Q1 Please provide your contact information below.

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

Peer Health Exchange (PHE) is a national organization that trains college student volunteers to teach a skills-based health program to high school students in under-resourced schools. PHE aims to reduce unplanned pregnancy and substance misuse and increase engagement in behavioral health care services among young people, as well as concretely link young people with adolescent friendly primary care options. PHE trains volunteers to teach sexual and mental health content to help enable students to make healthy decisions. We partner with health centers to connect students to community-based health resources and help them navigate a health care visit. In addition to improving student health outcomes, PHE aims to demonstrate the importance of investing in evidence-informed health education to both the health and education systems.

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).

Peer Health Exchange is a trauma- and evidence-informed, innovative health education program. We know that young people in New York living in high poverty communities are more likely to have poorer health outcomes – they are more likely to become pregnant unintentionally, are less likely to seek help when feeling sad, anxious or depressed, and are more likely to use substances as a coping mechanism for stress and mental health challenges. (Chaudry, Ajay, and Christopher Wimer . Poverty Is Not Just an Indicator: The Relationship Between Income, Poverty, and Child Well-Being. Apr. 2016, www.academicpedsjnl.net/article/S1876-2859(15)00383-6/pdf.) They are also less likely to seek primary care. In New York City, 17,000 adolescents under the age of 19 become pregnant. Of those, nearly 9 out of 10 are unintended (Kaplan, Deborah. “Teen Sexual and Reproductive Health in New York City.” CCnewyork.org,

2013, www.cccnewyork.org/wp-content/uploads/2013/11/DOHMHPresentation.pdf). One in five young people struggles with mental health, and 64% of those experiencing depression do not receive treatment. Each of these issues is more common in communities with concentrated poverty, where residents identify as Latinx or Black, and with young people that identify as LGBTQAI+.

Despite the need for high-quality health education and coordinated services with health systems, schools (facing budget shortfalls and competing priorities) often do not commit resources to deliver effective preventive health education - boosting health literacy - or connect students to the care they need, even when it is mandated by the State. Betty Rosa, Chancellor of the New York State Board of Regents, stated recently that “It’s more important than ever that students have access to quality health instruction taught by experts,” and Mary Ellen Elia, New York State Education Commissioner stated “Some schools have a hard time locating and hiring qualified health education instructors.”

Peer Health Exchange seeks to address social determinants of health: access to education opportunities, access to health care services, and social norms and attitudes, with our innovative model that sits at the nexus of the health and education systems. by empowering young people with the knowledge, skills, and resources they need to make healthy decisions and by connecting them to appropriate levels of care.

Unlike many traditional health education programs led by classroom teachers, our innovation (the PHE curriculum and model) leverages near-peer college volunteer health educators in the high school classroom. The PHE curriculum is place-based, which provides this critical information in a way that is understanding of the needs and opportunities of New York City communities specifically, rendering the content more accessible to young people. The curriculum is further accessible because of the use of a near-peer model, which fosters a safe space to engage in conversations about their health. Finally, there is a social aspect integrated into the curriculum, which encourages sharing their lived experiences, so not only are they receiving the information at the same time, they are also learning from each other.

We invest in evaluation to drive decision-making and continuously improve our program and its delivery. In addition to completing a quasi-experimental control trial with an outside evaluator, further detailed in the Evidenced Based Support section, PHE innovates in the way we create. Using data, PHE iterates on our program model using IDEO’s “human-centered design” principles to increase our program’s impact on students and their health outcomes. Over the past two years, we overhauled our health education curriculum and volunteer training program by creating and testing small-scale pilots in the classroom with volunteers before broadly rolling out changes. We have simultaneously developed the most impactful version of the PHE program to date and positioned our organization for rapid growth to serve more students and provide them with the health education they need.

ROI:

Evidence is clear that more preventative care correlates to fewer emergency care visits (Hernandez-Boussard, Tina, et al. “The Affordable Care Act Reduces Emergency Department Use By Young Adults: Evidence From Three States.”). PHE's summative evaluation results from an external study conducted by the American Institutes for Research suggest that PHE students are significantly more likely (54% vs. 19%) to seek preventative care for their health concerns as compared to students who did not receive PHE. In addition, PHE students are approximately four times as likely to use a birth control method when compared to students who have not received PHE. While it is challenging to directly tie PHE to health savings, we know that PHE can be a driving force toward young people taking the initiative to make healthy decisions, including seeking preventative care.

We have seen notable impact in regards to our program increasing young people’s desire and ability to access care. Where possible, PHE collaborates with school-based health centers (SBHCs) to deliver a SBHC tour to all students receiving PHE’s 13-session skills-based health education curriculum. Since 2013, 3,570 ninth and tenth graders have participated in a SBHC tour coordinated by PHE. In 2016-2017, PHE worked with three key SBHC network partners – Mount Sinai, NYU Langone Brooklyn, and New York-Presbyterian – in New York City to evaluate the impact of PHE’s PHE program plus SBHC tours on SBHC enrollment and utilization by 1,690 ninth and tenth graders.

