Medically Tailored Meal Partnerships Webinar

#TRCCWebSeries

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Food is Medicine

The Role of Medically Tailored Home-Delivered Meals in Holistic, Patient-Centered Models of Care and in Systems Change

The Root Cause Coalition

Webinar

March 21, 2017
David B. Waters, CEO
Community Servings, Inc.

Bill Pinakiewicz, Vice President
Nonprofit Finance Fund
Community Servings’ Mission

Community Servings is a not-for-profit organization with a 26 year history of providing medically tailored meals and nutrition services to homebound individuals and their families coping with critical and chronic illnesses.
Our History is Tied to the AIDS Crisis

Founded in 1990 to provide home-delivered meals to individuals living with HIV/AIDS, we initially served 30 people a day in Roxbury and Dorchester.

We now serve 1,850 clients each year in 20 cities and towns in Massachusetts, regardless of illness.
A Regional and National Movement

• We are the only program of our kind in New England, and will expand into Rhode Island this spring.

• We are founding partners of The Food is Medicine Coalition (FIMC), a volunteer association of nonprofit, medically-tailored food and nutrition services (FNS) providers seeking to preserve and expand coverage of FNS for the critically-ill.
Community Servings’ Clients: Homebound with 35+ Illnesses

- 37% HIV/AIDS
- 18% Cancer
- 16% Renal
- 11% Diabetes
- 7% Other
- 5% Cardiac
- 3% Lung
- 3% MS

71% of clients have multiple diagnoses

At least 92% live in poverty
Nutrition Interventions Tailored to Address Severe Illnesses and Co-Morbidity

Medically Tailored Home-Delivered Meals
- 17+ medical diets, up to three combinations per patient
- Appetizing, culturally appropriate foods
- Meals made from scratch
- Children’s menu

Additional Services
- Individualized nutrition counseling
- Disease-specific nutrition education
- Nausea care packages
The Urgent Challenge of Malnutrition

At least 1 in 3 patients enters the hospital malnourished*

Hospital stays for malnourished patients are up to 3x longer than for properly nourished patients.¹

Healthcare costs for malnourished patients are up to 3x higher than costs for properly nourished patients.²

Medically Tailored Home-Delivered Meals are a Low-Cost Healthcare Intervention

Individuals with severe chronic illnesses who received medically tailored home-delivered meals from MANNA of Philadelphia experienced:

- 50% fewer hospitalizations and
- 20% lower healthcare costs than comparison groups.

A pilot study by Project Open Hand in San Francisco found that individuals with HIV and/or type 2 diabetes receiving medically tailored meals for six months experienced:

- Significant improvements in food security, nutritional health, mental health, and behavioral health
- Dramatic improvements in depression, diabetes distress, diabetes self-management, trading-off between food and healthcare, and HIV medication adherence
- Potentially statistically significant improvements in glycemic control and reduced hospitalizations and ED visits among participants with Type 2 Diabetes

Gurvey et al., J Prim Care Comm Health, 2013; George, 10/21/2016 symposium at Harvard Law School; Palar et al., J Urban Health, 2017
Food is Medicine Policy Initiative

Advocating for the reimbursement of medically tailored home-delivered meals through public and private funding streams

- Reimbursement Partners and Prospects
- Research Partners and Prospects
- Policy and Advocacy Partners
Reimbursement Partners and Prospects

**Insurers**

- **Commonwealth Care Alliance** – since 2013 – through dual eligible demonstration projects for seniors and adults with disabilities – have served over 300 individuals to date
- **Neighborhood Health Plan of Massachusetts** – since summer 2015 – for highest utilizers of the plan’s healthcare services
- **PACE of Rhode Island** – beginning in January 2017

**ACOs**

- Massachusetts’ newly structured Medicaid ACOs will receive designated funding for social services beginning in January of 2018. We are partners in the Collaborative that is developing the ACO, and anticipate having our services funded when the ACO launches.
Meet “Sarah”:

52 Year old Woman with:
- Morbid obesity
- Pituitary dysfunction
- Type 2 Diabetes
- High blood pressure
- Chronic kidney disease
- Blindness
- History of blood clots
- Lives alone in a 1-bed apartment

Multiple medical co-morbidities, dependent on strict dietary compliance – unable to prepare her own food

Takes 32 daily medications, including a blood-thinner

Sarah’s dietary needs:
- Low potassium
- Low vitamin K
- Non-dairy
- Diabetic (low carbohydrate)

*Patient’s name, initials and identifying information have been changed to protect confidentiality
*Slide prepared and presented by Dr. Toyin Ayaji, Chief Medical Officer of Commonwealth Care Alliance, during Food is Medicine symposium at Harvard Law School on 10/21/2016
Research Partners and Projects

Projects
• Pilot study of impact of our diabetic meals on patients with food insecurity and advanced diabetes (anticipate results by Spring 2017)
• Retrospective evaluation of claims data of clients we have served through Commonwealth Care Alliance (anticipate results by Fall 2018)
• Surveys and structured interviews of our referral partners (complete)

Principal Investigators
• Dr. Seth Berkowitz, internist, faculty member, Massachusetts General Hospital, Harvard Medical School
• Daniel Cohn, Emerson National Hunger Fellow, Congressional Hunger Center

Funders
• Blue Cross Blue Shield of Massachusetts Foundation
• BNY Mellon
• AARP Foundation
Partners in Policy Development
Next Steps…

• Continue to build the evidence base, through research and evaluation projects
• Increase referrals for pending and prospective reimbursement partners
• Explore a state-wide policy agenda, and continue to build on federal policy requests, led by Congressman McGovern
• Continue to engage with The Root Cause Coalition’s Research, Education, and Advocacy Sub-committees
NFF envisions a world where capital and expertise come together to create a more just and vibrant society.

