NATIONAL ASSOCIATION OF Community Health Centers®

elevate

Advancing Health Center Models of Care

Transforming the Care and Workforce of the Future

PCA/HCCN Conference

November 16, 2021

Audience Participation

Chat
(use to talk with peers)

Polling/Q&A
(participate in polls, ask questions to faculty)

Cityblock

Abigail DeVries, MD
CItyblock NC Market Medical Director
abigail.devries@cityblock.com

Goals

- My background
- Cityblock overview
- Implications for FQHCs

My background and what has defined my career

- Family Physician
- CMO for large FQHC with a PACE program
- Medical director for FQHC-only Medicare MSSP ACO
- Community physician representative on Hospital Clinically-integrated Network
- Board Chair for Physician-Led Medicaid Managed Care Plan
- Associate Medical Director Consultant for NC Medicaid
- Market Medical Director for Cityblock

- Working with patients who are uninsured or have public insurance
- Working in or with organizations that address the barriers to care that low-income patients face
- A desire to provide high-quality, cost-effective care with dignity to these patients
- A desire to decrease unnecessary care and bend the cost curve
- Piloting new models of care that meet patients where they are

What is Cityblock?

A venture-capital backed startup that cares for patients with public insurance. We enter into at-risk contracts with health plans and deliver care in a three-pronged model that addresses physical, behavioral health and social needs, meeting patients where they are through in-person or virtual visits.

Our mission is to improve the health of underserved communities, one block at a time.

We built a profitable social enterprise that leans into radical change, breaking down deeply rooted racial and socioeconomic disparities.

We meet our members where they are, bringing care into the home and neighborhoods through our community-based care teams, and virtually through video, phone, and SMS.

Equipped with world-class, custom care delivery technology, we deliver personalized primary care, behavioral health, and social services to deliver a radically better experience of care for every member and community we serve.

Iyah Romm
CEO, Co-founder

Toyin Ajayi, MD
President, Co-founder

Former C-suite partners at *Commonwealth Care Alliance*, an integrated provider with 25,000 Duals and $1B+ revenue. Nationally recognized for novel programming, care outcomes, and cost savings.

Mitch Betses
COO
Acting CEO & COO at Haven

COO at Beacon Health

EVP at CVS

Lon Binder
CTO

CTO of Warby Parker ($1.75B)

Seasoned technical executive and founder.

Andrea Blankmeyer
CFO

CFO of Transfix

VP Finance of SoFi

Bain & Co., Hellman & Friedman, Gates Foundation

SUPPORTED BY

town hall

Alphabet

Maverick

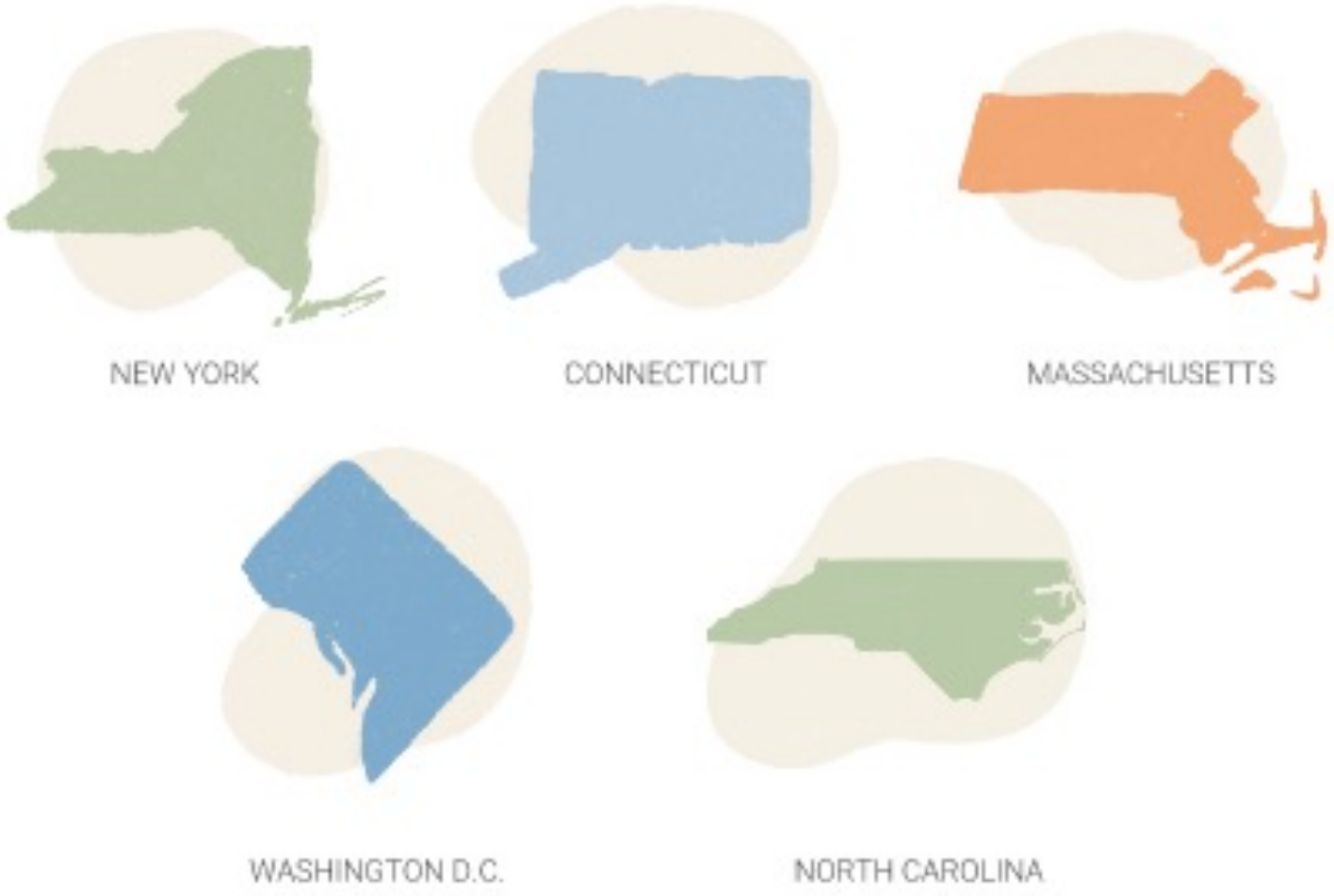
Redpoint

KINNEVIK

GENERAL CATALYST

WELLINGTON MANAGEMENT

Markets we currently serve:



Our partners:

