

Community Care Teams:

An Overview of State Approaches

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About this Resource

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Introduction

This white paper provides information about Community Care Teams (CCTs) and includes an overview of core program features, governance structures, financing, and health informatics. The paper includes several state examples, but draws heavily on CCT models in North Carolina and Vermont.

Community Care Teams

CCTs, also called community health teams (CHTs) or care networks, are locally based care coordination teams employed to manage patients' complex illnesses across providers, settings, and systems of care.¹ The goal of the CCT is to support primary care providers in delivering quality-driven, cost-effective, and culturally appropriate patient-centered care. Unlike traditional disease management programs, which focus on specific chronic diseases, CCTs coordinate care between primary care providers and community resources, and emphasize in-person contact with patients.

CCTs are generally connected to patient-centered medical homes (PCMH), and work with PCMH practices to assess patients' needs, coordinate community-based support services, and provide multidisciplinary care.² The composition of CCTs can vary greatly depending on prescribed staffing requirements set forth by the state, as well as available community resources; they can include primary care physicians, nurses, pharmacists, behavioral health care providers, social workers, and non-clinical service providers.

Coordination across the spectrum of clinical and community providers is intended to reduce duplication of services, reduce costs, and improve health outcomes for high-need patients – to date, primarily Medicaid enrollees. Moreover, for smaller primary care practices, particularly in rural areas, CCTs can serve as a mechanism for providing many of the fundamental functions of a PCMH (e.g., direct services and care coordination, population health management, and quality improvement activities).

Core features of CCTs include:³

- A multi-disciplinary team of providers who coordinate clinical and non-clinical services, including disease self-management, medication management, and behavioral health integration;
- Team members who routinely connect patients with relevant community-based resources;
- Sustained and continuous relationships with patients that are developed through face-to-face contact;
- A focus on transitions in care, especially between hospital and home;
- Routine sending and receiving of information about patients between practices and care teams;
- Whole-person care of patients with specific high-risk factors; and
- Enhanced reimbursement.

Governance Structures

States have established a variety of governance models to oversee the design, implementation, and administration of CCTs. Key elements of governance models include:⁴

- Legislative, regulatory, or executive authority;
- Operational oversight;
- Stakeholder engagement processes;
- Patient identification methodologies;
- Workforce staffing and core functions; and
- Scaling and replication.

Legislative, Regulatory, or Executive Authority

States have taken several approaches in developing authority for CCTs, such as regulatory policies, or using action through executive or legislative authority.

In many instances, the creation of CCTs has aligned with existing health reform efforts. For example, the Minnesota legislature enacted a landmark 2008 health reform law that created the health care homes initiative, which is focused on broad-scale population health improvement. Following its passage, the state developed two Medicaid ACO demonstrations and a one-year CCT pilot to deliver more person-centered and coordinated care across health clinics, local public health departments, and community providers in three communities.⁵ The original authority created a stepwise approach for the state to scale statewide efforts toward more comprehensive health care delivery system reforms. Similarly, Vermont passed legislation in 2009 that requires state-regulated health insurers' participation in the state's patient-centered medical home effort, Blueprint for Health, including established reimbursement rates for community health teams.

Operational Oversight

States and communities have created operational approaches that support the oversight of care teams. In North Carolina, Community Care of North Carolina (CCNC) has an established partnership between Medicaid, primary care physicians, and other local health care providers to achieve quality, utilization, and cost objectives in the management of care for Medicaid recipients.⁶ Each CCNC network includes a local steering committee for oversight functions and is comprised of a diverse range of stakeholders, including primary care providers, hospitals, public health offices, social service agencies, specialists, home health providers and school districts. The networks utilize data and expertise at the local level to inform decision-making about care team priorities, which allows for a balance between statewide oversight and regional variation.

Stakeholder Engagement Processes

The engagement of multiple sectors is critical for building effective CCTs. Collaboration among many stakeholders such as health care providers, patients/patient advocates, and community organizations ensures that the diverse range of patients and needs are represented. Stakeholders can include:

- Consumers who are representative of the patient population, including underserved, vulnerable and low-income patients in various geographic regions;
- Patient advocacy/consumer groups that serve the state and local communities;
- Health plans;
- Community-based organizations, including health care, food assistance, income support services, vocational services, cultural organizations, and housing services.
- Government entities; and
- Health care providers.

