# The Food and Nutrition Services Bundle

## Providing Food Navigation for Food Insecure Patients of Safety Net Hospitals

Report Update: One year of providing services during the COVID-19 pandemic. Data from March 2020 to March 2021

Public Health Solutions

## Authors

Mireille Mclean
Arielle Burlett
Lauren Haynes
Zachariah Hennessey
Julieta Velasco

## Thanks

Public Health Solutions (PHS) would like to thank all the people who have made this project possible, starting with our incredible team of Food Navigators: Gabrielle Miller and Roseanne Rodriguez, who started the work, and were later joined by Zuleika Pichardo, Janay Ramirez, Yulisa Diaz, and Alexis Simonetti. Our partners at NYC Health + Hospitals/Lincoln, Lara Rabiee, Colette Barrow, Hilda Reyes, and all their SDOH volunteers; at NYC Health + Hospitals/Jacobi, Dana Ferrante, Dr. Elana Sydney, Dr. Varsha Narasimhan, Marni Confino, Mary McGuirk, Leora Botnick and her team; at NYC Health + Hospitals/North Central Bronx, Dr. Frederick Nagel, Indira Tiwari, Margaret Robinson, Marcelino Villafane, Dr. Vimala Ramasamy, Edjanine Singletary, Miguelina Almonte and her team, and later Kyesha Turner and Juan Paredes; at NYC Health + Hospitals/Gotham Belvis, Dr. Elizabeth Natal, Gifty Amankwah and her team; at NYC Health + Hospitals/Gotham Morrisania, Theresa Landau and her team; at NYC Health + Hospitals/Metropolitan, Richard Siegel, Michael Lettera, Dr. Anjna Ganatra and her team and later Angela Montague and Marisol Feliciano; at NYC Health + Hospitals/Bellevue, Oshiozanime (Nime) Lakoju and her team, Elvis Durazzo, Carla Brekke and her team, Heather Borriello, Dr. Michelle McMacken and Joan Dixon; at NYC Health+Hospitals/Harlem, Lorraine Carvell and her team, and later Raffaele Dimatteo and Tara Howell; at OneCity Health during the peak of the pandemic, Marjorie Momplaisir-Ellis and Opeyemi Osuntuyi; at the Office of Population Health, Emily Foote and Jenna Lupi, and later Amrita Dasgupta, Jenifer Clapp, and Dr. Alessandra Calvo-Friedman. At our Community-Based Organizations, we deeply thank Bibi Karim, Rachel Gill, Ailsha Sepulveda, Kate Janeski, Alexandra Roem, Dorella Walters, Alissa Wassung, Lisa Zullig, Zanita Tisdale, Russell Gordon, Melissa Pino, Jesus Garcia, Stephen Cacace, Travias Cunningham, Stephen Cacace, Roslyn Shoulders*, and later Selenia Epps and Rashan Hodge, Maria Cintron, Elisa Bresba, Rosa Bernard, Pastor Emaeyak Ekanem, Josefina Enrique, Jose Cepeda, Jeannette Joseph, Cheryl Seeley, Muhammad Al-Amin, Judy Secon, Suheddy Pena, Tynisha Malone, Raquel Sabino, Teresa Concepcion, Alex Lawrence, Steve Fanto, Julio Quirindongo, Connie Fitzgerald, Chris Norwood, Juanita Lopez-Kump, Jamie Canton and their DSMP leaders/peers, Jeanette Means, Janneth Alvarez, and James Goldman along with all the staff and volunteers at their respective organizations that made this work possible. We are grateful to the Altman Foundation for supporting our evaluation efforts. At PHS, we also would like to thank Ailin Liu, Vanessa Mendez, Ralitsa Kona-Kalfas, Cleavlon Brooks, Melissa Flores, and Alva Rodriguez, who have all contributed to this project in small and big ways.