MOLINA HEALTHCARE

BlueCross BlueShield of North Carolina

CareFirst

TUFTS Health Plan

EmblemHealth

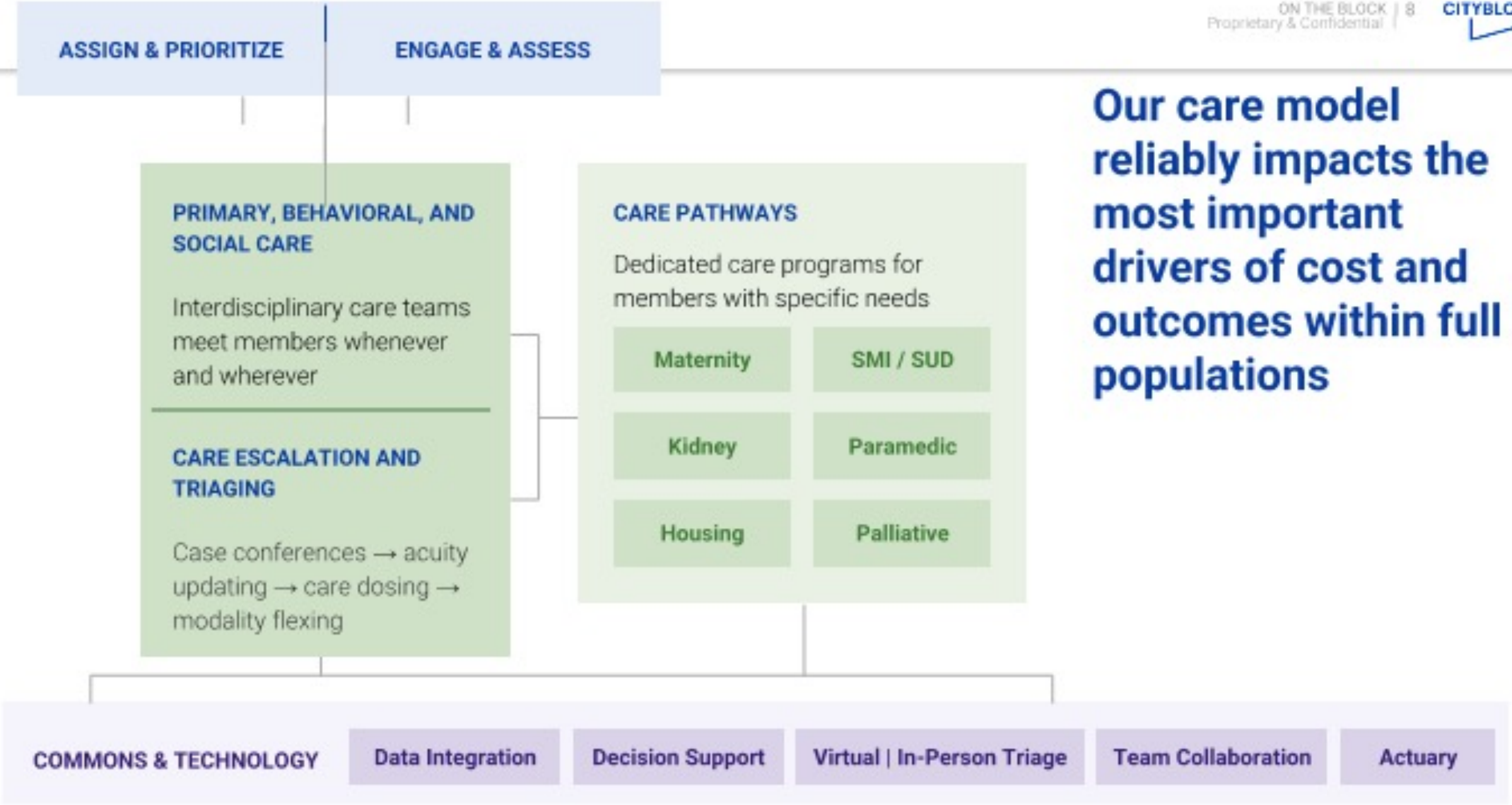
ConnectiCare

We deliver outcomes through a deep understanding of the continuum of needs of underserved populations with complex conditions.

Our care model is designed to meet people with the best care — wherever they are.

CITYBLOCK

Our care model reliably impacts the most important drivers of cost and outcomes within full populations

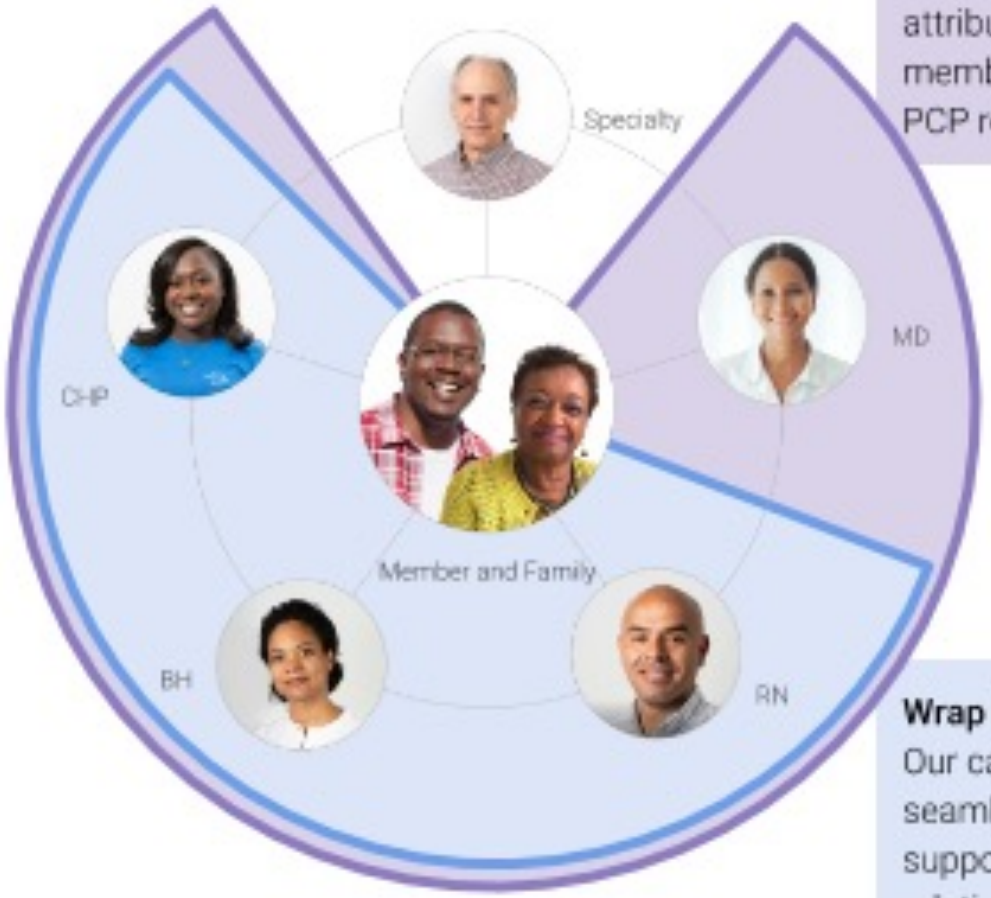


We deliver outcomes through advanced understanding of the heterogeneity of complex lower-income populations