The Vermont Blueprint for Health includes a robust stakeholder strategy. The design of the patient-centered medical home approach and community health teams involves primary care practices, hospitals, health centers, provider networks, insurers, elected officials, as well as consumers.⁷ A diverse set of stakeholders informed the development of administrative entities for each community health team. Local planning committees in Vermont's 14 hospital service areas provided feedback on the selection of the care team model to help organize and extend services directed at key patient needs.⁸

The Blueprint stakeholder process resulted in the establishment of several different care team models across the state, including the Support and Services at Home Program (SASH)⁹. The SASH approach extends community health services by providing the highest-risk Medicare beneficiaries with health promotion and independent living skills to allow individuals to live more safely in their homes. The SASH model includes coordinators who are based at multiple publicly funded housing sites across the state.

Workforce Staffing and Core Functions

Developing an effective team requires thoughtful planning in defining core team functions, responsibilities, abilities, and team workflow so that the care needs of the population can be adequately met. The core functions and staffing models of CCTs can vary significantly, depending on the population being served.

In the case of complex patients, the staffing needed may include a pharmacist and a community health worker to assist with medication reconciliation, care transitions, and linkages to social supports. For example, Maine's Medicaid Health Homes program (see figure on page 7 for more information on health homes) contracts with eight different CCTs throughout the state that include entities such as physician-hospital entities, behavioral health organizations, social service agencies, and FQHCs.¹⁰ Although Maine has created some flexibility in its staffing composition, adjusting for each individual organizations' capacity and care management approaches, there is a requirement for teams to at least employ a part-time medical director (at least four hours/month); a clinical care management leader; a part-time CCT manager, director or coordinator; and have an established partnership with a health home practice.¹¹

Scaling and Replication

As states implement a variety of care team models, they often develop pilot programs as incubators to inform the future development of statewide models. It can often take several years to realize, test, and evaluate models in order to develop the necessary infrastructure to support the model and demonstrate return on investment (ROI). Key factors cited for enabling the scaling and replication of care teams include: an assessment of the health status and needs of the population in the specific geographic area, an inventory of the existing infrastructure of community supports and services, assessment of provider capacity, and committed leadership to champion efforts.¹²

Developing mechanisms to support the up-front investments related to health information technology, additional staffing and workforce training often require innovative, collaborative agreements. For example, Colorado's Medicaid agency contracts with one Regional Care Collaborative Organization (RCCO) in each of seven regions of the state to create a network of primary care medical providers (PCMPs). The RCCOs support the Accountable Care Communities and the PCMPs and are responsible for network development; provider support; medical management and care coordination; accountability; and reporting.¹³ In those communities where CCTs are established, there is a local oversight committee that provides guidance and strategic support to the teams. The RCCOs have allowed the state to scale CCTs by leveraging a geographically based model of support.

Financing

To realize the potential benefits of CCTs, adequate financing is essential. The predominant method of reimbursement for CCT services is through a per-member, per-month (PMPM) rate. In order to generate these payments, states can pursue several different strategies to establish financing streams and engage Medicaid FFS and Medicaid managed care organizations (MCOs), Medicare, as well as commercial payers.¹⁴ Multi-payer participation allows for greater range and continuity of team services, particularly when a patient's health insurance coverage changes, and it also allows for the distribution of fixed costs associated with established and operating community care or health team.

There are many different approaches for states to receive financing to support CCTs. This section highlights the examples from North Carolina and Vermont.

1) **Network Support: Community Care of North Carolina**

CCNC began in 1997 as a reaction to fears of the federal government shifting financial responsibility for Medicaid to the states. North Carolina responded by planning a next-generation Medicaid program that could provide better budget predictability and control through four key elements: (1) formation of networks; (2) introduction of population management tools; (3) case management and clinical support; and (4) data and feedback.¹⁵

CCNC's statewide infrastructure developed further in 2006 as part of a Medicare Quality Demonstration (646) to improve service delivery through major system redesign. The centralized public-private quality initiative brought together the state's largest insurers and providers to collaborate and implement the Governor's Quality Initiative and the CCNC system.¹⁶

Since then, the responsibility of additional CCNC program development and support has shifted from the state to a new central not-for-profit organization representing all 14 CCNC networks.¹⁷ Funding to support the CCNC networks comes largely from state Medicaid coffers. In addition to initial infrastructure development funds, the state provides resources, information, and technical support to the 14 participating networks. Physician fee-for-service reimbursement is supplemented by a per-member per-month (PMPM) fee for case management. The regional networks also receive a PMPM fee to cover the cost of care management and network administration.¹⁸ At the network level, some also receive grant money targeted at specific initiatives or populations.

