April 10, 2015

Ipek Demirsoy  
Policy Director, Accountable Care  
Health Policy Commission  
50 Milk Street, 8th Floor  
Boston, MA 02109

Dear Director Demirsoy:

Thank you for the opportunity to submit comments as the Health Policy Commission (HPC) establishes a certification program for Patient-Centered Medical Homes (PCMH). Chapter 224’s PCMH certification program provides a critical opportunity to transform the care delivery system to be more patient-centered, and to provide patients with a robust benchmark assuring them that their practice will focus on their needs. Encouraging PCMHs to meet high standards will simultaneously advance the HPC’s goal of reducing health care costs and improving the quality of patient care. We greatly appreciate the HPC’s willingness to collaborate with stakeholders in the development of the PCMH certification program.

We applaud the HPC for proposing to adopt strong and meaningful standards that build off of the NCQA’s PCMH recognition program and include HPC-specific modifications. States often use a combination of national recognized standards and state-specific criteria for certification. As Massachusetts has long been a leader in advancing state-of-the-art care, we commend the HPC for following this path and designing a unique program that reflects our highest aspirations for the best possible care.

We believe that all Qualified and Best Practice PCMH’s should result in real improvement in how health care is delivered. While we understand that many Massachusetts practices currently certified under the NCQA 2011 standards are not yet ready to move to NCQA’s 2014 recognition, we hope that the HPC encourages these practices to adopt the revised 2014 NCQA standards in the near future. The updated standards address shortcomings in the 2011 standards through a greater emphasis on outcomes measures, increased focus on applying resources to patients with the greatest needs, promoting integration of behavioral health with primary care, and encouraging greater involvement of patients, their families and caregivers.
**Population Health Management**

**Recommendation:** Add “4.E.4 Adopts Shared Decision Making Aids” as a Priority Factor

Shared decision-making is required in the criteria for patient-centered medical homes pursuant to M.G.L. c. 6D, § 14 and thus should be included as a Priority Factor. Shared decision-making improves the informed consent process by ensuring that patients are truly fully informed before making health care decisions. There is also evidence that patients are more likely to choose options that are less costly and less invasive when they are presented with a complete set of options, and when they talk with their health care provider about the options and about their personal preferences. This relates to reducing both underutilization and overutilization as patients favor options that perhaps should be utilized more often (e.g., physical therapy for back pain) and reduce use of services that are overutilized (e.g., MRI for back pain).¹

**Recommendation:** Support the inclusion of the following Priority Factors:

- 2.C.1 The practice assesses the diversity of its population
- 2.C.2 The practice assesses the language needs of its population
- 2.C.3 The practice provides interpretation/bilingual services to meet the language needs of its population
- 2.C.4 The practice provides printed materials in the languages of its population

Cultural and linguistic proficiency is a core component of patient-centered care. Making these criteria Priority Factors ensures that all patient-centered medical homes provide equitable and effective care and communicate with patients, caregivers, and families in a manner responsive to their individual cultural and linguistic needs. We believe access to culturally and linguistically appropriate services helps reduce disparities in the health outcomes of racially and ethnically diverse populations served by medical homes.²

**Recommendation:** Support the inclusion of 4.B.4 (develop individual care plans including self-management plans) as a Priority Factor

Under 4.B.4, the care team and patient/family/caregiver collaborate (at relevant visits) to develop and update an individual care plan that includes a self-management plan. Individualized care plans and self-management plans that reflect the patient’s preferences and goals are necessary for improving healthy behaviors and health outcomes, as well as reducing unnecessary health care utilization. Evidence-based self-management strategies are recognized as central to managing a variety of chronic diseases.³ The Commonwealth Care Alliance (CCA) has succeeded at using a team-based, consumer-directed care approach for developing individual care plans for individuals with complex medical and behavioral health needs, resulting in improved health and better self-management of chronic illness.