**Our team was extremely saddened by the passing of Roslyn Shoulders. Roslyn helped countless Bronx residents get assistance from the food pantry at Shiloh Temple Pentecostal Church and we are deeply grateful for the time we spent with her and her dedication to this project.*

# Table of Contents



Last updated: July 2021

# Introduction

The Food and Nutrition Services (FNS) Bundle was launched on November 1st, 2018, as a pilot project in the Bronx, with an Innovation Award from OneCity Health, the Performing Provider System for New York City's municipal health system, Health + Hospitals.

The FNS Bundle established a coordinated network of food and nutrition services aimed at providing food navigation services to low income patients in safety net hospitals. The service created pathways between public hospitals and resources to include food pantries, congregate meal programs, home-delivered and medically tailored home-delivered meals (MTM), SNAP, WIC, and Diabetes Self-Management Program (DSMP), by using food security specialists trained in SNAP enrollment assistance and benefits screening.

Initial results and lessons learned were presented in November 2019[1]. At that point, OneCity Health had decided to scale up the pilot and launch a full-fledged Food Navigation services program co-located in healthcare facilities in four NYC boroughs.

Starting in December 2019, PHS began working on expanding its services in the Bronx and Manhattan.

Only weeks later, the first COVID-19 case was confirmed in the United States and by March 2020, New York City had become the epicenter of COVID-19 in the Western hemisphere. The Food Navigators pivoted from a co-location model to a phone outreach approach. The Office of Population Health at Health + Hospitals referred discharged COVID-19 patients for screening and the Food Navigators' role was expanded to direct patients to more resources than those initially included in the FNS Bundle[2].

This brief report updates our findings from the pilot project by focusing on the implementation period from March 1st 2020 to March 31st 2021, reflecting the period when the city faced the most infections, death, and restrictions. All results are from the Bronx and Manhattan, where PHS leads the services.

1 "The Food and Nutrition Services Bundle, Findings from a pilot project" Public Health Solutions, November 2019.

2 Clapp, J., Calvo-Friedman, A., Cameron, S., Kramer, N., Kumar, S. L., Foote, E., ... & Chokshi, D. A. (2020). The COVID-19 Shadow Pandemic: Meeting Social Needs For A City In Lockdown: Commentary describes how New York City Health+ Hospitals staff developed and executed a strategy to meet patients' intensified social needs during the COVID-19 pandemic. Health Affairs, 39(9), 1592-1596.

# What Did We Do?

## Expanded Partnerships

Recommendations from the pilot phase led PHS to include two new services: home-delivered meals for older adults, who may not qualify for medically-tailored meals provided by God's Love We Deliver or Mom's Meals, and nutrition education for people with diabetes.

PHS onboarded providers of Meals on Wheels including Neighborhood SHOPP and Lenox Hill Neighborhood House and one provider of the Diabetes-Self-Management Program, Health People, to meet the need.

For emergency food, we continued to work with BronxWorks and also grew the number of food pantries with the Food Bank for New York City to cover more neighborhoods. The FNS Bundle now has about 15 active providers of emergency food across the Bronx, Manhattan and Queens.

## Adapted to the Pandemic

Co-located Food Navigators left H+H facilities on March 16, 2020 and worked remotely through the pandemic except for a brief period of time in October 2020. Food insecurity screenings and SNAP application assistance were provided to clients over the phone. Food Navigators were onboarded by NYC's Emergency Food delivery program (GetFood) as trusted enrollers to help register people who had trouble accessing the online request form.

Our partners also had to adjust: some food pantries briefly suspended services to adjust to a shortage of volunteers and the implementation of social distancing rules for pick up, while volunteer organizations such as Invisible Hands joined in to help deliver groceries directly to patients' homes.

The demand for Home-Delivered Meals and Medically Tailored Home-Delivered Meals grew considerably. The Diabetes Self-Management Program, which is a group-based intervention heavily reliant on peer-support, was replaced by individual phone conversations between a patient and peer. This modification was designed to help patients manage their condition and deal with anxiety as they were forced to postpone in-person specialty care visits for months.

# Our Impact

From March 2020 to March 2021, our team of six Food Navigators reached and talked to 5,388 H+H patients.

