



CARE MANAGEMENT FOR MEDICAID ENROLLEES THROUGH COMMUNITY HEALTH TEAMS

MAY 2013

Mary Takach and Jason Buxbaum

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Abstract: The effective management of patients' complex illnesses across providers, settings, and systems places extraordinary demands on primary care providers, especially those that work in resource-limited small or rural practices. Medicaid programs in some states have adopted strategies to build practice capacity to care for high-need Medicaid beneficiaries through the development of local community health teams, with members in fields such as nursing, behavioral health, pharmacy, and social work. Using data from a 2011–2012 review of state Medicaid medical home programs, we identified community health team programs in eight states that provide an array of targeted services, from care coordination to self-management coaching. The programs feature frequent in-person contact with patients and integration with primary care providers and community resources. Early data suggests this model may reduce costs and improve quality while enabling many resource-strained practices to offer a full array of medical home services.

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EXECUTIVE SUMMARY

The use of shared resources can help primary care practices—especially small and medium-sized ones—thrive under new payment models that demand value and accountability. Community health teams, or networks, are one type of shared resource. These locally based care coordination teams are deployed to manage patients' complex illnesses across providers, settings, and systems of care. Comprising multidisciplinary staff from the fields of nursing, behavioral health, pharmacy, and social work, the teams provide crucial support to health care providers working in resource-limited small or medium-sized practices.

Unlike some traditional disease management strategies that focus on specific chronic diseases and rely on remote, telephonic management of patient care with limited success in controlling costs, community health teams emphasize in-person contact with patients and integration with primary care providers and community resources.

This report focuses on eight states—Alabama, Maine, Minnesota, Montana, New York, North Carolina, Oklahoma, and Vermont—that provide funding in support of multidisciplinary community health teams that are shared among multiple practices. Together these programs serve more than 2.1 million patients.

Program features. Each of these state-supported programs features a stakeholder engagement strategy, explicit expectations for community health teams, a defined payment and financing model, and an evaluation strategy. Core characteristics of the eight programs studied include:

- multidisciplinary care teams that coordinate services, promote self-management, and help manage medications;
- sustained, continuous relationships between patients and team staff that are established and cultivated through regular face-to-face contact;
- mechanisms to routinely send and receive information about patients between practices and care teams;

- whole-person care of patients identified as high-risk, high-need, or high-cost;
- a focus on transitions in care, especially between hospital and home;
- team members who routinely connect patients with relevant community-based resources; and
- enhanced reimbursement for primary care practices that collaborate with teams.

A hallmark of the community health team is the early and ongoing engagement of primary care providers throughout program development and implementation. Montana worked closely with the state primary care association to identify and select federally qualified health centers as locations for its teams. In other states, teams or networks are based in a variety of locations, including hospitals, home health agencies, practices, and nonprofit organizations, depending on local community needs.

Expectations for community health teams, which vary greatly across the eight states, are spelled out in contract language or requests for proposals. These expectations encompass:

- team functions and composition
- target population identification
- patient care
- linkages with hospitals
- electronic data tracking
- practice education, including helping primary care practices meet medical home standards and quality improvement standards.

Financing. Payers in the eight states have strived to build models that adequately fund the teams, ensure their accountability, minimize administrative burden, and are financially sustainable. Four of the programs have only a single payer—Medicaid—while four others have the support of multiple payers, such as commercial insurers, Medicare, and Medicaid managed care plans. Although adding payers adds administrative

complexity, there are advantages to multipayer participation, including greater continuity of team services when patients' coverage status changes, and the ability to spread the fixed costs of establishing and operating teams.

Effectiveness. All eight states are, to varying degrees, monitoring the effectiveness of their programs using quality, cost, and patient experience data. To date, data on the effectiveness of community health teams are very limited; with the exception of Community Care of North Carolina, state programs have been in operation for less than four years and generally are in the early stages of implementation.

CARE MANAGEMENT FOR MEDICAID ENROLLEES THROUGH COMMUNITY HEALTH TEAMS

INTRODUCTION

Effectively managing patients' complex illnesses across providers, settings, and systems of care places extraordinary demands on primary care providers and patients. Most primary care providers work in resource-limited small or medium-sized practices, creating the need for strategies to ensure practices have the capacity to meet the needs of complex patients.¹ One such approach—community health teams—is particularly promising. Community health teams, also known as community networks, pods, or hubs, are locally based care coordination teams comprising multidisciplinary staff from varied disciplines, such as nursing, behavioral health, pharmacy, and social work. In partnership with primary care practices, teams connect patients, caregivers, providers, and systems through care coordination, collaborative work, and direct patient engagement.

