# Food and Nutrition Stakeholder – Kickoff Meeting 4/21/2025

Video URL: <https://youtu.be/MGz44jWiPhQ>

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Thanking so many of you for, joining this conversation today for this update and discussion. My name is David Grande. I'm a special adviser to Secretary Arkoosh and the Department of Human Services. I'm joined by several colleagues from the Department of Human Services on this call today as well. And we're very much looking forward to the conversation around the Department of Human Services demonstration waiver Bridges to Success, Keystones of Health for Pennsylvania.

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So let me I know I've got the slides up on the screen. I just gotta move a few things around.

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All right. So let's cover quickly what to expect today on this call. This is the first in a series of sessions that we have planned. Focused on food as medicine opportunities in the demonstration waiver And we're planning three more monthly sessions over the next three months. And though this is the first in a series where we hope to have a lot of engagement and conversation, today, we are mostly focused on providing updates as to where we are in the process, as well as some technical updates on the specifics of CMS approvals.

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We will start with some broad updates, but mostly focus. Then on the food as medicine components of the waiver and leave some time toward the end for some discussion. But as I mentioned, the future sessions in this series will provide much more opportunity for us to hear from you about key factors, that are necessary to really drive impact and success in food as medicine programs.

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Before getting into, specifics of the waiver, I want to start by sharing a quick status update on the overall Bridges to Success Keystone of Health waiver. Before we get into details about the specific food as medicine opportunities. As many of you know, we received our approvals in late 2024. And as the Secretary shared and budget hearings this year, given uncertainties in the current federal landscape, we're moving forward with the waiver in a phased stepwise manner

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with respect to implementation. And therefore the Governor's proposed budget for the next upcoming fiscal year, which is 25-26, focuses just on the reentry initiative with our state correctional institutions. I also want to be clear that implementation of this and other components of the waiver are all contingent on budget appropriations from the General Assembly. And so, while other portions of the waiver are not in the Governor's proposed budget for the state, fiscal year 25-26, budget and future implementation is contingent again on budget appropriations.

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We do have deadlines for deliverables from CMS. We need to meet so that we have access to these important new tools in our Medicaid program in the future. And these CMS deliverables, which I'll talk about more, later in the hour are due in 2025, regardless of the year, we implement. And so we have important work ahead of us.

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So I know many of you are familiar with our demonstration waiver already. I don't want to spend, a long time reviewing the entire waiver, but I do want to share a little background for those that are less familiar with it. So we have a shared understanding of this work. And just for some level, setting demonstration waivers, they waive certain federal rules that govern state Medicaid programs that are approved by the center for Medicare and Medicaid Services, or CMS, as we refer to them, and are typically five years in duration.

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And they have a required independent evaluation requirement. They can be renewed and are focused on bringing innovation into state Medicaid programs to test and evaluate new tools. And ultimately, at the conclusion of a waiver, states can expand, adapt, or end programs depending on evaluation results. They're not new entitlements or state requirements, and there have been many states in recent years that have received approvals for waivers, including Pennsylvania, that strengthen work on health related social needs and create reentry programs.

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And that is the focus again, of our waiver as well. I will just touch on the CMS framework that has guided both our approval as well as quite a few states across the country. And so CMS created a framework for this work. That, again, has guided many state waivers, and it's based on this critical connection that we know exists between unmet social needs and health conditions.

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And the term that you see on this slide, health related social needs, speaks to those instances where an unmet social needs directly contribute to poor health and drive health care use. And so, the focus is on situations where there really is a direct linkage between clinical risk and social risks. So instances such as food insecurity impacting a chronic condition like heart failure or diabetes, that leads to steps.

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Sorry, I think somebody is unmuted. If somebody could go ahead and mute their microphone.

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Okay. Generally these tools are time limited, and available during key life transitions when they can have large impacts. So the tools are not intended for unlimited support, but rather those critical moments when an intervention can have a big impact, reduce avoidable health care spending, and improve health. So the Bridges to Success Keystones of Health waiver include several components.

