Agenda

I. Introduction (10 min)
   a. Background & Objective
   b. BPHC & CSO: Who We Are

II. Overview of Food Insecurity Initiative (15 min)
   a. Food Insecurity and The Bronx
   b. Food as Medicine
   c. Screening & Workflow

III. Community-based Nutrition Programs (20 min)
   a. BronxWorks
   b. Part of the Solution (POTS)

IV. Closing and Next Steps (15 min)
Background

- The Delivery System Reform Incentive Payment (DSRIP) program is focused on addressing unmet needs related to the social determinants of health, including food insecurity, which impact health and healthcare utilization
  - Evidence has shown that by addressing social needs, we can help reverse damaging health effects\(^1\)
  - Limited access to food results in increased subsequent health expenditures and overall poorer health outcomes

- Providers have expressed challenges around helping patients to overcome food insecurity due to a lack of knowledge of existing resources

- There is more we can do to increase access to nutrition-related services for food insecure families

Objective

1. **Raise awareness on food insecurity**
   - Discuss the food insecurity context in the community served by SBH

2. **Introduce pilot and screening/referral workflow**
   - Inform providers of built-in screening in EMR
   - Provide walkthrough of assessment and referral process

3. **Educate on nutrition-related services available**
   - Understand the various types of services available in the community
   - Utilize community-based services to address food insecurity
   - Increase patient education and access to services
BPHC & CSO: Who We Are

- Bronx Partners for Healthy Communities (BPHC) is a Bronx-based PPS led by SBH Health System
  - Leading the NYS Delivery System Reform Incentive Program (DSRIP)
  - Focused on the triple aim: improving quality, better outcomes and lowering costs
  - Central Service Organization (CSO) role is to support and advocate for the partner organizations to enable them to accomplish their DSRIP goals and objectives

- BPHC has focused on deepening the efforts of care coordination
  - Increasing continuity of care
  - Extending the reach of providers
  - Enhancing care team
  - Improving relationship with the patient

Food Insecurity was identified as a current challenge in which care coordination type staff can support!
Food Insecurity: Barrier to Healthy Living

- Food insecurity is defined as **lack of consistent access** to enough food for an active, healthy life.²

- Associated with some of the **most costly** and serious health problems including³:
  - Higher levels of chronic disease (i.e. Diabetes, Asthma, COPD, etc.)
  - Higher probability of mental health issues (i.e. depression)
  - Higher rates of iron-deficient anemia
  - Impaired growth in children
  - More hospitalizations and longer in-patient stays

Patients who are food insecure have nearly **twice as many unhealthy days** each month as food secure patients.³

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Poverty Drives Food Insecurity

Poverty is not the ultimate determinant of food insecurity, but it is a key factor.\(^4\)

<table>
<thead>
<tr>
<th>South Bronx Neighborhoods</th>
<th>% Living in Poverty(^5)</th>
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<tbody>
<tr>
<td>Belmont</td>
<td>46.1%</td>
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<tr>
<td>Fordham South</td>
<td>47.4%</td>
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<tr>
<td>Highbridge</td>
<td>43.0%</td>
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<tr>
<td>Hunts Point</td>
<td>42.7%</td>
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<tr>
<td>Morrisania-Melrose</td>
<td>36.2%</td>
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<tr>
<td>Mott Haven-Port Morris</td>
<td>46.4%</td>
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<td>Mount Hope</td>
<td>38.8%</td>
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The Bronx Median household income is $35,300\(^6\)

\(\Rightarrow\) 28.6% of overall Bronx population lives in poverty\(^6\)

The 2018 federal poverty level (FPL) is $25,100 for a family of 4.\(^8\)


The Bronx: NYC’s Hungriest Borough

31% of residents in The Bronx live in food insecure homes

37% (over 1 in 3) Bronx children live in food insecure households

Breaking the Barriers

- Families may be reluctant to seek assistance because of the *stigma associated* with hunger and food insecurity
- Providers can create an environment that provides *resources and provide assistance*
- Encouraging families to *feel comfortable* talking about their needs and receive help

**IDENTIFYING & ADDRESSING FOOD INSECURITY AT A HEALTHCARE SITE**

- **CONDUCT** Food Insecurity Screening
- **REFER** To Existing Food Bank Programs & Food Pantries
- **HOST** New Food Distribution Programs
- **CONNECT** Clients to SNAP, WIC, and Other Food Programs

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Food as Medicine

- Food plays a significant role in a patient's life
- Can support improvement of chronic disease management (i.e. diabetes, hypertension, etc.)
- Critical for patients to understand the health implications of the food they are eating
  - What they are eating
  - How to prepare/obtain healthy options
  - Available support services

Barriers to Food Security:
- Undocumented
- Homeless
- Low Income

BRONX PARTNERS FOR HEALTHY COMMUNITIES
PUTTING IT INTO PRACTICE: FOOD INSECURITY SCREENING/REFERRAL PILOT
Food Insecurity Pilot: Kickoff

