





Integrating Food & Nutrition Services to Improve Health Equity

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Public Health Solutions

healthsolutions.org

As the largest public health nonprofit serving New York City, Public Health Solution (PHS) support New Yorkers in achieving optimal health by:

1. Providing direct services that improve social drivers of health (SDoH)
2. Directing public health dollars to over 200 community-based organizations through our contracting and management services
3. Building trusted pathways between health care, managed care and human services to make a sustainable impact in community health

Putting New Yorkers at the center of care!

In 2018, PHS expanded our work and built a Community Resource Network (WholeYouNYC) which now reaches across all five boroughs of the city connecting New Yorkers to a variety of social services.

450 healthcare and human services organizations

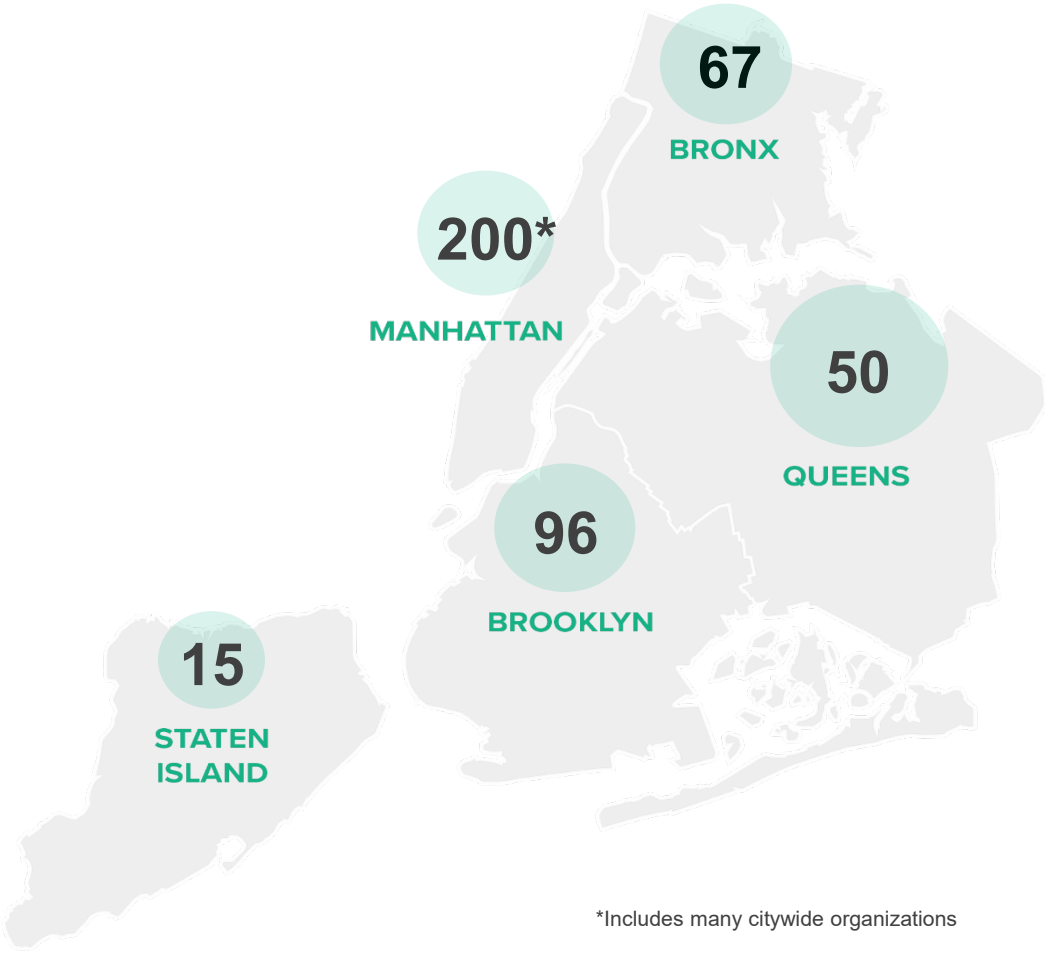
28,000 unique New Yorkers served

42,000 referrals

45 to 70% referrals result in enrollment

Expanded network services include:

- ✓ Food and nutrition
- ✓ Education/Income
- ✓ Behavioral Health
- ✓ Individual/Family Support
- ✓ Benefits access
- ✓ Healthcare
- ✓ Housing/Shelter
- ✓ Employment
- ✓ Legal
- ✓ Transportation



*Includes many citywide organizations

Through our healthcare partnerships, we tailor our network services to align to each organization's population health priorities and member / patient needs.

