INTEGRATING FOOD INTO HEALTH CARE: WHAT'S IT GOING TO TAKE?

Holly Freishtat 00:12

Good afternoon, everyone. I'm Holly Freishtat, senior director for Feeding Change at the Milken Institute. Feeding Change activates social and financial capital to create a more sustainable, equitable, resilient, and nutritious food system. We're going to be talking about "Integrating Food Into Health Care: What's It Going to Take?" So I want to first start with introducing my esteemed panelists. Dion Dawson, chief dreamer, Dion's Chicago Dream. Colleen Lindholtz, group vice president and president, Kroger Health. Glenn Parker, founder and CEO—co-CEO of NationsBenefits, and Maura Plante, founder and chief executive officer, Living Hungry. Welcome.

Dion Dawson 00:50

Let's go! Why are y'all just so quiet out there? Come on, we're not going to bore you.

Holly Freishtat 00:55

We were just saying that we have five really big personalities all on stage, so get ready for a wild ride, alright. So today we're going to talk about what happens when Food Is Medicine stops being treated as an adjunct to health care and starts becoming part of the system itself. The question captures exactly where we are in this moment in time, after years of pilots, passion projects and promising data, this moment marks a turning point, the shift from proof of concept to proof of implementation. This session is about the tensions and the systems change they demand. Food Is Medicine can evolve from movement into marketplace, from data collection into data intelligence, from reactive policy to adaptive policy, from innovation to integration. Food needs to be a built-in component into health-care delivery and not an add on. So today we're going to talk about health-care models where Food Is Medicine isn't prescribed as an exception, but built by design. So, the first part of what we're going to talk about now, is Food Is Medicine

a movement and/or a marketplace? So, it began as a movement rooted in the idea that nutritious food can prevent and treat diet-related diseases, and now it's evolving into a marketplace, as retailers, payers, providers start to integrate into care. Colleen, I'm going to start with you here.

Colleen Lindholz 02:23

Okay.

Holly Freishtat 02:23

From your vantage point at Kroger Health, where do you see Food Is Medicine on the continuum today, from movement into marketplace?

Colleen Lindholz 02:33

So I see it as being both movement and a market. You know, movement in that the consumer is now understanding and realizing that what they put in their basket cart inside the grocery store, or they're putting in their mouth—even food away from home is impacting their health overall, not only their health outcomes, but the way that they feel, the way that they are able to be the best of themselves at work. So I think it's a movement in that way. Holly, it's also a market in that the consumer is evolving into the demand around better for you, around bringing products and services that they need and want in order to live a healthier life. I believe that retail is really sort of the connection, the bridge between the movement and the market. One thing that we've done at Kroger with our nutrition scoring system is really made it very easy for people to make a better food choice, literally looking at commodities in which they shop and be it—basically being able to opt up to something that's healthier for them. So I think we're, we're really a bridge between both, but it is both a movement and a market.

Holly Freishtat 03:29

Great, thank you. And I think that you make this really good point of talking about, you know, nutrition scoring is opting up—to preventive care, clinical integration, and so now this vision of food becoming a clinical asset, right? Where nutrition is treated as a vital sign, captures the shift from philosophy to practice, right?

Colleen Lindholz 03:49

Yes, most definitely, yeah. One of the big, big dreams we have, actually, before I exit the industry, I say, is that nutrition would be a vital sign in the physician's office, because we now can, we can measure nutrition, and we know that in multiple different ways, whether it's the purchases that people make in a

grocery store, what they eat out in a restaurant, or what we can do from the gut microbiome, we can definitely measure it. So yes, it should be a vital sign—we are what we eat. We know that the foundational issues that are going on in the United States, a lot of that has to do with what we've put in our mouth over time. So yeah, we're really excited about the vital sign of nutrition.

Holly Freishtat 04:22

Well, thank you, Colleen. Glenn, you bring a unique perspective as a physician and a business leader. As Food Is Medicine gains momentum, how do you see the balance between a movement and a marketplace evolving, and what needs to happen for it to become a viable part of a health-care economy?

Glenn Parker 04:39

I think first of all, our perspective is really mostly from the health plan side, because our business really represents 150 health plans that are supplying the health care to the members, mostly Medicare Advantage and Medicaid. I think that we've seen also—we've all seen the movement. We've all seen the movement over the last 20 years or so as we've tried to kind of be in the space. But in order to really make it a marketplace, which we're all trying to do, it really requires a few things. So, you know, Kroger has a food scoring system where—but it really—we need standardization. We can't have a different market, a different scoring system, you know—we have one that—from a company that we bought. I wouldn't, I wouldn't know—we don't use it too much, but, you know. So, I would say we need standardization around what is healthy and also what is—what are people going to do? What are they going to eat? And what is the standard? You know, at the end of the day—and right now is an interesting time to talk about it, because we're not paying for a lot of people because of SNAP, because of their food—but at the end of the day, most people are still—the people that matter most are relying on the government to get money to pay for this food. And since they're relying on the government right now, we've not moved to a place where a lot of that—a lot of the dollars are are managed based on what people are buying. And if they are, like in EBT, it's at a very, very high level. So we're going to have to make decisions that may be really hard for people to accept, and that's, you know—and we may have to walk before we run, you know, because any calories are better than no calories, and we're going to find that out very soon as the SNAP dollars disappear. So any calories are better than no calories, but once we get past that, any calories are better than no calories, the next step is healthy calories are better than unhealthy calories. And then the step after that is, if you have a disease, if you have cancer, if you have lung cancer, you should probably be on a different diet than if you don't—if you have diabetes, you should—so, you know, there's a lot of room to run. But what we're so happy about at our company, and we'll serve 10 million fresh meals this year. We'll have $7 billion in spend that will be spent in places like Kroger on the flex card. So at least we're starting to see now dollars being spent and seriousness around these conversations, these meetings, that we're getting there. So you know, we're hitting the mark. Now, we all have to work hard over the next few years to start delivering that to health care.