	 Socially isolated & unmanaged	 Polychronic & undermanaged	 Serious mental illness	 Approaching end-of-life
Care model interventions	**Non-clinical engagement** (CHPs) and connection to CBOs and community resources	Interdisciplinary team (MD, RN, CHP) providing **MTM, BH care, and social care**	High-quality primary care integrated with **accessible behavioral health**	Advanced care planning with **aggressive home-based primary care** and palliative care
Desired outcomes	Reduced **social admits** to the hospital	Better **underlying health** and fewer acute events	Reduced inpatient **BH-driven admits**	Reduced unnecessary **end-of-life utilization**
Prevalence in early cohorts	70% reporting social vulnerability	69% with 3+ chronic conditions 33% with 5+ chronic conditions	30% with behavioral health diagnosis	15% identified as eligible for palliative care

Experience- and brand-driven retention captures recurring value over time

Our care teams can either serve as an attributed PCP or wrap around existing PCP relationships, based on member preference



Advanced Primary Care
Cityblock can be the attributed PCP for members without existing PCP relationships.

Wrap Care Management
Our care mgmt. services seamlessly augment and support existing PCP relationships.

- Each member is assigned a designated **Community Health Partner** to support them in creating a personalized care plan, called a **Member Action Plan**, and to ensure they are connected with the care and social services they need.
- Our **fully integrated care teams** — including PCPs, advanced care practitioners, NCPs, psychiatrists, BHSs, and LCSWs — collaborate closely on every member's care, coordinating delivery, **and integrating behavioral health** needs.
- These flexible care teams **meet members wherever and whenever is convenient**, be it in their home, at a community spot, or virtually by phone, text, or video.
- Our **care model and technology are flexible** enough to adjust between full ownership of the member relationship (Advanced Primary Care), or deeply impactful support for members with an existing PCP (Wrap Care Management).

Cityblock is able to care for patients with a variety of in-person, virtual, and at-home modalities

Community Integrated Care

Hub, community and home-based model targeted towards high risk populations with integrated care teams providing intensive physical, behavioral and social care.

Virtual Integrated Care

Integrated virtual care team providing longitudinal care across physical, behavioral and social needs and targeting high and rising risk patients who can be engaged through virtual engagement (phone, video, text), synchronously and asynchronously.

Virtual Care Now

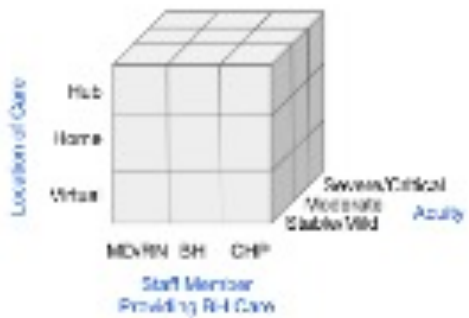
Virtual care teams available through app-based interface 24/7 to meet acute physical, behavioral or social needs, including virtual visits, Rx management, specialist, social services referrals and chronic condition management.

Community Rapid Response

In-home response with community paramedics to provide diagnostics, IV treatment, and other higher-intensity services, aimed at ED diversion. Connection via tele-visit for physician visit as needed.

Multimodal BH Care Potential Example - Substance Use Disorder Care

SUBSTANCE USE DISORDER CARE			
Critical Acuity (i.e. ACT Team)	**Medical Staff**	**BH Staff**	**CHP Staff**
Hub in-person	Follow-up for SUD related medical complication	Warm-handoff Care management	
Home/Mobile in-person	EMT or VNA given Sublocade injection	Post hospitalization transition of care visit	CHP in-home visit to facilitate care
Virtual		Virtual psychiatry appointment	

