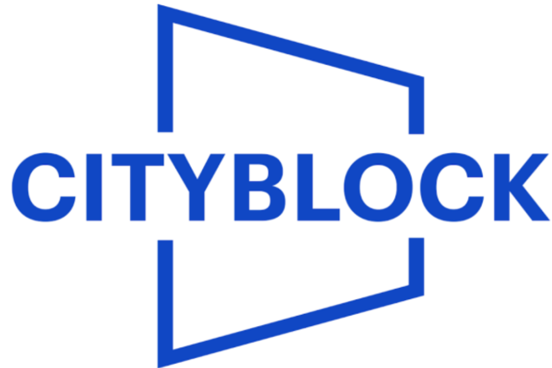
October Implementation Council

Cityblock Health, One Care Program

October 2020

Cityblock One Care Model

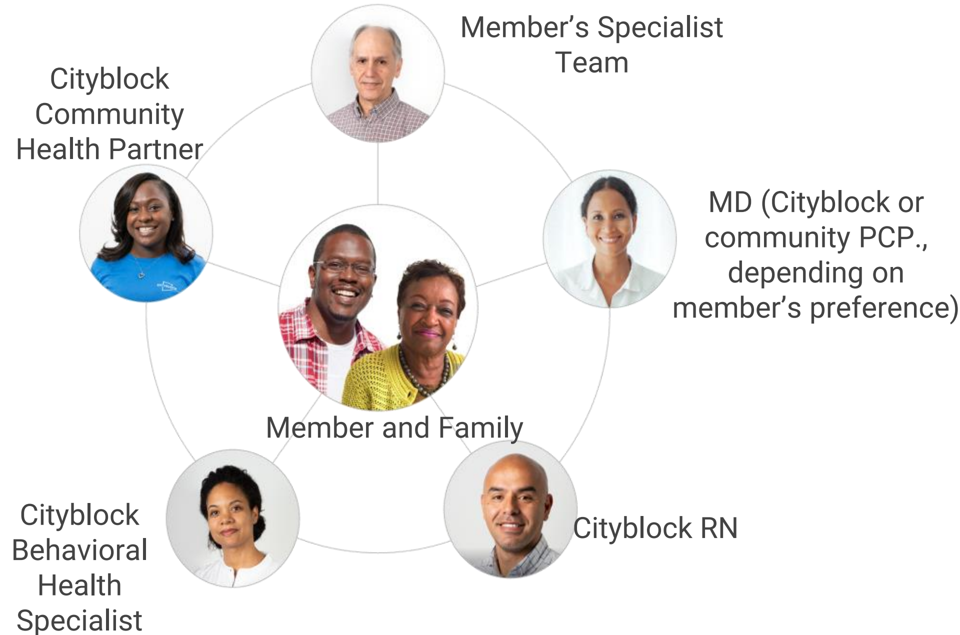
We have partnered with Tufts Health Plan to deliver complex care management and wrap-around clinical services for One Care members



- We've built a member-focused care delivery model that provides care coordination and health care services to fill gaps in our member's existing clinical care.
- Members have the same wide range of services:
    - **Care built for real life.** We partner with each member and their providers to understand what is going on in their health and daily life and create a care plan that works best for them.
    - **One team that's always there.** Every member has a multidisciplinary care team to support them in living an active and healthy life.
    - **Better care, anytime, anywhere.** We provide 24/7 clinical and social care services to ensure that members' needs are always met
- We are social workers, physicians, nurses, community members and advocates, all united by a passion to help our members accomplish their individual goals.

Our teams work with each member's chosen care team (including their family and other supports, their PCP, and others) to ensure a consistent, seamless, and responsive experience of care

CITYBLOCK



- Community Health Partners (CHP) partnering with every member to create their personalized care plan, and to integrate care with community partners
- **Care teams** — including PCPs, advanced care practitioners, RNs, psychiatrists, BHSs, and social workers -- provide direct care, wrap around existing providers, and bridge gaps in care, depending on the specific needs of each member.
- **Meeting m**embers wherever and whenever is convenient, be it in their home, at a community spot, or virtually by phone, text, or video.

One Care Example: Leaning in, many times in many ways

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Medically & psychosocially complex, undermanaged

Care model interventions

Interdisciplinary team planning (MD, Psychiatry, CHP, RN, Palliative Care Expert)

Desired outcomes

Better underlying health, reduced risk and more member control of care

BEFORE CITYBLOCK CARE

- Complicated medical history including quadriplegia, malfunctioning feeding tube, uncontrolled diabetes, bipolar disorder
- 23 day hospitalization for general health decline
- “Do Not Resuscitate” and declined to have feeding tube fixed; subsequent reversal.
- Dangerously high doses of multiple opioids

WITH CITYBLOCK CARE

- Palliative consultation at home to clarify goals of care and develop a strategy for medications
- Connection with PCP/hospitalist team to align on the overall goal of keeping out of the hospital
- Slow, safe taper of opioids given oversedation witnessed by Cityblock care team
- Ongoing collaboration with PCP/VNA to reduce splitting
- Plan for monitoring of feeding tube to ensure no future malfunctions.

Our Community Health Partners (CHPs) are at the forefront of our care teams

- Build and nurture respectful & trusting relationships
- Enable culturally fluent, linguistically appropriate, accountable care
- Partner with members to build and work toward a care plan that works for them
- Advocate for the member, and support them in their efforts, smoothing out the bumps along their care journey
- Our CHPs are trained in behavioral coaching, chronic disease management, health education, and interdisciplinary clinical communication.

