Medically Tailored Meals for Vermont: Needs, Opportunities and Challenges

Final Report to Bi-State Primary Care Association

April 30, 2021

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FRESH ADVANTAGE™
Food is Primary Care™

Scope of Work

Bi-State Primary Care Association ("Bi-State") engaged Marydale DeBor, Managing Director of Fresh Advantage® LLC ("Consultant") to conduct background qualitative research, primarily stakeholder interviews, in coordination with Bi-State (as the lead representative for the Food and Health Network) to produce a set of recommendations for initial steps that may be taken to support planning, resource identification and future implementation of Medically Tailored Meals ("MTM") programs in Vermont. Key areas of focus in the preliminary research and stakeholder interviews conducted from January 1- April 30, 2021 by the Consultant included:

- Identifying priority populations to serve in early-phase MTM programs
- Identifying options for bringing to scale
- Delivery systems for rural environments
- Approaches to systems for measuring impact of early-phase programs
- Path forward for funding

The following items were produced and are provided in support of Consultant's recommendations and as a part of this final report:

- Power Point Presentation to Stakeholders, with detailed Appendix, April 20, 2021
- List of stakeholders Interviewed and individual summaries of each (attached)
- Table of Vermont organizations with capacities to support planning and early phase MTM programs (attached)
- Expansion of Bibliography included at VTFoodinhealth.net

This report should be read in conjunction with the Power Point presentation to Stakeholders and its Appendix.

Methods

We reviewed relevant research and reports on the subject of MTM programs, their history, organizational characteristics and impacts (including peer reviewed publications) in the United States. This information formed the backdrop for analysis of the possibilities for developing this form of therapeutic care for Vermonters who may need and benefit from it.

Interviews were conducted with leading MTM organizations and legal and policy experts in other states, including:

- Community Servings, Boston MA
- Project Angel Heart, Denver, CO
- Center for Health Law and Policy, Boston MA

- Food is Medicine Coalition
- California Food is Medicine Coalition

Interviews were also conducted with other organizations outside of Vermont that work with existing MTM programs or that are engaged in activities (e.g., social risk stratification) designed to support integration of nutritious foods into clinical and public health practice, such as improvements in hospital inpatient food service and access to nutritious foods for people affected by food insecurity. Interviewees included:

- Health Care without Harm
- Algorex
- Community Care Cooperative (An Accountable Care Organization (ACO) created and governed by federally qualified health centers in Massachusetts.)

Over the past three decades and in response to "wasting syndrome" in HIV/AIDs patients, MTMs have emerged as a part of clinical care for certain patients with a range of severe chronic diseases. Across the U.S. and mainly serving urban settings, approximately 12 non-profit organizations are providing meals and nutrition education and counseling support to thousands of individuals suffering from serious chronic conditions and a range of social needs. Patients served represent a broad range of demographic characteristics. Over the past three decades, these organizations have become sophisticated in terms of their management and information systems, community partnerships and collaborations with clinical care providers and health care payers. The research and evaluation they have pursued, some with leading academic medical centers, is providing an evidence base of impact and health care cost savings--all of which is enabling them to expand the reach and volumes of patients served.

They have formed a national coalition and now sponsor an "Accelerator" training and technical assistance program. Importantly, they have honed their advocacy capabilities and impact at the state and federal level, identifying and engaging political leaders who champion their cause. In the U.S. Congress, their activism has been instrumental in the formation of a bipartisan "Food is Medicine" caucus.

As a result of their growth and influence, funding for statewide planning and expansion has been obtained. In Massachusetts, the Blue Cross/Blue Shield Foundation provided funds for a statewide MTM plan, and in California Medi-Cal has supported a large scale, multi-year pilot program.

Through this background research the essential elements needed to launch and sustain MTM programs, were identified:

- Food production/approved commercial kitchen capacity, with professional chef and R.D. staff to prepare meals customized to specific clinical conditions (e.g., heart failure and other cardiovascular disease, diabetes, renal failure)

- Food Storage (including refrigeration) capacity
- Delivery systems to take meals from food production sites to patient homes, consistent with applicable food safety guidelines,
- Experience working with health care providers
- Nutrition information and education for patients to facilitate progression to less intensive forms of nutritious, medically appropriate food support,
- Reliable information technology systems that are HIPAA compliant and capable of supporting:
    - efficient referral of patients from clinical providers to the MTM program,
    - patient assessment and screening for food insecurity and social needs,
    - tracking and monitoring patient experience, diet adjustments and documentation of clinical metrics to assess impact,
    - feedback loop back to the referring clinical provider and the food production center.
- Sustainable funding streams

In addition, these MTM organizations also have "medical advisory" committees with members representing diverse medical specialties who assist them with clinical matters and development in medical research.

