Community Health Teams Issue Report

INTRODUCTION

This issue report demonstrates how collaborations between primary care providers and community health teams can provide improvements in public health and disease prevention in accordance with provisions from the Patient Protection and Affordable Care Act. Additionally, it demonstrates health reform implementation by presenting innovative strategies undertaken by states to link primary care practices with community health teams. Methods of analysis include highlighting the successes and challenges the states Vermont, North Carolina, and Montana have had in implementing innovative programs featuring community care teams. By utilizing innovative strategies such as integrating community health teams with primary care practices, states can benefit from improved public health, prevention and cost savings.

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) LEGISLATION

The Patient Protection and Affordable Care Act (ACA) signed on March 23, 2010 by President Obama covers a broad spectrum of reform areas in its nine objectives. They include quality, affordable health care for all Americans, the role of public programs, improving the quality and efficiency of health care, prevention of chronic disease and improving public health, the health care workforce, transparency and program integrity, improving access to innovative medical therapies, the CLASS act, revenue provisions and improving the quality and efficiency of health care. The ACA also includes provisions to reduce fraud and waste in Medicare, Medicaid and the Children’s Health Insurance Program (CHIP).

Additionally, the ACA focuses on new incentives to increase the number of primary care physicians, nurses and physician assistants, which includes funding for scholarships and loan repayments, and increased payment to rural health care providers.

Currently, states are implementing various provisions of the ACA, with additional provisions scheduled for 2014 and beyond. On Oct. 1, 2010, the Independent Payment Advisory Board presented strategies to target waste in the Medicare system, reduce cost and extend the life of the Medicare Trust Fund. On Oct. 1, 2010 the states are to offer home- and community-based services to disabled individuals through Medicaid rather than institutional care through the Community First Choice Option. Effective January 2012, physicians will have incentives to form voluntary accountable care organizations for improved coordination of patient care. The regulation of standardized billing and secure electronic health information exchange will become effective Oct. 1, 2012. By 2014, ACA implementation will lead to the establishment of state-based health insurance exchanges. All new plans, including those offered through health insurance exchanges, will have a cap on out-of-pocket expenses that beneficiaries are required to pay. The Money Follows the Person Program, which supports long-term care systems of the states, will receive an additional $2.25 billion. Medicaid will offer an improved home-and-community-based services option.

ACA AND PUBLIC HEALTH

ACA includes a $15 billion Prevention and Public Health Fund for prevention and public health programs. For fiscal year 2010, states and communities received $500 million to improve prevention and public health efforts and to enhance health care quality. For fiscal year 2011, funding was provided for community prevention, clinical prevention, behavioral health screening and integration with primary health, public health infrastructure and training, and research and tracking. The community prevention efforts include the Community Transformation Grants, anti-tobacco media campaigns, obesity prevention and fitness.
through programs such First Lady Michelle Obama’s Let’s Move! and President Obama’s Childhood Obesity Task Force. The clinical prevention area encompasses critical wellness and preventive health services, preventive benefits newly made available by the ACA, immunization services and employer involvement in wellness programs. For behavioral health screening and integration with primary care services, it invests in publicly-funded community mental health services, suicide prevention and screenings for substance use disorders. The public health infrastructure and training focus supports state, local and tribal public health infrastructure to advance health promotion and disease prevention through improved information technology, workforce training and policy development. The funds for research and tracking are intended to increase resources for guidance and evaluation of preventive services.

ACA AND COMMUNITY HEALTH TEAMS

ACA’s Title III Section 3502 includes provisions specifically for community health teams to support a patient-centered medical home[1]. Under these provisions, the Secretary of Health and Human Services provides grants to a state or to designated community-based interdisciplinary health teams to support primary care providers. The law defines primary care as, “integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community[1].” A primary care provider is defined as, “a clinician who provides integrated, accessible health care services and who is accountable for addressing a large majority of personal health care needs, including providing preventive and health promotion services for all ages, developing a sustained partnership with patients, and practicing in the context of family and community[1].” To fulfill these definitions, community health teams must incorporate prevention initiatives, patient education and care management into the delivery of health care that is integrated with community-based prevention and treatment resources.

