

# Nourishing Seniors Through Medically Tailored Meals



August 8, 2019 Proceedings

Convened by the  
National Resource Center on  
Nutrition and Aging

Arlington, Virginia

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# Introduction

This event was hosted by the National Resource Center on Nutrition and Aging with support from the Administration for Community Living, Grant Number 90PPNU0001.

## **National Resource Center on Nutrition and Aging (NRCNA)**

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## **About the National Resource Center on Nutrition and Aging**

Hosted by Meals on Wheels America as part of a cooperative agreement with the Administration for Community Living, the National Resource Center on Nutrition and Aging (NRCNA) is designed to build the capacity of the aging services network to provide nutrition services for current and future older adult populations integrated into a home and community-based service system. The NRCNA also provides training and technical assistance to the aging network regarding nutrition services.

## **Event Overview**

For this convening, keynote speaker Katie Garfield, clinical instructor at the Center for Health Law and Policy Innovation of Harvard Law School, kicked off the day. Three speakers presented local success stories (Leslie Scotland-Stewart, Director of Health Care Innovation at Project Angel Heart, Colorado; Jean Terranova, leader of the Food is Medicine policy initiative, Massachusetts; and Alissa Wassung, Director of Policy and Planning at God's Love We Deliver, New York City). Afterward, small group discussions were led by trained moderators and recorders. All findings in this Proceedings document have been generalized from transcripts and the groups' observations. The graphic images were recorded on-site and reflect a quick summary of the discussions. The graphic images and ideas within them reflect the perceptions and experience of local program participants and are not the opinions or views of the funders or convener.



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# Executive Summary

For older Americans coping with chronic illness, part of the prescription for health just might be the right nutritious meal, tailored to special medical needs, delivered to one's doorstep. A growing number of experts and healthcare professionals think that such medically tailored meals (MTMs) look like a promising solution to both boost quality of life and trim healthcare costs.

That's because the number of older adults in America is growing quickly, overwhelming the resources available to help them—especially the most vulnerable ones—and jeopardizing their health and well-being. For some older adults, the lack of access to nutritious food is a particular challenge. Food insecurity, meaning lack of consistent access to enough food because of a lack of resources, can lead to malnutrition, and both conditions are associated with high annual healthcare costs.

Enter MTMs. MTMs “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.”

This is significant because recipients of MTMs can be some of the highest need and higher cost patients to treat. There is growing evidence that MTMs can lower healthcare costs. For instance, the Community Servings program in Massachusetts has led three clinical research studies that found a 16% net reduction in average monthly costs for patients who received their MTMs.

To further explore the potential of MTMs, the National Resource Center on Nutrition and Aging (NRCNA) hosted a day-long session in Arlington, Virginia, on August 8, 2019. Participants heard evidence-based research on the healthcare cost savings from MTM programs and firsthand accounts from three programs that employ different models to suit their differing local situations.

In small groups, participants voiced initial reflections and concerns. They expressed interest in information on how to fund MTM services, talked about how to bridge the different worlds of social science and healthcare, and outlined needs for research and infrastructure. They discussed and better understood the operational impacts of these programs and how best to address them. Participants also explored ideas for “building the apparatus,” for how to start offering MTM services such

as playbooks on reimbursement, referrals and stakeholder analysis.

They saw a need for a comprehensive picture of the national competitive landscape, available data and cost range of MTMs. Currently there is a lack of national standards, requirements and capacity, (including varying access to registered dietitians). A diversity of programs are at work.

Many local models have sprung up, shaped by each state's different populations, needs, regulations, healthcare structures, culture and opportunities. Community-based organizations (CBOs) that shared success stories include Community Servings (Massachusetts), God's Love We Deliver (New York City) and Project Angel Heart (Colorado). Launching such local programs, generally in public-private partnerships, can take time, yet a growing number of leaders are committed to finding what works and meets the concerns of payers and healthcare providers in their communities.

The NRCNA is responding to a need for thinking strategically, setting priorities, building infrastructure and business development, nurturing continued regional/national conversations, identifying training needs and providing technical help on such challenges as strengthening referral systems.

Participants heard that at the local level, proving that MTMs reduce healthcare costs and improve individuals' health is a critical first step before exploring partnerships, launching pilots or expanding current programs. Practitioners must first have evidence-based data, characteristics of target populations, and proof of ROI in hand—all tailored to the needs and structure of potential payers. (A payer could be any entity, such as a hospital, a private health insurer or government healthcare provider such as the Centers for Medicare or Medicaid Services, for example.) Then as with any new business opportunity, leaders must identify best practices, understand the training needed, develop reliable business models, and create practical, strategic paths for practitioners.

Many questions from participants were practical, such as how to price MTM services and how to determine which portion of a population to serve. Other issues require culture shifts and change management, such as bridging the different mindsets between the social service/aging services and medical worlds.

By providing thought leadership on both the local and national levels, the NRCNA aims to support a sustained MTM movement, nurtured by convening such discussions and partnering with like-minded others.

# Nourishing Seniors with Medically Tailored Meals



\$5.5M people are food insecure

doubled since 2001

"I have to make a hard choice!"

the DOMINO EFFECT

Solution?



SPECTRUM OF NEEDS

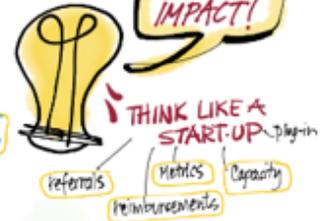
SHOWING POSITIVE HEALTH OUTCOMES!



SHOW WHERE THERE IS IMPACT!

Food is LOVE...

CLIENT AS A WHOLE "Family"



THINK LIKE A START-UP

## 1 Opportunities:

- Leverage existing Reimbursement systems
- HC Cost Environment
- Desire to get in Home
- CMS CENTER for Innovation/broader NIH Studies
- Robust Health-care system
- More Data



## 2 Challenges:

- local population & need
- Mindset / Culture change
- Competitive landscape
- lack of National FOR Consistent standards
- Building the Aparatus



## 3 Ideas:

- ID funders of select population
- outreach to HC professionals
- Proactively Market outreach
- Tell Story
- Access Data from partnerships
- Landscape Relationship
- Layout opportunities
- Understand Funding

# 1. The Opportunity

(Synthesized from remarks by keynote speaker Katie Garfield, JD, Clinical Instructor at the Center for Health Law and Policy Innovation of Harvard Law School.)

