Q1 Please provide your contact information below.

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

Mount Sinai St. Luke's (MSSL), part of the Mount Sinai Health System, is a safety net hospital located in Morningside Heights that has served communities in upper Manhattan since 1846. Its mission is to be the healthcare provider of choice by transforming care our providers and programs offer that puts patients at the center of everything we do, addresses unmet social needs, and forges clinical and community partnerships to improve the health of our population.

Q3 Please indicate which category your organization falls under.

Health Care Provider,

Other (please describe below: 150 character maximum):

member of Mount Sinai PPS

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).

It has become a given in modern health policy that social determinants of health, or SDH, plays a significant role, both directly and indirectly influencing people's and community's health behaviors, outcomes and costs. Examples of SDH such as housing instability, lack of access to healthy food, poor health literacy or exposure to violence, coexist and cluster by ZIP code, demographic and socioeconomic groups, and as a simultaneous cause and effect of chronic disease. In particularly vulnerable groups, like the Medicaid population, understanding and addressing social needs must be an integral, if not a central, part of the clinical care provided both in small organizations and in large healthcare delivery systems. To be most effective, information about a patient's SDH and those involved in managing a patient's social needs must be visible alongside clinical diagnoses like hypertension and heart failure so that communication and care planning can be done across settings and to reduce work.

As part of the Mount Sinai Performing Provider System's (MSPPS) emphasis on addressing SDH as part of its clinical strategy towards reducing preventable hospitalizations and ED visits and improving access to care, Mount Sinai St. Luke's (MSSL) hospital, piloted an SDH screen adapted from the MSPPS screening tool. The MSPPS SDH screening tool was developed over a one year period from existing evidence-based tools and best practices of multiple stakeholder partners in MSPPS, and recognizing that addressing SDH is "everyone's job," designed so it could be administered by both small and large organizations by a variety of staff types.

The screening results are documented in the electronic medical record (EMR), which will be combined with any existing EMR documentation regarding social needs done previously. Partnering with NowPow, a Chicago-based social impact technology company, the Mount Sinai Health System and MSPPS began offering a technology solution called the "Community Resource Guide" for connecting patients to resources in the community that would be able to address needs identified in the SDH screenings and soon allow referrals to be made in a "closed loop" fashion.

This web-based solution allows providers to match patients to a comprehensive directory of resources based on filterable criteria (e.g. location, ability to pay, preferred language, insurance types, accessibility). Providers are able to ensure a validated and curated match to appropriate services. In addition, the tool allows providers to identify special populations to which a patient may belong (refugee status, undocumented, homebound, LGBTQ+, etc.), which will prioritize organizations in the search results that have self-identified as catering to the specified population. This data-driven approach to matching patients to self-care resources is unique in this space. The MSSL pilot incorporated access to NowPow for all staff to address concerns about uncovering a need for which we did not have a trusted referral partner.

Providers can share the resource information with patients by texting, emailing or printing it from directly within the platform. The patient can add service providers to their contact lists if desired, and an interactive map with transportation instructions is included with every texted or emailed service they receive. Getting the vital information into the hands of the patient quickly and efficiently is key. NowPow allows providers to streamline a formerly analog and manual process of spreadsheets, databases, and paper files full of resources.

The next phase of MSSL's SDH effort is to leverage NowPow's comprehensive patient tracking and engagement tool, integration in the EMR, and beginning collaborations with other large health systems working to categorize positively screened items to ICD-10 codes ("Z codes") within the EMR which can then be used toward informing which social needs warrant investment and intervention, and if the screen can be administered across a large enough population size, result in improved risk score algorithms.

From a patient care perspective, this MSSL pilot serves to show feasibility of existing staff to administer the screen in settings outside primary care, where most SDH screening is currently done, and to start or continue the process of addressing the need if and when the patient is agreeable to the assistance. From a hospital/systems perspective, collecting and documenting social needs more systematically and alongside clinical data better quantifies true prevalence of a community's or group's social needs, allowing for more informed and scaled interventions to benefit communities, and ideally the ability of this information to more accurately predict health risk and cost for many vulnerable groups. This "grassroots" and "grasstops" pilot aims to reduce barriers in care, close gaps in communication, and ultimately improve patient health outcomes.

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 MSSL SDH screening pilot started in October 2017. As of early May 2018, 288 patients were screened (301 total screens) in one of the following settings: OBGYN prenatal clinic, outpatient specialty clinics, emergency department, inpatient services. Of those, 163 patients (54%) screened positive for at least one social need. The most commonly reported needs were access to mental health services, lack of contact with primary care, concerns about substance use, financial instability and transportation difficulties. Analysis will be done this summer to examine the association between screens completed and number of needs assessed and referrals to services made via NowPow as well as by traditional methods. The SDH screen, which started on paper, was recently incorporated into our electronic medical record (EMR) Epic, which allows for expansion of the pilot to the larger staff and results to be visible to all care team members across the health system. Our team continues to work with our EMR and IT groups, and recently with other NYC-area health systems, on translating reported social needs into ICD-10 codes (“Zcodes”) which can be used at system, payer and policy levels to quantify and inform which social needs should be targeted for intervention, and ultimately how health outcomes are impacted.
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**