Q1 Please provide your contact information below.

Name	**Jason Hyde**
Title and Organization	**Director, Patient Navigation Center - NYU Langone Health**
Address	**5411 2nd. Ave.**
City/Town	**Brooklyn**
State/Province	**NY**
ZIP/Postal Code	**11220**
Email Address	**jason.hyde@nyumc.org**
Phone Number	**347-377-3066**

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

NYU Langone Health is one of the nation’s premier academic medical centers. Our trifold mission to serve, teach, and discover is achieved daily through an integrated academic culture devoted to excellence in patient care, education, and research.

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 NYU Langone Brooklyn PPS has developed a Care Coordination strategy designed to assist patients and their families in addressing medical, behavioral health, substance use and social determinant issues that impact their ability to care for themselves. This coordination takes place through the Patient Navigation Center (PNC), which serves as the integrator of clinical and social services across the PPS by leveraging both centralized support services and existing community resources. Services are accessed through referrals from hospital, emergency room (ER), and community providers, as well as self-direction by patients. The main goal of the PNC is to reduce inpatient and ER utilization by helping high risk patients connect to the right interventions, at the right place, and at the right time.

To address care patterns of ER high utilizers a Community Health Worker (CHW) program has been implemented in the NYU Brooklyn Emergency Room, modeling after an evidence based program at UPenn. CHWs will help patients make and maintain connections to essential medical, behavioral health, and social services in order to improve the patient's ability to care for him or herself. This will be done by assessing needs, creating a transitional plan, and by providing a "hands-on" intensive 30 day follow after the patient leaves the ER. If a patient requires ongoing support beyond the 30 days, the CHWs will provide a warm handoff to the next level of care management services (e.g. - New York State's Health Home program). Timely follow-up with providers along with referrals to community based organizations that address identified social determinants of health will impact ER utilization for patients struggling with behavioral health, substance use, and complex medical and social issues.

Recognizing that there is a need for longitudinal care management support and that not all patients qualify and/or want intensive Health Home services, the PNC has identified a CBO partner to provide telephonic care coordination services to high risk patients who do not qualify for the Health Home. MJHS will be employing RNs, SWs, and administrative staff to support high risk patients who are identified by the PNC as well as referrals from PPS partners including payers, CBOs, AND FQHCs. Once engaged in the program, MJHS will perform a health risk assessments focused on clinical issues such as chronic conditions and behavioral health issues as well as non-clinical issues such as access to care, availability of food, and other social determinants. Assessments will be used to develop care plans that will guide the care management services provided to the patient.

The PNC will also be the central hub to coordinate with other efforts such as the DSRIP Max High Utilizer project which is identifying patients in the NYU Langone- Brooklyn Hospital campus with four or more admissions in the past 12 months. The High Utilizer Action Team is focused on developing new strategies to extend support beyond the hospitals four walls to more effectively respond to the needs of frequent flyers. These issues haven't historically been addressed by the health care system and include issues such as housing insecurity, social isolation, hidden substance use, and care of complex medical conditions in the home. As patients are identified in the Hospital, Social Workers and Case Managers work to understand and address the upstream needs of the patients.

In addition to specific interventions in the hospital and in the community, the PNC will employ a Housing & Benefits specialist to provide support to patients with complicated issues that impact one's ability to tend to health matters. All new staff hired from CHWs to the Specialist roles will go through the designated curriculum in the PPS Training Roadmap. This will ensure that all community navigator staff are familiar with programs, protocols, and procedures.

Reporting is another key component of the PNC which will help identify the ROI of the program. All interventions deployed including the ER CHW program, MJHS telephonic care management support, and Housing & Benefits specialist will have reports built that will help track the number of total patients identified for the specific service and engagement rates. Post intervention outcomes will also be analyzed to understand impact of support on utilization of emergency room and hospital services. Once finalized, these reports will be reviewed monthly as part of the PNC's continuous effort to improve all of its programs.

In conclusion, the PNC has identified and connected existing services and is building on an infrastructure which allows for the easy addition of new services aimed at improving population health. Because of this, the PNC is well-positioned to continue to deliver timely interventions across the continuum of care as well as add new services as new needs are identified that support the PPS patient population.

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): September 2017. ~300 patients so far.
Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)	**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**