NewYork-Presbyterian

healthfirst
Health Insurance for New Yorkers

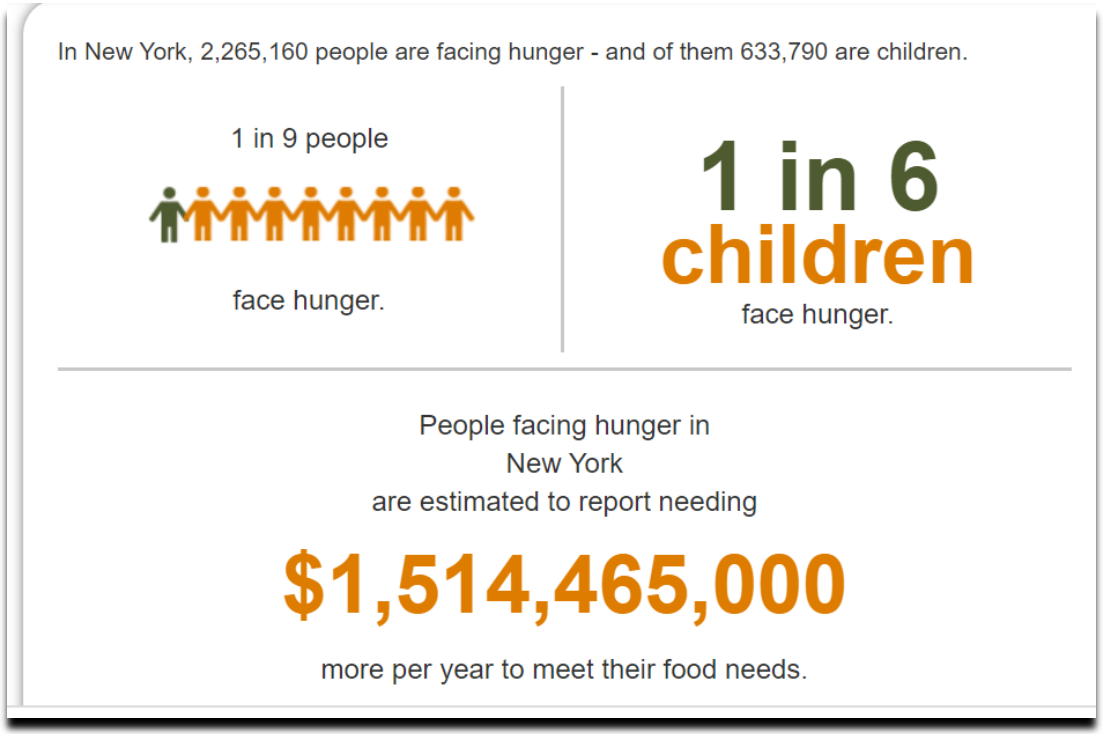
NYC HEALTH + HOSPITALS

Agenda

- PHS Food and Nutrition Programming Overview
- Program Development and Implementation
- Co-Designing and Collaborating with MCOs, Health systems, and CBOs
- Looking to the Future

Food and Nutrition Insecurity and Health Outcomes

- Exacerbates health conditions including hypertension, Type 2 Diabetes and Chronic heart conditions
- More consequential among key populations:
  - Older adults, infants and children, the homeless/unstably housed, pregnant people
- Many households must choose between food and other necessities, like housing, heat, etc.
- COVID-19 pandemic increased food and nutrition insecurity
- Barriers to accessing healthy food include:
  - Cost, quality options nearby, time, cooking skills, limited mobility and space to store and cook food



Source: Feeding America

There are 10 Food Banks serving New York State.