Holly Freishtat 07:31

Great, thank you, Glenn. So you underscored a critical reality of Food Is Medicine truly moving from proof of concept to implementation—it needs durable funding, right? And, you know, maybe more braided funding and consistent reimbursement. But as we talk about markets and business models, there's also this question of who benefits as this space commercializes, right? So Dion, I want to hear from your perspective, working in the community level. How do we make sure Food Is Medicine doesn't lose its roots as it scales? How do we frame it, both as a movement and a marketplace, with the very communities it's designed to serve remaining at the center of the decision making and economic participation?

Dion Dawson 08:15

Well, I think honestly, we have to really understand that most markets used to be movements, but most movements don't connect to markets. And so when you're thinking about the community level, what we have to understand is, is that if Food Is Medicine is already a market, then why are we not talking about it as if it's a market? This is already a market that has already surpassed—it's north of 25 billion. It's going to grow to about 45 billion over the next 12 years. And yet we still speak about the altruistic tone of the work that we're doing, instead of trying to figure out, how do we stabilize and standardize every player and every person in the supply chain? And so, at the community level, how do we make sure that we have a foundation of understandings of roles and responsibilities, so that every time the top goes down, we can meet them in the middle. And, instead of trying to basically fight it—and that's what we're seeing a lot of times, is okay, Food Is Medicine is great. But a lot of people that do the work in this room know that there are some rooms we're going to walk in that, if we lead with altruism, if we lead with saying people will live longer, that that won't be received, but if we can say that there's a connection at the community level, talking about small and medium businesses, talking about, how do we increase revenues? How do we increase and connect job creation in Food Is Medicine, then now we have a lot of different threads that we can pull on in every room and in all the work that we're building. So I think it's important that we have a nice balance of understanding, connecting the community and the altruism and the longer lives, but then also understanding that there are—there's a market and there are jobs, there's revenue and there's wealth creation inside of that vehicle as well.

Holly Freishtat 09:51

So you're bringing up this really good point of structure, right? How does a movement become to a marketplace? It's what's the structures that are needed. So this brings us to the main point, Maura. I want to hear a little bit—and this is very exciting to me—you've taken our Food Is Medicine stakeholder map the Milken Institute created, and you've translated it into this replicable leadership model across nine regions in Florida. I know you saw this coming. Walk us through how you adapted this framework, which, just to be honest, was really capturing who are the key players in the Food Is Medicine movement, then you've translated it into a region-specific governance structure, right? And these business principles are helping to bridge this movement into transaction-ready marketplaces. So talk to us about how you're using this as a governance structure to be transaction-ready to create this marketplace and act on this marketplace.

Maura Plante 10:48

Right. Okay, well, we started the Florida Health and Nutrition Coalition in 2021, it was like the Heart Association, University of Florida, a bunch of us community-based organizations that were doing Food Is Medicine early, and we were building this movement. We even called ourselves the movers and shakers. And you know, we went from, you know, a small group, and now we're 2500 members and nine regional networks of excellence. Well, how do you go from here to there? This was movement building, right? With intention. And we felt like, there's not a lot of people in the room, but the right people were in the room. So when we found your map—so Holly and the team made a food Rx stakeholder map, and it has 10 seats around the table, which are functional seats. These are like, each has an intentional role. And when you put them all together, then they are like, ready for business, right? So they are transaction-ready, because—you know, they're funding-ready, and then in return, health outcomes are coming out, you know, and lives are being saved, people are being served. And it really does take 10 to 14 people around this table. So when we took this map and we started introducing it around Florida—Florida's huge. We're just way too large, and AHCA divided us into nine regions this past February. So we were 12, now we're nine, and so we said, okay, why don't we take this stakeholder food Rx map of seats around a table and map it to the nine regions of Florida. And so what we started to do is, like, push it out there and recruit people in. And we basically have co-chairs in each region. And then these are natively, organically recruiting people from their community into each seat. So now we actually have eight networks of excellence running all the way from Pasco to Jacksonville to Miami and all the way over to Tampa. [Applause] Let's see, this is the marketplace. So then, you know, now today, we can finally sit here and all of us agree, like we are a marketplace, and this is what it took to get here. And really, when I think about it, from my business woman hat—and I was 20 year corporate business woman—it's a supply and demand. Okay, so we created the demand, and then here comes the supply, doing a great job. Yeah, so we're excited to see [inaudible] the supply and demand like rising because all the boats rise with the tide, and then people can be healed and live well.

Holly Freishtat 13:14

So thank you for sharing that. So to be clear, when we created this, we didn't know it was going to turn into a governance structure, and we never thought of it as seats around the table. So I really like your interpretation. We used it to show like the connectivity and the data sharing opportunities, and now it's turned into this structure, right? And what I thought was really interesting with what you did in Florida was that you added some seats around that table to make it custom to that community. You know, in some areas, it was a farmer, more farmers and libraries, whatever it was that you needed, and so it adapted, but you still kept the structure. So this brings us to, yes, we actually need structure. But now let's talk a little bit about when collaboration becomes governance, right? We just saw that. But this brings us to this other dimension of Food Is Medicine, which is an evolution of power ['The West Wing' theme plays from an audience member's telephone]. [Laughter] That could not have been timed better.

Dion Dawson 14:06

Just go with it. If you don't bring it up it gets worse, just keep going.

Holly Freishtat 14:10

That couldn't have been timed better. The point is—couldn't have been timed better. Let me repeat that statement—that brings us to another dimension of Food Is Medicine evolution, power. As this space matures, from pilots to policy, from movements to marketplace, it brings us to who does it serve and who leads it right? Consumers are becoming more informed, more connected, more accountable to their own health decisions. So the real question is, is the patient becoming the new CEO of their health? And if so, what does that mean to Food Is Medicine? How is it being delivered? How is the data being shared, and how is that value being created? So this is really about redefining power, shifting the system that acts on patients to one that works with them. So Glenn, I'm coming to you first this time. You've emphasized that Food Is Medicine like truly, for this to work, it can't actually be one CEO. You need to have multiple CEOs in the health-care channel, from payers to retailers to consumers themselves. So from your vantage point, what is preventing patients from acting as their own CEO of their health when it comes to diet-related diseases, and what does it take to generally put the patient in charge?

