Q1 Please provide your contact information below.

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Q2 Please describe your company or organizations overall goals and mission.

Public Health Solutions supports vulnerable New York families in achieving optimal health and building pathways to reach their potential. We help communities thrive and work toward achieving health equity for all New Yorkers.

We focus on a wide range of public health issues that overwhelmingly affect the ability of underserved New Yorkers to live their healthiest life. These issues include food and nutrition, health insurance, maternal and child health, reproductive and sexual health, tobacco control, and HIV/AIDS.

Our approach is multi-pronged. We provide services within communities that need them most; we conduct independent research to evaluate our impact, highlight public health topics, and help drive policy; and we lead highly successful public-private partnerships with government agencies to support the work of hundreds of community-based organizations throughout New York.

Q3 Please indicate which category your organization falls under.

Community Based Organization

Q4 Innovation Executive Summary. Please describe the innovation, and how it addresses the social determinants of health. Please identify how the innovation addresses the 6 innovation criteria (i.e. ROI, scaleability, feasibility, evidence based support for innovation, relevance to the Medicaid population and speed to market).

The community-based service landscape is large and fragmented, and appropriate evidence-based interventions that improve social determinants of health (SDH) vary by community, population, and individual/family needs and preferences. As screening for SDH begins to be instituted in medical settings, providers and care managers need to feel confident that patients can be reliably connected to the right services that work for them. But currently there are no coordinated intake and referral systems established as a next step for

SDH screening. And while a variety of new technologies and care management professions have been introduced to try to better coordinate referrals, there remain significant gaps, barriers, and inefficiencies due to a lack of tools that integrate eligibility assessment and activate reliable, local referral networks.

To address this problem, Public Health Solutions (PHS) has developed an innovation, the SDH-Bundle, to improve the effectiveness of referrals and increase access to the right service at the right time for individuals and families in need. The SDH-Bundle links local community-based service provider networks with healthcare providers and managed care organizations using coordinated intake tools and algorithms that optimize access to community-based services and can be integrated with technologies, workforce, and workflows to support a “no wrong door” approach. PHS is currently testing this innovation in the areas of early childhood development and food security, with promising preliminary results.

1. Potential Return on Investment

High Return on Investment (RoI) is anticipated through three mechanisms: 1) increased efficiency, effectiveness and appropriateness of referrals; 2) the combined impact of accessing multiple services as a result of one SDH screening; and 3) the inclusion of evidence-based interventions in local service bundles that have demonstrated positive RoI, such as SNAP, earned-income tax credit, WIC, home delivered meals, and maternal and child health home visiting.

2. Scalability

The SDH-Bundle employs a place-based and neighborhood-based approach, but the process to develop the coordinated intake tools and algorithms can be deployed widely and is likely to be effective in any community where there is a complex and fragmented community-based services landscape.

3. Feasibility

Consideration of limitations is key for feasibility. PHS has identified lessons learned from our work establishing coordinated intake for maternal and child health home visiting. There must be service capacity within the provider networks to accept referrals. Partners must agree to participate in the network, including those who have an overlap in services. Data sharing agreements may be needed for coordinated intake tools to be integrated with electronic referral platform(s), and to measure efficacy of referrals. The coordinated intake tools developed must have high usability for efficacy.

4. Evidence-based support for innovation

PHS has demonstrated that coordinated intake results in increased referrals among community-based maternal and child health home visiting providers in a pilot currently underway in Southeast Queens. PHS also measured a similar uptake in referrals from pediatric clinics to community-based maternal and child health services instituting a bundle in collaboration with New York Presbyterian-Queens. Because of this work, PHS was selected to develop recommendations for a NYC-wide coordinated intake process for maternal and child health home visiting. PHS is also testing a food and nutrition services bundle in the Bronx, linking hospital food insecurity screening and managed care identified high risk patients to SNAP, WIC, congregate meals, emergency food, and medically-tailored home delivered meals through one coordinated intake process. Results from this project will be presented in fall 2019.

5. Relevance to the Medicaid Population

The proposed approach is recommended as a part of a framework for State Medicaid programs to address social determinants of health produced by the National Quality Forum, in recognition that social determinants are known to have a profound impact on health outcomes for Medicaid recipients. The SDH-bundle is designed specifically to better coordinate and support navigation of services that are primarily a part of the safety net for low income individuals and families. Relevant statistics include that more than 12% of NYS families experience food insecurity, but just more than half of those eligible receive assistance from a nutrition assistance program; more than 60% of children under 5 in NYS are insured by Medicaid, but the majority of families eligible are not receiving maternal and child health home visiting.

6. Speed to market (how quickly could the strategy be launched)

Developing and instituting an SDH-bundle involves convening multiple partners over a period of approximately 6 months to develop the necessary components- a coordinated intake tool, a referral algorithm, a group charter or agreement, and a data sharing agreement. An additional 6 months is necessary to integrate tools into workflows and monitoring the uptake and outcomes of referrals.

Q5 Was your innovation implemented? If so, please explain when, the number of people impacted, and the results.	Yes (please specify when and the estimated number of people impacted): We have piloted this innovation to connect new families to SDH interventions in Queens across two projects. These projects have connected more than 1,500 families to community-based services so far.
Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)	**Education,** **Social and Community Context ,** **Health and Health Care ,** **Neighborhood and Environment ,** **Economic Stability**
Q7 I give the Department of Health the right to share the information submitted in this application publicly (for example: on the DOH website). I understand that there is no monetary reward/reimbursement for my submission or for attending the summit should my innovation be selected.	**I consent to have my innovation shared**