Community Care Teams

There is growing recognition that the most vulnerable members of our communities are not only ill served by fragmented service systems, but that the misalignment of those systems often perpetuate and exacerbate negative health and wellbeing. These paradoxical circumstances only further marginalize people from the support they may need at the time they may need it most. Likewise, poorly coordinated services can often be a contributing factor to housing instability or becoming homeless, both significant barriers to benefitting from services, and a barrier to re-acquiring housing.

How can communities align and coordinate services that operate in differently incentivized structures towards more unified, person-centered goals? Community Care Teams (CCTs) are a particularly effective approach to serving a population for whom traditional models of service, support and care delivery has not been effective to meet their complex needs. CCTs seek to develop and implement service plans that move beyond addressing discrete urgent needs, integrating the assets of partners from multiple sectors to address the social determinants of a given person’s health and wellness.

What referral pipelines exist for CCTs? The most vulnerable members of our communities tend to have frequent contact with crisis services at very high cost but little sustained benefit. One such service is hospital Emergency Departments (ED’s) though there are certainly other logical referral sources as well, including homeless shelters, community health centers, health care for the homeless programs, community mental health centers, and more. Many hospitals are seeking options to address “frequent visitors” to their ED’s in order to improve clinical outcomes, reduce hospital readmissions, and enhance staff morale and retention. The complex underlying problems that frequent ED visitors may be experiencing are beyond the scope of acute medical care alone. For those experiencing homelessness or unstable housing, discharge options are further constrained.

WHAT IS A CCT?

- A CCT is a working group comprised of decision-making representatives from agencies and organizations that serve the most vulnerable members of their community.
- A CCT requires a key direct services representative to engage, navigate and support potential participants, facilitating the CCT plan and serving as a liaison between systems. (This person can have various titles Health Promotion Advocate, Community Health Worker, etc.)
- A CCT is not synonymous with Medical Care Coordination. A CCT can and should include customized medical and/or behavioral treatment plans, but ideally will not serve as an “add on” to those plans. Rather, a CCT seeks to create a holistic and comprehensive plan that includes care coordination and customized treatment plans to address behavioral and/or chronic health conditions, as well as other important factors that may enable or constrain an individuals capacity to achieve their goals (e.g. housing, legal, domestic violence, children and family issues, etc.)
• CCTs are comprised of a wide range of service providers, the composition of which varies across communities. Typical members include Hospitals, Community Health Centers, Mental/Behavioral Health Services, Substance Use Services, Crisis Intervention Teams, Homeless Shelters, Transitional and Supportive Housing, Soup Kitchens, Coordinated Assessment Programs, Coordinated Health Care Teams, Re-entry and Corrections, or any organization that serves vulnerable members of a given community.

WHO DO THEY SERVE?
• CCTs typically begin by serving those members of the community who experience repeated contact with crisis or emergency services, often across multiple systems or sectors.
• CCT's create an operating infrastructure for serving community members who may not currently be the highest beneficiaries of emergency and crisis services, but may benefit from coordinated services that prevent further escalation and poor outcomes.

HOW DO THEY OPERATE?
• CCTs begin with a data driven approach to identifying highest need participants as indicated by their patterns of utilization of crisis/emergency services.
• CCTs meet face-to-face, weekly to review newly identified cases, create individualized plans of action, and to monitor progress and make any needed adjustments to active cases.
• A human services worker (Community Health Worker, Health Promotion Advocate, etc.) conducts the necessary outreach and engagement to initiate the plan. This can include active outreach or response to standing orders the next time a targeted individual presents for services.
• The CCT model helps to overcome typical barriers of communication between agencies, reduces the likelihood of client’s “bouncing” between agencies, and provides a structure for conducting more thorough follow-ups to plans created among and between agencies.

WHERE?
• A CCT can meet anywhere. Often a staging point for CCTs is Emergency Departments in local hospitals. EDs are a site where vulnerable community members may visit very frequently, and hospitals are likely to have accessible utilization data.
• In most communities the people who visit the ED most frequently are over-represented by those experiencing homelessness or unstable housing, at risk of becoming homeless (often between 15-35%). Therefore, a homeless shelter or healthcare for the homeless program can also serve as the staging point for a CCT.

WHAT ARE THE BENEFITS/OUTCOMES?
• When serving their most vulnerable and difficult and unstable clients, many agency providers who participate in CCTs were unaware of the frequency of their clients utilization of other services, or learned of them only in retrospect.
• CCTs report the significant reduction in frequency of crisis service utilization among identified individuals. For example, the CCT in Middletown, CT reported a 63% reduction in combined ED and IP hospital visits among the first 132 clients who had received the CCT intervention for at least six months.1
• CCT agencies report improved morale among staff members who come into high and frequent contact with the most vulnerable and symptomatic individuals in their community.
• Agencies involved in CCTs report that their participation pays dividends far beyond the one hour spent weekly in case conference, enhancing the efficiency and quality of their services to their respective and common clients.
• CCT agencies report that the cross-sector integration of services and resources (e.g. clinical care and housing) has been vital for addressing the complex needs, and affecting better outcomes for their most challenging clients.

WHAT ABOUT HOUSING?

• CCTs help to create an infrastructure for identifying and serving people who are unstably housed before they become homeless.
• CCTs help to engage people who are homeless and lower the threshold to providing coordinated support that is responsive to their needs and personal priorities.

WHAT IS NEEDED TO START A CCT?

• A Champion! A person within the lead organization who has the influence and enthusiasm to affect change
• A Health Promotion Advocate (or Community Health Worker, etc.). A skilled human services worker to serves as the primary point of engagement and navigation.
• Participants who are service level decision makers. The CCT must be comprised of individuals who are authorized to make decisions and take action on time sensitive interventions without unnecessary delays
• Multi-agency Release Form. Open and candid discussions about clients is essential
• Data-driven strategy for identifying and/or confirming participants. Often claims data
• A Screening Tool - should include housing status, as many hospitals have little experience screening for housing status or resources available for appropriate discharge.
• A trigger to initiate the services plan. In the ED setting the trigger can come in the form of Standing Orders written by an ED provider.
• Safe, affordable housing and the support services needed to maintain housing. Absent housing and services for those in need, the efforts of the CCT will be limited.

1 Middlesex County Community Care Team, Connecticut Coalition to End Homelessness, Annual Training Institute, May 8, 2014