The Food and Nutrition Services Bundle

Findings from a pilot project

A coordinated and accountable network bridges healthcare and local community food and nutrition resources for food insecure persons in the Bronx

Public Health Solutions

Authors

Zachariah Hennessey
Mireille Mclean
Lauren Haynes
Arielle Burlett
Sandra Jean-Louis
Ailin Liu

Thanks

Public Health Solutions (PHS) would like to thank all the people who have made this project possible, starting with the Food Security Specialists, Catalina Gonzales, Gabrielle Miller, and Roseanne Rodriguez, and our partners at NYC Health + Hospitals/Lincoln, Colette Barrow, Grace Kim, and Lara Rabiee; at NYC Health + Hospitals/Jacobi, Dana Ferrante, Lorraine Adler, Naomi Buchanan, Sara Costenino, Molly Gittleson, and Elana Sydney; and at OneCity Health, Marianne Krauskopf, Anita Ginsberg, Grace Wong, and Jasmine Warrick. At our Community-Based Organizations, we deeply thank Bibi Karim, Kim Wong, Kate Janeski, Alexandra Roem, Dorella Walters, Alissa Wassung, Lisa Zullig, Laine Rolong, Russell Gordon, Travias Cunningham, Stephen Cacace, Roslyn Shoulders, Maria Cintron, Rosa Bernard, Emaeyak Enakem, Emily Hespeler, Jose Cepeda, Jeannette Joseph, and Cheryl Seeley. At Healthfirst, Susan Beane, Rashi Kumar, Ronald Sanchez, and Tom Wang. At PHS, we also would like to thank Juanita Martinez, Flor Angel Rosario, Jackeline Bautista, and our intern, Joshua Souane, for their support with monitoring and evaluation.

Table of Contents

Last updated: November 2019

Executive Summary

On November 1, 2018, with support from a One City Health Performing Provider System Innovation Award, Public Health Solutions launched the Food and Nutrition Services Bundle (FNS Bundle), offering screening and navigation to community food and nutrition resources for food insecure patients at two public hospitals in the Bronx. This report presents a summary of accomplishments, evaluation findings, and lessons learned from the pilot project.

A Network of Local Partners

Public Health Solutions serves as a trusted broker for healthcare providers, managed care organizations, and community-based organizations to develop accountable care networks that connect patients and members to high-quality community resources that meet their non-medical needs and improve the social determinants of health. The FNS Bundle was a close partnership with Health + Hospitals/Lincoln Hospital and Health + Hospitals/Jacobi Hospital, God's Love We Deliver, BronxWorks, Food Bank For New York City, and Healthfirst. Collaborative design of the screening tool and workflows and continuous quality improvement were essential to our approach. The project used a dynamic care coordination platform, Unite Us, to manage the activities of the network, with integrated consent, assessment tools and outcome measures. PHS also provided contracting and management services to enable flexible and performance-based contracting between network partners.

Our Impact

- The FNS Bundle reached important populations of focus for social determinants of health improvement. Among those reached:

37% WERE OLDER ADULTS

76% WERE ON MEDICAID/ MEDICARE

14% WERE UNINSURED

21% ARE PREGNANT OR NEW PARENTS

- The FNS Bundle was successful in meeting the needs of food insecure families. Food and nutrition services were provided to 871 families over a 10-month period.
- The FNS Bundle assessment tool and technology platform were highly effective in connecting participants to resources.

86% **OF REFERRALS MADE TO THE NETWORK HAD A DOCUMENTED OUTCOME**

57% **OF REFERRALS RESULTED IN ENROLLMENT IN FOOD AND NUTRITION SERVICES**

- Participants who were connected to emergency food, such as a pantry or soup kitchen, had not previously known about or used these resources before. The proportion of participants in need of emergency food resources who were able to access such resources rose from 6% to 56%.
- The FNS Bundle was effective in connecting participants to multiple resources through one encounter, with the most frequent combination being enrollment in SNAP plus use of a food pantry: 58% of all enrollments were in SNAP, and 38% of all enrollments were in Food Pantries.
- The FNS Bundle reduced the administrative burden on participants and healthcare workers to access services with complex eligibility requirements, such as medically tailored home-delivered meals.
- Outcomes suggest a positive healthcare savings return on investment.

Background

Public Health Solutions (PHS) supports vulnerable New York City families in achieving optimal health and building pathways to reach their potential. Access to healthy, nutritious food is essential to good health. PHS has been working for decades to improve access to food for low-income families in NYC, as the largest provider of WIC, the Supplemental Food and Nutrition Program for Women, Infants and Children, and as a major provider of SNAP enrollment assistance, the Supplemental Nutrition Assistance Program.

