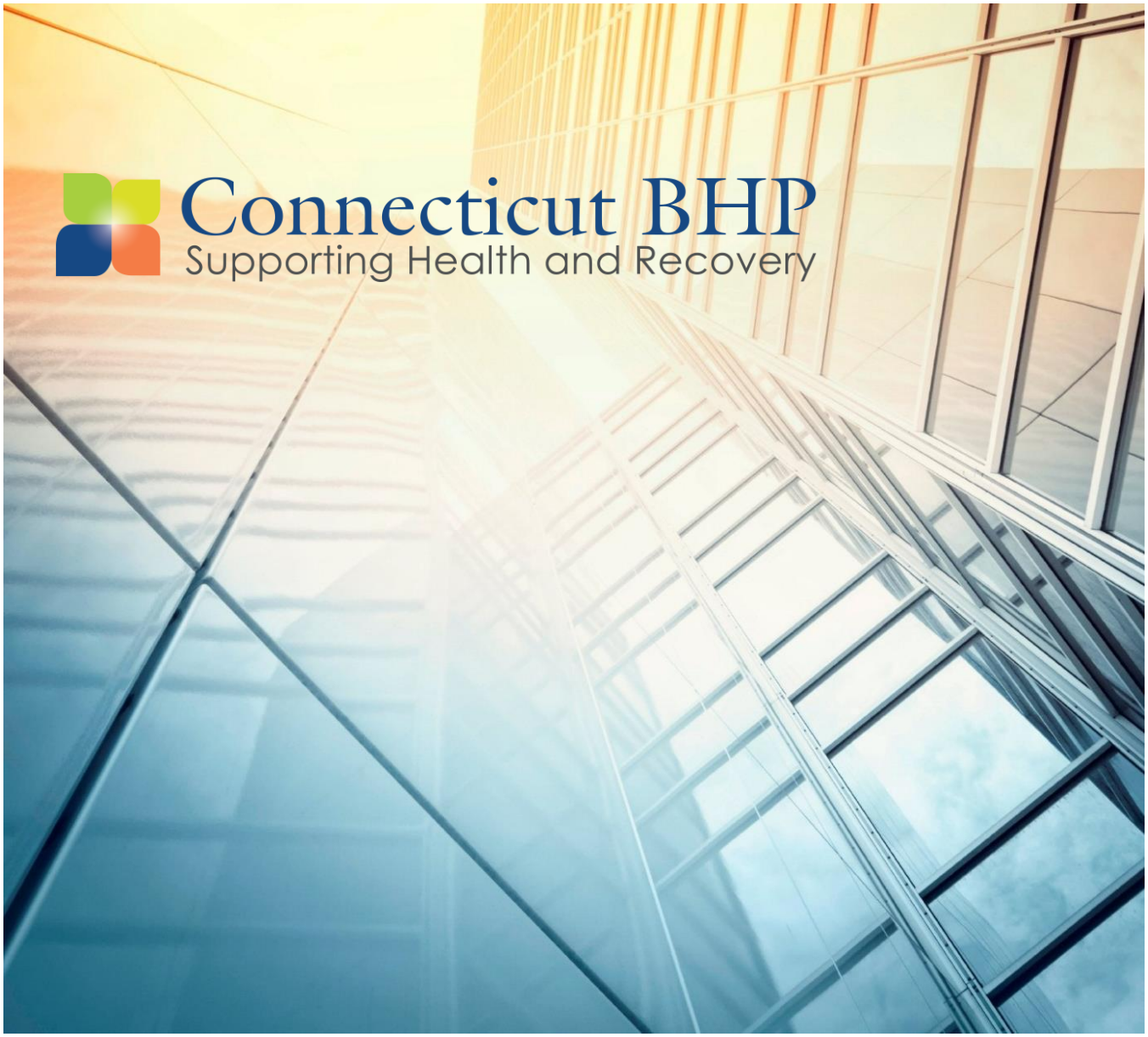

BUILDING A COMMUNITY CARE TEAM: A WEBINAR GUIDEBOOK

FALL 2015

Community Care Teams: An Approach to Better Meeting the Needs of Frequent Visitors to the ED

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Introduction to Community Care Teams

INTRODUCTION

Health care reform at the national level and the implementation of the Patient Protection and Affordable Care Act have focused attention on utilization of various health care services, particularly use of hospital Emergency Departments (EDs). Studies have shown that over the past decade the increase in ED utilization has outpaced the growth of the general population, despite a national decrease in the number of ED facilities.(1) It is estimated that overuse of the ED costs $38 billion in unnecessary spending each year.(2)

