**Q1** Please provide your contact information below.

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

The Family Health Centers at NYU Langone's mission is to improve the health of underserved communities by delivering high-quality, culturally-competent health care and human services. Our nine family health centers, 34 school-based health centers, and over 20 community-based programs serve 100,000 community residents a year. Central to this mission is our work to reduce barriers and address social determinants of health including economic stability, quality education, adequate housing, safety, and civic participation. As such, Family Health Centers' Department of Community Based Programs offers an extensive continuum of family strengthening and community development programs to address the broader needs of the community. Services include adult education; family literacy; youth development; workforce development; case management and supportive services; mental health services; early childhood and developmental centers; and community service opportunities.

**Q3** Please indicate which category your organization falls under.

**Health Care Provider**

**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 Family Health Centers at NYU Langone (FHC) has long recognized that addressing low income community members' social determinants of health has a direct impact on their and their families' health outcomes. For over three decades, FHC has played an important role in Brooklyn by helping connect patients and community members to services provided by both FHC and its partners to address these social determinants, including food insecurity, education, housing and environment and economic stability.

FHC's innovation falls under all six categories as outlined in the Department of Health's call for SDH innovations. FHC's innovative idea

will work to expand the reach of services, taking them from an individual to a community-wide level, through a systemic integration of social determinant screening, referral and follow-up across FHC sites and a consortium of community agencies. This consortium represents a full spectrum of critical services that address the social determinants of health – early childhood providers, preventive agencies, culturally specific organizations and other healthcare systems, to name a few – all engaged in codified processes of assessment, referral and service delivery, resulting in improved health outcomes through collective impact.

Our priority population is the low-income immigrant community of Sunset Park, Brooklyn. Sunset Park is a working class, low-income community that continues to experience the health and social problems connected to urban poverty. It is home to over 152,700 residents, 54% of whom are low income and living at or below 200% of the Federal Poverty Level. Almost 50% of the population is foreign-born with many being undocumented. Over 30% of Sunset Park residents report having fair or poor health. Whereas previously the majority of community members accessing services to address social determinants were either self-identified or in a crisis situation, FHC's innovative collective impact approach to identification, referral and services makes it possible to systematically address the SDH of an entire community, lifting its health outcomes. The project also connects service providers who may have been previously working in silos, thus creating a consortium with each partner playing a critical role in addressing SDH.

Potential Return on Investment: Addressing and documenting food insecurity, education, housing and other social determinants of health within a collective impact model has the potential to improve population health. The attendant collection of community-level data will help to identify gaps in the continuum that additional services can bridge, to provide a truly comprehensive place-based approach to mitigating the prevalent social determinants of health.
Further, because Medicare considers Value-Based Reimbursement systems that account for social risk factors in performance measurement and payment, FHC's innovative approach to document and address a community's risk factors and contribute to a growing body of evidence will support the achievement of policy goals to reduce disparities in access, quality and health outcomes.

Evidence-based support for innovation: There is strong evidence that people who are low-income, with less education and access to resources, have more health problems than those who are not. Research has determined that addressing the social determinants of this population's health – education, housing and the built environment, transportation, food insecurity, and safety, among others – positively impacts health outcomes for themselves and their families. Approaching this work through a collective impact model allows for the potential for a sturdier, wider, more finely meshed safety net that works to reach deeper into the community the consortium serves and address the needs of the entire community. Evidence is also mounting that collective impact models are a powerful means of addressing socioeconomic and health disparities. The Stanford Social Innovation Review has identified five characteristics of successful collective impact models: a common agenda, shared measurement systems, mutually reinforcing activities, ongoing communication and an anchor agency.

Feasibility and Speed To Market: The feasibility of operationalizing this idea in Sunset Park and its speed to market is projected to be rapid as the FHC has extensive experience convening consortiums of like-minded community partners and serving as anchor agency to address pervasive socioeconomic disparities in the community. FHC was a founding member of the Sunset Park Alliance for Youth to address the challenges faced by Sunset Park's disconnected youth and currently leads the Early Learning Network, a consortium of the community's early childhood providers that work to ensure every child enters school ready to learn. The Early Learning Network is an outgrowth of FHC'S Sunset Park Promise Neighborhood initiative, a federally supported neighborhood revitalization planning effort. Both instances featured the characteristics of a successful collective impact initiative listed above. This past experience lends itself to the proposed idea, increasing both its feasibility and its speed to market.

Scalability: There is significant potential for scalability through this initiative. As a multi-site organization, FHC has the bandwidth to pilot test SDH screening techniques and systems, make course corrections, and adapt the model to new centers and communities. This also has the potential to be scalable in engagement of new partners, including new service sectors or special populations.

Relevance to Medicaid Population: Addressing Social Determinants of Health is especially relevant to the Medicaid population, who are by definition low-income and vulnerable to the many non-medical issues that impact health outcomes. Approximately 54% of the Sunset Park population is below the 200% federal poverty level and Medicaid-eligible. FHC's innovation represents a community-wide intervention, with the ultimate goal of eradicating many of the SDH experienced by the community we serve, including food insecurity.

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| **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):<br><br>FHC is currently in various stages of two pilot programs. The first is focused at its Women's Health Center, where an SDH screening, referral and service delivery model has been embedded in the clinical care experience. While addressing a myriad of SDH through the use of the OCHIN tool embedded in Epic, FHC's electronic medical record, this initiative has been focused primarily on food insecurity as a means of measuring success. To date, approximately 500 patients have been screened. |
| **Q6** Please identify the SDH Domain that your innovation addresses. (Select all that apply.) | **Education,**<br>**Social and Community Context ,**<br>**Health and Health Care ,**<br>**Neighborhood and Environment ,**<br>**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** |