For people living with serious health conditions, health and food are linked. A growing number of older adults in America lack consistent access to quality food and also suffer from chronic diseases such as diabetes or renal failure. While the healthcare system has tended to their immediate medical needs, looking at “the whole person”—including meals at home and how meals can be tailored to medical needs—can uncover a new way of helping to address their problems.

This new focus is medically tailored meals (MTMs). 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.”

As MTM programs are being integrated into the healthcare system, the need for evidence-based results and data has increased. In particular, payers are primarily interested in

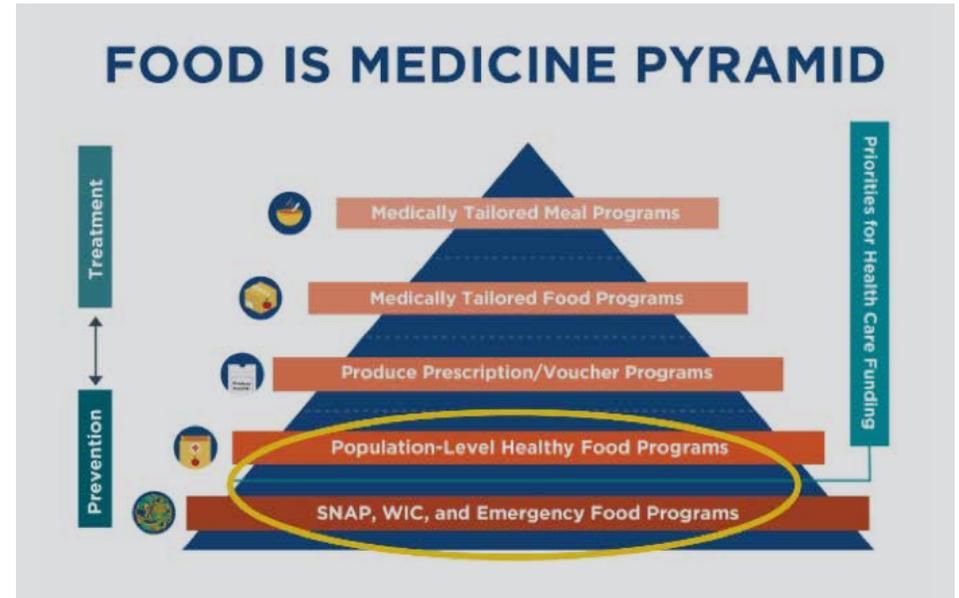
approaches that can show compelling evidence of how costs are trimmed—such as by reducing readmissions or emergency room visits—and how patient care improves.

Community-based organizations (CBOs) have an opportunity to develop effective MTM programs, targeting some of their services to local needs as expressed by healthcare providers and payers. The road from idea to rollout may be bumpy. Yet armed with an understanding of research, ROI, innovative demonstration projects, and back-end basics like referral systems, the opportunities are vast. The rewards? Seeing better health results for individuals (particularly older adults), and bending the curve on healthcare costs downward.

## A. THE UNMET NEED

Nationally, 5.5 million older adults are food insecure, or more than double the number in 2001. Food insecure percentages of the older adult population range from 2.8% in Minnesota, the lowest, to Louisiana at 12.3%, the highest.

Further challenges include vision loss and cognitive and physical changes. When consistently needing quality food, such a person faces tough choices. He may choose between food and other basic needs such as utilities, or consume low-cost, energy dense foods like potato chips.



She may delay medical care, save money by using less medication than prescribed, or go without food needed for special medical diets.

These hard choices lead to a domino effect, particularly if an older person is dealing with a chronic disease such as diabetes at the same time. It is striking to see the result of some of these hard choices. For instance, Seligman and colleagues found that hospitalizations for low-income, diabetic patients rose at the end of the month when food, finances and nutrition benefits such as SNAP (Supplemental Nutrition Assistance Program) were low. Hospitalizations, in turn, remained stable for middle- and upper-income households.

Meanwhile as the severity of food insecurity increases, health conditions can worsen and healthcare costs can increase. For instance, Craig and

Gunderson found that food insecure older adults were 57% more likely to have congestive heart failure than those who were not food insecure.

Various “nutrition interventions”—from prevention to treatment—can help keep the negative health effects under control. Basic programs like SNAP and emergency food programs can help forestall the domino effect. Still, for some people, a basic meal is not enough. Seeing the concept of “food as medicine” in a pyramid diagram demonstrates “basic” needs at the base and a narrower slice at the top for those who need the more specialized MTMs.

MTMs can help this smaller, yet even more vulnerable, slice of the older population who deals with severe or chronic illness, and often with multiple conditions. Though this is a smaller percentage of overall individuals in

NOURISHING SENIORS w/ MEDICALLY TAILORED MEALS

**KEYNOTE SPEAKER**  
KATIE GARFIELD  
AUG 8, '19

Today:

- 1) Baseline Med. Meals
- 2) Why??



**FOOD IS MEDICINE**

HIGH QUALITY RESEARCH DATA

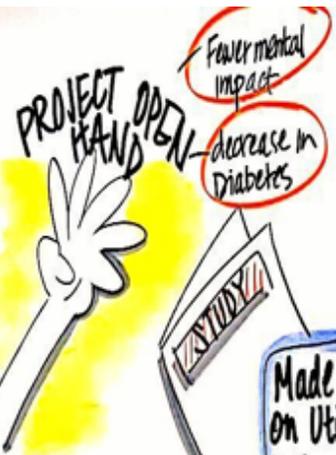
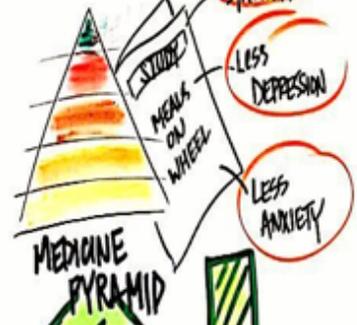
### PROBLEM?

