Q1 Please provide your contact information below.

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

Description of Organization

Our organization is MediSys Health Network. We are a network of health and behavioral health care providers serving predominately low-income communities of New Yorkers living in Queens and East New York.

MediSys Health Network includes: Jamaica Hospital Medical Center; Flushing Hospital Medical Center; a 228-bed skilled nursing facility operated by Jamaica Hospital Nursing Home Company, Inc.; a large multi-specialty physician group practice (TJH Medical Services, PC) with practice sites on the JHMC campus and in the community; Jamaica Hospital Psychiatric Services P.C.; Advanced Center for Psychotherapy, Inc. (operating Article 31 outpatient mental health clinics – Jamaica and Forest Hills branches); and pharmacies.

Collectively, MediSys Health Network proudly provides over one million total patient encounters and critical health and behavioral health services to over 150,000 Medicaid recipients every year.

Mission & Goals

The mission of MediSys Health Network is to serve our patients and the community in a way that is second to none. Since the establishment of Jamaica Hospital in 1891, our organization has served the culturally diverse, densely populated, urban and economically distressed communities of Queens and East New York. Jamaica Hospital's primary service area covers a span of 37 square miles and Flushing Hospital's primary service area covers a span of 24 square miles (by comparison, the land area of the Borough of Queens is 108 square miles).

The vast majority (80%) of the patients served by Jamaica Hospital and Flushing Hospital are covered by governmental payers (Medicaid and Medicare). As a result, our hospitals are true safety-net providers experiencing financial distress, but committed to the continued provision of essential care in the communities we serve.

As part of this commitment, we are often required to challenge ourselves, to develop creative and visionary paths to obtain our goals, and to lead in the developing of innovative approaches to meet the needs of the communities we serve. We are excited to share our vision for innovation, the "MediSys Hub for Healthy Communities," and look forward to your feedback.

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).

Our innovation is entitled the "MediSys Hub for Healthy Communities", or more simply, "The Hub".

Through our involvement in providing complex case management, we have experienced first-hand the need for an alternative to the care and services sought in the emergency departments of our hospitals on a daily basis. Frequently, there are a number of social determinants of health, including language barriers, housing needs, and behavioral health conditions that create addressable issues long before our community members seek assistance at the doors of our hospitals. While the services required can often be more appropriately met in an alternative setting, the hospital has a long-standing role in the community as the most dependable access point for care. This means that the hospital, working in partnership with community-based providers, has the potential to have the greatest impact on the social determinants of health.

It is in response to this need and opportunity for innovation, we have developed “The Hub” concept.

What is The Hub?

The details of The Hub innovation are set forth below:

- In The Hub model, we envision the creation of space and resources to essentially "house" the full complement of physical health and social determinant of health interventions for a community at a single location, close to and in affiliation with the hospital.

- The physical space of The Hub is located in close proximity to the hospital's emergency department. Working in partnership with the hospital, The Hub has the ability to significantly impact avoidable acute care in our emergency rooms related to the Social Determinants of Health.

- We envision The Hub providing working space for complex care managers to assess patient needs and make referrals. For example, the Hub would make it possible for:

  - A care manager to walk a mother to a cubical where she can find out more information about Early Intervention or "the first 1,000 days initiative", with experts available to walk her through the entire process;
  - A patient who is discharged from a hospitalization with severe mental illness to walk with a care manager to The Hub and enroll in a Health Home, receive an HCBS service assessment, and if housing is an issue, apply for supportive housing;
  - Individuals from the community to participate in an English course offered; or
  - Someone to receive donated work clothes so they can go on a job interview.

While there are many CBOs, providers, and other organizations capable of providing this work individually, the system is complex, fragmented, and inefficient. We believe The Hub can change this.

The Hub, as we see it, must be bi-directional. It should be able to serve individuals who originate from the hospital as well as individuals who walk in from the community. Working in concert with the community's hospital, The Hub would evolve to being known in the community as the locus of services and supports for the entire spectrum of health and non-health needs.

How do we know The Hub will work?

The idea for the Hub originated from case studies conducted by our care management team for high-end emergency department users. Our team found that providing complex, high-touch care management to individuals who were frequent users of the emergency room helped keep these individuals connected to the care they need, and as a result, substantially reduced their pattern of repeated emergency department use.

To illustrate, one case example involved a 60-year-old male with 60 hospitalizations at numerous hospitals in a six-month period, all related to chest pain. The Care Management team accompanied this individual to appointments to renew his green card, assisted in applying for housing and other benefits. The team secured his birth certificate and passport through the Trinidad embassy. An application to the Medicaid Redesign Team (MRT) DSRIP supportive housing program was submitted by the care management team and approved. The team Care Coordinator accompanied the patient to his interview and to visit his new apartment. The individual moved into his apartment in July 2016. The individual has since been compliant with all his medical appointments, has not been hospitalized, has maintained his sobriety, has continued treatment in the mental health clinic, and obtained SSI. He has remained in touch with the team, and recently announced that he is in the process of becoming an American Citizen.

This case study, and others like it, led our care management team to realize that it takes this level of coordination to prevent the most challenging individuals from "falling through the cracks". As a result, our team began developing the framework for a larger pilot program that could serve up to 90 high-needs emergency department users. In designing the pilot though, they thought, "what if this could be expanded not just for high-end users but for anyone from the community in need, leveraging existing hospital and CBO personnel, and providing support from the same single access point?"