Food insecurity and poor nutrition exacerbate health conditions, contribute to poor developmental outcomes, and result in high acute healthcare use and healthcare costs that are preventable. Food insecurity and malnutrition are more prevalent in specific neighborhoods and more consequential among key populations, such as seniors, infants and children, the homeless/unstably housed, pregnant women, and people living with chronic conditions. Multiple community-based services and resources exist to improve food security and nutritional health, but they are often fragmented and uncoordinated. Many providers are unsure about where to refer their food insecure patients, resulting in improper referrals that result in unsuccessful outcomes and frustrate both patients and community referral partners.

To address this problem, PHS and our partners developed a high quality, coordinated, and accountable food and nutrition services network, the Food and Nutrition Services Bundle (FNS Bundle), that connected community-based food and nutrition services to critical healthcare and community access points. The FNS Bundle was designed to include the full range of options available in the local community and increase the likelihood of a successful connection based on needs, eligibility, and preferences. The workforce consisted of Food Security Specialists embedded in healthcare settings who connected patients to the full range of local food and nutrition resources, including SNAP, WIC, medically tailored home-delivered meals, food pantries, congregate meals, individual and group nutrition counseling, and sources of fresh produce. The bundle was powered by an electronic platform, Unite Us, that enabled network partners across multiple health and social service settings to share information and coordinate care for participants.

The FNS Bundle was established in the South Bronx through a OneCity Health Innovation Fund Award in 2018. Partners included PHS, Health and Hospitals Corporation (H+H), God's Love We Deliver, the Food Bank for NYC, Bronxworks, Healthfirst, and numerous local pantries and congregate meal programs. Funding was used to develop and coordinate the network and provide food navigation, but also directly and flexibly supported food and nutrition services where there were unmet capacity needs.

What Did We Do?

PHS applied a clearly defined approach to developing the FNS Bundle, that coupled deep on-the-ground service delivery experience with robust technology and fiscal and administrative infrastructure to ensure resources reached the people and places that needed them the most.

The approach included:

- Working with healthcare partners (healthcare providers and managed care organizations) to identify priority needs for their service populations and proposing innovative, evidence-based ways to address them
- Curating and convening the most relevant healthcare and community-based organization partners to participate in community resource networks
- Facilitating collaborative development of shared goals, roles and responsibilities, workflows, and technology and infrastructure needs
- Developing, managing and monitoring complex and performance-based contracts between partners that were tailored to each type of service
- Supporting performance, including quality and efficiency, through applied data analytics and hands-on technical assistance

PHS' Approach

Early in the project, PHS facilitated a series of design sessions, which involved hospital representatives, the managed care partner, and partner Community Based Organizations. During these sessions, the group:

- Developed a team charter to ensure agreement on roles and responsibilities
- Reviewed technology options and selected a dynamic electronic care coordination platform (Unite Us) through a competitive review process
- Developed a coordinated intake and assessment tool and decision-tree logic, to evaluate participant needs, eligibility criteria, and preferences[1]
- Developed a decision tree that established workflows for coordinating referrals
- Determined key metrics and outcome measures for quality improvement and evaluation

Following the design sessions, PHS worked with Unite Us to configure the architecture of the FNS Bundle in the referral platform: this included building and testing the assessment tool and decision-tree logic; setting up accounts for all partner organizations; and building appropriate metrics to meaningfully track referrals.

1 God's Love We Deliver served as the lead organization on the development of the assessment tool, due to their expertise in Nutrition Assessment

PHS also organized technology training sessions to onboard partner organizations and finalize workflows. In parallel, PHS provided contracting and management services to execute deliverable and performance based contracts with all partner organizations, allowing funding to flow through to support required partner activities and services.

Simultaneously, PHS established a "Bronx Food Resource Table" in the lobbies of the Jacobi and Lincoln hospitals where Food Security Specialists could engage participants in the assessment. Food Security Specialists, in both English and Spanish, worked closely with participants and community resources to facilitate access to SNAP, emergency food (food pantries and soup kitchens), congregate meals, WIC, and medically tailored home-delivered meals. Referrals were sent electronically to community partners, who were responsible for reaching out to participants within two business days of receiving the electronic referral.

To maximize access to the FNS Bundle for the hospital patients and managed care members most likely to be food insecure, PHS collaborated closely with hospital sites to conduct multiple in-service trainings for social workers, case managers, and ambulatory and inpatient care providers.

During the service delivery period, PHS facilitated Unite Us User Groups and other meetings with network participants in order to make technology modifications, augment the network to include new partners based on identified gaps in service, adjust contracts and funding based on deliverables and performance, and identify and make changes for quality improvement, using outcomes data and customer experience feedback. The project was implemented with a strong investment in network alignment, both at community and the clinical setting levels, while fostering trust with participants.