5.5M people Food insecure  
 DOUBLED SINCE 2001

"I HAVE TO MAKE A HARD CHOICE!"  
 65% DIABETIC  
 57% Heart Failure



### SOLUTION?



Made case on Utilization & Healthcare cost



**TAKEAWAY:**  
Medically-Tailored Meals decrease Healthcare cost

30% Less Impatient Hospital  
 28% Less monthly cost

### EVIDENCE?



"positive Health Outcomes"



**REAL CHANGE**  
 SUPPORT, FOSTER, ENCOURAGE CHANGE  
 DUAL ELIGIBLE PROGRAM  
 WALKER PROGRAM  
 MANAGE CARE

**2020**  
 SPECIAL SUPPLEMENTAL BENEFITS  
 Medicare @ Medicaid  
 OLDER AMERICANS ACT

### ISSUES:

- DRIVING
- TRANSITION
- TRIAGING

### GAPS:

- RURAL AREAS
- NON-COASTAL STATES

need, these individuals consume a greater percentage of healthcare costs than do patients without severe or chronic illness.

A 2015 study commissioned by Meals on Wheels America showed how the provision of basic daily meals improved recipients' health and life. Compared to the waitlist group, daily meal recipients reported better health, less likelihood of falls, reduced feelings of isolation, and decreased depression and worry about being able to remain at home. A 2017 analysis of Medicare claims showed that rates of hospitalization, emergency department use and nursing home use all dropped after recipients began getting Meals on Wheels deliveries. The declines in healthcare use held up over 180 days.

Such interventions are at the base of the Food Is Medicine pyramid (see page x). The pyramid conveys a continuum of services.

The advent of MTM programs calls for still more research on implications for individual health and whether such meals can help put the brake on rising healthcare costs across the nation.

## **B. RESEARCH ON WHAT WORKS**

If they seek to be providing these services, the organizations that are delivering an MTM program or

contemplating providing MTMs must make the case to prospective payers for how they are lowering healthcare costs. Without evidence, payers and healthcare providers will not be interested. A handful of research studies illustrate how to deliver that proof.

In one study in Philadelphia, MANNA clients who were critically ill and nutritionally at-risk showed 50% fewer hospital admissions and 31% lower mean monthly healthcare costs after a year, compared to a control group. This was largely because MANNA clients were using fewer high-cost services.

Project Open Hand in San Francisco took a look at how some hard choices faced by resource limited individuals described earlier played out when medically appropriate food was added. The program showed decreased trade-offs. While 34.6% of those served had sacrificed health care for food previously, for instance, only 15.4% did so after the intervention.

Project Angel Heart in Colorado used health insurance claim data for a pre/post-comparison. After a six-month intervention for adults diagnosed with diseases such as cancer, congestive heart failure, multiple sclerosis and diabetes, hospital readmissions showed a 13% decrease. For

congestive heart failure, for instance, there was a \$736.00 cost reduction per member, per month.

Cost savings evidence takes on additional weight when data show the net savings after provision of the MTMs. A study from Community Servings in Boston did just that as it looked at patients dually-eligible for Medicare and Medicaid who had received MTMs. This group had 52% lower hospitalization rates and 16% lower healthcare costs after meals were paid for. A follow-up study, with a wider patient mix and larger sample size, found a similar 16% net reduction in healthcare costs after paying for the meals and delivery.

## **C. OPPORTUNITIES FOR INTEGRATION WITH HEALTH CARE**

As interest in MTMs increases, there is opportunity and incentive for greater coordination with healthcare providers. One concrete opportunity comes in 2020, when Medicare Advantage plans will allow special supplemental benefits for the chronically ill. That can mean greater options for providing meals to chronically ill individuals, and a particular opportunity for CBOs to consider MTMs. Potential MTM providers might look at Medicaid waiver programs (1115, 1915[c]) for support.

For senior nutrition program

providers, it is increasingly important to integrate with healthcare structures and to prove ROI. Providers must demonstrate that:

- MTMs can help get the right nutrition intervention to the right client.
- MTMs can help maximize health outcomes, quality of life, and save healthcare dollars.

These critical considerations come up on the back end, as well as when making the initial referral of a patient to a meal provider. Evidence-based data matter in crafting proposals that could resonate with healthcare providers' areas of greatest need for cost savings.

## **D. RESEARCH GAPS AND ACCESS GAPS**

Getting the right individual connected to the right nutrition intervention will continue to be a priority, so additional research could be done on triage and which intervention makes sense. For instance, non-tailored meals might work better than MTMs for certain clients. Additionally, one intervention might be appropriate for the acute phase after hospital discharge, while a transition to other interventions could be appropriate several months later.

The question of dosing also needs further study. How many meals per week, for how many weeks? How

personalized and tailored can MTMs be when a client has several medical conditions and resources may be limited?

The national competitive landscape needs to be more thoroughly studied. As the MTM field expands, traditional social service meal providers will focus not only on their own ROI and value-add proposition, but on how to stay competitive in the broader landscape. MTM programs so far have tended to be in urban areas or along the East and West Coasts. More work needs to be done in non-coastal states and in rural areas to ensure access and quality remain high for all older Americans who might benefit. Since the overall need is great, research also needs to explore which target populations will see the greatest benefit, both on health outcomes and healthcare costs.



# 2. Different Service Models

While practices in MTMs are standardized, MTM programs have developed with flexibility and diversity. Every state is different in its needs, people, regulations, variety of healthcare providers and meal providers, and even the number of registered dietitians who could be tapped for such an endeavor. These models show a range of services, population needs/focus, and structures. Their very diversity illustrates the possibilities and promise of MTM programs.

## A. PROJECT ANGEL HEART (COLORADO)

(Synthesized from remarks by Leslie Scotland-Stewart, Director of Health Care Innovation at Project Angel Heart)

**Approach.** Project Angel Heart began in 1991 and now provides MTMs throughout the state of Colorado. While meals can be volunteer-delivered in urban centers such as Denver and Colorado Springs, much of the state is rural, so the program had to develop a reliable shipping model. Now frozen meals can be sent to towns on the state's eastern and western edges, more than 200 miles from Denver. Having an efficient shipping model was key to being able to get Medicaid reimbursement. And having food within 24 hours after hospital discharge was another proof point getting healthcare providers and reimbursers interested.

**Challenges.** The program was one of the first in Colorado to do a reimbursement contract with healthcare providers. But the road was not easy. Project Angel Heart leaders had to be able to say to providers, "If you invest a dollar in MTMs, here is what you'll be getting." It took two years of relationship-building, showing the value-add and data, and advocating nonstop.