Glenn Parker 15:30

And you bring up, really, the crux of the issue, because you can't force—and you know, Colleen said the same thing that the—said that the retail chain, the retail stores, should be the place where those decisions are being made and with the data and you know, if I think about it from the health plan perspective, of course, everyone who's taking risk in a health plan would rather people eat more healthy, you know, and—however, the problem that we have is you can't force people to eat diets that you want them to have, because that doesn't work in the marketplace.

Holly Freishtat 16:11

You have registered dietitians, correct?

Holly Freishtat 16:14

Talk to us about how is that [inaudible] transition.

Glenn Parker 16:14

Yeah, we have—

Glenn Parker 16:15

This is the thing, and I'll get there in a second. But the thing is, people have to understand and be educated that this is what they want to do, and that they want to take this data and eat better, and that they want to be committed to it, and they have to have an understanding of the reasons why. So we could provide all the dietitians that we have, and they could provide, I'm sure, hundreds of—score of hundreds more than we have, multiples than we have and so on and so forth. And we could get the data to them, because that we could get—you know, I could say, AI, AI 10 times, and it'll magically appear. But the thing is, the people do have to be their own CEOs, because we can't force anyone to—even if you offer them money, and this is what we're seeing now, even in our own incentives and rewards programs, in all of these programs, even if you offer people money, if, in fact, they don't want to eat the food that you offer to them, they won't, or they won't join a health plan if you block them from getting—if you have two health plans, and one plan says I'm going to give you $50 but you're going to have to eat food that specifically I tell you to eat, versus I'm going to give you $40 but you could really kind of buy what you want, but I'll give you recommendations. Nearly everyone is going to take the $40 and the recommendations versus the $50 but I can only get carrots. So the—this is the biggest issue that we all have to deal with now is the patient has—the person has to be the CEO. They have to be educated. They have to buy into the fact that they want to be more healthy, that this is going to get them more healthy, and they're going to make the right choices. Otherwise, this is just not going to work.

Holly Freishtat 17:49

So, Maura, I want you to talk a little bit about—you work with our clients on their health transformation journeys. Can you share with us an example of a client who became their own CEO of their health, and what supports and structures do they need to be able to become their own CEO?

Maura Plante 18:16

Right, well, I run the healthy food prescription, which is a medically tailored groceries program to reverse—help our clients to reverse their diabetes. And actually one of the guys who helped get me started, Chris, right there—

Dion Dawson 18:32

Hey, Chris.

Maura Plante 18:34

He's the CEO of an FQHC called FoundCare. So he has these patients that are running with their A1Cs, 10, 11, 13, 14, so one of our patients, who's been—we call them clients, we don't call them patients—referred from Chris' team to us came because his doctor was like, you're out of control. And what are we going to do about this? Let me put you in this healthy food prescription program. So when he started, A1C 15. So

he comes in, and we have to really teach him to start to listen to himself, to start to trust himself. And it doesn't happen on day one. It probably just washes over, right? But then he meets the other people that are the peers who did the program last year, and then they encourage him, and they tell him what they did, and we have pictures of their transformation. So he starts to believe. This is how you gain competency over time. There's skills, there's onboarding, there's education, there's peer support. You have a bad day, you have a good day. And all of the food that we're piling into his life, you know, week after week is like going in and he's learning to cook it. So he goes to his doctors, maybe, like, two, three months in, and he goes back to Chris' spot and sees his doctor, and his doctor says, your A1C, is eight. Fifteen down to eight.

Holly Freishtat 19:46

Wow.

Maura Plante 19:47

Right.

Holly Freishtat 19:48

Big deal.

Maura Plante 19:49

Yeah, we cheer for him. Now, what he's just done is he's showing himself that he can do it. He is doing it. He's doing it like with other people in a group over time, which we call belonging. He's using evaluation, which is the technology readout of where is he in his body. He's using his food skills and the food we give him, nutrition, education, coaching, counseling, to find his motivation. This is agency that happens over time, right? And by the time he finishes at six months and he gets his graduation certificate, and he writes on there, what I'm most proud of, this is when he enters into his life with his, you know, his transformation, and he is the CEO of his own—you don't start, but you land.

Glenn Parker 20:29

But I have to make this one quick point, and that's every—when I was practicing medicine, every time somebody got a diagnosis of lung cancer, the next day they stopped smoking. So, you know, it's the same thing. You have to get them long before the diabetes and the person with the glycohemoglobin, A1C of 15, has already ruined their kidneys, ruined their—has neuropathy and all of that stuff. Yeah, so, you know, there's a really big point there that you know, once you've done the damage and you now, the doctors

walked in and said, you have cancer, you're going to die. All of a sudden, everyone stops smoking. So that's the analogy.

Colleen Lindholz 21:03

That's a need for us to concentrate on the kids and the high school, middle school age, like helping them understand the value of food as medicine, because I think preventing disease before it starts, and starting them young—type two diabetes, obesity, type two diabetes and obesity in young kids, is like, not okay. I mean, everyone this room needs to understand that what we see in our clinics is not okay. Age 17, people that are just going to start out on the, you know, the wrong foot. But can I make a comment about the CEO piece? I think that, like, if you think about what CEOs need, just in general, to run companies like they need the right right mindset, they need the right strategy, they need the right vision, they need the right tools, and more importantly, they need to put people all around them that are better than them, that know more than they know, in order to, like, you know, be successful in a job. So I think, like thinking about the consumer as a CEO, they have to put people around them, like the dietitians, like the pharmacists, like primary care physicians, like their family, like people that are going to support them in this journey.

Holly Freishtat 22:02

But also, as you're speaking into this, talk to me a little bit about how does a health passport play into this data exchange for a patient to be a new CEO.