Reducing Gaps in Access to Services

Between November 1st, 2018 and August 31, 2019, the FNS Bundle screened 1,713 participants, 1,598 of whom provided consent and completed the full assessment. These participants received 2,199 referrals. Of those referrals, 1,893 (86%) had documented outcomes about enrollment in services, including 1,071 (57%) that resulted in enrollment in services and 822 that were closed without services provided (43%). Because some participants enrolled in multiple services, the 1,071 service enrollments occurred among 871 unique households.

Figure 1. Enrollment by types of services

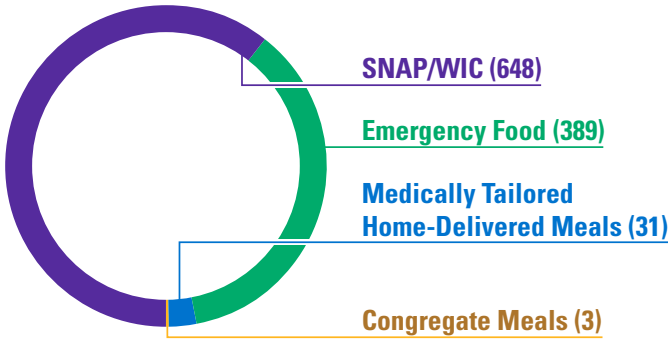


Figure 1. Enrollment per service type for people assessed 11/1/18-8/31/2019

The FNS Bundle facilitated access to services that tackle food insecurity in different ways. Nearly 15% of participants enrolled in two or more services, the most frequent combination being SNAP and food pantries. Additionally, among participants who enrolled in a food pantry, 27% enrolled in more than one food pantry. This result demonstrated the challenges and complexity participants face in meeting their food needs, and the importance of including a diverse portfolio of resources and partners within the FNS Bundle. The proportion of referrals that resulted in enrollment differed by the type of service offered (see Figure 2).

Figure 2. Referral Cascade per type of services

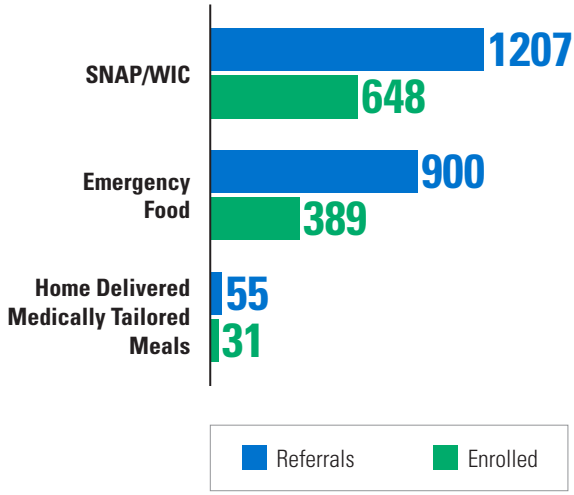


Figure 2. Referral cascade per service type for people assessed 11/1/18-8/31/2019

Meeting the Needs of People Who Are Hungry: Increasing Access to Food Pantries

More than half of the clients screened said they needed additional sources of food, even for those who were already enrolled in SNAP or WIC, which was a much larger proportion than anticipated. In order to verify whether the FNS Bundle was successful in connecting families to food pantries, PHS conducted a semi-structured interview of participants who received a referral to one of the 16 food pantry sites included in the Bundle. The goal was to

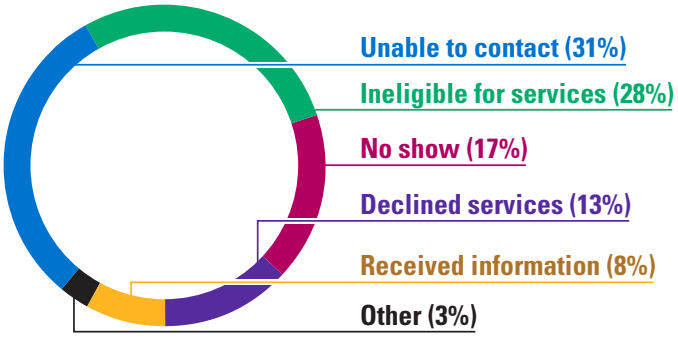
identify quality improvement strategies to improve communication with participants at the time of the referral. The interview assessed whether participants used the referral and accessed services, and if not, what the barriers were. PHS also validated whether records pulled from Unite Us corresponded to what participants indicated during the interview.

To conduct the interviews, PHS reached out to a sub-sample of 125 participants referred to a food pantry between February and March, 2019. Of those 125 participants, 54 completed the interview. Only 6% of participants reported using food pantries before the assessments and referrals, compared to 56% who reported using a pantry after the assessment. During the survey, participants reported that they had been successfully contacted by the food pantries to discuss referrals (80%, n=43). Among those who did not end up using the food pantries (n=24), 35% said that the main barrier was distance, 20% reported time constraints, 20% reported not remembering or no longer needing the referrals. These findings led to modifications in information provided to participants when making a referral.