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Those include reentry supports, housing supports food as medicine which will be our focus today, and targeted continuous eligibility policies. And the new waiver brings new tools to the Medicaid program to work upstream. And so the overarching goal is to reduce avoidable health care use, while at the same time improving health. And much of what was proposed in our waiver, and as now in our approved waiver, builds on national research and many local pilots and programs across the Commonwealth that have been led by a whole range of organizations, including community based organizations, managed care organizations, hospitals, health care providers, among others.

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And these new tools would be specifically targeted, at high risk populations. So they're targeted tools focused on high risk populations. So where are we in the overall process? So, some of you, certainly tuned in early on, during phase one, which started in mid 2023 and concluded in early 24, which is focused on developing our application.

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And in that process, we were able to learn a great deal about some of the remarkable work across the Commonwealth that we could build on, as well as successes in other states as well. And we really had some robust stakeholder engagement and public comment along the way. And, really heard a lot of strong support for the proposed work that made its way into our waiver application.

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These two came after submission, starting in early 2024 and concluded in late 2024 and was focused on negotiations with CMS for the final approval terms and conditions. So this includes things like the authorized federal dollars, specific policies around the new tools that CMS was authorizing for the Commonwealth, in addition to, defining what populations could be served, by these new programs.

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And as we look ahead, we want to focus on identifying what would really be needed to have maximal impact. If we have the opportunity to, implement these tools. And that's why this series of discussions is really important and intended to focus on. And I'll say more about that in the future. So let's focus on food as medicine.

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And that's really our, focus of conversation today. We know that food insecurity is both common and a cause of worse health. And certainly we also know that for many chronic conditions, and other high risk conditions, that special diets are often needed and in some cases hard to access, and that lack of access can drive poor health and avoidable health care use.

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We also know that food insecurity is common. In 2021, food insecurity impacted 1 in 8 adults in Pennsylvania and 1 in 6 children across the Commonwealth. And we see across the country that food insecurity is, in fact, much more common, in rural counties, across the US. And so the impact of food insecurity is certainly far reaching.

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And we've seen that targeted food as medicine programs have been shown to be effective and smart investments with some really, powerful outcomes, in some cases, decreasing hospital admissions and emergency room visits by more than 50% and driving down overall costs with a median of a 16% cost reduction. We've also seen food as medicine become a real national movement, a national priority.

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It was exciting to see the Rockefeller Foundation investing more than $100 million in developing and expanding food as medicine initiatives across the country. And so, you'll see some of the headlines here. When they announced this initiative, they have since partnered with the Department of Veterans Affairs to launch programs for veterans in the VA health system.

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And that's work that continues from the last administration with the current administration. Similarly, that partnered with a US Department of Health and Human Services on this important work as well. And the American Heart Association is playing a very big national leading role in this area as well. They have received support from Rockefeller as well to launch a national Food as Medicine initiative to work further to expand programs and study what programs have the biggest impact on outcomes.

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And it's been exciting to see support in Congress for these programs. Representative Buchanan, who leads the Make America Healthy Again caucus in the House, along with members from, Pennsylvania, have held hearings and events in support of food as medicine programs. So we're really seeing a lot of momentum built around food as medicine programs. And excited to see, that opportunity potentially come to Pennsylvania.

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And just this month, there was a new research article hot off the presses, published in the journal Health Affairs that estimated the financial, potential financial impact of food as medicine programs by state. And so they did these estimates across all 50 states in the country. And what you can see here is the researchers estimated that Pennsylvania could save an estimated $4,450 per person served through food as medicine programs, and that for every three people served, one hospitalization could be avoided, and they estimated that the financial savings in Pennsylvania would in fact be the second highest in the nation, behind only Connecticut.