Through this lens and to respond as thoroughly as possible to the key issues posed in the consulting agreement , the consultant interviewed 30 individuals and conducted two group interviews with organizations representing:

- Hospital food service professionals and health care providers
- Health care payers
- State and federal officials and staff from health care agencies and standing legislative committees
- Vermont Area Agencies on Aging
- Community Action Agency
- Evaluation Experts
- Community-based food support and hunger prevention organizations
- Commercial Food Service Management Companies

Names and contact information of stakeholders with an interest in MTM programs were initially provided to the consultant by Bi-State, and others were added as we learned more from the original cohort of proposed interviewees. Other potential stakeholders were identified by the interviewees themselves.

Interviews were structured as an "asset mapping" exercise. Questions for discussion, materials describing MTM programs generally and sample research on clinical impacts were provided to each interviewee in advance. Questions were structured to elicit information on each

organization's capacities as they align (or not) with the elements of viable MTM programs, listed above. Interviewees typically provided valuable information beyond the initial structured questions. Due to COVID-19 most interviews were held via ZOOM, with a few conducted by telephone. In some cases, Helen Labun, Director of Policy for Bi-State, joined the consultant in the interview. Several interviewees requested additional information to learn more about MTMs and the consultant provided the requested resources.

Initial Findings and Recommendations

Vast differences exist between the environment in Vermont, and that of states where mature MTM programs have operated over three decades, including geography, population demographics and the state of health care payment reform and models that allow reimbursement for MTMs.

The greatest challenges to initiating MTM services in Vermont include:

- Food production that ensures consistency, quality and food safety.
- IT systems that can accommodate the demands and "closed loop" of communication and feedback among parties that MTM services require
- Delivery system that can reach remote rural locations
- Start up and sustainable funding sources

It is highly unlikely that a new, single MTM focused organization capable of serving the entire State of Vermont can be created. However, options exist for collaborations among organizations that together could provide the structural elements necessary for a medically tailored meals service, adapted and customized to be a "VT MTM" branded program that could meet the actual needs in the state, building on the unique characteristics, culture, and tradition of mutual aid at the local level. "VT MTM" could:

- Focus on a narrower range of clinical conditions than those addressed by programs in other states
- Focus on a limited age range of patients to be served, reflective of the large and growing aging population of Vermont
- Engage a commercial food service company for certain components of food production and meal delivery
- Emphasize "Vermont Local" procurement, to support farmers consistent with other activities in the state (e.g. food service at colleges and universities)
- Align with the policy priorities of the "Vermont Action Plan for Aging Well" (Vermont Act 156).

The statewide system of Area Agencies on Aging, overseen and supported by DAIL, offers options for MTM development. These trusted agencies form a state-wide network and have:

- Strong local identities of service and caring---for the Vermonters most likely in need of a high degree of nutritious food supports, including MTMs.
- Meals on Wheels and nutrition learning programs
- Dedicated volunteers from local communities
- Administrative and staff capacities in varying degrees depending upon the individual AAA, including client assessment for social and physical needs, monitoring, and IT technology, with uniform tools and reporting mechanisms that may be adaptable to MTM services
- Systems to communicate with each other
- Experience working with the health care sector
- A state oversight agency (DAIL) that is firmly committed to the welfare of AAA clients, especially nutrition security, and connected to a federal agency (Administration for Community Living) that participates in policy development with other federal agencies, such as CMS, and offers a grants program to Area Agencies on Aging.
- Advocacy capacity, especially at the state level
- A funding base, although not adequate for all they do and requiring philanthropic support.

Two of the five Vermont AAAs we interviewed, Age Well and NEK Council on Aging (Options A and B in the Appendix to the Power Point presentation to stakeholders) are interested in pursuing next steps and a pilot if funds can be obtained. Each of them is already pursuing ways to provide meals via their Meals on Wheels programs that are customized to meet certain physical limitations (poor dentition) and clinical conditions (e.g., hypertension) of individuals they serve.