Solving Barriers to Enrollment

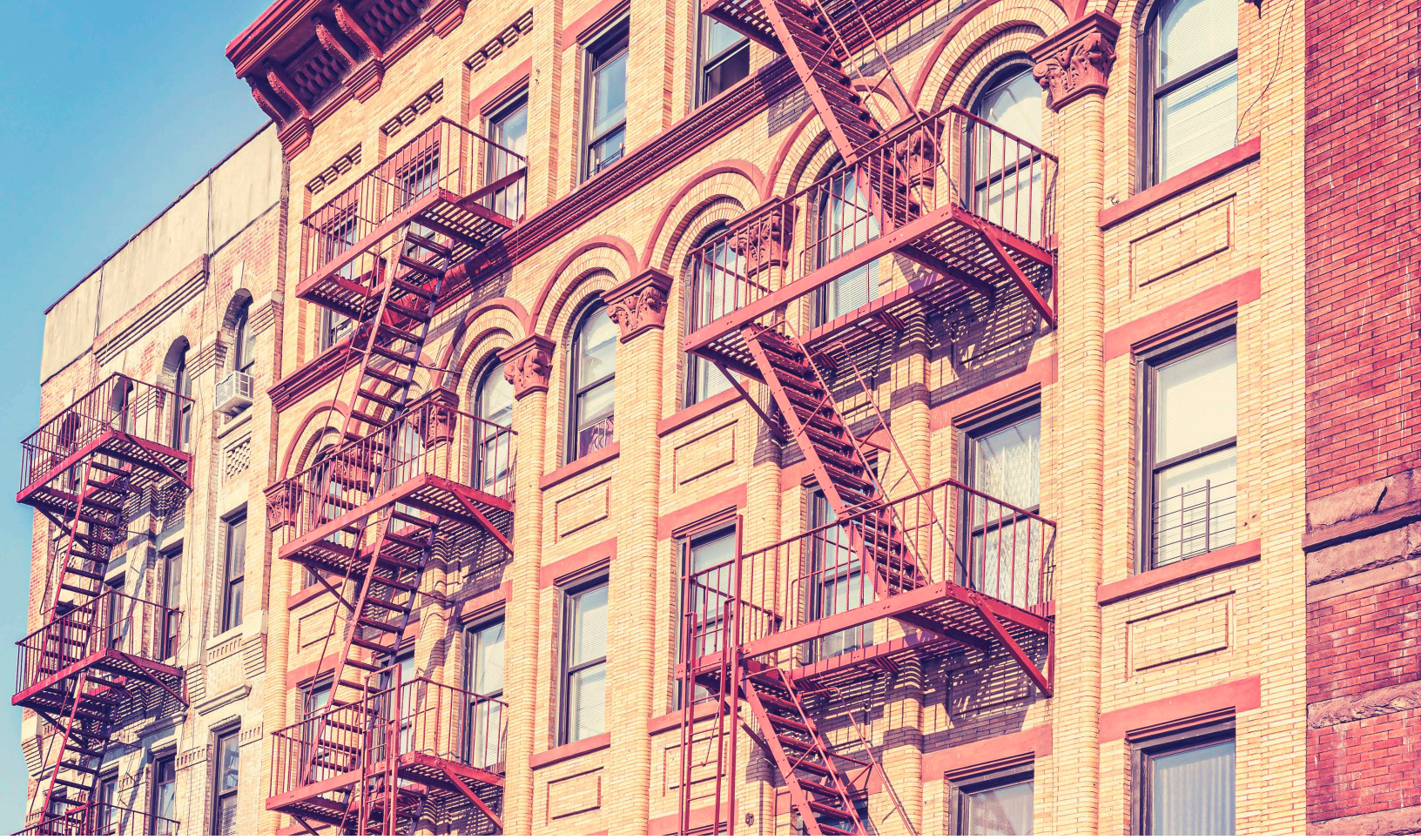
Barriers to enrollment were diverse (see Figure 3), but three reasons dominated: (1) the service provider was not able to reach the participant following receipt of electronic referral (2) The participant was deemed ineligible for the service, (3) Participants did not attend their scheduled appointment, usually at food pantries ("no shows"). Eligibility issues occurred most frequently with SNAP and medically tailored home-delivered meals, which have more stringent requirements than other services included in the FNS Bundle. Disqualifications most frequently included being above the maximum income level to qualify, or missing required documentation or paperwork.