In addition, it has been found that 1 of every 8 visits to an ED in the United States is related to mental health and/or substance use.(3) These behavioral health visits are 2.5 times more likely to result in an inpatient admission than other ED visits.(4)

In Connecticut the top 10 percent of high utilizers of EDs accounted for 39,222 ED visits in 2013, visiting an ED at least 4 times in 12 months.(5) Of high utilizers of EDs with a behavioral health diagnosis, those Medicaid members who have visited an ED at least 7 times in 6 months account for 16 percent of behavioral health ED visits statewide.(6) We have identified this cohort as "Frequent Visitors." These Frequent Visitors have significantly higher 7-day readmission rates to EDs than other adults. The statewide 7-day ED readmission rate for all adults was 21 percent; for the Frequent Visitor cohort, the rate was 47 percent.(7) This population also has a high incidence of medical comorbidities, which makes care coordination more challenging.

As a result of these findings, the CT Behavioral Health Partnership (CT BHP) sought to identify an effective approach for reducing unnecessary utilization of EDs by Frequent Visitors, reducing ED readmission rates and improving connections to and coordination of care following an ED visit. We have identified the Community Care Team as implemented in Middlesex County and led by Middlesex Hospital as a promising practice in this area.

WHAT IS A COMMUNITY CARE TEAM?

A Community Care Team (CCT) is a team composed of hospital staff, local community providers, and other stakeholders organized to meet the specific needs of individuals with a behavioral health diagnosis who are frequent visitors to the ED, high users of other behavioral health care services or any other identified population. The CCT approach relies upon interagency cooperation to meet the needs of the community's most vulnerable and complex individuals. CCTs utilize systemic and client-specific approaches to improve access, engagement, client outcomes and care experience and develop individualized care plans. The CCT model discussed in this guidebook was developed in Middlesex County by Middlesex Hospital and a core group of behavioral health providers, but may be customized to meet specific regional needs. As noted above, the goals of a CCT are to reduce unnecessary utilization of EDs by Frequent Visitors, reduce ED readmission rates and improve connections to and coordination of care following an ED visit.

THE MIDDLESEX EXPERIENCE (8)

1. When did they start?

   Development began in 2010 with 4 core agencies: Middlesex Hospital, Gilead Community Services, Rushford and River Valley Services. They initially met on a monthly basis. The CCT was formalized in 2012 and expanded to 9 member agencies who met weekly. The CCT expanded again in 2015 to 13 agencies, including a soup kitchen, food pantry and homeless shelters.

2. Why did they start the CCT?

   The idea of creating a Community Care Team was first introduced in 2007 when Middlesex County initiated a ten-year plan to end homelessness. The following year Middlesex Hospital conducted a Community Health Needs Assessment and recognized that enhanced coordination of care for the mental health and substance use population was sorely needed. They identified the target population as frequent visitors of the Emergency Department (ED) who had mental health or substance use diagnoses.

3. What challenges did they encounter?

   (a) The development of a common Release of Information (ROI) was the first challenge. The ROI is a critical step in the formation of a CCT because it is necessary for the sharing and presentation of protected health information (PHI) as required by HIPAA and 42 CFR Part 2. (Please see section on Release of Information on page 9.)
   (b) Resources to organize and run the CCT.
   (c) They had difficulty following up with people and realized that homelessness was a significant barrier to care.

4. What are their lessons learned and best practices?

   Middlesex data revealed that 40% of their frequent ED visitor population did not have stable housing. They concluded that it is critically important to involve community partners who work to find housing for people who are homeless or marginally housed.

   Middlesex CCT has identified the following lessons learned:
   - The CCT target population does not get better with the traditional model of care delivery.
   - Behavioral health chronic diseases require care coordination and customized treatment plans.
   - Individualized care plans must be flexible.
   - Many providers were unaware of the frequency of ED visits. The ROI allows for communication that leads to agency-specific care plans, so that each agency has a plan for when the frequent visitor comes to their facility.

- The integration of the housing and medical communities is critical for addressing the social and medical needs of the populations that they share.

5. Data

   Based upon a Middlesex Hospital presentation from June of 2015, the Middlesex CCT has provided care planning for 208 patients since inception. Middlesex tracks age, gender, payer status, diagnoses, ED visits and housing stability. Middlesex data shows a reduction in ED visits of 1,142 visits for an estimated total savings of $1,728,211.40. The savings for Medicaid claims alone was estimated to be $586,022.40.