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And so we see the research and programs across the country continue to grow as more people recognize the opportunity in food as medicine programs. And so let's come back to, our demonstration waiver. And, you know, our proposed food as medicine programs would build on this. And focus on how we can improve health and get more out of our health care dollars by focusing on high risk individuals.

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And, you know, it's our observation that food is medicine based on, you know, what I've just shared with you and, and other, important publications and programs is really now being recognized as a strategy to prevent, manage and treat disease. We've seen across Pennsylvania a history of small but strong partnerships across the entire Commonwealth. And data shows that they can really drive down avoidable healthcare use like emergency room and hospital visits, in a very cost effective way.

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And so the question is, what if we could expand on that work and really support those with high risk conditions like cancer and heart failure and support, you know, individuals, who are pregnant, to support healthy pregnancies. So what are the new tools that were authorized as part of the waiver? Again, I want to emphasize these are targeted short term interventions that create a bridge during a critical high risk period.

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And the first tool that was authorized as part of the waiver was medically tailored meals. And CMS has authorized those for up to six months for individuals with a cancer diagnosis, for individuals hospitalized with certain high risk diet sensitive health conditions, chronic conditions like heart failure, kidney failure, or poorly controlled diabetes. And it also includes food boxes for pregnant and postpartum individuals, with a goal of reducing pregnancy complications and long term adverse health effects of food insecurity.

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And all of these tools would be focused only on individuals facing food insecurity with a high risk condition.

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So in our application, when we applied for the waiver, we put forward our hypotheses and rationale, for the programs that were proposed. And it really, again, is based on this observation of food insecurity combined with certain high risk conditions, dramatically increases the risk of poor outcomes and high cost. And that food is medicine. Programs can really be a tool in our toolbox to improve health outcomes, reduce avoidable oops, sorry, reduce avoidable hospitalizations and emergency department use, and importantly, also build much stronger connections between food and nutrition providers across the Commonwealth and health care providers.

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Again, I want to emphasize we see these relationships growing across the Commonwealth, but with, like to see how the waiver could be leveraged to strengthen these relationships and these programs and build even stronger collaborations, and then at the same time, ultimately reducing food insecurity, improving disease management for certain high risk conditions, and really driving improvements in health outcomes.

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So as part of our approval, again, I want to note that CMS has approved populations and they've also approved service definitions for these food as medicine programs. So the first thing I want to walk through is the approved populations. In our, CMS approvals. And here you can see, what populations are, are approved by CMS for both medically tailored meals and food boxes.

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The conditions in light blue on the top are those. Those represent the ones that CMS approved for medically tailored meals and separately, down in the black where it says pregnant or postpartum. That is a program specifically for pregnancy food boxes. And so in light blue up there, you'll see, a number of conditions. The first is individuals who have a diagnosis of cancer, who are receiving active chemotherapy.

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And then we have three diet sensitive chronic health conditions, including at least one hospitalization. So that includes congestive heart failure and stage renal disease and diabetes. And then also separate from that is the high risk condition of gestational diabetes and pregnancy. And then, as I noted earlier, separately for the Pregnancy Food Box program, CMS allows states to include individuals during their pregnancy and up to eight weeks postpartum.

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So here we're going to get into some very fairly technical definitions that I think are important to review. And so I want to start with talking about medically tailored meals. And again I apologize for reading from my slides, but I think it's important to walk through the technical definitions of what was, approved, by CMS. And so with respect to medically tailored meals, they are fully prepared meals approved by registered dietitian nutritionist or a nutrition and dietitian technician technician registered to help eligible enrollees receive appropriate nutrition to support their specific medical condition.

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The quantity of meals provided will be no less than seven meals per week and no more than 14 meals per week, and will not constitute a full nutritional regimen change. So the definitions go on to say that meals approved by an Adon or MDT are overseen by an RDA and based on the benefit for beneficiaries specific condition and with consideration for any co-morbidities, nutrient, drug interactions and allergies, that there's a requirement to develop or review meal composition and compare against evidence based dietary guidelines appropriate for the beneficiaries.

