BRONX PARTNERS FOR
HEALTHY COMMUNITIES

SBH
Health System
BRONX

Addressing Food Insecurity for Pediatrics

Grand Rounds
October 2, 2018

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

[1]*Billioux, A., K. Verlander, S. Anthony, and D. Alley. 2017. Standardized screening for health-related social needs in clinical settings: The accountable health communities screening tool. Discussion Paper, National Academy of Medicine, Washington, DC. https://nam.edu/wp-content/uploads/2017/05/ Standardized-Screening-for-Health-Related-Social-Needsin-Clinical-Settings.pdf*

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 including[3]:
  - 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]

[2]Definitions of Food Security. *United States Department of Agriculture – Economic Research Service,* www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/definitions-of-food-security/.

[3]*Food Insecurity and Health: A Tool Kit for Physicians and Health Care Organizations.* (2017) Humana. Retrieved from: http://populationhealth.humana.com/documents/Food-Insecurity-Toolkit.pdf

Poverty Drives Food Insecurity

Poverty is not the ultimate determinant of food insecurity, but it is a key factor.[4]

The Bronx Median household income is $35,300[6]

- 28.6% of overall Bronx population lives in poverty[6]

South Bronx Neighborhoods	% Living in Poverty[5]
Belmont	46.1%
Fordham South	47.4%
Highbridge	43.0%
Hunts Point	42.7%
Morrisania-Melrose	36.2%
Mott Haven-Port Morris	46.4%
Mount Hope	38.8%

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

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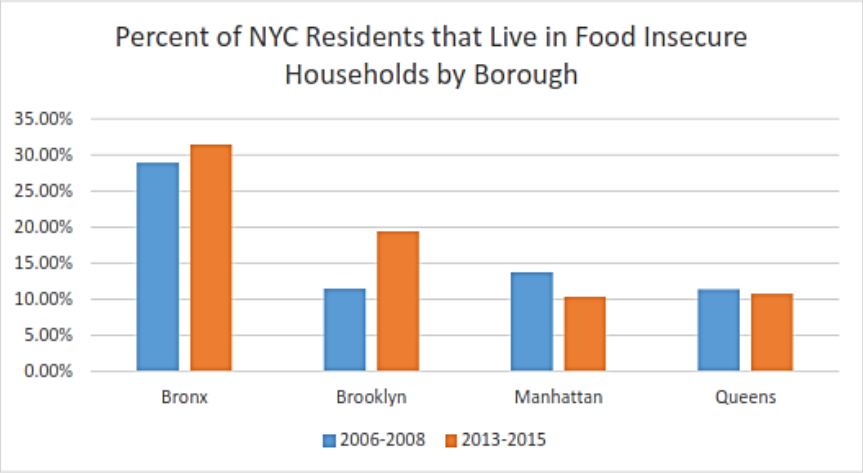
[4]*Poverty and Hunger Fact Sheet.* (2018) Feeding America. Retrieved from: http://www.feedingamerica.org/assets/pdfs/fact-sheets/poverty-and-hunger-fact-sheet.pdf

[5]New York City Neighborhood Health Atlas. (2018) NYC Health. https://public.tableau.com/profile/nyc.health#!/vizhome/NewYorkCityNeighborhoodHealthAtlas/Home

[6]QuickFacts Bronx County (Bronx Borough). (2017) United States Census Bureau. https://www.census.gov/quickfacts/fact/table/bronxcountybronxboroughnewyork,newyorkcitynewyork,ny/PST045217