OTHER RECENT CCT ACTIVITY

In addition to Middlesex Hospital, many other hospitals and community groups have either developed CCTs or are in the process of doing so. In fact, there are over a dozen CCTs throughout the state. Here are some other examples of fully operational CCTs.

1. Norwalk and Danbury

   Norwalk Hospital completed a federally mandated Community Health Needs Assessment and identified that people with mental health and substance use issues were a major concern for the community as was homelessness. Based upon this assessment, in 2014 they partnered with other community service providers to form a CCT, focusing on mental health, substance use and homelessness. Norwalk's CCT differs from the Middlesex model in that the navigator takes a more active role in reaching out to individuals in the community. They also have more active municipal involvement in the CCT. The CCT meets weekly and they discuss 20 to 25 individuals at each meeting. Dr. Tait Michael of Norwalk Hospital estimated that they discussed approximately 170 cases during the first year, found housing for 20 people and reduced ED utilization by the target population by 32%.(9)

   Based upon the success of the Norwalk CCT, Danbury Hospital, which is part of the same health care system as Norwalk Hospital, established a CCT in January of 2015 utilizing Norwalk's model.

2. The following hospitals are currently at some stage of CCT development:
   i. Day Kimball Hospital
   ii. Greenwich Hospital
   iii. Griffin Hospital
   iv. Lawrence and Memorial Hospital
   v. Saint Vincent's Hospital
   vi. Stamford Hospital

THE CT BHP FREQUENT VISITOR INITIATIVE

Based upon the success of the CCT at Middlesex Hospital, the state partners of the CT Behavioral Health Partnership (DSS, DCF and DMHAS) asked Beacon to develop or enhance CCTs at 5 hospitals with the highest

numbers of Frequent Visitors. Beacon examined data from the last 6 months of 2013 to identify Frequent Visitors at each hospital and subsequently asked the following hospitals if they would like to participate in this initiative: William W. Backus Hospital, Bristol Hospital, Hartford Hospital, Saint Francis Hospital and Yale New Haven Hospital.

Each of the hospitals agreed to participate in the project and beginning in July of 2014 Beacon Regional Network Managers (RNMs) worked with hospital staff to plan for the development of new CCTs or the enhancement of existing meetings to more closely resemble the Middlesex CCT model.

1. Backus: As of July 2014, Beacon identified 4 existing collaborative community meetings in southeastern Connecticut, including the Backus Hospital case conference. Each meeting focused on a different target population. Because there were already so many existing meetings, Backus staff did not want to establish a new CCT meeting, so the Beacon RNM worked with Backus to enhance their existing monthly case conference meeting by adding key community providers to the group and broadening its scope to include ED Frequent Visitors identified by Beacon.

2. Bristol: Bristol Hospital agreed to establish a new CCT meeting and a meeting with hospital behavioral health crisis staff and several key community providers was held to introduce the concept. At the same time, with the assistance of the Beacon RNM, Bristol developed an ROI. The first CCT meeting was held on September 9, 2014 and the CCT continues to grow and mature.

3. Hartford Hospital and Saint Francis Hospital: While Beacon initially held separate meetings with the two hospitals, since so many of the Frequent Visitors presented at both hospitals, the Beacon RNM took the lead in coordinating activities of the two hospitals to form one joint CCT. Beacon also partnered with Journey Home in this endeavor, thereby bringing the shelters and housing agencies into the mix from the beginning. An organizational CCT meeting was held on September 11, 2014 with Beacon, the 2 hospitals and a broad array of community providers. A common ROI was developed and approved and the first CCT meeting was held on November 13, 2014. This effort has led to a very productive, ongoing collaboration between the two hospitals and all the members of the CCT.

4. Yale New Haven Hospital: Yale had collaborated with other local organizations in 2013 on a grant for integrated healthcare funded by the Connecticut Health Foundation, so they had already done some of the groundwork necessary for creating a CCT. An initial organizational meeting was held on July 17, 2014 and the ROI was approved shortly thereafter. The first CCT meeting was held on August 21, 2014 and since then CCT meetings have been held on a weekly basis.

Lessons learned from all of these efforts have informed the discussion of CCT development that follows.