30% were 60 and older. 18%were pregnant or new parents. While these demographics remained similar to what we had observed in our first report, other indicators were sharply impacted by the COVID-19 pandemic: 63% of people who responded to the question "Are you interested in free groceries or free meals" said yes, compared to 49% in the first report. The proportion of those who had used free meals or groceries in the past month doubled, from 6% to 12%.

On a brighter side, the proportion of those who were uninsured dropped from 14% to 4%, probably in part due to the expansion of NYC Care (NYC's public health system healthcare option for the uninsured), which was mentioned by 12% of program participants with a documented insurance.

4,813 referrals to services provided by partners were made using the closed-loop referral platform, Unite Us. Of those, 4,344 were accepted by partners (90%). The main reasons why partners may not have accepted a referral is not having sufficient information to reach the patient and being too stretched to conduct outreach. When the Food Navigators were aware of these issues, they attempted to correct the referral information or re-direct it to another partner. 4,292 (99% of accepted referrals and 89% of total referrals made) have a documented outcome.

**89%**

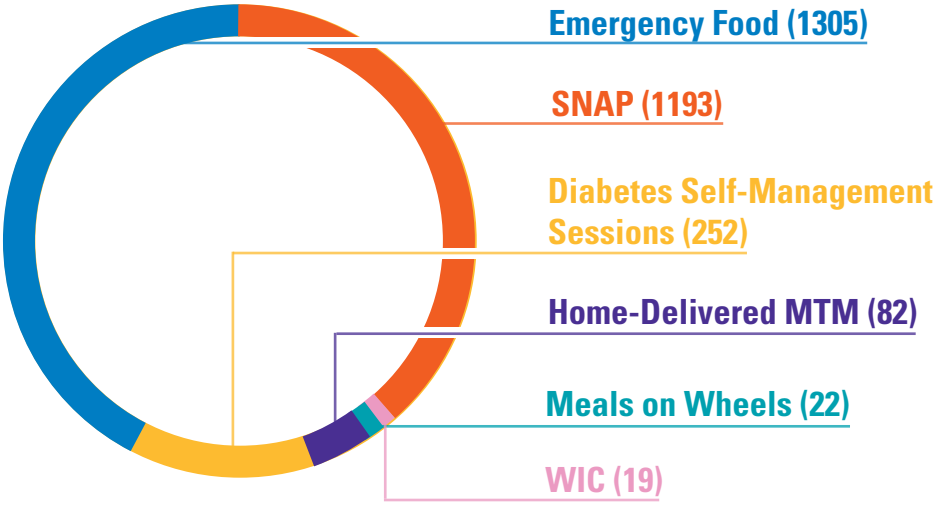
**OF REFERRALS MADE TO THE NETWORK HAD A DOCUMENTED OUTCOME**

**60%**

**OF REFERRALS RESULTED IN ENROLLMENT IN FOOD AND NUTRITION SERVICES**

The breakdown of these outcomes show that 2,905 (68% of referrals with a documented outcome, and 60% of all referrals made to the network) referrals ended successfully, with the patient accessing services. This success rate, up from 47% for all referrals from our previous report, is noteworthy given the incredible strain put on all the partner organizations during the toughest months of the pandemic. It demonstrates the resilience of NYC's social safety nets, and of the FNS Bundle in particular.