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Medical profile that meals need to reflect the appropriate nutritional needs of the enrollee based on their defined medical diagnosis and standards, reflecting evidence based practice guidelines enforced specific medical conditions. Evidence based guidelines being used should be documented and made available as requested. And lastly, of course, complying with applicable state and federal food safety laws and appropriate labeling of meals.

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To note all ingredients with specific labels for all potential allergens. So as you can see, an important aspect of medically tailored meal programs are that they are truly tailored to the unique medical and clinical needs of an individual, and that quality control is a key component in providing these meals so that they can have their intended effect. So next is the service definitions for the Pregnancy Food Box program.

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And as you can see here, the definition is an assortment of nutritious foods that will include but is not limited to nutritionally appropriate fresh fruits and vegetables, fresh proteins, dried goods, seasonings and or spices. Frozen, canned or dehydrated. Nutritionally appropriate items are acceptable if they do not include any added salt or sugar, and the healthy food box can be delivered to an enrollees home or made available for pickup, and is aimed at promoting improved nutrition for the service recipient.

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It's designed to supplement the daily food needs for food and secure individuals that are pregnant or postpartum, and their household. So a bit more on pregnancy food boxes. The service will provide a minimum of 25% of a nutritional regimen, and not more than a full nutritional regimen. Must include nutrition education materials related to the food provided, including but not limited to, healthy eating guidance, cooking instructions and our recipe ideas and similar to what was shared about medically tailored meals, the quantity cannot exceed a full nutritional regimen when combined with any other service payment.

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Secondly, payment for food made on behalf of the beneficiary. So where are we at in terms of next steps? As I've mentioned, we have our CMS deliverables that we need to work on over the course of this year that are due later this year. Again, they don't obligate us to move forward, but they are necessary for us to have these tools available to us regardless of when we implement.

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We will need to submit an evaluation plan, in the future, along with an implementation plan which is due in the fall. But again, I want to remind folks overall where food is, medicine fits into our overall picture. Again, the overall waiver. We are really looking at this phase stepwise implementation process. Again, it is just the reentry portion of the waiver that's in the governor's proposed budget for the next state fiscal year, and all implementation is contingent on budget appropriations from the General Assembly.

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But again, this series of conversations is incredibly important. As we look to develop these CMS deliverables, like the implementation plan, those deliverables, they don't obligate us to implementation, but we must meet them to have these tools available to us. The upcoming deliverables specifically, as I mentioned, are an evaluation plan. But most importantly, even for this group is an implementation plan, which will be due in the fall.

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And again, these conversations are really meant to facilitate dialog and discussion and inform key performance indicators and really identify what the needs are for program success.

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So we'd really like to focus our future discussions and upcoming sessions on broad areas where we know we need to design for success and develop key performance indicators around that design. We know we need to focus at critical points on the user journey. And so you could see, some of those key points described on this slide here.

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We know that these programs begin at the point of screening individuals and identifying eligibility for food, this medicine programs, and then making referrals to food as medicine providers. And so finding ways to ensure or being successful at screening to identify that need and developing very effective communication strategies and collaborations between the health care system and food and nutrition organizations as critical to success.

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We also know that once a referral is made, that that next step around client enrollment and engagement is important. And how do we design programs to really maximize successful engagement and initiation of services? And then once services are started, how do we ensure we're maximizing the quality and impact of the services being delivered? And then throughout all of these steps along the way, we need to be thinking about how do we leverage the fact that these are short term interventions to achieve long term impact?

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And so we want to think about that along this entire continuum.

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So we did ask all of you when you signed up for this session, what you're most excited about with these new food is medicine opportunities. And happy to share back with you what we heard from you and much of what you shared echoes what we see as the opportunities in food. As medicine programs. We see words like healthy community access, opportunities and learning.