Figure 3. Reasons for participants not being enrolled in the programs



PHS facilitated User Groups, which served as a forum for the network to address barriers to enrollment. Following discussions, some food pantries dedicated a special slot of time for participants referred by the FNS Bundle to reduce no-show rates (that may be associated with long lines). When linguistic barriers prevented some food pantries from communicating effectively with participants, the PHS staff stepped in and provided more detailed information on languages spoken by pantry staff to participants eligible for those pantries. Similarly, PHS staff supported the referral process for medically tailored home-delivered meals, as this service requires a significant amount of patient education and assistance for obtaining and submitting required clinical information from healthcare providers.

PHS's access to program data enabled a continuous quality improvement process that led the team to identify and troubleshoot issues as they arose: a slow number of referrals to WIC among eligible patients, and missing health insurance data led to work with the team to adjust the assessment tool and logic. Similarly, when the data indicated that in most cases, referring clients to more than one food pantry did not result in enrollment at multiple sites, Food Security Specialists were able to focus on identifying the most appropriate food pantry for the patient, and only refer to multiple food pantries if an in-depth conversation with the patient highlighted the need for more than one site. Finally, PHS reviewed referral acceptance data and reached out to partners during joint Users Group calls. These groups served to identify improvements, such as the type of information to provide to clients, clarifying eligibility requirements when applicable.

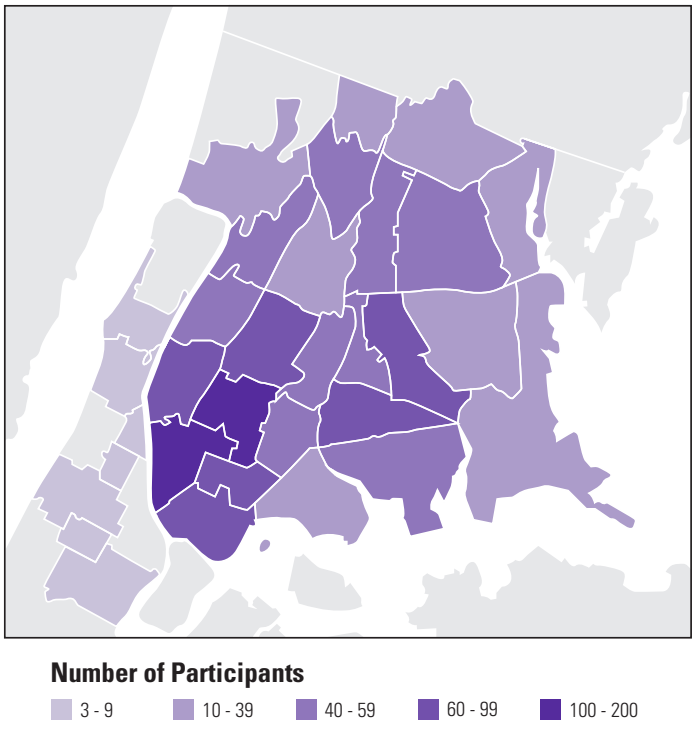


Who Did We Serve?

Demographics and Needs

Overall, 74% of participants assessed were walk-ins who came to the table or had been referred by friends and family. Twenty-three percent came from hospital services such as volunteers using a screening tools to identify Social Determinants of Health needs, WIC staff, social workers, or health plan enrollers. Direct clinical services (ambulatory care, pediatric, etc.) contributed only 2% of referrals. Participants were Bronx residents living close to the hospitals, although some came from Northern Manhattan or other parts of the Bronx, reflecting the wide reach of H+H sites (see Figure 4). Most participants resided in community districts with high or very high levels of meal gap, a food insecurity measure that represents the frequency with which household food budgets fall too short to secure adequate, nutritious food in a given year.

Figure 4.
Number of participants assessed per zip code area



Participants tended to be older (37%), and many lived by themselves (28%), although one in five were parents of young children. The average household size was 1.9 members. Participants spoke either English or Spanish (see Figure 5), with a smaller number of other languages, probably reflecting the linguistic capabilities of PHS Food Security Specialists rather than the linguistic diversity of the local neighborhood. Seventy-eight percent of assessed participants were enrolled in Medicaid or Medicaid Managed Care plans (Figure 7). While many participants eligible for SNAP were not previously enrolled, most of those potentially eligible for WIC were already enrolled. The needs for food resources were very high among the population (Figure 6).