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**Recommendation:** Support the inclusion of 4.E.6 (maintaining a community resource list) as a Priority Factor and recommend amendment that the practice also actively coordinates with community resources

Under 4.E.6, a practice must maintain a current resource list on 5 topics/community service areas of importance to the patient population including services offered outside the practice and its affiliates. Given that many patient populations face significant social, economic, and environmental barriers beyond their health concerns, it is critical that practices provide patients with information and access to education and community resources to address these needs. In order to ensure that the resource list is the most useful and that patients are truly utilizing these community resources, we recommend adding a criteria that practices not only provide patients with information and access to educational and community resources but also coordinate with those resources (with patient permission) to exchange patient information, particularly for Best Practice PCMHs. The community e-referral system being established under the state’s SIM grant, for example, provides an opportunity for practices to serve their patients through a broad array of services that contribute to overall health. Addressing these needs will enhance health care quality, lower costs, and improve patient satisfaction.⁴

We further recommend incorporating into this factor or adding another related factor regarding integrating community based programs and supports. This would require the practice to partner with community-based programs and supports (e.g., community organizations, social services, other agencies) and to integrate those services into the physical and behavioral healthcare that is already being provided. The practice would also promote community-based wellness programs and activities that integrate community public health interventions with an emphasis on the social/environmental determinants of health, including patient education and outreach provided by community health workers. Community-based programs can help practices better understand local resources and socio-cultural preferences, gain trust of patients and families, and serve as a referral service for much-needed support. The relationship between medical homes and community organizations not only helps the patient receive more comprehensive care, it also provides an opportunity for practices and community organizations to identify shared goals, uncover gaps, and join forces to achieve improved health care and quality of life for individuals in their communities.⁵

**Recommendation:** Add “support community-level changes in conditions which drive health outcomes” as a new HPC Factor

Population health management should include measuring and analyzing key population-wide health indicators to support community-level care and community-level changes in conditions. We believe it is necessary for a patient-centered medical home to look beyond its patients to address public health needs of the greater population (e.g., the service area or community where the practice is located). Practices should collaborate with external partners to address community-based drivers of poor health. This will ensure that medical practices and public health agencies work together towards improving health at the individual, delivery system, and community levels.⁶ If this factor cannot be included in the initial PCMH Certification Program, we hope that the HPC keeps it under consideration for future revisions of the program.

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**Recommendation:** Add explicit references to the role of community health workers (CHWs) as either stand-alone criteria in the population health management domain, or incorporated into the appropriate existing criteria under other domains.

We recommend that the factors include the following criteria:

- Utilize community health workers to provide care coordination for high-risk patients.
- Utilize community health workers to provide direct wrap around services or linkage to wrap around services for high-risk patients.
- Follow evidence-informed guidelines for the ratio of CHWs and practice-based clinical supervisors for Medicaid and commercial populations.

PCMHs have the opportunity to promote public and community health through strengthening the role of community health workers (CHWs) in connecting people to care resources and promoting overall health. The 2009 DPH study on community health workers highlighted the effectiveness of CHWs in assisting families with obtaining and maintaining health care coverage, engaging in prevention efforts, managing chronic disease, and coordinating health and social services. The report identified several strategies to leverage CHW skills to strengthen access to care, reduce disparities and lower health costs. See [www.mass.gov/dph/communityhealthworkers](http://www.mass.gov/dph/communityhealthworkers).

**PATIENT EXPERIENCE**

**Recommendation:** Support the inclusion of the following Priority Factors:

- **6.C.1** At least annually, the practice conducts a survey (using any instrument) to evaluate patient/family experiences on at least 3 of 4 categories (access, communication, coordination, whole person care/self-management support)
- **6.C.3** At least annually, the practice obtains feedback from patients/families on experiences of vulnerable patient groups
- **6.C.4** At least annually, the practice obtains feedback from patients/families on their experiences with the practice and their care through qualitative means
- **6.E.4** The practice demonstrates continuous quality improvement by achieving improved performance on at least 1 patient experience measure