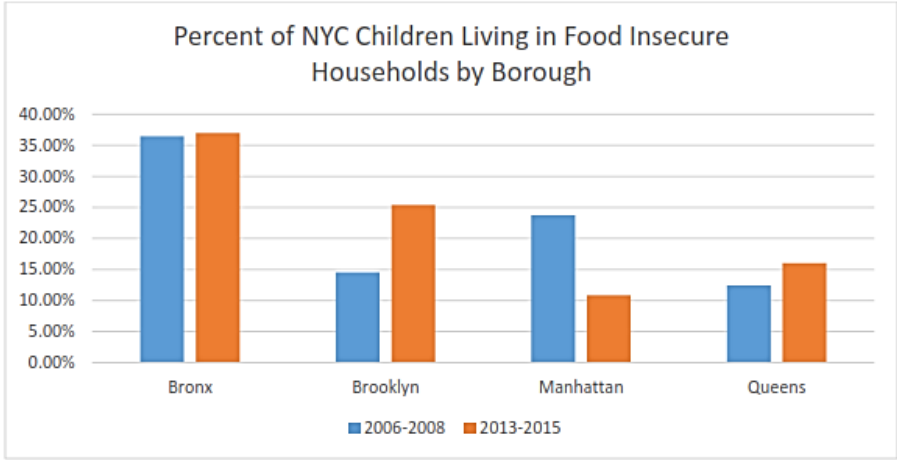
[8]Fedeeral Poverty Level (FPL). (2018). HealthCare.gov. Retrieved from: https://www.healthcare.gov/glossary/federal-poverty-

The Bronx: NYC's Hungriest Borough[7]



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

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



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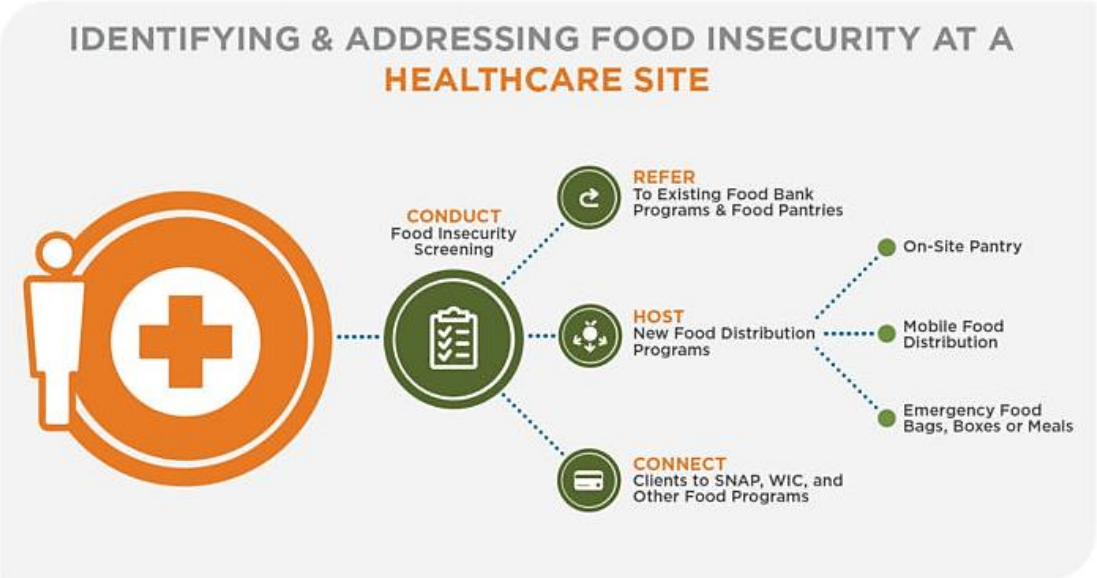
[7]Hunger Free America. (2016). *The State of the Working Hungry: Low Wages Chief Cause of Malnutrition. Retrieved from:* *https://www.hungerfreeamerica.org/sites/default/files/atoms/files/2016%20Annual%20Hunger%20Survey%20Report%20Final.pdf*