Colleen Lindholz 22:11

Health passport. I love it. That's important. That is the moonshot. All right.

Holly Freishtat 22:15

I want to hear it.

Colleen Lindholz 22:16

I just really believe that everyone in our country should be able to own and benefit and share their own data like, I don't know about you all, but it's kind of hard to share your data. I mean, obviously we have HIPAA—

Holly Freishtat 22:28

Find your own data first.

Colleen Lindholz 22:29

And, well, find, share, benefit, own, or whatever. So one of the moonshot ideas is to have a health passport, and so that everyone would be able to share their data with whom they want to share that with, so that they can get the help that they need. One of the things that we did at Kroger is we actually did a survey at the counter with our customers, asking them, hey, by the way, would you like us to cross your grocery data and your pharmacy data in order to help you with the recipes, items that you need the most, in order to help you with diabetes, heart disease, that type of thing—67 percent of the people said, yes, please help me. Please help me. But with the privacy laws and things, there's just barriers that we have. But if you had your own health passport, you can do it, like getting on the plane tonight that I'm gonna get on, and you could really, like, share that with anyone I think that would be very—but even visual—

Holly Freishtat 22:30

But even stepping stones, right? Like right now, and we were in dinner a few nights ago, where we have all these different portals for every single doctor, right? And there was like—one woman was talking about—there were 42 of them, right? And then like—and then you add in your benefits on your benefit cards for food, and you might even have three different cards for your food. We have so many different exchanges of data right now, but it's also very fragmented.

Dion Dawson 22:30

Well, I think first and foremost, we have to standardize something. I think that's—

Colleen Lindholz 22:50

To begin with.

Dion Dawson 22:50

Yes, like, because then from there, you can look at the data, you can tweak and go along. So for us, we didn't try to be everything for everybody. We said, okay, we're going to focus on fruits and vegetables. We've been able to scale exponentially because of it, because we understood our role, what we wanted to offer, and how we wanted to look at the data, instead of everybody taking everything. A lot—when you talk about that data and that passport, there's a lot of companies and a lot of industries that's taking a lot of data and doing nothing with it but sell it.

Colleen Lindholz 23:37

Yeah, well, our system is fragmented period. The framework is not good. So interoperability needs to be built in the long run for this to work.

Colleen Lindholz 23:40

So simplify it.

Holly Freishtat 23:45

So when I think about CEOs and us as patients and people as a CEO of our own health, we know it can't be in isolation, you were just talking about that, Maura. Like we need all these structures. So Dion, I want to know from your work with communities, how do you see—not just individuals and households and communities—how are they navigating their role in managing their health, and what would it take for them to have—be the CEO of their own health?

Dion Dawson 24:10

Well, I think they never stopped being the CEO of their health. I think that what we saw decades ago was there was a trust that was there, and technology hadn't caught up. Now that everything is fragmented, and now that everything is decoupled, it's so many options to do so many things. Like you said, you have four cards that you can get food with, and different prescriptions and all of this. And so you know, what we're seeing with our data collection is, number one, they're trying to just make sense of what the options are. And so even with the work that we've been able to do, we started with, number one, the data collection has to be simple. But what we've seen is at entry point, everyone's trying to take everything. You're giving social security numbers over here, you're giving how much you make and all—and none of it leads to any value given back to that household or that individual CEO. And so first and foremost, we have to ask what the value add is, because that's what they're asking. They're asking, okay, I can be healthier or, you know, like he said, well, listen, I'll take $20 less just to feel like I have more agency. And while I do understand that we want them to live longer, but agency and understanding and scale and scope, all of this is important, and all of it plays a role. And so what our data showed us was that okay, if we simplify the onboarding and then over time, have a way of—not necessarily just saying educating, because everyone doesn't need education, but more importantly, having a way to check in and an awareness of where they are in their journey and just kind of nudging a little bit, and nudging and offering—I think, you know—like I did not listen as a kid. If you have not noticed, I was a little on the hard-headed side, but when it came to nudges—I look back, you know, now I'm 35, I look back, there were a few nudgers in my life that kind of got me there. And I think that that's what we have to look at here, is when we're talking about them being about them being CEOs, they have to be respected as CEOs. A lot of times we see big pharmacy and big

health care talking down to the patient as if they've made sense of everything that's going on. No, we want them to live longer. How do we give them the best inputs to have the best output?

Dion Dawson 24:27

Exactly, exactly, and starting, okay, with the passport. What is the—instead of 10 things and 10 doctors, what's one thing? Right? What's one thing that you want to do industry wide, that every single Kroger patient and customer can say, okay, we know this about them, because then from there, one of the things that you thought is not going to be true. And I just think it's like simplifying and then from there, growing out.

Dion Dawson 26:19

How do you bring personalization into it, right?

Dion Dawson 26:21

Of course!

Colleen Lindholz 26:22

I mean, we're all individual people, and you're right. Sometimes the one size doesn't fit—well, definitely one size doesn't fit all. So how do we do that?

Holly Freishtat 27:24

So I think this brings in data is coming up in every conversation throughout this entire summit, right? And who owns it, you know, where's AI playing in it. And so this next theme that we've already been touching on is around, is data the new dietitian, you know, and should we trust it, right?

Holly Freishtat 27:45

You are going first [inaudible]. So Colleen, I really want to hear from your view, and I have this—and also talking about that, I really enjoyed Chat for these cards, because it told me—here's your question, it's around, is a digital dietitian in your pocket, right? Like, talk to us about this relationship between the data, right? And who can we trust? You know, all this digitalization of everyone's telling us what to eat. But also, how is it getting paired with your registered dietitians and your pharmacists? And we can't have data alone

in isolation and believe everything we're seeing and think that Chat is God, right? At the same time, we also need to figure out this balancing of the clinician, and how do we balance these together? I'd love to hear your thoughts.

Colleen Lindholz 27:50

Can I go first?