Measuring the experience of a patient, family member, or caregiver is the necessary step to examine whether high quality, patient-centered care is actually taking place in a practice. Improving patient experience allows a practice to address many aspects of care that matter to patients (e.g., timely access to care), but is also associated with patients being more engaged in their care and willing to follow their providers’ instructions, which leads to improved patient outcomes.\(^7\)

**Recommendation:** Add “Measure and Support Active Patient Engagement” as a new HPC Factor

We recommend adding a new HPC factor that a practice develops and supports patient knowledge, skills, and confidence to engage patients in care and encourage patients to take an active role in managing their health and healthcare. This is key to both improving health outcomes and patient experience and is simultaneously likely to reduce costs associated with adverse care.\(^8\)

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Active patient engagement improves health outcomes: A growing body of research shows that more activated patients are significantly more likely to engage in preventive and healthy behavior and have better health outcomes. Less activated patients are three times as likely to have unmet medical needs and twice as likely to delay medical care, compared with more activated patients. Highly activated patients are also two or more times as likely to prepare questions for a visit to the doctor; to know about treatment guidelines for their condition; and to seek out health information, including comparisons of the quality of health care providers. Chronically ill patients with higher activation levels are more likely than those with lower levels to adhere to treatment; perform regular self-monitoring at home; and obtain regular chronic care, such as foot exams for diabetes. In addition to the documented linkages between activation and healthy behavior, activation has been shown to be associated with better clinical outcomes, such as biometrics that include body mass index, hemoglobin A1c, blood pressure, and cholesterol in the normal range. These findings stem from studies of patients with a range of health conditions and economic backgrounds and were significant even after sociodemographic factors, disease severity, and insurance status were controlled for.

Active patient engagement improves health care experiences: Several studies have documented that more highly activated patients consistently report more positive care experiences, such as higher-quality interpersonal exchanges with physicians, greater fairness, and more out-of-office contact with physicians, as well as fewer problems with care coordination for patients with chronic diseases. When seeing the same physician, patients at higher levels of activation had more positive experiences than patients at lower levels. This suggests that highly activated patients may have the skills and confidence to elicit what they need from their providers.

Active patient engagement lowers health care costs: While cost data is more limited, a recent longitudinal study that specifically examined patient activation and cost of care found that patients engaged in their care cost significantly less than comparable patients who were not engaged. Several studies have reported that after disease severity and demographic characteristics were controlled for, highly activated patients had lower rates of costly use such as hospitalizations and emergency department visits, compared to less activated patients.

Practices can increase engagement, activation and confidence levels: Evaluations of interventions to increase patient activation across various settings and populations have documented improvements in activation scores, concurrent with improvements in health outcomes, including health-related quality of life; clinical indicators; adherence to treatment; improved health-related behavior; increased participation in care; and reduced symptoms, hospital readmissions, overnight hospital stays, and use of the emergency department. Evidence indicates that interventions that tailor support to the individual’s

11 Greene, J., Hibbard, J. H., Sacks, R. et al. (2013). When seeing the same physician, highly activated patients have better care experiences than less activated patients. Health Affairs, 32(7), 1295–1305.
level of activation, and that build skills and confidence, are effective in increasing patient activation.\(^{14}\) Furthermore, multiple intervention studies indicated that patients who start at the lowest activation levels tend to increase the most.

We further recommend that practices should measure patient engagement, activation, and/or confidence data to improve services. Practices should be required to report annually on the percentage of patients who report low, medium, and high patient engagement/activation/confidence scores so that such scores can be tracked over time. Research indicates that patient activation can and should be measured as an intermediate outcome of care that is linked to improved outcomes.\(^{15}\) In a study of adult patients from 15 primary care practices that used an internet-based assessment and reporting tool to measure patient confidence, primary care physicians used simple process changes and behavioral modifying techniques to dramatically improve health confidence and quality for their patients.\(^{16}\) Routinely measuring patient activation and performance and feeding that data back to the practice is necessary to ensure that practices make changes based on the data and improve patterns of performance.\(^{17}\) Measuring activation can improve and individualize patient care, and in turn strengthen the patient’s role in improving outcomes. Measuring patient activation and confidence also allows practices to efficiently enhance their ability to identify the attributes and impediments for patient engagement. Measuring activation further allows medical homes may make efficient use of their resources by providing more support to patients who have a heavy disease burden and limited self-management skills, and less support to patients with greater skills.

