Coordinated Care Network
A consortium of committed providers dedicated to connecting individuals to local services and resources to support wellness, independence, and recovery.

WHO IS CCN?

BAMSI
Bamsi.org

Bay State Community Services
Baystatecs.org

Child & Family Services
Child-familyservices.org

Duffy Health Canter
Duffyhealthcenter.org

High Point
Hptc.org

Steppingstone
Steppingstoneinc.org

Brockton Neighborhood Health Center
Bnhc.org

Community Health Center of Cape Cod
Chcofcapecod.org

CCN Central Intake
1-857-919-4721
FAX: 833-460-3671
ccnmass.org

CCN coordinates with enrollees' health care providers to facilitate engagement and works with health plans to coordinate services.

CCN is a consortium of provider agencies with more than 200 locations throughout Southeastern MA.
What is the Behavioral Health Community Partner program?

A Behavioral Health Community Partner (BH CP) program is intended to provide care management and coordination to qualifying MassHealth members. The Coordinated Care Network (CCN) is a BH CP program and can provide support to certain members with significant behavioral health needs, including serious mental illness and substance use disorders.

CCN coordinates care with the enrollee’s behavioral health and medical providers to ensure everyone has the most up-to-date information on the persons served including medical and behavioral health diagnosis, as well as medication changes. CCN can also advocate with the health insurance provider.

How can CCN help enrollees?

A care team, which includes clinical care managers, care coordinators and nurses, will assist with organizing medical and behavioral health appointments, including assistance with scheduling of routine and physician-suggested treatment, in addition to assisting with coordination of transportation if needed.

Work with insurers to assure no interruptions in coverage and/or assist in correcting insurance issues that may occur.

Make referrals for substance use disorder services, specialty programs, in-home supports such as a visiting nurse for medication management or wound care; home health aides, homemaking services, personal care assistance, and transportation resources, including Provider Request for Transportation form (PT-1).

FAQ

What do services look like?

You will be assigned a Care Team (care coordinator, clinical care manager, and a nurse), who will work with you to coordinate services across a continuum of care to ensure that you are at the right place for the right services at the right time. You will be in contact most frequently with your care coordinator to work towards your goals.

How do you know what services I need?

Your care coordinator will complete a Comprehensive Assessment and Person-Centered Treatment Plan with you that takes into consideration physical/behavioral health needs, long-term support services, and social factors that leverage your existing relationships and community behavioral health needs.

Will care coordination replace my other services?

No. Care coordination will complement your other services and help you achieve treatment goals.

BH CP Supports Include:

- Outreach and Engagement
- Comprehensive Assessment and Person-centered Treatment Planning
- Care management and coordination across medical, behavioral, and long-term services and supports
- Connection to social services and community resources
- Support for transitions of care
- Medication reconciliation support
- Health and Wellness Coaching