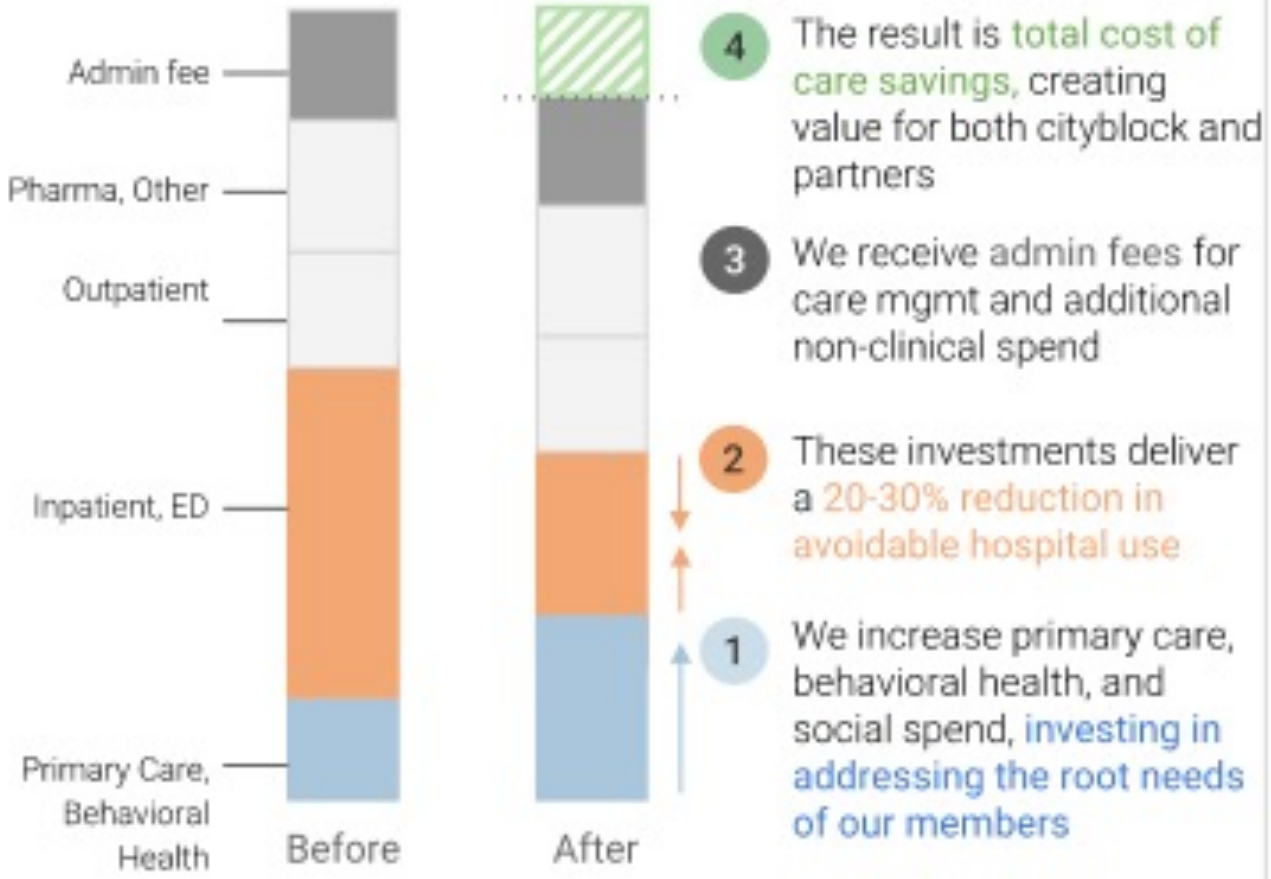


Transitions of Care

Identify Hospital Event	Engage & Assess in Hospital	Quick follow-up after D/C	Post D/C Contact	Clinical Visit	Mitigation Planning
Through the use of **admission, discharge, and transfer (ADT) data** from PatientPing, we receive real-time notification when members go to the hospital.	During an admission our RNs and/or BH Specialists **outreach the member & facility** to understand reason for encounter participate in discharge planning	Engage the member telephonically **within 24-48 hours** of discharge to assess member state and schedule a home visit, if relevant	**Conduct a Post D/C home visit** with the member within 72 hours of IP discharge to conduct med rec, discharge paperwork review, home safety, and readmission mitigation planning	Ensure member has a **follow-up visit with clinician within 7 days** of discharge, either in office, over video, or facilitated by Community Rapid Response EMT/Paramedic	**Proactively follow-up** with the member weekly **for 30 days**, at a minimum, to support member in reducing their chances of readmission

Cityblock is reducing avoidable costs through investment in primary care, behavioral health, and social care

CITYBLOCK VALUE PROPOSITION



- Cityblock increases investment in primary, behavioral, and social care to decrease avoidable hospital spend and drive total cost of care savings
- Cityblock's value proposition is best realized with total cost of care risk sharing arrangements for high-risk, low-income populations
- We work with partners to identify the highest risk / highest need populations we can best impact with our model (e.g., high IP, ED frequent fliers, multiple chronic conditions, BH needs, etc.)
- Together, we then align on geographic areas with sufficient concentration of these members where Cityblock will start

Our care model has yielded significant results in reducing admissions and driving lower total cost of care

IMPACT TO ER AND ADMISSIONS

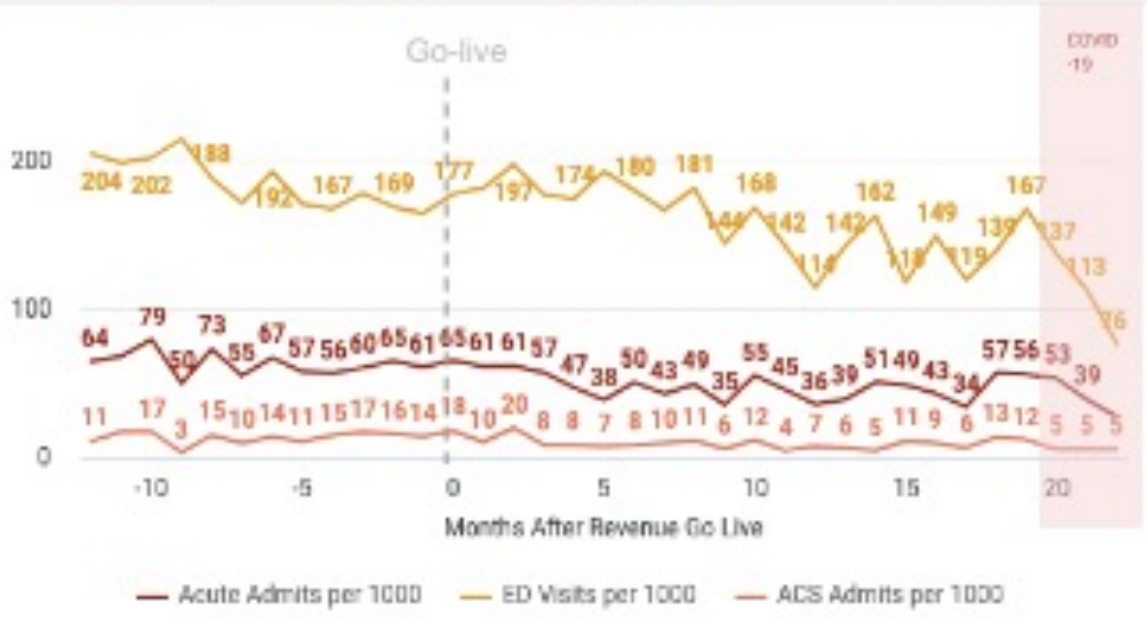
Member cohorts 1-3 have seen a steady decrease in acute admissions and ED visits, especially ambulatory care sensitive admissions

-26% Change in IP / 1000

-18% Change in ED / 1000

-36% Change in ACS IP / 1000

(measured as performance period data compared against a 12 month baseline pre-Cityblock)