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And so the question for us is really how do we achieve the greatest impact with food as medicine tools in the Commonwealth and achieve these goals?

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We also asked you to share any questions you may have and a number of you centers, and we appreciate that. I tried to summarize some of the questions that we received, or at least some of the themes that we heard. And so on this slide, you can see that the first sampling of those, how can we use local farms to provide food as medicine in the most effective manner?

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How can we take food as medicine programs that have been local variable, and turn that into a scalable, major statewide effort? How will community organizations and health care organizations be able to work together to implement programs like this? And how can we work together to provide a seamless, personalized experience that realizes the promise of meals as engagement?

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So let me say that a goal of these sessions and again, this is the first of four sessions, but the goal of these sessions is to really determine what is needed to achieve the greatest impact. And so it's these conversations and the sessions that we're hoping to have that will help inform the answers to these questions and many others.

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But I'll comment at least on some of these questions that were submitted. And just some, preliminary thoughts. And the first is we want to learn about how we can build effective partnerships between local farms and organizations that that could be providers and food as medicine programs. And I think leveraging Pennsylvania's agricultural resources would create a real win win for programs like this.

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We've also seen many wonderful examples of food as medicine programs across the Commonwealth. But what we've heard, in talking to, various stakeholders who've been involved in food as medicine programs, is that one of the challenges is often scaling these programs beyond pilot programs. And one of the opportunities of a demonstration waiver is to create the infrastructure, policies and funding to allow highly effective programs to grow and reach more people.

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And at the same time, as we grow, we would evaluate and determine what works and where we need to adapt. Also share with us the success of food as medicine programs will hinge a lot on. As I said earlier, the strength of partnerships between health care organizations and providers in this series. That's one of the issues we really want to discuss.

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As I mentioned in those key performance, measures and health care providers are going to be critical for identifying need and making referrals, and we need a efficient and effective system to do that. PA navigate is a great new resource in Pennsylvania. That's a closed loop referral platform and certainly provides us with a great starting point for some of this work.

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And again, the last question on this slide is one that we want to talk through as we go through this series, which is how do we strive for the highest quality service that has maximum engagement and maximum impact.

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And this next slide, I include a few more questions, that were submitted. How will this program be administered and what is the time frame for this to get implemented? Once authorized, what will the system be for reimbursement? How quickly can we get people the healthy food they need? How do we set people up for a sustainable life with a short term intervention?

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And when can we get started? So again, these are all great questions. And also questions will need to work together to develop the most effective approaches. We know that for programs like this to succeed, we need strong partnerships. Again. But we also need a system that makes it easy for community based organizations to participate. And so we've talked along the way, through some of our earlier engagements, about potentially utilizing a program administrator to simplify participation.

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We did have a request for information which some of you, perhaps responded to that echoed a lot of the potential value. And having a program administrator. That being said, though, it is really these sessions and future conversations that we hope can inform ultimately the most effective solution. And then the question of time frame, as I mentioned, given the uncertainties in federal policy right now, this component of the waiver is not in the governor's state fiscal year 25-26 budget.

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However, these conversations, again, are intended to lay the groundwork for the future and also inform the deliverables to CMS that I mentioned, including an implementation plan. Again, to make sure that we have access to these tools in the future. Other questions about reimbursement, speed and quality of services. How do we leverage short term interventions for a long term impact?

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These are all questions again that we hope to discuss in these sessions. And these are the exact questions we should be asking. So I thank you. All who sent those in advance.

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So, with that, I want to pause for a bit again. Our focus today was mostly on making sure to provide an update and what you can expect to see following this session is that the next three sessions are going to be a deeper dive, and much more of a conversation and back and forth dialog around what you all think will be most important factors to achieve success.

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But, we did want to leave a little time today to hear some initial thoughts and ideas and what you think will be most important for success with food as medicine programs. So we do want to open the floor for comments. You can use the raise hand feature. I think we've got this figured out well, where you'll be able to unmute yourself, or we may need to unmute you.