Other parts of the ACA have provisions with community health teams’ involvement. ACA’s Section 3503 includes provisions about medication management services in treatment of chronic diseases in collaboration with community health teams. Title IX of the Public Health Service Act offers grants to implement medication management services provided by licensed pharmacists for a collaborative approach to treating individuals with chronic diseases. The medication management services are intended to provide interdisciplinary and inter-professional care to improve quality and to reduce overall costs in the treatment services. The law encourages coordination of these services through local community health teams. Section 5405 of the ACA is about the Primary Care Extension Program, which is intended to provide support to primary care providers. It has provisions to educate primary care provider about preventive medicine; health promotion; chronic disease management; mental and behavioral health services, including substance abuse prevention and treatment; and evidence-based therapies and techniques. The program includes a health extension agent, who is “any local, community-based health worker who facilitates and provides assistance to primary care practices by implementing quality improvement or system redesign, incorporating the principles of the patient-centered medical home to provide high-quality primary care and culturally and linguistically appropriate guidance to patients, and linking practices to resources.” One of the activities of primary care
extension agencies is to provide technical assistance, training and organizational support for community health teams.

COMMUNITY HEALTH TEAMS

According to the ACA, a community health team is “an interdisciplinary, interprofessional team of health care providers” and “may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians’ assistants.” According to ACA’s Section 3502, community health teams have various requirements to follow. They need to provide support services to primary care providers by establishing collaborative contractual agreements. They support the patient-centered medical home model, which includes personal physicians, or primary care providers; whole-person orientation; coordinated and integrated care; evidence-based medicine for safe and high-quality care; use of health information technology; ongoing quality improvements; expanded access to care; and payment system that values ideas of patient-centered care. They are to work with local primary care providers and existing state and community-based resources in coordinating disease prevention, management of chronic diseases, and transition between health care providers and case management. The goal of community health teams is to develop and implement care models that integrate clinical and community health promotion and preventive services for patients. Priority is given to patients with chronic diseases. The program design should incorporate health care providers, patients and caregivers.

Another significant role of community health teams is to provide necessary support for local primary care providers. The teams assist providers in coordinating and providing access to high-quality health care, preventive and health promotion services, appropriate specialty care, inpatient services and pharmacist-delivered medication management services. They also support providers in providing quality-driven, cost-effective and culturally-competent patient- and family-centered care; coordinating appropriate complementary and alternative medicine services; incorporating effective treatment planning strategies; monitoring health outcomes and use of resources; sharing information and treatment decisions; avoiding duplication of care; and providing local continuum of care services such as access to coordinated care. The community health teams also aid in collecting and reporting data for evaluation of improvements on patient outcomes. Such data may include patient experience in care and areas for improvement. The collaboration between community health teams and primary care providers also aims at developing a coordinated system of early detection of children at risk for developmental or behavioral problems through the use of health information technology and information lines to provide prompt referral.

Community health teams are integral to providing support for transitions in care and for 24-hour care management. They provide onsite visits at hospital, nursing home or other institution settings, and aid in developing discharge and medication plans to ensure that post-discharge care plans include medication management. As appropriate, plans should also consist of referrals for mental and behavioral health services and for transitional health care needs from adolescence to adulthood. Overall, the community health teams may serve as a liaison to community prevention and treatment programs. They also take part in implementing and maintaining health information technology with certified electronic health records technology. The health information
technology facilitates coordination between the community health teams and affiliated primary care practice. The ACA also presents requirements for primary care providers, in collaboration with community health teams, to provide the teams with a care plan for each patient and access to health records and meet with the teams on a regular basis to maintain well-integrated care.

