Program Summary:

- Holistic & relational approach to member management of chronic conditions
- Enrollment doesn't replace primary care physician or specialists
- Integrated care teams including behavioral health specialists & pharmacists
- Individualized complex & chronic care plan
- Care coordination across entire health care continuum
- Member engagement in trusted relationships drives health improvement
- Lower cost to member & health plan
- Enrollment improves documentation, coding accuracy & member engagement

Holistic & Relational Approach

At CityLife Neighborhood Clinics, our approach to caring for complex members with chronic conditions is centered on the whole member, not just on episodic diagnoses & treatments. At traditional primary care practices, due to limited physician time and resources an interaction with a chronically ill member is primarily viewed through a medical lens with the focus of health care on problem identification (diagnosis) and solutions (treatment). Underlying factors, however, such as behavioral, social, emotional & environmental issues should also be incorporated into contacts and visits. We believe that getting the right diagnosis, following protocols, & prescribing the right treatment is only part of the role of health care.

Our fundamental opportunity at CityLife Neighborhood Clinics is to enter into personal, trusting & long term relationships with our complex & chronic care members & over time have many conversations about what creates illness, how to live well with chronic conditions, how to prevent further illness, & how to create wellness over time. Our goal is to support members & their families as they strive to improve their health. Lastly, the community is a key partner in influencing health beliefs & habits. We engage in community initiatives, data analysis & resource mapping to change the way members access care coordinated across the whole continuum.

Enrollment

Unlike telephonic case management, our complex & chronic care program enrolls & assigns members to a complex & chronic care team at a CityLife Neighborhood Clinic where in-person interactions & supportive environments foster trusted personal relationships with members & their caregivers. These relationships allow for critical assessments of social & behavioral determinants of health. CityLife Neighborhood Clinics become the hub of their health care interactions, which continue with their primary care physicians & specialists. Through the resources of CityLife integrated care teams, continued interactions become more organized and efficient for members, their caregivers, providers & health plans. Primary chronic, multi-chronic or complex acute conditions eligible for enrolment include, but are not limited to:

- Coronary Conditions-CHF, CAD, Hypertension, Hyperlipidemia;
- Respiratory Conditions-COPD, Asthma;
- Kidney Disease;
- Diabetes; &
- Cancer
- Physical Conditions Resulting from Mental Illness

Integrated Care Teams

Our care model is based on a team approach that includes several clinical disciplines, including behavioral health specialists & pharmacists. Simply co-locating team members is not sufficient—we have redesigned clinic workflows to ensure care team integration with interdependencies that enable efficient care delivery & coordination as well as shared responsibilities amongst the care team, the member & their caregivers.

Assignment to complex & chronic care teams fosters long term relationships with the members & their caregivers. This engagement and connectivity to a complex & chronic care team allows clinic visits to evolve from diagnosis, treatment & adherence to discussions about management of physical, emotional, social and mental needs to improve health.

Complex & Chronic Care Team Members

- Member
- Member's Family or Caregivers
- Doctor (Internal Medicine) or Nurse Practitioner
- Nurse
- Clinical Assistant
- Administrative Assistant
- Health Guide (Behavioral health Specialist)
- Medication Guide (Pharmacist)
- Food Guide (Registered Dietician)
- Standing behind the complex & chronic care care team is a team of business & health care professionals at CityLife Neighborhood Clinics & Ampersand Health, providing the support & resources necessary for the member, chronic care team primary care physician & specialists to succeed.

Integrated Behavioral Health

Many members with chronic conditions also struggle with managing pain, situational depression & anxiety, which can have as great or greater impact on a member's overall health as physical conditions. By integrating behavioral health support, our care teams are able to help members to proactively address environmental & behavioral stressors that are impacting their health and family relationships.

Visits & Contacts

In the delivery & coordination of care, members may interact with all members of their CityLife chronic care team at various points during the year. These "contacts" or interactions may be in person (visits), by phone, or by email. Some contacts will be scheduled to proactively address health needs – care coordination, following up on a specialist visit to discuss a change in medications, following up on a missed appointment for a blood test, or checking in to see how the member is adjusting to their new walker, for example. Other contacts may be used to address more acute situations; such as a post hospital discharge visit for medication reconciliation.

In order to effectively support member relationships & coordinate care, CityLife complex & chronic care teams must be accessible. CityLife Neighborhood Clinics are open 7 days a week, from 8am to 5pm. CityLife complex & chronic care teams are available 24 hours per day via telephone, email or text.

During the course of a year, members of the program may have 6-8 visits with their doctor or nurse practitioner. They may also have 4-6 visits with their Health Guide (Behavioral Health Specialist) & 4-6 visits with their Medication Guide (Pharmacist). The Nurse (Case Manager) may have 8-12 contacts with the member; in addition to various CityLife Neighborhood Clinic community & health events. And, the Administrative Assistant will also be in communication with the member regarding referrals, refills, etc. Working as a unified team, the care team is responsible for a panel of complex members.

Care Plans

Each member in the complex & chronic care program has a customized, detailed care plan. To create the member's care plan, the complex & chronic care team coordinates assessments, discusses findings & options with the member, & documents the plan. In co-creating the plan, the member identifies his or her own health goals & milestones for tracking progress. The care plan is created within the context of a member's life & their chronic condition(s). This helps ensure that the member understands his or her health conditions & allows the member to be an active manager of his or her health. The care plan is a "living" document that will be adjusted based on calibration of the pace of clinical & lifestyle changes of each member.

The care plan is also individualized based on the level of support needed based on the expressed & assessed needs of the member. We create a stepped care approach so that the team can use the "right"

amount of support based on the needs of the member in a unified way that treats the whole person. Lastly, the care plan provides for consistency & continuity across the care team & support resources, which is communicated & updated across all providers involved in the members care.

Care Coordination

Members who have multiple chronic conditions often need care outside of the complex & chronic care team & the member's primary care physician. It is the complex & chronic care team's job to coordinate all care outside of the CityLife Neighborhood Clinic. The nurse on the CityLife complex & chronic care team is responsible for care coordination inside of the clinic & across the continuum outside of the clinic.

This care coordination takes many forms and ranges in terms of the level of complexity & intensity. A simple example is coordinating & scheduling a mammogram for a member at a nearby imaging center. Always closing the loop on care delivered outside of CityLife's clinic, the complex & chronic care team ensures the test results are received & communicated to the member & his or her primary care physician. At the more complex end, for example, is coordinating care for a member who has been newly diagnosed with cancer. In this scenario, the CityLife care team will stay in close communication with the Oncologist's team so that we can support efforts to treat side effects & other impacts of cancer treatment.

CityLife's electronic health record has been customized with templates to support workflows within care coordination. A data analytics module on top of the electronic health record supports the complex & chronic care program. CityLife has joined Philadelphia's health information exchange to support real-time provider collaboration. These integrated systems enable the CityLife complex & chronic care team, the nurse in particular, to proactively address potential challenges to care plan adherence & disease prevention.

Member Engagement

We consider the member to be the most important individual on the complex & chronic care team. Our goal is to create a collaborative partnership with all of our members & their families. This partnership enables CityLife to better understand the member's health goals & to create a care plan that enables members to take personal ownership of their health & health care.

Lower Costs

- Targeted 20% medical cost reduction annually
- Access to complex & chronic care teams lowers emergency room utilization, hospital admissions & re-admissions
- Care coordination decreases duplication of services
- Members experience lowers co-payments for specialist & emergency room visits
- Enrollment improves documentation, coding accuracy & member engagement