.
- Meal production easier to manage in small volume.

Disadvantages

- Patient base may be too small to get a large enough sample for a focused set of treatments, partners, and payers.
- Meal production may have challenges scaling up from the starting point.
- If initial trial site is too exceptional then it might be a pilot with no scaling up potential.

Refer to Appendix for Detailed Example: NVRH and NEK Council on Aging

Proof of Concept – Option B

Start with organization(s) that has large catchment area and a meal delivery program that spans large geographic region that includes within its service Vermonters with various medical conditions that meet MTM eligibility. This requires identifying clinical need, matching to appropriate diet, increasing amount of daily nutrition/meal volume provided, adding monitoring & evaluation; coordination with multiple clinical providers.

Advantages

- Built on existing meal delivery capacity, MTM service as addition to existing services.
- Funding streams are a smidge more clear if we look at services to older Vermonters at home.
- Complex care management programs, which are a strong match to MTM, more developed for the demographic served by current home meal delivery.

Disadvantages

- May have structural issues later if trying to expand demographics, conditions (for example, gestational diabetes).
- If MOW is the base, MTM is a significant increase in volume of food delivered, capacity may be variable across state.
- Requires some centralization for volume, quality & data management, which may not match with decentralized / volunteer-based MOW structures.

Refer to Appendix for Detailed Example--Age Well

Proof of Concept – Option C

Build elements of statewide foundation, such as recipes, nutritional guidance, IT and data management structures, patient eligibility criteria, protocols for referrals, protocols for collecting clinical information for impact assessment. This foundational work could then support local/regional organizations interested in adding MTM to their existing work/services.

Advantages

- Addresses scalability questions immediately.
- If we're clever, we can focus on elements of the "foundation" to MTMs that are useful even without formal MTM programs. Many of these aspects can be applied to other strategies beyond MTM.

Disadvantages

- In a world of unclear funding streams, this is the least clear.
- Risk of building support structures but not having programs emerge to utilize the resources.
- Work lacks a clear organizational home.
- You can't solve all capacity issues by having statewide supports on certain elements of MTMs, we'll still hit on local constraints.

Refer to Appendix for Detailed Example

"Food is Medicine" Coalition Accelerator Program

2019: National Resource Center for Nutrition and Aging brought together several MTM programs to discuss:

- State of the MTM movement
- Capacities and Challenges
- Ideas for expanding MTM services beyond the organizations now doing this work

FIMC Coalition created an "Accelerator":

- Six-month long training program
- Non-profit organizations that already have significant food production capacity and seek to expand to include MTMs.
- Support creation of MTM programs where there are currently none
- First cohort included 3 food banks, including New Hampshire Food Bank, and 1 MOW program

http://www.fimcoalition.org/accelerator

Conclusion & Discussion

Role for an advisory group for MTMs

As different programs pursue versions of MTMs it may become desirable to have a coordinating or advisory group. That is not a current recommendation.

Potential role for a more formal advisory group to MTM development in the future:

- Coordinating across pilot projects – sharing results (clinical), sharing lessons learned (operational), identifying information needed to support future funding and program refinement. Includes connecting with projects in other states.

- Attention to scalability – moving beyond coordinating separate pilots to achieving sustainability by helping consolidate services appropriate for consolidation (see State & Local slide).
    - Includes managing definitions – critical for clinical replicability & payment

- Offering an entry point for Vermont organizations that want to learn more about MTMs and get connected with local initiatives.

- Acting as advocates in support of policy and funding to enhance MTM options.

MTM lessons relevant to other work

While an MTM-specific advisory group is not a current recommendation, we should still build on elements of MTM development that could help all food in health care programs:

- Understanding structures used to cover food as a benefit in insurance plans.
- Measuring the “dose” for food as medicine interventions – volume of daily diet / frequency of interaction with the program needed to move the needle on clinical measures.
- Setting expectations for results at different timeframes – you *can* expect the right intervention to show results on a short timeframe.
- Setting specific goals for clinical outcomes and measuring progress.
- Building a framework for collaborating beyond Vermont & utilizing research from beyond our state.

