Community Health Teams Improve Care Coordination Among Patients with Multiple Chronic Conditions

Patients with multiple chronic conditions (MCCs) -- as well as their families and caregivers -- have a difficult time navigating the healthcare system. In addition to a primary care provider, they may be seeing specialists across several disciplines, including cardiology, neurology, and rheumatology. When care is not carefully coordinated across this entire continuum, these multi-disease patients are especially vulnerable and likely to suffer the adverse effects of fragmented care. Of particular concern are dangerous medication interactions that result from lack of communication between providers. A team approach can play a critical role in managing the care of patients with multiple co-morbidities, as long as the team is high-functioning and patient-centric. One such model is the community health team (CHT).

The challenges of treating patients with co-morbidities

By definition, chronic illnesses are those that are persistent and require management over a patient's lifetime. They include asthma, diabetes, HIV infection, emphysema, chronic obstructive pulmonary disease (COPD), congestive heart failure, hypertension, arthritis, chronic pain, autoimmune disease, and certain forms of cancer. Treatment differs from that of acute illness in that it does not focus on a cure, but on managing symptoms and controlling disease progression to prevent complications and the onset of additional conditions. The picture can become even more complex when a particular combination of conditions has synergistic interactions or when a common medication for one is contraindicated with another.

Multiple co-morbidities are common. Annually, over half of Medicare patients are treated for five or more conditions,[1] and the typical Medicare beneficiary sees seven different doctors a year and some see as many as 16 physicians.[2] The resources consumed by treating multiple chronic conditions are immense, with 66 percent of total national healthcare spending going toward the estimated 27 percent of Americans who have MCCs.[3] Yet when each co-existing condition is treated separately according to clinical practice guidelines that are specific to that disease, the consequences can be devastating, according to a 2005 report published in the *Journal of the American Medical Association.* Researchers at Johns Hopkins University made up a hypothetical elderly woman suffering from five common conditions and then compiled a treatment regimen using federal guidelines – resulting in 12 different medications plus various treatment recommendations (nutrition, exercise, etc.) that conflicted with each other and created the potential for adverse interactions.[4] Patients cannot be expected to self-manage such a regimen – it's clear that there is a need for careful coordination of care across disciplines, with an emphasis on communication.

Community health teams stress collaborative care

Both the Institute of Medicine (IOM) and National Quality Forum (NQF) have endorsed community health teams as an efficient way to eliminate care gaps among certain patient populations, including those with MCCs. The Partnership to Fight Chronic Disease (PFCD) has endorsed CHTs and, in testimony to a Senate health committee, suggested

that barriers to their adoption be removed and reimbursement incentives aligned. The CHT has also been identified by the Department of Health and Human Services (HHS) as a model that has the potential to "improve health outcomes and quality of life while maintaining or decreasing net costs."[5] Currently, eight states (Alabama, Maine, Minnesota, Montana, New York, North Carolina, Oklahoma, and Vermont) are funding CHTs that support small primary care practices, allowing them to function as patient-centered medical homes (PCMH) for Medicaid beneficiaries.[6] Without such support, a small physician practice would be far less capable of closely coordinating care for patients with complex diseases or MCCs. Large, well established medical homes may have their own CHT, which is often led by a nurse case manager who is embedded in a clinic setting.

The strength of the CHT is its focus on communication, both between providers and with the patient and his/her family members. The CHT model emphasizes multidisciplinary care, provider collaboration, patient engagement and self-management, and the inclusion of community and public resources. Because it is a community-based service, it can more effectively engage patients and family caregivers in the care process by providing coaching and education in the home, to ensure patients with MCCs make appropriate behavioral changes. Home visits also create opportunities to assess the need for referrals to social services. When necessary, services provided in the home can be supported with technology, such as teleconferencing or biometric devices that transmit data wirelessly to a care manager. However, unlike disease management strategies that rely mainly on remote monitoring, CHTs emphasize in-person contact with patients and tight integration with specialists and primary care providers. Communication is key.

