Q1 Please provide your contact information below.

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

Central Nassau Guidance & Counseling Services (CN Guidance) has been a staple serving the Long Island community since 1972 and is one of only 13 federally recognized Certified Community Behavioral Health Clinics (CCBHCs) in populous NY State and 1 of just 67 in the nation (The Certified Community Behavioral Health Clinics (CCBHC) program is a Federal Government demonstration pilot project, underwritten by the Substance Abuse and Mental Health Services Administration and supported by New York State-- one of only 8 states approved to proceed. The concept behind the CCBHC is that by integrating behavioral health with physical health care and applying evidence-based practices, we can deliver high-quality care and improve outcomes for our clients). CN Guidance is known for its ability to meet rigorous standards in rolling out new projects, including partnership-driven evidence-based services. Evolving with community needs, CN Guidance's services springboard from: (1) a foundation of 348 employees (who served over 6,700 clients needing mental health and substance use disorder-related services in 2017), and (2) a host of community-wide partnerships. Anchored from a headquarters in Hicksville, CN Guidance offers a full array of comprehensive behavioral health services that include an Article 31 Office of Mental Health-certified mental health clinic; an 822 Office of Alcoholism and Substance Abuse Services-certified substance use disorder treatment center; integrated primary care services, and behavioral health support services for individuals and families.

For over four decades, our organizational MISSION and PURPOSE remain: to improve the quality of life for individuals and families on Long Island affected by mental health and/or substance use disorders by recognizing and addressing the integration of behavioral and physical health. We value a holistic perspective and believe in the ability of every individual to recover.

CN Guidance is one of the only providers serving local residents that offers a comprehensive safety net for people struggling with a combination of substance abuse (drugs and/or alcohol) and mental health disorders. We hold one of New York State's very few Integrated Outpatient Services licenses and the rigorously earned CCBHC designation, and so, more than most other providers, we outreach to and serve many individuals facing co-occurring disorders.

The overall GOALS of CN Guidance, in service to our mission, clients, and the greater community align with our deeply held triple aim to: (1) continually improve the patient experience of care (including quality and satisfaction); (2) continually improve the health of the populations and sub-populations we serve; and (3) continually reduce the per capita cost of health care, and overall healthcare costs (to individuals and the larger community).

MAJOR INTIATIVES/ACTIVITIES/ACCOMPLISHMENTS consistent with our organizational goals:

CN Guidance succeeds at helping over 6,700 struggling individuals each year. Since 1972, we have provided residents of Long Island with comprehensive behavioral health services. Here is a partial list of key ACTIVITES in support of our organizational GOALS:

Delivering Substance Use Disorder Treatment--CN Guidance leads Nassau County in providing a licensed outpatient treatment clinic that offers outpatient addiction recovery treatment and support to adolescents, adults, and their significant others and families whose lives have been affected by alcohol, drugs, and co-occurring substance use and mental health disorders. We are helping daily to fight the crippling opioid epidemic gripping our area.

Providing Mental Health Treatment--CN Guidance offers a comprehensive suite of mental health treatment services. Our Roads to Recovery program, based in Plainview, delivers interventions including Personal Recovery-Oriented Services (PROS), a structured, five-day-aweek program that assists adults in managing their psychiatric symptoms while developing skills they need to improve emotional, cognitive, and social functioning. Our Mental Health Outpatient Treatment Program provides individual, family, and group psychotherapy plus medication management to children, adolescents, and adults who have mental health diagnoses, co-occurring disorders, and other impairments. Our mental health treatment services also include our Assertive Community Treatment (ACT) teams. These teams are home-and community-based programs for individuals diagnosed with serious and persistent psychiatric disorders characterized by multiple psychiatric hospitalizations, frequent use of emergency rooms, involvement with the criminal justice system and/or alcohol/substance use.

Rendering Health Home Care Management (HHCM)--This aspect of our work refers to our comprehensive care management service model for clients who have heavily complex medical, behavioral, and long-term care needs. As one of few "Health Home" providers in our region, CN Guidance has become the central point for directing client-centered care. As such, we have succeeded at ensuring high-quality service while reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits-for many of the co-occurring-diagnosed clients whom we serve. Our Integrated Care program, like HHCM, also prioritizes co-treating clients' mental and physical health.

