



STATE-SUPPORTED COMMUNITY HEALTH TEAMS

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COMMUNITY HEALTH TEAMS (CHTS)

Under the Affordable Care Act, community health teams are interdisciplinary, inter-professional teams of health care providers who support primary care providers. These teams may include medical specialists, nurses, pharmacists, nutritionists, dietitians, social workers, behavioral and mental health providers, chiropractors, licensed complementary and alternative medicine practitioners, and physician assistants.

ISSUE

How do states support and implement community health teams (CHTs)?

SUMMARY

CHTs are multidisciplinary teams that support primary care providers in coordinating patient care, especially for patients with chronic diseases. The Affordable Care Act (ACA) authorizes federal grants and provides a framework for states to implement CHTs. The ACA also authorizes the Centers for Medicare & Medicaid Services (CMS) to fund grants through its State Innovation Models (SIM) Initiative, which has enabled states to launch and develop CHTs. In addition to these grants, CHTs are funded through mechanisms such as CMS-negotiated per member per month fees.

Vermont, North Carolina, Montana, Maine, and Minnesota are among the states that have implemented CHTs, sometimes known as “community care teams” (CCTs).

Vermont implemented programs containing CHT principles before the ACA was established. Blueprint for Health, Vermont’s state-led initiative, features CHTs that move throughout the community to work with patients, clinicians, and community organizations. The teams serve all patients regardless of whether they have health insurance.

Most CHT programs primarily serve low-income patients with limited resources. For example, Community Care of North Carolina (CCNC) provides services to Medicaid patients and features local networks, community partnerships, and

care managers across the state. Montana's Health Improvement Program (HIP) serves Medicaid patients by supporting primary care providers with care managers who regularly meet with and assist patients.

Maine and Minnesota are among the states that have launched pilot CCTs that work closely with health homes (sometimes known as health care homes), which coordinate care for Medicaid patients who have chronic conditions. Maine's CCTs support Medicaid patients with complex chronic conditions through outreach, preventive health, care coordination, and engagement. Minnesota's three pilot communities provide integrated services between health care, public health, behavioral health, social services, and community organizations. Pilot CCTs have expanded through CMS funding.

FEDERAL INITIATIVES

The ACA requires the Health and Human Services (HHS) secretary to establish a program to provide grants to or enter into contracts with states to establish CHTs. Among other things, these teams provide support services to primary care providers, promote the patient-centered medical home model, and work with existing local resources to coordinate care, with an emphasis on chronic diseases (42 U.S.C.A. § 256a-1). Other provisions of the act reference CHTs. For example, the ACA requires certain medication management services, where applicable, to coordinate their services through CHTs (42 U.S.C.A. § 299b-35).

The ACA authorizes CMS to fund grants through its SIM Initiative, which has enabled states to launch and develop CHTs. SIM funding provides states with financial support to develop and test health care payment and service delivery models (42 U.S.C.A. § 1315a).

VERMONT

Support and Implementation

A report by the Association of State and Territorial Health Officials (The [Community Health Teams Issue Report](#)) provides a comparison and overview of CHTs in Vermont, North Carolina, and Montana. In 2008, the Vermont Department of Health initiated a CHT pilot program that started in six communities and has since expanded statewide. Vermont's CHTs provide support to participating physician practices and focus on helping patients manage their health by addressing social, economic, and behavioral barriers. CHTs visit physician practices and move throughout the community to interact with patients, clinicians, and community organizations.

Blueprint for Health is a health reform initiative in Vermont that features CHTs. The [*Vermont Blueprint for Health 2014 Annual Report*](#) indicates that CHTs provide general and targeted populations with direct access to staff that can connect medical and non-medical providers to patients. CHT services are available to patients, regardless of whether they have health insurance. Patients and practices are not billed and do not pay co-payments for CHT services.