Figure 5. Demographics of interest

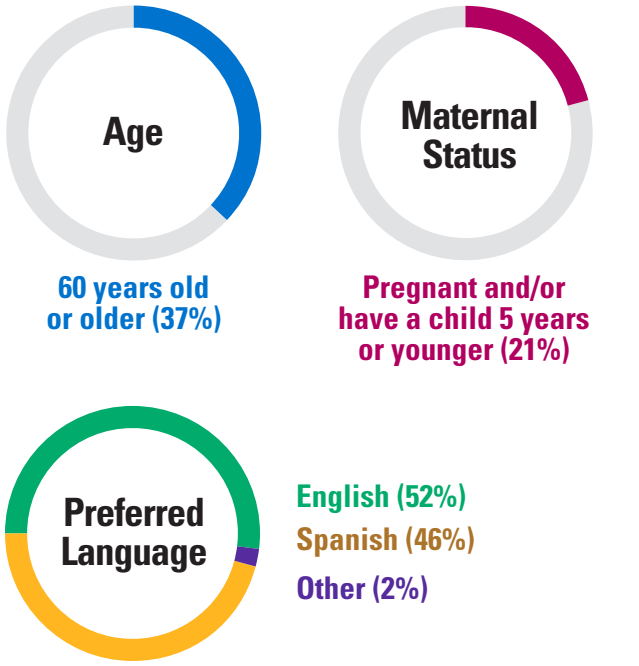


Figure 6. Needs

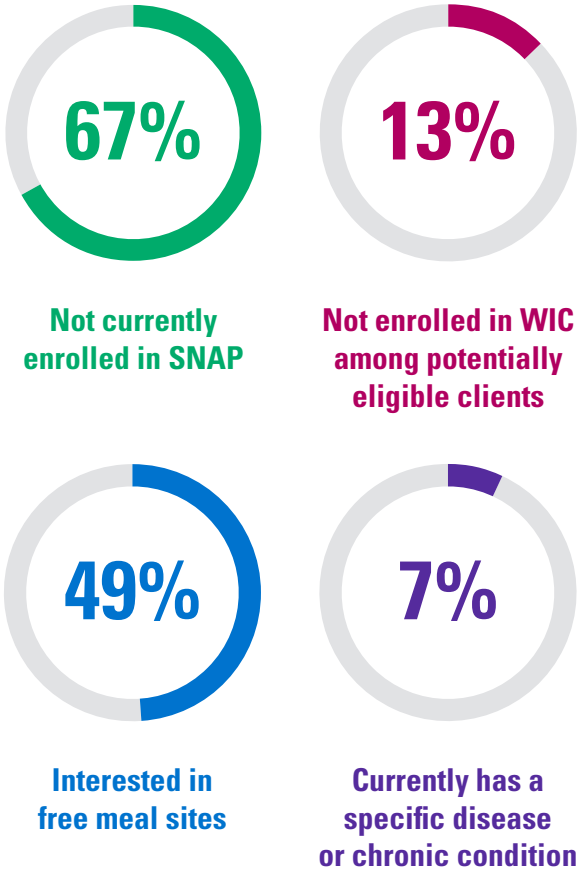
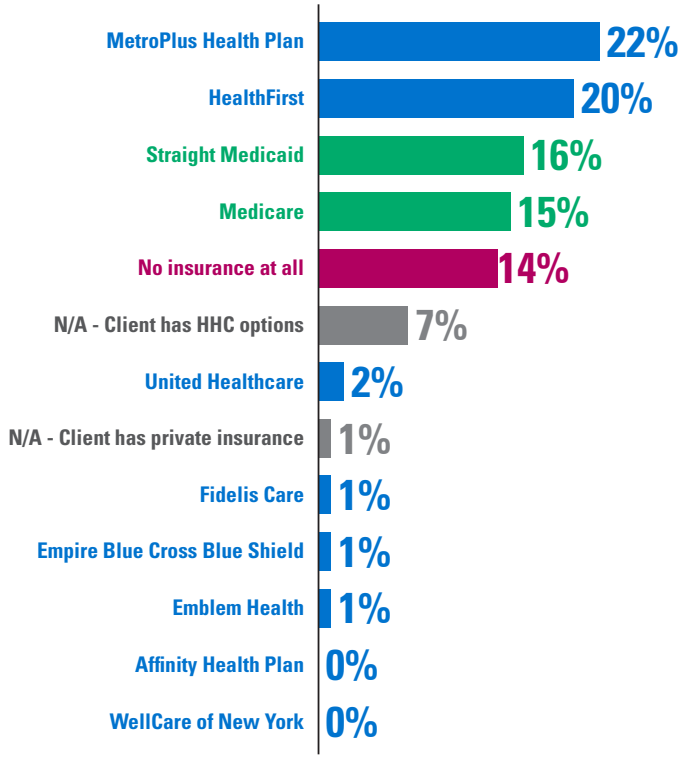


Figure 7. Health Insurance



Comorbidities, Healthcare Utilization, and Estimated Savings

To better understand the demographics, including comorbidities and healthcare use of participants, PHS identified a sub-group of participants who reported Healthfirst as their insurance provider. In August 2019, PHS identified 318 possible Healthfirst members. Of these, 166 (52%) were matched to Healthfirst records, including 136 (44%) participants matched to Healthfirst claims. Of those participants who were assessed, matched, and active, 59 (35%) were eligible and referred for SNAP enrollment, 45 (28%) were referred to one or more food pantries, 6 (4%) were eligible and referred for medically tailored home-delivered meals, and 1 (0.6%) was referred to a congregate meal program. Findings from the subset of 166 Healthfirst members showed that participants who sought food services and were deemed active Healthfirst Members, had an average of 2.7 comorbidities. Based on 2018 claims, the most prevalent comorbidities in this group were nutritionally-sensitive conditions such as hypertension, obesity, and diabetes with or without complications. In addition, pulmonary disorders and disease and depression were frequently observed.

