Addressing Health and Social Needs with Community Health Teams (CHTs)

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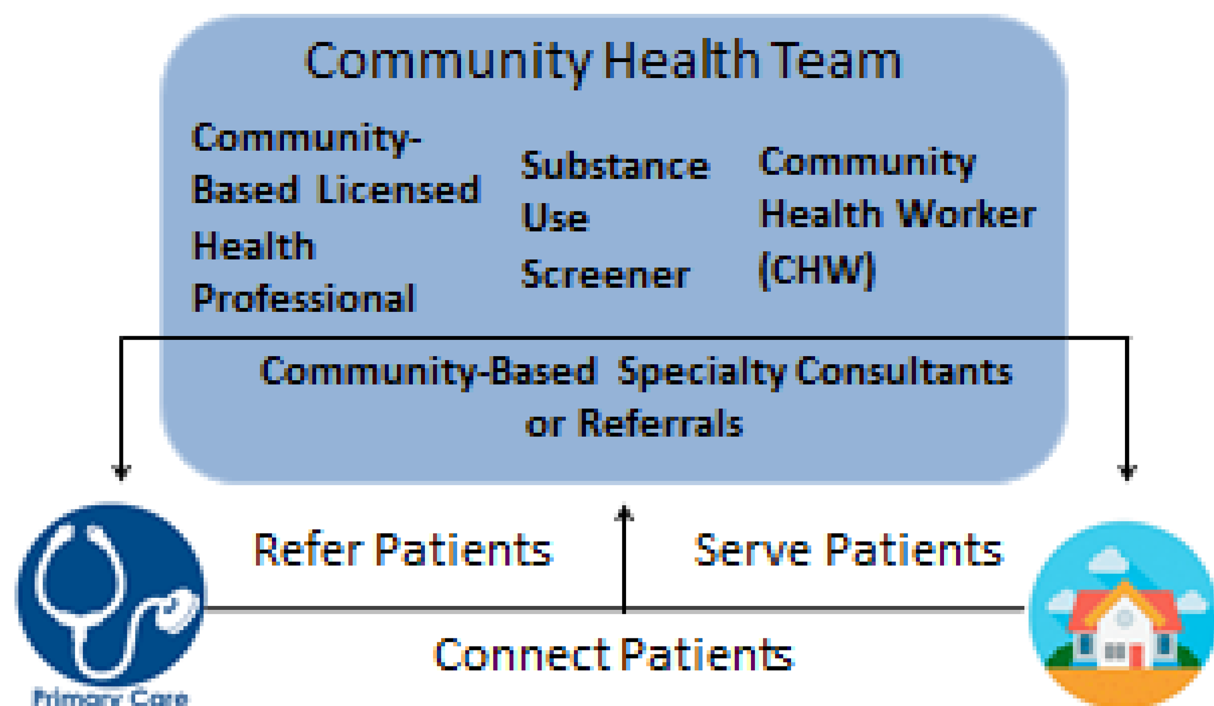
Background

CTC-RI piloted two Community Health Teams (CHTs) in 2014. South County Health and Blackstone Valley Community Health Center led the effort, working with primary care practices to outreach and co-manage the care of high risk and high need patients.