Another challenge was transitioning from a meal-for-free mindset to getting reimbursed for referrals and meals. In many places, food is still seen as a charity, rather than as part of the healthcare regimen. One participant recalled a patient with congestive heart failure who was offered a tailored low-salt meal. "Oh, no," replied the client, "give it to someone who really needs it." The takeaway from that exchange was the need to better frame their MTM service, both to clients and to partners.

**Opportunities.** Among the program's eight partnerships: a hospital system and a "money follows the person" demonstration (Medicaid waiver). As a CBO, Project Angel Heart found it needed to up its game in terms of making referrals simple, easy and quick. Setting up a referral system was one thing, but actually getting the referral was another. Finding the right person in the hospital to make the referral, who also had the time to do

so, made a difference. Project Angel Heart leaders focused on outcomes, who would care about the results, how they would get the necessary data, and how to relate it to money saved. For instance, by using health insurance claim data,

Project Angel Heart found that after a six-month intervention for adults diagnosed with diseases such as cancer, congestive heart failure, multiple sclerosis and diabetes, hospital readmissions showed a 13% decrease in one project. Zeroing in on the costly components of health care, such as readmissions or emergency room visits, helped make the case for investing in MTMs.

As they moved toward MTMs, program leaders had to start thinking like a start-up, and snap up opportunities when they arose. One innovative example: Paramedics now carry meals in their vans' freezers, so when they encounter certain situations and needs, the nutritious food is right at hand.

Looking back, Project Angel Heart compares its operations then and now, in the current day. "Then" was delivering meals and knowing the work was needed and good "because we got lovely stories." Today is a more focused delivery of MTMs, based on medical needs, and the ability to concretely show impact.

## B. GOD'S LOVE WE DELIVER (NEW YORK CITY)

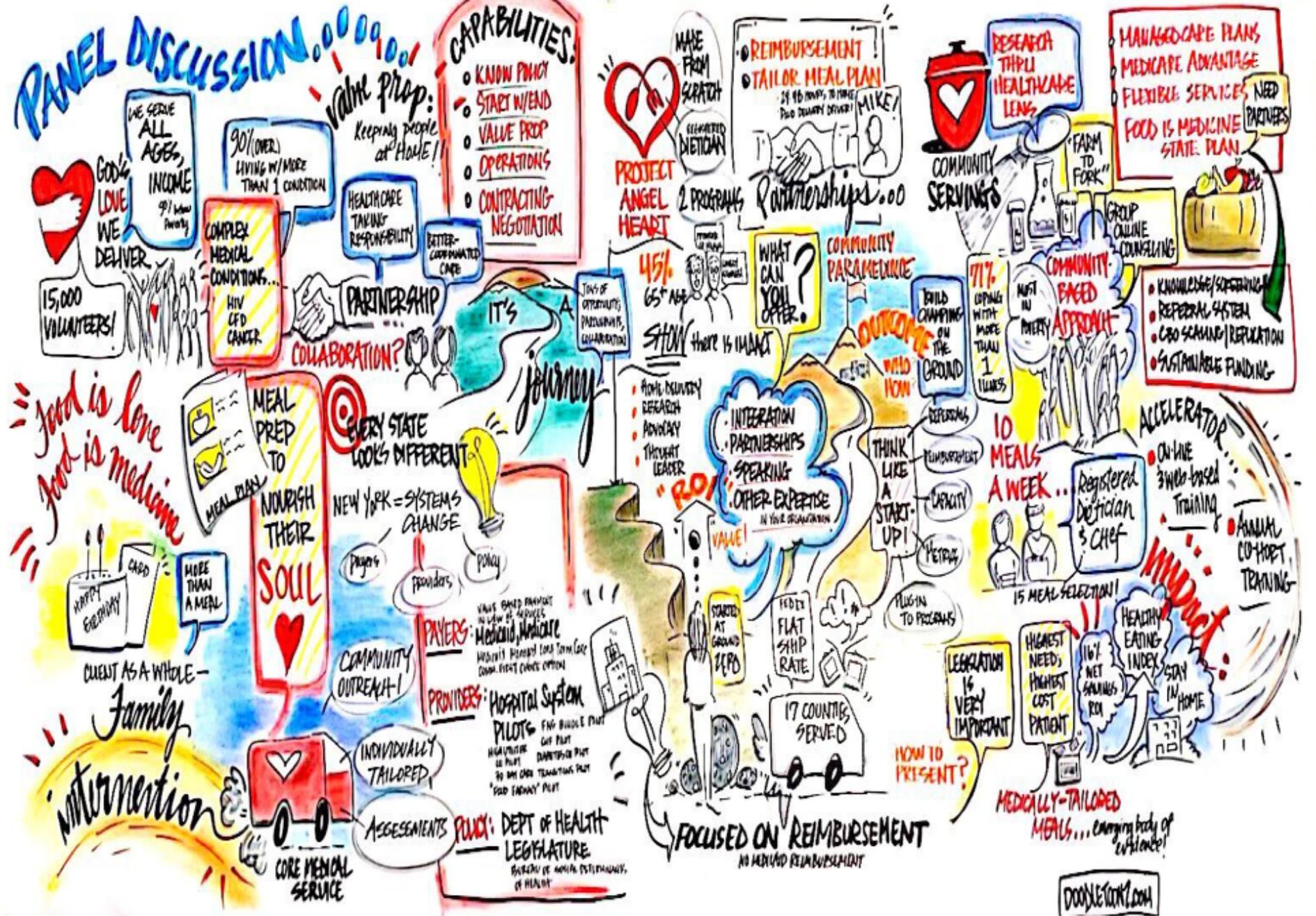
(Synthesized from remarks by Alissa Wassung, Director of Policy and Planning at God's Love We Deliver.)

**Approach.** This program delivers meals to people of all ages and incomes, but primarily low-income individuals. An average of 7,500 meals are cooked and delivered each weekday, for a total of 1.9 million meals to 7,600 people each year. Cheerful red-and-white vans go to all five New York City boroughs and almost all the surrounding counties.

The program started in 1986, and since 2005, the number of meals served has grown to 400,000 a year. The program started in 1985 as a service to people living with HIV, and later expanded to people with more than 200 different diagnoses. Some of the most common primary diagnoses now are cardiovascular disease, cancer, HIV and kidney disease. Yet it is important to note that 43% of recipients deal with more than five diagnoses at once, a statistic from God's Love We Deliver's proprietary database.