A third option for next step planning (Option C in the PowerPoint presentation to stakeholders) contemplates a structure of assigning certain functions to centralized management (Information technology, recipe development and food production oversight), with others delegated to local agencies (e.g., meal delivery, patient monitoring). Please refer to the Appendix to the PowerPoint presentation for details on this option.

Food Production/Storage

MTM food production must guarantee strict adherence to specific recipes, consistency in production and food safety procedures at every step of the process. Without these quality control measures, impact evaluation (essential to collaboration with health care providers and payers, and all forms of funding) would be impossible. The leading MTM organizations in the U.S. all conduct their own food production---a capability developed over the past three decades and made possible because of their deep and diverse funding base. They operate in dense urban environments with populations that have a broad range of demographic characteristics and chronic disease conditions. These programs have developed the capacity to provide a wide

range of medically tailored diets: one organization serves 13 different diets for patients it serves. However, and importantly for Vermont planning, the majority (as much as 85%) of patients are provided with a basic DASH diet (Dietary Approaches to Stop Hypertension) with some variation.

The "Accelerator" Program that these organizations now sponsor to train others across the country does not admit any commercial vendors to that program. Nevertheless, working with a commercial vendor in Vermont may be the most practicable way of building an MTM program, given what is already occurring on the ground in the Meals on Wheels programs managed by the regional AAAs.

Age Well, and the two of the other four regional AAAs contract with TRIO, a commercial food service management company, to produce meals for their "Meals on Wheels" ("MOW") programs. Professional chefs and registered dietitians develop the recipes and meals are produced in the company's commercial kitchen facility in Rutland, Vermont. Currently, to meet individual client needs at their customer organizations, the company offers the follow types of "therapeutic" meals:

- Low lactose
- Cardiac/ low sodium
- Renal
- Chopped/ soft
- Ground
- Puree
- Carbohydrate controlled

Note: "Therapeutic meals" is a term long used by professional registered dietitians.
The difference between these types of meals and those referred to as "medically tailored meals" by organizations such as Community Servings is arguably one of degrees of recipe refinement for individuals who have multiple serious disease conditions being treated with a variety of medications for those conditions, in addition to the meals.

The vendor is well aware of the importance in Vermont of local sourcing of ingredients.
The vendor also offers production services at client locations, where an approved commercial kitchen is in place.

Agewell staff (which includes registered dietitians supervised by a Wellness and Nutrition Director) order the meals, and the vendor's responsibility ends with delivery of the meals via a refrigerated vehicle, to "hub" locations where Agewell staff and volunteers package and deliver the meals to clients at home.

Recommendations:

Conduct more detailed research on the TRIO's Vermont operations and its relationship with Agewell and the other southern VT AAAs to obtain:

- *Cost data. We requested but were unable to obtain specific cost data from this vendor during our research.*
- *Patient satisfaction information*
- *Reasons the AAAs moved from multiple small production contracts to use of this vendor*
- *Greater detail on food production, oversight and training that TRIO represented, in an informational interview we conducted, it could provide at client sites. This vendor service could be an option for the two AAA regions that now do their own meal production via a number of contracts with local organizations (e.g., 18 different sites in the case of the NEK Council, with only one or two that have a professional chef and other infrastructure capacity to ramp up production for some level of MTM service).*
- *Information on TRIO's local sourcing. The vendor estimates the level at approximately 10%. Clear standards and percentage requirements for local sourcing could be extremely important to the "branding" of a VERMONT MTM program. The State has a history of a very successful collaboration with Sodexo, that serves most of the higher education institutions in the state. The Sodexo experience could serve as a model for work with TRIO or any other vendor with respect to MTMs.*

A site visit to the Rutland production facility should be conducted, with interviews of key staff (lead chef, an R.D., operations manager for Vermont.) Next step research should be done in cooperation with Age Well, given its relationship and experience with the vendor.

A site visit with NEK Council staff to the one or two of their MOW food production sites that could ramp up to produce MTMS.

A site visit to NVRH to meet with the Food Service Director and administrative staff regarding their capacity to produce MTMS, both for a pilot and beyond.

A site visit to the New Hampshire Food Bank commercial kitchen facility should be conducted. Ongoing communication should be maintained with their Executive Director, Eileen Liponis or her staff, to monitor the rollout of their MTM program.

