Q1 Please provide your contact information below.

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

Healthify envisions a world where funding, coordinating, and providing evidence-based, high-quality, non-medical services that address the social determinants of individuals' health is a core responsibility of any organization tasked with managing the health of a population.

To achieve that end, Healthify sees the following roadmap to get there:

First, leading healthcare stakeholders must pave the way by supporting providers to capture the health-related social needs of their patients, enabling improved clinical care through a more holistic understanding of each patient. Healthify's social needs screening and EHR integrations capabilities directly support this critical step.

But identifying social needs is not enough. The next step is to ensure that community members and healthcare providers alike have consistent access to accurate, comprehensive, validated information about social service providers in their community to support an efficient and effective community referral workflow. Healthify's version of the Social Service Finder ("Healthify Search") addresses this challenge head-on, enabling care teams to spend more time focusing on caring for patients and less time chasing down information about local agencies.

Beyond addressing the data challenges, the next step is building alignment across sectors -- bridging government, healthcare, health plans and social service organizations to work together towards supporting the health of their shared community members. Healthify's community care coordination platform ("Healthify Coordinate"), along with its hands-on Client Services team, addresses this challenge by building a collaborative, local network of healthcare, government, health plans and social service organizations committed to removing silos in service of better care for their community members.

As these cross-sector bonds are formed and strengthened in more and more regions over the coming years, Healthify will work to support the fundamental transformation of the relationship between health care and social service spending in the United States. By quantifying the social needs, available resources, and social services provided in a given population -- and ultimately tying those interventions to the health and financial outcomes of members -- Healthify's technology and services will strengthen the business case for investing in social services, leading to priorities, policies, and budgets that recognize that there is more to health than healthcare.

Q3 Please indicate which category your organization falls under.

Technology Solutions

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).

Effective intervention for SDoH demands a multi-step, end-to-end platform. The Social Needs Funnel, developed by Healthify as a framework for SDoH, is quickly being adopted as the way to think about a successful SDoH management process. An effective approach requires an ability to identify SDoH need (top of funnel), to match the most appropriate resource to that need (middle of funnel), to connect the individual with that resource provider in a quick and efficient way (middle of funnel), to validate delivery of service and then to measure outcomes through reporting and analytics (bottom of funnel). Managing a complete, end-to-end process across a patient panel demands an elegant technological approach. Solutions that act only as a resource database simply do not support case manager efficiency in a way that scales their work across an entire patient panel. Managing an outcomes driven approach to SDoH interventions successfully is only possible through the use of an end-to-end technology solution such as Healthify.

ROI - Healthify Coordinate customers receive ROI data which is calculated based on the increased volume of needs met. The Healthify model first assesses the percentage of the population predicted to have a social health need and then comparing that to the percentage of the population that is currently being assessed for those needs. Next, Healthify works to determine, of those with identified needs, the percentage being connected to the appropriate service for the resolution of need and of those connected who are having their needs resolved. Finally, the savings, or cost per patient, is derived based on a population (Medicaid, Medicare, Commercial, etc.). From those base lines, Healthify validates improvement at each step in the process, working to generate more positive outcomes for more patients. On average, Healthify clients realize a 8x ROI from their use of the platform.

Scalability - Healthify works with some of the largest payers and providers in the country, and can be scaled quickly and as needed once the initial implementation is completed.

Feasibility - Healthify provides a tiered platform offering to specifically address client objectives and requirements. Healthify Search, which offers teams the functionality to search the Healthify database of resources, is the least complex deployment of the tools we offer and will have teams up and running almost immediately. Healthify Track, which includes Search functionality, has the added ability to track where patients/members are being referred and is the middle tier product. This is also a low complexity deployment and includes PHI and the added referral step. The third tier, Healthify Coordinate, includes the functionality of both Search and Track, as well as the added benefit of bi-directional electronic communications to coordinate care with a preferred network of community organizations. Healthify Coordinate gives the ability for community organizations participating in the network to access Healthify to streamline and bring visibility to the referral process.

Evidence based support for Innovation - The evidence validating SDoH as a critical, and foundational element to reducing costs while improving the health of individuals and populations continues to mount. A recent report from AJMC documents a 13% reduction in Emergency Department (ED) utilization, an 8% reduction in readmissions and a 9% increase in days between encounters resulting from Community Navigator interventions for a cohort of super-utilizers. The Essential Hospitals Institute reports that 33% of “high utilizer” patients are food insecure and an additional 25% suffer from marginal food security. The implications for healthcare costs are enormous.

Relevance to the Medicaid population - Medicaid recipients report the highest incidence of chronic health conditions compared with all other groups. Over a third of adults in the Medicaid population are obese (36%), and a quarter say they suffer from depression -- the highest among all insurance groups. Additionally, Medicaid recipients (17%) are significantly more likely to have high cholesterol.* Social determinants, which Healthify aims to address, play a huge factor in managing these chronic illnesses and are often the missing link to someone getting healthier. Healthify serves at least 6.5M Medicaid members.

*http://news.gallup.com/poll/223295/medicaid-population-reports-poorest-health.aspx

Speed to market - Healthify Implementations take 3 months on average when EMR integrations need to be completed.

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): Healthify has 37 customers and is in the hands of over 15K care team staff. Since its inception, our end-users have performed over 600,000 unique searches for social services. For those that deployed Healthify's Coordinate and Track solutions, end-users have logged more than 8,000 referrals in the last 12 months, with an average referral completion rate of 71%. This represents an 8x to 10x improvement over the referral completion rate under the traditional, manual approach to referral management. Healthify expects these referral counts to increase exponentially in the next year, given our increased Coordinate partnerships and the continuing maturity of our closed referral networks over time.
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 do not consent to have my innovation shared**