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Community Care Teams and the Patient-Centered Medical Home (PCMH)

The Person-Centered Healthcare Home (PCHH) model can enhance the potential of the Patient-Centered Medical Home (PCMH) to ensure that appropriate care is structured, delivered and coordinated around the specific needs of each patient. Given that patients bring their medical, mental health (MH) and substance use (SU) conditions with them to medical care and specialty MH/SU care, planned care for all these conditions must be articulated in the PCMH model in order to successfully address a patient's whole health—the addition of this capacity is what makes it a PCHH. **For primary care practices with only one or two physicians, Community Care Teams are a mechanism for providing many of the fundamental functions of a PCMH, and could also be used to support a PCHH model by including MH/SU services and inclusion of these services in care coordination.**

Community Care of North Carolina

Since 1998, North Carolina has been working on an enhanced medical home model called North Carolina Community Care Networks (NCCCN). What makes NCCCN's model unique is that it is a delivery system design that can be effectively adopted in both urban and rural areas, while providing individuals effective, coordinated care.[i]

NCCCN is a public-private partnership between the state and 14 nonprofit Community Care Networks (CCNs). The networks are made up of local providers that deliver significant components of a medical home for low-income adults and children enrolled in Medicaid and the State's Children's Health Insurance Program. The program not only connects individuals with providers that are medical homes, but it assures care coordination, disease management, and quality improvement (PCMH functions that small physician practices would find difficult to directly deliver) through a shared CCN staff of care coordinators. Preliminary results suggest that the program has improved the care of patients with chronic conditions and yielded cost savings.

Within the CCNs, Medicaid enrollees receive care through a network made up of physicians, hospitals, social service agencies, and county health departments. The nonprofit hub of the network is responsible for managing its enrollees' care via linking them to a medical home, providing disease and care management services, and implementing quality improvement initiatives. The medical home allows patients access to acute and preventive services and after-hours coverage. Participating networks receive an enhanced care management fee of $3 per member per month (PMPM) or $5 per member per month for elderly or disabled enrollees. They hire local care managers and each network elects a physician to serve as a clinical director, who is responsible for working with a statewide board of directors to organize and direct disease and care management initiatives across the networks. [ii]

Care managers work in conjunction with the medical homes to identify patients who may benefit the most from targeted care management interventions, such as patients that make repeated visits to the ER or patients diagnosed with chronic conditions such as diabetes, asthma, or heart failure. Care managers serve as an integral part of the CCN model and are crucial to mitigating long term medical and financial risks from poorly controlled chronic diseases. Care managers assist in activities such as patent education and lifestyle change

promotion, as well as assessing the psychosocial needs of patients and addressing any barriers to care such as communication or transportation needs.[iii]

Recently, the NCCCN system began a gain-sharing demonstration with Medicare, designed to better serve dual eligibles (those who are covered by both Medicare and Medicaid). In the demonstration, the CCNs will expand current care coordination efforts for the Medicaid population to the dual eligibles and, over time, to the Medicare population as well. The CCNs will receive a PMPM fee to cover care management, care transitions and co-location of MH services. Medicare savings beyond an established threshold will be shared with the NCCCN and reinvested. [iv]

According to a recently released report, *Faces of Medicaid III*,[v] 49% of Medicaid beneficiaries with disabilities have a psychiatric condition (52% of dual eligibles). Psychiatric illness is represented in three of the top five most prevalent dyads among the highest-cost 5% of beneficiaries with disabilities. The study itself provides little information about SU conditions; however, if one were to apply a co-morbidity estimate to the population with psychiatric conditions, it would conservatively suggest that as many as 25% of these high cost beneficiaries also have a co-morbid SU condition.

Incorporating Behavioral Health into Community Care Networks

As part of the targeted statewide pilot, one of the largest Community Care Networks (CCNs) implemented a BH/SU pilot in one of the counties they serve. The project pooled MH staff for psychiatry and LCSW services in primary care practices. None of the practices were large enough to sustain full time MH staffing, so the MH practitioners rotated among the practices through the week. Initially the pilot grant paid for staff time, and the CCN learned in their sustainability work that if the MH practitioner services were billed by the primary care practices and/or through the independent billing capacity of the MH practitioner, the project could be sustained. (These practitioners were not part of the services offered by the Local Management Entity [LME], the regional authority for public mental health services.)

