October Implementation Council: Care Coordination Discussion

TUFTS Health Plan | cityblock

October 2023

Agenda for Today's Discussion

1. Approach to Care Coordination (2 minute)
2. Types of Visits (2 minute)
3. Care Coordinator Turnover, Current Vacancies and Team by Role (3 minute)
4. Staff Residence (2 minute)
5. Care Coordinator and Clinical Staff Collaboration (3 minutes)
6. Balancing Care Coordinator Requirements (2 minutes)
7. Member Story (time-permitting)

Approach to 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 Cityblock has on each member, 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**

Types of Visits

Presently, 33% of all Member visits are conducted face-to-face. This includes:

- Advanced practitioner/provider visits.
- Care coordinator or care team visits.
- BHS visits.
- Nursing and Assessment visits.

Cityblock's approach to assessment visits:

- RN-led to support individualizing member care plans connected to an interdisciplinary team.
- 22% of assessments are conducted face-to-face.
  - All members are offered in-person assessments and assessments are always completed in alignment with members' communication preference.
- We also use a variety of methods to continue to communicate with members, including telephonically and by text and email (with the member's consent).

Cityblock Massachusetts Team Attrition and Vacancy Rates

Market-Wide Attrition

- Trailing Twelve Month Overall Attrition: 19.6%
- Trailing Twelve Month Voluntary Attrition: 16.77%

Staff Cycling Data:

- YTD Hires: 29
- YTD Terminations (voluntary/involuntary): 20
- YTD Promotions: 11

Vacancy: Cityblock is growing! We currently have roles open to support care of new membership for member-facing roles as well as operational and administrative supports.

**Market wide data as of 7/31/2023*

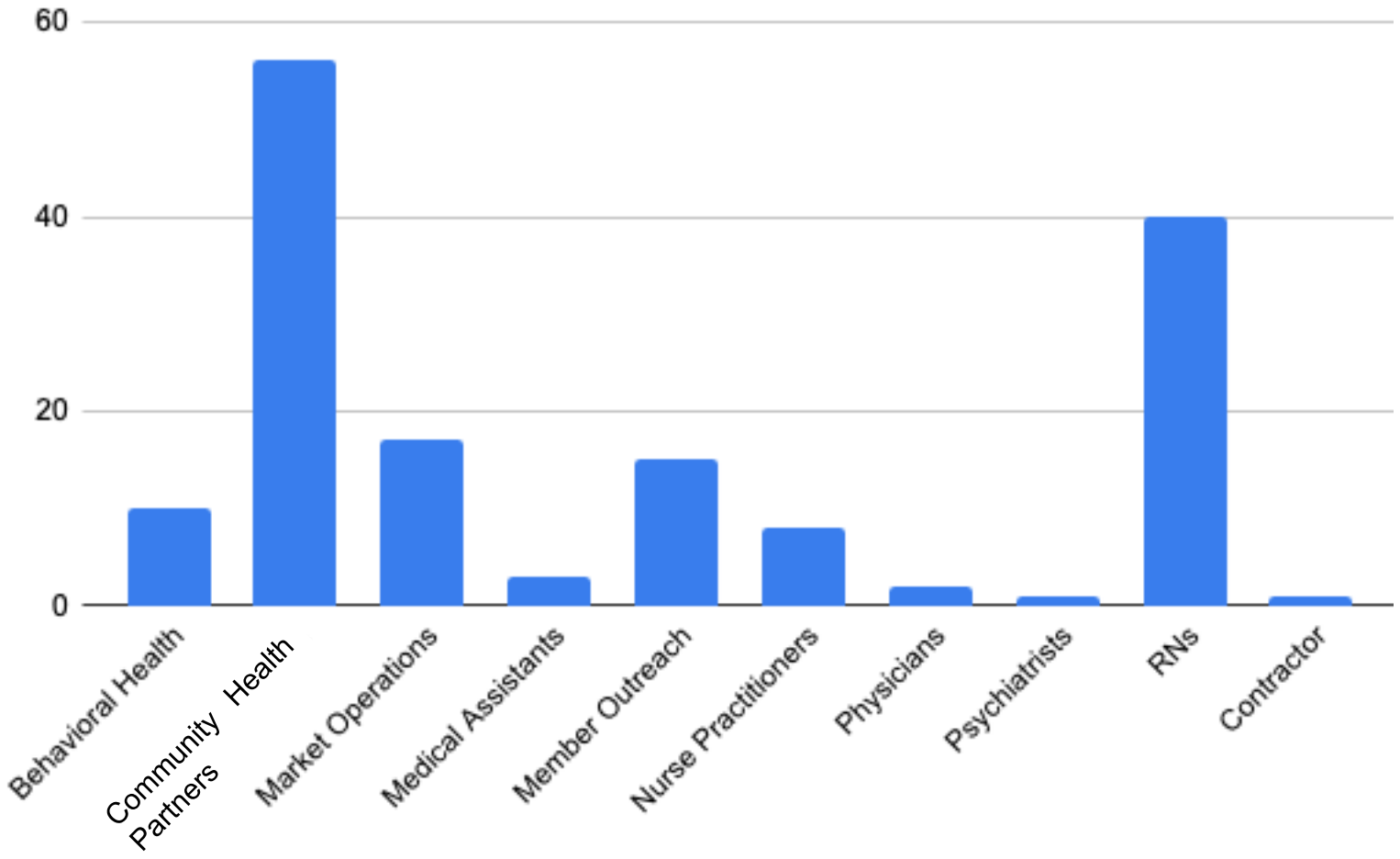
Cityblock Massachusetts Retention Strategies

