Q1 Please provide your contact information below.

Name	**Dr. Susmita Pati**
Title and Organization	**Medical Director, Keeping Families Healthy**
Address	**Stony Brook Children's**
Address 2	**Health Science Center, T-11, 020**
City/Town	**Stony Brook**
State/Province	**NY**
ZIP/Postal Code	**11794**
Email Address	**susmita.pati@stonybrookmedicine.edu**
Phone Number	**631-638-3082**

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

The overarching goal of Stony Brook Medicine's Keeping Families Healthy (KFH) program is to help "at risk" families achieve self-sufficiency in navigating the health care system and adhering to recommended clinical care. The program is fully aligned with Stony Brook Medicine's mission to "deliver world-class, compassionate care to our patients, advance our understanding of the origins of human health and disease, and educate the healthcare professionals and biomedical investigators of the future, so they can bring the fruits of scientific discovery to our patients." In particular, the KFH program serves patients (<18 yrs) deemed by referring clinicians to be "at-risk" for poor health outcomes, such as first-born infants, children with chronic conditions (e.g., asthma, obesity), psychosocial risk factors (e.g., limited English proficiency, insurance problems, limited transportation) receive Community Health Worker home visits (average 4-5 visits over 4 months) with additional phone/text message support as needed.

Q3 Please indicate which category your organization falls under.

Health Care Provider,

Community Based Organization

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).

Keeping Families Healthy (KFH) takes a particularly innovative approach to improving health outcomes because the program directly integrates the medical home model with CHW support. These types of health care delivery models have been implemented and evaluated separately, but rarely in a single bundle. Moreover, KFH leverages the strengths of technology and academic medical centers

by equipping and training CHWs in the use of Research Electronic Data Capture on tablet computers to enter program data and use of cell phones to communicate with families, program supervisors, and referring clinicians in any language, at any place, and at any time. The program facilitates bidirectional communication between clinicians and families because KFH program coordinator capitalizes on access to the clinical electronic medical record system to: 1) review and share recommended clinical care plans (e.g., subspecialist and community resource referrals, follow-up visits, medications) with CHWs who, in turn, support families' to understand and adhere to these recommendations; 2) send summaries of CHW activities, including content and number of contacts, to referring clinicians so that clinicians can refine CHW support goals and clinical care recommendations as needed. The KFH program further leverages the strengths of academic medical center institutional training programs across disciplines to rigorously evaluate its impact on outcomes. Rigorous evaluation of the program's impact/return on investment demonstrates a 15-20% improvement in vaccination rates among young children and a 50% reduction in preventable emergency department visits (published in Vaccine 2015 & Pediatrics 2018, respectively)1,2.

KFH's proven innovative model addresses health disparities and improves health outcomes by leveraging the strengths of inter-professional academic training programs that can be extended to other populations. Our experience in scaling the program over the past 7 years demonstrates its feasibility and speed to market. Within two years, KFH was initially launched in one Stony Brook [SB] pediatric clinical site, expanded to all SB pediatric primary care sites, and then offered to all ~80 SB affiliated general pediatricians and ~80 subspecialists with support from the Healthcare Efficiency and Affordability Law for New Yorkers service grant from the New York State Department of Health. The program was further sustained by the NYS Hospital-Medical Home Demonstration program because of its integration with patient-centered medical home recognition efforts. Stony Brook's IRB reviewed and approved all KFH-related research and Dr. Pati successfully obtained institutional competitive peer-reviewed research awards to perform this research. To date, KFH program staff have made more than 4700 visits to more than 1200 families with an average active caseload of 120 families per month.

In December 2016, KFH expanded county-wide and incorporated home environmental assessments for patients (0-26yrs) with asthma as part of the Promoting Asthma Self-Management project led by Dr. Pati as part of a contractual agreement supported by the NYS' Delivery System Reform Incentive Payment (DSRIP) program. NYS is using DSRIP to implement the Medicaid Redesign Team Waiver Amendment to reduce preventable emergency department and hospital utilization. KFH services have been integrated further with nursing and social work care management services for Stony Brook's primary care practices to expand the program's reach in addressing this population's health-related social needs. Since the county-wide expansion, 73% of KFH's entire service population is Medicaid-insured and all (i.e. 100%) of its DSRIP-contracted service population is Medicaid insured. Notably, KFH's service population includes 30% with limited English proficiency, 56% with a high school education or less, and 12% with transportation challenges.