Providing Residential Services and Supports--CN Guidance provides a variety of housing settings for individuals we serve who most urgently need reliable, long-term housing or shelter. We also supply mobile residential services to help vulnerable individuals maintain housing stability.

Supplying Drop-In Services--The CN Guidance Drop-In Center provides a nurturing environment for people diagnosed with serious mental illness. This center provides service recipients with a structured program three evenings per week, designed to offer these clients the opportunity to meet others, participate in recreational activities, learn computer skills and about community resources, and have a meal.

Promoting/Enabling Social Entrepreneurial Leadership--Through our unique client-operated Starry Night Café, Central Nassau Guidance has pioneered creative and enduring ways to combine engaging our community with raising cause-specific revenues and lifting spirits of the people we serve.

ACCOMPLISHMENT OF GOALS, a sampling:

As a RESULT of the breadth and depth of services, CN Guidance has achieved some major milestones over the last year. In part due to offering more SAME-DAY access hours, we increased the number of people enrolling in our clinic by 42% and reduced average waiting time for an appointment by 60%. We experienced a zero suicide rate by CN Guidance clients. We provided 103,626 distinct staff activities to 6,766 individuals served. We launched a new crisis respite program, which provides a residence with trained

supervisory staff and three beds dedicated entirely to short-term supportive stays from 1 to 30 days, as needed. Our Health Home Care Management program expanded to serve 1,974 clients, up 200%+ since 2015, with a fiscal surplus helping to subsidize other CN Guidance programs. CN Guidance also launched a Link-Age program that helps seniors, and forged/led a grant-fueled partnership with the Drug-Free Coalition (Task Force) in Northport and East Northport, NY to help area youth.

Across programs in 2017, our teams delivered a positive client experience, while promoting stability, recovery, better health, and preventing many people from needing emergency and inpatient care. A few examples of this are: a 78.9% decrease in hospitalizations among clients served by our ACT program compared to when they began receiving services; Demonstrated reductions in emergency room usage (for example, our Forensic ACT Team and ACT Team clients used emergency rooms 25% and 50% less than their baselines, respectively). Further, as an agency overall, we outperformed state benchmarks for : (a) 30-day hospital readmissions (CNG held a 16% readmission rate vs. the State's average of 20%), and (b) rates of engaging clients in alcohol and/or drug treatment within 14 days of identifying need.

The accomplishment of each of these milestones supports our triple aim (overarching GOALS) of: better quality care/service, improved population health, and decreased healthcare costs.

Q3 Please indicate which category your organization falls under.

Health Care Provider,

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).

Our innovation is based on a successful pilot program called Stability at Home (SAH). The SAH program was a short-term crisis intervention for Medicaid-eligible individuals living with Serious Mental Illness (SMI) in Nassau County and western Suffolk County, NY. Stability at Home aimed to connect individuals with SMI to stable supports in the community and thereby prevent or reduce the utilization of and costs due to avoidable emergency and inpatient services. The SAH pilot was funded through the New York State Department of Health's Balancing Incentives Program (BIP), which sought to engage providers in developing systemic improvements to address barriers to community-based, long-term supports and services among NY Medicaid beneficiaries. The program ended after the pilot period (it was subsequently pitched to DSRIP, but unfortunately they chose not to fund), but we are eager start it up again and build upon it.

Just as in the pilot, this new innovative program will provide in-home crisis de-escalation and prevention services for individuals with Serious Mental Illness (SMI) to increase the ability to self-monitor at home. Community out-reach and in-reach will be conducted within facilities to make safe transitions from institutional care back into community. Individuals will then be enrolled in more cost-effective Long Term Services and Support resources including Health Homes, medication and case management, and 24/7 hotline access.

Within our innovative program, consumer care will be managed by a CROSS-DISCIPLINARY TEAM of social workers, mental health counselors, a nurse practitioner, registered nurses, a psychiatrist, peers (specialists with lived experiences similar to clients), and care coordinators, who work together to provide comprehensive care and psychosocial supports.