**INNOVATIVE IMPLEMENTATION OF COMMUNITY HEALTH TEAMS**

- Vermont: Blueprint for Health\(^3\)

Some states implemented programs with core principles of community health teams even before provisions of ACA were decided. One notable example is the Vermont Department of Health’s Blueprint for Health program\(^3\). It was created to enhance high-quality preventive health care and for better management of chronic diseases. Under the traditional health care delivery system, physician practices lacked IT or community-based support to achieve such goals. Moreover, under the fee-for-service payment system, physician practices had few incentives to concentrate on those goals. To address these issues, Blueprint for Health gave physician practices access to insurer-funded community health teams, public health expertise and real-time information. Those participating practices received significant performance-based financial incentives. Overall, Blueprint for Health’s aim was to give physician practices the motivation, support and infrastructure needed to deliver coordinated, high-quality care within the existing work environment. Taking a true system-based approach to prevention and coordinated health care, the Vermont state legislature passed an act for creating Blueprint for Health, which would improve individual patient management and entire patient population assessment.

The first community implementation was in July 2008, and now the program is expanding statewide. It started as a pilot program in six communities targeted to improve diabetes care through focused support of physician practices. Physician practices were provided with financial incentives and training, expanded use of IT; improvement training, statewide self-management workshops, and community activity and prevention programs.

Blueprint for Health was innovative in many aspects. First, private insurers are required to participate by law. Medicare patients are covered by Vermont Department of Health, and Medicaid patients are covered by Vermont Medicaid. The community health teams provide support to participating physician practices based on local need by helping patients overcome social, economic and behavioral barriers that hinder proper management of their health. A typical community health team includes a care coordinator, who is usually a nurse, a chronic care coordinator and a behavioral health specialist. The team may also include a social worker, health educator, dietitian, nutritionist, exercise physiologist and others. A local organization such as the hospital hires the team members through insurer’s funding. Nevertheless, the community health teams visit physician practices and move within the community to interact with patients, clinicians and community-based organizations. They use IT to identify at-risk patients with ongoing management of chronic diseases and carry out structured assessments to find any barriers to their disease management and appropriate care. For example, it is possible that a patient with diabetes frequently visiting the emergency department has mental health or social issues that prevent them from adequately managing their disease. Thus, the community health teams can access behavioral health counselors or social workers who can address issues patients may have and link them to community-based resources such as...
nutrition counseling, home health care, substance abuse treatment and smoking cessation counseling. The community health teams also develop daily management and follow-up plans for patients.

Another innovative component of Blueprint for Health includes a preventive public health specialist who is based in the local Vermont Department of Health district office. The public health specialist works with existing data sources containing community risk profiles and collaborates closely with the community health teams to identify risk factors that may contribute to public health problems. Knowing these risk factors helps in developing, implementing and evaluating interventions. The Blueprint for Health model encourages the public health officials to work closely with local providers delivering care. Furthermore, Blueprint for Health established an effective use of health information technology. The physician practices access a Web-based clinical tracking system called DocSite. They also have a registry that supports age- and gender-appropriate, guideline-based care for prevention, health maintenance and chronic diseases. The practices with existing electronic medical records or a hospital-based data warehouse can obtain this support through existing systems. Those without electronic medical records can easily access the Web tool through a standard computer with Internet connection. The Web tool includes visit planners that inform providers about needed services for each patient and population-based reports, such as average blood glucose level and percentage of patients receiving flu shots, which guide providers in identifying and addressing areas for improvement.

The practices receive an enhanced per-person per-month payment for improved performance according to standards set by the National Committee for Quality Assurance Patient-Centered Medical Home program. The standards measure performance in access and communication, patient tracking and registry functions, care management, patient self-management and support, electronic prescribing, test tracking, referral tracking, performance reporting and improvement, and advanced electronic communications. Although a formal evaluation of the program has not yet been published, practices report positive feedback. The practices enjoy enhanced access to support services and improved teamwork across the community. The pilot communities report reduced average blood glucose levels, increased identification of patients with diabetes, increased number of patients with controlled levels of blood glucose and low density lipoprotein, and increased percentage of patients with diabetes with documented self-management goal. Please refer to http://www.innovations.ahrq.gov/content.aspx?id=2666 for ways to plan, develop and implement this innovation.

- North Carolina: Community Care of North Carolina

Community Care of North Carolina (CCNC) serves more than 1 million Medicaid beneficiaries and 4,200 Medicaid PCPs. North Carolina’s network model was built on an existing platform of primary care case management to improve quality of care. The networks now function as virtual health centers providing coordinated care and access to pharmacists, psychiatrists and informatics specialists. Administration of the local networks moved from Medicaid to North Carolina Community Care Networks, a nonprofit umbrella organization.