With this experience, our team is well equipped to expand further to help curb health care expenditures among populations with challenges related to social determinants of health. We have demonstrated proven positive impact on clinical outcomes and use a continuous quality improvement approach to refine our program that can easily be replicated to serve other populations (e.g., elderly, chronic conditions such as diabetes and heart disease) in diverse geographic locations. Due to its proven success, KFH won the Academic Pediatric Association's Health Care Delivery Award in 2017 and was selected by the American Academy of Pediatrics to be featured as a "Promising Practice" on its National Center for Medical Home Implementation website 3 as well as being highlighted as an exemplary Care Coordination program on their website.4 We hope KFH will be incorporated into new Medicaid payment models in collaboration with insurers to ensure that safety net providers, including academic medical centers responsible for training the next generation of health professionals, can succeed in future value-based purchasing environments.

1. Pati S, Ladowski KL, Wong AT, Huang J, Yang J. An enriched medical home intervention using community health workers improves adherence to immunization schedules. Vaccine. 2015;33(46):6257-6263.
2. Anugu M, Braksmajer A, Huang J, Yang J, Ladowski KL, Pati S. Enriched Medical Home Intervention Using Community Health Worker Home Visitation and ED Use. Pediatrics. 2017;139(5).
3. American Academy of Pediatrics. Promising Practices. 2017; https://medicalhomeinfo.aap.org/practices/Pages/Promising-Practices-Archives.aspx. Accessed 5/31/18, 2018.
4. American Academy of Pediatrics. Examples of Care Coordination in the Community. 2017; https://medicalhomeinfo.aap.org/tools-resources/Pages/Care-Coordination.aspx. Accessed 5/31/18, 2018.
5. Justvig SP, Li J, Caravella G, et al. Improving Adherence to Care Recommendations Using a Community Health Worker (CHW) Intervention with the Pediatric Medical Home. J Community Health. 2017;42(3):444-452.

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):

Keeping Families Healthy (KFH) was established in July 2011 and has been in continuous operation for almost 7 years. To date, CHWs have completed more than 4700 home visits for more than 1200 children. KFH demonstrates positive impact on health outcomes and family and provider satisfaction that translate into cost savings at the population level. We published our findings that program participation increases the absolute likelihood of up-to-date immunization status by 16.8% among infants/toddlers and 20.8% among newborns in Vaccine.1 Our results showing a 50% decline in ‘preventable’ emergency room department visits among participants has been published in Pediatrics.2 We qualitatively evaluated the CHW tasks comprising successful program completion to facilitate replication was published in the Journal of Community Health.5 Trainees and program staff have further presented the program’s functioning and impact at national meetings for hospital leaders, community health workers, asthma educators, practitioners, and researchers. Family surveys completed anonymously show that 98.9% strongly agree/agree that ‘The [KFH CHW] took my family’s preferences into account when addressing my child’s health care needs while they were in my home’ and 99.3% strongly agree/agree with ‘When the [KFH CHW] left my home, I had a good understanding of the things I was responsible for in managing my child’s health such as making appointments or following up on things discussed during the home visit.’ Anecdotally, clinicians report positive health impacts and family satisfaction; “saw patient today, and mother, in spite of language barrier, has significantly improved in terms of her understanding of asthma disease and management”; “KFH has been to the house. [The patient] and his mom came in with an asthma tool kit, all of his meds, his spacer, and the binder…he had no activity limitations due to asthma...[He] and his mom spoke highly of KFH.” As previously noted, our innovative program has won national recognition and remains an industry leader in health care service delivery innovations. 1. Pati S, Ladowski KL, Wong AT, Huang J, Yang J. An enriched medical home intervention using community health workers improves adherence to immunization schedules. Vaccine. 2015;33(46):6257-6263. 2. Anugu M, Braksmajer A, Huang J, Yang J, Ladowski KL, Pati S. Enriched Medical Home Intervention Using Community Health Worker Home Visitation and ED Use. Pediatrics. 2017;139(5). 3. American Academy of Pediatrics. Promising Practices. 2017; https://medicalhomeinfo.aap.org/practices/Pages/Promising-Practices-Archives.aspx. Accessed 5/31/18, 2018. 4. American Academy of Pediatrics. Examples of Care

Coordination in the Community. 2017;

https://medicalhomeinfo.aap.org/tools-resources/Pages/Care-Coordination.aspx. Accessed 5/31/18, 2018. 5. Justvig SP, Li J, Caravella G, et al. Improving Adherence to Care Recommendations Using a Community Health Worker (CHW) Intervention with the Pediatric Medical Home. J Community Health. 2017;42(3):444-452.

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