Medi-Cal Medically Tailored Meals Pilot Program

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Objectives for Today

1. Define medically tailored meals
2. Review research supporting the value of medically tailored meals
3. Provide an overview of the Medically Tailored Meals Pilot Program intervention
Sources

Research Content included the slide deck are from presentations held at the 2019 Root Cause Conference in New Orleans from the following presenters:

- Seth A. Berkowitz, MD MPH, Division of General Medicine and Clinical Epidemiology, University of North Carolina School of Medicine
- Rachael Robinson, Director of Strategic Partnerships, Project Angel Heart, Denver, CO
- Ann Hoskins-Brown, MANNA, Director of Policy & Institutional Affairs, Philadelphia, PA
Medically-Tailored Meals (MTM)

- Home delivery of freshly prepared meals tailored to specific medical needs
- Overcomes additional barriers
  - Complexity of diet
  - Need to shop and prepare foods
What We Know – The Issues

1 in 3
People enter the hospital malnourished

92% 77%
Older adults with at least one chronic disease
Older adults with at least two [NCoA]

86%
Portion of healthcare spending attributed to individuals with chronic health conditions [CDC]

57%
Predicted rise in chronic illnesses by 2020 [WHO]

Source: National FIMC www.fimcoalition.org
FNS CONTINUUM OF CARE

PREVENTION

- Prescription Fruit & Vegetable Programs
- Congregate Meals
- Senior Home-delivered Meals
- Food Banks, Pantry & Grocery Bag Programs
- SNAP/WIC/School Lunch

TREATMENT

- Medically Tailored Home-Delivered Meals
- Medically Tailored Home-Delivered Grocery Bags

Source: https://www.glwd.org/advocacy/updates.jsp
Prospective intervention with pre/post design

Saw improvements in food security, nutritional intake, adherence to medications, and reduced depressive symptoms and diabetes distress
Meal Delivery Programs Reduce The Use Of Costly Health Care In Dually Eligible Medicare And Medicaid Beneficiaries

- Retrospective evaluation of Community Servings participation using claims
- Compared with similar individuals who did not participate, and adjusting for pre-intervention values:
  - 30% lower ED use
  - 50% lower hospitalization rates
  - $220/month lower healthcare costs (including program costs)
Studied individuals admitted for heart failure
Found improved heart failure symptoms in intervention group
Food as Medicine: Reducing Health Care Costs with Comprehensive Medical Nutrition Therapy

- **Control Group Analysis**: compared key health care costs of individuals who received MANNA service for at least three months with a matched set of individuals who had not received the service.

- **Pre/Post Analysis**: tracked average monthly health care expenditures of 65 MANNA clients the year before receiving MANNA, during the service period, and for 6 months after cycling off the service.

- Results published in *Journal of Primary Care and Community Health, October 2013*
Food as Medicine: Reducing Health Care Costs with Comprehensive Medical Nutrition Therapy

**Control Group Analysis:**
- Overall average monthly healthcare costs for MANNA clients were 31% lower
- For people with HIV/AIDS, the mean monthly costs were 55% lower
- Average monthly inpatient costs were $219,639 for the comparison group and $132,441 for MANNA clients (40% less)
- MANNA clients had half the number of inpatient hospital stays and those stays were 37% shorter than the comparison group
- Those who were hospitalized were 23% more likely to be discharged to home rather than long-term care or subacute care facility

**Pre/Post Analysis:**
- Among all MANNA clients, average monthly healthcare costs dropped from $38,937 to $28,183 (28% drop)
- Average monthly inpatient costs dropped from $174,320 to $121,777 (30% drop)
What We Know – How Medically Tailored Meals Can Help

- **16%** net healthcare cost savings
- **23%** more likely to be discharged to home
- **50%** increase in
- **28%** reduction in hospitalizations
- **11** new studies on the impact of MTM are in progress across the country at FIMC agencies

*Source: National FIMC www.fimcoalition.org*
MTM Pilot Program Background

- Three-year, $6 million pilot to evaluate the impact of a medically tailored meal intervention on the health outcomes and health care costs of seriously ill Medi-Cal patients.

- The pilot is conducted in seven counties in California – Alameda, Los Angeles, Marin, San Diego, San Francisco, Santa Clara, and Sonoma – by the following organizations: Project Open Hand, Project Angel Food, Food for Thought, Mamas Kitchen, The Health Trust and Ceres Community Project.

- The California Department of Health Care Services (DHCS) has oversight over the program.