Stages of CCT Development

DEFINE THE TARGET POPULATION AND GOALS

When planning to establish a CCT, it is necessary to identify the target population at the start of the process. Two of the organically grown CCTs (Middlesex and Norwalk) appear to have grown out of the Community Health Needs Assessment. Since this is an activity that each hospital will undertake, the needs identified as a result of the assessment should inform the decision about the target population. For the CCTs formed as part of the Beacon initiative, data analysis drove the decision to focus on ED Frequent Visitors. In any case, the target population should be defined in a way that ensures that the CCT provider members can realistically handle the case load, given available resources.

(NOTE: The federal Affordable Care Act requires non-profit and government-run hospitals to conduct a Community Health Needs Assessment (CHNA) every three years. During the course of a CHNA the hospital will identify vulnerable populations based upon the following factors: socio-economic status, health behaviors, clinical care and the physical environment. The hospital will then assess the health and quality of life of the identified populations and determine what unmet needs there may be. Finally, the hospital will develop and implement a strategy to meet those needs, which must be updated annually.)(10)

SURVEY THE LANDSCAPE: A READINESS ASSESSMENT

Once the target population has been identified an additional assessment should be done to determine what organizations or meeting structures are already in place to meet the needs of the target population. Any such pre-existing meetings or other efforts should be consulted as part of the CCT development process so that the CCT can capitalize upon those resources. For example, as part of the Beacon Frequent Visitor initiative, we partnered with the Connecticut Hospital Association and the Partnership for Strong Communities on their joint initiative to develop CCTs with a focus on people who are homeless or unstably housed. Similarly, several hospitals and other community providers in southeastern Connecticut have worked with the Campaign to End Homelessness to provide care coordination for homeless individuals. Finally, where there are two or more hospitals in geographic proximity that share a cohort of Frequent Visitors, it may be practical to jointly develop one regional CCT.

IDENTIFY CCT RESOURCES/TROUBLE-SHOOTING SYSTEM ISSUES

Whose support is needed?

1. Internal to the hospital (ED, Inpatient BH, Medical)

   Based upon our experience at the 5 hospitals participating in the Beacon initiative, we have found that in addition to the support of the behavioral health ED or crisis staff, it is critically important to have the support of the ED medical staff. Because the Frequent Visitor cohort has a high degree of medical comorbidities, support of the medical staff is necessary to ensure that all of the individual's needs are being addressed. If the ED medical staff understand the potential benefits of the CCT process, they will be more likely to encourage their staff to make appropriate referrals and consult the care plan for

individuals who have been presented at the CCT. Where ED medical staff have not been engaged, it has been much more difficult to get ROIs signed, have patients referred to the CCT and ultimately to effectively coordinate care.

2. External to the hospital

   Key community providers include providers of outpatient and substance use services, soup kitchens and homeless shelters, Local Mental Health Authorities, FQHCs and other agencies providing case management services. Local human services agencies and peer-driven services also can be important team members.

   We recommend holding an initial organizational meeting with a broad array of providers to introduce the idea of the CCT and to obtain buy-in of providers of various levels of care.

3. Personnel/resources to manage the CCT

   Experience has shown that a dedicated resource is needed to manage the CCT. Middlesex Hospital hired a Community Health Advocate with the proceeds of a CHEFA (Connecticut Health and Educational Facilities Authority) grant; Norwalk has a dedicated navigator to manage the process. For the CCTs established as part of the Beacon initiative, Beacon staff have largely fulfilled this role. We would urge hospitals interested in creating a CCT to ensure that they have dedicated staff for this purpose. Based upon our experience, we estimate that it will take approximately 20 hours per week to manage all aspects of a CCT. For simplicity, we will call the person who performs these functions the CCT navigator although the navigator functions may be shared among several providers. See "Meeting Management" on page 13 for a list of the CCT navigator functions.

   We strongly urge creativity when seeking resources to support a CCT navigator. Grants from state and municipal governments as well as other funding sources have been successfully used to fund CCT navigator positions. In the absence of grant funding, consider pooling resources to share the CCT navigator workload among the CCT member agencies.