More specifically, after carrying out extensive outreach, our innovative program (which follows our successful Stability at Home pilot) will receive referrals from hospitals and other community-based organizations on behalf of individuals who are in crisis, Medicaid-eligible, and who have a diagnosed SMI. Consumers will then be presented with the aims of the innovative program and can elect to participate. CN Guidance staff will work with enrolled consumers for an average of three months to develop an overall STABILITY PLAN to link them to community mental health supports, meet psychosocial needs, and ensure a "warm" hand-off to long-term care for both mental and physical health through coordination in a state-recognized "health home." (As defined in the Affordable Care Act, a health home is a program and network offering coordinated care to individuals with multiple chronic health conditions, including mental health and substance use disorders.) The aim is to have consumers connected to necessary social services, outpatient behavioral and medical

health providers, and in many cases, immediate support from family and friends. The team will provide in-home medication education, medication adherence support, and crisis de-escalation services.

Intensive community-based crisis/transition interventions are an effective way to prevent unnecessary inpatient utilization in the population of people with Serious Mental Illness. However, as we learned from consumers' perspectives within our pilot SAH program, key features of the program that are most valued (and impactful) are: guidance from case management and care coordination; education and support around medications and diagnosis; support with social services, housing stability, financial literacy, job readiness, and economic empowerment; staff being on-call and having the ability to visit consumers' homes; and help with finding and navigating recovery programs. All of these—related to three aspects of the Social Determinants of Health (health/healthcare, economic stability, and neighborhood/environment) will be implemented in the proposed program.

Beyond features of the original Stability at Home pilot, our proposed program will offer the innovative practice of introducing Transcendental Meditation (TM) to enrolled individuals, which is a powerful, evidence-based approach toward reducing stress and trauma symptoms. Reducing risk factors and increasing protective factors vis-à-vis numerous determinants of health, TM is a simple, easily-learned technique, practiced for 20 minutes twice a day, sitting comfortably in a chair. TM produces a unique hypometabolic state of restful alertness, which is characterized by a deep level of physical rest combined with heightened mental alertness. Research has shown that TM practice produces levels of rest three to five times greater than simple eyes-closed rest [Dillbeck and Orme-Johnson (1987)]. The National Institutes of Health (NIH) has granted more than $27 million to study TM's effects and more than 350 peer-reviewed studies verify the physiological and psychological benefits of TM for reducing stress and stress-related disorders, including hypertension, anxiety, depression, and insomnia, while increasing cognitive ability, energy, focus, and overall wellness. Once learned, TM becomes a lifelong tool, able to be called upon for stress relief when needed.

The David Lynch Foundation (DLF) — which addresses trauma and toxic stress among under-resourced populations through the use of Transcendental Meditation — is a partner of CN Guidance. DLF has taught TM to over 40 CN staff to date and has begun to implement patient training. DLF's strategic and careful investigation of the benefits of TM for those with substance use disorders started in 2015 with its Avery Road Treatment Facility study in Rockville, MD. Published in the April 2018 issue of The Journal of Substance Abuse Treatment, the study at Avery Road showed promising results that TM could be easily integrated into a treatment environment and that regular practice of TM was associated with better outcomes. Patients reported a high satisfaction with TM: At follow-up, 85% of those who learned TM were still meditating on most days, and 61% were closely adherent to the recommended practice of doing TM twice daily. None of the participants who practiced TM as recommended returned to heavy drinking after three months, in contrast to nearly half of the remaining sample.

OUR INNOVATION(S) AND THE SOCIAL DETERMINANTS OF HEALTH

Our experience showed us: Many people have difficulty engaging in behavioral health treatment right away because they have a number of social determinant-based issues that make it difficult to focus on the therapeutic process. All of the aforementioned services / activities specifically address the HEALTH AND HEALTHCARE Social Determinants of Health barriers to treatment by providing comprehensive coordination of care – which improves patient health literacy, makes sure consumers secure benefits, and have access to all of the behavioral and primary care they need to achieve more positive health outcomes.

To address consumer vulnerabilities related to the Social Determinants of Health domain of ECONOMIC STABILTY and NEIGHBORHOOD AND ENVIRONMENT, the proposed program will again go beyond our original pilot and include access to various types of affordable/quality supportive housing, assistance with food security, transportation to get to behavioral or primary care appointments, and financial stability education programs.