Meal Delivery

Past discussions and pilot activities among stakeholders interested in pursuing MTMs across Vermont all contemplated using the Meals on Wheels volunteer delivery infrastructure. This infrastructure exists as a matter of policy (Older Americans Act) and brings the very meaningful benefits community support and human interaction that reduces the sense of isolation that

many homebound individuals suffer. This delivery mechanism alone may not be adequate for an MTM service.

Future planning for MTMs in Vermont should consider food production and meal delivery in tandem, with the following variables in mind:

- Moving meals from the point of production to the client-consumer requires certain cooling, refrigeration and perhaps freezing capacity to ensure food safety.
- MTMs are a much higher volume service (3 meals per day) than Meals on Wheels (one meal day)
- For individuals living in very remote areas of Vermont, a shipping option (used by the existing Colorado and Pennsylvania MTM programs) may be necessary. This alternative requires a higher level of client service with respect to monitoring client satisfaction, progress and compliance. Telehealth applications which are used in other states and have been suggested by several interviewees for patients living in remote locations, would go far in facilitating this type of support and human connection in Vermont.

The existing volunteer MOW delivery capacity could, with regulatory approval (DAIL), take a portion of its capacity in each AAA region and design a delivery process that could address the above variables.

TRIO has full vertical integration of centralized food production and meal delivery, with statewide capacity. Their resources include customized, refrigerated trucks that deliver to hub locations, and smaller vans with drivers that fan out from the hubs to other locations, in some cases in southern Vermont, even to patient homes. In the case of Age Well, the last steps of MOW delivery are still handled by volunteers who package meals into smaller units and then deliver to individual patients at home, thereby preserving the critical element of human connection so valued by both volunteers and MOW meal clients .

Identifying Priority Populations for Early Stage MTM programs.

Compared to the populations served in MTM programs in other states, Vermont has a much smaller, more homogenous population overall that is likely to have a narrower range of clinical needs that can be positively impacted by MTMs.

Precise identification of priority populations that could be served requires data analysis that is beyond the scope of this report; furthermore, privacy rules and regulations, IT security safeguards and proprietary interests in some data prevented Fresh Advantage from accessing data held by any of the organizations interviewed.

Publicly available chronic disease prevalence data, together with descriptive general information drawn from data held by various interviewees suggest that patients who could benefit from MTMs in Vermont include (but not necessarily limited to):

- Individuals over the age of 60, and are
- living with a range of serious chronic cardiac disease (e.g., CHF, hypertension, and/or poorly managed diabetes) and
- who are unable to cook or shop for themselves (most likely to be in complex care management programs through their clinical provider or health care plan) and
- who have limited income, and
- who are food insecure

<u>Recommendation</u>*: *Perform a preliminary data analysis "pilot" to quantitively identify potential patients in a specific region of Vermont.

Bi-State has received one grant to support future planning for "VTFoodinhealth" and is pursuing others that could provide support for data analysis to quantify populations in need of MTMs.

Rather than pursuing an "at-large" statewide data analysis, a group of collaborators, with supervision from a data analytics expert (perhaps from VDH or Bi-State), could focus on one AAA region and take the first step of culling from their existing datasets, within the bounds of HIPAA and using an agreed upon set of variables, to form a rough summary "snapshot" of the region, for a given period of time. Such an exercise could catalyze collaborative work that would familiarize the organizations interested in MTMs regarding their respective data collection and management capacities and provide a profile of the extent and location of needs as well as quantification that funders will require.

A general willingness to work together on data analytics was exhibited by the two AAAs interviewed, OneCare, VDH, DAIL and to some extent Blue Cross/Blue Shield; details are contained in the individual interview summaries.

A few basic ideas were offered in the interview process:

Age Well, or the NEK Council, could provide summary, anonymized data of:

- the ages of their clients in MOW and care management programs and the location of their home residence
- number of clients experiencing food insecurity
- the chronic conditions affecting those clients and the number of conditions per client,

Hospitals in the region (or via the Vermont Hospital Association) could provide summary discharge and readmission data for three conditions with the greatest potential for amelioration by MTMs (CHF, hypertension and poorly managed diabetes).

OneCare could provide summary data of individuals in complex care management in the region
Blue Cross/Blue Shield could provide anonymized Medicare Advantage claims data

VDH could provide the most up to date prevalence data available for the three conditions and perhaps other data and GIS mapping if possible.

