Community Care Teams (CCT's) and Related Care Coordination for Connecticut's Vulnerable Populations

Categories : Health Care Payment Assistance/Health Insurance, Health Issues, Mental Health Care, Substance Abuse

With health care reform at the federal level focused on the efficient utilization of health care services and on costs, hospital Emergency Departments (EDs), and their overuse by individuals with chronic physical and mental health issues has been highlighted. It was found that in the United States, many visits to the Emergency Department were related to mental health and/or substance abuse and in Connecticut, this same trend was reflected.

What are Community Care Teams?

Community Care Teams are made up of local hospital staff and community service providers, including mental health and substance abuse treatment providers, community health centers, city social services, faith-based organizations, shelters, and housing agencies, among others. These providers develop a care plan to address the healthcare and social service needs of CCT clients. Hospital EDs can help identify these "frequent visitors." Referrals to CCTs are also made by other community providers. An individual must sign a Release of Information (discussed below) before s/he is presented to a CCT meeting. When someone is presented to the CCT, the CCT team then assesses the person's health and social needs and sets up a plan to connect the individual with community care, housing and support services.

Virtually all of the Community Care Teams have their local hospitals involved and partner with community-based providers. Included in this partnership are local Coordinated Access Networks (CANs) which provide services for people who are homeless and/or at risk for homelessness, and also help identify and coordinate services for these individuals.

How A Community Care Team (CCT) Works:

The interdisciplinary Community Care Teams (CCTs) meet on a regular, usually weekly, basis and develop an intensive case management plan for these complex high-risk individuals, establishing a relationship and providing direct or indirect care and referrals. These plans may include working on the following, and other identified needs:

- **Quality of Life Issues**: Working on sobriety, mental health stabilization, homelessness, lack of work, building family connections
- **Linkages to Care/Support:** Primary care physicians, psychologists, specialists, supportive and other housing, outpatient services

What are "Release of Information" (ROI) Consent Forms?

Making sure individuals and health care agencies have the proper documentation to share information is vitally important. The "Release of Information" document authorizes CCT providers to discuss and share a participant's protected health information (PHI). Without that signed release, health care providers cannot share information about a client and a client will not be served by a CCT.

Benefits of Coordinated Care for Individuals and Agencies:

Individuals enrolled and participating in Community Care Teams (CCTs) across the state have experienced

improved health outcomes, reduced homelessness, re-entry to the workforce, and an overall improved quality of life. Hospitals have seen a reduced number of Emergency Department visits by these participants and cost savings.

For additional information on Community Care Teams (CCTs):

“Connecticut BHP Supporting Health and Recovery: Building a Community Care Team: A Webinar Guidebook: http://www.ctbhp.com/providers/pdfs/CCT-Webinar-Guidebook.pdf

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SOURCES: Connecticut Behavioral Health Partnership (BHP); Connecticut Hospital Association (CHA) Mental Health Recommendations: Support Community Care Teams and Related Care Coordination Services; Middlesex County Community Care Team: Care Management for Emergency Department Super Users PowerPoint; Partnership for Strong Communities
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