CCNC serves approximately 1.3 million eligible Medicaid beneficiaries, out of approximately 1.5 million, through PCMHs. Medicaid pays an administrative fee to participating providers for each beneficiary receiving care coordination; the PMPM rate depends on the type of member (i.e., higher if the beneficiary is aged/blind/disabled).¹⁹

2) Multi-Payer Pooled Payment: Vermont Blueprint

In Vermont, the funding for supportive services comes from a variety of sources. The Vermont state legislation requires private health insurers to participate in the Blueprint for Health, the state's broad payment and delivery system transformation initiative. Vermont's commercial and public payers all share equally in the costs: Medicaid, Medicare, BlueCross BlueShield, and CIGNA each pay 22.2 percent of the costs to run the community health teams. MVP Health Care, a not-for-profit plan with significantly fewer covered lives in Vermont, pays a reduced percentage (11.2 percent) of the costs.²⁰

Blueprint providers are paid a PMPM for each patient they serve, and the CHTs are funded by a capacity payment of \$350,000 for every 20,000 patients in the CHT's service region.²¹ The Medicaid portion of the capacity payment is made monthly and is based on a quarterly count of attributed patients.²² The Blueprint requires insurers to share CHT costs directly, rather than through PMPM payments. The exception is Medicare, which continues to pay on a PMPM rate that approximates the agreed-upon percentage of costs for CHT services.²³

Other Financing Considerations

Effective January 1, 2014, the Centers for Medicare & Medicaid Services (CMS) allows state Medicaid agencies to reimburse for preventive services provided by professionals that may fall outside of a state's clinical licensure system, as long as the services have been initially recommended by a physician or other licensed practitioner. This rule offers state Medicaid agencies the option to reimburse for more community-based preventive services, including those services provided by community health workers, which can be integral to CCTs.

Other strategies states can consider to finance both the upfront and ongoing costs of CCTs include:²⁴

- Adoption of payment policies to reimburse for community care services, such as community health workers;
- Including the provision of CCT services as a requirement in contracting arrangements with provider delivery systems, such as ACOs;
- Inclusion of the provision of CCT services in managed care organization (MCO) contract specifications for certain Medicaid beneficiaries; and
- To the extent possible, encouraging funding of CCT programs by private foundations, charitable organizations, and counties through grant making.

MEDICAID HEALTH HOMES

Section 2703 of the Affordable Care Act created Medicaid health homes, enhancing services for high-need, high-cost Medicaid beneficiaries. Medicaid health homes are intended to improve the coordination and integration of health care, reduce duplication of services, improve health outcomes, and reduce health spending.²⁵ Health home providers operate under the “whole person” philosophy to coordinate care for people who have multiple chronic conditions, including behavioral health and substance abuse conditions.

As one additional source of funds, health homes can serve as a foundation to develop or improve existing systems of care. To design and implement health homes, states may request federal planning funds at their medical assistance service match rate; this match rate is higher for some states than an administrative match.²⁶ The provision also offers eight-quarters of an enhanced (90 percent) federal match for health home services received by eligible Medicaid enrollees.²⁷ As of January 2016, 19 states (some with multiple State Plan Amendments) and the District of Columbia have Medicaid health home programs, and more than one million Medicaid beneficiaries nationwide have enrolled in health homes thus far.²⁸

Some health home programs have incorporated CCT models, which receive an additional payment to provide care coordination services for targeted enrollees. The following are two examples:

- The New York health homes are a networked model, where money goes to primary overarching entity, which then reimburses downstream providers—such as those in safety-net clinics and community-based organizations beyond the medical system. In the New York Adirondack Medical Home pilot, participating practices receive enhanced payments from Medicare, Medicaid, and several commercial insurers. The participating practices contract with one of three teams for shared-support services.
- In Maine, health home providers receive a PMPM payment for the provision of care management services. The amount (\$12) is based on estimates of the staffing costs associated with providing health home services not otherwise reimbursable under MaineCare. The CCT payment is described as an “add-on” payment to support care management services for the top five percent of referred high-need individuals, and is set at \$129.50 per month. Beneficiaries are expected to ‘graduate’ out of CCT care and return to a primary care practice (the period of treatment by a CCT is not defined). At a minimum, the CCT must conduct engagement and outreach with the identified enrollees, or must provide a core health home service, as defined in the State Plan Amendment, in order to receive payment.

After the enhanced federal match ends, CMS expects states to continue providing health home services, and most states have reported that they plan to continue their programs.²⁹

Workforce

The movement toward team-based care places new demands on the health care workforce. States that have implemented CCTs or community health teams need to consider certification, training and transitions of work to meet the new and expanded demands of delivering community-based health care. The team composition of CCTs can vary because of financing, regional needs, and workforce requirements.

Community Health Workers

Many states are looking at community health workers (CHWs) to play an integral role on community health teams. CHWs can serve as the link, or intermediary, between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.³⁰ CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, and informal counseling.

In Minnesota, for example, CHWs extend the reach of primary care providers by enhancing provider communication, and improving health outcomes and overall quality measures, particularly during care transitions. CHWs providing diagnosis-related patient education services to enrollees of MCOs must contact the MCOs for enrollment requirements and coverage policies.³¹ Minnesota's statewide certification program and reimbursement schedule for CHW services includes patient education for health promotion and disease management, which are covered if provided under the supervision of a physician, dentist, advanced practice registered nurse (APRN), certified public health nurse (PHN), or mental health professional.

Certification

A state can decide to create a formal certification process for various members of a CCT. Certification can offer the two-fold benefit of: (1) making hiring for team members more streamlined, as there is a common understanding of whether the applicant is qualified; as well as (2) defining the team member's scope of practice so there is a clear understanding of roles and expectations.

There are several good examples of certification, specifically for CHWs. New Mexico passed the Community Health Workers Act in 2014 to enable the state's Department of Health to offer certification of Community Health Workers in the state; the certification is still being developed.³² Texas also requires CHWs and *Promotores de Salud* to be certified in order to receive reimbursement.³³ In Minnesota, community health workers are able to complete a certificate through the statewide standardized, competency-based curriculum currently offered at seven different schools, though it is not required for employment. The certificate is required for billing for community health worker services covered by the Medicaid program and employers increasingly recognize it as evidence of foundational training for the role.³⁴

Training

New members of CCTs must be prepared for their roles. States have an opportunity to develop standards for the education of CCT members, which will help providers evaluate applicants, bolster the workforce, and potentially improve the quality of care delivery. Educational standards also provide payers with a better understanding of the value that team-based care can provide for their covered enrollees. Minnesota requires that organizations that train CHWs use an approved curriculum based on core competencies identified by the

Department of Human Services.³⁵ CCNC also provides training for providers to incorporate care teams into their practices.³⁶

Team-Based Care

Existing provider groups may be resistant to changes to their practices and to new workflows, particularly if new employees' scope of work is poorly defined. The High Plains Community Health Center (HPCHC), in the rural eastern plains of Colorado, took part in a "Patient Visit Redesign Collaborative," which was designed to address the changing workforce needs of the facility during a transition from traditional to team-based care.³⁷ The team at HPCHC consists of patient facilitators, patient navigators, community health workers, and health coaches, who work alongside the traditional nurses and physicians. Evaluators reported that as HPCHC transitioned to team-based care, the facility initially lost a number of staff members, but HPCHC has since retained 70-75 percent of its patient facilitators each year since. A follow-up evaluation found that the redesign of the practice saved time and decreased care costs while improving patients' health outcomes in several measures.³⁸

Health Informatics

Data are critical to CCTs' objectives of better managing population health, eliminating duplication of services, and creating and enhancing connections between health care providers and community resources. Currently, the use of health informatics to identify patients, facilitate communication among CCT providers, measure quality, and evaluate programmatic effectiveness at the CCT-level is fairly limited. More often, data are being used to support and assess broader practice-, organizational-, or state-based health care delivery activities. There is growing interest, however, in initiative-specific assessments of impacts on health care cost and quality within the context of broader health reform activities, and the ability to measure at a more detailed level is under development (for example, Vermont's work to link clinical and claims data described briefly below). Several state examples are described below, including CCT and other relevant models in North Carolina, Vermont, Colorado, Maine, and Montana.