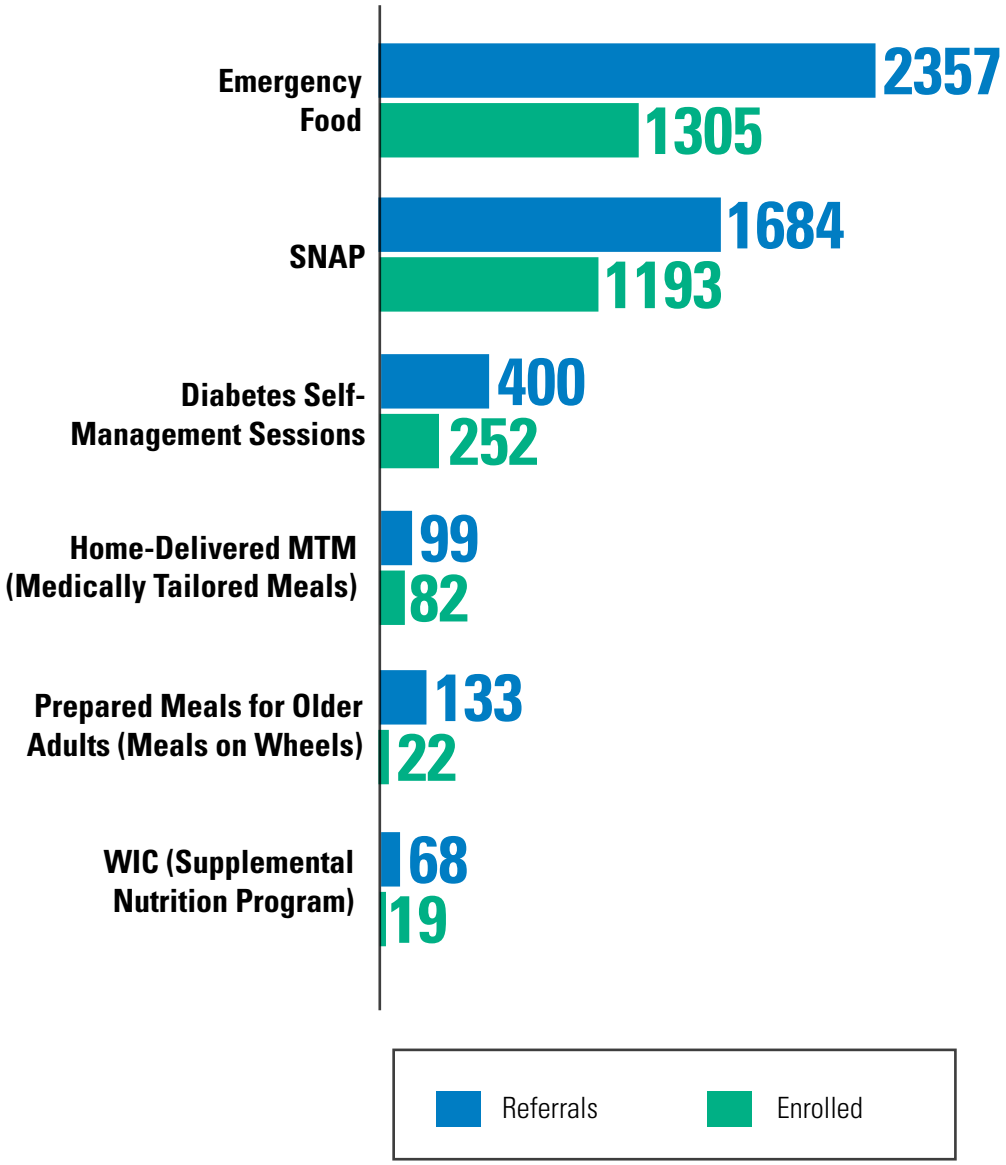
## Enrollment by types of services




Among the remaining 1,387 unsuccessful referrals, the main reasons documented were the inability of the partner to reach the patient by phone, followed by eligibility issues, missing deadlines to complete an application process (which is a recurring challenge among SNAP applicants due to the chronically overwhelmed call center that they are required to call for an interview), and a small number of patients declining to receive the service after receiving more information.

Finally, Food Navigators placed 5,475 home-delivered prepared meal orders through NYC GetFood for those in need.

## Referral cascade per type of service:




The 4,344 referrals accepted in the platform represented 3,702 individual patients. Of these 3,702 individuals, 563 (15%) received more than one referral in the closed loop platform.

Full addresses are documented for 3,557 patients (96% of patients). During the pandemic, PHS referred patients from 143 zip codes, all over the city.