We unlock the potential of mission-driven organizations through

• Tailored investments
• Strategic advice
• Accessible insights

Guided by our Core Values ➔

NFF’s Values

Responsive-ness
Leading By Doing
Rigor Without Attitude
Generosity of Spirit
The Intersection of Health and Health Care: The Opportunity and Challenge Before Us

- Within a changing healthcare landscape, the shift from volume- to value-based payments remains at the heart of healthcare reform amid increased focus on costs, outcomes and accountability.

- With their deep connections to the communities they serve, CBOs are critical stakeholders with health care systems as they seek to improve the health and resiliency of low-income communities....but CBOs need knowledge, advice and capital to successfully adapt to the new health landscape. The key questions are:

  ▪ What capacities do nonprofits need to develop and what investments do they need to make in order to be strong partners in improving health outcomes for community members?

  ▪ How can philanthropy and other funders move investments to an outcomes-focused framework that creates more sustainable networks of local, community-based support?

  ▪ Where do the boundaries of responsibility lie (as well as the shared responsibilities) among CBOs, healthcare providers, public and private payers, philanthropy, government, and impact investors in creating healthier communities?
With the move to risk- and value-based payment models, health care systems are increasingly responsible for population health outcomes.

High-need, high-cost patients have disproportionately high utilization rates and costs, and their poor outcomes are often, if not invariably, related to one or more unmet SDOH needs.

The need to match high-need, high-cost patients with social services that address their non-clinical SDOH needs is a significant bottom line and population health issue for health care systems.

NFF is working with both health care systems and CBOs to build their partnering capacities and develop a scalable and replicable platform for sustainable partnerships to address and integrate the SDOH of high-need, high-cost patients into their clinical care.

This platform will include tools and an accompanying line of business services for both CBOs and health care systems that will enable, inform and help to sustain these partnerships.
How Might the Pathways to This Systems Change Travel Along The Prevention to Clinical Care Continuum?

Proximity of SDOH Impacts to Clinical Care Outcomes & Costs

- **LOWER**
  - Counseling on Healthy Foods and Eating Habits
  - Longer timeframes to impacts

- **UPPER**
  - Medically Tailored Meals
  - Shorter timeframes to impacts

Preventative Programs

- **Upstream**
- **Midstream**
- **Downstream**
Some Current Capacity Building Initiatives That Support This Systems Change

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<th>Work</th>
<th>Impact</th>
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<td>Cohort-based capacity-building for CBOs exploring health outcomes-oriented partnerships, tool-building and national, multi-sector learning networks</td>
<td>Increased understanding of and readiness among CBOs for collaboration and partnership with healthcare organizations</td>
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<td>Identification, analysis and distribution of examples and lessons on partnership models between CBOs and healthcare organizations</td>
<td>Greater awareness and increased dialogue among health stakeholders, specifically funders, on successful partnership models</td>
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<td>Assessment of feasibility of launching and scaling Community Health Funds (CHF) as an innovative model to fund prevention and early intervention</td>
<td>Identification of feasibility drivers and resource/investment needs for future CHF development</td>
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Some Current Investments That Support this Systems Change

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<tr>
<td>$8MM construction loan</td>
<td>Better client outcomes as coordinated services for complex, high-need clients available under one roof</td>
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<td>$3MM bridge loan</td>
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<td>$2MM loan for build-out and launch of operations</td>
<td>Financed the infrastructure needed to successfully bid for senior congregate meals contracts, job training, healthy food</td>
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<tr>
<td>$6.0MM bridge loan</td>
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<td>$2.1 MM construction loan</td>
<td>Construction of a state-of-the-art, 80,000 sf campus offering continuum of integrated housing, health care, and social services</td>
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Key Takeaways on MTM From a Macro, Systems Perspective

- Interventions like Community Servings’ Medically Tailored Meals (MTM) lie largely at the end of the prevention continuum where they can have high, near-term impact on clinical care outcomes and costs as part of integrated care approaches.

- This can facilitate their ability to show impact evidence on Triple Aim objectives with high-need, high-cost patients in a relatively short time frame.

- With further investment and capacity building, this could well position MTM and other interventions at this end of the prevention continuum as the beachhead in driving SDOH-focused systems change through sustainable partnerships with health care systems and the expansion of reimbursement contracts with public and private payers.

- Further systems change could then be driven from this base and a strategy focused on leveraging best practices, accelerating the development of replicable and scalable templates and adapting the approach for interventions across the full prevention continuum.
Questions?

Thank you!

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