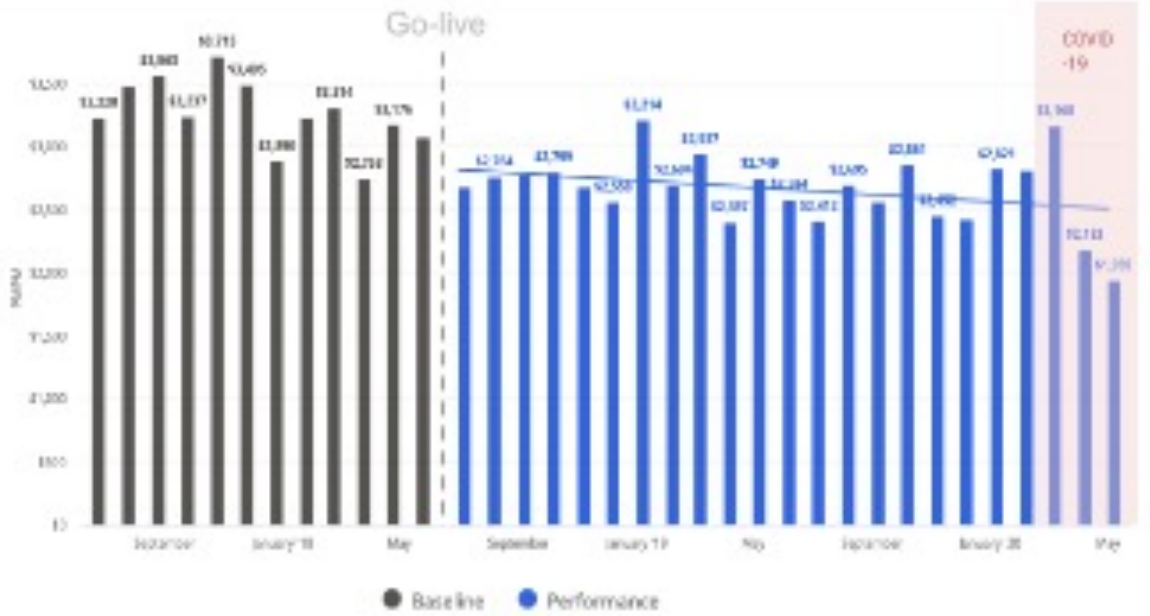


IMPACT TO COST OF CARE

Member cohort 1, with over two years of performance data, has seen a total cost of care reduction vs baseline

-19% Change in TCOC

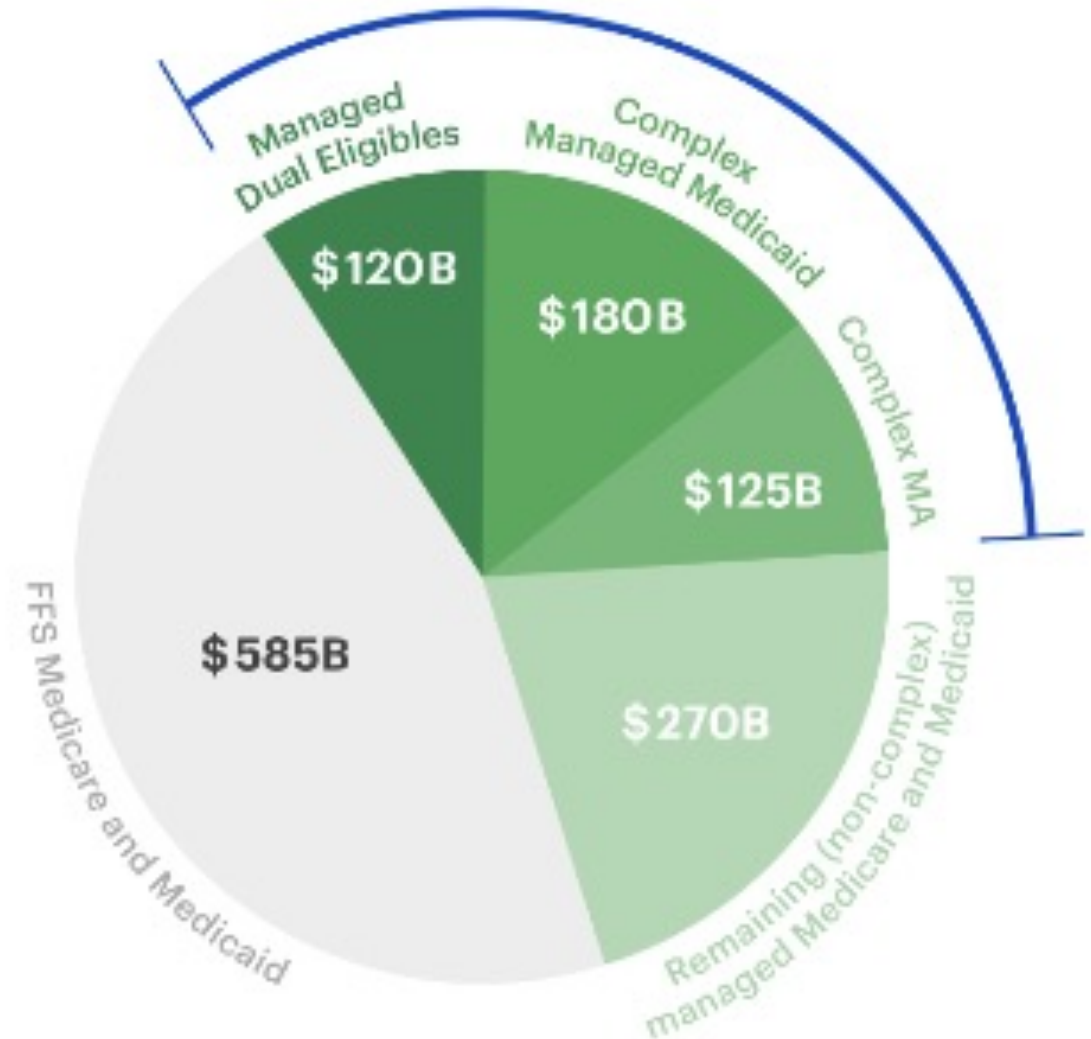
(measured as performance period data compared against a 12 month baseline pre-Cityblock)



There are millions of Americans who need access to better care.

Massive annual spending in Medicaid and Dual Eligibles, with further growth expected to managed care.

The public payer market *(Medicaid, Duals, Medicare)* is a **$1.2T+** market, with **$700B** under managed third-party care.



What Can FQHCs take away from the Cityblock model?

- Double down on whole-person care
- Push for at-risk contracts with your health plan partners
- Focus on the highest-cost and rising risk patients
- Implement transitions of care program
- Invest in population health platform and roles
- Advocate for HRSA to allow more room for innovation within FQHCs

CITYBLOCK

Thank you.