However, 1/3 of these patients came from just 5 zip codes in the Bronx: 10467 (204 people), 10451 (227 people), 10455 (239 people), 10454 (255 people) and 10456 (279 people).

# What's Next?

Just before the pandemic unfolded, New York State learned that its 1115 Waiver extension application had been rejected. The waiver was the mechanism that allowed the State Medicaid Office to invest in the Delivery System Reform Incentive Payment (DSRIP), which funded many innovative programs aimed at tackling the Social Determinants of Health.

Without DSRIP, hospital systems need to look to their own resources to continue supporting partnerships with community-based organizations. In the case of the FNS Bundle, NYC Health + Hospitals worked with PHS to continue providing more targeted services through the end of 2021.

We plan to enhance the FNS Bundle in several ways. First, we are committed to including patients who participate in the FNS Bundle screening in some key elements of our program design, thus working to make the FNS Bundle a more person-centered, inclusive service.

Secondly, we want to deepen our understanding of the added value brought by our coordinated needs assessment and intake tool, from the perspective of patients, and use these lessons learned to fine-tune the way we provide referrals and communicate information to patients.

Finally, we hope to conclude a partnership with the NYU Health Evaluation and Analytics Lab that will help illuminate the healthcare utilization of FNS Bundle participants.

# Conclusion & Recommendations

## for the future of healthcare community partnerships in addressing food insecurity

Despite the incredible pressure brought on the health systems and CBOs and their teams since 2020, our data shows that thousands of families were able to access critical services and support during an unprecedented time. The ability of all members of such partnerships to pivot and adapt while maintaining continuous communication is critical to this success.

Still, after over 3 years of implementation, the absence of a comprehensive and sustainable financial mechanism to support screening, referrals, and the delivery of services in the community contributes to the fragmentation and lack of coordination of services.

This hampers the ability of patients to access services when and where they need it most.

The inability to fully compensate many of the community-based organizations that accept referrals in the FNS Bundle creates the sort of "wrong pocket" problem, where benefits realized thanks to social services over the medium and long-term disproportionately accrue to the healthcare sector, which jeopardizes such initiatives. Strong healthcare community partnerships should address this issue.

**A sustained financial mechanism should go hand-in-hand with a straightforward, well-governed, data exchange and referral tool, akin to Community Information Exchanges that exist in other states and cities in the United States.**

Such a tool would allow CBOs and the health systems to identify gaps in services coverage, track referral performance, while avoiding the repetition of the same assessments over and over again. Properly shared, this information can be a powerful way to address inequitable distribution of, and access to, resources.

Finally, investment in the workforce, which allows community-based organizations to provide linguistically and culturally sensitive services, is essential to ensure quality.

# Partners


Bronxworks
Lifting Lives Building Futures


NEIGHBORHOOD
Helping Older Adults Help Themselves
Celebrating 40 Years of Service


HEALTH PEOPLE
Community Preventitive Health Institute


LENOX HILL NEIGHBORHOOD HOUSE
SINCE 1894


GOD'S LOVE
WE DELIVER


healthfirst
Health Insurance for New Yorkers


UNITE US


FOOD BANK
FOR NEW YORK CITY
foodbanknyc.org


NYC
HEALTH+
HOSPITALS
ONECITY
HEALTH

Health disparities among New Yorkers are large, persistent and increasing. **Public Health Solutions (PHS)** exists to change that trajectory, and support vulnerable New Yorkers in achieving optimal health and building pathways to reach their potential. We improve health outcomes and help communities thrive by providing services directly to vulnerable low-income families, and supporting 200 community-based organizations through our long-standing public-private partnerships. We focus on a wide range of public health issues including food and nutrition, health insurance, maternal and child health, sexual and reproductive health, tobacco control, and HIV/AIDS. Your support helps us to realize our vision for heath equity in New York City. Visit **healthsolutions.org** to learn more.

Public Health Solutions

40 Worth Street, 4th Floor
New York, NY 10013-2988
646-619-6400
healthsolutions.org

**@wearephsny**