When a consumer experiences food insecurity – s/he finds it difficult to consistently show up for treatment visits if s/he doesn't have enough food and need to go to the food bank. Through our proposed program, an outreach associate will be able to help each encountered, vulnerable individual work through food insecurity and other issues (social determinants of health) that prevent them from accessing care and getting to care appointments consistently.

TRANSPORTATION is a Long-Island-wide issue and a significant barrier to accessing services and achieving stability. Income

inequality and a poor public transportation infrastructure across our sprawling region combine here to create major obstacles to equal access to healthcare, including mental health and substance use treatment services. Many lower-income people in suburban areas struggle to find reliable transportation. The result is often missed appointments and poor illness management. And there is a lot of asymmetrical ACCESS to care even among people living the same distance away from healthcare resources. (For example, consider two mothers of young children, each living just five miles away (in different directions) from our clinic: one must work two jobs to pay the rent so cannot easily spend 50 minutes each way on buses to travel 5 miles to our facilities to receive care vs. the other who works one job, owns a car, can afford a babysitter, and can drive 10 short minutes to the clinic.) In addition, a 2012 survey of low-income patients in a NYC suburb reported that patients who rode the bus to the doctor's office were twice as likely to miss appointments and fill prescriptions as those who drove cars.

CN Guidance's hub clinic, in Hicksville in central Nassau County, is located along a major highway/bus route and not far from a train station. However, because our geography contains many barriers, from cultural/racial and economic divides to unusually challenging/deficient public transportation routing, our health system needs to take EVERY step possible to encourage access to care, despite these hurdles. By providing and coordinating reliable TRANSPORTATION to and from vital healthcare appointments, our proposed project will help reduce these obstacles and cut down drastically on missed/canceled appointments.

Our proposed program will enable consumers access to variety of CN Guidance affordable HOUSING options. In 2017, we oversaw 73 state-licensed beds/units (including via our Congregate Resident treatment and Apartment Treatment programs), alongside 241 units of "Supportive Housing," (funded by the New York State Office of Mental Health or the U.S. Department of Housing and Urban Development). We also offered other creative housing solutions, including 24/7-supervised Crisis Respite beds for stays up to 30 days. In 2017, our full housing spectrum served 444 unique individuals.

Residential Program Indicators for the period ending Dec. 31, 2017 show that CN Guidance
maintained substantial occupancy rate averages: in Nassau County, 94% in Supportive Housing, 90% in Congregate Residences, and 90.2% in Apartment Treatment. After the start-up period for new Supportive Housing units (typically a year), our vacancy rates remain well below 10%. Our average length of stay for Supportive Housing in in Nassau County as of last year's end was 3,234 days (8.9 years). Such figures show consistency of long-term housing stability for people we serve in Supportive Housing. Likewise, the shorter lengths of stay for our Congregate Residences (726 days in Nassau County, avg.) align with our goals of helping people move on from licensed housing settings to more independent settings, especially Supportive Housing.

Our work centrally addresses the SOCIAL DETERMINANTS OF HEALTH, in part, by helping people remain HOUSED, socially connected, and relentlessly linked to needed medical and non-medical resources and skilled people who care.

More specifically, Supportive Housing encompasses a combination of financial rental assistance plus supportive services to help previously high-resource-users who are advancing in their recovery to remain stably housed in the community, and free from unnecessary inpatient hospitalization or inpatient treatment programs. Our Supportive Housing is consistently affordable to those we serve. A requirement of the program is that tenants/patients pay 30% of their net income toward rent and utilities. Since CN Guidance holds leases directly with landlords, it is our organizational responsibility (leveraging funds we receive from government or other funders) to pay the remainder of the rent, which is typically at or near the Fair Market Rent rate for Nassau and Suffolk County apartments. These Supportive Housing units will be made available to nearly independently functioning people who are recovering from serious mental health, substance use, and/or medical disorders. Without support, these conditions would put them at high risk of: (1) homelessness; and/or (2) high usage of emergency room, inpatient, and Medicaid services. For any prospective residents with more complex needs, CN Guidance can instead provide more intensive residential/treatment service alternatives (covered by other funders).