The Hub innovation would be the first project to truly address the multitude of a community's needs in a single location. There would be no need to tell a patient with serious mental health issues who has made it to the hospital they need to go to three other places to get what they need, or for a homeless individual to present to the emergency room for an unnecessary admission, just to tell a doctor they need a place to stay. This idea could change behavior around emergency room utilization, and change lives in our communities.

Below please find additional information supporting the six criteria requested by the State to evaluate our innovation.

How does The Hub Address the Six Criteria of Innovation?

- Potential Return on Investment: MediSys believes the Hub offers extraordinary cost avoidance and long term system wide savings opportunities that will demonstrate tangible return on investment both in the near and long-term. Hubs, like the MediSys Hub for Healthy Communities, provide a unique opportunity to better care for the most costly, hard to treat patients in our delivery system. For high-end ED users, cost savings can be realized by reducing hospitalizations and better connecting individuals to Health Home care management and HCBS services and supports to allow recovery to begin. Permanently changing the behavior of a "super-utilizer" yields immediate, and substantial, Medicaid savings and helps the State meet vital DSRIP and VBP benchmarks related to hospitalizations. While it is difficult to quantify longer-term savings opportunities, particularly for non-health areas where costs are not as easily captured as a hospitalization, there is ample evidence to suggest that addressing the non-clinical factors that contribute to poverty, poor educational preparedness, and poor health outcomes may yield substantial savings over time that cannot be measured or used to incentivize the intervention in the near term. Of course, this factor does not mean the Innovation is not worthwhile or worth the return on investment; it's just that this return may not be as easily or immediately quantifiable as contractors currently expect. The benefit of The Hub is that it can address these areas as well as existing red flags within the current Medicaid system where cost savings opportunities are substantial. At its core, The Hub is simply a space and the will of a community to make services accessible. It can be operationalized on a small scale with minimum cost and still produce tangible outcomes.

- Scalability: The great thing about The Hub concept is that it is not a "one-size-fits-all demonstration". Certainly, it would be wonderful for MediSys and hospitals like ours to be able to obtain the space, staffing, and infrastructure to provide the full spectrum of community service offerings at a single location to truly pioneer the concept. However, this is not essential for a Hub to make a meaningful impact. A Hub can start small by focusing on critical services and needs first, and evolve over time as VBP funding, private financial support, or State capital grants support its expansion. The Hub can be offered in any building, and can tailor services and supports as it sees fit based on the needs of its Medicaid population and community. Because it can be offered in a variety of forms and modified based on the resources of the hospital, The Hub facilitates scalability.

- Feasibility: The Hub leverages existing community resources and in some instances, may even be able to leverage existing space. This reduces cost and further promotes integration with the greater system of CBO supports, facilitating long-term sustainability and feasibility. Additionally, because The Hub will operate through the hospital, opportunities for appropriate measurement of outcomes and tracking of costs related to care for the individual (to the extent applicable) would be quantifiable, and captured more easily than if each organization were responsible for managing this individually. All services provided can be "rolled up" and tracked through a single VBP arrangement, instead of multiple arrangements involving disparate CBOs, who may lack the capacity to track cost and outcomes efficiently. The flexibility of The Hub concept also means it can be tailored and modified as needed to ensure it is addressing the needs of the community and is financially feasible for the hospital and its CBO partners.

- Evidence–based support for innovation: The Hub centralizes, streamlines, and makes more accessible, already existing, evidence- based services and interventions. As for whether The Hub itself, as a concept, is "evidence-based", we are unaware of literature evaluating such a concept, though we have seen evidence of hospitals using their community infrastructure to support community health as part of their not-for-profit mission with positive results. We would argue that the overwhelming body of health literature, not to mention our own "case examples", provide evidence-based support for the effectiveness of high-touch care management for high-end users who cannot navigate our complex and fragmented system. The Hub would simply expand this effective approach to the entire community, streamlining services and supports of high value and making them more accessible than ever before.

- Relevance to the Medicaid Population: The MediSys Hub for Healthy Communities was designed to address the challenges experienced by our community, which includes approximately 150,000 Medicaid patients in Queens and East New York. Based our

experience, we know that social factors that affect care of our Medicaid patients, such as income, access to food and housing, and employment status, have just as significant an impact on their health and health outcomes as more traditional health care indicators. The need to better coordinate these services was a key consideration for The Hub. Another important consideration is the immediate need to reduce Medicaid avoidable hospitalizations and ED visits to generate cost savings and quality improvements under VBP and DSRIP. Finally, The Hub concept emanated from our consistent efforts to find ways to improve care and the quality of life of our patients using whatever resources we can. These patients are overwhelmingly Medicaid members. Thus, while The Hub will be open to all, we project that the majority of the individuals who use it, and the services and offerings that will be available, will be intended to make meaningful impacts for Medicaid members.

- Speed to market (how quickly could the strategy be launched): The MediSys Hub for Healthy Communities could be launched immediately on a small scale with funding to support initial staff involvement for high-end ED users, and a small scale capital investment to create physical space to serve as The Hub. We estimate that the full scale Innovation could be launched in less than a year with adequate capital and staffing support to secure a large enough space and obtain funding for essential staff.

We believe the MediSys Hub for Healthy Communities and The Hub model will positively impact the social determinants of health and is the future of essential care and services. Thank you for bringing the important issue of addressing the Social Determinants of Health to the forefront of Medicaid policy discussion. We look forward to your thoughts on our Innovation.

Q5 Was your innovation implemented? If so, please explain when, the number of people impacted, and the results.	**No**
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 consent to have my innovation shared**