Changing the System to Meet People Where They Are
Cityblock is a personalized care delivery company for underserved populations

Cityblock is led by innovators passionate about radically improving the health of urban communities, one block at a time
Cityblock Health, Overview

- Cityblock was launched in 2017 by senior healthcare executives with extensive experience serving Medicaid & Dual Eligible populations and designing value-based payment policy (federal/state).
- We offer an evidence-based and scalable delivery model that integrates full primary care with behavioral health, social need assistance, and high-value auxiliary clinical services.
- We are designing specifically for diverse urban populations, recognizing that caring for whole communities, not simply highest-need individuals, is necessary for maximal engagement and scale.
- We are built to take on significant financial risk, including capitation.
- We are developing an all-new digital platform, Commons, to fully engage members and support their care team in delivering best-in-class health outcomes.
- We are backed by world-class investors, and supported by leading policy experts.
- We are looking for partners to drive change.

Health is local.
A Problem Worth Solving
These individuals have complex and heterogeneous needs...

<table>
<thead>
<tr>
<th>Serious mental illness</th>
<th>Homebound isolation</th>
<th>Financial stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance use disorders</td>
<td>Lack of transportation access</td>
<td>Legal issues</td>
</tr>
<tr>
<td>Chronic medical diseases</td>
<td>End of life “utilization disorder”</td>
<td>Poor nutrition</td>
</tr>
<tr>
<td>Disabilities</td>
<td>Homelessness</td>
<td>etc, etc, etc.</td>
</tr>
</tbody>
</table>

... and the highest cost segment drives unmanageable spend

~$73,500
Total Cost of Care
avg NYS 2014

MLRs well in excess of +200% for the most complex lives
Meet Patti: a true story of a person who fell through the cracks

- Single mother, in her 40s
- Two kids with learning difficulties and asthma
- Subsidized housing in a violent neighborhood, with poor schools and no subway close by
- Did not complete high school
- Does not have a steady job
- Severe asthma
- Multiple allergies
- Post traumatic stress disorder and depression
- 10+ prescriptions to manage
- Uses pain pills and street drugs
- Disengaged from mental health or addiction treatment

*Name and other identifying features have been modified to protect confidentiality*
Today’s health system was simply not equipped to meet her needs

Rushed visits by primary care practices who are incentivized for throughput

Limited behavioral/mental health supports leave Patti to struggle alone

Care Management, if done at all, is over the telephone...and infrequently

Social challenges in Patti’s life not uncovered, certainly not addressed

Health record / data scattered across different systems

No clear owner of the relationship; no one accountable for outcomes

Patti died prematurely at 44, after a long, very high-cost series of hospitalizations

...and orphaning her two young children—likely to repeat the cycle of poverty and poor health
For low-income populations with complex medical, mental health and social needs, this is a real issue

<table>
<thead>
<tr>
<th>$1.6T</th>
<th>Healthcare costs are concentrated in a very small segment of people...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spent on 5% of the U.S. population</td>
<td>One in twenty individuals (5%) represent half of all health care spending. They are predominantly low income (50%), publicly insured (80%), older (50% over 65yo), female (2/3) less educated, and urban dwelling.</td>
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<thead>
<tr>
<th>40%</th>
<th>...and the costs of inefficient and unnecessary care are massive...</th>
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<tbody>
<tr>
<td>of that spending ($395B) is wasted each year</td>
<td>Unnecessary care, inefficient delivery structures, and failures to provide appropriate preventative care contribute to $395B in waste.</td>
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<table>
<thead>
<tr>
<th>$576B</th>
<th>...and hampering economic growth.</th>
</tr>
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<tbody>
<tr>
<td>In lost productivity</td>
<td>Absenteeism leads to $227B in lost productivity each year. The direct costs of an inefficient healthcare system are passed through directly to employers and communities, repressing healthy economies</td>
</tr>
</tbody>
</table>
Social Determinants of Health

The conditions in which people are born, grow, live, work, and age, which influence their health
We’ve all acknowledged that social determinants matter, but what does that mean?

- Individual behavior and social circumstances are frequently unrecognized, and are nearly always undertreated, despite being major drivers of health outcomes.
- Taken together, these non-medical factors contribute more significantly to an individual’s overall well-being than their genome, disease burden or even the quality of medical care they receive.
In order to improve care and meet people where they are, we must broaden our focus to include the roots of health.

<table>
<thead>
<tr>
<th>Contribution to health outcomes</th>
<th>Category of need</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDOH</td>
<td>Transportation</td>
<td>Getting to appointments</td>
</tr>
<tr>
<td></td>
<td>Nutrition</td>
<td>Nutritious, health food</td>
</tr>
<tr>
<td></td>
<td>Housing</td>
<td>Consistent, safe and clean</td>
</tr>
<tr>
<td></td>
<td>Loneliness</td>
<td>Meaningful relationships</td>
</tr>
<tr>
<td></td>
<td>Financial security</td>
<td>Avoiding constant debt</td>
</tr>
<tr>
<td></td>
<td>Connectivity</td>
<td>Being reachable via phone</td>
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Contribute to poor outcomes & cost

Anchoring all of this is a need for effective coordination and collaboration within trusted, longitudinal relationships.
A growing evidence-base supports the notion that investing in social determinants can meaningfully improve health outcomes.