Health Informatics Infrastructure

CCNC and Vermont's Blueprint for Health provide robust examples of informatics infrastructure to support CCT initiatives.

Community Care of North Carolina

CCNC supports a statewide infrastructure for information management and data support called the Informatics Center.³⁹ CCNC's Informatics Center primarily uses enrollment files that are updated monthly, and paid claims files that are refreshed weekly. The Medicaid claims data is enhanced with a growing number of additional data sources, including lab results, real-time hospital discharge data, and Medicare claims and Surescripts pharmacy data for people who are dually eligible. Additionally, the Informatics Center contains health information about program participants provided by their care team members and the primary care medical record that facilitates better communication and care coordination among a patient's caregivers.

Vermont Blueprint for Health

The Vermont Blueprint has developed a health information architecture that supports preventive health care; coordinated health services for individuals and populations; and an integrated health record.⁴⁰ The Blueprint and Vermont Information Technology Leaders (VITL) have worked collaboratively to connect electronic health records (EHRs) to the Vermont Health Information Exchange (VHIE), as well as assist practices to improve the quality of data in their EHRs and the VHIE. This has led to enhanced data and utilization, and the creation of a clinical data registry, which allows for better care coordination and transitions in care.

Patient Identification

Programs with CCTs use a variety of methods to identify patients for care coordination and management. The most common strategies involve risk stratification, predictive analysis, or targeting based on inpatient use. Some of the more sophisticated approaches to patient identification seek to not only categorize patients by health status, utilization patterns, and outcomes, but also account for social risk factors, such as housing instability, food insecurity, and income instability.

Community Care of North Carolina

The care managers in CCNC employ a number of strategies to identify patients who may be candidates for care coordination and care management. CCNC uses risk-stratification to identify patients who are high-risk or high-cost by severity of illness and past hospital use.⁴¹ The program prioritizes patients who have higher hospital costs, emergency department use, and readmissions than are expected for their clinical risk group. Patients are also identified for care management through direct physician referrals, reviews of administrative claims data, screening and assessment, and chart reviews to identify gaps in care (e.g., if a patient with diabetes has not received recommended care such as an eye exam). Administrative claims data includes information from CCNC's web-based care management information system (CMIS), case lists from the CCNC central office, and hospital admissions notifications. The local nurse care managers often work with primary care providers to identify patients who make frequent emergency department visits; patients with asthma, diabetes, or heart failure who may benefit from targeted care management; and patients with two or more chronic conditions, including behavioral health conditions, who have high service use or complex care needs. The program also assesses patients' social needs (e.g., transportation, housing supports, food assistance) and personal preferences (e.g., values, religious affiliations, social and employment goals) in order to drive activities, specific supports and case management services.⁴²

Other programs employ a variety of mechanisms to identify patients for care coordination or case management through a CCT. Examples include:

Community Care of Central Colorado

Community Care of Central Colorado, a RCCO, focuses its care coordination on frequent emergency department users (those with greater than 10 visits per year); patients who self-report their health as poor; and patients who have a clinical risk group (CRG) level of simple chronic, complex chronic, or catastrophic.⁴³ A CRG is a classification using software from 3M that uses standard claims data (inpatient, outpatient, pharmacy, and physician data) to assign patients to a single, mutually exclusive risk category.⁴⁴ CRGs are used to identify groups of patients who may need similar amounts and types of care coordination.