- Think of MTM services as a Medi-Cal benefit being tried out... the policy goal is to make MTM a permanent Medi-Cal benefit for seriously ill persons.
What is the Medi-Cal MTM Program?

The Medi-Cal MTM Pilot Program is a medical nutrition intervention for high utilizing Medi-Cal beneficiaries with a diagnosis of congestive heart failure (CHF). The intervention is 12 weeks in duration.

- **Who**: Persons with Medi-Cal with CHF and have a history of being a high utilizer of health care services and/or likely at risk for hospital readmissions

- **Intervention Goal**: Improve health outcomes and reduce healthcare utilization

- **Cost**: No cost to client. Must be on Medi-Cal.
### Pilot Client Eligibility Criteria

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Participants need to have congestive heart failure</td>
<td>1. Participants with late/end-stage renal disease</td>
</tr>
<tr>
<td>2. Must be currently enrolled in Medi-Cal for at least 12 continuous months</td>
<td>2. Participants with life expectancy of less than a year</td>
</tr>
<tr>
<td>3. Must have a primary physician or specialist visit within the last 12 months</td>
<td>3. Participants discharged to a living facility that provides more than seven meals per week</td>
</tr>
<tr>
<td>4. Must have one inpatient visit (ER, SNF, or Hospital) in the last 12 months</td>
<td>4. Participants receiving more than seven meals per week from another meal provider</td>
</tr>
<tr>
<td>5. Resident of a pilot County</td>
<td>5. Participants who don’t have food storage or heating capabilities</td>
</tr>
<tr>
<td>6. 18 or older</td>
<td>6. Participants who lack sufficient support or ability to adhere to program</td>
</tr>
<tr>
<td>7. Speak English or Spanish</td>
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</tr>
</tbody>
</table>
The Intervention

Medically Tailored Meals
- 12 weeks of complete nutrition, home delivery

Medical Nutrition Therapy
- Four Medical Nutrition Therapy sessions, 2 in-person

Information & Referral Services
- Case management support
Medical Nutrition Therapy

Community-Based Medical Nutrition Therapy

Community-based

Four sessions in the course in 12 weeks

Two sessions at home or in community-setting
Medical Nutrition Therapy (MNT)

- Each client receives **clear, detailed evidence-based plan of care** to ensure achievement of guideline determined medical therapy goals, effective management of co-morbid conditions, follow-up with healthcare team as appropriate.

- The MNT process is **updated** with each of the three (3) subsequent visits after the first.

- MNT follows the **Nutrition Care Process for Medical Nutrition Therapy** and incorporate the program-prepared nutrition education topic and materials. The process utilizes the Academy of Nutrition & Dietetics Heart Failure Toolkit and adopt evidence-based practices into their MNT as needed.

Academy of Nutrition and Dietetics at https://www.eatrightpro.org/practice
Academy of Nutrition and Dietetics Evidence-Based Nutrition Practice Guideline Heart Failure Toolkit
Academy of Nutrition and Dietetics Evidence Analysis Library Summary of Heart Failure Evidence Based Nutrition Practice Guideline updates 2017 www.andeal.org
<table>
<thead>
<tr>
<th>Visit #</th>
<th>Week</th>
<th>Medical Nutrition Therapy (MNT) Elements</th>
<th>Nutrition Education Concepts Covered</th>
</tr>
</thead>
</table>
| **Visit One In-Person** | 1 or 2 | Outcome Measures Questionnaire  
Nutrition Assessment and Diagnosis & Intervention Plan  
- 24 hour Recall /Typical  
- Determine intervention and set obtainable and measurable goal(s) based on assessment and needs or form PES statement if using this method. | Overview of Packet  
Plate Planner  
Nutrition Basics for Heart Failure |
| **Visit Two Phone**      | 4    | Monitoring and Evaluation  
- Review goal(s) and progress  
- Provide positive feedback and encouragement  
- Ask for weight (if client doing)  
- Ask about Hospitalizations | DASH Diet  
Focus on Sodium  
Fluid & Volume  
Label Reading |
| **Visit Three Phone**     | 7    | Monitoring and Evaluation  
- 24 hour recall  
- Weight if client checking  
- Homework check-in  
- Ask about Hospitalizations | Kitchen Basics  
Reading a Recipe  
EatFresh Navigation  
*Food Resources |
| **Visit Four In-Person (Last Session)** | 10   | Outcome Measures Questionnaire  
Evaluation of intervention and goal(s)  
Transition out of MTM Program | Grocery Shopping |
Medically Tailored Meals

All Meals for 12 weeks including 14 prepared meals and breakfast components

Medically tailored for CHF patients

Periodic wellness checks during delivery
Medically Tailored Meals

Medically Tailored Meals are meals that designated by Registered Dietitians as an appropriate part of a treatment plan for an individual with a defined health condition or combination of health conditions. For this program, agency dietitians design meals for by for persons with Congestive Heart Failure guided by the following evidence-based guidelines of the Academy of Nutrition and Dietetics.