As of July 2012, eight states—Alabama, Maine, Minnesota, Montana, New York, North Carolina, Oklahoma, and Vermont—provide funding to support multidisciplinary community health teams that are shared among multiple practices. Unlike some traditional disease management strategies that focus on specific chronic diseases and rely on remote, telephonic management of patient care with limited success in controlling costs,² community health teams emphasize in-person contact with patients and integration with primary care providers and community resources. State-supported community health teams are now helping primary care practices function as medical homes for Medicaid enrollees. A medical home is an enhanced model of primary care in which care teams, led by a primary care provider, provide accessible, comprehensive, coordinated, and continuous patient-centered care.

Across these eight states, community health team programs have the following core features:

- multidisciplinary care teams that coordinate services, promote self-management, and help manage medications;
- sustained, continuous relationships between patients and team staff that are established and cultivated through regular face-to-face contact;
- mechanisms to routinely send and receive information about patients between practices and care teams;
- whole-person care of patients identified as high-risk, high-need, or high-cost;
- a focus on transitions in care, especially between hospital and home;
- team members who routinely connect patients with relevant community-based resources; and
- enhanced reimbursement for primary care practices that collaborate with teams.

With the exception of North Carolina, each community health team program launched in or after 2008 (Exhibit 1). In general, state budget deficits—driven in part by rising Medicaid costs—have piqued interest in strategies to strengthening primary care, which is essential for improving quality and lowering costs.³ In addition, the Affordable Care Act encourages states to experiment in this area by offering start-up financing for Medicaid programs to develop community health teams to care for chronically ill Medicaid enrollees through the health homes state plan option and the State Innovation Models Initiative.⁴ Early data from two states—North Carolina and Vermont—suggest that these teams may slow cost growth and improve quality.

EXHIBIT 1. SELECTED COMMUNITY HEALTH TEAM PROGRAMS, JULY 2012

State	Program name	Teams/ Number of staff (FTEs)	Eligible patients^a	Organizations forming or hosting community health teams or networks	Core staff
Alabama	Patient Care Networks of Alabama (launched 2011)	4 teams, 56 staff	174,735	Networks must be based in nonprofit entities; all were newly created to form networks.	Network staff must include a clinical director or medical director, clinical pharmacist, a nurse serving as a chronic care clinical champion, nurses or social workers serving as care managers.
Maine ^b	Patient Centered Medical Home Pilot Community Care Teams (launched 2012)	8 teams, 28 staff	113,367	Current teams are based in a variety of organization types. State's community care team application identifies hospitals/health systems, home health agencies, FQHCs, RHCs, primary care practices, physician-hospital organizations, behavioral health organizations, and social service organizations as possible sites for teams.	Must include a part-time clinical leader. Teams are staffed based on each entity's care management strategy.
Minnesota ^b	Community Care Teams Planning Pilots (launched 2011)	3 teams, 18 staff	Unknown	Current teams are based in large practice and health systems. State identifies community-based nonprofits, for-profit organizations, government entities, clinics, hospitals, community or public health organizations, and institutes of higher education as eligible.	Requires inclusion of team members with expertise in coordination of chronic conditions, health maintenance, and prevention. No specific staffing requirements.
Montana ^c	Health Improvement Program (launched 2009)	14 teams, 38 staff	73,719	Teams are based in FQHCs and tribal health centers.	Nurse care managers or health coaches.
New York ^d	Adirondack Region Medical Home Pilot Pods (launched 2010)	3 teams, 32 staff	94,760	Two pods are based in local hospitals; one is based in a large FQHC.	No specific staffing requirements; structure across pods varies greatly.
North Carolina	Community Care of North Carolina Networks (launched 1998)	14 teams, 704 staff	1,248,874	Most networks are based in urban medical centers, but also include an FQHC and public health department.	All networks include an administrator, medical director, nurses and social workers serving as care managers, pharmacist, and psychiatrist. Additional staffing varies across networks.
Oklahoma	Health Access Networks (launched 2010)	3 teams, 33 staff	61,181	Networks must be nonprofit entities. The state identifies hospitals, public health departments, physicians, RHCs, and FQHCs as possible sites for networks.	No specific staffing requirements.
Vermont	Blueprint for Health Community Health Teams (launched 2008)	15 teams, 75 staff	395,725	Administrative entities for teams are chosen by local planning committees in each hospital service area.	Staffing structures are flexible; most teams include nurse care managers, behavioral health specialist/social worker, health coaches, panel managers, and tobacco cessation counselors.

