June 30, 2023

Christopher J. Lynch, Ph.D.
Office of Nutrition Research (ONR)
Division of Program Coordination, Planning and Strategic Initiatives (DPCPSI)

Submitted electronically via: https://rfi.grants.nih.gov/?s=6418bcd5d23bfe80540f6582

Dear Dr. Lynch,

On behalf of ADvancing States, I am writing in response to the Request for Information: Food is Medicine Research Opportunities (NOT-OD-23-107) published in the Federal Register on April 11, 2023. ADvancing States is a nonpartisan association of state government agencies that represents the nation's 56 state and territorial agencies on aging and disabilities. We work to support visionary state leadership, the advancement of state systems innovation, and the development of national policies that support home and community-based services for older adults and persons with disabilities. Our members administer a wide range of services and supports for older adults and people with disabilities, including overseeing Older Americans Act (OAA) programs and services in every state. Together with our members, we work to design, improve, and sustain state systems delivering long-term services and supports for people who are older or have a disability and for their caregivers.

Our members oversee and collaborate with numerous nutrition programs that provide essential support to older adults, people with disabilities, and their caregivers, including:

- OAA nutrition programs:
  - Title IIIC1 – congregate nutrition programs;
  - Title IIIC2 – home-delivered meals programs;
  - The Nutrition Service Incentive Program (NSIP);
- Medicaid waiver programs, some of which include home-delivered meals;
- Medicaid Managed long-term services and supports (MLTSS) programs whereby managed care organizations (MCOs) provide comprehensive care for enrollees, often including various nutrition supports; and
- Connection and coordination via information & referral/assistance to programs such as SNAP, the Commodity Supplemental Food Program (CSFP), as well as myriad state and local resources.

On behalf of our members, we are pleased to provide the following responses to NIH's questions.

Research

What are considered high priority research gaps and opportunities for Food is Medicine?

- Food is Medicine interventions are not provided in perpetuity; instead, they are limited to a specific timeline, such as 12 weeks or 6 months. Research is needed to better understand (1) what happens to participants when an intervention ends and (2) if the desired health outcomes can be sustained.
- Implementation studies are needed to determine the best strategies for incorporating evidence-based, Food is Medicine interventions into healthcare and community settings. These types of studies should be designed to help us better understand: how interventions can be adapted to fit different settings, the factors that impact intervention success, and intervention designs that could become sustainably embedded in organizations.
- Additional research and analysis are needed to determine the cost savings of certain Food is Medicine interventions for healthcare costs in the short and long term.
- It is important to develop standardized definitions for Food is Medicine interventions and the nutritional analysis this may include.

What short-term health care, quality of life or patient-centered outcomes (e.g., quality of care, disease-specific biometric measures, symptom and side effect management during treatment, engagement in preventive services such as primary care, mental health, behavioral health, and obstetrics/gynecology care, prenatal and postpartum outcomes in parent-child dyads, utilization, cost, etc.) can be most impacted by Food is Medicine services and for what populations (e.g., urban, rural, pregnancy, children, underrepresented, underserved populations with health disparities)?

- We suggest that older adults who are malnourished, poor eating habits, and/or with or predisposed to certain disease states including, but not limited to, diabetes, HIV/AIDS, chronic kidney disease (CKD), obesity, osteoporosis, heart failure and heart disease can be most impacted by Food is Medicine services. Numerous studies have demonstrated that eating habits significantly contribute to the onset of chronic illnesses such as heart disease, obesity, cancer, and diabetes. By making changes to diet, older adults can both prevent and treat these conditions. For instance, reducing the intake of certain fats and cholesterol while incorporating whole grains into meals can help prevent the buildup of plaque in our arteries (atherosclerosis), reducing the risk of heart disease and stroke. Consuming fewer calories leads to weight loss, while reducing the consumption of simple sugars (such as glucose, sucrose, fructose, and lactose) can aid in preventing diabetes. Additionally, diets rich in fiber, particularly soluble fiber, can assist in managing diabetes.
- In addition, Food Is Medicine services may be especially beneficial for individuals living in food deserts in urban and rural communities, low-income individuals with severe food restrictions, such as the need for puree diets, Celiac Disease, etc.

What models exist or can be developed or adapted to test the cost/benefits and/or cost/effectiveness of Food is Medicine strategies for health?