Cityblock promotes retention of our staff in several ways, including:

- Compensated professional development days (up to 3 per year).
- Annual stipend for professional development courses and classes.
- Access to robust in-house training repository on a variety of topics including access to Linked-In learning resources.
- Consistent supervisory access, including weekly 1:1 meetings between managers and their staff.
- Establishment of clear career pathways.

Cityblock Massachusetts Team By Role

42% of care coordinator staff are nurses while 58% are non-nurses. Care coordinators are supported by a team of peers and clinical staff.



- 37% of all Cityblock staff are Community Health Partners, 26% are Nurses and 7% are Behavioral Health Specialists
- Behavioral health non-nursing staff often have different clinical licensure (e.g. LCSW).
- Outside of care coordination, Cityblock RNs may perform:
  - Resource consultation
  - Follow-up after an emergency department or inpatient visit

Cityblock Massachusetts Team In and Out of State Demographics

- 100% of care coordinator staff live in Massachusetts.
- 87.6% of Cityblock's entire Massachusetts team, including operational staff, live in the state.
- 12.4% of Cityblock's Massachusetts team live out-of-state and reside in the bordering states of Connecticut, Rhode Island, and New Hampshire. None of this staff are care coordinators.

Finding the Balance

"What is your strategy to balance the "tensions" of requirements to be a care coordinator? (For example, the person may need to be RN, be located in MA, work in person, represent diversity of community, have a natural skill set, etc.) What are the health plan strategies to balance all of these elements in this environment?"

- **Setting expectations.** Care coordinators start their roles knowing they are expected to be in-person and active in their community. Most of Cityblock staff, including those who do not work with members face-to-face, still have in-person expectations.

- **Types of challenges.**
  - Finding candidates who represent meet care coordinator requiremnts.
  - Hiring staff with care coordinator skills that can flexibility meet the needs of many different individual members.
  - Determining panel sizes based on requirements and elements of Member care and Member abrasion when care coordinators change.

- **How we mitigate challenges**.
  - Purposeful and diverse recruitment strategies;
  - Location-specific hiring, the preference for multilingual staff, and being clear in the skill sets that would support success in a role.
  - RN-led, team-based approach to care coordination with robust training, development and internal promotion.

Care Team / Care Coordinator Profile

Cityblock prides itself on having **diverse representation** of team members.

We take great care in sourcing, recruiting, and hiring team members from the communities we serve and with lived experiences 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

Closing the Loop

Additionally, we would like to understand how you think through different cases so that we can understand how you approach policy design. For example, how would you address a mismatch of member needs and available care coordinator skills in a certain area?

Cityblock's process for managing member/staff mismatch is to have a supervisor or manager connect with the member to better understand the concern. This could be due to:

- Change in member needs (i.e., changing from a CHP to a RNCM or vice versa)
- Communication barriers
- Cultural or linguistic preferences
- Member grievance that cannot be resolved through manager intervention

Possible action items would include training/skill development for the care coordinator and/or supporting transfer to a different care coordinator.

MA Member Story

Care Model Interventions:

Joint visit with provider and nurse

In-person assessment with Spanish-speaking nurse

Member Background:

Rosa is a 62-year-old Hispanic female who speaks only Spanish and lives with her family in a non-government-subsidized single-family house. Rosa receives PCA services provided by her family members which include transportation to her appointments. Rosa had not engaged with CityBlock and was only utilizing the supports of her family, who also act as her PCA.

She had a great deal of difficulty “buying into” CityBlock to take advantage of our services, and a lot of communication from her team was met with a heavy sense of hesitation. Rosa was also struggling with her care in the community, and she had a lot of medical needs. She knew to call with issues pertaining to DME and would have her family reach out for her support. She would have her family call in for her due to the language barrier.

Impact:

After discussion in case conference following a hospitalization, a plan was made to have an in-person follow-up appointment with a Spanish-speaking RN to help bridge the language barrier and accommodate her cultural preferences. We were able to schedule an APV/HRA with the RN in-home to speak with family members directly about members' care and what we could do to support her support system as well as the member. Having a Spanish-speaking RN allowed for Rosa to speak directly with someone from Cityblock to address her needs rather than communicating exclusively through her family or translators.

We reviewed her medications, her problem list, any and all concerns that she had with her engagement with providers to the support that she needs in the community and from her family. Throughout the meeting the member as well as family members that supported her became friendlier and more engaged. We were able to meet the member and her family where they were at, and they felt supported and heard, leading to them being able to engage with CityBlock services and staff.

Thank you!

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