The value proposition of co-INNOVATING and partnering with CN Guidance is amplified compared to other agencies because CN Guidance is not only a housing provider (across the full spectrum of housing, ranging from congregate/group treatment residences to mostly independent supportive housing assistance), but as a Certified Community Behavioral Health Clinic, we are also the most robust, clinically integrated type of provider available in behavioral health.

To further illustrate, we are currently having discussions with United Health Care that could potentially facilitate referrals of high-needs individuals to CN Guidance supportive housing. We are confident, that if awarded we will continue negotiations and bring UHC aboard

as a partner.

HOW THIS INNOVATION ADDRESSES THE 6 INNOVATION CRITERIA:

1) POTENTIAL ROI – An aim of the Stability At Home pilot program was to reduce costs due to avoidable health services utilization. To understand changes in consumers' health services utilization, data was retrieved for a subsample of consumers from the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES), which is managed by the New York State (NYS) Office of Mental Health. Utilization was calculated for the 1-year and 3-month periods prior to the SAH program as well as the 3-month period following SAH program discharge. A sample of 37 consumers was obtained by simple random selection from 59 consumers who had completed SAH and had 6 months of follow-up data.

   Data analysis indicated that in the 3-month follow-up period, there were on average 11.1 less (SD=17.9) psychiatric inpatient days per consumer than in the 3-month period prior to SAH program enrollment (from 12.8 to 1.7 days per consumer). In the 3-month period prior to enrollment in SAH, 19 out of 37 consumers (51%) had a psychiatric inpatient stay. During the 3-month follow-up, 4 of these 19 consumers (21%) had a psychiatric readmission. The same data was compared for 19 high utilizers (consumers with more than 10 psychiatric inpatient days in the 3 months prior to SAH). High utilizers had an average of 22.9 less (SD=16.9) psychiatric inpatient days (from 24.2 to 1.3 days per consumer) and an average 0.8 less medical inpatient days (from 0.8 to 0 days per consumer) when comparing the 3-month pre-intervention and the 3-month follow-up periods. Overall, these results indicate that there was a statistically significant reduction in the average number of psychiatric inpatient days per consumer following SAH. This effect seemed to be amplified for both psychiatric and medical inpatient stays for consumers who were deemed high utilizers.

   OVERALL COST SAVINGS were calculated for the subgroup of consumers. Using the most recent, publically available data from the NYS Office of Mental Health, it was calculated that the unit cost of NYS Medicaid's daily average reimbursement for a behavioral inpatient stay ($835) and average reimbursement for a medical inpatient stay ($1,116). Based on the pre-post significant difference in psychiatric inpatient days (-11.1), the evaluator estimated that the average THREE-MONTH SAVINGS per SAH consumer was $9,247.40. This was calculated by multiplying the psychiatric inpatient pre-post SAH difference (-11.1) by the unit cost of NYS Medicaid's average reimbursement for a behavioral inpatient stay ($835). Based on the pre-post significant differences in psychiatric and medical inpatient days (-22.9 and -0.8, respectively) of the high utilizers, it was estimated that the AVERAGE three-month savings per SAH high utilizer consumer was $20,031.

   Based on CN Guidance's experience with and success of the highly effective Stability At Home pilot, we are very confident in the feasibility of this program. So much so, that we feel it can easily expand well beyond the almost 130 people impacted – to 200+ per year. Furthermore, we have extensive experience with this population--Medicaid-eligible individuals living with Serious Mental Illness (SMI) in Nassau County and western Suffolk County, NY.--from whom we can draw from to achieve this significant scalability.

2) SCALABILITY
   The proposed program expansion would allow for even greater economies of scale than were available during the limited pilot. The team-based approach provides a strong foundation for high resource utilization rates (i.e., for each team member, as the model spreads across more clients to be served). We envision eventually scaling to a point in which multiple concurrent Stability At Home cross- disciplinary teams can support and complement each other, further increasing staffing flexibility and ability to increasingly meet consumers 'where they are' (literally).

3) FEASIBILITY
   The pilot program from January 2015 to March 2016 provided many strong indicators of the innovation's feasibility. These were captured in a final report issued by the Adelphi University-affiliated program evaluator in July 2016.