A data analysis pilot could also facilitate accurate assessment of another key issue area:

- *Information Technology Systems available in the state to support MTMs, and*
- *Administrative and Management Capacities* highlighted in the "Options" portion of the PowerPoint presentation

MTM programs rely upon inputs and outputs that can facilitate reliable communication among entities providing the MTM service, health care providers and payers. Establishing this 360-degree information flow has required a significant investment of resources, both public and private, in other states. Vermont will need to look at what exists now and evaluate how those assets can be refined and deployed in support of MTMs.

The AAA network is one that has a common platform that may lend itself to adaptation to MTMs:

- Operations are conducted in accordance with regulations pursuant to the Older Americans Act that are administered at the federal level by the Administration for Community Living at the federal level, and by the Vermont Department of Disabilities, Aging & Independent Living at the state level.
- These agencies require the use of uniform data collection tools, utilization of a common database system. These tools may offer a scaffold that would be difficult to create anew at other organizations: A good example being that they all screen clients for food insecurity, a data point essential in MTM programs but that has met with variable acceptance among the clinical providers in Vermont.

AAA compliance with the regulatory requirements, and associated administrative demands confers a level of experience with client assessment, support and data management whereby they would compare favorably to other organizations that might be attracted to the mission of MTMs, but not fully aware or capable of the administrative demands they pose.

Recommendation: Learn more about AAA IT Systems, Assessment, Screening for Food Insecurity and other social needs, Case Management, Monitoring Capacities. Continue the dialogue with DAIL/Office of Aging and its nutrition professions in particular.

Working with the health care sector

The two AAAs considered in the "Options" portion of the Power Point presentation that accompanies this report have contracts for care management with OneCare and perhaps other payers or providers. They are well versed in the requirements and maintenance of HIPAA

compliant data management, sharing, storage. Through these established contractor relationships with health care providers and payers, they have acquired valuable experience in reporting and accountability and the unique dynamics of the interface with the health care sector.

The preliminary research by Fresh Advantage was weighted heavily on gaining insight into resources that exist with respect to the operational components of MTM programs. Two physicians were interviewed in the preliminary research process, but the context was their role as Chief Medical Officers of OneCare and Blue Cross/Blue Shield. Hospital staff was interviewed but limited to members of the food service staff. Thus, there is more work to do in the next planning phase to build bridges with clinical providers and key staff at hospitals in the state.

Recommendation: *Conduct additional interviews with clinical providers (physicians and nurse practitioners) who provide care for the priority populations. Examples include:*

- *Cardiologists*
- *Endocrinologists*
- *Primary Care Providers who coordinate care with specialists, and work in various practice settings*

Recommendation: *Conduct interviews with a sample of discharge planning and complex care management staff at hospitals and within health plans to obtain more detailed information on how referral to an MTM program might be integrated with their existing workflow.*

Screening for Food Insecurity and Medically Tailored Meals

Poverty, food insecurity, and poor nutrition have serious consequences for health and well-being across the lifespan. Over the past decade, the body of literature on the nexus of food security and health status among people of all ages has expanded greatly, demonstrating that:

- People living in or near poverty have worse health outcomes and less access to health care than those who do not.
- Food insecurity — even marginal food security (a less severe level of food insecurity) — is linked to some of the most common and costly health problems in the U.S., particularly cardiometabolic diseases such as obesity, diabetes and hypertension, as well as mental health disorders.
- The direct and indirect health-related costs of hunger and food insecurity in the U.S. have been estimated to be $160 billion.
- Research shows that the federal nutrition programs alleviate poverty, reduce food insecurity, and improve nutrition, health, and wellbeing.

As the research on the association of food insecurity with poor health has expanded, screening tools have been developed and a variety of approaches to conducting screening in the clinical setting have been taken and evaluated with respect to avoiding stigma, linking screening to referral systems for patients facing food insecurity, and minimizing administrative burdens for health care providers. Suggestions and toolkits for "how" to implement food insecurity screening are becoming more widely available.

While food insecurity screening is often seen as a component of prevention and population health, it is also a foundation for clinical management and building treatment focused programs such as Medically Tailored Meals.