4. What data is needed to justify the project?

   A successful CCT requires the commitment of personnel and other resources from the hospital or other entities sponsoring the CCT as well as from a broad array of community providers. All of these agencies, understandably, will want to know that their efforts are having the desired impact. It is necessary, therefore, to collect and analyze data that illustrates the impact of the CCT. The need for a system to collect, store and analyze data must be considered during the CCT planning process.

   a. Data collection

      Early on, CCT members will need to decide what data they will collect in order to demonstrate the effectiveness of the CCT. At a minimum, the data should include the number of people served, different types of needs identified and some outcome measures, such as reduction in ED

utilization from pre-CCT utilization, increased connections to care, and number of people who have achieved housing stability.

b. Data storage and analysis

The CCT navigator(s) will need a system for collecting, storing and analyzing the agreed-upon data measures as well as the capability to analyze the data to quantify the impact that the CCT has had. This will require consultation with the hospital's IT department.

Based upon our analysis of the Frequent Visitor cohort, we note the limitations of a strict cohort analysis. A recent study has shown that the majority of Frequent Visitors (61% of our sample population) do not maintain their high rate of ED utilization over time. (11)

We have been able to differentiate, however, between episodic Frequent Visitors (those who do not maintain their high rate of ED utilization) and persistent Frequent Visitors, who do persist in their frequent use of EDs. We believe further research is needed to identify the characteristics of persistent Frequent Visitors. Going forward, we would suggest that individuals who have the same characteristics as persistent Frequent Visitors would be an appropriate target population for the CCTs.

5. Tracking process for ROIs

a. Create ROI tracking process

As explained below, the CCT navigator(s) will need a system for tracking the signed ROIs. This need must be considered during the CCT planning process so that adequate resources are provided. **Based upon prior CCT experience, it is very helpful to have a flag in the hospital's electronic medical record to identify individuals with signed ROIs.** If an individual is flagged in the system, the hospital staff will know that there is a care plan for the individual and can follow the care plan and possibly divert the individual to other more appropriate services. During the CCT planning process, the hospital should attempt to have a flag created in their system for individuals with signed ROIs.

6. Maintaining care plan and ROI in the EHR

Once an individual has been presented at the CCT and a care plan has been developed, the care plan should be entered into the system so that whenever the individual presents at the hospital, the staff will be able to check the care plan and provide appropriate services or referrals. Once again, the resources for entering and maintaining the care plan and ROI in the system need to be considered during the CCT planning process.

7. Training

Based upon our experience, training for hospital staff in various departments is critical to efficient and effective functioning of a CCT. Staff must be trained about the purposes and

functions of the CCT, to look for flags in the system that identify individuals with signed ROIs, and, when they find someone who has been flagged in the system, to look for and follow the care plan for that individual. Even the best care plan is ineffective if not followed.

LOGISTICAL CONSIDERATIONS

1. How will individuals to be presented at the CCT be identified and referred?

   At the Middlesex CCT, initially individuals were identified off of the daily ED discharge report. Later, they expanded the referral process so that all CCT provider members could identify individuals to be presented at the CCT. For the CCTs created as part of the Beacon initiative, we initially focused on the list of Frequent Visitors generated by Beacon based upon claims data, but in most cases this has now been expanded so that any CCT provider member may identify an individual to be presented at the CCT.

2. How often will meetings be held?

   Meetings should be held on a regular basis so that there is opportunity for follow-up from previous meetings. Most CCTs meet weekly or every other week, and we would recommend this frequency. We have found that when working with Frequent Visitors, if meetings are held monthly, the Frequent Visitor may have presented at the ED or elsewhere several times between CCT meetings, rendering the care coordination efforts ineffective. The volume of potential CCT clients may also affect the meeting frequency.

3. Where will meetings be held?

   The CCT should have a regular meeting place so that there is no confusion about where meetings will be held.

4. Duration of the meeting

   CCT meetings typically last for 1 or 1 ½ hours. It is essential to keep to the agreed-upon timeframe so that participants' time is respected. There must also be a decision on how much time will be spent discussing each individual.

5. Who is responsible for getting ROI signed?

   In the early days of the CCTs, generally the hospital has been responsible for getting the ROI signed. At the hospitals participating in the Beacon initiative, Beacon staff has been responsible for getting them signed. The goal, however, should be that any provider participating in the CCT should be able to introduce the CCT services to the individual and have the ROI signed.

Implementation

RELEASE OF INFORMATION FORM (ROI)

A Release of Information is a legal document that authorizes any participant in a CCT to communicate with other CCT provider members about protected health information (PHI) of the individual who signed the ROI for purposes of care coordination and planning. All providers who will regularly attend the CCT must be listed on the ROI. The ROI is critical to the CCT process because it allows for the open discussion of PHI and is required for HIPAA and 42 CFR Part 2 compliance. The ROI language must be approved by the hospital's legal and compliance offices. Other organizations participating in the CCT may also need to have the ROI approved by their legal or compliance departments. For hospitals participating in the Beacon initiative, the ROI also had to be approved by the Beacon legal department. An ROI will typically be valid for either 6 or 12 months, but it may be revoked at any time.