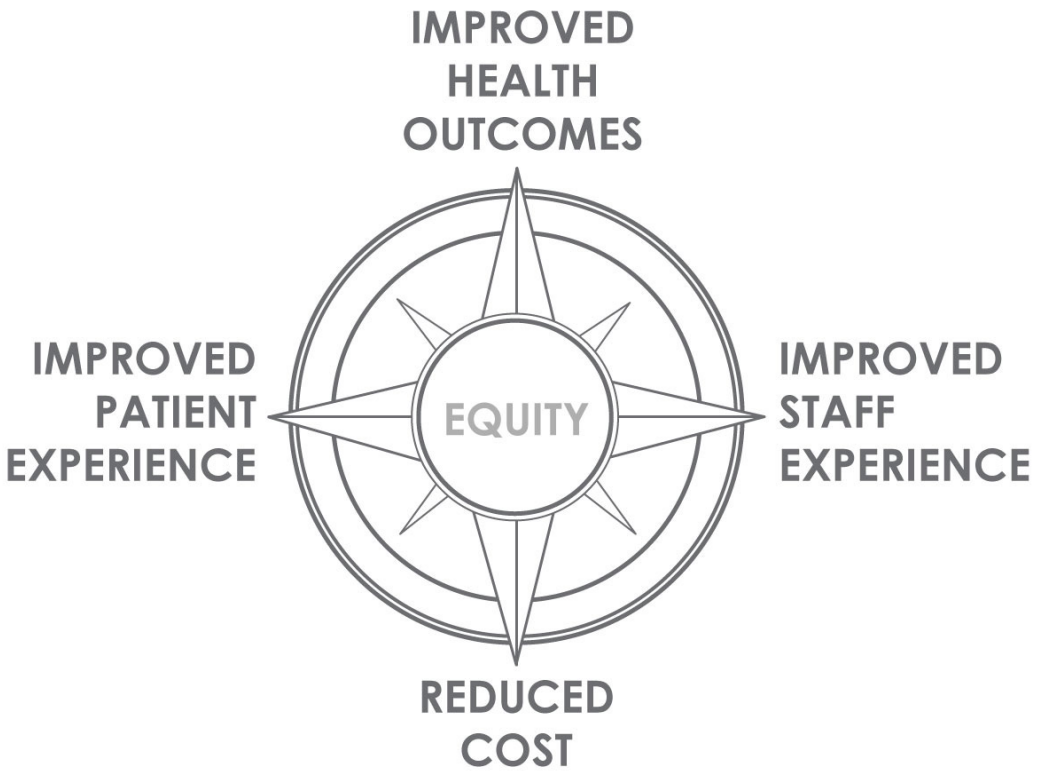
Packaging and implementing evidence-based transformational strategies for safety-net providers

Bringing science, knowledge, and innovation to practice

Cheryl Modica

Director, Quality Center
cmodica@nachc.org

Our Goal


IMPROVED HEALTH OUTCOMES
IMPROVED PATIENT EXPERIENCE
EQUITY
IMPROVED STAFF EXPERIENCE
REDUCED COST


Begin
with the end in mind
- Steven Covey

The 2022 Imperative

- **The threat is real…The opportunities endless!**
- Every health center across the nation should be able to document at least one value-based model of care (the mechanics) by December 2022.
- Together, **communicate a foundational model** that sits at the core of our collective work in serving 29 million patients across the nation.
- **Speak our value**. And through that message, be in a position of offense.

An unprecedented time in history.
Health centers have the opportunity to shift – rather than just recover.

CMMI Recognition: FQHCs and other safety-net providers

Rebalance the health care system towards primary care and prevention

Magnitude of Impact

CMS Innovation Center

28 Million

Beneficiaries Touched 2018-2020

https://innovation.cms.gov/data-and-reports/2021/rtc-2020

Community Health Centers

29 Million

Patients

https://bphc.hrsa.gov/about/healthcenterprogram/index.html

CMS Innovation Center

Alternative Payment Models (APMs)

CMS looking to define APMs for the following categories:

Provider Type	Primary care
Community	Safety-net
Health Conditions	e.g., cancer screening, diabetes, HTN, obesity, depression
Innovation	Equity lens

Health centers meet this need!

CMMI's 5 Strategic Objectives

CMS Innovation Center Strategy Refresh: https://innovation.cms.gov/strategic-direction-whitepaper