- Food security is an unaddressed issue in the SBH community
  - Screening built in EMR but no uptake
  - Providers have expressed barriers to addressing food insecurity
- Today’s session will be followed by the launch of the 6-month pilot which is aimed to:
  - Increase screening rates
  - Increase access to nutrition related services
  - Improve overall health outcomes

Current screening rate is 14%*

Pilot Contact:
Karen Coleman, LCSW
kcoleman@sbhny.org
x3954

*Data between January – June 2018
Pilot: Tackling Food Insecurity at SBH

- Pediatric clinic will engage in a Food Insecurity Pilot to identify and address the issue by:
  - Utilizing existing resources to extend the reach of providers
  - Linking the community-based services to bridge the gap between clinical and social needs
  - Meeting the patient/family where they are
Step 1: Identifying Food Insecurity

- Physicians/clinicians can identify and help address the issue by **screening** for food insecurity.
- Two question survey has been **proven to be effective**; sensitive, specific and valid when asked of low-income families\(^1\).
- Built in the EMR under *Nutritional Evaluation*; takes **one minute** or less!

\[\text{Food Insecurity (past 12 months)}\]

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<tr>
<td>Within the past 12 months family worried whether food would run out before they got money to buy more.</td>
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<tr>
<td>yes</td>
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<tr>
<td>no</td>
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<tr>
<td>Within the past 12 months the food the family bought did not last, and they did not have money to buy more.</td>
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<tr>
<td>yes</td>
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<td>no</td>
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Step 2: Warm Handoff

- If patient/family screens positive, Physician will make a referral to either Social Work (SW) or Patient Navigator (PN)
  - Introduce patient to SW/PN
    - Karen Coleman, LCSW x3954
    - Cynthia Pabon, Patient Navigator x3129
  - Discuss updates during huddles
  - Document essential information in the EMR
Step 3: Assessing the Patient/Family

Assessment and motivational interviewing to determine needs and encourage action

1. Discuss the nature of the food security problem
2. Identify the kind of resource
3. Identify specific need
Step 4: Referrals to Services

- SW/PN will make referral(s) to community-based organizations for nutritional services
  - Form will be completed and given to the patient/family
  - Provides necessary instructions
  - Supports breaking the barrier of discomfort in expressing the need

- Follow-up will be conducted to determine if intervention was successful
Food and Nutrition Programs

Kim Wong, MPH
Program Director, Community Health

October 2, 2018
Our Mission

Our mission is to help individuals and families improve their economic and social well-being. From toddlers to seniors, we feed, shelter, teach, and support our neighbors to build a stronger community.
In 2017:

450,000 Meals served
10,000 Pantry bags distributed
871 Households enrolled in to SNAP
19,000 pounds of fresh, local produce sold to community
1,900 people educated on healthy eating and nutrition
BronxWorks’ three Single Stop sites offer low-income residents one place where they have access to financial, housing, benefits, and family service help at no cost.

BronxWorks Tremont Office
60 East Tremont
Bronx, NY 10453
(718) 731-3114
**Monday through Friday 9am-5pm**

BronxWorks Townsend Ave. Office
1477 Townsend Ave. (entrance on 172nd St.)
Bronx, NY 10452
(718) 588-3836
**Monday through Friday 9am-5pm**

BronxWorks McLaughlin Community Center
1130 Grand Concourse
Bronx, NY 10456
(718) 508-3040
**Thursdays 9am-5pm**

For more information, please contact:
Maxene Foster, Program Coordinator
mfoster@bronxworks.org
Food Pantries

Carolyn McLaughlin Community Center  
1130 Grand Concourse, Bronx, NY 10456  
Hours: Saturdays 9am – 1pm  
Contact: Genesis Mejia, Pantry Coordinator  
(718) 508-3169

Morris Innovative Senior Center  
80 East 181st Street Bronx, NY 10453  
Hours: 2nd Friday and 4th Friday of the month  
(718) 933-5300

Heights Neighborhood Senior Center  
200 West Tremont Bronx, NY 10453  
Hours: 1st Friday and 3rd Friday of the month  
(718) 299-0300
Services for Seniors (60+)

- Breakfast and Lunch served daily
- Food Pantry monthly
- Assistance with benefits and other social services
- Recreational and social activities

**Morris Innovative Senior Center**
80 East 181st Street
Bronx, NY 10453
(718) 933-5300

**E. Roberts Moore Senior Center**
515 Jackson Avenue
Bronx, NY 10455
(718) 665-5559

**Heights Neighborhood Senior Center**
200 West Tremont Avenue
Bronx, NY 10453
(718) 299-0300

**East Concourse Neighborhood Senior Center**
236 East Tremont Avenue
Bronx, NY 10457
(718) 731-6300
Services for People Living with HIV/AIDS

Eligible participants can receive:

• Free breakfast, lunch, and dinner served Monday-Friday
• Food pantry
• Nutritional supplements
• Nutritional assessments and counseling
• Workshops on healthy eating

Contact:
Rebekah Facteau, Program Coordinator
rfacteau@bronxworks.org
(718) 716-5559 x 2525
Farm Stands

BronxWorks Farm Stand
1130 Grand Concourse
Bronx, NY 10456
Thursdays 2pm – 6pm
*Free cooking demonstrations

Mott Haven Farm Stand
Gotham Health/Belvis
545 142nd Street
Bronx, NY 10454
Mondays 9am – 3pm
*Free nutrition & cooking workshops with Health Bucks
Improving the Food Environment

Shop Healthy Program
Grocery Store and Farmers Market Tours
Contact: Carolina Espinosa, Nutrition Program Coordinator
cespinosa@bronxworks.org
718-508-3098
Questions? Contact me!