Breaking the Barriers

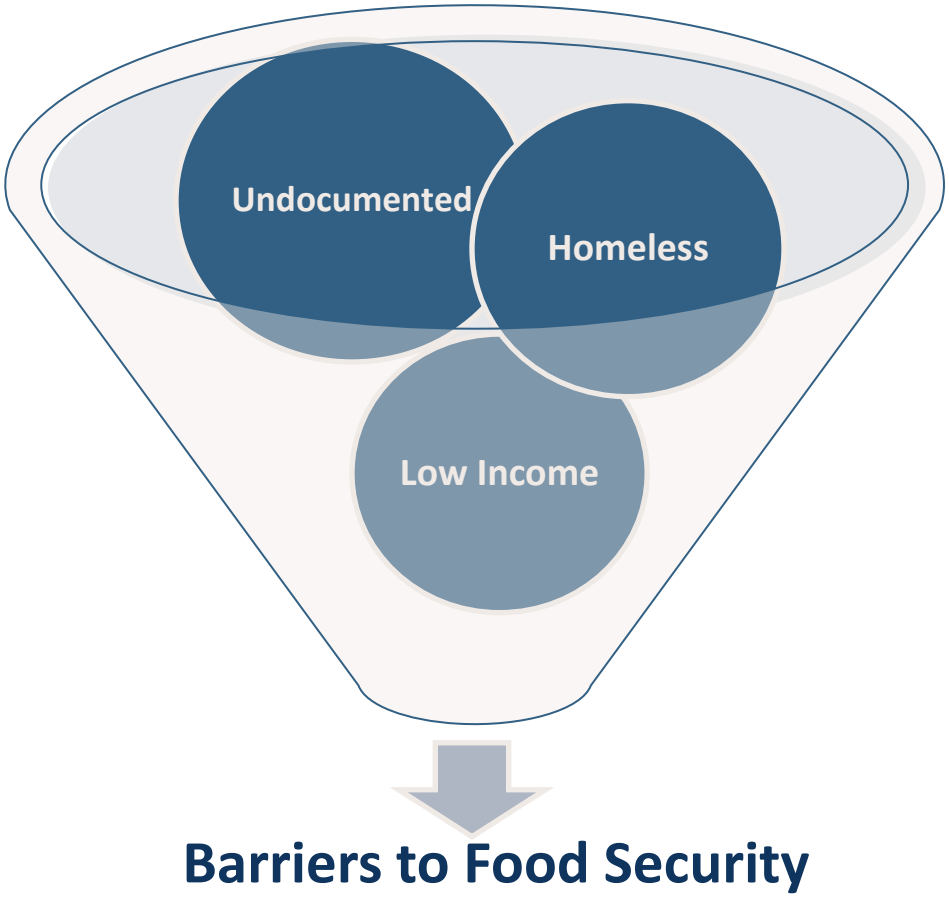


- Families may be reluctant to seek assistance because of the **stigma associated** with hunger and food insecurity
- Providers can create an environment that provides **resources and provide assistance**
- Encouraging families to **feel comfortable** talking about their needs and receive help

Image courtesy of: Addressing Food Insecurity in Health Care Settings. Accessed August, 2018, from https://hungerandhealth.feedingamerica.org/explore-our-work/community-health-care-partnerships/addressing-food-insecurity-in-health-care-settings/

Food as Medicine

- Food plays a significant role in a patients 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