Colleen Lindholz 28:23

Yeah, so we've learned a lot at Kroger over time. We've been working on this for probably about 13 years when it comes to nutrition scoring system. One thing that I do know is that there—that people need people, and I do not believe that dietitians can be replaced by data or by AI. I think data and AI are going to be like amplifiers, enablers, whatever word we want to use, for the people interaction piece. Because what I know, and by the lead dietitian from my company that I have here in this room, is that it's very personal. Food is very personal. It's very cultural. We have to be very careful when we try to move people along this spectrum. So—but data, I mean, we have a lot of it at Kroger. We've, we have the grocery card that we've had for over 27 years now. And we do know a lot, and it's interesting, because you got to use the data and the insights, obviously, to help people, but when you look at it at the population health level, and then you get down to the MSA level, and you get to—actually down to the store level, you are really able to attack, in many ways, some of these macro issues that we have going on in our country. Now the role of like the dietitian and the pharmacist and the primary care physician, I believe that AI can definitely help fill in the gaps for places that like—humans necessarily, we don't, we don't see patterns sometimes and what goes on in people's lives. Because I think health should be about the whole person, by the way, not just the food component, because it has a lot to do with everything else in your life, also, on how your health is, whether that's sleep, whether mental—all of that, all those pieces. So I think, no, it's data and AI are not a replacement, but yet like an enabler.

Holly Freishtat 29:58

Glenn, I want you to jump into this. So, tech is a huge part of the work you're doing with your flex cards, you're getting a tremendous amount of data. How are you maneuvering the data? How is it acting as a new dietitian? How is it not? Like, what are you doing with this data that's helping to drive the outcomes?

Glenn Parker 30:15

Yeah, I think we spend a lot of time and a lot of effort and a lot of man hours, so to speak, building software that, one, combines as much of the data across multiple things that—into one place. So I agree with the rest of the panel that you can't just have food, so we work with our partners where their members are shopping, so therefore we know what they're eating, but we also know what medications

they're taking. We also know basically what they're buying from OTC, from an OTC. We know that they're taking Tylenol, or if they're exercising, and we're also—you—and obviously we're applying, using AI to apply that, to also offer that, offer these members other solutions. So, you know, it appears, based on your entire spectrum of what you're doing, what you're eating, what medications you're taking, that this program might work for you, or might be a great opportunity for you. It appears that you may be at a risk of falling because of this, this or this. So I think that the answer is, the answer is obviously getting to the point where all of this data could be shared in some kind of a health-care passport. I think the concern is, there are, there are major issues, not just around HIPAA and things like that, but companies believe and work really hard to gather this data and believe it's valuable for them, and it's really hard for them to share. If I shop in Kroger and then I go shop at Publix, I don't know that the Publix people are going to want to share their data with the Kroger people. And I'm not saying that to split two things. It's a matter of, yeah, and it's a matter of, again, how do you get to some stabilization and some foundation where everyone's going to be comfortable? And that's really, really, really hard to do. And where do we start with some simple stuff, some really basic stuff to give—to get people to just get some wins. Let's get some early wins, so then everyone will buy into it, because—and you know, you talked about the one patient that you could get glycohemoglobin, A1C from 15 to eight, we can't—one patient is really nice, but we have to do it for hundreds of thousands and millions of patients. So that's kind of where I was saying, you know, we spend a lot of time, a lot of money and a lot of effort, and a lot of our thinking power trying to come up with ways to build these solutions so the members, or the health—the patients, can look at all of this in one easy place, and so they could get that information, and then just one last thing, and then going to our partners like Kroger and other retailers and health plans, and saying, guys, we know that this is all proprietary to all of you. We beg you, we beg, we beg, we beg, and we're really good at begging. What can you give that's not proprietary? That's our role.

Holly Freishtat 33:18

Great. So we're using data right to help inform and influence our health, it can be used as measurement. But Maura, you're using data in a really interesting way. You're using data related to funding and funding mechanisms. So talk to us about this innovation of a data driven model with your Food Is Medicine DAO. Can you share with us, how does it work? How does it connect data, funding, and community empowerment all in one space?

Colleen Lindholz 33:44

OptUp.

Maura Plante 33:44

Okay. Yes, we think that when you look at the power of AI and data, it does this magnetic north thing. Okay, so if we really pick one thing and we just absolutely focus ourselves on it, yeah, it really unlocks your own health. Because I think a lot of our RDNs here know you don't really know what's going on inside of you. You can put some food in and then something happens. They can put more food in and something

else happens. So part of this whole process of elimination and this experience of changing habits into lifestyle modification over time is you need that information. So these continual glucose monitors on your arm are giving you, you know, your little gamification. You did red, you did yellow, you did green, over time. And you actually, you know, improve. I love tech for this reason. Yeah, no. I think it unlocks health. I think it also unlocks health at the grocery store. I think, like, when you're shopping and you're like, in a grocery aisle and you don't know, you know—it's just like, almost like a football field length of, you know, salad dressings, right? And you're like, which—anyway, you know, something like a Sifter, or your nourished—

Maura Plante 34:51

Okay, OptUp, is able to pick like, here's six that meet your criteria. Thank you. Now I'm able to, you know, choose the right choice.

Colleen Lindholz 35:01

Narrow the choices, right.