<table>
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<th>Food</th>
<th>Housing</th>
<th>Connectivity</th>
<th>Care Coordination</th>
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<tr>
<td>Nutrition assistance for high-risk women, infants, and children, as well as older adults and people with disabilities are associated with decreased acute and post-acute care days (for seniors), and improved newborn health outcomes.</td>
<td>The evidence demonstrating a direct relationship between housing supports and improved health outcomes is strong and growing. Net savings range from $9K - 30K PMPY depending on the population targeted.</td>
<td>Up to 60% of new SIM registrations are defunct within 90 days. Pay-as-you-go phones are popular but churn. Early studies suggest that providing high-risk individuals with data reduces missed appointments, particularly at the end of the month.</td>
<td>Evidence suggests that vulnerable populations (in particular low-income families and frail seniors) experience health gains and decreased acute care utilization when their care is coordinated across primary, specialty, behavioral, and social services.</td>
</tr>
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A growing evidence-base supports the notion that investing in social determinants can meaningfully improve health outcomes.

**Transportation**
- Providing non-emergency medical transportation has been proven to improve appointment adherence, and, potentially, acute care utilization among high-need populations.

**Home Health**
- Investments in long-term services and supports, particularly for frail and homebound seniors, and individuals in disabilities, can reduce acute care utilization by as much as 25%.

**Family Engagement**
- Family and caregiver engagement in care models improves chronic disease management.
  - Additionally, family engagement is associated with fewer medical errors and shorter hospital length of stay.

**Financial Security**
- Direct financial support, especially in the form of government entitlement programs, has been associated with better health outcomes for individuals who qualify.
One Approach:
Cityblock Model Overview
Our care model leverages neighborhood hubs, personalized care teams, proven intervention strategies, CBOs and purpose-built technology.

Cityblock’s Personalized Care Model

**Personalized Care Teams**
Team-based, integrated care that wraps existing providers including: MD, NP/PA, RN, BH, LCSW, and more
Full primary care, BH, SUD & personalized care planning to address underlying SDoH
*Community Health Partner* anchors the team, owns relationship and trust

**Neighborhood Hubs**
Multi-functional footprints designed to meet local needs
Field-based and home-based care teams flex out from the hub, meet members where they are
Co-locate with local partners for social service delivery

**Custom Digital Platform**
Assessment and stratification, built over time with BH + SDoH data for a 360° view
Custom longitudinal health record
Protocolized workflows, with Google-caliber design and security
Direct service delivery with mHealth
What Do Our Community Health Partners Do?

Build and nurture trusting relationships
Recruited for empathy, emotional intelligence, problem-solving, accountability, and tenacity, our CHPs are the faces of the care team in the community. They build trust through persistent, respectful outreach to members, meeting them wherever they are without judgment or stigma.

Connect members to the right services, at the right time and place
We empower our CHPs with digital tooling to connect members with high-value social services partners and drive accountability for outcomes. This reduces inefficiency, and reinforces trust.

Support and champion members in their efforts
Our CHPs are trained in behavioral coaching, chronic disease management, health literacy and interdisciplinary clinical communication. They amplify the care team’s voice, collect health data, facilitate provider encounters, and support members in sustaining behavior change.

Field-based Community Health Partners are non-clinician individuals, hired from the local community, and upskilled through our intensive training program. They build trust and anchor our care teams, acting as the central quarterback to partner with members and drive all care.

Our care teams include MDs, RN Care Managers, Behavioral Health Specialists and Community Health Partners

CHPs represent a new and large professionalized workforce, driving systemic change in the communities they serve.
We recognize and involve the members’ families & support networks, including family caregivers—a powerful and unique approach

We recognize that the complexities in our members’ lives create spillover effects for their immediate networks of loved ones - and that these networks can be protective and enabling. We believe that caring for the member must include a relationship with the whole family unit.

Family caregivers carry a heavy burden, and are often key to preserving the independence and wellbeing of members with complex needs
Assessing, engaging, and supporting family caregivers is critical to managing cost and utilization

Our tech platform provides a lightweight way to keep loved-ones in the loop
Through Commons, our care-team can easily communicate with each other, our members, and our members’ family stakeholders

Social determinants of health impact entire family units, not solely individuals who are sick
Investing in meals, housing stability, social supports, and resilience will drive value for the entire family unit, potentially breaking generational cycles of poverty and ill-health

By engaging, educating, and coaching caregivers within the home environment, we reinforce family capabilities
Building the skill-set of family caregivers and health decision-makers in the household drives lasting benefits for the whole family unit
For Patti, a fully-integrated, personalized care system would have meant a radically different experience -- and significantly better outcomes.

- An integrated team of caregivers look after Patti and her family.
- Deep relationship with a community health partner, who comes to her home.
- Community health partner focuses on addressing underlying social needs.
- Care team is able to use a single platform to collaborate and share data.
- Patti’s meds are reconciled. Fewer meds = less risk for complications.
- Early identification of addiction and connection to treatment.

Outcomes:
Every additional year of quality life gained would have had dramatic implications for her children & community.
The time is right to deepen investments in community based care, with a deliberate strategy for addressing social determinants and meeting people where they are.
Thank You

Contact

Melanie Bella, Chief of New Business & Policy
melanie@cityblock.com

55 Washington St, Unit #552
Brooklyn, NY 11201
www.cityblock.com