FOOD AND NUTRITION SERVICES BUNDLE

FNS Bundle Overview

- Launched in November 2018 through DSRIP Innovation Award

- **Purpose**: A coordinated network of food and nutrition services aimed at providing food navigation services to low -income patients at Health + Hospitals facilities
  - **Resources**: Food pantries, congregate meal programs (pre-pandemic), home-delivered and medically tailored home-delivered meals (MTM), SNAP, WIC, fresh foods through the DOHMH Health Bucks program, and Diabetes Self-Management Program (DSMP) when funding is provided
- **Who**: Food security specialists (now called Community Resource Network Specialists) trained in SNAP enrollment assistance and Cash Assistance screening

- Since January 2021, the Bundle has been funded directly by NYC Health + Hospitals

Food and Nutrition Resources & Eligibility

Need	Resource	Eligibility
Immediate free groceries	Food pantry	Anyone, regardless of income or immigration status
Immediate free meals and/or company	Soup kitchen Congregate meals	Anyone, regardless of income or immigration status Often ages 60+
Immediate home-delivered meals, including for specific diets	Meal delivery	•Homebound older adults •Homebound adults with qualifying chronic disease •Limited ability to prepare food independently •Any immigration status
Money to buy food	SNAP (formerly called “Food Stamps")	•Anyone excluding undocumented immigrants •Based on income
Free healthy foods	WIC	•Pregnant, breastfeeding or postpartum mothers, and children under 5 •Any immigration status •Based on income

Collaborative Design with CBOs/MCOs/Hospital Systems

- A PHS-facilitated design session series with H+H hospital representatives and partner CBOs
- During these sessions, the group:
  - Developed a team charter
  - Reviewed technology options and selected Unite Us through joint decision making
  - Developed a coordinated intake and assessment tool (CIRA tool – see slide)
  - Developed a decision tree that established workflows for coordinating referrals
  - Determined key metrics and outcome measures
- PHS worked with Unite Us to configure the assessment tool in the system, set up accounts for partnering organization staff, and build metrics to track referrals

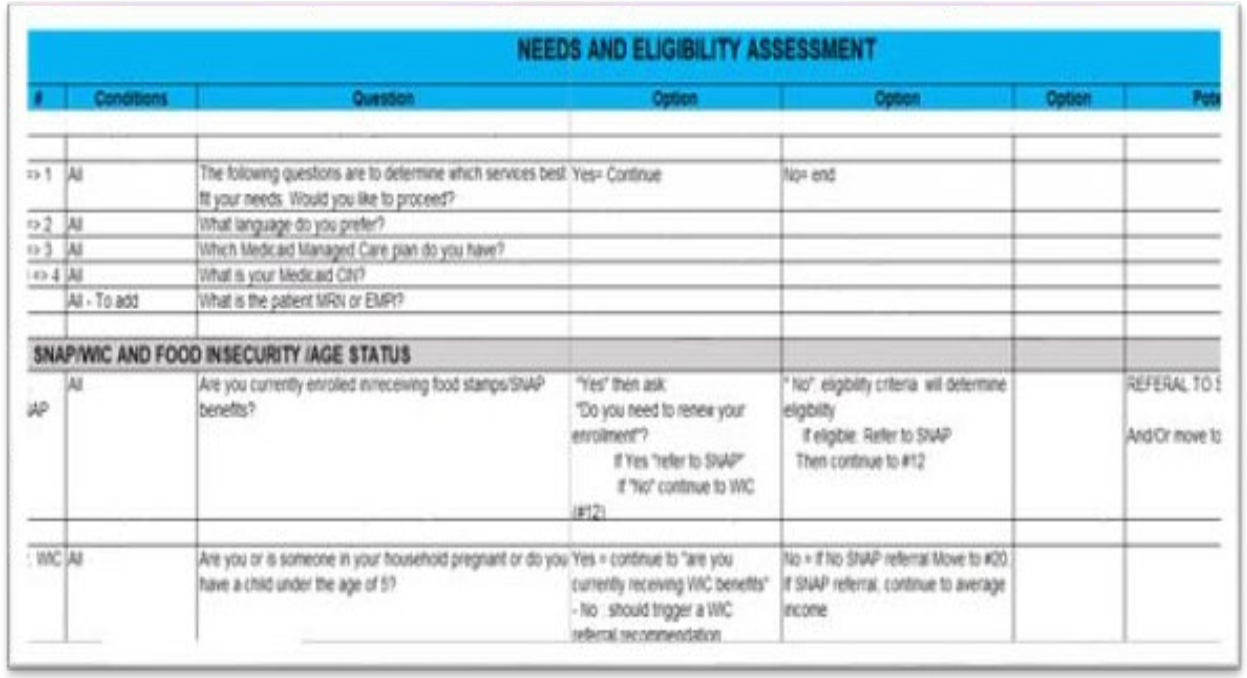
Food Navigation Partners Over the Years

+ more!