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Serious mental illness and substance use disorder: Integrated treatment as a critical component of our care model

Our in-house team of psychiatrists and behavioral health specialists seamlessly integrate with our PCPs, NPs, and CHPs, allowing for high-quality treatment of SMI and SUD, including physical comorbidities. We identify need early, and intervene when members are ready.

Intentional and proactive engagement driven by analytics

We achieve upwards of 70% engagement in complex populations, earning deep trusting relationships.

Whole population monitoring that meets members where they are

Not all members with SMI or SUD are ready to engage in treatment.

Our model includes a monitoring system that engages the member when they are ready.

High-quality treatment integrated with physical health

We deliver exceptional outpatient SMI and SUD care through counseling, group therapy, MAT, and social care.

By delivering physical and behavioral health care under the same roof, we maximize quality of care.

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COVID Response

Overview of COVID Screening Findings (Weekly or Monthly survey for all members)

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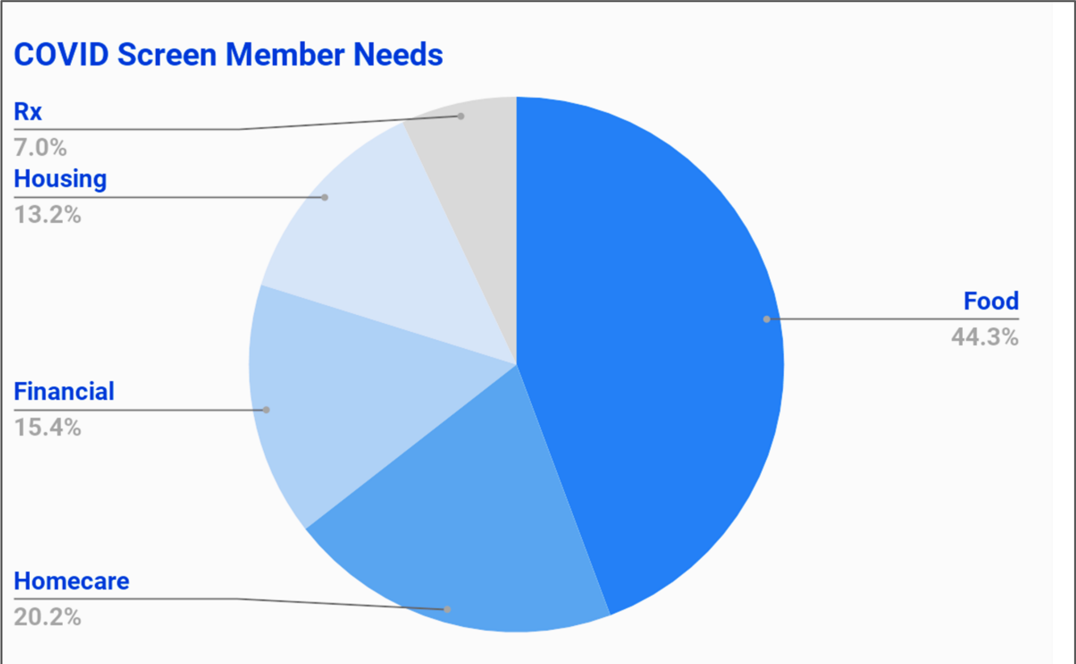
Area	Common Activities
Food	CHP educates member on available food resources via telephonic/video visit
	CHP arranges transportation to grocery store/food pantry or delivers emergency meals* via telephonic/video visit
	CHP assist in completing application for food benefits (SNAP) via telephonic/video visit
Home care	CHP assess reason for termination, coordinates with LTSC to identify options and completes necessary applications via telephonic/video visit
Financial	CHP identifies available resources and assist member with application process via telephonic/video visit
Housing	CHP assists member to complete applications/housing search, and occasionally provide temporary housing



Specialized Resources	CHP assesses member for needs specific to their unique conditions: Ostomy supplies, wound care supplies, Syringes, med access, etc...

Community Rapid Response member scenario:

1

CONTACT

Member contacts Cityblock with a medical, behavioral or social concern

2

ESCALATION

The issue gets escalated to a Cityblock provider via the member's care team

3

VIRTUAL VISIT

The provider conducts a virtual visit with the member

4

CRR IS ACTIVATED

Where the issue is acute and cannot be resolved virtually, provider activates the Community Rapid Response team

5

CRR ARRIVES

CRR paramedics arrive to the member's home within 3 hours

6

ER DOC VIDEO CALL

The paramedics set up a video call with CRR's emergency doc who, together with the member and the medics, creates a treatment plan for the medics to implement

7

CLOSING THE LOOP

After the visit, medics close the loop with the member's PCP and care team

CRR member case study:

LINDA
High risk

CASE STUDY

- Linda, a high-risk member calls Cityblock 24/7 on-call provider with high fevers, cough, lethargy and loss of smell

Community Rapid Response paramedics arrive at Linda's home in <90 mins.

Evaluate Linda with real-time video consultation with Board Certified Emergency Medicine Physician

Administer IV fluids and initiate antibiotic treatment in the home for presumed COVID pneumonia

Provide Linda with oxygen concentrator, home pulse oximeter and spirometer

OUTCOMES:

Linda remained home, per her wishes

Symptoms improved gradually, and has now fully recovered without ED or hospitalization

Thank You

- What are we missing? How can we be more helpful?
- Are there preferred ways to continue the dialogue?

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