- We encourage you to consider models implemented by partners of the Food is Medicine Coalition (FIMC) to test the cost, benefits, and/or cost-effectiveness of Food is Medicine Strategies.
- A recent study published in JAMA found that in Medicare Advantage post-hospitalization home-delivered meal provision was associated with lower chances of hospitalization and death.[1] Additional opportunities may exist for demonstrations under the Medicaid and Medicare programs that could be explored by the Center for Medicare & Medicaid Innovation (CMMI).

Provision of Services and Activities

What strategies are needed for populations with varied functional capabilities (e.g., ability to open a package, chew); housing supports (e.g., access to refrigeration or cooking utensils); or transportation (e.g., ability to access or receive food – delivery to a secure high rise or rural locations)?

- People with limited functional capabilities, like older adults and people with disabilities, may benefit from produce prescription and medically tailored grocery programs if they are able to prepare and eat the foods. However, large numbers of people with limited functional abilities, due to physical or cognitive impairment, need assistance with meal preparation and eating. Produce prescriptions and medically-tailored grocery programs should take into consideration how produce will become nutritionally appropriate meals consumed by the person(s) to whom prescribed.

- For produce prescriptions, building a partnership with food processing organizations could bridge the preparation gap. Catering firms, commissaries, culinary schools, and food processing plants are all examples of organizations that could fill this role. These firms would not be expected to cook or plate the produce, but to process it so it requires minimal preparation on the consumer's end. Examples include peeling and dicing winter squash, cutting cauliflower into florets, dicing or julienning bell peppers and onions, washing, stemming, and packaging leafy greens. There may be an additional cost to processing, but this could be included in budgetary planning.

- Medically tailored grocery programs need to consider ease of use for people with limited functional abilities. For example, items should be easy to open, such as choosing a pouch instead of a can. Provide smaller portions, such as two pints of milk instead of one quart or two small cans of vegetables instead of one of standard size for ease in portion allocations and food safety. The risk of improperly storing open containers can be high in food-insecure households leading to foodborne illness.

- Future demonstrations or interventions may consider embedding wraparound supports for individuals with functional limitations, such as transportation, meal preparation support, or other home and community-based services that are frequently provided under the OAA,

[1] https://jamanetwork.com/journals/jama-health-forum/fullarticle/2806411?utm_source=linkedin&utm_campaign=content-shareicons&utm_content=article_engagement&utm_medium=social&utm_term=062523

Medicaid home and community-based services (HCBS) waivers and to a limited extent Medicare Advantage.

How may Food is Medicine services be combined with other food assistance, nutrition and health education, and health care services (e.g., social services, meals on wheels, Community Health Workers, care transitions case management, etc.) to improve engagement and affect health outcomes?

- We recommend you consider partnering with Area Agencies on Aging (AAAs) and Centers for Independent Living (CILs) to meet the needs of community-residing older adults and individuals with disabilities. In addition, Aging and Disability Resource Centers (ADRCs) provide supports to older adults and adults with disabilities. We also recommend exploring opportunities to integrate Food is Medicine services with nutrition counseling administered by Registered Dietitians.

How may Food is Medicine services leverage ongoing nutrition education and existing nutrition assistance and access programs (e.g., WIC, SNAP, NSLP, VA Teaching Kitchens, etc.)?

- We recommend you consider Older Americans Act (OAA) service providers and AAA/local service providers who already follow robust home-delivered meal, congregate meal, nutrition education, and one-on-one nutrition counseling requirements, along with nutritional requirements for all meals.

In what ways can Food is Medicine services be used to address nutrition disparities and unequal access to nutritional foods?

- Research has already shown statistically significant improvements in food security, diet quality, and disease management when people are participating in a Food is Medicine intervention. The next step is to implement these interventions broadly and equitably using existing infrastructure.
- For older adults, federal funding already flows through the Administration for Community Living (ACL) to each state's agency on aging to implement home-delivered meals and congregate nutrition programs, in addition to several symbiotic programs that identify individuals who can benefit from improved nutrition or vice versa. For example, an older individual receiving a daily meal delivery who is later referred to Adult Protective Services (APS) when the delivery driver notices increasing self-neglect. Another example may be a family caregiver who becomes able to participate in the workforce because their parent or spouse has started receiving a daily meal delivery, which also serves as a daily wellness check.

<u>Community and Outreach</u>

How can health care organizations work effectively with community-based organizations and programs to adequately resource community-responsive approaches for Food is Medicine implementation and research?