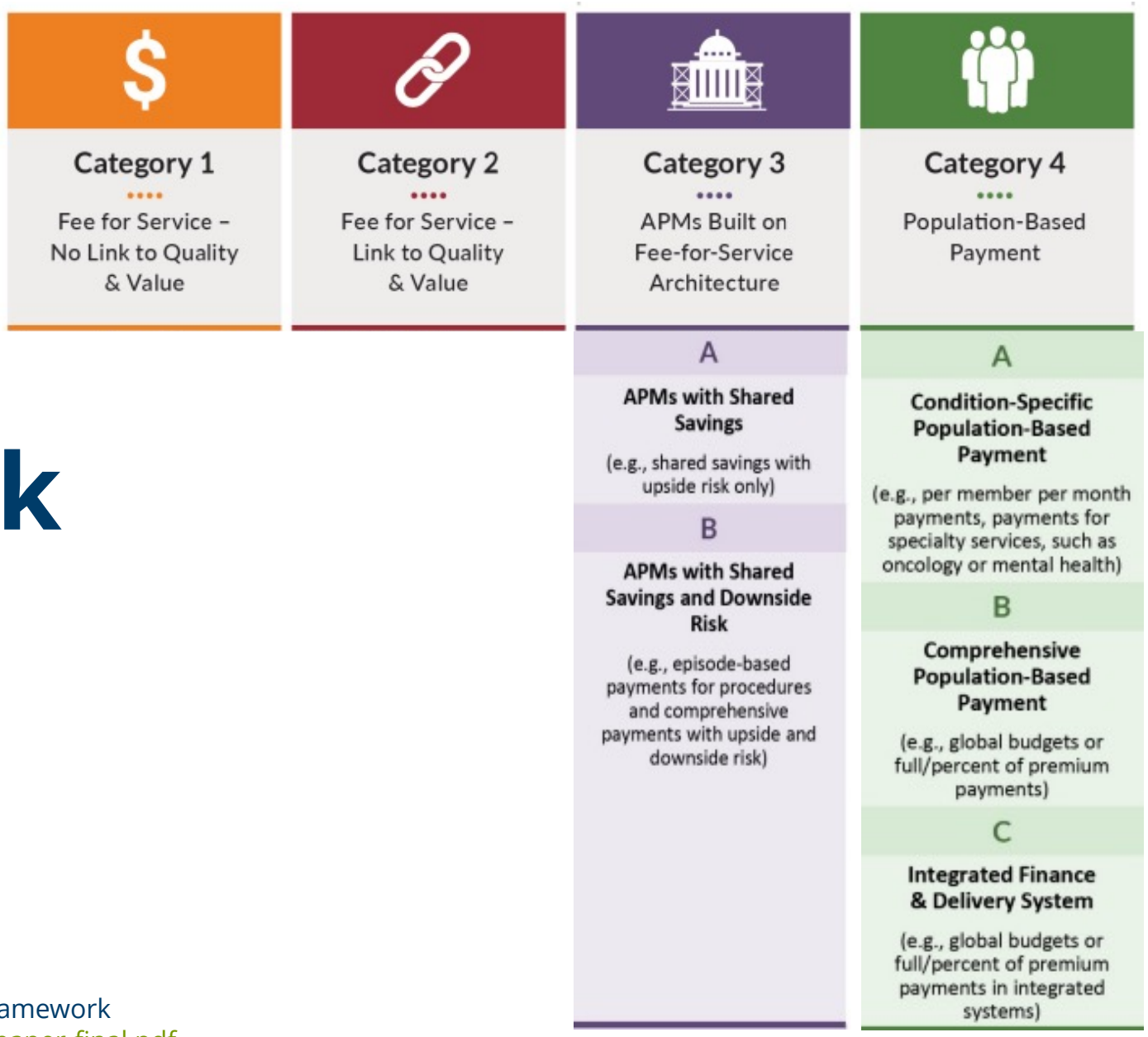
Alignment

CMMI's 5 Strategic Objectives & Value Transformation Framework

CMS Innovation Center Vision and 5 Strategic Objectives for Advancing System Transformation

The Value Transformation Framework: A Health Center Model for Advancing System Transformation and 5 Value-Based Goals

APM Framework



Source: HCP LAN, Alternative Payment Model Framework
https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf

NATIONAL ASSOCIATION OF Community Health Centers®

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Together, our voices elevate all.

- Recognizes and leverages the unique and critical role of PCAs, HCCNs, and NTTAPs
- Encourages health center individuality and flexibility while focusing on unifying approaches

COLLABORATE

LEARN

SHARE

CREATE

INNOVATE

NATIONAL ASSOCIATION OF Community Health Centers®

ELEVATE Impact

Improved Health Outcomes+

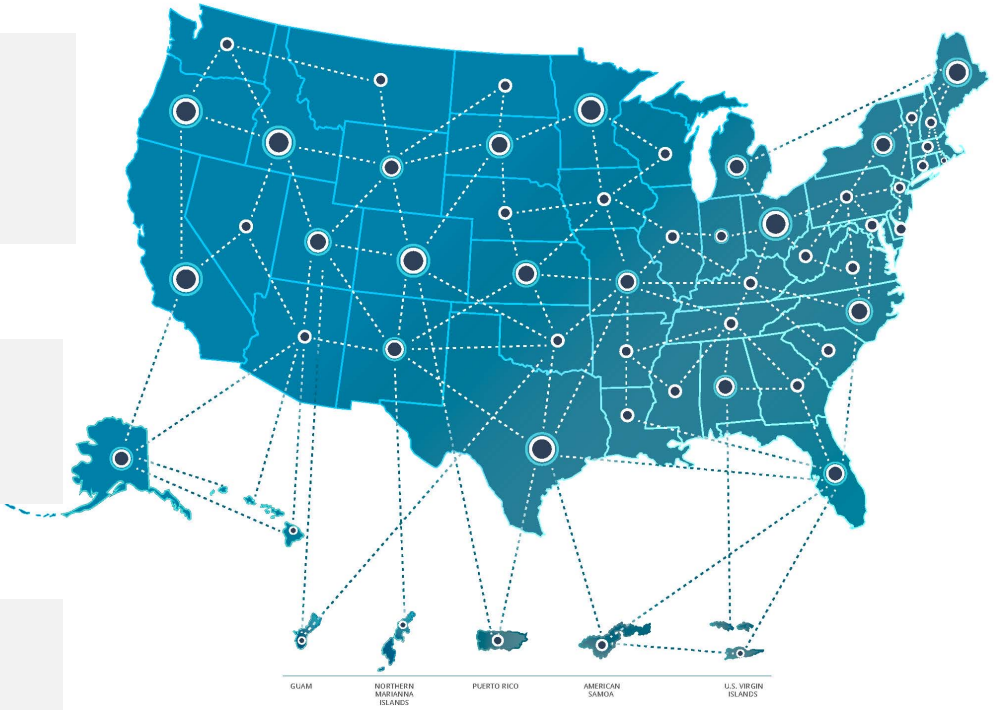
Colorectal & cervical cancer screening, diabetes control, HTN control, obesity, & depression.

Decreased Costs+

Decreased median overall cost per patient

High Pt & Staff Experience+

Satisfaction and experience remained highly rated amidst systems changes



+Comparison between health centers participating in Elevate vs non-participating health centers. Health outcomes and costs measured by UDS for the period of 2017-19. Patient and staff experience data was collected using project-developed surveys in 2017-18.

All
States & Territories

544
Health Centers

78
PCAs/HCCNs/NTTAPs

48
CDC Cancer Grantees

6,000
Peers

100%
Health Centers Indirectly Impacted

2022 Strategy

Outcomes:

- **Document a portfolio of health center care models** that can be held up as FQHC Alternative Payment Model options.
- **Demonstrate service delivery models** that can serve as the foundation of payment models that public and private payers (Medicare, Medicaid, and commercial plans) can use to align payments to primary care practices.
- **Document improvement on the Quintuple Aim goals:** improved health outcomes, improved patient and staff experience, reduced cost, and improved equity.

Elevate 2022: At A Glance

DURATION	PARTICIPANTS	ASSESSMENT	LEARNING PLATFORM	PERFORMANCE MEASURES	COST
1 year Jan – Dec 2022	All Health Center Program grantees and look-alikes invited Public health partners invited	All participants complete the 15-item VTF Assessment	VTF and Elevate learning bank (within Docebo learning management system)	UDS Clinical Measures: cancer screening, diabetes, HTN, obesity, depression	**FREE**

Developing a Primary Care Payment Model

1) Select a Population of Focus	2) Narrow the Target Group	3) Mobilize Care Team in New Ways	4) Optimize Health Information Systems	5) Engage Patients & Community	6) Maximize Revenue
DETAILS Patients aged 50-75 years (Medicare)	**DETAILS** Risk stratify	**DETAILS** Focus on care extenders	**DETAILS** Capture data; full coding	**DETAILS** Co-design	
WHY Medicare offers payment opportunities outside of PPS. Age group includes targeted conditions; lessons can be applied to Medicaid and other payers.	**WHY** Focus on high-risk population where impact can be the greatest and payment exists outside of PPS.	**WHY** Mobilize reimbursable care management and virtual care services; mobilize extended care team.	**WHY** Get credit for the work done; capture data to support primary care payment model.	**WHY** Build care models that work for patients and the community; address social risks.	**WHY** Use additional revenue opportunities to bridge the gap while transitioning to risk-based models.

