EFFECTIVE COMMUNITY CARE TEAMS: STATE SNAPSHOTS

Community Care Teams (CCTs) are an integral piece of healthcare transformation and are helping to bridge gaps at the local level. Here's what you need to know about their increasingly critical role:

Defining "Community Care"

A Community Care Team is a locally-based care coordination team employed to address a patient's complex needs across providers, settings and systems of care. These teams help to integrate essential needs and community-based resources into primary care – with a goal of delivering patient-centered care that is quality-driven, cost-effective and culturally appropriate.

While their composition can vary greatly, Community Care Teams are generally connected to patient-centered medical homes to assess individuals' needs, provide multidisciplinary care and coordinate community-based support services.

Core Features of Community Care

CCTs are **multidisciplinary teams** that often include primary care physicians, nurses, pharmacists, behavioral health providers, social workers, community-based service providers and others.

CCTs **coordinate critical services** like chronic disease management, medication assistance, essential resource connections and more.

Team members routinely **connect patients with relevant community-based resources**, emphasizing face-to-face contact. CCTs often focus on transitions in care, particularly between hospital and home.

The work of CCTs often spurs **enhanced reimbursement**, predominantly through capitated or per-member/per-month rates.

Model Community Care States

Vermont Blueprint for Health

Vermont passed legislation in 2009 requiring state-regulated health insurer participation in its patient-centered medical home effort. A diverse set of stakeholders informed the creation of each of its "community health teams," from hospitals and payers to elected officials and consumers. The result was the establishment of several different care team models, including the *Support and Services at Home* (SASH) program that provides high-risk patients with skills training for safe independent living in their homes.

The SASH program collaborates with Vermont information technology leaders to connect electronic health records to the Vermont Health Information Exchange (VHIE). In turn, this led to the creation of a clinical data registry that allows for better care coordination. *Blueprint for Health* also uses a web-based Central Clinical Registry called DocuSite (provided by the state at no cost) that connects to the VHIE to function as an integrated health record in support of social and medical care coordination.

Community Care of North Carolina (CCNC)

North Carolina established a partnership between Medicaid, primary care physicians and other area providers to leverage data and expertise at the local level and inform decision-making about care team priorities statewide. *Community Care of North Carolina* uses four elements to provide better budget predictability: network formation; population management tools; case management/clinical support; and data/feedback.

Community Care also offers a statewide information and data management infrastructure called the Informatics Center, which supports care teams with tools for providing patient-centered care. One such tool is its Care Management Information System, which houses a shared patient record, health assessment and screening tools. The web-based platform includes tailored patient self-management support resources, documentation of interventions and goals, and secure messaging among care providers and teams.

Additional Community Care Resources

These are just two examples of how Community Care Teams are being deployed to build stronger connections between health systems, government bodies and communities. Download the full Overview of State Approaches report from the Center for Health Care Strategies (CHCS) and State Health Access Data Assistance Center (SHADAC) for additional case studies and insight.

Read the full article at http://bit.ly/HLchcs3316 **published by:**

CHCS Center for Health Care Strategies, Inc.

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This resource created by: Health Leads