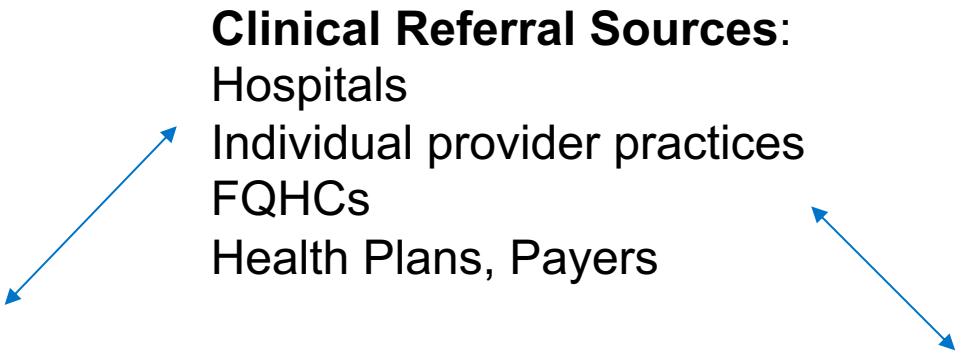
Appendix

STAKEHOLDER INTERVIEWS, JANUARY-MARCH 2021

- *In Vermont*
- Payers (BC/BS, OneCare)
- BPCA representatives
- Hospital Leadership (NVRH)
- Hospital Food Service Leadership
  - UVM, SVHC, Brattleboro
- Hospital Transition Care Nursing
- Hospital Community Health Staff (D-H)
- Social Service Agencies
  - Capstone, SASH, Area Agencies on Aging
- Food Organizations
  - Food Bank, Grateful Hearts
- State Agencies, former state officials
  - DOH, DVAH, DAIL
- Advocates (HCWH)
- Office of Senator Bernie Sanders
- TRIO Food Service Management
- Sodexo Food Service Management

- *Outside Vermont*
- Community Servings (Boston-FIMC)
- Project Angel Heart (Colorado-FIMC)
- Ceres (CA, FIMC California member)
- FIMC California, Director
- C3 (FQHC ACO, Boston)
- Center for Health Law & Policy, Food Law Clinic, Harvard Law School
- Algorex (data analytics for OneCare)
- Mamma Sez and Mom's Meals (taste test)
- JSI—Evaluation consulting team; often assists Vermont orgs

MTMs---Integration into individual patient treatment for specific disease(s)
Continuous Communication and Feedback Loop



Food Production:
Customized to individuals/specific medical conditions

Client/Patient Services
Nutrition Assessment; Ordering Meals;
Monitoring client progress, "compliance"
Managing diet adjustments;
Reporting for evaluation purposes

Delivery of meals to Home, or pick up site

**Client Services, Food Production, Meal Delivery may need to be distributed Among different organizations in Vermont*

MEDICALLY TAILORED MEALS

Who are the patients?

- Medically and socially complex: Chronic Heart Failure & other CVD; Kidney/Renal Disease; HIV/AIDS with Diabetes; Cancer. Soej programs (Community Servings in Boston) now serving pregnant women with gestational diabetes; pregnant women with food insecurity
- Food Insecure
- Patients in Transition from Hospital, Skilled Nursing
- Patients in Complex Care Coordination Clinical Management Pathways: Share Outcome Goals with Managed Care Plans, ACOs, Payers, Providers

What is the Evidence?

- Expanding body of peer reviewed research by academic investigators together w/ MTM programs, using strong methodology: Showing reductions in in patient, admissions; ED admissions associated with MTM , See: FIMcoalition/research.org
- Increasingly being tied to “quality of care” measures
- Some RCTs underway: (CHF Pilot: New York)
- NIH now funding more studies by leading investigators in the field

Proof of Concept – Option A - Summary

Replicate the elements of a full MTM program for a small region and discrete set of condition(s) e.g., chronic heart failure, working with patients in a single health care practice network. Work out the operational details, then scale to cover larger regions and more points of referral.

Advantages

- Can test out all elements of an MTM system before trying to scale a program.
- Can match initial patient focus to specific funding source (for example, by payer or by diagnosis treated).
- Focusing on a small region / community allows to start where partnerships across relevant organizations are strong.
- Meal production easier to manage in small volume.

Disadvantages

- Patient base may be too small to get a large enough sample for a focused set of treatments, partners, and payers.
- Meal production may have challenges scaling up from the starting point.
- If initial trial site is too exceptional then it might be a pilot with no scaling up potential.

Proof of Concept – Option A

Replicate the elements of a full MTM program for a small region and discrete set of condition(s) working with patients in a single health care practice network, work out the operational details, then scale to cover larger regions and more points of referral.

Example – Northeastern VT Regional Hospital (NVRH) and NEK Council on Aging

Food Production with trained chef & registered dietitian

- ❑ Hospital food services can handle food production for pilot in "off hours" . Volume of food services down (COVID); Executive Chef and R.D. on staff
- ❑ Gap: Hospital Future capacity and Council Capacity to pick up production unclear;

Food Storage infrastructure

- ❑ Capacity for a small pilot, future capacity unclear

Meal Delivery systems and options to reach patients at home

- ❑ NEK Council on Aging / MOW could handle home delivery via volunteer system
- ❑ Gap: MTM requirements could stress capacity, of Council; 18 different local small orgs means that integrating production & delivery in the future unlikely to have needed quality control /

Nutrition Education and counseling capacity

- ❑ Strong programs for general education, including with community programs. Practice can add individual counseling.