Maura Plante 35:02

Narrow the choices for health. So I just see tech unlocking it. So then when we look at it from those kinds of solutions, and you say, okay, we have all of this data. We know what the health outcome, the number one health outcome in A1C you know, in diabetes, is like HDA was, A1C. So whatever the health outcome is for whatever disease you're after, right? Because in Food Is Medicine, we're reverse engineering back to the disease. So whatever the disease is, is what your nutrition protocol, program and network, you know, needs to be serving. So we've decided that we are going to produce this mega dashboard. Yeah. So, in telehealth, if anyone has been in a doctor's office and worked in a telehealth, you know, you see the data all wrap up. We were sponsored by Life365, we used to get a data dashboard. It was like, here's the weight, here's the scale, here's the outcomes, right? So we all have these consumer wearables now which allow us to really pull all of this data up and like, let's pick a couple of key—just one key biomarker for each health outcome. And if you imagine in New York City, you're standing in Madison Square Garden, you look up and you see that debt clock that's like constantly ticking up and up and up and how you feel. Well, we really want to put up a giant dashboard, a live, real-time dashboard, with health outcomes where the weight is coming down, and the A1Cs are coming down, and the people are restoring their health. So this big data dashboard is actually part of our Food Is Medicine DAO. The Food Is Medicine DAO is where funders, family offices, people from Reddit, X, whoever, right, say, I'm interested in health for Americans, and I'll fund the treasury for this disease—autism, cancer, diabetes, childhood obesity. Okay, so when the childhood obesity treasury fills up enough and it tips over, it goes into this decentralized authority organization, which is a DAO. It's called a—it's a World Economic Forum model for impact. So it's funneling the funders into this experience of a DAO. Now you have these experts who are really proven to deliver health outcomes against those health outcomes, that's the one that gets the funded. Then those health outcomes come back into the data dashboard, right, showing that people can have their health restored,

the whole [inaudible]. Americans can be restored. So we partnered with Big Green, which is Kimball Musk, and he's been doing Gardens for 13 years, and since 2021 they've done a DAO. So they're in their 10th generation of funding. And so we are launching a Food Is Medicine DAO.

Dion Dawson 37:41

That's great.

Colleen Lindholz 37:42

That's awesome. It's really cool. Really cool.

Holly Freishtat 37:44

So it's really interesting to see this innovation, right? Because we keep talking about funding. We really wanted to see Medicaid funding into Food Is Medicine and then Medicare, and that's great, and we're looking at commercial plans and employers and their role, but also what's the role of philanthropy? And this is a real innovation in philanthropy of a Food Is Medicine DAO. So, thanks for the leadership and starting to set examples of other ways that we could be looking at funding Food Is Medicine. And this brings us to another very—I have to say, I like Chat here—let me say, policy whiplash. This is what we're going to talk about now, right? So what we really want to talk about is like, we have this innovation, right? We have this data, but it can't exist in a vacuum. We're jumping—we are head first in the realities of policy as we sit here today, right? You know, while data and technology are moving faster than ever, the rules that shape what's reimbursable, right, what's covered, who qualifies, is constantly shifting beneath us. You know, from SNAP waivers to CMS pilots, you know, all this Food Is Medicine is living in this policy environment, and sometimes it's colliding in real life, right? And I think we're seeing this. So Dion, I want to hear from you. Your work has been highlighting how shifting policies can feel exclusionary, especially from communities that have historically been left out of decision-making. How do you ensure that future policy frameworks center around the community voice and restore agency that you were just talking about earlier to the populations Food Is Medicine is actually meant to serve?

Dion Dawson 39:20

Well, I'll preface my comments by saying I believe I'm a crazy man, and—

Colleen Lindholz 39:27

You are.

Dion Dawson 39:28

Yeah, I feel like I'm that meme of the guy with like, the thread going everywhere. Exactly. I think I become obsessed with roles in what we're doing. I'm just the—at the most basic level, because what I realized is that when we're talking about Food Is Medicine, it's propped upon a food system that is having an existential crisis because it ate a weed brownie and so [laughter]. There were some people that didn't laugh at that, every joke won't land. But what I figured out was, you know, in our work, we've grown exponentially. And you go from borrowing $50 from your mom five years ago to being a $7 million social enterprise, and when that happened [applause] when it happened, what I realized was that we don't have defined roles and responsibilities when it comes to food as medicine or even the food system. And so when we talk about policy and when we talk about legislation or when we talk about advocacy, you know, everyone is focused on it without really understanding at the most basic level—my organization, my social enterprise, is not represented at all in legislation. So if you're, you know, historically, if you're not a grower, retail, or a food bank, you're not represented. We're not—we're neither. And so here I am in DC, talking about the great work and talking about AI, and talking about Food Is Medicine, and landing the plane, when every other day we're fighting to just show we exist. And then when I realized that, I said, okay, we have to start figuring out how to make sure that at the most basic level, the policy represents the players, because a lot of the players are over here in food doing this, and then over here in medicine doing this, and those two aren't talking until they are at a holiday retreat. They realize that their work is not as far along as they thought. So I think the biggest thing here is understanding when it comes to community and centering community voices, I think it's important that we ask ourselves first, what role do we want to play? And it's okay if you have multiple roles, but I'm just so interested in logistics and why there needs to be a clear-cut solution to delivering on whatever value we bring to community. Food has to get to community, health care has to get to community, and stay in community. How do we do that in a way where logistics is there, where supply chain is visualized, and where every role and responsibility is there? So that then when we're talking about policy, when we're talking about advocacy, it actually aligns to where AI and technology has already taken us, which is light years into the future.

Holly Freishtat 42:21

So I really, I really like this phrase. You just said policy needs to represent the players, and oftentimes it does not. So I think that brings up a really good point. I also want to—Colleen, I want you to talk a little bit, and this has already come up, but let's talk a bit more about it. You know, as policy shifts at the state level, right? Talking about players, retailers are a big player right here on this one—SNAP waivers, right? It's a huge policy. It happened really fast. We were talking just yesterday how retailers don't like jump and change in the next day. It takes time, and you guys need time to move, and suddenly you need to have the SNAP waivers, you know, the restriction waivers and need to be implementing in January in many of these states. Yeah, this January. Wow. So talk to me a little bit about how are you navigating these SNAP-changing policies as retailers, and how do you see moving forward with this? What do you think is necessary?

