

Medical Advisory Committee for the Elimination of Tuberculosis
c/o Cynthia Tschampl, 35 Bedford Ct, Concord, MA 01742

April 4, 2014

Stuart Altman, PhD
Chair, Health Policy Commission
Two Boylston Street, 6th Floor
Boston, MA 02116

Re: Request for Comments on the Patient Centered Medical Home Certification Criteria

Dear Prof. Altman:

On behalf of the Medical Advisory Committee for the Elimination of Tuberculosis (MACET), a panel of volunteer tuberculosis (TB) experts advising the Massachusetts Department of Public Health (DPH) on matters of TB prevention and control, we write in response to the request for comments on the proposed Patient Centered Medical Home Certification (PCMH) Criteria.

Much of the PCMH model is analogous to best practices for the management of potentially epidemic infectious diseases such as tuberculosis. Therefore, we urge the Commonwealth to seize this opportunity to improve individual and public health simultaneously. We propose one criterion refinement and two new criteria among three separate domains.

First, under the **Population Health Management** domain, advanced level, we recommend that the criteria “Use care reminders for preventive/follow-up care” include explicit reference to TB for high-risk groups. For example, refugees and recent immigrants should be flagged as at high-risk for TB and a reminder sent to the care team for further screening and LTBI treatment (if positive). Such reminders can easily be built into EHR systems, whether from a vendor or internally created. For example, the Beth Israel Deaconess Medical Center added a reminder flag for Hepatitis C (HCV) screening for persons born within the “Baby Boomer” cohort years. Once testing was ordered, if the antibody was positive, a series of automated steps occurred including viral load testing and immediate referral to a nurse specialist to handle patient questions and to help shepherd the patient into an appointment with an HCV specialist. Within the first month of implementation, the screening results exceeded the Centers for Disease Control and Prevention’s (CDC) annual goals for an institution, and new diagnosis rates were identical to CDC predictions. All patients were entered in to care.

Second, under the **Data Systems** domain, advanced level, we recommend the Commonwealth add an “Automatic reports for reportable diseases” criterion. This would require the PCMH’s data system to generate and send automatic reports for all reportable diseases to DPH, including active TB and LTBI. This would decrease errors, increase

clinician efficiency, and improve individual and public health outcomes. For example, food poisoning outbreaks from deadly bacteria such as *Listeria* occur with some frequency in all states, including Massachusetts. In such an outbreak, the sooner reports and bacterial genetic fingerprinting are sent to DPH, the sooner DPH can intervene and save lives by finding and neutralizing its source. Automatic reporting will improve our state's health. It will also help PCMH's meet their Meaningful Use (MU) requirement to show reporting for at least one disease.

Finally, under the **Care Coordination domain**, advanced level, we recommend the addition of a "Designated infectious disease liaison" criterion. The liaison will work with DPH and any relevant community entity to optimize care for patients with potentially epidemic and reportable infectious diseases, such as tuberculosis. These activities may include care coordination, clinician education and training, answering medical questions, and referral for subspecialty consultations where appropriate.

The Lynn Community Health Center (LCHC) runs a pilot program like this for the treatment of tuberculosis infection (LTBI). Although relatively rare in the United States, tuberculosis remains the second deadliest microbe in the world after HIV, and one third of all people in the world are living with LTBI. LTBI is highly prevalent within the US in specific populations. Therefore, targeted screening and treatment of LTBI is a cost-effective, preventive best practice endorsed by the CDC and the WHO. It is a keystone in our nation's TB elimination plan.

LCHC, taking advantage of its PCMH model, is collaborating with DPH and has expanded their clinical and operational capacity to meet their patients' TB screening, testing, diagnostic and treatment needs within their facility. They expanded TB prevention services, beginning with the populations for which DPH has additional resources available to support the initiative (i.e. HIV+ and refugees). In less than a year, they have dramatically increased the number of individuals whose TB infections are being treated at the health center, and are beginning to see their success in treatment completion rates that are high (approximately 90%, whereas the national average is 47%). Such progress has occurred through ongoing provider training through the DPH and frequent consultation with DPH tuberculosis experts. With proper support, the Commonwealth can replicate this model, not just for tuberculosis care, but for other serious contagious diseases such as MRSA, HIV and other STDs. Robust support for treatment and follow-up of such diseases saves lives; prevents broader contagion, morbidity, and mortality; and has the potential to be cost-saving.

Furthermore, opening regular lines of communication with DPH can expand clinical support for difficult diagnoses or undiagnosed chronic conditions. New Jersey, for example, connected 23 community health centers with the state TB clinics. This resulted in cross collaboration on individual cases, and with the TB experts' help, identified previously undiagnosed, poorly-controlled diabetes, hypertension, substance abuse, and other chronic and acute diseases. This clearly improved patient care, and in many cases, averted significant cost to the health care system.

Together these suggestions have the potential to empower providers to find additional value-based primary care opportunities for individual patients while strengthen system-wide efforts to protect the public's health. They will also contribute to better efficiency within the system as a whole by further linking (and reducing duplication among) the public health department and primary care efforts.

We thank the HPC for the opportunity to offer recommendations. Please contact Cynthia Tschampl (tschampl@yahoo.com, 617-875-8485) or Hanna Haptu (hhaptu@lchc.org) for questions, clarifications, or further documentation.

Sincerely,

Cynthia Tschampl, PhD(c) & Hanna Haptu, MD
Co-Chairs, Systems' Integration Subcommittee, MACET