

Care Coordination



April 11, 2023

Collaboration between two aligned, mission-driven organizations



The relationship between Tufts Health Unify and Cityblock brings together two aligned, mission-driven organizations that **believe deeply in a social model that supports holistic member care** including access to:

- Social care and supports
- DME
- Behavioral health, including SUD supports
- Primary and other medical care

Our shared goal is to support members in the **community** or other **setting of their choice**.

Values & Principles

At Cityblock, we provide **care that's built around our Members**, wherever they are.

All Members have access to a full complement of medical, behavioral, and social care wherever and whenever they want it because **healthcare is a right and not a privilege.**

[Cityblock Values Video](#)



How does Cityblock break the mold in providing care?

Cityblock delivers Member-centered care in the modality the member prefers:

- **Dedicated care team that is an advocate for the Member:** Each Member has a dedicated care team that works with community providers and specialists. There is one primary point of contact for each Member who has the ability to facilitate supports from other team members as needed and acts as an advocate for the Member's needs
- **Social support for the big things as well as the little ones:** Our care teams can assist with housing applications, access to subsidies, transportation needs, and social connections
- **Individualized Care Approach:** Our care team uses an individualized approach based on individual Member goals, priorities, and needs
- **Urgent Care and ED diversion with access to a medical provider 24/7**

Care Coordination

At Cityblock, **Care Coordination starts at the very beginning** when new Members are assessed by the Cityblock team. Care Coordination encompasses elements of advocacy and service navigation, ensuring Members are connected to the supports they need while continually aligning individual preferences and priorities with service delivery.

Using the information provided, a **Care Coordinator is suggested** based on the discipline that will **best suit the Member's needs and goals**, with other team members **orbiting the care management relationship** to provide support and expertise when needed.

The role of a Care Coordinator is consistent across roles/professions and could include:

- Nurse Care Manager
- Community Health Partner
- Behavioral Health Community Health Partner

Care Coordination is built upon core foundational principles of...

Dignity

Choice

Advocacy & Support

High quality care

How we operationalize the Care Coordination role

Recruiting and Hiring

Cityblock takes pride in hiring team members with relevant professional and lived experience. Understanding the principles of care coordination is a **mindset** and **not simply a job**:

- Required statement of interest and fit
- Panel style interviews
- Case studies
- Multilingual and culturally diverse team members

Training

Cityblock has a robust two-week company orientation followed by a 4-6 week market orientation program:

- New team members are paired with a buddy for job shadowing and to serve as a resource on an ongoing basis
- Required 1:1 meetings weekly with their direct manager
- Comprehensive competency checklist exists for all Member-facing roles
- Ongoing monthly and quarterly trainings

Resources

Care Coordinators have a plethora of resources available to them, including:

- A dedicated intranet of all Cityblock Massachusetts documentation, including workflows, policies, procedures and reference materials
- Access to our internal learning platform, Cityblock University, which houses all company training modules and can be accessed at any time as well as assigned to a team member

Care Team / Care Coordinator: Process and Profile

Assessment and Care Team Assignment

Members are assessed by a nurse initially and at minimum annually thereafter. The assessment process is meant to be **open-ended and conversational**, allowing for the beginning of a trusting relationship to be established and providing the nurse with relevant information of the Member's goals, priorities, and needs **in their own words**.

Based on the assessment, a primary care team member is suggested to be the Member's Care Coordinator **based on the primary area of identified need** with member input and at the member's discretion.

Care Team Profile

Cityblock prides itself on having a **diverse representation** of team members to support modeling in the population we serve. We take great care in sourcing, recruiting, and hiring team members from the communities we serve and with lived experience similar to our Members.

Examples of team member profiles:

- Living with disabilities
- Acting as primary caregivers for loved ones
- Past recipients of public benefits, or those who have supported loved ones in connecting to needed benefits
- Multicultural and multilingual including Spanish, Creole, Vietnamese and various African dialects
- Experienced in navigating behavioral health and SUD systems

Care Team / Care Coordinator: Training

Required and Optional Training Courses

Cityblock supports and encourages a model of **continual learning**.

We approach training efforts in a variety of ways, including annual mandatory and optional trainings in:

- Diversity, Equity & Inclusion
- Trauma Informed Care
- Person-Centered Care
- Peer Supports
- BH/SUD approaches including motivational interviewing and harm reduction

Formal and Informal Learning Forums

Cityblock provides space for **sharing common knowledge and expertise** among our team members both formally and informally, including topics such as:

- Navigating Section 8 and public housing
- Food security
- LTSS supports
- The PCA program
- Peer Recovery and group recovery models
- Cultural competency

Professional Development

Cityblock gives members of the care team **three days off per year for professional development** as well as a **stipend** to enroll in trainings or courses to strive for professional improvement!

At Cityblock, we embrace a process of continuous improvement while celebrating our successes

Member Feedback Surveys

After every scheduled team member encounter, Members are sent a survey to **rate their experience and give feedback** around their interaction with the Cityblock team. Surveys are reviewed daily and contribute toward our overall Net Promoter Score (NPS). Cityblock sets a high goal for overall NPS rating, high above typical industry standard.

Positive feedback is shared with the team in the form of **shout-outs and accolades**, and constructive feedback is followed up on within 2 business days with the goal of determining **how the Member could be better served**.