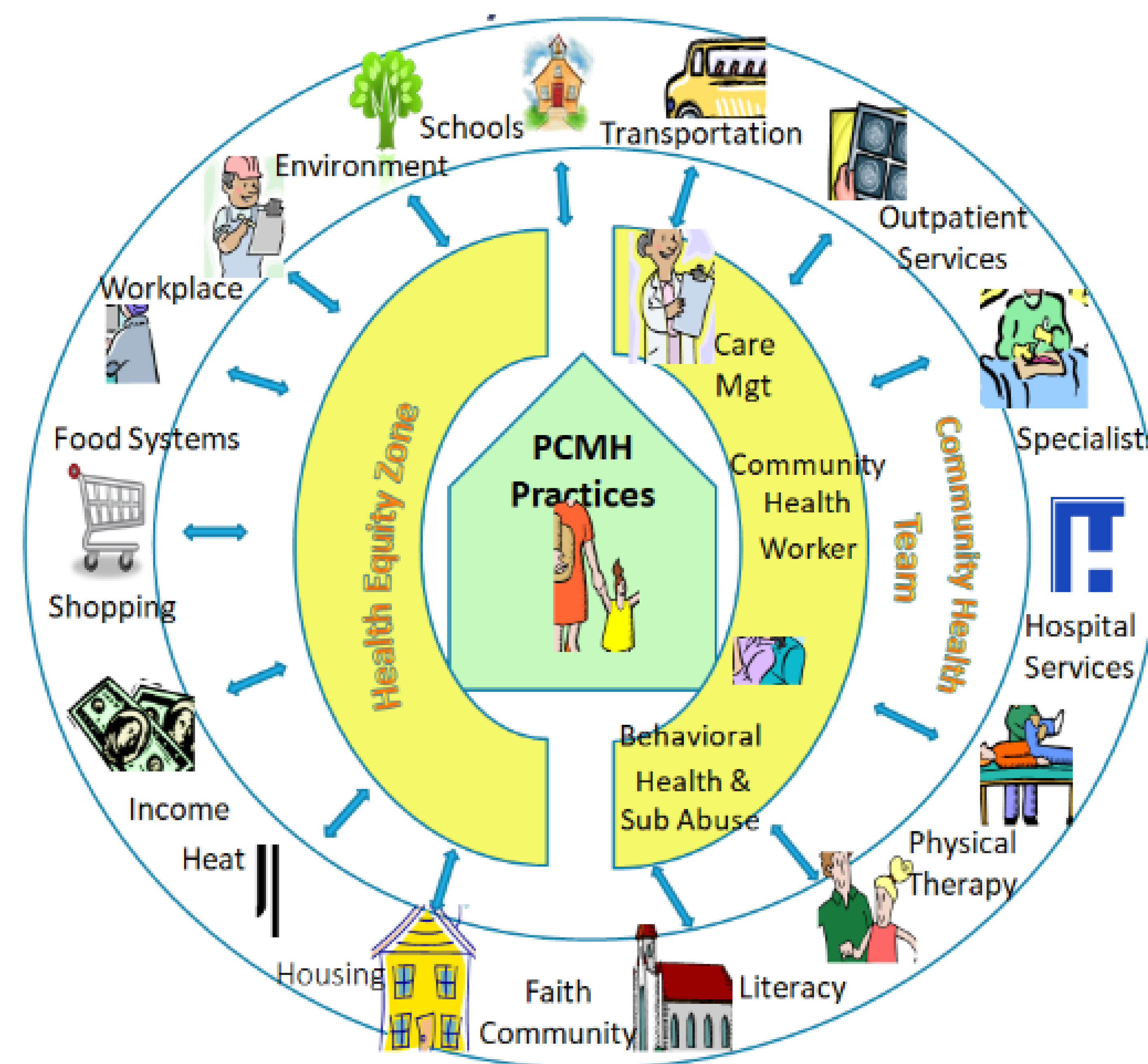
In 2015-2016, CTC-RI Board of Directors authorized a program evaluation of the CHT pilot which generated recommendations and lessons learned now guiding the RI state-wide CHT expansion.

Model

Small care teams work directly with patients and families, as extensions of primary care medical home (PCMH) teams. CHTs provide in-home, community and office engagement. CHTs work with patients to identify barriers to healthy living, provide linkages to community resources and develop plans to address long-term health needs, including behavioral health support for anxiety, depression and substance use. CHTs are based in local health systems, and are offered as part of the care continuum. Patients served are high risk/high cost, and identified by the health plans and the primary care practice team. Six teams are now working with PCMH practices across the state.



CTC-RI CHTs



CHT Data SEPTEMBER 2017-AUGUST 2018	
Total number of practices with referring relationship to CHTs	32
Total number of providers with referring relationships to CHTs	326
Total adult patients served by CHTs through Jan-July 2018	1420
Total Substance Use Screens (SBIRT) completed by CHTs	2535

Projects and Partnerships

Blackstone Valley

CHT Works with Central Falls Neighborhood Health Station

- A multidisciplinary team of healthcare, social service, and civic professionals gather regularly to coordinate care of local community residents
- Team attends to needs that are not addressed in the community, and uses its resources to create connections with other organizations to bridge gaps and meet the needs of the population of Central Falls

Providence

CHT is Co-located with and Receives Referrals from a Number of Primary Care Practices

- CHT coordinates care at Crossroads Homeless Shelter for patients who are homeless/at risk for homelessness and receiving care through PCHC Crossroads
- CHT is linchpin to care for patients between Crossroads and PCHC through regular meetings with primary care staff and Crossroads staff

South County

CHT Establishes Uber Services for Transportation using Charitable Donations

- Transportation available for patients in critical situations (i.e. bridging to community resources and health linkages)
- Rides arranged by knowledgeable CHT staff

Woonsocket

CHT Works with Homeless Support Group

- Increased PCP engagement
- Decreased ED use
- Linkage to public assistance

Newport

CHT Works Closely with EBCAP Nurse Care Managers

- NCMs collaborate with CHWs to manage high risk patients, including joint home-visits

Contact

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