Kimberley Wong, MPH
Program Director – Community Health Programs

kwong@bronxworks.org
718-508-31891
Taina Rodriguez, Emergency Food Programs Coordinator

PART OF THE SOLUTION (POTS)
How Emergency Food Programs Impact Stability

Emergency Food Programs is a main entry point. Through direct contact, distributing information, referrals EFP staff impact all areas of stability index.

• **Financial** - The food provided frees cash and SNAP resources to meet other needs. Approximately $33 worth of food per person in Pantry & $5 per meal in the Kitchen. Helping to connect clients to other services that increase benefits, access employment, tax services, etc.

• **Housing** - Food savings are often spent on rent. Information and referral to NSS.

• **Day to Day** - Information and referrals to Day to Day programs

• **Health** - Information and referrals to Care for the Homeless

• **Education** - Information and referrals to NSS
POTS emergency food services serve tens of thousands of households each year. These services provide a gateway to case management, legal, and many other services. The average POTS client uses between two and three of our services in tandem.
POTS Take away

• Food Security
  • An overwhelming majority of our clients are experiencing food insecurity
  • Many of these households are in crisis
• Remove the cause, not the symptom
  • Comprehensive services help reduce hunger by attacking the causes of hunger instead of the consequence
  • Emergency food support is essential, but is most effective when tied to other programs
Community Dining Room

• Open Seven Days a Week 12:30pm to 3:30pm
• Open all holidays with the Exception of Thanksgiving & Christmas
• Guest Line up out side to the right hand side of our building
• No questions asked and no Intake
• 450 Meals average day, 13,000 a month 160,000 a year
Pantry

• Monday Through Saturday 9am to 12pm & Saturday’s 3:30pm to 5:30pm
• Supermarket Style
• 10453, 10457, 10458, 10460, 10467 & 10468
• Intake- Screening for Public Benefits
• 3 meals x 3 days for each person in the house
• 80 to 100 Household per day, Average 65,000 meals per month & 800,000 meals a year.
First-Time Clients for Pantry

- Second Floor Monday- Saturdays 9am to 12pm & First Floor Saturday afternoons 3:30pm to 5:30pm
- Intake- Sales Force
- Screening/Public Benefits (Self Sufficiency Calculator)
- Documents requirement's
- Link to other Services
- Out side Zip codes or Non-Cooking Facility
Documents for Pantry

• **Proof of address:**
  • Shelter residency letter (if applicable)
  • If you **rent a room** bring a letter from the head of household stating that you live there along with one of the following dated within the last 30 days.
    • Con Edison / Cable / Home Phone / Current lease
  • **Note:** If the bill or lease is in your name bring it as your proof of address.

• **Proof for others in the home:** (based on age)
  • **18+:**
    Photo ID **(no photo copies)** with any non-personal mail the individual receives at that address.
  • **5 - 17:**
    School letter
  • **0 - 4:**
    Birth Certificate or Medical Insurance Card
Client Survey

How often do you experience stress or worry about having enough food?

- Never
- Rarely
- Sometimes
- Usually
- Always

Before Accessing POTS Services
- Never: 15%
- Rarely: 20%
- Sometimes: 35%
- Usually: 10%
- Always: 30%

After Accessing POTS Services
- Never: 10%
- Rarely: 15%
- Sometimes: 30%
- Usually: 25%
- Always: 15%

Crisis to Stability and, ultimately, Self-Sufficiency
Services Used at POTS

- 60% of clients use more than one service
- The average client uses 2.4 services
- Services include: case management, legal, food pantry, dining room, clothing room, mail, shower, haircuts

Clients using a combination of POTS services for more than a year reported the lowest rates of Food Insecurity
The Effect of Comprehensive Services

Accessing POTS emergency food services has helped 70% of our surveyed clients to reduce household hunger.

42% of surveyed clients have reported that fewer meals are skipped in the household after using POTS services.

Almost half of all surveyed clients report that relieving hunger through POTS Emergency Food Services has allowed them to focus on longer term goals.
Taina Rodriguez
taina@potsbrnx.org
Implementing the Food Insecurity Pilot

- Pilot will kick off after today’s session and will be conducted for **6 months**
- CSO will support **monthly monitoring and tracking** of screening rates and referrals
- Evaluate overall **patient outcomes** linked to the intervention
- **Assess the impact** on health and health utilization
  - Utilize the BronxRHIO, Medicaid claims data and/or EMR reports
  - Patient surveys
- Analysis of first cohort to be provided **Spring 2019**