Administrative Capacity including IT

- ❑ Hospital has reliable system; community orgs have capacity for case management, monitoring, data collection (experience as contractor in Choices for Care).
- ❑ Gap: IT Connectivity between hospital & community orgs

Health Care Experience

- ❑ Strong for both hospital and their community partners; established working relationships

Proof of Concept – Option A cont'd

Replicate the elements of a full MTM program for a small region and discrete set of condition(s) working with patients in a single health care practice network, work out the operational details, then scale to cover larger regions and more points of referral.

Geography

- ❑ Pilot would be Caledonia & Essex Counties

Client Characteristics

- ❑ Hospital can identify potential patient participants from discharge data
- ❑ Dominant condition is heart disease, various types
- ❑ Gap: Numbers are *extremely* small which affects how we consider:
  - Conditions targeted
  - Ability to match to payer type
  - Evaluation design and outcomes monitored

Funding Considerations

- ❑ Hospital participates in ACO for all payer types, participates in other APMs (eg Blueprint payments), has small Medicare Advantage pool.
- ❑ Gap: Because of very low patient numbers, unlikely to be able to additionally target by payer type. Any pilot would likely need to be grant funded and evaluation done prior to launch re. sustainable funding options that bring in multiple payers.

Other Considerations

- ❑ Adding Council clients who are not NVRH patients, SASH & FQHC patients could achieve sufficient pool of candidates, will mean data sharing & coordination burden is higher at the beginning.
- ❑ Council on Aging as basis for case management limits to one demographic (for example, mothers with gestational diabetes is a key target for MTMs in many states).
- ❑ GAP: Would need to integrate other med providers into partnership

Proof of Concept – Option B – Summary

Start with organization(s) that has large catchment area and a meal delivery program that spans large geographic region that includes within its service Vermonters with various medical conditions that meet MTM eligibility. This requires identifying clinical need, matching to appropriate diet, increasing amount of daily nutrition/meal volume provided, adding monitoring & evaluation; coordination with multiple clinical providers.

Advantages

- Built on existing meal delivery capacity, MTM service as addition to existing services.
- Funding streams are a smidge more clear if we look at services to older Vermonters at home.
- Complex care management programs, which are a strong match to MTM, more developed for the demographic served by current home meal delivery.

Disadvantages

- May have structural issues later if trying to expand demographics, conditions (for example, gestational diabetes).
- If MOW is the base, MTM is a significant increase in volume of food delivered, capacity may be variable across state.
- Requires some centralization for volume, quality & data management, which may not match with decentralized / volunteer-based MOW structures.

Proof of Concept – Option B

Start with organization(s) that have a meal delivery program that includes within its service Vermonters with medical conditions that meet MTM eligibility. This requires identifying clinical need, matching to appropriate meal plan, increasing amount of daily nutrition provided, adding monitoring & evaluation.

Example - Area Agency on Aging: Age Well

Food Production with trained chef & registered dietitian

- ❑ Commercial Vendor (TRIO in Rutland) handles food production from recipe development by chef and RD teams to fresh ingredient prep, fully cooked and blast chilled meals, packaged for delivery. High volume capacity
- ❑ Gap: Currently therapeutic meals, not MTM
- ❑ Gap: Would need to work on local sourcing

Food Storage infrastructure

- ❑ Ample, commercial scale.

Meal Delivery systems and options to reach patients at home

- ❑ Vendor has truck to deliver to “hubs”; Age Well volunteers, plus some paid drivers, deliver to homes, 60 different routes in current area

Nutrition Education and counseling capacity

- ❑ Strong foundation for adults over 60, including RD’s and broader communication channels
- ❑ Gap: Reaching a younger demographic (as noted before w/ gestational diabetes, for example).

Administrative Capacity including IT

- ❑ Reliable IT, experience with monitoring, tracking, evaluation for e.g., Choices for Care contracts; billing, accounting
- ❑ Gap: All AAAs use same IT platforms, assessment processes, case management as mandated by DAIL. Would need capability to interface with health care, payers.

Proof of Concept – Option B cont'd

Start with organization(s) that have a meal delivery program that includes within its service Vermonter with medical conditions that meet MTM eligibility. This requires identifying clinical need, matching to appropriate meal plan, increasing amount of daily nutrition provided, adding monitoring & evaluation.