ROI MANAGEMENT

1. Obtain signed ROI
   Regardless of who obtains the signed ROI, it must be forwarded to the CCT navigator who will keep track of it.
2. Enter ROI into system
   The CCT navigator will enter the ROI into the tracking system. Experience suggests that it is important to have a system for tracking ROIs so that it is clear who may be discussed at the CCT meeting.
3. Track ROI to ensure that it does not expire
   As previously mentioned, ROIs are typically good for 6 or 12 months. The CCT navigator must keep track of the expiration dates of the ROIs to ensure that a new ROI is signed before the old one expires.
4. Periodically update the ROI to add new providers as necessary.
   Based upon our experience, we suggest listing a broad range of service providers on the ROI so that they can all participate in the CCT meeting. We also suggest having a blank line for "Other Provider" on the ROI so that new CCT members can be added on an ad-hoc basis. If a new provider is added on the "Other Provider" line, the individual should sign his or her initials next to the name of the new provider. As the CCT meeting matures, it may be necessary to periodically update the ROI to add new CCT members. The revised ROI will need to be approved by the appropriate legal and/or compliance departments.

See Sample See sample ROI and ROI Tracking Document on the following pages.

Bristol Hospital
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BEHAVIORAL HEALTH

AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION

I hereby authorize: Community Care Team (CCT)

To discuss and/or disclose all medical information with respect to the treatment of the above-referenced patient, including information relating to diagnosis or treatment of mental illness or drug or alcohol abuse and/or confidential HIV related information.

The purpose of the discussion and/or disclosure:

To allow the Community Care Team (CCT) to discuss your behavioral health history to make treatment recommendations. CCT members include the following:

- ☐ ABH (Advanced Behavioral Health)
- ☐ Bristol Hospital Behavioral Health Department
- ☐ CMHA (Community Mental Health Affiliates/Liberty)
- ☐ CTBHP (CT Behavioral Health Partnership/Value Options)
- ☐ DMHAS (Department Mental Health and Addiction Services)
- ☐ MCCA (Midwest CT Council of Alcoholism)
- ☐ St. Vincent DePaul Emergency Shelter
- ☐ Wheeler Clinic (Adult Services/Adult Community response team CRT)
- ☐ Other:

The description of the information to be discussed or disclosed:

Any and all information related to treatment received at Bristol Hospital and The Counseling Center.

I understand that Bristol Hospital will not condition treatment, payment, enrollment or eligibility for benefits based on my signing this Authorization. I acknowledge that I am signing this Authorization freely, and no one has coerced or pressure me to sign the Authorization.

I understand that I may revoke this Authorization at any time by providing written notice to Bristol Hospital. I understand that I may not be able to revoke this Authorization if Bristol Hospital has taken action in reliance on the Authorization, or if the Authorization was obtained as a condition of obtaining insurance coverage.

BHAVAUTH

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SAMPLE

BRISTOL HOSPITAL
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BEHAVIORAL HEALTH

AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION

I understand that the Protected Health Information disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by the Federal Privacy Regulations.

I also understand that if the Protected Health Information that is disclosed under the Authorization is confidential HIV/AIDS related information or alcohol or drug abuse related information, the recipient may not re-disclose that information under Connecticut State Law.

Unless otherwise revoked, this Authorization will expire on the following date, event or condition:

_____

If I fail to specify an expiration date, event or condition, this Authorization will expire in **six months.**

_____

Signature of Patient or Patient Representative Signing Authorization on behalf of patient Date/Time

Psychiatric Records and Communications

In the event that information released is governed by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

"The confidentiality of this record is required under chapter 899 of Connecticut General Statutes. This material shall not be transmitted to anyone without the written consent or other authorization as provided in the aforementioned statutes." (§ 52-146i)

Drugs and Alcohol Abuse Records

In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:

"This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate for prosecute any alcohol or drug abuse patient." (42 CFR. §2.32)

HIV Related Information

In the event that information released constitutes confidential HIV related information protected under Connecticut Law.