As of December 2014, there were 124 primary care practices in Vermont operating as patient centered homes supported by CHTs. The primary care practices work with 682 unique primary care providers and are located in Vermont's 14 health service areas. Each has an entity that administers Blueprint for Health locally and hires a Blueprint project manager, who is responsible for working with the community to determine the design and function of CHTs. The project manager's duties include facilitating CHTs and coordinating with Vermont Information Technology Leaders to connect health practices to electronic systems that improve patient care. Covisint DocSite, Vermont's central clinical registry, collects demographic and clinical data and individualizes patient care by providing guidelines for preventative health care and treatment of chronic conditions.

Team Structure

CHT staff may include nurse care coordinators, social workers, dieticians, and health educators. CHTs are designed and hired at the community level by local organizations, such as hospitals. The local leadership holds a planning group to determine the team's structure based on the community's demographics, gaps in health services, and strengths of local partners.

The average number of full-time equivalent staff for each of the state's health service areas was 10. Of the CHT staff, 42.5% were care coordinators, 39.2% were nurses and licensed counselors, 25.6% were administrative personnel, and 17% were social workers.

Funding

Vermont enacted payment reforms in 2013, including establishing a support infrastructure for primary care practices by requiring insurers to share the cost of CHTs, amounting to \$1.50 per patient per month.

Funding for CHTs is proportional to the population they serve. Currently, this level is set at \$350,000 per year for a general population of 20,000 served by the practice.

NORTH CAROLINA

Support and Implementation

According to the [Community Health Teams Issue Report](#), North Carolina Medicaid started a pilot CHT program (now functioning under CCNC). As part of the program, the state's largest Medicaid practices established networks to address the needs of local providers in exchange for additional per member per month payments. These networks were based in various settings, such as Federally Qualified Health Centers (FQHCs) or community hospitals, and formed community partnerships and nonprofit organizations for member Medicaid providers.

According to its [Project Overview](#), CCNC is currently a public-private partnership sponsored by the North Carolina Department of Health and Human Services and the North Carolina Division of Medical Assistance. CCNC has 14 regional networks and includes health professionals, hospitals, health departments, social service agencies, and community organizations. According to CCNC, their networks serve over 1800 primary care practices (as of February 2015).

North Carolina's [CCNC Care Management](#) is a set of interventions and activities that address the state's health care needs to promote high quality and cost effective care. CCNC care managers are based in each regional network and provide general population management services, medical home support, and direct care management.

Case managers target recipients and provide interventions tailored to the population. They work with the patient, his or her primary care provider, and family or caregiver to develop an individualized care plan. The care manager ensures that the care plan is implemented, continuously monitors progress, and adjusts the plan as necessary.

Case managers use Case Management Information System (CMIS), a web-based record system, to plan and evaluate patient care. CMIS contains standardized health assessments, screening tools, and disease management tools, among other features. Additional components of the CCNC care model include in-person meetings, medication management, patient education, and follow-up calls and contact.

Team Structure

[CCNC Care Management](#) teams consist of primary care managers, licensed support staff, pharmacists, administrative personnel, and other staff to assist in community

outreach and education. Each network also has a medical director, psychiatrist, and other medical professionals available for consultation on complex patient care plans.

Funding

According to the [Community Health Teams Issue Report](#), CCNC teams are funded through negotiations with CMS. North Carolina Medicaid providers are enrolled in CCNC and receive added per member per month care management payments in addition to the fee-for-service payments.

MONTANA

Support and Implementation

According to the [Community Health Teams Issue Report](#), Montana's Health Improvement Program (HIP) supports private primary care providers that deliver services to Medicaid patients with serious health problems. The state Medicaid agency and the Montana Primary Care Association initiated the program in 2008 and aimed to develop an FQHC-based care management program. Montana selected 13 FQHCs and one tribal health care center to be pilot sites for the program. Medicaid gave participating health care centers payments to hire care managers for the program.

Montana's [HIP](#) care managers work with Medicaid patients with chronic health conditions to improve their health through coordinated services. They conduct health assessments, work with patients to develop care plans, and provide pre- and post-hospital discharge planning. They also remind patients of screening and medical appointments, educate clients on self-management and prevention, and provide assistance accessing local resources to reach health goals.