- First, a prescription needs to be written for a particular type of food and frequency. Just like typical medication prescriptions, it includes the type, dose, frequency, and duration of use of

the food prescribed. The prescriber sends the prescription to the local entity most able to deliver the type, dose, and frequency for the duration of the treatment – akin to a compounding pharmacy relationship. Additionally, enhancing communication between community-based organizations (CBOs) and health care systems is important for ensuring successful referral processes and feedback loops. A reimbursement mechanism for services provided is also imperative, as many existing public programs are already at or over capacity.

- Local community organizations can provide many additional resources for Food is Medicine. For example, knowledge and access to individuals in their community, frequent touch points with individuals, "warm handoffs" and face-to-face interaction.

How might Food is Medicine programs integrate a culture is medicine approach that incorporates cultural foods and food practices (e.g., Indigenous gathering, hunting, and agricultural food practices)?

- Work with local American Indians/Alaska Natives and local restaurants run by members of various cultures to teach communities how to incorporate a Food is Medicine approach within the current foods and menu items already provided. At the Federal level, coordinate initiatives with the Indian Health Service (IHS) and other relevant agencies.
- Evidence indicates that diet-related health disparities are impacted by race and ethnicity, education, and income.[2] In addition to working with American Indian/Alaska Natives, there are also opportunities to focus on other populations facing health disparities including Black, Hispanic, and Asian ethnic and racial groups. We also encourage you to review the Centers for Medicare & Medicaid Services (CMS) Framework for Health Equity[3], which may provide a useful lens for this work.

What issues may arise in a community-living setting, high-rise building, food deserts, rural locations, or other unusual community living settings that may influence Food is Medicine research interventions? There will not be a "one size fits all approach."

- We recommend conducting research in all of these areas and communities to identify best practices for specific settings.

Education and Training

What training is needed for health care providers (e.g., physicians, nurse practitioners, nurses, physician assistants, dentists, pharmacists, registered dietitian nutritionists, doulas, etc.) to successfully use and disseminate Food is Medicine services and information services?

- We recommend training providers across the healthcare delivery spectrum in all available options on Food is Medicine, presenting research in easily digestible formats, and including resources on funding sources for Food is Medicine programs.

[2] https://www.ajpmonline.org/article/S0749-3797(22)00126-X/fulltext
[3] https://www.cms.gov/about-cms/agency-information/omh/health-equity-programs/cms-framework-for-health-equity

What training is needed for community health workers, federally- and community-funded food and meal program staff (e.g., Older Americans Act Senior Nutrition program staff, 2-1-1, social service intake, referral and benefits counseling staff, food banks, etc.), and nutrition and health education staff to successfully use and disseminate Food is Medicine information or to successfully operate in or advance the Food is Medicine space?

- OAA program staff need to have tools and be aware of how to adapt their current processes to be a Food is Medicine approach (for example, what changes would they be able to make in existing programs/operations). Also, references to those who are knowledgeable and have lived experience with a successful approach. Lastly, knowledge of funding sources to support the approach.

What training/education is needed at individual, family, and community levels (including K-12, colleges, and universities) to increase knowledge of Food is Medicine throughout the lifecycle for all Americans to reduce diet-related diseases and disparities?

- We recommend developing easy-to-use resources and information from trusted sources about Food is Medicine. Include nutrition education in education curriculum in physician appointments. Consider the application of Food is Medicine approaches for the broader population, not just for targeted subsets.

Coverage for Services

How can federal, healthcare, philanthropic, and other funders effectively collaborate to support implementation of these programs (we are interested in strategies for innovative financing arrangements such as value-based payment and braiding together of funding sources as well as better understanding of how services and service components are priced)?

- We recommend considering all costs associated with Food is Medicine: overhead, food cost, delivery, the value of the service, etc. Have a "map" of all possible funding streams like The Emergency Food Assistance Program (TEFAP), Supplemental Nutrition Assistance Program (SNAP), OAA, Medicaid, Medicare Advantage, and other programs. Streamline and enhance ability for small community-based organizations to partner with insurance providers and other payers.

We appreciate the opportunity to provide feedback on this important RFI. Please feel free to reach out with any questions that you may have to Adam Mosey at amosey@advancingstates.org or Rachel Neely at rneely@advancingstates.org

Sincerely,

Martha A Roherty

Martha Roherty
Executive Director
ADvancing States