A healthcare professional's referral is key, and a team of seven RDNs makes nutrition assessments. The program can provide from 1-21 meals per week, plus ongoing, unlimited nutrition counseling. RDNs tailor the MTMs plans to a client's unique

# PANEL DISCUSSION



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medical situation, and they could range from high fiber/low fat for heart disease to pureed/minced for a cancer patient, in addition to multiple other combinations. For patients with such diseases, appetite is often one of the first things to falter, so the program works hard not to sacrifice flavor, choice or color. It starts with fresh ingredients with no preservatives, starters or fillers, and uses flash freezing for freshness and taste. The program also delivers a special cake on each client's birthday, and emergency meals during blizzards or blackouts.

MTMs are part of a high-quality continuum of care. So collaboration with a variety of stakeholders—from policy-makers to payers to providers—remains important.

Because God's Love has focused on breaking down the walls between hospitals and the community, it has several pilots with hospital systems. A sample:

- 30-day Care Transitions Pilot. Looks at efficacy of referral to MTMs post-discharge within the 30-day window. This is a focus in Medicare so that patients don't rebound to the hospital.
- Congestive Heart Failure Pilot. Tests efficacy of MTMs post-discharge using a validated tool against a randomized control.

In building partnerships, God's Love advises other CBOs to clearly craft their value proposition and know what they can do going in.

**Payers.** God's Love has 24 contracts with Medicaid Managed Long-Term Care. In mainstream Medicaid, there's an emphasis on value-based payment as the prevalence of chronic illness grows. Like other programs, God's Love looks forward to 2020, when home-delivered meals can be added to Medicare Advantage for chronically ill enrollees who are at risk for hospitalization or who need care coordination.

The population will influence the service offered, and the policy in one's state will help shape the scope. Different funding streams have different requirements and will determine the contracting target. For instance, the Ryan White federal funding stream changed to allow MTMs as a core medical service.

### C. COMMUNITY SERVINGS (MASSACHUSETTS)

(Synthesized from remarks by Jean Terranova, who leads the Food is Medicine policy initiative.)

**Approach.** Community Servings is a nonprofit organization with a 30-year history of providing scratch-made MTMs to chronically and critically ill individuals and their families. It was

founded in 1990 to provide home-delivered meals to people living with HIV/AIDS. As those individuals survived, they also had chronic health conditions, and the program evolved with them.

Today it provides MTMs to 2,300 high-need people a year with multiple chronic conditions. The main diagnoses are HIV/AIDS (32%), cancer (20%) and renal failure (18%). About 30% of clients are over age 60.

MTMs are cooked with whole, fresh ingredients, home-delivered five days a week (lunch, dinner, snack) after an initial nutrition assessment. Menus are developed by an RDN and trained chefs, and assessed over time as needs evolve. Customization is important because when an individual has multiple chronic conditions, no single meal selection might fit.

Recipients of MTMs can be some of the highest need, higher cost patients to treat, so healthcare providers are increasingly interested in seeing how MTMs can improve outcomes and lower costs. Community Servings has led three clinical research studies that found a 16% net reduction in average monthly costs for patients who received their MTMs, and significant improvements in dietary quality and self-efficacy in disease management. Savings came primarily from areas like reduced emergency room use,

reduced hospital admissions, and fewer admissions to skilled nursing facilities.

Proving an ROI was eye-catching and launched Community Servings into collaborations with decision-makers at bigger institutions. "But the ROI by itself may not be enough," said one leader. "It was important to be pertinent to a payer's population, to understand the payer's referral process and care structure, and tailor a proposal to each existing structure."

**Payers.** Community Servings has six contracts with insurers, for the most part being reimbursed by managed care plans serving individuals dually eligible for Medicaid and Medicare. They also are piloting reimbursement through a Medicare Advantage plan. Understanding that payers likely will not provide MTMs forever, they also are working on a transition plan for long-term sustainability.

**Opportunities.** On the local level, Community Servings includes nutrition education (workshops, web, counseling and assessments) and Teaching Kitchen, a 12-week foodservice job training program for individuals facing barriers to employment, with 80% of graduates finding meaningful employment.

On the state level, Community Servings and the Center for Health

Law and Policy Innovation of Harvard Law School co-lead the Massachusetts' Food is Medicine plan, which assesses nutrition access and need on the broader level. Its aim is to make systemic changes: provider education and buy-in, screening incentives, stronger referral systems with a seamless technology integration, scaling and replication by CBOs, and sustainable funding.



# 3. Participants' Insights

## A. REFLECTIONS: WHAT HOLDS PROMISE FOR YOUR ORGANIZATION

Participants represented varying locations, experience, organizations, and types of populations served. Each had varied interests in MTMs. After discussing questions and ideas in small groups, their reflections gave a range of reactions from on-the-ground providers of meal services, professionals and others.

- “To know that people are out there having successful campaigns, they are doing the work already—that has been really helpful to know.”
- “The idea that healthcare providers are actively looking to make referrals for MTMs, which is interesting because as a meal provider, we are actively looking to get the referrals to work on—there is clearly a disconnect in the system.”
- “The national system for MTMs needs to be flexible to meet the needs of local communities—the process needs to start at the local level.”

Participants appreciated the idea that not every person needs home-delivered MTMs, and that being responsive to a variety of nutrition and medical needs would continue to be paramount for providers and

healthcare partners. (See Food is Medicine Pyramid, page x). They stressed that individuals should be referred to the most appropriate program to best use the dollars, so finding the right level of intervention for each client is key and then transitioning them between these levels will be crucial.

## B. CONCERNS AND QUESTIONS

Participants were quick with their questions and concerns, particularly homing in on issues related to the costs of MTMs and funding sources.

**Funding and Costs.** MTMs seem like a productive idea, yet who would fund this and how would that work? Participants expressed needs for more information on costs compared to regular meals, a solid business model, reimbursement plan, referral plan, and more business experience and research to know which partnerships to pursue.