Among matched, active Healthfirst Members who participated in the FNS Bundle, a majority (69%) had used primary care in 2018; 42% had at least one Emergency Department (ED) visit within the past 12 months, and 15% had at least one inpatient (IP) hospitalization in the past 12 months. The availability of this data suggests future potential to compare rates of healthcare utilization before and after enrollment among FNS Bundle participants who are active Healthfirst members.

Based on research estimates of healthcare savings, it is likely that the FNS Bundle is cost effective. With average estimated savings associated with SNAP enrollment of $1,400 per enrollee per year, and $9,036 a year associated with medically tailored home-delivered meals, calculated savings based on enrollments generated by the project amount to more than $1.1 million, suggesting a positive return on the initial investment of $705,000.[2]

2 See Berkowitz et al, (2017) Impact of food insecurity and SNAP participation on healthcare utilization and expenditures, University of Kentucky Center for Poverty Research Discussion Paper Series DP 2017-12. And Berkowitz et al (2019) Association between receipt of a Medically Tailored Meal Program and health care use, JAMA Intern. Med 179 (6). Calculated for 648 SNAP enrollments and 31 HD MTM enrollments among 1713 participants.

Lessons Learned and Recommendations

The FNS Bundle was successful in meeting the needs of food insecure participants and the members of their household. More than 800 participants received food and nutrition support over a 10-month period. The FNS Bundle reached important populations of focus for meeting health-related social needs, including older adults (37%), Medicare/Medicaid enrollees (76%), the uninsured (14%), pregnant and newly parenting families (21%), persons with recent acute care use, and persons with multiple medical co-morbidities.

The FNS Bundle assessment tool and technology platform were highly effective in connecting participants to local resources: 92% of referrals made to the network had a documented outcome, and 60% of participants screened were enrolled in one or more food and nutrition services. Families who were connected to emergency food, such as a pantry or soup kitchen, had not previously known about or used these resources before. The proportion of families in need of emergency food who accessed an emergency food resources rose from 6% to 56%.

FAMILIES WHO ACCESSED EMERGENCY FOOD RESOURCES ROSE FROM 6% TO

56%

The FNS Bundle was also effective in connecting participants to multiple resources through one encounter, with the most frequent combination being enrollment in SNAP plus use of a food pantry. Fifty-eight percent of all enrollments were in SNAP, and 38% of all enrollments were in Food Pantries. Additionally, the project reduced the administrative burden on participants and healthcare workers to access services with complex eligibility requirements, such as Medically-Tailored Home Delivered Meals.

Finally, the project provided important baseline estimates for future use in value-based payment arrangements. Enrollment outcomes suggest a positive healthcare savings return on investment, with an estimated average savings of $625 per participant relative to an estimated cost of $375 per participant. The average length of participant engagement necessary to fulfill referrals was 30-50 days.

The FNS Bundle reinforced some key recommendations for developing future community resource networks:

1. Know your landscape and build on existing platforms of diversely funded and local community investments, to the greatest extent possible.

The FNS Bundle contained a mixture of services to address food insecurity, with different levels of capacity to serve new participants. SNAP and WIC are federally funded programs that have significant capacity in NYC. Medically tailored home-delivered meals have been incorporated into payment methodologies under Managed Long-Term Care (MLTC) in New York. Pantries and Soup Kitchens survive mainly through small local awards and charitable contributions. Our payment contracting structure acknowledged this landscape, providing funding only for navigation to funded services, such as SNAP and WIC; filling gaps in services for patients eligible for medically tailored home-delivered meals but not enrolled in an MLTC plan; and providing direct operational support to over-burdened pantries. The award from OneCity Health was one component of a diversely-funded network, with resources applied strategically based on anticipated increases in volume of services provided by the network.

2. Empower participants, engage stakeholders, and consider local neighborhood factors. Include partners and participants early in development, design, decision-making, quality improvement and evaluation.

Principles of Human Centered Design inform us that in order to develop effective new models of service delivery, participants should be engaged as early and as frequently as possible. During our participant survey, PHS identified several areas for quality improvement that might have been avoided if they had been engaged earlier in our design process. PHS did engage healthcare, managed care, and community-based organization stakeholder input early on in the development process, to obtain agreement on roles and responsibilities, processes and workflow, technology needs, and costs and value of participation in the network; a factor that may have helped the network to achieve a high level of alignment and buy-in for the project Including stakeholders in the design also helped us identify neighborhood-specific challenges to access, such as ease of transportation between and among the neighborhoods served.