North Carolina Medicaid went from a pilot of 8 networks to 14 networks statewide and reached all 100 counties. North Carolina Medicaid began by having the state’s largest Medicaid practices choose or develop a network that best suited their local providers’ needs in exchange for additional per
member per month payments of $3.72. This flexibility led to creation of a variety of network designs, such as those based in a Federally Qualified Health Center, a public health department, an academic teaching practice, a pediatric practice and a community hospital. The networks then formed community partnerships and nonprofit umbrella organizations for affiliated Medicaid providers to operate. Initially, the target patient populations were women and children under the former Aid to Families with Dependent Children program, but the population expanded with evolving networks and increasing resources to include the aged, blind and disabled population and patients dually eligible for Medicare and Medicaid. The networks use per member per month payments to work with Medicaid providers in improving coordination of care, decreasing fragmentation and enhancing care delivery.

There are unique aspects of CCNC that contributed to its success. The CCNC built program identity, achieved reliable performance and advanced long-term goals as a result of stability and secure leadership. At this time, 94 percent of all North Carolina Medicaid providers are enrolled in CCNC and are receiving added per member per month care management payment in addition to the fee-for-service payments. These incentives require providers to be more accountable for their results. At the outset of CCNC, the North Carolina Medicaid office formed a partnership with the Office of Rural Health and Community Care, followed by the formation of additional partnerships with other state and private entities. These partnerships provided the networks with more opportunities to offer a greater variety of services such as a telemonitoring program for homebound patients; a health check coordination program; and the Assuring Better Child Health and Development Program. Because providers gave significant input in program design and implementation, they were more likely to adopt a shared network resource. CCNC made sure to provide timely feedback to practices that relied heavily on forming collaborative relationships with hospitals to obtain real-time hospital claims data. Doing so was critical in improving quality of care and in controlling costs.

Several innovative features of CCNC can be found with Community Health Partners, a notable CCNC network. It has a high rate of Medicaid provider participation, giving them an incentive of $2.50 per member per month for each Medicaid patient. The providers’ enrollment in the network has additional requirements. The providers offer after-hours coverage, work with the assigned nurse care managers, implement protocols for disease management, use recommended screening tools, attend quarterly medical management meetings, and utilize data to improve their practice and management of patients. Some of the useful data the providers can refer to include Medicaid claims data, pharmacy claims data, case identification reports, gaps in care analysis reports, customized queries, baseline measures, ongoing monitoring and trend analysis data. The Area Health Education Center completes external chart audits in quality improvement initiatives to provide feedback for practices. Each network has a medical director, network manager, clinical care manager supervisor, care managers, pharmacist and psychiatrist. The staff works directly with the practices to improve patient care. Community Health Partners has used its own funds and grants to implement some unique programs: Telemonitoring Program, Health Check Coordination Program and Assuring Better Child Health and Development Program. The Telemonitoring Program is for homebound patients, in which their blood pressure level, pulse oximetry and weight can be transmitted to the care manager. The Health Check Coordination Program identifies
Medicaid-eligible children up to age 5 and educates their parents about the importance of receiving regular preventive care. The Assuring Better Child Health and Development Program is intended to provide practices with a standardized, validated screening tool for healthy development of children up to age 3.

CCNC networks’ care managers have significant roles in the program. Approximately 75 percent of each network’s budget is devoted to care managers. Each practice in the program has an assigned care manager. The care manager is network-based and provides patient education and services for medication compliance and reconciliation. The goal of their services is to improve continuity of care and patient management. At Community Health Partners network, each care manager works with two to eight practices, based on the number of Medicaid patients. The care managers working with small practices may move around while those working with larger practices may be based in the larger practices’ locations. Care managers meet with patients at practices, hospitals, homes or other locations. They also communicate through in-person meetings, regular phone calls and e-mail, offering patients a mix of services that a small practice may otherwise not be able to provide. The care managers also ensure a smooth transition for patients from the hospital to homes or other care settings. Such assistance is possible because of the communication among networks when a patient is ready for discharge. They also meet with the providers as valued members of the care team.