- “I foresee the greatest challenge is finding innovation/start-up funding. It’s hard to change service delivery when your program budget is already tight,” said one observer. “It goes back to the challenge of how to fund innovation just to get started and then long enough to show trends and hard, lasting data.”
- “MTM programs are nutritionist/

health professional heavy, which is expensive, and many senior nutrition programs/non-profits will never have the money to support this,” cautioned one observer.

### “Different Worlds” and Silos.

Participants pointed out that to be successful, MTMs must bridge two different worlds—healthcare and social services—and operational barriers generally exist between these two systems. Thinking strategically about how to remove such barriers was an important insight.

- “The healthcare side and social services side speak different languages—everyone wants to do the right thing, but it’s hard to get there, and this is not a new problem,” said one observer.
- “Ryan White [federal funding stream] had a medical model; Older Americans Act came in with social model (“as long as they get food it doesn’t matter”) so [they are] working with the home-delivered meal providers around the country.”

**Research.** Before some programs could start providing MTMs, more research needs to be done, particularly among populations and areas that have not yet been studied in sufficient detail.

**Infrastructure.** Technology, compliance, data gathering and sharing, and robust referral systems were commonly mentioned concerns. Many questions fell in the operational area, such as billing capabilities, HIPAA compliance and IT.

**Coordination among Different Programs.** Participants pointed out that the duration of MTMs and dosing is highly variable, depending on the client. Some clients might stay on the program until the end, while others with less severe conditions should eventually be transitioned to another community program. So programs—from food assistance to OAA programs to medical assistance—need to work together.

One participant also mentioned an underlying concern: “People have different needs, so MTMs will not be appropriate for everyone, and we don’t want to get to a point at which healthcare companies will pay for MTMs but not for regular Meals on Wheels.”

## C. OPPORTUNITIES/ CHALLENGES IN ESTABLISHING MTM PROGRAMS

Opportunities at the local level include a desire to respond to the holistic needs of older adults—nutrition, medical situations, and

social determinants of health (SDOH) such as socioeconomic status and connections to one's community and other people. MTM programs also offer an avenue to enhance current meal services, find new funding opportunities, and serve a new population as there is growing acceptance of the MTMs concept.

Opportunities at the national level include the ability to leverage existing reimbursement structures and systems, and the potential for new or additional funding. Additionally, there is room for innovation, such as working with the Innovation Center at CMS (Centers for Medicare and Medicaid), or being involved in demonstration projects and other research.

Local challenges include operating outside the traditional aging network, and perhaps losing a sense of ownership and the ability to control. In addition, participants mentioned:

- Identifying the most appropriate populations to work with: by age, disability status and other factors
- Ensuring meals meet religious, ethnic, cultural and regional tastes of individuals receiving MTM services
- Creating effective partnerships (using referral systems, through supplier networks, and with regulators)

- Ensuring quality control, contracting (less control over food quality). Many nutrition providers to older adults are contracted agencies that have little or no decision-making power; MTM initiatives may be challenging in these circumstances.
- Recognizing geography, including rural vs urban and variety in what is available

Major national challenges include:

- Needing a comprehensive picture of the national competitive landscape, data and cost range of MTMs (while understanding local variability and proprietary information). Such a study could include: total older adults in need, medical diagnoses, location, socioeconomic status, and what proportion is being served currently with MTMs. Some commercial alternatives are available as well, targeted for older adults.
- Finding funding options and leveraging existing reimbursement structures and systems.
- Building the apparatus and understanding operational impacts. Participants saw the need for change management, playbooks on reimbursement, referral, and stakeholder analysis.
- Understanding national capacity,

coverage, requirements and standards (including limited RDs/ RDNs). This could limit scalability. A diversity of programs are at work; it's challenging to partner and coalesce as a national, standardized network.

- Needing technical assistance on determining local population and need, as well as strategic focus to mesh with healthcare provider or payers' greatest needs.
- Becoming part of the healthcare system. There will likely be the need for a mindset and culture change as organizations with a social service background intersect with the medical/ healthcare structure.
- Other challenges include acknowledging that MTMs tend to be different (more "restaurant" quality) than the meal typically provided by programs serving older adults. Does this create a friction point with traditional providers? If a national movement toward MTMs became stronger, there was hope that the social service mission of providing "basic" meals not be lost or diminished.

Participants also voiced concerns about needing more communication on multiple levels: with other leaders who are involved with MTMs, with professionals making the referrals, with boards and stakeholders, and

eventually with consumers who would need to become aware of services available and eligibility. As MTMs continue to emerge as a promising solution, the need for continued communication came up often. "We also should be talking about this in Age-Friendly Network circles—this is a large movement that is working toward making cities more friendly for older Americans," said one observer.



REFLECTIONS? TAKEAWAYS?

IDEAS?

**BREAKOUT #1**

APPLYING INSIGHTS

CONSIDERATIONS?

- MEDICALLY-DRIVEN MEAL MODEL
- MTM PYRAMID
- FUNDING, FUNDING, FUNDING
- SOCIAL DETERMINANTS OF HEALTH

- H2 IDENTIFY NEED
- SURPRISED BY FUNDING
- THE "NEED"
- CASE STUDIES
- MEASURE

- IMPORTANCE OF REGULATION
- REFERRALS & REIMBURSEMENTS
- OPERATIONAL CHALLENGES
- COINATION OF "FOOD OF MEDICINE"
- DIVERGING HISTORY
- PYRAMID STOOD OUT
- AGENCIES/DISCONNECT
- TRANSITIONING DOWN TO DIFFERENT LEVELS
- INTERCONNECTEDNESS
- LEARNING FROM OTHERS
- ASSESS ORGANIZATION
- LOCAL OPPORTUNITIES
- RESOURCES FOR TRAINING
- SOURCE OF FUNDING
- ENTREPRENEURIAL/FLEXIBLE
- LEADERSHIP BUY-IN
- PARTNERSHIPS

- PYRAMID
- VALIDATION VALUE OF MEAL
- DISTINGUISH MTMs
- SCALE/VOLUME NEEDED
- BUILDING LOCAL
- CONSIDER PROG. SIZE, PRODUCTION, CONTRACTED
- LENS - HOW? WHAT ABOUT OTHERS?

**COST PYRAMID ROI**



CHALLENGES? IDEAS? SOLUTIONS?

BUILDING A MOVEMENT

OPPORTUNITIES? ACTION IDEAS?