Team members may include case managers, home health nurses, advanced practice nurses with various specialties, nutritionists, behavioral specialists, psychologists, social workers, and pharmacists. Any or all of these may make home visits, and a nurse case manager will usually forge a personal, sustained relationship with the patient and serve as a single point of contact for primary care providers and specialists. The case manager may also assume a leadership role in the CHT and take responsibility for developing a high-functioning, self-directed team.

The critical need for high-functioning teams

The IOM, in a discussion paper titled *Core Principles & Values of Effective Team-Based Health Care*, makes the point that dividing responsibility among providers does not necessarily ensure coordination of care. The authors state, "The incorporation of multiple perspectives in health care offers the benefit of diverse knowledge and experience; however, in practice, shared responsibility without high-quality teamwork can be fraught with peril. For example, "handoffs," in which one clinician gives over to another the primary responsibility for care of a hospitalized patient, are associated with both avoidable adverse events and "near misses," due in part to inadequacy of communication among clinicians." [7]

Without high-functioning care teams, patients with complex health needs may experience poor outcomes, while the system as a whole must absorb unnecessary waste and higher

costs. Yet most health care professionals have not been trained in team-based care. Across the board, providers have instead received specialized education that emphasizes separate disciplines rather than shared responsibilities. This is starting to change, as the industry looks toward collaborative education, which is built on the principles of cooperation and coordination, and brings team members together to engage in learning from each other.[8] The Veterans Health Administration, which is using a variant of the CHT known as the Patient Aligned Care Team (PACT) has started team-based training programs that are based on an experiential learning model.[9] ProvenHealth Navigator, an advanced medical home designed especially for patients with MCCs, is also training new case management hires in team-based care, first with classroom instruction and then by pairing them with a preceptor for the first six to eight weeks on the job.[10]

A recent issue brief from the Commission for Case Manager Certification recommends that case managers keep up with the changing landscape and become knowledgeable about the new care coordination models.[11]As new models, like CHTs, enter the mainstream, case managers will have to increase team-building and leadership skills, in order to be well suited to the demands of these newly defined roles. Case management will increasingly become not just about the science of decision making, but also the art of engagement, as case managers are called upon to forge strong relationships with providers and patients, based on effective communications.

---

[1] Thorpe KE, Howard DH. The rise in spending among Medicare beneficiaries: The role of chronic disease prevalence and changes in treatment intensity. Health Affairs. 2006;25(5):w378–w388.

[2] Bodenheimer T. Coordinating care—a perilous journey through the health care system. N Engl J Med. Mar 6 2008;358(10):1064-1071.

[3] U.S. Department of Health and Human Services. *Multiple Chronic Conditions: A Strategic Framework.* 2010. http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf

[4] *Journal of the American Medical Association*, news release, Aug. 9, 2005. http://www.globalaging.org/health/us/2005/co.htm

[5] U.S. Department of Health and Human Services. *Multiple Chronic Conditions: A Strategic Framework.* 2010. http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf

[6] The Commonwealth Fund. *Care Management for Medicaid Enrollees Through Community Health Teams.* May 2013. http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2013/May/1690_Takach_care_mgmt_Medicaid_enrollees_community_hlt_teams_520.pdf

[7] Institute of Medicine. *Core Principles & Values of Effective Team-Based Health Care.* October 2012. https://www.nationalahec.org/pdfs/VSRT-Team-Based-Care-Principles-values.pdf

[8] Brian Schuetz, Erin Mann and Wendy Everett. Educating Health Professionals Collaboratively For Team-Based Primary Care. Health Affairs, 29, no.8 (2010):1476-1480. http://content.healthaffairs.org/content/29/8/1476.full.html

[9] Commission for Case Management Certification. From “turf” to “team”--Case management interfaces with team-based care models. (Volume 2, Issue 3)

[10] Commission for Case Management Certification. Team-based chronic care management: Guided Care and ProvenHealth Navigator offer models of interdisciplinary team-based care. (Volume 3, Issue 3)

[11] Commission for Case Management Certification. Care Coordination: Case managers “connect the dots” in new delivery models. (Volume 1, Issue 2)