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

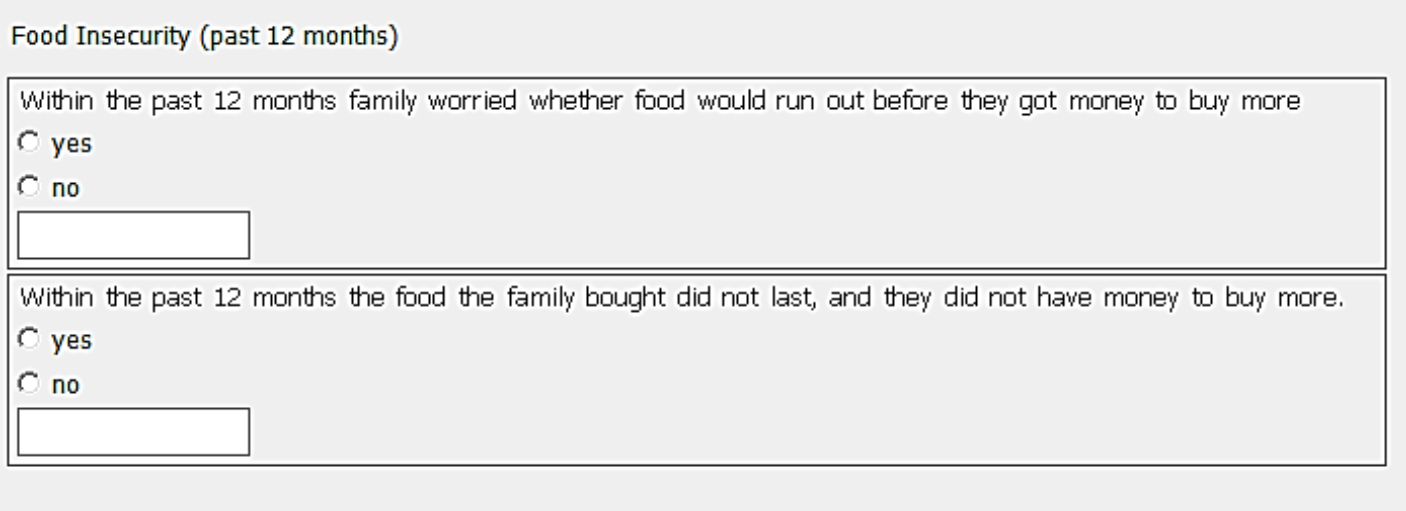
*Data between January – June 2018

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

Step1: 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!



[1]*Billioux, A., K. Verlander, S. Anthony, and D. Alley. 2017. Standardized screening for health-related social needs in clinical settings: The accountable health communities screening tool. Discussion Paper, National Academy of Medicine, Washington, DC. https://nam.edu/wp-content/uploads/2017/05/ Standardized-Screening-for-Health-Related-Social-Needsin-Clinical-Settings.pdf*