Food Navigation Assessment Tool

- Developed in 2019 in collaboration with God's Love We Deliver and other partners
- Configured and updated in Unite NYC
- Screener question categories include:
  - Starter questions
  - SNAP/WIC Eligibility
  - Emergency Food/HDM/Chronic Disease Mgmt
  - Nutrition Education

Sample of Assessment Questions:



NEEDS AND ELIGIBILITY ASSESSMENT

#	Conditions	Question	Option	Option	Option	Pote
=> 1	All	The following questions are to determine which services best fit your needs. Would you like to proceed?	Yes= Continue	No= end		
=> 2	All	What language do you prefer?				
=> 3	All	Which Medicaid Managed Care plan do you have?				
=> 4	All	What is your Medicaid CIN?				
	All - To add	What is the patient MRN or EMPI?				
SNAP/WIC AND FOOD INSECURITY /AGE STATUS						
iAP	All	Are you currently enrolled in/receiving food stamps/SNAP benefits?	"Yes" then ask "Do you need to renew your enrollment"? If Yes "refer to SNAP" if "No" continue to WIC (#12)	" No" eligibility criteria will determine eligibility If eligible Refer to SNAP Then continue to #12		REFERAL TO S And/Or move to
WIC	All	Are you or is someone in your household pregnant or do you have a child under the age of 5?	Yes = continue to "are you currently receiving WIC benefits" - No should trigger a WIC referral recommendation	No = If No SNAP referral Move to #20 If SNAP referral, continue to average income		

Role of PHS Navigators

- Knowledge of the range of services included in PHS' Community Resource Network (WholeYouNYC)
- Knowledge of tech platforms used by PHS, including Unite NYC
- Conduct outreach to a range of different clients in NYC to identify and prioritize their needs
- Screen clients for eligibility for a range of services, then refer to appropriate social support and clinical services across a portfolio of programs
- Carefully document the outreach, screening, and referrals in Unite Us
- Identify additional resources based on gaps in meeting needs within the referral platform
- Provide support and follow-up to enrolled clients
- Provide feedback on workflows and assist with troubleshooting to improve processes

“No Wrong Door” Referral Access Points

1. NowPow: Tracked Referrals from H+H Clinical Teams and CHWs
2. 1-800 Hotline:
   - English and Spanish
   - Separate lines for Bronx/Manhattan, Brooklyn, Queens
3. H&H email address for each borough (Queens, Brooklyn, Bronx, Manhattan)
4. On-site walk-in referrals at six H+H facilities

Lessons Learned

- Include all collaboration partners AND early in development, design, decision-making, quality improvement, and evaluation of the network
- Focus on SDOH assessment, referrals to services, and ability to monitor referral outcomes
- Ensure CBO partners are clear on the services requested to be offered and that they have the capacity; define outcomes and turnaround time (both for initial outreach and follow-up) from the start
- Reduce duplication of screening/assessment across settings
- Bring access as close as possible to point of clinical service, to make it easy for healthcare partners
- Importance of strong, trusted backbone organization to support capacity and infrastructure of CBOs to participate
- Ensure technology can both incorporate critical assessment data and outcomes necessary to measure success

Looking to the Future

- FNS model can be scaled / replicated for Waiver network
- Anticipate a unique payment point tied to screening and CBOs are best suited to serve in screening role and reaching “hard to reach” populations
- Must incorporate a blended and braided model so that clients not eligible for Medicaid AND clients not eligible for services such as MTM are still supported
  - Also, how to support clients receiving MTM services after six months of meals end
- Incentivizing food pantries is critical to active network engagement and utilizing technology platforms
- Increased interest from clients in healthy food home delivery from local food pantries

Looking to the Future (Cont.)

- Initiatives should be defined by lived experiences and designed and evaluated with community members' input
- New innovations should focus on making individual efforts easier and fit better into daily living through a spectrum of services, from prepared meals to hands-on learning.
- Incorporate food and nutrition screening questions together with other SDOH needs to further address the health-related social needs of patients.

QUESTIONS?