4) EVIDENCE-BASED SUPPORT FOR INNOVATION (from Stability at Home pilot)

Improving Consumer Experience of Care:
A combination of satisfaction surveys, follow-up phone calls, and interviews with servd consumers and family/friends showed a high quality of consumer experience of care and satisfaction, with few exceptions. (Most measurements exceeded 4.0 on a 5-point scale.)

Improving the Health of Consumers Served:
Via a combination of catalyzed enrollment in behavioral health treatment (mental health, with accompanying substance use services as needed), linkage to long-term programs such as Health Homes, and hundreds of immediate referrals and connection to community-based supports representing social, emotional, environmental, physical/ medical, financial, intellectual, and occupational dimensions of wellness, SAH participants indicated a measurably heightened sense of self-efficacy and 77% of the sample studied were still engaged in mental health treatment as of the 30-day follow up. Many reported feeling better connected to services and having new skills to manage daily problems.

Data utilized is from standardized program forms, a state-based behavioral health and health service utilization system for the Medicaid program, a 30-day follow up survey, and structured interviews with consumers and staff.

5) RELEVANCE TO THE MEDICAID POPULATION

Our innovation has high relevance to the Medicaid Population. The National Institute of Mental Health (NIMH) estimates that there are about 10 million adults with Serious Mental Illness (SMI) in the United States (2013). Compared to the general population, individuals with SMI – including many who are severely economically disadvantaged -- are more likely to have medical conditions that remain undiagnosed and untreated (De Hert et al. 2011). As a result, individuals with SMI have a higher morbidity and mortality rate due to a variety of comorbid physical conditions (Saha et al, 2007). Even when linked to the health care system, individuals with mental illness are less likely to receive recommended treatment; they also have worse outcomes when treated (Kisely et al., 2013; Kurdyak et al., 2012). Due to these and other inequities, the SMI population is prone to more hospitalizations and inpatient admissions (SAMSHA, 2012).

Previous studies have shown that community-based forms of crisis intervention have been effective and cost-effective compared to emergency and inpatient-based treatment (Scott, 2000; Guo et al., 2001; Fenton et al., 2002; Ben-Porath et al., 2004). Psychosocial interventions in the SMI population have also indicated positive results. For example, Griswold (2005) discovered that case management after psychiatric crisis had a significant positive influence with connection to primary care. VanMeerten et al. (2013) examined inpatient psychiatric hospitalization before and after the implementation of a psychosocial rehabilitation program for veterans with SMI. They found that participation reduced veterans' utilization of inpatient psychiatric hospitalization and saved about $17,700 each veteran per year in total mental health services.

All SAH pilot participants had a diagnosed SMI, and almost half had a history of substance addiction. More than a third of consumers had more than one chronic health condition; about 35% were HOMELESS; and 80% were UNEMPLOYED/DISABLED. These clinical and socio-economic characteristics indicate that the SAH serviced a particularly high-need population.

The proposed program provides short-term crisis intervention for MEDICAID-eligible individuals with SMI. The intervention aims to develop long-term community-based support and service provision for the SMI population and to reduce the utilization of avoidable emergency and inpatient services.

6) SPEED TO MARKET

CN Guidance has a strong track record of preparedness (to act quickly) based on our experience delivering similar services to similar populations; maintaining existing strong infrastructure (evolved over 46 years); leveraging a skilled leadership and implementation team; replicating and or adapting protocols and strategies/tactics that have consistently led to measureable outcomes (improved service,

better health outcomes, and/ or lower costs); and maintaining strong intra-team and inter-partner communication and continuity of care (across a continuum of available services). So upon any new program launch, we are leveraging existing momentum, know-how, infrastructure, and demonstrated ability to scale up quickly. As a result, and in addition to our experience developing, launching and running our impactful Stability At Home pilot for over a year, we are confident the proposed program can be up and running in 4-5 months.

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):

The Stability at Home (SAH) program pilot implementation ran from January 7, 2015 to March 31, 2016. A total of 129 people were enrolled in the program over this period. As a result of the services provided, the SAH program yielded measureable improvements by Improving Consumer Experience of Care; Improving the Health of Consumers Served; and Reducing Costs Related to Avoidable Inpatient Services. Lessons learned speak to the impact of cross-disciplinary teams and crisis intervention services that include traveling to clients' homes.

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

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