"This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose." Conn. Gen. Stat. 19a-585(a)

BHAVAUTH

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SAMPLE

BRISTOL HOSPITAL ROI TRACKING SHEET

NAME	DOB	MEDICAID #	DATE SIGNED	DATE DISCUSSED	DATE TO EXPIRE

SAMPLE

PRESENTATION OF CASES AT CCT

1. Identification of Individuals to be presented at CCT meeting

   CCT provider members should agree upon the criteria for presentation of individual cases at the CCT. Criteria may include individuals with behavioral health diagnoses and/or individuals with frequent ED utilization who have not responded well to a traditional approach and are likely to have improved outcomes as a result of enhanced care coordination. CCT provider members will identify such individuals with signed, valid ROIs to be presented at a CCT meeting and will notify the CCT navigator. The provider member that identifies the individual will take the lead in presenting the case.

2. Prepare cases for presentation at CCT meeting

   All CCT provider members should research their agency's involvement with the individuals on the list to be presented at the CCT and come to the meeting prepared to discuss their history of working with the individual, including their assessment of the individual's strengths, challenges and needs as well as any input from the individual about goals and care preferences.

3. Present case at CCT meeting

   The provider who identified the individual will present the individual's case at the CCT meeting. The presentation will typically include the following: insurance status; previous treatment history; diagnosis; medication history; presenting need; and other needs to be addressed including housing and transportation. Other CCT provider members may also discuss their involvement with the individual. Ideally, CCT members brainstorm to develop the best possible care management strategy and develop an individualized care plan. The care plan will typically include a follow-up by one or more of the provider members of the CCT. (See sample care plan on page 15.)

4. Description of Intervention
   The CCT provider member who has been identified as the lead will attempt to contact the individual to communicate the care plan and seek feedback. Alternatively, any provider who has recently seen the individual may attempt to contact the individual.

MEETING MANAGEMENT

There are many administrative functions involved in managing and facilitating the CCT. These tasks are critical to having an effective and efficient CCT. These tasks may be handled by a navigator or they may be shared by two or three of the provider members of the CCT to alleviate the administrative burden.

1. Maintain a list of the CCT provider members to be invited to meetings with names, agency name, street address, phone number and email address.
2. Schedule meetings and book meeting room.
3. Send invitations and agendas to all CCT provider members.
4. Compile a list of all individuals who will be presented at the meeting and send the list, via encrypted email to ensure HIPAA and 42 CFR Part 2 compliance, to all CCT provider members several days before the meeting, so that they can research individual histories and psycho-social backgrounds prior to the CCT meetings and will be prepared to address the individual's needs.
5. Prepare and maintain CCT sign-in sheet.
6. Facilitate CCT meeting
   a. Facilitating the meeting involves calling the meeting to order, circulating the sign-in sheet, announcing the agenda items, ensuring that the discussion progresses appropriately, taking meeting notes or designating someone else to take meeting notes and starting and ending the meeting on time.
7. Record the care plan and enter it into the EHR.
8. Either during the interim between CCT meetings or at the next CCT meeting, the CCT navigator will follow up with providers who were tasked with next steps as part of the care plan.
9. Send out meeting notes as soon after the CCT meeting as possible
   a. The navigator will send out the meeting notes, via encrypted email to ensure confidentiality and privacy, shortly after the meeting so that all participants have a record of the discussion and planned next steps.

IMPLEMENTATION

OTHER NAVIGATOR FUNCTIONS

1. To ensure that provider participation in the CCT remains strong, CCT provider member attendance should be monitored those whose attendance is inconsistent should be contacted to re-engage them in the process.
2. During the course of the CCT meetings it is important to identify and document systemic and local barriers to care and bring them to the attention of the CCT provider members on a weekly basis. Any suggestions that are generated to address the barriers similarly should be documented.

EVALUATION OF THE WORK OF THE CCT

As noted above, we suggest collecting and analyzing data that illustrates the impact of the CCT. This may include demographic information, diagnostic information and outcomes such as reduction in ED utilization from pre-CCT utilization, increased connections to care, and number of people who have achieved housing stability. Since the work of the CCT is incremental, we do not suggest measuring outcome data until the CCT has been operational for at least one full year.