Colleen Lindholz 43:18

Yeah, so it's definitely tough by state, especially the retailer. We've got across 35 states for Kroger across the country. But, yeah, it's definitely tough to adopt, you know, different formularies, different for each state, it's hard for us. It's costly too. But we're going to do what we need to do at Kroger in order to serve the public. So it, while it's tough, we're getting it done. But I think we need to step back for a second and, like, really think about, like, things that have worked in the past. Like, if you think about WIC just overall, you know, you talk about proving food as medicine and proving that getting nutrition, better nutrition is good, it's been proven in what's happened with WIC. So why can we not use the framework around things that have already been established? Do you know what I'm saying? To like, move forward, but the waivers and the SNAP stuff, I—it's hard.

Holly Freishtat 44:04

Alright, I'm going to prompt you here.

Colleen Lindholz 44:06

I don't have another like, great answer—

Holly Freishtat 44:08

Alright, I will. I'll give you a great answer. Ready? Here's a great answer. So as we were talking about SNAP waivers, and that's meaning that in one state, it might say soda is defined one way, let's say tax code and candy. In another state, it's going to say only soda, but it's defined differently, right? And so one of the things I know we've been working on, how do we create this standardization? So now let's prompt you again. Now talk about that.

Colleen Lindholz 44:31

Thank you. Definitely need some standardization around the definition of healthier. We have to be careful how we talk about this, but we need to say the definition of healthier. So yeah, I think that's what most definitely the next step is, is us figuring that out, so that we have the proper guardrails to then go back and try to make this something that's done, instead of state by state, federally, across the whole country.

Holly Freishtat 44:52

Great, and so that's—we're seeing that state by state, but it will have impact nationally as well. Maura, you're working on legislation as well. And you know, so many times we need to fail forward, right, in

policies. So I know 1115 waivers may not have been able with, you know, Medicaid, 1115 waivers in Florida, they did not necessarily move in the ways that you thought, but you have your in lieu of services. Thank you. Talk to me about how are you engaging in this policy. How are you using stakeholder maps? How are you engaging policymakers, and tell me a little bit about this policy pathway that you're looking at here.

Maura Plante 45:29

Okay, so Florida, again, big red state, big state, red state. So it's not a Medicaid expansion, and never will be. And so you have to work within—you have to innovate within the challenge set that you're provided. So we partnered with CHLPI at Harvard Law, and we're part of this NPPC, and we meet—National Produce Prescriptions Collaborative—we meet every month, and we all of the states, have been sharing information about what works. So I'm like, okay, I'm going to take that and bring that to Florida, the 1115 waiver. And so in '23 we had a bill, and in '24 we had a bill. So we started out with the Democrats, then we got into the Republicans, and we really thought we had something, but no. So now we've actually flipped things around, because we have moved into a Medicaid managed assistance capitation rates, prepaid per month model, so there are six plans only, and everybody is mapped to these risk tiers. So when we really look at these new contracts, which were surfaced during the invitation to negotiate, you can actually see that, of the five things we've identified that are Food Is Medicine program, a disease management plan that's Food Is Medicine program, three of them are covered benefits. Two of them are on the expanded benefits list, meaning they're not covered, they're not paid for, but plans offer them, and they have to, because in order to win the bids. So now we're just shortening the distance, right, between goal. Okay, so when we pulled up the Texas bill—they had a bill last year. They turned it into law. It's a Medicaid in lieu of services bill, and we're like, okay, we're going to take that bill, since it's a winner—our Republican state, they love to see what other red states have done that works. So, okay, pull it in, and they had a committee and a pilot. It's a really simple thing. So in our committee, we decided, okay, we're going to take this committee and we're going to map it back to the stakeholder Rx map, so the food Rx stakeholder map from the Milken Institute, and then the pilot information, 1000 families, will come right back into this committee to then offer the information up to medic—the ACA, Medicaid decision makers. So what that does is it allows all of these lobbyists to sit at the table. Everyone who has a stake in Food Is Medicine now has a seat at the table. And so you've just increased your impact, including, you know, somebody like Abbott and somebody like the Food Bank, and somebody like the health—somebody like that, you know. So anyway, we have a big enough table to support—to invite all the people into play. So anyway, we are recruiting House reps and senators, and we have a bill in drafting, so we're excited about that.

Holly Freishtat 48:11

Great, thank you. And Glenn, you've been right in this space related to Medicare Advantage and the special supplements for the chronically ill. You know, their final rule just went into effect in July, saying no non-healthy food, right, allowed. And I would love to hear a little bit of, how are you navigating this space right now, with all the plans that you're working with, with your flex card.

Glenn Parker 48:33

I think the first thing we have to think of—sorry—the first thing I have to think about is, you have to have the technology that can do that, because if, in fact, you're passing stuff over the counter and you're leaving it to the cashier to decide what's healthy or not healthy, it's just not going to work. And that's what's happening. If we're leaving it to even the current EBT rails to do it, they're not sophisticated enough to do it, so that's not going to do it. So that's why we went out and built our own that can do it. Little commercial. On top of that, though, it's very gray right now on what is non-healthy foods. So—and that's what I kind of leaned on before, is that, if, in fact, the plan calls something non-healthy and therefore disallows it from the benefit, is the person going to join? And that, that's really the conundrum. And the conundrum is, is that how much of these benefits are being used for health care versus being used for marketing. And again, there's a mixture of both. So what I would say is, right now, what we're seeing is the plans deciding what the approved product list is, and then—but then, once that's decided—and I think it's going to get stricter over time. So I think what—even what I'm hearing today, is that right now, we're dabbling, because you have to, again, walk before your own but over time, we're going to see those approved product lists get much more sophisticated and stronger. As you do, we have to have the tech in place to be able to manage that. I would think that you would agree.

Colleen Lindholz 50:19

Oh yeah, most definitely. But I think getting to the heart of the matter is also getting back to who makes food and the manufacturing of food, and what goes into food and all of that. So, I mean, I would argue that the rails need to be on the side of the people that actually put the food on the shelves too, making sure they're meeting the criteria.

Glenn Parker 50:34

No question.

Glenn Parker 50:34

No question.