The CCNC model has been evaluated in an independent report by the Mercer Human Resources Consulting Group. The report showed success in their program; it reported that CCNC saved $60 million in state fiscal year 2003, $124 million in state fiscal year 2004, and $231 million in state fiscal years 2005 and 2006, compared with the costs of the previous primary care case management model. Subsequent reports containing cost-effectiveness analysis showed that CCNC is holding costs down for the North Carolina Medicaid program. Health outcomes especially for asthmatic and diabetic patients have improved. Table 1 shows promising changes experienced by the Community Health Partners network.

<table>
<thead>
<tr>
<th>Preventable readmissions as a portion of total admissions</th>
<th>Fiscal Year 2010</th>
<th>Quarter 1 of Fiscal Year 2011</th>
<th>Change</th>
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<td></td>
<td>13.7%</td>
<td>13.2%</td>
<td>Decrease of 0.5 percentage points</td>
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<tr>
<td>Inpatient aged, blind and disabled admissions (per 1,000 member months)</td>
<td>32.1%</td>
<td>28.1%</td>
<td>Decrease of 4 admissions</td>
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<tr>
<td>Emergency department visit rate for aged, blind, and disabled population (per 1,000 member months)</td>
<td>107.8%</td>
<td>101.9%</td>
<td>Decrease of 5.9 visits</td>
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Montana: Health Improvement Program

Montana’s Health Improvement Program (HIP) started in 2008 when the state Medicaid agency and the Montana Primary Care Association (PCA) discussed creating an FQHC-based care management program. Montana Medicaid was seeking an innovative strategy to serve its high-risk, high-cost population with a focus on the whole person instead of focusing on treating the disease. The Montana PCA facilitated a meeting with the representatives of health centers to discuss ideas and target geographic areas. The goal of Montana’s HIP is to support private primary care providers caring for patients with complex health care needs with the guidance of a HIP care manager. The creators of HIP wanted to develop a program that Montanans can use to navigate a complex health system. The Community Care of North Carolina provided inspiration for HIP, and Montana Medicaid worked with CMS for a year to develop a system where the state pays $3.75 per member per month to a FQHC for each Medicaid beneficiary regardless of a patient’s health risk status. All Medicaid beneficiaries are eligible for HIP services, and 5 percent are currently participating in a care-management program. Montana’s State Medicaid agency selected 13 FQHCs and one tribal health center to be the HIP pilot sites. Medicaid gave the participating health centers capitated payments in addition to the PMPM payments to hire care managers. The HIP care managers then serve the Medicaid patients who receive primary care services from the health center or from private providers.

The HIP is innovative in myriad ways. It has a highly collaborative model, with Montana’s State Medicaid, PCA, and FQHCs working together. HIP care managers, who are typically registered nurses, licensed practical nurses, or social workers, complete a 40-hour online Chronic Care Professional course. This comprehensive training prepares them to address “challenges of evidence-based medical care, whole-person care, patient activation, adherence, cultural competence, self-care support and lifestyle change.” The care managers can receive continuing online education on targeted topics such as weight-loss coaching. For new patients, a HIP care manager contacts them first with a letter and then follows up by phone to arrange an in-person meeting. The meeting may take place at an FQHC, community center, the patient’s primary care provider or patient’s home. At this meeting, the care manager in collaboration with the patient, administers a health assessment tool, develops a treatment plan and establishes concrete goals. The patients also receive education about self-care skills and their medications. When appropriate, they are encouraged to use the Nurse First advice line and other routes of care instead of utilizing the emergency department. HIP care managers meet with their clients regularly and utilize motivational interviewing and other resources to encourage healthy lifestyles for their patients. Furthermore, the care managers offer stellar personal support such as monitoring patients’ compliance with their treatment plans, following up on patients who visited the emergency department or have been hospitalized and offering appointment reminders by phone and transportation arrangements. This may decrease no-show rates and thus encourage more PCPs to accept Medicaid. The care managers become the advocates for their patients and call the state Medicaid on the patients’ behalf when necessary. The patients also receive social support from HIP care managers in connecting with safety-net resources, such as food pantries and housing authorities. The HIP care managers also work closely with the patients’ primary care providers to discuss the patients’ needs and goals.

