

## **Community Health Teams to Support the Patient Centered Medical Home**

The Patient Protection and Affordable Care Act (ACA) required the Secretary of Health and Human Services (HHS) to implement a grant program in 2010 to establish community-based interdisciplinary, inter-professional health teams to provide service and financial (capitated payments) support to primary care practices serving as Patient Centered Medical Homes to individuals with chronic conditions. Grantees are required to be state or state designated entities. Patient-centered medical home are defined in the ACA as a mode of care that includes personal physicians with whole person orientation; coordinated and integrated care; and safe and high quality care through evidence based protocols, health information technology and continuous quality improvement; expanded care access; and payment recognizing the added value of patient-centered care.

### **Who can make up these health teams?**

The specific members of these Community Health Teams are determined by the Secretary of HHS as part of the regulatory process. The ACA indicates that the team members may include “medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physician assistants.”

### **What is required of these health teams under the grants?**

The health teams are required to carry out 10 specific activities, including establishing contractual agreements with primary care physicians and other providers to provide support services; developing plans that integrate preventive services for patients; providing 24-hour care management and support during transitions in care settings; promote effective strategies for treatment planning, monitoring health outcomes and resource use, sharing information, treatment decision support, and organizing care; and other related activities.

### **What constitutes a primary care practice under these grants and what is required of the primary care physicians who contract with these teams?**

A primary care practice is defined as a practice that provides integrated, accessible healthcare 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. Primary care clinicians who contract with these teams would be required to provide care plans for patient participants, provide access to participant health records to the teams, and meet regularly with the care team to ensure integration of care.

### **What impact will these health teams have on internists' practices?**

The health teams are expected to be beneficial in assisting primary care practices to offer care consistent with the Patient Centered Medical Home care model; but particularly helpful to smaller practices that often do not have the staff or financial resources to provide these services on their own. These entities will be able to provide both financial support to develop the infrastructure and capabilities to deliver medical home services, as well as access to actual resources (e.g. qualified staff to offer self care education, 24/7 triage or case management) in an effective and economical manner.

**What is the current status of this grant program?**

As of October 2013, federal funds for this program have not been appropriated. As a result, no grants have been awarded.