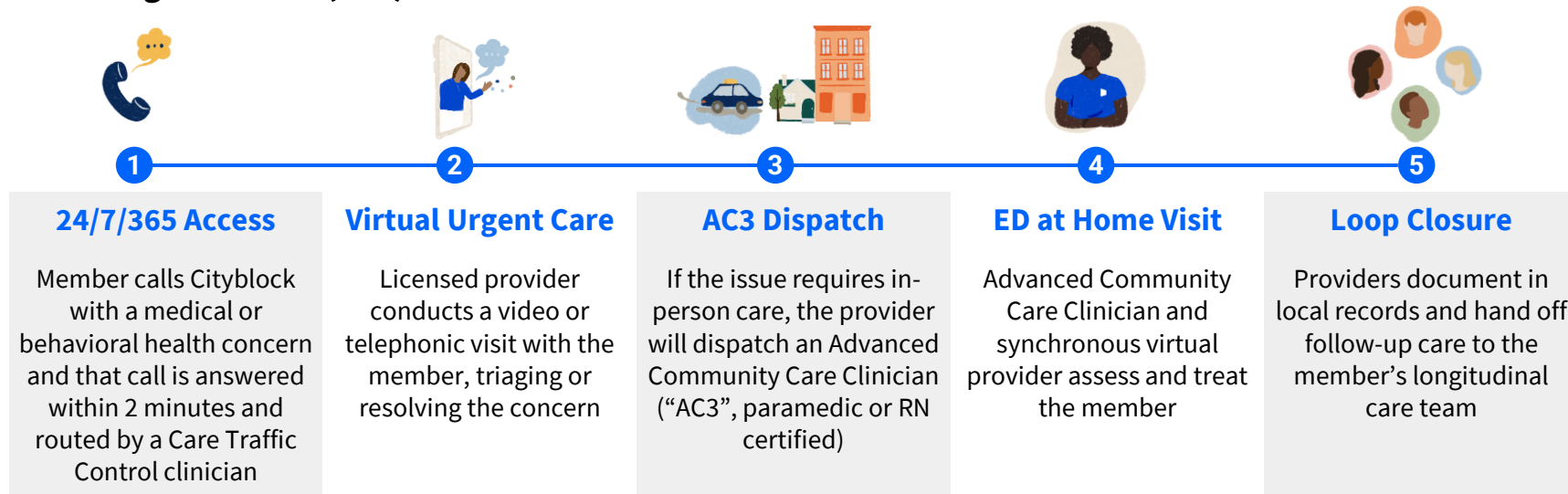
Unify Consumer Advisory Council

Cityblock co-facilitates the quarterly Unify Consumer Advisory Council, supporting participating Members in accessing the meeting, taking questions and feedback for follow up, and supporting the overall meeting agenda and content.

With recent expansion into Essex county in January and Barnstable in April, this is a **great opportunity to gather feedback from Members** across Unify's complete service area.

Cityblock has scaled a robust Mobile Integrated Care program to meet members where they are and conduct community visits

Mobile Integrated Care (MIC) Services:



The MIC program is **particularly welcome and effective** among members with the **most complex needs**, members who are **in recovery** from recent procedures or medical conditions, as well as those who are **homebound and socially isolated**.

As we move forward, we look to continue our momentum in key areas

- **Ongoing ability to provide community and virtual care modalities** based on member preference
- **Approaching hard to engage Members**
 - Alongside robust programs to try to reach these Members, we want to increase our connection rate in order to maximize impact in these individuals
 - Goals include building community partnerships to help reach these members, especially Members with substance use / behavioral health histories
- **Continue to build out our Mobile Integrated Care/in-home services**
- **Continued enhancements and culture of continuous improvement**, leveraging Member feedback and NPS results to drive efforts towards providing optimal Member experience

Member Story

Lisette:

Lisette is a 59 year old woman living in the Worcester area with complex medical and mental health comorbidities. She has a history of significant chronic pain requiring in-home physical therapy and other in-home services to accommodate her clinical/medical needs. Working with Cityblock Health, Lisette was able to obtain needed DME, in-home P/T, and receive holistic wrap around supports.

Tragically, a fire displaced Lisette in the fall of 2022. Her services were put on hold while she sought temporary housing supports which created anxiety about interruptions in other forms of care such as medication access in addition to her basic needs for food and shelter. Cityblock supported Lisette in connecting with a friend she could stay with while longer term arrangements were made, but shortly after Lisette was diagnosed with Covid and had a brief hospital stay for medical complications.

Prior to discharge from the hospital, Cityblock supported Lisette staying in a hotel until she was able to return to her friend's home and coordinated transportation, food, and in-hotel MIC visits to ensure a safe post-discharge recovery period. Cityblock also provided mental health bridge supports while Lisette connected to a community counselor, and assisted her in identifying suitable long-term housing.

In this transition period, Lisette's Cityblock care team provided her resources for food, home items, and ensured she remained connected to her community providers to maintain her mental and physical health.

Today, Lisette is doing well! She attends a day program, is connected to LTSS services, and sees her PCP and counselor regularly. Cityblock supports her transportation needs, collaborates with her LTSC, provides routine monitoring of her pain levels and other medical vitals, provides appointment reminders, and checks in on her connection to peer recovery supports.



Thank you!