The HIP care managers are geographically spread throughout the state to ensure that a patient is no more than 200 miles away from a care manager. The HIP currently employs 32.5 full-time equivalent care
managers, with plans to employ a total of 35 full-time equivalents for 3,200 beneficiaries. The state uses predictive modeling software that is commercially available to identify 5 percent of the Medicaid population most at risk for complications and high costs. The software analyzes patient diagnosis, demographics, procedure service history, and prescription drug records to predict future costs, relative risk for hospital admission, and inpatient stay probability. Such analysis is used to develop evidence-based intervention. The primary care providers can also refer patients whom they believe could benefit from HIP. Health centers also benefit by receiving more funding annually for Medicaid HIP care management fees. Furthermore, both health centers and patients benefit from having more consistency in care management and better relationships with hospitals and providers. HIP provides training opportunities and continuous funding to support care management and the patient-centered medical home model in FQHCs.

Montana Medicaid provided data on a small sample of HIP beneficiaries (n=158). The report showed a net per member per month savings of $304 five months after receiving HIP services. The agency is currently tracking effects on health outcomes. Furthermore, HIP is continuously assessing quality measures to guide program improvement. The October 2010 statistics illustrated that approximately 80 percent of Medicaid HIP patients were adults, and 90 percent had a private, non-FQHC primary care provider. However, many private primary care providers have been reluctant to use HIP because they are pressed for time, unfamiliar with HIP, or are hesitant to share responsibilities with someone who is not working for them. Therefore, Montana Medicaid and HIP staff brainstormed on strategies to engage more private primary care providers in HIP. HIP has plans to offer training to private primary care provider about HIP. The PCA and FQHCs have goals to improve in certain areas, including improving care manager burnout rates. The receptionists and community health workers may provide help for care managers in contacting patients. The care managers also need more timely information from Medicaid. They hope to accomplish this goal by sharing databases with the state Medicaid. The HIP care managers can also benefit from shared electronic health information with private primary care providers, hospitals and other caregivers for efficient care delivery.
### Highlights of Community Health Team Innovations

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<th>Vermont: Blueprint for Health</th>
<th>North Carolina: Community Care of NC</th>
<th>Montana: Health Improvement Program</th>
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<tr>
<td><strong>Program initiators</strong></td>
<td>Vermont Department of Health</td>
<td>North Carolina Medicaid</td>
<td>Montana Medicaid and PCA</td>
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<tr>
<td><strong>Funding</strong></td>
<td>Insurer-funded; performance-based per member per month payment.</td>
<td>Negotiations with CMS for additional per member per month fees.</td>
<td>Negotiations with CMS for additional per member per month fees.</td>
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<tr>
<td><strong>Team composition</strong></td>
<td>Nurse care coordinator, chronic care coordinator and behavioral specialist.</td>
<td>Each network of practices has a medical director, network manager, clinical care manager supervisor, care managers, pharmacist, and psychiatrist. Seventy-five percent of the network budget is for care managers.</td>
<td>HIP care manager, who is typically a registered nurse, licensed practical nurse or social workers.</td>
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<td><strong>Team base</strong></td>
<td>Employed by a hospital through insurer’s funding; the team moves within the community.</td>
<td>Care manager is based at a large practice or moves around small practices.</td>
<td>HIP care manager is usually based at a FQHC.</td>
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<td><strong>Patients served</strong></td>
<td>Private insurance, Medicaid, and Medicare patients.</td>
<td>Medicaid patients, ABD population, and Medicaid/Medicare dually eligible patients</td>
<td>Medicaid patients.</td>
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<tr>
<td><strong>Use of technology</strong></td>
<td>DocSite; registry.</td>
<td>Telemonitoring.</td>
<td>Software for patient identification.</td>
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<td><strong>Innovative points to note</strong></td>
<td>Locally based public health specialist to truly assess targeted issues within a population.</td>
<td>Primary care providers are offered trainings for care management.</td>
<td>HIP care managers receive extensive initial and continuous training.</td>
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