

# BRIDGING HEALTH & HEALTHCARE:

## A Systems Approach to Population Health

city  
**HEALTH WORKS**

### LEADERSHIP

**Manmeet Kaur, MBA**

Executive Director | Founder

**Donya Williams, MPH**

Director of Operations

**Jamillah Hoy-Rosas, RD, CDE**

Director of Health Coaching & Clinical Partnerships

**Aaron Baum**

Director of Technology & Business Development

### GOVERNANCE BOARD

**Stephanie Dodson**

Draper Richard Kaplan Foundation

**Jeffrey Hoffman**

Dechert LLP

**Manmeet Kaur**

City Health Works

**Todd Rudsenske**

Cain Brothers

**Andrea Wenner**

East Harlem Tutorial Program

### ADVISORS (select)

**Jahanara Ali**

Health + Business Dev

**Steven Dawson**

PHI National

**Deborah Estrin**

Cornell Tech

**Linda Green**

Columbia Business School

**Dr. Melanie Jay**

NYU Medical Center

**Dr. Diane Meier**

Center to Advance Palliative Care

**Johnny Rivera**

Harlem RBI

**Dr. Prabhjot Singh, MD PhD**

Lead Strategic Advisor

**Clyde Williams**

Policy & Strategy

### LEADING FINANCIAL SUPPORTERS



Robert Wood Johnson  
Foundation

**ROBIN HOOD**



### PURPOSE

- Create healthier neighborhoods & empower Individuals to take better control of their health
- Reduce healthcare spending and develop new payment streams
- Create meaningful local jobs and more effective care teams
- Bundle clinical & non-clinical services

### WHAT WE DO

#### PROFILE

We generate a **comprehensive risk score** based on a complete picture of an individual's medical needs, psychosocial profile and personal health goals.

#### PERSONALIZE

We create a **personal care plan** that bridges clinical and non-clinical services. The intensity and type of support varies based upon risk tier and goals.

#### LOCAL HEALTH COACHING

Full-time **local Health Coaches** motivate patients to better manage their health and proactively navigate the complicated healthcare and social service systems.

#### LOCAL INTEGRATOR

We serve as **infrastructure between clinics and neighborhoods** by tightening communications between individuals and providers of medical and social services.

#### PAYMENT

We evaluate cost savings and contract with risk-bearing entities to ensure **financial sustainability**.

### NEIGHBORHOOD: HARLEM

We launched services in Harlem, NY in the Fall of 2013 focused on **diabetes**. In 2015, our capabilities will broaden to include **asthma, cardiovascular health, and depression / anxiety**.

### PARTNERS

**CLINICAL:** We partner with **Mount Sinai & Settlement Health**. Four new partners are in the pipeline for 2015.

**NON-CLINICAL:** Feeding America, STRIVE, New York Common Pantry, Jobs Plus, Union Settlement, Corbin Hill, and more.



# BRIDGING HEALTH & HEALTHCARE:

## A Systems Approach to Population Health

city  
**HEALTH WORKS**

### WHY WE'RE NEEDED

**Primary care clinicians struggle to meet the needs of their patients during increasingly short visits.**

Half of patients leave visits not understanding what their doctor told them. The average rate of adherence to medications is about 50 percent. Adherence to lifestyle change recommendations falls below 10 percent.

**Determinants of poor health stretch far beyond clinical factors:** a Robert Wood

Johnson funded study estimates that 30 percent of health is shaped by behavior and 40 percent by socio-economic factors, while only 20 percent by clinical care.

**Clinics & hospitals are not optimized to deliver health services outside of facilities,** particularly in vulnerable neighborhoods. These institutions have limited reach into their patients' home and social environments, which play a far more significant role in shaping risk for illness than the medical establishment.

**City Health Works is Local Integrator** that partners with non-clinical and clinical providers to bridge this gap. We do this through bridging services, technology integration, focusing on outcomes and utilizing new & existing financing mechanisms.

### KEY ELEMENTS TO SUCCESS //

City Health Works partners with clinical and non-clinical providers to integrate teams of culturally competent, locally hired, clinically supervised Health Coaches.

Key elements of our approach include:

- **Coaches:** With shared life experiences and a desire to help their own neighbors, **locally hired Health Coaches trained with cognitive behavioral and motivational interviewing techniques** have a powerful ability to influence behavior and support individuals to take control of their health.
- **Information:** We establish **communication and care coordination protocols** with primary care providers & local non-clinical service providers. We are a **platform for bridging EMR, behavioral, social and economic data.**
- **High Quality Teams:** Our **Care Coordination Team** includes certified diabetes educators, depression specialists, social workers & nurses, who supervise & support Health Coaches. We **integrate, improve & extend** the capabilities of primary care teams.
- **Sustainability:** City Health Works contracts with risk-bearing entities (e.g. we are an active member of Mount Sinai's PPS for DSRIP) and prioritizes **payment model innovation (e.g. pay for success mechanisms)** to ensure financial sustainability. Currently forming partnerships with health plans for actuarial analysis of services and ROI.