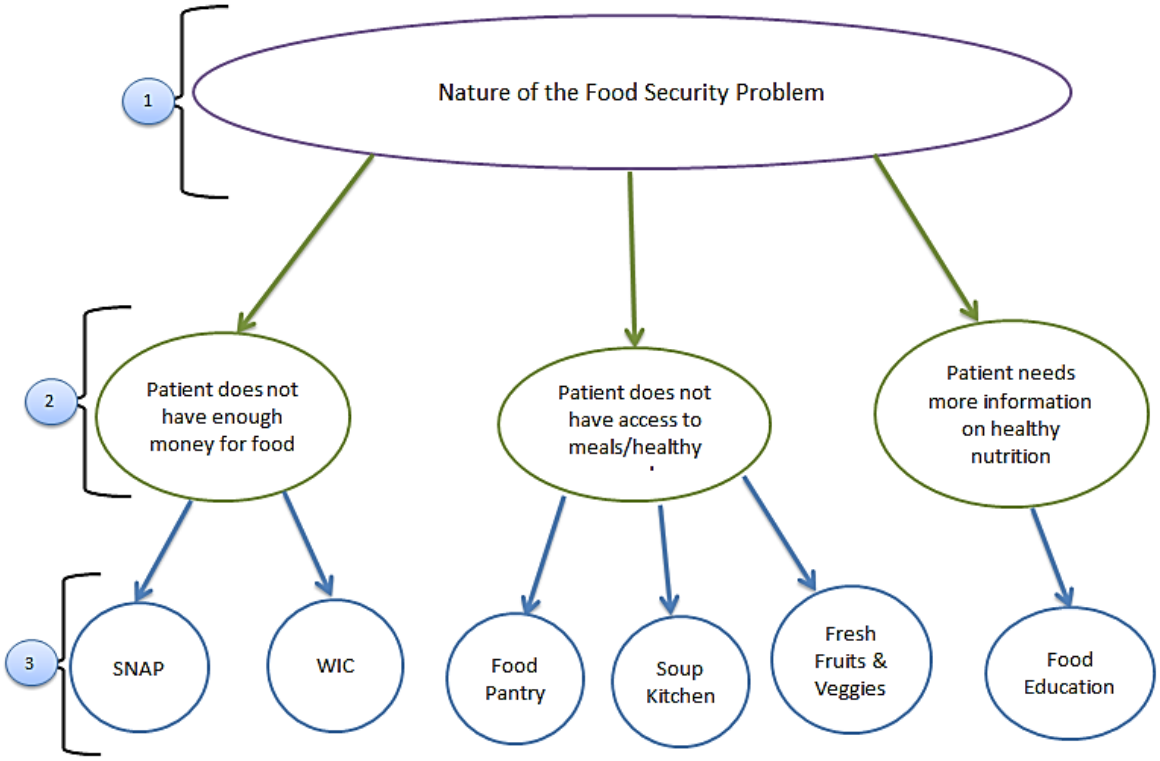
Step 2: Warm Handoff

- 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

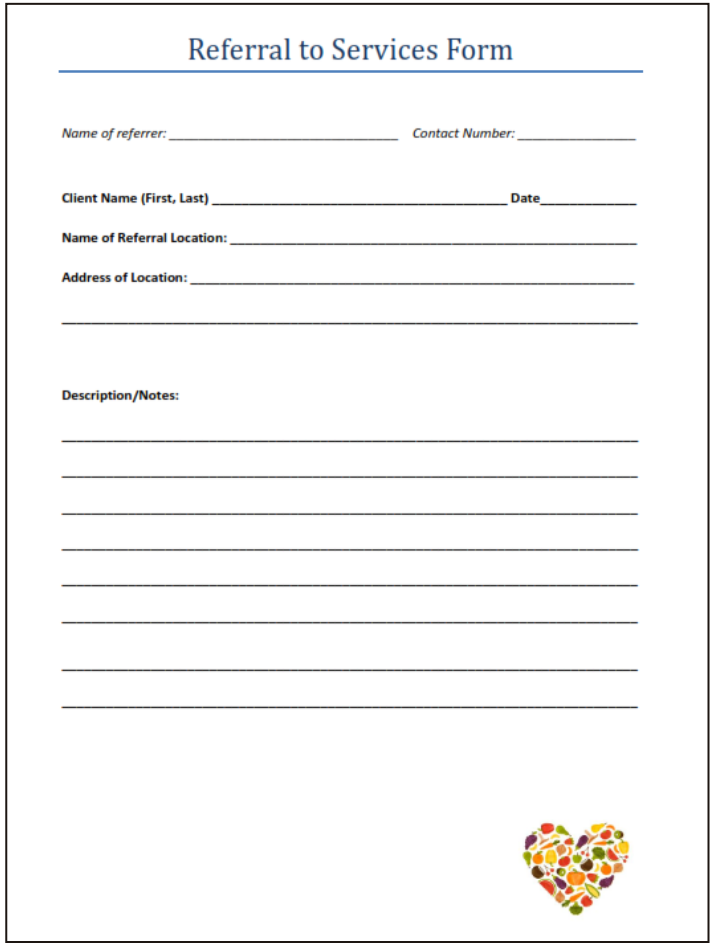
Assessment and motivational interviewing to determine needs and encourage action

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



Referral to Services Form

Name of referrer: _____ *Contact Number:* _____

Client Name (First, Last) _____ **Date**_____

Name of Referral Location: _____

Address of Location: _____

_____

Description/Notes:

_____

_____

_____

_____

_____

_____

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_____

Kim Wong, MPH; Program Director of Community Health Programs

BRONXWORKS

Bronxworks

Lifting Lives Building Futures

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.

BronxWorks FEEDS

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

Single Stop

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)

Part of the Solution
Feeding Our Neighbors. Nourishing Our Community.

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.