**BREAKOUT #2**

MAIN CHALLENGES:

- LOCAL POPULATION & NEED
- LACK OF NATIONAL FOR CONSISTENT REQUIREMENTS OR STANDARDS
- COMPETITIVE LANDSCAPE

- MINDSET/CULTURE CHANGE
- BUILDING THE APPARATUS
- ...

- IDENTIFY FUNDERS OF SELECT POPULATION
- OUTREACH TO HC PROFESSIONALS

- PROACTIVELY
- MARKET OUTREACH
- RESEARCH-EVIDENCE-BASED - TELL STORY
- GET ACCESS TO DATA FROM PARTNERSHIPS

OPPORTUNITIES

- LEVERAGE EXISTING REIMBURSEMENT SYSTEMS
- CMS CENTER FOR INNOVATION/ BROADEN NIH STUDIES
- ROBUST HEALTHCARE SYSTEM

- DESIRE TO GET IN HOME
- HC COST ENVIRONMENT
- MORE/MORE DATA

- LANDSCAPE RELATIONSHIP
- LAYOUT OPPORTUNITIES
- UNDERSTANDING ABILITY TO FUND MNT

# 4. Solutions for Building the Movement

Understandably, CBOs that want to offer MTMs will want to concentrate on local options. At the same time, a national movement will be gathering steam and each local effort contributes to that. With that framework in mind, here are action steps and solutions.

## A. DEVELOPING A LOCAL MTM PROGRAM

What would it take to establish a new MTM program? What would a current provider of meals to older adults need to consider? Participants mentioned that if in the early “I’m interested” stage, interested CBOs could partner with a mentor, engage online with the MTM community, participate in state or regional follow-up discussions and/or training, or have initial discussions with boards, healthcare providers and other leaders to debrief and gauge interest. A senior nutrition program might contact one’s Area Agency on Aging (AAA) or State Unit on Aging to explore regulatory or operational implications of offering MTMs locally, and if not, discover why.

**Focus and Scalability.** Participants appreciated the Food is Medicine Pyramid (see page x) and the visualization of a tiered system where one might focus at various places, depending on the local population, need, funding possibilities and opportunity. Having a way to discuss

scalability and practical implications was helpful.

**Organizational Self-Assessment.** It would be important to undertake a clear-eyed organizational self-assessment early on to see if an existing program is a good fit to serve MTMs. Some social service programs are adverse or simply not yet ready to provide a medical service or work within the healthcare system, participants observed. Organizations would need to consider how MTMs would mesh with an established system. Some organizations are ready and able to expand now, while others may need additional time. Leadership buy-in would matter at this early stage. One leader mused, “I am thinking of my board right now, and imagining those faces and who would respond how, and who I would have the first conversations with.” Finding a champion would be a boon, as well as agreement among stakeholders about the way forward.

**Knowledge of the Local Client Population.** Knowing the medical needs of the local client population would be a key first step, in concert with a healthcare provider or payer. Likewise, it would be important to understand the intersection between these needs and SDOH such as income and social connectedness. Only then would it be possible to strategically determine how to tailor a

new MTM program to ensure the best chances of success.

**Educational Resources, Business Acumen.** Participants wanted a basic playbook. While resources are available to learn the business concepts to initiate a successful MTM program, such training needs to be available for business beginners as well, they advised, and easily accessible, with perhaps some type of pairing or mentorship among meal providers. Others mentioned training available through ACL’s Business Acumen Institute, MTM Root Cause Coalition, the Aging and Disability Business Institute and other organizations. “There is a lot at risk for this for a social agency and it would require staff training, such as compliance with sensitive health information,” noted one observer.

To consider MTMs, an organization—especially one that has traditionally been more mission driven—would need increased awareness of the business aspects of MTMs, and skill in developing and maintaining new business processes. Understanding the local referral system and reimbursement processes would be critical.

Data collection is an important issue: what information to collect, how to collect it, how to communicate it, and how to build on it to make

one’s ROI case responsive to the needs expressed by payers. Without reliable and up-to-date technology, an otherwise good program could founder. So mastering information sharing, referral feedback loops, and interoperability would be essential.

For some programs, logistics such as shipping capability could be a deciding factor in getting a reimbursement contract. And for all locations, ensuring equitable access—despite geography or other challenges—should be a key consideration.

**Community and Healthcare Provider Outreach and Collaboration.** It would be important to showcase the expertise of programs for older adult nutrition and then identify opportunities to collaborate. Being able to strategically pinpoint funders of select participants in need would help successfully launch an MTM program, since not all funders share an issue or constituency of interest.

**Reliable Funding and Partnership Skills.** Participants felt that partnerships should be in place, with roles for each partner explicitly defined and reassessed as time goes on. When preparing for contract negotiation, leaders must be crystal clear about what their program can provide, and what they are expecting from the payer. Newcomers to the MTM field would need clear-headed

thinking about long-term expectations as they develop business models and focus on particular client populations.

## B. PROPELLING MTMs AT THE NATIONAL LEVEL

What would it take to support and sustain interest MTMs across the national network of aging services organizations? What would organizations with national reach and impact need to consider to support action at the local level? Participants identified next steps for consideration.

**Research on the Competitive National Landscape.** At the national level, participants saw the need for a better understanding of the comprehensive competitive landscape, with an estimate of number of persons in need and persons being served, broken down by income level, age range, type of disease and location. Such an overview would include totals of existing providers (commercial, local Meals on Wheels and others).

### **On-the-Ground Guidebook.**

Participants valued hearing case studies of programs that have had success (see Different Service Models, page x), how to leverage existing systems—what the state does, how funds flow, Medicare/Medicaid system and waiver programs, preventive-service reimbursement opportunities, successful referral systems and ideas, and a section on costs of MTMs and

how to do projections and realistic business cases (recognizing that each local situation is different).

### **Operational/Compliance Advice.**

Local entities need concrete help on measuring ROI and outcomes.

**Broader Conversation.** NRCNA intends to continue its leadership and convening role, facilitating conversations among members of Meal on Wheels America, anti-hunger organizations, healthcare entities and advocates to identify synergies and build on strengths. This includes nurturing and developing innovative partnerships.



# 5. A Call to Action

As the number of older people with chronic diseases continues to grow, there is an urgency about rolling out MTMs as part of an overall plan to help people enjoy better health and to reduce healthcare costs nationally. Yet some locations may not have a registered dietitian, for instance, or others may have such a small target population that it may not be economical to use existing delivery systems.