An early paper by one of the leading researchers in the U.S. on food insecurity and medically tailored meals asks **will it (or *could* it) change clinical management?** In the case of a diabetic patient (the example offered in the paper) knowing a patient's food security status has implications for clinical management. For example, incidents of hypoglycemia, often requiring emergency room visits and even hospitalization, may be attributable to lack of nutritious food -- adjustments to medication as well as effectively linking the patient to nutritious, diabetic appropriate food support will be in order. Food insecurity is known also to promote consumption of cheap, high fat foods, laden with salt, sugar and simple carbohydrates-- precisely the "foods" that a patient with hypertension and cardiac disease should avoid. Advising a food insecure patient to avoid these foods will be ineffective without an additional connection to resources to make this diet possible.

Because it is established that food insecurity affects not just quantity of food available but the *quality* of a diet, and therefore a patient's ability to comply with recommended medical diets, these screens become part of treatment plans. Food insecurity status also becomes a relevant component of evaluating the impact of a food-based medical intervention program because it allows us to review data across comparable patient groups by managing for a key variable.

Food insecurity screening protocols also establish a necessary system for referring patients to receive food resources paid for with health care service dollars. Although Vermont does not currently have robust health care funding for medically tailored meals, the intent is to develop more diverse funding streams and these usually require screening questions to determine eligibility. Screening is also a best practice for health care providers that wish to avoid conflict with inducements rules (practices should refer to their own legal counsel on this question).

Vermont is not waiting on the development of a medically tailored meals program to implement broad food insecurity screening; developing systems for screening and recording data in the EHR supports a range of interventions beyond MTMs. Food insecurity screening is most prevalent in pediatric practices in Vermont. However, for many patients, aging not only brings more health challenges, but also reduced income--another life circumstance that can lead to food insecurity. Thus, food insecurity screening serves as another clinical evaluation and treatment tool for this group, one that could eventually, and beneficially lead to identification of the need for a medically tailored meal regimen for the patient with serious disease and compromised ability to provide the needed diet for themselves. Well visits at primary care practices offer an opportunity to investigate the potential role of food insecurity in health care management. One resource is the AMA STEPS Forward Supplement to the Medicare Annual Wellness Visit. This AMA tool is specifically designed to fit with the changes being made to Medicare that emphasize preventive care and chronic disease management, and streamline workflow to accommodate these changes, which include screening for SDOH.

Recommendation*: Collaborate with Hunger Free Vermont and other organizations that support health care practices in implementation of food insecurity screening both to implement screening when tied to pilots of food intervention programs such as MTMs and as a standard component of well visits.*

Recommendation: *Bi-State, together with other health care organizations in Vermont, could sponsor collaborative educational forums (webinars, "live" meetings when possible) on the topic of screening, providing information on available tools, the literature available on screening and implementation successes, challenges and barriers to action. Presentations by leading experts and researchers on the topic of food insecurity and clinical practice could be invited to such forums:*

Hilary Seligman, M.D. MAS, UCSF, Center for Vulnerable Populations

Seth Berkowitz, M.D, MPH .University of North Carolina

John Steiner MD., MPH, Kaiser Permanente

Representative of Children's Health Watch, Boston, MA.

Sandra Stenmark, M.D. Clinical Professor of Pediatrics, University of Colorado School of Medicine, Anschutz Campus; Hunger Free Colorado

Kim Prendergast, R.D, Director of Social Determinants of Health at Community Care Cooperative (C3), formerly with Feeding America

Identifying options for bringing to scale.

Two approaches to scalability came about as a result of this preliminary research:

- Working through the AAA regional structure to pilot and then disseminate MTM services on a statewide basis. Given the extensive capacities and service scope of Age Well, that agency may be well positioned to serve as a mentor-leader to the other four AAAs in the state.
- Divide MTM functions between those that require centralized management, and those that can be implemented and maintained at the local level. Please refer to the PowerPoint presentation to stakeholders and recording of that session.

Approaches to systems for measuring impact of early-phase programs.

A starting point for identifying appropriate impact measurement is the reports and materials available from the national Food is Medicine Coalition and the Harvard Center for Health Law and Policy, both referenced in this report. The peer reviewed literature on MTMs is also a dependable source of information on impact measurement and methods. See the bibliography contained in the PowerPoint presentation.

Now that MTM organizations are contracting with health care payers and health plans, outcome goals, and measurement metrics are negotiated on an individual contract basis and confined to the conditions that the payer or health plan seeks to target. This is typically confidential information.