HIP uses predictive modeling software to identify chronically ill Medicaid patients. The software determines risk by considering medical claims and demographic information.

Team Structure

HIP's care managers are nurses and health coaches. As indicated in the [Community Health Teams Issue Report](#), care managers must complete a 40-hour online course in addition to continuing online education on targeted topics. They are usually based at FQHCs and are spread throughout the state.

Funding

HIP is funded through negotiations with CMS for additional per member per month fees. HIP and Montana Medicaid worked with CMS to develop a system in which the state pays \$3.75 per member per month to an FQHC for each Medicaid patient. Health centers also benefit by receiving additional funding from Medicaid HIP care management fees.

MAINE

Support and Implementation

According to MaineCare Services' [Value-Based Purchasing \(VBP\) Strategy](#), CCTs work with health homes to provide intensive care management and community support to the highest need patients. The program provides support to Medicaid patients with complex chronic conditions through outreach, preventive health, care coordination, and engagement.

The [MaineCare Stage A Health Homes Year 1 Report](#) contains an overview of how CCTs have been implemented. According to the report, Maine introduced eight CCTs in January 2012 as a new component of its medical home model addressing patients with high needs. Later in 2013, Maine established its Health Homes program, which further enabled the development of CCTs.

The services provided by CCTs to patients vary, but may include reconciling medicine, identifying goals, providing education, and assisting with social support services. While a majority of CCTs indicated that they conduct home visits, others meet with patients wherever they are comfortable. As of December 2013, the state had 10 teams serving 157 health home practices.

Maine's CCTs also depend on Electronic Health Records (EHRs) and other data to manage health care of the state's population. Health home practices and CCTs share EHRs.

Team Structure

Maine's teams each have varying staffing and service delivery models. According to the [MaineCare Stage A Health Homes Year 1 Report](#), all teams had at least one social worker and one nurse on staff. Teams reported that nurses and social workers are the first point of contact for patients who are referred for CCT services and serve as the care managers or care coordinators. Teams across the state also include pharmacists, pharmacy students, and psychiatrists.

Funding

According to the [Year 1 report](#), CCTs generally receive about \$130 per member per month for all health home eligible members enrolled and meeting requirements.

[MaineCare Services](#) indicates that in 2013, the state received a \$33 Million SIM grant from CMS to be spent over three years. Maine has used the funds for various purposes, including support of CCTs.

MINNESOTA

Support and Implementation

Minnesota's [Community Care Teams](#) are locally-based teams that work with primary care practices and hospitals to provide coordinated support to patients. They provide integrated services between health care, public health, behavioral health, social services, and community organizations. According to a report from the Minnesota Department of Health entitled [Health Care Homes: Annual Report on Implementation](#), the state launched a CCT pilot program in 2011 designed to improve coordination among clinics, local public health, and community providers. Minnesota's model was tested in three communities that serve as the foundation for Accountable Communities for Health established through SIM funding. Minnesota's CCTs work with health care homes, which provide patient- and family-centered care and require primary care practices to identify and work with community organizations and public health resources.

Team Structure

Minnesota's CCTs include health professionals, public health staff, and community members. The teams are locally defined and determined by the size of the primary care clinic, number and types of local hospitals, and population size. The local leadership hires a community specialist and service delivery team to implement the program and coordinate between primary care clinics and team members. The teams build on existing community resources and reflect the needs in a community assessment.

Funding

The Minnesota Department of Health and Minnesota Department of Human Services are both responsible for developing and implementing its health care homes initiative. These agencies received a \$600,000 grant from HHS to establish a research institute to study the implementation and quality performance of the program. Minnesota's health care homes also received a SIM grant to establish up to 15 Accountable Communities for Health to expand and build on the CCT pilot program.

SOURCES AND ADDITIONAL INFORMATION

The Association of State and Territorial Health Officials, *Community Health Teams Issue Report*, available at [http://www.astho.org/Programs/Access/Primary-Care/ Materials/Community-Health-Teams-Issue-Report/](http://www.astho.org/Programs/Access/Primary-Care/Materials/Community-Health-Teams-Issue-Report/).

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