Accountable Care Organizations

Patients with chronic illnesses require care from many physicians, thereby making it more challenging to coordinate care in a way that is most beneficial to the patient. By facilitating Community Care Teams, Accountable Care Organizations (ACOs) can focus on the community health system level in addition to the clinic level. The hope is that they can translate potential system wide savings into actual savings that can be reinvested into the community. In addition to payment reform, the use of ACOs is seen as a tool to improve performance.

Ultimately, ACOs may be able to analysis patient experiences across a population and hopefully inform quality improvement strategies. ACOs would achieve this by addressing three, key barriers to improved value for healthcare:

- Tackle a fragmented payment and delivery system by fostering local, organizational accountability for the continuum of patients' care including outcomes, quality and costs
- Focusing provider payments on improved health and outcomes, better quality, and reduced costs
- Support patient choice by providing information on the risks and benefits of treatment options. [vii]

As the North Carolina looks to the future, expansion of integrated services through employed or contracted MH/SU staff as a part of each CCN team would assist primary care practitioners in meeting the expectations for successful management of chronic health conditions. Experience in other integration projects around the country suggests that simply co-locating MH/SU clinicians does not necessarily create collaborative care and that outcomes improve when there is a clearly defined model of care and protocols that guide the collaboration. The NCCCN concept could be expanded to achieve the goals of the

Person-Centered Healthcare Home by adding the key concepts of the IMPACT model, locating these services within the care management hub of the network. Demonstrated first in depression research trials and subsequently in projects that apply the model to populations of all ages and presenting problems common to primary care (e.g., depression, anxiety/PTSD, bipolar disorder, substance use), the key IMPACT components are: [vi]

- Systematic diagnosis and outcomes tracking
- Care manager/behavioral health consultant (BHC)
- Self management goal setting, use of community resources, and activation
- Psychiatric consultant
- Stepped care

The IMPACT model was tested in Duke primary care clinics during the original research trials; a clinical nurse specialist/depression care manager rotated among three different clinic sites using the key components outlined above. Thinking about how this model could be applied within the CCN model, the primary care practice would implement universal screening (e.g., for depression, substance use); the practice MDs, RNs and support staff would be trained in documenting the results of the initial screening and setting up contact with the shared care manager/BHC; a registry would be implemented to track patient status, care manager/BHC contacts, and psychiatric consultation notes; and psychoeducation and patient activation strategies would be employed by both practice staff and the CCN team.

DIAMOND (Depression Improvement Across Minnesota, Offering a New Direction) is using the IMPACT model in a wide range of primary care practices (by March 2010, more than 90 clinics). Patient outcomes are far superior to results seen under the usual care given to patients with depression in primary care. Behind the clinical statistics, the DIAMOND project is applying the concept of a **case rate payment for depression care**. Minnesota health plans are paying a PMPM case rate to participating clinics for a bundle of services—including the care manager and consulting psychiatrist roles—under a single billing code. Note that the payments are being made from the healthcare side of the system, because they believe the cost offsets will benefit the health plans.[vii] Use of the DIAMOND case rate approach would align well with the CCN PMPM payment model, providing additional support for MH/SU capacity on the CCN teams.

Moving towards Person-Centered Healthcare Homes will require thoughtful, deliberate and adaptive leadership at every level, across sectors that currently segment how people are served. Key questions to address include how the delivery of care is organized, how communication among providers occurs, and how care is reimbursed.

For more information visit the National Council's Resource Center for Primary Care and Behavioral Health Collaboration (www.thenationalcouncil.org/resourcecenter) or contact Laura Galbreath, Director of Health Integration and Wellness Promotion at LauraG@thenationalcouncil.org.

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[vii] Jaeckels N. Early DIAMOND adopters offer insights. *Minnesota Physician*. April 2009. http://www.icsi.org/health_care_redesign_/diamond_35953/diamond_media_coverage/

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