Health Care Experience

- ❑ CEO is former CNO of a hospital; working with UVM discharge planning/meal project
- ❑ Age Well participates in Food is Medicine Coalition

Geography

- ❑ Largest of the 5 AAAs in VT Serves Addison, Chittenden, Franklin and Grand Isle Counties
- ❑ Food vendor also serves MOWs in Southern VT, could serve central & NEK if they wanted to access.
- ❑ Gap: Age Well may not be typical of capacity of AAAs in other regions of the state.

Client Characteristics

- ❑ Age 60 + for MOW**;** screening and assessment for various programs reveals individuals with many chronic illnesses, co-morbidities; high patient satisfaction
- ❑ Gap: Need to identify hospital/provider partners (that also serve Age Well clients)

Funding Considerations

- ❑ Base of Funding is Older American Act (federal and state funding), some philanthropy
- ❑ DAIL oversight; increasing its emphasis on nutrition; food security in AAA service plan requirements; Aging Well Action Plan
- ❑ Experience with grant applications; research

Other Considerations

- ❑ Balancing vendor-provided meals with MTM specifications and local meal production / community connections around the food.

Proof of Concept – Option C - Summary

Build elements of statewide foundation, such as recipes, nutritional guidance, IT and data management structures, patient eligibility criteria, protocols for referrals, protocols for collecting clinical information for impact assessment. This foundational work could then support local/regional organizations interested in adding MTM to their existing work/services.

Advantages

- Addresses scalability questions immediately.
- If we're clever, we can focus on elements of the "foundation" to MTMs that are useful even without formal MTM programs. Many of these aspects can be applied to other strategies beyond MTM.

Disadvantages

- In a world of unclear funding streams, this is the least clear.
- Risk of building support structures but not having programs emerge to utilize the resources.
- Work lacks a clear organizational home.
- You can't solve all capacity issues by having statewide supports on certain elements of MTMs, we'll still hit on local constraints.

Proof of Concept – Option C

Build elements of statewide foundation, such as recipes, nutritional guidance, IT and data mgmt. structures, patient eligibility criteria, protocols for referrals, protocols for collecting clinical information for assess impacts. This foundational work could then support local/regional organizations interested in adding MTM to their existing work/services.

Food Production with trained chef & registered dietitian

- ❑ Vermont has teams with this capacity, who already work as networks – notably hospital food service directors
- ❑ Gap: Keeping consistency as food production shifts out to smaller kitchens

Food Storage infrastructure

- ❑ Variable across state, but it exists.

Meal Delivery systems and options to reach patients at home

- ❑ This approach leaves local groups to decide / build from programs already in place
- ❑ Gap: Efficient delivery routes, ability to use shipping where needed, ability to use paid drivers where needed, may be hindered
- ❑ Gap: Marrying local delivery networks with data management (see Administrative capacity)

Nutrition Education and counseling capacity

- ❑ Can be centralized

Administrative Capacity including IT

- ❑ Can set common data collection and management practices, protocols
- ❑ For places without existing infrastructure, collaborative projects could make data and IT more accessible. Program evaluation, for example, could be outsourced
- ❑ Gap: This is not the first project to think it could accomplish common parameters for data collection, and it's been a very heavy lift
- ❑ Gap: Specific systems, if they exist at all, will be very different by health care practice and partner organization; orgs with platforms unlikely to have interest in adding more
- ❑ Gap: Local organizations will need to assess their capacity for case management

Proof of Concept – Option C cont'd

Build elements of statewide foundation, such as recipes, nutritional guidance, IT and data mgmt. structures, patient eligibility criteria, protocols for referrals, protocols for collecting clinical information for assess impacts. This foundational work could then support local/regional organizations interested in adding MTM to their existing work/services.

Health Care Experience

- ❑ Statewide work would begin with health care experience. Having a statewide foundation that goes beyond food production & recipe development provides a participation path for non-hospitals
- ❑ Gap: Different experience at local level with community orgs & health care practices

Geography

- ❑ This model is built with a statewide potential reach from the beginning. Could speed up the process of scale, but also high risk – would require significant work to ensure statewide foundation being created is useful at local level and be an iterative process

Client Characteristics

- ❑ Client characteristics will depend on local program. Statewide work can help with:
  - Identifying conditions appropriate for MTMs & matching meal plans
  - Models for information/data-sharing and referrals with clinicians
  - Establishing protocols for monitoring and follow up with patients

Funding Considerations

- ❑ Sustainable funding for MTMs is very complicated, it may be infeasible for local orgs to navigate the system without assistance from statewide group
- ❑ Gap: Would need an assessment of what (realistically) time demands are for setting up statewide foundation and secure funding to do this effectively. There isn't a clear starting structure to build from right now

BIBLIOGRAPHY

Resources for learning more about Medically Tailored Meals and supporting evidence referenced today are available at:

www.VTFoodInHealth.net