Nutrition content shall adhere to the heart healthy guidelines of the Therapeutic Lifestyle Change (TLC) Diet and with the Evidence-based Nutrition Practice Guidelines from the Academy of Nutrition and Dietetics Evidence Analysis Library.

The Dietary Approaches to Stop Hypertension (DASH) Diet meal pattern shall be used to ensure nutrition completeness of the overall meal plan, unless medical needs require otherwise.

Registered dietitians also collaborate with kitchen staff or subcontracted meal preparers to ensure meals adhere to nutrition guidelines and all other meal guidelines noted in this section.
Example of Meeting Daily Nutrition Targets

<table>
<thead>
<tr>
<th>Diet</th>
<th>Kcal</th>
<th>Protein (g)</th>
<th>Sodium (mg)</th>
<th>Sat Fat (7% of total Kcal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepared Meals x 2 (total for 2 meals)</td>
<td>1000</td>
<td>40-45</td>
<td>1200-2200</td>
<td>--</td>
</tr>
<tr>
<td>Breakfast/Snack Bag</td>
<td>800</td>
<td>34-45</td>
<td>800</td>
<td>--</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1800</td>
<td>74-90</td>
<td>2000-3000</td>
<td>14 g/day</td>
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</table>

Example of DASH Diet Plan (for 1800 kcal)

The intervention aims to provide the number of servings indicated for each food group to fulfill the DASH diet meal pattern.

<table>
<thead>
<tr>
<th>Food Group</th>
<th># of servings per day</th>
<th># servings provided in 2 POH regular meals</th>
<th># servings needed in breakfast bag per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole Grains</td>
<td>6</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Vegetables</td>
<td>4 to 5</td>
<td>4</td>
<td>~1</td>
</tr>
<tr>
<td>Fruits</td>
<td>4 to 5</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Fat-free or low-fat dairy products</td>
<td>2 to 3</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Lean meats, poultry, and fish</td>
<td>6 or less</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Nuts, seeds, and legumes</td>
<td>4 per week</td>
<td>~1</td>
<td>~1</td>
</tr>
</tbody>
</table>
Information & Referral Services

Program engagement case management by client services

Referral to community-based resources by client services

Contact medical provider(s) when a high risk for readmission is identified, and if appropriate
Information & Referral Services

- Make a good faith effort to contact clients that are **not responsive to requests** for MNT sessions and/or missing agreed upon meal deliveries to prevent disenrollment due to missed meals.

- Through the delivery process, **identify and report concerns** to appropriate staff for follow-up, which may include change of address, change of condition, self-neglect, and abuse.

- Through RD, make a good faith effort to **contact medical provider(s)** when a high risk for readmission is identified, and if appropriate.

- Provide information and referral services to clients **experiencing challenges preventing ongoing participation** in the intervention.
A completed referral form is required. A clinician (MD, PA, NP, LCSW, RN, etc.) must make the referral.

Client Services will manage eligibility.

Aim to have meals delivered within 72 hours of enrollment.
Referral for Sonoma County

https://ceresproject.org/CHFpilot/
Who We Are

Ceres Community Project
Project Open Hand
mama's kitchen
PROJECT ANGEL FOOD
Before 2016
FIMC was forming and research on MTM was being conducted.

October 2016
Senator McGuire embarked on a crusade to get funding secured in the budget for a statewide pilot program.

June 2017
SB 97 budget bill was approved by the legislature and signed by Governor Jerry Brown.

April 2018
The Medi-Cal Medically Tailored Meals Pilot Program started enrollment.

June 2016
California FIMC began to form National FIMC momentum.

April 2017
Assemblymember David Chiu sponsored the budget ask in the state assembly subcommittee.

March 2018
CalFIMC Website Launches promoting Pilot Program.

December 2018
Today

Before 2016
FIMC was forming and research on MTM was being conducted.
Website & Twitter

https://www.ceresproject.org
@CeresCommunity ⇐ follow us!

https://www.fftfoodbank.org
@FFTFoodBank ⇐ follow us!

https://calfimc.org/medical-pilot
@CalFIMC ⇐ follow us!