Notes: FQHCs = Federally Qualified Health Centers; RHCs = Rural Health Centers.

^a Only a subset of individuals are receiving services at any given time; ^b Figures are approximate; ^c Figures as of May 2012; ^d Figures as of March 2012.

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STATES PROVIDING CARE MANAGEMENT FOR MEDICAID ENROLLEES THROUGH COMMUNITY HEALTH TEAMS

We identified eight states that support community health team programs (Exhibit 1). Together, these programs comprise 64 teams serving more than 2.1 million patients.

Each of these state-supported programs features a stakeholder engagement strategy, explicit expectations for community health teams, a defined payment and financing model, and an evaluation strategy. The following sections illustrate common approaches to forming and sustaining community health teams.

Strategies for Gathering Stakeholder Input

A hallmark of the community health team is the early and ongoing engagement of primary care providers throughout program development and implementation—all eight states are doing this. Montana worked closely with the state primary care association to identify and select federally qualified health centers (FQHCs) as locations for its teams. In other states, including Maine and North Carolina, teams or networks are based in a variety of locations, including hospitals, home health agencies, practices, and nonprofit organizations, depending on local community needs. States also have sought stakeholder input in the following ways:

Team development. In Vermont, primary care providers, hospitals, and patients are included in the local workgroups that have designed the community health teams in each of the state's 14 health service areas.⁵

Ongoing collaboration. Alabama Medicaid provides incentive payments to primary care providers who maintain engagement with their local networks.⁶ In Maine, practices participating in the patient-centered medical home pilot are expected to meet 10 core functions as a condition of receiving enhanced payment—one of which is leveraging community resources. Collaboration with the local community care team helps fulfill that requirement.⁷ In Minnesota, certified

health care homes are required to meet standards for expanded community partnerships by showing working relationships with key local organizations at recertification.⁸

Operations oversight. Each Community Care of North Carolina network must have a steering committee composed of representatives from primary care provider offices, hospitals, county health departments, and county social service departments. Other groups—such as specialists, area health education centers, home health providers, and schools—are also often represented. Area primary care providers make up each network's medical management committee.⁹

Functions and Operations of Community Health Teams

Expectations for community health teams vary greatly. In the eight states studied here, these expectations are spelled out in contract language or requests for proposals.

Team functions and composition. Care coordination and management services are core functions of all state community health team programs. In Montana, the community teams are provided with little financing flexibility to hire other staff, therefore there is minimal variation in team functions and composition across the state. In Alabama, Maine, North Carolina, and Vermont, team functions and team composition vary from region to region depending on local needs. Services vary and may include behavioral health, nutrition, and patient coaching services. Although North Carolina requires networks to employ or contract with pharmacists and psychiatrists to support network staff and local primary care providers, the composition of the rest of the network varies by region.¹⁰ In Alabama, contract language includes specific guidance about educational requirements of staff as well as staffing ratios. Each network in Alabama is required to employ only staff with degrees in nursing or social work as care managers. In addition, networks must ensure that each care manager is actively serving no more than 50 patients.¹¹

Target population identification. Because high-risk patients demand such a high proportion of health

care resources, focusing services on this population ensures that enhanced care services pay for themselves.¹² All the programs identified in this brief have established processes and procedures to identify high-risk patients. Montana's Health Improvement Program, for instance, uses predictive modeling software to target the most at-risk 5 percent of eligible Medicaid enrollees. The state also provides a mechanism for primary care providers to manually identify an individual as an appropriate candidate for services.¹³

Patient care. All state programs have set out explicit guidelines for the services that community health teams are expected to deliver to targeted, high-risk patients. Examples include:

