Q1 Please provide your contact information below.

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

Community Healthcare Network (CHN) provides to its communities high quality, comprehensive health care and ensures, through direct provision or partnership, access to the broad array of supports necessary to improve health outcomes for diverse populations.

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).

As a New York City-based, Federally-qualified health center, Community Healthcare Network (CHN) is at the center of addressing the complex needs of underserved individuals. While the organization's network of eleven community-based health centers, two school-based health centers, and multiple mobile units are equipped to address varying critical medical and behavioral health needs, the agency's patients continue to be impacted by social determinants of health, including food access, legal needs, housing instability, and intimate partner violence, that contribute heavily to the barriers to achieve positive health outcomes. To ensure each patient is connected to the network of services they need within their community, CHN has made it part of its strategic plan to identify and address social determinants of health needs as a part of each patient's routine care.

To provide a roadmap for real and effective partnerships between primary care practices and CBOs, CHN has undertaken an initiative that leverages existing partnerships and refines existing clinical and social needs screenings to improve the patient experience and in turn health outcomes. This initiative has three components: 1. Development and implementation of a comprehensive SDH screening

tool and workflows; 2. Creation and expansion of community partnership models that “close the loop” between the provision of referrals and the reporting of referral outcomes; and 3. Evaluation of the initiative’s impact through metrics focused on screening provision, improved referral processes, and referral outcomes.

CHN began by convening an internal work group, consisting of representatives from the agency’s medical, behavioral health, operations, health education, social work, nutrition, care coordination, and data departments to vet and evaluate existing SDH tools to implement in its practice, including the Mount Sinai PPS Social Determinants of Health Screening Tool and the Children’s Hospital and Wisconsin Social Determinants of Health Screening Tool, and The Protocol for Responding to and Assessing Patient’ Assets, Risks, and Experiences (PRAPARE). When approaching screening development, CHN compared these tools with current activities within the practice to identify potential overlap and consolidate screening activities. In order to reduce redundancy and implement best practices within agency practice sites, CHN adopted this new screening tool and rolled out screenings for patients at their annual and initial visits on June 1st, 2018.

In addition to creating and implementing a new, streamlined tool, CHN’s interdisciplinary team also developed new workflows to ensure patients with identified SDH referral needs are immediately directed to CHN’s internal resources (including social workers, health educators, and nursing staff) that can facilitate a referral to an external partner. New workflows were rolled out in June with the initiation of the new screening tool.

While it is essential to ensure that internal procedures are expanded and modified to create a seamless integration of SDH screenings and linkage to services, CHN recognizes that it is equally essential to develop a new system of referrals and communication with external community-based organizations and providers who are equipped to address each patient’s SDH needs in a way that an FQHC or health care provider is not. To meet that need, CHN is piloting a model that incentivizes community partners to execute referrals and report back on referral outcomes in an effort to “close the loop” that is often left open by uncompleted or unreported external referrals. Through this model, CHN has selected eight partner organizations in one of the agency’s target communities (Jamaica, Queens). These organizations were selected for their ability to address SDH needs and on the strengthen of their historical relationship with CHN. CHN will execute agreements with these organizations that establish a system of financial incentives that CHN will provide upon the achievement of specific deliverables linked to the referral process. In turn, the CBO partners will also designate a “referral liaison” who will be the primary point person for communication between CHN and the CBO. The agency is currently establishing those parameters with each organization and is expected to have executed Memorandums of Agreement in place this summer. Referrals will be tracked through a template created internally by CHN and embedded into the agency’s electronic medical records system.

CHN believes that this innovation addresses the focus areas in the following ways:

Potential Return on Investment: By developing an improved system of referrals and communication between FQHCs/health care providers and community-based organizations focused on SDH services, CHN’s intervention will more effectively “close the loop” between the provision of the referral from the health care provider and the receipt of referral completion information. This will create a more effective system of referrals, helping to ensure patients are actually connected to the services they need and contributing to better health outcomes, which leads to costs savings related to value-based care, meaningful use, and quality measure achievement.

Scalability and Feasibility: While the referral-focused component of the program is currently being piloted in one target community, CHN has been able to successfully design and implement the first phase of the innovation, a new SDH screening and workflow models, across eleven service sites, spread across diverse, underserved communities throughout New York City, in a relatively short period of time. After the referral innovation has completed its pilot stage, the model will be rolled out to other CHN target communities. This project has been wholly the creation of internal staff and focused on leveraging pre-existing resources in a more effective way.

Evidence-based support: In the development of the new screening tool, CHN’s internal workgroup drew upon several evidence-based models in the selection and design of screening questions. CHN’s final screening tool questions are all evidence-informed and have been evaluated for compliance with health literacy standards. The success of the screening tool will be measured both qualitatively and quantitatively from multi-source assessments including patients, staff, and community partners. Data from the screening questions is collected via CHN’s electronic health record and will be reviewed monthly by an internal multi-disciplinary workgroup. The team adopts a continuous quality improvement framework to ensure questions appropriately captured patients’ circumstantial needs and that they

are connected to the necessary services.

The project will also include extensive qualitative and quantitative evaluation components. The evaluation will not only include metrics about screenings provided and referral completion rates, but will also look at data surrounding the experience and feedback of the staff delivering the intervention and the patients receiving the intervention, focusing on the acceptability and feasibility of the process. This information will be collected through focus groups, surveys, and individual interviews.

Relevance to the Medicaid Population: As a federally-qualified health center, CHN's patient population is primarily composed of Medicaid enrollees. In 2017, CHN provided services to 61,966 unique patients across the network. Approximately 57% of patients were covered by Medicaid and 4% were dually enrolled in Medicaid and Medicare. Using Medicaid as a proxy for income, research shows that income inequity can have negative biological and social consequences for individuals. In the US, higher income equity is significantly associated with many social determinants of health including employment, insurance coverage, access to education and even books per capita.

Speed to Market: As previously noted, CHN has designed and implemented the initial phase of this innovation within a relatively short period of time. Within a three-month timeframe, CHN's internal workgroup completed the development and implementation of a new SDH screening tool, workflows for screenings and follow-up, and a comprehensive staff training in SDH concepts and the new tool. Additionally, the workgroup also established parameters for the second phase of the innovation – the identification of community-based partners and the scheduling of initial meetings to discuss participation in the referral pilot. The screening and workflows were rolled out network-wide on June 1st and CHN anticipates initiating the referral pilot by early July.

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 first phase was implemented on 6/1/18. We do not currently have data available.
Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)	**Health and Health Care** , **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**