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I will double check, for individuals who want to make a comment. But these comments will really set the stage for future deeper discussions. I know we have a lot of folks on the call today, and again, we'll have more focused conversations, in the future. And we have members from our team who'll be taking some notes as you make your comments to ensure we collect input today and utilize some of that input toward organizing some of our, future conversations.

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So I see we have, I believe, one hand up, Stuart.

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Good afternoon. Thank you so much for this very informative update. Two quick questions. Are these slides going to be available? Following our call today, will they be sent out? That would be a huge resource. I think, in our planning steps.

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Sure. I think we are going to post the materials on the website. And so we can certainly we'll send a note after this session to those who, registered for it to make sure folks know where to find those resources.

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Perfect. And then the second part, in the meantime, as we're moving through this process and we're having these follow up calls, is there anything, that we can do for those of us who have submitted, rfis or just are in this process that we can be doing in the meantime to be productive while we wait.

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Sure. It's a great question. You know, at least from the perspective of the waiver. I think right now we have to sort of, you know, do the hard work of assembling, a good, strong, robust implementation plan and plan for the future. But there are lots of, you know, local programs. Within the food as medicine space that continue to grow.

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So we certainly encourage folks to continue that work. But in terms of the waiver, being able to support programs, that is something that has, as I mentioned, a bit longer of a timeline. But again, we want to make sure we're engaging with all of you, keeping you up to date on progress and creating opportunities for input along the way.

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Thank you.

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Megan Loftus, hi.

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I was just wondering, you mentioned the RFI if we if our organization did not participate in that, are we not able to be part of the process moving forward?

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The RFI was just to collect a round of information. So, you know, that's just a mechanism to collect some feedback. And in a particular systematic way, I think through these sessions we're really hoping to continue to collect, a lot of input as well. So, there will be plenty of opportunities to weigh in.

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Okay. Thank you.

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Sure. Dan, let's.

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Yeah. Hey, and I guess I also have an RFI related question. Sort of similar to an earlier question. Were there any, conversations with respondents to the RFI previously? Just wondering if that's some market research that you've already conducted, or is that something that you're planning to do when there's more definitive action about, moving towards an implementation?

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I mean, as of right now, we, you know, you have that, you know, systematic process of collecting responses to the RFI and internally kind of collecting all that information and incorporated into planning. But there hasn't been any, direct engagement with RFI respondents. Following that. But these again, these sessions are intended to create an open space for folks to, to engage.

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Jose Garcia Avila.

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right. I was just wondering if.

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There's a mailing list that we could sign up.

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For to stay informed.

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On these meetings. And when that happening.

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Yeah. So there are, maybe what I'll do is, I mean, click forward in a slide here. So there is a overall listserv, to receive communications about the overall waiver, but specifically with food and medicine. Everybody who registered for this session today will certainly get follow up information about the subsequent stakeholder sessions, as well as other opportunities as well.

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But, the website, which is up on the screen and I think was put in the chat, is a good place to keep checking there's a food as medicine little section on there and on the listserv, the QR code there, should also get to know the right place to sign up for the distribution list.

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Megan Loftus.

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Sorry, a second question popped up. One of the things that you had listed out about, like, meals provided or groceries, and I know you mentioned food boxes. Is there any piece of the discussion that will happen down the line about including client choice in that so that while they're given some nutritionally appropriate options, they're still picking things that are, you know, within their interests or culturally sensitive, those those kind of considerations.

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Absolutely. Just to go back to this slide here, I mean, I think these metal bullets, particularly the service delivery and maximizing impact, I think a lot of our internal discussions, we very much have talked about how do you maintain choice, you know, for these programs to work, people need to be able to exercise and choice. And so we want to incorporate that conversation and that important issue in one of our subsequent sessions coming up.

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So thank you for that.

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Marta, lunch.