Existing measures that quantify patient engagement and activation include the Patient Activation Measure and Patient Confidence Index.

- The “Patient Activation Measure” is a validated survey that scores the degree to which someone sees himself or herself as a manager of his or her health and care. Interventions that tailor support to the individual’s level of activation, and that build skills and confidence, are effective in increasing patient activation.\(^{18}\)
- Health confidence measures patients’ level of knowledge, skills, and self-efficacy about taking an active role in their health care and managing their health conditions. Its assessment can result in immediate provider action – leading directly to improved patient engagement. If a patient’s health confidence is low, motivational interviewing can be used to help the patient to reflect on personal strengths, identify behavioral goals and develop a support plan.\(^{19}\)

Both measures are assessed through a series of answers to questions that gauges a person’s self-concept as a manager of his or her health and health care. These measures have been proved to be reliable and valid across different languages, cultures, demographic groups, and health statuses.


**RESOURCE STEWARDSHIP**

**Recommendation**: Support the inclusion of 4.A.2 (care management processes) as a Priority Factor

Factor 4.A.2 requires that the practice establish a systematic process and criteria for patients who may benefit from care management, and includes consideration of high cost/high utilization. Care management for complex and high risk patients is required in the criteria of a patient-centered medical home under M.G.L. c. 6D, § 14. Identifying patients with specific conditions, including at-risk, high-risk or complex care needs and conditions, is a necessary first step for targeting care management at the costliest and neediest patients. By utilizing a system that identifies conditions or risk factors in a practice-based population, providers can use this information to identify target areas for population health management and preventive measures. Complex and high risk patients are two populations that need care management the most, and attention to these populations will result in the best potential for costs savings and improved health outcomes. For example, recent research shows that high risk patients who participated in PCMHs had significantly fewer hospital admissions than patients not treated in medical homes, saving 8-11% on total medical costs.

**BEHAVIORAL HEALTH INTEGRATION**

We support the HPC’s modifications to the 2011 and 2014 NCQA standards to place greater emphasis on behavioral health integration. In order to ensure patient access to health care services across the care continuum, PCMHs should integrate behavioral health services with primary care services to the greatest extent feasible, including through behavioral health screenings, coordination with behavioral health providers and co-location of services. We hope that practices additionally provide behavioral health services that include recovery coaching and peer supports and services provided by peer support workers, certified peer specialists and licensed alcohol and drug counselors. With the One Care program, co-located services have resulted in increased recognition of behavioral health needs previously undetected by primary care physicians. This allows for a broader reach to underserved populations that are less likely to seek care from mental health specialists and improves access to services.

PCMH certification will function like the Health Connector’s “Seal of Approval,” providing assurance that the practice provides the highest quality of coordinated care. While we recognize that PCMH certification is voluntary and thus overly burdensome criteria may discourage practices from applying for certification, we also recognize that minimal standards will not incentivize practices to reach higher standards and truly strive towards a more coordinated, patient-centered care system. We therefore commend the HPC for proposing strong and meaningful standards based on the revised 2014 NCQA standards, which support sustainability of the PCMH model, moving primary care practices towards improved outcomes, enhanced patient experience and reduced costs of care.

We appreciate the opportunity to share our thoughts with you on this complex but critical subject. As the HPC continues to work on this topic, we remain eager to be of assistance.

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Sincerely,

Alyssa Vangeli
Senior Health Policy Manager
Health Care For All

Brian Rosman
Research Director
Health Care For All

Rebekah Gewirtz
Executive Director
MA Public Health Association

cc: David Seltz, Executive Director
    Carole Allen, Chair of the Care Delivery and Payment System Transformation Committee