Colleen Lindholz 50:34

In general, not just, let's put a bunch of food out there and let's just exclude a bunch of stuff versus, like, give people alternatives—

Colleen Lindholz 50:35

—better for you alternatives, because we know it can happen. We know it.

Holly Freishtat 50:44

This brings us to our next part. Our next part is solutions, right? We're getting into solution phase here guys, alright?

Colleen Lindholz 50:52

[inaudible] Radiating.

Holly Freishtat 50:53

We're in a little bit of a lightning round, but not fully, right? But here's what I want to hear from each one of you, alright, and actually, Maura, you're going first on this one. All right, so it is, what's the solution in one year, five years, moon shot, 15?

Maura Plante 51:09

Okay, so in one year, we want to see the Food Is Medicine DAO up. I want to see my dashboard up, and I want to see proof positive that everyone else can see you can change your life using Food Is Medicine. Okay? Three years, I think employers have taken this on like full throttle. They have employees on food as health plans. Our CEO there, he funded half the produce prescription for his employees. There's no reason why, you know, other employees can't be doing—employers can't be doing this. We know that we have challenges with not just coming to work in attendance and sickness and all of that, but also like brain function and creativity and ingenuity. And I just think that this unlocks all of that. So I'd really like to see farms plugged in to meaningful local logistics, supply chains, into employers, and have that all take off. Moon shot is no more diabetes. It's over, game over. I don't see it anymore.

Holly Freishtat 52:11

Yeah, so, I mean, I'm glad you're saying moon shot 15 years. You didn't say 30, you said 15. So that's even better, right? So next one, Dion, for you, one year, five years, moon shot, 15.

Dion Dawson 52:23

Okay, one year, five years, okay. One year is less craziness, period. Just for everybody. I just want a day of the world not being on fire. What is it? Five years?

Holly Freishtat 52:40

Let me rephrase—around food, please?

Dion Dawson 52:42

[Inaudible] Everybody, one year, I would say—see, that's going to tie into five and 15. All in all. Listen—tomorrow morning, I'm announcing that we started another company that is going to connect supply chain with logistics, CRM, and last mile delivery. So I would say, in one year, I would—I want to have a job so that we can feed more people. Right now, we're at a quarter million, I'd like to be at a million pounds of purchased, packed, and delivered per month. Five years, I'd say we want to have at least 10,000 small or medium business users being able to have end-to-end traceability and track ability through their supply chain. And moonshot is—oh, I want to say moonshot is, in 20 years, Colleen buys me dinner.

Colleen Lindholz 53:37

Well, that's gonna happen in two months.

Dion Dawson 53:40

That's it, that's what I'm talking about.

Holly Freishtat 53:42

You dodged the moonshot!

Dion Dawson 53:44

I mean, I'm so anchored in micro, it's really hard.

Holly Freishtat 53:47

Alright, that's fair. Fair enough.

Dion Dawson 53:49

Yeah, I'm a logistics guy.

Holly Freishtat 53:50

So Glenn, I'm bringing you in here. So you have one year success, five, and then your moon shot.

Glenn Parker 53:56

My one year is to to start laying the train tracks—to put down the train track—and what we're talking about just Food Is Medicine here—but to just lay—the train tracks to be able to put these processes into place. And by putting these processes into place, I mean both the technological train tracks, the farming train tracks, the process—managing processed food train tracks, to understand what could go into the food, and to just holistically move towards a place where we're judging and managing what the food is, and our ability to manage who gets what based on, essentially, their disease state, based on how they are. And so that's one year. Five years, I think, you know, there's money involved here, and that's what—so I think that the government needs to be involved. And I think that the government is going to have to just apply more pressure towards the dollars that are put out there—are going to be spent more wisely on food that is—with a reasonable panel making the judgment—healthy, more healthy food, and specifically, also, specifically, if you have this disease, you may have this—the moon shot for me is that, in 15 years or 20 years, to be able to tie all of this together, so you're not just looking at food, but you're tying in all other parts of your health-care system. So this way, when making a decision, you're—with this data passport or whatever it is, but we're all able to share data and also be able to compete, but share enough data that the CEO in being that the person who is their CEO, can make these decisions and do it in a way that is going to give them the best care.

Holly Freishtat 55:50

And Colleen, you got the picture here: one year—

Colleen Lindholz 55:52

You guys all said mine.

Holly Freishtat 55:54

No, we're building off of it, but you're going to be able to close this in, right?

Colleen Lindholz 55:58

Yeah. Okay, so one year, I think intentional collaboration like we've never seen before. You talked about the guardrails, I think we need to come to a criteria around some of these standards and put it forth so that people can go execute, so then by year five, we will have a national sort of scoring system where all grocers have to implement it so that people can more easily make a healthy food choice, we can actually measure it—the nutrition vital sign in the doctor's office—and then plans can start to pay for it because of the change in behavior. And then I think the moon shot, I mean for me, is definitely—not only the health passport so that we can empower people—stop blaming people, and let's empower people to take care of their own health. And then also, just like the five-star rating system that's in the Medicare Advantage area, I believe that the grocer should step up and have a five-star rating in the area in which they will not only carry food, produce their own food, but be able to implement and market food in a better way that gets people to adopt.

Holly Freishtat 56:55

Great. So this brings us to our last few moments to wrap. So, Food Is Medicine is no longer an idea in search of validation, right? It's an emerging system in search of a structure, and we're starting to move towards that structure, and we're going to continue to move even faster. And so one of the things that I want to kind of bring it back to, is where, one day, we want to see, sooner than later, where food is not prescribed as an exception, but going back to how we started this, it's built into the systems and structures that we're creating today. And what we really want to be able to do is make this part of the mainstream, part of health care, food care, and part of our systems. So I really want to thank each one of you for all your different contributions in this system and helping this move, not only from the movement—and to be clear, it wasn't a movement, you know, it's become a movement, and now it's a movement and a marketplace, and we really want to see this in service of better health, and so how food is going to be central to our health and to our health-care systems. So thank you so much for being here today. Thank you for being lively and fun.