Q1 Please provide your contact information below.

Name	**Manmeet Kaur**
Title and Organization	**Founder and CEO**
Address	**127 W. 127 St**
Address 2	**Suite 207**
City/Town	**New York**
State/Province	**NY**
ZIP/Postal Code	**10027**
Email Address	**mkaur@cityhealthworks.com**
Phone Number	**9178425446**

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

City Health Works creates healthier, stronger neighborhoods through health coaching and care coordination delivered by locally hired health coaches. We improve outcomes and reduce spending among patients struggling with preventable chronic illnesses who are not successfully managing their condition(s) through traditional, clinic-based services alone.

The majority of activities required to manage the daily realities of living with chronic conditions take place at home, not in the doctor's office. Yet for most clinicians, the focus of care does not consider the home situations and other social determinants of health for patients with chronic conditions. City Health Works seeks to extend the reach of overburdened clinicians by serving as the eyes and ears to clinicians while providing extra support to individuals and their households. The goal of health coaching is to equip patients with the knowledge needed to successfully self-manage their condition(s) and serve as a resource for care coordination and social service referrals.

Q3 Please indicate which category your organization falls under.

Health Care Provider,

Other (please describe below: 150 character maximum):

Healthcare vendor specializing in health coaching to build patient capacity to self-manage their chronic condition(s)

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).

City Health Works helps patients build the confidence in their ability to live healthier lives, while strengthening their communication and trust with the doctor's office. In home or community settings, our teams of locally hired community health workers provide personalized health coaching and care coordination to help patients achieve realistic health goals, access the right care at the right time, prevent crises, and improve their health literacy so they may learn to solve their health problems more effectively. Our coaching programs are evidence-based and largely developed through academic medical partnerships. Critical features of our model include:

1. Workforce: We recruit and train individuals from the community with strong empathetic listening skills and personal experiences of overcoming health struggles. After selecting candidates through a four-part hiring review process, we implement rigorous, ongoing learning, and performance review processes to ensuring continued strong performance.
2. Who we serve: We serve vulnerable populations who have multiple chronic illnesses. Currently, we offer health coaching for diabetes, hypertension, asthma, and congestive heart failure. All of these conditions are exacerbated when the social determinants of health are not being addressed.
3. Health coaching and care coordination: Most patients are referred from a primary care clinic, while some are referred from a hospital or community setting. During the first 3 months of engagement, health coaches provide intensive, home-based health coaching on a weekly basis. After the intensive health coaching phase, health coaches continue to help patients navigate medical and social services to ensure ongoing stabilization and continued engagement in routine medical care.
4. Care model and clinic integration: Patients are set up with a dedicated coach who is supervised by clinicians (registered dieticians and social workers). The care team elevates urgent and routine medical, psychological, and social needs to ensure access to the right care at the right time. The care team coordinates across all care providers, empowering clinicians with critical insights, and reducing fragmentation.
5. Technology: Our custom software enables our field-based workforce to collect data, analyze patient cases, generate reports, and make smarter decisions in the field. We have read-only, HIPAA compliant, EMR access at partner clinics to align care plans and communicate in a timely way.

How the City Health Works model addresses the innovation criteria:

1. Potential return on investment: City Health Works has been successful in significantly decreasing the health care costs of patients by reducing avoidable hospitalizations and emergency room visits. For example, among patients with poorly controlled diabetes, we achieved a $600 drop in per member per month cost at week 10 and a $900 per member per month drop by month 5 of coaching.
2. Scalability: City Health Works has a significant presence across Upper Manhattan and is poised for expansion. We have received nearly 50 requests to scale our services or to provide technical assistance from city and state departments of health, large health systems, federally qualified health centers, individual clinicians and social workers, faith-based leaders, city mayors, etc. This fall, City Health Works is launching an operation in the Albany region.
3. Part of City Health Works competitive advantage is the ease of integration with providers, including primary care practice and hospitals. We have established partnerships with large and small primary care practices across upper Manhattan, as well as inpatient nursing teams. We work with providers to establish workflows to make their job easier. This includes workflows for making electronic referrals, receiving urgent information about time-sensitive medical needs of patients, and receiving updates on patient progress towards goals.
4. Evidence-based support for innovation: Health coaches are effective at not only building patient capacity to self-manage their health condition(s), but as a resource navigator for other social needs of clients. Our coaches refer clients to social services and behavioral health providers in the community to address social determinants of health needs. We have several evaluations underway with promising early data. Evaluations include NYC Health + Hospitals/Metropolitan matched control evaluation on diabetes and hypertension, Mount Sinai St. Luke's evaluation on CHF, and a PCORI funded RCT on asthma lead by researchers at Mount Sinai. The Urban Institute also produced two qualitative studies: one on the patient perspectives of health coaching and one about patient factors related to medication adherence.
5. City Health Works targets vulnerable populations. Since its inception, it has largely served low-income populations across east, west, and central Harlem. The majority of our clients are on Medicaid, Medicare, or are uninsured.
6. Speed to market: City Health Works incubates high performing neighborhood-based health coaching teams that are integrated into the workflows of neighborhood clinics. We have a well-defined process for launching teams and clinic partnerships in new regions that involves a 3-4 month pre-implementation phase and an intensive period of support during the first year (incubation phase) to ensure each new neighborhood team achieves strong outcomes repeatedly.

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): We have served nearly 1,000 individuals across upper Manhattan since 2014. Based upon preliminary data, here are key highlights: 1. One year after completing diabetes coaching, of our 83% of our first 103 clients had decreased their A1C, 44% dropped their A1c below 8. 2. Early outcomes from Mount Sinai St. Luke's study with patients enrolled in congestive heart failure coaching demonstrate that 30-day readmissions decreased, compliance is increasing for follow-up appointments, prescription refills, and improved adherence with lab/disease monitoring. 3. After initial screening by our clinical supervisor, we have escalated urgent medical, medication, or mental health issues for every 1 in 2 patients that were otherwise unknown to the provider.
Q6 Please identify the SDH Domain that your innovation addresses. (Select all that apply.)	**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**