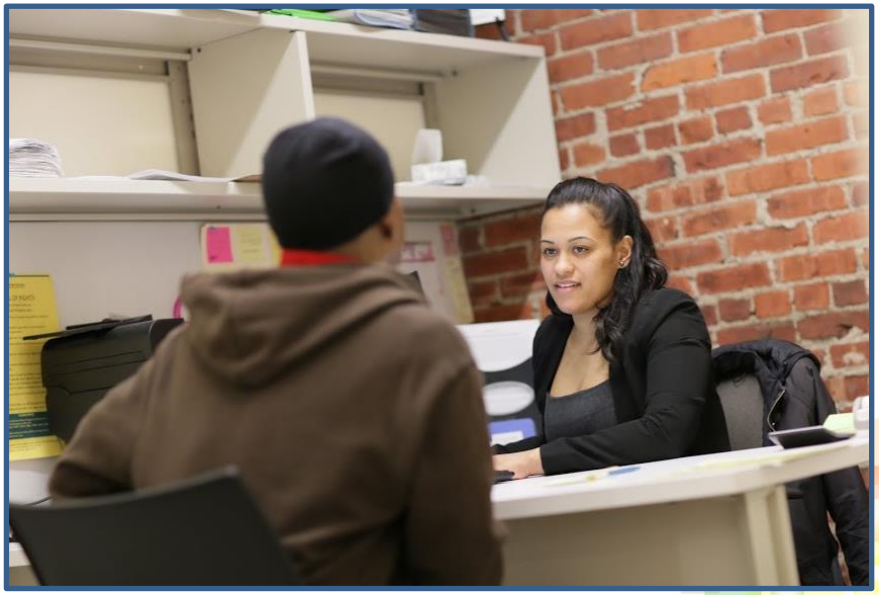
- Financial- The food provided frees cash and SNAP resources to meet other needs. Approximately $33 worth of food per person in Pantry & $5 per meal in the Kitchen. Helping to connect clients to other services that increase benefits, access employment, tax services, etc.
- Housing - Food savings are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

Holistic Approach to Hunger

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.

Part of the Solution
Feeding Our Neighbors. Nourishing Our Community.