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All right. Yeah. So in here, you said the implementation is dependent upon funding and currently food is medicine is not in the in the proposed budget. What kind of advocacy is going on to hopefully get food as medicine into the budget?

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Well, again, you know, the the the governor's budget and the Department of Human Services, what we are really focusing on right now, at least in the next fiscal year, is around the reentry initiative. But we really do hope to be able to move that food as medicine work forward in the future. So that's how we are approaching it.

00:35:09:00 - 00:35:39:11

You know, of course, us stakeholders, you know, can can advocate in, in various ways. But I think for us right now, when we look at the current landscape, just strategically, I think it makes sense to focus very much on the reentry initiative. Again. Even that is contingent on budget appropriations with the General Assembly and then, you know, looking to the future and making sure that we're doing the work right now to, make sure we have access to these tools in the future, regardless of when we implement.

00:35:39:14 - 00:35:41:11

Sure. That makes sense. Thank you.

00:35:41:11 - 00:36:05:09

So let me just say that, and certainly, you know, if you have other thoughts you want to put in the chat, for folks who don't want to, unmute, you can certainly do that. But let me just share what next steps will be. Again, I share those key performance indicators that I think are really based on how you kind of could imagine a user journey, in these food as medicine programs.

00:36:05:10 - 00:36:27:04

And so at least it's our current thinking that perhaps we would organize the next three sessions about these three steps in that journey. But, we're going to take some of this conversation today and, huddle and see if that seems like it's still the most logical way to organize these conversations. We are planning again over the next three months to have these conversations.

00:36:27:04 - 00:36:56:09

It's the third Monday of the month, from 1 to 2 p.m.. Again, if you signed up for this, you will definitely, hear about those sessions. And again, we want to really focus on these various steps in the process, from screening and referral to client enrollment, engagement to service delivery, and then again, thinking about how to, at every step of the process, determine how we can introduce aspects of design that will help us generate long term impact.

00:36:56:09 - 00:36:59:11

And and I see one more hand went up. So, Michael Raley.

00:37:00:00 - 00:37:01:14

Michael, did you want to make a comment?

00:37:02:09 - 00:37:21:10

Okay. Sorry about that. As you know, since reentry is moving forward, there is a component as food, as medicine, housing, etc. for the reentry population. How is that being addressed? The food is, you know, food piece in the reentry, if that's, you know, shouldn't that be something we should be talking about?

00:37:22:00 - 00:37:50:05

I agree, it's an important need, you know, and one that we hope to address in the future that's not currently part of the proposed reentry program. The proposed reentry program right now is very much focused on, really introducing more robust and intensive prerelease case management that continues in the post-release setting and also, ensuring, high quality substance use disorder care.

00:37:50:06 - 00:38:12:08

But I, I completely agree that there are obviously significant needs in the post-release, setting, from individuals after release to have a lot of, unmet needs. And certainly some of the needs we're talking about today are part of that. And perhaps they are, new tools. Again, we can bring to the reentry work in the future.

00:38:12:10 - 00:38:20:03

I would certainly hope to, but not part of what's currently proposed, at least in the next fiscal year.

00:38:20:03 - 00:38:25:08

All right, any other comments before we adjourn for the day?

00:38:25:08 - 00:38:39:00

Again, I'll just put this last slide up in case anyone needs the link. There's also again in the chat, the link to the Keystone Sub Health landing page where you can find more information.

00:38:39:04 - 00:39:00:00

All right. Well, again, it's wonderful to see, so many of you, logged on to this session today. I do believe it really demonstrates the interest across the Commonwealth in food as medicine and how we can really think about opportunities to bring these new tools to our Medicaid program. And so, really want to thank all of you for joining today.

00:39:00:00 - 00:39:14:15

Again, you can certainly expect to hear from us, and follow up as we plan for the next sessions and really hope we, get to talk with you all again in those subsequent engagement sessions, but have a great rest of the day.