- *Individualized care plan development.* Vermont specifies that these plans are to be comprehensive in nature and address clinical, prevention, and health promotion services.¹⁴
- *Health assessments.* Montana specifies that each health improvement program center should administer a standardized health status survey to patients receiving services at intake and on an ongoing basis.¹⁵
- *Helping patients keep their appointments and reducing no-show rates.* In the context of transitions in care, Alabama requires teams to address transportation needs and other potential barriers to care.¹⁶
- *Facilitating opportunities for self-management.* Vermont teams link patients to peer-led Healthier Living Workshops, for diabetes and chronic pain, as well as general health maintenance. Teams also link patients to tobacco cessation services and wellness recovery action planning classes for mental health conditions. These workshops, services, and classes are offered throughout the state.¹⁷
- *Referrals to local resources for social services.* Maine's community care teams are expected to connect patients with services like Meals on Wheels and the YMCA.¹⁸

Linkages. Each of the identified programs focuses on promoting strong links between hospitals and teams. In Alabama, each network must develop a transitional care program in collaboration with hospital discharge planners to coordinate and manage patient transitions between inpatient and outpatient settings. Networks also are expected to embed staff in large hospitals to better manage care transitions between inpatient and outpatient settings.¹⁹

Electronic data tracking. North Carolina has invested in a central health informatics platform that integrates clinical and claims data and logs staff interaction with patients. These data are used in providing care to Medicaid and Medicare patients, in areas implementing the state's Medicare Quality Demonstration 646 Waiver.²⁰ Oklahoma specifies that each Health Access Network must use an electronic registry to track services delivered to Medicaid patients and identify possible gaps in care.²¹

Practice education. In Oklahoma, team members are expected to help primary care practices meet medical home standards developed by the state. Networks support affiliated practices' medical home transformation by providing performance data, spearheading quality initiatives, and enabling 24-hour access.²² In North Carolina, networks are expected to support practices in pursuing quality improvement initiatives and using data to meet community-based goals focused on reducing the incidence of chronic disease.²³

Paying to Support Community Health Teams

Payers in the eight states have taken a variety of approaches to funding community health teams. They have strived to build models that adequately fund teams, ensure accountability, minimize administrative burden, and which are financially sustainable over time.

Of the eight programs we identified, four have only a single payer—Medicaid. Four others have the support of multiple payers, such as commercial insurers, Medicare, and Medicaid managed care plans. Although adding payers adds administrative complexity, there are several advantages of multipayer participation, including:

- facilitating the integration of the team into the patterns of practice of primary care providers; with multipayer support, primary care providers are better able to treat patients alike regardless of their source of insurance coverage;
- promoting continuity of team services when patients' coverage status changes; payers benefit when new beneficiaries enter coverage healthier and better managed;
- spreading the fixed costs of establishing and operating teams among multiple payers, thereby reducing the burden on any one payer; and
- a significant financing boost, if Medicare is participating, which allows practices help in coordinating care for some of the most frail members of the community—the elderly and disabled.

Per-member-per-month fees are the most prevalent method of financing community health teams (see Exhibit 2). In six of the programs, teams receive these monthly payments for each eligible patient in the team's geographic catchment area. Monthly payments are paid on behalf of all the payers' eligible patients—not just the individuals who are actively receiving services.

As detailed in Exhibit 2, five other programs also use per-member-per-month fees to provide ongoing support for their teams. The amounts of the monthly payments vary between states and sometimes within states from payer to payer. Payments range from a low of \$0.30 in Maine for an individual with commercial insurance²⁴ to a high of \$13.72 for an aged, blind, or disabled Medicaid enrollee in North Carolina.²⁵

New York and Vermont have unique payment approaches. In the New York Adirondack Region Medical Home Pilot, participating practices receive enhanced payments from Medicare, Medicaid, and several commercial insurers. Those practices, in turn, contract with one of three teams for shared-support services. The amounts remitted by the practice vary.²⁶ In Vermont, legislation requires state-regulated health insurers to participate in the Blueprint for Health, the

state's broad payment and delivery system transformation initiative.²⁷ This includes making payments to community health teams, as ordered by the state Blueprint Director. The established methodology requires payers to share community health team costs directly, without the use of per-member-per-month fees (Exhibit 2).²⁸ Medicare, however, pays its share using per-member-per-month fees that approximate the agreed-upon percentage of costs. The community health teams use these resources to provide services to all patients, including the uninsured.