Maine's Primary Care Medical Home Pilot Program

Maine's PCMH pilot focused on patients with (1) frequent hospital admissions (identified as having three or more hospital visits in the prior six months or six or more hospital visits in the prior 12 months); (2) emergency department utilization (identified as having three or more ED visits in the prior six months or six or more ED visits in the prior 12 months); or (3) patients determined to be high-risk or high-cost. To identify high-risk, high-cost, and high-need patients, CCTs reviewed data from reports generated through the state's concurrent Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration, utilization reports from MaineCare and other payers, and information captured by HealthInfoNet (HIN), Maine's statewide HIE.⁴⁵

Montana Health Improvement Program

The Montana Health Improvement Program (HIP) uses predictive modeling software to identify the most at-risk five percent of eligible Medicaid enrollees through analysis of patient diagnosis, demographics, procedure service history, and prescription drug records.⁴⁶ In addition, providers can manually identify patients through a form that is completed and sent to the HIP.⁴⁷

Communication between Care Teams and Providers

A number of programs are beginning to use HIT to facilitate and improve communication between providers and care teams.

Community Care of North Carolina

The CCNC Informatics Center supports the care team with tools for providing patient-centered care. The largest application CCNC hosts for care teams is Care Management Information System (CMIS), which has evolved over the past decade to meet changing practice needs. This secure web-based system houses a shared patient record and health assessment and screening tools. The CMIS includes tailored patient self-management support tools, documentation of interventions and goals, and allows for secure messaging among care managers.⁴⁸ Providers also have access to a Provider Portal that allows them to access patient information to prioritize patients in need of care coordination and helps facilitate communication across care settings.

Vermont Blueprint for Health

Vermont's Blueprint for Health program utilizes a Central Clinical Registry called DocSite provided by the state at no cost to practices and CCTs. This web-based application supports the activities of practices and community health teams for patient-centered care and population health management.⁴⁹ DocSite connects to practice EHRs and the Vermont Health Information Exchange (VHIE), allowing it to function as an integrated health record; this facilitates communication across settings of care.

DocSite is web-based, allowing practices with different technologies (i.e., EHRs) to exchange information through interfaces, flat files, or manual data entry. The guideline-based decision support and reporting capabilities for population health analysis make the application particularly beneficial to practices without an EHR. The Blueprint for Health Implementation Manual details the program's plans for linking DocSite, EHRs, and other data sources with Vermont's HIE.⁵⁰

Colorado Regional Care Collaborative Organizations

The seven regions that comprise Colorado's RCCOs, and the organizations within them, address communication across care teams in a variety of ways. Integrated Community Health Partners, a RCCO covering 19 counties in southern/southeastern Colorado, uses a software system that facilitates communication and information transfer across the variety of EHRs used by its member organizations.

Care coordinators in this system can send "alerts" to other providers to communicate their activities with a patient. When a care coordinator completes a care management assessment of a patient, the assessment is sent to the patient's primary care provider who then completes a health risk assessment for the patient and evaluates the appropriateness of the care coordinator's classification of the patient.⁵¹ High Plains Community Health Center, a federally qualified health center that is part of the Integrated Community Health Partners RCCO, employs patient facilitators who carry laptops with them as they meet with patients, allowing them to access patient records on the spot, track patient needs and services provided, and schedule future appointments.⁵²

Quality Measurement and Evaluation

Quality measurement and evaluation of CCTs are difficult because CCT programs are often embedded in broader programs. Very few programs that utilize CCTs, or similar mechanisms, track quality and outcomes separately for those components. Following are examples of broader quality measurement and evaluation efforts in programs that include CCTs.

Community Care of North Carolina

The information accessible in CCNC's Informatics Center is coupled with quality measurement feedback for providers intended to make performance measurement information actionable. CCNC tracks both chart review and claims-derived measures. The CCNC's quality measurement feedback initiative include common quality measures on chronic conditions (e.g., asthma, diabetes, heart failure) and preventive care (e.g., well child visits, cancer screenings). Quality measurement information is updated quarterly. Practices can access and customize longitudinal comparative reports at the practice-, network- and statewide-level through the Provider Portal.⁵³ The Portal also allows networks and providers to monitor cost, utilization, and quality of care. Please see the additional resources section for links to sample reports.

Vermont Blueprint for Health

Vermont has taken a systems-based approach to evaluation, using its robust data and reporting infrastructure including: (1) the clinical registry (Covisint DocSite); (2) multi-payer claims database (VHCURES); (3) chart review and independent scoring practices based on the NCQA standards for PCMH conducted by the University of Vermont; (4) public health registries and hospital discharge data set available through the Vermont Department of Health; and (5) the University of Vermont Informatics Platform for conducting advanced analytics.