We found that across the nine high schools with tours implemented, there was both an increase in enrollment and utilization attributed to the SBHC tours. We compared the percent change in enrollment and utilization immediately before the tours to a few months following the tours to the percent change during those same months in the previous year. Overall, enrollment increased by 32% across nine partner high schools in New York City in the period directly after SBHC tours were conducted (compared to only 10% during the same period last year). We saw an increase of 57% in utilization this year during the period directly after SBHC tours, compared to 43% during the same period the previous year. Young people who received PHE were also 10% more likely to know how to access condoms, 22%

more likely to know how to access other forms of contraception, and 11% more likely to know how to access mental health resources than their peers who did not receive a tour. Students who received a tour were almost twice as likely to use a school or community health center.

This data demonstrates Peer Health Exchange is positioned to concretely link young people to critical health resources. Further, these results suggest local healthcare may expect an uptick in primary and preventive care, and over time, a decrease in acute healthcare utilization, such as ER visits and unintended teen pregnancy.

Scalability:
PHE has a history of successfully scaling our program, having grown from one site to currently operating in five city sites. Still, we know there are many young people across the country still in need of effective, evidence-informed health education. Our organization is poised to scale our program rapidly, with current plans to reach at least 22,000 students in new and existing geographic areas of service by 2021. To reach these students (and more in the future), we must focus on the power of partnerships and collaborate with others to expand. As a complement to PHE's primary model of training near-peer health educators to teach ninth graders in under-resourced schools, we are exploring additional mechanisms of program delivery, which we refer to as our "scalable models." These models may include licensing of PHE's curriculum to school districts, creating self-sustaining college chapters to run our program with minimal support, and collaborating with other youth-serving organizations such as Boys & Girls Clubs or YMCAs so more young people can receive PHE, inside or outside the classroom.

Feasibility:
Implementation of our innovation (PHE's curriculum and models of delivery) is feasible – it is happening. This year, PHE NYC partnered with 54 high schools in all five boroughs reaching almost 6,000 young people by training 500 college volunteers.

Evidence Based Support for the Innovation:
PHE's program is evidence-informed and influenced by the trans-theoretical model, Life Course Health Development Model, social-cognitive theory, and positive youth development theory. The PHE curriculum was informed by the National Health Education Standards (NHES), CDC's Characteristics of Effective Health Education Curricula, and English and Language Arts Common Core State Standards (CCSS). The curriculum addresses all of the criteria for effective curriculum-based programs that help prevent teen pregnancy, including addressing peer pressure, teaching communication skills, and reflecting the age, sexual experience, and culture of young people in the program.

As previously noted, PHE has also conducted an external evaluation of our program and its impact with the American Institutes for Research. The study included 4,000 students, comparing those who received PHE to those who did not. We found that our program has a statistically-significant positive effect on sexual and mental health knowledge, skills, and help-seeking behavior. The majority of these outcomes persisted after a following year without PHE. In order to encourage investment from both the health and education systems in effective health education, we continue to invest in building evidence for the impact of skills-based health education on student health and academic outcomes.

Relevance to the Medicaid Population:
As an organization focused on advancing health equity, we intentionally partner with schools where the majority of students are living in poverty. Since the majority of our partner high schools in New York are Title I, PHE has found that many of our students are Medicaid eligible and/or enrolled. In New York City, 80% of the young people we serve qualified for free or reduced lunch; in some schools we serve, 100% of the young people do.

Speed to Market:
PHE is poised to quickly expand our innovative curriculum and model to other communities. In addition to growing on program on Staten Island this year, we will begin implementing pilots of our scalable models for delivering PHE in the 2018-2019 program year, having prepared for the rapid expansion and growth of our program. We envision bringing these and our standard model for health education to other areas after these pilots. The locations of our first round of pilot testing will be determined in the coming month and, though not yet official, will likely include the following: Denver, CO; San Bernardino, CA; Louisville, KY; and Stockton, CA. PHE is considering these cities for rapid expansion in large part because educators, university partners, and other community stakeholders in these locations

have reached out to us to explicitly express interest in having PHE in their area. The locations of these pilots are being driven by market demand.

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):

Yes, our innovation has been implemented. Since 2003, we have trained more than 10,000 college student volunteers to deliver health education to over 132,000 public high school students in Boston, Chicago, Los Angeles, New York City, the San Francisco Bay Area, and Washington, D.C. In our 2017-18 program year, PHE trained over 1,300 volunteers to teach over 17,000 young people in 133 high schools across the country. In New York City in 2017-18, PHE trained more than 500 volunteers to teach our curriculum to 5,835 9th graders in 54 schools. In October 2017, we launched in Staten Island, bringing PHE to all five boroughs for the first time. Peer Health Exchange teaches young people healthy decision-making skills to empower them to advocate for themselves and access the resources necessary to improve their own health now and in the future. Students learn critical sexual health and behavioral health knowledge and skills that they translate into increased protective factors and improved help-seeking behavior. In turn, PHE intends to increase support for student mental health, lower rates of substance use, and lower rates of unintended pregnancy. After a single year, young people demonstrate increased ability to make healthy decisions, as measured through knowledge, skills, attitudes and intentions in the areas of sexual health, mental health and substance use, exhibit increased decision-making, communication and accessing resources skills and report increased help-seeking behavior, such as enrollment in health centers and utilization of health center services.

Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)

Education,

Health and Health Care

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