Q1 Please provide your contact information below.

Name	**Lara Rabiee**
Title and Organization	**Chronic Disease Coordinator, Department of Ambulatory Care, New York City Health + Hospitals, Lincoln**
Address	**234 East 149th Street, 2nd Floor Annex**
City/Town	**Bronx**
State/Province	**NY**
ZIP/Postal Code	**10451**
Email Address	**rabieel@nychhc.org**
Phone Number	**(718) 579-6399**

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

NYC Health + Hospitals operates the public hospitals and clinics in New York City. Lincoln Hospital is located in the South Bronx and served approximately 180,000 people in 2017. Nearly half were Medicaid beneficiaries. The Department of Ambulatory Care provides services in three major primary care areas: Medicine, Pediatrics, and Women's Health. Related specialty services include dentistry, medical sub-specialties, ears, nose and throat (ENT) ophthalmology (eyes), asthma and dermatology.

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 innovation at NYC Health + Hospitals, Lincoln is to systematically screen patients in the Adult Medicine and Pediatric Outpatient Clinics for social determinants of health and make necessary referrals. The screening tool we have developed covers the following social/economic needs: 1) food insecurity; 2) the cost of medical care and being uninsured; 3) immigration legal advice; 4) general legal advice; 5) risk of eviction; 6) homelessness; 7) income assistance programs (public assistance, SSI, SSD); 8) home environment; 9) school and job training; and 10) domestic abuse. These areas were selected because they are actionable (Lincoln Hospital has internal or community resources it can refer patients to) and most were known to be top needs based on a mini-pilot conducted in January to April of this year. We intend to begin screening patients in late August 2018. The innovation is that without screening, our clinical care team waits for patients to raise social and economic issues they may be facing, and that frequently interfere with achieving optimal health. These patients are then referred to social workers for further referrals. Screening ensures that such issues are consistently and widely identified and addressed early in the care process. Furthermore, a screening and referral program ensures that staff make use of existing resources (for example, outside of social work, Lincoln has resources - such as a table staffed by a CBO called Public Health Solutions providing SNAP enrollment, but staff are not always aware of the resource; a screening and referral workflow by contrast, assures that patients with needs are consistently referred to these resources, as tools are created, such as cheat sheets telling providers where to refer patients who screen positive on particular questions). We hope that by addressing these social and economic needs, our clinicians will have greater success managing the chronic diseases faced by many of our patients, such as diabetes and hypertension. 1. There is a large return on investment as the cost of screening and referral is relatively low in our model: patients are connected to already existing resources within the hospital and the community (for example, being connected with legal services already offered by New York Legal Assistance Group within the hospital). In addition, we are using volunteer staff to assist patients in completing the screening tool and connecting them with the resources. The volunteers will be stationed in the waiting area of the clinics. We found volunteers through the Community Service Society of New York and our own Volunteer Office. 2. This innovation can be scaled up in a variety of ways. First, when individuals enroll in Medicaid, the State could require that they complete a brief one page social determinants screening tool. Referrals based on the beneficiary's response to question can be made automatic, such as mailing patients the appropriate resource packets. Alternatively, all participating Medicaid providers could be required to screen patients using the brief screening tool, and to make referrals to standardized or local resources. At minimum, screening and referral can be conducted at all public hospitals and community centers in New York State using a standard workflow. 3. Social determinants screening - using one page forms and listing top social and economic needs - is already being carried out at by a number of hospitals throughout the country, so such programs are feasible. 4. It is already well established that social and economic factors play a major role in health. There is early evidence that screening and referral for social determinants specifically improves health. See, e.g., Berkowitz et al, Addressing Unmet Basic Resource Needs as Part of Chronic Cardiometabolic Disease Management, JAMA Intern Med 2017;177(2):244-252 (Concluding that screening for and attempting to address unmet basic resource needs was associated with modest improvements in blood pressure and lipid, but not blood glucose, levels). As such programs are implemented and evaluated, further evidence is likely to become available. 5. Social determinants screening in clinical care settings is highly relevant to the Medicaid population, which suffers disproportionately from social and economic barriers as well as chronic medical conditions. 6. The innovation can likely be brought to market speedily, given other web-based services such as the NYS Marketplace, facilitated enrollment programs, and the move to uniform electronic medical records systems at the public hospitals in New York City.

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): Although full implementation will start only in late August 2018, between January and April 2018, a mini pilot was conducted using an initial version of the screening tool. The mini pilot took place in nurse led visits, resulting in 76 completed screens. From the pilot, we learned that we needed to shorten the screening tool to reduce the burden of completion on patients and staff, and that assisting patients who need help completing the screen and making the necessary referrals took up the clinical staff's time. Accordingly, based on the top needs indentified, we shorteded the screening tool to one page. We also reached out to the Community Service Society of New York and our own Volunteer Office to find volunteers to work on the project so as to reduce the burden on clinic staff.
Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)	**Education,** **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**