Quality measures have been assessed broadly across Vermont's Blueprint Health Service Areas (HSAs) rather than for individual initiatives within HSAs such as CHTs. Quality measures used in Vermont's Blueprint are nationally endorsed and include cost of care measures, utilization measures, preventive care, and ACO measures, and information from the Behavioral Risk Factor Surveillance Survey (BRFSS) on key health risk

factors and outcomes (e.g., smoking, obesity, and health status). In 2014, these reports also included measures that were generated by a linkage of clinical data from the statewide clinical registry with the claims data from the state's multi-payer claims database (e.g., health care expenditures, rate of hospitalizations, blood pressure, cholesterol).

The Blueprint also produces Practice Profile reports from VHCures, Vermont's multi-payer claims database. The Practice Profile reports provide practices with de-identified but longitudinal comparative utilization and quality of care information.

Maine's Primary Care Medical Home Pilot Program

Maine's PCMH pilot program tracked the performance of participating practices on key measures (e.g., hospitalizations and ER visits) before and after the CCT intervention.⁵⁴ These measures continue to be shared with participating providers on a quarterly basis.

University of Arizona

The University of Arizona's Community Health Worker (CHW) Evaluation Tool Kit is designed to train community health workers to be informed participants in the program's evaluation. The Tool Kit includes information on evaluation principles, logic model development, sample evaluation frameworks and tools, and case studies of eight CHW programs. Please see the additional resources section for a link to the toolkit.

Conclusion

CCTs can be an important piece of a broader health care transformation approach. CCTs complement a patient-centered medical home by increasing a practice's capacity, and help to address the behavioral health, chronic conditions and social needs of high-risk patients—including Medicaid beneficiaries. The multidisciplinary nature of CCTs are well-suited to ensure that the full range of patients' health and social needs are addressed, potentially reducing disparities in care and improving health outcomes.

Additional Resources

Community Care of North Carolina:

CCNC is a 25-year old, statewide infrastructure operated by practicing community physicians, in partnership with hospitals, health departments, and departments of social services. Each of the 14 networks has a full-time program director, a medical director, a team of case managers, a steering committee, and medical management committee. CCNC networks receive direct financial assistance in proportion to the number of patients in the network, and each patient is linked to a medical home. More information available at:

<http://www.communitycarenc.com/about-us/>

<http://www.annfammed.org/content/6/4/361.long>

Vermont Blueprint for Health & Community Health Teams (CHTs):

Community Health Teams (CHTs) work with primary care providers to coordinate community-based support services. CHTs are each staffed by the equivalent of five full-time employees, and each serves approximately 20,000 people; the composition of CHTs is locally determined (but typically includes nurse coordinators, behavioral health counselors, and social workers to offer health and wellness coaching, behavioral health counseling, and linking to social and economic support services). In addition to FFS payments from private insurers and Medicaid, PCPs receive a PMPM payment based on their National Committee for Quality Assurance score; CHT cost is shared among Vermont's three major commercial insurers, as well as Medicaid. More information available at:

<http://hcr.vermont.gov/blueprint>

<http://www.commonwealthfund.org/publications/newsletters/states-in-action/2009/july/june-july-2009/snapshots/vermont-community-care-teams-and-health-it>

Community Care of North Carolina Toolkit

With support from The Commonwealth Fund, Community Care of North Carolina developed a toolkit to provide a comprehensive step-by-step guide to creating and managing a program like CCNC. The Community Care of North Carolina Toolkit is available at: <http://commonwealth.communitycarenc.org>.

CCNC Quality Measurement and Feedback Report

A sample of CCNC's practice-level multi-year quality metrics feedback report is available at:

<https://www.communitycarenc.org/media/related-downloads/ccnc-practice-feedback.pdf>

A sample practice feedback report on quality metrics is available at:

<https://www.communitycarenc.org/media/related-downloads/quality-measurement-feedback.pdf>.

University of Arizona's Community Health Worker Evaluation Tool Kit

With support from the Annie E. Casey Foundation, the University of Arizona developed the Community Health Worker Evaluation Tool Kit to be a practical and useful guide to program evaluation for CHWs and CHW programs. The resource is available at: <https://apps.publichealth.arizona.edu/CHWToolkit/about.htm>.

ENDNOTES

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