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2022 Register Today

Focus Areas for 2022

Value-Based Payment Models

Evidence-Based Health Center Systems

Community Partnerships and Co-Design

Catalyzing Policy Changes

Value Transformation Framework
Self-Assessment

Infrastructure	Care Delivery	People
Improvement Strategy	Population Health Management	Patients
Health Information Technology (HIT)	PCMH	Care Teams
Policy	Evidence-Based Care	Leadership
Payment	Care Coordination and Management	Workforce
Cost	Social Determinants of Health (SDOH)	Partnerships

- Built around the **Value Transformation Framework**
- **3** domains
- **15** change areas

NEW TO ELEVATE:
PCAs and HCCNs can now get VTF Assessment reports for member health centers!

Value-Based Payment Question in
Elevate 2022 Registration

1

Q. **Risk-Based Payment Contracts**. Do any health centers in your state/network have risk-based payment contracts?

__No
__Yes, with shared savings (upside risk only)
__Yes, with shared savings (upside & downside risk)
__Yes, condition-specific population-based payment (e.g., per member per month payment or payment for a specific condition)
__Yes, comprehensive population-based payment (e.g., global budget)
__Not sure

If a PCA/HCCN selects any 'yes' on Question 1, they get the following question:

2

Q. **Risk-Based Payment Percentages**. Considering the 'yes' responses, what is the approximate percent breakdown of these risk contracts across the health centers?

__% shared savings (upside risk only)
__% shared savings (upside & downside risk)
__% condition-specific population-based payment (e.g., per member per month payment or payment for a specific condition)
__% comprehensive population-based payment (e.g., global budget)
__ Not sure

NEXT STEPS

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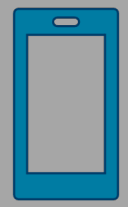
1

REGISTER

Sign up today using this link:
bit.ly/Elevate_2022

OR, use your phone to scan the QR code:



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ASSESS

https://reglantern.com/vtf

Organizations with 3+ VTF Assessments by November 19 eligible for one of 25 scholarships to attend the 2021 IHI National Forum!

FOR MORE INFORMATION CONTACT:

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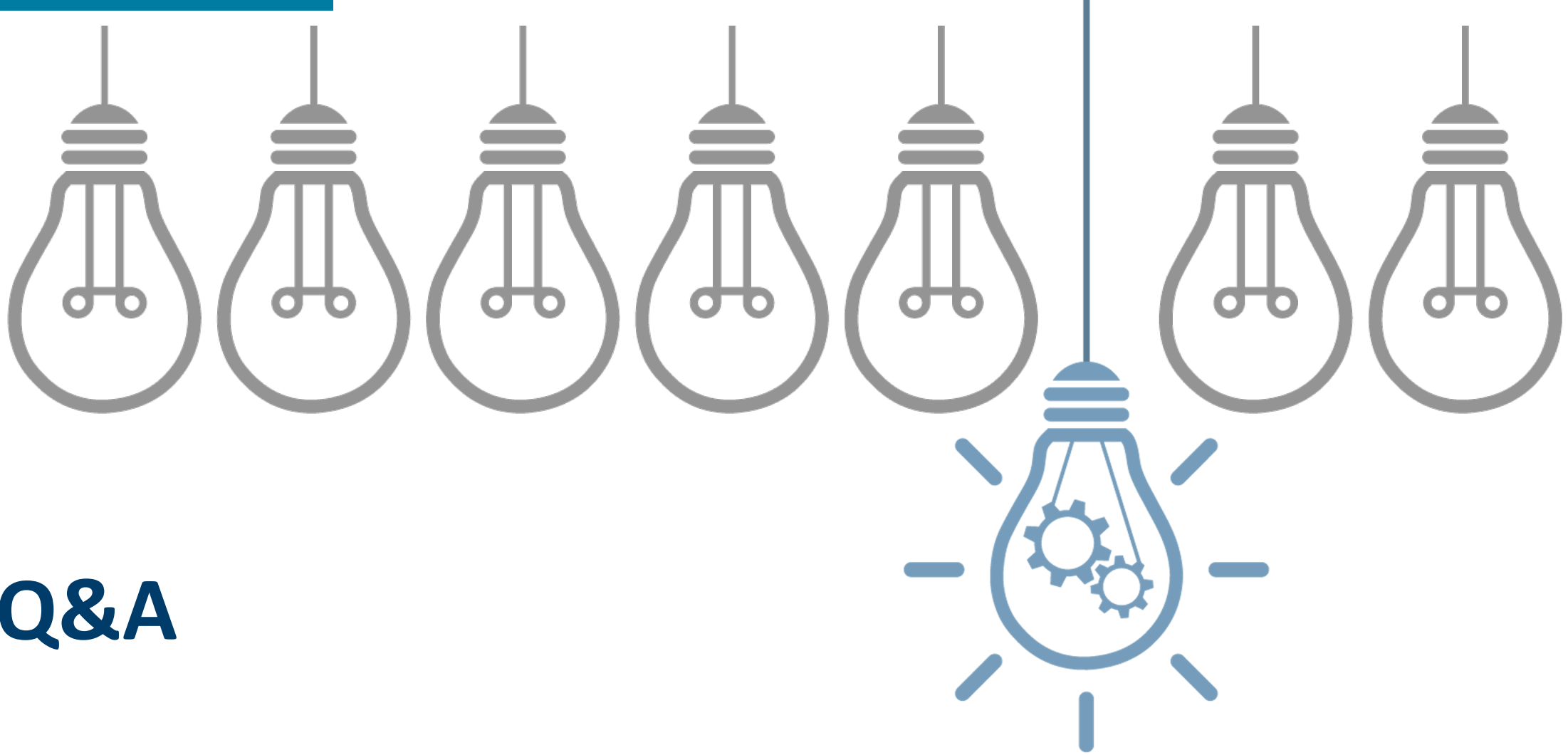
Thank you!



Q&A