Path forward for funding

Vermont does not now have the models of health care payment that are commonly used in other states to provide sustainable, long term funding for MTMs (Medicaid 1115 waivers and Medicare Advantage programs that include a flexible member benefit for food supports).

Interviews were held with representatives of Vermont's Medicaid program (Department of Health Care Access) who are now engaged in negotiations with CMS regarding renewal and amendments to the state's authorities under its waiver from that agency, which includes securing managed care type flexibility that could allow for reimbursement for MTMs in the future.

Recommendation. *Continue to monitor the CMS discussions and be available to provide any information that could be helpful. Since this negotiation process will finalize health care payment mechanisms for the next five years, any window to assist in promoting reimbursement flexibility would be helpful.*

Education and Advocacy at the National and State Levels

As Bi-State works to develop its "Food in Health" initiative, participating in the educational and collaborative activities of national organizations will enable it to stay informed on a broad range of policy and programmatic developments at the national level, including those relevant to MTMs:

- The Nutrition and Obesity Policy Research and Evaluation Network (NOPREN) is a collaborative applied research network that informs policies and practices designed to improve nutrition and prevent obesity. NOPREN members include researchers and practitioners interested in how policies and programs enacted at the federal, state, tribal, and local levels impact families' food security, access to healthy food and water, and nutrition and health. The mission of its Work Group structure is to build a network of researchers and leaders from academia, non-profit organizations, government, and other funding agencies to increase the amount and quality of research and evaluation in the area of nutrition and obesity prevention in the hunger safety net setting, and to support and facilitate the development and implementation of evidence-informed policies and practices. The NOPREN Food Security Work Group activities have a clinical nexus, developing tools such as clinical screening algorithms, as well as research and evaluation methods for interventions that engage health care service delivery systems, together with community-based partners. The Rural Food Access Work Group convenes researchers to share resources and conduct collaborative research addressing environmental, policy, and economic issues related to rural food access.

- The national Food is Medicine Coalition's (FIMC) purpose is
    - To provide a complete, evidence-based, medical food and nutrition intervention to critically and chronically ill people in their communities
    - To advance public policy that supports access to food and nutrition services for people with severe and/or chronic illnesses
    - To promote research on the efficacy of food and nutrition services on health outcomes and cost of care
    - To share best practices in the provision of medically tailored meals and of nutrition education and counseling.

Recommendation: Representatives of Bi-State and/or its member FQHCs should subscribe to the newsletters, digital updates and participate in the regularly scheduled online meetings

offered by the Food Security and Rural Food Access Work Groups of NOPREN, and regular on-line meetings of FIMC.

Monitoring the work of NOPREN and FIMC will assist Bi-State in raising awareness and educating various constituencies in Vermont regarding the potential benefits of MTMs and the "state-of-the-practice" nationwide. Once more detailed data can be obtained on the size and scope of the need for MTMs, this information, along with information obtained from the two national organizations and relevant research, can be used to:

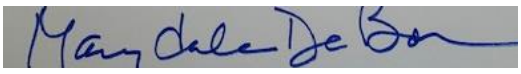
- Provide briefings at regularly scheduled meetings of Bi-state members, professional medical and nursing associations in the state, and committees within the health payer organizations. For example, a briefing to the Health Care Reform Committee of Blue Cross/Blue Shield was provided by the consultant and received a very positive reception. What was evident was that an MTM learning curve exists even within this group.

- Educate policymakers at the state level about the need and potential impact of MTMs, especially on older Vermonters, perhaps even leading to engagement by one or more elected officials as champions for development of this resource.

- Support a media strategy (building upon the VTFoodinhealth.net podcasts, "In plain English) through which Op-Eds and articles about MTMs, as a part of integration nutrition security measures into health care service delivery can reach the general public.

Recommendation: *Consider participation, as a starting point, in the process now underway at DAIL to develop a "Vermont Action Plan for Aging Well". Provision of testimony or position statements on the need for data driven needs assessment and health care payment reform that allows for flexibility for reimbursement for MTMs and perhaps other forms of nutrition supports integrated with health care service delivery could be helpful in advancing a range of innovation as a part of Bi-State's Food in Health initiative.*

Fresh Advantage appreciates the opportunity to assist Bi-State Primary Care Association in connection with its "VT Food in Health" initiative and stands ready to address any questions about our work or this report and to provide consulting assistance in the future.



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