Going forward, four of the eight states are looking to use Affordable Care Act funding opportunities to support and expand community health teams. The Centers for Medicare and Medicaid Services (CMS) has approved a North Carolina Medicaid health home state plan for the delivery of health home services to Medicaid enrollees with select chronic conditions. Services include comprehensive care management, care coordination, health promotion, comprehensive transitional care, patient and family support, and referral to community and social support services. In North Carolina, these services are being delivered through the Community Care of North Carolina networks. As indicated in Section 2703 of the Affordable Care Act,²⁹ this approval means the state will receive 90 percent federal financial participation for two years of health home services.³⁰

Alabama has an approved health home state plan amendment with CMS to expand the reach of its Patient Care Networks to serve chronically ill Medicaid enrollees with severe mental illness and substance abuse disorders.³¹ Maine has also an approved health home state plan amendment with CMS to provide health home services to Medicaid enrollees with chronic conditions through community care teams.³² Oklahoma has submitted a proposal to CMS for an Affordable Care Act-funded Duals Demonstration grant. If successful, the Oklahoma model would involve increased federal support for the state's Health Access Networks.³³

EXHIBIT 2. COMMUNITY HEALTH TEAM FUNDING MODELS

State	Payers ^a				Payment strategy (adjusted for)	Additional information
	Medicaid	Medicare	Private	Other		
Alabama	X				\$3.00–\$5.00 per-member-per-month (aged, blind, or disabled status)	Regional pilots Networks eligible for up to \$50,000 for start-up costs
Maine	X	X	X	X	\$0.30–\$3.00 per-member-per-month (payer type)	Regional pilots; statewide expansion under way Medicare participation through CMS MAPCP demonstration Several self-insured employers, including state employees, participate
Minnesota				X	teams share \$420,000 in grant funds	Regional pilots Minnesota Department of Health administered grant process to select teams Teams obtained funding by submitting budgets in response to state's request for proposals
Montana	X				\$3.75 per-member-per-month (none)	Statewide Community health centers receive per-member-per-month payments and host staff that serve patients of area primary care providers, including private providers
New York	X	X	X	X	varies (contracts with area practices)	Payments equivalent to \$7.00 per-member-per-month to practices Practices contract with pods for support services Amounts remitted by practice to pod vary by local arrangements State employees and select self-insured groups participate Medicare participation through MAPCP demonstration
North Carolina	X	X	X	X	\$3.72–\$13.72 per-member-per-month (aged, blind, or disabled status, payer type, region)	Statewide through Medicaid, regional pilots with multiple payers Participation of commercial payer, state employees, Medicare, and self-insured groups in select regions Medicare participation through MAPCP demonstration and 646 quality demonstration in select regions
Oklahoma	X				\$5.00 per-member-per-month (none)	Regional pilots
Vermont	X	X	X		\$350,000 per team of five staff, costs shared directly by payers	Statewide Four payers (including Medicare) each pay 22 percent of community health team costs; one smaller commercial payer pays 11 percent Medicare participation through MAPCP demonstration; Medicare makes per-member-per-month payments to community health teams equivalent to approximately 22 percent of team costs (about \$4.57) Several self-insured employers, including state employees, participate

Note: MAPCP = Multi-Payer Advanced Primary Care Practice.

^a X denotes participation in at least one region.

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Assessing Progress

To varying degrees, states are monitoring the effectiveness of their programs using quality, cost, and patient-experience data. For example, to assess the Patient Care Networks of Alabama, the state is:

- drawing on National Quality Forum–endorsed measures to gauge success in reconciling medications for discharged patients and ensuring the timely transmission of transition records;
- using Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to gauge change in patient experience; and
- tracking changes in inpatient readmissions and emergency department visits.³⁴

The data on the effectiveness of community health teams are very limited; we are not aware of peer-reviewed evaluations to date. With the exception of Community Care of North Carolina, state programs have been in operation for less than four years and generally in early stages of implementation. Of the eight programs identified, two are reporting results. In both, the results apply to models that employ community health teams as one component of a medical home initiative, so it is difficult to isolate the impact of the teams. Nevertheless, the data have encouraged these states and others to invest in community health teams.