3. Ensure technology can incorporate and share the critical assessment data needed to facilitate referrals and the outcomes necessary to communicate and measure success. Reduce duplication of screening, assessment and documentation across settings.

Partners were wary about adopting new technologies, given the multiplicity of systems already in use by service providers. Ultimately, high user acceptance of the Unite Us technology was achieved as a result of the collaborative design efforts to reduce duplication of screening, assessment and documentation across settings. The selection of a workforce aligned technology (care coordination workforce/ care coordination platform) was likely a positive factor for achieving this acceptance. Referral sites were able to get the assessment data they needed to evaluate the referral, which resulted in a high referral closure rate (86%) and high service enrollment rate (57%). Further, the ability to define outcomes and endpoints among a diversity of services enabled more robust information that could be shared with healthcare stakeholders, such as actual receipt of a meal or the amount of SNAP benefit received by a family. Continued measurement at these depths will contribute to improved cost and value estimates, increasing participants' readiness to engage in future value-based payment arrangements.

4. Bring access as close as possible to the point of clinical service, to make it easy for healthcare partners to participate.

Clinical integration presented both challenges and opportunities. Our presence on-site at the hospitals made it easy for their social determinants of health screening teams to directly refer and/or provide a warm hand-off to our Food Security Specialists. Screening by this team ultimately served as the second most frequent source of referrals, after self-referrals. However, despite extensive outreach to clinical departments, including the development and distribution of outreach materials to be used by clinical teams to make easy referrals, very few referrals came directly from clinical service providers. This integration challenge likely resulted in missed

opportunities to engage some of the most vulnerable patients in need of clinical nutrition interventions like medically tailored home-delivered meals, as their medical conditions may have prevented them from engaging with Food Security Specialists in the lobby of the hospitals. PHS is currently exploring new methods of integration, including making Food Security Specialists more mobile, to enable them to be on-site in more diverse clinical settings, particularly in practices where persons with nutrition-sensitive conditions are most likely to be found.

5. A strong, trusted backbone organization can support capacity, infrastructure, and contracting that enables diverse community-based organizations to participate. Create a modifiable and flexible network structure and introduce data systems and practices that enable the network to be adjusted based on performance.

A trusted broker is important to reaching agreement on costs and values, and establishing contracts and payments among partners. The incentives of managed care organizations, healthcare providers, and community-based organizations are not necessarily aligned, and the threshold for contracting with MCOs or healthcare providers is high or out of reach for many small community-based organizations. Our project enabled some very small but essential organizations, food pantries, to receive resources that otherwise would have been inaccessible to them. PHS also supported them with technology, including them in the selection of the platform based on their description of what would enable them to be successful. Coaching was provided to organizations, to assess needs, capacity, and gaps in service reimbursement. Based on these conversations, PHS was able to deploy multiple contract structures that could be flexibly modified based on performance.

Critical to the success of this Innovation Fund Award, the FNS Bundle data provided information about actual enrollment in services, in addition to the number of participants assessed and referred. With 871 low income people and their families accessing diverse food services, the FNS Bundle helped address food insecurity in the Bronx. The FNS Bundle demonstrated that conducting food insecurity assessments in the healthcare setting is feasible and well accepted, and that a tightly coordinated accountable network of organizations can help people access the community resources that they need.

The next step in this evaluation will be to examine healthcare use among participants, by partnering with healthcare plans and hospitals to study clinical quality and cost data and how it relates to particular access points or population cohorts. In addition, looking at specific populations, such as older adults or pregnant and newly parenting families may provide additional insight on the project's impact.

NYC HEALTH+ HOSPITALS | ONECITY HEALTH

About One City Health

OneCity Health is the NYC Health + Hospitals-sponsored Performing Provider System (PPS), formed under the auspices of the New York State Delivery System Reform Incentive Payment (DSRIP) program. Comprising hundreds of healthcare providers, community-based organizations, and health systems, OneCity Health is the largest PPS in New York State. OneCity Health envisions the establishment of a welcoming, accessible, and integrated health delivery system that encourages, supports, strengthens, and protects a state of wellness and healthy living for all. Through this transformative effort, it is our aim to demonstrably improve the health of all New Yorkers.

Partners

Bronxworks
Lifting Lives Building Futures

FOOD BANK FOR NEW YORK CITY
foodbanknyc.org

GOD'S LOVE WE DELIVER®

healthfirst®
Health Insurance for New Yorkers

UNITE US

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, 5th Floor
New York, NY 10013-2988

646-619-6400
healthsolutions.org

@wearephsny