IMPLEMENTATION

SAMPLE CARE PLAN

MEMBER'S CCT CARE PLAN

(Name of CCT)

Date of CCT Meeting _____

Name/DOB of Individual	Referral Source/Date	Discussion (Needs/Goals/Desires)	Plan/Recommendation /Outcome	Responsible Persons	Target Date
Name/DOB of person being presented	*Provider agency that referred or presented at CCT and date of initial presentation*	*Presentation and discussion of individual's stated needs & stage of change or mental status as well as supports, diagnoses, and areas of need such as housing, medical, social connectivity, basic needs, transportation, PCP connection, etc.*	*Action plan to meet needs & goals. List all providers currently involved and their role as well as record recommendations and which CCT member will assist with what part.*	*The person(s) to do follow up and who will provide update next week*	*Can be the next meeting date or if interventions are longer term, can put date of anticipated completion*
John Doe 2/2/1967	Local Community Health Center 7/5/2015	John resides in temp housing, attending AA & IOP. Amputated leg is infected because John is homeless and can't care for it properly. He is worried he will not get permanent housing as he failed to qualify before. IOP reports he has been compliant and he would like to obtain part time work.	VNA service to provide medical education. Referral to housing specialist to explore housing options. Vocation program recognized John's name and told case manager to have him call Shawn in intake.	Joan at VNA will outreach to John to schedule a visit. Steve at temp housing to refer to internal housing specialist. Jane Smith, case manager, to give John contact info for vocational program.	7/12/15

The above template contains the basic, yet critical components of a Care Plan for multiple individuals. A similar template is currently utilized by some care teams and at each meeting it gets updated. The updated plan is sent out after the meeting to all CCT provider members. Each provider member is responsible for implementing their piece of the plan. The hospital ED should upload pertinent parts of the plan into the EHR so that if the person represents to the ED they will be able to discharge with the appropriate connections.

It should be noted that care plans are frequently more comprehensive than what is presented here, covering more areas and referrals to services.

The Road Ahead

FUTURE EVOLUTION OF CCTS

As CCTs continue to mature and additional CCTs are established across the state, we continue to look for ways to increase communication and collaboration among health care providers and other community service organizations. We recommend consideration of the following ideas.

1. Opportunities for interactions/communications between CCTs

   As a result of the Beacon Frequent Visitor initiative we have learned that many Frequent Visitors use multiple EDs. Staff at any one hospital, however, may be unaware that an individual frequents multiple EDs. We, therefore, will work on facilitating communications between and among various different CCTs to better coordinate care for individuals who present at multiple EDs.

2. Use of predictive models to identify individuals who are likely to be high utilizers of care as well as those who are likely to fail to connect to care.

3. Work more closely with other community organizations to increase access to critical resources such as housing and housing supports and timely admission to detoxification facilities.

We encourage you to consult the resources listed below for more information.

ADDITIONAL RESOURCES

- Norwalk Hospital Community Relations Weblog Video interview on the Greater Norwalk Community Care Team with Dr. Katherine Michael retrieved from http://norwalkhospital.org/about-us/community-relations/

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- Middlesex Hospital Website pdf "Middlesex Community Care Team Facts At-A-Glance May 2015. http://cceh.org/wp-content/uploads/2015/06/Middlesex-County-CCT-Fact-Sheet-5_13_15.pdf

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5. High Risk Populations: Frequent Behavioral Health ED Visitors" June 19 Complex Care Committee Presentation retrieved from https://www.cga.ct.gov/med/committees/med2/2015/0619/20150619ATTACH_Complex%20Care%20Com%20BH%20ED%20Findings%20and%20Interventions%20(3).pdf

6. Adult Frequent Behavioral Health ED Visitors & Hospital Specific Measures" July 2015 CHA Presentation (to be uploaded to CTBHP.com).

7. CT Behavioral Health Partnership presentation to Complex Care Committee June 19, 2015, slides 15,17; https://www.cga.ct.gov/med/committees/med2/2015/0619/20150619ATTACH_Complex%20Care%20Com%20BH%20ED%20Findings%20and%20Interventions%20(3).pdf

8. Middlesex Community Care Team Presentation, July 8, 2015 https://www.cga.ct.gov/ph/bhpoc/related%5C20150101_2015%5C20150708/Middlesex%20County%20Community%20Care%20Team%20-%20Care%20Management%20for%20Emergency%20Department%20Super%20Users.pdf

9. Norwalk Hospital Community Relations Weblog Video interview on the Greater Norwalk Community Care Team with Dr. Kathryn Michael retrieved from http://norwalkhospital.org/about-us/community-relations/

10. For information regarding Middlesex, see Note 8; for information regarding Norwalk, see Note 9.

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