Compared with commercial managed care plans, Community Care of North Carolina ranks in the top 10 percent nationally for Healthcare Effectiveness Data and Information Set (HEDIS) measures related to diabetes, asthma, and heart disease.³⁵ Studies have also shown significant cost savings. In accordance with state legislation,³⁶ North Carolina has engaged independent actuaries to measure the program's efficiency. Three separate independent analyses found that Community Care of North Carolina saved Medicaid:

- in 2010, \$382 million (\$25.40 per member per month).
- from 2007 to 2009, \$1.5 billion.
- from 2005 to 2009, \$708 million.³⁷

It should be noted, however, that a 2012 analysis funded by the Agency for Healthcare Research and Quality did not classify these studies as meeting the agency's criteria for rigorous medical home evaluations.³⁸

In Vermont, Onpoint, the contractor that manages the state's multipayer claims database, found that annual expenditures per capita for Blueprint patients with commercial insurance increased 22 percent, from \$4,458 in 2007 to \$5,444 in 2010. For a matched control group, costs increased 25 percent, from \$4,136 in 2007 to \$5,186 in 2010. Information is not yet available for changes in annual expenditures per capita for Medicaid enrollees.³⁹

CONCLUSIONS

The Institute of Medicine's *Crossing the Quality Chasm* called for organizing and financing health care services in ways that make sense to patients and providers and foster coordination of care and collaborative work.⁴⁰ This is the goal of the community health team, and early data indicate the model can succeed. It has made significant gains in sophistication and penetration since North Carolina first began experimenting with the model for its Medicaid patients in the 1990s. The level of interest generated—particularly from commercial insurers open to collaboration with Medicaid—is one sign that this approach has broad appeal.

There are many reasons for the model's appeal. First, although data are limited and have not been vetted through peer review or public process, there are encouraging signs that community health teams may offer advantages in controlling costs. For Montana, for instance, an unsatisfactory experience with costs and health outcomes using commercial disease management has motivated the state to develop a community-based, provider-developed model.

Second, community health teams can help increase capacity in small and medium-sized primary care practices that have faced challenges meeting the intense behavioral health, chronic illness, and social needs of their Medicaid patients. Sharing resources allows small and medium-sized practices to enhance their capacity and fulfill aspirations to participate

in medical home, health home, or accountable care programs.⁴¹

Third, through strong links to community and social services, hospitals, specialists, and other providers, community health teams can meet federal health home criteria to care for chronically ill Medicaid patients. This can provide a ready federal funding stream.

Fourth, from the perspective of the medical practice, multipayer financing can ease the burden of interacting with multiple care coordinators and other health care staff that represent multiple payers. Half the states in this study (Alabama, Minnesota, Montana, and Oklahoma) have focused their initiatives on Medicaid populations. Spreading these initiatives to cover a greater share of a practice's panel could be challenging for commercial insurers without compelling data to demonstrate the return on investment, as well as the capacity to track patients by payer type. In states in which Medicaid, Medicare, and commercial payers finance the community health teams (Maine, New York,

North Carolina, and Vermont), federal evaluation will be important in promoting sustainability and dissemination. Ongoing monitoring and evaluations will be needed as all the programs mature.

Shared resources, such as community health teams, may be valuable for enabling primary care practices—especially small and medium-sized practices—to thrive under new payment models that demand value and accountability. Accordingly, establishing teams is a priority for many states. The Affordable Care Act and multipayer medical home initiatives provide opportunities to launch shared care team models. Millions of Americans—many with complex health care needs—will be gaining insurance coverage through the insurance exchanges and Medicaid expansion. As such, improving the capacity of primary care practices to consistently deliver outstanding care through community health teams is a promising strategy for public and private payers.

ABOUT THIS STUDY

We began our study by conducting an online scan of 2011–2012 medical home activity in all 50 states. Through that process, we flagged states with community health team programs that receive state payments to provide services to Medicaid enrollees and that have the following core features:

- multidisciplinary care teams that coordinate services, promote self-management, and help manage medications;
- regular face-to-face contact between patients and team staff;
- mechanisms to send and receive patient information between practices and care teams;
- whole-person care for high-risk patients;
- a focus on care transitions;
- connections to community-based resources; and
- enhanced reimbursement for primary care practices.

Based on these criteria, we identified community health team programs in eight states. Through state websites, state applications for federal and private programs, and direct communication with program leaders, we collected data on services offered, size and scope, payment strategies, organizational structures, team compositions, and community links. Data were then entered in standardized form into a spreadsheet and then analyzed for common attributes. All data were verified through correspondence with program leaders.

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