The to-do list is long: doing research on needs and population characteristics, establishing clear ROI on healthcare dollars saved, finding partners and payers, aligning with their most pressing needs, doggedly pursuing buy-in from stakeholders, strategizing on which population to focus on, ensuring effective referral systems and a feedback loop, building infrastructure and business acumen, and constantly communicating with all concerned.

There may be chafing between cultures, since MTM programs sometimes operate outside the traditional “aging services network.” At the same time, one’s own organization may voice concerns about “getting away from our mission” or the “medicalization” of providing new services. Establishing an MTM program is beyond a policy shift. However, if in so doing the health of older individuals with chronic diseases

improves, and net healthcare costs shrink, then both older adults and payers are finding value.

On the national front, the NRCNA will continue to lead and shape MTMs and this promising new direction. Among the most pressing tasks: analyzing the national competitive landscape; sparking needed research, especially on costs; leading learning collaboratives, sharing case studies and success stories; providing operational/compliance advice and concrete help on measuring ROI and outcomes; and encouraging local programs to be focused and sustainable over the long haul, while operating with the energy and can-do spirit of a start-up.

We invite you to join us in this journey!

# Key Resources

Center for Health Law and Policy  
Innovation of Harvard Law School  
<https://www.chlpi.org/>

Community Servings <https://www.servings.org/>  
Food is Medicine Coalition (FIMC)  
www.fimcoalition.org

Federal Aids Policy Partnership (FAPP)  
<https://federalaidspolicy.org>

God’s Love We Deliver <https://glvd.org>

Massachusetts Food is Medicine  
State Plan <https://www.chlpi.org/massachusetts-food-medicine-state-plan/>

Project Angel Heart <https://www.projectangelheart.org/>

# Endnotes

<sup>1</sup> Food is Medicine Coalition (2019). Available at: [www.fimcoalition.org](http://www.fimcoalition.org). Accessed on: August 16, 2019.

<sup>2</sup> Note: in this paper, the term “patients” is used when a person is in a healthcare setting or receiving MTMs; “clients” refers to those who may be getting basic or foundational meals.

<sup>3</sup> Project Angel Heart. Small Intervention, Big Impact: Health Care Cost Reductions Related to Medically Tailored Nutrition (2018).

<sup>4</sup> Food is Medicine Coalition (2019).

<sup>5</sup> James P. Ziliak and Craig Gunderson, The State of Senior Hunger in America 2017: An Annual Report, Feeding America (2019).

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<sup>7</sup> ME Morales et al., The Relationship between Food Insecurity, Dietary Patterns, and Obesity, *Curr Nutr Rep.* (2016) Mar;5(1):54-60. doi: 10.1007/s13668-016-0153-y.

<sup>8</sup> Adam Drewnowski, Obesity, diets, and social inequalities, *Nutrition Reviews*, 67 (Supplement 1), (2009). doi: 10.1111/j.1753-4887.2009.00157.x.

<sup>9</sup> K Edin et al., SNAP Food Security In-Depth Interview Study, USDA, FNS, ORA, (2013).

<sup>10</sup> VL Mayer et al., Food insecurity, coping strategies and glucose control in low-income patients with diabetes. *Public Health Nutrition*, (2016). doi: 10.1017/S1368980015002323.

<sup>11</sup> MB Kushel et al., Housing instability and food insecurity as barriers to health care among low-income Americans, *Journal of General Internal Medicine*, (2006). doi: 10.1111/j.1525-1497.2005.00278.x.

<sup>12</sup> D Herman et al., Food insecurity and cost-related medication underuse among nonelderly adults in a nationally representative sample. *American Journal of Public Health*, (2015). doi: 10.2105/AJPH.2015.302712.

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<sup>14</sup> C Knight et al., Household food insecurity and medication “scrimping” among US adults with diabetes. *Preventative Medicine*, (2016). doi: 10.1016/j.ypmed.2015.11.031.

<sup>15</sup> HK Seligman et al., Food insecurity

and glycemic control among low-income patients with type 2 diabetes. *Diabetes Care*, (2012). doi: 10.2337/dc11-1627.

<sup>16</sup> HK Seligman et al., Exhaustion of Food Budgets at Month’s End and Hospital Admissions for Hypoglycemia. *Health Affairs*, (2014). doi: 10.1377/hlthaff.2013.0096.

<sup>17</sup> Craig Gunderson and James P. Ziliak, The Health Consequences of Senior Hunger in the United States: Evidence from the 2019-2014 NHANES, *Feeding America* (2017).

<sup>18</sup> Meals on Wheels America. More Than a Meal Pilot Study. Available at: <https://www.mealsonwheelsamerica.org/learn-more/research/more-than-a-meal/pilot-research-study>. Accessed on: August 17, 2019.

<sup>19</sup> Meals on Wheels America. More Than a Meal Medicare Claims Analysis. Available at: <https://www.mealsonwheelsamerica.org/learn-more/research/more-than-a-meal/medicare-claims-analyses>. Accessed on: August 17, 2019.

<sup>20</sup> J Gurvey et al., Examining Health Care Costs Among MANNNA clients and a Comparison Group. *J Primary Care & Community Health*, (2013); 4(4):311-317. doi: 10.1177/2150131913490737.

<sup>21</sup> K Palar et al., Comprehensive and

Medically Appropriate Food Support is Associated with Improved HIV and Diabetes Health. *J Urban Health*, (2017); 94(1). doi: 10.1007/s11524-016-0129-7.

<sup>22</sup> Project Angel Heart. Small Intervention, Big Impact.

<sup>23</sup> SA Berkowitz et al., Meal Delivery Programs Reduce the Use of Costly Health Care in Dually Eligible Medicare and Medicaid Beneficiaries. *Health Affairs*, (2018); 37(4):535-542 doi: 10.1377/hlthaff.2017.0999.

<sup>24</sup> Project Angel Heart. Small Intervention, Big Impact.

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<sup>26</sup> SA Berkowitz et al., Association Between Receipt of a Medically Tailored Meal Program and Health Care Use. *JAMA Intern Med.*, (2019) 179(6):786–793. doi:10.1001/jamainternmed.2019.0198.

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