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

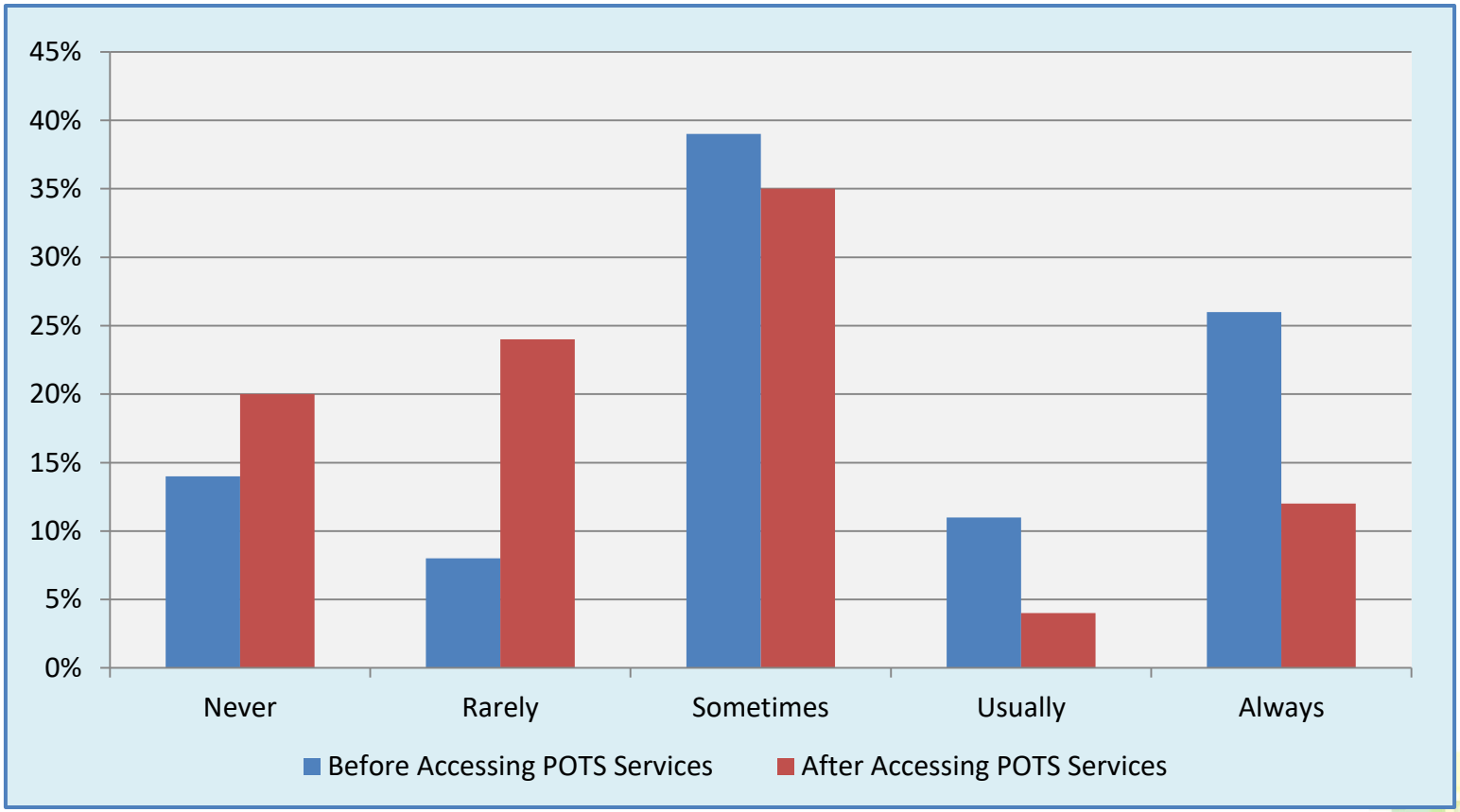
Documents for Pantry

- **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:**

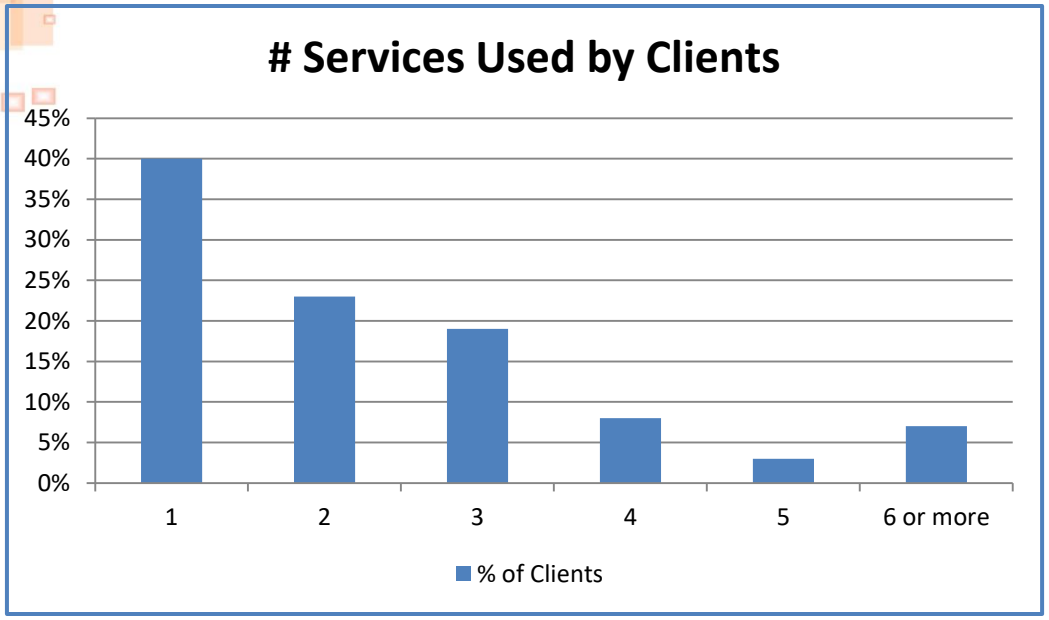
Birth Certificate or Medical Insurance Card

Client Survey

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



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 <u>half</u> 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@potsbronx.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**

Q&A

THANK YOU