Community Care Teams (CCTs) Initiative

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August 14, 2022

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Community care teams (CCTs), also known as community health teams (CHTs) or care networks, are deployed to manage patients' complex illnesses throughout many providers, places, and systems of care. The major goal of the CCT is to help primary care physicians deliver high-quality, patient-focused care that also takes into account patients' cultural backgrounds and perspectives. Instead of focusing on one chronic ailment at a time, as is done in traditional disease management programs, treatment coordination teams (CCTs) coordinate care between primary care physicians and community resources while emphasizing one-on-one interaction with patients. Patients' requirements are evaluated, community-based support services are coordinated, and multidisciplinary treatment is provided through CCTs, which are typically affiliated with patient-centred medical homes (PCMH). CCTs can consist of a wide range of professionals, from primary care doctors and nurses to pharmacists, psychologists, social workers, and even those who don't work in the medical field at all, depending on the needs of the community and the state's regulations. Reduced service duplication, lower costs, and better health outcomes for high-need patients (currently, largely Medicaid participants) are the goals of care coordination across the continuum of clinical and community providers. Moreover, CCTs can be a way for smaller primary care clinics, especially those in rural regions, to provide many of the same core services as a PCMH.

There is a proliferation of many chronic diseases, which affect 75% of persons aged 65 and over, and the prevalence is growing. Complications from the condition and the high cost of treatment place a heavy load on the sufferer. Overuse of healthcare facilities and personnel leads to exhaustion for everybody involved. The treatment of chronic diseases requires a team

approach that prioritizes the needs of the individual receiving care. Patient and family participation is essential for the effective delivery of patient-centred care. The Chronic Care Model originally encouraged such interactions (CCM). Organizational care management of patients in the primary care context is at the heart of this method. If you or someone you know is feeling overwhelmed by your treatment options, this model can help you find community-based organizations that can help (Kerkhoff et al., 2020). Partnerships between the current healthcare system and community activities are made easier with the help of Community Care Teams.

Possible implications if the gap is not addressed

An essential goal of healthcare gap analysis is to reveal where and why services or processes are deficient, or "gaps," in the delivery of care. This kind of analysis is absolutely necessary in order to improve both the quality of service and the outcomes. Unmet needs in the delivery of care can lead to incorrect or delayed diagnosis, which in turn can increase the need for expensive and sometimes invasive procedures (Freeman et al., 2022). Healthcare providers must seek to identify treatment gaps and use patient involvement to fill them if they are to transition successfully to value-based compensation.

Specific Goals of Community Care Teams

One of the main purposes of CCTs is to ensure that patients with chronic conditions receive care that is both high-quality and affordable. The knowledge gap in this group can be effectively addressed with this program. High healthcare expenses and subpar care quality are just two of the negative outcomes of a lack of care information. Care coordination teams (CCTs)

aim to bridge the gap between patients and their primary care doctors by establishing a network of community resources, as opposed to the more traditional disease management programs (Haddad et al., 2021). To evaluate community-based support services, patient needs, and the necessity of multidisciplinary treatment, this effort is linked to patient-centred medical homes (PCMH). Patients benefit from the collaborative efforts of their primary care physicians, pharmacists, behavioural health care experts, nurses, non-clinical service providers, and social workers as they inform themselves about their requirements and care management.

Creating Community-Based Health Care Teams

The program was developed with the Blueprint for Health program in Vermont as a guide. In 2008, it was created as a pilot program to treat diabetes in one county in a state in the upper Midwest of the United States. The experiment ran for six months. There were several viable healthcare delivery systems in the county, each with sufficient primary care practices. A big academic medical centre was also part of the system, in addition to a community hospital medical centre. The CCT was designed to ease three initiatives: the employment of a social worker or nurse to coordinate care; the formation of partnerships between healthcare systems and other community services; and the implementation of the Wraparound strategy. Also, the program was launched to make up for the Chronic Care Model's flaws. Critical components of other models, such as enhanced clinical information systems where patients may learn more about their conditions and how to manage them, were not incorporated into this one.

Resources to Fund Community Care Teams

Financial support is crucial for CCTs to deliver on their promise. Most CCT services are paid for on a per-member-per-month (PMPM) basis. State options for establishing finance streams and enlisting Medicaid fee-for-service (FFS) and Medicaid managed care organizations (MCOs), Medicare, and private payers to provide these payments vary widely (Ibe & McNair, 2021). As well as spreading the fixed costs of running established community care or health team, having multiple payers on board expands the scope and continuity of services available to patients, even if they switch health insurance providers.

CCTs are local teams that handle chronic and complex diseases, but their funding comes from the state government and private investors. The Blueprint Integrated Pilot Program is a public-private partnership aimed at reducing the health and financial burdens associated with prevalent chronic illnesses; CCTs are a part of this program at the state level. Direct care services and chronic disease population management are two areas where private investors and government agencies can work together.

CCTs don't meet their purpose and need improvement.

The five most common challenges faced by healthcare teams are accountability, conflict resolution, decision-making- making process, progress reflection, and coaching. These difficulties exist for both clinical and administrative teams. Further, the CCTs' potential is not being fully utilized because comprehensive and long-term large-scale programs have not yet been implemented. In 2008, only two communities participated soon the pilot phase; a third

county joined in afterwards. The effort is still in the trial phase to see if it improves primary care and self-care for persons with chronic diseases through the use of quality improvement services and health information technology. In order to meet patients' requirements in the community, each pilot project employs a small group of specially trained medical professionals. The initiative must be maintained by fostering communication channels amongst key players in the field of chronic disease management in order to provide crucial data to the public.

Future of community care teams

It is becoming more and more apparent to policymakers that they must address the social and clinical issues of patients. One effective method to achieve this goal is through the use of CCTs. Many CCTs use an "episode of care" model in which a single payment covers all services for a particular intervention, but this is just one of many possible payment structures. There is a risk-sharing agreement between the providers in other CCTs. The inclusion of CCT services as a mandate in provider delivery systems (e.g., accountable care organizations) and as a provision in managed care contracts are two examples of procurement options that states can examine. Non-clinical preventive services advised by a licensed health care provider may also be covered by Medicaid in some states. All of these possibilities hold promise for expanding CCTs' ability to meet the complicated demands of Medicaid's most disadvantaged enrollees.

Conclusion

Local gaps in care delivery are being closed in part because of the efforts of Community Care Teams (CCTs). In order to meet a patient's complex requirements across providers, contexts, and systems of care, organizations often use care coordination teams at the community level. The purpose of these teams is to provide patient-centred care that is quality-driven, cost-effective, and culturally acceptable by integrating basic needs and community-based resources into primary care. Community Care Teams are a type of interdisciplinary healthcare team that assesses patients' needs, offers treatment from a variety of specialists, and coordinates community-based services.

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